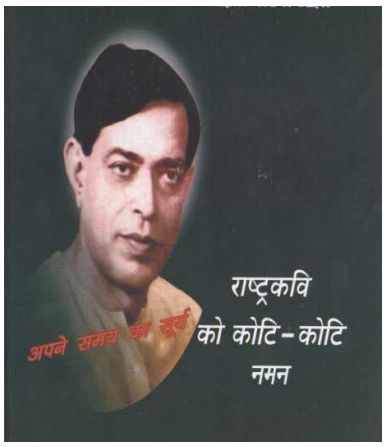
DISTRICT HEALTH ACTION PLAN
2011-2012



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 primitive 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) ACMO, 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. Ramjee
ACMO, BEGUSARAI

Dr. Sonalal Akela
Civil Surgeon cum Member Secretary
BEGUSARAI

CHAPTER-1

1. INTORDUCTION

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 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 PLANNING

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 DISTRICT PLANING PROCESS

13.1 Approach to District Planning

A decentralized participatory planning process has been followed in development of this District Health Action Plan. The health facilities in the block viz. HSCs, APHCs, PHCs and, FRUs were surveyed using the templates developed at the aforementioned workshop. The inputs from these Situation Analysis & “facility” surveys were taken into account while developing the District Health Action Plan. The findings of the DLHS – 3 have also been used to analyze the present situation in the district. The District Planning Team (DPT) provided technical oversight and strategic vision for the process of development of District Health Action Plan. The members of the DPT had also taken the responsibility of contributing to the selected thematic areas such as RCH, Newer initiatives under NRHM, immunization etc. Assessment of overall

situation of the District and development of broad framework for planning was done through a series of meetings of the DPT.

The process followed while developing the District Health Action Plans is as follows:

- Extensive District consultations of various interests groups/stakeholders and their feedback.
- Resources availability recommendations of stakeholders at all levels.
- Formation of District level core group to further the planning process.
- Participation of Block level functionaries in the planning process.
- District level consultation processes with workshops, meetings and discussions.
- Feed back & Consultative meetings with various allied Departments.

The major thrust areas in the NRHM namely, Reproductive & Child Health-II, Immunization, Control of Communicable Diseases, Strengthening & Mainstreaming & Establishing the Public Health Standards in the Health System have been taken into account while developing the District Health Action Plan.

1.3.2 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 complied to perform a situational analysis.

1.3.3 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 intesectoral 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.

1.3.4 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO (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 came 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 pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

AREAS AS IDENTIFIED DURING THE PROCESS:

National Rural Health Mission encompasses a wide range of health concerns including the determinants of the good health. Though there is a significant increase in resource allocation for the NRHM, there can never be adequate resources for all the health needs and all that needs to be done for ensuring good health of all the people. It is therefore necessary to Subcentres the areas where appropriate emphasis needs to be given. Based on the background and the planning process following are the overall priorities of the District:

1. Improving Infrastructure has to be the taken up as there is great gap in infrastructure at all levels.
2. Improving Maternal & Child Health & ensuring complete immunization, Ante natal and Post natal cover.
3. Improving Family Planning Services.

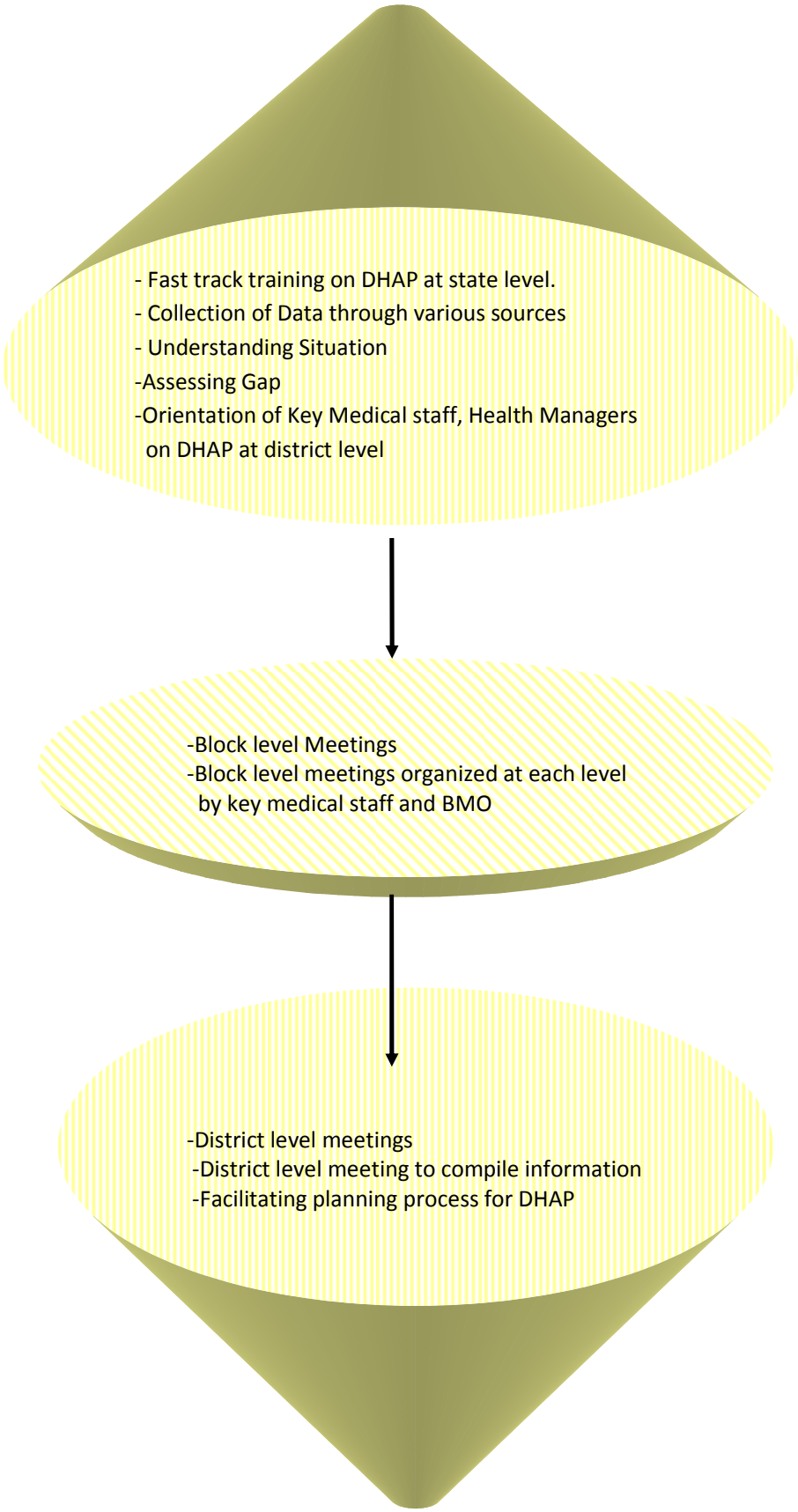
4. Reduction of morbidity/Mortality due to Kalaazar, malaria and TB through effective disease control and surveillance.
5. Increase in the number of facilities as per the population
6. Availability of personnel and their Capacity building
7. Adverse Sex Ratio
8. Improving behavior change communication.
9. Ensuring adequate supply of drugs particularly at primary level to poorer sections.
10. Ensuring development of effective and sustainable financing arrangements to protect the interest of marginalized sections.
11. Strengthening the HMIS and the monitoring system especially availability of correct data and its use.
12. Inter-sectoral convergence.
13. Strengthening of Civil Surgeon Office.
14. Quality services at all levels

SPECIFIC PRIORITIES OF THE DISTRICT

1. **Infrastructure**: Increase in the number of SHCs, APHCs, PHCs and Urban Health Centres for the slums and urbanized population. Special emphasis on making APHCs functional.
2. **Maternal Health:** Well managed system of institutional deliveries through Delivery huts and Emergency Obstetric Care services, JBSY extended to all poor categories of persons, Blood Storage Units at District Hospital, All PHCs to be developed as FRUs, PHCs to be developed as 24x7 facilities, good referral mechanisms. Ensure complete Ante antal and Post natal coverage.
3. **Neo Natal and Child Health:** Provision of Neonatal services at APHCs, PHCs, Training on IMNCI, addressing Anaemia and Malnutrition. Preparation of School Health Plan.
4. **Family Planning:** Improving the coverage for Spacing methods and NSV
5. **Immunization:** Total coverage for immunization
6. **Adolescent Health:** The focus is on provision of Adolescent Reproductive and Sexual health education through schools and also awareness building on good health practices, responsible family life, and harmful effects of Alcoholism.

7. **National Disease Control Programmes:** Prevention Vector borne diseases especially Kalazar which is very rampant in the district. The control on malaria & TB also remains high on the agenda.
8. **Gender & Equity:** Implementation of PNDT Act 1995 through regular monitoring of Ultrasound Clinics and regular meetings of advisory committee. Increase in BCC/IEC activities for awareness of PNDT Act.
9. **Demand Generation, IEC/BCC:** Nutrition, Health & RCH Education to Adolescents, Behaviour Change in the difficult Populations and for improving the adverse sex ratio. Health Plan for each village through Village Health Committee of the Panchyat.
10. **Programme Management:** Better functioning of the District Health Society and strengthened Civil Surgeon's Office and establishing BPMU.
11. **Human Resources:** Filling of the vacancies as per the population based norms for the year 2010-11, increased mobility, motivational issues, provision of quarters at all facilities, Availability of well trained ASHAs for each 1000 population
12. **Capacity Building:** Focused capacity building in Emergency Obstetric Care, Continuous skill building of all personnel as per needs expressed and also the new job responsibilities under NRHM. Training and capacity building of Panchayati Raj Institutions to establish decentralized and participative planning and training of all ASHAs.
13. **Procurement and Logistics:** Construction of a scientific Warehouse for Drugs.
14. **Monitoring and Evaluation:** Data validation and computerized data availability upto PHCs with district linkages
15. **Intersectoral Convergence:** Fixing Responsibilities of each sector for their accountability and hence better Intersectoral Coordination and ensure Inter Sectoral convergence with nutrition, Drinking water & sanition programme to derive synergies.
16. **Public-Private Partnership:** Increase in the number of private facilities for accreditation with the Government for providing services

District Health Action Plan Planning Process



CHAPTER-2

Begusarai : District Profile

Begusarai district is one of the thirty-eight districts of Bihar state, India, and Begusarai town is the administrative headquarters of this district. The district lies on the northern bank of river Ganga. It is located at latitudes 25.15N & 25.45N and longitudes 85.45E & 86.36E.

It was established in 1870 as a subdivision of Munger District. In 1972, it was district status. The name of the district apparently comes from "Begum" (queen) + "Sarai" (inn) as "Begum" of Bhagalpur used to come to the "Simaria Ghat" (a holy place at Ganges bank) for a month of pilgrimage which later took the present slang form Begusarai. It is the birthplace of famous Hindi poet Rashtrakavi Ramdhari Singh Dinkar.(However most people know Munger as his birthplace as Begusarai was the part of Munger during his birth and much of his lifetime.)and Eminent Historian Professor Ram Saran Sharma. Begusarai is the part of historic Mithila region.

Eminent Historian Professor Ram Sharan Sharma was born on 26 November 1919 in Barauni, Begusarai, Bihar .Shri Rajendra Prasd singh (who got the best farmer & social worker award by UNICEF & Indira Gandhi) was born in village harrakh (Begusarai).

Places of visit includes Jai Mangla Temple, Nauo Lakha Temple, Kabar Lake.

Geographical Feature

Begusarai lies in North Bihar between latitudes 25□15' and 25□ 45' north and longitudes 85□45' and 86□36" east. This town expands perpendicularly from east to west which used to be a main link road. It is bounded on the north by Samastipur, on the south

by the Ganga and the Lakhisarai district, on the east by Khagaria and Munger and on the west by the Samastipur and Patna districts.

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
2010 (proposed)	1581613	1440842	3022455	29.0	1918	1575

*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

(2) Seasonal : 4866.37 Hectares

Garama & Rabi maize : 50000 Hectares

Kharif maize : 63000 Hectares

Administrative Setup

PARTICULARS	NUMBER
Number of Sub-Division	**05**
Number of Blocks	**18**
Number of Municipality	**1**
Number of Gram Panchayat	**257**
Number of Police Station	**29**
Number of Inhibited Villages	**1198**
Number of Uninhibited Villages	
Number of Villages	

Sr. No.	Name of the Officers	I/C OF The Section/ Office	Office	Residence	Mobile No	Fax
1	Jitendra Srivastava I.A.S.	District Magistrate –cum-Collector	211285	230584	9431805000	230571
2	Dhananjay Thakur	Dy. Development Commissioner	212343	230506	9431818370	
3	Md. Nayeem Akhtar	Additional Collector	212940	230501	9473191413	
4	Sita Ram Yadav	Director (Accounts) DRDA	212934	230554	9431818427	
5	Md. Affzaloor Rahman	Director, NEP			9939342448	
6	Lalan Kumar Singh	District Welfare Officer			9431095882	
7	Narendra Kumar	District Informatics Officer(NIC,GOI)	213915		9431633014	
8	Devendra Srivastava	District Accounts Officer			9835640272	
9	Akhilesh Kumar Jha	District supply Officer			9431259184	
10	Ajay Kumar	District Transport Officer			9934208919	
11	Amzad Ali	District Panchayati Raj Officer			9470853786	
12	Binod Kumar Jha	Treasury Officer	228826		9473119419	
13	Sanoj Kumar	Asst. Treasury Officer	228826			
14	Shrawan Kumar	GPF Officer			9204063339	
15	Dawarika Ravidas	Sub. Election Officer			9472449285	
16	Dinesh Kumar	District Public Relation Officer		212809	9234734568	
17	Yogesh Mishra	District Education Officer			9431468635	
18	Ramakant Prasad	District Superintendent Of Education			9835404900	
19	Ganesh Ram	District Satistical Officer			9430532014	
20	Diwan Abuool Bshar Khan	D.P.O.ICDS, Begusarai			9835676232	
21	Ajay Kumar Mishra	District Planning Officer			9431166236	
22	Sayed Ghulam Mohammad	Asst. Director Social Security			9973117086	
23	Birendra Kumar	A.P.O., NAEGA			9470275348	
24		District Agriculture Officer			9431818803	
25	A. K. Jha	D.C.L.R., Begusarai			9431430035	
26	Suresh Kumar Manodia	District Sub. Registrar, Begusarai			9431244221	
27	Arun Kavyayan	Asst. Controller Weight &			9431879694	

		Measurement, Begusarai				
28	Uttam Kumar	Executive Officer National saving, Begusarai			9771298740	
29						
30	Ravindra Kumar	Ajivni, Begusarai			9470001175	
31	Sri Pati Singh	G.M., DIC, Begusarai			9430964919	
32	Sudhir Kumar Jha	Excise Superitendent			9430690779	

SENIOR DY COLLECTOR

Sr. No.	Name of the Officers	I/C OF The Section/ Office	Office	Residence	Mobile No	Fax
1	Ajay Kr Mishra				9431166236	
2	Ajay Kumar				9934208919	
3	Amzad Ali				9470853786	
4	Smt Mamta Minakshi				9430906765	
5	Muzffar Ahmad Buland Akhtar				8809848504	
6	Sudhir Kr Jha				9546107807	
7	Nazir Ahmad				9431033389	
8	Shambhu Saran				9431411137	
9	Md. Zafar Alam				9931224449	
10	Rabindra Kr Gupta				9431039312	
11	Nirmal Kumar				9835435520	
12	Barun Kr Mishra				9608248039	
13	Md Rizwan				9471890166	
14	Smt Kanak Bala				9934099434	
15	Arvind Kr Mishra				9431054067	

S.D.O.

Sr. No.	Name of the Officers	I/C OF The Section/ Office	Office	Residence	Mobile No	Fax
1	Kumar Anuj	Begusarai			9801806940	
2	Prabhat Bhushan	Teghra			9835491181	
3	Chandan Chowhan	Ballia			9835079010	
4	Suman Kumar Sah	Manjhole			9431066006	
5	Sahnabaj Ahmad Niyaji	Bakhari			9431818250	

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. 2nd October 1972 (A handnote on Begusarai district census-1991). Now it is a part of the Munger commissionery. Geographically, lying between latitudes $25^0$15'N & $25^0$14'N and longitudes 85045'E & $85^0$45'E, it covers an area of 1918km ^{2}. 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 is 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, Mattihani, Teghra, 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^2. 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 "Chaurs", 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 chaurs viz Kaulachaur and Bhagwanpur chaur. These chaurs serve as excellent fertile agricultural lands duing summer and are submerged during rains. Also the areas around these chaurs face the problem of submergence for around three-four months a year. Kawar lake, a large fresh water lake which is basically a huge wetland is present as an important physiographic feature of this part.

