

# **District Health Action Plan**

**2009-2010**



**District Health Society**  
**Samastipur**

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## **Forward**

Under the National Rural Health Mission this District Health Action Plan of Samastipur 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 capacity 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), ACOMO, MOICs, Block Health Managers, ANMs and AWWs for their excellent effort & support in making this District Health Action Plan of Samastipur District.

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

**Dr. Subhash Chandra Sharma (MD)**  
**Civil Surgeon**  
**Samastipur**

## **About the Profile**

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 launched 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. I especially thankful to Mr. Ajit Kumar of PHRN for the personally attention to preparation of District Health Action Plan. The proposed location of HSCs, APHCs, 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.

**Manish Kumar**  
**District Program Manager**  
**District Health Society**  
**Samastipur**

# 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*
- ❑ *Members of Political Parties*

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 APHC and PHCs of Samastipur district. In addition, a number of field visits and focal group discussions, interviews with senior officials, Facility Survey were also conducted. All the draft recommendations on workforce management and rationalization of services were then discussed with employees and their associations, the officers of the state, district and block level, the medical 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 intra-sectoral 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 District Health Action Plan document of Samastipur district has been prepared on the said context.

### **1.3.3 Preparation of DHAP**

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

After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in 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.

#### **Brief History:-**

As per district Gazetteers, Darbhanga, *the modern subdivision of Samastipur (originally Shamsuddinpur) was founded by Hazi Shamsuddin Ilyas of West Bengal* . In Kairian Local traditions associate this village to be the birthplace of Udayanacharya, a Maithil Brahmin and great philosopher of ancient times who is also supposed to be an incarnation of Lord Vishnu. Extensive excavations have revealed at this village antiques of as back as of 2nd century BC and afterwards from 6th century AD to post 1200 AD. This village is the birthplace of philosopher and scholar [Udayana](#) alias [Udayanacharya](#). Samastipur was the birth place of the

famous Kisan leader and freedom fighter Pandit Yamuna Karjee. He was a resident of Pusa, Samastipur and was associated with Swami Shajanand in the Kisan Movement during the freedom struggle.

### Geographic Location of district:-

The District is located at 25° to 30° North latitude and 84° to 85° east longitude. Samastipur is a district in Bihar which is spread over an area of 2904 sq. kms. Samastipur is bounded on the north by the *Bagmati* River which separates it from Darbhanga district. On the west it is bordered by Vaishali and some part of Muzaffarpur district, on the south by the Ganges it has separated to Patna, while on its east it has Begusarai and some part of Khagaria district. The district headquarters is located at Samastipur. The same is also shown in the following map.



The district comprises of 4 sub-divisions, and 20 Community Development Blocks as shown in the map. It has five towns and 1248 villages. The district is well connected by road and Railways. It has direct train to state capital, Kolkata, New Delhi, Dhanbad, Jamshepur and other important places. It is the Divisional Headquarters of the North Eastern railway. National Highway No. 28 passes through the district.

### Samastipur District : Sub-divisions/ Blocks

Sl. No	Subdivision Name	Blocks Name
1	Dalsinghsarai	Dalsinghsarai, Ujairpur, Vidyapatinar
2	Patori	Patori, Mohanpur, Mohiuddinnagar
3	Rosera	Rosera, Hasanpur, Bithan, Sighia, Bibhutipur, Shivajinagar

4	Samastipur Sadar	Samastipur, Kalyanpur, Warisnagar, Khanpur, Pusa, Tajpur, Morwa, Sarairanjan
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Map with blocks

**Socio-Demographic Characteristics of the district:-**

AS PER CENSUS 2001, THE DISTRICT HAS A POPULATION OF 3413439 WITH A DECADAL GROWTH RATE OF 28.35 %. IT IS ONE OF THE MOST DENSELY POPULATED REGIONS OF THE WORLD WITH VERY HIGH POPULATION DENSITY OF 1196 PER SQ.KM AS COMPARED TO BIHAR (880 PER SQ.KM). THE SEX RATIO IN THE DISTRICT AMONG POPULATION IS 928 AND AMONG 0-6 YEAR POPULATION IT IS 937 WHICH IS LITTLE BIT FAVORABLE AS COMPARED TO THE OTHER PARTS OF NORTHERN INDIA. THE MAJORITY OF PEOPLE RESIDE IN THE RURAL AREA (96.4%) WITH ONLY 3.6 % POPULATION RESIDING IN THE URBAN AREA. THE SC POPULATION IN THE DISTRICT IS 18.5 % AND ST POPULATION IS 0.1 %. THE SCHEDULE TRIBES INCLUDE MAINLY MUNDA, ORAON AND KHARWAR. THE SCHEDULE CASTE INCLUDE DUSADH, CHAMAR AND MUSAHAR.

**Literacy:**

IN THE DISTRICT THE FEMALE LITERACY RATE IS ONLY 32.7% AND MALE LITERACY RATE IS 57.8 % AS PER 2001 CENSUS. HOWEVER, DLHS-3 DATA REVEALS A PROMISING TREND WITH TOTAL PERCENTAGE OF LITERATE POPULATION BEING 60.1 % AND LITERACY RATE AMONG MALES AND FEMALES BEING 72.7% & 48% RESPECTIVELY INDICATING A GROWTH IN LITERACY AMONG MALES.

**Occupation:**

AS MAJORITY OF PEOPLE RESIDE IN THE RURAL AREA, AGRICULTURE IS THE MAIN OCCUPATION OF THE PEOPLE. THE FARMING IS MORE OR LESS SUBSISTENCE IN NATURE, WHICH IS MORE OF AN ENGAGEMENT TO THE RURAL PEOPLE WITH VERY LITTLE INCOME. THE CASH CROPS GROWN IN THE DISTRICTS ARE MAIZE, SUGARCANE, FISHING, MAKHANA, EDIBLE OIL FARMING AND DAILY WAGE LABORERS.

**Caste & Religions:**

MAJORITY POPULATION I.E. 89.4% BELONGS TO HINDU RELIGION FOLLOWED BY MUSLIMS (10%). AMONG HINDUS MAJORITY BELONG TO BRAHMINS, KAIYSTHA, KURMIS SAHNI CASTES ETC.

**Economic condtion:**

THE DLHS-3 DATA DEPICTS THAT 87.6% PEOPLE FALL IN LOW SLI (STANDARD OF LIVING INDEX) GROUP. ONLY 4 % OF PEOPLE FALL IN HIGH SLI CATEGORY. IT'S QUITE INTERESTING TO NOTE THAT IN SPITE OF DISPARITY IN WEALTH POSSESSION UNDER VARIOUS HEADS IN DLHS-3; ONLY 19.8% POPULATION IS REPORTED TO HAVE A BPL CARD.

### **Housing conditions:**

IN SAMSTIPUR DISTRICT 54.7% WERE LIVING IN PERMINANT HOUSES AND 25.5% IN TEMPORARY HOUSES. THE AVERAGE HOUSE HOLD SIZE IS SIX.

### **Culture**

THE MAIN FESTIVAL OF THE DISTRICT IS CHHAT,HANUMAN JAYANTI,EID,MOHRRAM, DURGA POOJA, DIWALI AND SARASWATI POOJA. OLD KALI MANDI NEAR RIVER , THANESHWAR TEMPLE IS A VERY FAMOUS TEMPLE OF LORD SHIVA, AND IS SITUATED AT THE HEART OF THE CITY.

