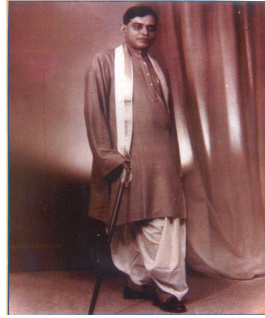


# District Health Action Plan 2009-2010



**District Health Society  
BEGUSARAI**

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## **Foreword**

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

This District Health Action Plan (DHAP) is one of the key instruments to achieve NRHM goals. This plan is based on health needs of the district.

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

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

I need to congratulate the department of Health and Family Welfare and State Health Society of Bihar for their dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants (NHSRC/ PHRN) to facilitate our DHS regarding preparation the DHAP. The proposed location of HSCs, PHCs and its service area reorganized with the consent of ANM, AWW, male health worker and participation of community has finalized in the block level meeting.

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

**(Jitendra Srivastava, IAS)**  
**DM, BEGUSARAI**

## **About the Profile**

Under the National Rural Health Mission this District Health Action Plan of BEGUSARAI district has been prepared. From this, situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block. I am grateful to the state level consultants (NHSRC/PHRN) and District Level consultants (DPM, DAM and District M&E Officer) ACO, MOICs, Block Health Managers and ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of BEGUSARAI District.

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

**Dr. \_\_\_\_\_**  
ACMO  
BEGUSARAI

**Dr. Anjani Kr. Gupta**  
Civil Surgeon  
BEGUSARAI

# Chapter-1

## Introduction

### 1.1 Background

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

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

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

Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state level to identify the gaps and constraints to improve services in regard to access, demand and quality of health care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principal instrument for planning, implementation and monitoring, formulated through a participatory and bottom up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of

good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

#### *Stakeholders in Process*

- ❑ *Members of State and District Health Missions*
- ❑ *District and Block level programme managers, Medical Officers.*
- ❑ *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- ❑ *Members of NGOs and civil society groups*
- ❑ *Support Organisation – PHRN and NHSRC*

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

## **1.2 Objectives of the Process**

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

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

### **1.3 Process of Plan Development**

#### **1.3.1 Preliminary Phase**

The preliminary stage of the planning comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were

finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were compiled to perform a situational analysis.

### **1.3.2 Main Phase – Horizontal Integration of Vertical Programmes**

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

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?
2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?
3. What structural features of the health care system as it has evolved affect its utilization and the effectiveness?

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

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

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

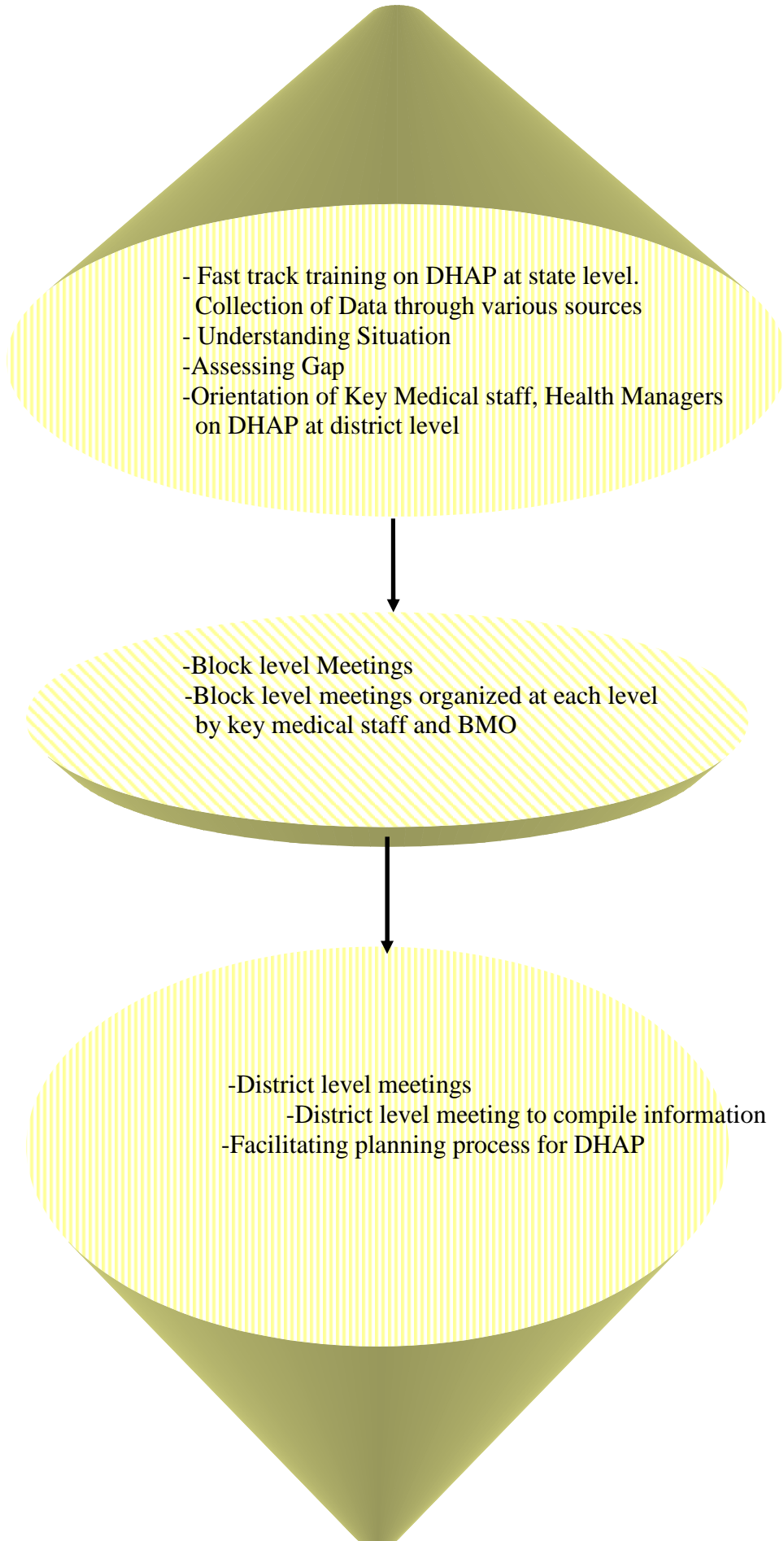
This Integrated Health Action Plan document of BEGUSARAI district has been prepared on the said context.

### **1.3.3 Preparation of DHAP**

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

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

# District Health Action Plan Planning Process





## POPULATION

Year	Male	Female	Total	Decadal Growth (in %)	Area per Sq.Km.	Density of Population per sq. km.
1991	956310	858463	1814773	24.61	1918	946
2001	1226057	1116932	2342989	29.11	1918	1222

Source: Census, 1991, 2001

**Land** : In accordance with the reports compiled by the District Agriculture Office, Begusarai, the principal characteristics of the land use pattern of the Begusarai district for the year 2002-2003 is as follows:

Total area	:	1, 87,967.5 Hectares
Total irrigated land:		74,225.57 Hectares
Forest area	:	Nil
Orch. etc. area	:	5000 Hectares
Kharif Paddy	:	22000 Hectares
Garma Paddy	:	10000 Hectares
Wheat	:	61000 Hectares
Irrigated Area	:	(1) Permanent: 6384.29 Hectares
Garama & Rabi maize:		50000 Hectares.
		(2) Seasonal: 4866.37 Hectares
		Kharif maize: 63000 Hectares

# *Begusarai : Geography and Geology*

## **A Note on the Geography and Geology of Begusarai**

### **Background**

The district Begusarai, an important district in the state of Bihar lies on the northern bank of river Ganga. Earlier it was a part of the greater Munger district. Begusarai district was carved out of it as a separate district on 2<sup>nd</sup> October 1972 (A handnote on Begusarai district census-1991). Now it is a part of the Munger commissionerate. Geographically, lying between latitudes 25°15'N & 25°14'N and longitudes 85°04'E & 85°05'E, it covers an area of 1918km<sup>2</sup>. In the north, it shares its boundaries with Samastipur district; in the east and NE it is surrounded by Khagaria district. In the southeastern part lies the Munger district. In the south is Lakhisarai and in the southwestern side, along the banks of River Ganga, it shares its boundaries with Patna district. It is situated in a part of Middle Gangetic plains, locally known as North Bihar plains. Administratively it is divided into five subdivisions- Begusarai, Teghara, Balia, Manjhaul and Bakhri and eighteen blocks namely Begusarai, Matihani, Teghara, Samho, Bachhwara, Barauni, Bhagwanpur, Balia, Sahibpur Kamal, CheriaBariarpur, Khudabandpur, Bakhari, Mansurchak, Birpur, Dandari, Nawkothi, Garhpura, and Chhaurahi. The average population density is app. 900 persons per square kms. The economy is mainly agriculture based and the major crops are wheat, maize, chilli, sugarcane etc.



*: The views presented in this article belongs to the author and in no case represent the views of the organization to which he belongs or the website which hosts the article.*

Two big industries mark the skyline of the district i.e. Thermal power station and Petro-Chemicals factory and Oil refinery complex at Barauni. Earlier Barauni Fertilizer was also an important industry which is now non functional. Rajendra Bridge across Ganges at Barauni forms an important link way connecting north and south Bihar, Resting spot

for migratory birds in a wetland known as Kanwar tal and the Ghats of Ganga at Simaria possessing religious importance, exists as a potential tourist spots.

#### Climate

Being a part of Gangetic plain of Indian subcontinent, the district experiences three climatic seasons – summer from late March to mid time rainy season from mid June to October and the winter season from November to February. The month of February & March fall in the transitional season from winter to summer described as spring or “Basant”. Similarly the months of September & October falls in the transitional season from rainy season to winter season described as “Shishir”.

#### **Temperature Data (1993) Source: Meteorological Dept., Patna**

Month	Mean monthly (°C)	Mean min (°C)	Mean max (°C)
January	6	6	17.5
February	20	8	20
March	25	13	28
April	33	16	30
May	35	19	34
June	30	22	31
July	28	20	29
August	26	18	27.5
September	25	15	22
October	14	10	21
November	10	9	17
December	7	7	15

During summer due to high temperature this becomes an area of low pressure. During this period Bay of Bengal, due to its geographical characteristics, serves as homeland for cyclones. Being on area of low presser, the plains of Begusarai and associated areas attract these cyclonic winds. This leads to the dust storms. These dry, hot, dusty storms are locally termed as ‘Loo’. These are prevalent in the month of May-June.

The rainfall is average in this area. The average annual rainfall in this belt of Ganga- Burhi Gandak is 1384mm of which 83% falls between Mid June and & Mid-October. Monsoon normally starts in June and lasts till October. The early monsoon currents, channeled to he NW are the principal source of rainfall of the region. 17 % of pre monsoonal rains, which is spread in the different months of the year (specially in the months of November- December-January) have been explained as due to Norwester affect and rest during monsoons

due to Himalayan affect. Heavy rains, supplemented by physiographic/geomorphic features lead to heavy flood.

The chilling winter starts in mid-october and continues till initial periods of March. Most part of the winter is dry except some sporadic rains as mentioned above.

### **Physiography and Relief**

North Ganga plain is a major physiographic unit of the Indian landmass. It extends from the Himalayan terrain in the north to the river Ganga in the south covering about 56980 km<sup>2</sup>. a roughly quadrilateral shape. Generally recognized as "a water-surplus area", this quadrilateral region is bounded by a northern piedmont belt where water oozes to the surface, followed by a broad belt of swampy lands, depressions and lakes, and finally an aggregation of alluvial fans as all these northern streams bend to form confluence points with the Ganga (Singh & Kumar, 1970).Hence, the surface is characterized by palaeo levees, swamps or flood basins locally called "Chaur", relict palaeo channels aggraded in varying degrees, meander belts, ox-bow lakes and cut-of loops (Ahmad,1971). Its fluvial geomorphology is dominated from west to east by the Ghagra-Gandak Interfluves, the Gandak-Kosi Interfluves and the western Kosi Fan Belt. Some of these rivers frequently change their channels. Their channels are called by different names in different parts of their courses. According to a study in 1976 on Wetlands in Bihar, by Govt. of Bihar, natural wetlands of more than 100 ha each covered about 46828 ha (Directory of Wetlands, Govt. of Bihar)

The district of Begusarai lies in the middle part of this great plain known as mid Ganga plain. In general, it is a low-lying flat terrain (MSL45m-32m) having a southerly to southeasterly slope. This factor governs the flow of streams. Geomorphologically it is a part of the Gandak- Kosi inerfluve (please refer subheading Geomorphology given below). The southern part of the district, except those of low-lying flood plains of Ganga, appears to be an elevated landmass when compared to the adjoining districts of Khagaria and Samastipur. Hence, being a safer destination amidst the flood drained region, it supports the human activities in a better way.

The district Begusarai is divided into three flood plains namely

- i. Kereha-Old Bhagmati flood plains,
- ii. Burhi Gandhak Flood plain and
- iii. Ganga Flood plain

The first two flood plains of the district are very low lying areaS and are prone to the flood. The floods owe their origin to the complex interplay of fluvial geomorphic elements in

the upstream sections of the Kosi, Bagmati-Kareh-Budhi Gandak and related rivers. These two flood plains converge in the southeastern part of the district, which is lowland. The streams flowing in the region show a shifting tendency. In the course of their shifting, the rivers leave behind their scars of their previous channels. Thus due to shifting nature of streams and physiographic characteristic, this part is full of wetlands, backswamps and oxbow lakes. However, in the southern part, the flood plains of Ganga are least prone to flodd. Interestingly the Railway track passing through the district marks a prominent divider line for Ganga flood plain and Kereha- old Bhagmati flood plains & Burhi Gandhak flood plain. The Flood plains of Burhi Gandak and Kareha are marked by the presence of paleo levees, oxbow lakes, paleochannels, relict streams and chaur viz Kaulachaur and Bhagwanpur chaur. These chaur serve as excellent fertile agricultural lands duing summer and are submerged during rains. Also the areas around these chaur face the problem of submergence for around three-four months a year. Kavar lake, a large fresh water lake which is basically a huge wetland is present as an important physiographic feature of this part.

In the Ganga flood plain, which is approximately 50-55km long and 5-6kms wide, in the southern part of the district, except those low lying areas of “Taals and chaur”, the typical fluvial characteristics of North Bihar rivers are not visible, which are prominent in the north of Railway track. This is the least flood prone area of the district, which gets drowned only in cases of exceptional floods in Ganga and Burhi Gandak. This relatively upland area appears to be the levee of river Ganga.

### **Geomorphic Setup**

The mid-Ganga plains may be broadly divided into a number of major geomorphic units(Fig-).The northernmost part is the region of the Siwalik ranges and is followed by the piedmont fan surface fringing the foothills, 10-30km wide, built up by coalescing fan surfaces of major Himalayan rivers. This surface includes both the bhabar and tarai land. Built upon these surfaces are fluvial regimes classified into megafans (f) and interfluves, characterised by upland terraces (T2), river valley terraces (T1) and active flood plain surfaces (T0). The entire district of Begusarai falls in this T0 surface. The southern and northern banks of the Ganga and around Begusarai are characterised by tributaries that flow parallel to the Ganga for long distances over the floodplain itself, before it joins at deferred junctions. This belt is named as the Gangayazoo belt (Sinha and Friend,1994).The Gandak-Kosi interfan has been divided into an upper area of gently converging rivers that flow SE , Perpendicular to the mountain front and a downstream area (the

district of Begusarai and neighbouring area) where the more sinuous channels of the Burhi Gandak, Bagmati, Kamla and Balan systems flow gently to the SE.

### Drainage

The district is drained by a no of rivers viz. Ganga, Burhi Gandak, Bagmati and Balan rivers and in addition, small rivulets, dhars, nalas which are originated locally and preserve rain water, mark the landscape. Among the rivers, Ganga, Burhi Gandak, Kosi, Kareha and Bagmati are perennial, whereas Channa River, Bainti nadi, Kachna nadi, Monrya nadi and Malti nadi are seasonal.

All the types of streams i.e. the mountain fed, foothill fed, plain fed and mixed fed, drains the district. Ganga is a mountain fed river while Bagmati is a foothill fed river. Burhi Gandak, Baya, Balan, Baintia, Chanha etc are originated in the plains and present examples of plain fed rivers. The small rivulets serve as tributaries to the streams of higher order. These rivulets are often dry lowlands during summer and flooded during rainy season.

In general, the drainage pattern of the rivers of this region forms a part of the greater Gangetic Plain, which is characterized as dendritic drainage pattern. However, locally they exhibit their typical characteristics. The Ganga River here shows Yazoo pattern of drainage and the area is known a Ganga Yazoo belt. Yazoo pattern of drainage is defined by the streams, which travel in a parallel fashion before confluence. Burhi Gandak, Bagmati, Kareha and Balan, Baintia, shows very high sinuosity and are typically meandering rivers.

River Ganga enters into the southwest part draining the Chamtha block in the district. This river along with its flood plains, “Chauras” and “Tals” determines the boundary of the district in the southern part.

The Burhi Gandak, the 2<sup>nd</sup> most important river, also known as Sirkahana in its upper reaches, enters the district near Parihara about 10 km upstream of its confluence with the Balan River. It forms the boundary with Samastipur district in Khodawandpur and Cheriabariyarpur blocks. This is a river showing very high sinuosity and has characteristically low silt content than other Himalayan rivers. After traversing a distance of approximately 100 Km. it drains in Ganga near Khagaria. The river cause periodic floods in the western part of the district.

River Balan enters the district in the Bachhwara block. After taking a course of app 30kms km. it drains into Burhi Gandak River 5 km west of Manjhaul. This is also a highly sinuous stream

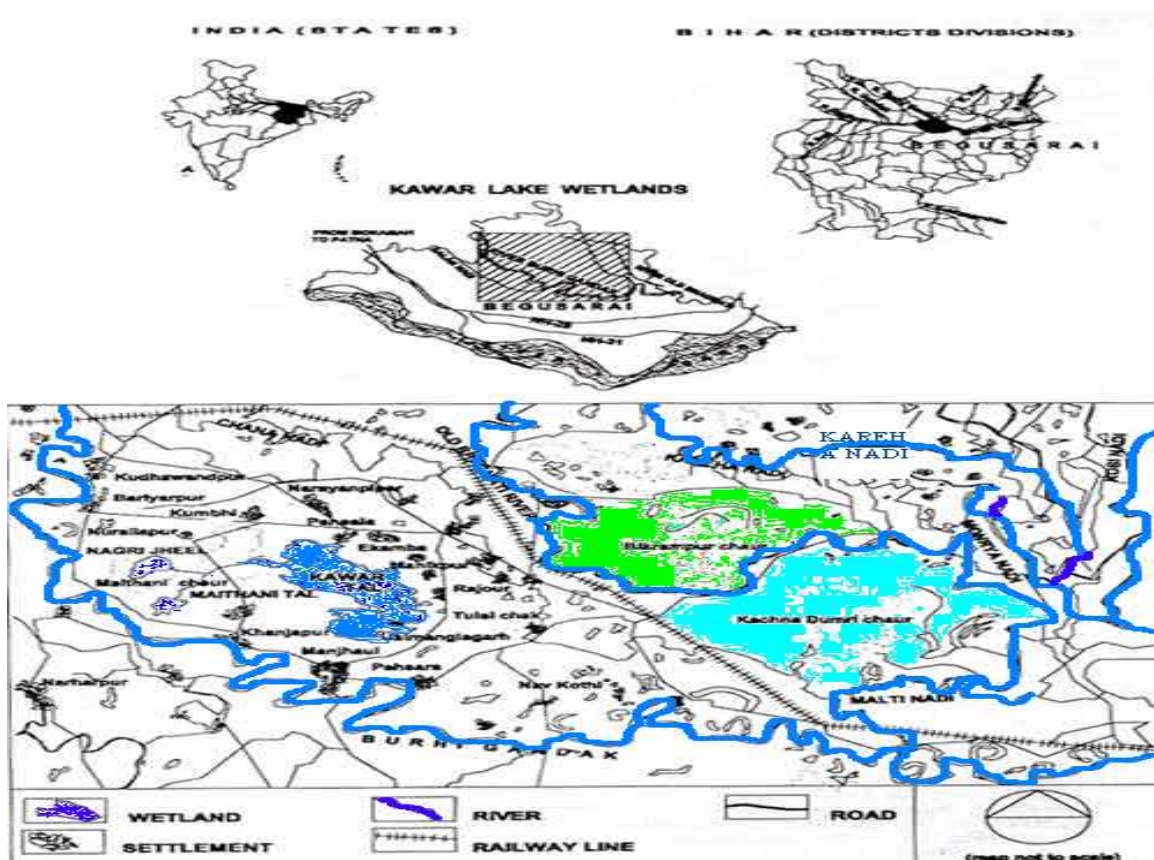
Bagmati – A very Juvenile stream of North Bihar plains, drains only the northeastern corner of district. It enters into the district near Bakhri and is well known for its unstable nature and spill

channels. After traversing the low-lying valley areas, it meets the Kosi near Sankosh outside the territories of the district. It is responsible for floods in the northern part of the district.

Baintia River is a plain fed stream originated in the adjoining district of Samastipur and enters in Bhagwanpur block of the district. Upstreams, in the Samastipur district, it is known as Jamwari Nadi. This drains into Burhi Gandak after joining the Balan River. It is also a stream having water round the year. Baya Nadi drains the district Teghra, Bachhwara and Barauni block. It merges with river Ganga at Roopnagar near Barauni fertilizer factory. This is a stream which does not show any sinuosity in the Begusarai district and is a perennial stream. In the mid of the Burhi Gandak flood plain lies a vast fresh water lake known as Kawer Tal, which is basically a wetland formed by shifting of river Burhi Gandak. Kawartal gets its water either due to rains or due to near-by overflowing rivers such as Burhi Gandak, Bagmati

### Kawar Tal

Kawar Tal is one of the examples of excellent wetlands, which are found in the flood plains, and is the largest freshwater lake in Northern Bihar. It lies between Burhi Gandak, Old Bhagmati and Kareh rivers. The lake is formed by the meandering action of Gandak River and is now a residual ox-bow lake, one of the thousands in Bihar and Uttar Pradesh flood plains. In years of high rainfall, vast areas of these two states get flooded. This causes coalescing of wetlands and forms one huge expanse of water. During these times the wetlands of the Kawartal region may cover hundreds of sq. kms. The floods leave behind deposits of sand, silt and clay in layers of varying thickness. In years of average rainfall, Kawartal gets connected with Burhi Gandak (a tributary of River Ganga) and with nearby Nagri Jheel and Bikrampur chaur, unite to form a lake of about 7400 ha. By late summer however, the water is confined to the deeper depressions and only about 300-400 ha of Kawartal remains flooded and cut off from the adjacent floodplains (chairs). As the water level recedes, over 2800 ha of the exposed mudflats are converted into rice (paddy) fields. In 1951, a drainage channel was excavated to expose additional areas for agricultural purposes, but the channel silted up in few years, and the lake reverted to its former condition. In recent years, further siltation of the overflow channel has resulted in slight fluctuation in water levels throughout the lake. There is a permanent island (Jaimangalgarh) of about 130ha in the Southeast corner of the lake. The Kawar and its adjoining lakes are probably oxbow lakes fed by highly meandering river, the Burhi Gandak that once flowed through these areas. As this lake area remains wet and submerged for a longer period, it has developed specially adapted wetland vegetation and organisms. The emergent, submerged and floating plants present some unique type or representative flora and fauna particularly of this lake and its adjoining areas. Hence, it is a spectacular wetland habitat and perhaps one of the largest freshwater inland wetlands in the country.



## DRAINAGE AROUND KAWAR TAL

(From Kumar, Sanjeev, 2004)

### Drainage Characteristics of the Gandak Kosi interfan

The district of Begusarai lies in the southern part of the Gandak Kosi interfan area. The region between the Gandak and the Kosi megafans is a vast plain with a south-easterly slope reflected in the drainage directions. The major interfan rivers are the foot-hill-fed and the plain-fed Burhi Gandak, Bagmati, Kamla and Balan. These rivers determine the architecture of the flood plains. However, numerous interconnected minor channels participate in carving out the features of the plains by reworking and redistributing the sediments deposited by the major tributaries of the river. All the channels constitute low-lying areas and remain waterlogged during the monsoon. Channel avulsion and overbank flooding are the two most important factors controlling the floodplain development of the region (Sinha,1996). Avulsion is the sudden diversion of a part or whole of a river channel to a new course at a lower level on the flood plain. There is also a paucity of cut-offs, consistent with their moderate sinuosities.

The Burhi-Gandak river system has developed along the palaeochannel of the Gandak (Mahadevan 2002). Its channel has, however, become much smaller and highly sinuous and provides an example of river "metamorphosis". The river has however, been changing its course locally through avulsion, leaving extensive

floodplain scars such as sinuous abandoned channels, "neck cut-offs" and ox-bow lakes, unmatched in their scale and abundance by any other part of the North Bihar Plains. Such cut-offs have resulted in reduction of channel lengths and sinuosity. Distinct topographic levels similar to what has been described earlier in the Kosi channel characterize the Burhi-Gandak floodplains near Muzaffarpur. The development of the different levels is attributed to local fluctuations in discharge and sediment load resulting in downcutting by the channel and lateral migration.

