# District Health Society

# Buxar

## District Health Action Plan

## 2012-2013

**Developed & Designed**

**By**

**Mohd Nurul Hoda (DPC)**

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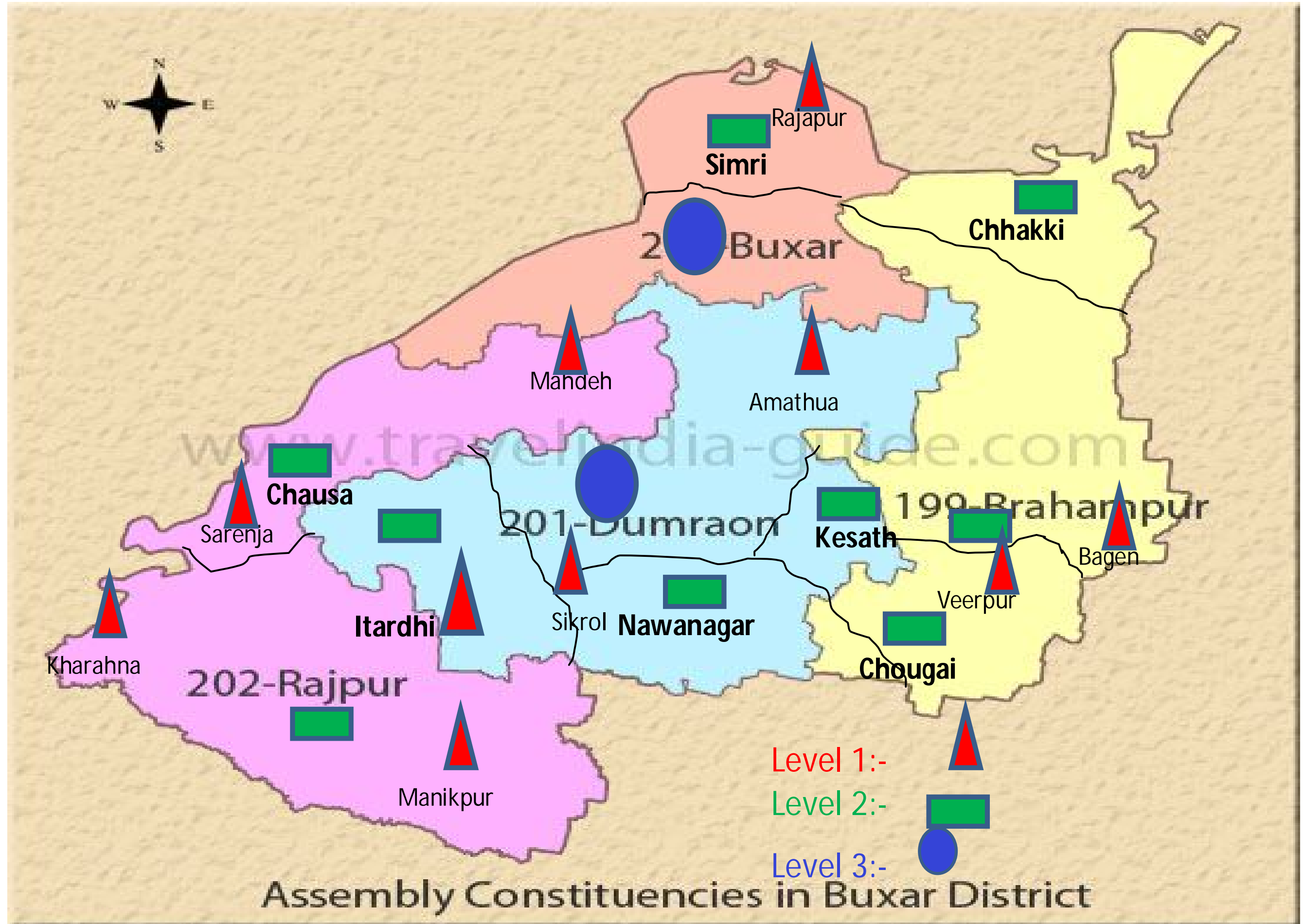
# MAP OF BUXAR




## STRUCTURE OF DISTRICT PLAN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# PREFACE

National Rural Health Mission (NRHM) is one of the major health schemes run by
Ministry of health and family welfare, GoI. The basic concept of the mission is to
enhance the access of Quality health services to the poorest of the poor of the society and improve the health status of the community. It envisages to improve the health status of the rural mass through various programmes. All the health services should be provided to the pregnant women such as ANC checkups, Post Natal Care, IFA tablets for restricting the anemia cases and other reproductive child health related services. It also focuses on promotion of institutional delivery for restricting the infant and as well as maternal deaths. Immunization is also a very important component which plays a vital role in child and mother health. Family planning and control of other diseases are also other focus areas.

The NRHM has a strong realization that it is important to involve community for the improvement of health status of the community through various stake holders such as ASHA, AWWs, PRI, and NGOs etc. ASHA is a link worker between the client and the health service providers. The skill of the health functionaries such as ANMs LHVs should be upgraded through proper orientation to ensure quality of care in health services. Apart from that there is a need to strengthen the infrastructure and area of human resource for getting the quality of care in health services at the health centers. To achieve the better health status of the District, there is need to develop a District Health Action plan. There is need to conduct situational analysis by going through available data of healths delivery centres, and making community interaction at grassroots level with PRI, Local power group etc. The District Health Society will develop a District Health Action Plan for the year 2012-2013 and implement the DHAP for betterment of the health status of the rural mass of the society.

Thanks to the Capacity Building Training organized by the State Health Society Bihar with support from National Health System Resource Centre (NHSRC) & Public Health Resource Network (PHRN) from continuously last three years that the planning team from the district got trained to be able to be confident enough to prepare the DHAP. Planning team members needs to be acknowledged. Without their untiring efforts this document would not have been out.

**Shri Ajay Yadav, IAS**

**(DM, Buxar)**

## About the Profile

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

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

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

| **Shri Dhananjai Sharma** | **Dr. R.N. Ram** | **Dr. R. C. Prasad** |
|---|---|---|
| **DPM - Buxar** | **ACMO, Buxar** | **Civil Surgeon,** |

## ABBREVIATIONS:-

| | |
|---|---|
| AWW | Anganwadi Worker |
| BCC | Behavior Change Communication |
| BEmONC | Basic Emergency Obstetric & Neonatal Care |
| BPL | Below Poverty Line |
| CEmONC | Comprehensive Emergency Obstetric & Neonatal Care |
| CHC | Community Health Centre |
| AFHS | Adolescent Friendly Health Services |
| ANM | Auxiliary Nurse Midwife |
| ANC | Ante Natal Care |
| DH | District Hospital |
| FHS | Female Health Supervisor |
| FHW | Female Health Worker |
| FNGO | Field Non Government Organization |
| FP | Family Planning |
| FRU | First Referral Unit |
| ICDS | Integrated Child Development Scheme |
| IDSP | Integrated Disease Surveillance Project |
| IFA | Iron Folic Acid |
| IIPS | Indian Institute of Population Studies |
| IMNCI | Integrated Management of Neonatal and Childhood Illness |
| IMR | Infant Mortality Rate |
| IPHS | Indian Public Health Standard |
| ISM | Indigenous System of Medicine |
| MMU | Mobile Health Unit |
| MMR | Maternal Mortality Rate |
| MNGO | Mother Non Government Organization |
| MO | Medical Officer |
| MTP | Medical Terminate of Pregnancy |
| NGO | Non- Government Organization |
| NLEP | National Leprosy Eradication Programme |
| NMR | Neonatal Mortality Rate |
| NNC | Neo Natal Care |
| NVBDCP | National Vector Born Disease Control Program |
| PIP | Program Implementation Plan |
| PPP | Public Private Partnership |
| QA | Quality Assurance |
| RCH | Reproductive and Child Health |
| RMT | Regional Monitoring Team |
| RNTCP | Revised National Tuberculosis Control Program |
| RTI | Reproductive Tract Infection |
| SBA | Skilled Birth Attendants |
| STI | Sexual Transmitted Illness |
| TBA | Trained Birth Attendant |
| TFR | Total Fertility Rates |

TT Tetanus Toxide

# Chapter 1:-
## Introduction And Demographic Indicator of the District

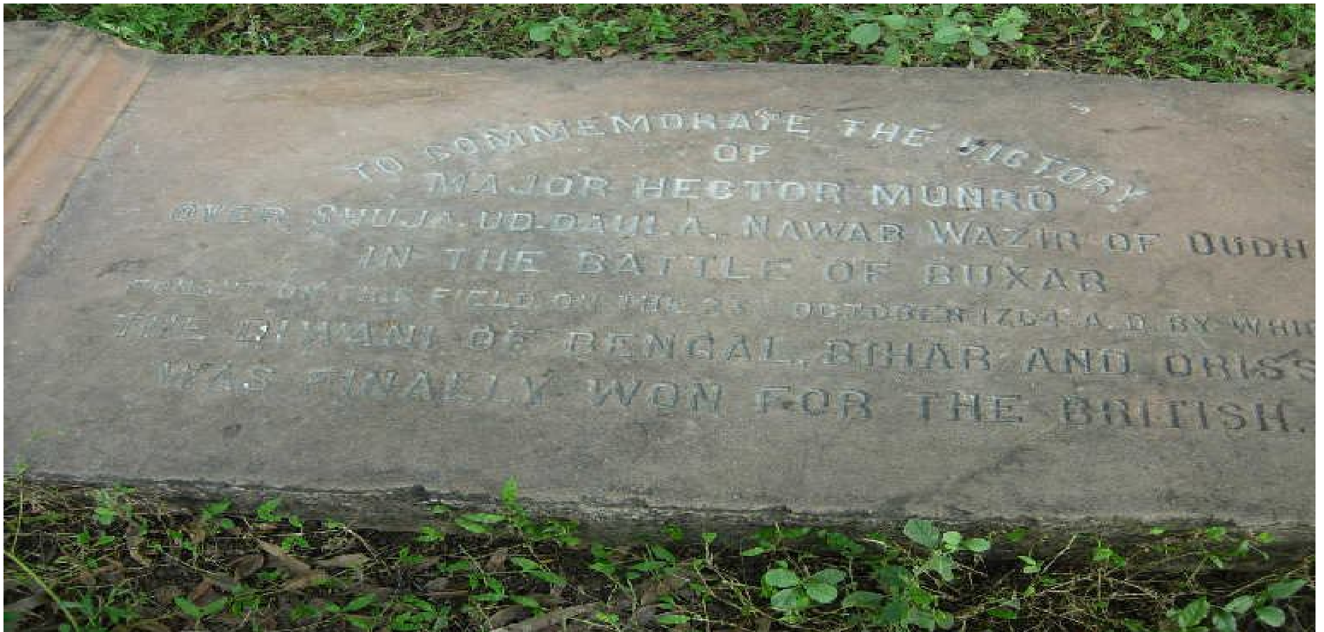
Buxar district has close linkage with that of its parent district Bhojpur and has an old and an interesting history.
Buxar is famous since the epic period for being the seats of eminent saints, battlefield of Gods and Demons as per Puranas and a combat zone between foreign invasion and countrymen in modern history. The remains from archaeological excavations have established the link of Buxar with ancient civilizations of Mohanjodaro and Harappa. This place was also known as "Siddhashram", "Vedgarbhapuri", "Karush", "Tapovan", "Chaitrath", "VyaghraSar", "Buxar" in ancient history. The History of Buxar dates back even prior to the period of Ramayana. The word Buxar is said to have been derived from VyaghraSar. The tiger face of Rishi Vedshira, an outcome of the curse of the sage Rishi Durvasha, was restored after bathing in a holy tank which was later named as VyaghraSar.
According to mythology, sage Vishwamitra the family guru of Lord Rama and eighty thousand saints had their sacred ashram at the banks of holy river Ganges that reside inside the modern District Buxar. He was disturbed in the yagna (sacrificial offering) by the demons. The place where due killing of the famous Rakshasi (demoness) Tadika by Lord Rama, is said to fall within the present Buxar town area. Besides, Lord Rama and his younger brother Laxman took their teachings at Buxar. It is also said that Ahilya, the wife of Gautam Rishi restored her human body from that of stone and got salvation by a mere touch of the feet of Lord Rama. This place is presently known as Ahirauli and is situated six kilometers away from the Buxar town. The Kanwaldah Pokhara also known as VyaghraSar is a tourist spot now a days.
Ancient Significance of Buxar is mentioned in ancient epics like Brahamana Purana and Varah Purana:
During the Mughal period, the historic battle between Humayun and Sher Shah Shuri was fought at Chousa in 1539 A.D. The British forces under Sir Heoter Munro defeated the Muslim army of Mir Qasim, Shuja-ud-Daulah and Shah Alam-II on 23rd June 1764 on the grounds of Katkauli situated at about 6 kilometers from Buxar town. The stone memorial erected by Britishers at Katkauli bears testament to the fight even today.
Buxar district is an administrative district in the state of Bihar in India. The district headquarters are located at Buxar. The district occupies an area of 1624 km² and has a population of 18, 23,115 (as per census 2011).
The town Buxar is located on the bank of river Ganges (Ganga). A road bridge over Ganges connects Buxar with Ballia District of neighboring state Uttar Pradesh. The town is connected to the state capital Patna by rail and

road routes. Substantial proportion of trade activities are with well connected towns and cities in Uttar Pradesh such as Chandouli, Ballia and Ghazipur.
Main economic activity of the district is agriculture and related trade. Rice and wheat are main crops. Sugarcane production, once prominent, has come down since closure of the local sugar factory.

## History

Battle of Buxar: Mir Kasim (reign : 1760 to 1763), attempted to recover Bengal from the hands of British. In 1764, he enlisted the help of Mughal Emperor Shah Alam II and Nawab Shuja Ud Daulah of Oudh (Awadh). On October 23, 1764, Mir Kasim with his army was defeated by the British Major Hector Monro who led a contingent of 857 European soldiers and 6,213 sepoys. This victory paved the way for British Empire in India.

**Battle of Buxar**




## Religious Importance of Buxar

Buxar is a very important place for Hindus. Rishi Vishwamitra conducted his yagya here and brought lord Ram in his childhood from Ayodhya to protect his yagya from the evils of rakshasha, which he did by killing a lady evil named Tarkasur. Her deity is now installed and people usually go to see that. Lord Ram also released Ahilya by touching her through his foot and Ahilya lying in the form of stone converted into the human. Some one kilometer away from the city of Buxar the village at the bank of holy river Ganga AHIROULI is still there which has a small temple of Ahilya. The name Ahirouli of the village seems to be converted from ahilyavali (abode of ahilya). Degree college of Buxar is named on Rishi Vishwamitra established by famous saint late Shri Khaki Baba. This is the place from where lord Ram started his journey to attend the **Swayamwar** of Devi Sita, daughter of king Janak at Janakpuri in north Bihar, Mithila and married Devi Sita under the noble guidance of rishi Vishwamitra even without the knowledge of his father king Dasarath of Ayodhya. Many people once in a year take round of this religious area called **Panchkosi Parikrama**. They perform it in five days by halting in night in five villages surrounding Buxar. During this visit they cook their own food called

**Litti-Bhanta**. This recipe is famous in Bihar, especially in the Bhojpuri speaking area. Dried dung cakes are used to prepare this recipe as fuel. It is easily available in whole of the area. Litti is ball like structure made of wheat flour by filling the black gram roasted powder mixed with salt and spices called Sattu. Bhanta (Round Brinjal) roasted in the fire of dung along with potato and tomato. Finally, all are mashed after removing its peel and taken with litti which is also roasted in the same fire. It's very delicious and famous recipe of bhojpuri speaking area. About ten kilometers east to the Buxar City on the Patna main road is the village Bhojpur. A broken and neglected fort of king Bhoj is still there. Perhaps, this is the place which originated the Bhojpuri language. It is said that the lamp light put on the top of this fort was visible in Delhi in night and some mughal emperor did not like the height of such fort and finally he smashed it. Although, this place is Historically very important, needs research to authenticate the references.

**Tadika Badh**

## ABOUT NRHM:-

### Executive Summary

The **NRHM** seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the **Maternal Mortality Rate (MMR)** in the country from 407 to 100 per 1,00,000 live births, **Infant Mortality Rate (IMR)** from 60 to 30 per 1000 live births and the **Total Fertility Rate (TFR)** from 3.0 to 2.1 within the 7 year period of the Mission.

The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalzing community health centers into

functional hospitals meeting Indian Public Health Standards in each Block of the Country.

In baseline surveys, key information required for planning of various health activities are collected. The information collected provides a picture of the local situation and determines the appropriate strategy programme development and implementation. The method of data collection is both primary as well as secondary. The secondary data were collected by reviewing records, registers, and annual reports. For primary data; the procedure involved; focus group discussions, personnel interviews, and meetings. These were held at various stages to have opinion from all the programme officers, health staff, NGOs, and grass root workers. The entire planning revolves around participatory planning. Planning involve all the programmes i.e. NRHM, RCH, NVBDCP, NLEP, NBCP, IDSP, and RNTCP. The budget lines and work activities for different programmes are separately discussed.

Under NRHM special focus is given to mobile medical units, urban health, formation of village health sanitation and nutrition committee, infrastructure development, village health and nutrition day and most importantly selection and training. Reproductive and child health is another important area involving maternal health, child health, immunization, nutrition rehabilitation centre (NRC), adolescent health, RTI/STI management, and family planning and Asha program. In order to increase institutional delivery attention has been given to 24x7 PHCs. For management of malnutrition support to GMIS project is included in the plan. "National programme for Control of Blindness, include innovative approach for cataract management through formation of cataract identifying team. This team constitutes of multipurpose health worker, religious leaders of the village, link person, community based volunteers, ASHA, Mamta, ophthalmic assistant, and supporting staff. School eye examination is also strengthened for managing refractive errors.

The goal of NLEP phase-2 was to eliminate leprosy by March-2005 by reducing the prevalence rate of leprosy to below 1 per 10,000 populations. Tackling urban leprosy is also an important component. The activities include training, EDPT, case validation, RFT, deformity care and rehabilitation. The Revised National Tuberculosis Control Programme (RNTCP) aims to stop the spread of TB by curing patients. The major activities include technical, institutional strengthening, IEC, training, quality assurance, and research and surveys to accomplish the set Objectives. To expand the horizons of NAMP operational activities the various vector borne diseases like Dengue, Filarias, Japanese Encephalitis, Chikungyuniea, Kala-azar etc, have been incorporated and subsequently the name of the programme changed to National Vector Borne Disease Control Programme (NVBDCP). Under the plan the activities include EDPT, selective vector control, IMNP, biological control, management information system, and human resource development.

To have effective surveillance system, IDSP was introduced. The planning of IDSP include case detection and recording, compiling the weekly reports, report transmission, analysis and interpretation, taking appropriate action, investigation and confirmation of suspected cases and outbreaks if any, providing feedback and dissemination of results, and evaluation leading to

improvement in the system.For all the endeavors the district will follow ***"Triple A Approach"-***Assess the problem, Analyze its causes, and Take Action.

## Objective And Strategies Of the National Rural Health Mission:-

### INTRODUCTION:-

The **National Rural Health Mission (NRHM)** has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for primitive and preventive health care.

### THE OBJECTIVES OF THE MISSION

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases,
- Including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

### The expected outcomes from the Mission as reflected in statistical data are:

- IMR reduced to 30/1000 live births by 2012.
- Maternal Mortality reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.
- Malaria Mortality Reduction Rate - 50% up to 2011, additional 10% by 2012.

- Kala Azar Mortality Reduction Rate - 100% by 2011 and sustaining elimination until 2012.
- Dengue Mortality Reduction Rate - 50% by 2011 and sustaining at that level until 2012.
- Filaria / Microfilaria Reduction Rate - 70% by 2011, 80% by 2012 and
- Elimination by 2015.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8/10,000 in 2005 to less than 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.
- Upgrading all Community Health Centers to Indian Public Health
- Standards.
- Increase utilization of First Referral units from bed occupancy by referred
- Cases of less than 20% to over 75%.
- Engaging 4, 00,000 female Accredited Social Health Activists (ASHAs).
-

**The expected outcomes at Community level:**

- Availability of trained community level worker at village level, with a drug kit for generic ailments.
- Health Day at Aanganwadi level on a fixed day/month for provision of
  Immunization, ante/post natal check ups and services related to mother and child health care, including nutrition.
- Availability of generic drugs for common ailments at sub Centre and Hospital level.
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and assured referral-transport-communication systems to reach these facilities in time.
- Improved access to universal immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization
  Services under the programme.
- Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under the Janani Evam Bal Surakshya Yojana (JBSY) for the below poverty line families.
- Availability of assured health care at reduced financial risk through pilots of Community Health Insurance under the Mission.
- Availability of safe drinking water.
- Provision of household toilets.
- Improved outreach services to medically under-served & remote areas through mobile medical units and Health Camps.
- Increase awareness about preventive health including nutrition.

**The core strategies of the Mission:**

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.

- Promote access to improved healthcare at household level through the
  Accredited Female Health Activist (ASHA).
- Health Plan for each village through Village Health Sanitation & Nutrition Committee of the Panchayat.
- Strengthening sub-centre through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)
- Preparation and implementation of an inter sector District Health Action
  Plan prepared by the District Health Mission, including drinking water,
  sanitation, hygiene and nutrition.

**Role of the District Health Mission :-**

- Responsible for planning implementing, monitoring and evaluating progress of mission.
- Preparation of annual and perspective plan for the district.
- Suggesting district specific interventions.
- Carrying out survey of non-governmental providers to see what contribution they can make.
- Partnership with NGOs, Panchayats for effective action.
- Strengthening training institutions for ANMs/ Nurses etc.
- Provide leadership to Village Gram Panchayat, Cluster and block level teams.
- Establish Resource Group for professional also can facilitate implementation of CORE strategies of the mission.
- Experiment with risk pooling for hospitalization.
- Ensure referral chain and timely disbursement of all claims.
- Arrange for technical support to the blocks teams and for itself.
- Arrange for epidemiological studies and operational research to guide district level planning.
- Nurture community processes.
- Transparent system of procurement and accountability.
- Activate women's groups; adolescent girl's for to ensure gender sensitive
  Approach.
- Provide _data analysis and compilation facility in order to meet regular MIS needs.
- Carry out Health Facility and supervision of household surveys.

- District Health Mission to ensure that district annual action plans as per RNTCP requirement would continue to be submitted by the district to the state TB cell.

## Planning Objectives:-

The aim of the present study is to prepare DHAP based on the broad objective of the NRHM. Specific objectives of the process are:

To identify critical health issues and concerns with special focus on vulnerable /disadvantage groups and isolated areas and attain consensus on feasible solutions.

- To examine existing health care delivery mechanisms to identify performance gaps and develop strategies to bridge them.
- To actively engage a wide range of stakeholders from the community, including the Panchayat, in the planning process.
- To identify priorities at the grassroots level and set out roles and responsibilities at the Panchayat and block levels for designing need-based BHAPs.
- To espouse inter-sectoral convergence approach at the village, HSC, block and district levels to make the planning process and implementation process more holistic.
- Emphasis on resource management and integrated development.
- Enhancing the quality of basic services offered by local bodies with emphasis on the services relating to health, education, water supply and sanitation and waste management.
- Exploring avenues for increasing social participation, gender and financial equality etc.
- Enhancing the efficiency of local bodies, particularly for resource management.

## District Planning Process:-

The District Health Action Plan of Buxar has been prepared under the guidance of the Chief Medical Officer, the Additional Chief Medical Officer, Deputy Supremetendent, DIO, Nodal Officer- Family Planning, DPM, DAM, MEO, DCN of Buxar with a joint effort of the District Health Educator, the BMOs and various M.O-PHCs as well as other concerned departments under a participatory process. The field staffs of the department have also played a significant role. Public Health Resource Network has provided technical assistance in estimation and drafting of various components of this plan.

| Summary Of The Planning Process |
| --- |
| **Constitution of District Planning Team and Block Planning Team for timely preparation of DHAP 2012-13** |

| Preliminary meeting with CMO and ACMO along with other concerned officials. Designated one District Programme Officer as Nodal Officer per block. |
| --- |
| Organized One Day Workshop for Development Partners, Block & Facility Team & Shared Planning Formats. |
| Data Collection for Situational Analysis – MOIC, BHM, BAM & BCM meeting chaired by CMO/CS & ACMO. |
| Block level consultations with MOICs and BHMs |
| Writing of situation analysis |
| District Planning workshop to review situation analysis and prepare outline of district health plan- the meeting was chaired by CMO and facilitated by ACMO. The workshop was attended by MOICs, BHMs and other key health functionaries at the district level. |
| District Consultations for preparation of 1st Draft |
| Preliminary appraisal of Draft |
| Final Appraisal |
| Final DHAP: Submission to DHS and State |
| Adoption by DHS and Zila Parishad |
| Printing and Dissemination |

## Planning, Monitoring and Evaluation processes:

Planning, Monitoring and Evaluation of health services program is carried out at the district/PHC/SC level. A check list is prepared. The items can be responded through interview, document review and observation of processes at three levels.
At district level annual plans prepared by group discussion with MOPHC at meeting and District Program Management Unit. Plans are implemented very well at field level. There is a district plan made for resources. Programs are monitored by different category of supervisory staff through field visits, records and registers, check-list, observations. Feed back given by subordinates is satisfactory and corrective measures taken for future action. Program evaluation is done by central/state government through NFHS, SRS and ORG. This NRHM action plan is the compilation of the planned activities to be carried out at all level of care. The activities for a year is divided into four quarters and distributed accordingly. This plan is based on the past performance of the district. The records were used as a source of secondary data.

There are 11 blocks in the district and from each block 2 villages were chosen for conducting focused group discussions.

The Vision 2013 document aimed to lower both infant and maternal mortality to less than one third of the prevailing levels and stabilize population by reducing TFR from 2.8 to 2.1 by 2013. The RCH program launched in the district in 1997-2004 provided impetus for achieving policy goals as reflected in the Vision 2013 document.
In accordance with India's National Population Policy, Buxar's population policy also focuses on improving the quality of life of the people, reducing gender discrimination, empowering women, and ensuring extensive service support to achieve replacement level fertility <2 by 2013. Respecting the reproductive rights of men and women is an underlying principle of Buxar's Population Policy. Achievement of this goal calls for 100% access to quality and affordable reproductive health services, including family planning and sexual health services, and significant reduction in infants and maternal mortality. Women's education remains an important objective not only because it is closely associated with lower infant mortality and lower fertility, but for its own sake. Universal access to primary education particularly, for girls, and closing of the "gender gap" in education receives priority. Specific measures are being undertaken to achieve gender equity and equality, and to empower women. The latter requires strong support from men, and their participation in women's empowerment. Women's health and women's education is being encouraged. The proposed RCH-II program is in conformity with an integrated approach to the program, aimed at improving the health status of women and children.

## Collection of basic data for planning:-

### Primary Data:

All the Medical Officers were interacted and their concern was taken in to consideration. Daily work process was observed properly and inputs were taken in account. District officials including CMO, ACMO, DIO, DMO, DLO, RCHO and Development Partners were interviewed and their ideas were kept for planning process.

### Secondary Data:

Following books, modules and reports were taken in account for this Planning Process:

- RCH-II Project Implementation Plan
- NRHM operational guideline
- DLHS Report
- Report Given by DTC
- Report taken from different programme societies e.g. Blindness control, Routine Immunization, Faleria, VBDCP.
- Leprosy Society, District TB Center , District Malaria Office
- Census-2011
- National Habitation Survey-2003

- Population foundation Of India 2007
- National Family Health Survey (NFSC 3) 2005-2006
- Special bulletin on Maternal In India 2004-2006 Published on April 2009
- Bihar State official website

## Tools:

Main tools used for the data collection were:

- Informal In-depth interview
- Group presentation with different district level officials
- Informal group discussions with different level of workers and community representative

**Review of secondary data**

## Data Analysis and Plan Preparation:-

**Primary Data:** Data analysis was done manually. All the interviews were recorded and there points were noted down. After that common points were selected out of that.

**Secondary Data:** All the manuals books and reports were converted in to analysis tables and these tables are given in to introduction and background part of this plan.

## The priorities, the constraints, and action to overcome them:-

The table given below brings out an analysis of the priorities, constraints in achieving progress in those priority areas and the action needed to overcome those constraints: -

| Priorities | Constraints | Action to overcome constraints |
|---|---|---|
| **Functional facilities - Establishing fully functional Sub Health Centers / APHCs / PHCs CHCs/Sub Divisional/District Hospitals.** | Dilapidated or absent physical infrastructure<br>• Non-availability of doctors /paramedics<br>• Drugs/ vaccines shortages<br>• Dysfunctional equipments<br>• Untimely procurements<br>• Chocked fund flows<br>• Lack of accountability<br>• framework<br>• Inflexible financial | • Infrastructure/ equipments<br>• Management support<br>• Streamlined fund flows<br>• Contractual appointment and support for capacity<br>• development<br>• Pooling of staff/optimal utilization<br>• Improved HMIS<br>• Streamlined procurement<br>• Local level flexibility |

| | | |
|---|---|---|
| | resources.<br>• No minimum mandatory service provision standards for every facility in place which makes full use of available human and physical resources and no road map to how desirable levels can be achieved | • Community /PRI/RKS for accountability / M&E<br>• Adopt standard treatment guidelines for each facility and different levels of Staffing, and develop road maps to reach desirable levels in a five to seven year period. |
| **Increasing and improving human resources in rural areas** | • Non-availability of doctors<br>• Non-availability of paramedics<br>• Shortage of ANMs/ LHVs / MPWs.<br>• Large jurisdiction and poor monitoring.<br>• No accountability<br>• Lack of any plan for career advancement or for Systematic skill upgradation.<br>• No system of appraisal with incentives / disincentives for good / poor performance and Governance related problems. | • Local preference<br>• Contractual appointment to a facility for filling short term gaps.<br>• Management of facilities including personnel by PRI Committees.<br>• Train and develop local residents of remote areas with appropriate cadre<br>• Structure and incentives.<br>• Multi-skilling of doctors /paramedics and continuous skill upgradation<br>• Convergence with AYUSH<br>• Involvement of RMPs.<br>• Partnership with non-State Stakeholders. |
| **Accountable health delivery** | • Panchayati Raj Institutions /user groups have little say in health system<br>• No village / hamlet level unit of delivery<br>• No resources for flexible community action | • Referral chain from hamlet to hospital<br>• Control and management of Health facilities by PRIs<br>• Budget to be managed by the PRI/User Group<br>• PRI/User Group mandate for action<br>• Untied funds and Household surveys |
| **Empowerment for Effective decentralization And Flexibility for Local action** | • Only tied funds<br>• Local initiatives have no role<br>• Centralized management | • Untied funds at all levels including local levels with flexibility for innovation.<br>• Increasing Autonomy to SHC/APHC/ PHC/ |

| | | |
|---|---|---|
| | and schematic inflexibility<br>• Lack of mandated functions of PRIs / User Groups<br>• Lack of financial and human resources for local action<br>• Lack of indicators and local health status assessments that can contribute to local Planning.<br>• Poor capability to design and plan programmes. | CHC/Taluk/ District Hospital along with well monitored quality controls and matched fund flows.<br>• Hospital Management Committees<br>• Evolving diverse appropriate PRI / User framework<br>• PRI/User group action at Village / GP / Block and District level |
| **Reducing maternal and child deaths and population stabilization** | • Lack of 24X7 facilities for safe deliveries.<br>• Lack of facilities with for emergency obstetric care.<br>• Unsatisfactory access and utilization of skilled assistance at birth<br>• Lack of equity/ sensitivity in family welfare services/ counseling.<br>• Non-availability of Specialists for anesthesia, obstetric care, pediatrics care, etc.<br>• No system of new born care with adequate referral support.<br>• Lack of referral transport systems.<br>• Need for universalization of ICDS services and universal access to good quality antenatal care.<br>• Need for linkage with parallel improvement efforts in social and gender equity dimensions.<br>• Lack of linkages with | • Functional public health system including CHCs as FRUs, PHC-24X7, SHCs, Taluk/District Hospital<br>• Trained ANM locally recruited<br>• Institutional delivery<br>• Quality services at facility<br>• Expanding facilities capable of providing contraception including quality sterilization services on a regular basis so as to meet existing demand and unmet needs.<br>• Thrust on Skilled Birth Attendants/ local appointment and training<br>• Training of ASHA<br>• New born care for reducing neo natal mortality;<br>• Active Village Health and Sanitation Committee;<br>• Training of Panchayat members.<br>• Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas. |

| | | |
|---|---|---|
| | other dimensions of women's health and women friendliness of public health facilities. | • Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees.<br>• Linkage of all above to the Panchayat committee on health. |
| **Action for preventive and promotive Health** | • Poor emphasis on locally and culturally appropriate health communication efforts.<br>• No community action & household surveys<br>• No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc.<br>• Weak school health programmes<br>• Absence of Health Counseling/ early detection.<br>• Compartmentalized IEC of every scheme | • Untied funds for local action<br>• Convergence with other departments/institutions<br>• IEC Training and capability building<br>• Working together with ICDS/TSC/ CRSP/SSA/ MDM<br>• Improved School Health Programmes<br>• Common approach to IEC for health<br>• Involvement of PRIs in health.<br>• Oral hygiene movement. |
| **Disease Surveillance** | • Vertical programmes for communicable diseases<br>• No integrated / coordinated action for disease surveillance at various levels in place yet.<br>• No periodic data collection and analysis and no district and block specific epidemiological data available. | • Horizontal integration of programmes through VH & SC, SHC, APHC, PHC, CHC.<br>• Initiation and Integration of IDSP at all levels.<br>• Building district / sub district level epidemiological capabilities. |
| **Forging hamlet to hospital linkage for curative services** | • Entitlements of households not defined<br>• No community worker<br>• No well defined functional referral / transport/ | • ASHA/AWW/ANM<br>• Household /facility surveys/survey of non – governmental providers for entitlements.<br>• Linkages with SHC |

| | | |
|---|---|---|
| | communication system.<br>• No institutionalized feedback mechanism to<br>referring ASHA/ peripheral health facility in place. | /APHC/ PHC/ CHC for referral services. |
| **Health Information System.** | • Absence of a Health Information System facilitating smooth flow of information.<br>• Not possible to make informed choices | • A fully functional two way communication system leading to effective decision making.<br>• Publication of State and District Public Reports on Health. |
| **Planning and monitoring with community Ownership** | No local planning, no household surveys, no Village<br>Health Registers.<br>Lack of involvement of local<br>community, PRI, RKS, NGOs<br>in monitoring of public health institutions like SHC/APHC/ PHC/ CHC/ Taluka / District Hospitals. | Habitation/village based household surveys and Facility Surveys as the basis for local action. Untied resources for planning and monitoring. Management of health facilities by the PRIs.<br>Thrust on community monitoring, NGO involvement, PRI action, etc.<br>Ensure Equity & Health.<br>Promote education of women<br>SC/ST & other vulnerable groups. |
| **Work towards women Empowerment and Securing entitlements of SCs /STs /OBCs /Minorities** | Standard package of interventions under current schemes.<br>Coverage and quality of services to women, SCs/STs/OBCs/ Minorities not tracked<br>health institution wise.<br>No analysis of access to services and its quality. | Facility and household services to generate useful data for disaggregated monitoring of services to special categories. NGO and<br>research institution involvement in Facility surveys to ensure focus on quality services for the poor. Visits by ASHAs.<br>Outreach services by Mobile Clinics. |
| **Convergence of programme for combating/preventing HIV / AIDS, chronic diseases, malnutrition,** | • Vertical implementation of programme.<br>• Only curative care.<br>• Inadequate service delivery. | • Convergence of programmes.<br>• Preventive care.<br>• Health & Education<br>• Empowering Communities. |

| | | |
|---|---|---|
| **providing safe drinking water etc. with comm. Support.** | • Non-involvement of community. | • Providing functional health facility [SHC], PHC [CHC] for effective intervention. |
| **Chronic disease burden.** | • Double disease burden.<br>• Lack of stress on preventive health.<br>• Lack of integration of programmes with main health programmes.<br>• No IEC/advocacy.<br>• Inadequate Policy interventions. | • Village to National level integration.<br>• Stress on preventive Health<br>• IEC/Advocacy<br>• Help of NGOs<br>• Policy measures. |
| **Social security to poor to cover for ill health linked impoverishment and bankruptcy.** | Large out of pocket expenditures even while attending free public health facilities- food transport, escort livelihood loss etc. Economically atastrophic illness events like accidents, surgeries need coverage for everyone especially the poor, | • Innovations for risk pooling mechanisms that either cross subsidies the poor or are forms of more efficient demand side financing so that the economic burden of disease on the poor decreases.<br>• Guaranteeing hospitalization at functional facilities |

## Historical Perspactive:-

## District Profile:-

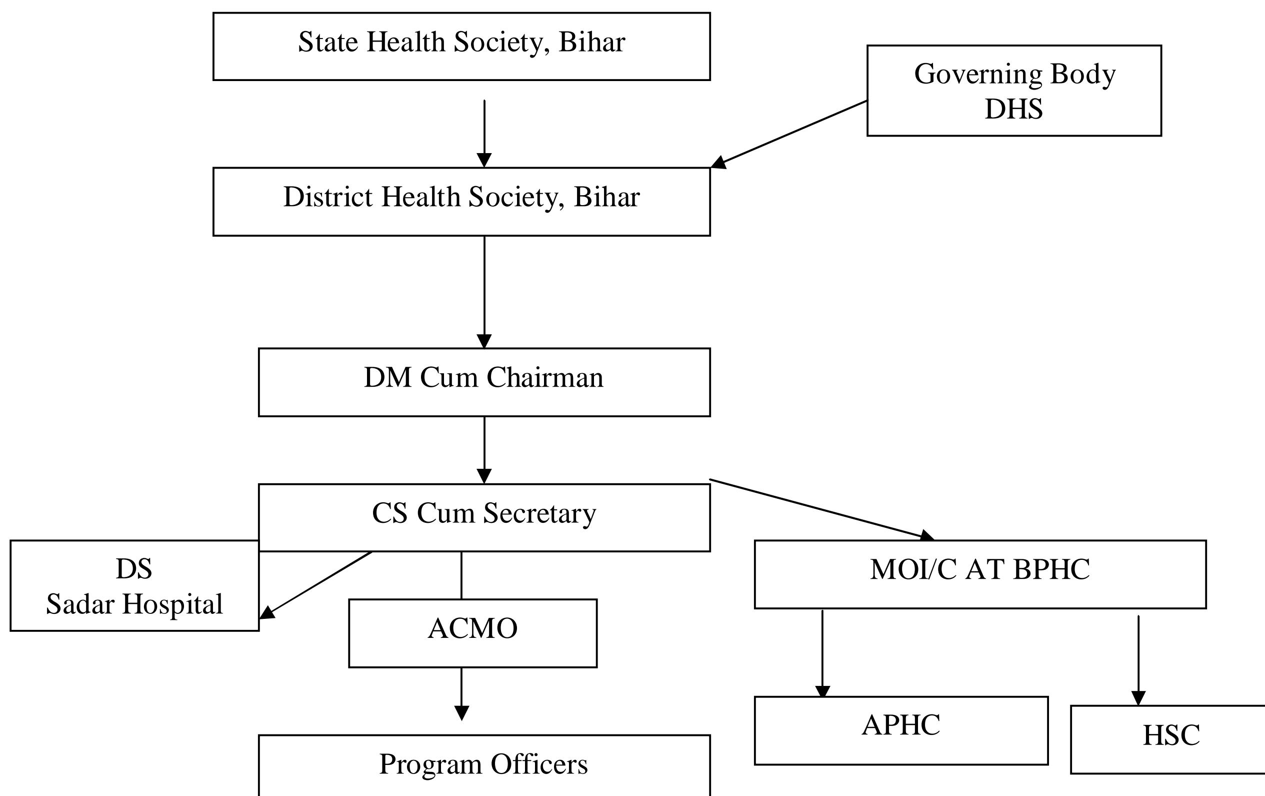
The present district of Buxar consists of areas under Buxar Sadar and Dumraon Sub-Division of the old Bhojpur district and came in existence in the year 1991. Buxar town is the headquarter of the district and also its principal town. The district is bounded on the north by Ballia district of U.P., on the south by Rohtas district, on the west by Ghazipur and Ballia districts of U.P. and on the east by Bhojpur district.

Buxar district consist of 2 Sub-division and 11 Blocks. Of the 11 Blocks, 7 are in Dumraon Sub-division while 4 in Buxar Sadar Sub-division. A town is located each in Buxar and Dumraon Sub-division. All the blocks and the towns of the district are distributed within the Sub-division as below:-

| Name of Sub-division | Name of Blocks | Name of Towns |
|---|---|---|

| Buxar | Buxar<br>Itarhi<br>Chousa<br>Rajpur | Buxar (Municipality) |
|---|---|---|
| Dumraon | Dumraon<br>Nawanagar<br>Brahmpur<br>Kesath<br>Chakki<br>Chougain<br>Simri | Dumraon (Municipality) |

## District Health Administrative Setup:-




## DEMOGRAPHY AND DEVELOPMENT INDICATORS:-

## FROM CENSUS 2001

| **No. of Household** | 192426 | **Household size** | 7.3 |
|---|---|---|---|
| **Population** | 1402396 | **Proportion of Urban population** | 9.2 |
| **Rural Population** | 1273422 | **Sex Ratio** | 899 |
| **Urban Population** | 128974 | **Proportion (0-6 yrs)** | 925 |
| **Population (0-6 yrs)** | 271849 | **SC** | 890 |
| **SC** | 198014 | **ST** | 843 |
| **ST** | 8428 | **Proportion of SC** | 14.1 |
| **Literates** | 642167 | **Proportion of ST** | 0.6 |
| **Illiterates** | 760229 | **Literacy rate** | 56.8 |
| **Total workers** | 408186 | **Illiteracy rate** | 67.2 |
| **Main workers** | 305398 | **Work Participation rate** | 29.1 |
| **Marginal workers** | 102788 | **% of Main workers** | 21.8 |

## बक्सर जिला की सामान्य सूचनाएँ

| 1 | जिला की भौगोलिक स्थिति | 25 डिग्री 34 मिनट आक्षांश उत्तर, 83 डिग्री 58 मिनट आक्षांश पुरब |
|---|---|---|
| 2 | जिला की चौहद्दी | उत्तर मे गंगा नदी, दक्क्षिन मे रोहतास, पुरब मे भोजपुर व पश्चिम में गाजीपुर (उत्तर प्रदेश) |
| 3 | जिला का स्थापना दिवस | 17 मार्च 1991 |
| 4 | जिले का वातावरण | Extreme type |
| 5 | अनुमण्डल की संख्या | 2 |
| 6 | कुल प्रखण्डों की संख्या | 11 |
| 7 | कुल अंचल की संख्या | 11 |
| 8 | थानों की संख्या | 16 |
| 9 | चौकी | 5 |
| 10. | कुल पंचाय़तो की संख्या | 142 |
| 11 | कुल ग्रामों की संख्या | 1134 ( 811- चिरागी) |
| 12 | कुल शहरी क्षेत्र की संख्या | 2 |
| 13. | बक्सर जिला का भौगोलिक क्षेत्रफल | 17575 वर्ग किलो मीटर |
| 14. | औसत वर्षापात (2007) | 312.6 mm |
| 15 | अंगीभूत महाविधालय | 2 |
| 16 | कॉलेज | 15 |
| 17 | विद्युतीकृत गांवों की संख्या | 337 |
| 18 | उच्च विद्यालय | 68 |
| 19 | मध्य विद्यालय | 271 |
| 20 | प्रथमिक विद्यालय | 836 |
| 21 | बुनियादी विद्यालय | 7 |
| 22 | पक्की सड.को की लम्बाई | 175 किलोमीटर |
| 23 | कच्ची सड.को की लम्बाई | 350 किलोमीटर |
| 24 | लघु उद्योग | 492 |
| 25 | उप स्वास्थ केन्द्र | 161 |
| 26 | राजकीय नलकूप | 199 |
| 27 | बैंको की कुल संख्या | 75 |
| 28 | मुख्य फसल | धान,गेहुं, दलहन ,तेलहन |
| 29 | मुख्य नदीयां | गंगा ,ठोरा, कर्मनाशा, धर्मावती |
| 30 | प्रमुख मेला | पंचकोश,खिचरी, आमावस्या, वामनद्वादशी |

Table 1: Buxar District at a Glance:-

| Total Area | 17575 sq km |
|---|---|
| Population | 1707643 |
| Rural Population | 1543476 |
| Urban Population | 164167 |
| Number of sub-divisions | 2 |
| Number of blocks | 11 |
| Total no. of Panchayats | 142 |
| Number of villages | 1134 |
| Decadal growth rate | 27.2 |
| Sex Ratio | 922 |
| Percent of urban population | 9.61 |
| Percent of SC population | 14.1 |
| Percent of ST population | 0.6 |
| Male Literacy Rate ( 7Yrs. & above ) | 82.78 |
| Female Literacy Rate ( 7Yrs. & above ) | 59.84 |
| Total literacy | 71.77 |
| Total workers | 408186 |
| No. of Medical College | 0 |
| No. of Government of India Hospitals (military, railways, ESI, CGHS) | 1 |
| NGO Hospitals and centres undertaking RI with government vaccines | 1 |
| Total ICDS projects | 11 |
| Total Number of Anganwadi centres | 1403 |

# Geography:-

Buxar is located at coor d | 25.34 | N | 83.58 | E | [1]. It has an average elevation of 56 meters (183 feet).

**Following are the Government health facilities available in district :**

| Sl. No. | Health Facility | Nos. |
|---|---|---|
| 01 | District Hospital | 01 |
| 02 | Sub Divisional Hospital | 01 |
| 03 | CHCs | 00 |
| 04 | PHCs | 11 |
| 05 | APHCs | 29 |
| 06 | Sub Centres | 161 + 109 |
| 07 | Mobile Medical Unit | 02 |
| 08 | Animal Husbandry | 01 |
| 09 | Ayurvedic Hospital | 01 |

## NATURE DIVISION

Buxar district consist of two Sub-divisions viz. Buxar Sadar and Dumraon stretching over an area of 1,62,380 hectares. The entire strip of land between the river Ganges on the north and the main line of the Eastern Railways on the South, is a low lying alluvial place. The region is considered to be the best wheat growing area in the the State.
The Ganges forms the northern boundary of the district. The river Karmansa joins the Ganges near Chousa.

## CLIMATIC CONDITION

The climate of the district is moderate. The hot weather begins from the middle of March when hot westerly winds begin to blow during the day. The months of April and May are extremely hot, normally the monsoon sets in by the third week of June and continues with intermission till the end of September. The cold weather begins from the months of November and lasts till the beginning of March, January is the coldest month when the temperature comes down as low as 10˚ C. From the month of April, till the break of monsoon, the district experiences occasional thunder storms also.

## RAINFALL

Rain sets sometimes in June accompanied by fall in temperature and increase in humidity. The district experiences maximum rain during the months of July and August. There is slight rainfall in October but November and December are quite dry.

## FORESTS

Due to deforestation, the forest area of this district is very thin. Some common trees of this district are Mango, Seasum, Mahua, Bamboo and some types of long grasses (Jhalas) are found near diara area of the river Ganga. Jhalas grass is mostly used in roat making of kuccha houses.
The forests of the district are not rich in their products. Fire wood is the most important among its products.
The district had variety of wild animals and game birds when the forests were thick. With the increase in irrigation facilities, the area under cultivation has grown, consequently diminishing the forest. The wild animals have suffered in the process and their number has gone down very considerably. Neelgain, spotted deer, are found in the Plains and near the Ganga bank. A considerable number of monkeys are also found in the Buxar Town area.
Birds of different types like Parrot, Patridges, Quails are also found in the district.

## IRRIGATION FACILITIES

The river Sone and Ganges are the perennial source of surface water. They can provide irrigation to major portion of agricultural land. In the pre Zamindari abolition days the zamindars used to maintain hars and pynes which served the purpose of both irrigation and drainage.
The district Gazetteer of Shahabad (1966) mention as follows:-
The agricultural prosperity of the district depends on artificial irrigation without which may tracts would be uncultivated and the land would be unable to grow sufficient food crops to sustain its population. The three great sources of irrigation were artificial reservoirs, wells and Sone Canal, all of which helped to supplement the natural supply of water and to compensate for its inadequacy or untimely distribution. Ahars are artificial reservoirs meant to collect the rain water. These long shallow tanks where protected by small embankments and served as artificial catchment basin for receiving the water coming down from the adjacent lands. From the ahars, water channels (pines) are connected. The maintenance of the pines was the responsibility of the landlords.
The swoons of artificial irrigation mentioned so far however are of minor importance as compared to the Sone Canal system which has been the most important source of irrigation in the district.

## LAND USE PATTERNS

In this district both the irrigated and non-irrigated areas are being exploited for cultivation purpose. Even some of the large ponds (Jhils) like one at Dumraon which was a duck shooting area have been put to use for cultivation purpose.
Rice, wheat, grams and pluses are the main crops of the district: in some areas near, old Bhojpur vegetables are abundantly grown. These crops and

vegetables are transported to other districts. The straw is used as fodder and for rooting the Houses.

## MINES AND MINERALS

The mineral resources of this district are negligible.

