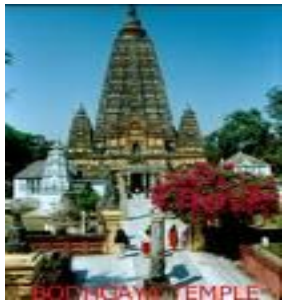
District Health Plan

2009-2010



District Health Society, Gaya

Foreword

NRHM was launched in April 2005. The State Health Society (Bihar) and the District Health Societies (Gaya) were formed by end of 2005. The recruitment of Block level managers and other staff were completed by May 2007. The data centre was established by 2006, which worked on outsourced mode. However, a new system replaced the out sourced mode and the data centres were put in place by 2008.

Public health system has witnessed an increased utilization of services in 2008 reflected by an increased number of persons being provided every type of service that is available- be it outpatient care, inpatient care, institutional delivery services or emergency services, or surgical services, or laboratory services. The strategy of revitalizing the BPHC and District hospital has shown results. Human resources and Quality of services remains an issue that needs to be addressed.

The District Health Planning in Gaya used a situational analysis form focusing on areas in health covered by NRHM viz; RCH, NRHM Additionalities, Immunization, Disease control, and Convergence. This DHAP has been evolved through a participatory and consultative process, wherein community, NGO and other stakeholders have participated and deliberated on the specific health needs.

I need to congratulate the SHS Bihar for its dynamic leadership and enthusiasm provided to district level so that the plan is made. We are grateful to Mr. Prasanth K S, NHSRC, New Delhi, for providing the necessary technical support and guidance in making the District Plan. We also acknowledge PHRN (NGO partner) for organizing the capacity building programme for the preparation of District Health Action Plan.

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. The documentation will be an opportunity for other districts to learn from Gaya experience.

Mr. Sanjay Kumar Singh
(DM) Gaya, Bihar.

About the Profile

Health Action Plan of Gaya district has been prepared under the National Rural Health Mission. The plan 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 focus of the plan has been on the health care needs of rural poor especially women and children, preventive and promotive interventions, barriers in access to health care and 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.

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 appreciate the tremendous effort put in by the district planning team in making this District Health Action Plan of Gaya District.

I am sure that this attempt will incite the leaders and administrators of the primary health care system in the district, enabling them to go into the district health plan. I hope that this District Health Action Plan will ably contribute to the State Programme Implementation Plan.

Dr. Prakriti Gupta
Civil Surgeon, Gaya
Bihar.

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INTRODUCTION

Gaya District is situated in the Southern part of Bihar. It has an average elevation of 111 metres (364 ft). The Dist has 24 blocks & 35 Police Stations & 4 Subdivisions. The total land area of the district is 4937.75 sq/km. which is about 5% of the total area of Bihar.

As of 2001 India census, Gaya had a population of 3,473,428. Males constitute 53% of the population and females 47%. Gaya has an average literacy rate of 51.07%, lesser than the national average of 59.5%; male literacy is 63.81%, and female literacy is 37.40%.

Gaya Historical

Gaya has experienced the rise and fall of many dynasties in the Magadh Region. From the 6 th century BC to the 18 th century AD, about 2300-2400 years, Gaya has been occupying an important place in the cultural history of the region. It opened up with the Sisunaga dynasty founded by Sisunaga, who exercised power over Patna and Gaya around 600 BC. Bimbisara, fifth in line, who lived and ruled around 519 BC, had projected Gaya to the outer world. Having attained an important place in the history of civilization, the area experienced the bliss of Gautam Buddha and Bhagwan Mahavir during the reign of Bimbisara. After a short spell of Nanda dynasty, Gaya and the entire Magadh region came under the Mauryan rule with Ashoka (272 BC – 232 BC) embracing Buddhism. He visited Gaya and

built the first temple at Bodh Gaya to commemorate Prince Gautama's attainment of supreme enlightenment. Gaya then passed on to the Pala dynasty with Gopala as the ruler. It is believed that the present temple of Bodh Gaya was built during the reign of Dharmapala, son of Gopal Gaya finds mention in the great epics, Ramayana and Mahabharata. Rama alongwith Sita and Lakshmana visited Gaya for offering PINDDAN to their father Dasharath. In Mahabharat, the place has been identified as Gayapuri. About the origin of the name 'Gaya' as referred to in Vayu Purana is that Gaya was the name of a demon (Asura) whose body was pious after he performed rigid penance and secured blessings from Vishnu. Bodhgaya, where Lord Buddha has achieved enlightenment, is now a international heritage centre.

Gaya formed a part of the district of Bihar and Ramgarh till 1864. It was given the status of independent district in 1865. Subsequently, in May 1981, Magadh Division was created by the Bihar State Government with the districts of Gaya, Nawada, Aurangabad and Jehanabad.

Modern History

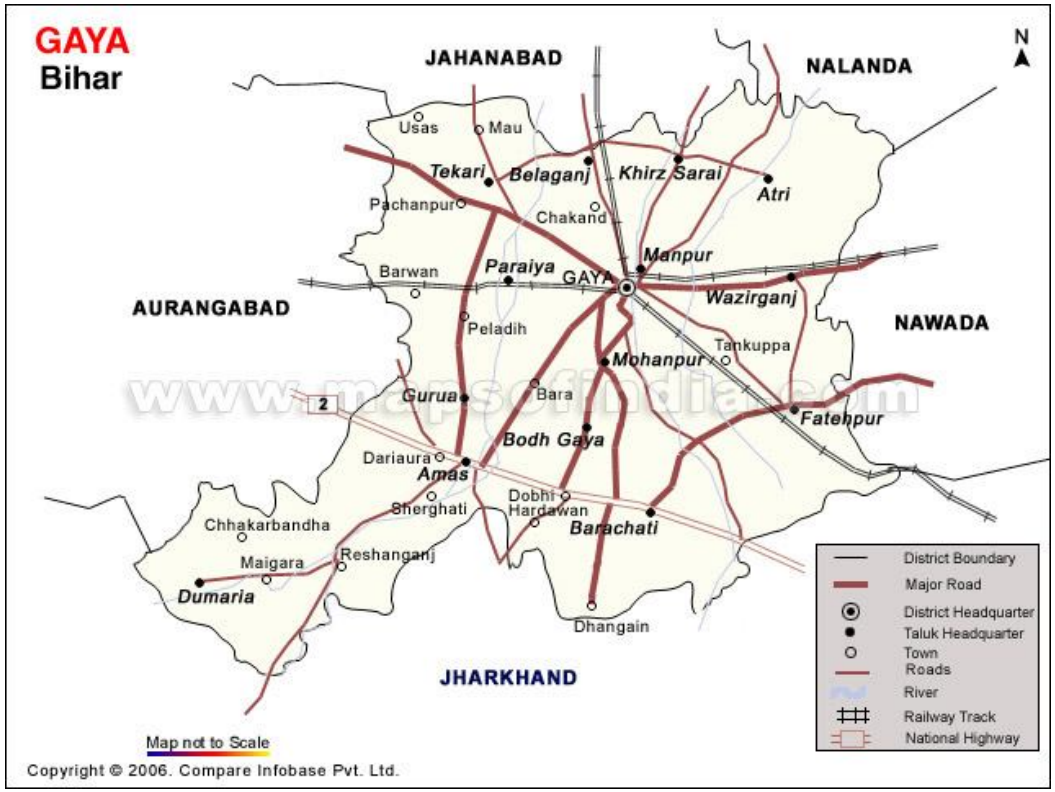
Gaya has also immensely contributed in the Indian Independence Movement. It has also been a place of the Gandhian leader Bihar Bibhut Dr.Anugrah Narayan Sinha. During the independence movement,the All india session of the Congress was held under the presidency of Deshbandhu Chittaranjan Das in 1922, which was attended by great illumanaries and prominent leaders of the Indian Independence Movement, such as Mahatma Gandhi, Rajendra Prasad, Anugrah Narayan Sinha , Sardar Patel, Maulana Azad, Nehru and Sri Krishna Sinha. Jai Parkash Narayan spend months in patluka village in Barachatti when he flew from Hazaribagh jail in 1942. One of the finely run PHCs in Gaya is in Barachatti.

Transportation

Gaya is well connected to the rest of India and the world by roadways, railways and airways.The Grand Trunk Road (NH-2, which is undergoing a revival under The Golden Quadrilateral project) is about 30 km. from Gaya city. Gaya has the second most important railway station in Bihar after Patna. It is a junction and is connected to the all the four metropolis New Delhi, Kolkata, Mumbai and Chennai through Important Broad Gauge Routes (direct trains). Now it is also directly connected to Guwahati(N-E India) including the Grand Chord line. There is a direct non-stop train, the Mahabodhi Express from New Delhi to Gaya daily. It takes around 16 hours to reach Gaya from

New Delhi through train. Gaya Airport is the only international airport in Bihar and Jharkhand taken together. It is an international airport connected to Colombo, Sri Lanka, Bangkok, Thailand, Singapore, and Bhutan.

Communication Map of Gaya



Delicacies

Gaya has been the origin of several sweet delicacies popular in the whole of Bihar, Jharkhand and the rest of India. Tilkut, Kesaria Peda, Lai, Anarsa of Ramana road and tekari road are the most popular sweets that bear the trademark of Gaya.Tilkut being the most popular of

them is prepared using til or sesame seeds (Sesamum Indicum) and jaggery or sugar. It is a seasonal (winter) sweet and only the karigars (workers) from Gaya are believed to impart the real taste of Tilkut. One can find Tilkuts carrying the label "Ramna, Gaya" even in far flung places like Kolkata and Delhi. Ramna and Tekari Road are the areas in the city where every other house is a Tilkut factory. Kesaria peda is yet another delicious sweet prepared from khoya (solid milk cream) and kesar (saffron). The Chowk area of the city specializes in Kesaria Peda production. Anarsa is also based on khoya, but is deep fried and processed with sugar. Anarsa comes in two shapes 'thin disk' and 'spherical'. The sweet is finally embedded with til (sesame) toppings.

These sweets are dry and hence easily packagable, preserved, and transported, unlike the bengali sweets which are soaked in sugar syrups. There is a tradition among the residents to gift the visitors with these sweets when they depart, as a token of love. Most of these sweets are but made and dispensed in places which are not so hygienic and hence posing an issue of food safety.

Education

The only university at Gaya is Magadh University established by eminent educationist and then Education Minister. Late Satyendra Narayan Sinha in 1962, located near Bodhgaya. Gaya has several colleges with graduate and post-graduate courses offered in sciences, arts, commerce, management and Computer Application. Anugraha Narayan Magadh Medical College and Hospital (ANMMCH) is the medical college in Gaya.

The planning process

The District Programme Implementation Plan has evolved through a consultative process wherein Health Managers, Medical Officers, PRIs and NGOs have been involved. A capacity building programme had been organized for the district planning team prior to the consutative process. A preliminary draft was prepared by 24th January 2009 and by 27th January 2009 the first version was prepared and submitted to SPMU for inputs and positive inclusion into the State Programme Implementation Plan. After incorporating the inputs the current version is made.

The budget line prepared from the list of activities proposed under the respective strategies followed the FMR guideline. Budget head on infrastructure, human resource, infection control & environmental plan, logistic management, HMIS, Monitoring evaluation, training, IEC

/BCC, procurement, strengthening of services, AYUSH & initiative for quality improvement have been incorporated along the respective programme heads (A to E).

DISTRICT PROFILE

No.	Variable	Data
1.	Total area	4937.75 SQ. KM
2.	Total no. of blocks	24
3.	Total no. of Gram Panchayats	333
4.	No. of villages	2925
5.	No of PHCs	22+2
6.	No of APHCs	46+56
7.	No of HSCs	439+204
8.	No of Sub divisional hospitals	0
9.	No of referral hospitals	2
10.	No of Doctors	116R+69C
11.	No of ANMs	531R+300C
12.	No of Grade A Nurse	17R+80C
13.	No of Paramedicals	53
14.	Total population	3464983 (CENSUS-2001)
15.	Male population	1789231 (CENSUS-2001)
16.	Female population	1675752 (CENSUS-2001)

17.	Sex Ratio	973/1000
18.	No of Eligible couples	892759
19.	Children (0-6 years)	527708 (ESTIMATED POPULATION)
20.	Children (0-1years)	123864
21.	SC population	788293
22.	ST population	1468
23.	BPL population	24.6
24.	No. of primary schools	2221
25.	No. of Anganwadi centers	3334
26.	No. of Anganwadi workers	3334
27.	No of ASHA	2780
28.	No. of electrified villages	24.4%
29.	No. of villages having access to safe drinking water	4.2%
30.	No of villages having motorable roads	7.6%

Part A. RCH II

MATERNAL HEALTH

Objectives

1. To reduce MMR
2. To increase institutional deliveries
3. To increase access to emergency obstetric care
4. To reduce anaemia among pregnant mothers
5. To reduce incidence of RTI/STI cases

Objective. 1

- **To reduce MMR (target - 200/1000 live births by 2010)**

Strategies 1&2

- Increase 3 ANC coverage
- To increase birth assisted by trained health personnel

Activities

1. Improve Access of ANC Care by Organising fixed day ANC clinic
2. Ensure quality service and Monitoring of ANC Care by checking of ANMs duty rooster and visits of LHVs and MOs.
3. Refresher training of ANMs on ANC care
4. Proper maintenance of ANC Register and Eligible couple register
5. Ensure safe delivery at Home
6. Provision of Disposable delivery kits with ANMs and LHVs
7. Training of ANMs on SBA
8. VHND services to be provided through Mahila Mandal meetings

Strategy

- To increase the coverage of Post Natal Care

Activities

- Ensuring proper practice of PNC services and follows ups at the health facility level. Currently the percentage of mothers visited by health worker during the first week after delivery is low (range: 5-52%).
- Refresher sessions for all ANMs on guidelines to be followed for PNC care
- Ensuring follow up PNC care through out reach services (ANM) for delivery cases where the patient does not return to facility for follow up check ups.
- Referral of all complicated PNC cases to FRU level.
- LHV and MO to monitor and report on PNC coverage during their filed visits
- Utilizing the ASHA network to strengthen the follow up of PNC services through tracking of cases, mobilization to facilities and providing IPC based education / counselling.