The Bagmati avulsive system is characterized by abandoned channels to the east of the present mid-reaches of the river. These are "underfit" channels and are activated and recaptured from time to time (Sinha 1996). A westward shift of the river is, however, still evident. The Bagmati system encompasses what are termed "chute cut-offs", that may be a reflection of the "active migration where loop development and floodplain erodability during brief overbank flows are such as to allow the creation of new short-circulating channels". The Kamla and Balan systems show less evidences of avulsion. The westward shift of the Balan river is linked with the growth of the Kosi megafan. The Kamla river, however, is outside the influence of the growth of the Kosi megafan.

The transformation of channels, their metamorphosis, and the development of underfit channels, according to Sinha (1996), are both not due to climatic changes, as often assumed, but due to channel avulsion and channel-floodplain relationships. The development of "cut-offs" in the river systems is not so sudden an event and has taken place over a period of time, which, therefore, opens up scope to investigate the phenomenon more thoroughly. Some of the cutoffs have also evolved into ox-bow lakes. Other features of interest in understanding the evolution of the floodplains include features developing from lateral accretion, such as point bars and bedding structures and features resulting from vertical accretion as natural levees, crevasse splays, backswamps, wetlands and lakes.

### **Controls in Shifting Courses**

The rivers of this area exhibit a migrating tendency. The migration of rivers has to be viewed in the context of the fluvial evolution of the Indo-Gangetic plains. Brubank et al. (1996 in Mahadevan, 2002) address this question. A plausible model that helps to view the course changes is that the Himalayan provenance for the foreland rivers changed from a period tectonically dominated by thrust-loading and uplift in the Miocene to an erosionally dominated climatic-unloading, causing isostatic uplift. This concept is supported by the onset of suggested monsoonic climate due to Himalayan uplift around 8 Million years back.

As mentioned in the Geology subtitle, this MidGangaplain is a foreland basin which is subsiding with continuous sedimentation in front of rising Himalayas. The cross-sectional geometry of the foreland and the patterns of fluvial deposition, inferred from the limited data now available, also support a dichronous evolution. In the Miocene period, when thrust loading dominated, the Indo-Gangetic foreland had an axial river system across its medial and distal parts flowing over its own accumulated sediments. With the onset of climate, induced erosional unloading of the Himalaya, transverse river systems started, dominating. The medial foreland pushing the medial axial river southwards to almost the featheredge of the foreland basin, even as the proximal part of the foreland was witnessing uplift.

In the context of the fluvial setting outlined above, channel shifting has been attributed to regional tilting, depletion of flow by fanhead tilting, derangement of drainage by earthquakes, the coriolis effect and auto cyclic mechanisms (Wells and Dorr.Jr. 1987 and references there in, from Mahadevan 2001).

Recent publications have emphasized the role of neotectonic changes in shifting river courses. Mohindra et al. (1992) and Mohindra (1995) attribute the shifting of the river Gandak to neotectonic tilting of the megafan eastward. However, the recent shifting of the Gandak River to its present channel from the Burhi Gandak channel westwards, suggests that there are also other factors (?autocyclic) which play an important role. A detailed analysis of the causes of shifting of the Kosi river by Wells and Dorr Jr. (1987 in Mahadevan 2002) leads to the conclusion that the

major shifts are "stochastic and autocyclic " and they do not well correlate with many severe earthquakes and floods, though they may have primed the system for shifts.

Diverse avulsion mechanisms have been inferred from the channel systems in the Gandak-Kosi interfluvium. The Burhi Gandak shifts its channel eastwards due to paleotopography and sedimentological readjustment. The Bagmati shifts westward through the same mechanisms. The avulsion of the Balan river channels, however, is attributed to neotectonic response and the westward shift of the Kamla to the expanding growth of the Kosi megafan, on whose fringes the channels of Balan flow. The widely differing explanations of the shifting behaviors of North Bihar Rivers underline the complexity of the problem and the need for further research.

## Geology and Soil

The geology of the area constitutes the highest alluvial plain in the domain of the Himalayan Rivers to the north of the Ganga. It is a part of the Great Gangetic Basin. The basin was formed during late Paleogene-Neogene times and is related to the upheaval of the Himalayas vis a vis flexural downwarp of the Indian Lithosphere under the supracrustal load of the Himalayas (Wadia, 1961). The entire segment abounds in buried faults and grabens. The basin came into existence as a result of the collision of India and China continental Plates (Dewcy and Bird, 1970 in Parkash) during the Paleocene. Collision resulted in intraplate subduction along the MCT(Main Central Thrust lying in the Himalayas) raising the Higher Himalaya to form source rocks and “popping through” of the more southerly part of the Indian plate to form the basin. This “popping through” might have lead to the development of longitudinal and transverse lineaments throughtout the basin. With time more southerly areas were raised and by mid-Paleocene subduction also started along the MBF(Main Boundary Fault lying in the Himalayas). These phenomena are reflected in the presence of a coarsening up megacycle with at least two superimposed minor cycle and in the composition of the sandstone and conglomerates of the basin. Later folding of the northern edge of basin to form the Siwalik Ranges during the Early Pleistocene led to cannibalism of this part of the basin.

The basin had east west elongated shape and started with a shallow marine environment, which changed to estuarine and deltaic one with time. By mid-Miocene, continental sedimentation marked by fluvial environment dominated the scene and this set up has continued to the recent with minor modifications. The basin had predominantly transversal pattern controlled by southerly flowing rivers emerging from the Himalaya and during Neogene period, a master stream along the southern margin of the basin drained into the Bay of Bengal. The fluvial sedimentation took place the form of mega-alluvial cones. Sedimentation in the basin was influenced by tectonism through out its evolution.

The Indogangitic Basin, still an active one, needs to be studied for detailed stratigraphic correlation, sedimentary facies relationship, change in climate through space and time and modern sedimentation.

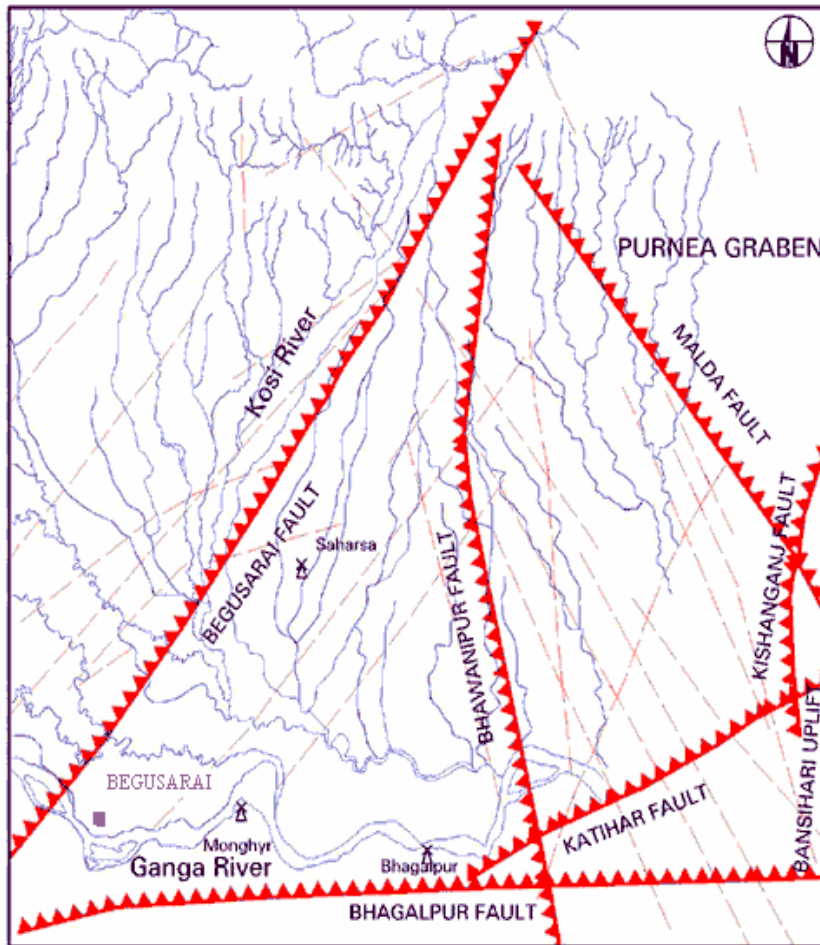
A Quaternary fault system has been identified in the region. This is an echelon pattern of surface faults associated with Begusarai fault (Fig). Within this fault zone, various geomorphic features are found which have their origin in both the lateral and vertical movement of fault-bounded slices, as well as in the persistent strike-slip. In regions where tectonic activity is less pronounced, streams generally flow more or less perpendicular to the adjacent highlands

The Quaternary sediments of the Indogangitic plains have been traditionally subdivided into the older and younger alluvium and locally called Bhangar and Khader. Entire area of Begusarai falls in the domain of “Khader” sediments

The soil of this land unit is primarily unaltered alluvium, which is yet to undergo pedogenesis (process of soil formation). Texturally it varies from sandy loam to loam in the meander scroll and levee (the upland bounding the flood plains of the river) areas, to silty loam and silt in flood basin areas of the Himalayan rivers and from loam in the levees of Ganga to clayey loam and clay in the basin of Burhi Gandak and Bhagmati river. The soil of the area is sandy loam rich with humus and is also very fertile.

**Referances:-**

1. The subsurface Geology of the Indo-Gangetic plains M.B.R Rao,1973,no:-3,vol-14,journal of Geological Society of India,pp-217-242.
2. Geological Evolution of Gangaplains an overview, Indra Bir singh,Journal of Paleontological Society of India vol-41,1996,pp-99-137
3. The Indogangetic Basin- B.parkash and Sudhir Kumar,Sedimentary burins of India,Tectonic contest.
4. Study of spatio-temporal changes in the weltands of North Bihar through Remote Sensing,A.K.Ghosh,N.Bose.K.R.P.Singh and R.K.Sinha July 204,ISCO-204,International soil conservation organisation conterence Brisbane
5. kanwar lake wetlands, strategies for conservation Sanjeev Kumar<http://sndp.nic.delhi.in>, downloaded in March 2004
6. Tectonic Zonation using Multi-Criteria Decision-Making (MCDM) Techniques: A case study of Kosi Fan, India Ajay Srivastava , [www.gisdevelopment.net/application/geology](http://www.gisdevelopment.net/application/geology), downloaded in March 2004



**LEGEND**

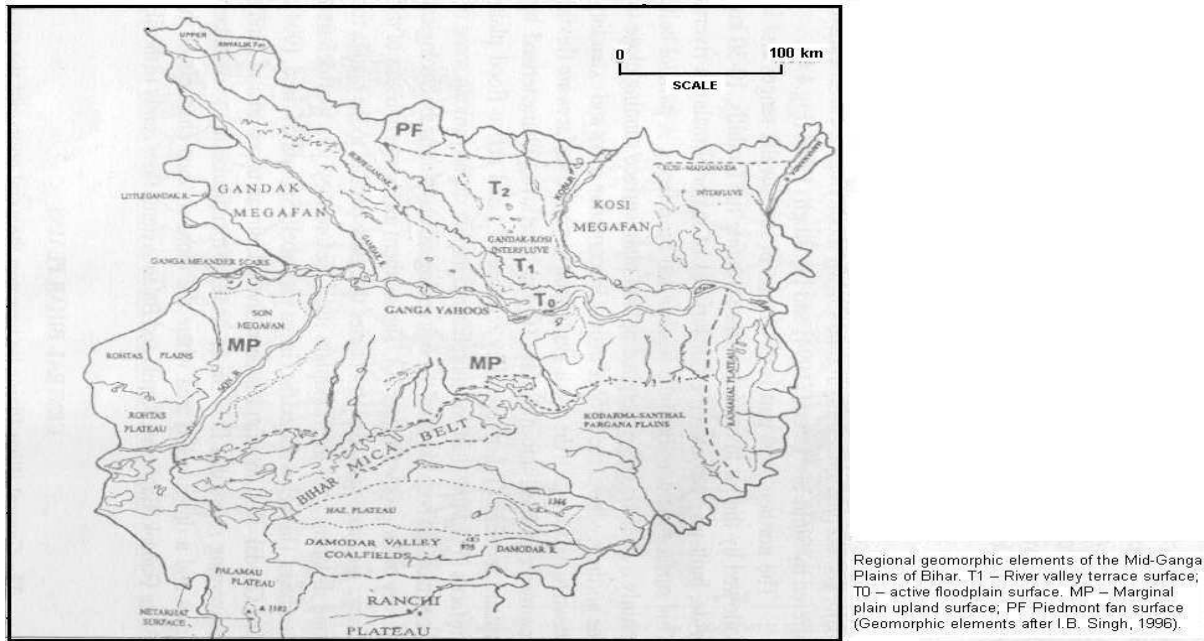


-  Basin Margin Fault
-  Fault/Lineament
-  River

**LINEAMENTS AND MAJOR FAULTS**

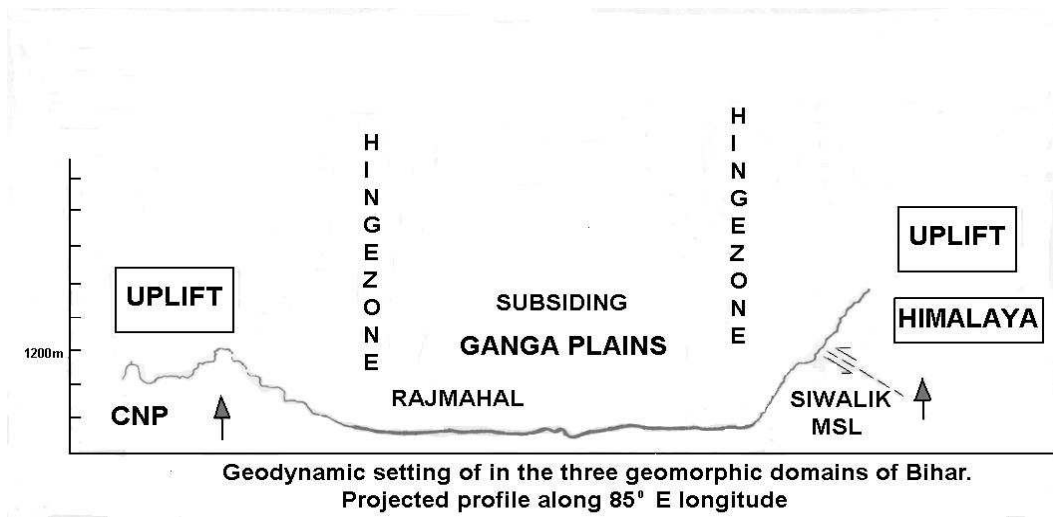
## MAP SHOWING AROUND BEGUSARAI

(from Srivastava, A, 2004 )



Regional geomorphic elements of the Mid-Ganga Plains of Bihar. T<sub>1</sub> – River valley terrace surface; T<sub>0</sub> – active floodplain surface. MP – Marginal plain upland surface; PF Piedmont fan surface (Geomorphic elements after I.B. Singh, 1996).

(from Geology Of Bihar And Jharkhand, T.M. Mahadevan, 2002 )



2.1. **Administrative structure:** The administrative divisions of the district are the following :

<b>Administrative Division</b>	<b>Number</b>
<b>No. of Sub-Division</b>	<b>05</b>
<b>No. of Blocks</b>	<b>18</b>
<b>No. of Panchayats</b>	<b>257</b>
<b>*No. of Revenue Villages</b>	<b>1229</b>
<b>*No. of Habitations</b>	<b>1198</b>

**Demographic feature:** The 2001 census count placed the Begusarai population at 23,42,989 as on the first of March. The population has grown at an annual average rate of 2.9%. There are many stages in the demographic transition beginning with a declining mortality and continuing fertility to a stage where both mortality and fertility rates decline more or less at the same rate and keep the population stable over a period of time.

## 2.2

*Begusarai : Health*

ITEM	REF. YEAR	UNIT	BEGU SARAI SUB. DIV.	MANJH AL SUB. DIV	BALLIA SUB. DIV	BAKHARI SUB. DIV	TEGHARA SUB. DIV	BEGUSARAI DISTRICT
Civil Hospital Govt.	2004	Nos	1					1
Referral Hospital	2004	Nos	1	1				2
Primary Health Centres	2004	Nos	3	2	2	1	3	11
Additional Primary Health Centres	2004	Nos	10	4	4	3	6	27
Health Sub Centres	2004	Nos	89	50	42	31	76	288
States Dispensaries	2004	Nos					1	1
Family Welfare Centres	2004	Nos	9	6	6	3	3	33
No. of Beds	2004	Nos	114	12	12	6	24	168
Doctors (Allopathec)								
(a) Sanctioned Post	2004	Nos	55	19	16	10	25	125
(b) Fillup Post	2004	Nos	45	16	13	8	20	102
Doctors (Homeopath)	2004	Nos			1			1
Doctors (Aurvedic)	2004	Nos					1	1
Nurses & Midwives	2004	Nos						
Para Medical Staff	2004	Nos						

## *Begusarai : Industry*

### **DIC(District Industries Centre)**

District Industry Centre manages and control the entire industrial activity of the district. It provides registration of industrial units, keeps data, gives training to new entrepreneur. It provides loan (PMRY) to educated unemployed youths and hence them in establishing industry/business/services.

The registered small and tiny industries from year 1975 to Dec 2003 is as follows

.....

<b><u>Sub-division</u></b>	<b><u>No. of Registered Units</u></b>
<b>Begusarai</b>	<b>2004</b>
<b>Teghra</b>	<b>810</b>
<b>Bakhri</b>	<b>184</b>
<b>Ballia</b>	<b>237</b>
<b>Manjhaul</b>	<b>172</b>
<hr/>	
<b>Total</b>	<b>3407</b>

### ● **OIL REFINARY**

● Barauni refinery is one of the country's biggest oil refinery's at Barauni in Bihar State. The refinery is managed and controlled by Indian Oil Corporation Ltd.(IOC). Barauni Refinery was built in collaboration with Soviet Union at a cost of Rs. 49.40 crore and went on stream in July 1964. By November 1967, the initial capacity was expanded from 2 MMTPA (million metric ton per day) to 3 MMTPA. The present capacity of the refinery is 6.00 MMTPA.

### ● **BARAUNI THERMAL POWER STATION**

- BTPS was established on 26 January 1963 , starting from 15 MW with a unit of (Kerosine Oil to Coal) 365 MW, BTPS went through different stages of revolutions.

### ● **FERTILIZER**

- Chemical fertilizer plants are located at Barauni in Begusarai District. In Nov'1962 it was proposed to the govt. In 1967 it was established. Here 330 Ton urea is ready per year. It is expanded in 330 acre Lands. The name of final product is Moti Urea.

### ● **BARAUNI DAIRY**

- Established in 1959, a fully co-operative organisation, marketing its product to Kolkotta, Ranchi, Jamshedpur, Bokaro, Gaya, Danbad etc. M.D. Barauni Dugdh Utpadak Sahkari Sangh Ltd, Barauni Dairy. Ph No -- 32202, 32888, 32908. Fax----- 32430

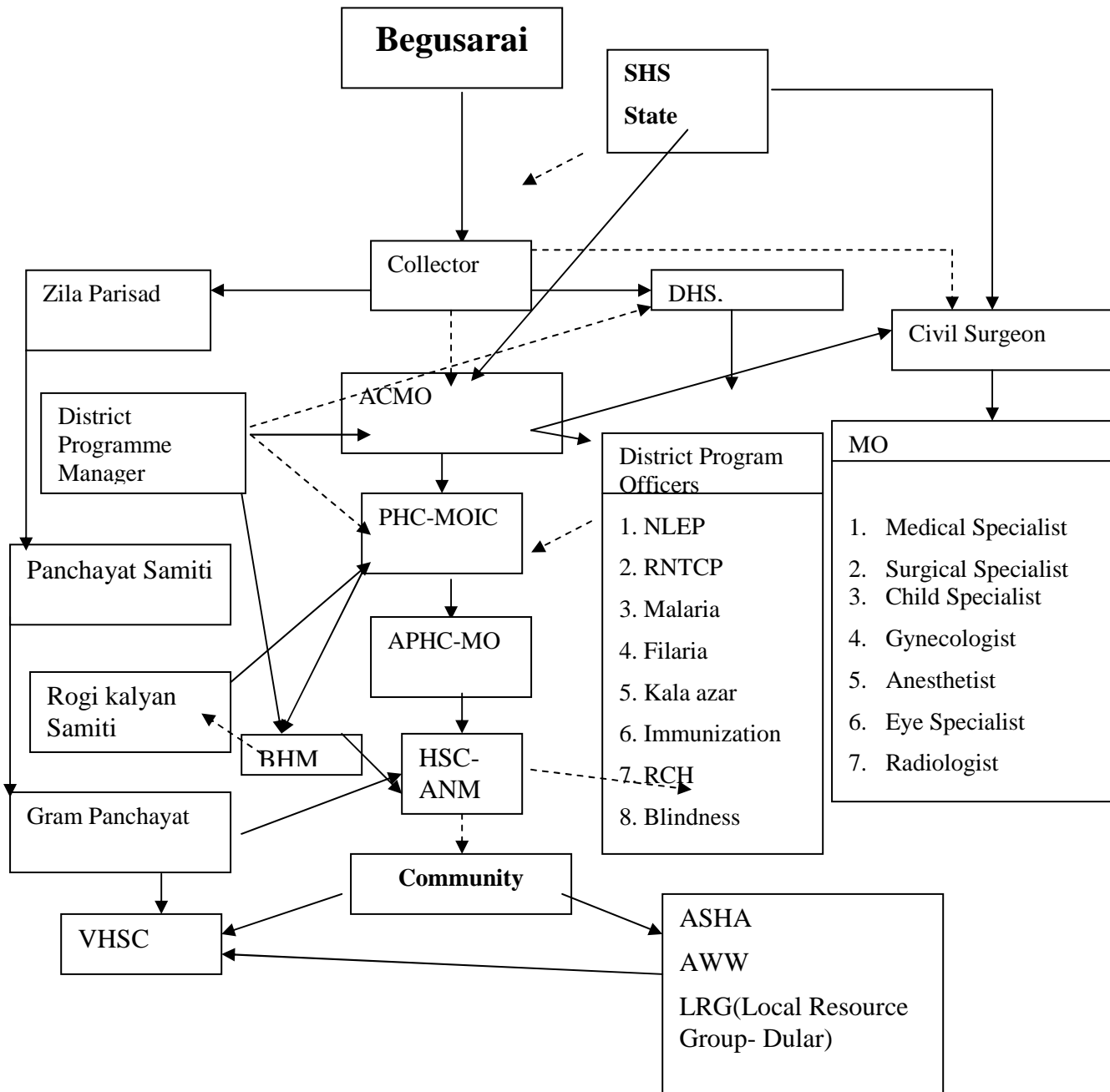
### ● **OTHER INDUSTRIES**

1. Kumar Hydro Carbon Industries Private Limited  
Manufacturer & exporter of calcined petroleum coke.  
Address: Industrial Area, Barauni, P.O-Tilrath, Begusarai - 851112, India  
Phone: +(91)-(06243)-22880 Fax: +(91)-(06243)-23373
2. Kanishka Carbon
3. Airson Retailers
4. Surekha Metal Enterprises
5. National Auto Works
6. Ram Padharth Show Mill
7. Bihar Machinery Product
8. Bihar Petrol Chemical
9. Kumar chemicals
10. Electro Cabon India Pvt Ltd.
11. Bihar Chemical Co-orporation
12. Hindusthan Industries
13. Vikas Industries

14. Panvan Mahabir Wax Industries
15. Choudhary Chemical
16. Mahabir par product Pvt. Ltd.
17. Nipo Carbon
18. Barauni Carbon
19. Graphite India Ltd.
20. Jai Mata di Metal Pvt. Ltd.
21. Binod Petroleum
22. M/S. Mregandra Cold storage pvt. Ltd. ,Rajbara Barauni.
23. Sarkari Seth Bhandar Barauni
24. Begusarai Cold Storage
25. Jai Shankar Hume Pipe Tilrath
26. Mahavir Industries Unit-2 ,Industrial area baruni
27. Universal Hydro carbon
28. Bharat Chemical Co-orporation Insustrial Area
29. Ranjeet Congrit Industrial Area.
30. M/S Plastic Imporium BajalPura Teghra Bazar.
31. Bharat Masaca Industries, Guara Teghra.
32. Anamika Volyag Laxman Tola, Bachwara.
33. M/S BajRand Floor Mill Pvt. Ltd. Teghra.
34. Bina washing Acid Works Sahvri Barauni.
35. Impherial Industries ,18 Barauni Industrial Area Tilrath
36. Barauni Engineer Co-orporation,Industrial area Baruni ,Tilrath.
37. Kanhai Masala Udyad, Malti Baruni
38. Mukesh Bakery, Rajdhani chowk Bihat
39. Om. Coal Briqutte, Kesaway Barauni
40. Janki Bhandav,ratnpur
41. Jai Lakshmi Industries ,Chatarbhuj Asthan
42. Permanad Bakery ,Panchambha ,Sahivd Nagar
43. Venketeshwar Industries ,Power House Road

44. Laloo Biscuit Industries,Anandpur
45. Rohit Bakery, Bus Stand
46. Navi Hast Kala Mandir, Azad Krtiv Mugerl Ganj
47. Roy Electrical Co-orporation ,Pokharia
48. Milkoj Food Products, Sindhaul
49. Diamond Atka Chakki, Diviyapur,Matihani
50. M/S Janta Bakery, Sabjee Bazar
51. M/S Anand Dal Mill, Bakhri Bazar
52. Deo. Coal Brequate Sind,Bakhri Bazar
53. Keshri Floor Mill,Bakhri Bazar
54. M/S Sahu Dal Mill,Bakhri Bazar.
55. New Choudhary Bakery
56. New Hero Bakery,Lakminia
57. Pachbir Atta Chakki, Pachbir Bazar, SahebpurKamal
58. Leather Finishing Indutry {1958}
59. Gautam Oil Industries.Ratanpur.