## INDUSTRIALISATION

There are however different types of small scale and cottage industries located in this district of Buxar, the details of which have been given below::

1. Soap Industry: It is mainly concentrated in Buxar and Dumraon.
2. Timber and Furniture works: It is located at Buxar and Dumraon.
3. Leather Industry: There are individual leather workers all over the district. There is a concentration of them at Khilafatpur village in Buxar Sadar Sub-division who are engaged in shoe making. There is shoe making centre in the village which has also been receiving help from the industries department.

## LIVE STOCK

The district of Buxar has large majority of the people engaged in agricultural pursuits and deriving their livelihood from agricultural pursuits. The possession of livestock generally adds to the social status of the farmer. The quality of the live stock has improved because of serious efforts by the Government and the response of the farmers. Since the district has quite a large population of prosperous agriculturists mostly due to the suitability of facilities of canal irrigation the farmers of the canal irrigated area have considerably cattle wealth. Agricultural census conducted taken in 1991 shows the cattle wealth of the district as: Cow-184325, Sheep-15430, Horse-3341, Camel-15, Buffalo-114112, Goat-82186, Mula-240, Ass-1646, Pig-13235, and Poultry-70305.

## COMMUNICATIONS

The district has been fairly rich in road communication for a longtime. Francis Buchanan has mentioned in Buxar Journal that there are some very good roads in the district. He traveled by a very good road with brick bridges from Koilwar to Buxar. He also mentioned a few other good roads viz. the great road to Buxar, the Varanasi road to Sasaram and the great road to Dumraon-Patna-Arrah-Buxar road, Behiya-Piro road, Dumraon-Nasriganj road, Sasaram-Bikramganj-Arrah road as also worth mentioning.
Buxar, the district headquarters is on the the main line of the Eastern Railways. The Ganges is navigable all the year round and goods are transported to Kolkatta on the east and places in Uttar Pradesh on the west through the rivers.

## CREDIT FACILITIES

The Central Co-operative Banks located in the important towns of the district work as the pivot of Co-operative banking and credit. All the Co-operative

Societies are supposed to be affiliated to these banks for credit facility/these banks finance Co-operative institutions which in turn pass on the same to their members. Financing by these banks is restricted to short term and medium term loans for agricultural purposes only. Short term loans are advanced to agriculturist members to meet their needs of seeds, manures etc. Medium term loans are advanced for purchase of live stock, agricultural implements etc.

## TRADE AND COMMERCE

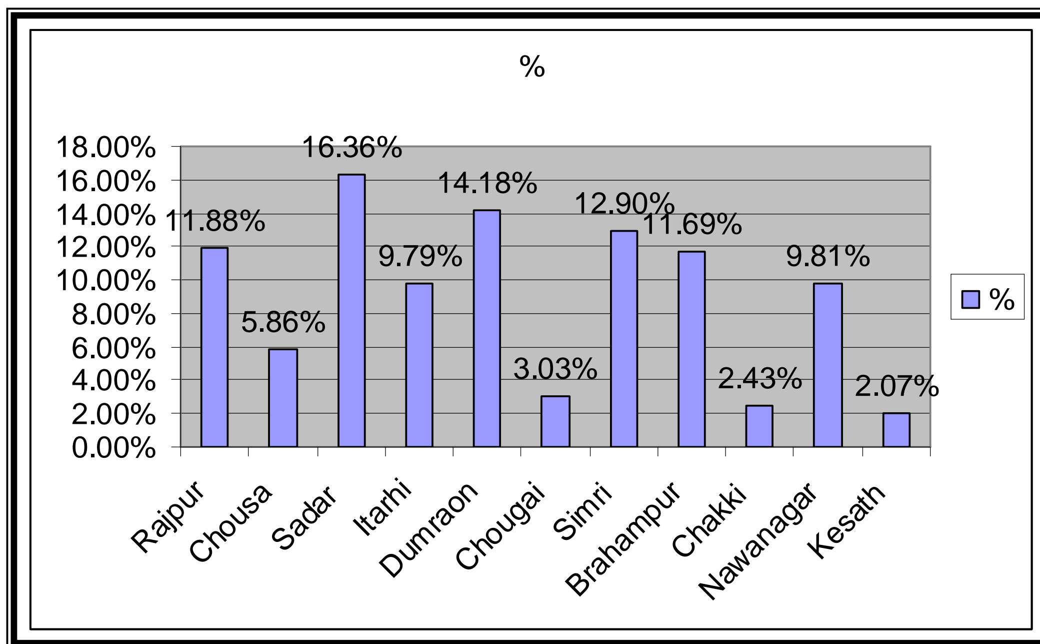
The important wholesale markets in the district are at Buxar and Dumraon. The main commodities exported from Buxar Railway Station are rice, paddy, gur, mango, and the main imports are engineering goods, medicine etc.
Buxar is a district town and an important trade centre. It is also served by railways, roadways and waterways. It is located on the bank of river Ganges and the main trade of the town is grain, vegetables, fish and manufactured goods of jail industry (Central Jail, Buxar manufactures, carperts etc.). There are also a number of mandies and important marketing centres located at Arrah and Buxar.

## POPULATION DISTRIBUTION:-

### Block wise population distribution % of Total population:

| Sl. No. | Name of Block | Population | % of Total Population |
|---|---|---|---|
| 1 | Rajpur | 202810 | 11.88% |
| 2 | Chousa | 100028 | 5.86% |
| 3 | Sadar | 279483 | 16.36% |
| 4 | Itarhi | 167071 | 9.79% |
| 5 | Dumraon | 242226 | 14.18% |
| 6 | Chougai | 51808 | 3.03% |
| 7 | Simri | 220402 | 12.90% |
| 8 | Brahampur | 199521 | 11.69% |
| 9 | Chakki | 41559 | 2.43% |
| 10 | Nawanagar | 167513 | 9.81% |
| 11 | Kesath | 35222 | 2.07% |
| | TOTAL | 1707643 | 100.00% |

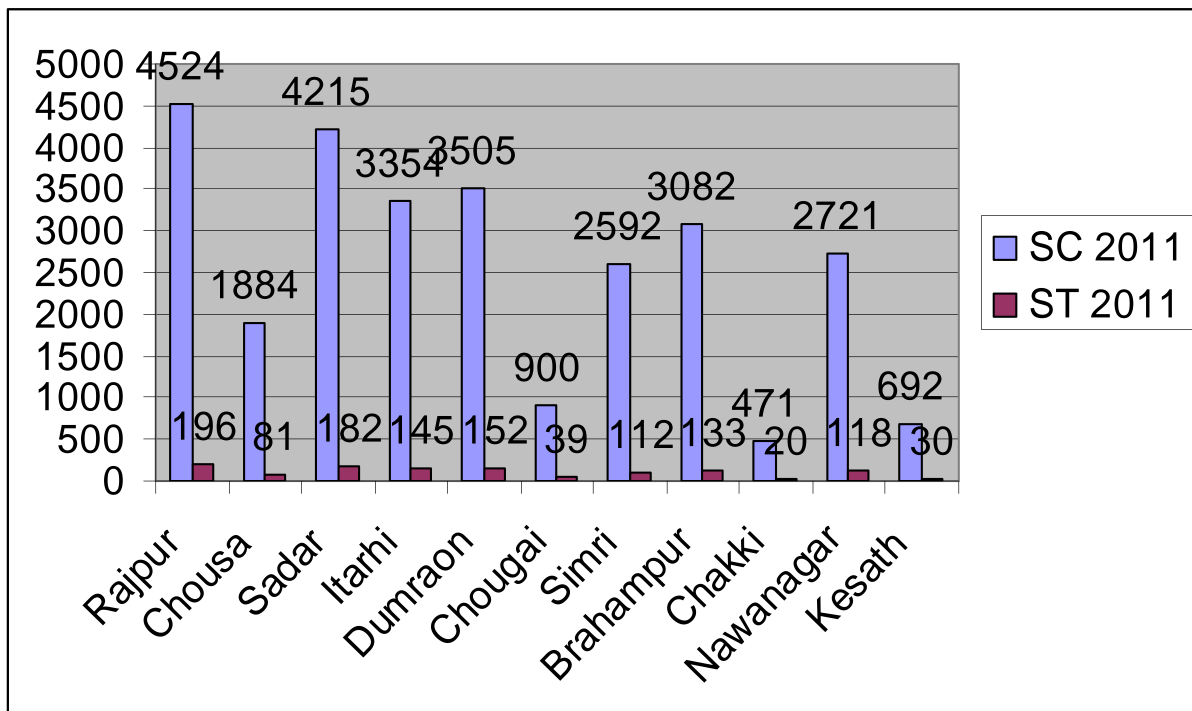
## Blockwise population distribution % of Total population:-




## Blockwise SC / ST population & % of Total population:-

| Sl. No. | Name of Block | Population | SC | % | ST | % |
|---|---|---|---|---|---|---|
| 1 | Rajpur | 202810 | 28616 | 1.67 | 1237 | 0.07 |
| 2 | Chousa | 100028 | 14114 | 0.82 | 610 | 0.03 |
| 3 | Sadar | 279483 | 39435 | 2.30 | 1705 | 0.09 |
| 4 | Itarhi | 167071 | 23574 | 1.38 | 1019 | 0.05 |
| 5 | Dumraon | 242226 | 34178 | 2.00 | 1478 | 0.08 |
| 6 | Chougai | 51808 | 7310 | 0.42 | 316 | 0.01 |
| 7 | Simri | 220402 | 31099 | 1.82 | 1344 | 0.07 |
| 8 | Brahampur | 199521 | 28152 | 1.64 | 1217 | 0.07 |
| 9 | Chakki | 41559 | 5864 | 0.34 | 254 | 0.01 |
| 10 | Nawanagar | 167513 | 23636 | 1.38 | 1022 | 0.05 |
| 11 | Kesath | 35222 | 4970 | 0.29 | 215 | 0.01 |
| | TOTAL | 1707643 | 240948 | | 10417 | |

**Blockwise SC / ST population & % of Total population:-**




## GROWTH RATE:-

The district has experienced an annual exponential growth rate of **21.77 %.** (Census 2011)

## LITERACY RATE:-

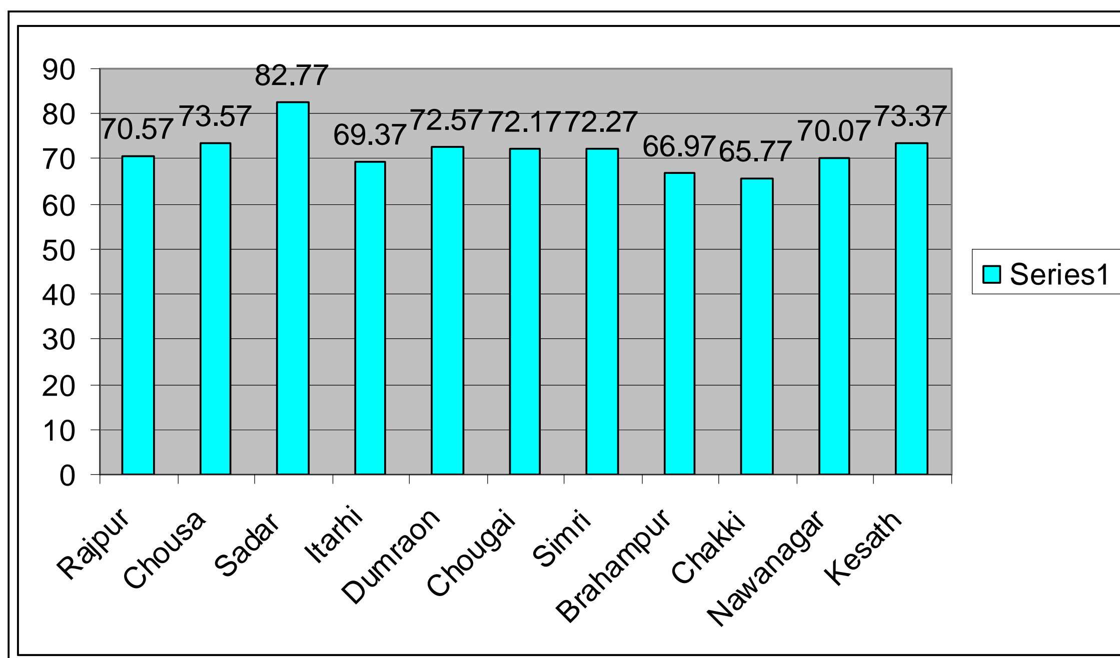
The literacy rate (population age 7+ years) of the district is **71.77 percent**, with **82.78 Percent** for males and **59.84 percent** for females, which are comparable to the respective rates in the state. Thus, in terms of urbanization, Buxar district is at a disadvantageous Position as compared to the state as a whole.

## Blockwise literacy rate % of Total Rate:

| Sl. No. | Name of Block | Population (2011 Census) | Total Literacy Rate | Total Litrates |
|---|---|---|---|---|
| 01 | Rajpur | 202810 | 70.57 % | 143123 |
| 02 | Chousa | 100028 | 73.57 % | 73591 |

| 03 | Sadar | 279483 | 82.77 % | 231328 |
|---|---|---|---|---|
| 04 | Itarhi | 167071 | 69.37 % | 115897 |
| 05 | Dumraon | 242226 | 72.57 % | 175783 |
| 06 | Chougai | 51808 | 72.17 % | 37390 |
| 07 | Simri | 220402 | 72.27 % | 159285 |
| 08 | Brahampur | 199521 | 66.97 % | 133619 |
| 09 | Chakki | 41559 | 65.77 % | 27333 |
| 10 | Nawanagar | 167513 | 70.07 % | 117376 |
| 11 | Kesath | 35222 | 73.37 % | 25842 |
| | TOTAL | 1707643 | 71.77 % | 1240567 |

**Blockwise literacy rate % of Total Rate:**




## VITAL RATES:-

The Crude Birth rate & crude death rate of the district is 25.6 & 7.4 respectively. The infant mortality rate of the district is 57; neonatal mortality rate is 40.2 & the post neonatal mortality rate 17.07. (DLHS RCH II 2002)

## WORK PARTICIPATION:-

Around 45.08 % of the population is working class out of which 53.30% are males & 36.27 % are females. But district is having 46.70% Male & 63.73 Female unemployed out of 54.92 % of total unemployed population. This shows that it is economically underdeveloped & thus is a matter of concern for the district.

(Census 2001) The reason for unemployment can be the low literacy rate of the district.

**Current Staff Position in the District :-**

| cDlj ftykUrxZr rrh; ,oa prqFkZ Js.kh ds deZpkfj;ksa dh v/kru fLFkfr %& | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| Ø0la0 | Iknuke | Lohd`r in | dk;Zjr | fjfDr | vfHk;qfDr |
| 1 | xzke , uIZ | 74 | 03 | 71 | |
| 2 | p{kq lgk;d | 02 | 02 | 00 | |
| 3 | LoPNrk fufj{kd | 11 | 00 | 11 | |
| 4 | LokLF; if'k{kd | 11 | 09 | 02 | |
| 5 | iz;ksx'kkyk ikoSf/kd | 26 | 05 | 21 | |
| 6 | ,Dl jsfMfDfuf'k;u | 01 | 00 | 01 | |
| 7 | efgyk LokLF; ifjn'kZd | 19 | 07 | 12 | |
| 8 | QkekZlLV | 27 | 12 | 15 | |
| 9 | 'kY; x`g lgk;d | 01 | 00 | 01 | |
| 10 | LokLF; dk;ZdrkZ | 23 | 01 | 22 | |
| 11 | cqLokLF; dk;ZdrkZ | 23 | 10 | 13 | |
| 12 | ,0,u0,e0 | 217 | 209 | 08 | |
| 13 | iz[k.M izlkj if'k{kd | 07 | 00 | 07 | |
| 14 | lax.kd | 07 | 05 | 02 | |
| 15 | ifjokj dY;k.k dk;ZdrkZ | 21 | 11 | 10 | |
| 16 | Pkyd | 13 | 07 | 06 | |
| 17 | Fyfid | 43 | 37 | 07 | |
| 18 | iz/kku fyfid | 02 | 02 | 00 | |
| 19 | jksdM+iky | 02 | 02 | 00 | |
| 20 | LVsuks¼vk'kqfyfid½ | 03 | 01 | 02 | |
| 21 | vfpfdRlk lgk;d | 21 | 05 | 16 | |
| 22 | fpfdRlk lekt lsoh | 04 | 00 | 04 | |
| 23 | Lok0 ifjn'kZd ¼ch0ch0½ | 04 | 02 | 02 | |
| 24 | ch0lh0th0ny uk;d | 01 | 01 | 00 | |
| 25 | ch0lh0th0 ikoSf/kdh | 06 | 06 | 00 | |
| 26 | fMLiSUlj | 01 | 01 | 00 | |
| | dqy ;ksx | 571 | 338 | 233 | |
| prqFkZ oxhZ; deZpkfj;ksa dh v/kru fLFkfr %& | | | | | |
| 1 | ifj/kkid | 27 | 03 | 24 | |
| 2 | d{k lsod | 33 | 21 | 12 | |
| 3 | >kM+w d'k | 40 | 20 | 20 | |
| 4 | vkns'kkiky | 10 | 10 | 00 | |

| 5 | jkf= iz gjh | 01 | 01 | 00 | |
|---|---|---|---|---|---|
| 6 | Dqd | 01 | 01 | 00 | |
| 7 | dqd l jokUV | 01 | 01 | 00 | |
| 8 | Ekyh | 01 | 00 | 01 | |
| 9 | prqFkZ oxhZ; deZ pkjh0ch0Ol hUVj½ | 04 | 04 | 00 | |
| 10 | Lok0 l sod | 33 | 19 | 14 | |
| | dqy ;ksx | 151 | 80 | 71 | |

**cDl j ftys esa fpfdRl dksa dh l nj vLirky@vuq@vLi0@jsQjy vLi0@iz0Lok0dsUnz@vfr0iz0Lok0dsUnzksa esa Lohd`r] dk;Zjr ,oa fjfDr dh v/kru fLFkfr**

| dz0l 0 | l aLFkku dk uke | Lohd`r in | dk;Zjr | fjfDr | vfHk;qfDr |
|---|---|---|---|---|---|
| 1 | l nj vLirky] cDl j | 30 | 16 | 14 | |
| 2 | vuq.Myh; vLirky Mqejkao | 19 | 06 | 13 | |
| 3 | iz0Lok0dsUnz] l nj iz[k.M] cDl j | 2 | 2 | 0 | |
| 4 | iz0Lok0dsUnz] pkS l k | 3 | 3 | 0 | |
| 5 | iz0Lok0dsUnz] jktiqj | 3 | 2 | 1 | |
| 6 | iz0Lok0dsUnz] bVk<+h | 3 | 2 | 1 | |
| 7 | iz0Lok0dsUnz] fl ejh | 3 | 3 | 0 | |
| 8 | iz0Lok0dsUnz] Mqejkao | 3 | 3 | 0 | |
| 9 | iz0Lok0dsUnz] ukokuxj | 3 | 2 | 1 | |
| 10 | iz0Lok0dsUnz] czãiqj | 3 | 3 | 0 | |
| 11 | iz0Lok0dsUnz] pkSxkbZ | 3 | 2 | 1 | |
| 12 | iz0Lok0dsUnz] pDdh | 3 | 1 | 2 | |
| 13 | iz0Lok0dsUnz] dsl B | 3 | 0 | 3 | |
| 14 | vfr0iz0Lok0dsUnz] egng | 2 | 1 | 1 | |
| 15 | vfr0iz0Lok0dsUnz] l jSatk | 2 | 1 | 1 | |
| 16 | vfr0iz0Lok0dsUnz] ekfudiqj | 2 | 0 | 2 | |
| 17 | vfr0iz0Lok0dsUnz] eukgjiqj | 2 | 0 | 2 | |
| 18 | vfr0iz0Lok0dsUnz] fugkyiqj | 2 | 0 | 2 | |
| 19 | vfr0iz0Lok0dsUnz] nqYygiqj | 2 | 0 | 2 | |
| 20 | vfr0iz0Lok0dsUnz] jktkiqj | 2 | 1 | 1 | ek0mPp U;k;ky; esa ifr0 |
| 21 | vfr0iz0Lok0dsUnz] cM+dk fl guiqjk | 2 | 1 | 1 | |
| 22 | vfr0iz0Lok0dsUnz] veFkqvk | 2 | 1 | 1 | |

| | | | | | |
|---|---|---|---|---|---|
| 23 | vfr0ik0Lok0dsUnz fl djkSy | 2 | 0 | 2 | |
| 24 | vfr0ik0Lok0dsUnz cygjh | 2 | 0 | 2 | |
| 25 | vfr0ik0Lok0dsUnz Hknoj | 2 | 1 | 1 | |
| 26 | vfr0ik0Lok0dsUnz cxu | 2 | 0 | 2 | |
| 27 | vfr0ik0Lok0dsUnz pUnzijk | 2 | 2 | 0 | |
| 28 | vfr0ik0Lok0dsUnz uSuhtkj | 2 | 1 | 1 | |
| 29 | vfr0ik0Lok0dsUnz pqjkeuiqj | 2 | 1 | 1 | |
| 30 | vfr0ik0Lok0dsUnz cMsdk xkWo | 2 | 1 | 1 | |
| 31 | vfr0ik0Lok0dsUnz /kul kbZ | 2 | 1 | 1 | |
| 32 | vfr0ik0Lok0dsUnz l kuik | 2 | 1 | 1 | |
| 33 | vfr0ik0Lok0dsUnz iqjkuk Hkkstiqj | 2 | 1 | 1 | |
| 34 | vfr0ik0Lok0dsUnz u;k Hkkstiqj | 2 | 2 | 0 | |
| 35 | vfr0ik0Lok0dsUnz jktiqj dyk | 2 | 1 | 1 | |
| 36 | vfr0ik0Lok0dsUnz Hknkj | 2 | 1 | 1 | |
| 37 | vfr0ik0Lok0dsUnz vkFkj | 2 | 1 | 1 | |
| 38 | vfr0ik0Lok0dsUnz l sejk | 2 | 1 | 1 | |
| 39 | vfr0ik0Lok0dsUnz cEgiqj | 2 | 1 | 1 | |
| 40 | vfr0ik0Lok0dsUnz ukcdiqj | 2 | 1 | 1 | |
| 41 | vfr0ik0Lok0dsUnz frydnjiqj | 2 | 1 | 1 | |
| 42 | vfr0ik0Lok0dsUnz fxj/kj cjkWo | 2 | 1 | 1 | |
| | **dqy ;ksx** | **139** | **69** | **70** | |

# CHAPTER 3:-

## SWOT Analysis:-

**STRENGTHS – WEAKNESSES – OPPORTUNITIES – THREATS:**

### Part-A

| S.No. | Strengths | Weaknesses | Opportunities | Threats |
|---|---|---|---|---|
| 1 | • **Infrastructure** - No of HSC-161,<br><br>No of APHC-28, No of PHC-11, No of SDH-1, No of DH-1<br><br>Own Building | • Proposed HSC-109, Required HSC as per District data base-78,<br><br>Rent building HSC- 109 | • It would be well equipped 161 HSC for Maternal & Child health services | • Large scale pove rty beco mes the caus e of nutriti |

|  |  |  |  |  |
|---|---|---|---|---|
|  | HSC-39 |  |  | onal deficiency leading to health problems.<br>• In case of remaining without practice for long time health staff training become useless.<br>• Extending services in remote rural areas is still a challenge in |
|  | • **Human Resource-** No of MO-56 regular & 44 contractual, No of ANM-208 regular & 117 contractual,<br>SBA Trained ANM- 75 | • Required ANM-77, Lack of SBA trained ANM. | • It would be well trained ANM for Maternal & Child health, Increase SBA trained ANM according to schedule |  |
|  | • Decentralized Planning and availability of Resources and Fund for program till HSC level.<br>• Huge pool of Human Resource working at ground level as ANM, Asha and Anganwadi workers.<br>• Provision of incentive money for Asha, ANM according to | • All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms for providing emergency care.<br>• Lack of doctors and other human resource in the remote areas medical facilities<br>• Achievements in most of the program are far less than target.<br>• Slow pace of most of training like SBA and | • All the time support from state health society for all financial and logistics requirements for program implementation<br>• Scope for involving Private partner like Surya clinic for timely achievement of targets. |  |

| | | | | |
|---|---|---|---|---|
| | their performance in mobilizing community for institutional delivery ,FP etc.<br>• Provision of Incentive money for beneficiary under JBSY, Family Planning .<br>• Extension of emergency facilities in remote rural areas and posting of skilled doctors.<br>• Regular training program of doctors and other medical staffs for skill up gradation.<br>• Strong provision of IEC and BCC activity under the programs for effective program implementation and sensitizing people. | IMNCI.<br>• Monthly VHND is not operational as yet.<br>• Institutional delivery is still less than 50% in the district.<br>• No NRC has been made operational in the district.<br>• Seat for contractual medical officer and specialist, ANM and Asha are still vacant.<br>• Achievements in Family Planning and IUD insertation is far less than tagets.<br>• Insensitivity of Doctors and other health staffs for patients.<br>• Unavailability of doctors and staffs in hospital at the time of duty.<br>• No timely procurement of equipments and drug in the remote health facilities. | • Scope of getting full support from people through their participation in RKS and VHSC.<br>• Favorable political and administrative environment for program implementation<br>• Increasing literacy and awareness among public to support Family planning and institutional deliveries.<br>• Better coordination and support from other line departments like ICDS, Municipality etc | achieving targets of MCH and FP, RI.<br>• Traditional and religious attitude of public is hindrance for increasing Institutional deliveries, Family planning etc. |

| | | | | |
|---|---|---|---|---|
| | • Decentralized implementation process of all the program.<br>• Involvement of people in uplifting health facilities through RKS and VHSC. | | | |

**Part-B:-**

| S.No | Strengths | Weaknesses | Opportunity | Threats |
|---|---|---|---|---|
| | • Sufficient no of Ashas working as volunteer at village level.<br>• Professional expertise in Buxar distt- BHM – 10, Accountant-11, Data Operator – 10, HM- 2, DCM- 1, DPC- 1.<br>• Untied fund available at every level.<br>• No. of AYUSH Doctor- 21.<br>• Asha support system with DCM and BCM has been made functional in the district.<br>• Motivational program for Asha like Umbrella distribution is completed in time.<br>• Formation of VHSC has been completed in | • Low no of Ashas who have completed module 1 to 4 training .<br>• Requirement Professional expertise- BHM- 1, Data Operator – 1, DPM – 1.<br>• Untied fund is not utilize properly<br>• Requirement AYUSH Doctor- 8 as per APHC.<br>• Asha Selection is not 100% complete<br>• RKS is not function in any APHC.<br>• Utilization of untied fund in most of the health centers is very less.<br>• Replenishment of Asha kit and drugs is not timely and complete.<br>• Construction of HSC, APHC, PHC buildings | • It would be trained all module to Ashas, Fully participation by Ashas in all health programme,<br>• Fulfill all Vacant post so that use for health programme.<br>• It would be utilize untied fund properly at every level.<br>• It would be used AYUSH Doctor in Health Programme.<br>• Participation of Mukhiyas and Surpanch in Asha selection | • Corruption and ill intention in construction of buildings and selection process of employees.<br>• Lack of people interest and support for proper maintenance of health infrastructure and quality of services.<br>• Less knowledge and sensitivity for work among Asha and other contractual employees. |

| | | | | | |
|---|---|---|---|---|---|
| | most villages of the district.<br>• Deployment of BHM and Hospital Managers is complete at all the vacant places in the district.<br>• Services of advanced life saving ambulance (108) is started in the district<br>• Contractual AYUS doctors have been placed in APHC.<br>• Decentralized planning at HSC level has been started from this year in the district. | and staff quarters moving with very slow pace.<br>• ISO certification process of health facilities is still to start in the district.<br>• Pathology and Radiology services under PPP initiatives are not properly functional at most of the health facilities.<br>• Lack of orientation among members of RKS regarding their scope of works for Health facilities. | process to expedite the process and also proper and complete utilization of Untied fund for health facility development.<br>• Favorable administrative and political condition for program implementation.<br>• Availability of fund from both NRHM and State funding for development of health infrastructure. | |

**Part - C:-**

| S.No | Strengths | weaknesses | Opportunities | Threats |
|---|---|---|---|---|
| | • Maximum no of vaccinators are accountable who works in polio team.<br>• Underserved area in buxar district is low (only 33) according to this reason ANM reaches easily to all targeted children & women.<br>• Maximum no of session to be held according to micro plan.<br>• Left session to be held as soon as possible after discussion with DIO. | • Lack of coordination is poor in grass root worker like- Asha, AWW, ANM & other.<br>• Micro plan updation is poor at HSC level.<br>• Lack of awareness is poor in community for immunization. | • Timely updation micro plan at HSC level<br>• Improve coordination among ANM, Asha, AWW & others | • Mass resistant due to major AEFI. |

# Situation Analysis:-

**Situation Analysis of Health Facilities**

The three tiers of the Indian public health system, namely village level **Sub centre, Additional Primary Health Centre and Primary Health Centers** were closely studied for the district of Buxar on the basis of three crucial parameters:

1) **Infrastructure**
2) **Human resources and**
3) **Services offered at each health facility of the district.**

The Indian Public Health System (IPHS) norms define that a Village **Health Sub centre** should be present at the level of 5000 population in the plain regions and at 2500-3000 population in the hilly and tribal regions. As most of the Buxar is situated in the plain terrain, the norm of Sub centre per 5000 population is expected to be followed. A sub centre is supposed to have its own building with a small OPD area and an exam room.. Sub centres are served by an ANM, Lady Health Volunteer and Male Multipurpose Health Worker and supported by the Medical Officer at the APHC. Sub centres primarily provide community based outreach services such as immunization, antenatal care services (ANC), prenatal and post natal care, management of mal nutrition, common childhood diseases and family planning. It provides drugs for minor ailments such as ARI, diarrhea, fever, worm infection etc. The Sub centre building is expected to have provisions for a labour room, a clinic room, an examination room, waiting area and toilet. It is expected to be furnished with essential equipment and drugs for conducting normal deliveries and providing immunization and contraceptive services. In addition equipment for first aid and emergency care, water quality testing and blood smear collection is also expected to be available.

The **Additional Primary Health Centre (APHC)** is required to be present at the level of 30,000 populations in the plain terrain and at the level of 20,000 populations in the hilly region. APHC is a six bedded hospital with an operation room, labour room and an area for outpatient services. The APHC provides a wide range of preventive, promotive and clinical services. The essential services provided by the PHC include attending to outpatients, reproductive and child health services including ANC check-ups, laboratory testing during pregnancy, conducting normal deliveries, nutrition and health counseling, identification and management of high risk pregnancies and providing essential newborn care such as neonatal resuscitation and management of neonatal hypothermia and jaundice. It provides routine immunization services and tends to other common childhood diseases. It also provides 24 hour emergency services, referral and inpatient services. The PHC is headed by an MOIC and served by two doctors. According to the IPHS norms every 24 *7 PHC is supposed to have three full time nurses accompanied by 1 lady health worker and 1 male multipurpose worker. NRHM stipulates that PHC should have a block health manager, accountant, storekeeper and a pharmacist/dresser to support the core staff.

According to the IPHS norms, a **Primary Health Centre** (PHC) is based at one lakh twenty thousand population in the plain areas and at eighty thousand populations for the hilly and tribal regions. The Primary Health Centre is a 30 bedded health facility providing specialized care in medicine, obstetrics & gynecology, surgery, anesthesia and pediatrics. IPHS envisage CHC as an institution providing expert and emergency medical care to the community.

**In Bihar,** CHCs are absent and PHCs serve at the population of one lakh while APHCs are formed to serve at the population level of 30,000. The absence of CHC and the specialized health care it offers has put a heavy toll on PHCs as well as district and sub district hospitals. Moreover various emergency and expert services provided by CHC cannot be performed by PHC due to non

availability of specialized services and human resources. This situation has led to negative outcomes for the overall health situation of the state.

### 1.Situation Analysis: Health Sub centre level Infrastructure

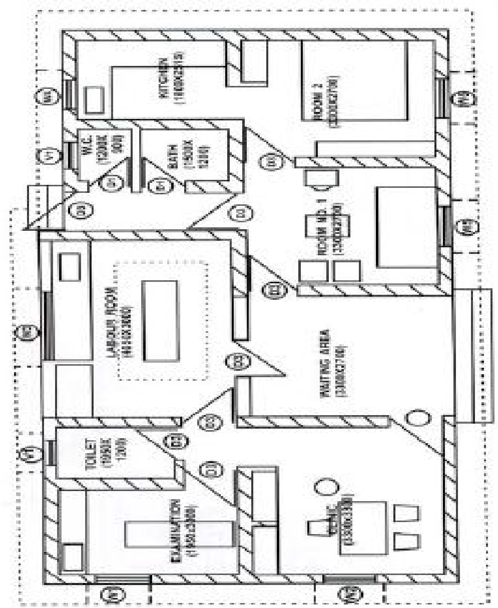
Table 1: **Sub centre Data:-**

| Name of Block | Total Population | Total requirement as per District Database | PRESENT (functional) | ALREADY PROPOSED | Further requirement based on District Database |
|---|---|---|---|---|---|
| 1. RAJPUR | 202810 | 40 | 24 | 13 | 03 |
| 2. CHOUSA | 100028 | 20 | 08 | 05 | 07 |
| 3. SADAR | 279483 | 55 | 14 | 29 | 12 |
| 3. ITARHI | 167071 | 33 | 17 | 09 | 07 |
| 4. DUMRAON | 242226 | 48 | 22 | 14 | 12 |
| 6. CHOUGAI | 51808 | 10 | 05 | 04 | 01 |
| 7. SIMRI | 220402 | 44 | 20 | 16 | 08 |
| 8. BRAHAMPUR | 199521 | 39 | 23 | 08 | 08 |
| 9. CHAKKI | 41559 | 08 | 03 | 05 | 00 |
| 10. NAWANAGAR | 167513 | 33 | 23 | 06 | 04 |
| 11. KESATH | 35222 | 07 | 02 | 00 | 05 |
| Total | 1707643 | 337 | 161 | 109 | 67 |

Table No. 1 presents the additional requirements of Sub centres as per population norms mandated by IPHS as well as according to the database available with District Health Society Buxar. As per IPHS norms, Buxar district requires a total of 337 Sub centres (As per census 2011) of which 161 are present in the district.

**Situation Analysis: Health Sub centre level Infrastructure and Human Resource (Detailed)**

Typical Layout of Sub- Centre with ANM Residence




SUBCENTER
COVERED AREA - 73.50 SQ. MTS.

Waiting Area : 3300mm x 2700mm

Labour Room : 4050mm x 3300mm

Clinic room : 3300mm x3300mm

Examination room : 1950mm x 3000mm

Toilet : 1950mm x 1200mm

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

Room -1 (3300mm x 2700mm)

Room-2(3300mm x 2700mm)

Kitchen-1(1800mm x 2015mm)

W.C.(1200mm x 900mm)

Bath Room (1500mm x 1200mm)

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

Table 2 **Sub centre Details:-**

| | Rajpur | Sadar | Chousa | Itarhi | Dumraon | Chougai | Simri | Nawanagar + Kesath | Brahampur + Chakki |
|---|---|---|---|---|---|---|---|---|---|
| Total Number of Sub centres | 24 | 14 | 08 | 17 | 22 | 05 | 20 | 25 | 26 |
| ANM Sectioned | 24 | 14 | 08 | 17 | 22 | 05 | 20 | 25 | 26 |
| ANMs present | 39 | 27 | 11 | 26 | 36 | 10 | 35 | 32 | 38 |
| ANMs regular | 18 | 14 | 06 | 16 | 21 | 05 | 20 | 17 | 21 |
| ANMs contract | 21 | 13 | 05 | 10 | 15 | 05 | 15 | 15 | 17 |
| ANM residing at HSC | 04 | 04 | 01 | 00 | 05 | 02 | 00 | 02 | 01 |
| Residential facility for ANM required | 24 | 14 | 08 | 02 | 22 | 05 | 20 | 23 | 26 |
| HSC in Govt building | 02 | 05 | 00 | 04 | 04 | 01 | 08 | 03 | 03 |
| HSC in Panchayat building | 01 | 00 | 01 | 06 | 03 | 00 | 00 | 01 | 02 |
| HSC in rented Building | 20 | 06 | 07 | 08 | 15 | 04 | 12 | 21 | 21 |
| SC building under construction | 00 | 00 | 00 | 00 | 00 | 00 | 00 | 00 | 00 |
| Building required | 20 | 09 | 04 | 08 | 15 | 04 | 12 | 21 | 23 |
| Running water supply available | 00 | 00 | 00 | 00 | 01 | 00 | 01 | 00 | 03 |
| Water supply required | 24 | 14 | 06 | 18 | 21 | 05 | 19 | 25 | 23 |
| Cont. power Supply | 00 | 00 | 00 | 00 | 01 | 00 | 00 | 00 | 00 |
| Power supply required | 24 | 14 | 08 | 18 | 21 | 05 | 20 | 25 | 26 |
| Untied Funds | 00 | 00 | 00 | 00 | 00 | 00 | 00 | 00 | 00 |

## 1. Situation Analysis: APHC level Infrastructure :-

The gaps in the availability of PHC are calculated as per the IPHS norms of one APHC at the level of 30,000 populations. However in Bihar, the current state practice is one PHC at one lakh population level. Since the APHCs function at the level of 30,000 populations at present in Bihar, the number of present and proposed APHCs is taken into account for the purpose of calculating the overall requirement of PHCs. The matrix also estimates requirement of CHCs in each block. Like Sub centres, the district has also proposed APHCs. A total 32 APHCs are proposed and 27 has sanctioned by the Sanchalan committee.

**Table 3 APHC Details**

| Name of Block | Total Population | Total requirement as per District Database | PRESENT (functional) | ALREADY PROPOSED | Further requirement based on District Database |
|---|---|---|---|---|---|
| 1. RAJPUR | 202810 | 06 | 03 | 02 | 01 |
| 2. CHOUSA | 100028 | 03 | 02 | 00 | 01 |
| 3. SADAR | 279483 | 08 | 02 | 03 | 03 |
| 3. ITARHI | 167071 | 05 | 02 | 02 | 01 |
| 4. DUMRAON | 242226 | 08 | 03 | 04 | 01 |
| 6. CHOUGAI | 51808 | 02 | 01 | 00 | 01 |
| 7. SIMRI | 220402 | 07 | 04 | 01 | 02 |
| 8. BRAHAMPUR | 199521 | 06 | 06 | 00 | 00 |
| 9. CHAKKI | 41559 | 01 | 00 | 00 | 01 |
| 10. NAWANAGAR | 167513 | 05 | 05 | 00 | 00 |
| 11. KESATH | 35222 | 01 | 00 | 01 | 00 |
| Total | 1707643 | 52 | 28 | 13 | 11 |

### 2. Situation Analysis: APHC level infrastructure and Human Resource (Detailed)

In Bihar Additional PHCs operate at the population of 30,000. The APHC is the cornerstone of the public health system since it serves as a first contact point for preventive, curative and promotive health services. It is the first port of the public health system with a full time doctor and provision for inpatient services. There are 28 functional APHCs in Buxar. In general the APHCs in Buxar suffer from:

- lack of facilities including availability of building
- constant power and water shortages

- unavailability of doctors
- doctors not residing at the facility
- insufficient quantities of drugs and equipment
- lack of capacity to use untied funds.

**Table 4: APHC Human Resource**

| S.No | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Mahdeh | Churamanpur | Nihalpur | Badka Gaon | Manikpur | Dhansoi | Manoharpur | Sarenja | Sonpa | Amathua | Purana | Naya Bhojpur | Dulahpur | Badka Sighanpura | Rajpur Kala |
| Total No. of APHC | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Doctors | 2 Drs Sanctioned | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| | 1 Drs Sanctioned | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2 Drs in Position | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 |
| | 1 Drs in position | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 |
| | 0 Drs in position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ANM | 2 ANMs Sanction | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | 2 ANM in position | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 |
| | 1 in position | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 1 |
| | 0 in position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Laboratory | Sanctioned | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | in Position | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pharmacist/Dresser | Sanction | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | in Position | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Nurses | 2 Sanctioned | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | 2 in Position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |

| S.No | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Mahdeh | Churamanpur | Nihalpur | Badka Gaon | Manikpur | Dhansoi | Manoharpur | Sarenja | Sonpa | Amathua | Purana | Naya Bhojpur | Dulahpur | Badka Sighanpura | Rajpur Kala | | | | |
| Total No. of APHC | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | |
| | 1 in position | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | | | | |
| Accountant | In position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| Peon | In position | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | | 0 in position | 0 | 0 | 0 | 0 | 0 | 0 |
| Sweeper | In position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| Specialist | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |

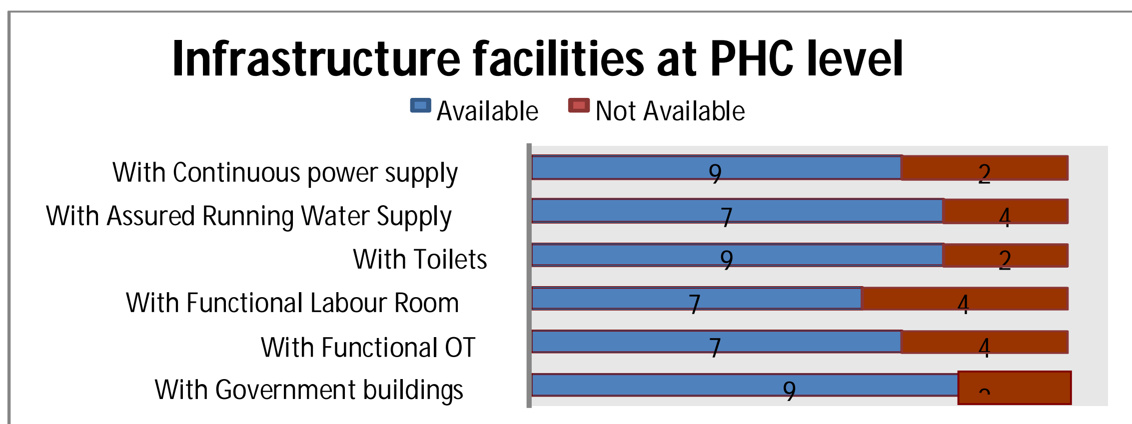
Continue.... APHC Human Resource

| S.No | | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Rajapur | Sikrol | Bhadar | Ather | Girdhar Baraon | Belahari | Nainijor | Bhadwar | Bagen | Chandrapura | Semra | Brahmpur | Nokhpur | Tilakdarpur |
| Total No. of APHC | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Doctors | 2 Drs Sanctioned | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| | 1 Drs Sanctioned | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2 Drs in Position | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| | 1 Drs in position | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 |
| | 0 Drs in position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

| S.No | | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Rajapur | Sikrol | Bhadar | Ather | Girdhar Baraon | Belahari | Nainijor | Bhadwar | Bagen | Chandrapura | Semra | Brahmpur | Nokhpur | Tilakdarpur |
| Total No. of APHC | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| ANM | 2 ANMs Sanction | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | 2 ANM in position | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 |
| | 1 in position | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 0 |
| | 0 in position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Laboratory Technicia | Sanctioned | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | in Position | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pharmacist/Dresser | Sanction | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | in Position | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Nurses | 2 Sanctioned | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | 2 in Position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 1 in position | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Accountant | In position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sweeper | In position | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Specialist | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

3. **<u>Situation Analysis: PHC Infrastructure:-</u>**

PHCs fare well in terms of infrastructure as compared to APHC and Health Sub centres. All the PHCs in the district are based out of government buildings. Out of 09 functional PHCs, 07 have functional OT and labour rooms. Yet the condition of the operation theatres and labour rooms needs to be improved in nearly all the PHCs. Toilets are available in all the PHCs. PHCs are in better condition in terms of running water supply and continuous availability of power. Out of 11 PHCs, 10 have access to running water and 9 have continuous power supply.
The main problem at the PHC level is not the total lack but inadequacy of facilities. As PHC serves 1 lakh twenty thousand population, the level of infrastructure in terms of size of building, number of rooms, and size of wards is clearly inadequate. The gaps arise as the infrastructure was designed to serve 30,000 populations.