### **Climatic conditions of district:**

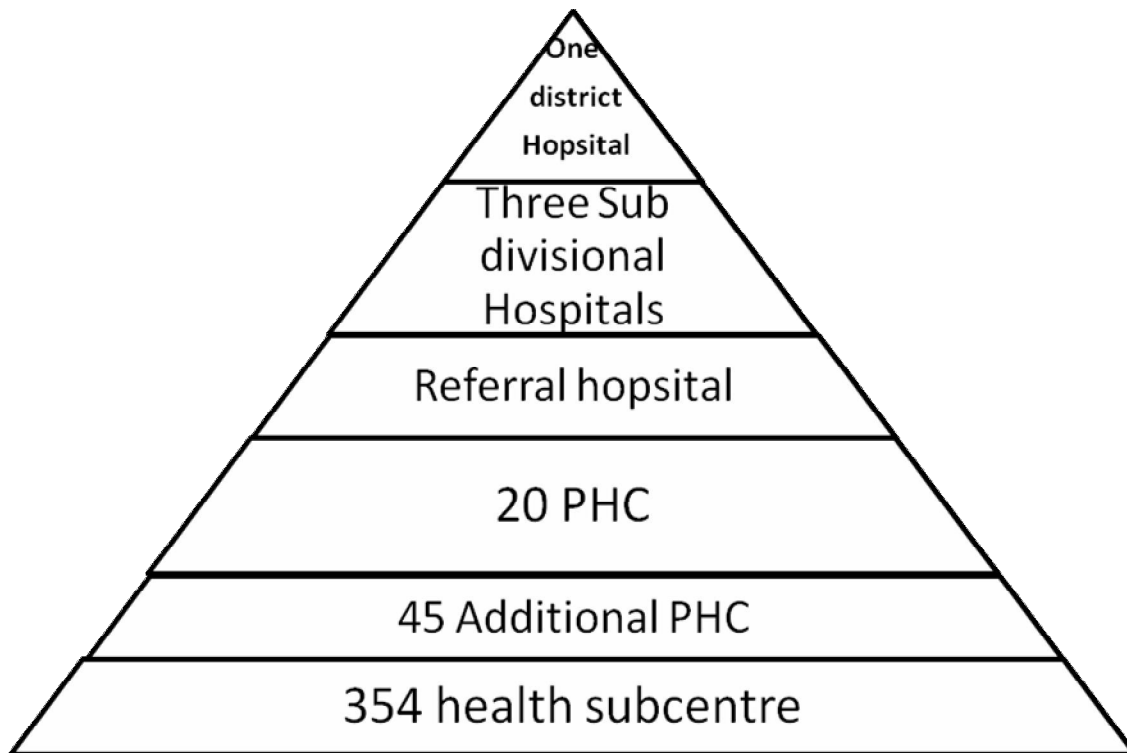
THE DISTRICT RECEIVES MEDIUM TO HEAVY RAINFALL (AVERAGE RAINFALL 1161 MM), AND FACES CONDITION OF SEVERE FLOOD. IN THE YEAR 2007 THE FLOOD CONDITION WAS SO BAD THAT ALMOST 145 GRAM PANCHAYATS AND 583 VILLAGES GOT MAROONED. BITHAN, HASANPUR, SINGHIA, KALYANPUR, SIVAJINAGAR, ROSERA, KHANPUR, AND WARISHNAGAR BLOCKS WERE THE WORST AFFECTED BLOCKS. ACCORDING TO THE ESTIMATES OF NATIONAL DISASTER MANAGEMENT DEPARTMENT, IN THE YEAR 2007, 16,00,000 PEOPLE WERE DIRECTLY AFFECTED BY THE FLOODS. CROPS WERE DAMAGED, AND THERE WAS IRREPARABLE DAMAGE TO PROPERTY AND HUGE LOSS OF LIVES. THE ECONOMIC LOSS DUE TO FLOODS THIS YEAR AMOUNTS TO RS. 100 CRORE OF CROP LOSS, RS. 25 CRORE OF HOUSING LOSS AND RS. 27 CRORE OF PUBLIC PROPERTY LOSS. THE DISTRICT HAS POOR DRAINAGE SYSTEM AND NEARLY 4% OF THE AREA IS WATER LOGGED.

SAMASTIPUR DISTRICT IS ALSO AFFECTED BY DROUGHTS. CYCLES OF FLOODS AND DROUGHTS SEVERALLY AFFECT THE FOOD PRODUCTION AND FOOD DISTRIBUTION SYSTEM, AND LEAD TO DISTRESSFUL SITUATION FOR MOST PEOPLE.

### **Health Care delivery system:**

#### **HEALTH INFRASTRUCTURE:**

IN SAMASTIPUR ONE DISTRICT HOSPITAL, ONE REFERRAL HOSPITAL, THREE SUB-DIVISIONAL HOSPITAL, TWENTY PRIMARY HEALTH CENTRE (FIFTEEN FUNCTIONAL + FIVE NON FUNCTIONAL), 45 ADDITIONAL PRIMARY HEALTH CENTRE AND 354 HEALTH SUB CENTRE CATERS THE VARIOUS HEALTH SERVICES IN THE DISTRICT. APART FROM THESE A THREE GRAMIN AUSHADALAYA ARE ALSO CATERING THE SERVICES.



Among the 354 Health sub centre's, 112 sub centre's are in Govt Building and remaining in Private or hired buildings.

#### **Human Resources in Health care delivery in Samastipur district:-**

THE PRIMARY HEALTH SERVICES (PROMOTIVE, PREVENTIVE AND CURATIVE SERVICES) ARE PROVIDED BY 714 ANMS AND 187 DOCTORS IN THE DISTRICT. AMONG THEM 25 DOCTORS PROVIDE SPECIALIST SERVICES TO THE PUBLIC. THE REFERRAL SYSTEM FROM HEALTH SUB-CENTRE TO PHC AND FURTHER IF NEEDED TO REFERRAL HOSPITAL AND DISTRICT HOSPITAL IS WELL FUNCTIONAL.

#### **NGO:**

MAJOR NGO WHICH WORK IN THE DISTRICT ARE PRAYAS, BIHAR,SAMAJ NAV NIRVAN BHARTI, BIHAR JAN SEVA MUNCH APART FROM INTERNATIONAL NGOS LIKE CARE WHO & UNICEF

## Infant and child mortality in Samastipur district

Indicators	Rural			Urban			Total			Area
	Male	Female	Total	Male	Female	Total	Male	Female	Total	
Infant Mortality Rate	41	57	50	34	36	35	40	56	48	Samastipur
	56	60	58	41	42	42	55	58	57	Bihar
Child Mortality Rate	54	65	59	37	43	40	53	65	59	Samastipur
	59	69	64	42	46	44	57	66	62	Bihar

THE TABLE GIVES THE ESTIMATES OF INFANT MORTALITY RATES AND CHILD MORTALITY RATES OF SAMASTIPUR AND COMPARED WITH THE DATA OF BIHAR. IMR IN RURAL AREAS (50) ARE HIGHER THAN THE URBAN AREAS (35). ALSO CMR IN RURAL AREAS (59) IS HIGHER THAN IN URBAN AREAS (40). THE DIFFERENTIAL RATIO OF INFANT MORTALITY RATE OF MALE/FEMALE IS 0.7 AND RURAL/URBAN IS 1.4. THE DIFFERENTIAL RATIO OF CHILD MORTALITY RATE OF MALE/FEMALE IS 0.8 AND RURAL/URBAN IS 1.5.

## Reproductive and Child health indicators:

### MATERNAL INDICATORS: TABLES FROM DLHS 3

Indicators	DLHS2		DLHS3	
	Total	Rural	Total	Rural
<b>Marriage and Fertility</b>				
Percentage of girls before completing 18 years	51.4	53.1	68	68.7
Percentage of Birth of Order and above	52.7	52.5	56.2	55.9
<b>Family Planning (currently married women, age 15-49)</b>				
Any Method (%)	34.8	34.3	23.2	22
Any modern Method (%)	28.9	29.3	22.4	21.1
Female Sterilization (%)	26.6	27.1	19.9	18.8
Male Sterilization (%)	0.4	0.4	0.2	0.2
IUD (%)	0.4	0.4	0.1	0.1
Pills (%)	0.7	0.6	0.9	0.7
Condom (%)	0.8	0.8	1.2	1.2
Total unmet need (%)	36.3	36.2	42.7	43.2
Ante-natal Care (%)	18	18.7		
Delivery at Health Facility (%)	17.4	17.9		
Use of Family Planning methods (%)	3.6	3.8		
<b>Knowledge of HIV/AIDS and RTI/STI amount ever married women</b>				
<b>Women heard of HIV/AIDS (%)</b>	<b>20.1</b>	<b>19.8</b>	<b>17.9</b>	<b>17.5</b>
<b>Women having correct knowledge of HIV/AIDS %</b>	<b>94.5</b>	<b>94.2</b>		
<b>Women heard of RTI/STI %</b>	<b>46.1</b>	<b>45.3</b>	<b>7.0</b>	<b>86.7</b>

## MARRIAGE & FERTILITY:

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Use of Family Planning methods (%)	3.6	3.8		

## IMMUNIZATION:

Indicators	DLHS2		DLHS3	
	Total	Rural	Total	Rural
<b>Child Immunization</b>				
Children (12-23 months) fully Immunized (BCG, 3does each of DPT and Polio and Measles %	51.1	50.9	16.7	14.0
Children (12-23 months) who have received BCG %	83.6	84.3	46.3	46.4
Children (12-23 months) who have received 3 doses of Polio %	60.0	60.4	37.2	24.5
Children (12-23 months) who have received 3 doses of DPT %	62.6	63.0	38.0	25.9
Children (12-23 months) who have received Measles %	57.5	57.8	19.1	17.1