- ASHA to make 3 PNC visits - for home delivery cases (1st within 2 days, 2nd within 4 days and 3rd within 42 days of delivery) and 2 follow up visits for institutional delivery cases. She will also make visits (3 times) during post natal period.
- Counselling of all pregnant women on ANC and PNC during monthly meetings of Mahila Mandal / VHND Meetings.
- Linking of ASHA's incentives on institutional deliveries to completion of the PNC follow-ups.
- ASHA should be able to report maternal deaths directly to district level though an SMS service, which will be stored in the DHS database. This will facilitate maternal death audit.

Objective : 2

To reduce anaemia among pregnant mothers

Strategies

- Increase the consumption of IFA tablets
- IEC

Activities

1. distributed door to door esp. to all teenage pregnancy cases. Ensure timely supply of IFA Tablets to the Health Institutions. The tablets may be
2. Awareness generation for consumption of IFA Tablets among Pregnant mothers by ASHA and AWW
3. District to purchase IFA tablets in the case of stock out
4. Convergence with ICDS for regular supply of IFA tablets through AWWs
5. Half yearly de-worming of all adolescent girls.
6. Necessary training and logistics for ASHA in adolescent health / family
7. Ensure referral of severely Anaemic Pregnant Mothers to higher centres
8. IEC on consumption of locally available iron rich foodstuffs

Objectives .3 &4

- To increase institutional deliveries
- To increase access to emergency obstetric care for complicated delivery.

Strategies

- JSY
- Operationalisation of Health Facilities (Upgrading BPHCs/CHCs in to FRUs, Operationalising 24*7 PHCs, Operationalising Sub Centres)
- Provision of Referral Support system

Activities

For **JSY** the State Health Society entered into an agreement with SBI for transfer of funds electronically to respective DHS account. The SBI will release funds against an advice issued by DHS. But since SBI is not having braches in every block, the fund is released to Punjab National Bank. This process causes delay and in most of the blocks a delay of around 1-2 months results. Another issue is that since release of fund from SHS level is dependent upon utilization certificate, unless a UC showing 60% funds being spend, is produced, a further release will not be made. Since DHS is not able to send the SOE in time, a this delay often results. Presently SHS has released funds to clear the back log.

Another issue is to give maximum support to pregnant mothers by way of disbursing some advance money before she reaches institution. From the Rs.1400/- which is being paid to mothers Rs.500/- can be given during ANC registration and the rest of the money can be paid once institutional delivery occurs. This will ensure pregnant women have some money at hand for emergencies before she reaches institution for delivery. Yet another issue is regarding the role of ASHA in activities where she is not being paid (e.g. postnatal visits). Appropriate mechanism needs to be devised so that ASHA is motivated to do the complete range of MCH services, whether she is paid for all such services or not.

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

- The IEC would focus on communicating the benefits of institutional delivery, benefits under JBSY scheme, danger signs to be taken note of and location of functioning FRUs where such cases can be treated.
- Equip the ASHA network to reinforce the IEC messages through IPC interventions at village / community level.
- Provide incentives to ASHA for every institutional delivery achieved in her village / designated area.
- Involvement of PRIs for JBSY scheme to monitor and generate awareness for institutional delivery.
- Home deliveries are still prevailing in villages where untrained traditional dais are involved. These deliveries seldom get reported also. The Dai delivery kit will be provided to all dais who will be identified through ASHAs. All home deliveries will be reported by ASHA to ANM.

Operationalisation of FRUs

As of now two FRUs are existing in Gaya; one in Shergatti and another in Dumaria. The FRU in Sherghati is functional but the one in Dumaria is defunct. Again, Dumaria is a place where access is difficult because of poor condition of roads and infestation of naxals. It is hence proposed that; one, the FRU in Shergatti be strengthened and second; the Lady Elgin hospital, which is located in Gaya be developed as FRU.

Please refer to table on FRU in Tables list.

For each facility an additional HR requirement as per table below is proposed.

HR	**Additional Requirement (2010)**	**IPHS norms to be fulfilled by 2012**
Doctors (MBBS)	4	
Paediatrician	2	
Gynaecologist	2	
Anaesthetist	2	

ANM	6	
Staff Nurse A grade	4	

Activities

- The grade A nurses for Sherghati FRU will be mobilised from Dobhi PHC. For Lady Elgin new recruitment would be required. Equipments for Blood Storage centre has already been purchased in Sherghati, Lady Elgin and Pilgrim hospital. The unit will run through PPP.
- Private Anaesthetist will also be brought in to serve in FRUs.
- Currently C-sections are conducted only in Lady Elgin. But infection control protocols needs to be strengthened.
- All complicated delivery cases gets referred to medical college. The FRUs will be strengthened to cater to complicated cases also.
- Training of Lab technicians / staff nurse in blood storage, grouping, cross matching and management of transfusion reactions.
- Construction work in Shergatti is going on. In Lady Elgin lot of renovation work needs to be done. The running water supply and functioning of toilets are primary. (So in budget renovation is shown only for Lady Elgin). Both the centres require to buy equipments for labour room and operation theatre.
- Blood is to be made available free of cost to all pregnant women
- Health facilities may be graded as women and child friendly hospitals
- Community mobilization for voluntary blood donation — ASHA Diwas / meeting / Mahila Mandal meeting / PRI meetings will be used for dissemination of information – NGO partners in awareness campaign as well as mobilising the voluntary donors.

Operationalisation of 24x7 facility at the PHC level

As of now 17 PHCs are offering 24*7 services. In 2010 we propose to operationalise 5 more PHCs and 2 APHCs to be offering 24*7 services.

Activities

- Training of MOs and Staff Nurses of PHCs in EmOC
- Appointment of at least 3 Staff Nurse in each PHCs
- Repair and renovation of PHCs
- Timely supply of PHC kits
- Training of ANMs on SBA
- Provision of labour room, ward and lab facility
- Training of MOs / staff nurse on BEmOC Repair and renovations
- Appointment of lady MO, and Staff Nurses

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HR requirement for running 24*7 BPHCs

HR	Requirement per PHC (2010)	Total requirement for 22 PHCs	IPHS norms to be fulfilled by 2012
EmOC trained doctor	3	66	
Trained Anaesthetist	1	22	
ANM	6	132	

For the posts of Surgeon, paediatrician, gynaecologist and anaesthetist sanctioned posts are currently been filled by general MBBS, since specialist are not available. PHC level Panchayat Committee will be encouraged to participate in the functioning of 24 x 7 PHC. Since it will tax much to have residential buildings available in every PHC, it is proposed

that a rest cum relax room for duty staff be provided in the premises. However, provision for residential facility is recommended for Paraiya, Fatehpur, Dumariya, Imamganj, Wazirganj & Atri.

Inorder to operationalise APHCs, one AYUSH doctor per APHC needs to be appointed. The medical doctor who is currently in APHCs can be deployed in BPHCs.

Operationalise Sub Centres

Residential quarters for ANM are preliminary for strengthening of sub centre. Currently none of these exist. Another requirement is that the ANM should be available either in Sub Centre or in the village 6 days a week. A chart of the daily work expected out of ANM would be printed and pasted on the Sub Centre. Ensuring availability of adequate drugs is another issue. ANM and ASHA, with the active support of PRI will conduct councelling services in the village on various health and nutrition issues, hygienic practices, environmental sanitation, primary health care etc. In Gaya VHND are not conducted. Mahila Mandal meetings are conducted where VHND services are being provided. A calendar of Mahila Mandal meetings will be planned in advance for the year (third Friday every month). ASHA will do priority mapping on pregnant women, malnourished children, newborns, Mahadalit Tola etc. and focus will be laid on those areas.

Safe abortion services at health facilities

Activities

- To prepare E-list of MTP practitioners.
- Support for IEC /BCC mobilisation
- Training of MO and ANM
- Awareness drives will be undertaken in the community regarding availability of MTP services, consequences of sex selective abortions and PNDT act.
- Drugs & procurement for MTP will be provided.
- To built awareness on MTP a co ordination programme in rural and urban areas will be conducted.
- A quality improvement programme to strengthening the societies for MTP

- It is proposed that the facility be made available at District hospital & FRU Sherghati. Those will be developed to be model centres.
- Strengthening of Comprehensive abortion care services of Sadar hospital. Currently no centre in Gaya is providing MTP services.
- Training to include MTP, legal operation aspect of MVA etc.
- Formation of District level committee to accredit private providers /sites
- Exploring possibilities on PPP mode for Safe Abortion Services esp. in hard to reach areas like Dumaria, Tikari etc. Private providers will be accredited who will then provide abortion services.
- Develop reporting system from public sector as well as private.
- Pregnancy testing services should be provided at all HSCs, and BPHCs. It is done in some APHCs also. This service may be linked with MTP services as well. ASHA has already been be trained by an NGO called Nishyay.

Referral Support system

- The issue to be addressed is the absence of pick-up service of pregnant women. The women has to make arrangement for transport and a travel reimbursement Rs.200/- is given irrespective of the actual amount spent on travel.
- Provision of referral transport system to refer patients from home/HSCs/PHCs to referral centres. (102 ambulance service is available as of now)
- Monitoring of referral transport system
- Development of proper referral system between Health Institutions.
- Fill vacant ANM posts and appoint additional ANMs in a phased manner to achieve GOI norm of one ANM per 5000 population by the year 2010.

Objective. 5

Reduce incidence of RTI/STI

Now a days this facility is being provided only in Medical colleges and Sadar hospital. The FRUs is presently proposed to offer these services.

Strategies

- Ensuring early detection through regular screenings and contact surveillance strategies.
- Strengthening the infrastructure, service delivery mechanism and capacity of field level staff for handling of RTI / STI cases.

Activities

- Early diagnosis of RTI / STI through early detection of potential cases through syndromic approach and referral by ANM and ASHA.
- Integrated counselling services will be provided
- Conducting VDRL test for all pregnant women as part of ANC services.
- Implementing contact surveillance of at risk groups in convergence with Bihar AIDS Control Society.
- Conducting community level RTI / STI clinics at PHCs
- Training to all MOs at PHC / DH level in Syndromic Management of RTI / STI cases in coordination with Bihar AIDS control Society
- Training of frontline staff, LHV, ANM and ASHA in identifying suspected cases of RTI / STI in coordination with Bihar AIDS Control Society.
- Strengthening RTI / STI clinic at the FRUs
- Counsellor and doctor will be required in both FRU. It is proposed to involve specialist doctors in Skin & VD from private sector, who could offer services in FRUs.

IEC

- Public awareness through IEC in highway (e.g. GT road)

- For prevention of RTI/STI condom distribution by ASHA
- Training – Doctors, Para Medical Staff, Counsellors, ANM, ASHA AWW should be trained. Most of the RTI / STI problem can be then sorted out at village level.
- Procurement of Drugs & Equipment for treatment of RTI/STI
- To improve access to RTI /STI at referral Hospital
- Referral Hospital and District Hospital will be strengthened for diagnosis and treatment of RTI/STI
- At district level RTI/STI management by NACO includes awareness programme by way of Red ribbon express, road show, etc. A counsellor is provided by BSACS in district hospital, and medical college has facility for ELISA test. The cases are referred from OPD to VCTC for counselling.

CHILD HEALTH

High levels of maternal malnutrition and low levels of female literacy, particularly in rural areas increase risk of child mortality. Failure of family to properly plan their family in matters related to delaying and spacing of births leads to significantly high mortality among children. Failure of programme to effectively promote breastfeeding immediately after birth and exclusive breastfeeding is yet another factor affecting IMR. A high level of child malnutrition, particularly in rural areas and in children

belonging to disadvantaged groups adds to the problem. The Anganwadi centre and Sub Centre often lacks drugs, ORS packets, weighing scales, etc. The plan for child health takes these factors into consideration.