A detailed version of status of infrastructure at all the PHCs is as follows:

**Table 5 : PHC Infrastructure**

| | Rajpur | Sadar | Chousa | Simri | Itarhi | Dumraon | Chougai | Brahampur | Chakki | Nawanagar | Kesath |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Building** | Govt | Govt | Govt | Govt | Govt | Govt | Govt | Govt | Panchayat | Govt | NA |
| **Building Condition** | Good but insufficient | Good but insufficient | Good but insufficient | Good | Good but insufficient | Good | Good but insufficient | Good but insufficient | Need New Building | Good insuffic | NA |
| **Running Wate** | YES | YES | YES | YES | YES | YES | YES | YES | NO | YES | NO |

| r Supply | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Power Supply | YES | YES | YES | YES | YES | YES | YES | YES | NO | YES | NO |
| Toilets | YES | YES | YES | YES | YES | YES | YES | YES | NO | YES | NO |
| Functional Labour Room | YES | NA | YES | YES | YES | NA | YES | YES | NO | YES | NO |
| Condition of Labour Room | GOOD | NA | GOOD | GOOD | GOOD | NA | GOOD | GOOD | NO | YES | NO |
| Functional OT | YES | NA | YES | YES | YES | NA | YES | NO | NO | YES | NO |
| Condition of OT | Adequate | NA | Adequate | Adequate | Inadequate | NA | Adequate | Inadequate | NA | Adequate | NA |
| Condition of ward | Adequate | NA | Adequate | Adequate | Inadequate | NA | Adequate | Inadequate | NA | Adequate | NA |

4. **Situation Analysis: PHC Human Resources:-**

Most of the PHCs are served by three doctors in position. Availability of specialists is still a major constraint for the district. The situation regarding number of ANMs at PHC level is satisfactory since the gap between sanctioned and in position is either absent or very narrow for most of the PHCs. Pharmacists are sanctioned in all the PHCs but are in position only 6 of them. Similarly Store keepers are in position in 9 PHCs. The biggest gap is in the availability of Staff Nurses. All other PHCs don't yet have nurses sanctioned or in position. District's human resources availability across all the PHCs can be summarized as follows:

Table 6 : Human Resources at PHC

| | | Number of PHCs |
|---|---|---|
| Doctors | Number of PHCs with 4 and more sanctioned doctors | 0 |
| | Number of PHCs with 4 and more doctors in position | 0 |
| | Number of PHCs with 3 doctors sanctioned | 11 |
| | Number of PHCs with 3 doctors in position | 8 |
| | Number of PHCs with 2 or less than 2 doctors sanctioned | 0 |
| | Number of PHCs with 2 or less than 2 doctors in position | 3 |
| | Total number of doctors | 105 |
| | Regular Doctors | 56 |
| | Contractual Doctors | 49 |
| Specialists | PHCs with 2 specialist | 0 |
| ANMs | PHCs with 3 or more than 3 ANMs | 6 |
| | PHC withless than 3 | 5 |
| Nurses | PHCs with Nurses | 0 |
| Lab tech | PHCs with lab tech sanctioned | 11 |
| | PHCs with lab tech in position | 07 |
| Pharmacist | PHCs with at least 1 pharmacist sanctioned | 11 |
| | PHCs with at least 1 pharmacist in position | 6 |
| Store keepers | PHCs with storekeepers | 9 |

5. Situation Analysis: Support Services at PHCs:

Table 7 : Support Services at PHC

| PHC Services at a Glance | |
|---|---|
| Total number of PHCs | 11 |
| NBCC Services | 7 |
| Availability of Ambulance | 7 |
| Generator | 7 |

| X – Ray | 0 |
|---|---|
| Laboratory Services (Pathology) | 7 |
| Laboratory Services (Malaria/Kalazaar) | 0 |
| Laboratory Services (T.B) | 7 |
| Cleanness | 7 |
| Canteen & Washer man | 0 |
| Electric Transformer | 0 |
| Gardening | 1 |
| Housekeeping | 7 |
| Rogi Kalyan Samiti set up | 11 |
| Untied funds received | 7 |
| Untied funds utilized | 7 |

6. **Situation Analysis: Sub Divisional Hospital (SDH) (Dumraon)**

**Table 8 : Human Resource at SDH**

| | | SDH Dumraon |
|---|---|---|
| Doctors | Sanctioned | 25 |
| | In position | 06 |
| ANMs | Sanctioned | 00 |
| | in Position | 00 |
| Laboratory Technician | Sanction | 08 |
| | in Position | 01 |
| Pharmacist/Dresser | Sanctioned | 02 |
| | in Position | 01 |
| Nurses | Sanctioned | 52 |
| | in position | 00 |
| Storekeeper | in position | 00 |
| Specialist | in position | 00 |

| Hospital Manager | In position | 01 |
|---|---|---|

**Support Services at SDH Dumraon:-**

| Sub Divisional Hospital Services at Glance | |
|---|---|
| Availability of Ambulance | 01 |
| Generator | 01 |
| X – Ray | 01 |
| Laboratory Services (Pathology) | 01 |
| Cleanness | 01 |
| Canteen & Washer man | 00 |
| Electric Transformer | 00 |
| Gardening | 00 |
| Housekeeping | 00 |
| Rogi Kalyan Samiti set up | 01 |
| Untied funds received | 01 |
| Untied funds utilized | 01 |

## 9. Situation Analysis: Sadar Hospital (Buxar):-

Table 9: Human Resource at Sadar Hospital

| | | Sadar Hospital |
|---|---|---|
| Doctors | Senctioned | 30 |
| | In Position | 16 |
| ANMs | Senctioned | 01 |
| | In Position | 01 |

| Laboratory Technicians | Senctioned | 03 |
|---|---|---|
| | In Position | 03 |
| Pharmacists/Dressers | Senctioned | 02 |
| | In Position | 02 |
| Nurses | Sanctioned | 26 |
| | In position | 03 |
| StoreKeeper | In Position | 01 |
| Specialist | In Position | 03 |
| Hospital Manager | In Position | 01 |

**Support Services at District Hospital Buxar:-**

| District Hospital Services at Glance | |
|---|---|
| Availability of Ambulance | 01 |
| Generator | 01 |
| X – Ray | 01 |
| Laboratory Services (Pathology) | 01 |
| Cleanness | 01 |
| Canteen & Washer man | 00 |
| Electric Transformer | 00 |
| Gardening | 00 |
| Housekeeping | 00 |
| Rogi Kalyan Samiti set up | 01 |
| Untied funds received | 01 |
| Untied funds utilized | 01 |

## *Services Trends of Buxar district:-*

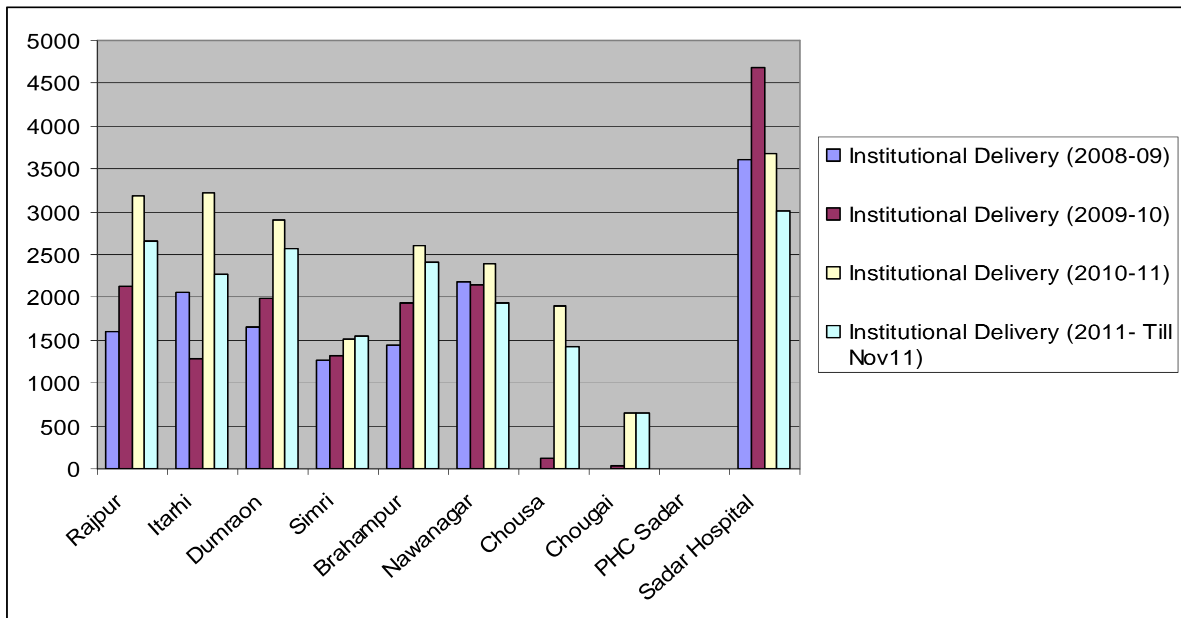
### 7. Situation Analysis: Service Delivery:-

**Deliveries Registration:**

**Block wise**

| S.No. | Name of PHCs | Institutional Delivery (2008-09) | Institutional Delivery (2009-10) | Institutional Delivery (2010-11) | Institutional Delivery (2011-Till Nov11) |
|---|---|---|---|---|---|
| 1 | Rajpur | 1603 | 2123 | 3192 | 2655 |
| 2 | Itarhi | 2054 | 1287 | 3214 | 2267 |
| 3 | Dumraon | 1648 | 1993 | 2908 | 2577 |
| 4 | Simri | 1267 | 1323 | 1517 | 1553 |
| 5 | Brahampur | 1443 | 1930 | 2602 | 2404 |
| 6 | Nawanagar | 2180 | 2147 | 2397 | 1932 |
| 7 | Chousa | 0 | 116 | 1909 | 1420 |
| 8 | Chougai | 0 | 39 | 656 | 651 |
| 9 | PHC Sadar | 0 | 0 | 0 | 0 |
| 10 | Sadar Hospital | 3613 | 4685 | 3681 | 3007 |
| | Total | **13808** | **15643** | **22076** | **18466** |

**Status of Institutional Delivery**



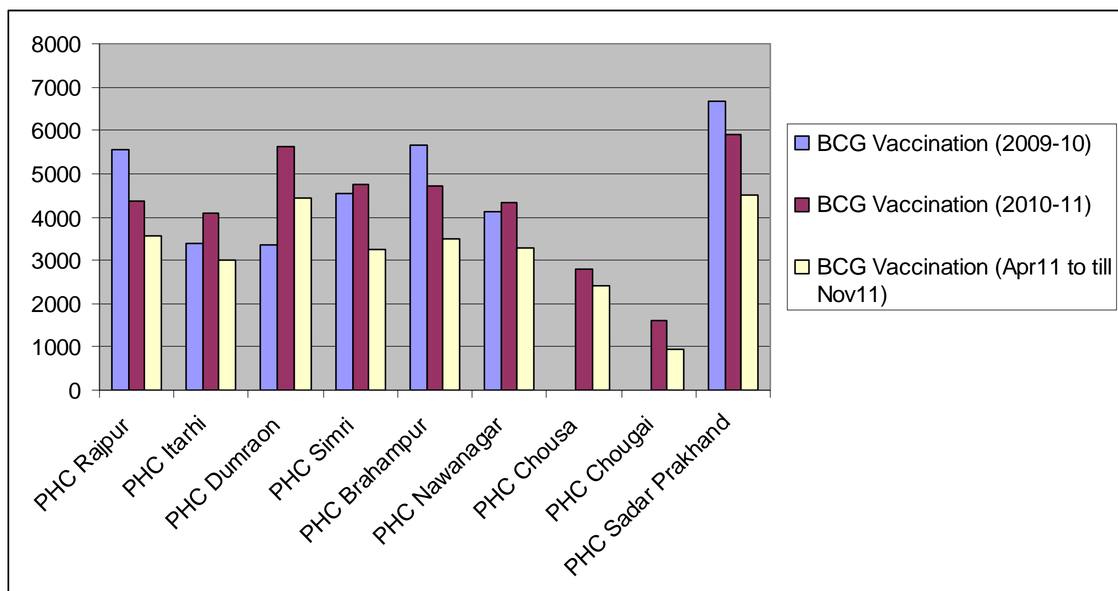

**Child Health:-**

The Child health care is one of the important components of RCH program. Complete immunization, diarrhea management, pneumonia management are some of the important indicators of child health care. In Buxar district, full immunization is 38540 in the financial year 2009-10 which is much more than the previous one. In Buxar district the health functionaries are working properly due to strong liasioning of district officials and block officials. But there must be the scope of improvement which is very important. The data of Buxar district in the financial year 2009-10 and 2010-till sept for immunization BCG, DPT, OVP and MEASLES are shown below:

**Status of BCG Vaccination:-**

| Status of BCG Vaccination | | | | |
|---|---|---|---|---|
| S.No. | Name of PHC | BCG Vaccination (2009-10) | BCG Vaccination (2010-11) | BCG Vaccination (Apr11 to till Nov11) |
| 1 | PHC Rajpur | 5572 | 4366 | 3556 |
| 2 | PHC Itarhi | 3377 | 4089 | 2994 |
| 3 | PHC Dumraon | 3367 | 5619 | 4422 |
| 4 | PHC Simri | 4556 | 4765 | 3258 |
| 5 | PHC Brahampur | 5644 | 4731 | 3495 |
| 6 | PHC Nawanagar | 4111 | 4326 | 3290 |
| 7 | PHC Chousa | 0 | 2789 | 2397 |
| 8 | PHC Chougai | 0 | 1600 | 949 |

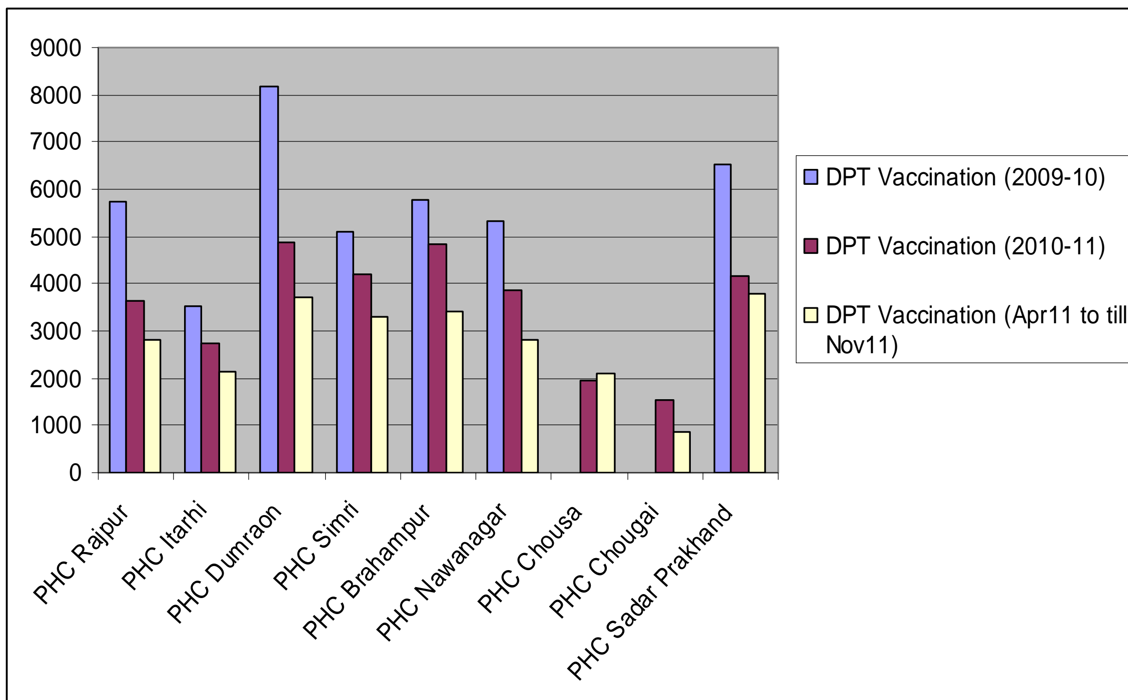
| 9 | PHC Sadar Prakhand | 6684 | 5904 | 4499 |
|---|---|---|---|---|
| **Total** | | **33311** | **38189** | **28860** |




## Status of DPT Vaccination:-

| Status of DPT Vaccination | | | | |
|---|---|---|---|---|
| **S.No.** | **Name of PHC** | **DPT Vaccination (2009-10)** | **DPT Vaccination (2010-11)** | **DPT Vaccination (Apr11 to till Nov11)** |
| 1 | PHC Rajpur | 5719 | 3630 | 2821 |
| 2 | PHC Itarhi | 3517 | 2731 | 2140 |
| 3 | PHC Dumraon | 8185 | 4871 | 3694 |
| 4 | PHC Simri | 5089 | 4204 | 3306 |
| 5 | PHC Brahampur | 5789 | 4854 | 3394 |
| 6 | PHC Nawanagar | 5321 | 3864 | 2799 |
| 7 | PHC Chousa | 0 | 1944 | 2103 |
| 8 | PHC Chougai | 0 | 1538 | 874 |
| 9 | PHC Sadar Prakhand | 6540 | 4176 | 3804 |
| **Total** | | **40160** | **31812** | **24935** |

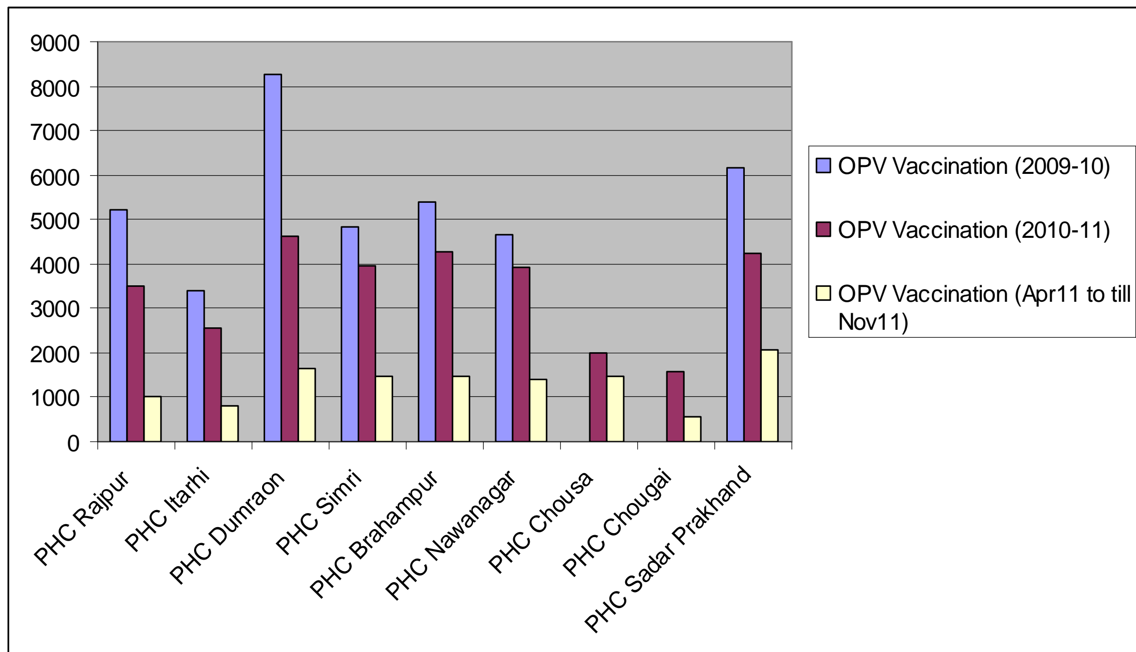
## Status of DPT Vaccination:-




**Status of OPV Vaccination**

| Status of OPV Vaccination | | | | |
|---|---|---|---|---|
| **S.No.** | **Name of PHC** | **OPV Vaccination (2009-10)** | **OPV Vaccination (2010-11)** | **OPV Vaccination (Apr11 to till Nov11)** |
| 1 | **PHC Rajpur** | 5223 | 3498 | 1019 |
| 2 | **PHC Itarhi** | 3386 | 2570 | 813 |
| 3 | **PHC Dumraon** | 8252 | 4636 | 1659 |
| 4 | **PHC Simri** | 4816 | 3952 | 1482 |
| 5 | **PHC Brahampur** | 5402 | 4260 | 1478 |
| 6 | **PHC Nawanagar** | 4658 | 3908 | 1411 |
| 7 | **PHC Chousa** | 0 | 1985 | 1488 |
| 8 | **PHC Chougai** | 0 | 1575 | 572 |
| 9 | **PHC Sadar Prakhand** | 6167 | 4249 | 2070 |
| **Total** | | **37904** | **30633** | **11992** |

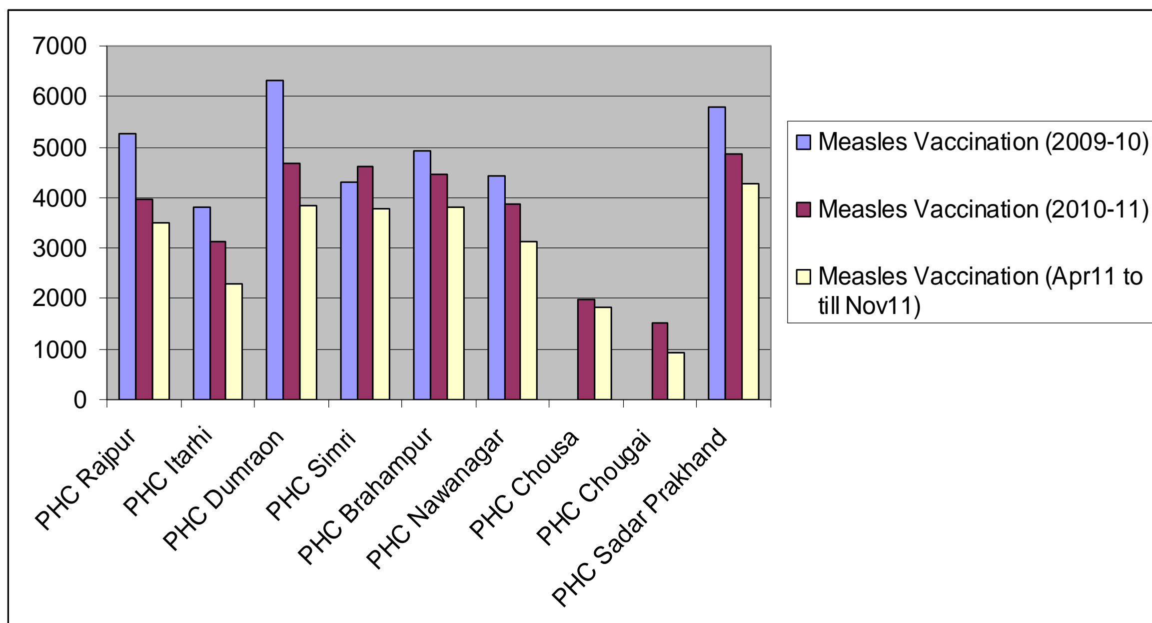
**Status of OPV Vaccination:-**




**Status of Measles Vaccination:**

| Status of Measles Vaccination | | | | |
|---|---|---|---|---|
| **S.No.** | **Name of PHC** | **Measles Vaccination (2009-10)** | **Measles Vaccination (2010-11)** | **Measles Vaccination (Apr11 to till Nov11)** |
| 1 | PHC Rajpur | 5259 | 3959 | 3495 |
| 2 | PHC Itarhi | 3815 | 3122 | 2305 |
| 3 | PHC Dumraon | 6312 | 4689 | 3836 |
| 4 | PHC Simri | 4312 | 4627 | 3791 |
| 5 | PHC Brahampur | 4917 | 4472 | 3796 |
| 6 | PHC Nawanagar | 4418 | 3875 | 3136 |
| 7 | PHC Chousa | 0 | 1968 | 1820 |
| 8 | PHC Chougai | 0 | 1527 | 940 |
| 9 | PHC Sadar Prakhand | 5802 | 4876 | 4259 |
| **Total** | | **34835** | **33115** | **27378** |

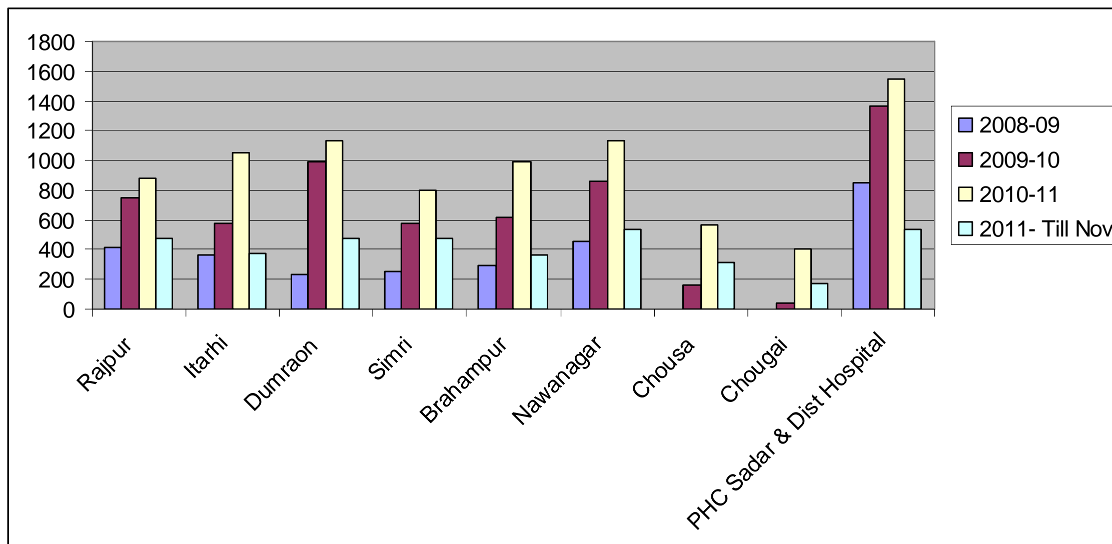
**Status of Measles Vaccination:-**




**Block wise data of Family Planning:**

| Status of Blockwise Family Planning Report (Yearly) | | | | | |
|---|---|---|---|---|---|
| S.No. | Name of PHCs | 2008-09 | 2009-10 | 2010-11 | 2011- Till Nov |
| 1 | Rajpur | 419 | 753 | 875 | 479 |
| 3 | Itarhi | 361 | 578 | 1051 | 378 |
| 4 | Dumraon | 230 | 994 | 1132 | 471 |
| 5 | Simri | 251 | 576 | 799 | 472 |
| 6 | Brahampur | 296 | 617 | 993 | 369 |
| 7 | Nawanagar | 451 | 858 | 1130 | 534 |
| 8 | Chousa | 0 | 166 | 564 | 309 |
| 9 | Chougai | 0 | 44 | 404 | 170 |
| 10 | PHC Sadar & Dist Hospital | 852 | 1361 | 1547 | 540 |
| | Total | 2860 | 5947 | 8495 | 3722 |

**Block wise data of Family Planning:-**



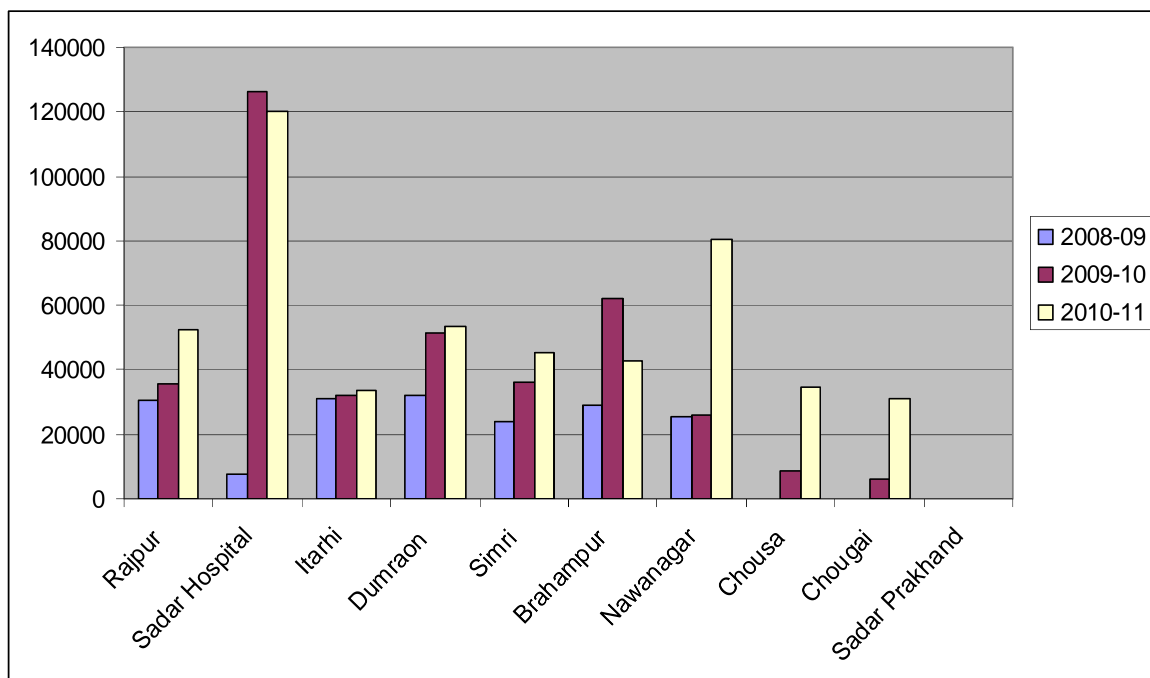

The infrastructure, human resources and support services available for the PHCs need to be compared with the work burden of each PHCs. Primary data for outpatient services given in the table below indicates significant work pressure on all the PHCs in the district.

**Table 9: Treatment of OPD Patients in PHCs**

| Treatment of OPD Patient in PHCs | | | | |
|---|---|---|---|---|
| **S.No.** | **Name of PHCs** | **2008-09** | **2009-10** | **2010-11** |
| 1 | Rajpur | 30650 | 35799 | 52294 |
| 2 | Sadar Hospital | 7552 | 126357 | 120108 |
| 3 | Itarhi | 30965 | 32031 | 33813 |
| 4 | Dumraon | 31824 | 51625 | 53200 |
| 5 | Simri | 24069 | 36287 | 45544 |
| 6 | Brahampur | 28808 | 62177 | 42622 |
| 7 | Nawanagar | 25517 | 25745 | 80387 |
| 8 | Chousa | 0 | 8416 | 34595 |
| 9 | Chougai | 0 | 6320 | 30929 |

| 10 | Sadar Prakhand | 0 | 0 | 0 |
|---|---|---|---|---|
| | **Total** | **179385** | **384757** | **493492** |

**Treatment of OPD Patient in PHCs**



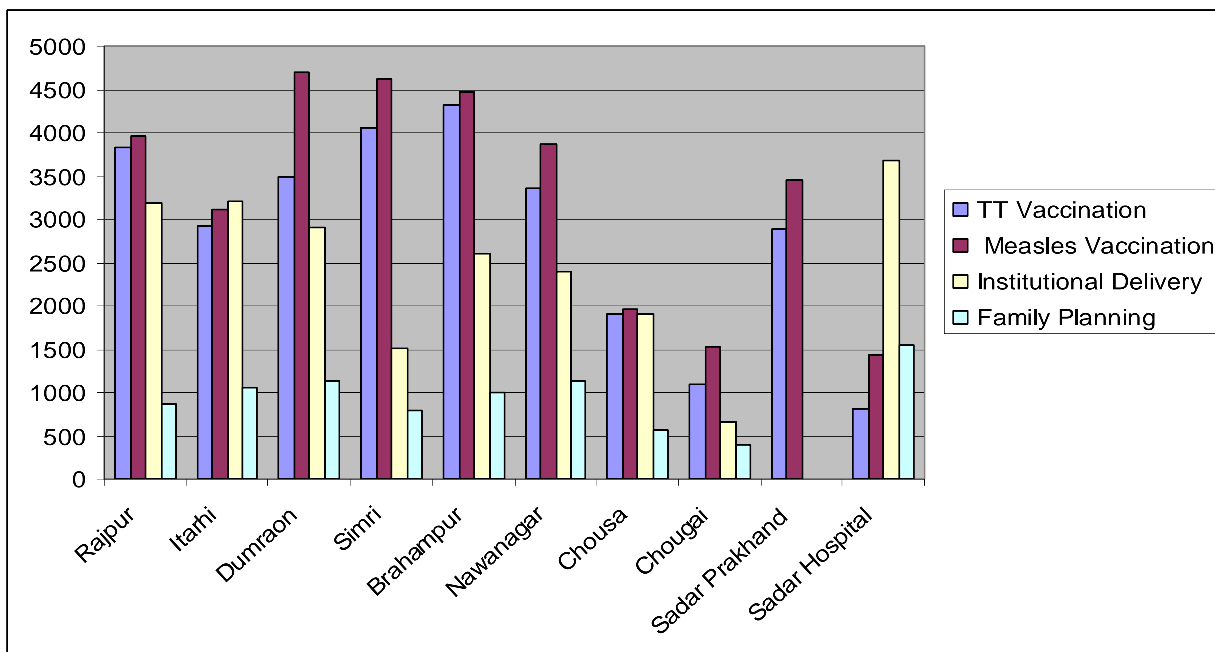

## 8.Situation Analysis: Reproductive and child health:-

Salient RCH statistics for the district are given in the district profile section of this document. Mentioned below are the performance figures of PHCs across the district. The below mentioned data is for the financial year 2010-11.

**Table 10: Reproductive and Child Health (2010-11)**

| Reproductive and Child Health (2010-11) | | | | | |
|---|---|---|---|---|---|
| **S.No** | **Name of PHCs** | **TT Vaccination** | **Measles Vaccination** | **Institutional Delivery** | **Family Planning** |
| **1** | Rajpur | 3822 | 3959 | 3192 | 875 |
| **2** | Itarhi | 2924 | 3122 | 3214 | 1051 |
| **3** | Dumraon | 3482 | 4689 | 2908 | 1132 |
| **4** | Simri | 4060 | 4627 | 1517 | 799 |
| **5** | Brahampur | 4320 | 4472 | 2602 | 993 |

| 6 | Nawanagar | 3353 | 3875 | 2397 | 1130 |
|---|---|---|---|---|---|
| 7 | Chousa | 1912 | 1968 | 1909 | 564 |
| 8 | Chougai | 1089 | 1527 | 656 | 404 |
| 9 | Sadar Prakhand | 2895 | 3451 | 0 | 0 |
| 10 | Sadar Hospital | 806 | 1425 | 3681 | 1547 |
| | **Total** | **28663** | **33115** | **22076** | **8495** |

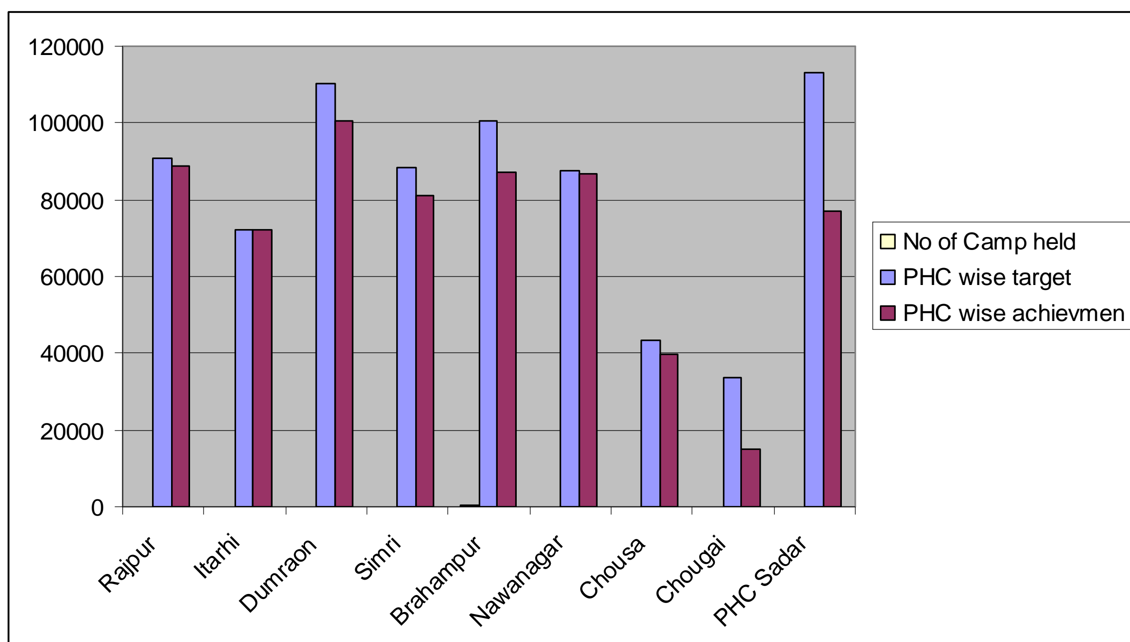



| **Nai Pidhee Swasth Guarantee Yojna** | | |
|---|---|---|
| Situation Analysis: There are about all Govt, Private schools & AWC where NPSGY camps are conducting. In Buxar NPSGY Camps started from 22.03.11 to continue Initially we shall start with 60 children in a camp for whole day. A sum of about 1590 camps organized by health department. Target of buxar district is 7, 39,664 given by SHSB, we achieved 6, 48,123 against target. The services provided include refraction, general check up, and distribution of medicines. | | |
| Strategy | Activity | Budget |
| • Continuing the school health programme<br>• Initiation of School Health Programmes in Primary/high school<br>• Ensuring proper referral and follow-up of students | • Requisition to be sent to the state health society for expanding the school health programme to priamy and high school of government schools.<br>• Requisition to state for providing spectacles for | As per SHSB |

| | | |
|---|---|---|
| | refractive corrections<br>• Providing referral cards for the needy children to the nearest PHC/SH<br>• Providing an award for the 'Healthiest' school in the block | |

**Status of Blockwise Nai Pidhee Swasth Gaurantee Yojna**

| S.No. | Name of PHCs | No of Camp held | PHC wise target | PHC wise achievmen | % |
|---|---|---|---|---|---|
| 1 | Rajpur | 118 | 90751 | 88862 | 98 |
| 2 | Itarhi | 169 | 72139 | 71979 | 100 |
| 3 | Dumraon | 178 | 110071 | 100725 | 92 |
| 4 | Simri | 198 | 88575 | 81047 | 92 |
| 5 | Brahampur | 429 | 100459 | 86975 | 87 |
| 6 | Nawanagar | 153 | 87484 | 86654 | 99 |
| 7 | Chousa | 98 | 43397 | 39707 | 91 |
| 8 | Chougai | 84 | 33851 | 15176 | 45 |
| 9 | PHC Sadar | 163 | 112937 | 76998 | 68 |
| | Total | 1590 | 739664 | 648123 | 85 |




## 8. Situation Analysis: ASHA Training:-

Accredited Social Activist (ASHA) is a key strategy of the NRHM to link the community with the health systems. ASHA works with the community to raise awareness about various health programmes, provide basic health knowledge, and provide information on health practices thus generating demand for health services. She also helps and supports the community to access health services. Proper selection and training of ASHAs is a crucial step for the success of NRHM. In Buxar ASHAs have been selected in all the blocks. In most of the blocks ASHAs have completed **one to four rounds** of training. Only one Block Simri has not completed their most targets for the give target. Salient information related to ASHAs in the district can be found in the matrix below:

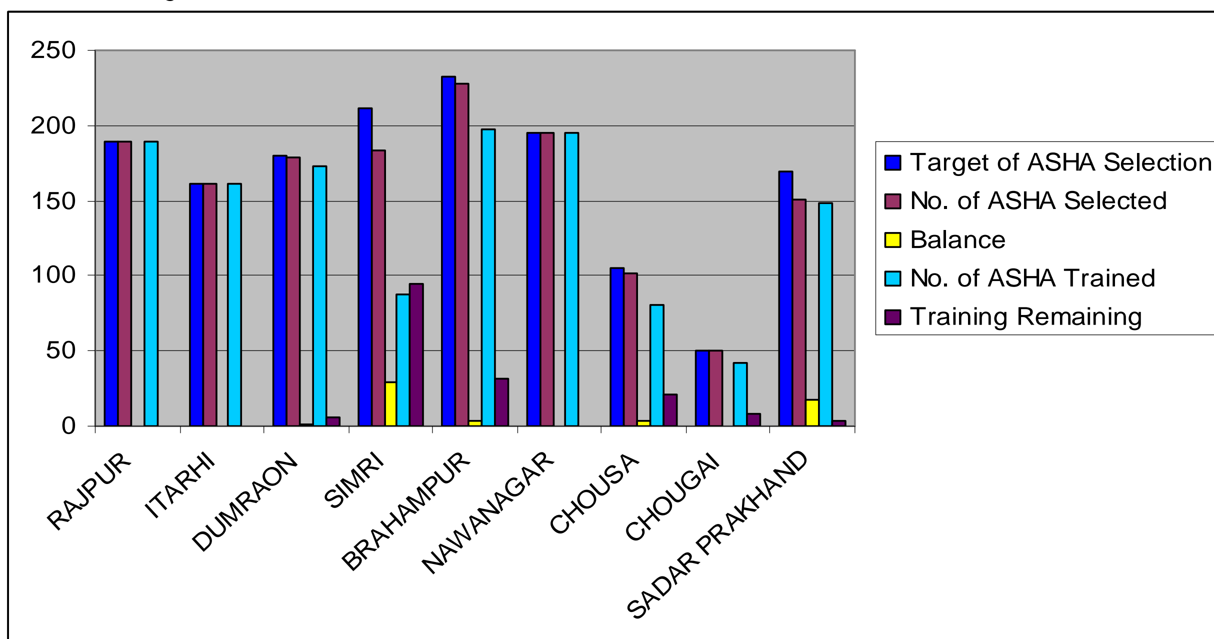
**Table 11: Selection and Training of ASHA**

**ASHA Training Status**

| S.No. | Name of Block | Target of ASHA Selection | No. of ASHA Selected | Balance | No. of ASHA Trained | Training Remaining |
|---|---|---|---|---|---|---|
| 1 | RAJPUR | 189 | 189 | 0 | 189 | 0 |
| 2 | ITARHI | 161 | 161 | 0 | 161 | 0 |
| 3 | DUMRAON | 180 | 180 | 0 | 180 | 0 |

| 4 | SIMRI | 212 | 202 | 10 | 202 | 10 |
|---|---|---|---|---|---|---|
| 5 | BRAHAMPUR | 232 | 228 | 4 | 228 | 4 |
| 6 | NAWANAGAR | 195 | 195 | 0 | 195 | 0 |
| 7 | CHOUSA | 105 | 105 | 0 | 105 | 0 |
| 8 | CHOUGAI | 50 | 50 | 0 | 50 | 0 |
| 9 | SADAR PRAKHAND | 169 | 169 | 0 | 169 | 0 |
| Total :::: | | **1493** | **1479** | **14** | **1479** | **14** |

**ASHA Training Status**:-




## Table 12: Aanganwadi workers in PHCs:-

| S.No. | Name of PHCs | AWW worker | |
|---|---|---|---|
| | | Sanctioned | Position |
| 1 | Rajpur | 167 | 167 |
| 3 | Itarhi | 137 | 136 |
| 4 | Dumraon | 199 | 195 |
| 5 | Simri | 182 | 176 |
| 6 | Brahampur | 197 | 193 |
| 7 | Nawanagar | 167 | 166 |
| 8 | Chousa | 82 | 78 |

| 9 | Chougai | 41 | 41 |
|---|---|---|---|
| 10 | Sadar Prakhand | 231 | 227 |
| | **Total** | **1403** | **1379** |

For Buxar and Bihar NRHM is a challenging task. However it also provides the opportunity to identify gaps, innovate and invest in the public health system. The above situation analysis presents a detailed review of the status of infrastructure, human resources and services in the district. This analysis can be used as a baseline from which to design new strategies and approaches to achieve the goals of the National Rural Health Mission in Buxar.

## Synapse of Rajiv Gandhi Scheme for Empowerment of Adolescent Girls or SABLA

## Synapse of Media Workshop Regarding Measles Round

# Chapter3

# Part A

### Reproductive and Child Health:-

## A. Maternal and Neonatal health:-

Objectives:-

- Ensuring 100% registration of pregnant women for ANC
- Increase in the percentage of pregnant women registered in the first trimester from 30% to 70%
- Increase in the percentage of pregnant women with full ANC from 40% to 80%
- Ensuring that 80% of pregnant women receive 2 TT injections.
- Ensuring that 70% of pregnant women consume 100 IFA tablets
- Increase in skilled attendance during delivery from 25% to 60%
- Increase in institutional delivery from 50% to 80%
- Increase in the percentage of mothers receiving postnatal care within 48hrs of delivery from 40% to 80%
- Increase in percentage of neonates breastfed within 1 hour of birth from 35% to 70%
- Ensuring colostrums feeding of 80% of neonates
- Ensuring that all newborns are weighed within 48 hrs of birth
- Facility and community based management of sick newborns and low birth weight babies

| Ante-natal Care | | | |
|---|---|---|---|
| Situation Analysis: For Buxar as per DLHS 3 figures, percentage of pregnant women registered for ANC is only 79.96%.For Buxar as per HMIS Analysis (2010-11) Figures. Mothers who receive at least 3 ANC visits during the last pregnancy is 33.46%, percentage of mothers who got at least one TT injection in their last pregnancy is 54.80%. Percentage of mothers who were motivated by ASHA for ante natal care is 25.43%. | | | |
| **Strategies** | **Activities** | **Budget** | **Remarks** |
| • Increasing early registration through counseling of eligible couples by ASHAs and ANMs and distribution of home based pregnancy kits<br>• Case management of pregnant women to ensure that they receive all relevant services by ASHAs and ANMs<br>• Creating awareness about maternal health through Mahila Mandal Meeting day<br>• Providing ANC along with immunization services on immunizatio | • Training of ASHAs for counseling of eligible couples for early registration and the use of the home based pregnancy kit<br>• Regular updating of the ANC register.<br>• Preparation of the due list with the dates for Ante Natal Checkups for every pregnant woman in the Sub centre area.<br>• Preparing format for the due list in Hindi & updating time to time.<br>• Training ASHAs and AWWs to fill out and update due list and ANC schedule list for every pregnant woman in their work area.<br>• Organizing Antenatal checkups on immunization days.<br>• ASHAs and AWWs to coordinate with ANM to provide Antenatal care according to the ANC schedule | **<u>Maternal Health-</u>** Rs.79852811/- of all maternal health activity in Buxar district & Please see more detail in budget excel sheet. | • Campaigning for registration for ANC along with immunization budget<br>• Monthly Mahila Mandal days budgeted in immunization section<br>• ANC (SBA) trainings for ANM. For details refer to training section.<br>• The handbill would include information on ANC days, immunisation days, breast feeding practices, RTI/STI counseling days, Family Planning, RCH camps days at APHC level.<br>• Conducting VHSND Meeting every AWC & HSC per month. |

| | | | |
|---|---|---|---|
| n days<br>• Strengthening ANC services at the Sub centre level by ensuring availability of appropriate infrastructure, equipment and supplies<br>• Ensuring quality ANC through appropriate training of the ANM<br>• Effective monitoring and support to HSCs for ANC by APHC.<br>• Setting up of referral transport system at every APHC level.<br>• Providing ANC, PNC, IFA distribution, Deworming, Nutrition & Counseling services along with immunization services on VHSND days at every AWC in Buxar. | maintained in the register for every expectant mother. ASHAs and AWWs to track left outs and drop outs before every ANC & immunization day and ensure their participation for the coming day.<br>• Organizing Mahila Mandal day to share information and create awareness about maternal and child health on every third Friday of the month at each AWC.<br>• Wide publicity of Mahila Mandal day.<br>• Training to ANMs to provide complete Ante natal care and identify high risk pregnancies.<br>• Strengthening of Sub centre in terms of equipment to conduct ANC services. (refer to health facilities section)<br>• Ensuring regular supply of IFA tablets at each Sub centre level. (refer to health facilities section)<br>• Setting up Helpline with Ambulance at every PHC (APHC). (refer to health facilities | | |

| | | | |
|---|---|---|---|
| | section),<br>• Ensuring one day ANC service conducted at HSC by ANM.<br>• Updating every week Mother & Child status through Mother & Child tracking system (MCTS). | | |

Natal, neo-natal and postnatal care

Situation Analysis: Percentage of institutional deliveries in Buxar district is low at 30%. Deliveries at home assisted by doctors or another skilled attendant such as a nurse/LHV/ANM is even lower at 15% whereas only 24% of mothers received postnatal care within 48 hours of delivery for their last child. Factors leading to the low rates of assisted and institutional deliveries include a shortage of Sub centres, poor infrastructure and skills at the Sub centre level and an almost exclusive focus of the Sub centre on immunization activities. Similarly, APHCs suffer from severe shortages in labour rooms and medical officers, though staff nurses have recently been appointed. There are currently no APHCs providing 24X7 services and no ambulance services available at the APHC level. Also, because of lack of appropriate infrastructure most mothers are not able to stay for the required 48 hrs at the facility. At the PHC level the District faces a shortage of Gynecologists and Pediatricians. 02 PHCs in the district – Chakki and Kesath do not have fully functional labour rooms due to newly established PHCs and need almost all PHC has blood storage facilities. There is also a need of appointing lady doctors at APHC, PHC, CHC and above.

In addition, breastfeeding practices need to be improved. According to DLHS 3, only 22.6% infants were fed within one hour of birth. While 36.1% children were exclusively breastfed for 6 months and only 30% of neonates received a check up within 24 hours after delivery. There are almost no facilities for the management of sick newborns. Infant mortality rate for Buxar is reported to be 52 as per 2001 census data which, although down from 70 in 1991, is still quite high.

Furthermore, there are have been problems in the implementation of the Janani and Bal Suraksha Yojana (JBSY) launched to increase the utilization of ANC, assisted deliveries and postnatal care and immunization services with delays in payments.

Percentage of Institutional delivery of Buxar district is 56.40% as per HMIS (2010-11)

| **Strategies** | **Activities** | **Budget** |
|---|---|---|
| • Strengthening 25% of APHCs to provide 24*7 services | **Strengthening facilities for institutional deliveries (please see facilities section)**<br>• Ensuring availability of fully | |

| | | |
|---|---|---|
| • Strengthening 45% of APHCs to provide institutional delivery care.<br>• Strengthening PHCs to provide institutional delivery care<br>• Setting up 5 CHCs to provide Emergency and Comprehensive Obstetric Care<br>• Ensuring that ambulance services are available for transportation to APHCs and referral to PHCs and CHCs<br>• Developing a pool of skilled births attendants for each block.<br>• IMNCI Training for ASHAs and ANMs<br>• Improving accessibility of skilled birth attendants to communities<br>• Creating community level awareness on the importance of assisted and institutional deliveries through ASHAs<br>• Counseling of mothers and families for early initiation of breastfeeding, colostrum feeding and exclusive breastfeeding for 6 months by ASHAs<br>• Weighing of all newborns by ASHAs and AWWs | functional and equipped labour rooms, maternal wards, ambulance services and blood storage facilities<br>• Equipping 24*7 APHCs and PHCs to provide minimum 24 hours post delivery stay to mothers and newborns by setting up maternity and neonatal wards<br>• Equipping CHCs, SDH and DH to enable 48 hrs of post delivery stay for mothers and newborns by setting up maternity and neonatal wards<br>• Ensuring availability of required medical officers, nurses and ANMs at all facilities<br>• Appointment of Pediatricians and Gynecologists at every PHC and CHC<br>• Regular stocks of PPH controlling drugs.<br>**Ambulance services**<br>• Identifying ambulance service providers for 15 APHCs, 09 PHCs, 1 SDH and 1 DH and signing contracts for services<br>• Focus on increasing exemption to BPL patients in the utilization of ambulance services<br>**Developing a pool of Skilled Birth Attendants for each block**<br>• Regular rounds of SBA training for ANMs, LHVs and Nurses.(see training section)<br>• ASHAs to have the names and numbers of skilled birth attendants for every block<br>• Extending the Helpline 102 to enable calling for skilled birth attendants during deliveries<br>**Accessibility of skilled birth attendants**<br>• Providing mobile phones to | |

| | | |
|---|---|---|
| at the community level within 48 hours<br>• Ensuring timely payment of JBSY funds to mothers and ASHAs<br>• Proper Functioning a Sick Newborn Care Unit at the District Hospital.<br>• Proper Functioning a New born Care Unit at the PHCs<br>• Ensuring telephone connectivity between all facilities providing institutional delivery care | ANMs at Sub centre to enable them to be available for assistance during delivery at the community level<br>**IMNCI Training for all ASHAs,AWWs and ANMs**<br>• IMNCI training for all ASHAs,AWWs and ANMs<br>**EmOC Training**<br>• EmOC training for all MOs and Grade A Nurses at PHCs and CHCs<br>**Improving communication between facilities providing institutional delivery services**<br>• Ensuring that 15 APHCs, 11 PHCs, 1 SDH and 1 DH are connected through functional phone lines<br>**JBSY**<br>• Creating a JBSY card which combines the services in the MCH card along with info on JBSY payments<br>• Streamlining JBSY money from district to PHC to provide timely payment to beneficiaries and ASHAs.<br>• Support ASHAs to open accounts in the bank.<br>• Explore the options of direct money transfer to ASHAs' accounts.<br>**Counseling and support to new mothers for initiation of the breast feeding after one hour of delivery, colostrums feeding and post natal care within 48 hrs**.<br>• ASHAs to visit newborn baby in first 48 hours to ensure exclusive breast feeding and counsel the families about newborn care and postnatal care.<br>• ANM and staff at facility to provide counseling and support for exclusive breast feeding.<br>• Each mother to receive a | |

| | | |
|---|---|---|
| | post natal check up before discharge<br>• Postnatal follow up by ASHAs and ANMs at the village level<br>**Sick Newborn Care Unit**<br>• Setting up a Sick Newborn Care Unit at the District Hospital | |
| **Other services** | • Weekly RTI/STI clinics to be held at all PHCs with OBG visits during these days<br>• Monthly RCH camps at distant villages, Doctors and OBG specialists<br>• Deputing health workers MOs, SNs/ANMs from PHC, three other staff.<br>• Procurement of drugs from the district drug house following the requisition of separate drugs for 12 camps. | |

The objective of RCH is to contribute to increasing availability, access and utilization of quality reproductive health services induce positive behavior change among women, men and adolescents and improve their reproductive health. Cost-effective approaches will be developed to reduce maternal mortality, through strengthening of referral networks and improving access to quality services for emergency obstetric care. Community outreach capacities of NGOs, PRIs and community-based organizations will be strengthened to increase the use of and access to quality reproductive health services. The availability of different contraceptive methods will be expanded through community-based distribution and social marketing initiatives.