## TREATMENT OF CHILDHOOD ILLNESS:

Indicators	DLHS2		DLHS3	
	Total	Rural	Total	Rural
<b>Treatment of Childhood disease</b>				
Children with Diarrhea in the last two week who received ORS %	20.9	18.6	4.0	4.2
Children with Diarrhea in the last two week who were given treatment %	84.9	84.1	85.7	89.3
Children with acute respiratory infection / fever in the last two weeks who were given treatment %	78.9	77.7		
Children had check-up within 24 hours after delivery (based on last five birth) %	29.1	29.6		
Children had check-up within 10 days after delivery (based on last five birth) %	32.4	32.7		

## CHILD FEEDING HABITS:

Indicators	DLHS2		DLHS3	
	Total	Rural	Total	Rural
<b>Child Feeding practices (children under 3 years)</b>				
Children breastfed within one hour of birth %	10.9	10.0		

## HIV/AIDS

Indicators	DLHS 3		DLHS 2	
	Total	Rural	Total	Rural
<b>Knowledge of HIV/AIDS and RTI/STI amount ever married women</b>				
<b>Women heard of HIV/AIDS (%)</b>	<b>20.1</b>	<b>19.8</b>	<b>17.9</b>	<b>17.5</b>
<b>Women having correct knowledge of HIV/AIDS %</b>	<b>94.5</b>	<b>94.2</b>		
<b>Women heard of RTI/STI %</b>	<b>46.1</b>	<b>45.3</b>	<b>7.0</b>	<b>86.7</b>

## ROLE OF ASHA:

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilisation and accountability of the existing health services. She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child. ASHA will mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunization, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.

## HEALTH STATUS AND BURDEN OF DISEASES

*Table. CASE FATALITY RATE*

S.No	2007				2008		
	Disease	Case	Death	Case fatality rates	Case	Death	Case fatality rates
1	Gastroenteritis	67	6	8.9%	166	0	0
2	Diarrhea / Dysentery	1515	5	0.3	882	2	1.2%
3	Cholera	0	0	0	0	0	0
4	Meningitis	0	0	0	0	0	0
5	Jaundice	0	0	0	0	0	0
6	Tetanus	0	0	0	0	0	0
7	Kala-azar	12603	6	0.04%	5312	3	0.05%
8	Malaria	0	0	0	0	0	0
9	Measles	0	0	0	0	0	0

Indicators	Samastipur	Bihar
Couple Protection Rate (CPR)	33%	
Crude Death Rate (CDR)	8.1	8.1
Crude Birth Rate	31.9	30.4
Infant Mortality Rate	61	61
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	85	85
Still Birth Rate	2%	NA
Abortion rate	NA	NA

## Chapter 3

### Situation Analysis

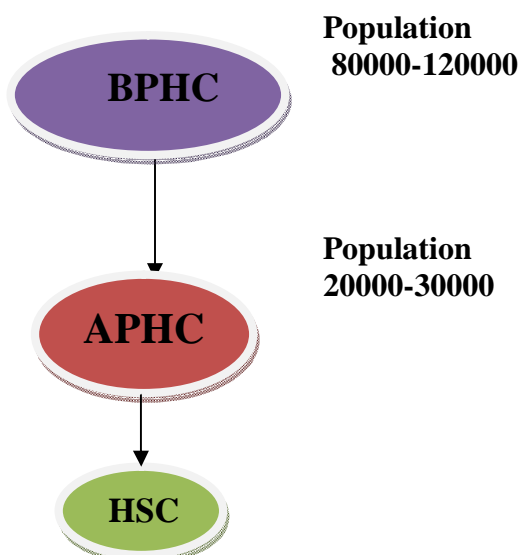
In the present situational analysis of the blocks of district Samastipur the vital statistics or the indicators that measure aspects of health/ life such as number of births, deaths, fertility etc. have been referred from census 2001, report of DHS office, Samastipur and various websites as well as other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

**Table: Health Indicators**

Indicator	Samastipur	Bihar	India
CBR	34.8	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	51.1	32.8	44

**Sources: DLHS3, NFHS3, SRS2007**

#### 3.1.1. GAPS IN INFRASTRUCTURE:



**Population 5000**  
**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.

**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 be rented in a central location with easy access to population

- i. Location of the centre: The location of the centre should be chosen that:
  - a. It is not too close to an existing sub centre/ PHC
  - b. As far as possible no person has to travel more than 3 Km to reach the Sub centre
  - c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)
  - d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary.  
For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.
- ii. The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq mts. depending on climatic conditions (hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labor room. A typical layout plan for Sub-Centre with ANM residence as per the RCH Phase-II National Programme implementation Plan with area/Space Specifications is given below

**Health Sub Centers:** Total population of the district as per 2001 census is 3413413. After considering three percent growth rate of the total population it comes around 4100000 (Decadal Growth Rate 2.3). After considering projected population in 2008, the district needs altogether 683(354 existing HSC AND 329 Proposed HSC) HSCs to cater not its whole population but cover 83% population, so, we need 820 HSCs our present population requirement. As per the IPHS norms (5000 population in plain area) the district still requires 466 new HSCs to be formed. Again, out of 354 established HSCs, only 112 have their own buildings and rest 242 run in rented houses or in panchyat Bhavan. Out of 112 HSCs 67 HSCs need renovation work? All the above mentioned HSCs need equipments, drugs, furniture and stationeries.

<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 354 HSCs only 112 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>A. Strengthening of HSCs having own buildings</b>
	B. In existing 112 buildings 45 are running in			B.1.White washing of HSC buildings. B.2.Organize adolescent girls

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

				renovation/construction works through VHSC members/ Mothers committees/VECs/others as implemented in Bihar Education Project. 4. Training of VHSC/Mothers committees/VECs/Others on technical monitoring aspects of construction work. 5. Monthly Meeting of one representative of VHSC/Mothers committees on construction work
	1. Lack of community ownership in the construction of Health infrastructures.	1.Community ownership	Strengthening of 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

### 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.

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	1. Identification of the best HSC on service delivery 2.Listing of required equipments and medicines as per IPHS norms 3. Purchasing/ indenting according to the list prepared 4.Honouring first delivered baby and ANM
		Improvement in quality of services like ANC, NC and PNC, Immunization and family planning	1. Phasewise strengthening of 39 HSCs for Institutional delivery and fix a day for ANC as per IPHS norms.	1 Gap identification of 242 HSCs through facility survey 2. Eligible Couple Survey 3. Ensuring supply of contraceptives with three month’s buffer stock at HSCs.

			2. Community focused family planning services	4. training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 5. Training of ANMs on IUD insertion
	Lack of counseling services	Training	Training	1. Training to ANMs on ANC, NC and PNC, Immunization and other services.
	HSC unable to implement disease control programs	Integration of disease control programs at HSC level.	Implementation of disease control programs through HSC level	1 Review of all disease control programs HSC wise in existing Tuesday weekly meetings at PHC with form 6. ( four to five HSC per week) 2.Strengthening ANMs for community based planning of all national disease control program 3. Reporting of disease control activities through ANMs 4. Submission of reports of national programs by the supervisors duly signed by the respective ANMs.
	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 from field  Lack of appropriate HMIS formats.	Reporting	Strengthening of reporting system	1.Training to the field staffs in filling up form 6, Form 2, Immunization report format, MCH registers, Muskan achievement reports etc 2.Printing of adequate number of reporting formats and registers 3. Hiring consultants to develop software's for reporting.