Objectives

- **To reduce IMR (target – from 59[1] to 45 by 2010)**
- **To reduce child mortality rate**
- **To reduce malnutrition among children**
- **To reduce the prevalence of anaemia among children**

Strategies (cross cutting across objectives)

1. Promote immediate and exclusive breastfeeding
2. Appropriate infant and young child feeding
3. IEC
4. To strengthen neonatal care services in all PHCs/CHCs/SDHs
5. Strengthen essential newborn care at home
6. Full immunization of Children
7. To reduce morbidity and mortality among infants due to diarrhoea and ARI
8. Special care neonatal care unit

Strategy

Promote immediate and exclusive breastfeeding

Activities

[1] Infant and Child death, District level estimates, PFI, May2008.

1. Use mass media to promote breastfeeding immediately after birth (colostrums feeding) and exclusively till 6 months of age.
   (a) Production and broadcast of radio spots, jingles, folk songs and plays promoting importance of correct breastfeeding practices
   (b) Production and broadcast of TV advertisements and plays on correct breastfeeding practices
   (c) Publication of newspaper advertisements, booklets and stories on correct breastfeeding practices
2. For ensuring breast feeding Health Manager would be responsible to monitor every patient before discharge. He /she would be required to mention the breast feeding status on BHT and in delivery register. Medical Officer will enter status of mother and baby and status of breast feeding in the delivery register.
3. Involve frontline Health workers, Anganwadi Workers, PRIs, TBAs, local NGOs and CBOs in promoting correct breastfeeding and complementary feeding through IPC, group meetings, folk media and wall painting.
4. Educate adolescent girls about correct breastfeeding and complementary feeding practices through school -based awareness campaign.

Strengthening community awareness through IEC/BCC on Malnutrition

1. Regular house visit by ANM / ASHA. A check list will be prepared by PHC and with the help of check list ANM or ASHA will visit the house, and counsel the pregnant women, eligible couple and lactating mother.
2. Identity the villages where the prevalence of Malnutrition grade III and grade IV are high.
3. Severe Malnourished children will be referred to health facilities by AWW & ASHA
4. During weekly meeting in PHC at least one (on 2nd Tuesday) meeting in every month would be focused on any health topic. This will be delivered by the MO and topic will be suggested by Health Manager.
5. Device appropriate interventions like the nutrition requirements of children in the age group of 5 to 6 years and the possible support being provided by the AWC.

6. With the help of ICDS Officials and PRI BCC Activity would be organized in villages (through posters, banners and wall writing of the messages)
7. De worming tablets will be distributed among children of Middle School, low socioeconomic area (frequency 6 months)
8. Growth monitoring of each child
   (a) Supply of spring type weighing machine and growth recording charts to all ASHAs, AWWs. All ASHAs, Anganwadi centres and sub centres will have a weighing machine and enough supply of growth recording charts for monitoring the weight of all children.
   (b) Weighing and filling up monitoring chart for each child (0-6 years) every month during VHNDs/Mahila Mandal Meetings
   (c) Each child in the village will be monitored by weight and height and records will be maintained
   (d) Training for indications of growth faltering and SOPs for referral to AWWC for nutrition supplementation and to PHC for medical care.
9. Establishment of Nutrition Rehabilitation Centres (2) in blocks having severe problems of malnutrition. The tendering process for NRC is on.

Strategy

To strengthen neonatal care services in all PHCs/CHCs/SDHs by setting newborn care centres

Activities

1. Home based neonatal care will be done by ANM of respective HSC. This will be monitored by LHV
2. Build state IMNCI training pool – inadequate monitoring of this activity at field level is an issue. Local Resource Persons can be roped in to ensure community based monitoring.
3. Care of babies by “MAMTA” and ANM needs to be ensured. Training of MO and staff nurse in IMNCI / operation of baby warmer machines. Fixing a day in a week for IMNCI related work at HSC level.
4. (Re) train health and ICDS staff in IMNCI protocols

5. Ensure implementation of IMNCI clinical work following training
6. Community Awareness on home-based care of new born (skin-to-skin contact, bathing after a week, not removing vermix, etc.); early recognition of danger signs - ARI, diarrhoea; proper weaning practice
7. The ASHAs / MPWs / AWWs at every point of contact for ANC and PNC will reinforce tenets of home-based care of new born as per IMNCI guidelines. The training will be part of IMNCI.
8. Capacity building in the area of facility Based newborn care

Full immunization of Children

1. Ensuring cold chain maintenance
   (a) Ensure ILR and Deep Freezer are available in appropriate number in every PHC.
   (b) Cold chain handler to ensure by way of regular check up of ILR & Deep freezer.
2. Conduct fixed day and fixed-site immunisation sessions according to district microplans.
3. Update district microplan for conducting routine immunization (now Muskan Ek Abhiyan) sessions
4. Ensure timely and adequate supply of vaccines and essential consumables such as syringes, equipment for sterilisation, Jaccha-Baccha immunisation cards (card is issued after registration of pregnant women), and reporting formats at all levels.
5. Supply AD Syringes to conduct outreach sessions in select areas.
6. Enlist help of AWW/ASHA in identification of new-borns and follow-up with children to ensure full immunisation during sessions. New Born tracking system to be implemented through Muskan by way of tracking register
7. Replace all Cold Chain equipment, which is condemned, or more than five years old in a phased manner and supply new Cold Chain equipment based on analysis of actual need of the health facilities
8. Build capacity of immunisation service providers to ensure quality of immunization services.
9. Provide comprehensive skill upgradation training to immunisation service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.
10. Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunisation services

11. Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment

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

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

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

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

16. Strengthen Supervision and monitoring of immunization services
    - Build capacity of Medical Officers, MOICs and DIOs in supervision and monitoring of implementation of immunisation services as per the micro-plan.
    - Provide mobility support to MOICs and DIOs for supervision and monitoring of implementation of immunisation services.
    - Develop effective HMIS to support supervision and monitoring of implementation of immunisation services.
    - Coordinate with representatives of PRI to strengthen supervision and monitoring of immunization services.

Strategy

To reduce morbidity and mortality among infants due to Diarrheoa and ARI

Activities

1. Increase acceptance of ORS by awareness generation by ASHA
2. The ASHA drug kit will have ORS (with Zinc) and cotrimoxazole tablets which would be replenished as per need. Anganwadi centres should also be given ORS. In the absence of ORS, the use of home-based sugar & salt solution will be encouraged.
3. ASHAs will be specifically trained to identify symptoms of Diarrhea and ARI and to provide home-based care. Danger signs requiring transportation to seek medical care will also be taught to ASHAs.
4. ASHA and AWW will be trained in providing Home based care. The training will be held at Block PHC level.
5. Strengthening of referral services for infants seeking care for life threatening diarrhoea and ARI

6. Vitamin A supplementation, and 6 monthly de-worming

ADOLESCENT HEALTH

Objectives

1. To improve adolescent Health
2. To reduce anaemia.

Strategies

1. Adolescent friendly Health Clinics
2. Increase awareness levels among adolescents on health issues.

Activities

1. Adolescent friendly Health services will be conducted in every PHC
2. MTP services to be provided in both FRUs (Sherghati and Lady Elgin)
3. Integrated councelling on breast feeding, Nutrition, birth preparedness, iodine, HIV, RTI/STI
4. HIV counselling be started with the help of Bihar State AIDS Control Society
5. Mahila Mandal Meeting would also be organised at VHDS. Currently Mahila Mandal Meeting's are not following a structured format. So, it is proposed that topics like Adolescent Health, Nutrition, restriction of under 18 marriage etc. are discussed in such meetings.
6. Organise regular adolescent clinics/counselling camps at SC / PHC / CHC / SDH / DH
7. Adolescent health sessions/clinics will be held in each Sub Centre/ PHC / CHC/SDH and DH with service delivery & referral support

8. Risk reduction counselling for STI/RTI. ASHA/AWW to act as nodal persons at village level for identifying & referring adolescents in need of such services.
9. All ASHAs and AWWs will be oriented on problems faced by adolescents, signs and symptoms of the problems and where to refer the cases.
10. Nukkar Natak – 100 sessions are planned for the year 2009-10.
11. Premarital counselling on reproductive health issues at PHC/RH/SDH/DH
12. IEC / Counselling – on Prevention of adolescent pregnancy, general health, sex, legal age of marriage, anaemia, and safe abortion services
13. Adolescent pregnancy should be addressed with priority care esp. Eclampsia, provision of IFA tablets, ensuring 3 ANC visits, conducting institutional delivery, postnatal care etc.

FAMILY PLANNING

Objectives

1. **Reduce TFR**
2. **To increase Contraceptive Prevalence Rate**

Strategies

- Permanent methods to be provided in all 24 x 7 PHCs
- Awareness generation in community for small family norm
- Promote male sterilizations
- Promote Spacing Methods
- Promote Post abortion contraception and postpartum tubectomy

Permanent methods to be provided in all 24 x 7 PHCs

Activities

a. Tubectomy & vasectomy services to be provided in every 24 x 7 PHCs.
b. Supplies and equipments for providing permanent method will be purchased.
c. MO- Skill up gradation for permanent method.
d. Private providers are accredited (7) who are currently providing sterilization services

Awareness generation in community for small family norm

Activities

1. Communication materials highlighting the benefits of a small family will be prepared for radio, TV and newspapers.
2. Regularise supply of contraceptives in adequate amounts through proper Indent and supply of contraceptives for all depots and subcentre/ AWCs and social outlets
3. Each AWC and ASHA will have at least one month's stock requirement of condoms and OCPs. Sub centres will have adequate supplies of IUDs also.

Promotion of male sterilizations

Activities

1. NSV /Promotion – Family planning worker will motivate the male for NSV. Where (in Health Sub Centre) Family planning worker is not available NGO Partners will performs the work. In Gaya District, there are 439 HSC, AND only 30 Family planning workers are working.
2. NSV camps will be organised in PHC where in NGO / Private Providers cooperation will be invited in conducting the camps as well as motivating the beneficiary.

3. Use of mass media to promote family planning practices
4. Increased demand for NSVs through Village level meetings in which men who already underwent NSV share experiences to motivate men to undergo NSV. All the GP Villages will be chosen in the district to hold meetings in which men who have undergone NSV will tell male members of the community about their experience and the benefits of NSV. These meetings will be repeated every month. NSV will be conducted on the motivated men. The same men will then be requested to share their experiences in the next batch of five villages for the next three months.
5. Dissemination of manuals on sterilization standards & quality assurance of sterilization services. The guidelines will be provided in Hindi.

Strengthening of District Programme Management Unit

- District / Block level managers would take part in the PPP contracts and negotiate on TOR
- Capacity building of District / block managers in epidemiology through distance learning mode
- Networking of all relevant NGO's in the area will be done by Block level managers
- Exposure visit of DPM/BHM to other districts / states where model facilities are functioning
- Training of district / block health managers on the HMIS format

(Budget given separately)

PART B. Additionalties under NRHM (Mission Flexi Pool)

ASHA is one of the core strategies of National Rural Health Mission implementation plan in Gaya, Bihar. ASHA is the female health activist who would promote access to improved health care at household level. Selection of Asha started in 2006 and the total target of selection of Asha was 2997 in the District out of this 2780 have already been selected. Remaining 217 Asha would be selected in 2009 – 10. The training of 2nd & 3rd Modules would also be completed in 2009 – 10.

Streamlining the working and incentive payment of ASHA

1. For easy identification and authentication, an Identity Card with photograph had been provided to each ASHA.
2. In every PHC of the District Asha Divas is being conducted every month. Asha Divas is conducted twice month i.e. 1st & 3rd Thursday.
3. Various incentives are being given to ASHA on time. i.e. incentives for JBSY, Muskan Ek Abhiyan, motivating for sterilization, and as Vaccinator in Pulse Polio.
4. Asha is working as a mobilizer to strengthen Institutional delivery.
5. Asha is also working to mobilize the woman (Pregnant) as well as children to increase number of immunization

Untied Fund For HSC

The objective is to facilitate meeting of urgent yet discrete needs that require relatively small sums of money at Health Sub Center level. In 2009 – 10 Rs. 10000/- will be given to all 439 +102 (new) = 541 health sub centre.

Village health & sanitation committee would be formed in every village in (2009- 10). Guidelines regarding the same would be made available in each village.

The suggested areas where Untied Funds can be used would be discussed with PRI and ASHA. Block Health Manager would be entrusted to make sure that the money is spent.

1. Curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;

2. Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
3. Purchase of consumables such as bandages in sub center;
4. Purchase of bleaching powder and disinfectants
5. Supplies for environmental sanitation (larvicides)
6. Payment/reward to ASHA for certain identified activities.

Untied fund for PHC & APHC

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

46 APHC+ 27(New) = 73

24 PHC = 24

Annual Maintenance grant for APHC & PHC & Subcentre

Rs. 50000 will be given to every APHC & PHC (73 APHC + 24 PHC=97) in 2009-2010.