In the Gangaflood 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 chaurs”, 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 Gangain and around Begusarai are charactersied by tributaries that flow parallel to the Gangafor 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 ,Baghmati,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, “Chaurs” and “Tals” determines the boundary of the district in the southern part.

The Burhi Gandak, the 2nd 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 slit 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

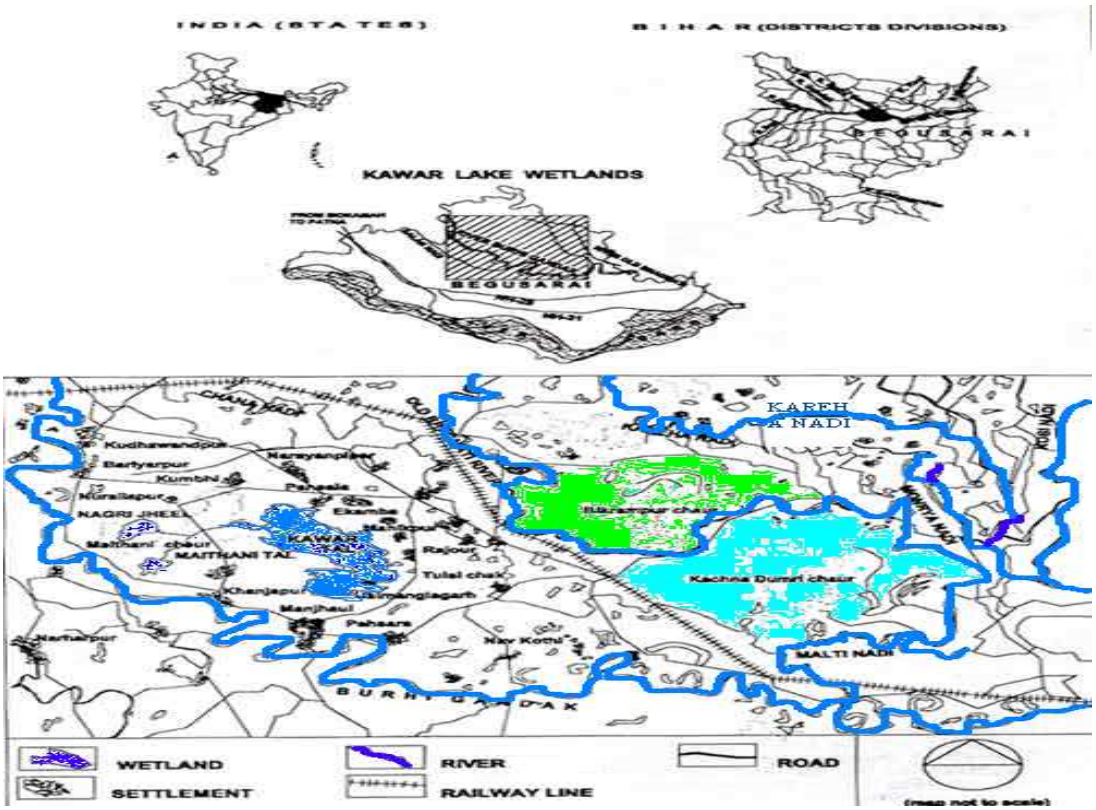
Bagmati – A very Juvenile stream of North Bihar plains, drains only the northeastern corner of district. It enters into the district near Bakhri and is well known for its unstable nature and spill channels. After traversing the low-lying valley areas, it meets the Kosi near Sankosh outside the territories 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 perrennial 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 BurhiGandak. 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, slit 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 chaurs, 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 sight 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 adopted 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(Sinha1996) .A westward shift of the river is ,however, still evident. The Baghmati system encompasses what are turned "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 featured 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 Mid Gangaplain 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 severs 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 interfluve. The Burhi Gandak shifts its channel eastwards due to paleotopography and sedimentological readjustment. The Baghmati 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 thougout 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 Quaternernay sediments of the Indogangetic plains have been traditionally subdivided into the older and younger alluvium and locally called Bhanger 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.

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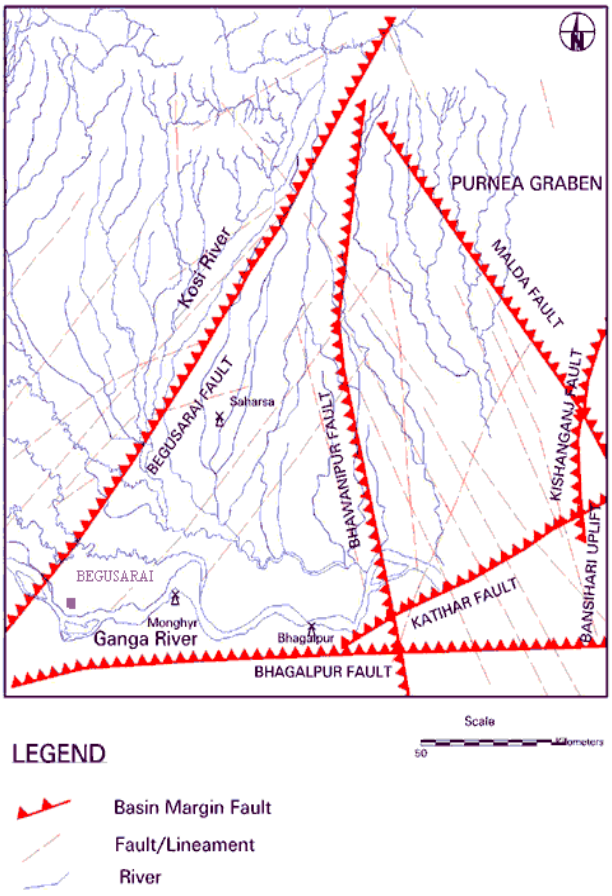
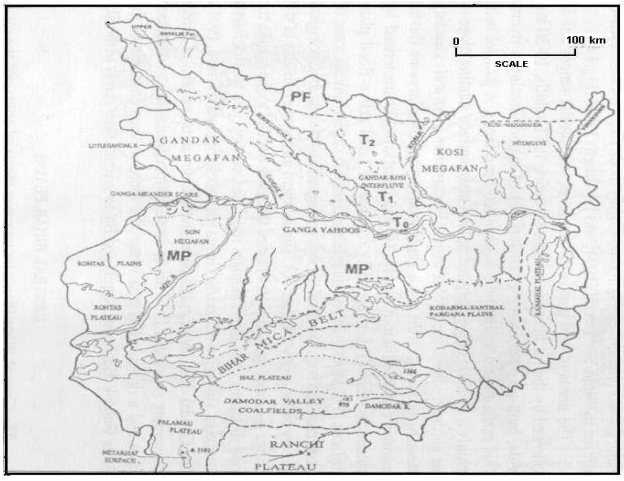


LINEAMENTS AND MAJOR FAULTS

MAP SHOWING AROUND BEGUSARAI

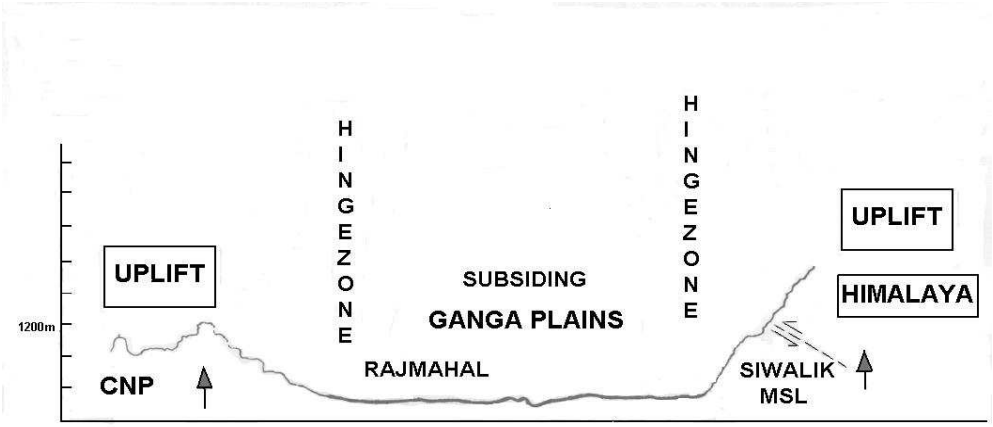


Regional geomorphic elements of the Mid-Ganga Plains of Bihar. T1 – River valley terrace surface; T0 – active floodplain surface. MP – Marginal plain upland surface; PF Piedmont fan surface (Geomorphic elements after I.B. Singh, 1996).

Regional geomorphic elements of the Mid-Ganga Plains of Bihar. T_1 – River valley terrace surface; T0 – 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)

Demographic Feature:

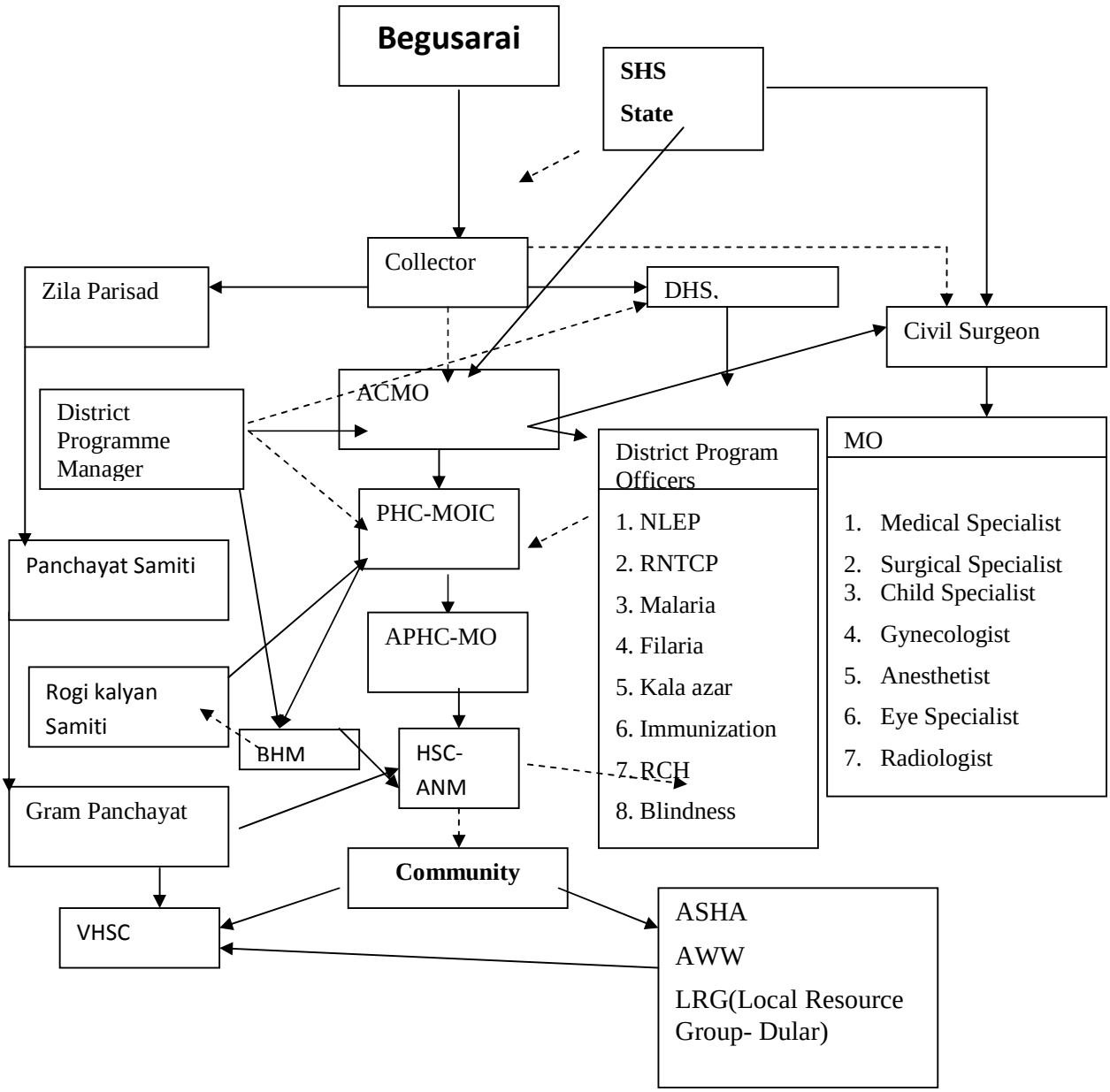


Geodynamic setting of in the three geomorphic domains of Bihar. Projected profile along 85° E longitude

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.

2.1

District Health and Administrative Setup



Situation Analysis for DISTRICT Health Action Plan

BEGUSARAI

Date - 09/12/2010

By- District Health Society, BEGUSARAI

No.	Variable	Data
1.	Total area	1, 87,967.5 Hectares
2.	Total no. of blocks	18
3.	Total no. of Gram Panchayats	256
4.	No. of villages	1250
5.	No of PHCs	18
6.	No of APHCs	22
7.	No of HSCs	288
8.	No of Sub divisional hospitals	2
9.	No of referral hospitals	2
10.	No of Doctors	71
11.	No of ANMs	230
12.	No of Grade A Nurse	72
13.	No of Paramedicals	Not available
14.	Total population	2791026
15.	Male population	1451333
16.	Female population	1339693
17.	Sex Ratio	1000-956
18.	No of Eligible couples	92103
19.	Children (0-6 years)	390743
20.	Children (0-1years)	111641
21.	SC population	405310
22.	ST population	1788
23.	BPL population	1451333
24.	No. of primary schools	1622
25.	No. of Anganwadi centers	2308
26.	No. of Anganwadi workers	2300
27.	No of ASHA	2055

28.	No. of electrified villages	1205
29.	No. of villages having access to safe drinking water	1250
30.	No of villages having motorable roads	1243

Section A: Health Facilities in the DISTRICT

S.No	District Name	Population	Sub-centres required	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	BEGUSARAI	2791026	558	288	179	91	59	408	10

Health Sub-centres

Section A: Health Facilities in the DISTRICT

Additional Primary Health Centers (APHCs)

No	DISTRICT NAME	Population	APHCs required (After including PHCs)	APHCs present	APHCs proposed	APHCs required	Status of building		Availability of Land
							Own	Rented	
1	BEGUSARAI	2791026	93	22	63	8	10	75	3

Section A: Health Facilities in the DISTRICT

Primary Health Centers/Referral Hospital/Sub-Divisional Hospital/DISTRICT Hospital

No	DISTRICT Name/sub division	Population	PHCs/Referral /SDH/DH Present	PHCs required (After including referral/DH/SDH)	PHCs proposed
1	BEGUSARAI	2791026	23	0	0

Section B: Human Resources and Infrastructure

Additional Primary Health Centre (APHC) Database: Human Resources

Doctors and ANM

क्र0	संस्थान का नाम	Doctors			ANM		Remarks for Doctors
		Sanction	In position	Vacant	Sanction	In position	
1	अति0 प्रा0 स्वा0 केन्द्र, शेरपुर (भग0)	2	0	2	2	2	
2	अति0 प्रा0 स्वा0 केन्द्र, बनवाड़ी पुर	2	2	0	2	2	अनाधिकृत रूप से अनु0
3	अति0 प्रा0 स्वा0 केन्द्र, नवटोल	2	0	2	2	2	
4	अति0 प्रा0 स्वा0 केन्द्र, लखनपट्टी	1	0	1	2	2	
5	अति0 प्रा0 स्वा0 केन्द्र, अमारी	2	2	0	2	2	एक चिकित्सा पदा0 चे0 बरियार में प्रति0
6	अति0 प्रा0 स्वा0 केन्द्र, मलहीपुर	2	3	-1	2	2	योगदान के पश्चात अनाधिकृत रूप से अनु0
7	अति0 प्रा0 स्वा0 केन्द्र, मोहब्बा	2	1	1	2	2	
8	अति0 प्रा0 स्वा0 केन्द्र, देवपुरा	2	2	0	2	2	एक चि0 पदा0 अनाधिकृत रूप से अनु0
9	अति0 प्रा0 स्वा0 केन्द्र, पहसारा	2	0	2	2	2	
10	अति0 प्रा0 स्वा0 केन्द्र, परिहारा	2	2	0	2	2	
11	अति0 प्रा0 स्वा0 केन्द्र, हनुमाननगर पहाड़पुर	2	1	1	2	2	
12	अति0 प्रा0 स्वा0 केन्द्र, सिहमा	2	2	0	2	2	दोनो पटना में प्रति0 एक वर्ष के लिए संविदा पर
13	अति0 प्रा0 स्वा0 केन्द्र, रामपुर बसबन	2	0	2	2	2	
14	अति0 प्रा0 स्वा0 केन्द्र, सिमरिया	2	2	0	2	2	
15	अति0 प्रा0 स्वा0 केन्द्र, महना	2	2	0	2	2	
16	अति0 प्रा0 स्वा0 केन्द्र, मोहनपुर	2	3	-1	2	2	दो चि0 पदा0 निलंबित
17	अति0 प्रा0 स्वा0 केन्द्र, भैरवार	2	2	0	2	2	
18	अति0 प्रा0 स्वा0 केन्द्र, कोरिया बासुदेवपुर	2	1	1	2	2	
19	अति0 प्रा0 स्वा0 केन्द्र, बिनोदपुर	2	2	0	2	2	एक चि0 पदा0 पटना में प्रति0