**Source: DHS Samastipur Report.**

Sub Heads	Gaps	Issues	Strategy	Activities
<b>Human Resource</b>	486 seats of contractual ANM®, 134 seats of contractual ANMs and 456 seats of Regular ANMs are vacant. Out of 30 sanctioned post of LHVs only 22 are placed, Seat of 28 male workers are vacant	Filling up the staff shortage	Staff recruitment	1.Selection and recruitment of 262 ANMs 2.Selection and recruitment of 28 male workers
	All 352 contractual ANMs needs training on different services.	Untrained staffs	Capacity building	1.Training need Assessment of HSC level staffs 2.Training of staffs on various services
	The ANM training school situated at Sadar Hospital campus, lacks adequate number of trainers, staffs and facilities	Training	Strengthening of ANM training school	1.Analyzing gaps with training school 2.Deployment of required staffs/trainers 3.Hiring of trainers as per need 4. Preparation of annual training calendar issue wise as per guideline of Govt of India. 5.Allocation of fund and operationalization of allocated fund
<b>Drug kit availability</b>	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, 2.No Drug kit for AWCs(@one kit per annum,) 3.No ASHA kit	Indenting	Strengthening of reporting process and indenting through form 6	1.Weekly meeting of HSC staffs at PHC for promoting HSC staffs for regular and timely submission of indents of drugs/ vaccines according to services and reports
	Only need based emergency supply Irregular supply of drugs	Logistics		1.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.Hiring vehicles for supply of drug kits through untied fund. 3.Developing three coloured indenting format for the HSC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red)
		Operationalization	Couriers for vaccine and other drugs supply	1 Hiring of couriers as per need 2 Payment of courier through ANMs account
			Phase wise	1.Purchasing of cold chain

			strengthening of APHCs for vaccine / drugs storage	equipments as per IPHS norms 2. training of concerned staffs on cold chain maintenance and drug storage
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**3.2 Additional PHCs:** --There are 45 APHCs functioning in the district and 56 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 100 APHCs but there are 45 APHCs functioning in the district and 55 more are proposed to be established.</p> <p>2. Four more are required to be formed.</p> <p>3.Out of 55 APHCs only 16 are having own building</p> <p>4.Existing 16 buildings are not properly maintained</p> <p>5.Non payment of rent of 14 APHCs for more than three years</p> <p>Lack of equipments, Lack of appropriate furniture</p> <p>Non availability of HMIS formats/registers and stationaries</p>	<p>Lack of facilities/ basic amenities in the constructed buildings</p> <p>Non payment of rent 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.Strengtheing of APHCs having own buildings</b></p> <p>A.1Renovation 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><b>B. Strengthening of APHCs running in rented buildings.</b></p> <p>B1. Estimation of backlog rent and facilitate the backlog payment within two months</p> <p>B2. Streamlining the payment of rent through untied fund/ RKS 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 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</p>



<p><b>Drug kit availability</b></p>	<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 emergency supply Irregular supply of drugs</p>	<p>Indenting  Logistics  Operationalization</p>	<p>Strengthening of reporting process and indenting through form 2 and 6  Couriers for vaccine and other drugs supply  Phase wise strengthening of APHCs for vaccine / drugs storage</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 2.Ensuring supply of Kit A and Kit B biannually through Developing PHC wise logistics route map 2.1 Hiring vehicles for supply of drug kits through untied fund. 2.3 Developing three coloured indenting format for the APHC to PHC(First reminder-Green, Second reminder-Yellow, Third reminder-Red) 3.1 Hiring of couriers as per need 3.2 Payment of courier through APHC account 4.1 Purchasing of cold chain equipments as per IPHS norms 4.2 training of concerned staffs on cold chain maintenance and drug storage</p>
<p><b>Service performance</b></p>	<p>RKS has not been formed at any of the APHC. Unutilized untied fund at APHC level No institutional delivery at APHC level No OPD At any of the APHC No inpatient facility available No ANC, NC and PNC and family planning services. No lab facility No Ayush practitioner posted No rehabilitation services No safe MTP service No OT/ dressing and Cataract operation services. Approx 80% of APHC staffs not reside at place of posting Lack of counseling services Problem of mobility during rainy season Lack of convergence at APHC level Operational gaps: There is no link</p>	<p>Formation of RKS Operationalization of Untied fund.  Improvement in quality of services like ANC, NC and PNC, Immunization and other services as identified as gaps.  Integration of disease control programs at APHC level.  Family Planning services  Convergence Operational issues</p>	<p>Capacity building of account holder of untied fund  Phasewise strengthening of 16 APHCs for Institutional delivery and fix a day for ANC as per IPHS norms.  Implementation of disease control programs through APHC level where APHC will work as a resource center for HSCs. At present the same is being done by PHC only.</p>	<p>1.Training of signatories on operating Untied fund /RKS account, book keeping etc 2. Assigning PHC RKS accountant for supporting operationalization of APHC level accounts 2. Timely disbursement of untied fund/ seed money for APHCs RKS. 3. 1 Gap identification of 16 APHCs through facility survey 2.strengthening one APHC per PHC for institutional delivery in first quarter 3.Honouring first delivered baby and ANM 1 Review of all disease control programs APHC wise in existing Tuesday weekly meetings at PHC with form 6 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. 5.Weekly meeting of the staffs of concerned HSCs ( as assigned to the APHC) 1.Eligible Couple Survey 2. Ensuring supply of</p>

	between HSCs and APHCs and the same way there is no link between APHC and PHC		Community focused Family Planning services  PPP Convergence	contraceptives with three month's buffer stock at HSCs. 3.Training of AWW/ASHA on family planning methods and RTI/STI/HIV/AIDS 4. Training of ANMs on IUD insertion  1.Outsourcing services for Generator, fooding, cleanliness and ambulance.  1. Fixed Saturday for meeting day of ANM, AWW, ASHA,LRG with VHSCs rotation wise at all villages of the respective HSC.
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**3.3 Primary Health centers:** The district has 20 PHCs, 3 Sub-div. 1 Referral hospitals and a District hospital.

<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 15 PHCs are working with average 10 delivery per day, 4 inpatient Kala-azar, 10 FP operation/emergency operation and 120 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 DLHS3 facility survey(06-07) , the service availability tremendously increased but the quality of services is still the area of improvement.</p> <p>Lack of equipments as per IPHS norms and also under utilized equipments.</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 Sadar hospital.)</p> <p>3. Training to the RKS signatories for account operation.</p> <p>4. Trainings of BHM and accountants on their responsibilities.</p> <p>1.Meeting with community representatives on erecting boundary, beautification etc,</p>



	staffs			
<b>Drug kit availability</b>	<p>Irregular supply of drugs because of lack of fund disbursement on time. Only 70 % essential drugs are rate contracted at state level .</p> <p>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.</p>	<p>Indenting</p> <p>Logistics</p> <p>Operationalization</p>	<p>Strengthening of reporting process and indenting through form 7</p> <p>Strengthening of drug logistic system</p>	<ol style="list-style-type: none"> <li>1.Training of store keepers on invoicing of drugs</li> <li>2.Implementing computerized invoice system in all PHCs</li> <li>3.Fixing the responsibility on proper and timely indenting of medicines( keeping three months buffer stock)</li> <li>4. Enlisting of equipments for safe storage of drugs.</li> <li>5. Purchase of enlisted equipments.</li> <li>6. Ensuring the availability of FIFO list of drugs with store keeper.</li> <li>7. Orientation meetings on guidelines of RKS for operation.</li> </ol>
<b>Service performance</b>	<ol style="list-style-type: none"> <li>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.</li> <li>2. Total 59 seats of Regular and 25 seats of contractual doctors in the district is vacant.</li> <li>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 days during April 08-Nov 08, however the IPHS norms says that the OPD should be 40 per Doctor.)</li> <li>4. 5 PHCs out of 15 are lacking 24 hrs new born care services.</li> <li>5. 2 PHCs are still not providing Tubectomy services.</li> <li>6. Only one PHC (Mahnar) provides safe abortion service.</li> <li>7. Only five PHCs provides 24 hrs BEMoC services.</li> <li>8. None of the PHC provides 24 hour blood transfusion services, however PHC Mahnar has been provided the equipments for blood storage unit.</li> <li>9. 8 PHC does not have laboratory facilities.</li> </ol>	<p>Optimum Utilization of Human Resources</p> <p>Epidemic outbreaks and Need based intervention in epidemic areas.</p> <p>Service Load centered at PHC</p>	<p>Quality improvement in residential facility of doctors/ staffs.</p> <p>Recruitment</p> <p>Proper and timely information of outbreaks</p> <p>Strengthening of</p>	<ol style="list-style-type: none"> <li>1. Hiring of rented houses from RKS fund for the residence of doctors and key staffs.</li> <li>2. Incentivizing doctors on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.</li> <li>3. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day</li> </ol> <p>1.Selection and appointment of contractual doctors and staffs</p> <ol style="list-style-type: none"> <li>1. Mapping of the areas having history of outbreaks disease wise.</li> <li>2.Developing micro plans to address epidemic outbreaks</li> <li>2.Assigning areas to the MOs and staffs</li> <li>3.Motivating ASHA on immediate information of outbreaks</li> <li>4. Purchasing folding tents, beds and equipments and medicines to organize camps in epidemic areas.</li> <li>1. Repairing of all defunct Ambulances</li> <li>2. Repairing of PHCs gensets and initiating their use.</li> <li>3. Hiring of ambulances as per need.</li> <li>1. Appointment of one AYUSH practitioner and Yoga teacher in every PHC</li> <li>1.Insurance of all properties</li> </ol>