Up gradation of CHC to IPHS

7PHCs would be up graded to Community Health Centre in (2009-10)

Water, Sanitation, Electricity, toilet facilities etc. will be provided in 7 CHC in 2009-10 & the health facilities would be raised to the standard of IPHS by 2012.

Mobile Medical Unit

Eligibility criteria in appearing for tenders has often found to be a hindrance, for interested parties and hence a relaxation of this criterion (Financial) may be suitably effected.

Publicity of Mobile Medical Unit services would be done

Requirement of HR (Specialist, MO, Nurse, LT) and giving orientation to these staff is a priority.

Mobile phones have already been given to all MOICs in the PHC.

Rogi Kalyan Samiti

RKS have been set up in all the BPHCs. RKS meetings have also been conducted in most of the places except in Mohra, Tan Kuppa and Town Block. In these 3 facilities, funds were also not been utilised.

(budget given separately)

Part C. IMMUNIZATION

Complete Immunization among children in the age group 12-23 months is 41.4%. The immunization rate among various categories is given in the table below.

Child Immunization: Gaya[2]

Category	Total	Rural	Urban
Number of children age 12-23 months	6,967	6,515	452 5
Children 12-23 months fully immunized (%)	41.4	41.4	41.2
Children 12-23 months not received any vaccination (%)	16.7	16.7	17.9
Children 12-23 months who have received BCG vaccine (%)	81.5	81.6	80.4
Children 12-23 months who have received 3 doses of DPT vaccine (%)	54.4	54.5	53.8
Children 12-23 months who have received 3	53.1	53.0	54.0

[2] DLHS 3

doses of polio vaccine (%)			
Children 12-23 months who have received measles vaccine (%)	54.2	54.1	55.8
Children (age 9 months and above) received at least one dose of vitamin A supplement (%)	49.9	49.6	53.4

Objectives

Reduction in the IMR *(target – 59[3] to 45 per 1000 live births)*

100 % Immunization of children

Issues

1. The number of access compromised villages in Gaya would be 241, which is spread in 15 out of the 24 blocks. In such areas special outreach camps (4 per year) can be organized.
2. Regular & timely supply of vaccines especially at PHC level. (DPT and Polio vaccines are given together. But due to delay in delivery of DPT vaccines, children end up not having the DPT vaccine. In fact, in a year around 8 to 10 rounds of Polio (S.N.I.D,&N.I.D) occurs & each polio program takes 5days [I day for A team, 1day for B team, preceded by 15to 20 days of planning (Making of Micro plan, orientation & training of supervisors, training of all vaccinators, Block level task force meeting, sub divisional task force meeting & finally district task force meeting in the presence of D.M. & district officers) followed by another 2or 3 days for submission of report & pack-up of the round. This way, on an average the pulse polio program takes up 224 to 280 days in a year which taxes the available human resources at the

[3] Infant and Child Mortality in India, District Level Estimates, PFI, May 2008

district level affecting routine immunization. A plan which makes use of Human resources to the best extent possible would be to do polio rounds with RI.

3. Release of Fund for Routine Immunization is not regular. Certain months it does not come and yet other times, DHS receives a lump sum for 3-4 months.
4. Incentive for courier is currently Rs.50/-. Recently this have been raised to Rs.75/-. This was a much awaited demand.
5. Training of ANM, ASHA, AWW, Health Managers, Cold Chain Handler and MOICs in R.I.
6. Sector wise monitoring for district level by district level officers (Sector in charge DIO, DPO, DMO & DPM).
7. Need of sufficient fund for monitoring.
8. Better Co-ordination between ICDS & Health department.
9. The Muskan programme is going on in Gaya district; two days in a week, (Wednesday in sub centre and on Friday in the AWC). The role of AWW on immunization day is to collect the mother and child for immunization and complete the due repot, administered report and summery report for the month. In Mahila Mandal meeting pregnant woman & lactating women are invited by AWW & ASHA. In that meeting importance of Immunisation, JBSY, FP & services provided by PHC are discussed. These meeting are held every 3rd Friday of the month.
10. Special focus on Mahadalit Tola
11. In rainy season communication & transport facility are virtually cut of specially in Barachati, Immamganj,Bakebazar,Pariya,Guraru,Dumariya,Atri,Mohara, and Mohanpur. In order to provide services in this area, suitable mechanisms will be devised jointly by PRI and NGO partners. Micro plan has already been made is available with the district.
12. Ensuring availability of vaccine courier, Ice pack, cold box (big& small) AD Syringe, RI card, Banner, Poster, Hubb cutter, PCN Tablet, ANM KIT, and IFA Tablets (small & large) and cold chain equipments (ILR, Deep freezer, stabilizer etc).

		REMARKS / SUGGESTIONS / ANY OTHER REQUIREMENT											
SI	LOCATION	D.F. Large	D.F. Small	ILR Large	ILR Small	Stablizer	Cold Box Large	Cold Box Small	Vaccine Carrier	IEC Pack	Vaccine Van	Hub Cutter	Safefy Box
1	District Head Quarters	2	2	2	2	8	12	10	400	4000	2	300	600
2	Atari	1	0	0	0	1	8	5	300	1000	0	100	152
3	Amas	1	0	0	1	2	4	3	150	500	0	50	80
4	Bodhgaya	1	0	0	0	1	7	8	200	500	0	100	186
5	Belaganj	1	0	0	1	2	6	6	200	1000	0	100	177
6	Barachatti	1	0	0	0	1	5	4	150	500	0	50	112
7	Bankebazar	0	1	0	0	2	5	4	150	500	0	50	100
8	Dumariya	0	1	0	0	1	4	5	100	300	0	50	100
9	Dobhi	0	1	0	0	2	5	4	100	300	0	50	118
10	Fatehpur	1	0	0	0	1	7	7	200	1000	0	100	225
11	Gaya Sadar	0	1	0	1	2	6	5	200	500	0	50	133
12	Gurua	0	1	0	0	1	5	5	150	500	0	50	143
13	Guraru	0	1	0	0	1	4	5	100	500	0	50	112
14	Imamganj	1	1	0	0	1	6	4	150	500	0	50	151
15	Khizasarai	1	0	0	0	1	5	6	200	500	0	100	143
16	Konch	0	1	0	0	1	4	7	150	500	0	50	156
17	Manpur	1	0	0	0	1	5	5	200	500	0	100	109
18	Mohanpur	0	0	0	0	0	6	4	200	500	0	100	161
19	N. Bathani	0	1	0	1	2	4	5	150	500	0	50	79
20	Paraiya	0	1	0	1	2	6	4	200	500	0	100	84
21	Sherghati	0	0	1	0	2	4	6	200	500	0	100	121

22	Tekari	1	0	0	0	1	6	4	200	500	0	100	210
23	Wazirganj	1	0	0	0	1	7	7	300	800	0	100	186
	Total	13	12	3	7	37	131	123	4350	16400	2	1950	3638

RCH PART "C" - **DISTRICT PROGRAMME IMPLEMENTATION PLAN: DISTRICT - GAYA. YEAR (2009-2010)**

1 District Profile

1.11	Total Population:	(2008-2009)	4128814	1.12	2009-2010	4232034

Estimated beneficiaries for 2009-2010

		a.Pregnant women	b.Infants (birth-1 year)			a. Pregnant women	b.Infants (birth-1 year)
1.13	Annual	136251	123864	1.14	Monthly	11354	10322

1.15	Total Community development blocks	24		1.22	Total Urban areas	Nagar panchayat, nagar Nigam, Nagar parishad. 4
1.16	Total Sadar Hospitals	3		1.24	Total Urban Hospitals and dispensaries	4
1.17	Total Subdivisonal Hospitals	0		1.25	Total PHC with Cold chain equipment	21
1.18	Total Referral Hospitals	2		1.26	Total PHC with no cold chain equipment	4
1.19	Total ICDS projects	25		1.27	Total Additional PHCs	73
1.2	Total Aganwadi centers	3334		1.28	Total HSCs	541
1.21	NGO Hospitals and centres undertaking RI with Govt vaccines		10	1.29	No of Medical colleges	1
1.3	**Key District functionaries**	Name		1.292	No fo Govt of India Hospitals (Miltilitary, railway, ESI, CGHS)	3

	Commissioner	Dr. K.P. Ramaiyya			
	District Magistrate	Sri Sanjay Kr. Singh			
	RDD (Health)	Dr. Arun Kr. Sinha			
1.31	Civil Surgeon	Dr. Prakirti Gupta		1.51 No of PHCs with Govt generator in running condition	0
1.32	Additional Chief Medical Officer	Dr. Dinbandhu Sharma		1.52 No of PHCs with outsourced generator	20
1.33	District Immunization officer	Dr. Sridhar Upadhyaya		1.53 No of PHCs with power supply > 8 hrs daily	6
1.34	District Program Manager	Pawan Kumar		**Please give the information below in "Yes" or "No"**	
1.35	District Accounts Manager	Santosh Kumar		1.61 Whether DIO regular or in-charge	In Charge
1.36	District Data Asisstant	Alok Kumar		1.62 Whether Govt Vehicle available for DIO	No
1.37	RIMS Data Operator	N.A		1.63 Whether vaccine van available for District	Yes (Need Reparing)
1.38	Urban RI Nodal officer	Dr. Sridhar Upadhyaya		1.64 Whether Vaccine van in fuctional condition	No
1.39	WIC/WIF store manager	N.A		1.65 Whether RIMS data operator available	No
1.4	District Cold chain keeper	Gopal Prasad Gupta		1.66 Whether RIMS data operator received training	No
1.41	District Cold chain handler	Ashok Kumar Sinha		1.67 Whether RIMS installed and functional	No

2 Training in Immunization

(*Training means formal organised training on Immunization as per directions from SHSB in 2007-2008)

2.1 **Trainers**

	a.Name of trainers		c.Designation	Whether received training of trainers
2.11	**Dr. Madhusudan Prasad**		**MOIC**	**Yes**
2.12	**Dr. Rajendra Chaudhry**		**MOIC**	**Yes**
2.13	**Dr. Ijraul haq**		**MO**	**Yes**
2.14	**Dr. Sridhar Upadhyaya**		**DIO**	**Yes**
2.15				
2.16				

2.2 **Trainees**

	aTotal Number in District	bNm trained in Immunization*	c.Nm needing training*
Deputy Superintendants	1	0	1
Medical Officers in charge	22	2	20
Medical Officers	116	1	115
Contractual Medical Officers	71	0	71
CDPOs	25	0	25
ICDS Supervisors	15	0	15
Block Health Managers	19	0	19
Total Officers and Managers	**269**	**3**	**266**

LHVs	26	15	11
BHWs and other male Health workers	112	68	44
ANM-Regular	539	430	109
ANM-Contractual	338	29	309
Alternate Vaccinators	0	0	0
Total Health workers	**1015**	**542**	**473**

Cold Chain Handlers	**25**	**0**	**25**

ASHA	2997	0	2997
Anganwadi workers	3334	0	3334
Anganwadi Helpers	3334	0	3334
Total Mobilisers	9665	0	9665

2.3 Training Budget for (Remaining) Health workers training in Immunization

	Activity Head	Norm	Requirement for year 09-10	Justification / Rationale
2.31	No. of Trainers	3 trainers per district	**6**	2 Batch Per Day
2.32	No of training batches	30 persons per batch	**16**	30 x 16 Batches
2.33	Honorarium plus TA for Participants	Rs. 250 for 2-day training	**118250**	
2.34	Honorarium for Trainers	Rs. 600 for 2-day training	**57600**	
2.35	Contingency	Rs. 100 participant per day (incl of refreshments, venue, TV/LCD hiring and logistics	**94600**	
	Total		**270450**	

4 Budget requirement for Muskaan ek Abhiyaan

S No	Activity Head	Norm	Requirement for year 2009-2010	Remarks
A	Incentive money			
	For ANMs	Rs 150/- per month per AWC for 12 months	6001200	
	For AWW	Rs 200/- per month per AWC for 12 months	8001600	
	For ASHA	Rs 200/- per month per AWC for 12 months	8001600	
B	Mahila Mandal	Rs 250 per AWC	10002000	**200 Per AWW As per letter No. 3004, Dated-23.12.08**
	Total for Muskaan ek Abhiyaan		**32006400**	

5 Budget details and requirement Regular RI

S No	Activity Head	Norm	Requirement for year 09-10		Justification / Rationale
A	**Printing activities:Reporting and Recording Formats**				
	All RI formats	Rs 4 per beneficiary (pregnant women)	**545004**		
B	**POL for cold chain**				
	At WIC/WIF	Rs 600 per day	**0**		
	At District	Rs 300 per day	**109500**		
	At PHC	Rs 400 per day	**3504000**		
C	**Vaccine and Logistics Mobility**				
	For WIC and WIF points	Purnea Rs 10000 per month, Bhagalpur , Darbhanga, Motihari and Aurangabad Rs 8000/-per month, Sran and Muzaffarpur 6000/- per month	**0**		
	For Districts	Rs 5000 per month	**60000**		
	For PHC	Rs 1500 per month	**432000**		
D	**Mobility for Supervison**				
	For RDD	Rs 5000 per month	**60000**		
	For DIO	Rs 4000 per month if Govt Vehicle is functional , Rs 10000 if Govt vehicle is non functional/ not available	**120000**		
E	**Usage of Courier**				
	For APHC and HSC	Rs 50 per session day per APHC and HSC	**322350**		
	For Urban sessions	Rs 50 per Vaccinator per session day	**168000**		
F	**Hiring of Computer operator at district level for RIMS**	Rs. 5000 * 1 person * per districts	**60000**		
G	**Catch up campaigns(subject to approval by GOI)**				

1	Measles Campaign for pilot in select districts	Detail annexure 1		**4684579**	
2	Hard to reach areas strategy	Detail annexure 2		**12270**	
3	RI catch up campaign	Detail annexure 3		**2449626**	
H	**Other separate activities proposed under RI (subject to approval)**				
1	**One day RI training for Total Anganwari**	**=3334 AWC *150 = 500100**		**500100**	**Need to training of all AWW**
2	**One day RI training for Total ASHA**	**=2997 AWC *150 = 449550**		**449550**	**Need to training of all ASHA**
3	**One day RI training for Total CDPO**	**=25 CDPO *200 = 5000**		**5000**	**Need to training of all CDPO**
4	**One day RI training for Total Cold Chain Handler**	**=25 CCH *100 = 2500**		**2500**	**Need to training of all Cold Chain Handler becouse all Handler are new.**
5	**One day RI training for Total BHM**	**=22 BHM *200 = 4400**		**4400**	**Need to training of all BHM**
	Total for Regular RI activities			**13488879**	

6 **Annexures**

Annexure 1

6B Hard to reach areas strategy

(For villages difficult to access all the year through, 4 outreach sessions can be planned in a year, additional only mobility support to teams can be budgeted for this activity and remaining expenses arranged from regular RI funds.)