Behavioral change and communication programmes for men, women and adolescents will be developed. Male participation based on gender equality and equal responsibility for sexual and reproductive health will be promoted. The services at facility will include following points.

**1. Advance Safe Motherhood through Human Rights**

Defining maternal death as a "social injustice" as well as a "health disadvantage" obligates governments to address the causes of poor maternal health through their political, health and legal systems. International treaties and national constitutions that address basic human rights must be applied to safe motherhood issues in order to guarantee all women the right to make free and informed decisions about their health, and access to quality services before, during and after pregnancy and childbirth.

**2. Empower Women : Ensure Choices**

Maternal deaths are rooted in women's powerlessness and their unequal access to employment, finances, education, basic health care, and other

resources. These realities set the stage for poor maternal health even before a woman becomes pregnant, and can worsen her health when pregnancy and childbearing begin. Legal reform and community mobilization is essential for empowering women to understand and articulate their health needs, and to seek services with confidence and without delay.

**3. Safe Motherhood is a Vital Economic and Social Investment**

All national development plans and policies should include safe motherhood programs, in recognition of the enormous cost of a woman's death and disability to health systems, the labor force, communities and families.

Additional resources should be allocated for safe motherhood, and should be invested in the most cost-effective interventions (in developing countries, basic maternal and newborn care can cost as little as US$3 per person, per year).

**4. Delay Marriage and First Birth**

Pregnancy and childbearing during adolescence can carry considerable risks. To delay first births, reproductive health information and services for married and unmarried adolescents need to be legally available, widely accessible, and based on a true understanding of young people's lives. Community education must encourage families and individuals to delay marriage and first births until women are physically, emotionally and economically prepared to become mothers.

**5. Every Pregnancy Faces Risks**

During pregnancy, any woman can develop serious, life-threatening complications that require medical care. Because there is no reliable way to predict which women will develop these complications, it is essential that all pregnant women have access to high quality obstetric care throughout their pregnancies, but especially during and immediately after childbirth when most emergency complications arise. Antenatal care programs should not spend scarce resources on screening mechanisms that attempt to predict a woman's risk of developing complications.

**6. Ensure Skilled Attendance at Delivery**

The single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case of an emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities.

**7. Improve Access to Quality Reproductive Health Services**

A large number of women in developing countries do not have access to maternal health services. Many of them cannot get to, or afford, high-quality care. Cultural customs and beliefs can also prevent women from understanding the importance of health services, and from seeking them. In addition to legal reform and efforts to build support within communities, health systems must work to address a range of clinical, interpersonal, and logistical problems that affect the quality, sensitivity, and accessibility of the services they provide.

**8. Prevent Unwanted Pregnancy and Address Unsafe Abortion**

Unsafe abortion is the most neglected – and most easily preventable – cause of maternal death. These deaths can be significantly reduced by ensuring that safe motherhood programmes include client-centered family planning services to prevent unwanted pregnancy, contraceptive counseling for women who have had an induced abortion, the use of appropriate

technologies for women who experience abortion complications, and, where not against the law, safe services for pregnancy termination.

**9. Measure Progress**

Maternal mortality is difficult to measure, due to problems with identification, classification and reporting. Therefore, safe motherhood partners have developed alternative means for measuring the impact and effectiveness of programs; for example, by recording the proportion of births attended by a skilled health provider. These indicators can identify weaknesses and suggest programmatic priorities so that maternal deaths can be better prevented in the future.

**10. The Power of Partnership**

Reducing maternal mortality requires sustained, long-term commitment and the inputs of a range of partners. Governments, non-governmental organizations (including women's groups and family planning agencies), international assistance agencies, donors, and others should share their diverse strengths and work together to promote safe motherhood within countries and communities and across national borders. Programs should be developed, evaluated and improved with the involvement of clients, health providers and community leaders. National plans and policies should put maternal health into its broad social and economic context, and incorporate all groups and sectors that can support safe motherhood.

### 1.3.2 Village Health Sanitation & Nutrition Day

Under NRHM the Village Health and Nutrition Day is planned to provide comprehensive Maternal and Child health and nutrition and sanitation services, and ensure early registration, identification and referral of high risk children and pregnant women.

The VHSND is to be organized once every month (preferably on Wednesdays and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHSND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for intersectoral convergence. VHSND is also to be seen as a platform for interfacing between the community and the health system. Keeping in view the significance of holding the VHSND, the important steps that need to be taken while organizing the event have been put together in this manual. The roles of the ANM, ASHA and AWW should be well defined. The quality of the VHSND needs to be improved, and hence the outcomes should be measured and monitored. This document will help AWWs, ASHAs and PRI members to understand their respective roles in providing their services effectively to the community during the monthly VHSND and will also help in educating them on matters related to health. VHSND if organized regularly and effectively can bring about the much needed behavioural changes in the community, and can also induce health-seeking behaviour in the community leading to better health outcomes. Programme managers at district/block level should ensure availability of necessary supplies and expendables in adequate quantities during the VHSNDs. Similarly, supportive supervision by Programme Managers at different levels will result in improved quality of services.

**Budget**

**Rs.2500/- district level convergence meeting under DM One time, Rs.100/- per person for 2 days for participating microplan & capacity building program for ANM+ASHA+AWW+VHNSC-PRI member,Rs.100/-POL per block level monitoring (MOIC,CDPO,BHM,BCM) & Rs.2500/- per qtr VHSND review meeting under DM.**

**Total – Rs.7,63,232/-**

### 1.1.2 Operationalise 24*7 PHCs (MCH Centre – APHC & HSC)

On the basis of SHSB instruction & MCH Planning operationalise 1 APHC from 24*7 PHCs and 2 HSC of entire district as a MCH Centre. Buxar district identified 8 APHC (APHC Mahdeh from PHC-Sadar, APHC Manikpur from PHC-Rajpur, APHC Sarenja from PHC-Chousa, APHC Badka Gaon from PHC-Itarhi, APHC Rajapur from PHC-Simri, APHC Amathua from PHC-Dumraon, APHC Bagen from PHC-Brahampur, APHC Sikrol from PHC-Nawanager ) and 2 HSC (HSC Veerpur from PHC-Chougai, HSC Kharahana from PHC-Rajpur. Increase institutional & safe delivery of rural areas on above MCH centre reducing MMR of Buxar. 2 PHCs have no any APHC & 1 PHC like Chougai has no own building and other reason.

**Budget**

**Rs. 30,000/- per APHC * 8 = 2,40,000/-**

**Rs. 60,000/- per HSC * 2 = 1, 20,000/-**

## Innovative Activity Proposed

**Integrated Mahadalit Camp**

Article 38 and Article 46 of Indian Constitution has laid great stress on Scheduled caste & Scheduled tribe communities to bring them in the mainstream of society. In view of these directives of the constitution, Govt. has launched several schemes for socio-economic & cultural development of Scheduled castes. It has been found that certain sections of scheduled caste have been able to take considerable benefits from these schemes and develop themselves. But it has also been seen that a considerable section of Scheduled caste have remained socially and economically backward.

State govt. took the decision of including Chamar caste into mahadalit category after approving the 3rd recommendation of State Mahadalit Commission.

The prime basis of selecting these castes is their existing socio–economic status, participation in Government job, participation in social and cultural activities and low health & educational status. Buxar District has planed a

**Integrated Mahadalit Camp** through camp provide them comprehensive health services in rural areas.

**Budget**

Rs.10, 000/- per camp * 55 camp = 5,50,000/-

## District Data

**Progress on Key MH Indicators** :

| MMR | RGI(2004-06) | RGI(2007-09) | AHS(2010-11) |
|---|---|---|---|
| | 312 | 261 | 258 |

| Indicators ( in %) | DLHS-III | CES(2009) | HMIS(2010-11) | HMIS (2011-12) upto Nov, 2011 |
|---|---|---|---|---|
| Any ANC | 22.1 % | 84.3 | 79.96 % | 61.36 % |
| 3+ANC | 22.1 % | 33.8 | 33.46 % | 39.95 % |
| Registration within 12 weeks | 25.3 % | 31.4 | 30.69 % | 33.71 % |
| Full ANC | 22.1 % | 4.5 | 33.46 % | 39.95 % |
| Ins. Delivery. | 48.0 % | 48.3 | 56.40 % | 53.27 % |
| Safe Delivery | | 53.2 | 57.60 % | 54.63 % |
| Home Delivery | 4.8 % | 51.7 | 3.14 % | 4.79 % |
| % of C-sections out of total reported institutional deliveries | 1.92 % | NA | 2.71 % | 0.17 % |
| At Public | NA | NA | 86.55 % | 100 % |
| At Private | NA | NA | 13.44 % | 0 % |
| % of anemic women out of total registered pregnancies | NA | NA | 2.95 % | 3.10 % |
| % of severely anemic women out of total | NA | NA | 17.48 % | 25.39 % |

| anemic pregnant women | | | | |
|---|---|---|---|---|

**Achievements**

| Activity | 2010-11(cumulative) | 2011-12( till Nov)( Cumulative) |
|---|---|---|
| | | |
| No. of fully functional FRUs | O1 | 02 |
| No. of fully functional 24X7 PHCs | 08 | 07 |
| No. of Blood bank licensed and functional | 01 | 01 |
| No. of Blood Bank non functional due to any reason | 0 | 0 |
| No. of Blood Storage Units licensed and functional | 0 | 0 |
| No. of Blood Storage Units non functional due to any reason | 0 | 0 |
| No. of VHNDs held | NA | 10059 |
| No. Trained in LSAS | 0 | 0 |
| No. Trained in EmOC | 01 | 0 |
| No. Trained in SBA | 69 | 30 |
| No. Trained in MTP | 0 | 6 |
| No. Trained in RTI/STI | 0 | 0 |
| No. of Maternal Deaths | 0 | 07 |

| reported | | |
|---|---|---|
| No. of Maternal Deaths reviewed | 0 | 0 |

## Activities Proposed:

**Name of the Activity:**

**a.** Provision of Establishment Blood Storage Unit in District Hospital & Sub Divisional Hospital which is working as a FRU in the District so it is very needful for maternal health.

**b.** Operationalise fully functional FRUs of District Hospital & Sub Divisional Hospital.

**c.** Provision of Blood Donation Camp 2 in each quarter of the district. 1 camp for District Hospital BSU & 1 camp for SDH BSU.

**d.** Provision of Human Resource for FRUs:-

1. 12 staff nurse for FRUs in which 6 for DH & 6 for SDH.
2. 6 Lab technician for FRUs in which 3 for DH & 3 for SDH.
3. 4 MO for BSU in which 2 for DH & 2 SDH.
4. Need 6 Specialist MO for SDH Dumraon in which 1 of Papediatrician, 1 of Surgeon, 1 of Anesthetic, 1 of Gynecologist.

**Funding Proposed:**

| Name of Activity | No of Units* | Cost per unit | Total Cost |
|---|---|---|---|
| Blood Storage Unit in Dist Hospital & Sub Divisional Hospital (Working As FRU) | 2 | Rs.150000/- | Rs.300000/- |
| Blood Donation Camp One in each qtr | 8 | Rs.10000/- | Rs.80000/- |
| Operationalise full functioning FRU | 2 | Rs.50000/- | Rs.100000/- |
| Staff Nurse for FRU | 12 | Rs.180000/- | Rs.2160000/- |

| Lab Technician for Blood Storage Unit establish in FRU | 6 | Rs.90000/- | Rs.540000/- |
|---|---|---|---|
| MO for Blood Storage Unit | 4 | Rs.270000/- | Rs.1080000/- |
| Provision of Specialist Medical Officer for SDH Dumraon | 4 | Rs.210000/- | Rs.840000/- |

**Note* -** Attach separate sheet for the detail components and tentative cost of each component e.g. if Labour Rooms are to be created here unit cost of the LR is to be indicated, however different components of LR and its tentative cost is to be annexed

## TECHNICAL INTERVENTIONS TO ACHIEVE GOALS:-

**Key technical interventions to achieve goals include:**

**MATERNAL HEALTH**

**Antenatal Coverage**

***Facility level***

- Have a fixed day and time at PHC and Sub Centers for conducting ANC clinics.
- Have a regular mobile team visiting difficult / remote / Mahadalit areas on fixed day and time.
- Identify and involve private practitioners in ensuring ANC checkups, link up with Vandematram scheme.
- Ensure conducting ANC clinics on immunization day.
- To ensure timely and regularly conducting VHND in AWC for ANC.

***Community Level***

- Social mobilization to create demand in the community for ANC clinics by ASHAs.
- Use local resources in terms of Gram Mitra, ASHA, TBA, link couples, Panchayat members to inform the ANMs about teenage pregnancy an first time pregnancy
- BCC in the community on the importance of seeking timely ANC.
- Build coordination in grass root workers during provide health services to community.

**Intranatal Care**

***Facility level***

- Ensure availability of contractual staff nurses at the facilities for 24 hours PHCs.
- Strengthen FRUs and PHCs for C/BEmOC services.
- Provision for comprehensive emergency obstetric care services in FRUs.
- Ensure access to safe blood services for all FRUs.
- Identify and link with private practitioners, grants in aid hospitals and Trusts hospitals, especially in tribal areas and urban slums, for basic and

comprehensive emergency obstetric care services especially for BPL families

***Community Level***

- Promote community mobilization through BCC by community based organizations, link couples and IEC.
- Ensure linkages for referral transport.
- Increase awareness in the community on the need to minimize the three delays for obstetric care.

**Postnatal Care**

***Facility level***

- Monitoring of ANM and LHV home visits especially for post natal care.
- Link up the AWW along with the ANM to use IMNCI protocols and visit neonates and mothers within three days and six weeks for delivery.

***Community Level***

- Involvement of Dais and CBHVs in PNC.
- Undertake BCC among women on the need of contacting health personnel after home delivery.

**Safe Abortion Services**

***Facility level***

- Ensure availability of MTPs in all FRUs, PHCs and 50 percent of PHCs.
- Encourage private practitioners to get their facilities recognized for providing MTP services.
- Use of private facilities for MTP training.
- Promote culture of counseling among the providers.
- Promote the use of MVA technique and medical abortion.
- Grass root workers to be strengthened in MTP counseling.

***Community Level***

- Disseminate information regarding the legal status of MTP and its availability.
- Take support of influencers during counseling for MTP to community.

**Prevention and Treatment of RTI/STIs**

***Facility Level***

- Training of medical officers, ANM/LHV, lab technician for diagnosis and treatment of RTI/STI
- Ensure availability of drugs, lab testing kits and equipments for RTI/STI services
- Network with private practitioners and Trust hospitals for the services in especially difficult and remote areas

***Community Level***

- Promote awareness regarding causes, prevention and early treatment seeking behavior for RTI/STI.

## B. Child Health:-

**Objectives:-**

- Ensuring that 70% of children (0-6 months old) are exclusively breastfed
- Increase in percentage of children (12-23 months) fully immunized (BCG, 3 doses of DPT, Polio and Measles) from 70% to 95%

- Ensuring initiation of complementary feeding at 6 months for 70% of children
- Increasing the percentage of children with diarrhea who received ORS and Zinc from 55% to 70%
- Increasing the percentage of children with ARI/fever who received treatment from 77% to 100%
- Ensuring monthly health checkups of all children (0-6 months) at AWC.
- Ensuring that all severely malnourished children are admitted, receive medical attention in **nutritionally rehabilitated.**
- Ensuring that all severely malnourished children are admitted in NRC.

| **Nutrition** | | |
|---|---|---|
| Situation Analysis: Ensuring exclusive breastfeeding and timely initiation of complementary feeding is critical for appropriate child development | | |
| **Strategies** | **Activities** | **Budget** |
| • Counseling mothers and families to provide exclusive breastfeeding in the first 6 months<br>• Identification of severely undernourished children (Grade III & Grade IV) through monthly health checkups at AWC & use MUAC tape By ANM, CBC extender, ASHA.<br>• Proper Functioning a Nutrition Rehabilitation Centre at DH Buxar | • Training by Health Department of crèche workers on nutrition and child care<br>• Organizing health checkups at AWC for children in the 0-6 year age group on the 2nd Monday of every month<br>• Referral of severely undernourished sick children to Nutrition Rehabilitation Centre (NRCs)<br>• Proper Functioning 20 bedded NRCs at SDH Buxar<br>• Providing food and wage loss support for one parent of every child admitted to enable the child to stay at the NRC for the required period of time | **Child Health-** Rs.6912600/- for all child health activity in buxar district & please see more detail in budget excel sheet |
| Health Services | | |
| Situation Analysis: Only 43% children with diarrhea received ORS whereas 23% of children with acute respiratory infection/ fever did not receive any medical attention | | |
| **Strategies** | **Activities** | **Budget** |

| | | |
|---|---|---|
| • Promotion of health seeking behavior for sick children through BCC campaigns.<br>• BCC for pregnant women and mothers to regarding feeding practices, immunization, and other aspects of child care.<br>• Capacity building of ASHA, AWW and ANM for the management of common childhood diseases and identification of serious cases for referral. | • Training of ANM and AWW for IMNCI<br>• Training ASHAs to refer sick child to facility in case of serious illness.<br>• ASHAs equipped to provide ORS to children with diarrhea and suggest referral in case of emergency.<br>• Regular stock up of ASHA drug kits.<br>• Providing weighing machines to every AWC to ensure monthly weighing<br>• ASHAs to support AWWs in monthly weighing | |

**Health Services – Immunization**

Situation Analysis: According to DLHS 3, percentage of children (12-23 months) fully immunized (BCG, 3 doses each of DPT, Polio and Measles) is only 50.0%. The immunization coverage has increased from 43.4 which was DLHS 2 figure, however much improvement is still required. As per DLHS 3, percentage of children who received BCG vaccine is 88.5%, percentage of children who received 3 doses of polio vaccination is 62.4%, children who receive 3 doses of DPT is 62.8%, and children who receive measles vaccine is 71.9%. Children who received at least one dose of vitamin A is 63.9% while those who received three doses of Vitamin A is 22.8. The District currently faces a shortage of skilled vaccinators. According to HMIS Analysis (2009-10), Percentage of fully immunization children against Expected Live Births are only 78%.Percentage of BCG given against Expected Live Births are only 76%. Percentage of DPT3 given against Expected Live Births are only 78%..Percentage of OPV given against Expected Live Births are only 75%..Percentage of Measles given against Expected Live Births are only 69%.

**Musk an EK Abhiyan: Immunization of all pregnant women for T.T. and children up to one year (full immunization):-**

All 1403 AWCs are to be covered under this programme at least once a month. 161+109 HSCs are to be covered under this programme on all Wednesdays observed as immunization day. APHCs will also provide immunization services on Wednesday and all days in PHCs/CHC/SDH and

SH. Incentives are provided under this programme for AWW, ANM and ASHA when 90 er cent immunization is achieved. The programme involves organizing Mahila Mandal camps at the AWCs.

Many ANMs in the district are not proficient in administering the vaccines. Skills level of ANMs is low. Routine immunization training has not been taking place on a regular basis. 453 participants need to be trained in Routine Immunization in batches of 30. There is a shortage of cold chain equipment such as ILR and deep freezer at PHC level. 2newly functional PHCs in the district Chakki & Kesath don't have ILR and deep freezer. Most of the PHCs are operating with either ILR or deep freezer.

.

The District has also not received vaccine funds from April 2008. Buxar gets vaccines from WIC, Patna. The District does not have a vaccine van which obstructs timely supply of vaccines to the district. DPT needle supply is not timely. The maintenance and repair of cold chain equipment is not being done properly by the company currently appointed. The District also needs to adopt better waste management practices for the disposal of syringe and needles.

Funds for Printing of RI formats are underutilized.

| **Strategies** | **Activities** | **Budget** |
|---|---|---|
| • Improving availability of skilled vaccinators.<br>• Increasing utilization of immunization services through awareness generation by ASHAs and AWWs.<br>• Ensuring continued tracking of pregnant women and children for full immunization<br>• Establishing sound monitoring mechanism to review and guide the progress<br>• Improving availability and maintaining quality of cold chain equipment<br>• Improving timely supply of the vaccines<br>• Timely supply of DPT | • Organizing regular routine immunization training for ANM and AWW and IPC/IEC/BCC trainings for ASHA and AWWs.<br>• Organizing immunization camps at every Sub centre level on every Wednesday and at the AWCs on every Saturday.<br>• Regular house to house visits for registration of pregnant women for ANC and children for immunization<br>• Developing tour plan schedule of ANM with the help of BHM and MOIC.<br>• Timely payment to | Please see Budget excel sheet |

| | | |
|---|---|---|
| and syringes.<br>• Discussion with the state to acquire power of issuing maintenance and repair contract for cold chain equipment from district.<br>• Adopting safe disposal policies for needles and syringes | MOICs to arrange transportation of vaccines from district hospital to PHCs.<br>• Regular disbursement of funds from the DIO to MOs for providing incentives to ANMs<br>• Regular disbursement of funds for ANMs to provide incentives to AWWs and ASHA workers<br>• Providing per diem for health workers, mobilizes, supervisors and vaccinators and alternative vaccinators<br>• Maintaining the disbursement records<br>• Visits by MOIC, CDPO, BHM, LHV and health educator to monitor the progress of immunization schedule and prepare report.<br>• Ensuring the unrestricted movement of the monitoring team with fuel for vehicle and funds for hiring of the vehicle.<br>• Maintaining continuous power supply at PHC level for maintaining the cold chain.<br>• Applying for acquisition of ILR | |

| | | |
|---|---|---|
| | and deep freezer for the 3 PHCs which do not have ILR at present<br>• Applying to State Heath society for the funding for Vaccine van to get timely stock of vaccines for the districts.<br>• Timely and regular requests from district to state as well as blocks to district to replenish the supply of DPT and syringe.<br>• Rationalization of courier rates and making request to the SHS for increased funding for courier in order to ensure timely supply of vaccines to sub centres.<br>• Reviewing the contract of Kalka Cooling Company, currently responsible for repair and maintenance.<br>• Submitting a proposal to the state health society to acquire power of issuing maintenance and repair contract for cold chain equipment from district.<br>• Procure stock of hub cutters for all the PHCs for safe disposal of needles and syringe. | |

**Vitamin A Supplementation Programme-**

The programme faces lack of skilled manpower for implementation of program. There is also shortage of drugs and RCH kits. The shortages put constraints on ensuring first dose of Vitamin-A along with the measles vaccination at 9 months. There are also problems for procurement of Vitamin-A bottles by the district for biannual rounds. The reporting mechanisms of the district need to be improved. There is lack of coordination among health & ICDS workers for report returns & MIS. The district also needs a joint monitoring & supervision plans with ICDS department.

| Strategies | Activities | Budget |
|---|---|---|
| • Updation of Urban and Rural site micro –plan before each round.<br>• Improving inter-sectional coordination to improve coverage.<br>• Capacity building of service provider and supervisors.<br>• Bridging gaps in drug supplies.<br>• Urban Planning for Identification of Urban sites and urban stakeholders.<br>• Human resource planning for Universal coverage.<br>• Intensifying IEC activities for Community mobilization.<br>• Strengthening existing MIS system and incorporating 9 doses of Vitamin-A in existing reporting structure.<br>• Strong | • Orientation , stationary, data compilation, validation and updating<br>• Constituting district level task force and holding regular meetings<br>• Organizing meeting of block coordinators<br>• Training and capacity building of service providers.<br>• Strategy planning meetings, orientation of stakeholders, resource planning and site management for urban centre and orientation of urban supervisors.<br>• Ensuring availability of immunization cards<br>• Procurement of | Please see Budget excel sheet |

| monitoring and supervision in Urban areas. | Vit A Syrup | |
|---|---|---|

***Facility Level***

- Provide new born card at community and facility level.
- Promote the concept of early and exclusive breastfeeding, warmth and prompt care seeking for newborns.
- Implement program for managing ARI and diarrhea.
- Support for the polio eradication efforts of the state.
- Special outreach immunization clinics in difficult areas.
- Link up with private practitioners and trust hospitals for new born & critical new born care.
- Implementation of IMNCI.
- Operationalise NRC units in FRUs.

***Community Level***

- Link up with AWWs to provide IMNCI care.
- BCC for promoting newborn care, exclusive breastfeeding and complementary feeding.

## 2.6. Nutrition Rehabilitation Centres (NRCs) for Treatment of Severe and Acute Malnutrition (SAM)

Child malnutrition extracts a heavy toll on both human and economic development, accounting for more than50 % of child deaths world wide. The consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defense and impaired development. More than one-third of worlds malnourished children live in India.

In India, as revealed by the recent National Survey (NFHS-3, 2005-06), malnutrition burden in children under three years of age is 46 %. With the current population of India of 1100 million, it is expected that 2.6 million under-five would be suffering from severe and acute malnutrition which is the major killer of children under five years of age. It can be direct or indirect cause of child death by increasing the case fatality rate in children suffering from such common illnesses as diarrhea and pneumonia.

The risk of death in these children is 5-20 times higher compared to well-nourished children.

MALNUTRITION IN BIHAR:

In Bihar, malnutrition is a serious concern with a high prevalence of 58.4 % as revealed by the National Health and Family welfare Survey (NFHS-3, 2005-06). Children suffering from severe and acute malnutrition are reported to be 8.33 %. Based on population figures, it is estimated that in Bihar, 2.5 million children under five years of age are threatened to face the consequences of severe

malnutrition. With the situation of nutrition among children being far from satisfactory, it will not be surprising to find that these children who have already arrived in a poor state of nutritional status, with further deterioration are at a high risk of morbidity and mortality.

MEASURES TO MANAGE MALNUTRITION:

While mild and moderate forms of malnutrition in the absence of any minor or major illness among children can be addressed through Anganwadi centres, by supporting mothers to ensure service utilization and appropriate feeding and care practices at the household level; the treatment of children with severe and acute malnutrition calls for facility-based treatment by admitting children to a health facility or a therapeutic feeding centre. This is mainly because these children generally are seen to suffer from acute respiratory infections, diarrhea and pneumonia. In additional to curative care, special focus is given on timely, adequate and appropriate feeding to children. Efforts are also made to build the capacity of mothers through counseling to identify the nutrition and health problems in their child.

***Budget***

**Activities Total proposed budget (in Rs.)**

Running cost of one NRCs = 2,78,300/- x 12month= 33,39,600/-

## C. <u>Family planning:-</u>

Objective

- Fulfilling unmet need of 35% for family planning services at the community level
- Increasing the use of any modern method of family planning from 35% to 50%
- Increasing male sterilization rates from 0.5% to 2%
- Increasing the utilization of condoms as the preferred choice of contraception from 2.7% to 8%.

Situation Analysis: The utilization of any method of contraception has increased a bare 2 percentage points in the district over the past five years whereas the utilization of modern methods has increased from 28% to 35%. Of this, nearly 30% is contributed by female sterilization. Male sterilization is low at 0.5%. Other spacing methods are equally low with the use of IUD at a mere 0.6%, oral contraceptive pills at 1.8% and condoms at 2.7%. According to HMIS Analysis (2010-11)No of Family Planning Methods Users (Sterilizations – Male & Female + IUD + Condom Pieces + OCP Cycles) are only8873 % of Sterilization against reported FP Methods is only 72%.

Percentage of IUD Insertions against reported FP Methods is only 16%.
Percentage of Condom Users against reported FP Methods is only 6%.
Percentage of OCP Users against reported Fp Methods is only 6%.

A significant unmet need for family planning services has been recorded at 37% which importantly comprises of 13% need for spacing and 24% for limiting methods.

| Strategies | Activities | Budget |
|---|---|---|
| • IEC/BCC at community level with the help of ASHAs, AWW<br>• Addressing complications and failures of family planning operations<br>• Training male peer educators to increase awareness amongst men about the importance of contraception and the ease of spacing methods<br>• ASHAs to have a stock of contraceptives for distribution<br>• Mobilize Couple by ASHA, AWW & ANM with the help of eligible couple survey.<br>• Provide IUD services in community by trained ANM & Nurse after IUD training.<br>• Decrease unmeet need of the district with help of strengthening of family planning through BCC & IEC activities. | **Spacing methods**<br>• Selecting and training male peer educators (1 for every 500 persons) in 5 blocks to counsel men for the adoption of spacing methods<br>• Interpersonal counseling of eligible couples on family planning choices by ASHAs and male peer educators<br>**Limiting methods**<br>• Family planning day at all health facilities every month.<br>• ANM and ASHA to report complications and failure cases at community to facility.<br>• Quick facility level action to address complications and failures.<br>• Streamlining compensation channels<br>• Streamlining incentives for MOs<br>**Abortion services**<br>• MTP services to be provided at all PHCs.<br>**Training**<br>• Training of MOs for conducting tubectomy and vasectomies procedures using Laparoscopy<br>• Training of MOs for providing MTP services<br>• Training of ANMs on encouraging reproductive choices and the features of | **Family Planning-**<br>Rs.20220000/- for all family planning activity in Buxar district & please see more detail in budget excel sheet. |

| | | |
|---|---|---|
| | different methods<br>• Training of ASHAs on family planning choices, contraceptives and behavior change communication | |

**FAMILY PALNNING:-**

***Facility Level***

- Promote accessibility to spacing methods and emergency contraceptive.
- Develop at least one facility in each block to provide all FP services
- Including terminal methods on a regular basis.
- Promote the use of 380 A – IUD as an alternative to sterilization.
- Popularize NSV.
- Monitoring and supportive of ANM/LHV to ensure that follow up
- services are being provided.
- DH,SDH & ALL PHCs will be conducted fix day in a week for family Planning.

***Community Level***

- Increase male involvement in the use of contraceptive and motivate
- them for NSV.
- Use local resources in the villages such as the link couples s depot
- holders.
- Use link couples for promoting the use of contraceptives.

**D. Adolescent Reproductive & Sexual Health:-**

Objectives

- Reducing the percentage of births to women during age 15-19 years from 96% to 85%
- Reducing anemia levels in adolescent girls and boys

| Situation analysis: Nearly 96% of births are to women in the age group of 15-19 years. This is a very vulnerable age group deserving of special attention and support. | | |
|---|---|---|
| Strategies | Activities | Budget |
| • Providing life skills education to married and unmarried adolescent girls by ASHAs and AWWs<br>• Treating anemia among adolescent girls and boys | • Training of ASHAs and AWWs on providing life skills education to adolescent girls<br>• Screening of all adolescents especially girls for anemia during the monthly health | RTI/STI Screening budget included in the RCH camp.<br><br>**IFA tablets** budget included in the Procurement of Drugs & Supplies. |

| | | |
|---|---|---|
| | checkups of children at AWC on the 2nd Monday of every month<br>• Screening of all adolescents for RTIs and STIs<br>• Providing IFA supplementation to adolescents | |

**OBJECTIVE :**

- Regular annual health check-up of Children registered in government primary and middle school.
- To detect any defect in progress of health and nutritional deficiencies.
- Early detection of serious illnesses and to refer them in the nearest specialized government health facilities.
- To develop good habit for better health and hygiene to remain healthy.
- To inculcate through the children habit to remain healthy among Family members and community.
- To improve quality of food supplied to children by adding micronutrients.

Additionally Counseling sessions will be organized in Govt. Schools in collaboration with BSACS. Storylines and slogans will be published in text books of schools in collaboration with the Education Deptt. Reference Books on Health Issues and Healthy Life-Style will be published for School libraries. Health

Camps will be organized for health check-ups for school children. Innovative strategies will be adopted to orient school children about healthy practices.

**Adolescent Reproductive & Sexual Health:-**

The World Health Organization (WHO) defines adolescence as the period between 10 and 19 years of age, which broadly corresponds to the onset of puberty and the legal age for adulthood. Commencement of puberty is usually associated with the beginning of adolescence. In some societies, adolescents are expected to shoulder adult responsibilities well before they are adults; in others, such responsibilities come later in life.

Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual

relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime. Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs. The reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services. Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron deficiency anemia. The prevalence of early marriage in India poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidities during childbirth. The following facts will help understand the situation objectively.

- The median age of marriage among women (aged 20 to 24) in India is 16 years.
- In rural India, 40 percent of girls, ages 15 to 19, are married, compared to only 8 percent of boys the same age.
- Among women in their reproductive years (ages 20 to 49), the median age at which they first gave birth is 19.
- Nearly half of married girls, ages 15 to 19, have had a least one child.
- India has the world's highest prevalence of iron-deficiency anemia among women, with 60 percent to 70 percent of adolescent girls being anemic.

Underlying each of these health concerns are gender and social norms that constrain young people –especially young women's – access to reproductive health information and services. Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child bearing continues to bean impediment to improvements in the educational, economic and social status of women in India. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

In many societies, adolescents face pressures to engage in sexual activity. Young women, particularly low income adolescents are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including

HIV/AIDS; and they are typically poorly informed about how to protect themselves.

To meet the reproductive and sexual health needs of adolescents, information and education should be provided to them to help them attain a certain level of maturity required to make responsible decisions. In particular, information and education should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction.

Information and education programs should not only be targeted at the youth but also at all those who are ina position to provide guidance and counseling to them, particularly, parents and families, service providers, schools, religious institutions, mass media and peer groups. These programs should also involve the adolescents in their planning, implementation and evaluation.

Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioral components of the educational process. Thus it can be conclusively stated that adolescents are a diverse group, and their diversity must be considered when planning programs. Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health programme, as it would remain in the reproductive age group for more than two decades. Early marriages seem to be still a key problem. Percentage of boys who are married before attaining 21 years in consistently high in most districts. The mean age of marriage for girls is 16.9. 25% pregnant mothers in the state are in the age group of 15-19 years. This is due to the reason that most of the girl's married before18 years. The various anecdotal evidences emerging from the community level participatory planning exercises and opinions voiced by the various levels of health officials during consultation exercise indicate that there is lack of a cohesive ARSH strategy at the state level. Possibility of bifurcating the total target into school going and out of school going adolescents have not been examined as a strategy option. Hence the current school health program by and large lacks any adolescent oriented interventions.

The possibility of convergence between the RCH II program priorities and NACP priorities require to be integrated.

Specific capacity building initiatives to orient the health providers at various levels to specific necessities of the ARSH program like adolescent vulnerability to RTI/STI/HIV /AIDS, communication with adolescents, gender related issues, designing adolescent friendly health services, body and fertility awareness, contraceptive needs etc have not been actively taken up the state health department to prepare itself to tackle the problems / issues of this important segment.

### Logistics

Validation of equipments and drugs procurement is within the domain of state level decision making. The Districts generally purchase the requirements and distributed to the other Health institutes mostly Block PHCs. However stock out of drugs still a problem for concern and require insurability of drug availability in the health institutes. There should provision of contingency funds for emergency drugs at the district level and health facilities.

Under NRHM there is scope for huge and rapid flow of materials from the MOHFW, GOI and the State level. RCH Kit A & Kit B are being supplied by MOHFW, GOI.

District and the peripheral institutions need to be strengthened through capacity building for enhancing their capabilities of indenting, procurement, inventory management and distribution of drugs and supplies and maintenance of medical equipment and transport. Cold Chain Vans are available in the districts for distribution of Vaccines to PHCs/ HSCs during vaccination programs and camps. Generally PHC vehicles are used to collect the drugs and supplies from the district store. Currently local purchase of drugs and supplies are not approved. Drugs, consumables, and vaccines are directly supplied by the districts for HSCs, PHCs and other facilities very irregularly. There is need to streamline the process for estimation and indenting of vaccines, drugs and supply of consumables. The supply system would ensure smooth flow of indented materials as per guidelines from state to all levels of utilization.

## 2.11 Convergence/Coordination

Convergence with ICDS has been taken care of to cover immunization and ANC Service. ASHA, AWW and ANMs together hold monthly meetings with Mahila Mandals under MUSKAAN Programme. Government of Bihar has decided to merge "Village Health and Sanitation Committee" with "*Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti*" constituted by Department of Panchayat Raj in Bihar.

There are 142 Panchayat in Buxar district. VH& SC are constituted in all panchayat.

### 8.1. Incentives, Contractual Salaries

As human resources are the most important resource steps shall be taken to motivate them through timely Payment.

**1.Salaries for contractual Staff Nurses:-**

@20000 X 30 Staff Nurse X 12 months = Rs.,72,00,000/-

**2.Contract Salaries for ANMs:-**

@11500 x 80 ANM ® X 12 months =Rs.11040000/-

## TRAINING:

Training plays vital role in accomplishment of the goals effectively. RCH-II program has made good progress in terms of translating service guidelines and giving program directions to districts. Service guidelines for BEmOC, FP, and IMNCI have been duplicated and made available to all the concerned staff. Professional development programs aimed at improving technical and managerial competencies of staff have helped in sustaining interest of the medical officers thereby health systems capacity to deliver quality services. The number of the training given to health professionals is as mentioned below:

## PNDT Act:-

- Implementation of Medical Termination of Pregnancy Act, 1971 and Pre-natal Diagnostic Techniques(prohibition) Act, 1994.
- In order to arrest the abhorrent & growing menace of illegal termination of pregnancies as well that of prenatal diagnostic test ascertaining sex-selection, the Medical Termination of Pregnancy Act, 1971 read with Regulations & Rules 2003 and the pre-natal Diagnostic Techniques (Prohibition of sex selection)Act were formulated. The misuse of modern science & technology by preventing the birth of girl child by sex determination before birth & thereafter abortion is evident also from the fact that, there has been a decline in sex ratio despite the existing laws. The Apex court has observed that:-
- "We may state that there is total slackness by the Administration in implementing the Act. Some learned counsel pointed out that even though the Genetic Counseling Centre, Genetic Laboratories or Genetic
- Clinics are not registered, no action is taken as provided under Section 23 of the Act, but only a warning issued. In our view, those Centers

which are not registered are required to be prosecuted by the Authorities

- Under the provision of the Act and there is no question of issue of warning and to permit them to continue their illegal activities" .The apex court accordingly directed the central as well as state Governments to implement the PNDT Act. In Bihar too the concerned authorities have been directed to implement the provisions of the both the Acts forcefully. Following actions have been taken and planned in this regard.

A. State, District and block level workshops on PNDT has been planned.

B. Create public awareness against the practice of prenatal determination of sex and female feticide through advertisement in the print and electronic media by hoarding and other appropriate means

C. A district wise task force to carry out surveys of clinics and take appropriate action in case of non registration or non compliance of the statutory provisions. Appropriate authorities are not only empowered to take criminal action but to search and seize documents, records, objects etc.

D. Beti Bachao Abhiyaan – As female feticide is a concern both in rural and urban areas, this year, Beti Bachao Abhiyan will be launched to sensitize people against this heinous practice. Massive awareness drive with the support of College students, women's organizations and other voluntary associations is planned this year. Human Chain, rallies, seminars, workshops and press conferences will be organized for the same.

## MUSKAAN Programme

The state has started a New Programme called MUSKAAN Programme to track pregnant women and Newborn Child. Under this programme ASHA, AWW and ANMs jointly track the pregnant mothers and Newborn Child. This programme launch in October 2007. Under this programme ASHA, AWW and ANM will hold meeting with Mahila Mandals in AWWCs. The main objective is to cover ANC coverage and Immunization.

After the introduction of this programme it has been seen that the coverage of ANC and Immunization increased.

***Budget:***

**Activity @ Proposed Budget**

Audit of DHS by CA for 2010-11 Rs. 20,000/-X 12 month = Rs. 2,40,000,-

## 8. Role of District and Blocks:-

The role of State, District and Block are well defined. The role of each one has been clearly indicated in the work plan as per activity wise. The decentralization process has given more roles to Districts and Blocks to perform in executing the various programs. The State mainly looking after Monitoring, Policy decisions, Centralize capital purchase, technical support etc and help the district in execute the actions panned.

## 9. Monitoring and Evaluation:-

One of the major weaknesses of the RCH program in the Bihar is the absence of an effective Monitoring and Evaluation system that would provide accurate and reliable information to program managers and stakeholders and enable them to determine whether or not results are being achieved and thereby assist them in improving program performance. A triangulated process of Monitoring and Evaluation would enable cross checking and easy collection, entry, retrieval and analysis of data.

Activities

- Strengthening and up gradation of monitoring and evaluation cell
- Mobility support
- Equipping and furnishing demographic cells
- Conducting survey and concurrent evaluation
- Formation of Databank
- Revised CNAA for all levels would be persuaded and guidelines for preparation district plans
- Web/internet based computer software for use at district and state level
- Reporting formats for providing requisite information.

## 10. PROGRAMME / NRHM MANAGEMENT COSTS

### 10.2.1 District Programme Management Unit

The Buxar district has already established District Programme Management Unit. DPMU consist of One District Program Manager, One District Account Manager, One District Monitoring & Evaluation Officer, One District Planning Coordinator, One District Community Mobilizer (Asha), One District Data

Assistant (Asha), One Account Assistant, One Office Assistant and Two Data Entry Operator. Till date 2 data operator has not appointed in Buxar DPMU. It has been observed that after the establishment of DPMU the implementation of National Rural Health Mission (NRHM) and Other National Programmes has been managed efficiently and getting improved results.

**Budget:-**

**Sl. Particulars Qty Amount (Rs.)**

Rs. 35200/- Per Month Per Honorarium for DPM (with 10% annual increment), Rs. 35200x1x12=Rs. 422400/-

Rs. 29700/- Per Month Per Honorarium for DAM (with 10% annual increment), Rs. 29700x1x 12=Rs. 356400/-

Rs.25300/- Per Month Per Honorarium for DMEO (with 10% annual increment),Rs. 25300x1x12=Rs. 303600/-

Rs.85000/-Per Month for Recurring Expenses for DPMU Rs.95000x1x12=Rs.1140000/-

**Proposed Human Resource for DPMU**

Provision of One Accountant for DPMU Rs.8000/- x 1x 9= 72000/-

**10.3 Block Programme Management Unit**

The district has already established Block Programme Management Unit in all the 11 Block PHCs.. Each BPMU consist of One Block Health Manager and One Accountant. It has been observed that after the establishment of BPMUs the implementation of National Programmes has been managed efficiently and getting improved results.

**Budget:-**

**Sl Particulars Qty Amount (Rs.)**

Rs.19800/-Per Month Per Honorarium for 6BHM,Rs.19800X6X12=Rs. 1425600/-

Rs. 23958/- per month Honorarium for 5 BHM, Rs23958X5X12 = Rs.1437480/-

Rs. 15972/- Per Month Per Honorarium of 10 Accountant, Rs.15972X10X12 =1916640/-

Rs. 13200/- per month Honorarium of 1 Accountant, Rs.13200X1X12 = Rs.158400/-

Mobility & Office Expenses Rs. 17245/- Per Month Per BPMU =Rs.17245X12X11 =Rs.2276340/-

**Proposed Human Resource for BPMU**

Provision of One Account Assistant for each PHCs Rs.8000/-x11x9=Rs.792000/-

Provision of One Block MEO for each PHCs Rs.10000/-x11x9= Rs.990000/-

# Chapter 4:-

## PART-B NRHM Flexible Pool /NRHM Additionalities

## B. Synergie with NRHM Additionalities:-

The NRHM is an effort to bring about the architectural change to overall program management to enable rationalization of resources and simultaneously to augment then limited resources so that equity in health is ensured. The commonality of initiatives in the following areas would be complementing the similar efforts under NRHM;

- Infrastructures for facility development,
- Manpower recruitment,
- Capacity building through training, program management, institutional strengthening, organizational development,
- Communitization,
- Promotional efforts for demand generation and
- Improved monitoring & evaluation systems developed under RCH II
- Public Private Partnership
- Convergence & Coordination

The convergence approach which was mooted earlier now finds a clear policy initiative and procedural development by health and all health determinants sectors so that a joint effort is made in tandem from planning to impact evaluation / outcome to ensure investments in health reach the poor /unnerved/underserved/excluded segment of the population. These common efforts would also strengthen gender equity through adolescent and other initiatives of both RCH & NRHM to provide a safety net to young women and girl children.

### 1. Decentralization

For effective decentralization in principle as well as practice, health societies have been established at all levels of the healthcare delivery structure. Systematic involvement of various stakeholders at all levels through these societies has helped make healthcare delivery responsive to the needs of the people via participatory planning and removal of bottlenecks at implementation levels. State Health Society provides overall guidance and supervision for effective planning and implementation, and also coordinates activities across the board. The State Health Mission, the Governing Body and the Executive Committee meet at regular intervals and take decisions

regarding all matters. District level activities are taken care of through the District Health Society. Rogi Kalyan Samitis at PHC, CHC, Sub Divisional Hospitals and District Hospitals have been set up. The formation of societies under NRHM has given a new direction to management and overall functioning of the health department towards the achievement of its goals.

### ASHA

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA is trained to work as an interface between the community and the public health system.

Under NRHM, 1493 ASHAs (revised as per the decadal growth in 2008) are to be selected and trained in Buxar. The previous target was 1273 (as per 2001 census). The 1st, 2nd, 3rd and 4th round /1, 2, 3 & 4th module training is being done by PHED and its NGOs.

### 1.1.5.a At the District Level

**Additional Personnel District Community Mobilizer/ District Project Manager ASHA –** She/He will be appointed in the capacity of Community Mobilizer and will act as a Nodal Officer at the district level for effective ASHA programme management, implementation and execution.

**District Data Assistant:** She/He will assist the community mobilizer and existing staff of the District PMU in all the ASHA related work.

### 1.1.5.b At the Block Level

**Block Community Mobilizer :–** An Officer will be appointed as a block Community Mobilizer for effective ASHA programme management, implementation and execution and to act as a link and network between the ASHAs and the District and will be assisted by a facilitator – 1 on every 20 ASHAs. The Facilitator will be the21st ASHA worker. This will help in building up and developing the necessary skill required for a community health worker in a sustainable way.

**Community Monitoring and Community Need Assessment:** Community-based Monitoring ensures that the services reach those for whom they are meant, for those residing in rural areas, especially the poor, women and children. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health and to understand if the work is moving towards the decided purpose. Although, ASHA hails from the same village, she may not be having knowledge and information on the health status of the village population. For this purpose, she will be advised to visit every household and undertake a sample survey of there sidents of the

village to understand their health status. In this way she will come to know the villagers, the common diseases which are prevalent amongst the villagers, the number of pregnant women, the number of new born, educational and socio-economic status of different categories of people, the health status of weaker sections especially scheduled castes/scheduled tribes etc. She will be provided with a simple format for conducting the surveys. The ASHA Activity Diary will also help her keep a record of the base level. In this she should be supported by the AWW and the Village Health & Sanitation Committee. Such a review will help to identify obstacles in the work, so that appropriate changes can be made to cross the obstacles by the team of the block level organizers.

**Networking with VHSC, PRI and SHGs –** All ASHAs will be involved in this Village Health and Sanitation Committee of the Panchayat, as Members. ASHAs will coordinate with Gram Panchayat in developing the village health plan, along with the Block Level Organizer, Block Medical Officer and Block Facilitator. The untied funds placed with the Sub-Centre or the Panchayat will be used for this purpose. The SHGs, Woman's Health Committees, Village Health and Sanitation Committees of the Gram Panchayat will be major sources of support to ASHA. The Panchayat members will ensure secure and congenial environment for enabling ASHAs to function effectively to achieve the desired goal.

### 1.1.1 ASHA Training

The third phase of ASHA training which includes the 5th, 6th and 7th modules would be doing in 4th qtr of FY 2011-12 by it's NGOs & continued in FY 2012-13

### 1.1.2 ASHA Drug Kit and it's replenishment

To ensure provision of ASHA Drug Kit to all ASHAs and replenishment as it is one of the key components of NRHM

### 1.1.5.c Emergency Services of ASHA

Bihar has been experiencing regular floods which have created havocs in lives of lakhs of people both economically and psychologically. During the time of floods, health related problems become extremely acute.

In such a situation the role of ASHA becomes extremely crucial. Thus ASHAs will be provided intensive training/capacity building preferably of three days and would then be deputed in 16 flood prone districts or similar natural disaster areas.

### 1.1.3 ASHA *Divas*

ASHA *Divas* will be held per month. This will include the following components-

- Monthly Meetings for ASHA Divas of ASHAs, ANMs and AWWs shall provide the necessary platform to share the work experiences, identify the loop holes and work towards the same.
- Best ASHA worker and ANM worker felicitation as per their monthly performance at the
- ASHA Divas will provide motivation. The performance will be rated as per the ASHA Activity Diary.
- Provision of I-Card will be done to the newly selected ASHA workers.
- Replenishment of ASHA Drug Kit for at least the next two months. This will ensure treatment of common ailments and first level prompt care and referrals initiated based on symptoms of necessary cases. For this, effective access to basic drugs in every village should be ensured through ASHA Drug Kit.

## Innovative Activity

**A. Provision of Award to ASHA Regarding Family Planning –** The provision of Award will ensure the following:-

- Provide Rs.5000/- As Award to Asha who motivate 20 or more than 20 cases of family planning in complete financial year will help in building up of better motivation of the ASHA workers.

**B. Provision of One Day ASHA Facilitator Training at District Level –** The provision of Asha Facilitator Training will ensure the following:-

- Enhance the capacity of Asha facilitators after that they will work better than previous experience.
- After training Asha Facilitators shall facilitate better to undertaken Asha and help in boosting the work of the Asha, it would be good sign for Asha program in the district.
- It will help in building up capacity to Ashas.