	<p>11. 2 Lab services provided by PPP services have fled away.</p> <p>12. Only one PHC provides adolescent sexual and reproductive health services.</p> <p>13. Health facility with AYUSH services is not being provided</p> <p>14. 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>15. Quality of food, cleanliness (toilets, Labour room, OT, wards etc) electricity facilities are not satisfactory in any of the PHC.</p> <p>16. All PHCs have their own generator sets but are not in use.</p> <p>17. 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>18. Several cases of theft of instruments, computers, and submersible pumps etc at PHCs.</p> <p>19. No guidance to the patients on the services available at PHCs.</p> <p>20. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.</p> <p>21. Lack of inpatient facility for kala-azar patients.</p> <p>22. Lack of counseling services</p> <p>23. Problem of mobility during rainy season</p> <p>24. Lack of convergence</p> <p>25. Lack of timely reporting and delay in data collection</p>	<p>Availability of AYUSH pathy.</p> <p>Insecurity ( Staff and Properties)</p> <p>Govts existing services like lab, x-ray, generator, fooding and cleanliness services.</p>	<p>equipments and services and increase in the number of ambulances.</p> <p>Strengthening of AYUSH services at PHC level in the first level.</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> <p>HMIS and strengthening of reporting process</p>	<p>and staffs of PHC</p> <p>2. Placing one TOP in every PHC</p> <p>1. Assigning mothers committees of local BRC for food supply to the patients in govt's approved rate.</p> <p>2. Recruitment of lab technicians as required</p> <p>3. Purchase of equipments/ instruments for strengthening lab.</p> <p>4. Hiring of menial workers for cleanliness works.</p> <p>1. Assigning LHV for counseling work</p> <p>2. Wall writing on every section of the building denoting the facilities</p> <p>3. Name plates of doctor</p> <p>4. Displaying Roster of doctors with their details.</p> <p>5. Gardening</p> <p>6. Sitting arrangement for patients</p> <p>7. Installation of LCD TV with cable connection</p> <p>8. Installation of safe drinking water equipments/water 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. Puchase of Laptops for DPMs and BHM</p>
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### 3.4 District Hospital:

<b>District Hospital Samastipur:</b>																				
<b>Indicators</b>	<b>Gaps</b>	<b>Issues</b>	<b>Strategy</b>	<b>Activities</b>																
<b>Infrastructure</b>	<p>1. There are 90 beds in the Sadar hospital which is not adequate as per the requirement.</p> <table border="0"> <tr> <td><b>Ward</b></td> <td><b>No of beds</b></td> </tr> <tr> <td>Male medical ward:</td> <td>10</td> </tr> <tr> <td>Male surgical ward:</td> <td>10</td> </tr> <tr> <td>Female ward</td> <td>: 20</td> </tr> <tr> <td>Child ward</td> <td>: 20</td> </tr> <tr> <td>Delivery ward</td> <td>: 10</td> </tr> <tr> <td>Infectious disease</td> <td>: 30</td> </tr> <tr> <td><b>Total</b></td> <td><b>: 90</b></td> </tr> </table> <p>2. At present District hospital is working with average 45 deliveries per day, 10 inpatient Kala-azar, 05 FP operation/emergency operations and 800 OPD per day. This huge workload is not being addressed with only 90 beds inadequate facility.</p> <p>3. Lack of equipments as per IPHS norms and also under utilized equipments.</p> <p>4. Lack of appropriate furniture</p> <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 for doctors and staffs.</p> <p>21. No canteen facility</p>	<b>Ward</b>	<b>No of beds</b>	Male medical ward:	10	Male surgical ward:	10	Female ward	: 20	Child ward	: 20	Delivery ward	: 10	Infectious disease	: 30	<b>Total</b>	<b>: 90</b>	Lacks in infrastructure	Strengthening of infrastructure	<p>1. Purchase of 500 beds.</p> <p>2. Repairing of beds.</p> <p>3. Listing of required equipments as per IPHS norms and their purchase.</p> <p>4. Listing of required furniture and their purchase.</p> <p>5. Simplifying process of RKS operation.</p> <p>6. Computerization of registration system for the OPD/IPD patients.</p> <p>7. Construction of shed for waiting patients</p> <p>8. Installation of 3 Water cooler freezers as per requirement.</p> <p>9. Installation of seven vapor lights as per requirements.</p> <p>10. Renovation of 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>
<b>Ward</b>	<b>No of beds</b>																			
Male medical ward:	10																			
Male surgical ward:	10																			
Female ward	: 20																			
Child ward	: 20																			
Delivery ward	: 10																			
Infectious disease	: 30																			
<b>Total</b>	<b>: 90</b>																			
<b>Human Resource</b>	<p>1. Post of gynecologist may be increased and pathologist are vacant.</p> <p>2. Post of one dresser, one OT assistant and one ophthalmic</p>	Lack in Staff position	Recruitment	<p>1. Appointment of gynecologist and pathologist on contract basis.</p> <p>2. Appointment of one</p>																

	assistant are vacant.		Deputing staffs	dresser, one OT assistant and one ophthalmic assistant on contract basis.  1. Deputation of required staffs from field.
<b>Drug kit availability</b>	<ol style="list-style-type: none"> <li>1. Irregular supply of drugs because of lack of fund disbursement on time.</li> <li>2. Only 70% essential drugs are rate contracted at state level.</li> <li>3. There is no clarity on the guideline for need based drug procurement and transportation.</li> <li>4. Lack of proper space, furniture and equipments for drug storage</li> </ol>	<p>Improper Supply and logistics</p> <p>Lack in storage facility</p>	Capacity building and strengthening of reporting process and indenting through form 7	<ol style="list-style-type: none"> <li>1. Training of store keepers on invoicing of drugs</li> <li>2. Implementing computerized invoice system</li> <li>4. Enlisting of equipments for safe storage of drugs.</li> <li>5. Purchase of enlisted equipments.</li> <li>6. Ensuring the availability of FIFO list of drugs with store keeper.</li> </ol>
Service performance	<ol style="list-style-type: none"> <li>1. Excessive load in delivering all services</li> <li>2. Blood storage unit is present but not utilized</li> <li>3. No 24hrs Lab facility</li> <li>4. Health facility with AYUSH services is not being provided</li> <li>5. Referral <ol style="list-style-type: none"> <li>a. No pick up facility for PW or patients.</li> <li>b. BPL patients are not exempted in paying fee of ambulance.</li> <li>c. Lack of maintenance of ambulances</li> <li>d. Shortage of ambulances</li> </ol> </li> <li>6. No guidance to the patients on the services available at DH.</li> <li>7. Non friendly attitude of staffs towards the poor patients in general and women are disadvantaged group in particular.</li> </ol>	<p>Workload</p> <p>Lack in infrastructure</p>	<p>Motivation building</p> <p>Strengthening of infrastructure</p>	<ol style="list-style-type: none"> <li>1. Incentivizing doctors/ staffs on their performances especially on OPD, IPD, FP operations, Kala-azar patients treatment.</li> <li>2. Purchase of equipments for Blood storage unit,</li> <li>3. IEC on blood storage unit.</li> <li>4. Revising Duty rosters in such a way that all posted doctors are having at least 8 hrs assignments per day</li> <li>5. Repairing of all defunct Ambulances</li> <li>6. Hiring of ambulances as per need.</li> <li>7. Appointment of one AYUSH practitioner and Yoga teacher</li> <li>8. Purchase of equipments/ instruments for strengthening lab.</li> <li>9. Wall writing on every section of the building denoting the facilities</li> <li>10. Name plates of doctor</li> <li>11. Displaying Roster of doctors with their details.</li> <li>12. Gardening</li> <li>13. Apron with name plates with every doctors</li> <li>14. Presence of staffs with uniform and name</li> </ol>

DISTRICT HEALTH SOCIETY SAMASTIPUR				plates.
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**BUDGET PLAN 2009-10 RCH Flexipool PART - A**