Number of Access compromised villages	241
Number of Block with Access compromised areas	15

a	b	c	d=bxc
Type of Mobility	Estimated Cost per Unit per day of use	Number needed for 1 session day in all hard to reach villages combined	Total costs for 4 sessions
Tractor	650	40	26000
Jeep / vehicle	650	100	65000
Motor Cycle	300	101	30300
Labour	100	14	1400
Total	**1700**	255	**122700**

Annexure 2

6C RI catch up campaign

Number of Round if any to be decided according to directions of GOI

Activity	**Norm**		**Expenditure**	**Remarks**
No of teams formed	1 vaccinator to form 1 team	APHC + HSC = 614		
District task force meeting	1 per district	Rs 1000 per district	1000	
Ice pack freezing	4 icepacks per team for 7days	@ Rs 3 per ice-packs	51576	614*7 Days*4*Rs.3
Vaccine & Logistic Mobility	For WIC/ WIF points	Rs 5000/-	0	
	For Districts	Rs 2500/-	2500	
	For PHCs	Rs 1750/- per PHC	42000	24 PHC*1750

Usage of Couriers (Alternate Vaccine Delivery)	1courier per team for 14 days	Rs 50 per courier per day	92100	614*7 Days*Rs.50
Vehicle/boat/tractor/labour for teams for Hard to reach activity	1 vehicle for 2 teams for 4 days	Rs 650/- per vehicle per day	798200	614/2*4*650
Perdiem for workers and mobilisers	3 days per ASHA and AWW	Rs 50 per person per day	949650	(3325+2997)*3Days* Rs. 50
Perdiem for workers and Vaccinators	7 days per trained vaccinator	Rs 75 per person per day	322350	614*7 Days.*Rs.75
Perdiem for Supervisors	1 supervisor per 3 teams for 7 days	Rs 100 per person per day	143500	(614/3) 205 Super.*7Days.*Rs.100
Alternate vaccinators	Number of trained manpower available Vs shortfall	Rs 100 per person per day	0	
Miscellenous & Contengencies etc.	for entire activity	Net Rs. 1750/- per block and Rs3000/- district	46750	24 PHC*1750+3000
Total for 1 round of catch up			**2449626**	

PART D. DISEASE CONTROL PROGRAMMES

National Vector Born Diseases Control Programme

Malaria

Malaria is a important public health issue in the district. PHCs like Amas, Mohanpur, Gurua, Barachatti, Sherghati and Dumaria are the worst affected places. And in those areas cerebral malaria cases have also been reported. Malaria is also linked to poor sanitary conditions, and lack of DDT Spray. In Some of the areas DDT Spray is being carried out but it requires intensive intervention. Anti Malarial Drugs are available in the PHCs. During rainy session special camps should be organized to detect malaria cases so that they may be treated promptly. Lab surveillance needs strengthening and blood slide collection should be increased.

Malaria scenario:

Item	Number
1. No. Of slides collected	15312
2. Blood examination conducted	24186
3. Malaria positive	125
4. Cases treated	119

Activities

Facility Level

- Selective insecticide spray operation in areas having incidence of malaria of 2 or more cases per thousand population per year for regular rounds of spray.
- Decentralization of malaria laboratories of PHCs for Early Detection & Prompt Treatment of cases.
- Ensuring continuous availability of anti malarial drugs at facility level

- Establishment of drug distribution centres & fever treatment depots where anti malarias will be available.
- Provision of disinfectant mosquito nets.
- Blood slide examination of all febrile children with presumptive treatment

Community Level

- Anti malarial drugs shall be made available through Panchayat, Post Offices.
- Eliciting public cooperation through voluntary agencies.
- Initiating trainings & workshops for creating understanding among the community regarding the disease.
- Involving Village health sanitation committee for ensuring cleanliness in the community.
- In endemic areas, most children are anaemic due to repeated bouts of malaria. Any febrile child needs to be checked for malaria compulsorily.

Filariasis

Filarial cases even though very less, have been reported from Gaya district. As of now a total of 15312 slides have been collected and 705 cases have been treated.

Early detection and prompt treatment, Mass Drug Administration and appropriate IEC strategies would be helpful in addressing this menace.

Japanese Encephalitis

JE is the next important public health issue in the Dist. Incidence of JE has been reported in the Gaya Dist. On 10th January 2009, a district level review meeting was convened by ACMO and attended by representatives from WHO, UNICEF, all MOIC, DIO, DPO DMO, Health managers attended. It was decided that a Micro plan for vaccination of JE would be made by every PHC.

Revised National Tuberculosis Control Programme (RNTCP)

Objectives

1. Case Detection Rate - 70%
2. Cure Rate - 85%

TB is a big public health problem in the district. Poverty, and Crowded areas have added to the increase of prevalence of TB in the District. Gaya district has been included in the RNTCP program and Anti-TB drugs are available. (Please refer to table.10 in Annexure). A total of 1567 patients are on the regimen now.

Facility Level

- Ensuring continuous supply of medicines & health education at PHC, CHC & HSC level.
- Making DOTS centres available at underserved areas.

Community Level

- Involvement of PRIs members, religious leader for motivating TB patients for seeking treatment.
- Involvement of NGOs for tracking of suspected TB cases.

National Leprosy Eradication Programme (NLEP)

- Though the number of cases of Leprosy has gone down still Leprosy control program needs to be carried out intensively. As of now 830 patients are undergoing treatment in Gaya district for leprosy. International Agencies like DFID & WHO needs to review the progress of the program, laying stress on Drug Compliance as well as rehabilitation program.
- Gaya District Is implementing the NLEP but an increased level of coordination is required among the NLEP & PHC staff.

- To strengthen the close monitoring and supervision at District & PHC level of the Non-medical Assistant (NLEP) by Health Managers
- Development of referral system to deal with complication of leprosy also needs to be operationalised.

National Blindness Control Programme (NBCP)

Objective : To reduce prevalence of trachoma / preventable blindness

Facility Level

- Increase Cataract operation performance with priority to bilateral cataract blind patients. A total of 32141 cataract operations were conducted last year.
- Base Hospital approach
- Strengthening District Hospital FRU by providing equipments, separate ward, operation theatres and OPD facilities.
- Development of permanent eye care centers at PHC, providing diagnostic and operative equipment.
- Mobile Units to serve in underserved areas
- Organization of Eye checkups camps at PHC level.
- Treatment of trachoma cases and BCC on hygiene and eye care

Community Level

- Active involvement of NGOs linking with district Hospitals
- Organization of Eye donation camps with the help of NGOs
- Partnership with Private practitioners for eye checkup camps & cataract operation at PHC level.
- Eye checkup camps at Schools with the help of PRIs, teachers & MO PHCs and Screening for refractive errors of children along with school health programme

Iodine deficiency diseases control program (IDDCP)

Integrated Disease Surveillance Program (IDSP) is intended to be the backbone of public health delivery system in the District. It is expected to provide essential data to monitor progress of on- going disease control programs and help in optimizing the allocation of resources. It is intended to detect early warning signals of impending outbreaks and help initiate an effective and timely response. IDSP will also facilitate the study of disease patterns in the District and identify new emerging diseases. It will play a crucial role in obtaining political and public support for the health programs in the District.

Activities

- Operationalisation of District Level Task Force under the chairmanship of Civil Surgeon with heads of different supportive person like ANM, ASHA, and Health Staff.
- Formation of District Level Co-ordination Committee of supportive department like ICDS, Education/General Administration, NGO.
- Monitoring of Quality of Salt.
- Distribution of Salt Testing Kits (STK).
- Analysis of Iodized Salt Samples tested with STK

  (budget given separately)

PART. E CONVERGENCE

Nutrition

Anganwadi Centre (AWC) functions one day in a month as a centre where children (0-6 years) are being provided with nutrition and health services. The AWC would continue to serve as the focal point for all health and nutrition services. As part of NRHM, a Health Day is proposed to be fixed every month at the AWC to provide antenatal, postnatal, family planning and child health services. An ANM and preferably a Medical Officer from the PHC will be available. With active support from Community Groups such as Self Help Groups (SHGs) to motivate the AWW and ASHA women and children would be motivated to access services. Services to be provided on the Health Day (by the ANM or PHC

MO) would include ANC, Newborn check up, Postnatal Care, Immunization of mothers and children, IFA and Vitamin A administration, growth monitoring, treatment for minor ailments, and health education. AWW and ASHA would provide counselling to the community regarding the importance of institutional deliveries and refer cases requiring expert management. AWW and ASHA will also counsel communities on the importance of balanced diets and promote the use of locally available foodstuffs, particularly for micronutrient supplementation. AWW, ASHA & ANM will sit together with the help of PRI and will device methods & possible interventions towards addressing issues of severe malnutrition.

Water

In summer water levels in Dumaria, Barachatti, Imamganj, Bankebazar, and Mohanpur blocks goes down and hand pumps won't work, and people have to take water from wells, and streams, which are not hygienic. In such areas deep borewell needs to be made in coordination with PHED. Chlorination of wells in such areas also needs to be made. In Town areas also water layer comes down and there is electricity problem because of which water could not be pumped. Water supply needs to be strengthened (higher capacity of tank, alternate electricity source).

Waste management

In three Nagar Panachayats, waste management is proper and the facility is available in Shergatti, Tikari, and Bodh Gaya. In Gaya urban, Nagar Nigam works. In rest of the places, especially in villages no such arrangement is available. The responsibility to ensure this rests with Gram Panchayat and under the aegis of VHSC, plans (Shramadhan etc.) would be devised.