## District Health and Administrative Setup



# Chapter 3

## Situation Analysis

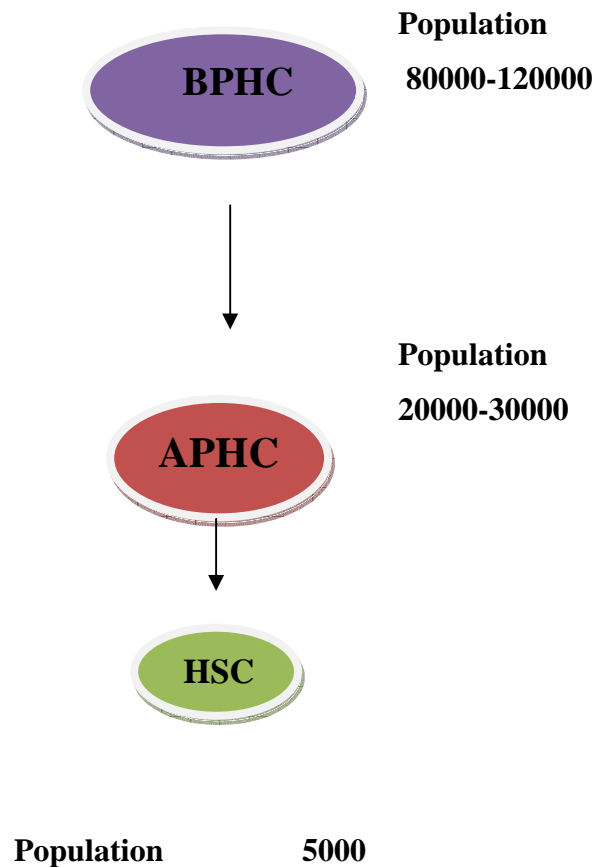
In the present situational analysis of the blocks of district BEGUSARAI the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, BEGUSARAI and various websites as well as other sources. These indicators help in pointing to the health scenario in BEGUSARAI from a quantitative point of view, while they cannot by themselves provide a complete picture of the status of health in the district. However, it is useful to have outcome data to map the effectiveness of public investment in health. Further, when data pertaining to vital rates are analyzed in conjunction with demographic measures, such as sex ratio and mean age of marriage, they throw valuable light on gender dimension. Table below indicates the Health indicators of BEGUSARAI district with respect to Bihar and India as a whole.

**Table: Health Indicators**

<b>Indicator</b>	<b>BEGUSARAI</b>	<b>Bihar</b>	<b>India</b>
CBR	31.9	29.2	23.8
CDR	8.1	8.1	6
IMR	61	61	58
MMR	371	371	301
TFR	4.6	4	2.68
CPR	33	34.1	56.3
Complete Immunization	26.1	32.8	44

Sources: DLHS3, NFHS3, SRS2007

### 3.1 GAPS IN INFRASTRUCTURE:



First contact point with community

#### Introduction:

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

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

#### 3.1.1 Infrastructure for HSCs:

#### IPHS Norms:

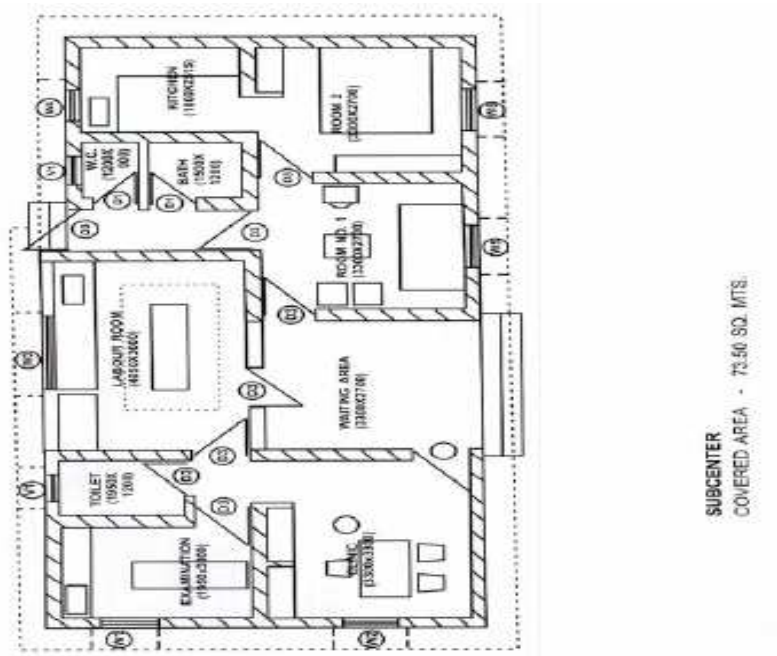
A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population.

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

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

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

Typical Layout of Sub- Centre with ANM Residence



- Waiting Area : 3300mm x 2700mm
- Labour Room : 4050mm x 3300mm
- Clinic room : 3300mm x 3300mm
- Examination room: 1950mm x 3000mm
- Toilet : 1950mm x 1200mm

Residential accommodation : this should be made available to the Health workers with each one having 2 rooms, kitchen, bathroom and WC. Residential facility for one ANM is as follows which is contiguous with the main sub centre area.

- Room -1 (3300mm x 2700mm)
- Room-2(3300mm x 2700mm)
- Kitchen-1(1800mm x 2015mm)
- W.C.(1200mm x 900mm)
- Bath Room (1500mm x 1200mm)

One ANM must stay in the Sub-Centre quarter and houses may be taken on rent for the other/ANM/Male Health worker in the sub centre village. This idea is to ensure that at least one worker is available in the Sub-Centre village after the normal working hours. For specifications the “Guide to health facility design” issued under Reproductive and Child Health Program (RCH-I and II) of Government of India, Ministry of Health and Family Welfare may be referred.

**Health Sub Centers:** Total population of the district as per 2001 census is 2718421. After considering two percent growth rate of the total population it comes around 3187470 (Decadal Growth Rate

2.3). After considering projected population in 2008, the district needs altogether 637 HSCs to cater its whole population. At present BEGUSARAI have 339 established Health Sub Centers and 154 more Health sub centers are proposed to be formed. As per the IPHS norms (5000 population in plain area) the district still requires 135 new HSCs to be formed. Again, out of 339 established HSCs, only 39 have their own buildings and rest 300 run in rented houses. All these 39 HSCs need renovation work. All the above mentioned HSCs need equipments, drugs, furniture and stationaries.

<b>Health Sub Centers:</b>				
<b>Sub Heads</b>	<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>
<b>Infrastructure</b>	A. Out of 339 HSCs only 39 are having own building	Inadequate facility in constructed building and lack of community ownership	Enhance visibility of HSC through hardware activity by the help of community participation	<b>AStrengtheing of HSCs having own buildings</b>
	B. In existing 39 buildings 26 are running in comparatively in good condition, 6 are in under construction , one is in very poor condition and one is constructed but not handed over to health department.			B.1.White washing of HSC buildings.  B.2.Organize adolescent girls for wall painting and plantation./hire local painter for colorful painting of HSC walls. List out all services which are provided at HSC level on the wall.  B.3.Gardening in HSC premises by school

				children.
	C. Not even one building is having running water and electric supply.			C. Mobilize running water facility from nearby house if they have bore well and water storage facility and it could be on monthly rental.
	D. Lack of equipments and ANMs are reluctant to keep all equipments in HSC .  E. Lack of appropriate furniture	Operational problem in availability of equipment in constructed HSC		D.1.Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/) D.2. Purchase of equipments according to services D.3. Purchase one almirah to keep all equipments safely and it could be keep in AWW / ASHA house.
	1.Non payment of rent of 300 HSCs for more than three years	1.Non payment of rent	Regularizing rent payment	<b>3B. Strengthening of HSCs running in rented buildings.</b> B1. Estimation of backlog rent and facilitate the backlog payment within two

				<p>months</p> <p>B2. Streamlining the payment of rent through untied fund from the month of April 09.</p> <p>B3.Purchase of Furniture as per need</p> <p>B4 Prioritizing the equipment list according to service delivery</p> <p>B5 Purchase of equipments as per need</p> <p>B6 Printing of formats and purchase of stationaries</p>
	<p>1. The district still needs 135 more HSCs to be formed.</p>	<p>1. Land Availability for new construction</p> <p>2. Constraint in transfer of constructed building</p>		<p><b>3C. Construction of new HSCs</b></p> <p>C1. Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs</p> <p>C2. Community mobilization for promoting land donations at accessible locations.</p> <p>C3. Construction of New HSC buildings</p> <p>C4. Meeting with local PRI /CO/BDO/Police Inspector for smooth transfer of constructed HSC buildings.</p>

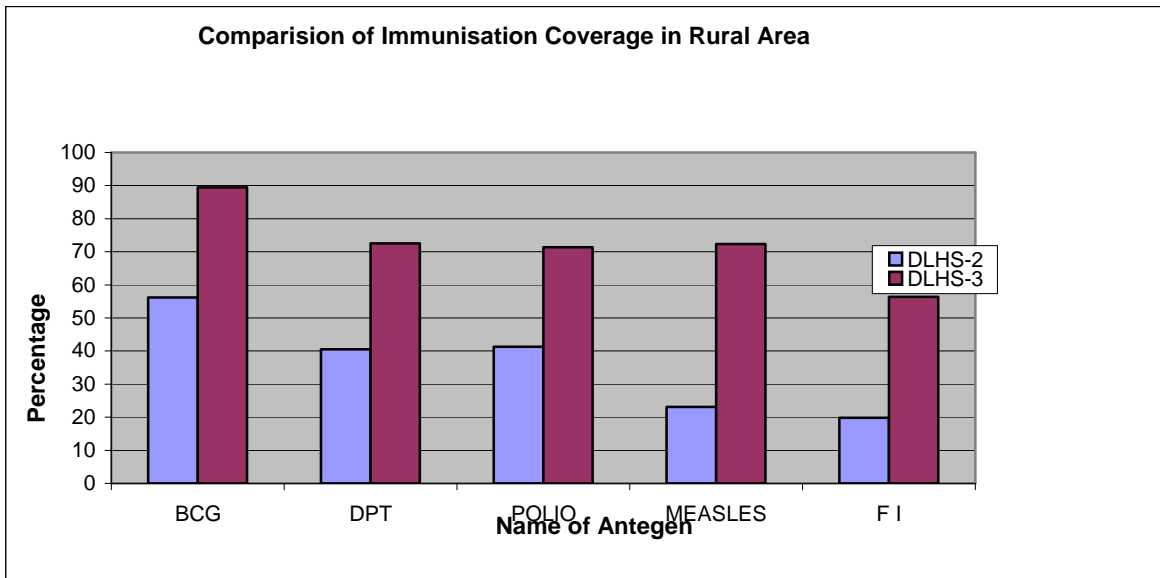
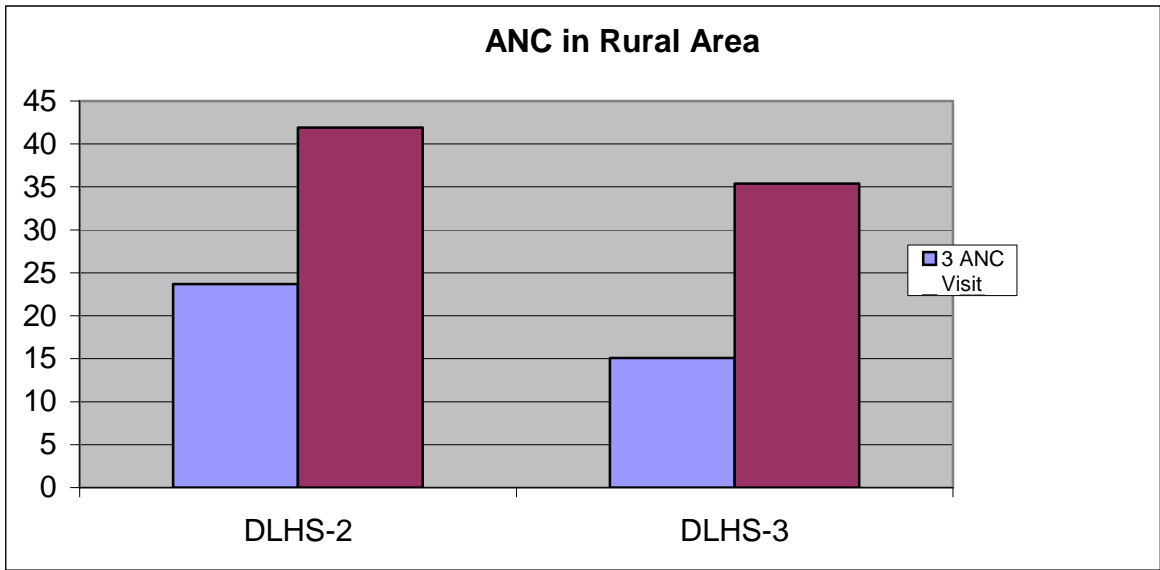
	Non participation of Community in monitoring construction work	Monitoring	Ensuring community Monitoring	<ol style="list-style-type: none"> <li>1. Biannual facility survey of HSCs through local NGOs as per IPHS format</li> <li>2. Regular monitoring of HSC facilities through PHC level supervisors in IPHS format.</li> <li>3. Monitoring of renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project.</li> <li>4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work.</li> <li>5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work</li> </ol>

	1. Lack of community ownership in the construction of Health infrastructures.	1.Community ownership	Strengthening of VHSCs, PRIs	1.Formation and strengthening of VHSCs, Mothers committees, 2.“Swasthya Kendra Chalo Abhiyan” to strengthen community ownership 3.Nukkad Nataks on Citizen’s charter of HSCs as per IPHS 4.Monthly meetings of VHSCs, Mothers committees
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### 3.1.2 Services of HSCs:

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

As per the DLHS3( 2007-08)reports the percentage of full immunization(BCG, 3 doses each of DPT and Polio and measles) coverage(12-23 months) in the district is 56.4%. And BCG coverage of the district is 89.5%. 3 doses of polio vaccine is 72.5%, 3 doses of DPT vaccine is 71.4% and Measles Vaccine is 72.3%. The coverage of Vit A supplementation for the children 9 months to 35 months is 66.6 percent.



Sub Heads	Gaps	Issues	Strategy	Activities
Service performance	Unutilized untied fund at HSC level	Operationalization of Untied fund.	Capacity building of account holder of untied fund	1. Training of signatories on operating Untied fund account, book keeping etc 2. Timely disbursement of untied fund for HSCs

				3. Hiring a person at PHC level for managing accounts
	No ANC at HSC level	Improvement in quality of services like ANC, NC and PNC, Immunization	Strengthening one HSC per PHC for institutional delivery in first quarter	<ol style="list-style-type: none"> <li>1. Identification of the best HSC on service delivery</li> <li>2. Listing of required equipments and medicines as per IPHS norms</li> <li>3. Purchasing/ indenting according to the list prepared</li> <li>4. Honouring first delivered baby and ANM</li> </ol>
	<p>Only 14.2% PW registered in first trimester</p> <p>PW with three ANC's is 15.1%, TT1 coverage is 35.4%,</p> <p>Family Planning Status:</p> <p>Any method- 43.6%</p> <p>Any modern method-39.8%</p> <p>No sterilization at</p>	Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	<ol style="list-style-type: none"> <li>1. Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms.</li> <li>2. Community focused family planning services</li> </ol>	<ol style="list-style-type: none"> <li>1 Gap identification of 39 HSCs through facility survey</li> <li>2. Eligible Couple Survey</li> <li>3. Ensuring supply of contraceptives with three month's buffer stock at HSCs.</li> <li>4. training of AWW/ASHA on family planning</li> </ol>

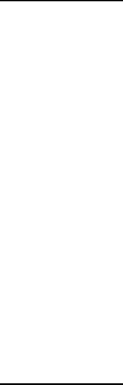
	HSC level IUD insertion - 0.5% Pills-1.5% Condom-1.9% Total unmet need is 32.7%, for spacing-14.9,			methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion
	Lack of counseling services	Training	Training	1. Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6. ( four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of

				reports of national programs by the supervisors duly signed by the respective ANMs.
	80% of the HSC staffs do not reside at place of posting	Absence of staffs	Community monitoring	1. Submission of absentees through PRI
	Problem of mobility during rainy season	Communication and safety		1. Purchasing Life saving jackets for all field staffs 2. Providing incentives to the ANMs during rainy season so that they can use local boats.

	Lack of convergence at HSC level	Convergence	Convergence	1. Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHSCs rotation wise at all villages of the respective HSC. 2. Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.
	Lack of proper	Reporting	Strengthening of reporting system	1. Training to the field staffs in filling

	<p>reporting from field</p> <p>Lack of appropriate HMIS formats.</p>			<p>up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc</p> <p>2. Printing of adequate number of reporting formats and registers</p> <p>3. Hiring consultants to develop softwares for reporting.</p>
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**3.1.3**  
**Resource**



Sub Heads	Gaps	Issues	Strategy	Activities
<b>Human Resource</b>	<p>Out of 360 seats 135 seats of contractual ANM®, are vacant.</p> <p>Out of 101 seats of Staff Nurses 30 seats are vacant.</p>	Filling up the staff shortage	Staff recruitment	<p>1. Selection and recruitment of 135 ANMs</p> <p>2. Selection and recruitment of 30 staff nurse.</p>
	All 360 contractual ANMs needs training on different services.	Untrained staffs	Capacity building	<p>1. Training need Assessment of HSC level staffs</p> <p>2. Training of staffs on various services</p>
	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	<p>1. Analyzing gaps with training school</p> <p>2. Deployment of required staffs/trainers</p> <p>3. Hiring of trainers as per need</p> <p>4. Preparation of annual training calendar issue</p>

				<p>wise as per guideline of Govt of India.</p> <p>5.Allocation of fund and operationalization of allocated fund</p>
<b>Drug kit availability</b>	<p>1.No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives,</p> <p>2.No Drug kit for AWCs(@one kit per annum,)</p> <p>3.No ASHA kit</p>	Indenting	Strengthening of reporting process and indenting through form 6	<p>1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports</p>
	<p>Only need based emergency supply</p> <p>Irregular supply of drugs</p>	Logistics		<p>1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map</p> <p>2.Hiring vehicles for supply of drug kits through untied fund.</p> <p>3.Developing three coloured indenting format for the HSC to</p>

				PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)
		Operationalization	Couriers for vaccine and other drugs supply	1 Hiring of couriers as per need 2 Payment of courier through ANMs account
			Phase wise strengthening of APHCs for vaccine / drugs storage	1.Purchasing of cold chain equipments as per IPHS norms 2. training of concerned staffs on cold chain maintenance and drug storage

**3.2 Additional PHCs: --** There are 22 APHCs functioning in the district and 63 more are proposed to be established.

<b>Additional PHC:</b>				
<b>Sub Heads</b>	<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>
<b>Infrastructure</b>	<p>1.The district altogether need 85 APHCs but there are 22 APHCs functioning in the district and 63 more are proposed to be established.</p> <p>2. Four more are required to be formed.</p> <p>3.Out of 22 APHCs only 09 are having own building</p> <p>4.Existing 13 buildings are not properly maintained</p>	<p>Lack of facilities/ basic amenities in the constructed buildings</p> <p>Non payment of rent</p> <p>Land Availability for new construction</p> <p>Constraint in transfer of constructed building.</p> <p>Lack of community ownership</p>	<p>Strengthening of VHSCs, PRI and formation of RKS</p> <p>Strengthening of Infrastructure and operationalization of construction works in Three phase</p>	<p>1.“Swasthya Kendra Chalo Abhiyan” to strengthen community ownership</p> <p>2.Nukkad Nataks on Citizen’s charter of APHCs as per IPHS</p> <p>3. Registration of RKS</p> <p>4.Monthly meetings of VHSCs, Mothers committees and RKS</p> <p><b>A.Strengthening of APHCs having own buildings</b></p> <p>A.1 Renovation of APHCs buildings</p> <p>A.2 Purchase of Furniture</p> <p>A.3 Prioritizing the equipment list according to service delivery</p> <p>A.4 Purchase of equipments</p> <p>A.5 Printing of formats and purchase of stationeries</p> <p>Purchase of equipments</p>

			<p>as per need</p> <p>B6 Printing of formats and purchase of stationeries</p> <p>3C. Construction of new APHC buildings as standard layout of IPHS norms.</p> <p>C1. Preparation of PHC wise priority list of APHCs according to IPHS population and location norms of APHCs</p> <p>C2. Community mobilization for promoting land donations at accessible locations.</p> <p>C3. Construction of New APHC buildings</p> <p>C4. Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed APHC buildings.</p> <p>4 Biannual facility survey of APHCs through local NGOs as per IPHS format</p> <p>4.1 Regular monitoring of APHCs facilities through PHC level supervisors in IPHS format.</p>
			<p>Monitoring</p>



	<p>training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities</p> <p>Most of the APHC staffs are deputed to respective PHC hence APHC are defunct</p>		<p>Strengthening of ANM training school</p>	<p>various services</p> <p>3.EmoC Training to at least one doctor of each APHC</p> <p>1.Analyzing gaps with training school</p> <p>2.Deployment of required staffs/trainers</p> <p>3.Hiring of trainers as per need</p> <p>4. Preparation of annual training calendar issue wise as per guideline of Govt of India.</p> <p>5.Allocation of fund and operationalization of allocated fund</p>
<b>Drug kit availability</b>	<p>No drug kit as such for the APHCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives, Only need based</p>	<p>Indenting</p> <p>Logistics</p> <p>Operationalization</p>	<p>Strengthening of reporting process and indenting through form 2 and 6</p> <p>Couriers for vaccine and other</p>	<p>1.Weekly meeting of APHC staffs at PHC for promoting APHC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports</p> <p>2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map</p> <p>2.1 Hiring vehicles for supply of drug kits</p>

	<p>emergency supply</p> <p>Irregular supply of drugs</p>		<p>drugs supply</p> <p>Phase wise strengthening of APHCs for vaccine / drugs storage</p>	<p>through untied fund.</p> <p>2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)</p> <p>3.1 Hiring of couriers as per need</p> <p>3.2 Payment of courier through APHC account</p> <p>4.1 Purchasing of cold chain equipments as per IPHS norms</p> <p>4.2 training of concerned staffs on cold chain maintenance and drug storage</p>
<p><b>Service performance</b></p>	<p>RKS has not been formed at any of the APHC.</p> <p>Unutilized untied fund at APHC level</p> <p>No institutional delivery at APHC level</p> <p>No OPD At any of the APHC</p> <p>No inpatient facility available</p> <p>No ANC, NC</p>	<p>Formation of RKS</p> <p>Operationalization of Untied fund.</p> <p>Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps.</p> <p>Integration of disease control</p>	<p>Capacity building of account holder of untied fund</p> <p>Phasewise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms.</p>	<p>1.Training of signatories on operating Untied fund /RKS account, book keeping etc</p> <p>2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts</p> <p>2. Timely disbursement of untied fund/ seed money for APHCs RKS.</p> <p>3. 1 Gap identification of 16 APHCs through facility survey</p> <p>2.strengthening one</p>

	<p>and PNC and family planning services.</p> <p>No lab facility</p> <p>No Ayush practitioner posted</p> <p>No rehabilitation services</p> <p>No safe MTP service</p> <p>No OT/ dressing and Cataract operation services.</p> <p>Approx 80% of APHC staffs not reside at place of posting</p> <p>Lack of counseling services</p> <p>Problem of mobility during rainy season</p> <p>Lack of convergence at APHC level</p> <p>Operational gaps: There is no link between HSCs and APHCs and the same way there</p>	<p>programs at APHC level.</p> <p>Family Planning services</p> <p>Convergence</p> <p>Operational issues</p>	<p>Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCs. At present the same is being done by PHC only.</p> <p>Community focused Family Planning services</p>	<p>APHC per PHC for institutional delivery in first quarter</p> <p>3.Honouring first delivered baby and ANM</p> <p>1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6</p> <p>2.Strengthening ANMs for community based planning of all national disease control program</p> <p>3. Reporting of disease control activities through ANMs</p> <p>4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.</p> <p>5.Weekly meeting of the staffs of concerned HSCs ( as assigned to the APHC)</p> <p>1.Eligible Couple Survey</p> <p>2. Ensuring supply of contraceptives with three month's buffer stock at HSCs.</p> <p>3.Training of AWW/ASHA on family planning methods and</p>
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	<p>is no link between APHC and PHC</p>		<p>PPP</p> <p>Convergence</p>	<p>RTI/STI/HIV/AIDS</p> <p>4. Training of ANMs on IUD insertion</p> <p>1. Outsourcing services for Generator, fooding, cleanliness and ambulance.</p> <p>1. Fixed Saturday for meeting day of ANM, AWW, ASHA, LRG with VHSCs rotation wise at all villages of the respective HSC.</p>
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**3.3 Primary Health centers:** The district has 18 PHCs, 02 referral hospitals, 01 sub divisional hospital and a District hospital. The PHC of MATIHANI and referral hospital of MATIHANI is running in the same building.