Sl.No.	Particulars	1st qtr	2nd qtr	3rd qtr	4th qtr	Total	
1	<b>Part - A RCH – II</b>	<b>16651414</b>	<b>20658209</b>	<b>21132649</b>	<b>27792013</b>	<b>86234285</b>	
	<b>FMR Code</b>						<b>Maternal H</b>
	1.1.1	216000	216000	40000	40000	512000	Operationaliza unit
	1.1.2	0	25000	0	0	25000	24*7 PHC wor
	1.3.1	0	50300	50300	0	100600	RCH outreach
	1.4.1	53375	53375	53375	53375	213500	Home Deliveri
	1.4.2.1	20000000	30000000	30000000	1491340	81491340	Rural Institutio
	1.4.2.2	2000000	3000000	3000000	1779268	9779268	Urban Institutio
	1.4.2.3	88690	88000	85000	93102	354792	Caesarean De Dr
	1.4.3	0	271439	271439	271439	814317	Monitor quality
	<b>Sub –Total</b>	<b>22358065</b>	<b>33704114</b>	<b>33500114</b>	<b>3728524</b>	<b>93290817</b>	
	<b>FMR Code</b>						<b>Child Health</b>
2	2.2	0	40164	0	40164	80328	implementatio
	2.4	1565823	1565823	1565823	1565862	6263331	School Health
	<b>Sub –Total</b>	<b>1565823</b>	<b>1605987</b>	<b>1565823</b>	<b>1606026</b>	<b>6343659</b>	
	<b>FMR Code</b>						<b>Family Pl</b>
3	3.1.1	0	25000	0	0	25000	Dissemination sterilis
	3.1.2.2	0	10000	30000	30000	70000	NSV Camps @
	3.1.4	2693833	2693833	2693834	8081500	16163000	Compensation Sterilisation
	3.1.5	0	0	689873	689873	1379746	Compensation
	3.1.6	0	1493750	1493750	1493750	4481250	Accreditation Hos
	3.2.1	0	40000	40000	40000	120000	IUD Camps
	3.3	0	62539	62539	62539	187617	POL for Famil
	3.5	0	0	8014	10435	18449	Community ba cent
	<b>Sub –Total</b>	<b>2693833</b>	<b>4325122</b>	<b>5018010</b>	<b>10408097</b>	<b>22445062</b>	
	<b>FMR Code</b>						<b>ARSH</b>
4	4.1	0	25000	0	0	25000	ARSH urban F cell
5	5.1	375000	375000	375000	375000	1500000	Urban RCH D
8	8.1	0	93183	93183	93183	279549	PNDT activitie
	<b>Sub-Total</b>	<b>375000</b>	<b>493183</b>	<b>468183</b>	<b>468183</b>	<b>1804549</b>	

<b>PART – A</b>							
	<b>FMR Code</b>	<b>1st qtr</b>	<b>2nd qtr</b>	<b>3rd qtr</b>	<b>4th qtr</b>	<b>Total</b>	<b>Health Cam Infra.</b>
9	9.1.1	0	800000	800000	800000	2400000	Hiring of Retir
	9.1.2	175500	175500	175500	175500	702000	laboratory Tec
	9.1.4	2016042	2016042	2016042	2016042	8064168	Hiring of Doct
	9.1.5	45837	45837	45837	45837	183348	Other cotract

	9.1.6	3311390	3311390	3311390	3311390	13245560	Incentive ASH
	9.3.1	100000	0	0	0	100000	estab. New bo
	9.3.2	87500	87500	87500	87500	350000	24 hour servic
	<b>Sub-Total</b>	<b>5736269</b>	<b>6436269</b>	<b>6436269</b>	<b>6436269</b>	<b>25045076</b>	
	<b>FMR Code</b>						<b>Institutiona</b>
10	10.4	0	708000	708000	708000	2124000	Sub - center r
	<b>Sub-Total</b>	<b>0</b>	<b>708000</b>	<b>708000</b>	<b>708000</b>	<b>2124000</b>	
	<b>FMR Code</b>						<b>T</b>
11	11.3.1	374400	294400	294400	294400	1257600	SBA Training
	11.3.4	0	25000	0	0	25000	Safe abortion
	11.5.1	1407004	1407004	1407004	1407003	5628015	IMNCI training
	11.8.2	31500	31500	71500	31500	166000	DPMU Trainin
	<b>Sub - Total</b>	<b>1812904</b>	<b>1757904</b>	<b>1772904</b>	<b>1732903</b>	<b>7076615</b>	
	<b>FMR Code</b>						<b>E</b>
12	12.2	12500	0	12500	0	25000	BCC/ IEC
	12.4	379500	379500	379500	379500	1518000	Other Activitie
	<b>Sub - Total</b>	<b>392000</b>	<b>379500</b>	<b>392000</b>	<b>379500</b>	<b>1543000</b>	
13	13.1.1	74671	74671	0	0	149342	<b>Procurement</b>
							<b>Programme</b>
14	14.2	184796	184796	184796	184796	739184	DPMU salary
	14.3	60000	60000	60000	60000	240000	Appointment c
	14.4	209836	209836	209836	209836	839344	Mobility Supp
	<b>Sub - Total</b>	<b>454632</b>	<b>454632</b>	<b>454632</b>	<b>454632</b>	<b>1818528</b>	
	<b>GRAND TOTAL PART A</b>	<b>35463197</b>	<b>49939382</b>	<b>50315935</b>	<b>25922134</b>	<b>161640648</b>	<b>RCH Flexip</b>

**DISTRICT HEALTH SOCIETY SAMASTIPUR  
BUDGET PLAN 2009-10 ADDITIONALITIES**

**PART - B**

Sl.No.	Particulars	1st qtr	2nd qtr	3rd qtr	4th qtr	Total	
	<b>FMR Code</b>						
1	1.12	0	12000	12000	12000	36000	ASHA support
	1.13	749997	749997	749997	750009	3000000	ASHA support
	1.14	49307	49307	49307	49308	197229	ASHA support
	1.16	0	0	992600	0	992600	ASHA drug Ki
	1.18	695093	695094	695094	695094	2780375	Motivation of /
	1.20	892050	892050	892050	892050	3568200	ASHA Divas
	<b>Sub - Total</b>	<b>2386447</b>	<b>2398448</b>	<b>3391048</b>	<b>2398461</b>	<b>10574404</b>	
	<b>FMR Code</b>						<b>Untied,VHS</b>
	1.21	1395183	1395183	1395183	1395451	5581000	Untied Fund fo
	1.22	2817505	2817505	2817505	2817485	11270000	Village Health Committee
	1.23	3000000	600000	200000	200000	4000000	Rogi Kalyan S
	<b>Sub - Total</b>	<b>7212688</b>	<b>4812688</b>	<b>4412688</b>	<b>4412936</b>	<b>20851000</b>	
	<b>FMR Code</b>						<b>Infrastructu</b>
2	2.1	1900000	1900000	1900000	1900000	7600000	Construction o
	2.2	750000	750000	750000	750000	3000000	Const. of Resi Nurse
	2.2	1328750	1328750	1328750	1328750	5315000	Const.of Build
	2.3	7000000	7000000	7000000	7000000	28000000	Upgradation o

		2.5	500000	2000000	0	0	2500000	Upgradation o
		2.6	1025000	1025000	1025000	1025000	4100000	Annual Mainte
		<b>Sub – Total</b>	<b>12503750</b>	<b>14003750</b>	<b>12003750</b>	<b>12003750</b>	<b>50515000</b>	
		<b>FMR Code</b>						<b>Contractua</b>
3		3.1A	0	0	0	687517	687517	Incentive for F
		3.1B	3227000	3227000	3227000	3223315	12904315	Salaries for C
		3.1C	2790000	2790000	2790000	2790000	11160000	Contract Salari
		3.1D	562850	562850	562850	562857	2251407	Mobile Faciliti functionari
		<b>Sub – Total</b>	<b>6579850</b>	<b>6579850</b>	<b>6579850</b>	<b>7263689</b>	<b>27003239</b>	
		3.2	2715985	2715985	2715985	2715985	10863940	Block program
		3.4	0	291000	291000	291000	873000	Addl manpowe
		<b>Sub – Total</b>	<b>2715985</b>	<b>3006985</b>	<b>3006985</b>	<b>3006985</b>	<b>11736940</b>	
		<b>FMR Code</b>						<b>PPP Initiati</b>
4		4.6	0	374767	374767	374766	1124300	Hospital Wast Disposal
		4.11	0	1053000	1053000	2106000	4212000	Operationalisi
		4.14	585000	585000	585000	585000	2340000	Monitoring & E Block
		<b>Sub – Total</b>	<b>585000</b>	<b>2012767</b>	<b>2012767</b>	<b>3065766</b>	<b>7676300</b>	
		<b>PART – B</b>						
		<b>FMR Code</b>	<b>1st qtr</b>	<b>2nd qtr</b>	<b>3rd qtr</b>	<b>4th qtr</b>	<b>Total</b>	<b>Procureme</b>
5		5.1	0	262307	0	0	262307	Delivery Kits H 25
		5.2	0	241455	0	0	241455	SBA drug kits
		5.3	0	25000	0	0	25000	Availability of
		5.4	1589760	0	0	0	1589760	Procurement o DH
		<b>Sub – Total</b>	<b>1589760</b>	<b>528762</b>	<b>0</b>	<b>0</b>	<b>2118522</b>	
		<b>FMR Code</b>						<b>Procure</b>
6		6.1	0	0	943904	0	943904	Cost of IFA fo moth
		6.2	0	1613238	0	0	1613238	Cost of IFA fo
		6.3	0	1479915	0	0	1479915	Cost of IFA fo
		<b>Sub – Total</b>	<b>0</b>	<b>3093153</b>	<b>943904</b>	<b>0</b>	<b>4037057</b>	
		<b>FMR Code</b>						<b>Strenthenin</b>
9		9.1	100000	200000	200000	200000	700000	Proper elect.fo Distt
		9.2	0	200000	0	0	200000	Earthing & wir
		<b>Sub – Total</b>	<b>100000</b>	<b>400000</b>	<b>200000</b>	<b>200000</b>	<b>900000</b>	
		<b>FMR Code</b>						<b>Prep.o</b>
10		10.1	0	0	100000	0	100000	Preparation of
		<b>FMR Code</b>						
11		<b>Sub – Total</b>	<b>0</b>	<b>5380800</b>	<b>5380800</b>	<b>5380800</b>	<b>16142400</b>	Mainstreaming
		<b>FMR Code</b>						<b>RCH Procu</b>
13		13.2	0	1705263	0	0	1705263	Equipment for
		13.4	4802932	0	0	0	4802932	Equipment for
		13.5	0	2789840	0	0	2789840	Equipments fo
		13.6	0	20000	0	0	20000	NSV Kits
		13.7	0	15000	0	0	15000	IUD insertion
		13.8	0	39474	0	0	39474	Minilap sets
		<b>Sub Total</b>	<b>4802932</b>	<b>4569577</b>	<b>0</b>	<b>0</b>	<b>9372509</b>	
		<b>Grand Total Part B</b>	<b>38476412</b>	<b>46786780</b>	<b>38031792</b>	<b>37732387</b>	<b>161027371</b>	