20	अति0 प्रा0 स्वा0 केन्द्र, शोकहारा	2	2	0	2	2	एक चि0 पदा0 मंझौल में प्रति0
21	अति0 प्रा0 स्वा0 केन्द्र, सकरौली	2	1	1	2	2	
22	अति0 प्रा0 स्वा0 केन्द्र, चमथा	2	2	0	2	2	
23	राजकीय औषधालय नौलागढ़	1	0	1	2	2	
	कुल	**44**	**32**	**12**	**46**	**46**	

Laboratory Technician and Pharmacists dresser

क्र0	संस्थान का नाम	Laboratory Technician			Pharmacists / dresser		Remarks
		Sanction	In position	Vacant	Sanction	In position	
1	अति0 प्रा0 स्वा0 केन्द्र, शेरपुर (भग0)	0	0	0	0	0	
2	अति0 प्रा0 स्वा0 केन्द्र, बनवाड़ी पुर	0	0	0	0	0	
3	अति0 प्रा0 स्वा0 केन्द्र, नवटोल	0	0	0	0	0	
4	अति0 प्रा0 स्वा0 केन्द्र, लखनपट्टी	0	0	0	0	0	
5	अति0 प्रा0 स्वा0 केन्द्र, अमारी	0	0	0	0	0	
6	अति0 प्रा0 स्वा0 केन्द्र, मलहीपुर	0	0	0	0	0	
7	अति0 प्रा0 स्वा0 केन्द्र, मोहब्बा	0	0	0	0	0	
8	अति0 प्रा0 स्वा0 केन्द्र, देवपुरा	0	0	0	0	0	
9	अति0 प्रा0 स्वा0 केन्द्र, पहसारा	0	0	0	0	0	
10	अति0 प्रा0 स्वा0 केन्द्र, परिहारा	0	0	0	0	0	
11	अति0 प्रा0 स्वा0 केन्द्र, हनुमाननगर पहाड़पुर	0	0	0	0	0	
12	अति0 प्रा0 स्वा0 केन्द्र, सिहमा	0	0	0	0	0	
13	अति0 प्रा0 स्वा0 केन्द्र, रामपुर बसबन	0	0	0	0	0	
14	अति0 प्रा0 स्वा0 केन्द्र, सिमरिया	0	0	0	0	0	
15	अति0 प्रा0 स्वा0 केन्द्र, महना	0	0	0	0	0	
16	अति0 प्रा0 स्वा0 केन्द्र, मोहनपुर	0	0	0	0	0	
17	अति0 प्रा0 स्वा0 केन्द्र, भैरवार	0	0	0	0	0	
18	अति0 प्रा0 स्वा0 केन्द्र, कोरिया बासुदेवपुर	0	0	0	0	0	
19	अति0 प्रा0 स्वा0 केन्द्र, बिनोदपुर	0	0	0	0	0	
20	अति0 प्रा0 स्वा0 केन्द्र, शोकहारा	0	0	0	0	0	

21	अति0 प्रा0 स्वा0 केन्द्र, सकरौली	0	0	0	0	0	
22	अति0 प्रा0 स्वा0 केन्द्र, चमथा	0	0	0	0	0	
23	राजकीय औषधालय नौलागढ़	0	0	0	0	0	
	कुल	0	0	0	0	0	

A Grade Nurse and Night Guard

क्र0	संस्थान का नाम	A Grade Nurse			Night Guard		Remarks
		Sanction	In position	Vacant	Sanction	In position	
1	अति0 प्रा0 स्वा0 केन्द्र, शेरपुर (भग0)	2	2	0	0	0	
2	अति0 प्रा0 स्वा0 केन्द्र, बनवाड़ी पुर	2	2	0	0	0	
3	अति0 प्रा0 स्वा0 केन्द्र, नवटोल	2	2	0	0	0	
4	अति0 प्रा0 स्वा0 केन्द्र, लखनपट्टी	2	2	0	0	0	
5	अति0 प्रा0 स्वा0 केन्द्र, अमारी	2	2	0	0	0	
6	अति0 प्रा0 स्वा0 केन्द्र, मलहीपुर	2	2	0	0	0	
7	अति0 प्रा0 स्वा0 केन्द्र, मोहब्बा	2	2	0	0	0	
8	अति0 प्रा0 स्वा0 केन्द्र, देवपुरा	2	2	0	0	0	
9	अति0 प्रा0 स्वा0 केन्द्र, पहसारा	2	2	0	0	0	
10	अति0 प्रा0 स्वा0 केन्द्र, परिहारा	2	2	0	0	0	
11	अति0 प्रा0 स्वा0 केन्द्र, हनुमाननगर पहाड़पुर	2	2	0	0	0	
12	अति0 प्रा0 स्वा0 केन्द्र, सिहमा	2	2	0	0	0	
13	अति0 प्रा0 स्वा0 केन्द्र, रामपुर बसबन	2	2	0	0	0	
14	अति0 प्रा0 स्वा0 केन्द्र, सिमरिया	2	2	0	0	0	
15	अति0 प्रा0 स्वा0 केन्द्र, महना	2	2	0	0	0	
16	अति0 प्रा0 स्वा0 केन्द्र, मोहनपुर	2	2	0	0	0	
17	अति0 प्रा0 स्वा0 केन्द्र, भैरवार	2	2	0	0	0	
18	अति0 प्रा0 स्वा0 केन्द्र, कोरिया बासुदेवपुर	2	2	0	0	0	
19	अति0 प्रा0 स्वा0 केन्द्र, बिनोदपुर	2	2	0	0	0	
20	अति0 प्रा0 स्वा0 केन्द्र, शोकहारा	2	2	0	0	0	
21	अति0 प्रा0 स्वा0 केन्द्र, सकरौली	2	2	0	0	0	
22	अति0 प्रा0 स्वा0 केन्द्र, चमथा	2	2	0	0	0	
23	राजकीय औषधालय नौलागढ़	2	2	0	0	0	
	कुल	**46**	**46**	**0**	**0**	**0**	

Section B: Human Resources and Infrastructure

Primary Health Centres/Referral Hospital/Sub-Divisional Hospital/DISTRICT Hospital: Infrastructure

No	PHC/ Referral Hospital/SDH/DH Name	Population served	Building ownership (Govt/Pan/RENT	Building condition (+++/++/#)	Assured running water supply (A/NA/I)	Continuous power supply (A/NA/I)	Toilets (A/NA/I)	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. of rooms	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1	PHC MATIHANI	76493	Govt	#	A	A	A	A	++	10	0	NA	#	#
2	REF. HOS MATIHANI	76492	Govt	+++	A	A	A	A	++	29	30	A	++	++
3	BARAUNI	280980	Govt	+++	A	A	A	A	++	10	6	A	++	++
4	BALLIA	183407	Govt	+++	A	A	A	A	++	10	6	A	++	++
5	SAHEBPUR KAMAL	191951	Govt	+++	A	A	A	A	++	10	6	A	++	++
6	BACHWARA	190270	Govt	+++	A	A	A	A	++	10	6	A	++	++
7	TEGHRA	261879	Govt	+++	A	A	A	A	++	10	6	A	++	++
8	BHAGWANPUR	162441	Govt	+++	A	A	A	A	++	10	6	A	++	++
9	CH. BARIYARPUR	110873	Govt	+++	A	A	A	A	++	10	6	A	++	++

10	KHODAWANDPUR	84324	Govt	+++	A	A	A	A	++	10	6	A	++	++
11	BAKHRI	134094	Govt	+++	A	A	A	A	++	10	6	A	++	++
12	SADAR BEGUSARAI	120000	Govt	+++	A	A	A	A	++	3	0	A	++	++
13	SAMHO AKHA KURHA	33702	Govt	+++	A	A	A	A	++	10	6	A	++	++
14	BIRPUR	92383	Govt	+++	A	A	A	A	++	10	6	A	++	++
15	DANDARI	73763	Govt	+++	A	A	A	A	++	10	6	A	++	++
16	MANSURCHAK	80428	Govt	+++	A	A	A	A	++	10	6	A	++	++
17	CHHAURAHI	111767	Govt	+++	A	A	A	A	++	10	6	A	++	++
18	NAWKOTHI	99584	Govt	+++	A	A	A	A	++	10	6	A	++	++
19	GADHPURA	103679	Govt	+++	A	A	A	A	++	10	6	A	++	++
20	SADAR HOSPITAL	286518	Govt	+++	A	A	A	A	++	40	108	A	++	++
21	REF. HOS MANJHAUL	36000	Govt	+++	A	A	A	A	++	29	30	A	++	++
	Total	2791026								271	264			

ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned; Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

Section B: Human Resources and Infrastructure

Primary Health Centres/Referral Hospital/Sub-Divisional Hospital/DISTRICT Hospital: Human Resources

Allopathic (A),Ayush (Ay), Regular (R), Contractual (C)

Allopathic (A),Ayush (Ay), Regular (R), Contractual (C)

O- Outsourced/ I- In sourced/ NA- Not available

Section E: Health Services Delivery

Sl.	PHC /Referral/SDH/DH Name	POPULATION SERVED	Doctors © + ®		ANM		Laboratory TECHNICIAN		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
			Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	PHC MATIHANI	76493	7	4	28	28	0	0	0	0	0	0	0	0	1

2	REF. HOS MATIHANI	76492	4	2	0	0	2	1	4	1	4	4	0	0	1
3	BARAUNI	280980	7	7											
4	BALLIA	183407	7	6											
5	SAHEBPUR KAMAL	191951	7	6											
6	BACHWARA	190270	7	4											
7	TEGHRA	261879	7	3											
8	BHAGWANPUR	162441	7	3											
9	CH. BARIYARPUR	110873	7	5											
10	KHODAWANDPUR	84324	7	4											
11	BAKHRI	134094	7	4											
12	SADAR BEGUSARAI	120000	4	3											
13	SAMHO AKHA KURHA	33702	7	2											
14	BIRPUR	92383	7	2											
15	DANDARI	73763	7	1											
16	MANSURCHAK	80428	7	3											
17	CHHAURAHI	111767	7	1											
18	NAWKOTHI	99584	7	0											

19	GADHPURA	103679	7	2											
20	SADAR HOSPITAL	286518	23	17											
21	REF. HOS MANJHAUL	36000	4	4											
	Total	2791026	154	83	28	28	2	1	4	1	4	4	0	0	2

Name of the District- Begusarai			
No.	**Service**	**Indicator**	**Data**
1	***Child Immunisation***	% of children 9-11 months fully immunized (BCG+DPT123+OPV123+Measles)	70%
		% of immunization sessions held against planned	100%
2	***Child Health***	Total number of live births	23952
		Total number of still births	46
		% of newborns weighed within one week	90%
		% of newborns weighing less than 2500 gm	7%
		Total number of neonatal deaths (within 1 month of birth)	76
		Total number of infant deaths (within 1-12 months)	57
		Total number of child deaths (within 1-5 yrs)	34
		Number of diarrhea cases reported within the year	360
		% of diarrhea cases treated	100%

		Number of ARI cases reported within the year	320
		% of ARI cases treated	100%
		Number of children with Grade 3 and Grade 4 undernutrition who received a medical checkup	0
		Number of children with Grade 3 and Grade 4 undernutrition who were admitted	0
		Number of undernourished children	0
		% of children below 5 yrs who received 5 doses of Vit A solution	70%
3	***Maternal Care***	Number of pregnant women registered for ANC	23952
		% of pregnant women registered for ANC in the 1st trimester	23%
		% of pregnant women with 3 ANC check ups	87%
		% of pregnant women with any ANC checkup	100%
		% of pregnant women with anaemia	17%
		% of pregnant women who received 2 TT injections	82%
		% of pregnant women who received 100 IFA tablets	67%
		Number of pregnant women registered for JSY	23952

		Number of Institutional deliveries conducted	23952
		Number of home deliveries conducted by SBA	0
		% of institutional deliveries in which JBSY funds were given	55%
		% of home deliveries in which JBSY funds were given	0%
		Number of deliveries referred due to complications	27
		% of mothers visited by health worker during the first week after delivery	52%
4	***Reproductive Health***	Number of MTPs conducted	0%
		Number of RTI/STI cases treated	8
		% of couples provided with barrier contraceptive methods	23%
		% of couples provided with permanent methods	8%
		% of female sterlisations	99%
5	***RNTCP***	% of TB cases suspected out of total OP	8%
		Proportion of New Sputum Positive out of Total New Pulmonary Cases	90
		Annual Case Detection Rate (Total TB cases registered for treatment per 100,000 population per year)	1060

		Treatment Success Rate (% of new smear positive patients who are documented to be cured or have successfully completed treatment)	98%
		% of patients put on treatment, who drop out of treatment	4%
6	***Vector Borne Disease Control Programme***	Annual Parasite Incidence	N/A
		Annual Blood Examination Rate	5%
		Plasmodium Falciparum percentage	N/A
		Slide Positivity Rate	0%
		Number of patients receiving treatment for Malaria	0
		Number of patients with Malaria referred	0
		Number of FTDs and DDCs	0
7	***National Programme for Control of Blindness***	Number of cases detected	0
		Number of cases registered	0
		Number of cases operated	0
		Number of patients enlisted with eye problem	276
		Number of camps organized	0
8	***National Leprosy Eradication Programme***	Number of cases detected	121
		Number of Cases treated	121

		Number of default cases	0
		Number of case complete treatment	121
		Number of complicated cases	0
		Number of cases referred	0
9	***Inpatient Services***	Number of in-patient admissions	14267
10	***Outpatient services***	Outpatient attendance	537993
11	***Surgical Servics***	Number of major surgeries conducted	0
		Number of minor surgeries conducted	3158

Section F: Community Participation, Training & BCC

Community Participation Initiatives

S. No	Name of District	No. of GPs	No. VHSC formed	No. of VHSC meetings held in the block	Total amount released to VHSC from untied funds	No. of ASHAs	Number of ASHAs trained		Number of meetings held between ASHA and Block offices	Total amount paid as incentive to ASHA
							Round 1	Round 2		
1.	BEGUSARAI	256	249	249	2030000	2055	2055		12	9580800

Training Activities:

S.No	Name of Block	Rounds of SBA Trainings held	No. of personnel given SBA Training	Rounds of IMNCI Trainings held	No. of personnel given IMNCI Training	Any specific issue on which need for a training or skill building was felt but has not being given yet
1.	BEGUSARAI	1	7	2	168	

BCC Activities

No.	Name of DISTRICT	BCC campaigns/ activities conducted
1	BEGUSARAI	0

DISTRICT and Block level Management

S.No	Name of Block	Health Manager Appointed (Y/N)	Accountant appointed (Y/N)	Store keeper appointed (Y/N)
1	PHC MATIHANI	YES	YES	NO
2	REF. HOS MATIHANI	NO	NO	NO
3	BARAUNI	YES	YES	NO
4	BALLIA	YES	YES	NO
5	SAHEBPUR KAMAL	YES	YES	NO
6	BACHWARA	YES	YES	NO
7	TEGHRA	YES	YES	NO
8	BHAGWANPUR	YES	YES	NO
9	CH. BARIYARPUR	YES	YES	NO
10	KHODAWANDPUR	YES	YES	NO
11	BAKHRI	YES	YES	NO
12	SADAR BEGUSARAI	YES	YES	NO
13	SAMHO AKHA KURHA	NO	YES	NO
14	BIRPUR	YES	YES	NO
15	DANDARI	YES	YES	NO
16	MANSURCHAK	YES	YES	NO
17	CHHAURAHI	NO	YES	NO
18	NAWKOTHI	YES	YES	NO
19	GADHPURA	NO	YES	NO
20	SADAR HOSPITAL	NO	NO	NO
21	REF. HOS MANJHAUL	NO	NO	NO

5. GOALS:

The District will strive 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 and will achieve the following goals :

Reduction in Infant Mortality Rate (IMR)
Reduction Maternal Mortality Ratio (MMR)
Reduction in Birth Rate
Reduction in Total Fertility Rate
Reduction in Death Rate
Increase in Couple Protection Rate
% of Pragnant receiving full ANC
Increase % of Women getting IFA tablets
Increase Institutional Deliveries
Increase Delivery by Skilled Birth Attendants
Increase Delivery by Skilled Birth Attendants
Increase in Annualized NSP CDR (TB)
Decrease in API of Malaria (NVBDCP)
Pravelance rate (Leprosy)

CHAPTER II SWOT ANALYSIS OF THE BEGUSARAI DISTRICT

The health care system in the district has improved in certain areas like in leprosy, Malaria and MMR & IMR with the improved network of Govt . health care institutions and provision for free medical care and free medicines . The district is having one district district headquater hosrital(Sadar hospital) two Referal units one at Manjhul and other situated at Balia block and 18 primary health centers apart from network of ground level health institutions like sub-centres and AWC . Wihle IMR in BIHAR has declined considerably from in 200 to in 200 , at district level the rate has reduced from to during 200 to 2009-10 . Occurance of relatively high MMR in district is attributed to poor availability of professional attendance at birth high percentage of low birth weight babies and lack of pre and post natal care . In the front of mother mortality rate during 2009-10 ,mother mortality in district was above In order to achieve the goals of reduced MMR emphasis is being given to increase ANC coverage ensuring at least three ANC check up for 100% of women ,registration of pregnancy /antenatal , provision of other health services , free transportation through janani express for institutional delivery etc To identify the strength, weakness, opportunities and threats of districts a workshop was organized during the plan preparation process and suggestions were taken from different stakeholders from different sectors. The strategic planning workshops highlight the followings as SWOT in different sectors / sub-sectors.