**Budget:**

**A) ASHA Support System at the District Level**

1 Strengthening of the District PMU for undertaking ASHA support system

(a) Community Mobilizer /District Project Manager-ASHA (Master in Social Work) Rs.24,200/-(10% 2 Annual increment) per month x 12 months =Rs.2,90,400/-) who will report to District Nodal Officer

(b) Data Assistant (Graduate with Basic Computer knowledge) – to strengthen the District PMU to take additional work. He/She will assist the existing staff of District PMU in all the work related to

NRHM including ASHA related work. Rs.15,000/- per month x12 months = Rs. 1,80,000/-)

(c) Office expenses at District Level for District Asha Resource Centre (5000 x 12 month = Rs.60,000/-)

**B) ASHA Support System at the Block Level**

(A) Block Community Mobilizer – Block Level Organizer in all the blocks. (Rs. 13200 x 11 x 12 months = Rs.1742400/-)

(B) Asha Facilitator:- Provision of 20 Asha per 1 Asha facilitator in entire of the district Rs.1050/- Per Month Per Asha Facilitator (1050 x 12 x 74 = 9,32,400/-)

(C) Office expenses at block level for Block Asha Resource Centre (2000 x 12 x 11 = 2,64,,000//-)

(D) Provision of Laptop for BCM (30000 x 11 = 3,30,000/-)

**(C) ASHA Drug Kit & Replenishment**

1 Drug Kit @ Rs. 350/- for 1493 ASHA two time ie.( Rs. 350 x 2 time x 1493 =Rs. 210,45,100/-)

**(D) ASHA Divas**

1. TA/DA for ASHA Divas @ Rs.125/- per ASHAs per month

(1493 ASHA x Rs.125 x12month) = Rs.22,39,500/-)

2. Best performance award to ASHAs at district level. @ Rs.3000 per block=3 ASHAs from each block @ Rs.1200 for 1st, Rs.900 for 2nd and Rs. 600 for 3rd prize, Rs. 300 for Certificate printing and distribution

= Rs. 3000 x 11 Block) = Rs. 33,000/-

4. identity Card (Rs. 50 x 1483) = Rs.74,150/-

**(E)Budget of Innovative Activity Regarding Asha Program**

1. Provision of Rs.5000/- as award to ASHAs who motivate 20 or more than 20 family planning case of selected 10 Asha entire of the district (10 ASHA x Rs.5000 = Rs.50,000/-)

2. One Day Asha Facilitator Training at District Level

## 2. Untied Fund for Health Sub Centre, APHC and PHC

The objective of the activity is to facilitate meeting urgent yet discrete activities that need relatively small sums of money at Health Sub Centers.

The suggested areas where Untied Funds can be used mentioned below:

- Cover minor modifications to sub center-curtains to ensure privacy, repair of taps, installation of bulbs, other minor repairs, which can be done at the local level;
- Ad hoc payments for cleaning up sub center, especially after childbirth; transport of emergencies to appropriate referral centers;
- Purchase of consumables such as bandages in sub center;
- Purchase of bleaching powder and disinfectants for use in common areas of the village;
- Labour supplies for environmental sanitation, such as clearing/ larvicidal measures for stagnant water
- Payment/reward to ASHA for certain identified activities.

***Budget***

**Budget Head Untied Fund**

| | | |
|---|---|---|
| Untied fund for sub-centre | 161HSC x Rs.10,000 | Rs.16,10,000/- |
| Untied fund for APHCs | 28 APHC x Rs.25,000 | Rs. 7,00,000/- |
| Untied fund for PHCs | 11 PHC x Rs.25,000 | Rs. 2,75,000/- |

**PHC level ANMs:-**

**1.Orientation on Guidelines for Untied Funds for HSC & VHSC**

(11 PHCs x Rs.3000) Rs.33,000/-

**2.Quarterly review meeting of the ANMs under the chairmanship of PHC**

**Medical Officer to monitor the usage of the Untied fund**

(Rs.1000 per meeting x 4quarter x 11 PHC) Rs.44,000/-

**Total Rs.77,000/-**

## 2.4 Village Health and Sanitation Committee:-

One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services at various levels. The Village Health & Sanitation Committee (VHSC), the standing committee of the Gram Panchayat (GP) will provide oversight of all NRHM activities at the village level and be responsible for developing the Village Health Plan with the support of the ANM, AWW and Self Help Groups. Block level Panchayat Samitis will co-ordinate the work of the GP in their jurisdiction and will serve as link to the DHM. The DHM will be led by the Zila Parishad and will control, guide and manage all public health institutions in the district.

States will be encouraged to devolve greater powers and funds to Panchayati Raj Institutions.
Untied grant of Rs. 10,000/- given in previous 2 year to all village health and sanitation committees. The committee will run in full coordination with AWW in the village. Integration with ICDS implies joint planning, use of AWC as the hub of the NRHM interventions in the village, joint reporting and monitoring on common indicators, and engagement with the AWW as a key figure in village planning and implementation.
Government of Bihar has decided to merge "Village Health and Sanitation Committee" with ***"Lok Swasthya Pariwar Kalyan and Gramin Swaschata Samiti***" constituted by Department of Panchayat Raj in Bihar.

***Budget***

**Budget Head Untied Fund for VHSNC**

Untied fund for VHSNCs 811 revenue village Rs.10,000/-=81,10,000/-

Training of members of VHSC regarding functioning mechanism at the PHC level 11PHCx Rs.2500 =Rs…………..,000/-

## 6. Seed Money for Rogi Kalyan Samitis

**Aims and Objectives**

The objectives of the RKS is :

» Upgrade and modernize the health services provided by the hospital and any associated outreach services

» Supervise the implementation of National Health Programme at the hospital and other health institutions that may be placed under its administrative jurisdiction

» Organize outreach services / health camps at facilities under the jurisdiction of the hospital

» Monitor quality of hospital services; obtain regular feedback from the community and users of the hospital services

» Generate resources locally through donations, user fees and other means

**Functions of the RKS**

To achieve the above objective, the Society utilizes it's resources for undertaking the following activities/initiatives:

» Acquire equipment, furniture, ambulance (through, donation, rent or any other means) for the hospital

» Expand the hospital building, in consultation with and subject to any guidelines that may be laid down by the Gob Make arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipments available with the hospital

» Improve boarding/lodging arrangements for the patients and their attendants

» Enter into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc

» Develop/lease out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society

» Encourage community participation in the maintenance and upkeep of the hospital

» Promote measures for resource conservation through adoption of wards by institutions or individuals

» Adopt sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water re-charging systems etc.

***Budget RKS:-***

**Budget Head Rogi Kalyan Samiti**

| | |
|---|---|
| 1.District Hospitals (01 hospitals X 5 lakhs ) | Rs.5,00,000/- |
| 2.Sub Divisional Hospitals (01 hospitals x 1 lakhs) | Rs.1,00,000/- |
| 3.PHCs (11 PHCs x 1 lakhs ) | Rs.11,00,000/- |
| 4.APHCs ( 28 APHCs x 1 lakhs ) | Rs.28,00,000/- |

**UPGRADATION OF COMMUNITY HEALTH CENTRE (CHC)**

NRHM aims to ensure CHCs on the Govt. of India population norm of 1 per 1.20 Lakhs populations. The Govt.of Bihar plans to upgrade all its PHCs and Referral Hospitals below the headquarter level to CHC as per IPHS standards. In the district Buxar total no of existing PHCs are 11 and the no of Referral Hospital is 1 (inclusive of 01 PHC). Hence a total of 11 units are needed to be upgraded to CHC standard and converted to 30-bedded hospitals. The State Health Society Bihar had Sanctioned Rs. 1.60 crore in SPIP 2009-10 for 4 PHC @Rs. 40Lakhs. The work of upgradation is under progress. The costs also

include provision of equipment at these hospitals either as per IPHS standard or as required.

### 3. Annual Maintenance Grant

During the course of up-gradation in setting up of different units in the different health facilities of the District ,maintenance will also be essentially required. State Health Society Bihar had approved Annual Maintenance Grant for district hospitals and sub divisional hospital @ Rs.5 lacs and Referrals/PHCs @ Rs.in SPIP 2009-10

*Budget*

**Fund Requirement for 2010-11**

| | | |
|---|---|---|
| 1.DH | @ Rs. 1,00,000/-x 1 | Rs.1,00,000/- |
| 2.SDH | @ Rs. 1,00,000/- x 1 | Rs. 1,00,000/- |
| 2.PHC (11) | @Rs. 50,000/-x 11 | Rs. 550,000/- |
| 3. APHC (15) | @Rs.50,000/-x 1 | Rs.7,50,000/- |

## PPP Initiatives in State

## 11. Operationalising Mobile Medical Unit

### Mobile Medical Unit (MMU):-

To reach out the marginalized communities living in far flung areas, the state has Mobile health units (MMU) that are currently functioning in tribal, peri urban, difficult areas and earthquake affected areas. Some of these MMUs are equipped with patient examination facilities, basic lab facilities and have the ability to provide reproductive and health services, along with general health services. The mobile is staffed with one Medical Officer, one GNM (Gr. A ), one ANM, one Lab Technician, one pharmacist, X-ray Technician, one OT assistant and one supervisor. Experiences show that the community living in remote and difficult areas better utilizes these services. These Mobile units would be re routed and Strengthened to provide basic health and RCH services in remote areas, which are so far not served or difficult to cover by sub centres. These MMU will be linked with Block Health Officers so that they can monitor the services. Provision for necessary drugs and consumable, POL and staff has been made available under this program. The guidelines, daily schedule and suggestive list of services that they need to provide will be given to them. A state level consultant has been made responsible to ensure that these services would increase RCH coverage in the marginalized communities. Periodic reviews of Mobile units are undertaken to strengthen the services. It has also planned to collect and analyze monthly performance each mobile units and coverage status of the areas. Currently, all the three mobile health units in the district have been initiated and they are functional.

Operationalisation of Mobile Medical Unit in district is under progress .This project is undertaken under PPP. SHS Bihar finalize firm and rate for the project.

Scope of Work

Private Service Providers for providing mobile health care services in rural Bihar of curative, preventive and rehabilitative nature, to be provided by the service provider along with all deliverables like Mobile Clinic (each unit fitted with GPS- Global Positioning System), professional manpower, and other such services, to provide and supplement primary health care services for the far flung areas in the various districts of Bihar and to provide a visible face for the Mission.

Project Objective

To provide and supplement regular, accessible and quality primary health care services for the farthest areas in the districts of Bihar and to provide visible face for the mission and the Government, also establishing the concept of Healthy Living among the rural mass

Project Scope

The detailed roles and responsibilities of the private partners to meet the aforesaid objectives are as follows:

- ✓ Providing the requisite vehicle and equipments and software for Operationalization of the MMU.
- ✓ Install, Operate and maintain appropriate GPS facility.
- ✓ Technical manpower support to run the MMU and provide the services
- ✓ Continued technical back up for maintenance of the system.
- ✓ Ensuring Quality Standards
- ✓ Providing detailed reports and maintain database of information of MMU services as per the Proformas provided at the time of signing of the contract, or as issued by the SHS from time totime.

To meet above project objective SHS Bihar had approved an amount of Rs.10.00 crores for the project in SPIP 2009-10.

***Budget:-***

Fund Required (in Rs.) Projected cost for 1 MMU project at district level Rs.3,51,000 x 12months

=Rs. 42,12,000/-

## 12.2 Advanced Life Saving Ambulance (108)

Patna: 108, the ambulance service that became a favourite of Bihar in a short period of time has run into a problem that should have been avoided! Well-equipped, staffed by trained professionals and reasonable in their fee structure, the 108 has been quite popular in Bihar.

Unfortunately, the 108 Ambulance service is no longer available in 19 out of the 38 districts of Bihar since Sunday. The reason – non-payment of dues by the Health Committees [Swasthya Samitis]. According to Sumit Basu, the Project Head of Health care Ltd that runs the facility, the 38 districts of Bihar together owe the company Rs 120 lakh. He said that those districts who have continued to make payments have not been deprived of the service.

The Health Minister Ashwini Choubey, the Principal Health secretary Amarjeet Sinha and the Executive Director Bihar Health Society Sanjay Kumar were all informed before the services for the 19 districts was withheld. A letter to the CM will be sent by the company in this regard.

The ambulances recalled from the districts are now parked in front of the Bihar Health Society, Patna.

According to Basu, other states like Punjab, Rajasthan and Kerala have over 1000 ambulances running in their towns. They however have a centralized system of payment which simplifies matters considerably. Why Bihar continues to have an inefficient system of district level payments is not clear.

The executive director of the Bihar Health society has called for a meeting of all the civil surgeons on Tuesday after which some action may be taken in this regard.

The districts deprived of the 108 include - **Jamui, Lakhisarai, Madhubani, Samsatupur, Gaya, Jahanabad, Rohtas, Motihari, Sitamarhi, Bhojpuri, Buxar, Betiya, Saran, Kishenganj, Vaishali, Madhepura, Supaul, Banka, and Nawada.**

The patients and their families in distant corners of Bihar are in the meantime suffering due to official apathy. The private ambulance operators are making use of the opportunity to charge high rates for transporting the sick.

In the meantime according to reports, the employees of 108 in Patna have gone on a strike against non-payment of salaries and long hours of duty. Each 108 ambulance apart from the driver carries an assistant and a paramedic. The ire of the employees is clearly directed at the State Swasthya

Samiti [Bihar Health Society] which has failed to pay their salaries since October. Earlier, the employees went on a strike on 12 January but withdrew the strike after assurances from the Swasthya Samiti officials. Thus the problem has been brewing for some time and the present crisis seems far from unforeseen.

**Budget:- Rs.**130000/- per month x 1 x 12 = Rs.1560000/-

### 12.2. Referral Transport Service

Under this scheme Ambulance for emergency transport is being provided in all the DH to PHC . The empanelled ambulance & ambulance available in Govt. institutions are made available for beneficiaries. This service has been outsourced to a private agency for Operationalisation.

Requirement of Ambulance in District:-

- ✓ Primary Health Centre (PHC): 11
- ✓ Sub-Divisional Hospital (SDH): 01
- ✓ District Hospital: 01

***Budget summary of Ambulance :***

Rs.130000/- per month per PHC, Rs.130000X12X9 = Rs.1,40,40,000/-

### 13.3.d Bio Medical Waste Management

Bio medical waste management has emerged as a critical and important function within the ambit of providing quality healthcare in the country. It is now considered an important issue of environment and occupational safety. As per the Bio-Medical Waste (Management & Handling) Rules, 1998, all the waste generated in the hospital has to be managed by the occupier in a proper scientific manner. The GoI has also issued the IMEP guidelines for SCs, PHCs and CHCs. The state has outsourced the Biomedical Waste Management system for all the Government hospitals.

**Budget:-**

**Rs.105235/- per PHC x 9 PHC = Rs.947115/- in th district.**

### 13.3.b Outsourcing of Pathology and Radiology Services from PHCs to DHs

Under this scheme Pathology and Radiology services have been outsourced to different Private agencies. The agencies have and/or are in the process of setting up centers/diagnostic labs/collection centers at the hospitals/facilities. The state has fixed the rates .

All the remaining cost for setting up centers and providing services will be borne by the private providers.

**Budget:-**

**Rs.2,00,000/- x 22 = 44,00,000/-**

### 15.3.1.a Monitoring and Evaluation

**District & Block Data Centres**

The Data Centers at each and every hospital (PHC, Sadar Hospital, Sub-Divisional Hospital etc.) are being established through outsourcing. District Hospital Sub-Divisional Hospital require two Data Centre . The main purpose of these Data Centers of Hospitals is to gather and maintain health related data under RCH/NRHM programme in their computer system and they upload the gathered health related data on the web-server of SHSB on daily basis. The Data Centers contain one computer with UPS, Laserprinter, Phone connection, Internet connection, Computer operator, Misc. etc.The GPRS enabled mobile setshave been given to each and every data centers. The total no. of Data Centers to be established is 685 and theestimated cost is Rs. 10,000/- per Data Centre per month.

The District/Block Data Centres units would be as such:

- ✓ Primary Health Centre (PHC) : 11
- ✓ Sub-Divisional Hospital (SDH) : 01
- ✓ District Hospital : 01
- ✓ District Health Society : 01

**Total Data Centre : 14**

***Budget***

**Activities Total proposed budget (in Rs.)**

**Rs.10,000/- per month per Data Operator X 14 X 12 month = Rs.16,80,000/-**

### 15. Health Management Information System

**15.3.3 Web Server System**

The State Health Society has established one web-server with 512 kbps leased-line connection for on-lineuploading and reporting of Health related data through web-server application of State Health Society, Bihar.

The following system shall be introduced in parallel to the existing system of Data centers:

1. Online uploading of Health related data directly from Data Centers of PHC/Hospitals.

2. Compilation and reporting of Health related data through developed application software in very less time.

3. The reports will be more accurate and consistent.

4. The DM/CS/DHS can view the different reports of Health services of district in on-line mode, therefore proper action can be taken quickly.

5. The officers/staff of state level also can view the reports of Health services of all districts in online mode, therefore proper action can be taken promptly.

6. According to requirement, any new report can be added and the information can be obtained from PHC/Hospitals in online mode quickly.

7. More security and safety of Health related database.

Therefore ,website for Buxar districts is required to be designed, created and maintained

***Budget***

***Rs.4000/- Per Year***

### 15.3.3.b HMIS Supportive Supervision, Data Validation & Reports

### HMIS and Monitoring & Evaluation

The National Rural Health Mission has been launched with the aim to provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable. In order to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need of proper HMIS system so that regular monitoring, timely review of the NRHM activities should be carried out. The quality of MIES in districts is very poor. Reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete, and inconsistent. Formats are not filled up completely at the sub center level. There information is not properly reviewed at the PHC level. No feedback is provided upon that information.

For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. .At district level, there

is a District Health Society who will be responsible for the data dissemination from the sub-district level to the district level. District M & E Officer at the district level and Accountant cum M& E Officer at block level will be responsible for management of HMIS. As such, there is a Monitoring Team constituted district level as well as block level to monitor the implementation of the NRHM activities. There is a Hospital Management Committee/Rogi Kalyan Samiti at all PHCs and CHCs. The PHC / CHC Health Committee will monitor the performance of HSC under their jurisdiction and will submit the report and evaluate the HSC performance, and will be submitted to the District, which will compile and sent it to the State.

As we know that NRHM aims to continuously improve and refine its strategies based on the inputs and feedback received from the State and from various review missions. One of our priorities is to build a robust Health Management Information System (HMIS) that is used for improving, planning and programme implementation at all levels. NRHM has introduced Revised HMIS formats. District Monitoring & Evaluation Officer will prepare schedule of the month for visit to PHC for HMIS data validation & supportive supervision. DM&EO give the plan to resource pool for PHC visit to entire district.

**Budget**

**Rs.2,30,000/- Per Year.**

### 15.3.1.b MCTS & HRIS

When a mother dies, children lose their primary caregiver, communities are denied her paid and unpaid labour, and countries forego her contributions to economic and social development.

A woman's death is more than a personal tragedy--it represents an enormous cost to her nation, her community , and her family. Any social and economic investment that has been made in her life is lost.

More than a decade of research has shown that small and affordable measures can significantly, reduce the health risks More than a decade of research has shown that small and affordable measures can significantly, reduce the health risks that women face when they become pregnant. Most maternal deaths could be prevented if women had access to appropriate health care during pregnancy, childbirth, and immediately afterwards.

Provision of MCTS training of MOIC, BHM, BAM, BCM, Data Operator at district level after that MCTS training will be given to ANM, LHV, HE at Block Level.

**Budget**

**Rs. 28702/- per batch x 8 batch = Rs.229616/-**

### 5.2 Strengthening of Cold Chain

Effective cold chain maintenance is the key to ensuring proper availability and potency of vaccines at all levels.

With a steadily increasing immunization coverage for Routine Immunization, rise in demand for Immunization services throughout the state, the consumption of large quantities of vaccines in frequent Supplementary Immunization activities and the possibility of introduction of newer vaccines in the near future, it is necessary that the capacity of existing cold chain stores as well as the proper management of immunization related logistics be strengthened on a urgent basis. For this there is need for refurbishment of existing cold chain stores at all levels

### Budget

**Rs.70,000/- per year for Dist & Rs.1,40,000/- for all PHC.**

**Infrastructure Strengthening for Cold Chain**

**Items Units Amount**

Refurbishment of existing Cold chain room of districts with proper electrification, Earthing for electrical cold chain equipment and shelves and dry space for non electrical cold chain equipment and logistics @Rs 7 Lakhs per district Earthing and wiring of existing Cold chain rooms in all 11 PHCs @Rs 10000/- per PHC 110000

**Total Requirement of fund=District +PHC**

## 9. Mainstreaming AYUSH under NRHM

The Indian systems of medicine have age old acceptance in the communities in India and in most places they form the first line of treatment in case of common ailments. Of these, Ayurveda is the most ancient medical system with an impressive record of safety and efficacy. Other components such as Yoga, Naturopathy are being practised by the young and old alike, to promote good health. Now days, practice of Yoga has become a part of every day life. It has aroused a world wide awakening among the people, which plays an important role in prevention and mitigation of diseases. Practice of Yoga prevents psychosomatic disorders and improves an individual's resistance and ability to endure stressful

situation. Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) are rationally recognized systems of medicine and have been integrated into the national health delivery system. India enjoys the distinction of having the

largest network of traditional health care, which are fully functional with a network of registered practitioners, research institutions and licensed pharmacies. The NRHM seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs), to strengthen the Public Health System at all levels. It is decided that AYUSH medications shall be included in the drug kit of ASHA, The additional supply of generic drugs for common ailments at SC/PHC/CHC levels under the Mission shall also include AYUSH formulations.

At the CHC level two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health Standards (IPHS) model. At the same time, it has been decided to place or provision one Ayush doctor on contract at the APHCs for the purpose and to ensure complete coverage of the population.

Activities Improving the availability of AYUSH treatment faculties and integrating it with the existing Health Care Service.

Strategies

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

1. Integration of AYUSH services in 1234 APHC with appointment of contractual AYUSH Doctors.

2. Appointment of paramedics where AYUSH Doctors shall be posted.

3. Strengthening of AYUSH Dispensaries with provision of storage equipments.

5. Making provision for AYUSH Drugs at all levels.

6. Establishment of specialized therapy centers/Ayush wings in District Head Quarter Hospitals & Medical Colleges.

7. AYUSH doctors to be involved in all National Health Care programmes, especially in the priority area slike IMR, MMR, JSY, Control of Malaria, Filaria, and other communicable diseases etc.

8. Training of AYUSH doctors in Primary Health Care and NDCP.

9. All AYUSH institutions will be strengthened with necessary infrastructure like building, equipment, manpower etc.

10. Yoga trainings were held in various District hospitals to provide Yogic therapy for specific diseases and also as a synergistic therapy to all other systems of treatment.

**BUDGET AYUSH - Requirement of the funds from NRHM –**

**1.** Ayurvedic, Unani and Homeopathic dispensaries-

(i) Provision of 1 Ayush doctor at each APHC on contract

@ Rs.22,000/- x 28 APHC x 12 months =73,92,000/-

## 10.a IEC

- *The Annual Action Plan 2012-13 for IEC/BCC has been prepared in the light of the number of initiatives taken by Dept. of Health, GoB, and State Health Society, Bihar, in the implementation of NRHM. It follows in essence, form and content, the National Communication Strategy. The National PIP for RCH and instructions and guidelines received from GoI and GoB from time to time has also been kept in mind. The selection and implementation of set of behavior change have been adopted with a view to improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy level. The IEC/BCC Programme will focus on building an environment favoring health seeking practices, preferably through low cost an d no cost interventions, especially for the disadvantaged and the marginalized sections of society. This outlook will set the tone and tenor of the mobilization process for effectuating a positive change in the existing socio-cultural mores, systems and processes.*
- *Organized One Health Mela (Leprosy)in the high risk area in the district regarding leprosy .*

## 10.b Behavior Change Communication

The district does not have any comprehensive BCC strategy. All the programme officers implement the BCC activity as per their respective programmes.

The IEC logistic is designed, developed and procured at the district level and distributed to the PHC in an adhoc manner. However some activity is done at the state level. There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various

focus areas of interventions like breast feeding, community & family practice regarding handling of infants, ARSH issues etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures.

***Budget***

***Rs.300000/- per year for Dist & Rs.15000/- per PHC .***

## 7. Discenterlise Planning

Under the National Rural Health Mission the District Health Action Plan is play key role of achieve the NRHM Goal d. It is prepared on the base of situational analysis the study proceeds to make recommendations towards a policy on workforce management, with emphasis on organizational, motivational and capability building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It looks at how the facilities at different levels can be structured and reorganized.

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

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

**Budget**

1. **Salary of District Planning Coordinator Rs.24,200/- per month (With 10% 2 increment), 24200 x 12 x 1 = 2,90,400/-**
2. **Provision of Laptop for DPC is very necessary Rs.40,000/-**
3. **Rs.50,000/- for DHAP, Rs.10,000/- for each BHAP & Rs.1500/- for each HSC.**
4. **Planning Cell at Distt Level-1 Computer Assistant Rs.6000/- per month = 6000x12 = 72000/-**

## 8. Panchayati Raj Institution

Panchayati Raj is a system of governance in which gram panchayats are the basic units of administration. It has 3 levels: village, block and district.

The term 'panchayat raj' is relatively new, having originated during the British administration. 'Raj' literally means governance or government. Mahatma Gandhi advocated *Panchayati Raj*, a decentralized form of Government where each village is responsible for its own affairs, as the foundation of India's political system. This term for such a vision was "Gram Swaraj" (Village Self-governance).

It was adopted by state governments during the 1950s and 60s as laws were passed to establish Panchayats in various states. It also found backing in the Indian Constitution, with the 73rd amendment in 1992 to accommodate the idea. The Amendment Act of 1992 contains provision for devolution of powers and responsibilities to the panchayats to both for preparation of plans for economic development and social justice and for implementation in relation to twenty-nine subjects listed in the eleventh schedule of the constitution.

The panchayats receive funds from three sources – (i) local body grants, as recommended by the Central Finance Commission, (ii) funds for implementation of centrally-sponsored schemes, and (iii) funds released by the state governments on the recommendations of the State Finance Commissions.

In the history of Panchayati Raj in India, on 24 April 1993, the Constitutional (73rd Amendment) Act, 1992 came into force to provide constitutional status to the Panchayati Raj institutions. PRIs plays big role in rural community so health department must be share their services to PRIs member which is conducting in rural areas. Constitution & Orientation of PRIs member regarding health services.

**Budget**

**a.Rs.2.84,000/- for training of community leader.**

**b. Rs.96,390/- for workshop of PRIs member.**

# CHAPTER – 6

## National Aids Control Programme :-

The National AIDS Control Program was started with a view to create awareness among population regarding the disease & to reduce the prevalence rate & the incidence rate of the disease.

### Performance of VCTC Buxar

The number of patients, which had, came for getting tested for HIV & those who have been found reactive both are showing an increasing trend. But last year reactive cases are increased. The increase in number of patients turning up for HIV test shows increase in awareness among the masses about the disease & it also shows that there has to be more & more centers for counseling & testing. At present the district has one VCTC center at Buxar Sub Divisional Hospital. The workload on the only counselor at the center is huge & the district being very large with blocks at a distance of around 40-45 kms also shows the demand for more & more VCTC centers. The increasing number of reactive patients also creates demand for special care for positive patients; as such there are no centers at the district providing specialist care to the positive patients.

## DHAP- Kala azar District Plan : -

Goal:

Strategy No.1: Vector control

Activities:

1. Undertaking indoor residual insecticide spraying.
   i. Ensure planning for timely spray of DDT in Feb-March and May-June for 60 days each block.
   ii. Ensure adequate stock of DDT through proper and timely indenting to improve the quality of spray.
2. Use of insecticide-treated bed nets.
   i. Ensure availability of insecticide-treated bed nets through compensation given to the patients.
3. Environmental management

   i. Reduction of organic rubbish accumulation in and around houses.
   ii. Ensure well lighted and ventilated rooms in houses.

Strategy No.2: Early Diagnosis

Activities:

1. Identification of houses with Kala- azar patients by ANM & ASHA @Rs.50 per patient.
2. Kala azar Test Kit to be present in each HSC.
3. Regular Kala azar health camps.

Strategy No.3: Complete treatment

Activities:

1. Treatment protocols to be followed.
2. Availability of essential medicines and injections in buffer stock at each PHC and District Hospitals.
3. Follow up of each case.
4. Detection and management of PKDL cases.
5. Availability of referral transport system.

Strategy No.4: IEC, BCC and Community Mobilization

Activities:

1. Mapping of Hot spots at each sub centre.
2. Knowledge sharing with the community on signs and symptoms of Kala- azar through Participatory Rural Appraisal.
3. IEC activities through nukkad nataks, Kala jathas, mass media like radio etc
4. Wall paintings of treatment protocols and services for patients in PHC.
5. Counseling to each patient of kala azar about the preventions and control methods of Kala azar.
6. Formation of 5 members monitoring team of the villagers at the village level.
7. Wall writings of small slogans for prevention and treatment of kala azar in villages.
8. Awareness among the villagers regarding prevention strategies and change in their habits.

Strategy No. 5: Effective and timely monitoring and evaluation

Activities:

1. Monthly visit done by the supervisors and the MO in charge.
2. Strict supervision of spraying and quality of DDT Spray should be done.
3. Quarterly Maintenance and comparison of data of No. of new Kala azar cases and treatment of detected cases at the PHC and District level.
4. Mop up where needed should be found out and effectively done.
5. Vehicles to be provided to Supervisors and in Charges for regular visits.

Strategy No. 6: Intersectoral convergence

Activities:

1. ASHAs, ANMs, AWWs, PRI members should be actively involved in detection and prevention of Kala azar cases.
2. VHSC could be helpful in environment management and monitoring vector control.

3. Self help groups can be utilized in creating sensitivity regarding the epidemic and even foe increasing the use of insecticide-treated nets.
4. Actively involve private practitioners (formal and informal) in reporting suspected cases and providing incentives and support to ensure that this happens.
5. Local level NGOs can be shared partners in providing trainings at PHC and doing PRAs at villages.

Strategy No.6: Capacity Building and training

Activities:

1. Increase efficiency of case detection through training of ASHAs, ANMs, AWWs and PRI members on signs, symptoms and provisions of treatment of Kala-azar.
2. Regular orientation and training to in charges and supervisors.
3. One Day training to the sprayers including field practice.

Strategy No.7: Regular fund transfer and maintenance of Equipments

Activities:

1. Fund would be allocated for regular payment of wages (147 SFW to be used and 735 FW to be used for monitoring and spraying works.
2. Fund allocation and timely release for: maintenance of old sprayer pumps, Purchase of new pumps and other articles needed- buckets, mugs etc.

## Chapter-6
## Action plan for NDCP:-

### Action Plan for Tuberculosis Control (R.N.T.C.P.) Programme :-

**Introduction :**

Tuberculosis is an infectious disease caused by Mycobacterium tuberculosis. Pulmonary tuberculosis is the most common form of TB (more than 85% of all TB cases), while extra-pulmonary tuberculosis can affect almost any organ in the body. Transmission occurs by airborne spread of infectious droplets and droplet nuclei containing the tubercle bacilli. The source of infection is a person with sputum smear positive pulmonary TB. Transmission often occurs indoors, where droplets and droplet nuclei can stay in the air for a long time.

**Implementation of RNTCP :**

On the recommendations of an expert committee, a revised strategy to control TB was pilot tested in 1993. The RNTCP applies the WHO recommended DOTS (Directly Observed Treatment, Short-course) strategy. The programme was expanded in a phased manner to cover the entire country in 2005. By June 2005, over 1 billion of the population was covered under RNTCP. The majority of TB patients have pulmonary TB, with the sputum smear positive pulmonary TB patients constituting the infectious pool in the community. Early diagnosis and cure of these patients can break the chain of

transmission of TB infection in the community; However, RNTCP provides treatment services to all patients including both pulmonary and extra pulmonary TB patients.

**Goal :**

The goal of RNTCP is to decrease mortality and morbidity due to TB and cut transmission of infection until TB cases to be a major public health problem. It aims to control TB by detecting and curing sputum smear-positive patients thereby interrupting the chain of transmission. The objectives of RNTCP are to achieve and maintain a cure rate of at least 85% among new sputum smear positive cases and to achieve and maintain detection of at least 70% of such cases in the population. The only effective means to achieve the goal of RNTCP is the application of DOTS.

**Objectives :**

The objectives of RNTCP are :

• To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases, and

• To achieve and maintain detection of at least 70% of such cases in the population

**Components of DOTS :**

DOTS is a systematic strategy having 5 components.

• Political and administrative commitment
• Good quality diagnosis, primarily by sputum smears microscopy
• Uninterrupted supply of good quality drugs
• Directly observed treatment (DOT)
• Systematic monitoring and accountability

**Scientific basis of DOTS**

DOTS is primarily based on sputum microscopy, domiciliary treatment, short course chemotherapy, and directly observed treatment.

**Structure of the RNTCP**

The Structure of RNTCP comprises of five levels, as follows:

**National Level (Central TB Division)**

The Central TB Division (CTD) is a part of the Ministry of Health and Family Welfare (MoHFW), and is responsible for tuberculosis control in the whole, country. A National Programme Manager, the Deputy Director General TB (DDG TB), is in charge of the tuberculosis programme for the entire country. CTD plans, supervises, monitors and evaluates programme activities throughout the country.

**State Level**

With the rapid expansion of the programme, MoHFW has re-structured and strengthened the functions of the State TB Control Society (STCS). The States have increases ownership and accountability for implementation. Capacity building and de-centralization are taking place in the technical, financial as well as logistic aspects of the programme. The States, via the STCSs, are now directly responsible for monitoring and supervising the work of District TB Control Societies (DTCSs). At the State level, the State Tuberculosis Officer (STO) is responsible for planning, training, supervising and monitoring the programme in their respective states as per the guidelines of the STCS. The STO bases at the State TB Cell is administratively answerable to the State Government and technically follows the instructions of the CTD, and coordinates with CTD and the districts for executing the duties mentioned above. There should be a full-time STO trained in RNTCP for each state. In

major states of the country, a state TB Training and Demonstration Centre (STDC) supports the state TB Cell by providing training, supervision coordination, monitoring and technical functions.

**District Level**

The district is the key level for the management of primary health care services. The district level (or municipal corporation level) performs functions similar to those of the state level in its respective area. The Chief District Health Officer or an equivalent functionary in the district is responsible for all medical and public health activities including control of TB. The District Tuberculosis Centre (DTC) is the nodal point for TB control activities in the district. In RNTCP, the primary role of the DTC has shifted from a clinical one to a managerial one. The District TB Officer (DTO) at the DTC has the overall responsibility of physical and financial management of RNTCP at the district level as per the guidelines of the DTCS. The DTO is also responsible for involvement of other sectors in RNTCP and is assisted by an MO, Statistical Assistant and other paramedical staff. For each district, there should be a full-time DTO, who is trained in RNTCP at a central level institution.

**Sub-district Level (Tuberculosis Unit Level)**

A team, comprising a specifically designated Medical Officer – TB Control (MOTC), Senior Treatment Supervisor (STS) and Senior Tuberculosis Laboratory Supervisor (STLS), is bases in a Community Health Centre (CHC), Taluka Hospital (TH) or Block Primary Health Centre (BPHC). The team of STS and STLS at the Tuberculosis Unit Level (TU level) are under the administrative supervision of the DTO/MO-TC.

The TU covers a population of approximately 5 lakhs (2.5 Lakhs in tribal, desert, remote and hilly regions). The TU will have one Microscopy Centre for every 1 Lakh population (0.5 Lakh in tribal, desert, remote and hilly regions) referred to as the Designated Microscopy Centre (DMC). DMCs are also provided in Medical Colleges, Corporate hospitals, ESI Railways, NGOs private hospitals, etc, depending upon requirements. The TU is responsible for accurate maintenance of the Tuberculosis Register and timely submission of quarterly reports to the district level. The TU is the nodal point for TB control activities in the sub-district. MOTC at the TU has the overall responsibility of management of RNTCP at the sub district level and is assisted by the STS and STLS. MO-TC is also responsible for involvement of other sectors in RNTCP. The MO-TC is trained in RNTCP at a state level institution, preferably State TB Training and Demonstration Centre (STDC).

The MO-TC at the TU is responsible for organizing sputum smear examination at all DMCs of the sub-district, carrying out treatment categorization of diagnosed patients (and supporting other MOs of the sub-district to do the same), and ensuring that DOT is taking place as per guidelines at all DOT centres. He should ensure a regular supply of drugs and other logistics and ensure their uninterrupted availability in all peripheral health institutions in the sub-district. MOTC is responsible for updating records and preparing quarterly reports on case finding, sputum conversion, results of treatment outcome and programme management of the corresponding TU.s

**Key functions of the Tuberculosis Unit team are to**

- Maintain the Tuberculosis Register
- Organize and ensure effective diagnosis and direct observation of treatment

• Prepare quarterly reports on case finding, sputum conversion, results of treatment, and programme management.
• Ensure adequate supply of drugs, reagents and logistics regularly
• Involvement of other sectors in RNTCP
• Ensure effective IEC activities

**Peripheral Health Institutions (PHIs)**

At this level are the dispensaries, PHCs, CHCs, referral hospital, major hospitals, and specialty clinics/hospitals (including other health facilities) within the district. Some of these PHIs will also be DMCs.

**Main responsibilities of the MO at the PHIs**

Refer tuberculosis suspects or send their sputum specimens to DMC for examination.

• Carry out treatment categorization of diagnosed patients; give health education to them; identify DOT providers for them (in consultation with the concerned workers as well as the patients) and start DOT within 7 days of diagnosis.
• Trace patients who interrupt treatment and bring them back to treatment. Maintain up-to-date Tuberculosis Treatment Cards and records and make them available to supervisory staff when they visit the health facilities.
• Monitor and facilitate follow-up sputum smear examinations.
• Identify and investigate contacts.
• Mention treatment outcomes in the treatment cards.
• Identify and train DOT provider as and when needed, update list of DOT providers under intimation to MO-TC.
• Submit monthly report on programme implementation and logistics to the TU.
• Supervise and monitor DOT services in their jurisdiction
• MOs of DMC are also responsible for supervision and monitoring the microscopy activities of their institution.

The central state, district and sub district levels must carry out their responsibilities to achieve the objectives of RNTCP.

**The main tools for diagnosing**

• **Sputum microscopy** is easy to perform at the peripheral laboratories, not expensive and specific with low inter and intra reader variation. Therefore, this is the key diagnostic tool used for case detection in RNTCP.
• **X-Ray as a diagnostic** tool is sensitive but less specific with large inter and intra reader variations.
• **Culture of Mycobacterium tuberculosis** bacilli is very sensitive and specific but is expensive as it requires a specialized laboratory set-up and results are available only after several weeks.

**Definitions:**

**Type of Cases:**

**New :** A TB patient who has never had treatment for tuberculosis or has taken anti-tuberculosis drugs for less than one month.

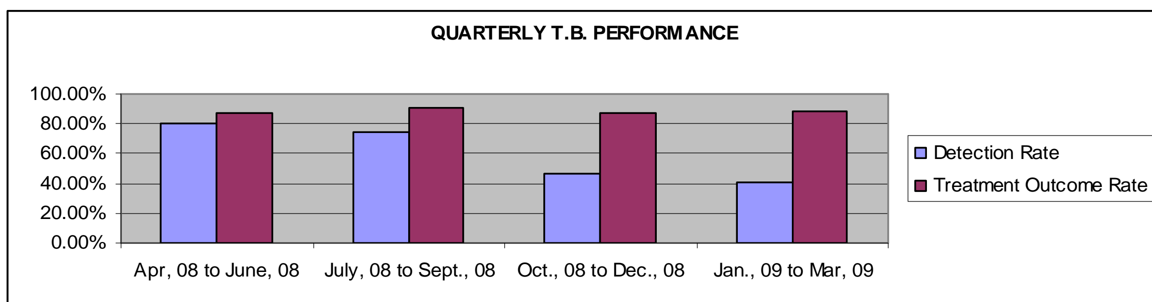
**Relapse :** A TB patient who was declared cured or treatment completed by a physician, but who reports back to the health service and is now found to be sputum smear positive.

**Transferred in :** A TB patient who has been received for treatment into a Tuberculosis Unit, after starting treatment in another unit where s/he has been registered.

**Treatment after default :** A TB patient who received anti-tuberculosis treatment for one month or more from any source and returns to treatment after having defaulted, i.e. not taken anti-TB drugs consecutively for two months or more, and is found to be sputum smear positive.
**Failure :** Any TB patient who is smear positive at 5 months or more after starting treatment. Failure also includes a patient who was treated with Category III regimen but who becomes smear positive during treatment.
**Chronic:** A TB patient who remains smear positive after completing a retreatment regimen.
**Other:** TB Patients who do not fit into the above mentioned types. Reasons for putting a patient in this type must be specified.

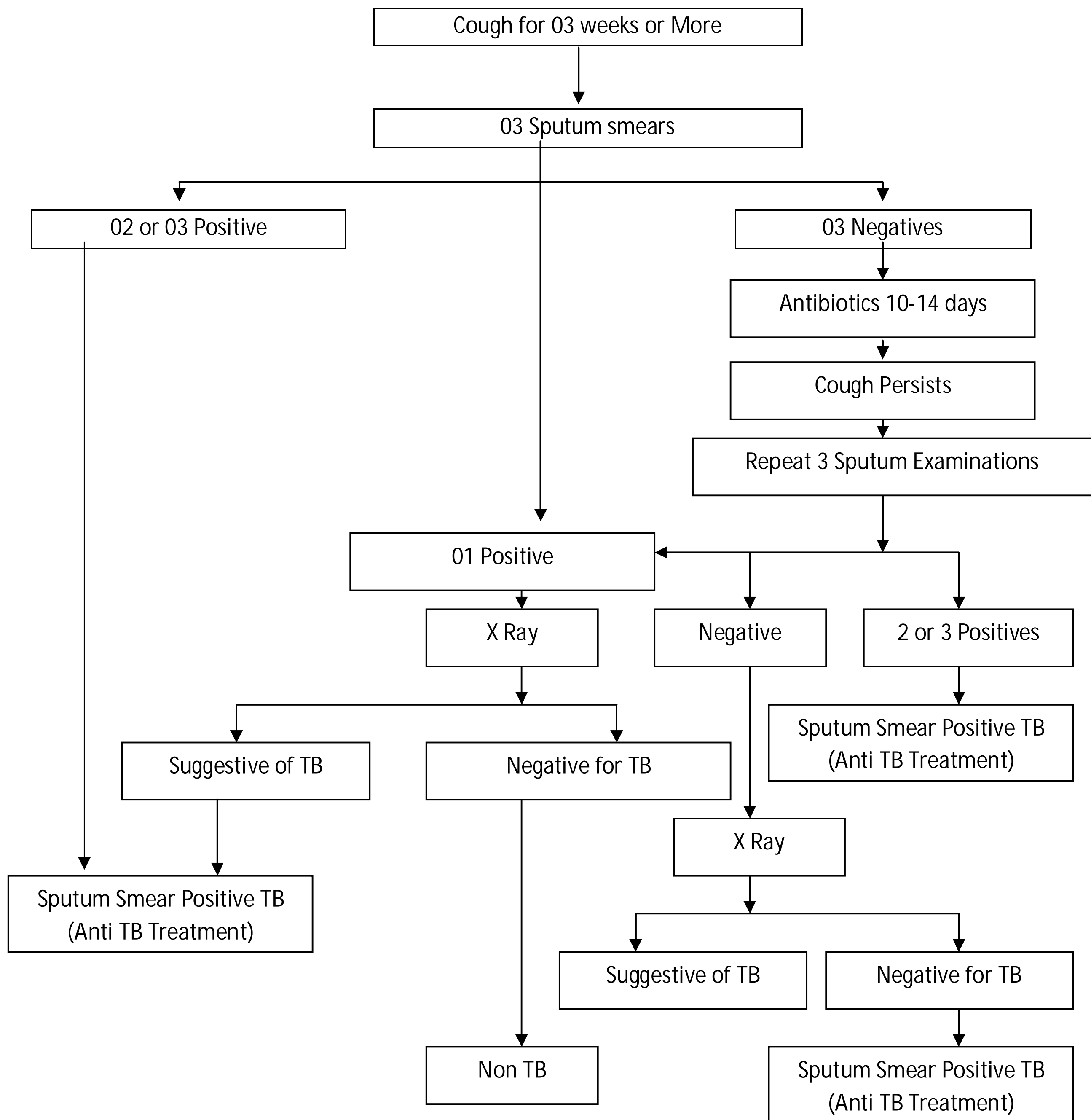
**QUARTERLY T.B. PERFORMANCE IN LAST YEAR :**

| Quarter Case | Detection Rate | Treatment Outcome Rate |
|---|---|---|
| Apr, 08 to June, 08 | 80.77 % | 86.79 % |
| July, 08 to Sept., 08 | 74.00 % | 91.00 % |
| Oct., 08 to Dec., 08 | 46.96 % | 87.67 % |
| Jan., 09 to Mar, 09 | 40.51 % | 88.00 % |




The data reveals the fact that the case detection rate & cure rate for Buxar is quite good. The district doesn't fall in the high priority area & the treatment outcome rate is also showing an increasing trend. There are 03 TU and 14 DMC's in which one is not working due to non availbality of lab technician and rest 13 DMCs are working full fledged for RNTCP in the district.

### Diagnostic Algorithm For Pulmonary TB



**Categories of Treatment**

| Categories of Treatment | Type of Patient | Regimen and Duration IP | CP | Total Duration |
|---|---|---|---|---|
| Cat-I | • New sputum smear-positive<br>• Seriously ill** new sputum smear negative<br>• Seriously ill** new extra-pulmonary | 2 (H3R3E3Z3)<br>8 weeks<br>24 doses | 4(H3R3)<br>18 weeks<br>54 doses | 6 months<br>78 doses |
| Cat-II | • Relapse<br>• Failure<br>• Treatment After Default<br>• Others | 2 (S3H3R3E3 Z3)<br>1 (H3R3E3 Z3)<br>12 weeks<br>36 doses | 5 (H3R3E3 )<br>22 weeks<br>66 doses | 8 months<br>102 doses |
| Cat-III | • New Sputum smear-negative, not seriously ill<br>• New Extra pulmonary, Not seriously ill | 2 (H3R3Z3)<br>8 weeks<br>24 doses | 4(H3R3)<br>18 weeks<br>54 doses | 6 months<br>78 doses |

**Treatment outcomes**

**Cured :** Initially sputum smear-positive patient who has completed treatment and had negative sputum smears, on two occasions, one of which was at the end of treatment.

**Treatment completed:** Sputum smear-positive patient who has completed treatment, with negative smears at the end of the intensive phase but none at the end of treatment.

**Or :** Sputum smear-negative TB patient who has received a full course of treatment and has not become smear-positive during or at the end of treatment.

**Or :** Extra-pulmonary TB patient who has received a full course of treatment and has not become smear-positive during or at the end of treatment.

**Or :** Extra-pulmonary TB patient who has received a full course of treatment and has not become smear-positive during or at the end of treatment.

**Died :** Patient who died during the course of treatment regardless of cause.

**Failure :** Any TB patient who is smear positive at 5 months or more after starting treatment. Failure also includes a patient who was treated with Category III regimen but who becomes smear positive during treatment.

**Defaulted :** A patient who has not taken anti-TB drugs for 2 months or more consecutively after starting treatment.

**Transferred out :** A patient who has been transferred to another Tuberculosis Unit/District and his/her treatment result (outcome) is not known.

Quarterly Report for RNTCP :

**Action Plan for National Leprosy Eradication Programme :-**

**Introduction :**

Leprosy is a chronic infectious disease caused by the bacteria known as Mycobacterium leprae. The disease mainly affects the peripheral nerves, skin, and occasionally some other structures. All systems and organs can be involved in leprosy except the Central Nervous System. Leprosy, with long incubation period between 9 months to 20 years after infection can affect all age groups. The signs and symptoms many vary between PB to MB depending upon the degree of patient's immunity to M. leprae, the causative agent. Nevertheless, 95% of the people in our community are immune to Leprosy. Since the Leprosy bacilli affect the peripheral nerves, and if not properly cared, the patients lose sensation by and large, in their hands, feet and eyes, and injuries to these insensitive parts may lead to disfigurement, which is the main consequence of this disease that generates fear and stigma. The early detection and prompt treatment of Leprosy with prescribed MDT not only cures Leprosy but also interrupts its transmission to others.

**Epidemiology :**

In 1991, the World Health Assembly took a measure initiative towards global elimination of Leprosy, an age old public health problem with devastating effects on its sufferers. The WHO's leadership, strong commitment of endemic countries and active support of NGO/VOs as well as donor agencies have jointly helped in reducing the global situation of Leprosy by about 90% and the elimination level achieved in more than a hundred countries. Currently, only a dozen countries have Leprosy as a major problem, and India contributes a large proportion (66%) of global Leprosy burden as Leprosy had been widely prevalent in this vast and populous country for centuries. With efficient implementation of well-planned efforts since 1953-54, India has also very substantially controlled Leprosy, During 1981, our country recorded a prevalence of 57.6 cases/10000 population, whereas, in March 2004, the prevalence had been brought down to 2.4 cases/10000 population.

