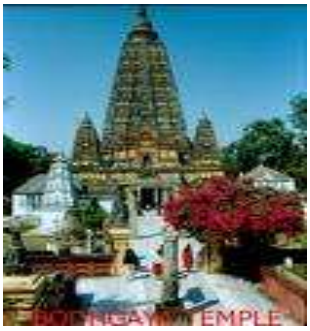
District Health Plan

2010-2011



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 2009 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 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. K. K. Singh
Civil Surgeon, Gaya
Bihar.

TABLE OF CONTENTS

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

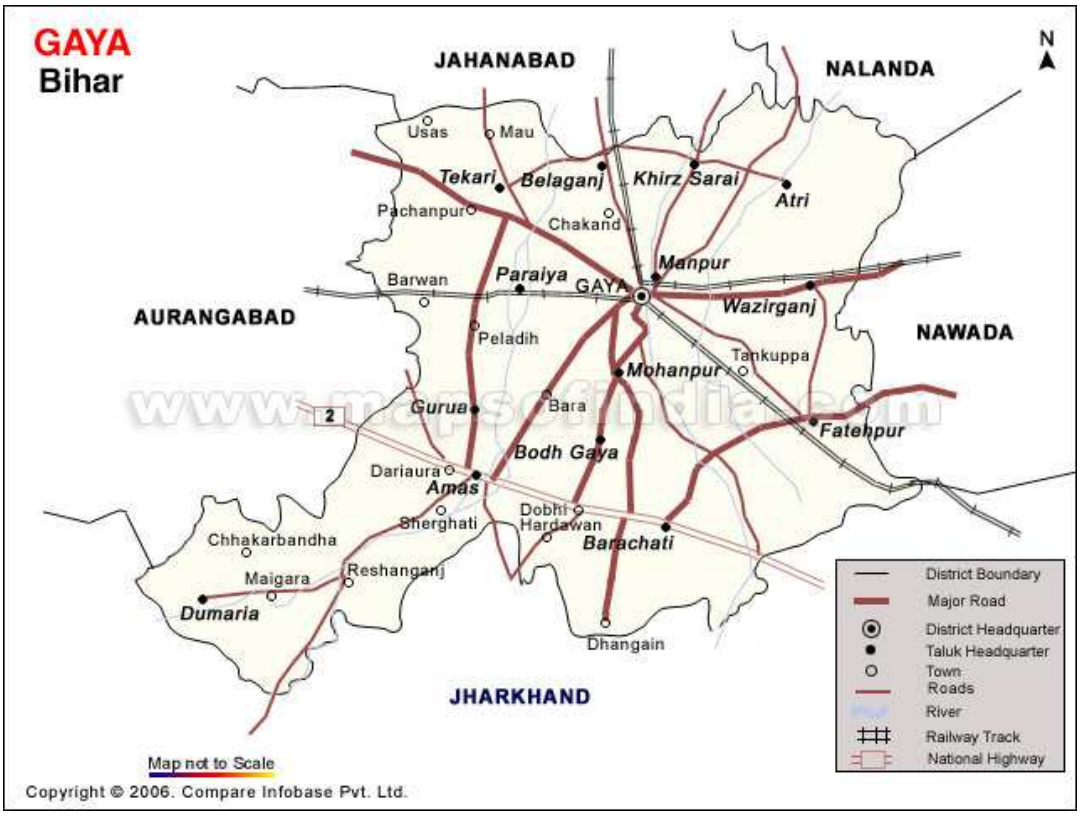
Gaya has also immensely contributed in the Indian Independence Movement. It has also been a place of the Gandhian leader Bihar Bibhut Dr.Anugrah Narayan Sinha. During the independence movement,the All india session of the Congress was held under the presidency of Deshbandhu Chittaranjan Das in 1922, 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 25th Dec. 2009 and 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+ 76C
11.	No of ANMs	531R+405C
12.	No of Grade A Nurse	21R+112C
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	2925
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 2011)**

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 roaster 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 VHSC 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.
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

- 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.
- Involvement of Mamta to monitor & generate awareness for institutional delivery & exclusive breastfeeding.

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 (2011)**	**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 by Pilgrim & 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.
- 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 19 PHCs are offering 24*7 services. In 2011 we propose to operationalise 3 more PHCs and 4 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

Deleted: ¶

HR requirement for running 24*7 BPHCs

HR	**Requirement per PHC (2011)**	**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.

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 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.
- 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, Atri 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 Nischay.

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 2011.

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 2011)**
- **To reduce child mortality rate**
- **To reduce malnutrition among children**
- **Mamta Training**
- **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

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

8. Special care neonatal care unit

Strategy

Promote immediate and exclusive breastfeeding

Activities

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.
5. Involvement of Mamta

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 by VHSC
   (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.

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. (Muskan ek Abhiyan – 2nd Phase)
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 intersect oral convergence. VHSC members should also monitor it.

15. Involve ICDS and PRI networks in behaviour 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.
    - Separate monitoring should me made at PHC & Dist. Level.
    - 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 FRUs (Sherghati, Lady Elgin & Pilgrim)
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 has to be organised by VHSC. 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 2010-11.
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
e. More accreditation of Private Nursing Home / Clinics

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
- Office Assistant required for DPMU
- Procurement of office furniture & Computer / Laptop

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 is 3514 in the District out of this 2925 have already been selected. Remaining 589 Asha would be selected in 2010 – 11. The training of 2nd , 3rd & 4th Modules of about 10 blocks completed & rest will covered in 2010 – 11.

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 2010 – 110 Rs. 10000/- will be given to all 439 +102 (new) = 541 health sub centre.

Village health & sanitation committee has been formed in every panchayat in. 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 & Sub centre

Rs. 50000 will be given to every APHC & Rs. 100000 to every PHC (73 APHC + 24 PHC=97) in 2010-2011.

Up gradation of CHC to IPHS

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

Water, Sanitation, Electricity, separate toilet facilities etc. will be provided in 7 CHC in 2010-11 & the health facilities would be raised to the standard of IPHS by 2012.

Mobile Medical Unit

MMU agreement signed & should be start shortly.