(budget given separately)

FRU: Lady Elgin and Shergati
AVAILABILITY OF SERVICES RELATED TO DELIVERIES

	AVAILABLE 24X7		NOT AVAILABLE	
	Lady Elgin	**Sherghati**	**Lady Elgin**	**Sherghati**
NORMAL DELIVERIES	√	√		
ASSISTED DELIVERIES	√			√
CESAREAN SECTION	√			√
ADMINISTRATION OF PARENTAL OXYTOCINS	√	√		
ADMINISTRATION OF PARENTAL ANTIBIOTICS	√	√		
ADMINISTRATION OF MAGNESIUM SULPHATE INJECTION			√	√
MANAGEMENT OF POST□PARTUM HEMORRHAGES	√			√
MANAGEMENT OF OTHER DELIVERY COMPLICATIONS	√			√

AVAILABILITY OF SERVICES RELATED TO EMERGENCY CARE

	Lady Elgin	**Sherghati**
BLOOD BANK	No	No
BLOOD STORAGE FACILITY	No	No

ABORTIONS

	Lady Elgin	**Sherghati**
MANUAL VACUUM ASPIRATION (MVA)	No	No
ELECTRIC VACUUM ASPIRATION (EVA)	No	No
DILATATION AND CURETTAGE (D&C)	Yes	No

RTI/STI TREATMENT AND COUNSELING

	Lady Elgin	Sherghati
TREATMENT	Yes	No
COUNSELING	Yes	No

LABOUR ROOM

INFRASTRUCTURE/ EQUIPMENT IN THE LABOUR ROOM	AVAILABLE AND FUNCTIONAL		AVAILABLE BUT NOT FUNCTIONAL		NOT AVAILABLE	
	Lady Elgin	Sherghati	Lady Elgin	Sherghati	Lady Elgin	Sherghati
LABOUR TABLE WITH MCINTOSH SHEET	√	√				
SUCTION MACHINE	√	√				
AUTOCLAVE/STERILIZER	√	√				
OXYGEN CYLINDER WITH FACE MASK, WRENCH AND REGULATOR	√	√				
MVA EQUIPMENT WITH ADEQUATE CANULAS					√	√

AVAILABILITY OF FOLLOWING EMERGENCY DRUGS (EMERGENCY DRUG TRAY)

	Lady Elgin		Sherghati	
OXYTOCIN INJECTION	Yes		Yes	
DIAZEPAM INJECTION	Yes			No
MAGNESIUM SULPHATE INJECTION		No		No
LIGNOCAINE HYDROCHLORIDE INJECTION	Yes		Yes	
NIFEDIPINE TABLET	Yes			No

Table No. 1

PHC /Referral/SDH/D: Human Resources

	PHC /Referral/SDH/DH Name	Popn 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	AMAS	126903	3	3	15	14	01	01	01/01	01/1	0	0	4	2	0
2	ATRI	69000	03	02	20	18	01	0	01/01	0	0	0	4	2	0
3	BANKEY BAZAR	42235	03	01	26	22	01	0	01/01	0	0	0	4	0	0
4	BARACHATTI	111985	03	03	19	19	01	01	01/01	01/01	0	0	4	0	0
5	BELAGANJ	243564	03	03	28	28	01	01	01/01	01	0	0	4	4	0
6	BODHGAYA	221685	03	03	23	23	01	0	01/01	01	0	0	4	4	0
7	DOBHI	117763	03	01	18	15	01	0	01/01	0	0	0	4	4	0
8	DUMARIYA	110000	2	1	2	0	1	1	01/01	0	0	0	4	2	0
9	FATHEPUR	226825	03	03	30	27	0	0	01/01	0	0	0	4	3	0
10	TOWNBLOCK	131000	3	2	20	20	0	0	01/01	0	0	0	0	0	0
11	GURARU	11200	3	2	3	3	0	0	01/01	0	0	0	4	0	0
12	GURUA	169562	3	2	24	23	1	0	01/01	0	0	0	4	2	0
13	IMAMGANJ	168993	3	3	3	2	1	0	01/01	0	0	0	4	1	0
14	KHIJARSARAI	172743	3	2	25	25	01	0	01/01	0	0	0	4	2	0
15	KONCH	208773	3	2	31	29	0	0	01/01	0	0	0	4	2	0
16	MANPUR	108516	3	3	23	23	1	1	01/01	0	0	0	4	4	1
17	MOHANPUR	177844	3	2	25	18	1	0	01/01	0	0	0	4	4	1
18	MOHARA	Not functional													
19	BATHNI	87168	3	02	15	11	0	0	01/01	0	0	0	4	1	0
20	PARIYA	84000	3	3	1	1	0	0	01/01	0	0	0	4	2	0
21	SHERGHATI	160369	3	3	14	13	1	0	01/01	0	0	0	4	3	0
22	TEKARI	218000	3	3	34	33	1	0	01/01	1	0	0	4	3	0
23	WAZIRGANJ	178356	3	3	2	2	1	0	01/01	0	0	0	4	4	0

Table No. 2

PHC LEVEL INFRASTRUCTURE, GAYA

S. 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 (+++/++/#)	PHC Renovation
1	ATRI	79000	Govt.	+++	NA	I	I	A	+++	06	12	A	+++	+++	Yes
2	AMAS	126903	Govt.	++	NA	A	A	A	#	11	06	A	#	#	Yes
3	BANKEY-BAZAR	112235	Govt.	#	A	A	A	NA	#	08	06	NA	#	#	No
4	BARACH-ATTI	111985	Govt.	+++	A	I	A	A	++	06	06	A	++	++	Yes
5	BODH- GAYA	243,564	Govt.	+	I	A	A	A	I	06	06	A	+++	#	Yes
6	DOBHI	117763	Govt.	#	NA	NA	NA	NA	#	06	06	NA	#	#	No
7	DUMARIA	1,10,000	Govt.	++	NA	A	NA	NA	#	03	06	NA	++	#	Yes
8	FATEHPUR	226825	Govt.	++	A	A	A	A	++	08	06	A	+++	++	Yes
9	TOWN BLOCK	131080	Govt.	++	NA	NA	NA	NA	#	02	00	NA	#	#	No
10	GURARU	1,12000	Rent	#	NA	A	NA	NA	#	06	05	NA	#	#	No
11	GURUA	167352	Govt.	+++	A	A	NA	NA	+++	06	06	A	+++	+++	Yes
12	IMAMGANJ	168993	Govt.	+++	NA	I	A	A	+ + +	12	06	A	+ + +	+ +	Yes
13	KHIZARSARAI	172743	Govt.	+++	A	A	A	A	+ + +	08	06	A	+ + +	+ + +	Yes
14	MANPUR	108516	Govt.	+++	NA	I	A	A	+ + +	02	06	A	+ + +	+ +	Yes
15	MOHANPUR	177844	Govt.	#	NA	A	A	NA	#	08	06	A	+ +	+ +	Yes
16	BATHANI	87168	Rent.	++	NA	I	NA	NA	#	07	06	A	+ +	+ +	No
17	PARAIYA	84000	Govt.	#	NA	NA	NA	A	+ +	07	06	A	++	+ +	Yes
18	SHERGHATTI	1,60,369	Govt.	++	A	I	A	A	+	26	17	A	+ +	+ +	No
19	TEKARI	218000	Govt.	#	A	NA	A	A	+ +	23	06	A	+ +	+ +	No
20	WAZIRGANJ	178356	Govt.	#	NA	A	NA	NA	+ +	08	06	A	+ +	+ +	Yes
21	KONCH	208753	Govt.	#	NA	NA	A	A	+	08	06	A	+ + +	+	Yes
22	BELAGANJ	243564	Govt.	++	A	I	A	A	++	06	06	A	++	+++	Yes
23	DUMARIYA REFRAL	110000	Govt.	+ +	NA	A	NA	NA	#	03	17	NA	++	++	Yes

Table No. 3

Additional Primary Health Centre (APHC) Database: Human Resources

PHC Name	No. of APHC	Doctors		ANM		Laboratory technician		Pharmacists / dresser		Nurses A Grade		Accnt/Peons/ Sweeper/Night Guards	Availability of specialist
		Sanction	In Position	Sanction	In position	Sanction	In position	Sanction	In position	Sanction	In Position		
Atri	2	4	0	4	2	1	0	2/2	0	4	1 (C)	0	0
Barachatti	1	2	0	2	1	1	0	1/1	0	2	1 (C)	2	0
Belaganj	5	10	2	10	10	5	0	5/5	0	10	9 (C)	0	0
Bodhgaya	2	4	3	4	4	2	0	2/2	0	4	4 (C)	3	0
Dobhi	2	4	0	4	4	2	0	2/2	0	4	4 (C)	0	0
Dumariya	2	4	0	4	4	0	0	2/2	1	4	3 (C)	0	0
Fatehpur	3	6	3	6	3	3	0	3/3	0	6	4 (C)	0	0
Town Block	1	2	1	2	2	1	0	1/1	0	2	2 (C)	1	0
Guraru	2	4	1	4	4	2	0	2/2	0	4	4 (C)	3	0
Imamganj	2	4	2	4	5	2	0	2/2	0	4	2 (C)	3	0
Khizarsarai	6	12	3	12	12	6	0	6/6	1	12	10 (C)	6	0
Konch	7	12	2	12	8	6	0	6/6	0	12	6 (C)	5	0
Mohanpur	1	2	0	2	1	1	0	1/1	0	2	0	1	0
Mohra	3	6	4	8	7	4	0	4/4	0	6	5 (C)	0	0
Tankupa	1	Not Functional											
Tekari	5	10	0	10	8	5	1	5 / 5	1	10	6 (C)	0	0

Wazirganj	3	6	4	6	6	2	2	3/3	0	6	5 (C)	0	0

Non APHC at Sherghati, Gurua, Nimchak Bathani, Amas, Bankebazar Manpur & Paraiya
Note : C= Contractual

Table No. 4

Additional Primary Health Centre (APHC) Database: Infrastructure

PHC Name	No. of APHC	Population served	Building ownership (Govt/Pan/ Rent)	Building condition (+++/++/#)	Assured running water supply (A/NA/I)	Continuous power supply (A/NA/I)	Toilets (+++/++/+/#)	Condition of Labour room (+++/++/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulance/ vehicle (Y/N)
Atri	1	30000	Rent	#	NA	NA	++	++	1	6	++	N	NO	N
Barachatti	1	13785	Pan.	++	NA	NA	#	#	2	2	#	N	NO	N
Belaganj	5	33242	Govt.-1 Rent-4	#-1 ++-4	NA	NA	#	#	9	6	#	N	YES	N
Bodhgaya	2	58174	Govt.-2	++-2	NA	NA	#	#	2	6	#	N	NO	N
Dobhi	2	35850	Rent-1 Govt.-1	#, ++	NA	NA	#	#	7	2	#	N	YES	N
Dumariya	2	2957	Rent-2	++-1 #-1	NA	NA	#	#	3	2	#	N	NO	N
Fatehpur	3	29298	Rent-2 Govt.-1	#-1 ++-2	NA	NA	#	#	5	18	#	N	NO	N
Town Block	1	35000	Govt. 1	++	NA	NA	#	#	3	0	#	N	YES	N
Guraru	3	97961	Govt.-1 Rent -2	#-1 ++-2	NA	NA	#	#	9	4	#	Y	NO	N
Imamganj	2	16328	Rent-1 Govt. -1	#-1 ++-1	NA	NA	+	#	12	9	#	Y	YES	N
Khizarsarai	6	150000	Rent-5 Govt. 1	#-1 ++-5	NA	NA	#	#	15	36	#	N	YES	N
Konch	6	38919	Rent-6	#-1	NA	NA	#	#	12	24	#	N	YES	N

				++-5										
Mohanpur	1	35000	Rent-1	#	NA	NA	+++	#	5	6	#	N	NO	N
Mohra	3	122000	Rent-1 Govt. 2	#-2 ++-1	NA	NA	#	#	10	24	#	N	YES	N
Tekari	5	27784	Rent-2 Govt. 3	#-2 +-2	NA	NA	#	#	14	30	#	N	NO	N
Wazirganj	3	37458	Rent-2 Govt. 1	+-1 #-2	NA	NA	#	#	5	10	#	N	YES	N

Table No. 5
Sub Centre Facilities

S. No.	Name of PHC	Pop.	No of	ANMs		ANMs		Building ownership			Building condition				Assured running water supply			Cont. power supply (A/NA/I)			ANM residing at HSC area		Condition of residential facility				Sta furr	
			G. P at /villages served	(R)	C)	(R)	(C)	Govt	Pan.	Rent	+++	++	+	#	A	NA	I	A	NA	I	Y	N	+++	++	+	#		
				posted formally		in position																						
1	Amas	126903	104	10	2	10	2	4	0	8	0	1	3	8	0	12	0	0	12	0	1	11	0	1	0	11	I	
2	Atari	115560	109	18	12	18	12	3	0	17	2	10	4	4	0	11	0	0	11	0	5	25	5	0	0	15	I	
3	Bankebazar	112235	120	13	9	13	9	1	0	10	0	0	0	13	1	12	0	0	13	0	0	0	0	0	13	12	I	
4	Barachatti	111985	105	11	5	11	5	6	0	10	2	3	1	10	1	15	0	1	15	0	4	12	1	15	0	0	`	
5	Belaganj	243564	244	24	4	25	13	0	0	26	0	0	0	26	5	21	0	2	24	0	26	0	0	0	0	26	I	
6	Bodhgaya	221685	222	21	0	21	8	4	4	13	2	1	1	17	2	19	0	0	21	0	0	21	0	0	1	20	I	
7	Dobhi	117763	118	13	4	14	3	2	7	7	0	0	0	16	1	15	0	0	16	0	16	0	0	1	0	15	`	
8	Dumariya	110000	111	19	5	1	5	0	0	0	0	0	0	0	0	20	0	0	0	0	0	0	0	0	0	0	I	
9	Fatehpur	226825	227	24	8	24	9	5	8	15	0	0	0	3	15	13	0	0	28	0	0	0	0	0	0	0	I	
10	Guraru	112000	113	7	7	7	7	1	3	3	7	0	0	0	0	7	0	0	7	0	1	6	0	0	0	0	`	
11	Gurua	169562	170	23	7	23	7	3	0	19	2	0	1	19	0	22	0	0	22	0	0	22	0	0	0	22	I	
12	Imamganj	152186	153	28	0	18	0	6	15	2	2	2	2	18	0	24	0	0	24	0	18	6	0	0	0	24	`	
13	Khizarsarai	172743	173	24	3	24	3	3	0	25	0	3	0	25	0	28	0	0	28	0	3	25	0	3	0	25	I	
14	Konch	208753	209	28	5	28	6	1	0	29	0	0	1	29	0	30	0	0	30	0	0	30	0	0	0	30	I	
15	Manpur	108516	109	21	21	20	13	5	7	9	0	0	4	16	0	21	0	0	21	0	0	21	0	0	0	21	I	
16	Mohanpur	177844	178	13	6	13	6	2	2	17	1	1	0	19	0	21	0	0	21	0	6	15	0	0	0	21	I	
17	N. Bathani	87168	88	9	8	9	8	3	0	9	2	2	3	5	3	9	0	0	10	2	12	0	3	1	0	8	I	
18	Paraiya	83800	84	15	4	15	4	0	0	15	0	0	0	15	0	15	0	0	15	0	15	0	0	0	0	15	I	
19	Sherghati	160369	161	12	0	17	1	1	0	11	0	1	0	11	4	7	1	0	12	0	0	12	0	0	0	12	`	