District: Part A,B,C,D

Strength	Weakness	Opportunity	Threat
Special health aid	**Acute shortage of doctors & paramedical**	**Effective utilization funds in a output manner**	**Occasional outbreak of epidemics**
Institutional network & improved facilities	**Lack of proper health care supervision and monitoring**	**Establishment Nutritional Rehabilitation Centre in Remote blocks.**	**Increased health expenses become burdensome for poor families**
Industrialization	**No additional incentive provision for remote area staff, except doctors.**	**Regular capacity building programme for ANM, LMV & ASHA workers.**	
Regular health camps at GP / village level	**Low water, sanitation and hygienic condition**	**Improved health care system in existing health institutions**	
ASHA on ground	**Blind belief of people / high dependency on untrained quacks**	**Posting of Medical officers in the vacant places.**	

Implementation of NRHM	**Medical personnel do not stay in their respective stations**	**Posting of Staff Nurses and additional pharmacists in the PHC (N)/PHC/CHC**	

Chapter III: Part A

VISION STATEMENT

At the end of 2012, on completion of the implementation of the proposed interventions under the Reproductive and Child Health Project – II in Andhra Pradesh state, every rural and below-poverty-line pregnant woman will have the full information and awareness about the advantages of obtaining comprehensive antenatal care services, institutional delivery care services, postnatal and neonatal care services, and will be utilizing these services either on her own initiative, or on the advocacy and promotional efforts of the field healthcare workers. 100% of the pregnant women in the state would register themselves for antenatal care services either with the ANM in the rural areas, or with the urban family welfare centers in the urban areas or with the private health care providers. At least 90% of the women in the state will have three antenatal care check-ups, one of which will be with a medical
doctor. At least 90% of the women in the state will have childbirth in facilities that have at least basic emergency obstetric care services. All the First Referral Unit Hospitals in the state will have comprehensive emergency obstetric care services, i.e., obstetricians and anesthetists, and blood transfusion facilities. Emergency health transportation facilities will be in place in the rural parts of the state, to enable a villager even in the remotest village to call for the emergency health transportation vehicle and transport the pregnant woman ready for delivery, or a child in critical health condition to the nearest First Referral Unit hospital with the confidence that the person will receive assured medical attention. Every person in the state, in need of a reproductive or child healthcare service would be able to obtain full information about the availability of such services and proceed to such place to access the services with full confidence that they are of good quality.

The **objectives, strategies, and proposed intervention activities** under the important program areas of the RCH-II project are described in the following chapters.

4. MATERNAL AND REPRODUCTIVE HEALTH STRATEGY

Objective :

Reduction of the currently estimated MMR of 195 per 100,000 live births in the state to less than 100 per 100,000 live births by 2012, and commensurate reduction in the maternal morbidity rate, particularly among the women in rural areas of the state; and, reduction in the prevalence levels of RTI/STI in the general population by 50% of the levels existing in 2005.

Strategies:

The strategies that are being adopted for achievement of these objectives are:

- Universal registration of pregnancies and utilization of antenatal care services;
- Universal availability and utilization of supplemental nutrition services for all rural poor pregnant women;
- Radical improvements of availability, affordability and accessibility of basic and comprehensive emergency obstetric care services;
- Intensive promotion of institutional deliveries through health emergency transportation-linkage, motivation of rural poor women for institutional delivery through village level ASHAs and through compensation for indirect costs to be incurred in accessing institutional delivery services, community-level motivation through rewards to village panchayats for high tilization of maternal healthcare services;
- Intensive promotion of postnatal care utilization in rural areas through training of Anganwadi workers and ASHAs.
- In the remote and un-served and under-served areas, the services will be delivered through mobile delivery service units with trained nurses engaged by NGOs.
- In order to achieve a significant reduction in the Maternal and Infant Mortality Rates, Comprehensive Emergency Obstetric & Neonatal Care (CEMONC) Centres are being established in at least 5 to 6 identified FRUs in each district of the state with round-the-clock specialist services and blood transfusion facilities.

MATERNAL HEALTH INTERVENTIONS - VILLAGE LEVEL:

1. ASHA at Habitation Level:

There are 21,943 Gram Panchayats, and 67,561 habitations in the state and 70,700 ASHAs were identified and selected during the year 2005-06, 2006-07 and 2007-08 to act as Health Resource Persons of first resort in all maternal & child health services and to act as Link persons between the community and the service providers.

a) Training of the ASHA candidates:

The ASHA candidates are being trained in all preventive healthcare aspects of pregnancy, antenatal care, Intranatal care, postnatal care, neonatal care, diarrhoea, acute respiratory infections, first-aid and treatment of minor ailments, in a four-week training program. This training conducted at Durgabai Mahila Sishu Vikasa Kendram in coordination with Women & Child Welfare department. The overall organization, monitoring and coordination of the ASHA training has been entrusted to M/s Academy

for Nursing Studies, Hyderabad as a State Level Nodal Agency for guidance and supervision and district level training agency in 23 districts.

b) Supply of Drug Kits to ASHAs:

On completion of the training, the ASHAs are being provided with a first-aid kit and a health guide / manual, certificate and identity card.

c) Incentives for ASHAs:

The ASHAs will not be paid any fixed salary or honorarium. They are being paid incentive amounts mainly for carrying out specific activities related to the utilization of maternal and child healthcare services by families of underserved communities such as SC/STs and non SC/ST families below poverty line.

EXPECTED OUTPUTS:

- Availability of a trained female health resource-person for 24x365 days at the village level, especially, in the areas of maternal, infant and child health for minor aliments and to advice the villagers regarding emergency health care services.
- Increased utilization of maternal healthcare services including Antenatal care services and intranatal care services, post-natal care services, immunization for children, institutional deliveries, etc.
- Reduced incidents of Infant Mortality, particularly of neonatal morality.
- Reduced Incidents of Maternal Mortality
- Increased percentage of fully immunized children

Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death.

The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour.

Global Strategy for Women's and Children's Health

The “Global Strategy for Women’s and Children’s Health” sets out how we can work together to save women and children. The document was developed under the auspices of the United Nations Secretary-General with support and facilitation by The Partnership for Maternal, Newborn & Child Health. Leaders from government, international organizations, business, academia, philanthropy, health professional

associations and civil society have come together to develop this strategy, recognizing that the health of women and children is key to progress on all development goals. The Global Strategy calls for all partners to unite and take real action.

State of Maternal Health in India

Maternal death is defined as death of women while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by pregnancy or its management. The maternal mortality ratio is maternal death per 100,000 live births in one year. Reliable estimates of maternal mortality in India are not available. WHO estimates show that out of the 529,000 maternal deaths globally each year, 136,000(25.7%) are contributed by India. This is the highest burden for any single country. There are variations in MM by region and state. The indirect estimate done by Bhat (Maternal mortality in India: An update. Studies in Family planning, 2002) show that MMR is higher in eastern and central regions and is lower in north-western and southern region. Similar picture is also shown by data collected under Sample registration system by Registrar General of India in 1997.Socio-economic variations in MM are known but not well documented in India. Study of Bhat shows that generally MMR is more in scheduled caste and tribe community and those living in less developed villages. Variation with income is somewhat inconsistent with the expectation that the poor will have higher mortality. There are no precise estimates of MM it is difficult to say with certainty that maternal mortality has gone down over time. But data shown by various studies as those by Bhat show that there is a gradual decline in MMR.However direct measurement (RGI and NFHS) are inconsistent and do not show any decline.

NFHS shows that in urban areas the estimate of MMR (267) has gone down but in rural areas (619) it seems to have increased substantially even though it may not be statistically significantly different. The most common causes of maternal deaths are hemorrhage (ante partum or post partum), eclampsia, pre-eclampsia, infection, obstructed labor and complications of abortion; they are generally same throughout the world. The studies in India of causes of maternal mortality by and

large show similar results. One difference is that the data on cause of maternal mortality from the Registrar General of India show large proportion of maternal deaths attributed to anemia which is not reported from other countries.

*Table-1(***Causes of maternal mortality: India studies and global pattern (% of total deaths by causes)**

Source and location	**Registrar General of India 1998**	**Bhatia data 84-85 (Causes of mm in south India)**	**Kumar data 1986 (MM enquiry in rural community of north India)**	Maine **(Safe motherhood program)**
Causes of death	National	Ananthpur district	Rural north India	Global pattern
Hemorrhage	29.6	6.8	18.2	28
Anemia	19.0	9.2	16.4	-
Hypertensive disease of pregnancy	8.3	8.0	5.5	17
Puerperal sepsis	16.1	30.5	16.4	11
Abortion	8.9	10.3	9.1	19
Obstructed labour	9.5	4.9	7.3	11
Not classifiable	2.1	-	10.9	15
Other/indirect	6.4	25	10.9	15
MMR per 100000 live birth	407	830	230	

In the 60s and 70s maternal health services under MCH focused on ante-natal care and high risk approach. It was thought that good antenatal care along with high risk approach will help in reducing maternal mortality. As traditional birth attendants were conducting many deliveries, it was thought that by training them MMR will decline. But after several years of implementing these approaches it was realized in mid-80s that MM was still very high in many developing countries including India. A re-look at the causes of maternal death and the socio-medical factors contributing to maternal death brought out a completely new understanding of how to prevent maternal mortality. This showed that

It is not possible to predict which mother will develop complications and hence the high-risk approach does not help much.

Most complications cannot be prevented by good antenatal care. Hence ANC alone cannot prevent maternal mortality.

If obstetric complications are handled effectively the mortality could be substantially reduced.

It was also shown that once major obstetric complications which can cause death develop, even a trained TBA or a nurse cannot do much at home as many of these complications require surgical interventions, injections of antibiotic, blood transfusion and other aggressive treatment.

Cost-effective approach to reducing maternal mortality was by ensuring high quality emergency obstetric care (EmOC) to mothers who develop complications during delivery.

It was proposed that development of First Referral Units where emergency obstetric care can be provided would be required to reduce maternal mortality. It was also argued that development of FRUs was the most cost effective way of reducing maternal mortality. This approach was also accepted by many international donors and became the main strategy for many country programs for preventing maternal mortality.

The government of India has been time and again making policy and

programmatic statements and setting goals of reducing MM.

Table: *2*
Major policy and program goals in MM

Year	**Document**	**Goals**
1983	Health policy statement by Govt of India	MMR reduction by 200-300 by 1990 and below 200 by the year 2000
2000	National population policy	MMR reduction to less than 100 by 2010
2002	National health policy	MMR reduction to less than 100 by 2010
2002-007	Tenth Five year plan	MMR reduction to less than 200 by 2007

In spite of these clear policy intentions the progress on the ground has been very slow. Review of 8th and 9th Five year plan shows that there was hardly any description of strategies or achievements related to maternal care and maternal mortality reduction goals.

To ensure that safe motherhood agenda does not get neglected it is important to have high priority, clear objectives and effective long-term strategy in RCH II programme which plans to cover wider spectrum of services. Specific long- term objectives should be set up such as reducing unmet need for EmOC and increase in coverage of skilled attendance. Such clear objectives should be followed by effective long term strategy to increase access, utilization and quality of EmOC and maternity services. There should be detailed implementation guidelines and plans and powers to local managers who can make changes in order to keep the services running without interruption. The project development process should ensure that all the critical inputs such as staff, drugs and equipment are provided at strategically selected locations for addressing the objectives. It would also ensure that all the inputs are coordinated. The supervision and monitoring should assess the functioning of the facility, their output and quality. The monitoring should be based on appropriate indicators such as the UN process indicators for

EmOC.A national maternal mortality study should be carried out every 10 years to ensure that there are reliable data to indicate progress towards ultimate goal of safe motherhood. As this program has substantial technical components as compared to other preventive programmes, hence the government needs high quality technical support by public health experts, obstetricians, midwives and management experts. There is also an urgent need to expand the size of the technical staff for maternal health in the ministry at state and central levels which is extremely small. Long term skills development should be taken up for medical officers and nurses to provide basic EmOC services even in the absence of an obstetrician. Good performance should be recognized and rewarded and wanting performance should be duly corrected.

Maternal Health Status in Begusarai district

Indicators	**DLHS-3 - Begusarai**	**Bihar**
Mothers registered in the first trimester when they were pregnant with last live birth/still birth	25.8	24.2
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	25.8	24.2
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth%	76.5	58.4
Institutional births (%)	26.9	27.7
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	3.6	4.2
Mothers who received post natal care within 48		

hours of delivery of their last child (%)		

GAPs & ISSUES OF BEGUSARI DISTRICT

1. Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%): 18.7*
2. Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%): 32.4*
3.Increase community awareness about need and benefits of ANC, Institutional delivery and PNC;
4. Mothers who got at least one TT injection when they were pregnant with their last live birth /still birth (%): 69.7*
5. Institutional births (%): 24.9*
6. Delivery at home assisted by a doctor/nurse /LHV/ANM (%): 2.4*
7. Mothers who received post natal care within 48 hours of delivery of their last child (%): 9.5*

OBJECTIVES

1. 100% pregnant women to be given two doses of TT
2. 90% pregnant women to consume 100 IFA tablets by 2011
3. 70% Institutional deliveries by 2011
4. 90% deliveries by trained /Skilled Birth Attendant by 2011
5. 95% women to get improved Postnatal care by 2011
6. Increase safe abortion services from current level to 80 % by 2011

Strategies

1. Provision of quality Antenatal and Postpartum Care to pregnant women
2. Increase in Institutional deliveries
3. Quality services and free medicines to all the deliveries in the health facilities.
4. Availability of safe abortion services at all PHCs
5. Increased coverage under Janani Bal Suraksha Yojna & Janani Suvidha Yojna.
6. Strengthening the Maternal, Child Health and Nutrition (MCHN) days
7. Improved behaviour practices in the community
8. Referral Transport
9. EmOC at PHCs
10. Organizing RCH Camps

Activities

1. Increase availability of ANC services through reinforced network of frontline ANC service providers
2. Strengthen supervisory network to support network of frontline ANC service providers
3. Ensure delivery of ANC services through strengthening of health sub-centres, APHCs and PHCs

4. Ensure timely and adequate supply of essential equipment and consumables with frontline ANC providers (ANMS and LHVs) and health facilities (HSCs, APHCs and PHCs)
5. Build capacity of frontline ANC service providers (ANMs and LHVs)
6. Form inter-sectoral collaboration to increase awareness, reach and utilization of ANC services
7. Promote institutional delivery through reinforced network of APHCs, PHCs/Referral Hospitals, Sub-divisional Hospitals and District Hospitals
8. Promote institutional delivery by involving private sector/NGO providers of EmOC in un-served and under-served areas
9. Ensure safe delivery at home
10. Revamp existing referral system for emergency deliveries
11. Form inter-sectoral collaboration to increase awareness regarding safe delivery and referral;
12. The specific strategies to achieve this objective have been discussed in the previous two objectives
13. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs
14. Fixed Maternal, Child Health and Nutrition days

☐ Once a week ANC clinic by contract LMO at all PHCs and CHCs

☐ Development of a microplan for ANMs in a participatory manner

☐ Wide publicity regarding the MCHN day by AWWs and ASHAs and their services

☐ A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day

☐ Registration of all pregnancies

☐ Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets

☐ Nutrition and Health Education session with the mothers 15. Postnatal Care

☐ The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary

16. Provision of Weighing machines to all Sub centres and AWCs
17. Establishing Delivery Huts for all the Sub centres along with provision of additional ANMs in all these Delivery huts for 24 hour deliveries.
18. Availability of IFA tablets

☐ ASHAs to be developed as depot holders for IFA tablets

☐ ASHA to ensure that all pregnant women take 100 IFA tablets

19. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building)
20. Developing the CHCs and PHCs for quality services and IPHS standards (Details in Component Up gradation of CHCs & PHCs and IPHS Standards)

a. Availability of Blood Bank at the District Hospital
b. Certification of the Blood Storage Centres

21. Improving the services at the Sub centres (Details in Component on Up gradation of Sub centres and IPHS) 22. Behaviour Change Communication (BCC) efforts for awareness and goodpractices in the community (Details in Component on IEC)
23. Increasing the Janani Suraksha Yojna coverage

☐ Wide publicity of the scheme (Details in Component on BCC …)

☐ Availability of advance funds with the ANMs

☐ Timely payments to the beneficiary

☐ Starting of Janani Bal Suraksha Yojana Helpline in each block through Rogi Kalyan Samitis

☐ Increase in the No. of Private Health Providers in Urban Areas for JSY.

24. Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning
25. Safe Abortion:

☐ Provision of MTP kits and necessary equipment and consumables at all PHCs

☐ Training of the MOs in MTP

☐ Wide publicity regarding the MTP services and the dangers of unsafe abortions

☐ Encourage private and NGO sectors to establish quality MTP services.

☐ Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol

26. Development of a proper referral system with referral cards and arrangement of referral facilities to the complicated deliveries at all PHCs

State support

1. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour APHCs, PHCs and two ANMs at the sub centres
2. Ensuring availability of formats and funds with the ANM for JSY and timely payments
3. Certification of PHCs as MTP centres
4. The State should closely monitor the progress of all the activities

Budget proposed

Activity / Item	Year 2011-12
Consultancy for support for developing Microplan for MCHN days	**1,00,000/-**
40 Delivery Huts @ Rs 1,00,000 /hut	**40,00,000/**
Recurring cost of 40 Delivery Huts @ Rs 1,50,000 per year during flood time	**60,00,000/**

Blood Storage Unit @ Rs 5 lakhs per unit	**10,00,000/**
Referral Cards @ Rs 3 per card x 1,00,000	**3,00000**
MTP kits @ Rs 15000 Per kit at GH & PHCs/APHCs	**10,00,000/**
JBSY beneficiaries @ Rs 2000/person X 80000	**16,00,00,000/-**
Total	

Recurring Costs per Delivery Hut for one year

Sl no	**Head**	unit	Unit cost	**Amount**
1	O C	1 YEAR	50000	50000
2	Material & supply	1 year	70000	70000
3	Motor Vehicles	12 months	2000	24000
4	Honorarium for TBA	` 12 months	500	6000
		Total		15,0000

CHILD HEALTH

India has an estimated population of 1.095 billion, making it the world's second most populous nation in the world after China. With a multi-cultural, multi-lingual and multi-ethnic society, India is home to 17 major regional languages. It has a sophisticated civilisation dating back 5,000 years and is the birth place of four major world religions: Hinduism, Buddhism, Sikhism and Jainism whilst Islam, Christianity, Judaism and Zoroastrianism add to the religious diversity.

Although India is the world's fourth largest economy in purchasing power, it suffers from high levels of poverty, illiteracy and malnutrition.

According to the World Bank, India has one of the highest percentages of under-nourished children in the world. In addition, more than 350 million people in India still live on less than a dollar a day (DFID).

Due to poverty, lack of access to healthy food, lack of nutritional knowledge and hygienic food preparation practices, 53% of children under the age of four are malnourished and 60% of women are anaemic.

Almost one third of babies are born with a low birth weight and nearly 50% remain underweight until the age of three (UNICEF).

Mumbai is a city of huge contrasts. Home of Bollywood and the world's diamond polishing trade, it boasts some of the most expensive real estate in the world. However, statistics indicate that more than half of the city's swelling 16 million population lives in 'informal' housing or slums.

CHILD HEALTH Situation-analysis & current status

Breast Feeding

1. Children breastfed within one hour of birth (%): 9.8*
2. Children (age 6 months above) exclusively breastfed (%): 6.9*
3. Children (6-24 months) who received solid or semisolid food and still being breastfed (%): 80.7*

Immunization:

1. Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%): 30.2*
2. Children (12-23 months) who have received BCG (%): 76.2*
3. Children (12-23 months) who have received 3 doses of Polio Vaccine (%): 39.7*
4. Children (12-23 months) who have received 3 doses of DPT Vaccine (%): 45.3*
5. Children (12-23 months) who have received Measles Vaccine (%): 40.4*
6. Children (9-35 months) who have received at least one dose of Vitamin A (%): 27.3*
7. Children (above 21 months) who have received three doses of Vitamin A (%): 1.6*

Diarrhoea

1. Children with Diarrhoea in the last two weeks who received ORS (%): 13.9*
2. Children with Diarrhoea in the last two weeks who were given treatment (%): 58.8
3. Children with acute respiratory infection/fever in the last two weeks who were given treatment (%): 62.1
4. Children had check-up within 24 hours after delivery (based on last live birth) (%): 9.9
5. Children had check-up within 10 days after delivery (based on last live birth) (%): 9.2

Objectives

1. Reduction in IMR
2. Increased proportion of women who are exclusively breastfed for 6 months to 100%
3. Increased in Complete Immunization to 100%
4. Increased use of ORS in diarrhoea to 100%
5. Increased in the Treatment of 100% cases of Pneumonia in children
6. Increase in the utilization of services to 100%
7. To strengthen school health services

Strategies

1. Promote immediate and exclusive breastfeeding and complementary feeding for children
2. Improving feeding practices for the infants and children including breast feeding
3. Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months
4. Eradication of Poliomyelitis
5. Increase early detection and care services for sick neonates in select districts through the IMNCI strategy in select districts
6. Improve curative care services for children less than three years of age for minor ARI and diarrheal.
7. Promotion of health seeking behaviour for sick children
8. Community based management of Childhood illnesses
9. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals
10. Enhancing the coverage of Immunization
11. Zero Polio cases and quality surveillance for Polio cases
12. Preparation of operational plan and guidelines for School Health
13. Regular Monitoring and supervision

Activities

1. Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrums feeding) and xclusively till 6 months of age.
2. Increase community awareness about correct breastfeeding practices through 47 traditional media.
3. Improving feeding practices for the infants and children including breast feeding
   - Education of the families for provision of proper food and weaning
   - Educate the mothers on early and exclusive breast feeding and also giving Colostrums
   - Introduction of semi-solids and solids at 6 months age with frequent feeding
   - Administration of Micronutrients – Vitamin A as part of Routine immunization, IFA and Vitamin A to the children who are anaemic and malnourished
   - Growth Monitoring by ANM/AWW and Health Staff for early detection of Malnutrition.
4. Conduct fixed day and fixed-site immunisation sessions according to district micro plans.
5. Build capacity of immunisation service providers to ensure quality of immunization services
6. Form inter-sectoral collaboration to increase awareness, reach and utilization of immunisation services
7. Strengthen Supervision and monitoring of immunization services

8. Promotion of health seeking behaviour for sick children and Community based management of Childhood illnesses
   - Training of LHV, AWW and ANM on IMNCI including referral
   - BCC activities by ASHA, AWW and ANM regarding the use of ORS and increased intake of fluids and the type of food to be given
   - Availability of ORS through ORS depots with ASHA
   - Identification of the nearest referral centre and also Transport arrangements for emergencies with the PRIs and community leaders with display of the referral centre and relevant telephone numbers in a prominent place in the village
9. As per Intensified Pulse Polio Immunisation Campaign (IPPI) based on ongoing Supplementary Immunisation Activities (SIAs).
10. Build state IMNCI training pool
   - (Re)train health and ICDS staff in IMNCI protocols
   - Ensure implementation of IMNCI clinical work following training
   - Upgrade the capacity of PHC/FRUs to delivery quality paediatric services
   - Involvement of private facilities to accept emergency referrals for BPL children
   - Raise awareness about early recognition of childhood illnesses, home-based care and care-seeking
11. Improving newborn care at the household level
   a. Adaptation of the home based care package of services and scheduling of visits of all neonates by ASHA/AWW/ANM on the 1st, 2nd, 7th, 14th and 28th day of birth.
   b. In case of suspicion of sickness the ASHA /AWW must inform the ANM and the ANM must visit the Neonate
   c. Referral of the Neonate in case of any symptoms of infection, fever and hypothermia, dehydration, diarrhoea etc;
   d. Supply of medicine kit and diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy
   e. Strengthening the neonatal services and Child care services in District hospital, Sub-Divisional Hospitals and all PHCs : This will be done in phases
   f. In all of these units, newborn corners would be established and staff trained in management of sick newborns and immediate management of newborns.
   g. The equipment required for establishing a newborn corner would include Newborn Resuscitation trolley, Ambubag and masks (newborn sizes),
   Laryngoscopes, Phototherapy units, Room warmers, Inverters for power backup, Centralized oxygen and Pedal suctions
   h. Training of staff in Newborn Care, IMNCI and IMCI (MOs, Nurses, ANM, AWW, ASHA) including the management of sick children and severely malnourished children.
   i. Availability of Paediatricians in all the General hospitals and Referral hospitals.
   j. Ensuring adequate and free supply of drugs for management of Childhood illnesses.
12. Strengthening the Fixed Maternal and Child health days
   - Developing a Microplan in joint consultation with AWW
   - Organize Mother and Child protection sessions twice a week to cover each village and hamlet at least once a month
   - Tracking of Left-outs and dropouts by ASHA, AWW and contacting them a day before the session
   - Information of the dropouts to be given by ANM to AWW and ASHA to ensure their attendance
   - Wide publicity regarding the MCHN days
13. Strengthening Immunization
14. School Health Programme
   - Preparation and dissemination of guidelines for School Health
   - Monthly visit by Deputy Civil Surgeon (School Health).

- Coordination and convergence with education department.
- Training to School Teachers on Health Activities.

Support required

1. Availability of trained staff including Paediatricians
2. Technical Support for training of the personnel
3. Timely availability of vaccines, drugs and equipment
4. Good cooperation with the ICDS, Edu. Dept. and PRIs

Budget

Activity /item	Budget planned for 2011-12	Remarks
Newborn Corner maintenance @ 2 lakh per facility	3600000	18phcx2 lakhs
Examination table, chair, stool, table, other equipment @ Rs. 5000 x 2248 AWCs	11240000	
Referral cards @ Rs 4 x 100000	400000	
Free availability of medicines	100000	
Training on IMNCI and IMCI of LHV/ASHA/AWW/ANM/MOs on the home based Care package and management at facilities	Component on training	
Supply of Diagnosis and treatment protocols (chart booklets) for IMNCI & IMCI strategy	Component on training	
Supply of medicine kit for IMNCI	Provided by state	

FAMILY PLANNING

The awareness regarding contraceptive methods is high except for the emergency contraception. This is because of inadequate IEC carried out for Emergency Contraception. .

- Current Use of Any method (%): 32.3*
- Any modern method (%): 27.8*
- Female sterilization (%): 26.3*
- Male sterilization (%): 0.2*
- IUD (%): 0.0*
- Pill (%): 0.6*
- Condom (%): 0.4*

In temporary methods commonest use is of Condom, which has a high failure rate. Use of Copper –T is low. The community prefers female sterilization since there is gender imbalance and limited male involvement. Women also do not have decision-making power.

Total unmet need for Family Planning (%): 36.9* The reasons for the low use of permanent methods and Copper –T are due to inadequate motivation of the clients, inadequate manpower, limited skills of the ANMs for IUD insertion and also their irregular availability. The rejection rate is high since proper screening is not done before prescribing any spacing method.
Copper T-380 – 10 year Copper T has been recently introduced but there is very little awareness regarding its availability. There is a need to promote this 10 yr Copper T
Some socio-cultural groups have low acceptance for Family Planning. Promotion efforts for Vasectomy have been very infrequent and only 122 men have undergone Vasectomy.
The current number of trained providers for sterilization services is insufficient

Objectives

1. Reduction in Total fertility Rate from 2.5 to 2.4
2. Increase in Contraceptive Prevalence Rate to 70 %
3. Decrease in the Unmet need for modern Family Planning methods to 0%
4. Increase in the awareness levels of Emergency Contraception from 60% to 80 %

Strategies

1. Training of Mos in NSV & Female Sterilization.
2. Raise awareness and demand for Family Planning services among women, men and adolescents
3. Availability of all methods and equipments at all places
4. Increase access to and utilization of Family Planning services (spacing and terminal methods)
5. Increasing access to terminal methods of Family Planning
6. Promotion of NSV
7. Increased awareness for Emergency Contraception and 10 yr Copper T
8. Decreasing the Unmet Need for Family Planning
9. Expanding the range of Providers
10. Increasing Access to Emergency Contraception and spacing methods. Through Social marketing & Training of ANMs for IUD Insertions.
11. IEC/BCC activities for Family Planning Methods

Activities

Extensive campaign using multiple channels to raise awareness and demand for Family Planning
Broad inter-sectoral collaboration to promote small family norm, late marriage and childbearing
Promotion of Family Planning Services at community level through peer educators (satisfied acceptor
Each APHC and PHC will have one MO trained in any sterilization method.
 All the PHC will have at least one MO posted who can be trained for abdominal Tubectomy. This method does not require a postgraduate degree or expensive equipment.
 Similarly Mos will be trained for NSV
 Specialists from District hospitals and CHCs will be trained in Laparoscopic Tubal Ligation.
 At PHCs, one medical officer will be trained in NSV
 Each PHC will be a static centre for the provision of sterilization services on regular basis. The Static centres will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets.
Provide quality Family Planning Services through expanded network of health facilities

and frontline health workers
Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives
Increase utilization of Family Planning services through provision of incentives to acceptors and private providers of FP services.
About 4 -7 PHCs come under the catchments area of PHCs and the camps will be organized on fixed days in each of the PHCs.
Equipments and supplies will be provided at PHCs and PHCs for conducting sterilization services.
A systemic effort will be made to assess the needs of all facilities, including staff in position and their training needs, the availability of electricity and water, Operation theatre facilities for District hospitals/PHCs/APHCs, Inventory of equipment, consumables and waste disposal facilities and the condition, location and ownership of the building.
At least three functional Laparoscopes will be made available per team, as will the equipment and training necessary to provide IUD and emergency contraception services. The existing Laparoscopes need to be replaced. For effective coverage 4 teams are required with minimum three Laparoscopes for each team.
Training in Spacing methods, Emergency Contraceptives and interpersonal communication for dissemination of information related to the contraceptives in an effective manner.
Supply of Emergency Contraceptives to all facilities
Access for the quality IUD insertion improved at all the 117 sub centres.
All the ANMs at 117 sub centres will be given a practical hands on training on insertion of IUD
IUD 380-A will be used due to its long retention period and can be used as an alternative for sterilization. IEC/BCC
 Awareness on the various methods of contraception for making informed choices
 Discussed in the Component on IEC
 Increasing male involvement in family planning through use of condoms for safe sex and also in Vasectomy.
 BCC activities to focus on men for Vasectomy. Inter Sectoral convergence
 A detailed action plan will be produced in co-ordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services.
 Staff of ISM department will be trained in communication and non-clinical methods to promote and increase the availability of FP methods.
 Engaging the private sector and provide incentives and training to encourage them to provide quality family planning services
 Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD.
 Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies.
 Accreditation of private hospitals and clinics for sterilization and NSV
 Creating an enabling environment for increasing acceptance of contraceptive services
Innovative schemes will be developed for reaching out to younger men, women, newly married couples and resistant communities.
Role of ASHAs:
 Training for provide ensitizat and services for non-clinical FP methods such as pills, condoms and others.