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.

It should be more effective in under served & naxal fested areas.

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.

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
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

[2] DLHS 3

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 doses of polio vaccine (%)	53.1	53.0	54.0
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

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

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 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. Training of ANM, ASHA, AWW, Health Managers, Cold Chain Handler and MOICs in R.I.
4. Sector wise monitoring for district level by district level officers (Sector in charge DIO, DPO, DMO & DPM).
5. Need of sufficient fund for monitoring.
6. Better Co-ordination between ICDS & Health department.
7. 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.
8. Special focus on Mahadalit Tola
9. 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.
10. 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).

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	15815
2. Blood examination conducted	15771
3. Malaria positive	62
4. Cases treated	62

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.
- 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 13984 slides have been collected and 82 cases have been treated.

Early detection and prompt treatment, Mass Drug Administration and appropriate IEC strategies would be helpful in addressing this menace and spray of Larvicidal is going on.

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 CMO 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 & JE catch-up round held at Gaya in the month of Nov. –Dec. 09 & 1100000 children vaccinated.

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. 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 930 patients are undergoing treatment in Gaya district for leprosy. International Agencies like DFIT & 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 23922 cataract operations conducted in this 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

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.

FRU: Lady Elgin, Pilgrim and Shergati

AVAILABILITY OF SERVICES RELATED TO DELIVERIES

	AVAILABLE 24X7			**NOT AVAILABLE**				
	Lady Elgin	**Pilgrim**	**Sherghati**	**Lady Elgin**	**Pilgrim**	**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

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

ABORTIONS

	Lady Elgin	Pilgrim	**Sherghati**

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

RTI/STI TREATMENT AND COUNSELING

	Lady Elgin	Pilgrim	Sherghati
TREATMENT	Yes	Yes	No
COUNSELING	Yes	Yes	No

LABOUR ROOM

INFRASTRUCTURE/ EQUIPMENT IN THE LABOUR ROOM	AVAILABLE AND FUNCTIONAL			AVAILABLE BUT NOT FUNCTIONAL			NOT AVAILABLE		
	Lady Elgin	Sherghati	Pilgrim	Lady Elgin	Sherghati	Pilgrim	Lady Elgin	Sherghati	Pilgrim
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		Pilgrim	
OXYTOCIN INJECTION	Yes		Yes		Yes	
DIAZEPAM INJECTION	Yes		Yes		Yes	
MAGNESIUM SULPHATE INJECTION	Yes			No	Yes	
LIGNOCAINE HYDROCHLORIDE INJECTION	Yes		Yes		Yes	
NIFEDIPINE TABLET	Yes			No	Yes	

Table No. 1

PHC /Referral/SDH/D: Human Resources

	PHC /Referral/SDH/DH Name	Popu. Served	Doctors		ANM		Laboratory Technician		Pharmacist / Dresser		Nurses		Specialist		
			Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Pos o	
1	AMAS	94677	3	3	15	14	01	01	01/ 01	01/ 1	0	0	4	2	
2	ATRI	75887	03	02	20	18	01	0	01/01	0	0	0	4	2	
3	BANKEY BAZAR	116380	03	01	26	22	01	0	01/01	0	0	0	4	(	
4	BARACHATTI	129868	03	03	19	19	01	01	01/01	01/01	0	0	4	(	
5	BELAGANJ	205572	03	03	28	28	01	01	01/01	01	0	0	4	4	
6	BODHGAYA	180494	03	03	23	23	01	0	01/01	01	0	0	4	4	
7	DOBHI	136569	03	01	18	15	01	0	01/01	0	0	0	4	4	
8	DUMARIYA	116446	2	1	2	0	1	1	01/01	0	0	0	4	2	
9	FATHEPUR	220741	03	03	30	27	0	0	01/01	0	0	0	4	3	
10	TOWNBLOCK	127695	3	2	20	20	0	0	01/01	0	0	0	0	(	
11	GURARU	165666	3	2	3	3	0	0	01/01	0	0	0	4	(	
12	GURUA	176489	3	2	24	23	1	0	01/01	0	0	0	4	2	
13	IMAMGANJ	165805	3	3	3	2	1	0	01/01	0	0	0	4	1	
14	KHIJARSARAI	172743	3	2	25	25	01	0	01/01	0	0	0	4	2	
15	KONCH	208773	3	2	31	29	0	0	01/01	0	0	0	4	2	
16	MANPUR	108516	3	3	23	23	1	1	01/01	0	0	0	4	4	
17	MOHANPUR	177844	3	2	25	18	1	0	01/01	0	0	0	4	4	
18	MOHARA	Not functional													
19	BATHNI	87168	3	02	15	11	0	0	01/01	0	0	0	4	1	
20	PARIYA	84000	3	3	1	1	0	0	01/01	0	0	0	4	2	
21	SHERGHATI	160369	3	3	14	13	1	0	01/01	0	0	0	4	3	
22	TEKARI	216000	3	3	34	33	1	0	01/01	1	0	0	4	3	
23	WAZIRGANJ	178356	3	3	2	2	1	0	01/01	0	0	0	4	4	