20	Tekari	218000	219	31	15	31	15	3	0	29	1	6	21	4	0	32	0	0	32	0	0	32	0	0	0	32	I	
21	Town Block	133080	158	19	14	19	14	4	8	7	5	0	0	14	0	19	0	0	19	0	0	19	0	0	0	19	I	
22	Wazirganj	178356	159	29	12	18	17	3	3	23	1	3	25	0	0	29	0	0	29	0	0	29	0	0	0	29	`	
23	Mohra	91775	92	7	4	7	4	1	1	7	0	2	3	4	0	9	0	0	9	0	9	0	0	1	0	8	I	

ANM (R) -REGULAR /ANM (C) - CONTRACTURAL, GOVT. GOVT. /RENTED REN / PLAN -
PAN - PANCHAYANT OR OTHER DEPT. OWNED GOOD CONDITION +++ / NEEDS MAJOR REPAIRS ++ / NEEDS MINOR REPAIRS LESS THAN RS 10000 +/ NEEDS NEW BUILDING # WATER SUPPLY,
AVAILABLE - A / NOT AVAILABLE -NA, INTERMITTENTLY AVAILABLE -I

Table No. 6
CHILD IMMUNIZATION

SL	Name of PHC	% of children 9-11 months fully immunized (BCG+DPT123+OPV123+Measles)	% of immunization sessions held against planned
1	AMAS	98%	98%
2	ATRI	82%	88%
3	BANKEY BAZAR	90%	90%
4	BARACHATTI	89.65%	96%
5	BELAGANJ	76%	100%
6	BODHGAYA	85%	94%
7	DOBHI	96%	100%
8	DUMARIYA	33%	100%
9	FATHEPUR	91%	68%
10	TOWNBLOCK	81.6%	92.2%
11	GURARU	81%	96%
12	GURUA	82%	97%

13	IMAMGANJ	42.95%	68.30%
14	KHIJARSARAI	53%	100%
15	KOACH	41%	92%
16	MANPUR	90%	90%
17	MOHANPUR	76%	95%
18	MOHARA	72	78%
19	BATHANI	78%	100%
20	PARAIYA	72%	90%
21	SHERGHATI	94.5%	92.1%
22	TEKARI	56%	90%
23	WAZIRGANJ	96%	98%

Table No. 7
Child Health

S. No.	Total no. of live Birth	Total no. of still births	% of new borns weighted within 1week	% of new borns weighting less than 2500gm	Total number of neonatal deaths (within 1 month of birth)	Total number of infant deaths(within 1-12 months)	Total number of child deaths (within 1-5 yrs)	Number of diarrhea cases reported within the year	% of diarrhea cases treated	Number of ARI cases reported within the year	% of ARI cases treated	Number of children with Grade 3 and Grade 4 undernutrition who received a medical checkup	Number of children with Grade 3 and Grade 4 undernutrition who were admitted	Number of undernourished children
Amas	668	NA	48%	38%	2	NA	NA	NA	NA	NA	NA	NA	NA	NA
Atri	312	8	2%	2%	3	4	6	76	98%	72	98%	264	112	NA
Bankebazar	NA	NA	NA	NA	NA	NA	NA	210	100%	NA	NA	60	NA	250

Barachatti	1253	17	100%	3%	6	17	23	49	100%	22	97%	600	20	64
Belaganj	2107	54	75%	NA	NA	NA	NA	88	100%	178	98%	NA	NA	NA
Bodh-Gaya	635	0	96%	3%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Dobhi	NA	NA	NA	NA	NA	NA	NA	196	100%	NA	NA	NA	NA	NA
Dumariya	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Fatehpur	1710	54	12%	1%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Town block	3089	152	43%	7%	28	21	26	113	100%	20	100%	538	10	74
Guraru	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Gurua	702	15	86%	10%	1	2	12	151	100%	155	100%	NA	NA	NA
Imamganj	1367	24	80%	5%	4	NA	NA	NA	NA	NA	NA	NA	NA	NA
Khizarsarai	2064	24	88%	10%	5	2	3	233	100%	NA	NA	NA	NA	NA
Konch	1357	14	85%	12%	14	7	6	48	100%	6	100%	NA	NA	NA
Manpur	1653	11	100%	15%	NA	NA	NA	16	100%	NA	NA	NA	NA	NA
Mohanpur	376	12	100%	30%	7	NA	NA	83	100%	849	81%	NA	NA	171
Mohra	114	4	78%	2%	NA	NA	NA	12	100%	10	NA	NA	NA	NA
Bathani	NA	NA	NA	NA	NA	NA	NA	66	100%	123	97%	33	NA	1100
Paraiya	383	21	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Shreghati	1490	44	NA	12%	44	6	2	400	100%	582	100%	NA	NA	NA
Tankuppa	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Tekari	2748	53	86%	12%	NA	NA	NA	60	100%	20	100%	NA	NA	4109
Wazirganj	3474	112	90%	7%	60	NA	NA	25	NA	NA	NA	NA	NA	NA

Table No. 8

PHC LEVEL MATERNAL CARE, GAYA

PHC Name	% of pregnant women registered for ANC in the 1st trisemester	% of pregnant women registered for ANC in the 1st trisemester	% of pregnant women with 3 ANC check ups	% of pregnant women with any ANC checkup	% of pregnant women with anaemia	% of pregnant women who received 2 TT injections	% of pregnant women who received 100 IFA tablets	Number of pregnant women registered for JSY	Number of Institutional deliveries conducted	Number of home deliveries conducted by SBA	% of C-sections conducted	% of Pregnancy complication managed	% of institutional deliveries in which JBSY funds were given	% of home deliveries in which JBSY funds were given	Number of deliveries referred due to complications	% of mothers visited by health worker during the first week after delivery	Number of Maternal Deaths
AMAS	1531	96%	94%	94%	3%	81%	NA	662	628	0	NA	0	100%	0	5	100%	0
ATRI	364	80%	82%	8%	0%	98%	NA	1602	1573	0	NA	99%	100%	0	8	52%	0
BARACHATI	2509	85.6%	51.77%	20%	40%	82%	NA	2509	951	0	NA	62%	100%	0	15	5%	0
BELAGANJ	1640	NA	74%	NA	56%	86%	NA	NA	1250	0	NA	75%	100%	0	15	2%	0
BODH-GAYA	2004	NA	NA	NA	NA	48%	NA	2432	865	0	NA	0	100%	0	0	0%	0
GURUA	549	56%	25%	56%	15%	93%	NA	802	702	0	NA	0	100%	0	26	0%	0
IMAMGANJ	4898	100%	33.41%	100%	40%	100%	NA	462	462	0	NA	0%	100%	0	26	0%	0
KHIZERSARAI	2217	40%	33%	53%	15%	83%	NA	1340	1340	0	NA	0%	100%	0	20	0%	0
KONCH	2062	11%	43	23%	23%	23%	NA	771	771	0	NA	5%	100%	0	7	100%	0
MANPUR	2186	15%	91%	91%	14%	91%	NA	1653	1653	0	NA	2%	100%	0	251	15%	2
MOHANPUR	NA	NA	59%	100%	49%	41%	NA	2987	388	0	NA	2%	100%	0	23	21%	2
BATHANI	2490	80%	70%	90%	10%	81%	NA	NA	NA	0	NA	0%	NA	0	0	0%	0
PARAIYA	332	NA	NA	NA	NA	90%	NA	383	383	0	NA	0%	100%	0	0	0%	0
SHERGHATI	1977	90%	89%	78%	60%	86%	NA	1977	1508	0	NA	0%	100%	0	103	21%	0
TEKARI	1645	33%	65%	73%	50%	50%	NA	1700	1753	0	NA	0%	100%	0	0	10%	0
WAZARGANJ	3714	40%	17%	NA	NA	34%	NA	6910	2260	0	NA	12%	46%	0	43	13%	0
FATEHPUR	1883	131	394	NA	NA	82%	NA	431	1717	0	NA	0%	100%	0	6	0%	0

Note : Bankebazar, Dobhi, Dumariya, Guraru & Town Block PHC is not conducting delivery.

Table No. 9

S. No.	Name of PHC	Number of MTPs conducted PHC level	Number of RTI/STI cases treated	% of couples provided with barrier contraceptive methods	% of couples provided with permanent methods	% of female sterlisations
1	AMAS	0	0	0	0	13.5%
2	ATRI	0	112	54%	56%	30%
3	BANKEY BAZAR	0	505	0	0	32%
4	BARACHATTI	0	NA	45%	45%	44.8%
5	BELAGANJ	0	NA	53%	56%	NA
6	BODHGAYA	NA	NA	NA	NA	NA
7	DOBHI	0	0	0	0	0
8	DUMARIYA	0	0	0	0	0
9	FATHEPUR	0	0	0	0	42%
10	TOWNBLOCK	0	0	14%	17%	95.4%
11	GURARU	NA	NA	NA	NA	NA
12	GURUA	0	78	30%	20%	15%
13	IMAMGANJ	0	0	6.2%	0	0
14	KHIJARSARAI	0	0	25%	20%	20%
15	KOACH	0	0	58%	0%	0

16	MANPUR	0	0	5%	1%	10%
17	MOHANPUR	0	680	87%	4%	10%
18	MOHARA	0	0	0	60%	24%
19	BATHNI	NA	NA	NA	NA	NA
20	PARIYA	NA	NA	NA	NA	NA
21	SHERGHATI	0	0	48%	94%	94%
22	TEKARI	0	0	17%	25%	25%
23	WAZIRGANJ	0	0	80%	20%	0

Table No. 10

S. No.	Name of PHC	% of TB cases suspected out of total OP	Proportion of New Sputum Positive out of Total New Pulmonary Cases	Annual Case Detection Rate (Total TB cases registered for treatment per 100,000 population per year)	Treatment Success Rate (% of new smear positive patients who are documented to be cured or have successfully completed treatment)	% of patients put on treatment, who drop out of treatment
1	AMAS	3%	25%	55%	35%	20%
2	ATRI	0	NA	NA	NA	NA
3	BANKEY BAZAR	1.5%	NA	NA	NA	NA
4	BARACHATTI	3%	75%	78%	96%	4%
5	BELAGANJ	NA	28%	26.5%	16%	NA
6	BODHGAYA	NA	NA	NA	NA	NA
7	DOBHI	NA	NA	NA	NA	NA
8	DUMARIYA	NA	NA	NA	NA	NA
9	FATHEPUR	NA	17%	NA	NA	NA
10	TOWNBLOCK	4%	27%	20.5%	15%	0
11	GURARU	NA	NA	NA	NA	NA
12	GURUA	NA	75%	.006%	26%	3%
13	IMAMGANJ	6%	10%	13%	40%	0
14	KHIJARSARAI	1.4%	13.5%	10%	93%	3%
15	KOACH	2%	2%	26%	82.6%	5%
16	MANPUR	2.8%	45%	56%	93%	7%
17	MOHANPUR	3%	40%	64%	90%	5%
18	MOHARA	Not Functional				
19	BATHANI	5%	28%	2.3%	92.8%	7%
20	PARAIYA	6.12%	17.3%	NA	NA	NA
21	SHERGHATI	3%	29%	58%	92%	NA
22	TEKARI	3%	58%	58%	72%	2%
23	WAZIRGANJ	NA	NA	NA	NA	NA
N A = Not available						

Table No. 11

Vector Born Disease Control Programme

S. No.	Name of PHC	Annual Parasite Incidence	Annual Blood Examination Rate	Plasmodium Falciparum percentage	Slide Positivity Rate	Number of patients receiving treatment for Malaria	Number of patients with Malaria referred	Number of FTDs and DDCs	In patent services	Out patient services
1	AMAS	2	80%	0	2%	28	0	30	4000	3000
2	ATRI	0	0	0	0	110	02	0	1600	1600
3	BANKEY BAZAR	0	0	0	0	0	0	0	452	19500
4	BARACHATTI	12	100%	71%	5%	97	1	0	2005	27110
5	BELAGANJ	NA	NA	NA	NA	NA	NA	NA	1840	19097
6	BODHGAYA	NA	NA	NA	NA	NA	NA	NA	NA	NA
7	DOBHI	NA	NA	NA	NA	NA	NA	NA	NA	797
8	DUMARIYA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9	FATHEPUR	0	0	0	0	2	0	0	0	0
10	TOWNBLOCK	0	0	0	0	10	0	0	0	0
11	GURARU	NA	NA	NA	NA	NA	NA	NA	NA	28582
12	GURUA	2	NA	0	2%	2	0	0	1371	23132