**DISTRICT HEALTH SOCIETY SAMASTIPUR  
BUDGET PLAN 2009-10 ROUTINE IMMUNIZATION PART - CRI**

SI.No.	Activities	1st qtr	2nd qtr	3rd qtr	4th qtr	Total	Activities
1	Mobility Support	12500	12500	12500	12500	50000	Mobility support
2	Vaccine Van	6250	6250	6250	6250	25000	Cold chain ma
3	Minor Repair	13576	13576	13576	13576	54304	Minor Repair
4	Underserved AWC	572800	572800	572800	54000	1772400	Focus on slum
5	Alternate Vaccinators Hon	112350	112350	112350	112350	449400	
6	Alternate Vacc Deliv hard to reach area	112200	112200	112200	112200	448800	
7	Alternate Vacc. Deliv in other area	897900	897900	897900	897900	3591600	
8	Computer Assistant	24000	24000	24000	24000	96000	
9	Review Meeting of RI Distt level	0	20000	20000	0	40000	
10	Review Meeting of RI at Block level	0	314300	314300	314300	942900	
11	Cold chain hand trg	0	26200	0	0	26200	
12	1 day trg block level	19500	0	0	0	19500	
13	Dev of Microplan	38850	38850	0	0	77700	
14	Consolidation of Microplan block level	0	22000	0	0	22000	
15	POL for vacc delivery	25000	25000	25000	25000	100000	
16	Consumables for RIMS	1200	1200	1200	1200	4800	
17	Twin bucket	8000	0	0	0	8000	
18	Red/ Black Plastic bag	37296	0	0	0	37296	
19	Bleach/hypochloride	10000	0	0	0	10000	
	<b>Sub – Total</b>	<b>1891422</b>	<b>2199126</b>	<b>2112076</b>	<b>1573276</b>	<b>7775900</b>	
20	Training	6550	6550	6550	6550	26200	
21	Training	4875	4875	4875	4875	19500	
	<b>Sub – Total</b>	<b>11425</b>	<b>11425</b>	<b>11425</b>	<b>11425</b>	<b>45700</b>	
23	Contr.ANM Break period Salary 1400pm	112350	112350	112350	112350	449400	
	<b>Sub – Total</b>	<b>112350</b>	<b>112350</b>	<b>112350</b>	<b>112350</b>	<b>449400</b>	
	<b>Grand Total Part CRI</b>	<b>2015197</b>	<b>2322901</b>	<b>2235851</b>	<b>1697051</b>	<b>8271000</b>	

**DISTRICT HEALTH SOCIETY SAMASTIPUR  
BUDGET PLAN 2009-10 Pulse Polio Round PART - CPP**

SI.No.	Activities	1st qtr	2nd qtr	3rd qtr	4th qtr	Total	
1	Vaccinator Hon	4979362	3319575	3319575	4979363	16597875	
2	Per diem Supervisor	731137	487425	487425	731138	2437125	
3	Sub-depo cold chain handler	163800	109200	163800	109200	546000	
4	Vehicle/ POL	1023750	682500	682500	1023750	3412500	

5	Ice Pack	659556	439704	439704	659556	2198520
6	Mobility Support	959250	639500	639500	959250	3197500
7	Supplies & Logistic	215715	143810	143810	215715	719050
8	IEC & Social Mobiliza	44677	29785	29785	44678	148925
9	Contingencies	119250	79500	79500	119250	397500
10	Vaccine Cold Chain Handler	76500	51000	51000	76500	255000
11	Vaccine Lifting	69000	46000	46000	69000	230000
	<b>Total A Team</b>	<b>9041997</b>	<b>6027999</b>	<b>6082599</b>	<b>8987400</b>	<b>30139995</b>
1	B Team	1174119	782746	782746	1174119	3913730
	<b>Total ( A+B ) Team</b>	<b>10216116</b>	<b>6810745</b>	<b>6865345</b>	<b>10161519</b>	<b>34053725</b>