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 (+++/++/#)		
1	ATRI	79000	Govt.	+++	NA	I	I	A	+++	06	12	A	+++		
2	AMAS	130075	Govt.	++	NA	A	A	A	++	12	5	A	++		
3	BANKEY-BAZAR	130192	Govt.	++	A	I	A	A	++	08	06	A	++		
4	BARACH-ATTI	111985	Govt.	+++	A	I	A	A	+++	06	06	A	+++		
5	BODH- GAYA	222685	Govt.	+	A	A	A	A	++	12	06	A	++		
6	DOBHI	117763	Govt.	#	NA	NA	NA	NA	#	06	06	NA	#		
7	DUMARIA	1,10,000	Govt.	++	NA	A	NA	NA	#	03	06	NA	++		
8	FATEHPUR	226825	Govt.	++	A	A	A	A	++	08	06	A	+++		
9	TOWN BLOCK	131080	Govt.	++	NA	NA	NA	NA	#	02	00	NA	#		
10	GURARU	1,12000	Rent	#	NA	A	NA	NA	#	06	05	NA	#		
11	GURUA	171576	Govt.	+++	A	A	A	A	+++	20	06	A	+++		
12	IMAMGANJ	168993	Govt.	+++	I	I	A	A	+ + +	12	06	A	+ + +		
13	KHIZARSARAI	172743	Govt.	++	A	A	A	A	+ + +	06	06	A	+ + +		
14	MANPUR	108516	Govt.	+++	NA	I	A	A	+ + +	02	06	A	+ + +		
15	MOHANPUR	177844	Govt.	#	NA	A	A	NA	#	08	06	A	+ +		
16	BATHANI	87168	Rent.	++	NA	I	NA	NA	#	07	06	A	+ +		
17	PARAIYA	84000	Govt.	#	NA	I	NA	NA	#	07	06	A	++		
18	SHERGHATTI	1,60,369	Govt.	+++	A	A	A	A	+++	24	17	A	+ ++		
19	TEKARI	218000	Govt.	++	A	A	A	A	+ +	15	14	A	+ +		
20	WAZIRGANJ	178356	Govt.	#	NA	A	NA	NA	+ +	08	06	A	+ +		
21	KONCH	208753	Govt.	++	NA	I	A	A	+	08	06	A	+ + +		
22	BELAGANJ	243564	Govt.	++	A	I	A	I	++	06	06	A	++		
23	DUMARIYA REFRAL	110000	Govt.	+ +	NA	A	NA	NA	#	03	17	NA	++		

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	2	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	2	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	3	6	1	4	4	3	0	3/3	0	6	4 (C)	3	0
Imamganj	2	4	0	4	5	2	0	2/2	0	4	2 (C)	3	0
Khizarsarai	6	12	3	12	12	6	0	6/6	1	12	9 (C)	6	0
Konch	6	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	1	1	0
Mohra	3	6	4	6	7	3	0	3/3	0	6	4 (C)	0	0
Tankuppa	1	2	1	2	2	1	0	1/1	0	2	1	3	0
Tekari	6	12	0	12	8	6	1	6 /6	1	12	6 (C)	0	0
Wazirganj	3	6	1	6	6	3	2	3/3	0/1	6	5 (C)	0	0

Non APHC at Sherghati, Gurua, Nimchak Bathani, Amas, Bankebazar Manpur & Paraiya

Note : C= Contractual

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 (A/NA/I)	Functional of Labour room (A/NA/I)	Condition of Labour room (+++/++/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Stat of furnit	
Atri	2	30000	Rent	#	NA	NA	NA	NA		1	6	++	N	N(	
Barachatti	1	13785	Pan.	++	NA	NA	NA	NA		2	2	#	N	N(	
Belaganj	5	33242	Govt.-1 Rent-4	#-1 ++-4	NA	NA	NA	NA		9	6	#	N	YE	
Bodhgaya	2	58174	Govt.-2	++-2	NA	NA	NA	NA		2	6	#	N	N(	
Dobhi	2	35850	Rent-1 Govt.-1	#, ++	NA	NA	NA	NA		7	2	#	N	YE	
Dumariya	2	2957	Rent-2	++-1 #-1	NA	NA	NA	NA		3	2	#	N	N(	
Fatehpur	3	29298	Rent-2 Govt.-1	#-1 ++-2	NA	NA	NA	NA		5	18	#	N	N(	
Town Block	1	35000	Govt. 1	++	NA	NA	NA	NA		3	0	#	N	YE	
Guraru	3	97961	Govt.-1 Rent -2	#-1 ++-2	NA	NA	NA	NA		9	4	#	Y	N(	
Imamganj	2	16328	Rent-1 Govt. -1	#-1 ++-1	NA	NA	NA	NA		12	9	#	Y	YE	
Khizarsarai	6	150000	Rent-5 Govt. 1	#-1 ++-5	NA	NA	NA	NA		15	36	#	N	YE	
Konch	6	49144	Rent-2 Govt. 4	# -2 ++-4	NA	NA	NA	NA		12		#	N	YE	
Mohanpur	1	35000	Rent-1	#	NA	NA	NA	NA		5	6	#	N	N(	
Mohra	3	122000	Rent-1 Govt. 2	#-2 ++-1	NA	NA	NA	NA		10	24	#	N	YE	
Tekari	6	27784	Rent-2 Govt. 3	#-2 +-2	NA	NA	NA	NA		14	30	#	N	N(	
Wazirganj	3	37458	Rent-2 Govt. 1	+-1 #-2	NA	NA	NA	NA		5	10	#	N	YE	

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

Table No. 5 Sub Centre Facilities

S. No.	Name of PHC	Pop.	No of at /villages serv	ANMs		ANMs		Building ownership			Building condition				Assured running water supply			Cont. power supply (A/NA/I)			ANM residing at HSC area		Condition o residential fac					
				(R)	(C)	(R)	(C)	Govt	Pan.	Rent	+++	++	+	#	A	NA	I	A	NA	I	Y	N	+++	++	+			
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			
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			
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			
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			
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			
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			
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			
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			
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			
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			
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			
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			
13	Khizarsarai	172743	173	28	3	28	3	3	0	25	0	3	0	25	0	28	0	0	28	0	3	25	0	3	0			
14	Konch	208753	209	28	5	28	6	1	0	29	1	2	2	27	0	32	0	0	32	0	0	32	0	0	0			
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			
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			
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			
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			
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			
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			
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			
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			
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			

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	78.26%	79.53%
2	ATRI	90%	90%
3	BANKEY BAZAR	85%	92%
4	BARACHATTI	89.%	90%
5	BELAGANJ	62%	100%
6	BODHGAYA	90%	84%
7	DOBHI	96%	100%
8	DUMARIYA	33%	100%
9	FATHEPUR	91%	68%
10	TOWNBLOCK	80%	90%
11	GURARU	81%	96%
12	GURUA	84%	98%
13	IMAMGANJ	69.44%	82.33%
14	KHIJARSARAI	75%	100%
15	KOACH	41%	92%
16	MANPUR	90%	90%
17	MOHANPUR	76%	95%
18	MOHARA	72	78%
19	BATHANI	78%	100%
20	PARAIYA	92%	88%
21	SHERGHATI	90.5%	91%
22	TEKARI	80%	90%
23	WAZIRGANJ	96%	98%