 Act as depot holders for the supplies of pills and condoms by the ANMs for free distribution
 Procurement of pills and condoms from social marketing agencies and provide these contraceptives at the subsidized rate
 Provide referral services for methods available at medical facilities
Assist in community mobilization and ensitization.
Formation of District implementation team consisting of DC, CS, District MEIO, Distt NSV trainer
 One day Workshop with elected representatives, Media, NGOs, departments for ensitization and implementation strategy, fixing precamp, camp and post-camp responsibilities
 Development of a Microplan in one day Block level workshops
 NSV camp every quarter in all hospitals initially and then PHCs and APHCs
 IEC for NSV
 Trained personnel
 Follow-up after NSV camp on fixed days after a week and after 3 months for Semen analysis 52
 Access to non-clinical contraceptives increased in all the villages
 AWWs and ASHAs as Depot holders

Support required

 Availability of a team of master trainers/ANM tutors and RFPTC trainers for follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers
 A training cell will be created in the medical college for the training of the medical officers in the area of various sterilization methods
 Availability of equipment, supplies and personnel

Timeline

Training of Mos for NSV	**20 MOS**
Training of Mos for Minilap	**10 MO.S**
Training of Specialists for Laparoscopic Sterilization	**10 MO.S**
Development of Static Centre at General hospital	**DISTRICT & SUB DIVISION**
Sterilization Camps (Persons)	**25000**
NSV Camps	**25**
Accreditation of private institutions for sterilization	**10**
Supply of Copper T	**25000**
Emergency Contraception	**4000**

Budget

Activity	**Amount planned for 2011-12**
NSV camps @ Rs. 250000 per camps x 12	3000000
Sterilization Camps @ 1000 & 650 for 25000 cases	24000000
Copper T-380 @ Rs 50 / piece x 25000	1250000

Emergency Contraception @ Rs10/2 tabs	15000
Development Static Centres @ Rs 2 lakh	400000
NSV Equipment @ Rs 10000 x 20	200000
Laparoscopes @ Rs 3.00 lakhs x 2	**600000**
IEC activities for NSV for per 2 camps	137200
Total	**29602200**

Distirct Health Society, Begusarai

S. No.	District	Total Operation done during the Ist Quarter & 2nd Qtr.							Total Cumulative of the year	Total death reported after Sterilazation		Total Conception / Failure after Sterilazation		death /failure Audit & Action taken if any
		Vasectomy			Tubectomy									
		Conventional	NSV	Total Vas.	Mini Lap / Conventional	Laparoscopic	Total Tub.	Total col. 5 & 8 (Total Sterilization)		During the Quarter	Cumulative of the year	During the Quarter	Cumulative of the year	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Qtr. 1st	Begusarai	0	52	52	591	0	591	643	2030	0	0	0	0	0
Qtr. 2nd	Begusarai	0	89	89	1298	0	1298	1387		0	0	0	0	0
			oct	72	284									
			total	213	2173									

ADOLESCENT REPRODUCTIVE & SEXUAL HEALTH

Objectives

1. Improve sex ratio 901 -> 950
2. Increase the knowledge levels of Adolescents on RH and HIV/AIDS
3. Enhance the access of RH services to all the Adolescents
4. Improvement in the levels of Anaemia to 50% by 2012

Strategies

1. Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.
2. Improve micronutrient service for adolescents primarily to reduce anaemia.
3. Awareness amongst all the adolescents regarding Reproductive health and HIV/AIDS.
2. Provision of Adolescent Friendly Health & counselling services

Activities

The Adolescent Health package will consist of the following activities:
 Create conducive environment to promote adolescent health needs among health service providers and community at large.
 Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents.
 Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.
 Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers

1. Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents.
2. Increase availability and distribution of micronutrient Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan.
3. Supplements to adolescents at grassroots level primarily through health and education networks
4. Provision of Adolescent friendly health services at PHCs, CHCs, FRUs and district hospitals in a phased manner. Training of the MOs, ANMs on the needs of this group, vulnerabilities and how to make the services Adolescent friendly.
5. Adolescent Health Clinics will be conducted at least twice in a month by the MO to provide Clinical services**,** Nutrition advice, Detection and treatment of anaemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and counselling, Treatment of psychosomatic problems, De-addiction and other health concerns
6. Awareness building amongst the PRIs, Women's groups, ASHA, AWWs
7. Provision of IFA tablets to all Adolescents, deworming every 6 months, Vitamin A administration and Inj. TT.
8. Carrying out the services at the fixed MCHN days.
9. Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counsellor in the villages.
10. Involvement of ASHAs as counsellor and one Male & Female person of all the villages, and training of all the health personnel in the Sub centres, PHCs and CHC in the block
11. There will be equal number of Male and Female counsellors and will alternate between two PHCs – one week the male counsellor is in one PHC and the female counsellor in the other and they switch PHCs in the next week so that both the boys and girls benefit.
12. The counsellor will be
 Facilitating group meetings
 Organizing Counselling session once per week at the PHCs with wide publicity regarding the days of the sessions.
 Collecting data and information regarding the problems of Adolescents
13. Close monitoring of the under 18 marriages, pregnancies, prevalence of

Budget

ACTIVITY	AMOUNT FOR PLANNING YEAR 2011-12 IN LAKH
Awareness generation @ Rs 2000 per village	40.0
Workshop of all the partners	2.0
Training a district pool of Master trainers	1
Training of Councillors at every SDH/PHC/@ 10000/batch x 25	2.5
Orientation & Reorientation Health personnel	0.25
Counselling sessions @ Rs 1000/per month/per APHC/ PHC	3.0
Counselling Clinics renovation, furnishing and Misc expenses @ Rs 10000 x all APHCs/PHCs	2.5
Joint Evaluation by an agency & Govt	1
TOTAL	52.05

Program Management

Situation analysis

The District Health Society have formed been registered in BEGUSARAI. The Society is reconstructed and with these following members and the Deputy Commissioner as the Governing board President. The members are all the Programme Officers, Education, SDM, IMA president, ICDS, PWD. The Governing body meetings are held monthly under the chairmanship of the Deputy Commissioner. Although the DHS formed and meetings conducted regularly but still they are not focused on health issues and need proper training on planning and management

Objectives / Milestones/ Benchmarks

District Health Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.

Strategies

1. Capacity building of the members of the District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews.
2. Establishing Monitoring mechanisms
3. Regular meetings of Society

Activities

Activities 1. Orientation Workshop of the members of the District Health Society on strategic management, financial management & GOI/GOB Guidelines.
2. Monthly Review and planning meetings.
3. Improving the Review and planning meetings through a holistic review of all the

programmes under NRHM and proper planning.
4. Formation of a monitoring Committee from all departments.
5. Development of a Checklist for the Monitoring Committee.
6. Arrangements for travel of the Monitoring Committee
7. Sharing of the findings of the committee during the Field visits in each Review Meeting with follow-up of the recommendations.

Support required

1. Technical and financial assistance needs to be imparted for orientation and integration of societies.
2. A GO should be taken out that at the district level each department should monitor the meetings closely and ensure follow-up of the recommendation
3. Instructions & directions from GOB for proper functioning of the societies and monitoring committee.
4. Funds to maintain society office & staff

Budget In Lakhs

Activity	Amount planning for 2011-12
Orientation Workshop	**0.50**
Monthly Meetings	**0.12**
Mobility for Monitoring	**0.50**
total	**1.12**

District Programme Management Unit-STATUS

In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers. In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and M&E Officer have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level under DHS. The District Programme Manager is responsible for all programmes and projects in district under the umbrella of NRHM and the District Accounts Manager (DAM) is responsible for the finance and accounting function of District RCH Society including grants received from the state society and donors, disbursement of funds to the implementing agencies, preparation of submission of monthly/ quarterly/annual SOE, ensuring adherence to laid down accounting standards, ensure timely submission of UCs, periodic internal audit and conduct of external audit and implementation of computerised FMS. The District Nodel Monitoring and Evaluation Officer (M&E Officer) has to work in close consultation with district officials, facilitate working of District RCH Society, maintain records, create and maintain district resource database for the health sector, inventory management, procurement and logistics, planning and monitoring & evaluation, HMIS, data collection

and reporting at district level.
There is a need for providing more support to the Civil Surgeon office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre. The Civil surgeon's office is located in the premises of the only General hospital in the district. The office of all the Deputy Civil Surgeons is also in hospital premises

Objectives

Strengthened District Programme Management Unit

Strategies

1. Support to the Civil Surgeon for proper implementation of NRHM.
2. Capacity building of the personnel
3. Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities
4. Provision of infrastructure for the personnel
5. Training of District Officials and MOs for management
6. Use of management principles for implementation of District NRHM
7. Streamlining Financial management
8. Strengthening the Civil Surgeon's office
9. Strengthening the Block Management Units
10. Convergence of various sectors

Activities

1. **Support to the Civil Surgeon** for proper implementation of NRHM through proper involvement of DPMU and more consultants for support to civil surgeon for data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the Civil Surgeon and the other district officers:
 Finalizing the TOR and the selection process
 Selection of consultants, one each for Maternal Health, Civil Works, Child health, Behaviour change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons.

2. Capacity building of the personnel
 Joint Orientation of the District Officers and the consultants
 Induction training of the DPM and consultants
 Training on Management of NRHM for all the officials
 Review meetings of the District Management Unit to be used for orientation of the consultants

3. **Development of total clarity in the Orientation workshops** and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities:
 Disease Control
 Disease Surveillance
 Maternal & Child Health
 Accounts and Finance Management

 Human Resources & Training
 Procurement, Stores & Logistics
 Administration & Planning
 Access to Technical Support
 Monitoring & MIS
 Referral, Transport and Communication Systems
 Infrastructure Development and Maintenance Division
 Gender, IEC & Community Mobilization including the cultural background of the Meos
 Block Resource Group
 Block Level Health Mission
 Coordination with Community Organizations, PRIs

4. Quality of Care systems

5. 4. **Provision of infrastructure for officers**, DPM, DAM, M&E Officer and the consultant

6. of the District Project Management Unit.

5. Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc

6. Use of Management principles for implementation of District NRHM

1. Development of a detailed Operational manual for implementation of the NRHM activities in the first month of approval of the District Action Plan including the responsibilities, review mechanisms, monitoring, reporting and the time frame. This will be developed in participatory consultative workshops at the district level and block levels.

2. Financial management training of the officials and the Accounts persons

3. Provision of Rs. 500000 as Untied funds at the district level under the jurisdiction of the Civil Surgeon

7. **Strengthening the Block Management Unit**: The Block Management units need to be established and strengthened through the provision of :

 Block Programme Managers (BPM), Block Accounts Managers (BAM) and Data Operators (DO) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered.
 Office setup will be given to these persons
 Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each, besides the funds for the PHCs.
 Provision of Computer system, printer, Digital Camera with date and time, furniture

8. Convergence of various sectors at district level

 Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon

9. **Monitoring the Physical and Financial progress** by the officials as well as independent agencies

10. **Yearly Auditing** of accounts

Support from state

1. State should ensure delegation of powers and effective decentralization.
2. State to provide support in training for the officials and consultants.
3. State level review of the DPMU on a regular basis.

4. Development of clear-cut guidelines for the roles of the DPMs, DAM and District Nodal M&E Officer.
5. Developing the capacities of the Civil Surgeons and other district officials to utilize the capacities of the DPM, DAM and M&E Officer fully.
6. Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities.
7. If qualified persons for the posts of DPM, DAM are not available then State should allow the appointment of facilitators or Coordinators or retired qualified persons by the District Health Society

Time Frame for work

1.**Development of an operational Manual 2011-12 Capacity building up of District and Block level Management Units** **Training of personnel** Reorientation of personnel

Monitoring of the progress by independent agencies	

Procurement of instruments & equipments and drugs /supplies

Situation analysis

In Begusarai district there is no proper Warehouse. There are rooms in which drugs are stored but it is not a scientific Warehouse. Most of the drugs are supplied by the State but some drugs are locally procured. Inventory Management is not very scientific and the records are not computerized. There is no system of wastage control, replacements, transfer of stocks from one centre to the other. Record Keeping is done manually. There is some storekeepers in the District is different PHCs and District Hospitals. But they are not trained about storekeeping. Requirements are also not made scientifically.

Objective & Strategies

Development of a Scientific Warehouse system
1. Developing a Warehouse
2. Capacity building of the personnel for stores and also record keeping
3. Computerization of all the stocks

Activities

1. Construction of a scientific Warehouse
2. Procurement of software and computer hardware for the Warehouse from TNMSC
3. Proper Equipment and hardware
4. Availability of Pharmacist, Assistant Pharmacist, Packers
5. Training of personnel
6. Appointment of an agency for Operationalization of the Scientific Warehouse

Support Required

State to develop a scientific and transparent Procurement, Logistics and Warehousing system with quality control

Convergence and coordination

Issues / Areas	Areas of cooperation	Areas of convergence
Curative ; Patient care, Surveillance Referral	Traditional treatment Notification of diseases outbreak	For outreach and coverage of areas not covered by MOs Joint training in Surveillance Joint meetings
Preventive; Immunization, Promotive and Prophylaxis services	Traditional treatment to increase the immunity IEC for prevention	Joint planning for BCC
Specific issues in Implementation of national programmes - Maternal care - Child care - Adolescent health - School Health - Malaria - Leprosy - IDD - Tuberculosis - IDSP - HIV / AIDS - Water borne diseases	Participation in Pulse Polio, Family Welfare, school health, Malaria, Skin diseases Participation in all national programmes	To cooperate the health dept and participate in programmes. Joint Review and joint planning Joint participation and monitoring Participation in MCHN days Provision of medicine kits DOTS providers Diseases Surveillance

ICDS projects

Issues / Areas	Areas of cooperation	Areas of convergence
Maternal and child health care, complete immunization Anaemia and Malnutrition	□ Fixed MCHN days □ Joint CNAA □ Data Validation □ Common sectors □ Out reach to children and pregnant women	□ Training for counselling clients, □ Provision of spacing methods including oral pills, condoms, LAM and SDM and community mobilization. □ Convergence of services at the grassroots would ensure increasing the access to and demand for services □ Provision of Examination table and Infant weighing machine to all AWCs

		□ Joint sector meetings, block and district meetings □ DDCs □ DOTS providers □ Diseases Survei

Rural Development Department

Issues / Areas	Areas of cooperation	Areas of convergence
1. 90% of BPL houses in rural areas are without latrines and 64% of APL houses, in rural areas are without latrines. Only 44% households were covered. School Sanitation and IEC are important components of Total Sanitation Campaign. The performance is relatively poor on sanitation 2. Roads, Maintenance of buildings, Electricity and water supply are the domain of the rural development.	Formation of a Core group at the gram Panchayat level for joint action Support in total sanitation campaign	Joint action for electricity and water, Latrines in Ayush facilities also. Roads to be developed trill the health facilities Maintenance of buildings through joint reviews and plans DOTS providers Diseases Surveillance

Public Health Department

Issues / Areas	Areas of cooperation	Areas of convergence
Provision of safe drinking water. Presently there are 782 Hand pumps and 717well used for drinking water	Safe Water supply to all households and all health facilities Ensuring the proper drainage of stagnant water	Provision of GLRs, tanks Periodic Chlorination Health facilities Proper drains to be built near hand pumps Covering all open drains and puddles of water. Notification of diseases in villages Diseases Surveillance

PRI Members

Issues / Areas	Areas of cooperation	Areas of convergence
The PRIs have been envisaged to play a very important role in NRHM At the village level they are	Motivating the community Availability of personnel and	Joint plans Joint review and monitoring Mobilization of the

part of the VLC.\ At the Gram Panchayat level they are part of the Gram Panchayat health committee. Similarly at the Block and the District they are part of the Block and District health mission. At the Sub centre the Sarpanch is the joint signatory to the bank account for the operation of the Untied funds of Rs 10000. In the Gram Panchayat meetings held twice each month the PRIs review the activities of the health department along with the ICDS	services Participation in the MCHN days Giving importance to issues of health in the Gram Panchayats meetings	community for action on health care issues, safe drinking water and sanitation. Advocacy at village, Gram panchayat, block and district level

Education Department

Literacy rate of females is 25.9%. Malnutrition and anaemia management in school going children Prevention and control of drug addiction in adolescent Family life education	In Pulse Polio campaign School health programme Member of Village, health and Water Sanitation Committee Proper implementation of mid day meal program Support in various IEC campaigns organised by health department	IEC activities School health Education Screening of children for health problems, vision defects DOTS provider Motivating Community members Diseases Surveillance

Monitoring and Evaluation Situational analysis

Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the MOIC, MO, BHM at PHCs are supposed to make regular visits and monitor the progress and check on the activities and also the data provided by the ANMs. The reports have to be submitted and discussed in the monthly review meetings at the entire forum. The District Health Society is not monitoring the progress and neither are the committees at the Block and Gram Panchayat levels. No proper Check-lists exist for monitoring. Also analysis is not done of the visits and any data collected No Verbal Autopsies (Maternal, Neo-natal, Infant & Child Death audits)

are carried out any levels. The Role & Functioning of the Sub centre level Committee, PHC level Committee, RKS at PHC and VLC need to be clearly defined.
There is no system of concurrent Evaluation by independent agencies so that the district officials are aware regarding the progress .