**DISTRICT HEALTH SOCIETY SAMASTIPUR  
SUMMARY OF BUDGETS 2009-10**

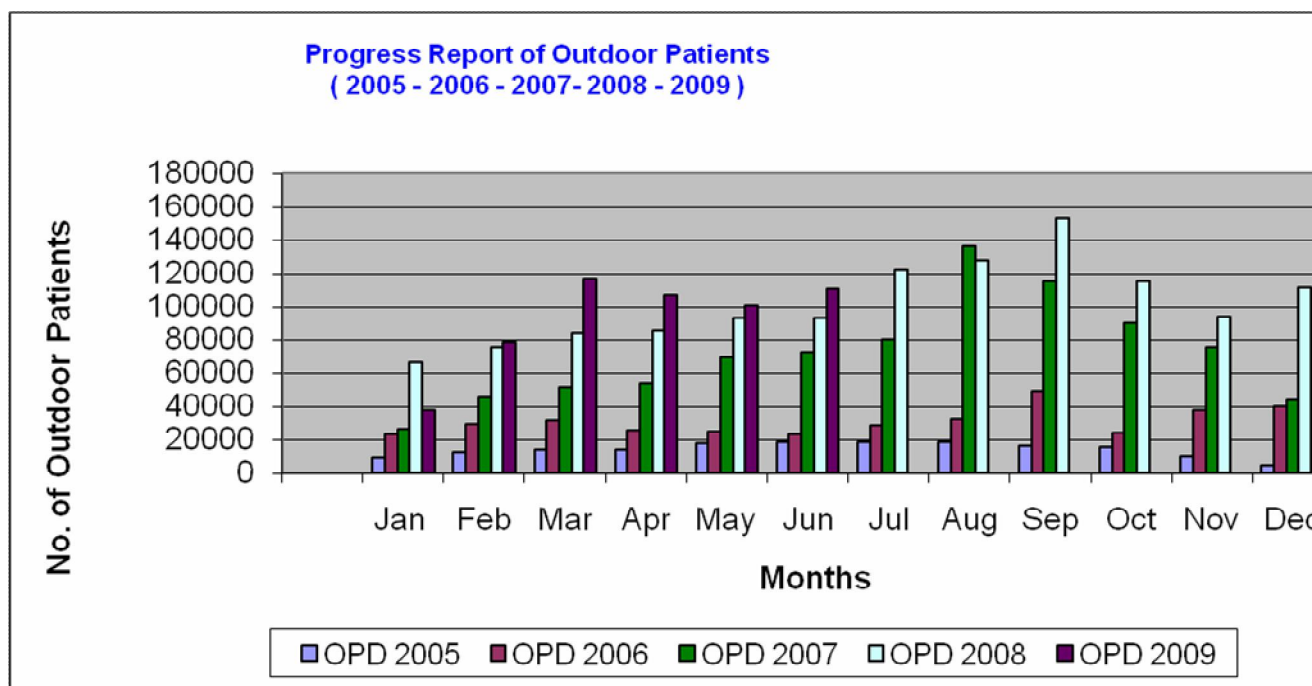
SI.No.	Name of Activities FMR code	1st qtr	2nd qtr	3rd qtr	4th qtr	T
1	Institutional Del/Blood storage /monitoring	22358065	33704114	33500114	3728524	9
2	FBNC/School Health Camp	1565823	1605987	1565823	1606026	
3	Family Planning & Others	2693833	4325122	5018010	10408097	2
4,5,8	ARSH/Micro plan/PNDT	375000	493183	468183	468183	
9	Contractual Services	5736269	6436269	6436269	6436269	2
10	Sub - Center Rent	0	708000	708000	708000	
11	Training	1812904	1757904	1772904	1732903	
12	BCC/IEC	392000	379500	392000	379500	
13	Procurement of Equipment	74671	74671	0	0	
14	DPMU/CA/Mobility Support	454632	454632	454632	454632	
	<b>Total Maternal Health RCH - II</b>	<b>35463197</b>	<b>49939382</b>	<b>50315935</b>	<b>25922134</b>	<b>16</b>
	<b>Additionalities - PART - B</b>					
1	ASHA support system	2386447	2398448	3391048	2398461	1
	Untied fund/VHSC/RKS	7212688	4812688	4412688	4412936	2
2	Construction/upgradation	12503750	14003750	12003750	12003750	5
3.1	Salary ANM/Nurse/Mobile	6579850	6579850	6579850	7263689	2
3	BPMU/Manpower	2715985	3006985	3006985	3006985	1
4	MMU/Monitoring/waste management	585000	2012767	2012767	3065766	
5	Procurement of Kits/Beds/Napkins etc	1589760	528762	0	0	
6	IFA Tablets	0	3093153	943904	0	
9	Electrical works/earthing etc	100000	400000	200000	200000	
10	Preparation of Distt.Action Plan	0	0	100000	0	
11	Ayush Programme	0	5380800	5380800	5380800	1
13	Equipment ICU/Labour Room etc.	4802932	4569577	0	0	
	<b>Total NRHM Additionalities</b>	<b>38476412</b>	<b>46786780</b>	<b>38031792</b>	<b>37732387</b>	<b>16</b>
1	<b>Routine Immunization</b>	1891422	2199126	2112076	1573276	
	Training	11425	11425	11425	11425	
	ANM break period salary	112350	112350	112350	112350	
	<b>Total – CRI</b>	<b>2015197</b>	<b>2322901</b>	<b>2235851</b>	<b>1697051</b>	
2	<b>Pulse polio Round</b>	<b>10216116</b>	<b>6810745</b>	<b>6865345</b>	<b>10161519</b>	<b>3</b>
	<b>Grand Total</b>	<b>86170922</b>	<b>105859808</b>	<b>97448923</b>	<b>75513091</b>	<b>36</b>

# Annexure

## Progressive Report of Sadar / Sub Div. Hospitals /PHCs

### OUTDOOR PATIENTS

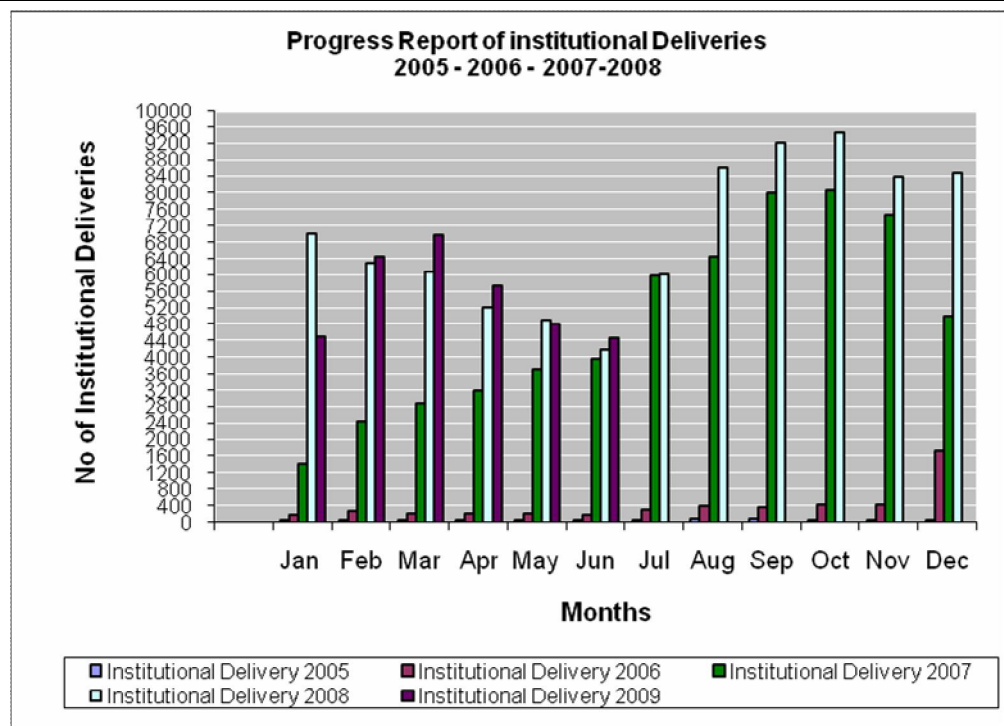
Sl. No.	Name of Month	OPD 2005	OPD 2006	OPD 2007	OPD 2008	OPD 2009	In 2006	In 2007	In 2008
							% increased comparison with 2005	% increased comparison with 2006	% increased comparison with 2005
1	Jan	9461	22708	26157	65994	37371	176.47	15.19	152.30
2	Feb	11924	29406	45097	75267	78692	278.20	53.36	66.90
3	Mar	13562	31253	51769	83926	117149	281.72	65.64	62.12
4	Apr	14203	25198	53796	85320	107256	278.77	113.49	58.60
5	May	17912	24445	69443	93221	100680	287.69	184.08	34.24
6	Jun	18551	22803	72373	93399	110680	290.13	217.38	29.05
7	Jul	18214	28664	80152	122379		340.06	179.63	52.68
8	Aug	18175	32371	136279	127862		649.82	320.99	-6.18
9	Sep	16162	49451	115309	152721		613.46	133.18	32.44
10	Oct	15757	24220	90164	115281		472.22	272.27	27.86
11	Nov	10124	37363	75447	94120		645.23	101.93	24.75
12	Dec	4328	39733	43473	111253		904.46	9.41	155.91
<b>Total</b>		<b>168373</b>	<b>367615</b>	<b>859459</b>	<b>1220743</b>	<b>551828</b>	<b>410.45</b>	<b>133.79</b>	<b>42.04</b>



## Institutional Deliveries

Sl. No.	Name of Month	Institutional Delivery 2005	Institutional Delivery 2006	Institutional Delivery 2007	
1	Jan	59	175	1435	
2	Feb	55	289	2462	
3	Mar	61	219	2879	
4	Apr	64	204	3193	

5	May	71	209	3714
6	Jun	65	192	3987
7	Jul	70	296	6007
8	Aug	84	398	6468
9	Sep	91	380	8019
10	Oct	72	420	8067
11	Nov	75	442	7498
12	Dec	68	1749	5002
<b>Total</b>		<b>835</b>	<b>4973</b>	<b>59000</b>



**Progressive  
Report of Sadar /  
Sub Div. Hospitals  
/PHCs**

Family Planing Operation			
2005- 06 - 07- 08 - 90			
Name of Month	Tubectomy 2005 - 06	Tubectomy 2006 - 07	Tubect 2007 -
Apr	39	12	278
May	3	9	239
Jun	26	5	330
Jul	38	2	303
Aug	1	14	311
Sep	6	7	355
Oct	14	8	507
Nov	125	88	100
Dec	411	508	323
Jan	411	584	573
Feb	801	2121	433
Mar	326	1142	199
Total	<b>2201</b>	<b>4500</b>	<b>1863</b>

**District Health Society, Samastipur**  
**Progressive Report of Sadar / Sub Div. Hospitals /PHCs**  
**Family Planning**

Sl. No.	Name of Month	Vasectomy	Tubectomy2007 – 08
1	Apr	0	278
2	May	0	239

3	Jun	0	330	
4	Jul	0	303	
5	Aug	0	311	
6	Sep	0	355	
7	Oct	0	507	
8	Nov	2	1004	
9	Dec	3	3234	
10	Jan	4	5739	
11	Feb	6	4339	
12	Mar	44	1996	
	<b>Total</b>	<b>59</b>	<b>18635</b>	