Table No. 7
Child Health

PHC	Total no. of live Birth	Total no. of still births	% of new borns weighted within 1week	% of new borns weighting less than 2500gm	Total no. of neonatal deaths (within1 month of birth)	Total number of infant deaths(within 1-12 months)	Total number of child deaths (within 1-5 yrs)	No. of diarrhea cases report within year	% of diarrhea cases treated	No. of ARI ases reported within the year	% of ARI cases treated	No. of children with Grade 3 and Grade 4 undern utrition wreceived a medical heckup	No. of children with Grade 3 & Grade 4 undern utrition who were admitted	Numb under ished childr	
Amas	1587	182	48%	40%	13	8	42	230	243	0	48	261	48	191	
Atri	656	12	80%	2%	5	5	12	73	50%	20		520	520		
Bankebazar	440	6	100%	10%	0	0	0	32	32%	10	100%	5	0	2	
Barachatti	4033	20	98%	87%	0	0	0	117	100%	131	97%	0	0	0	
Belaganj	2107	54	75%	NA	NA	NA	NA	88	100%	178	98%	20		64	
Bodh-Gaya	681	0	0%	0%	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	2453	102	47%	8%	30	23	34	120	98%	32	88%	544	0	0	
Guraru	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Gurua	652	3	88%	12%	1	2	13	0	0%	160	100%	NA	NA	NA	
Imamganj	2129	33	78%	12%	0	0	0	10	10	0		1256	2	206	
Khizarsarai	2967	34	95%	15%	5	6	11	215	100%						
Konch	1357	14	85%	12%	14	7	6	48	100%	6	6				
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	47	0	100%	NA	NA	NA	NA	12	100%	NA	NA	NA	NA	NA	
Shreghati	1638	53	NA	15%	9	53	0	108	100%	0	0%	NA	NA	NA	
Tankuppa	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Tekari	3937	50	100%	566	0	0	0	423	100%	739	100%	0	0	0	
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	No. of pregnant women registered for ANC	% 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	
AMAS	1642	96%	94%	15%	3%	81%	25%	710	664	0	0	0	100%	0	0	100%	
ATRI	656	60%	60%	90%	30%	90%	90%	656	656	0	0		90%	14%	20	20%	
BARACHATI	3136	75.6%	58.1%	0	44%	86%	86%	2327	4033	0	0	5%	100%	0	35	53%	
Bankebazar	130	80%	85%	80%	2%	100%	80%	440	440	0	NA		100%	0	0	0	
BELAGANJ	1640	NA	74%	NA	56%	86%	NA	NA	1250	0	NA	75%	100%	0	15	2%	
BODH-GAYA	3027	20%	16%	0	75%	37%	33%	0	425	152	NA	0	100%	0	0	0%	
GURUA	562	100%	58%	27%	15%	92%	0%	58		0		0	58%	0	27	72%	
IMAMGANJ	2665	48%	35.3%	0	11.44 %	90.7%	11.44%	741	741	0	NA	0%	80.33%	0	28	88.93%	
KHIZERSARAI	1098	95%	82%		24%	96%	96%	1098	1887	863		0%	100%	0	12	0%	
KONCH	2062	11%	43	23%	23%	0		771	771	586	NA	5%	100%	0	7	100%	
MANPUR	2186	15%	91%	91%	14%	91%	NA	1653	1653	0	NA	2%	100%	0	251	15%	
MOHANPUR	NA	NA	59%	100%	49%	41%	NA	2987	388	0	NA	2%	100%	0	23	21%	
BATHANI	2490	80%	70%	90%	10%	81%	NA	NA	NA	0	NA	0%	NA	0	0	0%	
PARAIYA	128	100%	60%	85%		94.3%		47	47	0	NA	0%	100%	0	2		
SHERGHATI	1988	40%	90%	98%	15%	90%	92%	1638	1638	0	NA	0%	95%	0	5	20%	
TEKARI	3166	36%	86%	60%	6%	99%	18%			1358	NA	0%	80%	0	25	10%	
WAZARGANJ	3714	40%	17%	NA	NA	34%	NA	6910	2260	0	NA	12%	46%	0	43	13%	
FATEHPUR	1883	131	394	NA	NA	82%	NA	431	1717	0	NA	0%	100%	0	6	0%	

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

Table No. 9

REPRODUCTIVE HEALTH PHC LEVEL, GAYA

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	32%	141%	14.12%
2	ATRI	0	50%	60%	60%	0.5%
3	BANKEY BAZAR	0	5	0	0	311
4	BARACHATTI	0	0	55%	52%	64.80%
5	BELAGANJ	0	0	53%	56%	42%
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	20%	4%	0%
11	GURARU	NA	NA	NA	NA	NA
12	GURUA	0	12	77%	46%	46%
13	IMAMGANJ	0	268	38.5%	67.2%	38.5%
14	KHIZARSARAI	0	0	112%	44%	45.2%
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	22%	0	60%
22	TEKARI	0	0	35%	0	552
23	WAZIRGANJ	0	0	80%	20%	0

Table No. 10

RNTCP

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)	% patien o treat who out treat
1	AMAS	0.08%	NA	NA	NA	N
2	ATRI	3%	9%	111	90%	3
3	BANKEY BAZAR	1%	46	105	80%	0
4	BARACHATTI	3%	75%	360	96%	4
5	BELAGANJ	NA	21%	26.5%	16%	9
6	BODHGAYA	NA	NA	NA	NA	N
7	DOBHI	NA	NA	NA	NA	N
8	DUMARIYA	NA	NA	NA	NA	N
9	FATHEPUR	NA	17%	NA	NA	N
10	TOWNBLOCK	0	0	0	0	(
11	GURARU	NA	NA	NA	NA	N
12	GURUA	152	2/4	6	37%	12
13	IMAMGANJ	3%	203	90%	78%	80
14	KHIJARSARAI	2%	13	93	80%	3
15	KOACH	2%	2%	2.16	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	N
21	SHERGHATI	1%	0.10%	80	120	1
22	TEKARI	3%	74	215	92%	25
23	WAZIRGANJ	NA	NA	NA	NA	N