**Goal**

**Elimination**

It is well known that tow initiatives:

1. The introduction of WHO recommended MDT in the 1980s and
2. The 1991 resolution of World health assembly to eliminate Leprosy as a public health problem.

**Objectives :**

To reduce the prevalence rate of leprosy below 1.

Made possible the remarkable progress the world has seen in the battle against Leprosy.

Our goal is to achieve elimination of Leprosy as a public health problem in India. Elimination of Leprosy aims at reducing the disease burden to very low levels so that after reaching such low levels the disease will disappear over a period of time. This very low level has been defined by WHO as a level of prevalence of less than 1 case per 1000 population.

**Incubation Period**

The incubation period in Leprosy in variable. It could be as small as 6 months or as long as 30 years. It is believed that the incubation period could be an average of 2-5 years.

**Diagnosis of Leprosy**

A case of Leprosy is diagnosed by eliciting cardinal signs of Leprosy through systematic clinical/bacterial examination.

1. Hypo pigmented or reddish color skin patch (es) with definite loss of sensation
2. Thickness and / or tenderness of peripheral nerves, resulting into damage to them, demonstrated by loss of sensation and weakness of muscles of hands, feet or face.
3. Demonstration of acid-fast bacilli in skin smears.

**Classification of Leprosy**

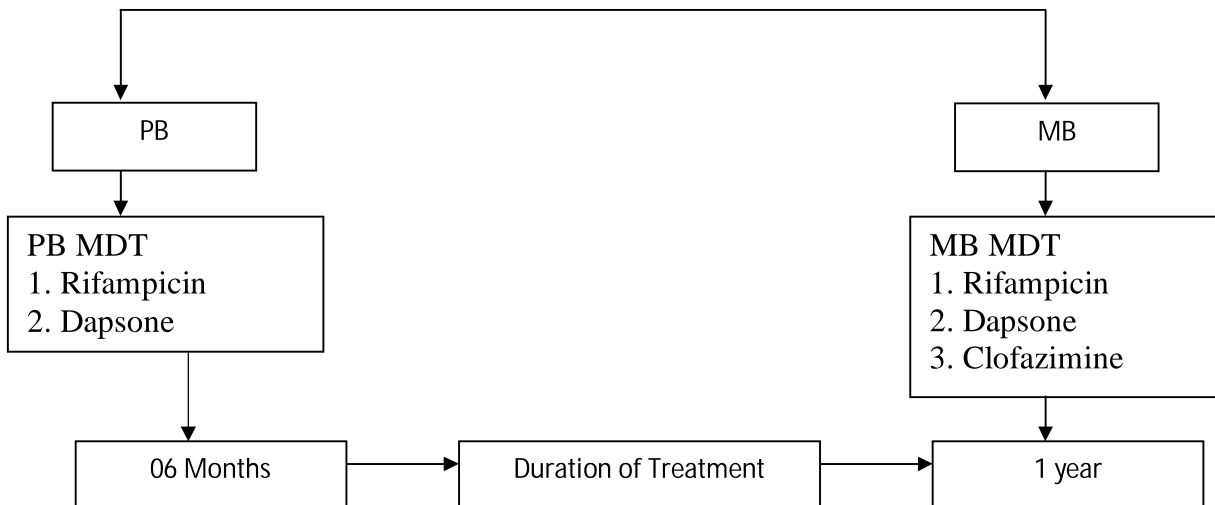
As per WHO classification, Leprosy is classified into two types for the purpose of treatment.

This classification is based on the number of skin lesions and nerve involvement.

1. Paucibacillary Leprosy (PB)
2. Multibacillary Leprosy (MB)

| Lesions | Paucibacillary Leprosy (PB) | Multibacillary Leprosy (MB) |
|---|---|---|
| Skin Lesions : Includes Macules-Flat Lesions Papules-Raised Lesions | • 1 to 5 lesions<br>• Big to medium<br>• Asymmetrical<br>• Definite loss of sensation<br>• Dryness over the patch present<br>• Loss of hair over the patch | • > 5 lesions<br>• Small<br>• Symmetrical<br>• Loss of sensation (May be/May not be)<br>• Dryness over the patch absent<br>• No loss of hair over the patch |
| Nerve Damage: Resulting in loss of sensation or weakness of muscles supplied by the affected nerve | • Only 1 nerve involved | • 2 or more nerves involved |

**Treatment for Leprosy**




**Disability in Leprosy**

Leprosy is associated with intense stigma because of the disabilities and deformities that from Leprosy.

> Most of the disabilities that occur in Leprosy are preventable. Therefore, it is very important to prevent these disabilities from occurring.

> Deformity: It is an alteration in the form, shape or appearance of a part of the body, i.e., anatomical changes, for example, depressed nose.
> Disability: It is deterioration in one's ability or capacity, i.e., physiological change, for example, anesthesia of hand.

**Simplified Information System (SIS)**

The National Leprosy Eradication Programme (NLEP), which was a vertically administered programme so long, is now integrated with primary health care system in the state. The changes will need transfer of responsibility of running the programme from Leprosy oriented staff (Vertical staff) to general health care staff.

**Elimination Indicators**

Indicators are tools that are used to measure progress and achievement under a programme. Following are the indicators which are essential for monitoring of elimination of Leprosy:

**1. Prevalence Rate**

$$\text{P.R.} = \frac{\text{Total no. of Leprosy cases on treatment}}{\text{Total Mid-year population of PHC}} \times 100000$$

**2. Annual New Case Detection Rate**

$$\text{N.C.D.R} = \frac{\text{Total no. of Leprosy cases newly detected}}{\text{Total Mid-year population of PHC}} \times 100000$$

**3. Child proportion among new cases**

$$\text{Child} = \frac{\text{Total no. of new Leprosy cases detected upto 14yrs of age}}{\text{Proportion Total no. of newly detected Leprosy cases}} \times 100$$

**4. Proportion of Visible Deformity among new cases**

$$\text{Deformity} = \frac{\text{Total no. of newly detected cases with visible Deformity}}{\text{Proportion Total no. of newly detected Leprosy cases}} \times 100$$

**5. Proportion of MB among new cases**

$$\text{MB} = \frac{\text{Total no. of new MB cases}}{\text{Proportion Total no. of newly detected Leprosy cases}} \times 100$$

**6. Proportion of females among new cases**

$$\text{Female Proportion} = \frac{\text{Total no. of female cases}}{\text{Total no. of newly detected Leprosy cases}} \times 100$$

**7. SC New Case Detection Rate**

$$\text{SC NCDR} = \frac{\text{Total no. of new SC cases detected}}{\text{Total SC population in the given area}} \times 100$$

**8. ST New Case Detection Rate**

ST = NCDR = (Total no. of new ST cases detected / Total ST population in the given area) X 100

**9. Patient Month BCP's Stock**

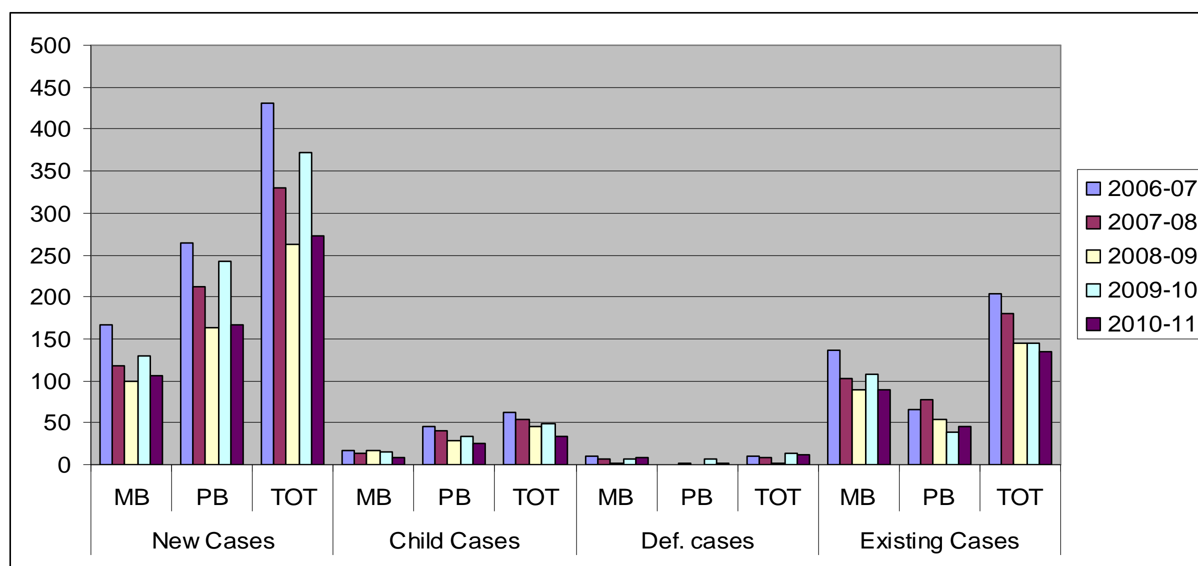
PBM = No. of blister packs of each category / No. of cases detected during the previous 3 months in each category

**10. Proportion of Health Sub-centers providing MDT**

Proportion Of Health SC = Health sub-centers providing MDT X 100 / Total no. of sub-centers

**The NLEP status indicates following:--**

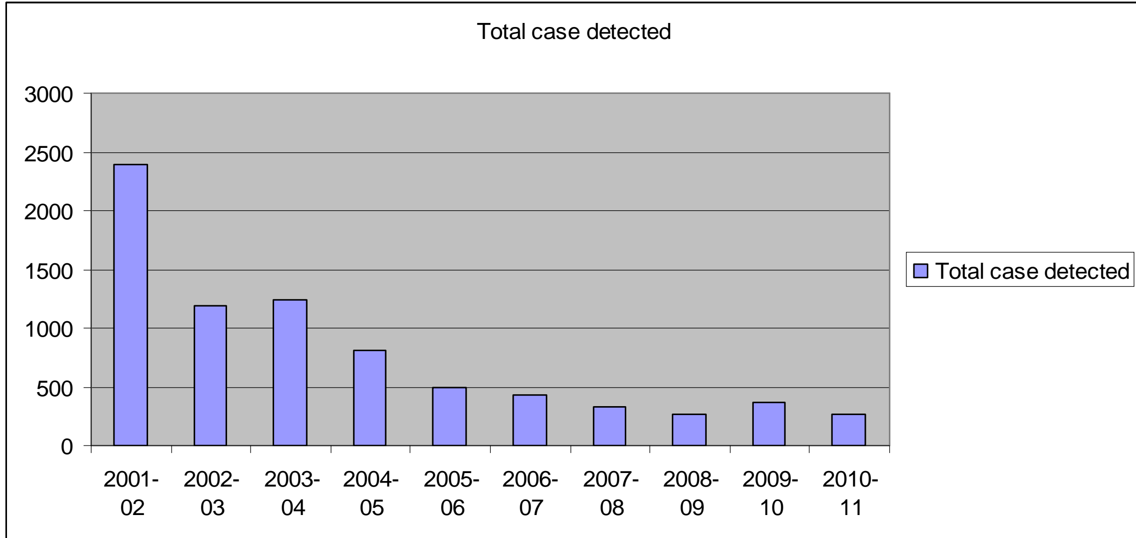
| | New Cases | | | Child Cases | | | Def. cases | | | Existing Cases | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MB | PB | TOT | MB | PB | TOT | MB | PB | TOT | MB | PB | TOT |
| 2006-07 | 166 | 265 | 431 | 16 | 46 | 62 | 10 | 00 | 10 | 137 | 66 | 203 |
| 2007-08 | 118 | 212 | 330 | 13 | 41 | 54 | 7 | 1 | 8 | 103 | 77 | 180 |
| 2008-09 | 99 | 163 | 262 | 16 | 29 | 45 | 2 | 0 | 2 | 90 | 54 | 144 |
| 2009-10 | 129 | 243 | 372 | 15 | 33 | 48 | 7 | 7 | 14 | 107 | 38 | 145 |
| 2010-11 | 106 | 166 | 272 | 8 | 25 | 33 | 9 | 2 | 11 | 89 | 45 | 134 |




<u>**Trend of Total New Cases Detected :**</u>

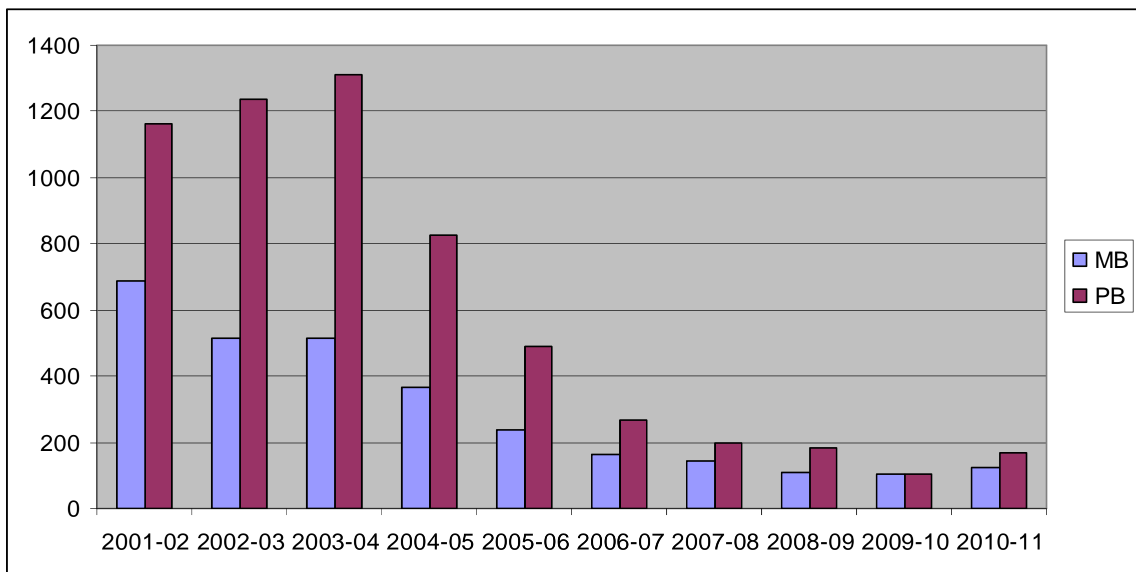
| Yrs. | 01- | 02- | 03- | 04- | 05- | 06- | 07- | 08- | 09- | 10- |
|---|---|---|---|---|---|---|---|---|---|---|

|  | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total case detected | 2397 | 1196 | 1241 | 812 | 500 | 431 | 330 | 262 | 372 | 272 |



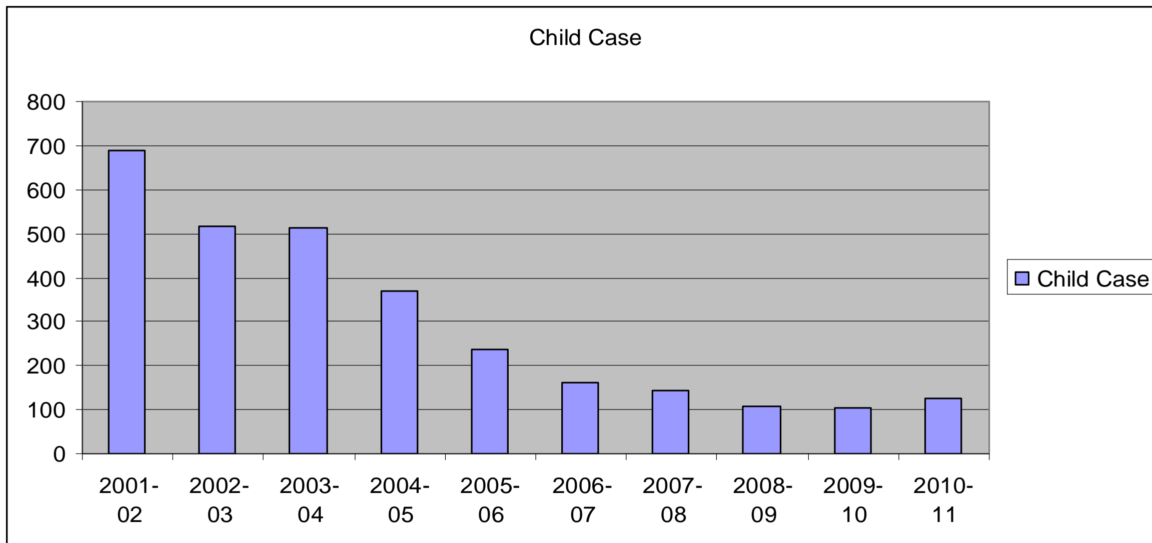

**Trend of Cases cured (RFT) Detected :**

| Yrs. | 01-02 | 02-03 | 03-04 | 04-05 | 05-06 | 06-07 | 07-08 | 08-09 | 09-10 | 10-11 |
|---|---|---|---|---|---|---|---|---|---|---|
| MB | 689 | 515 | 514 | 368 | 238 | 163 | 144 | 107 | 104 | 124 |
| PB | 1164 | 1235 | 1311 | 824 | 492 | 266 | 197 | 183 | 105 | 170 |



**Trend of Child Cases Detected :**

| Yrs. | 01-02 | 02-03 | 03-04 | 04-05 | 05-06 | 06-07 | 07-08 | 08-09 | 09-10 | 10-11 |
|---|---|---|---|---|---|---|---|---|---|---|
| Child cases | 95 | 156 | 192 | 132 | 72 | 62 | 54 | 45 | 48 | 33 |




**Trend of Disability Gr. II :**

| Yrs. | 01-02 | 02-03 | 03-04 | 04-05 | 05-06 | 06-07 | 07-08 | 08-09 | 09-10 | 10-11 |
|---|---|---|---|---|---|---|---|---|---|---|
| Dis. Gr. III | 39 | 47 | 24 | 07 | 04 | 10 | 08 | 02 | 14 | 11 |

**Action Plan for N.V.B.D.C.P. (National Vector Born Disease Control Programme) :-**

**Early Diagnosis and Case Management Strengthening surveillance system**

** Active surveillance :**

- As such malaria is a Vector-borne disease and a local and focal problem.
- Malaria affects the Buxar district more then half of its area, and out of 7 blocks there are 4 blocks affected.
- Distributions of man power in epidemic prone blocks are proportionately lese so man power should be increased to this zone.
- Approximation to high risk blocks are for away to low risk blocks from the district for the purpose of supply as well as monitory of supervision.
- Level of attitude, knowledge and skills are definitely lacking in high risk blocks.

**Referral to PHCs and SDH :**

**• Referral Malaria Cases :-**

In PHC out of the total Malaria cases attending OPD or admitted as Indoor Patients, Some cases can develop complication and this requires to be referred to the nearest CHC or General Hospitals. In such referral centres anti Malaria Drugs and other facilities are very essential, therefore in each CHC and General Hospital such facilities will be provided such as E.Mail injections, IV sets, Glucose, Dextrose etc. Such Medical insti. Will also require Rapid Diagnostic kits such as Dipstik for complicated malaria cases.

**Integrated Vector Management :**

**Selective use of IRS in high-risk areas :**

As per the epidemiological parameters prescribed under MAP high-risk section having API-5 and above requires to be cover under spray. How ever in this project it has been suggested to select problematic village for IRS Promotion of Insecticide Treated Bed Nets (ITBN)

During current year (2006) in Buxar District mosquito net users survey as well as insecticide treated mosquito net distribution in Co-ordination with NGO is initiated the work done .

**MIS :**

Field level : Information and reporting agency is field health worker reports to primary health centers

PHC level : Collection and analysis of information and reports by supervisor and laboratory technician.

CHC level : Reporting to district level District Level : Collection, analysis, feedback, and forwarding such (Malaria branch) report at state level.

**Action Plan for National Program for Control of Blindness (NPCB):**

**Introduction:-**

The National programme for control of Blindness (NPCB) was launched in 1976. India was the first country in the world to have launched a national level programme. The programme was initiated after it was realized that cataract was the major cause of blindness in the country and that surgical facilities were not accessible to blindness was 1.38%. The NPCB thus adopted a goal of reducing the prevalence of blindness to 0.3% by the turn of the century. With the current cataract load, it is not possible to achieve this goal by 200 AD but all efforts are directed towards this end.

The Programme is being implemented as a 100% centrally sponsored programme since this inception. In 1982, it was included in the Prime minister's 20 point Socio-economic programme.

**Objectives :-**

1. Provision of comprehensive eye care facilities at primary, secondary and tertiary health care levels.
2. To achieve & substantial reduction in the prevalence of eye disease in general.
3. To achieve overall reduction in the prevalence of blindness to 0.3% by 2000 AD.

**Critical Analysis :-**

It is estimated that there are nearly 40 million people worldwide who are blind as per criteria defined by world health organization (W.H.O.)

**W.H.O. Definition (1975) :-**

Inability to count fingers at a distance of 3 meters (< 3/60) with the better eye, even after being provided best spectacle correction.

**India NPCB definition :-**

Visual acuity less than 6/60 (inability to count fingers at 6 meters or unable to read the top line of snellen's chart) in the better eye, with the available correction.

In India, it is different from the WHO way of defining blindness. This is because it is not possible for the eye care services in the country to provide refraction Services to the whole population.

Under National Program for Control of Blindness Buxar Dist. had given target for cataract surgery **2005-06 (3000), 2006-07 (3000) 2007-08 (3000) & 2008-09 (3000).** This includes surgery at District & Sub-District hospitals, Private Hospitals & NGO's. Since last 3 years Buxar District has achieved 34.40% performance in cataract surgery. This is very low due to non availability sufficient Eye surgeon and full fledged NGOs. In Sub Divisional hospital with Eye surgeon doing cataract surgery while the OT of the hospital is not proper. Apart form this the eye surgeon is very few as per the requirement. Therefore the cataract operation in govt. hospital is very less against the target.

**Trend of Blindness Operation and School Screening Test**

| Sl. No. | Financial Year | Target | Cataract Operation | | | School Screening Eye Test | |
|---|---|---|---|---|---|---|---|
| | | | IOL | ICCE | TOTAL | Target | Achievement |
| 01 | 2005-06 | 3000 | 97 | 1187 | 1284 | 50000 | 5016 |
| 02 | 2006-07 | 3000 | 252 | 1228 | 1480 | 50000 | 4017 |
| 03 | 2007-08 | 3000 | 626 | 123 | 749 | 50000 | 22037 |
| 04 | 2008-09 | 3000 | 201 | 415 | 616 | 50000 | 4316 |
| 05 | 2009-10 | 3000 | 930 | 613 | 1543 | 50000 | 32518 |
| 06 | 2010-11 | 3000 | 2354 | 234 | 2588 | 50000 | 2468 |

**District Blindness Control Society (DBCS)**

The scheme of setting up a District Blindness Control Society in each district of the country was launched in the year 1994-1995 with the objective of decentralizing the implementation of the programme. The Government of India has been issuing guidelines from time to time to utilize the funds released to the DBCS in an effective and efficient manner.

The primary purpose of the District Blindness Control Society is to plan, implement and monitor all the blindness control activities in the district under overall guidance of the State/Central organization for NPCB.

**Functions of DBCS:-**

1. To assess the magnitude and spread of blindness in the district by means of active case finding village wise to be recorded and maintained in Blind Registers.
2. To organize the Screening camps for identifying those requiring cataract surgery.
3. To assess the status to available facilities and resources in the district infrastructure and manpower.
4. To identify and organize one day orientation for Govt. Functionaries, Community representatives and NGO's in order to secure their involvement in case finding, escort services, counseling and follow up of cases.
5. To plan training of personnel involved in eye care and identify trainers.
6. To periodically review and monitor the implementation of the District Action plan.
7. To assess and ensure the availability of drugs & consumables.
8. To review the level of utilization of equipments.
9. To receive and monitor use of funds equipments and materials from the government and other agencies.
10. To prepare a list of voluntary agencies and private hospitals and actively involve then in the programme.
11. To organize screening of school and preschool children for eye defects by involving parents, teachers and other functionaries.
12. To provide free spectacles to the poor patients who have undergone cataract surgery as well as those suffering from eye defects/refractive errors.
13. To motivate people to pledge their eyes for donation by utilizing all available media.
14. To ensure distribution of prophylactic vitamin A to prevent blindness due to Vit. A deficiency among children as part of child survival and safe motherhood programme, through the health functionaries of the district.
15. To collect /compile and review information of work done.

**Strategies:**

The four-pronged strategy of the programme is.

a) Strengthening service delivery.
b) Developing human resources for eye care.
c) Promoting outreach activities and public awareness.
d) Developing institutional capacity.

**Micro-Planning at District level.**

- ***Listing of Blind persons: (50+years)***
  In each village of the district screening done by trained health staff involvement of NGOs. Panchayat or Volunteers after one day training for preparation of village-wise registers of blind persons.

- ***Mapping of eye care infrastructure:-***
  By plotting all fixed facilities and eye surgeons in Govt. Voluntary and private sectors available within the district. Distribute the target among the villages based on the village wise population of the blind.
- ***Target Setting:-***
  Considering the objective of clearing the backlog of cataract blind persons in next 3 years and addressing new cases of cataract the cataract surgery rate of about 600 operations per 1,00,000 populations needs to be achieved.
  As there is higher prevalence of blindness amongst women it is expected that more than 50% of all operations should be for women. To emphasize equitable distribution of services in various blacks, it would be preferable to assign targets for each block on the basis of its population. This will help in identifying blocks which have no facilities and require a camp approach.

**Options for surgical Services**

- ***Reach in strategy :-***
  It is suggested that 75 to 80% of total target must be achieved through institutions/hospital based operations. A vehicle should be assigned/hired by the PHC/DBCS/NGO/Govt. Hospital to bring the blind to the base hospital and after being discharged drop they back to villages.
- ***Reach out strategy (Camps) :-***
  There would be on an average 20% villages, which are remote (50k.m. away from any eye care facility or more than 10 km of walking with no roads or bus) such identified remote villages can be grouped in to clusters to arrive at the nodal campsite which has a basic facility of building are rooms which can be sterilized and concerted into an operation theatre.

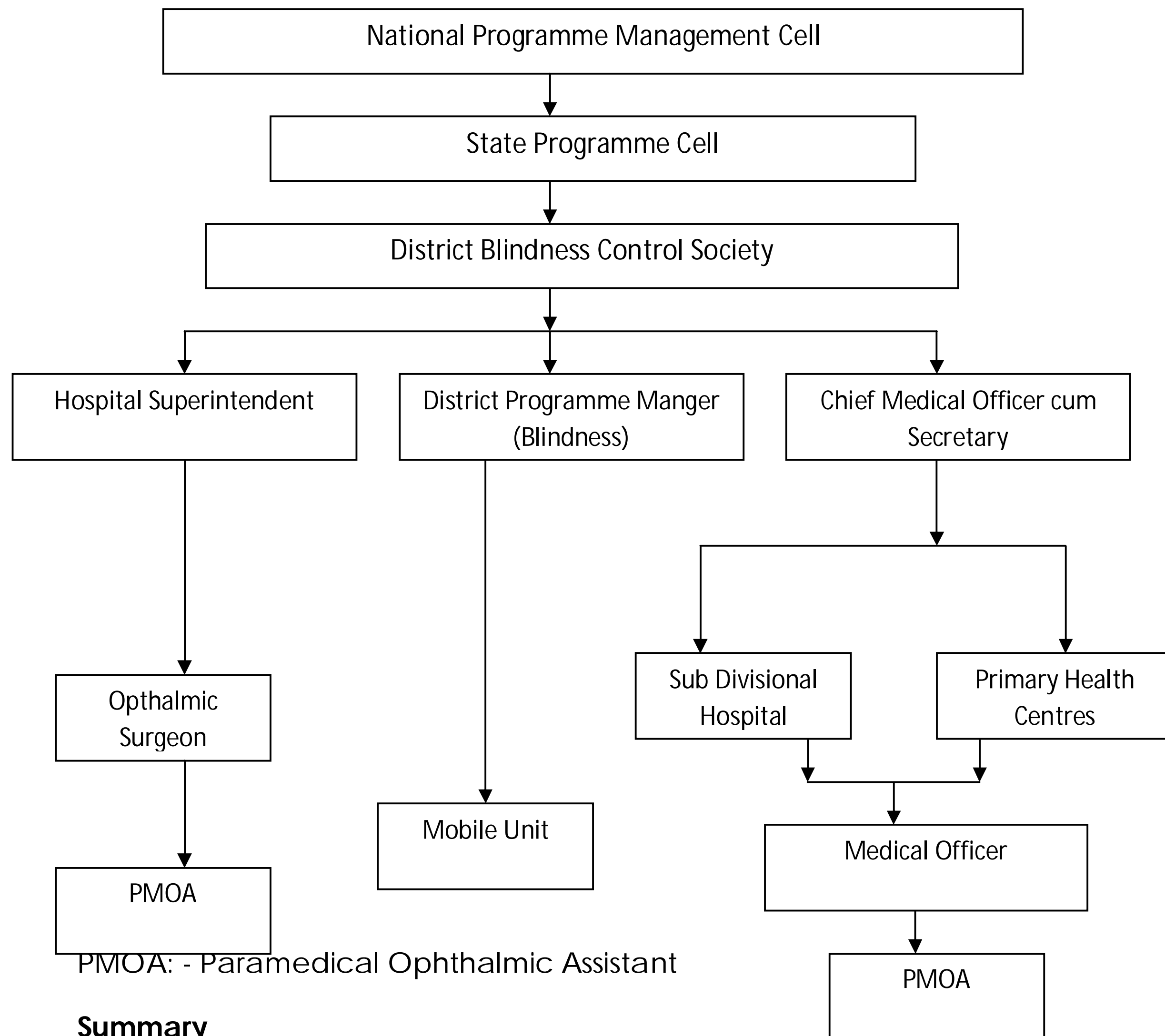
**Assessment of Resources**

- ***Material requirements :-***
  For providing services in an on interrupted manner, a careful assessment of requirements of drags and consumables.
- ***Manpower requirement:-***
  Support staff like ophthalmic assistants, nurses, O.T. assistants should be assessed for each facility. Those personnel requiring training in various fields should be identity and their training should be planned.
- ***Preparation of cases where:-***
  Involvement of NGOs is anticipated should be carefully assessed.
- All free surgeries should be followed by provision of best possible corrective glasses after refraction.

**Monitoring for quality Control:-**

- Random checks need to be carried out to assess the validity of reported data, status of follow-up provision of glasses, and patient satisfaction.

- Standard cataract surgery records should be filled up for each operation performed.
- Periodic review to assess the progress in each block and by each provider unit.




PMOA: - Paramedical Ophthalmic Assistant

**Summary**

National programme for control of Blindness (NPCB) decentralized the implementation of the programme by setting up a District Blindness Control Societies (DBCS) in each district of the country with the goal of achieving 0.3% level of prevalence of blindness and to achieve excellence in eye care services resting of high quality patient care the upgraded PHC & CHC have been identified as important service delivery points under the NPCB The Medical Officer's Posted at Such centers along with their support staff have a major role to play in the national efforts.

**Action Plan for Integrated Disease Surveillance Program :-**

**Introduction :**

Integrated Disease Surveillance Project (IDSP) is a decentralized, state based surveillance program in the country. It is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. It is also expected to provide essential data to monitor progress of on-going disease control programs and help allocate health resources more efficiently.

All outbreaks cannot be predicted or prevented. However, precautionary measures can be taken within the existing health infrastructure and service delivery to reduce risks of outbreaks and to minimize the scale of the outbreak, if it occurs. The effectiveness with which national programs are implemented and monitored, the alertness for identification of early warning signals and the capacity for initiating recommended specific interventions in a timely manner are important to achieve the above objectives.

The course of an epidemic is dependent on how early the outbreak is identified and how effectively specific control measures are applied. The epidemiological impact of the outbreak control measures can be expected to be significant only if these measures are applied in time. Scarce resources are often wasted in undertaking such measures after the outbreak has already peaked and the outcome of such measures in limiting the spread of the outbreak and in reducing the number of cases and deaths are negligible.

When outbreaks occur or when the risk of such outbreaks his high, the co-operation of other government departments, non-governmental agencies and the community often becomes necessary. Such help will be more forthcoming if mechanisms for interactions have been development before the onset of and outbreak.

The frequency of the occurrence of epidemics is an indication of the inadequacy of the surveillance system and preparedness to identify and control outbreaks in a timely manner.

**Objective :**

The overall general objective of the IDSP is to provide a rational basis for decision-making and implementing public health interventions that are efficacious in responding to priority diseases. Keeping this in mind the main objectives of the IDSP are :

- To establish a decentralized district-based system of surveillance for communicable and non-communicable diseases so that timely and effective public health actions can be initiated in responses to health challenges in the urban and rural areas.
- To integrate existing surveillance activities (to the extent possible without having a negative impact on their activities) so as to avoid duplication and facilitate sharing of information across all disease control programs and other stake holders, so that valid data are available for decision making at district, state and national levels.

**Strategy :**

The IDSP proposes a comprehensive strategy for improving disease surveillance and response through an integrated approach. This approach provides for a rational use of resources for disease control and prevention. In the integrated disease surveillance system :

- The district level is the focus integrating surveillance function.

- All surveillance activities are coordinated and streamlined. Rather than using scarce resources to maintain vertical activities, resources are combined to collect information from a single focal point at each level.
- Several activities are combined into one integral activity to take advantage of similar surveillance function, skills, resources and target population.
- The IDSP integrates both public and private sector by involving the private practitioners, private hospitals, private labs, NGOs, etc and also emphasis on community participation.
- The IDSP integrates communicable and non-communicable diseases. Common to both of them are their purpose in describing the health problem, monitoring trends, estimating the health burden and evaluating programmes for preventing and control.
- Integration of both rural and urban health systems as rapid urbanization has resulted in the health services not keeping pace with the growing needs of the urban populace. The gaps in receiving health information from the urban areas needs to be bridged urgently.

Integration with the medical colleges (both private and public) would also qualitatively improve the disease surveillance especially through better coverage.

# Chapter- 7

## Budget

| S.No | Part | Amount |
|---|---|---|
| 1 | Part-A – RCH 2 | Rs.192066860 /- |
| 2 | Part-B – Additional ties | Rs. 172120146.1 /- |
| 3 | Part-C – Immunization | Rs. 14610885.13 /- |
| 4 | Part-D – Disease Control Program | Rs. 11006940 /- |
| | Summary of Budget | Rs. 389804831/- |

| FMR CODE NO. | Activities | 2011-12 | 2012-2013 FY | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Base line / Current Status (As per Oct2011) | Unit of Measure (In words) | Physical Target | | | | | Tentative Unit Cost (In Rs.) | Financial Requirement (In Rs) | | | | | Commited Fund If Required (If any) | Budgetary Source (other than NRHM source) | Remarks |
| | | | | Q1 | Q2 | Q3 | Q4 | Total No of Unit | | Q1 | Q2 | Q3 | Q4 | Total Annual Proposed Budget (In Rs.) | | | |
| A | <u>RCH - TECHNICAL STRATEGIES & ACTIVITIES (RCH Flexible Pool)</u> | | | | | | | | | | | | | - | | | |
| A.1 | MATERNAL HEALTH | | | | | | | | | | | | | 0 | | | |
| A.1.1.a | Operationalise Blood Storage Unit in Dist Hoapital & Sub Divisional Hospital (Working As FRU) | | Two | 2 | 2 | 2 | 2 | 2 | 432000 | 216000 | 216000 | 216000 | 216000 | 864000 | | | Rs.30000/.Per FRU For Generator & Fuel+Lubricant & Incidental Charge of generator+Miscellaneous Expenditure & Rs.6000/.Per Month Each Facility. |
| A.1.1.b | Blood Donation Camp One in each qtr | | Eight | 2 | 2 | 2 | 2 | 8 | 10000 | 20000 | 20000 | 20000 | 20000 | 80000 | | | Rs.10000/- Per Camps one in each qtr for DH,SDH. |
| A.1.1.2 | Monitoring Progress and Quality of service delivery in | 0 | Eight | 1 | 1 | 1 | 1 | 4 | 12500 | 12500 | 12500 | 12500 | 12500 | 50000 | | | Rs.12500/- for quaterly meeting of FRU |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | FRU | | | | | | | | | | | | | | | | |
| A.1. 1.2 | Operationalise 24*7 PHCs (MCH Centre - APHC) | 0 | Eight | 4 | 4 | 0 | 0 | 8 | 30000 | 120000 | 120000 | 0 | 0 | 240000 | | | Rs.30000/- Per APHC |
| A.1. 1.5 | Operationalise Sub Centre (MCH Centre - HSC) | 0 | Two | 1 | 1 | 0 | 0 | 2 | 60000 | 60000 | 60000 | 0 | 0 | 120000 | | | Rs.60000/- Per HSC |
| A.1. 3 | Integrated outreach RCH services | | | | | | | | | | | | | 0 | | | |
| A.1. 3.1 | RCH Outreach Camps / Others. | 0 | Thirty Three | 0 | 11 | 11 | 11 | 33 | 7000 | 0 | 77000 | 77000 | 77000 | 231000 | | | Rs.7000/- Per RCH Camp. |
| A.1. 3.2 | Monthly Village Health and Nutrition Days | 1403 | Fourteen hundreds three | 1403 | 1403 | 1403 | 1403 | 1403 | 544 | | | | | 763232 | | | Rs.2500/- district level convergence meeting under DM One time, Rs.100/- per person fpr 2 days for participating microplan & capacity building program for ANM+ASHA+AWW+VHNSC-PRI member,Rs.100/-POL per block level monitoring (MOIC,CDPO,BHM,BCM) & Rs.2500/- per qtr VHSND review meeting under DM. |
| A.1. 4 | Janani Suraksha Yojana / JSY | | | | | | | | | | | | | 0 | | | |
| A.1. 4.1 | Home Deliveries | 0 | Five hundreds | 100 | 100 | 150 | 150 | 500 | 500 | 50000 | 50000 | 75000 | 75000 | 250000 | | | Rs.500 Per Home Delivery |
| A.1. 4.2 | Institutional Deliveries-: | | | | | | | | | | | | | 0 | | | |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.1. 4.2. a | Rural | 15790 | Thirty Seven Thousand Fourty Nine | 5557 | 12970 | 11115 | 7407 | 37049 | 2000 | 11114000 | 25940000 | 22230000 | 14814000 | 74098000 | | | Rs.2000/. Per Institutional Deliveries in rural (Rural Delivery=70% of total ANC, ANC= Live Birth + Still Birth, Live Birth= 2.9% of Total Population) |
| A.1. 4.2. b | Urban | 248 | Ninteen Hundreds Twenty Six | 290 | 675 | 580 | 381 | 1926 | 1200 | 348000 | 810000 | 696000 | 457200 | 2311200 | | | Rs.1200/. Per Institutional Deliveries in urban (Urban Deliver= 70% of Total ANC) |
| A.1. 4.2. c | Ceasarean Deliveries | 17 | Three hundreds fifty | 50 | 120 | 120 | 60 | 350 | 1500 | 75000 | 180000 | 180000 | 90000 | 525000 | | | Rs.1500/.Per Ceasarean Deliveries |
| A.1. 4.3 | Administrative Expences | | One | 1 | 1 | 1 | 1 | 1 | 493516 | 123379 | 123379 | 123379 | 123379 | 493516 | | | Rs.493516/. Per District for 1. Micro Birth Plan Asha, MCH Protection Card, Parto Graph and any other printing which is relevant to emplimentation and promotion of programme. 2. POL /Hiring Vehicle. 3. POL / Hiring Vehicle for physical varification of be |
| A.1. 5 | Other strategies/Activities | | | | | | | | | | | | | 0 | | | |
| A.1. 5.1 | Institution based death review/Community based MDR | 0 | One hundred eight | 20 | 25 | 35 | 28 | 108 | 750 | 15000 | 18750 | 26250 | 21000 | 81000 | | | Rs.750/- Per MDR case. |

| | Innovative Activity | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Integrated Mahadalit Camp | | Fifty five | 0 | 22 | 22 | 11 | 55 | 10000 | 0 | 220000 | 220000 | 110000 | 550000 | | | Rs.10000/- Per Mahadalit Camps. |
| | Operationalise full functioning FRU | | Two | 2 | 2 | 2 | 2 | 2 | 50000 | 25000 | 25000 | 25000 | 25000 | 100000 | | | Rs.50000/- per FRU. |
| | Provision of Purchage One 10 KVA Generator for Blood Bank | | One | 0 | 1 | 0 | 0 | 1 | 225000 | 0 | 225000 | 0 | 0 | 225000 | | | Rs.225000/- for Generator Purchage. (10 KVA Gen.) |
| | Outsource of Generator for MCH Centre Level 1 | | Ten | 0 | 10 | 10 | 10 | 10 | 144000 | 0 | 480000 | 480000 | 480000 | 1440000 | | | Rs.16000/- Per Month Per Generator. |
| A.2 | CHILD HEALTH | | | | | | | | | | | | | 0 | | | |
| A.2 .1.1 | Implementation of IMNCI activities in district | 0 | One | 1 | 1 | 1 | 1 | 1 | 50000 | 12500 | 12500 | 12500 | 12500 | 50000 | | | Rs.50000/- Per District |
| A.2 .1.3 | Incentive for HBNC to ASHA/AWWS 3 PNC for normal baby | 0 | Fifteen thousands | 3750 | 3750 | 3750 | 3750 | 15000 | 100 | 375000 | 375000 | 375000 | 375000 | 1500000 | | | Rs.100/- per case |
| A.2 .1.4 | Incentive for HBNC to ASHA/AWWS 6 PNC for low birth baby | 0 | Six Thousands | 1500 | 1500 | 1500 | 1500 | 6000 | 200 | 300000 | 300000 | 300000 | 300000 | 1200000 | | | Rs.200/- Per case |
| A.2 .2 | Facility based New born care / FBNC | 0 | One | 1 | 0 | 0 | 0 | 1 | 775000 | 775000 | 0 | 0 | 0 | 775000 | | | Rs.775000/- per FBNC establishment |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.2.4 | Nayee Pidhee Swasth Guarantee Yojna (School Health Program) | | Thirteen | 13 | 13 | 13 | 13 | 13 | 248000 | 805999.99 | 805999.99 | 805999.99 | 805999.99 | 3224000 | | | Rs.650/-per day cost for travelling/transportation (650*120*13), Rs.250/- pers on for 120 days for cost for staff hiring (120*250*2*13), Rs.1000/- per unit for each item for IEC activities (4000 for poster, banner,flex & hand bill), Rs.250/- per day / PA sestem for 40 days (250*40*13), Rs.Rs.15000 per unit for cost of purchases of medicine & lab testing equipment (15000*13), Rs.30000/- per unit for cost for specialized treatment (13*30000), Rs.15000/- per unit for cost for contigency. |
| A.2.6 | Management of Diarrohea, ARI and Micronutrient Malnutrition (Nutritional Rehablitation Centre) | 1 | One | 1 | 1 | 1 | 1 | 1 | 4332000 | 1083000 | 1083000 | 1083000 | 1083000 | 4332000 | | | Rs.100/- per child incentive to mobilizer,Rs.70/-food for per child,Rs.70/- food for per mother,Rs.100/-loss wages to per mother,Rs.125/- per child for transportation to bring child,Rs.125/- per child for transportation after 21 days, Rs.15000/- fuel for generator,Rs.16000/- miscellaneous,Rs.35000/- per month per MO,Rs.20000/- per month per Grade A nurse,Rs.9500/- per month for CBC Extender,Rs.9000/- per month per FD,Rs.3800/- per month per caretaker,Rs.3800/- per month per cook,Rs.3800/- per month per security guard, Rs.3300/- per month per sweeper. |
| | **Innovative Activity** | | | | | | | | | | | | | | | | |