Objectives & Strategies

Effective Monitoring and Evaluation system **Strategies**
1. Developing the system for visits, reporting and review
2. Developing a system of Concurrent Evaluation

Activities

1. Fixing the dates for visits, review meetings and reports
2. Development of Checklist for Monitoring
3. Software for the checklist and entry of the findings in the checklist
4. MOIC, MOs & BHM to make at least 5% facility visits and also of the villages
5. Quality assessment of all health institutions.
6. Maternal Mortality Audit by MO and by involving LW/AWW for reporting of maternal deaths,
7. Mobility for monitoring at all levels and with the use of district monitors

Support Required

Appointment of Agencies for Concurrent Evaluation Monitoring by State from time to time State officials to attend Review meetings

Budget

Activity / Item	**Amount for planning for 2011-12**	**remarks**
Review meetings @ Rs 1000/- x facilities x 12 mths		
Mobility support for Deputy C.S. (Immunization and Family Welfare) for Monitoring for POL	**60000/**	
Mobility support for monitoring MCHN days @ Rs. 800 X 5 days X 4 monitors X 12 months	**192000**	
Quality assessment of all health institutions each year @ Rs 2000/inst	**50000**	
Maternal, Child death Audit @ Rs 1000/death	**300000**	
` total		

CHAPTER IV PART B

ASHA – Accredited Social Health Activist

Situation analysis

No. of AWC =
No. of ASHA = 2629 target present = 2323
GAP = 303
Trained ASHA = 513 (43 old+470 new) ASHA needs Training
Reorientation (2nd Phase) Training not given

Objectives

1. To select remaining ASHA & 153
2. To give training to remaining 513 ASHA
3. Reorientation training to ASHA

Strategies

1. Selection and capacity building of ASHA
2. Constant mentoring, monitoring and supportive supervision by district Mentoring group

Activities

1. Strengthening of the existing ASHAs through support by the ANMs and their involvement in all activities.
2. Reorientation of existing ASHAs
3. Selection of new ASHAs to have one ASHA in all the villages and in urban slums
4. Selection of New Mamta.
5. Training of all remaining ASHAs who have not received any training regarding the related other modules.
6. Provision of a kit to ASHAs
7. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving
8. Review and Planning at the Monthly sector meetings
9. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency

Untied Funds for HSC & APHC /Fund for the Village health & sanitation committee

Situation analysis

NRHM has placed a lot of stress on Community involvement and formation of Village Health & Sanitation Committees (VHSC) in each village. These committees are responsible for the health of the village. In **District BEGUSARAI** these

Committees have been formed but need strengthening to improve their functioning. The selection of ASHA, her working, progress of the village is part of the Responsibilities of the Gram Panchayat. Rs 10000 to all Revenue Village Level Committee was
provided under NRHM.
In **Begusarai** there are 1250 villages with 257 panchyats revenue villages

Objectives & Strategies

1. Strengthening the Village Level Committees through financial support Strategies 1. Provision of annual funds of Rs 10000 each year to the revenue villages .

Activities

1. Provision of Annual Untied funds of Rs 10000 each year to the village's level health sub centres for maintenance
This untied fund is to be used for household surveys, health camps, sanitation drives, revolving fund etc;
2. Orientation of the ANMs for the utilization of the Untied Funds and she in turn will orient the Village Level committee.
3. Monthly meetings of the VHSC for reviewing the funds and activities. This is to be facilitated by the ANMs & phc level officers

Support Required

1**. State should ensure the orientation procedure for the VHSC& UNTIED FUNDS**
2. Funds to be transferred on time to the ANMs
3. PRIs to ensure proper usage and accounts

Time line & Budget

Time line	
Orientation and reorientation of the VHSC	As decided by DHS
Monthly meetings of the VHSC	First week of month
Review of the VHSC functioning at PHC level	Last week/ day of month
Activity / item	Amount
Untied Fund of Rs 10000/ x 288 subcentres	2880000
Untied Fund of Rs 10000/unit x 22	220000

Village health & sanitation committee fund 10000x 257 revenue villages	2570000

Rogi kalayan Samitis – present status

For sustainability and needs based care, health financing is the key. Rogi Kalyan Samity has been formed in each of the PHCs and District Hospital. These are hospital autonomous societies which are allowed to take user fees for services
provided at the facilities. Formation of these RKS has resulted in great satisfaction amongst the patients and also the staffs since now funds are available with the facilities to care for the people.

1. In most developing countries, provision of basic preventive, promotive and curative services is a major concern of the Government and decision makers. With growing population and advancement in the medical technology and increasing expectation of the people especially for quality curative care, it has now become imperative to provide quality health care services through the established institutions. In public Sector 15,393 allopathic hospitals (Health Information of India 2003) are functioning. In the rural areas, the secondary level care is being provided through 3222 CHCs (Bulletin on Rural Health Statistics in India 2005) with 30 beds each with specialist services of physicians, paediatricians, O & G specialists, and surgeons being made available. However, these services have not been successful in gaining the faith and confidence of the people because of lack of specialists, facilities and accountability, alongwith the paucity of resources and non-involvement of the community.

2. Upgradation of CHCs to Indian Public Health Standards (IPHS) is a major strategic intervention under the National Rural Health Mission (NRHM). The purpose is to provide sustainable quality care with accountability and people's participation alongwith total transparency. However, there is a general apprehension that this may not be possible unless a system is evolved for ensuring a degree of permanency and sustainability. This requires the development of a proper management structure which may be called as Rogi Kalyan Samiti (RKS) (Patient Welfare Committee) / Hospital Management Society (HMS).

Main Objectives

Availability of sufficient funds for meeting the needs & proper care of the patients

Strategies

1. Generation of funds from User charges
2. Donations from individuals
3. Efficient management of the RKS
4. Provision of Seed money to each RKS

Activities

1. Generation of funds from User charges: User charges are taken for Registration, IPD, Laboratory investigations from persons who can afford to pay.
2. Donations from individuals: Donations are to be generated from individuals. For the betterment of hospitals, equipment, additions to the buildings, etc
3. Efficient management of the RKS: Training will have to be given for efficient management and utilization of the funds for activities that generate funds. Computerization of data and all the parameters need to be carried out preferably through customized software. Trainings can be organized with the help of SIHFW Rajasthan who have developed modules and conducted trainings for the management of these Societies.
4. Provision of Seed money to each RKS of Rs 100000 each year for repair, purchase of new equipment, additions, alterations, etc.
5. Development of customized software and training of staff for the use of this software
6. Regular filling of formats

Support Required

. Timely meetings of Rogi Kalyan Samitis
. Trainings on the management of the RKS

Budget

Activity	Amount proposed for year 2011-12
Provision of Seed money @ Rs 1 lakh per PHC for RKS	1800000
Training of the Incharges and second in command @ Rs 1000 per person x 1 day	180000
Total	

PPP INITIATIVES(**Public-Private Partnership)**

CURRENT STATUS

The private sector includes NGOs, Private Practitioners, Trade and Industry

Organizations, Corporate Social Responsibility Initiatives. The private sector is the major provider of curative health services in the country. 43% of the total IUD clients obtain their services from the private sector. Engaging with it to provide family planning services has the potential to significantly expand the coverage of Quality services. Public-private partnerships can stimulate and meet demand and have a synergistic impact of the RCH. To ensure efficient services of good quality from the private and public sectors, robust monitoring and regulatory mechanisms need to be developed so that the private sector can come forward and cooperate in all the National programmes and also in sharing its resources.

Objectives

1. Increasing the coverage of the health services and also increasing the accessibility for health services
2. Widening the scope of the services to be provided to the clients

Activities

1. Accreditation of facilities for specialized treatment

2. Provision of fixed payments for clients

 Developing the clinical skills of private doctors will be developed in vasectomy, abdominal tubectomy and laparoscopy. Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD.

3. Hiring of Specialists for providing services

 Gynaecologist @ Rs 1500 per visit
 Anaesthetists @ Rs 1000 per visit
 Paediatrician @ Rs 500 per visit

4. Encouraging the use of public facilities by private doctors on a fee-sharing basis

Private doctors will be allowed to use public facilities on a fee sharing basis, e.g. in the evening when PHC/APHC s are normally closed. This will optimise the utilization of the existing infrastructure of public health facilities and make services more accessible, especially to day labourers.

 Local private doctors will be identified and invited to participate through consultative meetings, and assist in drawing up a partnership action plan
 A detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary, and safeguards to ensure equity of access.
 Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies

5. **Arogya Kosh** to continue
6. **PPP- Various Schemes under RNTCP**

Support Required

1. State to agree for allowing the private sector to use facilities
2. State to develop the Public Private Policy
3. Finalization of Incentives for the Private sector for various services
4. Private providers should get payment on a monthly basis

Services of Hospital waste treatment and disposal of Bio-Medical Waste Management in all govt. health facility up to phc

As per the Bio-Medical Waste Rules, 1998, indiscriminate disposal of hospital waste was to be stopped with handling of Waste without any adverse effects on the health and environment. In response to this the Government has taken steps to ensure the proper disposal of Biomedical waste from all Nursing homes, hospitals, Pathological labs and Blood Banks.
The District Health Officer is the Nodal Person in each district for ensuring the proper disposal of Biomedical Waste.
Trainings to the personnel for sensitizing them have been imparted, Pits have been dug, Separate Colour Bins/containers and Segregation of Waste is taking place though has to be done more systematically. Proper Supervision is lacking.
GOI has sanctioned a Plasma Pyrolysis Plant. Plasma Pyrolysis is a state-of-the-art technology for safe disposal of medical waste. It is an environment friendly technology, which converts organic waste into commercially useful by-products in a
safe and reliable manner. The plant will soon be installed and training will be imparted to two persons from the district

Objectives

1. Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2011-12
2. Ensuring proper handling and disposal of Biomedical Waste in each Facility in district

Strategies

1. Capacity Building of personnel
2. Proper equipment for the disposal and disposal as per guidelines
3. Strict monitoring and Supervision

Activities

1. Review of the efforts made for the Biomedical Waste Interventions
2. Development of Microplan for each facility in District & Block workshops
3. Capacity Building of personnel
 One day reorientation workshops for District & Block levels
 Training to two persons for Plasma Pyrolysis Plant. The company persons will impart this training.
 Biomedical Waste management to be part of each training in RCH and IDSP
4. Proper equipment for the disposal
 Plasma Pyrolysis Plant to be installed
 Installation of the Separate Colour Bins/containers and Plastic Bags for the bins
5. Segregation of Waste as per guidelines
6. Partnering with Private providers for waste disposal
7. Proper Supervision and Monitoring
 Formation of a Supervisory Committee in each facility by the MOs and the supervisiors

Budget

Activity/item	Amount for planning year 2011-

	12
Orientation and reorientation for Biomedical Waste Management at District and Block levels	100000/-
Consumables	1,00,000/-
Maintenance of the Plasma Pyrolysis plant	350000/
Payment for incinerators@ Rs. 8 per bed 12 months x 1000 beds	**96000/-**

Oursourcing pathology and Radiology services from phc to DISTRICT HOSPITAL

Pathology services at primary health centres is not renewed yet radiology services infrastructure is installed in most of PHC .

Operationalising Mobile medical Unit

Objectives

Meeting the unmet health needs of the people residing in difficult and underserved areas, through provision of healthcare at their doorstep

Activities

Formation of a Monitoring Committee
Need Analysis to be carried out for determining the areas of MMU
Wide publicity before the arrival of the MMU
Periodic Review

Performance of mobile medical unit in Begusarai district in June 2010

Date.	PHC	DOCTOR	NURSE	LAB ATTD.	X-RAY TECHN	PHARMAST	O.T.ASSTT.	DRIVER
1/6/2010	Nowkothi	y	y	y	y	y	y	y
2/6/2010	Nowkothi	y	y	y	y	y	y	y
3/6/2010	Nowkothi	y	y	y	y	y	y	y
4/6/2010	Gardhpura	y	y	y	y	y	y	y
5/6/2010	Gardhpura	y	y	y	y	y	y	y
6/6/2010	SUNDAY							
7/6/2010	Gardhpura	y	y	y	y	y	y	y
8/6/2010	Bakhari	y	y	y	y	y	y	y
9/6/2010	Bakhari	y	y	y	y	y	y	y
10/6/2010	Bakhari	y	y	y	y	y	y	y
11/6/2010	S.Kamal	y	y	y	y	y	y	y
12/6/2010	S.Kamal	y	y	y	y	y	y	y
13/6/2010	SUNDAY							
14/6/2010	S.Kamal	y	y	y	y	y	y	y

15/6/2010	S.Kamal	y	y	y	y	y	y	y
16/6/2010	Balia	y	y	y	y	y	y	y
17/6/2010	Balia	y	y	y	y	y	y	y
18/6/2010	Balia	y	y	y	y	y	y	y
19/6/2010	Dandari	y	y	y	y	y	y	y
20/6/2010	SUNDAY							
21/6/2010	Dandari	y	y	y	y	y	y	y
22/6/2010	Dandari	y	y	y	y	y	y	y
23/6/2010	Birpur	y	y	y	y	y	y	y
24/6/2010	Birpur	y	y	y	y	y	y	y
25/6/2010	Birpur	y	y	y	y	y	y	y
26/6/2010	Barauni	y	y	y	y	y	y	y
27/6/2010	SUNDAY							
28/6/2010	Barauni	y	y	y	y	y	y	y
29/6/2010	Barauni	y	y	y	y	y	y	y
30/6/2010	Barauni	y	y	y	y	y	y	y
31/6/2010								

Budget

Activity/item	Amount planned for year 2010-11
Payment of rental of MMU SERVICE PROVIDER	45500000.00

MAIN STREAMING AYUSH UNDER NRHM

The Indian systems of medicine have age old acceptance in the communities in India and in most places they form the first line of treatment in case of common ailments. Of these, Ayurveda is the most ancient medical system with an impressive record of safety and efficacy. Other components such as Yoga, Naturopathy are being practised by the young and old alike, to promote good health. Now days, practice of Yoga has become a part of every day life. It has aroused a world wide awakening among the people, which plays an important role in prevention and mitigation of diseases. Practice of Yoga prevents Psychosomatic disorders and improves an individual's resistance and ability to endure stressful situation. Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognised systems of medicine and have been integrated into the national health delivery system. India enjoys the distinction of having the largest network of traditional health care, which are fully functional with a network of registered practitioners, research institutions and licensed pharmacies. The NRHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. It is decided that AYUSH medications shall be included in the drug kit of ASHA, The additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations. At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health Standards (IPHS) model. At the same time, single Doctor PHCs shall be upgraded to two Doctor PHCs by inducting AYUSH practitioner at that level. There are 5 Ayurvedic Hospitals,619 Ayurvedic Dispensaries, 4 Homoeopathic Hospitals, 560 Homoeopathic Dispensaries and 9 Unani Dispensaries.