N A = Not available

Table No. 11

Vector Born Disease Control Programme

No.	Name of PHC	Annual Parasite Incidence	Annual Blood Examination Rate	Plasmodium Falciparum percentage	Slide Positivity Rate	Number of patients receiving treatment for Malaria	N pa	
1	AMAS	19%	19%	10	10%	19		
2	ATRI	0	0	0	0	0		
3	BANKEY BAZAR	0	0	15	0	5		
4	BARACHATTI	1	1	71%	5%	97		
5	BELAGANJ	NA	NA	NA	NA	NA		
6	BODHGAYA	NA	NA	NA	NA	NA		
7	DOBHI	NA	NA	NA	NA	NA		
8	DUMARIYA	NA	NA	NA	NA	NA		
9	FATHEPUR	0	0	0	0	2		
10	TOWNBLOCK	0	0	0	0	10		
11	GURARU	NA	NA	NA	NA	NA		
12	GURUA	2		0	2	2		
14	KHIZERSARAI	NA	NA	NA	NA	NA		
15	KOACH	0	0	0	0	0		
16	MANPUR	0	0	0	0	0		
17	MOHANPUR	17	91%	3%	2%	39		
18	MOHARA							
19	BATHNI	NA	NA	NA	NA	NA		
20	PARIYA	NA	720	NA	NA	NA		
21	SHERGHATI	27	1642	7	2%	27		
22	TEKARI	0	500	0	0	1200		
23	WAZIRGANJ	0	0	0	0	0		

Table No. 12

NATIONAL LEPROSY 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 ca	
1	AMAS	21	21	0	14	0	
2	ATRI	39	39	0	27	0	
3	BANKEY BAZAR	0	30	30	10	20	
4	BARACHATTI	0	0	0	0	0	
5	BELAGANJ	57	57	0	25	0	
6	BODHGAYA	NA	NA	NA	NA	0	
7	DOBHI	NA	NA	NA	NA	NA	
8	DUMARIYA	41	41	0	39	0	
9	FATHEPUR	NA	NA	NA	NA	NA	
10	TOWNBLOCK	40	25	3	15	1	
11	GURARU	46	46	1	17	0	
12	GURUA	132	132	0	70	2	
13	IMAMGANJ	67	67	0	27	0	
14	KHIZERSARAI	22	22	0	0	0	
15	KONCH	66	39	5	21	1	
16	MANPUR	0	68	0	28	0	
17	MOHANPUR	45	45	10	14	0	
18	MOHARA	Not Functional					
19	BATHANI	23	23	0	10	5	
20	PARAIYA	27	27	0	21	0	
21	SHERGHATI	30	30	0	5	0	
22	TEKARI	38	30	8	18	0	
23	WAZIRGANJ	43	43	0	36	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	908
3	BANKEY BAZAR	0	311
4	BARACHATTI	3	232
5	BELAGANJ	0	0
6	BODHGAYA	0	291
7	DOBHI	0	0
8	DUMARIYA	0	0
9	FATHEPUR	0	0
10	TOWNBLOCK	0	0
11	GURARU	0	0
12	GURUA	215	302
13	IMAMGANJ	0	40
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	61
21	SHERGHATI	274	131
22	TEKARI	0	0
23	WAZIRGANJ	0	0

Table No. 14

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

Sl.	Name of PHC	Number of cases detected	Number of cases registered	Number of cases operated	Number of patients enlisted with eye problem	Number of camps organized
1	AMAS	0	0	0	150	1
2	ATRI	0	0	0	0	0
3	BANKEY BAZAR	0	0	0	13	1
4	BARACHATTI	0	0	0	0	0
5	BELAGANJ	0	0	0	0	0
6	BODHGAYA	0	0	0	0	0
7	DOBHI	0	0	0	0	0
8	DUMARIYA	0	0	0	0	0
9	FATHEPUR	0	0	0	0	0
10	TOWNBLOCK	0	0	0	0	0
11	GURARU	0	0	0	0	0
12	GURUA	0	0	0	0	0
13	IMAMGANJ	0	0	0	0	0
14	KHIJARSARAI	0	0	0	0	0
15	KOACH	425	425	0	425	0
16	MANPUR	0	0	0	0	0
17	MOHANPUR	1221	0	0	0	0
18	MOHARA	0	0	0	0	0
19	BATHNI	0	0	0	0	0
20	PARIYA	0	0	0	0	0
21	SHERGHATI	0	0	0	0	0
22	TEKARI	0	0	0	0	0
23	WAZIRGANJ	0	0	0	0	0

Table No. 15

Support Services

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

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget

Name of the State/ UT: BIHAR (GAYA)

Sr. NO	STRATEGIES / Activities	Component Code (only at state level)	Output 2012	Activity Plan											Budget Plan								
				2009-2010FY					2010-2011 FY						2009-2010 FY						2010-2011 FY		
				Activity planned (X)	Activity Executed (Y)	Activity to be Executed till march (Y1) it includes Y	Variance (X~Y1)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C (< or > than planned)	Budget utilised {Y x (A)} = D	Budget to be utilised {Y1x(A)}= D1	under or over-utilised Budget {(B~D1} =E	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
				1	2		3		5	6	Q1	Q2	Q3	Q4	8	9		11		12	13		15
A	RCH			-	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-
A.1	MATERNAL HEALTH	Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																					
A.1.1	Operationalise facilities																						
A.1.1.1	Operationalise FRUs																						
	a. Operationalise blood storage unit			3	0		3	not executed by red cross society	3	empower with DHS to run the blood storage unit	3				8.64	25.92	4.32	0		4.32	21.6		
	b. Construction of FRU			3	0		3	fund not received	2	separate cont. wing for health dept.	1	1			450	900	0	0		0	900		
	c. Human resource																						
	Spl. Doctots								6		6				4.2	25.2	0	0		0	25.2		
	MBBS								4		4				3.6	14.4	0	0		0	14.4		
	ANM								6		6				0.96	5.76	0	0		0	5.76		