| Col 1 | Col 2 | Col 3 | Col 4 | Col 5 | Col 6 | Col 7 | Col 8 | Col 9 | Col 10 | Col 11 | Col 12 | Col 13 | Col 14 | Col 15 | Col 16 | Col 17 | Col 18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.3 | FAMILY PLANNING | | | | | | | | | | | | | 0 | | | |
| A.3.1 | Terminal/Limiting Methods | | | | | | | | | | | | | 0 | | | |
| A.3.1.1 | Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services | 0 | One | 0 | 1 | 0 | 0 | 1 | 22000 | 0 | 22000 | 0 | 0 | 22000 | | | Rs.2250/- Venue for one day+Rs.150/-*75 participants for Lunch & Tea+Rs.1000/- Honorarium to Guest Faculty/State for One Day+Rs.100/-*75 participants for Photocopy/Stationery |
| A.3.1.2 | Female Sterilisation camps | 3 | Two hundreds seventy five | 22 | 66 | 110 | 77 | 275 | 5000 | 110000 | 330000 | 550000 | 385000 | 1375000 | | | Rs.5000/- per Camp |
| A.3.1.3 | NSV camps | 0 | Three | 0 | 1 | 1 | 1 | 3 | 10000 | 0 | 10000 | 10000 | 10000 | 30000 | | | Rs.10000/- per Camp |
| A.3.1.4 | Compensation for female sterilisation | 2765 | Ten thousands | 1000 | 1500 | 4000 | 3500 | 10000 | 1000 | 1000000 | 1500000 | 4000000 | 3500000 | 10000000 | | | Rs.1000/- per case |
| A.3.1.5 | Compensation for male sterilisation | 54 | One hundred fifty | 20 | 40 | 60 | 30 | 150 | 1500 | 30000 | 60000 | 90000 | 45000 | 225000 | | | Rs.1500/- per case |
| A.3.1.6 | Accreditation of private providers for sterilisation services | 34 | Two thousands sixty | 200 | 400 | 760 | 700 | 2060 | 1500 | 300000 | 600000 | 1140000 | 1050000 | 3090000 | | | Rs.1500/- per case for Private Hospital |
| A.3.2 | Spacing Methods | | | | | | | | | | | | | 0 | | | |
| A.3.3 | POL for Family Planning/others | 0 | Eleven | 11 | 11 | 11 | 11 | 11 | 17000 | 46749.99 | 46749.99 | 46749.99 | 46749.99 | 187000 | | | Rs.17000/- Per PHC for FP camp (Rs.12000/- per PHC & Rs.5000/- District will be spent per PHC wise. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.3.5.4 | Provide IUD Services at health facility (IUD Camps) | 2 | Fourty four | 6 | 10 | 18 | 10 | 44 | 1500 | 9000 | 15000 | 27000 | 15000 | 66000 | | | Rs. 1500/- Per IUD Camp |
| | Innovative Activity | | | | | | | | | | | | | 0 | | | |
| | Camp Management Rs15000/- if case is more than 50 in the camp. | | Three | 0 | 0 | 2 | 1 | 3 | 15000 | 0 | 0 | 30000 | 15000 | 45000 | | | Rs.15000/- Per Camp. |
| A.4 | ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH | | | | | | | | | | | | | | | | |
| | Operationalise ARSH Clinic at PHC. | | Three | 0 | 3 | 3 | 3 | 3 | 20000 | 0 | 20000 | 20000 | 20000 | 60000 | | | Rs. 20000/- per clinic for IEC & Others. |
| A.7 | | | | | | | | | | | | | | | | | |
| A.7.2 | Other PNDT Activities (Monitoring of Sex Ratio at Birth) | 0 | One | 1 | 1 | 1 | 1 | 1 | 100000 | 25000 | 25000 | 25000 | 25000 | 100000 | | | Rs.100000/- Per district for Monitoring |
| A.8 | INFRASTRUCTURE (Minor Civil Works) & HUMAN RESOURCES (Except AYUSH) | | | | | | | | | | | | | 0 | | | |
| A.8.1 | ANMs, Staff Nurse,Supervisory Nurse (Salary of Contractual ANM/Contractual Staff Nurse) | 85 | One hundred Ninty nine | 191 | 191 | 191 | 191 | 191 | 170400 | 8136600 | 8136600 | 8136600 | 8136600 | 32546400 | | | Rs20000/- per month per staff nurse for 30 (Staff Nurse) & Rs.11500/- per month per ANM for 80 ANMs (ANMr=161 & Grade Nurse=30) |
| A.8.1.2 | Laboratory Technicians (in Blood Bank) | 3 | Three | 3 | 3 | 3 | 3 | 3 | 120000 | 90000 | 90000 | 90000 | 90000 | 360000 | | | Rs.10000/- per month per Lab Technician |
| A.8.1.5 | Salary of Medical Officer in Blood Bank | 1 | One | 1 | 1 | 1 | 1 | 1 | 420000 | 105000 | 105000 | 105000 | 105000 | 420000 | | | Rs.35000/- per month |
| A.8.1.7 | Salary of Contractual Staff "Family Planning" Counsellor | 0 | Two | 2 | 2 | 2 | 2 | 2 | 180000 | 90000 | 90000 | 90000 | 90000 | 360000 | | | Rs.15000/- Per Month Salary Per FP Counsellor |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.8.1.8 a | Incentive/ Awards etc. to ASHA Link worker/ SN/ MOs etc. (Incentive for ASHA & ANM for Muskan Ek Abhiyan) | 14784 | Thirty one thousands eight | 7752 | 7752 | 7752 | 7752 | 31008 | 300 | 2325600 | 2325600 | 2325600 | 2325600 | 9302400 | | | Rs. 200/- Incentive of Asha per Session Site if they moblise more than 21 benificery + Rs. 100/- Incentive of ANMs per session Site if they vaccinate more than 16 benificery. |
| A.8.1.8 b | Intersectoral Convergence: Incentive for AWW under Muskan Project | | Thirty one thousands eight | 7752 | 7752 | 7752 | 7752 | 31008 | 200 | 1550400 | 1550400 | 1550400 | 1550400 | 6201600 | | | Rs.200/- Incentive of AWW per Session Site if they mobilise more than 21 beneficiary. |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | Staff Nurse for FRU | | Twelve | | 12 | 12 | 12 | 12 | 180000 | 0 | 720000 | 720000 | 720000 | 2160000 | | | Rs,20000/- per month per staff nurse for 9 month (6 in each FRU) |
| | Lab Technician for Blood Storage Unit establish in FRU | | Six | | 6 | 6 | 6 | 6 | 90000 | 0 | 180000 | 180000 | 180000 | 540000 | | | Rs.10000/- per month per LT |
| | MO for Blood Storage Unit | | Four | | 4 | 4 | 4 | 4 | 270000 | 0 | 360000 | 360000 | 360000 | 1080000 | | | Rs.30000/- per month per MO for 9 month. |
| | Provision of Specialist Medical Officer for SDH Dumraon | | Four | 0 | 0 | 4 | 4 | 4 | 210000 | 0 | 0 | 420000 | 420000 | 840000 | | | Rs.35000/- per month per MO for 6 month (1 PAEDIATRICIAN-1,SURGEON-1,ANASTHETIC-1,GYNAECOLOGIST) |
| | Provision of OT Assistant | | Twelve | 0 | 12 | 12 | 12 | 12 | 135000 | 0 | 540000 | 540000 | 540000 | 1620000 | | | Rs.15000/- per month per OT Assistant (3 for DH,2 for SDH & 1 for 7 PHCs,) |
| | Provision of Dresser | | Fourteen | 0 | 14 | 14 | 14 | 14 | 72000 | 0 | 336000 | 336000 | 336000 | 1008000 | | | Rs.8000/- per month per dresser. (4 for DH, 3 for SDH & 1 for 7 PHCs) |
| A.9 | TRAINING | | | | | | | | | | | | | 0 | | | |
| A.9.3 | Maternal Health Training | | | | | | | | | | | | | 0 | | | |
| A.9.3.1 | Skilled Birth Attendance / SBA | 3 | Nine | 1 | 3 | 3 | 2 | 9 | 88110 | 88110 | 264330 | 264330 | 176220 | 792990 | | | Rs.88110/- Per Batch for SBA training at District Level (for 6 participant) |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.9.3.4 | MTP training | 2 | Five | | | 3 | 2 | 5 | 23280 | 0 | 0 | 69840 | 46560 | 116400 | | | RS.33120/- per batch for MO & Rs.10350 per batch for Nursing Staff (3 batch of MO & 2 Batch of Nursing Staff) |
| A.9.3.7 | Other MH Training (Training of MO & Paramedicals at sub centre level | 0 | Four | | 2 | | 2 | 4 | 67500 | 0 | 135000 | 0 | 135000 | 270000 | | | Rs.75000/- per batch for MO & Rs.60000/- per batch for Paramedicals |
| A.11.5 | Child Health Training | | | | | | | | | | | | | 0 | | | |
| A.9.5.1 | IMNCI | 8 | Fourty eight | 12 | 12 | 12 | 12 | 48 | 150000 | 1800000 | 1800000 | 1800000 | 1800000 | 7200000 | | | Rs. 150000/- per batch (24 participant in a batch) |
| A.9.5.5.3 | NSSK Training (SN/ANM) | 0 | Four | | 1 | 1 | 2 | 4 | 52900 | 0 | 52900 | 52900 | 105800 | 211600 | | | Rs.52900/- per batch |
| A.11.6 | Family Planning Training | | | | | | | | | | | | | 0 | | | |
| A.9.6.2 | Minilap Training | 0 | Two | | | 1 | 1 | 2 | 71240 | 0 | 0 | 71240 | 71240 | 142480 | | | Rs.71240/- Per batch for 4 doctores. |
| A.9.6.3 | NSV Training | 0 | Two | | 1 | 1 | | 2 | 35000 | 0 | 35000 | 35000 | 0 | 70000 | | | Rs.35000/- Per batch for 4 participant. |
| A.9.6.4.1 | Trainingof MO in IUD insertion | 1 | Two | | 2 | | | 2 | 63595 | 0 | 127190 | 0 | 0 | 127190 | | | Rs. 63595/- per batch (10 participant in a batch) |
| A.9.6.4.2 | Trainingof ANMs/LHVs/SNs in IUD insertion | 3 | Four | | 1 | 2 | 1 | 4 | 33838 | 0 | 33838 | 67676 | 33838 | 135352 | | | Rs.33838/- per batch (10 participants in a batch) |
| A.11.8 | Programme Management Training | | | | | | | | | | | | | 0 | | | |
| A.9.8.2 | DPMU Training | 0 | One | 1 | 1 | 1 | 1 | 1 | 57500 | 0 | 57500 | 0 | 0 | 57500 | | | Rs. 57500/- Per district for DPMU Training. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.11.7 | ARSH Training for MO, AYUSH MO, ICTC Staff BHM, ANM, Nurse | | Seventy | 2 | 5 | 5 | 5 | 17 | 6600 | 13200 | 33000 | 33000 | 33000 | 112200 | | | Rs.150/- Per participant for refreshment, Rs.50/- per participant for stationary, Rs.2000/- Per batch for Contigency. (Total 17 Batch, Max 30 participants & 2 trainers). |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | Establishment of District Skill Lab | | One | | | 1 | | 1 | 1500000 | 0 | 0 | 1500000 | 0 | 1500000 | | | Rs. 1500000/- for per District. |
| | Training of Tally for BAM. | | One | | 1 | | | 1 | 6000 | 0 | 6000 | 0 | 0 | 6000 | | | Rs.6000/- for 11 BAM +1 DAM,Aount Asst+2 Trainers, Total 15 Participants. |
| A.10 | PROGRAMME / NRHM MANAGEMENT COSTS | | | | | | | | | | | | | | | | |
| A.10.1.5 | Mobility Support (District Malariya Office) | 1 | One | 1 | 1 | 1 | 1 | 1 | 207000 | 51750 | 51750 | 51750 | 51750 | 207000 | | | Rs.207000/- Per District. |
| A.10.2.1 | Contractual Staff for DPMU recruited and in Position | 3 | Three | 3 | 3 | 3 | 3 | 3 | 360800 | 270600 | 270600 | 270600 | 270600 | 1082400 | | | Rs.35200/- Per Month Salary for DPM, Rs.29700/- Per Month Salary for DAM & Rs.25300/- Per Month Salary for MEO with 10 % increament. |
| A.10.2.2 | Provision of equipment/furniture & Mobility support for DPMU Staff | 1 | One | 1 | 1 | 1 | 1 | 1 | 1140000 | | | | | 1140000 | | | Rs.1140000/- for DPMU Recurring Expenses. |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.1 0.3 | Strengthening of Block PMU | 11 | Eleven | 11 | 11 | 11 | 11 | 11 | 915600 | 2517900 | 2517900 | 2517900 | 2517900 | 10071600 | | | Rs.21780/- Per Month Salary for BHM, Rs.14520/- Per Month Salary for BAM with 10 % increament. Recurring Expenses. |
| A.1 0.4. 2 | Renewal (Upgradation) | 1 | One | | 1 | | | 1 | 8100 | 0 | 8100 | 0 | 0 | 8100 | | | Rs.8100/- Renewal & Upgradation of Tally |
| A.1 0.4. 3 | AMC (State,Regeonal & DHS) | 0 | One | | 1 | | | 1 | 22500 | 0 | 22500 | 0 | 0 | 22500 | | | Rs.22500/- for AMC |
| A.1 0.4. 9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | 2 | Four | 4 | 4 | 4 | 4 | 4 | 271500 | 271500 | 271500 | 271500 | 271500 | 1086000 | | | Rs.30250/- Per FRU Manager per Month with increament & Rs.15000/- per month Per FRU Accountant |
| A.1 0.5. 1 | Annual audit of the programme (statutory Audit) | 0 | Seven | 0 | 3 | 4 | 0 | 7 | 12000 | 0 | 36000 | 48000 | 0 | 84000 | | | Rs.12000/- Per Unit Cost |
| A.1 0.6 | Concurrent Audit (State & District) | 1 | One | 1 | 1 | 1 | 1 | 1 | 264000 | 66000 | 66000 | 66000 | 66000 | 264000 | | | Rs. 22000/- Per Month Concurrent audit |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | HR consultant for DHS | | One | 0 | 1 | 1 | 1 | 1 | 180000 | 60000 | 60000 | 60000 | 60000 | 180000 | | | Rs.20000/- per month for 9 months |
| | One Accountant in DHS & 11 Account Assistant for PHC | | Twelve | 0 | 12 | 12 | 12 | 12 | 72000 | 0 | 288000 | 288000 | 288000 | 864000 | | | Rs.8000/- Per Month per Account Assistant & Accountant |
| | Block Monitoring & Evaluation Officer | | Eleven | 0 | 11 | 11 | 11 | 11 | 90000 | 0 | 330000 | 330000 | 330000 | 990000 | | | Rs.10000/- per Month Per BM&E |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Tally Purchase for DH & SDH | | Two | 0 | 2 | 0 | 0 | 2 | 17100 | 0 | 34200 | 0 | 0 | 34200 | | | Rs.17100/- per unit. |
| | Computer for DH,SDH & PHC | | Three | 3 | 0 | 0 | 0 | 3 | 50000 | 150000 | 0 | 0 | 0 | 150000 | | | Rs.50000/- per computer. |
| | NRHM-A | | | | | | | | | | | | | 0 | | | |
| | Grand Total of RCH II (NRHM-A) | 35227 | 0 | 29696 | 38474 | 39513 | 34890 | 137443 | 14252373 | | | | | 192066860 | | | |
| | NRHM-B | | | | | | | | | | | | | | | | |
| B1 | ASHA | | | | | | | | | | | | | 0 | | | |
| B.1.1.1 | Selection & Training of Asha | 0 | Fourteen hundreds ninty three | 747 | 746 | 0 | 0 | 1493 | 4624 | 3454128 | 3449504 | 0 | 0 | 6903632 | | | Rs.4624/- Per Asha Training Cost |
| B.1.1.2 | ASHA Drug Kit & Replenishment | 0 | Twenty nine hundreds eighty six | | 1493 | | 1493 | 2986 | 350 | 0 | 522550 | 0 | 522550 | 1045100 | | | Rs.350/- Per Asha Per Drug Kit twice in a year. |
| B.1.1.3 | ASHA Diwas | 1470 | Fourteen hundreds ninty three | 1493 | 1493 | 1493 | 1493 | 1493 | 1500 | 559875 | 559875 | 559875 | 559875 | 2239500 | | | Rs. 125/- Per Asha Per Asha Day. |
| B.1.1.4 A | Best Performance Award to ASHAs at District Level | 0 | Eleven | 0 | 0 | 11 | 0 | 11 | 3000 | 0 | 0 | 33000 | 0 | 33000 | | | Rs.3000/- Per PHC |
| B.1.1.4 C | ASHA Identity Card | 0 | Fourteen hundreds eighty three | 0 | 1483 | 0 | 0 | 1483 | 50 | 0 | 74150 | 0 | 0 | 74150 | | | Rs.50/- per Asha Identity Card. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B.1.1.5 | Asha Resource Centre / Asha Mmentoring Group | 80 | Eighty five | 85 | 85 | 85 | 85 | 85 | 44400 | 943500 | 943500 | 943500 | 943500 | 3774000 | | | Rs. 24200/- Per month DCM Salary with 2 Increament, Rs.15000/- Per Month DDA Salary, Rs.5000/- Per Month Office Expenses at Dist Level, Rs.13200/- Per month Per BCM Salary with Increament, Rs.1050 per month per Asha Facilitator, Rs.2000/- Office Expenses at Block Level & Rs.30000/- Lop top for BCM. |
| | **Innovative Activity** | | | | | | | | | | | | | | | | |
| | One Day Asha Facilitator training at district level | | Seventy one | 30 | 41 | 0 | 0 | 71 | 3294.5 | 98835 | 135074.5 | 0 | 0 | 233909.5 | | | Rs.150/-Compensation for Each Asha Facilitator. Rs.150/- Refreshment, Venue for Participants & Rs.100/- TA/DA for Asha Facilitator. Rs.350/- Honorarium for Trainers & Rs.150/- TA for Trainers. |
| | Motivation of Asha:- Give Rs.5000/ as award to Asha who motivate 20 case or 20+ of Family Planning in complete financial year. | | Ten | 0 | 0 | 0 | 10 | 10 | 5000 | 0 | 0 | 0 | 50000 | 50000 | | | Rs.5000/- per Asha. |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One day training of Panchayat Mukhiya regarding ASHA program at block level | | Eleven | 0 | 11 | 0 | 0 | 11 | 5872.72 | 0 | 64599.92 | 0 | 0 | 64599.92 | | | Rs.100/- TA/DA per participant(no of mukhiya=142) +Rs.120/- per participant for lunch & tea+Rs.50/- stationary per participant+Rs.2000/-per block for contingency |
| | One Day District Level Orientation Program with all Department & Partner Agency Regarding Asha Program | | One | 0 | 1 | 0 | 0 | 1 | 20000 | 0 | 20000 | 0 | 0 | 20000 | | | Rs.20000/- for Orientation Program. |
| B.2 | Untied Fund | | | | | | | | | | | | | | | | |
| B.2.1 | Untied Fund for District Hospital & Sub Divisional Hospital | 0 | Two | 2 | 0 | 0 | 0 | 2 | 50000 | 100000 | 0 | 0 | 0 | 100000 | | | Rs.50000/- Per Unit |
| B.2.2A | Untied Fund for Primary Health Centre | 4 | Eleven | 11 | 0 | 0 | 0 | 11 | 25000 | 275000 | 0 | 0 | 0 | 275000 | | | Rs.25000/- Per Year for PHC |
| B.2.2B | Untied Fund for Additional Primary Health Centre | 1 | Twenty eight | 28 | 0 | 0 | 0 | 28 | 25000 | 700000 | 0 | 0 | 0 | 700000 | | | Rs.25000/- Per Year for APHC |
| B.2.3 | Untied fund for Health sub centre | 25 | One hundred sixty one | 161 | 0 | 0 | 0 | 161 | 10000 | 1610000 | 0 | 0 | 0 | 1610000 | | | Rs. 10000/- Per Year for HSC. |
| B.2.4 | Village Health and Sanitation Committee | 185 | Eight hundred eleven | 811 | 0 | 0 | 0 | 811 | 10000 | 8110000 | 0 | 0 | 0 | 8110000 | | | Rs. 10000/- Revenue Village Per Year. |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | Orientation on Guidelines for Untied Funds for HSC & VHSC | | Eleven | 11 | 0 | 0 | 0 | 11 | 3000 | 33000 | 0 | 0 | 0 | 33000 | | | Rs.3000/- per PHCs |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Quarterly review meeting of the ANMs under the chairmanship of PHC Medical Officer to monitor usage of Untied Fund | | Fourty four | 11 | 11 | 11 | 11 | 44 | 1000 | 11000 | 11000 | 11000 | 11000 | 44000 | | | Rs.1000/- per qtr per PHCs |
| B.3 | Annual Maintenance Grant | | | | | | | | | | | | | | | | |
| B.3 .1A | Annual Maintenance Grant for Dist Hospital | 0 | One | 1 | 0 | 0 | 0 | 1 | 100000 | 100000 | 0 | 0 | 0 | 100000 | | | Rs.100000/- Per Year for Dist Hospital. |
| B.3 .1B | Annual Maintenance Grant for Sub Divisional Hospital | 0 | One | 1 | 0 | 0 | 0 | 1 | 100000 | 100000 | 0 | 0 | 0 | 100000 | | | Rs.100000/- Per Year for Sub Divisional Hospital. |
| B.3 .2A | Annual Maintenance Grant for PHCs | 4 | Eleven | 11 | 11 | 11 | 11 | 11 | 50000 | 137500 | 137500 | 137500 | 137500 | 550000 | | | Rs.50000/- Per Year for PHC. |
| B.3 .2B | Annual Maintenance Grant for APHCs | 0 | Fourteen | 14 | 14 | 14 | 14 | 14 | 50000 | 175000 | 175000 | 175000 | 175000 | 700000 | | | Rs.50000/- Per Year for APHC.(Total APHC in govt building are 14) |
| B.3 .3 | Annual Maintenance Grant for HSC | 4 | Thirty four | 34 | 34 | 34 | 34 | 34 | 25000 | 212500 | 212500 | 212500 | 212500 | 850000 | | | Rs.25000/- Per Year for HSC (Total HSC in govt building are 34) |
| B.4 | Hospital Strengthening | | | | | | | | | | | | | | | | |
| B.4 .1 | Renovation of Building of HSCs | | Five | 2 | 3 | 0 | 0 | 5 | 750000 | 1500000 | 2250000 | 0 | 0 | 3750000 | | | Rs.750000/- per unit for HSC. |
| B.4 .1.1 | Construction of the Building of HSCs | | Seventeen | 9 | 8 | 0 | 0 | 17 | 1557000 | 14013000 | 12456000 | 0 | 0 | 26469000 | | | Rs.1557000/- per unit. |
| B.4 .1.2 | Renovation of the Building of APHCs | | Two | 2 | 0 | 0 | 0 | 2 | 1550000 | 3100000 | 0 | 0 | 0 | 3100000 | | | Rs.1550000/- per unit. |
| B.4 .1.3 | Construction of the Building of APHCs | | Two | 2 | 0 | 0 | 0 | 2 | 3050000 | 6100000 | 0 | 0 | 0 | 6100000 | | | Rs.3050000/- per unit. |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B.4 .1.4 | Construction & Renovation of the Building of 4 PHCs upgrade in CHCs | | Four | 2 | 2 | 0 | 0 | 4 | 6050000 | 12100000 | 24200000 | 0 | 0 | 24200000 | | | Rs.6050000/- per unit. |
| B.4 .1.5 | Construction of boundary wall of the PHCs | | Five | 5 | 0 | 0 | 0 | 5 | 500000 | 2500000 | 0 | 0 | 0 | 2500000 | | | Rs.500000/- per unit |
| B.4 .1.6 | Construction of residence facility for MO at PHCs | | Nine | 4 | 5 | 0 | 0 | 9 | 1000000 | 4000000 | 5000000 | 0 | 0 | 9000000 | | | Rs.1000000/- per unit |
| B.4 .2A | Installation of Solar Water System in PHC | 0 | Four | 0 | 2 | 2 | 0 | 4 | 150000 | 0 | 300000 | 300000 | 0 | 600000 | | | Rs.150000/- Per PHC |
| B.4 .3 | Sub Centre Rent & Contigencies | 4 | One hundred twenty seven | 127 | 127 | 127 | 127 | 127 | 6000 | 190500 | 190500 | 190500 | 190500 | 762000 | | | Rs.500/- Per Month Per HSC. |
| B.5 | Renovation & Setting up | | | | | | | | | | | | | | | | |
| B.5 .2C | Strengthening of Cold Chain Room | 0 | Twelve | 12 | 12 | 12 | 12 | 12 | 46166.66 | 138499.99 | 138499.99 | 138499.99 | 138499.99 | 554000 | | | Rs.400000/- Per Year For Dist & 14000/- Per Year for PHCs. |
| B.6 | Rogi Kalyan Samiti | | | | | | | | | | | | | | | | |
| B.6 .1 | Rogi Kalyan samiti for Dist Hospital | 1 | One | 1 | 1 | 1 | 1 | 1 | 500000 | 125000 | 125000 | 125000 | 125000 | 500000 | | | Rs.500000/- Per Year for Dist Hospital. |
| B.6 .2 | Rogi Kalyan samiti for Sub Divisional Hospital | 0 | One | 1 | 1 | 1 | 1 | 1 | 100000 | 25000 | 25000 | 25000 | 25000 | 100000 | | | Rs.100000/- Per Year for SDH |
| B.6 .3 | Rogi Kalyan samiti for PHC | 11 | Eleven | 11 | 11 | 11 | 11 | 11 | 100000 | 275000 | 275000 | 275000 | 275000 | 1100000 | | | Rs.100000/- Per Year for PHCs |
| B.6 .4 | Rogi Kalyan samiti for APHC | 0 | Twenty two | 28 | 28 | 28 | 28 | 28 | 100000 | 700000 | 700000 | 700000 | 700000 | 2800000 | | | Rs.100000/- Per Year for APHCs |
| B.7 | Decentarlise | | | | | | | | | | | | | | | | |

| | Planning | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B.7.1 | Salary of DPC | 1 | One | 1 | 1 | 1 | 1 | 1 | 290400 | 72600 | 72600 | 72600 | 72600 | 290400 | | | Rs.24200/- Salary of DPC with 2 Increament. |
| B.7.2 | District Health Actiona Plan (Including BHAP & HSC Plan) | 173 | One hundred seventy three | 0 | 173 | 173 | 0 | 173 | 2320.81 | 0 | 200750 | 200750 | 0 | 401500 | | | Rs.30000/- for DHAP, Rs.10000/- for Per BHAP & Rs.1500/- for Per HSC Plan |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | Loptop for DPC | 0 | One | 1 | 0 | 0 | 0 | 1 | 40000 | 40000 | 0 | 0 | 0 | 40000 | | | Rs.40000/- for Loptop. |
| | Planning Cell at district level-1 Computer Assistant | | One | 1 | 1 | 1 | 1 | 1 | 72000 | 18000 | 18000 | 18000 | 18000 | 72000 | | | Rs.6000/- per month |
| B.8 | Panchayati Raj Initiative | | | | | | | | | | | | | | | | |
| B.8.1 | Constitution and Orientation of Community Leader & of VHSC,HSC,PHC,CHC etc. | 0 | One hundred fourty two | 142 | 142 | 142 | 142 | 142 | 1650 | 58575 | 58575 | 58575 | 58575 | 234300 | | | Rs.100/- per month per VHSNC meeting, Rs.150/- Monitoring of VHSNC meeting for Block Level Officers 3time in a year. |
| B.8.2 | Orientation Workshop, Training and Capacity Building of PRI at DHS, CHC, PHC | 153 | One hundred fifty three | 0 | 153 | 0 | 0 | 153 | 988.23 | 0 | 151199.19 | 0 | 0 | 151199.19 | | | Rs.100/-Refreshment for Participant in Workshop at Distt Level, Rs.50/- per participant for Stationary & Rs.150/- DA for VHSNC Member at Block Level, Rs.75/- Snack & Stationary for VHSNC member. |
| B.9 | Mainstreaming of AYUSH | | | | | | | | | | | | | | | | |
| B.9 | Mainstreaming of AYUSH- Medical Officer only AYUSH | 21 | Twenty eight | 28 | 28 | 28 | 28 | 28 | 258000 | 1806000 | 1806000 | 1806000 | 1806000 | 7224000 | | | Rs.22000/- Per Month Per AYUSH MO (21) & Rs.20000/- Per Month Per New AYUSH MO (7) |
| B.10 | IEC-BCC NRHM | | | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B.10.1 | Development of State BCC/IEC Strategy | 3 | Twelve | 12 | 12 | 12 | 12 | 12 | 47916.66 | 143749.98 | 143749.98 | 143749.98 | 143749.98 | 574999.92 | | | Rs.300000/- for Dist Level & 25000/- for PHC |
| B.10.3 | Health Mela (Leprosy) | 0 | One | 0 | 0 | 1 | 0 | 1 | 5000 | 0 | 0 | 5000 | 0 | 5000 | | | Rs. 5000/- for Health Mela |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | Honorarium of IEC Consultant | 0 | One | 0 | 1 | 1 | 1 | 1 | 135000 | 0 | 45000 | 45000 | 45000 | 135000 | | | Rs.15000/- Per Month Salary for IEC Consultant |
| | Provision of Advertisement Cost for Newspaper | | Eighteen | 4 | 5 | 4 | 5 | 18 | 10000 | 40000 | 50000 | 40000 | 50000 | 180000 | | | Rs.10000/- per advertisement. |
| | IEC for Social Marketing through Asha (Holding, Banner, Poster & Slogan) | | Eleven | 0 | 11 | 0 | 0 | 11 | 6028.63 | 0 | 66314.93 | 0 | 0 | 66314.93 | | | Rs.1000/- Per Holding One in each PHC (No of PHC-11), Rs300/- Per Banner One in each HSC (No of HSC- 161) & Rs.5/- Per Poster One in each AWC (No of AWC-1403). |
| B.11 | Referral Transport | | | | | | | | | | | | | | | | |
| B.11 | Mobile Medical Units | 1 | One | 1 | 1 | 1 | 1 | 1 | 4212000 | 1053000 | 1053000 | 1053000 | 1053000 | 4212000 | | | Rs.4212000/- Per Year For MMU |
| B.12.2 C | Advanced Life saving Ambulance (Call 108) | 1 | One | 1 | 1 | 1 | 1 | 1 | 1560000 | 390000 | 390000 | 390000 | 390000 | 1560000 | | | Rs.1560000/- Per Year for 108 Ambulance |
| B.12.2 D | Referral Transport in Districts | 0 | Nine | 9 | 9 | 9 | 9 | 9 | 1560000 | 3510000 | 3510000 | 3510000 | 3510000 | 14040000 | | | Rs.130000/- per month per Ambulance. |
| B.13 | NGO / PPP | | | | | | | | | | | | | | | | |
| B.13.3 B | Outsourcing of Pathology & Radiology Services from PHCs to DH | 17 | Twenty two | 22 | 22 | 22 | 22 | 22 | 300000 | 1650000 | 1650000 | 1650000 | 1650000 | 6600000 | | | Rs.300000/- Per Year Per Unit. |
| B.13.3 D | IMEP (Bio-Waste Management ) | 0 | Nine | 9 | 9 | 9 | 9 | 9 | 105235 | 236778.75 | 236778.75 | 236778.75 | 236778.75 | 947115 | | | Rs.105235/-Per Unit. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B.14.A | Rajiv Gandhi Scheme for Empowerment of Adolecent Girls or SABLA | 0 | Fourteen hundred three | 0 | 1403 | 0 | 0 | 1403 | 180 | 0 | 252540 | 0 | 0 | 252540 | | | Rs.216636/- For SABLA. |
| B.14.B | YUKTI Yojana of Public & Private Sector for Providing Safe Abortion Services | 0 | Four hundred seventy three | | | | | 473 | 339.26 | 40117.49 | 40117.49 | 40117.49 | 40117.49 | 160469.98 | | | Rs.160469.98/- for YUKTI. |
| **B.15** | **Planning, Implementation & Monitoring** | | | | | | | | | | | | | | | | |
| B.15.3.1.A | State,District,Divisional,Block Data Centre. | 11 | Twelve | 12 | 12 | 12 | 12 | 12 | 120000 | 360000 | 360000 | 360000 | 360000 | 1440000 | | | Rs.10000/- Per Month Per Data Centre |
| B.15.3.1.B | MCTS & HRIS | 0 | Eight | 0 | 0 | 8 | 0 | 8 | 28702 | 0 | 0 | 28702 | 0 | 229616 | | | Rs.28702/- Per Batch Training. |
| B.15.3.2.B | RI Monitoring | 0 | One | 1 | 1 | 1 | 1 | 1 | 130000 | 32499.99 | 32499.99 | 32499.99 | 32499.99 | 130000 | | | Rs.130000/- Mobility for DIO |
| B.15.3.3.A | Strengthening of HMIS | 0 | 0 | | | | | 0 | | | | | | | | | |
| B.15.3.3.B | Plans for HMIS supportive Supervision and Data Validation. | 1 | One | 1 | 1 | 1 | 1 | 1 | 230000 | 57499.99 | 57499.99 | 57499.99 | 57499.99 | 230000 | | | Rs.230000/- Mobility for DM&E, Resource Pool. |
| **B.16** | **Procurement** | | | | | | | | | | | | | | | | |
| B.16.1.1a | Procurement of equipment: MH (Labour Room) | 0 | Ten | 5 | 5 | | | 10 | 125000 | 625000 | 625000 | 0 | 0 | 1250000 | | | Rs.125000/- Each Labour Room. |
| B.16.1.1b | Procurement of equipment (MH)- Blood Storage Unit at FRUs | | Two | 1 | 1 | 0 | 0 | 2 | 18600 | 18600 | 18600 | 0 | 0 | 37200 | | | Rs.18600/- Per FRU for Equipment. |
| B.16.1.2 | Procurement of Equipment: CH (SCNU & NBCC equipment) | | Hundred | 0 | 100 | 0 | 0 | 100 | 20563.59 | 0 | 2056359 | 0 | 0 | 2056359 | | | Rs. 2056359/- for SNCU & NBCC Equipments. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B.16.1.3A | Procurement of Minilap Set: FP | 0 | Fifty five | 0 | 33 | 22 | 0 | 55 | 4000 | 0 | 132000 | 88000 | 0 | 220000 | | | Rs.4000/- Per Kit |
| B.16.1.3B | Procurement of NSV Kit : FP | 0 | Five | 0 | 5 | 0 | 0 | 5 | 1500 | 0 | 7500 | 0 | 0 | 7500 | | | Rs.1500/- Per Kit |
| B.16.1.3C | Procurement of IUD Kit : FP (PHCLevel) | 0 | Two | 1 | 0 | 1 | 0 | 2 | 20000 | 20000 | 0 | 20000 | 0 | 40000 | | | Rs.20000/- Per IUD Kit. |
| B.16.1.5A | Dental Chair Procurement | 0 | Four | 0 | 2 | 2 | 0 | 4 | 339473.5 | 0 | 678947 | 678947 | 0 | 1357894 | | | Rs.339473.5/- Per Dental chair |
| B.16.1.5C | A.C.1.5 Ton Window in Blood Bank | 0 | One | 0 | 1 | 0 | 0 | 1 | 25000 | 0 | 25000 | 0 | 0 | 25000 | | | Rs.25000/- for AC |
| B.16.2.1A | Parenatal Iron Sucrose (1V / 1M) as therapeutic measure | 0 | One | 0 | 1 | 0 | 0 | 1 | 500000 | 0 | 500000 | 0 | 0 | 500000 | | | Rs.500000/- for Parental Iron Source |
| B.16.2.1B | IFA Tablets for Pregnant & Lactating Mothers | 0 | Sixty nine thousands six hundred seventy six | 0 | 69676 | 0 | 0 | 69676 | 14.21 | 0 | 990584 | 0 | 0 | 990095.96 | | | Rs.990584/- for IFA Tablets. |
| B.16.2.2A | IFA Small Tablets & Syrup for Children (6-59 Months) | 0 | Two lakh sixteen thousand seven hundred sixty nine | 0 | 216769 | 0 | 0 | 216769 | 5.69 | 0 | 1233415.61 | 0 | 0 | 1233415.61 | | | Rs.1233415.61 for IFA Small Tablets. |
| B.16.2.2B | IMNCI Drug Kit | 0 | Three thousand six | 1800 | 0 | 1800 | 0 | 3600 | 250 | 450000 | 0 | 450000 | 0 | 900000 | | | Rs.250/- Per IMNCI Drug Kit. |

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| | | | hund red | | | | | | | | | | | | | | |
| B.1 6.2. 5 | General Drugs & Supplies for health facilities | | | | | | | | | 3750000 | 3750000 | 3750000 | 3750000 | 15000000 | | | Rs.15000000/- For Drug |
| B.2 2.4 | Support Strengthening RNTCP | 0 | Seve n | 7 | 7 | 7 | 7 | 7 | 18000 | 31500 | 31500 | 31500 | 31500 | 126000 | | | Rs.126000/- for RNTCP Staff. |
| B.2 3.A | Payment of monthly bill to be BSNL | 0 | Seve n | 7 | 7 | 7 | 7 | 7 | 3405 | 5958.75 | 5958.75 | 5958.75 | 5958.75 | 23835 | | | Rs.23835/- frp BSNL Bill. |
| | Innovative Activity | | | | | | | | | | | | | | | | |
| | One Day Midea Advocacy Work Shop | | Two | | 2 | | | 2 | 15750 | 0 | 31500 | 0 | 0 | 31500 | | | Rs. 200/- TA/DA for per participant, Rs. 120/- Refreshment for per participant, Rs. 5000/- hall Arrangement, Rs. 50/- Stationery for per participant, Rs. 1500/- contingency (max.-25 participant.) |
| | Grand Total of Additionalities (NRHM-B) | | | | | | | | 26203580.5 | | | | | 172120146.1 | | | |
| C | IMMUNISATION | | | | | | | | | | | | | | | | |
| C.1 .a | Mobility support for Supervision and Monitoring at districts and state level. | 1 | One | 1 | 1 | 1 | 1 | 1 | 50000 | 12500 | 12500 | 12500 | 12500 | 50000 | | | Rs. 50000/- Per Year for DIO |
| C.1 .c | Printing and dissemination of immunization formats, tally sheets, monitoring formats etc.(@ Rs.5/- per | 0 | Sixty four thous and seve n hund red seve | 16194 | 16195 | 16194 | 16195 | 64778 | 5 | 80970 | 80975 | 80970 | 80975 | 323890 | | | Rs.323890/- for Printings of RI formats. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | beneficiaries) + 10% extra. | | nty eight | | | | | | | | | | | | | | |
| C.1.e | Quaterly review meetings exclusive for RI at district level with MOIC,CDPO & other stakeholder @ Rs. 100 per participants for 5 participants per PHCs. | 1 | Four | 1 | 1 | 1 | 1 | 4 | 8250 | 8250 | 8250 | 8250 | 8250 | 33000 | | | Rs.150/- Per Participants for 1 Quaterly meeting (Max 5 participants per PHCs. |
| C.1.f | Quaterly review meetings exclusive for RI at block level @ Rs.50/- PP as travel for ASHAs and Rs. 25 per persons for meeting expenses for ASHAs. | 1 | Four | 1 | 1 | 1 | 1 | 4 | 149300 | 149299.99 | 149299.99 | 149299.99 | 149299.99 | 597200 | | | Rs.50/- Partricipants travel & Rs.50/- Per participants meeting expenses (Total ASHA-1493*4 meeting) |
| C.1.g | Focus on slum & underserved areas in urban areas / alternate Vaccinator for slums. | 120 | Eleven hundred four | 276 | 276 | 276 | 276 | 1104 | 278 | 76728 | 76728 | 76728 | 76728 | 306912 | | | Rs.306912/- for Slum & Underserved areas. |
| C.1.h | Mobilization of children through ASHA under Muskan Ek Abhiyan | 14784 | Thirty one thousands eight | 7752 | 7752 | 7752 | 7752 | 31008 | 200 | 1550400 | 1550400 | 1550400 | 1550400 | 6201600 | | | Rs.200/. Per Month Per Asha/Volunteer |
| C.1.j | Alternate Vaccine Delivery in other areas. | 14784 | Thirty one thousands eight | 7752 | 7752 | 7752 | 7752 | 31008 | 52 | 403104 | 403104 | 403104 | 403104 | 1612416 | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.1 .k | To develop micro plan at sub-centre level | 0 | One hund red sixty one | 0 | 161 | 0 | 0 | 161 | 100 | 0 | 16100 | 0 | 0 | 16100 | | | Rs.100 /- Per HSC microplan, |
| C.1 .L | For consolidation of micro plan at District & block level. | 1 1 | Twelv e | 0 | 12 | 0 | 0 | 12 | 1083.33 | 0 | 12999.9 6 | 0 | 0 | 12999.96 | | | Rs.1000/- Per PHC & Rs.2000/-Per District. |
| C.1 .m | POL for vaccine & Logistics delivery from State to district and from District to PHCs. | 1 1 | Eleve n | 11 | 11 | 11 | 11 | 11 | 7100 | 19524.9 9 | 19524.9 9 | 19524.9 9 | 19524.9 9 | 78100 | | | Rs.78100/- for POL for Vaccine Delivery. |
| C.1 .n | Consumables for computer including provision for internet access for RIMs Rs.400 per month per district. | 0 | One | 1 | 1 | 1 | 1 | 1 | 6000 | 1500 | 1500 | 1500 | 1500 | 6000 | | | Rs.500/- per month per district. |
| C.1 .o & p | Red/Black Plastic bags etc. Bleach / Hypchlorite Solution/twin bucket. | 0 | Two thous ands three hund reds thirty three | 0 | 116 7 | 0 | 116 6 | 2333 | 26.37 | 0 | 30773.7 9 | 0 | 30747.4 2 | 61521.21 | | | Rs.61530/- for Red/ Black Plastic Bags. |
| C.1 .q | Safety Pits for those PHC / Hospitals where there is no pit or is not in working condition. | 0 | Four | 0 | 4 | 0 | 0 | 4 | 5277 | 0 | 21108 | 0 | 0 | 21108 | | | Rs.5277/- for safety pits. |
| C.1 .r | Alternate Vaccinator hiring for Access Compromised Areas, POL of Generators for Cold Chain and For serious AEFI | 0 | Five | 5 | 5 | 5 | 5 | 5 | 3000 | 3750 | 3750 | 3750 | 3750 | 15000 | | | Rs.1000/-per year per district for Major AEFI investigation (average 5 cases per year) + Rs.5000/- per year per district for after Major AEFI . |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | cases investigation for every district. | | | | | | | | | | | | | | | | |
| C.2 .b | Computer Assistants support for District Level @ Rs.10000/- per person per month for one computer assistant in each District | 1 | One | 1 | 1 | 1 | 1 | 1 | 144000 | 36000 | 36000 | 36000 | 36000 | 144000 | | | Rs.12000/- per month for Computer Assistants. |
| C.3 .a | District Level Orientation training including Hep-B, Measles, JE for 2 days ANM, MHW, LHV & ors staff etc. | 20 | Three hundreds fourty | 40 | 100 | 100 | 100 | 340 | 1550 | 62000 | 155000 | 155000 | 155000 | 527000 | | | Rs.527000/- for Ri Training. |
| C.3 .d | One day cold chain handlers trainings | 11 | Eleven | 0 | 11 | 0 | 0 | 11 | 1229 | 0 | 13519 | 0 | 0 | 13519 | | | Rs.13519/- for Cold Chain Handler training. |
| C.3 .e | One day training of block level date handlers. | 0 | Eleven | 0 | 0 | 11 | 0 | 11 | 1229 | 0 | 0 | 13519 | 0 | 13519 | | | Rs.13519/- for block level data Handler training. |
| C.4 | Cold Chain Maintenance | 0 | Twelve | 12 | 12 | 12 | 12 | 12 | 5833.33 | 17499.99 | 17499.99 | 17499.99 | 17499.99 | 69999.96 | | | Rs.70000/- per district. |
| | office expenses for RI. | | One | 1 | 1 | 1 | 1 | 1 | 24000 | 6000 | 6000 | 6000 | 6000 | 24000 | | | Rs. 2000/- per month for office expenses of RI Office. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Provision of Tickler Bag | | Two thousands five hundreds eighty four | 0 | 2584 | 0 | 0 | 2584 | 200 | 0 | 516800 | 0 | 0 | 516800 | | | Rs.200/- per tickler bag per year. |
| | One day Orientation of AWW & ASHA Regarding RI | | Seventy three | 13 | 20 | 20 | 20 | 73 | 14400 | 187200 | 288000 | 288000 | 288000 | 1051200 | | | Rs.14400/- per batch (Rs.100/-TA for Trainees,Rs.150/- Refreshment for trainees & Rs.200/- |
| | Hiring RI Supervisor for RI Day | | Fifty three | 53 | 53 | 53 | 53 | 53 | 55000 | 728749.99 | 728749.99 | 728749.99 | 728749.99 | 2915000 | | | |
| | Grand Total of Immunization (NRHM-C) | | | | | | | | 408513.03 | | | | | 14610885.13 | | | |
| D | IDD | | | | | | | | | | | | | | | | |
| D.3.1 | One Day Capacity Building & Orientation of AWW & Asha | | Eleven | 0 | 11 | 0 | 0 | 11 | 1500 | 0 | 16500 | 0 | 0 | 16500 | | | Rs.1500/- per phc. |
| D.3.1 | Intersecteral Coordination Meeting at Distt Level | | One | 0 | 1 | 0 | 0 | 1 | 5000 | 0 | 5000 | 0 | 0 | 5000 | | | Rs.5000/- For Distt level meeting |
| | | | | | | | | | | | | | | | | | |
| E | IDSP | | | | | | | | | | | | | | | | |
| E.1 | Operational Cost | | One | 1 | 1 | 1 | 1 | 1 | 180000 | 45000 | 45000 | 45000 | 45000 | 180000 | | | Rs.15000/- per month for format. Report printing,reviev meeting field visit & office expense. |
| E.2 | Honorarium of Epidemiologist, Data Manager & Data Entry Operator | | Three | 3 | 3 | 3 | 3 | 3 | 208000 | 156000 | 156000 | 156000 | 156000 | 624000 | | | Rs.30000/- per month for epidemiologist,Rs.13500/- per month for data maneger & Rs.8500/- per month for DEO. |
| F | NVBDCP | | | | | | | | | | | | | | | | |
| F.1.1 | Malaria | | T | | | | | | | | | | | | | | |
| | Asha Hona. For KA Part 11 (B) | | One | 0 | 1 | 0 | 0 | 1 | 1600 | 0 | 1 | 0 | 0 | 1600 | | | Rs.1600/- for Asha Hono. |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| F.1. 1.e | IEC/BCC | | One | 1 | 0 | 0 | 0 | 1 | 20000 | 0 | 20000 | 0 | 0 | 20000 | | | Rs.20000/- for IEC/BCC. |
| F.1. 2 | FILARIASIS | | | | | | | | | | | | | | | | |
| F.1. 4a | | | One | | | | | | 71552 | | | | | 71552 | | | |
| F.1. 4b | | | | | | | | | 44778 | | | | | 44778 | | | |
| F.1. 4c | | | | | | | | | 10000 | | | | | 10000 | | | |
| F.1. 4d | | | | | | | | | 229850 | | | | | 229850 | | | |
| F.1. 4e | | | | | | | | | 190000 | | | | | 190000 | | | |
| F.1. 4f | | | | | | | | | 351760 | | | | | 351760 | | | |
| F.1. 3 | Dengue/Chikungun ya | | | | | | | | | | | | | | | | |
| F.1. 4 | AES/JE | | | | | | | | | | | | | | | | |
| F | KALA-AZAR ( Operational cost including wages, IEC, Transportation of DDT) | | | | | | | | | | | | | | | | |
| F.1. 5 | Kala-Azar, Search-Comp Mode | | Sixty Six | 0 | 33 | 33 | 0 | 66 | 1140.15 | 0 | 37625 | 37625 | 0 | 75250 | | | Rs.75250/- for Kala Azar Camp. |
| F.1. 5.1 | KALA-AZAR IEC/BCC | | Eleve n | 0 | 6 | 5 | 0 | 11 | 400 | 0 | 2400 | 2000 | 0 | 4400 | | | Rs.4400/- for IEC/BCC. |
| G | NLEP | | | | | | | | | | | | | | | | |
| G-2.1 | Sensitization of Asha One batch each PHCs | | Eleve n | 0 | 11 | 0 | 0 | 11 | 2000 | 0 | 22000 | 0 | 0 | 22000 | | | Rs.2000/- Per Batch. |
| G-2.2 | Honorarium to Asha | | Eleve n | 11 | 0 | 0 | 0 | 11 | 4000 | 44000 | 0 | 0 | 0 | 44000 | | | Rs.4000/- Per PHCs. |
| G-3.1 | DLC (Leprocy) for others | | One | 1 | 0 | 0 | 0 | 1 | 20000 | 20000 | 0 | 0 | 0 | 20000 | | | Rs.20000/- Per District. |
| G-3.2 | Consumable Expenses | | One | 1 | 1 | 1 | 1 | 1 | 15000 | 3750 | 3750 | 3750 | 3750 | 15000 | | | Rs.15000/- per year per District. |
| G-4.1 | Two Days Module Training of New entrant Mos | | One | 1 | 0 | 0 | 0 | 1 | 18425 | 18425 | 0 | 0 | 0 | 18425 | | | Rs.18425/- for One Batch Training. |

| G-4.2 | One Day Orientation training of Supervisors,HW, ANM, LHVs, & Pharmacistser | | One | 1 | 0 | 0 | 0 | 1 | 7025 | 7025 | 0 | 0 | 0 | 7025 | | | Rs.7025/- for Training. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| G-5.1 | School Quiz | | Eleven | 2 | 3 | 3 | 3 | 11 | 3500 | 7000 | 10500 | 10500 | 10500 | 38500 | | | Rs.500/- Per Quiz (7 Quiz per PHC) |
| G-5.2 | Health Mela/Fairs | | One | 0 | 1 | 0 | 0 | 1 | 5000 | 0 | 5000 | 0 | 0 | 5000 | | | Rs.5000/- For Mela. |
| G-5.3 | Wall writing - 2 wall writing per PHCs | | Eleven | 5 | 6 | 0 | 0 | 11 | 1400 | 7000 | 8400 | 0 | 0 | 15400 | | | Rs.700/- Per Wall Writing. |
| G-5.4 | Celebration of Leprocy Day | | One | 0 | 1 | 0 | 0 | 1 | 10000 | 0 | 10000 | 0 | 0 | 10000 | | | Rs.10000/- for Leprocy Day. |
| G-6 | Vehicle Operation/ Hiring POL & Maintenance. | | One | 1 | 1 | 1 | 1 | 1 | 7500 | 1875 | 1875 | 1875 | 1875 | 7500 | | | Rs.7500/- Per Year Per District. |
| G.7.2 | Aids 7 Appliances | | One | 1 | 0 | 0 | 0 | 1 | 8000 | 8000 | 0 | 0 | 0 | 8000 | | | Rs.8000/- per district. |
| G.8.1 | Supportive Medicines | | One | 1 | 1 | 1 | 1 | 1 | 25000 | 6250 | 6250 | 6250 | 6250 | 25000 | | | Rs.25000/- Per Year Per District. |
| G.8.2 | Laboratory Reagents & Equipments | | One | 1 | 1 | 1 | 1 | 1 | 12000 | 3000 | 3000 | 3000 | 3000 | 12000 | | | Rs.12000/- per year per district. |
| G.9 | Urban Leprocy Control Programme for 24 Twon Ship | | One | 1 | 1 | 1 | 1 | 1 | 50000 | 12500 | 12500 | 12500 | 12500 | 50000 | | | Rs.50000/- Per Year. |
| H | NBCP | | | | | | | | | | | | | | | | |
| H-1.1 | Cataract Operation | | Three thousands | 750 | 750 | 750 | 750 | 3000 | 750 | 562500 | 562500 | 562500 | 562500 | 2250000 | | | Rs.750/- Per Case |
| H-1.3 | School Eye Screening Program | | One Thousands | 0 | 500 | 500 | 0 | 1000 | 200 | 0 | 100000 | 100000 | 0 | 200000 | | | Rs.200/- Per Case. |
| H-1.13 | Strengthening of District Hospitals | | 1 | 0 | 1 | 0 | 0 | 1 | 2000000 | 0 | 2000000 | 0 | 0 | 2000000 | | | Rs.2000000/- Per year. |
| H-1.12 | Maintenance of Ophthalmic equipments | | One | 0 | 0 | 1 | 0 | 1 | 65000 | 0 | 0 | 65000 | 0 | 65000 | | | Rs.65000/- Per year. |
| H-2.3 | Vision Centre | | Four | 0 | 4 | 0 | 0 | 4 | 50000 | 0 | 200000 | 0 | 0 | 200000 | | | Rs.50000/- per Vision centre. |
| I | RNTCP | | | | | | | | | | | | | | | | |

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| I.1 | Civil Works | | One | 0 | 0 | 1 | 0 | 1 | 52400 | 0 | 0 | 52400 | 0 | 52400 | | | Rs.52400/- Per Year. |
| I.2 | Lab Consumables | | One | 0 | 0 | 1 | 0 | 1 | 240000 | 0 | 0 | 240000 | 0 | 240000 | | | Rs.240000/- Per Year Per district as per need. |
| I.3 | Honorarium | | Fourteen hundreds | 350 | 350 | 350 | 350 | 1400 | 250 | 87500 | 87500 | 87500 | 87500 | 350000 | | | Rs.250/- per Dots Provider. |
| I.4 | IEC | | One | 0 | 1 | 0 | 0 | 1 | 30000 | 0 | 30000 | 0 | 0 | 30000 | | | Rs.30000/- per year for IEC. |
| I.5 | Equipment maintenance | | One | 0 | 0 | 1 | 0 | 1 | 30000 | 0 | 0 | 30000 | 0 | 30000 | | | Rs.30000/- per year for Equipment Maintenance. |
| I.6 | Training | | One | 0 | 1 | 0 | 0 | 1 | 88000 | 0 | 88000 | 0 | 0 | 88000 | | | Rs.88000/- Per Year. |
| I.7 | Vehicle Maintenance | | One | 0 | 1 | 0 | 0 | 1 | 75000 | 0 | 75000 | 0 | 0 | 75000 | | | Rs.75000/- Per Year. |
| I.8 | Vehicle Hiring | | One | 1 | 1 | 1 | 1 | 1 | 414000 | 103500 | 103500 | 103500 | 103500 | 414000 | | | Rs.414000/- Per Year. |
| I.9 | NGO/PP Support | | One | 1 | 1 | 1 | 1 | 1 | 120000 | 30000 | 30000 | 30000 | 30000 | 120000 | | | Rs.120000/- Per Year. |
| I.11 | Miscellaneous | | One | 1 | 1 | 1 | 1 | 1 | 240000 | 60000 | 60000 | 60000 | 60000 | 240000 | | | Rs.240000/- Per Year. |
| I.12 B | Others - Contractual Services | | Nine | 9 | 9 | 9 | 9 | 9 | 277777 | 625000 | 625000 | 625000 | 625000 | 2500000 | | | Rs.2500000/- Salary for Contractual staff. |
| I.13 | Printing | | One | 1 | 1 | 1 | 1 | 1 | 30000 | 7500 | 7500 | 7500 | 7500 | 30000 | | | Rs.30000/- for Printing. |
| | Grand Total of Part-D | | | | | | | | | | | | | 11006940 | | | |
| GT | Grand Total (A+B+C+D) | | | | | | | | | | | | | 389,804,831 | | | |