<b>Primary Health Centers:(30 bedded)</b>				
<b>Indicators</b>	<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>
<b>Infrastructure</b>	<p>All PHCs are running with only six bed facility. At present 10 PHCs are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 150 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility. Identified the facility and equipments gap before preparation of DHAP and almost 50-60% of facilities are not adequate as per IPHS norms.(List attached )</p> <p>The comparative analysis of facility survey(08-09) and</p>	<p>Available facilities are not compatible with the services supposed to be delivered at PHCs.</p> <p>Quality of services</p> <p>Community participation.</p>	<p>Upgradation of PHCs into 30 bedded facilities.</p> <p>ISO certification of selected PHCs in the district.</p> <p>Strengthening of BMU</p>	<p>1.Need based ( Service Delivery)Estimation of cost for upgradation of PHCs</p> <p>2.Preparation of priority list of interventions to deliver services.</p> <p>1.Selection of any two PHCs for ISO certification in first phase.</p> <p>2. Sending the recommendation for the certification with existing services and facility detail.</p> <p>1. Ensuring regular monthly meeting of RKS.</p> <p>2. Appointment of Block Health Managers, Accountants in all institutions.(16 PHCs, 3 Referrals and</p>



			Monitoring	through local NGOs as per IPHS format 2. Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.
<b>Human Resource</b>	As per IPHS norms each PHC requires the following clinical staffs:(List attached)  Only 16 BHM's and 18 accountants are placed at present. Demotivated BPMU staffs	Staff shortage Untrained staffs	Staff recruitment	1.Selection and recruitment of Doctors 2.Selection and recruitment of ANMs/ male workers 3.Selection and recruitment of paramedical/ support staffs 4.Appointment of Block Health

			Capacity building	Managers, PHCs, 2 Referrals 1 and Sadar hospital. 1) 1. Training need Assessment of PHC level staffs 2. Training of staffs on various services 3. Trainings of BHM and accountants on their responsibilities. 4. Trainings of BHM on implementation of services/ various National programs.
<b>Drug kit availability</b>	Irregular supply of drugs because of lack of fund disbursement on time. Only 70 % essential drugs are rate contracted at state level .  Lack of fund for the transportation of drugs from district to blocks. There is no clarity on the guideline for need based drug procurement and transportation.	Indenting  Logistics  Operationalization	Strengthening of reporting process and indenting through form 7   Strengthening of drug logistic system	1. Training of store keepers on invoicing of drugs 2. Implementing computerized invoice system in all PHCs 3. Fixing the responsibility on proper and timely indenting of medicines( keeping three months buffer stock) 4. Enlisting of equipments for safe storage of drugs. 5. Purchase of enlisted equipments. 6. Ensuring the availability of FIFO list

				<p>of drugs with store keeper.</p> <p>7. Orientation meetings on guidelines of RKS for operation.</p>
<p><b>Service performance</b></p>	<p>1.Excessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 150 OPD per day in each PHC.</p> <p>2. Total 54 seats of Regular and 39 seats of contractual doctors in the district is vacant.</p> <p>3. All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less( only average 16 patients per Doctor per OPD</p>	<p>Optimum Utilization of Human Resources</p>	<p>Quality improvement in residential facility of doctors/ staffs.</p> <p>Recruitment</p>	<p>1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs.</p> <p>2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.</p> <p>3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day</p> <p>1.Selection and appointment of contractual doctors and staffs</p> <p>1. Mapping of the areas having history of</p>



	<p>cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.</p> <p>10. In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs are reluctant to handle emergency cases.</p> <p>11. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.</p> <p>12. No guidance to the patients on the services available at PHCs.</p> <p>13. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.</p> <p>14. Lack of inpatient</p>	<p>and Properties)</p> <p>Govts existing services like lab, x-ray, generator, fooding and cleanliness services.</p>	<p>Confidence building measures</p> <p>Strengthening of the Govts existing services like lab, x-ray, generator, fooding and cleanliness services.</p> <p>Creating friendly environment</p>	<ol style="list-style-type: none"> <li>1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.</li> <li>2. Recruitment of lab technicians as required</li> <li>3. Purchase of equipments/ instruments for strengthening lab.</li> <li>4. Hiring of menial workers for cleanliness works.</li> <li>1. Assigning LHV for counseling work</li> <li>2. Wall writing on every section of the building denoting the facilities</li> <li>3. Name plates of doctor</li> <li>4. Displaying Roster of doctors with their details.</li> <li>5. Gardening</li> <li>6. Sitting arrangement for patients</li> <li>7. Installation of LCD TV with cable connection</li> <li>8. Installation of safe drinking water equipments/water</li> </ol>
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	<p>facility for kala-azar patients.</p> <p>15.Lack of counseling services</p> <p>16.Problem of mobility during rainy season</p> <p>17. Lack of convergence</p> <p>18. Lack of timely reporting and delay in data collection</p>		<p>HMIS and strengthening of reporting process</p>	<p>cooler,</p> <p>9.Installation of solar heater system and light with the help of BDO/Panchayat</p> <p>9. Apron with name plates with every doctors</p> <p>10. Presence of staffs with uniform and name plates.</p> <p>1.Orientation of the staffs on indicators of reporting formats</p> <p>2.Purchase of Laptops for DPMs and BHM</p>
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	<p>5.Operation of RKS: Delayed process of operation. Delay in disbursement of fund</p> <p>6.Lack of facilities/ basic amenities in the PHC buildings</p> <p>7.Huge workload in central registration unit</p> <p>8. No sitting arrangement for patients.</p> <p>10. No safe drinking water facility.</p> <p>11. Half of the hospital area remains dark at night.</p> <p>12. Delivery room lacks beds, labor table, stretchers, equipments.</p> <p>13. No proper gate and boundary wall.</p> <p>14.No proper post mortem room and equipments.</p> <p>15. Heavy water logging during rainy season.</p> <p>16.Buildings for ICU, Causality ward are ready but due to lack of equipments, facilities are not functional.</p> <p>17. No use of paying wards.</p> <p>18.No enquiry counter as such for the patients.</p> <p>20.No residential facilities</p>			<p>boundary wall and gate.</p> <p>11. Construction of new Post mortem room with all facilities.</p> <p>12. Renovation of drainage system and leveling of internal area up to the level of outer area.</p> <p>13. Construction of enquiry counters at the gate.</p> <p>14. Hiring of ambulances.</p> <p>15. Construction of new residential buildings.</p> <p>16.Hiring of rented houses from RKS fund for the residence of doctors, BMU and key staffs.</p> <p>16.Tender for canteen facility.</p> <p>17. Sitting arrangement for patients</p> <p>18. Installation of LCD TV with cable connection</p>
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	<p>guideline for need based drug procurement and transportation.</p> <p>4. Lack of proper space, furniture and equipments for drug storage</p>	Lack in storage facility		<p>equipments for safe storage of drugs.</p> <p>5. Purchase of enlisted equipments.</p> <p>6. Ensuring the availability of FIFO list of drugs with store keeper.</p>
Service performance	<p>1.Excessive load in delivering all services</p> <p>2. Blood storage unit is present but not utilized</p> <p>3.No 24hrs Lab facility</p> <p>4.Health facility with AYUSH services is not being provided</p> <p>5. Referral</p> <p>a. No pick up facility for PW or patients.</p> <p>b.BPL patients are not exempted in paying fee of ambulance.</p> <p>c. Lack of maintenance of ambulances</p> <p>d. Shortage of ambulances</p> <p>6. No guidance to the patients on the services available at DH.</p> <p>7.Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in</p>	<p>Workload</p> <p>Lack in infrastructure</p>	<p>Motivation building</p> <p>Strengthening of infrastructure</p>	<p>1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.</p> <p>2. Purchase of equipments for Blood storage unit,</p> <p>3. IEC on blood storage unit.</p> <p>4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day</p> <p>5. Repairing of all defunct Ambulances</p> <p>6. Hiring of ambulances as per need.</p> <p>7. Appointment of one AYUSH</p>

	particular.			practitioner and Yoga teacher 8. Purchase of equipments/ instruments for strengthening lab. 9. Wall writing on every section of the building denoting the facilities 10. Name plates of doctor 11. Displaying Roster of doctors with their details. 12. Gardening  13. Apron with name plates with every doctors 14. Presence of staffs with uniform and name plates.
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## **Chapter 4**

### **Setting Objectives and Suggested Plan of Action**

#### **4.1 Introduction**

District health action plan has been entrusted as a principal instrument for planning, implementation and monitoring of fully accountable and accessible health care mechanism. It has been envisioned through effective integration of health concerns via decentralized management incorporating determinants of health like sanitation and hygiene, safe drinking water, women and child health and other social concerns. DHAP envisages accomplishing requisite amendments in the health systems by crafting time bound goals. In the course of discussions with various stakeholder groups it has been anticipated that unmet demand for liable service provision can be achieved by adopting Intersectoral convergent approach through partnership among public as well as private sectors.

#### **4.2 Targeted Objectives and Suggested Strategies**

During consultation at district level involving a range of stakeholders from different levels, an attempt has been made to carve out certain strategies to achieve the specific objectives that are represented by different indicators. The following segment of the chapter corresponds to the identified district plan objectives demonstrating current status of the indicators along with the expected target sets that are projected for period of next three years (2009-12).

## 4.3 MATERNAL HEALTH

### Logical Framework

Sl.	Goal	Sl.	Impact indicators				
1	To improve maternal health	1.1	Reduction in MMR				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To increase institutional safe delivery by 28.2% (DLHS3) to 100% by year 2010	1.1	% of institutional delivery reported	1.1.1	To make functional PHC (24hr x7days) for institutional deliveries	1.1.1.1	% of PHC having functional OT and Labour room with equipment
						1.1.1.2	% of PHC having Obestetric First Aid medicine 24hrx 7 days
						1.1.1.3	% of Grade A nurse available 24hrx7days
						1.1.1.4	% of PHC having functional Neo-natal care units
				1.1.2	To make functional FRUfor institutional deliveries	1.1.2.1	No of FRUs having functional blood storage units linkage with blood banks and 24hr ready referral transport
				1.1.2.2	No of FRUs having EmOc and CEmOc facilities		
				1.1.2.3	No of FRUs having specialist doctors/ multiskilled Medical Officers		

						1.1.2.4	No of FRU having functional Neo-natal care units
				1.1.3	To provide Referral transport services at FRU /PHC	1.1.3.1	No of pregnant women availed the referral facilities (pick up and drop)
				1.1.4	To strengthen Janani Suraksha Yojana / JSY	1.1.4.1	% of pregnant women received JBSY payments immediately after delivery
2	To increase safe delivery by trained SBA 9.6% ( DL HS3) to 100% by year 2010	2.1	Proportion of birth attendant by skilled health personnel	2.1.1	To ensure support of SBA at home deliveries	2.1.1.1	% of home deliveries attended by SBA
3	To increase ANC coverage with quality 16% (DLHS3) to 50% by year 2010	3.1	% ANC reported through HMIS formats / Form -7	3.1.1	To strengthen HSC for providing outreach maternal care	3.1.1.1	% of HSCs having ANMs
						3.1.1.2	% of HSCs conducted fixed ANC and clinics (planned & held)
				3.1.2	To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas	3.1.2.1	% of RCH camps planned and held
				3.1.3	To improve adolescent reproductive and sexual health	3.1.3.1	No of pregnant adolescent counselled by ANM/ AWW/ASHA
				3.1.4	To accelerate APHC for OPD and Fixed AN clinics	3.1.4.1	% of OPD clinics organised at APHC level.

4	To provide safe abortion services at all facilities	4.1	% MTP cases reported through HMIS formats / Form -7	4.1.1	To provide MTP services at health facilities	4.1.1.1	No of facilities having MTP services (public and private )
5	To increase community participation in maternal care	5.1	% of Mahila mandal meetings conducted.	5.1.1	To strengthen Monthly Village Health and Nutrition Days	5.1.1.1	% of monthly Village Health & Nutrition Days planned and held
<b>MATERNAL HEALTH</b>							
Sl.	Strategy	SI	Gaps	SI	Activities	Unit Cost	Total Budget
	<b>To make functional PHC (24hr x7days) for institutional deliveries</b>		<b>Infrastructure</b>				
A1		1.1	All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms.(List attached, Annexure..)	1.1.1	Need based ( Service delivery)Estimation of cost for upgradation of PHCs Selection of any two PHCs for ISO certification in first phase	@2000 00/-Per PHC	3600000
		1.2	At present 10 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 150 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	1.2.1	Preparation of priority list of interventions to deliver services.	NA	0

	1.4	The comparative analysis of facility survey(08-09) and DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still the area of improvement.	1.4.1	Sending the recommendation for the certification with existing services and facility detail.	NA	0
	1.5	Lack of equipments as per IPHS norms and also under utilized equipments.	1.5.1	Prioritizing the equipment list according to service delivery and IPHS norms.	NA	0
			1.5.2	Purchase of equipments	NA	0
	1.6	Lack of appropriate furniture	1.6.1	Purchase of Furniture	NA	0
	1.11	Lack of facilities/ basic amenities in the PHC buildings	1.11.1	Renovation of PHCs	NA	0
<b>To make functional PHC (24hr x7days) for institutional deliveries</b>	1.12	<b>As per IPHS norms each PHC requires the following clinical staffs:(List attached)</b>				0
				Salary of Contractual Doctors	94 MBBS @20000/	22560000
	1.12.1	The actual position is not sufficient as per IPHS norms List of Human resource is attached in Annexure.		Selection and recruitment of Doctors (SPL) on contractual basis and give priority in selection those who are living in same PHC.	36 Doctors to be appointed	10800000
			1.12.10.1	Salary of Contractual Grade A nurses	71 Grade A Nurse	6390000
	1.12.10			Selection and recruitment of grade A nurses for conducting delivery	31 Grade A nurse for	

					each PHC	
					Selection and recruitment of dresser	18 Dresser , one for each PHC  972000
					Selection and recruitment of Pharmacist.	18 x2 Pharma sist for each PHC  2160000
					Three month induction training of Grade A nurse under supervision of District level resource team.	100/- per day x 90 days for 102 grade A nurse  918000
	1.13		1.13.1	Training need Assessment of PHC level staffs	NA	0
				Honorarium of Block Accountants	18 Accou ntant @ 12000/	2592000
				Rent of Data Center	19 Data Center @ 7500/	1710000
				Honorarium of BHM	18 BHM @ 18000/ -	3888000
				Mobility support to BHM	Rs 2000 per month per BHM	432000
	1.14		1.14.1	Appointment of Block Health Managers, Accountants in all	4 BHM and 4 Accou ntants Budget	

1440000  
Budget

				institutions.(1 SDH, 2 Referrals and Sadar hospital.)	in RKS head	
				Process of all recruitments	6 types of recruitment @ 10000	60000
				Trainings of BHM's on Health statistics	22 BHM's	44000
				Training on Program, Finance management and HMIS	22 BHM's, 22 Block Accountants and 22 Data Center operators	132000
		<b>Drug Supply</b>				
	1.16	Irregular supply of drugs because of lack of fund disbursement on time.	1.16.1	Ensuring the availability of FIFO list of drugs with store keeper.	NA	0
	1.17	Only 38 essential drugs are rate contracted at state level .	1.17.1	2.Implementing computerized invoice system in all PHCs	NA	0
				Purchase of Drug invoice software	Rs 10000 per PHC	180000
		Lack of fund for the transportation of drugs from district to blocks.	1.17.2	3.Fixing the responsibility on proper and timely indenting of medicines ( keeping three months buffer stock)	NA	0
						0
	1.18		1.18	4.Payment from Rogi Kalyan samiti account. (VEHICLE+OF	Rs 20000 per	

			FICE EXP.)	month per PHC	
1.19	There is no clarity on the guideline for need based drug procurement and transportation.	1.19.1	5. Orientation meetings/ training on guidelines of RKS for operation.	Rs 2000 per PHC	38000
1.2	Drugs are not properly stored	1.20.1	6. Enlisting of equipments for safe storage of drugs.	NA	0
		1.20.2	7. Purchase of enlisted equipments.	Rs 15000 per PHC	285000
		1.20.3	8.training of store keepers on invoicing of drugs	Rs 2000 per PHC	38000
	<b>Performance</b>				0
1.21.1	Excessive load on PHC in delivering all services i.e. 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 OPD per day in each PHC.	1.21.1	Recruitment of Doctors on contractual basis	NA	0
1.21.2	Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant.			NA	0
1.22	All posted doctors are not regularly present during the OPD time so the no of OPDs done is very less (only average 16 patients per Doctor per OPD days during April 08- Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.)	1.22.1	Hiring of rented houses from RKS fund for the residence of doctors and key staffs.	Rs 5000 per PHC per month	1140000
		1.22.2	Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients	Rs 5000 per PHC per month	

				treatment.			
			1.22.3	Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day	NA	0	
<b>To make functional PHC (24hr x7days) for institutional deliveries</b>	1.24	5 PHCs are lacking 24 hrs new born care services.	1.24.1	Ensure 24 hrs new born care services in 10 PHC.	Budget in Child health care activity	0	
	1.27	Only five PHCs provides 24 hrs BEmoC services.	1.27.1	Ensure 24 hrs BEmoC services at 10 PHC		0	
				Training of one Doctor from each PHC on BEmoC.	2000/- Per Docter	20000	
				Equipments for BEmoC	50000 per facility	500000	
	1.29	13 PHC does not have laboratory facilities on PPP based srvcies.But except Mahnar all Phc have T.B lab Technician. In addition to this the regular lab technician has been deputed for this purpose.	1.29.1	Deputation of 17 regular Lab tech at PHC level for providing free of cost lab services to all pregnant women and BPL families.	NA	0	
	1.3			1.30.1	Recruitment of 5 lab technicians as required for regular support of lab activity	6000/- per head	360000
					Training of TB lab technician on other pathological tests.	1000/- per trainin g	17000
					Purchase reagent(recurrin	5000 per unit	1020000

			g) for strengthening lab.	per month	
			Purchase of equipments/ instruments if needed . Fund could be rooted through RKS and if it is not utilised it could be diverted to other women and child friendly activites.	50000/-per PHC	850000
1.32	Health facility with AYUSH services is not being provided		Establising one Panchkarm center in Chehrakala PHC	10000 Per PHC	120000
			Establishing two homeopathy centers in Jandaha and Vaishali	5000/- each PHC for medicine , equipments and Furniture.	120000
<b>1.33</b>	<b>Referral Services</b>				<b>0</b>
1.33.1	No pick up facility for PW or BPL patients.	1.33.1.1	Provision for pick up & drop pregnant mothers and BPL families free of cost using existing Ambulance services at PHC level.	60000/-each PHC per month	13680000
			Provide EDD list of pregnant women to Ambulance driver and Number of ambulance diriver and 102 /PHC tel No to all Pregnant woment	NA	0

	1.33.3	Lack of maintenance of VEHICLE	1.33.3.1	Repairing of all defunct VEHICLE	TEN VEHICLE @ rs 50000 per VEHICLE	500000
	1.33.4	Shortage of ambulances	1.33.4.1	Hiring of ambulances as per need.	one in each PHC @ Rs 10000 Per month	2280000
				Prepare list of Vehicle those are utilised in Monitoring work in PHC that can be use in pick up and dropping facility for PW.	NA	0
	1.34	Quality of food, cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.	1.34.1	Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.	Rs 50 per patients into 25 patients per day per PHC	8550000
				Rewiev of Cleanliness activity in all PHC by Qulity assurance committee and payment of agency should be link with it.		0
			1.34.2	Hiring of workers for cleanliness of OT and Labour room in PHC	Two workers per PHC for maximum 30 days @ Rs 100 per day by	1368000

					concerned RKS	
				Purchase equipments and uniform for cleanliness in all PHC	50000/each PHC	950000
				Training of Workers on using machine/equipments and importance of cleanliness .	2500/- per PHC twice in a year.	95000
				Develop mechanism for monitoring of cleanliness work	NA	0
	1.35	All PHCs have their own generator sets but are not in use.	1.35.1	Repairing of PHCs gensets and initiating their use.	Rs 5000 per PHC	95000
	1.7	Non availability of HMIS formats/registers and stationeries	1.7	Printing of formats and purchase of stationaries	Rs 50000 per PHC	950000
			1.7.2	Biannual facility survey of PHCs through BHM as per IPHS format	NA	0
				1.7.3	Regular monitoring of PHC facilities through PHC level supervisors in IPHS format.	NA
	1.8	Operation of RKS:	1.8.1	Ensuring regular monthly meeting of RKS.	Confec tionary costs @ Rs 500 per month per	114000

					PHC	
			1.8.2	Appointment of Block Health Managers, Accountants in all institutions.(16 PHCs, 3 Referrals and Sadar hospital.)	Nine more BHM's and 6 more Accountants( Rs 18000 per month for BHM's and Rs 12000 per month for Accountants)	2808000
	1.9	Lack in uniform process of RKS operation.	1.9.1	Training to the RKS signatories for account operation.	Rs 1000 per participant, Two participants from each PHC	38000
			1.9.2	Trainings of BHM and accountants on their responsibilities.	Rs 1000 per participant, Two participants from each PHC	34000
	1.1	Lack of community participation in the functioning of RKS.	1.10.1	Meeting with community (School children or	5000/- per PHC	95000

				other)representatives on erecting boundary, beautification etc,		
			1.10.2	Meeting with local public representatives/ Social workers and mobilizing them for donations to RKS.	NA	0
	1.36	In serving emergency cases, there are maximum chances of misbehave from the part of attendants, so staffs reluctant to handle emergency cases.	1.36.1	Meeting in RKS with Local Police Station incharge to handle emergency situation .	NA	0
				Training local NCC/NYK/Scout & Guide/NSS etc.volunteers on identification of emergency situation. And deployment of volentears at PHC.	5000/- per PHC	95000
<b>To make functional PHC (24hr x7days) for institutional deliveries</b>	1.37	Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.	1.37.1	Insurance of all properties and staffs of PHC	Rs 10000 per PHC	190000
	1.38	No guidance to the patients on the services available at PHCs.	1.38.1	Pictorial wall painting on every section of the building denoting the facilities and attached trained volenters to guide paitents.	Rs 2000 per PHC	38000
	1.39	Non friendly attitude	1.39.1	Name plates of Doctors	Rs	38000

	of staffs towards the poor patients in general and women are disadvantaged group in particular.		Displaying Name Photograph and DOB of all staff of PHC and put cleanliness staff name on top of the list.	2000 per PHC	
1.41	Lack of counselling services	1.41.1	There are 22 LHV in the district we can utilise their experience in counseling work of women and adolescent girls after training.	1000 per person	22000
1.42	There is no hot water facility for PW and there is no adequate lighting facility at adjoining area of PHC	1.42.1	Installation of solar heater system and light with the help of BDO/Panchayat at PHC or purchase equipments from market.	100000 /-per PHC	1900000
1.43	Lack of convergence	1.43.1	Convergence meeting by RKS & DHS	NA	0
1.44	Lack of timely reporting and delay in data collection	1.44.1	Orientation of the staffs on indicators of reporting formats	NA	0
		1.44.2	Purchase of MOBILE for DPMU -3 and BPMU-36 with maintenace.	Rs 10000 per unit+ 500 per month	624000
		1.44.3	Purchase of Laptops for DPMU -3 and BHM-18 with internet facility.	Rs 35000 per unit+ 2000 per month	1239000
1.45	Lack of space for waiting, environmental cleanliness around PHC, provision for hospitality etc	1.45.1	Gardening	Rs 5000 per PHC	95000
		1.45.2	Sitting arrangement for	Rs 5000	95000

					patients	per PHC	
					Construction of patients waiting shade	75000/ -Per PHC	1425000
				1.45.3	Installation of LCD projector for manage wait over time of OPD patients.	Rs 100000 /- per PHC	1900000
				1.45.4	Installation of safe drinking water equipments/water cooler,	Rs 10000 per PHC	190000
				1.45.5	Apron with name plates with every doctors	Rs 250 per Doctor for total 205 doctors	51250
				1.45.6	Presence of staffs with uniform and name plates.	NA	0
				1.45.7	“MAMTA” should be appointed at PHC level as well.	Rs 75 per deliver y for approx 60000 instituti onal deliver y	4500000
2	<b>To make FRU functional and upgradation of PHC to CHC for institutional deliveries</b>	2.1	C-Section deliveries are not conducted in institution.	2.1.1	Devlop SAMHO, MANSURCHAK, BIRPUR, GARDHPURA, DANDARI, CHAURAH and NAWKOTHI PHC for C-section facility	500000 PER PHC	3500000

			2.1.2	Training of MOs of 07 PHCs in mulltiskilling.	3 Doctor s from each PHC @ 2000/- per person	42000
			2.1.5	Specialist should be posted at Sadar Hospital/and above mention three PHC	NA	0
			2.1.6	Incentive for C-section to PHC those who conducted 10 - 15 = 10000,15-20=20000, 25-30= 50000/,C-section in a month the incentive money should be distributed among all staff of the PHC after the decision of RKS.	Rs 25000 per PHC per month	2100000
			2.1.8	Need based Equipments and drugs in O.T and Labour room.	List of Equipm ent attache d(1000 00 per PHC)	1900000
		None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.		Establishing blood storage units at Lalganj, Mahua & Rahopur,	60000/- Per PHC	180000
				Training of lab technicians on management of blood storage	3 lab technic ions	3000