	Staff nurse							4		4				1.44	5.76	0	0		0	5.76				
	Ambulance							3	running under PPP	3				1.44	4.32	0	0		0	4.32				
	Blood donation camp							12		12				0.1	1.2	0	0		0					
A.1.1.2	Operationalise 24x7 PHCs																							
	a. Organise workshop			1	1		0		1		1				0.25	0.25	0.25	0	0.25	0	0.25			
	b.																							
	c.																							
	d.																							
	e.																							
A.1.2	Referral Transport																							
	a. Payment to ambulance								66						1.44	95.04	0	0			95.04			
	b.																							
	c.																							
	d.																							
	e.																							
A.1.3.1	RCH Outreach Camps																							
	a. RCH outreach camps in un served /unserved areas			85	0		85		85						0.007	0.63	0.63	0	0.63	0	0.6316			
	b.																							
	c.																							
	d.																							
	e.																							
A.1.3.2	Monthly Village Health and Nutrition Days																							
	a. Mahila mandal meeting								40008		1002	1002	1002	1002	0.003		0	0	0	0	100.02			
	b.																							
	c.																							
	d.																							
	e.																							
A.1.4	Janani Suraksha Yojana / JSY																							
A1.4.1	a. Home deliveries			456	228		228		456		114	114	114	114	0.005	2.28	1.28	0.07	1.07	0.14	2.14			
A.1.4.2.1	b. Institutional delivries (Rural)			41690	18450	17550	5690		48000		12000	12000	12000	12000	0.02	833.78	596.5	369	351	113.78	846.22			
A.1.4.2.2	c. Institutional delivries (Urban)			8338	2464	1705	4169		8000		2000	2000	2000	2000	0.012	100	70.4	12.32	37.7	20.38	75.62			
A.1.4.3	Other Activities(JSY) 1.4.3. Monitor quality and															8.62	5.74	0	0	5.74	2.88			

	utilisation of services and Mobile Data Centre at HSC and APHC Level and State Supervisory Committee for Blood Storage Unit																						
	e.																						
A.1.5	Other strategies/activities																						
A.1.5.1	Maternal Death Audit 1.1.3 Survey on maternal and perinatal deaths by verbal autopsy method (in two districts) @ 850 per death								mmr is 371 so no. of md is aprox 1780	md audit is conducted in every institution so that finding the main factor for md					0.009	0	0	0	0	0	15.13		
A.2.2	Facility Based Newborn Care/FBNC																						
	a. Fild fisiv for monitoring of monitor of progress against plan															1.08	0.815	0	0	0.815	0.265		
	b.																						
	c.																						
	d.																						
	e.																						
A.2.4	School Health Programme																						
	a. Health camp			3926	46	1500	2380		4000		1000	1000	1000	1000	0.021	58.89	29.44	1	31.47	0	83.92		
	b.																						
	c.																						
	d.																						
	e.																						
A.3.1.1	Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services																						
	a. Organise workshop			1	1		0		1				1		0.25	0.25	0.25	0.25	0	0	0.25		
	b.																						
	c.																						
	d.																						
	e.																						
A.3.1.2	Female Sterilisation camps								48		12	12	12	12	0.1	0	0	0		0	4.8		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						

A.3.1.3	NSV camps			7	0		7		4		1	1	1	1	0.1	0.7	0.4	0	0.3	0.1	0.3		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.3.1.4	Compensation for female sterilisation			17248	3853	9947	3448		24000		4800	2400	4800	7200	0.01	172.48	86.22	38.53	99.47	39.5	200.05		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.3.1.5	Compensation for male sterilisation			981	5	495	381		1000		100	100	400	400	0.015	14.72	9.8	0.073	7.42	2.3	12.7		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.3.1.6	Accreditation of private providers for sterilisation services			3183	795	2388	0		5000		1000	1000	1500	1500	0.015	47.73	35.8	11.93	35.8	0	75		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.3.2	Spacing Methods																						
A.3.2.1	IUD camps			216	0	108	108		200		50	50	50	50	0.01	2.16	1.44	0	1.08	0.36	1.64		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.3.3	Other strategies/activities																						
	a. POL for family planning															3.37	1.5	0	1.5	0	0	3.37	
	b.																						
	c.																						
	d.																						
	e.																						
A.4	ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH																						

A.4.1	Adolescent services at health facilities.			1	0		1		1		1				0.25	0.25	0.25	0	0	0.25	0		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.7	VULNERABLE GROUPS																						
	a. Camp at Mahadalit Tola								264		66	66	66	66	0.1	26.4	0	0	0	0	26.4		
	b.																						
	c.																						
	d.																						
	e.																						
A.8	INNOVATIONS/ PPP/ NGO																						
A.8.1	PNDT and Sex Ratio			*15*	*0*	*10*	*5*		*15*		*2*	*3*	*5*	*5*	*0.25*	3.77	2.51	0	2.5	0	3.75		
	a.																						
	b.																						
	c.																						
	d.																						
	e.																						
A.8.3	INFRASTRUCTURE & HR																						
A.9.1.1.	a. 9.1.1 ANMs 10.1.1.2. Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM			40	0		40		20		20				0.6	24	8	0	0	8	4		
A.9.1.2.	b. Laboratory Technicians			3	0		3		3		3				2.34	7.02	3.51	0	0	3.51	3.51		
A.9.1.4.	c. Doctors and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians) Hiring Specialists 1.1.1.1 Operationalise Blood Storage units in FRU -Salary of Medical Officer - 1,82,40,000/-; 10.1.2.1. Empeanelling Gynaecologists for gynaecology OPD in under or un served areas @ Rs. 1000/- week x 52 weeks ; 10.1.2.3. Empanelling Gyaneocologists for PHCstoprovide OPD services @ Rs. 300/- weekx 52 weeks; 10.1.2.4 Hiring Anaesthetist positions @ Rs.1000 per case x 120000; 10.1.2.5. Hiring Paediatrician for facilities where there are															86.36	43.18	0	0	43.18	0		