- Integrate and mainstream ISM &H in health care delivery system including National Programmes.
- Encourage and facilitate in setting up of specialty centres and ISM clinics.
- Facilitate and Strengthen Quality Control Laboratory.
- Strengthening the Drug Standardization and Research Activities on AYUSH.
- Develop Advocacy for AYUSH.
- Establish Sectoral linkages for AYUSH activities

Strategies

Broad Objectives

Mainstreaming of AYUSH in the health care service delivery system to strengthen the existing public health system

- **Activities**

- **Improving the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service Delivery System**

- **Making provision for AYUSH Drugs at all levels AYUSH doctors to be involved in all National Health Care programmes, especially in the priority areas like IMR,MMR,JSY, Control of Malaria, Filaria, and other communicable diseases etc All AYUSH institutions will be strengthened with necessary infrastructure like building, equipment, manpower etc**

SL	APHC	MOIC	Hospital	PHC	AAYUSH Doctors	TYPE OF DOCTO	Mob N0.-
1	BINODPUR	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. ARBIND KR. JHA	AYURVED	"9199200469
2	KORIYA BASUDEOPUR	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. NIRANJAN KUMAR	AYURVED	"9534826749
3	BHAIRWAR	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. (SMT) SARITA KUMARI	AYURVED	"9199200469
4	MOHANPUR	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. MARUTI NANDAN	AYURVED	"9234748432
5	MAHNA	Medical Officer I/C	Primary Health Centre	BARAUNI	DR. BYAS DEV	HOMOEOPATH	9471045562
6	SIMARIYA	Medical Officer I/C	Primary Health Centre	BARAUNI	DR. SANJIV KUMAR	HOMOEOPATH	"9234720082
7	SHOKHARA	Medical Officer I/C	Primary Health Centre	TEGHRA	DR. NARENDRA NATH PRASAD	HOMOEOPATH	"9431083058"9135045661
8	CHAMTHA	Medical Officer I/C	Primary Health Centre	BACHWARA	DR. JIBACHH KUMAR SHAW	HOMOEOPATH	"8084044809
9	BANWARIPUR	Medical Officer I/C	Primary Health Centre	BHAGWANPUR	DR. SHASHI BHUSHAN KR.	AYURVED	"9471976204
10	NAVTOL	Medical Officer I/C	Primary Health Centre	BHAGWANPUR	DR. (SMT) SUSHMA KUMARI	AYURVED	"9934126398
11	SHERPUR	Medical Officer I/C	Primary Health Centre	BHAGWANPUR	DR. NOUSAD ANSARI	UNANI	"9801293289
12	PAHSARA	Medical Officer I/C	Primary Health Centre	NAWKOTHI	DR. RAVI KANT	AYURVED	"9708344940
13	DEVPURA	Medical Officer I/C	Primary Health Centre	NAWKOTHI	DR. PREM CHAND KUMAR	AYURVED	"9708707620,9135617068
14	SAKRAULI	Medical Officer I/C	Primary Health Centre	CHERIYA BARIYARPUR	DR. MOHAMMAD ABRAR HUSSAIN	HOMOEOPATH	"9973162250
15	AMARI	Medical Officer I/C	Primary Health Centre	CHAURAHI	DR. VARSHA RANI	HOMOEOPATH	"9234220438
16	LAKAHNPATTI	Medical Officer I/C	Primary Health Centre	CHAURAHI	DR. UDAY SHANKAR SHARMA	HOMOEOPATH	"9471757165
17	SIHMA	Medical Officer I/C	Primary Health Centre	MATIHANI	DR. SHAILENDRA KUMAR	AYURVED	"9934725092
18	RAMPUR BASWAN	Medical Officer I/C	Primary Health Centre	MATIHANI	DR. RAMANAND RAM	AYURVED	"9771248835
19	MOHABBA	Medical Officer I/C	Primary Health Centre	SAHEBPUR KAMAL	DR. MUSTAFEEZUR RAHMAN	UNANI	"9835633116,9939605340
20	MALHIPUR	Medical Officer I/C	Primary Health Centre	SAHEBPUR KAMAL	DR. SAMIM AKHTAR	UNANI	
21	HANUMAN NAGAR PAHARPUR	Medical Officer I/C	Primary Health Centre	BALLIA	DR. SANJAY KR. RASTOGI	AYURVED	"9934602230
22	LAKHO	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. (SMT) SAROJ KUMARI	AYURVED	"9431093888
23	ULAO	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. MD. HESSAN ANSARI	UNANI	"9905545256
24	PAKTHAUL	medical Officer I/C	Primary Health Centre	TEGHRA	DR. SHEO NANDAN MAHATON	AYURVED	"7488186441
25	SONMA	Medical Officer I/C	Primary Health Centre	BAKHRI	DR. PARMANAND SINHA	AYURVED	"9430069190
26	SATHA	Medical Officer I/C	Primary Health Centre	BACHWARA	DR. MD. BARKATULLAH	UNANI	"9471663988
27	THAKURICHAK	Medical Officer I/C	Primary Health Centre	BARAUNI	DR. AMARNATH SHARMA	AYURVED	"9709603077
28	CHANDPURA	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. ABDULLAH JAWED	UNANI	"9304849710
29	DHABAULI	Medical Officer I/C	Primary Health Centre	SADAR BLOCK	DR. NILAY KANT KUMAR	AYURVED	
30	KESAWE	Medical Officer I/C	Primary Health Centre	BARAUNI	DR. CHANDRA BHUSHAN PRASAD	HOMOEOPATH	"9534968860
31	JAGDAR	Medical Officer I/C	Primary Health Centre	BIRPUR	DR. GANESH PRASAD	AYURVED	"9835513875
32	MUKTIYARPUR	Medical Officer I/C	Primary Health Centre	BHAGWANPUR	DR. ASHOK KUMAR	AYURVED	"9955734598
33	SANHA PURVI	Medical Officer I/C	Primary Health Centre	SAHEBPUR KAMAL	DR. AJAY KUMAR	AYURVED	"9708599003,9570265958
34	TETRI	Medical Officer I/C	Primary Health Centre	DANDARI	DR. HARINANDAN PASWAN	AYURVED	"9334034990,9234688343
35	BARI BALLIA	Medical Officer I/C	Primary Health Centre	BALLIA	DR. RAMANAND PASWAN	HOMOEOPATH	
36	SIMARIYA GHAT	Medical Officer I/C	Primary Health Centre	BARAUNI	DR. PAWAN KUMAR	HOMOEOPATH	"8877544863

CHAPTER V PART –C

Immunization

Objectives

Reduction in the IMR to 49
100 % Complete Immunization of children (12-23 month of age)
100 % BCG vaccination of children (12-23 month of age)
100% DPT 3 vaccination of children (12-23 month of age)
100% Polio 3 vaccination of children (12-23 month of age)
90% Measles vaccination of children (12-23 month of age)
100% Vitamin A vaccination of children (12-23 month of age

Strategies

1. Strengthening the District Family Welfare Office
2. Enhancing the coverage of Immunization
3. Alternative Vaccine delivery
4. Effective Cold Chain Maintenance
5. Zero Polio cases and quality surveillance for Polio cases
6. Close Monitoring of the progress

Activities

1. Strengthening the District Family Welfare Office
 Support for the mobility District Family Welfare Officer (@ Rs.3000 per month towards cost of POL) for supervision and monitoring of immunization services and MCHN Days
 One computer assistant for the District Family Welfare Office will be provided for data compilation, analysis and reporting @ Rs 15000 per month.
2. Training for effective Immunization Training for all the health personnel will be given including ANMs, LHVs, MPWs, Cold chain handlers and statistical assistants for managing and analyzing data at the district.
3. Alternative vaccine delivery system (mobility support to PHCs for vaccine delivery)
a. For Alternative vaccine delivery, Rs. 50 to the ANM will be given per session. It is proposed to hold one session per week per Sub centre.
b. Mobility support (hiring of vehicle) is for vaccine delivery from PHC to MCHN days site where the immunization sessions are held for 8 days in a month
4. Incentive for Mobilization of children by Social Mobilizers
 Rs.100 per month will be given to Social Mobilizers for each village for mobilization of children to the immunization session site. This money will be provided to ASHA wherever possible but if there is no ASHA then it will be given to someone nominated from the village by the PRIs.
6. Contingency fund for each block
 Rs. 1000/ month per block will 8. Outbreak investigation
 Rapid Action Team for epidemics will be formed
 Dissemination of guidelines

 Training of Rapid Action Team for investigating outbreaks who will in turn orient the ANMs during Sector meetings

9. Adverse effect following Immunization (AEFI) Surveillance:

 Standard Guidelines have been developed at national level and will be disseminated to the district officials and block levels in Review meetings.

10. IEC & Social Mobilization Plans

Discussed in details in the Component on IEC

11. Cold Chain

 Repairs of the cold chain equipment (@ 750/- per PHC & CHC will be given each year

 For minor repairs, Rs. 10,000 will be given per year.

 Electricity & POL for Genset & preventive maintenance (Running Cost) of Walk in Coolers (WICs) & Walk in Refrigerators (WIF) () @ 15000/equipment per two months plus Rs. 1000 per machine for POL for Genset.

 Payment of electricity bills for continuous maintenance of cold chain for the PHCs @ 300 per month PHCs (vaccine distribution centres) has been budgeted under this head.

 POL & maintenance of vaccine delivery van

 @ Rs. 3000/month for maintenance and POL for Vaccine delivery van for reg be given as contingency fund for communication.

7. Disposal of AD Syringes

 For proper disposal of AD syringes after vaccination, hub cutters will be provided by Govt. of India to cut out the needles (hub) from the syringes. Plastic syringes will be separated out and will be treated as plastic waste. Regarding the disposal of needles, PHCs a sum of Rs. 2000/ PHC has been provisioned.

8. Outbreak investigation

 Rapid Action Team for epidemics will be formed

 Dissemination of guidelines

 Training of Rapid Action Team for investigating outbreaks who will in turn orient the ANMs during Sector meetings

9. Adverse effect following Immunization (AEFI) Surveillance:

 Standard Guidelines have been developed at national level and will be disseminated to the district officials and block levels in Review meetings.

10. IEC & Social Mobilization Plans

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 Payment of electricity bills for continuous maintenance of cold chain for the PHCs @ 300 per month PHCs (vaccine distribution centres) has been budgeted under this head.

 POL & maintenance of vaccine delivery van

 @ Rs. 3000/month for maintenance and POL for Vaccine delivery van for regular supply of vaccine to the PHCs.

Support required

 Regular supply of vaccines and **Autodestruct syringes**

 Reporting and Monitoring formats

 Monitoring charts

 Cold Chain Modules and monitoring formats

□ Temperature record books □ Polythene bags to keep vaccine vials inside vaccine carrier □ Polythene for the vaccines to avoid labels being damaged □ Training of Cold Chain handlers □ Training of Mid level managers

Budget

Activity	Amount planned for 2011-12 in lakhs
Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Sub centre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 monthsx 288 HSCs	
Vehicle for distribution of vaccines in remote areas @ Rs 800 per PHC for 1 times per week x 4 weeks x 12 months x 18 PHCs	**6.91**
Mobility Support Mop up campaign @ Rs 10000 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	**10.80**
Mobilization of Children by Social Mobilizers @ Rs. 200/ per month x 12monthx 6400 Mobilizers (ASHA + AWW + ANM)	**160**
Contingency fund for each block @ Rs.1000/month x 18 blocks x 12 months	**2.16**
Printing of Immunisation cards @1.50 per card x 100000 cards each year	**1.50**

Status of pulse polio immunization in district begusarai

DETAILS OF MANPOWER in teams for SIA Round

	Total Number of HtoH teams	Total Number Manpower of HtoH teams	Total Number of Transit teams	Total Number Manpower of Transit teams	Total Number of Mobile/ Special teams	Total Number Manpower of Mobile/ Special teams	Total Number of Supervisors	Total Number of Depot/ Sub Depot Holders
BGS_BACHHWARA	82	164	14	27	4	8	32	6
BGS_BAKHRI	60	120	22	41	2	4	26	6
BGS_BALIA	81	162	17	34	8	16	33	5
BGS_BARAUNI	110	220	31	62	2	4	47	10
BGS_BEGUSARAI	150	300	16	28	3	6	57	12
BGS_BEGUSARAI URBAN	61	122	54	88	1	2	31	1
BGS_BHAGWANPUR	67	134	6	12	1	2	25	5
BGS_BIRPUR	39	78	3	6	1	2	15	5

BGS_CHAURAHI	50	100	4	8	2	4	18	4
BGS_CHERIA BARIARPUR	56	112	12	22	2	4	19	5
BGS_DANDHARI	35	70	5	10	2	4	14	3
BGS_GADHPURA	47	94	8	14	1	2	17	4
BGS_KHUDABANDPUR	32	64	8	15	3	6	12	2
BGS_MANSOORCHAK	36	72	8	14	1	2	14	4
BGS_MATIHANI	66	132	10	20	6	12	26	8
BGS_NAWKOTHI	39	78	8	16	1	2	18	6
BGS_SAHEBPUR KAMAL	75	150	22	43	2	4	29	8
BGS_SAMHO	11	22	4	7	3	6	7	2
BGS_TEGHRA	96	192	61	119	16	32	49	9
	1193	2386	313	586	61	122	489	105

Part D CHAPTER VI

Part D – National Disease Control Programmes

IDSP BEGUSARAI

Draft - Annexure 2

PIP of IDSP Begusarai

Sub-activity		Tasks	Unit Cost	No. of Units	2011-12	Remarks
1 Staff Salary	1.1	Epidemiologists	35000	12	35000*12=4,20,000	Increase from last year salary
	1.2	Microbiologists	0	0	0	N/A
	1.3	Entomologist	0	0	0	N/A
	1.4	Consultant (Finance)	0	0	0	N/A
	1.5	Consultant (Training)	0	0	0	N/A
	1.7	District Data Manager	32000	12	32000*12=3,84,000	Assumed from last year salary
	1.8	Data Entry Operator	8500	12	8500*12=102000	New post
	1.9	Accountent (Part Time)	4000	12	4000*12=48000	New post
	1.1	Peon	3000	12	3000*12=36000	New post
		Sub Total			**990000**	
2 Training	2.1	Training of Hospital Doctors	20000	20 (Per batch)	20000*2=40000	N/A
	2.2	Training of Hospital (Reporting Person)	15000	20 (Per batch)	15000*4=60000	N/A
	2.3	Training of Data Managers	0	0	0	N/A
	2.4	Training Health Manager & Data Operator	15000	20 (Per batch)	15000*2=30000	N/A
		Sub Total			**130000**	
3 Operational Cost	3.1	Mobility Support for IDSP and RR Team	20000	1	20000*12=240000	Vehical for IDSP office & RRT
	3.2	Office Expenses	5000	1	5000*12=60000	Stationary 2000*12, News Paper for News Allarts 500*12=6000, Contengency 1000*12=12000 & Others Expences 1500*12=18000
	3.3	ASHA incentives for Outbreak reporting	100	1	100*10*12=12000	Estimated to get 10 informations per month from volunteers a total of 120 such information in a year per district. Each informant to be given an incentive of Rs.100/-
	3.4	Consumables for District Labs	50000	1	50000*1=50000	Consumables items for District Labs
	3.5	Collection & transportation of samples	10000	1	10000*1=10000	Collection & transportation of samples from field to lab
	3.6	IDSP reports including alerts	20	20 * 52	1054	N/A
	3.7	Post card for Out break Information & alerts (Hard to Reach area)	2	1	2*2629=5258	Rs 2 par post card with printig of all mater & office Address (one time in year)
	3.8	Printing of Reporting Forms	10000	1	10000*1=10000	Printing of Reporting Forms at HQ
	3.9	Phone & Broadband Expenses	1500	1	1500*12=18000	Phone & Broadband Expenses @ Rs 1500 par month
	3.10	Mobile Expences	500	2	500*2*12=12000	Mobail Expenses Epidemiologist & Data Manager
		Sub Total			**418312**	
4 New Innovations	4.1	TA For Pvt Instituation	100	15	50*15*52=39000	Par visit for weekly reports Rs 50 for 15 Reporting units X 52 weeks
	4.2	Social Mobilization and Intersectoral co-ordination	1000	10	1000*20*12=240000	Social Mobilization and Intersectoral co-ordination in 10 block @ Rs 1000 par month
	4.4	Community based surveillance	1000	1	1000*12=12000	N/A
	4.5	Case based study reports	500	1	500*4=2000	Per case 500
	4.6	Farniture for IDSP VC cum Training Hall	500000	1	500000*1=500000	Stablisment of VC cum Training hall with Round table & 30 Chairs
		Sub Total			**793000**	
		TOTAL			**2331312**	

Dist. Data Manager

NLEP

SITUATION ANALYSIS

NLEP Has been integrated with GHS . Drugs for the treatment (MDT) are available at PHC , MO diagnosing cases who have come voluntarily or with ASHA, and pharmacist are distributing MDT to them NLEP staff is ssisting GHS at every day as per need.

Now NLEP is also integrated with NRHM and involvement of ASHA to be ensured for regular treatment for in addition of supervision and monitoring will become more effective.

It is supported that at each and every level, regular and repeated orientations of staff (both GHS & NLEP) are need for provide quality services. We have to initiate regular IEC activities in the community to reduce stigma and discrimination.

Sl.	**District Profile**	**Population – 2628832**
1	**DLO**	**01**
2	**NMS**	**01**
3	**NMA**	**19**
4	**PTT**	**Nil**
5	**Number of ASHA**	**2323**

<u>Epidemiological status</u>

Cases on record 31st March 2009	P.R.	New Cases detected from 1st April to Dec 2010	Proportions				TCR		
			MB	Female	Child	DG2	MB (2006-07)	PB (2007-08)	Total
202	0.7	333	44%	35%	18%	2.1%	98.4%	98.5%	98.95%