		Infection control protocols is not at all maintained at all facilities	2.2.2	Licensing blood storage / blood bank	NA	0
			2.2.3	Meeting infrastructure requirements as per norms for Blood storage	10000 Per PHC	30000
			2.2.4	Training of MO and lab tech/ staff nurse blood storage on grouping /cross matching and management of transfusion reactions stabilized linkages with mother blood bank.	Rs 1000 per participant, Two participants from each PHC	38000
			2.2.5	Provide free of cost Blood for pregnant women who need blood transfusion for severe anemia/ PPH on prescribed through RKS Fund	20000/-for each PHC per month	720000
			2.2.11	Organize Blood donation camps at all institution and mobilize community for voluntary blood donation	Rs 10000 per camp per PHC for organizing two camp annually	380000
	2.3	Welcome PW at Institution and PHC and FRU	2.3.1	Provision of food for the delivered mothers and mothers under gone in tubectomy in all the health	NA	0

				facilities.			
				2.3.2	Mobilize community Resources for providing Free food for PW at Institution.	NA	0
				2.3.3	Quality indicators (clean environment, wards with clean linen, clean toilets , clean labour rooms, running waters supply, hot water and safe water for inpatients, new born corners, treatment protocols, aseptic precautions, immediate disbursement of JBSY funds	NA	0
		2.4	Reporting of maternal death Maternal death reporting is usually not reported by worker	2.4.1	Training of ASHA & ANM on reporting of Maternal deaths and conduct Verbal Autopsy	Rs 5000 per PHC	95000
				2.4.2	Incentives for maternal death reporting by ASHA @ Rs 50/-per maternal death	Rs 50/-per maternal death for approx 300 maternal deaths	15000
				2.4.3	Reporting line should be in five columns – name of mother, place of death, date of death, cause of	NA	0

					death and no. of birth.		
				2.4.4	Institution and urban center also to report Maternal death to the district CS/ACMO.	NA	0
				2.4.5	Maternal Death should be reported by ASHA, AWW, ANM Staff Nurse & Doctors to the district data center .	NA	0
				2.4.6	Investigation of maternal death by district team. and third party review(District magistrate)	NA	0
				2.4.7	Training of ASHA and investigation team objective and process of investigation and review of maternal death	Rs 3000 per PHC	57000
		2.5	Biomedical waste management is not properly taken care off at all institution	2.5.1	Procurement of equipment	Rs 50000 per PHC	950000
				2.5.2	As per example Introduce color coded buckets for facilities as per IMEP	NA	0
4	<b>To strengthen Janani Suraksha Yojana / JSY</b>	4.1	Tracking of pregnant women from first Trimester is not done form the register.	4.1.1	Review of early registration with 3 AN checkup ,two TT.100/200 IFA Tab. in ASHA Diwas.	NA	0
		4.2	Too much documentation process. Photo required for mother and baby. It cost	4.2.1	Ensure 100 %Pregnancy Test Kit is to ASHA and regular supply.	Rs 50 for 99000 pregnancies	4950000

			Rs.30/- to Rs.60/- .	4.2.2	Direct transfer of funds from district to PHC through core banking / directly from DHS	NA	0
				4.2.3	Finger print technology for JSY beneficiaries at facility level where computer with internet facility is available. This will help in financial monitoring.	NA	0
				4.2.4	The photo system should be replaced by some other alternatives like- bank account opening of pregnant women in first trimester and directly transfer the money to their account after delivery.	Incentive to ASHA for rs 50 per PW for opening of bank account of PW for 99000 pregnancies	4950000
					Incentive for institutional delivery.	Rs 2000 per delivery	132000000
5	<b>To ensure support of SBA at home deliveries</b>	5.1	Home Delivery is still prevailing through untrained traditional Dai's	5.1.1	Home Delivery should be conducted by SBA trained Staff Nurse or ANM.	NA	0
				5.1.2	Provision of Dai Delivery kit(DDK) to TBA where institution access is poor. And it should be supervised by ANM for	NA	0

				home deliveries.			
			5.1.3	Delivery kit (equipment, medicine)for ANM should be supplied	Rs 10000 per PHC	190000	
			5.1.4	Supply of delivery Kits as per number of deliveries conducted in home.	NA	0	
		5.2	Reporting of home delivery is not done so the PNC is not provided	5.2.1	Incentive based system for reporting of home delivery by ASHA and it should be linked with ANM	NA	0
		5.3	Non paiment of Home delivery through JSY	5.3.1	The JSY money to the mother who has delivered baby at Home paid by ANM.	Rs 500 per home deliver y for approx 33000 home deliveri es	16500000
6	<b>To strengthen HSC for providing outreach maternal care</b>	<b>Infrastructure</b>					0
		6.1	Out of 338 HSCs only 39 are having own building	6.1.1	Strengtheing of HSCs having own buildings		0
		6.2	In existing 39 buildings 26 are in running comparatively in good condition, 6 are in under construction ,one is very poor condition and one is constructed but not handed over to health department.	6.2.1	White washing of HSC buildings.	Rs 2000 per PHC	38000
				6.2.2	Organize adolescent girls for wall painting and plantation./hire local painter for colourful painting of HSC walls.	NA	0
				6.2.3	List out all services which is provided at	NA	0

				HSC level. On the wall.		
			6.2.4	Gardening in HSC premises by school children.	NA	0
	6.3	No one building is having running water and electric supply.	6.3.1	Mobilize running water facility from near by house if they have bore well and water storage facility and it could be on monthly rental.(Untied fund)	Water rent for 39 HSC, Rs 100 per month from untied fund.	0
				Arrangement of water supply upto HSC ( Wiring ) from water source	Rs 5000 per HSC	195000
<b>To strengthen HSC for providing outreach maternal care</b>	6.4	Lack of appropriate equipments and ANM are reluctant to keep all equipments in HSC .	6.4.1	Purchase of Furniture Prioritizing the equipment list according to service delivery(for ANC /Family planning /Immunization/)	Rs 20000 per HSC having own buildings	780000
			6.4.2	Purchase of equipments according to services	NA	0
			6.4.3	Purchase one almirah for keep all equipment safely and it could be keep in AWW / ASHA house.	Rs 10000 per HSC	3390000
	6.5	Non payment of rent of 300 HSCs for more than three years	6.5.1	Strengthening of HSCs running in rented buildings.		0
			6.5.2	Estimation of backlog rent and facilitate the backlog payment within two months	Rs 300 per HSC per month for 36	0

					months (State fund)	
			6.5.3	Streamlining the payment of rent from the month of April 09.	Rs 300 per HSC per month for 12 months (from State fund)	0
			6.5.4	Purchase of Furniture as per need where building is on rent	From untied fund	0
			6.5.5	Prioritizing the equipment list according to service delivery	NA	0
			6.5.6	Purchase of equipments as per need	From untied fund	0
	6.6	The district still needs 135 more HSCs to be formed.	6.6.1	Construction of new HSCs. 39 are having own building, 54 new is proposed and rest 480 are supposed to be constructed.	From State Govt fund	0
			6.6.2	Preparation of PHC wise priority list of HSCs according to IPHS population and location norms of HSCs	NA	0
			6.6.3	Community mobilization for promoting land donations at accessible locations.	NA	0

			6.6.5	Meeting with local PRI /CO/BDO/Police Inspector in smooth transfer of constructed HSC buildings.	NA	0
<b>To strengthen HSC for providing outreach maternal care</b>	6.7	Non participation of Community in monitoring construction work	6.7.1	Biannual facility survey of HSCs through local NGOs as per IPHS format	Rs 200 per HSC biannually	135600
			6.7.2	Regular monitoring of HSCs facilities through PHC level supervisors in IPHS format.	NA	0
			6.7.3	Monitoring of renovation/construction works through VHSC members/ Mothers committees/VE Cs/others as implemented in Bihar Education Project.	NA	0
			6.7.4	Training of VHSC/Mothers committees/VE Cs/Others on technical monitoring aspects of construction work.	Rs 20000 per PHC	340000
			6.7.5	Quartely Meeting of one representative of VHSC/Mothers committees on construction work and other issues	Rs 50 for TA to VHSC members for attending monthly meeting at PHC	204000

		6.8	Lack of community ownership in the monitoring of construction work.	6.8.1	Formation and strengthening of VHSCs, Mothers committees,	NA	0
				6.8.2	“Swasthya Kendra chalo abhiyan” to strengthen community ownership	NA	0
					One week Training of Nukkad Natak team on IPHS	Rs 300 per participant per day for 85 persons for 7 days	178500
				6.8.3	Nukkad Nataks on Citizen’s charter of HSCs as per IPHS	Three days performance at 339 HSCs	1525500
				6.8.4	Monthly meetings of VHSCs, Mothers committees	NA	0
7		<b>Human Resource</b>					
		7.1	1.Out of 29 sanctioned post of LHVs only 22 are placed, 2.All 195 posted ANM ® are not trained enough to deliver services. 3. 223 seats of contractual ANM®, 12 seats of contractual ANMs and 27 seats of Regular ANMs are vacant.	7.1.1	Selection and recruitment of 262 ANMs	Honorarium of 262 ANMs @ Rs 6000 per month for 12 months	18864000
					Honorarium of existing 202 ANMs	Honorarium of existing 202 ANMs @ rs 6000 per month for 12	14544000

					months	
			7.1.2	Selection and recruitment of 28 male workers	Honarium of 28 male workers @ Rs 5000 per month for 12 months	1680000
			7.1.3	Training need Assessment of HSC level staffs by BHM in weekly meeting	NA	0
			7.1.4	Training of staffs on various services in the PHC,	Rs 1000 per participant (Total no of participants 262 new ANMs, 202 existing ANMs and 28 new male workers)	492000
<b>To strengthen ANM Training School for providing regular training of</b>	7.2	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	7.2.1	Analyzing gaps with training school		0
			7.2.2	Deployment of required staffs/trainers		0
			7.2.3	Hiring of trainers as per		0

	ANMs.				need		
				7.2.4	Preparation of annual training calendar issue wise as per guideline of Govt of India.		0
				7.2.5	Allocation of fund and operationalization of allocated fund	Rs 200000 in a year	200000
8	<b>To strengthen HSC for providing outreach maternal care</b>	<b>Drug Kit Availability</b>					0
		8.1	No drug kit as such for the HSCs as per IPHS norms.(KitA, Kit B, drugs for delivery, drug for national disease control program (DDT, MDT, DOTs, DEC)s)and contraceptives,	8.1.1	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
			No Drug kit for AWCs(@one kit per annum,) . No ASHA kit, only need based emergency but that too being irregular in supply	8.1.2	Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map	From state fund	0
				8.1.3	Hiring vehicles for supply of drug kits through untied fund.	Rs 200 per HSC per month	691200
				8.1.4	Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Rs 2000 per PHC	38000

				8.1.5	Hiring of couriers as per need	Rs 50 per courier for 200 couriers for 8 days per month	960000	
				8.1.6	Payment of courier through ANMs account	Fund for the payment of Couriers should be transferred to ANMs account.	0	
9	<b>To strengthen HSC for providing outreach maternal care</b>	<b>Performance</b>						0
9.1		Unutilized untied fund at HSC level	9.1.1	Training of signatories on operating Untied fund account, book keeping etc	Rs 100 per person for two persons for 339 HSCs	67800		
			9.1.2	Timely disbursement of untied fund for HSCs	Rs 10000 per HSC per year for 339 HSCs	3390000		
			9.1.3	Assigning a person at PHC level for managing accounts	NA	0		
9.2		No ANC at HSC level Only 14.2% PW registered in first trimester PW with three ANCs is 15.1%, TT1 coverage is 35.4%,	9.2.1	Identification of the best HSC on service delivery	NA	0		
			9.2.2	Listing of required equipments and medicines as per IPHS norms in facility	NA	0		

				survey		
			9.2.4	Honouring those ANMs who devlope women friendly HSC in given criteria (list is attachet)	5 ANM in a year per PHC social honouring with one shawl.	47500
	9.3	Family Planning Status:-Any method-43.6%,Any modern method-39.8%,No sterilization at HSC level,IUD insertion - 0.5%,Pills- 1.5%,Condom- 1.9%,Total unmet need is 32.7%, for spacing-14.9,Lack of counselling Skill.	9.3.1	Gap identification of 39 HSCs through facility survey	NA	0
			9.3.2	Eligible Couple Survey	NA	0
			9.3.3	Ensuring supply of contraceptives with three month's buffer stock at HSCs.	State Fund	0
			9.3.4	One day training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS	Rs5000 per PHC	95000
			9.3.5	Training of ANMs on IUD insertion	Rs 10000 per PHC	190000
	9.4	HSC unable to implement disease control programs	9.4.1	Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6.( four to five HSC per week)	NA	0
<b>To strengthen HSC for providing outreach maternal</b>			9.4.2	Strengthening ANMs for community based planning of all national disease control	NA	0

care				program			
			9.4.3	Reporting of disease control activities through ANMs	NA	0	
			9.4.4	Submission of reports of national programs by the supervisors duly signed by the respective ANMs.	NA	0	
		9.5	80% of the HSC staffs do not reside at place of posting	9.5.1	Submission of absentees through PRI	NA	0
		9.6	Problem of mobility during rainy season	9.6.1	Purchasing Life saving jackets for all field staffs	3 units per PHC at the rate of Rs 3000 per unit	171000
	9.6.2			Providing incentives to the ANMs during rainy season so that they can use local boats.	From untied fund	0	
		9.7	Lack of convergence at HSC level	9.7.1	Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.	from untied fund	0
				9.7.1	Monthly Video shows in all schools of the concerned HSC area schools on health, nutrition and sanitation issues.	From untied fund	0

		9.8	Lack of knowledge and skill of field level staffs in data compilation in HMIS formats	9.8.1	Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc	NA	0
				9.8.2	Printing of adequate number of reporting formats and registers	Discussed earlier	0
10	<b>To organise integrated RCH camps specially for hard to reach areas, isolated population and Maha Dalit Tolas</b>	10.1	Out reach camps are not organised in plan manner. It is totally based on demand of organisation and eventually it is not reported to respective HSCs and PHCs.	10.1.1	Identifying Socially Backward, Slums & Maha Dalit Tolas.	NA	0
				10.1.2	Hiring trained alternate vaccinator/ retired ANMs and Medical officer .hiring vehicle for fixed day out reach camps with drugs.	Rs 10000 per PHC per month	2280000
				10.1.3	Fixed day OPD clinics at APHC level and adjoining HSC of respective APHCs. with dedicated MO and support staff.	NA	0
				10.1.4	To make calendar for camps with date and identified areas.and link NGOs those who are willing to organise Camps .	NA	0
				10.1.5	Community based reporting system through SMS. involve PRI members and training on reporting and	NA	0

					Camp approach		
11	<b>To improve adolescent reproductive and sexual health</b>	11.1	No training programme for adolescent particularly health and sex.	11.1.1	Multipurpose counsellor can be used for adolescent care. For this services of LHV can be used.and callender of activity could be devloped.	NA	0
		11.2	Preventions of anemia in adolacencent girls	11.2.1	Linkage with adolescent anemia control programme in Schools with Unicef. And training to one teacher from the school	Rs 5000 per PHC	95000
		11.3	Marriage before legal age.	11.3.1	Sensitization of PRI members pertcularly women	Rs 5000/- Per PHC	95000
		11.4	Preventions of teen age pregnancy and abortion.	11.4.1	Adolescent pregnancy should be addressed with priority care( eclampsia, 3 ANC, anemia, 100 IFA, 100% institution delivery, low birth Wight baby, Brest feeding.PNC with in 48 hours.	NA	0
		11.6	Limited interventions for empowering adolescent girls	11.6.1	Family counseling for adolescent pregnancy tracking on above mentioned through ASHA and AWW.	NA	0

				11.6.2	State to develop and issue guidelines for implementation of Kishori Mandals Formation of Kishori Mandals by registration of all girls(11-18 yrs)	NA	0
	<b>To improve adolescent reproductive and sexual health</b>			11.6.3	Prepare a monthly plan of activities for one day per week	NA	0
				11.6.4	Counseling nutrition, health and social issues every week at AWCs by AWW	NA	0
				11.6.5	Weekly distribution of IFA Tablets to out-of-school girls at AWCs	From State	0
				11.6.6	Deworming adolescent every 6 months	Purchase of 12 lac tablets	900000
				11.6.8	Initiate family schools for learning child care , safe motherhood life skills and Family life education	Rs 10000 per Schools each in each PHC	190000
12		<b>To provide MTP services at health facilities</b>	12.1	MTP services are not available in Public sectors	12.1.1	Selection of facilities for provision of safe abortion services	NA
	12.1.2				Location of facility availability of trained service provider, space, equipments.	NA	0
	12.1.3				To Provide appropriate equipments at all facilities and MVA syringes.	50000/-per PHC	950000

			12.1.4	Putting the trained doctors at appropriate facilities to commence the services	NA	0	
			12.1.5	Training of Medical officers and Para medical staffs on Safe abortion services training including awareness about legal aspects of MVA/ EVA and Medical abortion by IPAS .	One doctor and one ANM from each PHC @ Rs 2000	38000	
			12.1.6	Formation of district level committee (DLC) to accredit private sites as per GOI guide line .	NA	0	
			12.1.7	Develop reporting system of MTP services in private and public sector.	NA	0	
			12.1.8	Through training program make the govt doctors skilled to perform MTP in the approved sites.	NA	0	
			12.1.9	To Involve community to aware about location of services , process and legal aspects of MTP services through - AWW, ASHA & ANM, LRG and mass media.(IEC)	Rs 5000/- Per PHC	95000	
			<b>To provide MTP services at health facilities</b>				

				12.1.10	The services of Pregnancy testing should be strengthened and it should be linked with MTP services.	NA	0
				12.1.11	NGO's and local Practitioner should be involved for counseling and information of facility	NA	0
				12.1.12	Assurance of privacy and link with family welfare services counseling at all facility.	NA	0
				12.1.13	Linkage with MTP services with NGOs (PPP) those who are working in Safe abortion services. and create one modal center at district and PHC level.	NA	0
				12.1.14	Training of ASHA on medical abortion.	Incorporated in ASHA training	0
13	<b>To strengthen Monthly Village Health and Nutrition Days</b>	13.1	Nutrition and Counselling Component is not visible in VHND and there is no monitoring of VHND activity by Community.	13.1.1	AWC should be developed as a Hub of activities (VHND)	NA	0
				13.1.2	Develop an activity plan calendar for VHND as seasonality.	NA	0
				13.1.3	Counseling of mothers on ANC, preparation for Child care ,STI/RTI, and AYUSH,	NA	0

				adolescent Health		
			13.1.4	Organize VHND in Four Table concept regularly where One place is for registration, one is for weighing, one is for immunization and fourth is for counseling	Booklet on four table concept @Rs 5 for 10000 booklets	50000
			13.1.4	Meeting of VHSC and preparation for area specific epidemiological planning and community based monitoring.	NA	0
			13.1.5	Skill development training is required to ANM , ASHA & AWW and Dular (LRG)	Rs 5000 per PHC	95000
			13.1.6	Develop monitoring plan map of each village and displaced at AWC with identification of priority houses with PW, lactating women ,Malnourished children , New born, DOTs and other services	From untied fund	0
			13.1.7	SMS reporting system of conducting VHND and ANM collect Data from field level and compile it in weekly/Monthly formats.	NA	0

B	<b>APHC</b>		<b>Infrastructure</b>				0
	<b>To form /strengthen APHC in Phase manner</b>	1.3	Out of 30 APHCs only 16 are having own building	1.3.1	Registration of RKS	NA	0
		1.4	Existing 16 buildings are not properly maintained	1.4.1	Renovation of APHCs buildings from RKS Fund	Rs 150000 per APHC	2850000
		1.5	Non payment of rent of 14 APHCs for more than three years	1.5.1	Payment Of Rent of APHC building	From state fund	0
		1.6	Lack of equipments,	1.6.1	Purchase of equipment as per service need from RKS fund	From state fund	0
		1.7	Lack of appropriate furniture	1.7.1	Purchase of Furniture from RKS fund	From state fund	0
2			<b>Human Resource</b>				0
		2.1	in the district no any APHC functioning as per IPHS norms	2.1.1	Operationalising one APHC in each PHC by conducting daily OPD by Doctor and support staff.	NA	0
		2.2		2.2.1	Notification from district for operationalising APHC	NA	0
3			<b>Drug Supply</b>				0
		3.1	No drug kit as such for the APHCs as per IPHS norms.,	3.1.1	Purchasing 23 listed OPD Drugs of PHC for APHC	Rs 200000 /- Per PHC for OPD drugs for one year.	3800000
5	<b>RTI/STI services at health facilities</b>	5.1	No regular clinic at all PHCs & APHCs.	5.1.1	Trained service provider on syndrome management of RTI/STI (As per GOI guideline) up to APHC level.	Rs 1000/- for Two person from each PHC	34000

				5.1.2	Logistics of setting of clinics and free drugs availability	NA	0
				5.1.3	Integrated Counselling services in four public sector facilities by trained personnel .	NA	0
				5.1.4	IEC/BCC for awareness available RTI/STI services at all health facilities.	Rs2000 0 for Per PHC	380000
					<b>Total</b>		<b>393724350</b>

## 4.4 Child Health

## Logical Framework

Sl.	Goal	Sl.	Impact indicators						
1	To improve Child health & achieve child survival	1.1	Reduction in IMR						
		1.2	Child performance in the school - enrolment, attendance and dropout						
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators		
1	To increase ORS distribution from 51%(DLHS3) to 80%	1.1	% increase of ORS distribution .	1.1.1	<i>IMNCI, Home Based Newborn Care/HBNC</i>		% of PHC initiated IMNCI and HBNC training.		
2	To increase treatment of diarrhoea from 77.1% to 90% within two weeks		% increase of treatment of diarrhoea within two weeks						
3	To increase treatment of ARI/Fever in the last two weeks from 82.2%(DLHS3) to 95%		% increase of treatment of ARI/Fever in the last two weeks						
4	To increase of infant care with in 24hr of delivery from 29.7%(DLHS3) to 50%		% increase of infant care with in 24hr of delivery .					Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.	No of PHC initiated FBNC with trained MAMTA on facility based newborn care..
5	To increase % of breastfeeding from 33.8% to 70% within 1 hr of birth		% increase of breastfeeding within 1 hr of birth .	1.1.2				Infant and Young Child Feeding/IYCF	No of training organised in PHC on IYCF
6	To increase initiation of complimentary feeding among 6 month of children from 88.3% to 90%		% increase of complimentary feeding among 6month of children.						
7	To increase exclusive breastfeeding		% increase of exclusive breastfeeding among						

	among 0-6 month of children from 36.4% to 80%		0-6 month of children .				
8	To increase immunization coverage from 53.3% to 70%		% increase of full immunization coverage .				
9	To increase vit A coverage of received atleast one dose (9month to 35 months ) from 67.3% to 80% and include up to 5 years.		To increase Vit A reported adequate coverage among (9m to 5ys )	1.1.3	Management of diarrhea, ARI and Micronutrient Malnutrition through Child survival months		Two round of Child survival Month organised in one financial year.
10	To decrease Malnutrition form 58%(NFHS III state ) to 30% of the age group of (0 to 5 yrs)		% of decrease Malnutrition age group of (0 to 5 yrs)	1.1.4	Care of Sick Children and Severe Malnutrition and strengthen VHND at all AWCs		No of VHND organised vs Planned .
		2.1		2.1.1	School Health Programme		No Of school health programme organised in the PHC
<b>Sl.</b>	<b>Strategy</b>		<b>Gaps</b>		<b>Activities</b>	<b>Unit Cost</b>	<b>Budget</b>
	<i>IMNCI, Home Based Newborn Care/HBNC</i>		<i>Training Gaps(AWW-2308/2500,ASHA-0,ANM-225/360,MO-55/94,Health supervisors-27,NGOs-06)</i>		<i>Assessment of Training load and prepare calendar of training</i>	NA	0
					<i>Incorporate ASHA in IMNCI training team</i>	NA	0
					<i>ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.</i>		
				<i>No ASHA is trained on IMNCI</i>			
			<i>Inadequate monitoring of this activity at field level</i>		<i>Division of area among all trained supervisors for revision of IMNCI activity in their area.</i>	NA	0

					<i>BHM will be responsible for review of health supervisor sand LS(ICDS)on given format.Unicef staff will support in developing review mechanism in PHC.</i>	NA	0
					<i>Incorporate IMNCI reports in HIMS formate</i>	NA	0
					<i>Encouraging mother regarding child care.in VHND</i>	NA	0
					<i>Frequent checkups of babies by Paediatrician.  Distribute telephone number to AWW and ANM of respective doctors those who are supervising them in the field.</i>	NA	0
					<i>Wednusday could be fixed a day for IMNCI related work at HSC level</i>	NA	360000 0
					<i>Community based Monitoring support system devlop with SHG in one PHCTraining of Group membersseed money to SHG for reffral services and other need based services.</i>	Rs 100000 for one PHC	100000
	Facility Based Newborn Care/FBNC		only eight institutions have baby warmer machines but maintenance of machine is not up to the mark and district having referral six bedded SNCU		All PHCs should be equipped with baby warmer machines.	Mobilizing nine units from UNICEF	0

		ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANMs to operate baby warmer machine.	Rs 5000/- for demonstration at District level	5000
		There is no provision of stay of mothers of neonates at PHC.		Organize training programme for newborn care for the nurses in the district hospitals	One Nurse from each PHC Cost will be 5000/-	5000
		Neonatal Care Unit not up to mark.		District level Supporting supervisory team should be developed with the responsibility of nonfunctioning of neonatal care unit. Training of team on monitoring of NCU	Rs.5000/-for one time training	5000
		Non availability of "MAMTA" at PHC level.		Training of Mamta and staff nurse on logistics of New born Care units by district level supervisory Team.	Rs 1500 for team members for each PHC per month	342000
	Infant and Young Child Feeding/IYCF	Non awareness of breast feeding and proper diet of young children.		Colostrum feeding and breast feeding inclusively for six months. Through IMNCI Training.	NA	0
				Baby friendly hospital Training of one doctor from each Nursing hospital at District Level	94 MBBS @20000/	22560000
				Selection and recruitment of Doctors (SPL) on contractual basis and give priority in selection those who are living in same PHC.	Rs 20000/- for training programme	20000
				Accreditation of nursing home and facility according to norms of baby friendly hospital initiatives	71 Grade A Nurse	6390000
				Poor knowledge regarding new born care and	Development and Printing of BCC materials	31 Grade A nurse for each PHC

		child feeding practices		Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA	18 Dresser, one for each PHC	972000
				Linking JBSY with colostrums feeding	18 x2 Pharmasist for each PHC	216000 0
		Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding		Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings	100/-per day x 90 days for 102 grade A nurse	918000
				Folk performance to promote exclusive breast feeding	Included in maternal health	0
				Uniform message on radio from state head quarter	18 Accountant @ 12000/	259200 0
		Lack of awareness on importance of appropriate and timely IYCF		Organize social events through VHSCs	19 Data Center @ 7500/	171000 0
				Strengthening of Mahila Mandal meetings- fortnightly with involvement of adolescent girl	18 BHM @ 18000/-	388800 0
				Organize healthy baby shows, healthy mother / pregnant woman.	Rs 2000 per month per PHC	432000
				Appointment of Block Health Managers, Accountants in all institutions.(1 SDH, 2 Referrals and Sadar hospital.)	4 BHM and 4 Accountants Budget in RKS head	144000 0

					Celebration of "Annaprashan( Muhjuthi) Day" at AWC	NA	0
					Demonstration of recipes.	22 BHM's	44000
					Exposure visits to existing NRCs to observe different models in the country	22 BHM's, 22 Block Accountants and 22 Data Center operators	132000
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severely malnourished children could be treated.		Establish rehabilitation center in district hospital, FRU and one PHC and promote locally available food formula for nutritional Therapy as Hadrabad Mix	Rs 1000000 per unit	400000 0
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priority among service providers.		Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	100000 ORS packets at the rate of Rs 5 per packet.(If ORS is not provided in Kit A) IFA syrup for 800000 children at rate of Rs 4 per children	370000 0
					Include coverage of Vitamin A and IFA, children in New HIMS format.	NA	0
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 yrs) respectively in the month of April And Oct as per GOI guide line.	Rs 1500000 per round into two rounds( If Vit A is not provided in Kit A)	180000
					Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	0
	School Health Programme				Half yearly health checkup camp for children in schools should be organized.	Rs 2000 per PHC	38000

		card.				
		No training of school teacher for basic health care and personnel hygiene.		4.Payment from Rogi Kalyan samiti account. (VEHICLE+OFFICE EXP.)	Rs 20000 per month per PHC	456000 0
		No regular health checkup camp at school.		Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA
		No Training & Screening of school's teacher for eye sight test.		Linking existing 7 ophthalmic paramedics with this program and developing school wise calender.	Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.	190000
		No other specific program has been formulated in the district.		School health anemia control programme should be strengthened with biannually de worming .	Budget incorporated in adolescent health	0
				Organizing competitions/Debates/P ainting competitions/Essay/demonstration and model preparation of nutritional food and health.	Rs 20000 per PHC	380000
				Half yearly Health checkups and health card of all school going children.	Printing of Health Card at the rate of Re 1 per card for the children of class 6 to 10	100000
				Films shows on health, sanitation and nutrition issues	Use LCD projector in this activity.	0

			Social science Lab activities.	Included in adolescent health	0
			Rally and Prabhat Pheri in epidemic areas. (Kala-azar & Malaria)	Local contribution/ Untied Fund/VHSC	0
			Referral system for the school children for higher medical care.	From RKS fund	0
<b>Total</b>					<b>113473 000</b>

## 4.5 Family Planning

### Logical Framework

Sl.	Goal	Sl.	Impact indicators				
1	Population stabilisation	1.1	To decrease TFR upto replacement level To increase sex ratio				
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
2	To increase female sterilization from present 35%(DLHS3) to 50%	2.1	% increase in female sterilisation	2.1.1	Terminal/Limiting Methods	2.1.1.1	% of terminal/limiting methods use
				2.1.2	Dissemination of manuals on sterilization standards & quality assurance of sterilization services	2.1.2.2	No of facilities providing quality manuals on sterilization standards of sterilization services.
				2.1.3	Female Sterilization camps	2.1.3.3	No of camps organised for female sterilization .
				2.1.4	Compensation for female sterilization	2.1.4.4	% of Female received compensation
				2.1.5	IUD camps	2.1.5.5	No of IUD used in Camps
				2.1.6	Accreditation of private providers for IUD insertion services	2.1.6.6	No of Private providers accreditate for IUD Insertion services.
3	To increase male sterilization from 0.6%( DLHS 3) to 2%	3.1	% increase in male sterilization	3.1.1	NSV camps	3.1.1.1	No of NSV Camps organised.
				3.1.2	Compensation for male sterilization	3.1.2.2	% of Male received compensation
				3.1.3	Accreditation of private providers for sterilization services	3.1.3.3	No of Private providers accredited for Sterilization services.
4	To increase use of condoms from 1.9% (DLHS3) to 5%	4.1	% increase in the use of condoms	4.1.1	Promotion to Social Marketing of condoms	4.1.1.1	No of Condoms distributed through Social Marketing.
				4.1.2	Contraceptive Update seminars	4.1.1.2	No of Seminars Organised on Contraceptive Update.
5	To increase use of pills from present 1.5%(DLHS3)	5.1	% increase in the use of pills	5.1.1	Promotion to Social Marketing of pills	5.1.1.1	No of Pills distributed through Social Marketing.

among current married women age 15-49 yrs to 5%						
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Sl.	Strategy	Gaps	Activities	Unit Cost	Total Budget
	Terminal/Limiting Methods	Lack of knowledge of small family norms.	Ensure one MO trained on minilep and NSV up to PHC	Rs 20000	380000
			Training of nurses and ANMs on IUD and other spacing methods at PHC level.	Rs 10000	190000
			Ensure availability of contra ceptives (indenting , logistic	Rs 500000 per PHC	9500000
	Female Sterilization camps	Laparoscopy surgery not done.	Trained doctors on laparoscopy.	Above mentioned	0
			Procure Laparoscopy equipments for trained doctors	Rs 100000 per PHC	1900000
			Training of doctors needed.	Mentioned above	0
	NSV camps	Trained doctors are not available.	Procurement of equipment.	Mentioned above	0
	Compensation for female sterilization	Fund for Compensation for sterilization is not aviliable on time at facility.	Immediate disbursement of incentive after sterilization camps.	Rs1000 each for 25000 male and 5000 female operations	3800000
	Compensation for male sterilization		Logistic planning is needed before organizing camps.	NA	0
			Block Health manager can hire one support staff for logistic support.	NA	0
			Immediate disbursement of incentive after sterilization camps.	Discussed earlier	0
			Logistic planning is needed before organizing camps.	NA	0

				Block Health manager could be hire one support staff for disbursement for logistic support.	NA	0
				Accreditation of private nursing home. As per GOB	NA	0
	IUD camps		Camps not held	Training of ANM & staff nurse for IUD insertion.	Discussed earlier	0
	Accreditation of private providers for IUD insertion services		No accreditation of private providers for IUD insertion services	Procurement of IUD.	94 MBBS @20000/	22560000
Selection and recruitment of Doctors (SPL) on contractual basis and give priority in selection those who are living in same PHC.				Discussed earlier	0	
Accreditation of private providers for IUD insertion services. As per GOI guide lines.				71 Grade A Nurse	6390000	
Social Marketing of contraceptives			Monitoring of Social Marketing is not monitored by PHC.	Social marketing of need based OC & IUD.	31 Grade A nurse for each PHC	53010000
				Increasing access to contraceptive through communities based distribution system free of cost.	18 Dresser, one for each PHC	972000
Contraceptive Update seminars			Not being held.	seminars for MO and other through Professional bodies (FOGSI, BMA, Nursing association etc..on	18 x2 Pharmasist for each PHC	2160000
				Copper-T 380-A should be popularized.	100/-per day x 90 days for 102 grade A nurse	918000
				Awareness for emergency contraceptive.	NA	0
<b>Total</b>						<b>101780000</b>

## 4.6 Kala a Zar

	<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>	<b>Unit Cost</b>	<b>Total Budget</b>
<b>1</b>	Poor coverage of DDT spray	Vector control through insecticide spray in the attack area	To increase the coverage of DDT spray in the endemic zone , there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals	1. Ensure planning for timely spray of DDT in Feb-March and May-June for 40 days in each block	NA	0
				2. Identification of Houses with Kala-azar patients by ANM & ASHA @ 50/ per village.	Rs 50 for 1229 villages twice in a year	122900
				3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed	NA	0
				4. DDT spray should be at the rate of 1gm/sq. meter upto the height of 6 feet.	NA	0
		Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that every corner of the house is properly spraye upto heigth of six feet from ground level.	Rs 5000 per PHC	95000

		Poor condition of Sprayer, pump and nozzles etc No of Pumps available- 266, No of pumps required- 20, No of bucket savailable- 421, No of buckets required- 167, No of gallon available- 102, No of gallon required- 45, No of pond measure available- 119, No of pond measure required- 28, .	Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces.	Fund allocation and timely release for : maintencae of old sprayer pumps, Puchase of new pumps and other articles needed- buckets, mugs etc.	Rs 150000 for the district	150000
		Inadequate stock of DDT, DDT available- 41mt, DDT required- 33mt	Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray	DDT Carriage	30000
		Faulty payment plan	Appropriate fund allocation for the payment of the spraying of DDT	Fund would be allocated for regular payment of wages (147 SFW to be used and 735 FW to be used for monitoring and spraying work)	147SFW x Rs113 x 40 days	664440
					735FW x Rs 92 x 40 Days	2704800

2	Poor rate of case detection of Kalazar	Early diagnosis and treatment through PHC system	Case detection rate should be increased with appropriate diagnostic test	Increase efficiency of case detection through training of Community workers on signs and symptoms of Kala-azar: <b>1)</b> three weeks persistent fever not responding to antibiotics, malaria being excluded, with palpable spleen. <b>2)</b> Ensure availability of aldehyde test at PHC level <b>3)</b> Purchase of RK 39 kit for detection of Kalazar	Purchase of 50000 units of RK39 @ Rs 25 per unit	1250000			
					Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotericin at all level	Purchase of 10000 vails of Amphotericin B @ Rs 65 per unit	650000
							Loss of wages for KZ patients(case detection in year 2007-3275)	Rs 50 for 22 days for 3200 patients	3520000
							2. Replacing of medicines on priority based	NA	0
							3. Training of ANMs and ASHA for IM injection	Rs 5000 per PHC	95000
3	Lack of monitoring and supervision mechanism,		Monitoring and supervision mechanism	Preparation of Monthly visit plan for supervision :- Checking spraying schedule- For supervision & treatment follow up	Mobility support for CS, ACMO and DMO	45000			
					Mobility for MOIC 19x 40days x Rs 100	76000			
					Mobility for supervisor 33x 40 daysx Rs100	132000			
					Office expenses	25000 for the district	25000		
4	Lack of appropriate BCC & Community Mobilization.	Increasing awareness for prevention of Kala-azar	Community participation in reducing mortality and morbidity due to Kala-azar	1. Fund allocation for training activities	NA	0			
				2. Identification of NGO/Private partner as trainer	NA	0			
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC	NA	0			
				4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-azar	NA	0			

			5. Regular monitoring of IEC activities	NA	0
			6. IEC activities through nukkad natak, kalajatha mass media like radio etc	Rs 20000 per PHC	380000
			7. Activity for surveillance like polio surveillance	NA	0
			8. Wall painting of Treatment protocols and provisions for patients in PHC in Hindi.	Above mentioned	0
			IEC van for each PHC	16x 40x 750	480000
			<b>Total Budget</b>		<b>10420140</b>

#### 4.7Blindness

Gaps	issues	Strategy	Activities	Unit Cost	Total Budget
Lack of adequate eye surgeon and staffs in the district.Only 4 eye surgeons are posted in the district out ofwhich one is on deputation to the other district.	Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	Already discussed in maternal health	0
Only 7 Ophthalmic Assistants are posted in the district,however the requirement is 19.			Recruitment of Ophthalmic Assistants on contractual basis.	Only 4 in the current year @ Rs 8000 per month	384000
Most of the doctors and staffs are not trained enough on new IOL tehniques	Untrained staffs	Capacity building	Training of Doctors on IOL technique	Rs 10000 per person for 5 person	50000
			Training of Ophthalmic Assistant	Rs 5000 for 4 Ophthalmic assistants	20000
In the Year2008-09 only 66 Cataract operationshave been done by the Govt facilities and 1763 bythe private facilities(till Nov 08).In the year 2007-07,altogether 1945 surgeries were performedout of 3000 and in the year 2007-08 2966 surgeries have been performed.	Low achievement	Increasing no of camps	Organising Operations at District level	Rs750 per operation for 3000 operations	2250000
		PPP	Accreditation of Nursing Homes capable of doing Cataract surgeries	NA	0
			Establishing another Cataract Operation Center at PHC Lalganj	Rs 500000	500000
			Purchase of equipments and medicines		

Lackof awareness among community regarding cataract blindness and its treatability.	Lackof awareness	Awareness building	Assigning LHV/Supervisor counselling work	NA	0
Fear of eye operation.			Organising eye screening camps in villages/ schools	NA	0
Lack of Education among the masses about the existing facilities: Need of wide publicity.			IEC on cataract and its facilities	Rs 100000 at district level	100000
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		InvolvingNGOs	Meeting with Local NGOs onthis issue	NA	0
Lack of adequate referral services to take care of complications.	Lack of adequate referral services	Strengthening referral system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	Rs 10000 per PHC	190000
Lack of monitoring and follow up	Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients to manage any post treatment complication.	Rs 10000 per PHC	190000
			Developing records of cataract cases fromOPD registers at PHC level	NA	0
<b>Total</b>					<b>3684000</b>

## 4.8 Leprosy

Gaps	Issues	Strategy	Activities	Unit Cost	Total Budget
· Existing PR of the district is 1.1 and the target is only 1, so the existing program performance is good.					
• Lack of awareness is still a problem with the Leprosy Program as most of the cases are detected accidentally.	Lack of Awareness	Awareness generation	IEC on Leprosy	Rs 5000 per PHC in a year	95000
• Inadequate staff, Only 6 supervisors and 11 Non Medical Assistants are working while the requirement of Supervisor is 17 and that of NMA is 33( One NMAeach in each APHC)	Lack of Human Resource	Staff Recruitment in contract basis	Recruitment of 11 supervisors	Rs 7000per superisor per month	924000
• There is no active involvement of the Medical officers at sector and Block levels.		Strengthen Health Care Services	Orientation of MOs and staffs on Leprosy	NA	0
• Lack of PHC staff involvement. No manpower support,			Case validation, to have check on wrong diagnosis and re registration	NA	0
			Prompt and early detection of the cases to avoid deformity and disability,	NA	0
			Ulcer care foot ware reorientation training of medical & para medical staff.	Rs2000 per PHC	38000
No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Establishing Lab at district level	Rs 200000	200000
			Recurring expenditure like reagents	Rs 1000 per month	12000
Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Updation of master register	NA	0
			Mobility support for DLO	RS 3000 per month	36000
			Office expenses	Rs 2000 per month	24000
<b>Total</b>					<b>1329000</b>

### 4.9 T.B.

	Indicators	Gaps	Activities	Unit Cost	Total Cost
1	Infrastructure	Lack of well equipped/Designed Microscopy Centre	Development and Renovation of DMCs with proper water supply and Electricity connection	Rs 5000 per PHC	95000
		Microscopes of many Designated Microscopy Centers(DMC) are not functioning	Supply of New binocular Microscopes	Rs 50000 per PHC	950000
		Poor Maintenance of Microscopes	Special Training to Lab Technician/Microscopist for maintenance of Microscopes	NA	0
2	HR	Many DMCs are closed due to lack of Microscopist/Lab Technician	Recruitment Process should be followed.	NA	0
			Honorarium for 17 TB technicians	Rs8000 per month for 20 technicians for 12 months	1920000
		Constraint in selection Process of new Staffs by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	0
		Remuneration of Pvt DOT Providers has not been paid	Problems in payment of remuneration will be solved	Rs 50 per DOTS provider for 500 units	25000
3	Drugs and Chemicals	Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)	To ensure regular and adequate supply of drugs and other Laboratory materials	From state budget	0
		Supply of short expiry drugs which causes difficulties in drug management	Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS.	NA	0
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	0
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	Rs 2000 per PHC per month	456000
		Delay in purchasing of chemicals and other logistics at District level	Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will be simplified.	NA	0
			Proper and Regular supervision and monitoring of programmes will be ensured.	NA	0
4	Service Performance	Poor quality of DOTS		NA	0
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure- rate.	Motivation and Sensitization of Staffs by Refreshment training on friendly behavior with patient	NA	0

	Due to irregularities in DOTS cases of MDR TB may be increased	Proper counseling of patient should be done regarding importance of DOTS and importance of Follow-up Sputum examination	NA	0
	Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS	Appointment of a Counselor at all PHC	Discussed in maternal health	0
	Poor Case Detection i.e., <70%		NA	0
	Poor Cure Rate i.e., <85%	Organizing Community meetings	NA	0
	High Default Rate		NA	0
		Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	0
		Proper Follow-up Schedule should be maintained	NA	0
		Proper care for side effects of drugs.	NA	0
		<b>Total Budget</b>		<b>3446000</b>

## 4.10 Filaria

<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>	<b>Unit Cost</b>	<b>Total Budget</b>
It affects mainly the economically weaker sections of communities		1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.	Line listing of the cases	NA	0
			Purchase of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc	Rs 500 per HSC for 288 old and 179 new HSCs	233500
			DEC distribution through AWCs and paying hon to AWWs for this.	Rs 100 for all 2308 AWC	230800
			Purchase of DEC	Rs 300000	300000
			Training to AWWs/ASHA on DEC distribution and filaria case management	Rs 2000 per PHC	38000
Result in low priority being accorded by governments for the control of lymphatic filariasis.		2. Continuous use of vector control measures.	Meeting with VHSC members	NA	0
Low effectiveness of the tools used by the control programme			Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.	NA	0
The chronic nature of the disease		4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.	Wall paintings	Rs 2000 per PHC	38000
			<b>Total budget</b>		<b>840300</b>

## 4.11 INSTITUTIONAL STRENGTHENING

### Logical Framework

Sl.	Goal	Sl.	Impact indicators				
1	To improve institutional setup as per IPHS norms	1.1	Improved service delivery for women and children friendly with quality				
2	To bring required architectural correction in the Institutional System						
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators
1	To strengthen NGOs Partnership/ PPP for communitization of Health services .	1.1	No and Type of MOU signed between NGO and DHS/RKS for strengthening of communitization of health services and NGO partnership/ PPP in place	1.1.1	To enforce PNDT Act and to increase sex ratio of female child	1.1.1.1	% decrease in sex selective abortions. % increase in birth of female babies ( delivery registers)
				1.1.2	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routine facility where it is not functional.	1.1.2.1	No of cases supported by referral transport system under PPP.
						1.1.2.2	No of canteen facility functional at institutional facility level.
						1.1.2.3	No of STD booth and other routine facility carried out under PPP.
				1.1.2.4	No of cases supported and payments made by RKS/ DHS to BPL families in availing these services		
1.1.2	To develop partnership with NGO Programmes in the districts	1.1.2.1	No of partnership with NGO for programme implementation for				

							pecially Kalazar elimination
					Strengthen Logistics management system for regular supply of Drugs and equipments	1.1.2.2	No and % of drug & equipments available and supplied ( stock ledger)
					Develop a strong Monitoring & Evaluation / HMIS System in all PHC	1.1.2.3	Regular monitoring and evaluation reports
3	To develop IEC and BCC and Training support system .	3.1	No of IEC materials developed and BCC event carried out No of training support system developed	3.1.1	Establishing BCC and training cell at District & BPHC level	3.1.1.1	Functional BCC cell at DHS/ RKS level
					Net working with folk media team	3.1.1.2	No of folk media team engaged in BCC activity. Type and No. of BCC event organised
4	To strengthen ASHA support System	4.1	No of ASHA capacities	4.1.1	Develop ASHA support System in all PHC(One persin per 20 ASHA)	4.1.1.1	Establishment of ASHA support system at DHS and RKS level
					Strengthening RKS	4.1.1.2	No of RKS having monthly meetings.
		4.2	No of activities carried out by RKS	4.1.1.3		% of untied fund, JSY fund, referral transport etc utilised	

Sl.	Strategy		Gaps		Activities	Unit Cost	Budget
	To enforce PNMT Act and to increase sex ratio of female child		No registration of ultra sound clinic.		Registration and monitoring of ultra sound clinic.	NA	0

				MTP clinic should be watched for termination of pregnancy following USG.	NA	0
				IEC on PNDDT act	Rs 5000 per PHC	95000
	To make Public Private Partnerships for referral transport, IPD care canteen facility, STD booth and other routine facility where it is not functional.		Out sourcing of services is not as per the need of local Need and BPL families are not exempted from Fee of out source services	District /PHC level managers should be aware about the TOR of PPP which is finalized at State level.	NA	0
				Build the capacity of manager to manage contracts of PPP	NA	3600000
			At present 10 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 150 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	Accreditation of institutions and to set standards, an institute of paramedical sciences may be started in the state. This would create more employment opportunities in addition availability of para medical personnel for absorption into the government health system.	NA	0
	Develop partnership with NGO Programmes in the districts		Non involvement of NGO in F.P programme, Institutional delivery, Blindness control		NA	0

				control programme.		
				Accreditation of these facility from state Health Society.	NA	0
			programme. There is no MOU with NGO/VO/individuals for Donation and voluntary support in PHC	Process of MOU should be dicentralization and it should oprationlise through RKS.	NA	0
			Strengthening of DPMU  NGOs Management aspects is one of the area of improvement	ASHA Programme manager facilitate the NGO management process in the district and ASHA Facilitators will be managed at the PHC level	NA	0
				Honourarium to DPM, DPM(ASHA), DAM and Dist M&E Officer	Rs 30000 pm for DPM, Rs 28000 pm for DPM(ASHA), Rs 28000 pm for DAM and Rs 25000pm for Dist M& E Officer	1332000

				Capacity building training programme for NGOs office bearer with the help of professionals on linkage with health system strengthening component.	Rs 5000 per PHC	95000
				Mentoring Group at district level.	94 MBBS @20000/	22560000
				Selection and recruitment of Doctors (SPL) on contractual basis and give priority in selection those who are living in same PHC.	NA	0
			There is no any VHSC in the district.	Co-ordination with community based organisation at SHG, LRG, VEC, ,PRI for VHSC formation.	71 Grade A Nurse	6390000
	Capacity buiding of Managers and Doctors.			Expoure visit of DPM/BHM /ASHA DPM/ selected ASHA to other state where facility is comparatively working better.	31 Grade A nurse for each PHC	53010000
				To start DNB (Family Physician) 3 year course in the district hospitals.	18 Dresser, one for each PHC	972000

				ASHA/ AWW career advancement programme may be planned to retain them in the system. Seats in the ANM course, staff nurses and other paramedical courses may be reserved for the qualified ASHAs	18 x2 Pharmasi st for each PHC	2160000
	Preparation of dicentralised District Health Action Plan		First time five members of the districts were trained on DHAP preparation	Trainings of DPMU,BPMU members on implementation of services/ various National program and district Health action Plan through distance education	100/-per day x 90 days for 102 grade A nurse	918000
				Start preparation of plan from the month of October with situational anlysis, Facility survey, line reporting system and qulitative finding from Community and users of facility.	Rs 50000 for the district	50000
	Devlop a strong Monitoring & Evaluation / HMIS System in all PHC		Monitoring of all programme is one of the weakest link of all programme.  Lack of Supervisers in all PHC	Distribution of role and responsbility among MO and Managers of programme implementation.	18 Accountant @ 12000/	2592000

			Lack of skill of use of data	Use Process indicatore as monitoring of respective programme.	19 Data Center @ 7500/	1710000
			Community is not aware about monitoring aspects of Health Programme.	Devlop Programme review calander for review of HSC/PHC performance as per form 6 & 7	18 BHM @ 18000/-	3888000
				Gradation of Health Sub centers in three categories.	NA	432000
				Appointment of Block Health Managers, Accountants in all institutions.(1 SDH, 2 Referrals and Sadar hospital.)	4 BHM and 4 Accountants Budget in RKS head	1440000
				Social recognition of Grade one ANM.	NA	0
				Devlop four potential VHSCs in all PHC on Community based Monitoring of Health and Nutrition programme.	22 BHM	44000
				Organise "JAN ADALAT" in with PRI & VHSC and invite nearby VHSC to observe thr process of "JAN ADALAT"	22 BHM, 22 Block Accountants and 22 Data Center operators	132000