	vacant Paediatricians positions @ Rs. 35,000/- month (2 per district); 10.1.2.6 Hiring Gynaecologists for facilities that have vacant positions @ Rs. 650 per case x 75000 cases																							
A.9.1.5	Other contractual Staff 9.1 Fast-Track Training Cell in SIHFW 9.2 Filling Vacant Position at SIHFW/Hiring Consultant at SIHFW 10.1.1 Honorarium of Voluntary Workers @ of 1200/- PA x 3106 No.															1.95	0.97	0	0	0.97	0.98		
A.9.1.6	Incentive/Awards etc. 8.2.1 Incentive for ASHA per AWW center (80000x200 per month) and Incentive toANMs per Aganwari Centre under Muskan Programme (@80000 x Rs.150 Per Month															141	70.67	21.59	49.08	0	121.25		
A.9.2	Major civil works (new construction/extension/addition)																						
A.9.2.1	9.2.1 Major Civil works for operationalisation of FRUS										1	1			450	900	0	0		0	900		
	9.3 Minor Civil Works																						
	9.3.1 Minor civil works for operationalisation of FRUs 10.4.1 Facility improvement for establishing New Born Centres at 76 FRUs across the state - @ Rs. 50,000 / per FRU			3	0	2	1		3		3				0.5	1.5	1.5	0	1	0.5	1		
	9.3.2 Minor civil works for operationalisation of 24 hour services at PHCs 10.4.2. Facility improvement for establishing New Born Centres at PHCs across the state - @ Rs. 25,000 / per PHC			19	19		0		22		5	5	5	7	0.25	5.5	4.75	0.25	4.5	0	5.5		
A.10	Intitutional Strengthening																						
	10.4 11.4 Sub-centre rent and contingencies @ 1770 no. x Rs.500/- x 60 months								414						0.06	48.22	32.14	10.59	2	19.55	5.29		
A.11	Training																						
A.11.3.1	Skilled birth attendence			21	2	6	13		27		5	8	7	7	0.59	12.57	6.68	0.98	3.54	2.16	13.77		
A.11.3.4	MTP training			1	0	1	0		1			1			0.25	0.25	0.25	0	0.25	0	0.25		
A.11.3.5	RTI/ STI training								1				1		0.969	0.969	0	0	0	0	0.969		

A.11 .5	Child Health Training																					
A.11 .5.1	IMNCI TOT on IMNCI for health and ICDS worker			80	8	22	50		60		15	15	15	15	1.139	83.25	41.62	9.85	25.05	6.72	61.62		
A.11 ..2	Facility based newborn care								1			1			1.44	1.44	0	0	0	0	1.44		
A.11 .6.2	Minilap Training								24		6	6	6	6	0.28	6.72	0	0	0	0	6.72		
A.11 .8	Programme Management Training																					
A.11 .8.1	DPMU			1	0		1		2		1		1		2	1.98	1.23	0	0	1.23	0		
A.12	BCC/IEC																					
A.12 .2	Development to state BCC/IEC			1	1		0		1		1				0.25	0.25	0.25	0	0.25	0	0.25		
A.12 .4	BCC/IEC stretery															22	11	1.65	5	4.35	17.65		
A.14 .2	Strengthening of DPMU														12	7.39	5.54	4.11	3	0.28	11.72		
A.14 .3	Strengthening of financial management system			1	1		0		1		1				2.4	2.4	1.2	0.6	0.6	0	2.4		
A.14 .4	Programme Management exp. Including infrastruture of DHS														12	8.39	8.39	5.11	3.28	0	12		
	Total														**960.3**	**3718.12**	**1088.4**	**487.9**	**667.7**	**278.14**	**3694.4**		

Structured approaches for State/ District/ Block PIP planning

National Rural Health Mission

Strategy & Activity Plan with budget

Name of the State/ UT: Gaya Dist. NRHM Part - B

Sr. NO	STRATEGIES	Activities	Component Code (only at state level)	Output 2012	Activity Plan											Budget Plan								
					2009-2010 FY					20010-2011 FY						2009-2010FY						2010-2011FY		
					Activity planned (X)	Activity Executed (Y)	Activity to be Executed till march (Y1) it includes Y	Variance (X-Y)	Reasons for Variance	Activity planned including previous yrs gap {Z+(X~Y)} =AP	Special efforts to overcome constraints (Process to be adopted)	time line of activities				Tentative Unit Cost (A)	Budget Planned {X x (A)} = B	Budget received B or C or > than planned) (<	Budget utilised {Y x (A)} = D	Budget to be utilised {Y1x(A)}= D1	under or over-utilised Budget {(B~D)} =E	Budget Planned (including spill over amount) {(AP x A) ± E} = BP	Budgetary Source (other than NRHM source)	Remarks
												Q1	Q2	Q3	Q4									
B	Additinalities under NRHM (Mission Flexible Pool)				-	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-	-	-
			Please Note: plan all possible activities you think necessary for your area to realistically operationalise each strategy. Consider during planning: Infrastructure, Human Resources- all specialist, Para medics etc, Infection control & Environmental Plan, Logistics Management, HMIS, Monitoring & evaluation, Training- PMU, Dai, others, BCC/ IEC, Procurement of equipments/ Drugs, Strengthening Societies, PMU, RKS, VHSC, AYUSH inputs, initiatives for quality management																				
B.1	Selection &Training of ASHA																							
B1.12		Asha support system at dist.level			1	0		1		1			1											
		a. Dist. Asha Manager			1	0		1		1		1				2.4	0	0	0	0	0	2.4		
		b. establishment of asha help desk			1	0		1		1		1				0.48	0.48	0	0	0	0	0.48		
		c. asha sammlean								1				1		4.7	0	0	0	0	0	4.7		