14	KHIZERSARAI	NA	NA	NA	NA	NA	NA	NA	0	0
15	KOACH	0	0	0	0	0	0	0	2107	22765
16	MANPUR	0	0	0	0	0	0	0	0	0
17	MOHANPUR	17	91%	3%	2%	39	0	0	789	15078
18	MOHARA	Not Functional								
19	BATHNI	NA	NA	NA	NA	NA	NA	NA	0	23
20	PARIYA	NA	NA	NA	NA	NA	NA	NA	590	16712
21	SHERGHATI	0	86%	8%	3%	31	0	0	2282	42932
22	TEKARI	0	100%	0	0	3224	0	0	0	0
23	WAZIRGANJ	0	0	0	0	0	0	0	0	0

Table No. 12

NATIONAL LEROSY ERADICATION PROGRAMME

SL	Name of PHC	Number of cases detected	Number of Cases treated	Number of default cases	Number of case complete treatment	Number of complicated cases	Number of cases referred
1	AMAS	48	48	0	25	0	0
2	ATRI	32	32	0	20	0	0
3	BANKEY BAZAR	301	290	NA	290	2	2
4	BARACHATTI	31	31	4	12	3	0
5	BELAGANJ	NA	NA	NA	NA	0	0
6	BODHGAYA	NA	NA	NA	NA	0	0
7	DOBHI	NA	NA	NA	NA	NA	NA
8	DUMARIYA	41	41	0	39	0	0
9	FATHEPUR	NA	NA	NA	NA	NA	NA

10	TOWNBLOCK	40	25	3	15	1	0
11	GURARU	46	46	1	17	0	0
12	GURUA	73	73	0	44	3	1
13	IMAMGANJ	0	52	52	0	42	0
14	KHIZERSARAI	NA	NA	NA	NA	NA	NA
15	KONCH	66	39	3	21	1	0
16	MANPUR	0	68	0	28	0	0
17	MOHANPUR	45	45	10	14	0	0
18	MOHARA	Not Functional					
19	BATHANI	23	23	0	10	5	0
20	PARAIYA	21	21	0	10	0	0
21	SHERGHATI	32	32	0	32	0	0
22	TEKARI	38	38	38	2	13	0
23	WAZIRGANJ	43	43	0	36	0	0

Table No. 13

SURGICAL SERVICES

SL	Name of PHC	Number of major surgeries conducted	Number of minor surgeries conducted (with Family Planning)
1	AMAS	0	55
2	ATRI	0	0
3	BANKEY BAZAR	0	165

4	BARACHATTI	3	232
5	BELAGANJ	0	0
6	BODHGAYA	0	0
7	DOBHI	0	0
8	DUMARIYA	0	0
9	FATHEPUR	0	0
10	TOWNBLOCK	0	0
11	GURARU	0	0
12	GURUA	0	0
13	IMAMGANJ	0	0
14	KHIJARSARAI	0	0
15	KOACH	0	443
16	MANPUR	0	165
17	MOHANPUR	0	254
18	MOHARA	Not Functional	
19	BATHNI	0	0
20	PARIYA	0	0
21	SHERGHATI	0	374
22	TEKARI	0	0
23	WAZIRGANJ	0	0

Table No. 16
Support Services

S. No	PHC Name	Food	Ambulance	House Keeping	Lab Services	Generator
1	Amas	No	Yes	Yes	No	Yes
2	Atri	No	Yes	Yes	No	Yes
3	Bankebazar	No	No	Yes	No	Yes
4	Barachatti	No	Yes	Yes	No	Yes
5	Belaganj	No	Yes	Yes	No	Yes
6	Bodhgaya	No	Yes	Yes	No	Yes
7	Dobhi	No	No	Yes	No	Yes
8	Dumariya	No	No	No	No	Yes
9	Fatehpur	Yes	Yes	Yes	No	Yes
10	Town Block	No	No	No	No	No
11	Guraru	No	Yes	Yes	No	Yes
12	Gurua	Yes	Yes	Yes	No	Yes
13	Imamganj	Yes	Yes	Yes	No	Yes
14	Khiersarai	Yes	Yes	Yes	No	Yes
15	Konch	Yes	Yes	Yes	No	Yes
16	Manpur	No	Yes	Yes	No	Yes
17	Mohanpur	No	Yes	Yes	No	Yes
18	Mohra	Not Function				
19	Nimchak Bathani	No	Yes	No	No	No
20	Pariaya	No	No	Yes	No	Yes
21	Sherghati	Yes	Yes	Yes	No	Yes
22	Tankupa	Not Function				
23	Tekari	Yes	Yes	Yes	No	Yes
24	Wazirganj	Yes	Yes	Yes	No	Yes

Budget Gaya Dist.

S. No.	Budget Head	Units	Qty. Yr. (9-10)	Rate Rs. (in lacs)	Amount
1	**1. MATERNAL HEALTH**				
1.1	Operationalise facilities (details of infrastructure & human resources, training, IEC/BCC, equipment, drugs and supplies in sections				
1.1.1	Operationalise Block PHCs /CHCs / SDHs / DHs as FRUs				
	Blood Storage centre	2		6.2o	12.4
1.1.1.1	Organise dissemination workshops for FRU guidelines				
	Human Recource	2 FRU		23.76	47.52
	Logistic Management	2FRU		1	2
	Procurement of Drugs supply	2FRU		20	40
	Training for HR				as per state norms
1.1.2.	Operationalise 24 x 7				
	Infrastructure				
	Residence in HSC	17		4	68
	Residence in PHC	6		6	36
	Human Recource (A Grade nurse)	24		0.9	21.6
	Monitoring & Evaluation	24		1.2	28.8
	Logistic Management	24		1	24
	Training for HR				as per state norms
	Infrastructure	1		150	150
1.1.2	Operationalise PHCs hour services				
1.1.2.1	Prepare plan for operationalisation across districts (including staffing, infrastructure, training, equipment, drugs & supplies etc)				
1.1.2.2	Monitor progress against plan (meetings at Dist. Level in every trimester)				

1.1.2.3	Monitor quality of services delivery (printing of monitoring format & registers)				
1.1.2.4	Monitoring of activities related to FRUs & 24 x 7 PHCs				
1.1.3	**Operationalise MTP services at health facilities**				
	Training of MO				as per state norms
	Monitoring	5		0.5	2.5
	Training of Asha & AWW	159 BATCH			as per state norms
	Procurement of MTP Kit	5		2	10
1.1.3.1	Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies etc)				
1.1.3.2	Monitor progress against plan follow up with training, procurement, etc				
1.1.3.3	Monitor quality of services delivery and including through field visits.				
1.1.4	**Operationalise RTI/STI services at health facilities**				
	I.E.C for RTI / STI services	2		0.5	1
	Ambulance services	2		1.8	3.6
	Contigency	2		1.2	2.4
	Training of ANM	877			as per state norms
1.1.4.1	Prepare plan for operationalisation across districts (including training, equipment, drugs & supplies etc) (it is planned to provide RTI /STD services from all PHCs and CHCs for which training will be organized and drugs and medicines @ Rs. 4.5 per district / per annum)				
1.1.4.2	Monitors progress against plan ; follow up with training procurement etc				
1.1.4.3	Monitor quality of services delivery and utilisation including through field visits				
	Operationalise sub centres				

	Infrastructure	541			as per state norms
	Human Recource	541		3.6	194.76
	Logistic Management	541		0.1	54.1
	Monitoring & Evaluation	541		0.72	389.52
	Untied fund	541		0.6	324.6
1.1.5.1	Prepare plan for operationalising services at sub centres (for a range of RCH services including antenatal care and post natal care)				
1.1.5.2	Monitor quality of services delivery and utilisation including through field visits				
1.2	**Referral Transport**				
	Free dail services	1		5.4	5.4
	Ambulance services at PHC & APHC	73		1.8	131.4
	Contigency at PHC level	24		1.2	28.8
1.2.1	Prepare and disseminate guidelines for referral transport for pregnant women and sick newborns children				
1.2.2	Implementation by Districts				
1.3	Integrated outreach RCH services				
1.3.1.1	Implementation by dist. Of RCH camps in un served / under served areas				
1.3.1.2	Monitor quality of services and utilisation				
1.3.2	Monthly village health and Nutrition Days at Anganwadi Centres				
1.3.2.1	Implementation by dist. Of Monthly village health and Nutrition Days at Anganwadi Centres				
1.3.2.2	Monitor quality of services and utilisation				
1.4	Janani Suraksha Yojana / JSY (details of IEC / BCC in section 12)				
1.4.2	**Implementation of JBSY by Districts**				

1.4.2.1	Home deliveries				
1.4.2.2	**Institutional deliveries**	36000		0.02	720
1.4.3	Monitor quality of services and utilisation				
1.5	Other strategues / activites (please specify - PPP / Innovations / NGO to be mentioned procurement of Dai delivery kit under section 8)	3000		0.005	15
2	2. Child Health				
2.1	**IMNCI (details of training, drugs and supplies, under sections 11 and 13)**				
	Training of HR	72 batch		100359	72.5
	Contingency for Logistic	72 batch		0.50 batch	3.6
	Procurement of Madicine	72 batch		0.15 batch	10.8
A.2.6	**NRC**	1 centre			29.14
A. 2.4	**School Health Programme**				
	Health Camp in middle school	323 camp		0.05	16.15
	Procurement of drugs	324 camp		0.005	1.61
A.2.7	Management of Diarrohea, ARI and Micronutrient Mahlnutrition				
	Procurement of drugs equipment				
	Vehicle for 4 month				
A.2.8	IEC / BCC	24 PHC		0.2	4.8
A.2.9	DY. CHILD HEALTH SUPERVISOR	1		0.72	0.72
A. 3.1.2	**Female stenilisation camps**				
	4 camp in PHC & 4 camp in Dist.	100 camp		1000 / camp	100000
A. 3.1.3	**NSV camps**				
	NSV camps in every PHC & Dist. Hospital	27 camps		1000/ camp	27
A. 3.1.4	**Compensation for females sterilisation**	20000 person		1000 / person	20

A. 3.1.5	**Compensation for male sterilisation**	1200 person		1500 person	18
A. 3.1.6	**Accreditation of private provider for sterilisation services**	1000 person		1000 person	10
A.3.2.2	**IUD services at health facilities**				
	Training of ANM	1078 ANM			as per state norms
	Training of Doctors	209 Doctors			as per state norms
A.4.	**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH /ARSH**				
	Counselling, Nukar Natak, AFH clinic at every PHC	46 APHC		0.15 / PHC	6.9
	INSENTIVE TO MAMTA	6000 DELIVERY		0.001 /DEL.	6
A.8.3	**NGO Programme**				
	Hospital maintancenc, Generator services				
2.3.2	**Ambulance services in PHC & Dist.**				
	Implementation of HBNC activities in districts.	27		1.8	48.6
	Untied fund for Sub centre	541		0.1	54.1
	APHC Untied fund	46		0.25	11.5
	PHC Untied fund	24		0.25	6
A.13.2.6 RCH KIT					50
A.14	**Programme management**				
	Dist. Programe management support unit				
	DPM	1		2.76	2.76
	DAM	1		2.16	2.16
	DA	1		1.8	1.8
	BHM	24		1.44	34.56
	B.A	24		0.96	23.04
	A Grade	146		0.9	131.4
	ANM (R)	541		0.72	389.52

	DATA CENTRE OPERATER	28		0.72	20.16
	DHS	1		6	6
	PHC	24		2.4	57.6
B	**RCH FLEXI POOL**				20
B.4	**ASHA DIVAS**	2997		0.0072	21.58
B.5	**Corpus grant to HMS/RKS**				
	Sadar Hopital	3		5	15
	PHC RKS	24		2	48
B.9	**Untied Grant for PHC**	24		0.25	6
B.11	**Maintainance grant to sub centre**	541		0.1	54.1
B.12	**Maintainance grant to PHC**	24		0.5	12
B.18	**AYUSH Doctor for APHC**	73 doctor		2.4	175.2
B.25	**Upgradation of PHC to IPHS**	10		20	200
B.14	**Construction of Sub centre**	102		8.48	864.96
B.7	Mobile medical unit	1		40	40
	1911 CONTROL ROOM	1		0.96	0.96
B.6	**Procurement of ASHA drug kit**	2997		0.06	18
	Dieases Cotrol Programme				
	NVBDCP (1. Falariya)				19.8
	2. Malaria				
	NLEP (Leprosy)				6.5
	NBCP Blindness				3.5
	RNTCP				30