				Devlop Health and Nutrition Report Card by using growth monitoring chartsof Village and present in "JAN ADALAT" By VHSC	Rs 2000 in each PHC	38000
	Strengthen Logistics management system for regular supply of Drugs and equipments		There is no system of logistic management of Drugs and other supply at any level.  Only vaccine supply management is comparatively stronger than other logistic work.	Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports	NA	0
				Hiring vehicles for supply of drug kits	Rs 20000 per PHC per month	4080000
				Hiring of courriers as per need	Discussed in maternal health	180000
				Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)	Discussed in maternal health	0
				Training of all ANM and Stock keepers on Indenting and Logistic Management.	Rs 5000 per PHC	85000
				4.Payment from Rogi Kalyan samiti account. (VEHICLE+OFF ICE EXP.)	Rs 20000 per month per PHC	4560000

	Establishing BCC and training cell at District & BPHC level		There is not as such designated post for BCC and Training at the district and PHC level	ASHA Programme manager facilitate the process of training and BCC in the district and ASHA Facilitators will be managed at the PHC level	NA	0
				Develop resource team at District Level.	NA	0
				MOU with Local NGOs for logistic management of training and Develop issue wise Master trainers in district	Na	0
				Develop ASHA support system on one person/20 ASHA for on the job training of ASHA and AWW	NA	0
	Net working with folk media team		There is no BCC management unit at District Level	Identify Health Communication organisation for identification of BCC issues as per need of District.	Discussed in child health	0
				MOU with organisation for formative research .	NA	0
				Develop IEC/BCC material based on Findings of formative research	Discussed in child health	0
				Printing of IEC and BCC	Discussed in child	0

				material	health	
				Training of Folk Media group on IEC/BCC material	Discussed in maternal health	0
				Planning of performance route chart of Folk media Group	NA	0
				Monitoring of performance through SMS of PRI members	NA	0
				Impact analysis of Performance by Organisation	NA	0
	Strengthening RKS		RKS are not uniformly functioning in the district	Ensure registration of RKS of all functional APHC	NA	0
				Training of RKS signatory and BHM on financial Management of RKS	Discussed in maternal health	0
				Presentation of case study of functional RKS in district level Meeting.	NA	0
	Strengthening community process through supportive supervision of ASHA program		Poor monitoring mechanism of ASHA program	Appointment of PHC level ASHA facilitator	Rs 12000 per Facilitator per month for 19 facilitator	2736000
				Provide training cum supervisory support @ one supervisor for 20 ASHA	Rs 250 per supervisor for 133 supervisors for maximum 15 days in a month	5985000

				Training of DPM (ASHA), Facilitator and supervisors at block level.	Rs 250 per participant for three days for 180 participants.	45000
	Media Sensitization		Wrong and provocative Reporting Having baseless News.	Media Sensitization work shop	Rs 5000 per Quarter at district level.	20000
<b>Total</b>						119149000

#### 4.12 HIV/AIDS

Issues	Strategy	Activities	Unit Cost	Total Budget		
1. Program Management System, District HIV/AIDS action Plan, District AIDS prevention and control unit, Strengthening the evidence base for program tracking progress	Recruitment	Deployment of personnel	District Coordinator	264000		
			M&E officer	162000		
			Office Assistant	96000		
				Refurbishing of Office	Lmsm 20000	20000
				Recurring Expenditure		84200
				Travel		170000
2. Strengthening systems for service delivery	Meetings	DACC Meeting	Rs 1000 per month	12000		
- PPTCT						
- Pediatric AIDS		Dist level HIV program Review meeting	Rs 2400 per month	28800		
- Prevention (ICTCs, Condom promotion)		BHMs meeting	Rs 6400	6400		
- Protection, care and support for children affected by HIV/AIDS		Consultation meeting		9600		
		Meeting with PLHA		27600		
Partnerships at all levels (community, district, networks,		Meeting with Principals of Govt., High Schools for AEP		25600		

different Govt departments, civil society, positive networks	Trainings	Two days refresher Training of Nodal Teachers/ Master Trainers of AEP		74000
		One day Meeting of district level medical professionals		10000
<b>Behaviour change communication</b>		One day Link Worker Conference at district level ( Youth Camp)		100000
<b>LAKSHYA (Link Workers – rural HRGs), Young people (Peer education with young people RRCs)</b>	Day celebration	World AIDs day celebration		25000
Scale Up Intervention up to Young Vulnerable Population Easy access to ART center		Travel support to HIV positive women with children		15000
Capacity Building Of Local Administration/ NGO/CBO for reach out to Maximum Young Population		Two day residential Capacity Building Training of executive members of Farmers Club,ATMA		189000
		Two days Refresher Training of Facilitators of RRC.		36000
		Two days training of Youth facilitators of VICs of IVPP		360000

		Two days refresher training of Peer Educators/ Volunteers		72000
<b>Owning this project by Village Community</b>		<b>Two days residential Capacity Building Training of ANM</b>		288000
<b>Capacity Building of Different service Providers</b>		Two days residential Capacity Building Training of AWW	At present 10 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 150 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	360000
		Two days residential Capacity Building Training of AWW		360000
		Total		2795200

### 4.13 RI/Muskan

SI No	Activities	Unit Cost	Total Budget
1	Training of Health workers on Immunization	Rs 100 for 500 workers	50000
2	Printing of RI Formats	Rs 4 for approx 1089000 PW	4356000
3	Printing of Muskan Registers	Rs 100 for 2308 AWCs	230800
4	Suuplementary immunization during flood	Rs 50000 per PHC	950000
5	Catch up immunization	Rs 50000 per PHC	950000
6	Incentive money	Rs 550 per AWC	1269400
7	Mahila Mandal	Rs 250 per AWC	577000
9	POL for cold chain	Rs 1300 per day	474500
10	Vaccines and logistics mobility	Rs 38500 per month	462000
11	Mobility for supervisor	Rs 9000 per month	108000
12	Usage of courier	As discussed in child health	0
13	Hiring of computer operator for RIMS	Rs 5000 per month	<b>60000</b>
14	Measles Campaign	Rs 200000 for the district	200000
15	Hard to Reach area strategy	Rs 10000 per month per PHC	2280000
16	RI Catch up round	Rs 100000 per PHC	1900000
17	Training of Medical Officers	Rs 1000 per person	19000
18	Meeting of epidemic Response Teams	Rs 5000 per PHC	95000
19	Travel expenses for case investigation per outbreak	Rs 20000 per month	240000
20	Shipment cost of lab specimen	Rs Rs 10000 per PHC per month	2280000
21	Outbreak Response	Rs 20000 per PHC	380000
	<b>Total</b>		<b>16881700</b>

## 4.12 Programme wise Budget

Srl No	Budget Head	%	TotalBudget
1	TB	0.44%	3446000
2	Kala azar	1.33%	10420140
3	Leprosy	0.17%	1329000
4	Filaria	0.11%	840300
5	Blindness	0.47%	3684000
6	Child Health	14.51%	113473000
7	Maternal Health	50.33%	393724350
8	Family Planning	14.90%	116558000
9	Institution Strengthening	15.23%	119149000
10	HIV AIDS	0.36%	2795200
11	RI / Muskan	2.16%	16881700
	<b>Total</b>		<b>782300690</b>

## Chapter 5 Annexure

Table 1: OPD in 2007-08

Month	OPD
Apr-07	35060
May-07	43557
Jun-07	53940
Jul-07	70600
Aug-07	104815
Sep-07	67172
Oct-07	65836
Nov-07	55809
Dec-07	41227
Jan-08	50657
Feb-08	58613
Mar-08	66195
	713481

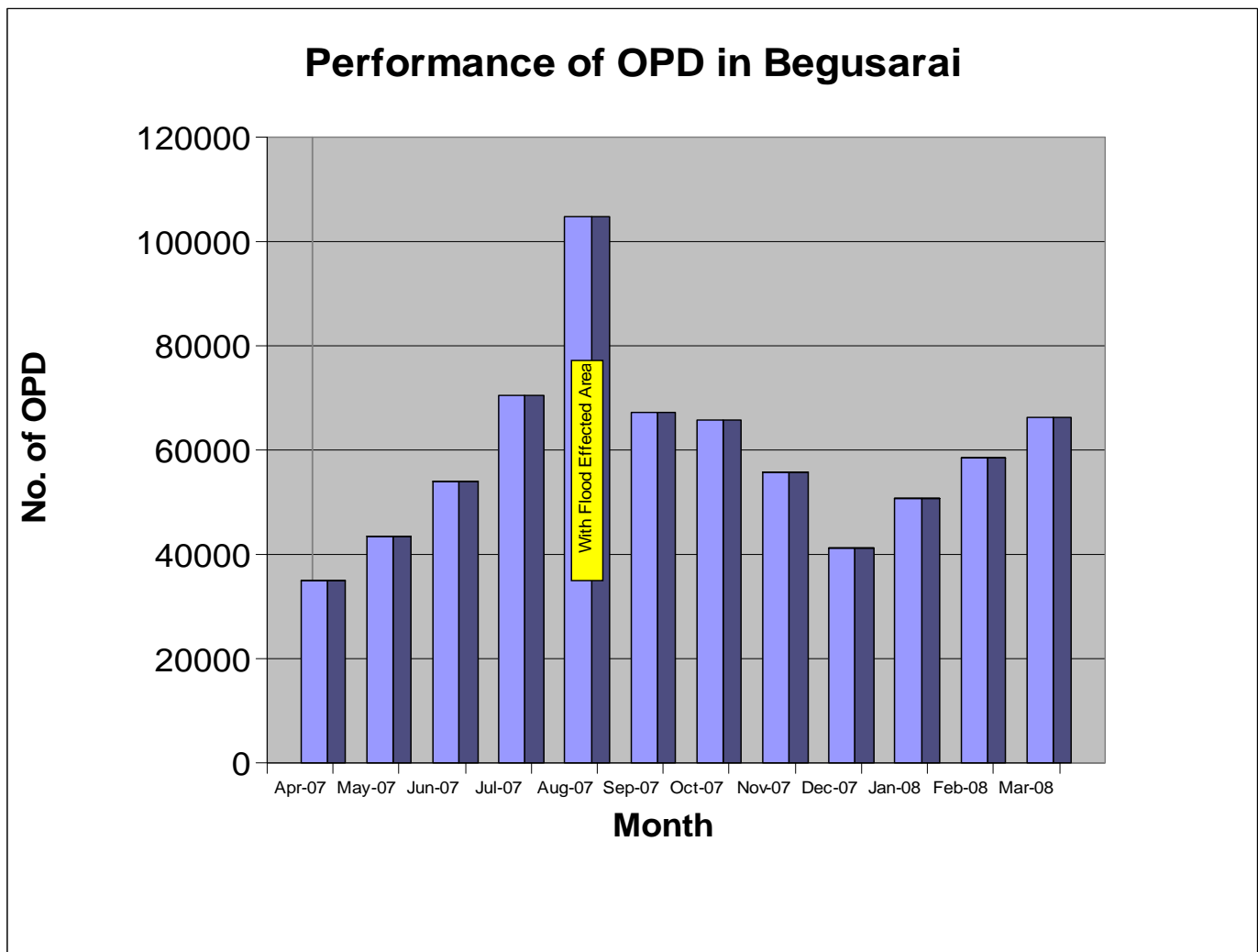
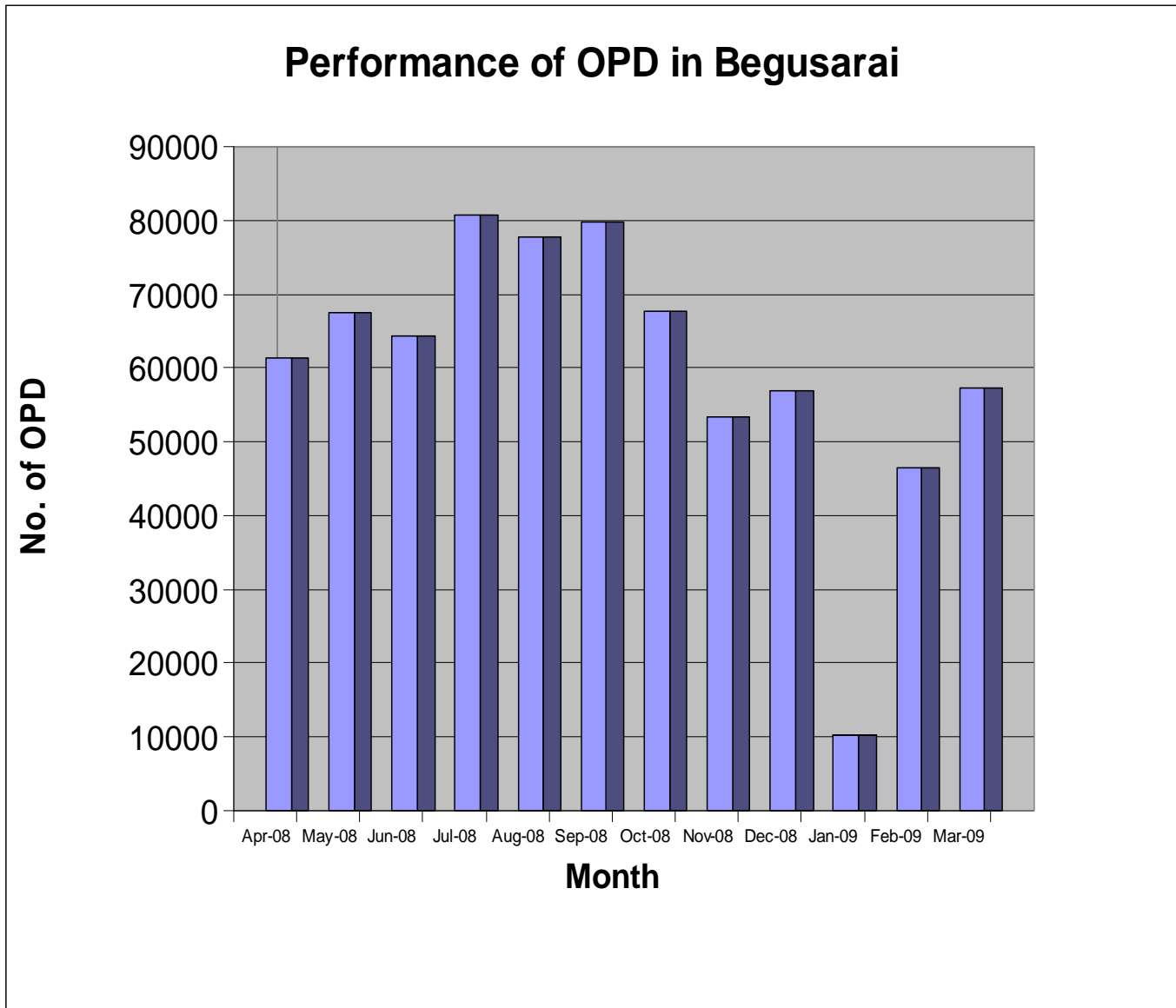


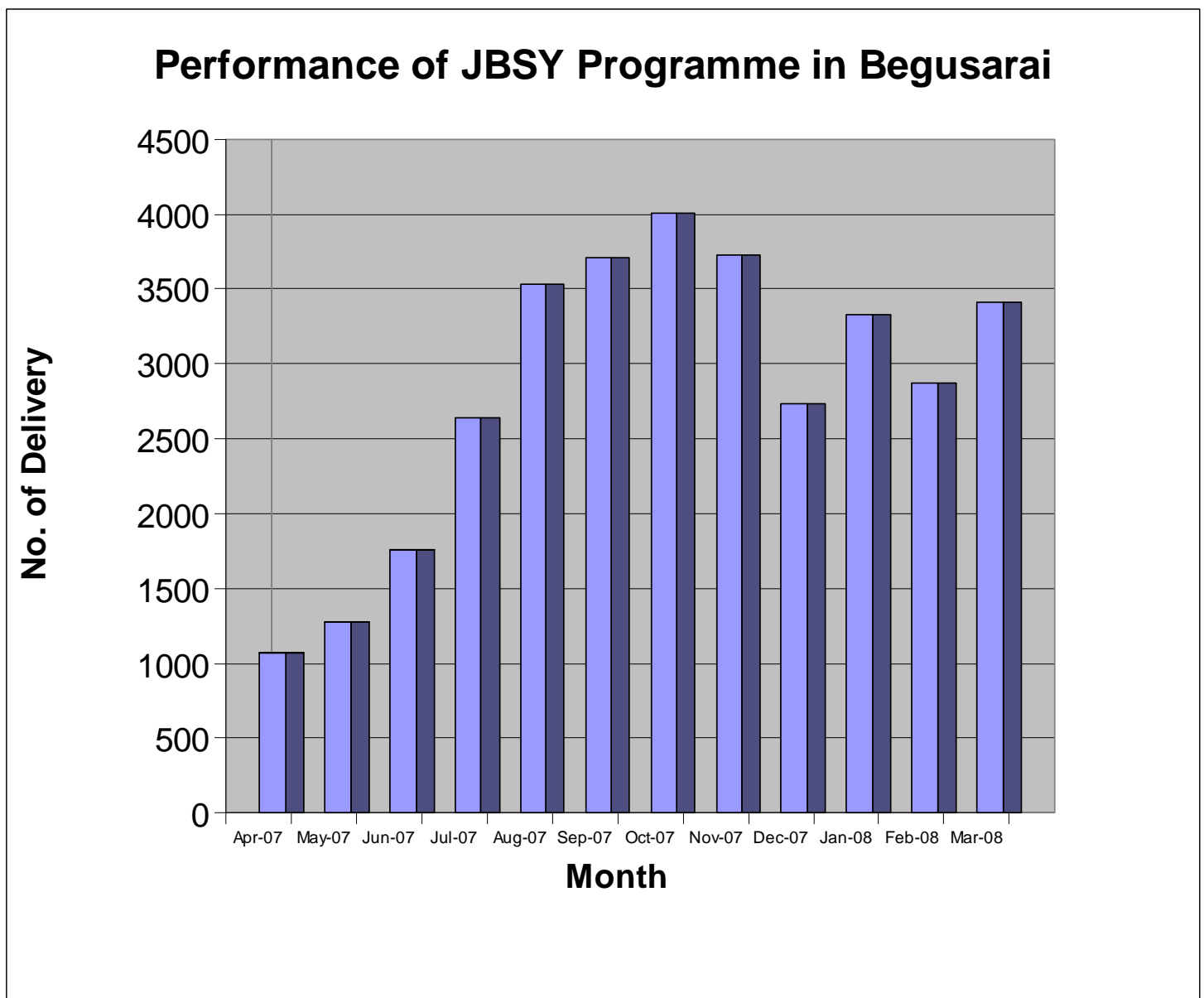
Table 2: OPD in 2008-09

Month	OPD
Apr-08	61420
May-08	67529
Jun-08	64426
Jul-08	80804
Aug-08	77806
Sep-08	79862
Oct-08	67728
Nov-08	53436
Dec-08	56921
Jan-09	10273
Feb-09	46497
Mar-09	57269
Tot	723971



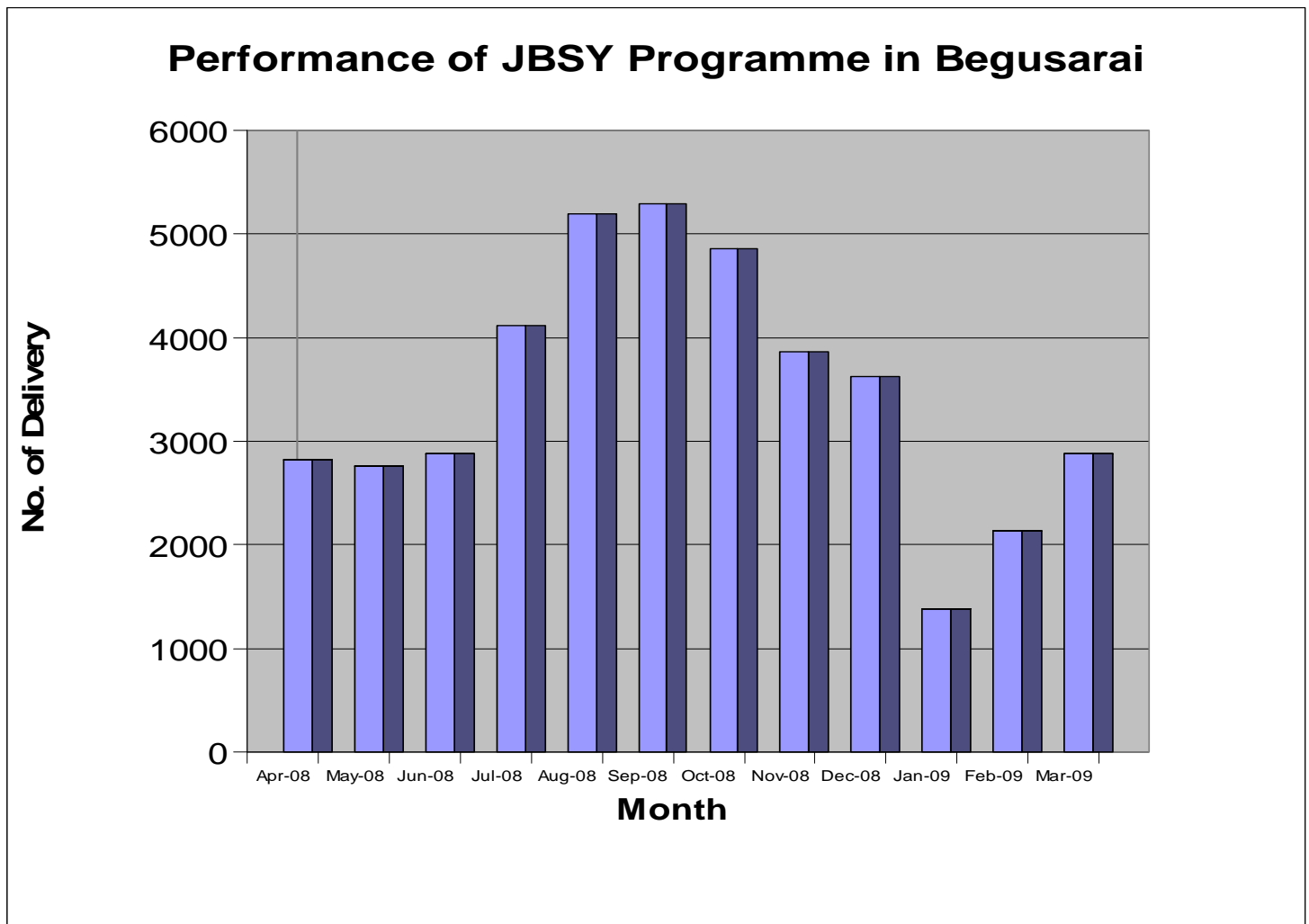
**Table 3 JBSY in 2007-08**

Month	Delivery
Apr-07	1069
May-07	1272
Jun-07	1762
Jul-07	2642
Aug-07	3535
Sep-07	3707
Oct-07	4004
Nov-07	3730
Dec-07	2732
Jan-08	<b>3331</b>
Feb-08	2875
Mar-08	3412
<b>Total</b>	<b>34071</b>



**Table 4 JBSY in 2008-09**

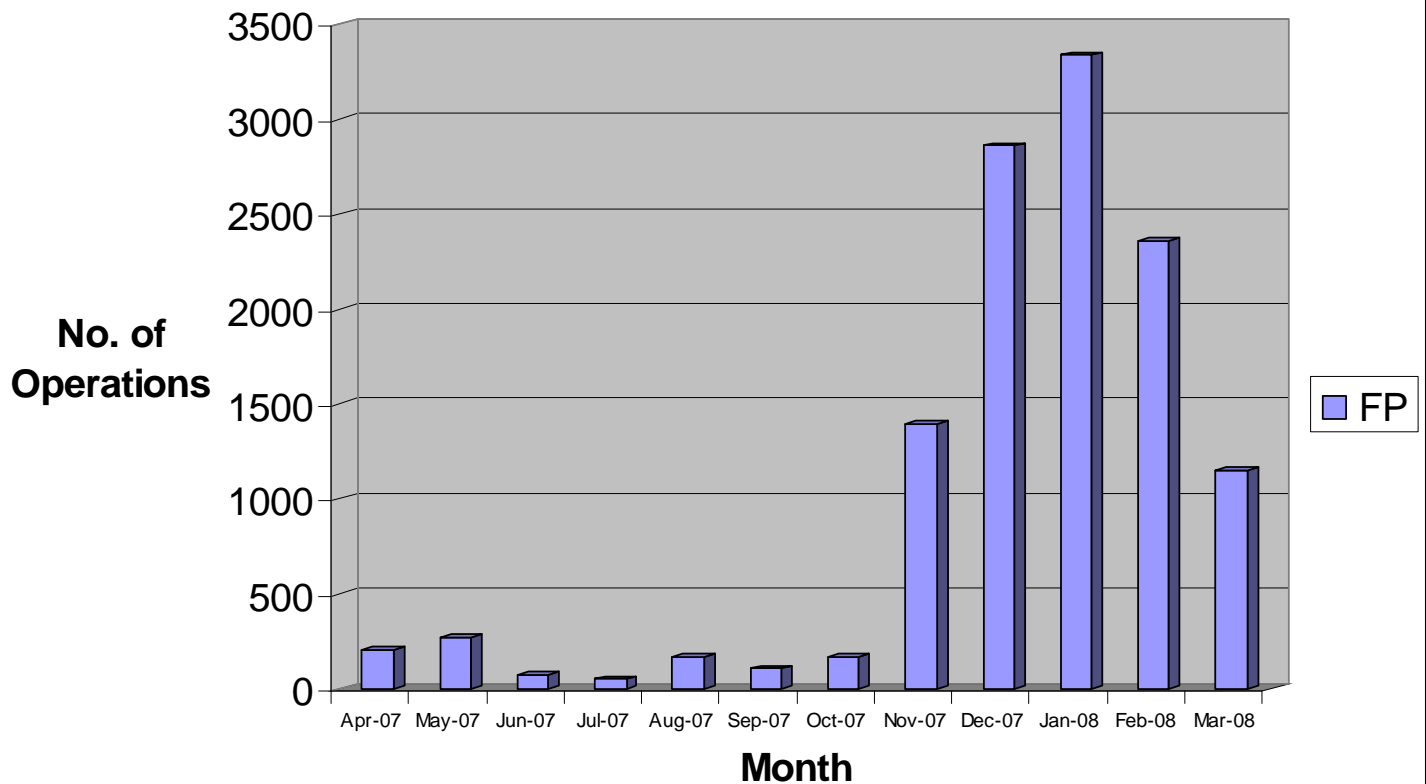
Month	Delivery
Apr-08	2821
May-08	2756
Jun-08	2881
Jul-08	4113
Aug-08	5197
Sep-08	5291
Oct-08	4862
Nov-08	3866
Dec-08	3625
Jan-09	1386
Feb-09	2141
Mar-09	2884
<b>Total</b>	<b>41823</b>