B.1.13		Asha support system at block level																								
		Block Asha Manager									24		24				1.44	25.92	0	0	0	0	34.56		
		establishment of asha help desk									24		24				0.06	1.08	0	0	0	0	1.44		
B. 1.14		Asha support system at village level									24		24				0.36	1.64	0.41	0	0	0	1.64		
B.1.15		Asha Training									33		6	6	6	15	0.708	0	0	0	0	0	23.4		
B.1.16		Asha drugs kits replenishment				832	0	832	0		3514			3514			0.01	8.3	0	0	0	0	35		
B.1.18		Motivation of asha																								
		Procurement of sari & chhata				3206	0	3206	0		3514			3514			0.007	23.24	5.81	0	5.81	0	25.47		
		Awards														24	0.02	0	0	0	0		0.48		
		I card									3514		3514				0.002	0	0	0	0	0	0.7028		
B.1.2.		Asha divas									12		3	3	3	3	2.63	29.85	7.46	7.46	22.39	0	31.56		
B.1.21	untied fund																									
		a. PHC									23		23				0.25	5.5	5.5	3	2.5	0	5.75		
		b. APHC									73		73				0.25	11.5	11.5	5.5	6	0	18.25		
		c. Sub centre									541		541				0.1	43.9	43.9	6.63	37.27	0	54.1		
		d. Orientation at dist. Level									1		1				0.02	0	0	0	0	0	0.02		
		d. Orientation at PHC Level									24		24				0.03	0	0	0	0	0	0.72		

		Monitoring & review									1		1				0.04	0	0	0	0	0	0.04		
B.1.23	Corpus Grant to HMS/RKS																									
		a. PHC				22	22	0	0		23		23				1	22	22	7.76	14.24	0	23		
		b. sadar hospital				2	2	0	0		3		3				5	10	10	2.5	7.5	0	10		
		c.																								
		d.																								
		e.																								
B.1.2.2	Untied fund for Village Health & Sanitation Committee																									
		a. untied fund									2686		2686				0.1	268.6	0	0	268.6	0	268.6		
		b. Orientation at PHC Level									24		24				0.025	0	0	0	0	0	0.6		
		c.																								
		d.																								
		e.																								
b.2	infrastructure strengthening																									
B.2.1		a. const. of hsc				12	3	9	0		25						9.5	114	28.5	28.5	85.5	0	237.5		
		b. cont. of rest. Qtr.				2	0	2	0		3						30	60	15	0	15	0	90		
		c. cont.of APHC				2	1	1	0		4						53.15	106.3	26.575	26.575	79.725	0	212.6		
		d.																								
		e.																								

B.2.3	Upgradation of CHCs to IPHS					12	0	0	12		12		3	3	3	3	40	480	120	0	0	120	360		
B.2.5	Upgradation of ANM Training school					1	0	0	1		1		1				50	50	10	0	0	10	40		
B.2.6	Annual Maint. Grant										23		23				1	28	7	2.51	4.49	0	28		
B. 3.1.A	Incentive for PHC doctors & staff																	6.4	0	0	0	0	6.4		
B.3.1.B	Salaries for staff nurses					129	72	57	0		146		146				0.075	116.1	67.28	57.57	9.71	0	131.4		
B.3.1.C	Salaries for ANMs					161	161	0	0		405		405				0.06	115.9	28.98	28.98	0	0	291.6		
B.4	PPP initiatives																								
	B.4.1	102 ambulance services				1	1	0	0		1		1				4.92	4.92	1.23	1.23	0	0	4.92		
	B4.2	1911 doctors on call				1	1	0	0		1		1				0.14	1.36	0.45	0.45	0	0	1.68		
	B.4.1	outsourceing of pathology & radiology services																90	90	2	20	68	22		
B.4.6.		Services of hospital wast treatment																22.23	0	0	0	0	22.23		
B.4.8.		setting up of ultramodern diagnostic				1	1	0	0									48	30	30	0	0			
B.4.11		Operationlising MMU				1	1	0	0		1		1				56.16	42.12	0	0	0	0	56.16		
B.4.14	Monitring &evaluation					25	25	0	0		26		26				0.624	29.7	7.42	7.42	0	0	16.22		
B.4.16		NRC									1		1				24.67	0	0	0	0	0	24.672		
B.5.		Procurement of supplies																							
	B.5.1	Delivery kit									6570						0.003	1.64	0	0	0	0	1.65		
	B.5.2.	SBA drug kits									1051						0.025	2.57	0	0	0	0	2.57		

	B.5.3.	Availabilty of sanitary napkins				1	1	0	0		1						0.25	0.25	0.25	0	0	0	0.25		
	B.5.4	Procurement of beds																14.15	14.15	14.15	0	0	4		
B.6.	Procurement of Drugs																								
	B.6.1	Cost of IFA for pregnant &lactating monthers															0.0011/1000	10.07					10.07		
	B.6.2	Cost of IFA for (1-5) years children																17.21	0	0	0	0	17.21		
	B.6.3.	Cost of IFA for adolescent girls																15.79	15.79	0	15.79	0	15.79		
B. 9.		Strenthening of cold chain																							
	B.9.1.	Refurbishment of existing warehouse for r.i. as well asprovision for hirining external																							
	B.9.2.	Refurbishment of existing cold chain room for dist. Stores																7	1	1	2	4	0		
	B.9.3.	Earthing and wiring of exixting cold chain rooms in all PHCs																1.8	0	0	0	0	3		
B.10.		Preparation of action plan																1	0	0	0	0	2		
	B.13.6.	NSV kit																0.2	0	0	0	0	0.2		
	B.13.7	IUD insection kit																0.15	0	0	0	0	0.15		
	B.13.8	Minilap sets																0.3	0	0	0	0	0.3		
B.13.8		AYUSH																							
		Human resource																							

B.19	Ayush doctors									73						2.4	68.4	0	0	0	0	175.2		
	Paramedical									73						0.468	0	0	0	0	0	34.16		
	Pharmacist									73						0.72	0	0	0	0	0	52.56		
	Procument of medicine									73						0.5	0	0	0	0	0	36.5		
	infrastructure strengthening									46						15	0	0	0	0	0	690		
	contigence									73						0.3	21.9							
	Relife for blood transfusation fund																					10		
	Procurement of racks for drugs store									200		200				0.05	0	0	0	0	0	10		
	Total															309.6	1930	570.21	233.235	596.53	202	3153.9		