**Table 5 FP in 2007-08**

Month	FP
Apr-07	204
May-07	269
Jun-07	72
Jul-07	51
Aug-07	171
Sep-07	106
Oct-07	164
Nov-07	1397
Dec-07	2860
Jan-08	3337
Feb-08	2357
Mar-08	1153
<b>Total</b>	<b>12141</b>

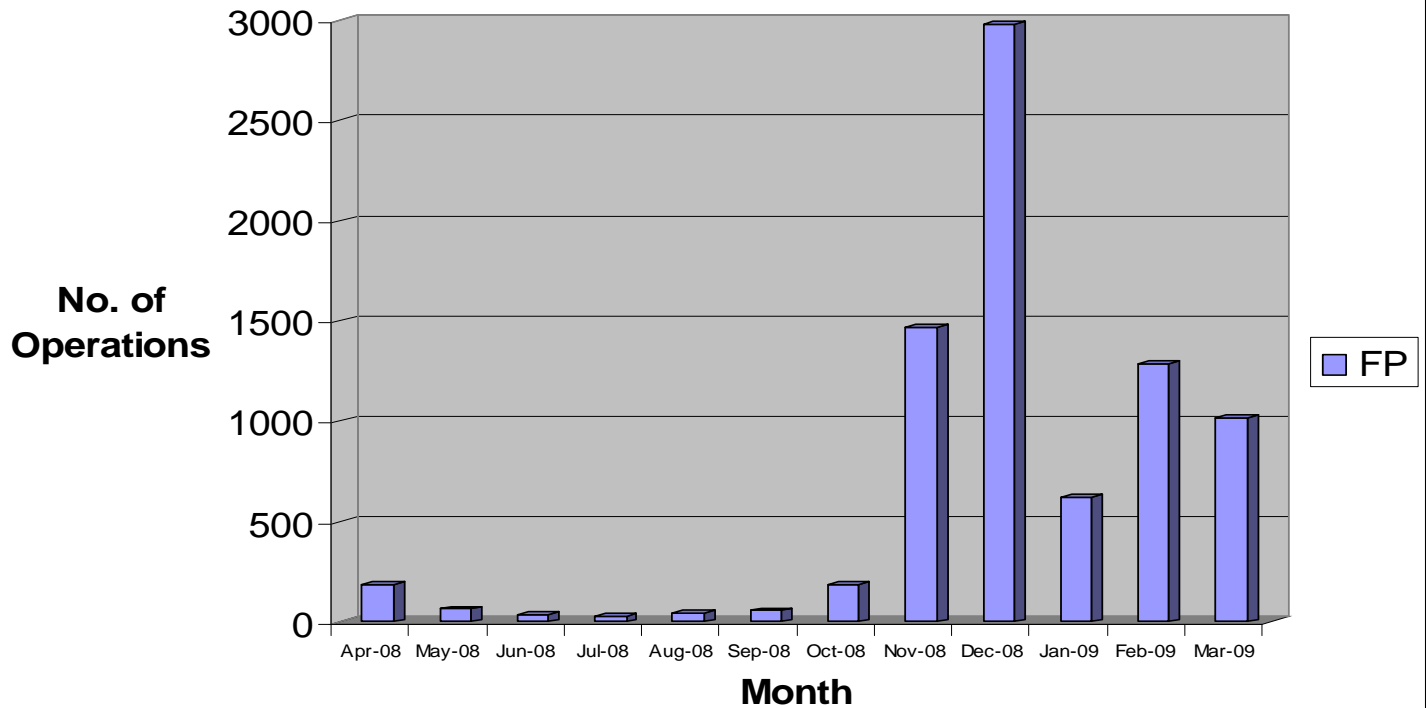
### Performance of Family Planing Programme in Begusarai



**Table 6 FP in 2008-09**

Month	FP
Apr-08	185
May-08	63
Jun-08	36
Jul-08	29
Aug-08	44
Sep-08	55
Oct-08	183
Nov-08	1471
Dec-08	2981
Jan-09	620
Feb-09	1287
Mar-09	1014
<b>Total</b>	<b>7968</b>

### Performance of Family Planing Programme in Begusarai



### 4.3 MATERNAL HEALTH

1	To make functional PHC (24hr x7days) for institutional deliveries	3600000
2	To make FRU functional and upgradation of PHC to CHC for institutional deliveries	10010000
3	To strengthen Janani Suraksha Yojana / JSY	9900000
4	To ensure support of SBA at home deliveries	16690000
5	To strengthen HSC for providing outreach maternal care	233000
6	To strengthen ANM Training School for providing regular training of ANMs.	200000
7	RCH Camps	2280000
8	To improve adolescent reproductive and sexual health	1280000
9	To provide MTP services at health facilities	1090000
10	To strenghten Monthly Village Health and Nutrition Days	145000
11	To form /strenghten APHC in Phase manner	6650000
12	RTI/STI services at health facilities	414000
13	<b>Total</b>	<b>52492000</b>

#### 4.4 Child Health

<b>1</b>	<b><i>IMNCI, Home Based Newborn Care/HBNC</i></b>	<b>3700000</b>
<b>2</b>	<b>Facility Based Newborn Care/FBNC</b>	<b>357000</b>
<b>3</b>	<b>Infant and Young Child Feeding/IYCF</b>	<b>96136000</b>
<b>4</b>	<b>Care of Sick Children and Severe Malnutrition</b>	<b>4000000</b>
<b>5</b>	<b>Management of diarrhea, ARI and Micronutrient Malnutrition</b>	<b>3880000</b>
<b>6</b>	<b>School Health Programme</b>	<b>5268000</b>
<b>7</b>	<b>Total</b>	<b>113341000</b>

## 4.5 Family Planning

1	Terminal/Limiting Methods	10070000
2	Female Sterilization camps	1900000
3	NSV camps	0
4	Compensation for female sterilization	3800000
5	Compensation for male sterilization	0
6	IUD camps	0
7	Accreditation of private providers for IUD insertion services	28950000
8	Social Marketing of contraceptives	53982000
9	Contraceptive Update seminars	3078000
	<b>Total</b>	<b>101780000</b>

### 4.6 Kala a Zar

	<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>	<b>Unit Cost</b>	<b>Total Budget</b>
<b>1</b>	Poor coverage of DDT spray	Vector control through insecticide spray in the attack area	To increase the coverage of DDT spray in the endemic zone , there should be proper monitoring by the supervisors, capacity building of the sprayer, supervisors and other healthcare professionals	1. Ensure planning for timely spray of DDT in Feb-March and May-June for 40 days in each block	NA	0
				2. Identification of Houses with Kala-azar patients by ANM & ASHA @ 50/ per village.	Rs 50 for 1229 villages twice in a year	122900
				3. Two round of spraying scheduled in Feb-March and May-June should be strictly observed	NA	0
				4. DDT spray should be at the rate of 1gm/sq. meter upto the height of 6 feet.	NA	0
				Less time spent on spraying DDT	Training and capacity building for proper spraying	Regular capacity building training on prescribed module for the sprayer to ensure that every corner of the house is properly sprays upto height of six feet from ground level.

	Poor condition of Sprayer, pump and nozzles etc No of Pumps available-266, No of pumps required-20, No of bucket savailable-421, No of buckets required-167, No of gallon available-102, No of gallon required-45, No of pond measure available-119, No of pond measure required-28, .	Regular checking of the spraying pumps for better functioning and timely replacement of the faulty pieces.	Fund allocation and timely release for : maintencae of old sprayer pumps, Puchase of new pumps and other articles needed- buckets, mugs etc.	Rs 150000 for the district	150000
	Inadequate stock of DDT, DDT available-41mt, DDT required-33mt	Making available DDT during spraying round	Ensure adequate Stock of DDT through proper & timely indenting to improve the quality of spray	DDT Carriage	30000
	Faulty payment plan	Appropriate fund allocation for the payment of the spraying of DDT	Fund would be allocated for regular payment of wages (147 SFW to be used and 735 FW to be used for monitoring and spraying work)	147SFW x Rs113 x 40 days	664440
				735FW x Rs 92 x 40 Days	2704800

2	Poor rate of case detection of Kalazar	Early diagnosis and treatment through PHC system	Case detection rate should be increased with appropriate diagnostic test	Increase efficiency of case detection through training of Community workers on signs and symptoms of Kala-azar: 1) three weeks persistent fever not responding to antibiotics, malaria being excluded, with palpable spleen.2) Ensure availability of aldehyde test at PHC level 3) Purchase of RK 39 kit for detection of Kalazar	Purchase of 50000 units of RK39 @ Rs 25 per unit	1250000
		Reduction of kala-azar mortality and morbidity	Early diagnosis and treatment through PHC system	1. Ensuring availability of Amphotericin at all level	Purchase of 10000 vails of Amphotericin B @ Rs 65 per unit	650000
	Loss of wages for KZ patients(case detection in year 2007-3275)			Rs 50 for 22 days for 3200 patients	3520000	
	2. Replacing of medicines on priority based			NA	0	
	3. Training of ANMs and ASHA for IM injection			Rs 5000 per PHC	95000	
3	Lack of monitoring and supervision mechanism,		Monitoring and supervision mechanism	Preparation of Monthly visit plan for supervision :- Checking spraying schedule- For supervision & treatment follow up	Mobility support for CS, ACMO and DMO	45000
					Mobility for MOIC 19x 40days x Rs 100	76000
					Mobility for supervisor 33x 40 daysx Rs100	132000
				Office expenses	25000 for the district	25000
4	Lack of appropriate BCC & Community Mobilization.	Increasing awareness for prevention of Kala-azar	Community participation in reducing mortality and morbidity due to Kala-azar	1. Fund allocation for training activities	NA	0
				2. Identification of NGO/Private partner as trainer	NA	0
				3. Knowledge sharing with the community on signs and symptoms of Kala-azar through VHSC	NA	0

			4. Training of VHSC/PRI and community health worker on sign & symptom of Kala-azar	NA	0
			5. Regular monitoring of IEC activities	NA	0
			6. IEC activities through nukkad natak, kalajatha mass media like radio etc	Rs 20000 per PHC	380000
			7. Activity for surveillance like polio surveillance	NA	0
			8. Wall painting of Treatment protocols and provisions for patients in PHC in Hindi.	Above mentioned	0
			IEC van for each PHC	16x 40x 750	480000
			<b>Total Budget</b>		<b>10420140</b>

#### 4.7Blindness

<b>Gaps</b>	<b>issues</b>	<b>Strategy</b>	<b>Activities</b>	<b>Unit Cost</b>	<b>Total Budget</b>
Lack of adequate eye surgeon and staffs in the district.Only 4 eye surgeons are posted in the district out ofwhich one is on deputation to the other district.	Staff shortage	Recruitment	Recruitment of Eye Specialists and surgeons on contractual basis.	Already discussed in maternal health	0
Only 7 Ophthalmic Assistants are posted in the district,however the requirement is 19.			Recruitment of Ophthalmic Assistants on contractual basis.	Only 4 in the current year @ Rs 8000 per month	384000
Most of the doctors and staffs are not trained enough on new IOL techniques	Untrained staffs	Capacity building	Training of Doctors on IOL technique	Rs 10000 per person for 5 person	50000
			Training of Ophthalmic Assistant	Rs 5000 for 4 Ophthalmic assistants	20000
In the Year2008-09 only 66 Cataract operationshave been done by the Govt facilities and 1763 bythe private facilities(till Nov 08).In the year 2007-07,altogether 1945 surgeries were performedout of 3000 and in the year 2007-08 2966 surgeries have been performed.	Low achievement	Increasing no of camps	Organising Operations at District level	Rs750 per operation for 3000 operations	2250000
		PPP	Accreditation of Nursing Homes capable of doing Cataract surgeries	NA	0
			Establishing another Cataract Operation Center at PHC Lalganj	Rs 500000	500000
			Purchase of equipments and medicines		

Lack of awareness among community regarding cataract blindness and its treatability.	Lack of awareness	Awareness building	Assigning LHV/Supervisor counselling work	NA	0
Fear of eye operation.			Organising eye screening camps in villages/schools	NA	0
Lack of Education among the masses about the existing facilities: Need of wide publicity.			IEC on cataract and its facilities	Rs 100000 at district level	100000
Poor coordination between the health functionaries and the voluntary organisations resulting in less cataract surgeries.		Involving NGOs	Meeting with Local NGOs on this issue	NA	0
Lack of adequate referral services to take care of complications.	Lack of adequate referral services	Strengthening referral system	Arrangement of carrying patients to the Operation Centers and then taking them back homes	Rs 10000 per PHC	190000
Lack of monitoring and follow up	Monitoring and follow up	Monitoring and follow up	Mobility support for Visiting homes of the patients to manage any post treatment complication.	Rs 10000 per PHC	190000
			Developing records of cataract cases from OPD registers at PHC level	NA	0
<b>Total</b>					<b>3684000</b>

## 4.8 Leprosy

Gaps	Issues	Strategy	Activities	Unit Cost	Total Budget
· Existing PR of the district is 1.1 and the target is only 1, so the existing program performance is good.					
<ul style="list-style-type: none"> <li>Lack of awareness is still a problem with the Leprosy Program as most of the cases are detected accidentally.</li> </ul>	Lack of Awareness	Awareness generation	IEC on Leprosy	Rs 5000 per PHC in a year	95000
<ul style="list-style-type: none"> <li>Inadequate staff, Only 6 supervisors and 11 Non Medical Assistants are working while the requirement of Supervisor is 17 and that of NMA is 33( One NMAeach in each APHC)</li> </ul>	Lack of Human Resource	Staff Recruitment in contract basis	Recruitment of 11 supervisors	Rs 7000per superisor per month	924000
<ul style="list-style-type: none"> <li>There is no active involvement of the Medical officers at sector and Block levels.</li> </ul>		Strengthen Health Care Services	Orientation of MOs and staffs on Leprosy	NA	0
<ul style="list-style-type: none"> <li>Lack of PHC staff involvement. No manpower support,</li> </ul>			Case validation, to have check on wrong diagnosis and re registration	NA	0
			Prompt and early detection of the cases to avoid deformity and disability,	NA	0
			Ulcer care foot ware reorientation training of medical & para medical staff.	Rs2000 per PHC	38000
No lab testing facility in the district	Infrastructure Gap	Establishing Lab	Establishing Lab at district level	Rs 200000	200000
			Recurring expenditure like reagents	Rs 1000 per month	12000
Lack of monitoring at all level	Monitoring Gap	Increasing mobility	Updation of master register	NA	0
			Mobility support for DLO	RS 3000 per month	36000
			Office expenses	Rs 2000 per month	24000
<b>Total</b>					<b>1329000</b>

4.9 T.B.

	Indicators	Gaps	Activities	Unit Cost	Total Cost
1	Infrastructure	Lack of well equipped/Designed Microscopy Centre	Development and Renovation of DMCs with proper water supply and Electricity connection	Rs 5000 per PHC	95000
		Microscopes of many Designated Microscopy Centers(DMC) are not functioning	Supply of New binocular Microscopes	Rs 50000 per PHC	950000
		Poor Maintenance of Microscopes	Special Training to Lab Technician/Microscopist for maintenance of Microscopes	NA	0
2	HR	Many DMCs are closed due to lack of Microscopist/Lab Technician	Recruitment Process should be followed.	NA	0
			Honorarium for 20 TB technicians	Rs8000 per month for 20 technicians for 12 months	1920000
		Constraint in selection Process of new Staffs by the District Health Society	Obstacle in recruitment Process will be rectified.	NA	0
		Remuneration of Pvt DOT Providers has not been paid	Problems in payment of remuneration will be solved	Rs 50 per DOTS provider for 500 units	25000
3	Drugs and Chemicals	Irregular supply of Drugs specially of Pediatric Drug Boxes (PC-13, PC-14)	To ensure regular and adequate supply of drugs and other Laboratory materials	From state budget	0
		Supply of short expiry drugs which causes difficulties in drug management	Proper care should be taken regarding short expiry drugs. Short expiry drugs may be used where there is large number of patients having DOTS.	NA	0
		Poor Retrieval of Drug Boxes of Defaulted patient	Retrieval of Drugs may be ensured by STS.	NA	0
		Irregular supply of slides and other Chemicals and other logistics	Proper supply of Slides and other Chemicals should be ensured	Rs 2000 per PHC per month	456000
		Delay in purchasing of chemicals and other logistics at District level	Constraints in purchasing of Chemicals and other logistics will be removed. Official Process will be simplified.	NA	0

4	<b>Service Performance</b>	Poor quality of DOTS	Proper and Regular supervision and monitoring of programmes will be ensured.	NA	0
		ANMs providing DOTS at the HSCs do not visit the Center on DOTS day resulting irregular intake of drugs by the patient causing poor Cure-rate.	Motivation and Sensitization of Staffs by Refreshment training on friendly behavior with patient	NA	0
		Due to irregularities in DOTS cases of MDR TB may be increased	Proper counseling of patient should be done regarding importance of DOTS and importance of Follow-up Sputum examination	NA	0
		Not friendly behavior of Lab Technician and other staffs with patient who comes for sputum examination or for DOTS	Appointment of a Counselor at all PHC	Discussed in maternal health	0
		Poor Case Detection i.e., <70%		NA	0
		Poor Cure Rate i.e., <85%	Organizing Community meetings	NA	0
		High Default Rate		NA	0
			Medical Officers should take care of referring all chest symptomatic patients for sputum examination	NA	0
			Proper Follow-up Schedule should be maintained	NA	0
			Proper care for side effects of drugs.	NA	0
			<b>Total Budget</b>		<b>3446000</b>

## 4.10 Filaria

<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>	<b>Unit Cost</b>	<b>Total Budget</b>
It affects mainly the economically weaker sections of communities		1. Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.	Line listing of the cases	NA	0
			Purchase of equipments for the management of Filaria cases like towel, Bucket, soap, mug etc	Rs 500 per HSC for 288 old and 179 new HSCs	233500
			DEC distribution through AWCs and paying hon to AWWs for this.	Rs 100 for all 2308 AWC	230800
			Purchase of DEC	Rs 300000	300000
			Training to AWWs/ASHA on DEC distribution and filaria case management	Rs 2000 per PHC	38000
Result in low priority being accorded by governments for the control of lymphatic filariasis.		2. Continuous use of vector control measures.	Meeting with VHSC members	NA	0
Low effectiveness of the tools used by the control programme			Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.	NA	0
The chronic nature of the disease		4. IEC for ensuring community awareness and participation in vector control as well as personal protection measures.	Wall paintings	Rs 2000 per PHC	38000
			<b>Total budget</b>		<b>840300</b>

#### 4.11 INSTITUTIONAL STRENGTHENING

1	To enforce PNDT Act and to increase sex ratio of female child	95000
2	Strengthening of DMU NGOs Management aspects is one of the area of improvement	1332000
3	Capacity buiding of Managers and Doctors.	390000
4	Prepration of Dicentralised District Health Action Plan	130000
5	Devlop a strong Monitoring & Evaluation / HMIS System in all PHC	76000
6	Strengthen Logistics management system for regular supply of Drugs and equipments	4165000
7	Strengthening community process through supportive supervision of ASHA program	8766000
8	Media Sensitization	20000
9	<b>Total</b>	<b>Total</b> 14974000

#### 4.12 HIV/AIDS

Issues	Strategy	Activities	Unit Cost	Total Budget
1. Program Management System, District HIV/AIDS action Plan, District AIDS prevention and control unit, Strengthening the evidence base for program tracking progress	Recruitment	Deployment of personnel	District Coordinator	264000
			M&E officer (HIV)	162000
			Office Assistant	96000
		Refurbishing of Office	Lmsm 20000	20000
		Recurring Expenditure		84200
		Travel		170000
		2. Strengthening systems for service delivery	Meetings	DACC Meeting
- PPTCT				
- Pediatric AIDS		Dist level HIV program Review meeting	Rs 2400 per month	28800
- Prevention (ICTCs, Condom promotion)		BHMs meeting	Rs 6400	6400
- Protection, care and support for children affected by HIV/AIDS		Consultation meeting		9600
		Meeting with PLHA		27600

Partnerships at all levels (community, district, networks, different Govt departments, civil society, positive networks		Meeting with Principals of Govt., High Schools for AEP		25600
	Trainings	Two days refresher Training of Nodal Teachers/ Master Trainers of AEP		74000
		One day Meeting of district level medical professionals		10000
<b>Behaviour change communication</b>		One day Link Worker Conference at district level ( Youth Camp)		100000
<b>LAKSHYA (Link Workers – rural HRGs), Young people (Peer education with young people RRCs)</b>	Day celebration	World AIDs day celebration		25000
Scale Up Intervention up to Young Vulnerable Population Easy access to ART center		Travel support to HIV positive women with children		15000
Capacity Building Of Local Administration/NGO/CBO for reach out to Maximum Young Population		Two day residential Capacity Building Training of executive members of Farmers Club, ATMA		189000
		Two days Refresher Training of Facilitators of RRC.		36000

		Two days training of Youth facilitators of VICs of IVPP		360000
		Two days refresher training of Peer Educators/ Volunteers		72000
<b>Owning this project by Village Community</b>		<b>Two days residential Capacity Building Training of ANM</b>		288000
<b>Capacity Building of Different service Providers</b>		Two days residential Capacity Building Training of AWW	At present 10 PHC are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 150 OPD per day in each PHC. This huge workload is not being addressed with only six beds inadequate facility.	360000
		Two days residential Capacity Building Training of AWW		360000
		Total		2795200

### 4.13 RI/Muskan

SI No	Activities	Unit Cost	Total Budget
1	Training of Health workers on Immunization	Rs 100 for 500 workers	50000
2	Printing of RI Formats	Rs 4 for approx 1089000 PW	4356000
3	Printing of Muskan Registers	Rs 100 for 2308 AWCs	230800
4	Suuplementary immunization during flood	Rs 50000 per PHC	950000
5	Catch up immunization	Rs 50000 per PHC	950000
6	Incentive money	Rs 550 per AWC	1269400
7	Mahila Mandal	Rs 250 per AWC	577000
9	POL for cold chain	Rs 1300 per day	474500
10	Vaccines and logistics mobility	Rs 38500 per month	462000
11	Mobility for supervisor	Rs 9000 per month	108000
12	Usage of courier	As discussed in child health	0
13	Hiring of computer operator for RIMS	Rs 5000 per month	<b>60000</b>
14	Measles Campaign	Rs 200000 for the district	200000
15	Hard to Reach area strategy	Rs 10000 per month per PHC	2280000
16	RI Catch up round	Rs 100000 per PHC	1900000
17	Training of Medical Officers	Rs 1000 per person	19000
18	Meeting of epidemic Response Teams	Rs 5000 per PHC	95000
19	Travel expenses for case investigation per outbreak	Rs 20000 per month	240000
20	Shipment cost of lab specimen	Rs Rs 10000 per PHC per month	2280000
21	Outbreak Response	Rs 20000 per PHC	380000
	<b>Total</b>		<b>16881700</b>

## 4.12 Programme wise Budget

Srl No	Budget Head	%	TotalBudget
1	TB	0.44%	3446000
2	Kala azar	1.33%	10420140
3	Leprosy	0.17%	1329000
4	Filaria	0.11%	840300
5	Blindness	0.47%	3684000
6	Child Health	14.51%	113473000
7	Maternal Health	50.33%	393724350
8	Family Planning	14.90%	116558000
9	Institution Strengthening	15.23%	119149000
10	HIV AIDS	0.36%	2795200
11	RI / Muskan	2.16%	16881700
	<b>Total</b>		<b>782300690</b>

THE END