## Annexure

**Block PIP**

**(Year 2012-13)**

## Name of the block:- Sadar Prakhand District:-Buxar

**Part A RCH Flexipool**

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 12 camps | Rs. 12000/- | 12 outreach camps in a year | Rs.1000/- per camp (12camp*1000) |
| A.1.3.2 | Monthly Village Health and Nutrition Days | No. of SC x 12 months | Rs. 184000 | 1 VHND / SC | Rs184000/- for monitoring of Session site(230*2*100=46000)+Rs.100/ Participants for Training of ANM,AWW,ASHA & PRI Member( |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | Not Applicable |
| A.1.4.1 | Home Deliveries | | | ______ deliveries | Not Applicable |
| A.1.4.2 | Institutional Deliveries | | | | Not Applicable |
| A.1.4.2.1 | Rural | | | -------------- deliveries | Not Applicable |
| A.1.4.2.2 | Urban | | | -------------- deliveries | Not Applicable |
| A.1.4.2.3 | Caesarean Deliveries | | | | Only if its an FRU |
| A.1.4.3 | Other activities (JBSY) | | | 15-15% more than previous year | Not Applicable. |
| A.1.5.1 | Maternal Death Audit | | | | The GoI guidelines on Facility and Community based MDR should be followed. |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 2028 | Rs. 202800 | | 169x12x100=202800 (Rs.100/- Case) |
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 1014<br>Per Asha 6 PNC Per 2 Month | Rs. 101400 | | Rs. 101400(169x6x100) |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 12 camps to be held in a year, 2012-13 female sterilisations to be conducted | Rs. 360000 | -------- camps to be held in a year, ------- female sterilisations to be conducted | Rs. 360000(12x30000) |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 360 | 360000 | | Rs.1000*360 |
| A.3.1.5 | Compensation for male sterilisation | | | | |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 1 | 12000 | | This could also be for bringing poor clients from hard to reach areas. Also for mobilising clients and transporting doctors and surgical teams |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 12 | Rs. 18000 | | Rs. 18000(12x1500) |
| | **Innovative Activity** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 14 | | | Rs. 11500 per ANM Per month (14*11500*12) |
| A.8.1.1.b | Staff Nurses | 2 | | ---- new staff Nurse posted | |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | ----- specialists needed | | ----- specialists in place | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 3612 | 1083600 | | **Rs.3612*300** |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | 1 | Rs. 765600 | | **Rs.765600(261360+174240+330000)** |
| A.10.4.9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | | | | **Only DH & SDH** |
| | **Innovative Activity** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Salary of Account Assistant in BPMU** | 1 | Rs. 96000 | | **Rs. 8000/- per month** |
| | **Block M & E officer** | 1 | Rs. 96000 | | **Rs. 8000/- per month** |
| | **GRAND TOTAL RCH II** | | **Rs.3291400** | | |

### Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| 1 | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenishment | **169** | **Rs. 42250** | 169 | Rs. 42250(169x250) |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | **169** | **Rs. 14534** | 169 | Rs. 14534(169x86x12) |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | **36** | **Rs. 24000** | 36 | Rs. 12000(12x1000)<br>Rs. 6000(12x50)<br>Rs. 3600(12x300)<br>Rs. 2400(12x200) |
| B1.1.5 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1 | Rs. 208400 | Block level ASHA Resource Centre functional with staff | Rs.208400(12000x12=144000 +64400) |
| | **Innovative Activity** | | | | |

| | **Sub Total ASHA-Decentralisation** | | | | |
|---|---|---|---|---|---|
| **B2** | **Untied Fund** | | | | |
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 1 | Rs. 25000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 2 | Rs. 50000 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 14 | Rs. 140000 | | Rs. 14x10000=140000 (Per Sub centre Rs.10000) |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | --96-- VHSCs formed | Rs. 960000 | ------ VHSCs formed and -----% of last years budget spent | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B3.2 | Annual Maintenance Grant for PHCs | 1 | Rs. 50000 | | Rs.50000 per PHCs |
| B3.2.A | Annual Maintenance Grant for APHCs | 1 | Rs.50000 | | Rs.50000 per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 5 | Rs. 50000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 8 | Rs. 4000 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | 1 | | | |

| | | | | | |
|---|---|---|---|---|---|
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | 1 | | | APHC Mahdah |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | Rs.500000 per DH |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | Rs.100000 per SDH |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | **Rs. 100000** | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **2** | **Rs.200000** | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | | | |
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 14 | 26000 | | Rs.26000 (14x1500=21000+5000=26000) |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | | 10400 | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | | | | As per need of PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 2 | 480000 | | Rs.20000/- per Mo per month |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | 1 | 85000 | | 17x5000=85000 |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | | | | |
| B.13.3.D | IMEP- Bio-Waste Management | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total PPP/NGO** | | | | |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | 93600 | | Rs.7800/- per data centre per month |
| | **Innovative Activity** | | | | |
| | **Sub Total Planning, Implementation & Monitoring** | | | | |
| **B.16** | **Procurement** | | | | |
| | | | | | |
| | | | | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | | | |
| | | | | | |
| | **Innovative Activity** | | | | |
| **Grand Total** | | | **Rs.2613184** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C.1.f | Quaterly Reveiew Meeting at Block Level | 4 | 50700 | 169X4X75=50700 |
| C.1.g | Focus on Slum & Underserved Area | 552 | 152400 | 200/ month slum area Asha, 50/ANM Deputation for immunization |
| C.1.h | Mobilization of Children through ASHA | | | |
| C.1.k | Developed Micro Plan at Sub Centre Level | 14 | 21000 | 14X1500 |
| C.1.l | Consolidated Micro Plan at Block Level | 1 | 5000 | 1X5000 |
| C.1.m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 1 | 12000 | 12x1000 |
| C.1.o | Red & Black Plastic bag etc | | | 2/per session site |
| C.1.q | Safety Pits For PHCs | 1 | 5000 | 1X5000 |
| | Safety Pits For APHCs | 2 | 10000 | 2X5000 |
| **Total** | | | **Rs.256100** | |

# Block PIP

**(Year 2012-13)**

**Name Of The Block:-Brahmpur + Chakki** **District:-Buxar**

## Part A RCH Flexipool

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | 1 | Rs.25000 | | Rs.25000/- per year |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 6 | Rs.42000 | | Rs.7000/- per camp |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.1.3.2 | Monthly Village Health and Nutrition Days | 197 | Rs120700/- | 1 VHND / SC | Rs.46000,(Rs.100/-Per Person for Participating micro planning & Capacity building program for ANM+AWW+ASHA+VHSC member & Rs.100/- for POL per block level monitors for MOIC,BHM,BCM CDPO) |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | | | | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 4200 | Rs.8400000 | -------------- deliveries | Rs.2000/- Per Institutional Delivery |
| A.1.4.2.2 | Urban | | | | |
| A.1.4.2.3 | Caesarean Deliveries | | | | |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 20 | Rs.15000 | | Rs.750/ per MDR |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 636 | Rs.63600 | | Rs.100/- per 3 PNC for normal baby |
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 259 | RS.52000 | | Rs.200/- per 6 PNC for Low weight baby |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 24 | Rs.120000 | | Rs.5000/- per camp management |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 1200 | Rs.2880000 | | Rs.2400/- Per Female sterilisation case. |
| A.3.1.5 | Compensation for male sterilisation | 10 | Rs.30000 | | Rs.3000/- Per Male sterilisation case. |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 2 | Rs.15000 | | Rs.30000/- for POL |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 6 | Rs.9000 | | Rs.1500/- Per Camp |
| | **Innovative Activity** | | | | |
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 24 | Rs.3312000 | | Rs.11500 per month per ANM® |
| A.8.1.1.b | Staff Nurses | 12 | Rs.2880000 | | Rs.20000/- Per month per Grade A Nurse |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 5340 | Rs.1602000 | | **Rs.200/- per session site for ASHA & Rs.100/- per session site for ANM** |
| **A.10** | Programme Management Costs | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.10.3 | Strengthening of Block PMU | 2 | Rs.1752000 | | **Rs.28000/- per month per BHM increment & Rs.20000/- per month per BAM** |
| A.10.4.9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | | | | **Only DH & SDH** |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | **Rs.18342000** | | |

## Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| **1** | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | 232 | Rs.58000 | | Rs.250/per ASHA per year |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | 232 | Rs.348000 | | Rs.125/-per month per ASHA Day |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | **2** | **4000** | | Rs.2000/- per year |

| | | | | | |
|---|---|---|---|---|---|
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 2 | Rs.594600 | Block level ASHA Resource Centre functional with staff | Rs.18000/- per month per BCM + Rs.1800/ per Asha facilitator per year + Rs.2000/ per month Office expenses |
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 2 | Rs.50000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 6 | Rs.150000 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 25 | Rs.250000 | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 20 | Rs.200000 | | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs | 2 | Rs.200000 | | Rs.100000 per PHCs |
| B3.2.A | Annual Maintenance Grant for APHCs | 6 | Rs.600000 | | Rs.100000 per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 4 | Rs.40000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 26 | Rs1000000 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | Rs.12000 | | Rs.12000/- Per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **2** | Rs.200000 | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **6** | Rs.600000 | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | | | |
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 2+26 | Rs.49000 | | Rs.5000/- per BHAP & Rs.1500/- per HSC |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | plan |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 22 | Rs.40000 | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 22 | Rs.14300 | | Rs.100/- DA of VHSC member for participant meeting & Rs.30/- for Refreshment of VHSC member |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 3 | Rs.720000 | | Rs.20000/- per MOs per month |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | 2 | Rs.30000 | | Rs.15000/- per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 2 | Rs.800000 | | Rs.400000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | 2 | Rs.96000 | | Rs.8000/- per month |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | **Innovations( If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)** | 1+232 | Rs.23200 | | Rs.13955/- for training |
| B.14.A | **YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services** | 2 | Rs.10000/- | | Rs.5000/- per PHC |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 2 | Rs.288000 | | Rs.12000/- per data centre per month per PHCs |
| | **Innovative Activity** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Sub Total Planning, Implementation & Monitoring** | | | | |
| **B.16** | **Procurement** | | | | |
| | | | | | |
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | 1 | Rs.118654 | | Rs.118654/- for labour room |
| **B.16.1.1** | **General Drugs & Supplies for Health Facilities** | 2 | Rs.1500000 | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | 2 | Rs.24000 | | Rs.1000/- per month per PHCs |
| | | | | | |
| | **Innovative Activity** | | | | |
| **Grand Total** | | | **Rs.8019754** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C .1.f | Quaterly Reveiew Meeting at Block Level | 4 | Rs.\83100/- | |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C .1.h | Mobilization of Children through ASHA | | | |
| C .1.k | Developed Micro Plan at Sub Centre Level | 42 | Rs.4200/- | |
| C .1.l | Consolidated Micro Plan at Block Level | 2 | Rs.2000/- | |
| C .1. m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 12 | Rs14400/- | |
| C .1.o | Red & Black Plastic bag etc | 5340 | Rs.3000/- | |
| C .1.q | Safety Pits For PHCs | | | |
| | Alternate Vaccine Delivery (Courier) | 5340 | Rs.340000 | |
| **Total** | | | **Rs.446700** | |

# Block PIP

**(Year 2012-13)**

**Name of the block:-Chousa** **District:-Buxar**

## Part A RCH Flexipool

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | 1 | Rs.25000 | | Rs.25000/- per year |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 5 | 35000 | | Rs.7000/- per camp. |
| A.1.3.2 | Monthly Village Health and Nutrition Days | 82 | Rs46000/- | 1 VHND / SC | Rs.46000,(Rs.100/-Per Person for Participating micro planning & Capacity building program for ANM+AWW+ASHA+VHSC |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | | | | | member & Rs.100/- for POL per block level monitors for MOIC,BHM,BCM CDPO) |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | | | | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 2500 | Rs.5000000 | --------------- deliveries | Rs.2000/- Per Institutional Delivery |
| A.1.4.2.2 | Urban | | | | |
| A.1.4.2.3 | Caesarean Deliveries | | | | |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 20 | Rs.15000 | | Rs.750/ per MDR |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 500 | Rs.50000 | | Rs.100/- per 3 PNC for normal baby |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 150 | RS.30000 | | Rs.200/- per 6 PNC for Low weight baby |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 24 | Rs.120000 | | Rs.5000/- per camp management |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 550 | Rs.550000 | | Rs.1000/- Per Female sterilisation case. |
| A.3.1.5 | Compensation for male sterilisation | 10 | Rs.15000 | | Rs.1500/- Per Male sterilisation case. |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 1 | Rs.15000 | | Rs.15000/- for POL |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 3 | Rs.4500 | | Rs.1500/- Per Camp |
| | **Innovative Activity** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 5 | Rs.690000 | | Rs.11500 per month per ANMr |
| A.8.1.1.b | Staff Nurses | 2 | Rs.480000 | | Rs.20000/- Per month per Grade A Nurse |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 1680 | Rs.504000 | | **Rs.200/- per session site for ASHA & Rs.100/- per session site for ANM** |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | 1 | Rs.735600 | | **Rs.21780/- per month per BHM include 10% increment & Rs.14520/- per month per BAM include 10% increment.** |
| A.10.4.9 | Management Unit at FRU (Hospital | | | | **Only DH & SDH** |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | Manager & FRU Accountant) | | | | |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | **Rs.8280100** | | |

**Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12**

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| **1** | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | 105 | Rs.26250 | | Rs.250/per ASHA per year |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | 105 | Rs.108360 | | Rs.86/-per month per ASHA Day |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | | | | |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1 | Rs.191400 | Block level ASHA Resource Centre functional with staff | Rs.13200/- per month per BCM + Rs.1800/ per Asha facilitator per year + Rs.2000/ per month Office expenses |
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | | | |

| B2 | **Untied Funt** | | | | |
|---|---|---|---|---|---|
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 1 | Rs.25000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 2 | Rs.50000 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 8 | Rs.80000 | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 54 | Rs.540000 | | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs | | | | |
| B3.2.A | Annual Maintenance Grant for APHCs | 2 | Rs.100000 | | Rs.50000 per APHCs |

| | | | | | |
|---|---|---|---|---|---|
| B3.3 | Annual Maintenance Grant for HSC | 4 | Rs.40000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 4 | Rs.24000 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | Rs.8000 | | Rs.8000/- Per PHC |

|  |  |  |  |  |  |
|---|---|---|---|---|---|
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total Construction/Renovation & Setting up** |  |  |  |  |
| **B6** | **HMS/RKS** |  |  |  |  |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital |  |  |  |  |
| B6.2 | Corpus Grant to HMS/RKS-SDH |  |  |  |  |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | Rs.100000 |  | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **2** | Rs.200000 |  | Rs.100000 per APHCs |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total Corpus Group to HMS/RKS** |  |  |  |  |
| **B7** | **Decentralise Planning** |  |  |  |  |
| B.7 | Block, HSC & Village Health Action Plan | 1+8 | Rs.17000 |  | Rs.5000/- per BHAP & Rs.1500/- per HSC plan |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total Decentralise Planning** |  |  |  |  |
| **B8** | **Panchayati Raj Institution** |  |  |  |  |

| | | | | | |
|---|---|---|---|---|---|
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 10 | Rs.15000 | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 10 | Rs.6500 | | Rs.100/- DA of VHSC member for participant meeting & Rs.30/- for Refreshment of VHSC member |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 2 | Rs.480000 | | Rs.20000/- per Mo per month |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | 1 | Rs.15000 | | Rs.15000/- per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | 1 | 78000 | | Rs.13000/- per month for 6 month |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 1 | Rs.200000 | | Rs.200000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | 1 | Rs.96000 | | Rs.8000/- per month |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | **Innovations( If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)** | 1+82 | Rs.13955 | | Rs.13955/- for training |
| B.14.A | **YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services** | 1 | Rs.5000/- | | Rs.5000/- per PHC |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | Rs.93600 | | Rs.7800/- per data centre per month |
| | **Innovative Activity** | | | | |
| | **Sub Total Planning, Implementation & Monitoring** | | | | |
| **B.16** | **Procurement** | | | | |
| | | | | | |
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | 1 | Rs.118654 | | Rs.118654/- for labour room |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| B.16.1.1 | General Drugs & Supplies for Health Facilities | | Rs.500000 | | |
| B.23.A | Payment of monthly bill to be BSNL | | | | |
| | | | | | |
| | Innovative Activity | | | | |
| Grand Total | | | Rs.3053719 | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C .1.f | Quaterly Reveiew Meeting at Block Level | 4 | Rs.31500/- | |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C .1.h | Mobilization of Children through ASHA | | | |
| C .1.k | Developed Micro Plan at Sub Centre Level | 8 | Rs.800/- | |
| C .1.l | Consolidated Micro Plan at Block Level | 1 | Rs.1000/- | |
| C .1. m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 1 | Rs4800/- | |
| C .1.o | Red & Black Plastic bag etc | 1680 | Rs.3360/- | |
| C .1.q | Safety Pits For PHCs | | | |
| | Alternate Vaccine Delivery (Coorier) | 1680 | Rs.252000 | |
| **Total** | | | **Rs.293460** | |

# Block PIP

**(Year 2012-13)**

## Name of the block:-Nawanagar District:-Buxar

**Part A RCH Flexipool**

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | 1 | 25000 | | Rs.25000/- per year |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 3 | Rs.21000 | | Rs.7000/- per Camp |
| A.1.3.2 | Monthly Village Health and Nutrition Days | 50 | 50000 | 1 VHND / SC | Rs.46000,(Rs.100/-Per Person for Participating micro planning & Capacity building program for |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | | | | | ANM+AWW+ASHA+VHSC member & Rs.100/- for POL per block level monitors for MOIC,BHM,BCM CDPO) |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | | | | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 3600 | Rs.7200000 | --------------- deliveries | Rs.2000/- Per Institutional Delivery |
| A.1.4.2.2 | Urban | | | | |
| A.1.4.2.3 | Caesarean Deliveries | | | | |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 20 | Rs.15000 | | Rs.750/ per MDR |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 500 | Rs.50000 | | Rs.100/- per 3 PNC for normal baby |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 150 | RS.30000 | | Rs.200/- per 6 PNC for Low weight baby |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 20 | Rs.100000 | | Rs.5000/- per camp management |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 1200 | Rs.1200000 | | Rs.1000/- Per Female sterilisation case. |
| A.3.1.5 | Compensation for male sterilisation | 50 | Rs.75000 | | Rs.1500/- Per Male sterilisation case. |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 1 | Rs.15000 | | Rs.15000/- for POL |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 10 | Rs.15000 | | Rs.1500/- Per Camp |
| | **Innovative Activity** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 0 | 0 | | Rs.11500 per month per ANMr |
| A.8.1.1.b | Staff Nurses | 4 | Rs.960000 | | Rs.20000/- Per month per Grade A Nurse |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 2004 | Rs.601200 | | **Rs.200/- per session site for ASHA & Rs.100/- per session site for ANM** |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | 1 | Rs.779160 | | **Rs.23958/- per month per BHM include 10% increment & Rs.15972/- per month per BAM include 10% increment.** |
| A.10.4.9 | Management Unit at FRU (Hospital | | | | **Only DH & SDH** |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | Manager & FRU Accountant) | | | | |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | **Rs.11136360** | | |

**Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12**

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| 1 | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | 195 | Rs.48750 | | Rs.250/per ASHA per year |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | 195 | Rs.201240 | | Rs.86/-per month per ASHA Day |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | | | | |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1 | Rs.308400 | Block level ASHA Resource Centre functional with staff | Rs.13200/- per month per BCM + Rs.1800/ per Asha facilitator per year + Rs.2000/ per month Office expenses |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 1 | Rs.25000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 5 | Rs.1250000 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 23 | Rs.230000 | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 95 | Rs.950000 | | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B3.2 | Annual Maintenance Grant for PHCs | | | | |
| B3.2.A | Annual Maintenance Grant for APHCs | 5 | Rs.250000 | | Rs.50000 per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 23 | Rs.230000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 20 | Rs.120000 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | Rs.8000 | | Rs.8000/- Per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | Rs.100000 | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **5** | Rs.500000 | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | | | |
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 1+23 | Rs.39500 | | Rs.5000/- per BHAP & Rs.1500/- per HSC plan |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 75 | Rs.15000 | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 110 | Rs.14300 | | Rs.100/- DA of VHSC member for participant meeting & Rs.30/- for Refreshment of VHSC member |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 4 | Rs.960000 | | Rs.20000/- per Mo per month |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | 1 | Rs.15000 | | Rs.15000/- per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 1 | Rs.400000 | | Rs.400000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | 1 | Rs.96000 | | Rs.8000/- per month |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | **Innovations( If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)** | 1+164 | Rs.26760 | | Rs.26760/- for training |
| B.14.A | **YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services** | 1 | Rs.10000/- | | Rs.10000/- per PHC |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | Rs.94368 | | Rs.7864/- per data centre per month |
| | **Innovative Activity** | | | | |
| B.15.3.2 | **MCTS &HRIS** | | Rs.12000 | | 6000*2 per year |
| **B.16** | **Procurement** | | | | |
| | | | | | |
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | 1 | Rs.118654 | | Rs.118654/- for labour room |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **B.16.1.1** | **General Drugs & Supplies for Health Facilities** | | Rs.1000000 | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | Rs.12000 | | |
| | | | | | |
| | **Innovative Activity** | | | | |
| **Grand Total** | | | **Rs.5909972** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C .1.f | Quaterly Reveiew Meeting at Block Level | 4 | Rs.31500/- | |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C .1.h | Mobilization of Children through ASHA | | | |
| C .1.k | Developed Micro Plan at Sub Centre Level | 23 | Rs.2300/- | |
| C .1.l | Consolidated Micro Plan at Block Level | 1 | Rs.1000/- | |
| C .1. m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 1 | Rs.12000/- | |
| C .1.o | Red & Black Plastic bag etc | 2004 | Rs.4008/- | |
| C .1.q | Safety Pits For PHCs | | | |
| | Alternate Vaccine Delivery (Coorier) | 2004 | Rs.252000 | |
| **Total** | | | **Rs.302808** | |

# Block PIP

**(Year 2012-13)**

**Name of the block:-Rajpur** **District:-Buxar**

## Part A RCH Flexipool

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | 1 | Rs.25000 | | Rs.25000/- per year |
| A.1.1.5 | Operationalise Sub Centre (MCH Centre - HSC) | 1 | Rs.30000 | | Rs.30000/- Per Year |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, | 5 | 35,000 | | 7,000 Rs. Per RCH Outreach Camps |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | | | | |
| A.1.3.2 | Monthly Village Health and Nutrition Days | 167 | Rs98,900/- | 1 VHND / SC | Rs.46000,(Rs.100/-Per Person for Participating micro planning & Capacity building program for ANM+AWW+ASHA+VHSC member & Rs.100/- for POL per block level monitors for MOIC,BHM,BCM CDPO) |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | | | | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 3500 | Rs.7000000 | --------------- deliveries | Rs.2000/- Per Institutional Delivery |
| A.1.4.2.2 | Urban | | | | |
| A.1.4.2.3 | Caesarean Deliveries | | | | |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 20 | Rs.15000 | | Rs.750/ per MDR |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 2000 | Rs.2,00,000 | | Rs.100/- per 3 PNC for normal baby |
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 1500 | RS.3,00,000 | | Rs.200/- per 6 PNC for Low weight baby |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 20 | Rs.1,00,000 | | Rs.5000/- per camp management |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 1000 | Rs.10,00,000 | | Rs.1000/- Per Female sterilisation case. |
| A.3.1.5 | Compensation for male sterilisation | 10 | Rs.15000 | | Rs.1500/- Per Male sterilisation case. |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.3.3** | POL for Family Planning/ Others | 1 | Rs.15000 | | Rs.15000/- for POL |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 3 | Rs.4500 | | Rs.1500/- Per Camp |
| | **Innovative Activity** | | | | |
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 8 | Rs.11,04,000 | | Rs.11500 per month per ANMr |
| A.8.1.1.b | Staff Nurses | 3 | Rs.7,20,000 | | Rs.20000/- Per month per Grade A Nurse |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 3780 | Rs.11,34,000 | | **Rs.200/- per session site for ASHA & Rs.100/- per session site for ANM** |
| **A.10** | Programme Management Costs | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.10.3 | Strengthening of Block PMU | 1 | Rs.7,79,160 | | **Rs.23,958/- per month per BHM include 10% increment & Rs.15,972/- per month per BAM include 10% increment.** |
| A.10.4.9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | | | | **Only DH & SDH** |
| | **Innovative Activity** | 1 | Rs.3,00,000 | | **Required Separate Transformer for PHC** |
| | | 1 | Rs.24,000 | | **Rs. 2000 per BHM per** month<br>**For** communication. |
| | **GRAND TOTAL RCH II** | | **Rs.1,28,99,560** | | |

**Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2012-13**

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| 1 | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | 189 | Rs.47,250 | | Rs.250/per ASHA per year |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | 189 | Rs.1,95,048 | | Rs.86/-per month per ASHA Day |

| | | | | | |
|---|---|---|---|---|---|
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | | Rs. 2,000 | | Rs.2,000 per PHC |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1 | Rs.3,71,640 | Block level ASHA Resource Centre functional with staff | Rs.14520/-per month per BCM + Rs.1050/ per Asha facilitator per month +Rs.7,000/per month mobility suppor |
| | **Innovative Activity** | 1 | Rs. 59,000 | | Rs.35,000 per BCH for One laptop+Rs. 2,000 per month for data card and communication |
| | **Sub Total ASHA-Decentralisation** | | | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 1 | Rs.25000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 3 | Rs.75,000 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 24 | Rs.2,40,000 | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 170 | Rs.17,00,000 | | Rs.10000 per revenue village |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs | 1 | 50,0000 | | Rs.50000 per PHCs |
| B3.2.A | Annual Maintenance Grant for APHCs | 2 | Rs.2,00,000 | | Rs.1,00,000per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 3 | Rs.30,000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 24 | Rs.1,44,000 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction** , | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | Rs.8000 | | Rs.8000/- Per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | Rs.1,00,000 | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **3** | Rs.3,00,000 | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 1+24 | Rs.41,000 | | Rs.5000/- per BHAP & Rs.1500/- per HSC plan |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 19 | Rs.22,800 | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 19 | Rs.12,350 | | Rs.100/- DA of VHSC member for participant meeting & Rs.30/- for Refreshment of VHSC member |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 2 | Rs.480000 | | Rs.20000/- per Mo per month |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | 1 | Rs.15000 | | Rs.15000/- per PHC |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 1 | Rs.7,00,000 | | Rs.7,00,000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | 1 | Rs.96000 | | Rs.8000/- per month |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | **Innovations( If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)** | | | | |
| B.14.A | **YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services** | 1 | Rs.5000/- | | Rs.5000/- per PHC |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH | 1 | Rs.93,600 | | Rs.7800/- per data |

| | | | | | |
|---|---|---|---|---|---|
| | & Blocks | | | | centre per month |
| | **Innovative Activity** | | | | |
| | **Sub Total Planning, Implementation & Monitoring** | | | | |
| **B.16** | **Procurement** | | | | |
| | | | | | |
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | 1 | Rs.1,18,654 | | Rs.118654/- for labour room |
| **B.16.1.1** | **General Drugs & Supplies for Health Facilities** | | Rs.10,00,000 | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | | | |
| | | | | | |
| | **Innovative Activity** | | | | |
| **Grand Total** | | | **Rs.79,31,348** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C .1.f | Quaterly Reveiew Meeting at Block Level | 4 | Rs.56,700/- | |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C .1.h | Mobilization of Children through ASHA | | | |
| C .1.k | Developed Micro Plan at Sub Centre Level | 24 | Rs.2,400/- | |
| C .1.l | Consolidated Micro Plan at Block Level | 1 | Rs.1000/- | |
| C .1. m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 1 | Rs4800/- | |
| C .1.o | Red & Black Plastic bag etc | 7,560 | Rs.15,120/- | |
| C .1.q | Safety Pits For PHCs | | | |
| | Alternate Vaccine Delivery (Coorier) | 3,780 | Rs.3,78,000 | |
| **Total** | | | **Rs.4,58,020** | |

**Block PIP**

**(Year 2012-13)**

## Name of the block:- SIMRI District:-BUXAR

**Part A RCH Flexipool**

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | **Applies only if there is a referral hospital** |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 12 camps | 94000/- | 12 outreach camps in a year | **Rs.7000/- per camp (12camp*7000)** |
| A.1.3.2 | Monthly Village Health and Nutrition Days | 438+910 | 134800 | 438 PRI MEMBER& 910 VHSND SITE | **RS.100/=PER PRI MEMBER/MONITORING RS.100/=PER SITE *300/=PER YEAR (182*5*300)** |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | 1500 | 750000 | 1500 deliveries | **Rs.500/= per deliveries** |
| A.1.4.2 | Institutional | | | | |

| FMR<br><br>Code | ACTIVITY | Physical Target | PROPOSED AMOUNT<br><br>(Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | Deliveries | | | | |
| A.1.4.2.1 | Rural | 2500 | 5000000 | 2500deliveries | **Rs.2000/case**<br><br>**(5000000)** |
| A.1.4.2.2 | Urban | N.A | N.A | | **N.A** |
| A.1.4.2.3 | Caesarean Deliveries | | | | **Only if its an FRU** |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 10 | 7500 | | **The GoI guidelines on Facility and Community based MDR should be followed.** |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | **5949500** | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 3000 | 300000/= | 3000-3PNCfor normalbaby | **Rs.100/ case 3pnc for normal baby** |
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 1000 | 2,00,000/= | 1000 -6pnc for low birth baby | **Rs.200/= per 6pnc for low birth baby** |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | **4000** | **5,00,000** | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 24camp the year | 1,20,000/= | 24 camps to be held in a year, | **RS.5000/=PER CAMP** |

| FMR<br><br>Code | ACTIVITY | Physical Target | PROPOSED AMOUNT<br><br>(Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | | | | 745female sterilisations to be conducted | |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 1800 | 19,80,000/= | 1800 | **Rs.1100/= per beneficiary** |
| A.3.1.5 | Compensation for male sterilisation | 15 case | 24000/= | 15 **benificiary** | **Rs.1600/= per beneficiary** |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | 340 | 51000/= | 340 IUCDs inserted at PHCs, APHCs and SCs | **Rs.150/=per iucd inserted (asha-100/=+anm 50/=)340*150** |
| **A.3.3** | POL for Family Planning/ Others | 1 | 15000/= | 15000/= | **RS.15000 PER PHC** |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 24 | 36000 | 24 camp | **Rs.1500/= per camp** |
| | **Innovative Activity** | | | | |
| | **Sub-total Family Planning)** | | **2245000** | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 10 ANM | 1380000/= | 10 | **RS.11500/=PER ANM PER MONTH(10*12*11500)** |
| A.8.1.1.b | Staff Nurses | 04 | 960000/= | 04 | **RS.20000/= PER MONTH PER STAFF NUESE(4*12*20000)** |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | ----- specialists needed | | ----- specialists in place | **Only DH & SDH** |

| FMR<br><br>Code | ACTIVITY | Physical Target | PROPOSED AMOUNT<br><br>(Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 5265 | 1316250/= | 405 SITE PER MAONTH | **RS.150/=PER SITE & RS.ANM RS.100/=PER SITE**<br><br>**(ASHA212*AWW182*ANM42*250*12)** |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | 2 | 750000/= | 24+12=36 | **RS.18000= SALARY PER MONTH BHM/BAM RS.14520/=PER MONTH /VICHLE RENT RS.15000/=PER MONTH /OFFICE EXP.RS.15000/=PER MONTH** |
| A.10.4.9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | | | | **Only DH & SDH** |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | **68,96,250/=** | | |

## Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| 1 | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | **212** | **106000/=** | 212 | RS.250/= PER ASHAKIT (212*2*250) |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | **212** | **218784/=** | 212 | RS.86/= PER ASHA TA/DA/PER MONTH(212*12*86) |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | **3** | **2000** | 3 | RS.1000/500/300/200 PER YEAR |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1+10 | 324000/= | 1+10 | RS.12000/=PER MONTH+RS.150 SITE ASHA MONITORING(1+10*12*27000) |
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | **648400/=** | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | N.A | N.A | N.A | N.A |
| B2.2.A | Untied Fund for PHCs | 1 | 25000/= | 1 | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 4 | 100000/= | 4 | Rs.25000 per PHC |

| | | | | | |
|---|---|---|---|---|---|
| B2.3 | Untied Fund for Health Sub Centre | 20 | 2,00,000 | 20 | Rs.10000= per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 87 | 870000/= | 87 | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | **1195000/=** | | |
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs | 1 | 1,00,000/= | 1 | Rs.100000 per PHCs |
| B3.2.A | Annual Maintenance Grant for APHCs | 4 | 400000/= | 4 | Rs.100000 per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 20 | 2,00,000/= | 20 | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | **7,00,000/=** | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 144 | 144000/= | 144 | Rs.500 per HSC PER MONTH * 12 HSC& RS.72000/= BACK LOG |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | **1,44000/=** | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | Rs.500000 per DH |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | Rs.100000 per SDH |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | **1,00,000/=** | 1 | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **4** | **4,00,000/=** | 4 | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | **5,00,000/=** | | |

| | | | | | |
|---|---|---|---|---|---|
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 20 | 30000 | 20 | RS.1500/= PER HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | 30000/= | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 20 | 48000/= | 20+20 | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 1 | 13000/= | 1 | 13000/PER YEAR |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | 61,000/= | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 3 | 720,000/= | | Rs.20000/- per Mo per month(3*12*20000) |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | 720,000/= | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | | 15000/= | | PER YEAR |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | 15000/= | | |

| | | | | | |
|---|---|---|---|---|---|
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 2 | 12,00,000/ | 2 | Rs.100000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total PPP/NGO** | | 12,00,000/= | | |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | 94368/= | 1 | Rs.7864/- per data centre per month |
| | **Innovative Activity** | | | | |
| | **Sub Total Planning, Implementation & Monitoring** | | 94368/= | | |
| **B.16** | **Procurement** | | | | |
| | | | | | |
| | | | | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | | | |
| | | | | | |
| | **Innovative Activity** | | | | |
| **Grand Total** | | | | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C. 1.f | Quaterly Reveiew Meeting at Block Level | 438 | 131400/= | RS.50/= ASHA TA AND RS.25/PER LINKWORKER(438*4*75) |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C. 1.h | Mobilization of Children through ASHA | | | |
| C. 1.k | Developed Micro Plan at Sub Centre Level | 20 | 5000/= | RS.250/ PER HSC |
| C. 1.l | Consolidated Micro Plan at Block Level | 1 | 1000/= | |
| C. 1.m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 24 | 37400/= | |
| C. 1.o | Red & Black Plastic bag etc | | 20,900/= | RS.2/= PER BAG |
| C. 1.q | Safety Pits For PHCs | | | |
| **Total** | | | **123800/=** | |

# Block PIP

**(Year 2012-13)**

## Name of the block:-Dumraon & SDH Dumraon District:- Buxar

**Part A RCH Flexipool**

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Yes for SDH DUMRAON |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 12 camps | 12000/- | 12 outreach camps in a year | Rs.1000/- per camp (12camp*1000) |
| A.1.3.2 | Monthly Village Health and Nutrition Days | No. of SC x 12 months | 1 Lakh | 1 VHND / SC | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | | 21*12 | | | |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | 10% more than previous years | 2.7 Lakh | 550 deliveries | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 15% more than previous year | 50.40 Lakh<br>21.60 Lakh | 3600- deliveries | 50.40 Lakh for SDH 21.60 Lakh For PHC (ASHA) |
| A.1.4.2.2 | Urban | 15% more | 14.40 Lakh | 1200- deliveries | 14.40 Lakh for SDH |
| A.1.4.2.3 | Caesarean Deliveries | | 1.2 Lakh | | 1.2 Lakh |
| A.1.4.3 | Other activities (JBSY) | 15-15% more than previous year | 0 | 15-15% more than previous year | |
| A.1.5.1 | Maternal Death Audit | | 0 | | The GoI guidelines on Facility and Community based MDR should be followed. |
| | **Innovative Activity** | | 0 | | |
| | | | 0 | | |
| | **Sub-total Maternal Health** | | **91.42 Lakh** | | |
| **A.2** | **CHILD HEALTH** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | | 0.72 Lakh | | |
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | | 0.72 Lakh | | |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | **1.44 Lakh** | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 25- camps to be held in a year, 2012- female sterilisations to be conducted | 1.25 Lakh | -------- camps to be held in a year, ------- female sterilisations to be conducted | 10 in PHC 15 in SDH |
| A.3.1.3 | NSV camps | 2- camps to be held in a year, 2012- NSVs to be conducted | 0.5 Lakh+0.5 Lakh | -------- camps to be held in a year, ------- NSVs to be conducted | 0.5 Lakh for PHC and 0.5 Lakh for SDH |
| A.3.1.4 | Compensation for female sterilisation | For 20-30% more female sterilisations from last year | 25 Lakh | For 20-30% more female sterilisations from last year | |
| A.3.1.5 | Compensation for | For 20-30% more male | 0.3 Lakh | For 20-30% more male sterilisations | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | male sterilisation | sterilisations from last year | | from last year | |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | 120- cases to be inserted at PHCs, APHCs and SCs | 0.060 Lakh | ------ IUCDs inserted at PHCs, APHCs and SCs | The money is for ASHA / ANM for motivating the clients for IUD, it could be Rs. 25 per case |
| **A.3.3** | POL for Family Planning/ Others | | 0.05 Lakh | | This could also be for bringing poor clients from hard to reach areas. Also for mobilising clients and transporting doctors and surgical teams |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | | 0 | | |
| | **Innovative Activity** | | | | |
| | **Sub-total Family Planning)** | | **27.66 Lakh** | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 21 new ANM hired | 28.98 Lakh | 15 new ANM posted | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.8.1.1.b | Staff Nurses | 6- new staff Nurse needed | 14.40 Lakh | 2--- new staff Nurse posted | |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | 3 lab technician FOR SDH | 3.60 Lakh | For RS.10000 PER LAB TECHNICIAN | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | 3- specialists needed FOR SDH | 10.8 Lakh for 3 dr. | RS.30000 / MONTH PER DOCTOR ,3-specialists in place . | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | 1 | 1.8 Lakh | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | | 38.0 Lakh | | |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | | 7.76 Lakh | | |
| A.10.4.9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | One Accountant and One Hospital Manager | 2.40 Lakh 4.20 Lakh | SALARY OF FRU MANAGER SHOULD BE RS.10000/MONTH INCREASED BECOUSE NOW ANM AND OTHER 3rd CLASS EMPLOYEES ARE GETTING MORE THAN HOSPITAL MANAGER SALARY AND | **Only DH & SDH** |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | | | | THE NATURE OF WORK & QUALIFICATION ARE MUCH MORE THAN THE OTHER EMPLOYEE.IF IT POSSIBLE THEN DO IT PLEASE. | |
| | **Innovative Activity** | Salary Of PMU Should be Doubled | | | |
| | **GRAND TOTAL RCH II** | | **232.46 Lakh** | | |

## Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| **1** | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | **180** | **5.4 Lakh** | | Rs 250*180*12 Month |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | **180** | **1.86 Lakh** | | 180*86*12 |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | **3** | **0.0170** | | |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | | 2.45 Lakh | Block level ASHA Resource Centre functional with staff | |
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | **9.88 Lakh** | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | 1 | 1.0 Lakh | | Rs.100000 for SDH |
| B2.2.A | Untied Fund for PHCs | 1 | 0.25 Kakh | | Rs.25000 per PHC |

| | | | | | |
|---|---|---|---|---|---|
| B2.2.B | Untied Fund for APHCs | 3 | 0.75 Lakh | | Rs.25000 per PHC |
| B2.3 | Untied Fund for Health Sub Centre | 21 | 2.10 Lakh | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 63--VHSCs formed | 6.3 Lakh | 63 VHSCs formed and 50% of last years budget spent | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | **10.4 Lakh** | | |
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs/SDH | 1+1 | 1.0 + 0.5 LAKH | | Rs.50000 per PHCs + 100000 Lakh for SDH |
| B3.2.A | Annual Maintenance Grant for APHCs | 3 | 1.5 Lakh | | Rs.50000 per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 21 | 2.10 Lakh | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |

| | **Sub Total Annual Maintenance Grant** | | **5.10 Lakh** | | |
|---|---|---|---|---|---|
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | 0 | 0 | | |
| B4.3 | Sub Centre Rent & Contingencies | | 1.02 Lakh | | Rs.500 per HSC |
| | **Innovative Activity** | Sub Center Must Have One Building | | | |
| | **Sub Total Annual Maintenance Grant** | | 1.02 Lakh | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | | 0.50 Lakh | | |
| | **Innovative Activity** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Sub Total Construction/Renovation & Setting up** | | 0.50 Lakh | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | **0** | | Rs.500000 per DH |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | **5 Lakh** | | Rs.500000 per SDH |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | | **1 Lakh** | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | | **3 Lakh For APHC** | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | **9.0 Lakh** | | |
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | | 0.365 Lakh | | |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | 0.365 Lakh | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | | 0.316 Lakh | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | | 0.104 Lakh | | As per need of PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | 0.42 Lakh | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 2 | 4.8 Lakh | | Rs.20000/- per Mo per month |
| | **Innovative Activity** | 1 ayush Required For Amathua and One for SDH | | | |
| | **Sub Total AYUSH** | | 4.8 Lakh | | |
| **B.10** | **BCC/IEC Strategy** | | 0.015 Lakh | | |
| B.10.1 | BCC/IEC Activities | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | 0.015 Lakh | | |
| **B.12** | Referral Transport | | 1.56 Lakh | | |
| B.12.2.D | Referral Transport in PHCs | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | 1.56 Lakh | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | | 4 Lakh | | Rs.200000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | | 0.8 Lakh | | |
| | **Innovative Activity** | | | | |
| | **Sub Total PPP/NGO** | | 4.8 Lakh | | |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 2 | 1.872 Lakh | | Rs.7800/- per data centre per month |
| | **Innovative Activity** | | | | |
| | **Sub Total Planning, Implementation & Monitoring** | | 1.872 Lakh | | |
| **B.16** | **Procurement** | 1 | 1.4 Lakh | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | 0.03405 | | |
| | **Innovative Activity** | | | | |
| | **Grand Total** | | **49.732 Lakh** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C.1.f | Quaterly Reveiew Meeting at Block Level | 4 | 0.765 Lakh | |
| C.1.g | Focus on Slum & Underserved Area | | 1.56 Lakh | For Curriar |
| C.1.h | Mobilization of Children through ASHA | | 4.32 Lakh | |
| C.1.k | Developed Micro Plan at Sub Centre Level | | 0.021 Lakh | |
| C.1.l | Consolidated Micro Plan at Block Level | | 0.010 lakh | |
| C.1.m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | | 0.048 lakh | 0.50 required |
| C.1.o | Red & Black Plastic bag etc | | 0.6240 Lakh | |
| C.1.q | Safety Pits For PHCs | | 0.090 Lakh | |
| **Total** | | | **7.438 Lakh** | |

**EXTRA BUDGET AND REQUIREMENT FOR STARTING NEW FRU_SDH Dumraon**

| | | | |
|---|---|---|---|
| **1** | **FOR OPERATION AND C-SECTION FOR STARTING FRU** | **RS-5,00,000 FOR FRU STARTING** | **RS FOR EQUIPMENT , LIGHTS, EXT.** |
| **2** | **FOR STARTING BLOOD STORAGE UNIT IN FRU** | **RS-3,00,000 FOR ONE UNIT STABLISHMENT** | **RS- FOR MACHINE, REFRIGERATOR EXT.** |
| **3** | **MANPOWER STAFF NURSE** | **15 A GRADE NURSE** | **FOR ROATATIONAL WORK IN FRU** |
| **4** | **DOCTORS (SPECIALIST)** | **6 DOCTORS** | **5 DR EXTRA LIKE ORTOPAEDIC SURGEON-1, PAEDIATRICIAN-1,SURGEON-1,ANASTHETIC-1,GYNAECOLOGIST-2** |
| **5** | **SUPPORTING 3rd CLASS EMPLOYEE** | **9 STAFF** | **LIKE DRESSER,OT TECHNICIAN IN ROATATIONAL DUTY** |
| **6** | **ASSISTENT** | **2** | **ONE ASSISTANT FOR ADMINISTRATIVE AND QUALITY MANAGEMENT WORK** |

# Block PIP

**(Year 2012-13)**

## Name of the block:-itarhi District:-Buxar

**Part A RCH Flexipool**

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | 1 | Rs.30000 | | Rs.30000/- per year |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 9 | Rs 45000 | | Rs 5000 each camp |
| A.1.3.2 | Monthly Village Health and Nutrition Days | 137 | Rs75700/- | 1 VHND / SC | Rs.75700,(Rs.100/-Per Person for Participating micro planning & Capacity building program for |

| FMR<br>Code | ACTIVITY | Physical Target | PROPOSED AMOUNT<br>(Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | | | | | ANM+AWW+ASHA+VHSC member & Rs.100/- for POL per block level monitors for MOIC,BHM,BCM CDPO) |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | | | | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 4800 | Rs.96000000 | --------------- deliveries | Rs.2000/- Per Institutional Delivery |
| A.1.4.2.2 | Urban | | | | |
| A.1.4.2.3 | Caesarean Deliveries | | | | |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 20 | Rs.15000 | | Rs.750/ per MDR |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 1500 | Rs.150000 | | Rs.100/- per 3 PNC for normal baby |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 1000 | RS.200000 | | Rs.200/- per 6 PNC for Low weight baby |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 24 | Rs.120000 | | Rs.5000/- per camp management |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 1700 | Rs.1700000 | | Rs.1000/- Per Female sterilisation case. |
| A.3.1.5 | Compensation for male sterilisation | 20 | Rs.30000 | | Rs.1500/- Per Male sterilisation case. |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 1 | Rs.15000 | | Rs.15000/- for POL |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 3 | Rs.4500 | | Rs.1500/- Per Camp |
| | **Innovative Activity** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 7 | Rs.966000 | | Rs.11500 per month per ANMr |
| A.8.1.1.b | Staff Nurses | 2 | Rs.480000 | | Rs.20000/- Per month per Grade A Nurse |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 3180 | Rs.636000 | | **Rs.200/- per session site for ASHA & Rs.100/- per session site for ANM** |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | 1 | Rs.735600 | | **Rs.21780/- per month per BHM include 10% increment & Rs.14520/- per month per BAM include 10% increment.** |
| A.10.4.9 | Management Unit at FRU (Hospital | | | | **Only DH & SDH** |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | Manager & FRU Accountant) | | | | |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | **Rs.8280100** | | |

**Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12**

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| **1** | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | 161 | Rs.40250 | | Rs.250/per ASHA per year |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | 161 | Rs.166152 | | Rs.86/-per month per ASHA Day |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | **3** | **2000** | | |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1 | Rs.283200 | Block level ASHA Resource Centre functional with staff | Rs.13200/- per month per BCM + Rs.1800/ per Asha facilitator per year + Rs.2000/ per month Office expenses |

| | | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 1 | Rs.25000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 2 | Rs.50000 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 17 | Rs 170000 | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 132 | Rs1320000 | | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B3.2 | Annual Maintenance Grant for PHCs | 1 | 50000 | | Rs 50000 per phc |
| B3.2.A | Annual Maintenance Grant for APHCs | 2 | Rs.100000 | | Rs.50000 per APHCs |
| sB3.3 | Annual Maintenance Grant for HSC | 4 | Rs.40000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 10 | Rs.60000 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | Rs.8000 | | Rs.8000/- Per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | Rs.100000 | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **2** | Rs.200000 | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | | | |
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 1+17 | Rs.35500 | | Rs.10000/- per BHAP & Rs.1500/- per HSC plan |
| | **Innovative Activity** | | | | |

|  |  |  |  |  |  |
|---|---|---|---|---|---|
|  | **Sub Total Decentralise Planning** |  |  |  |  |
| **B8** | **Panchayati Raj Institution** |  |  |  |  |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 75 | Rs.7500 |  | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 75 | Rs.9750 |  | Rs.100/- DA of VHSC member for participant meeting & Rs.30/- for Refreshment of VHSC member |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total PRI** |  |  |  |  |
| **B.9** | **Mainstreaming of AYUSH** |  |  |  |  |
| B.9.1 | Salary of AYUSH MO | 2 | Rs.480000 |  | Rs.20000/- per Mo per month |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total AYUSH** |  |  |  |  |
| **B.10** | **BCC/IEC Strategy** |  |  |  |  |
| B.10.1 | BCC/IEC Activities | 1 | Rs.15000 |  | Rs.15000/- per PHC |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total of BCC/IEC** |  |  |  |  |

| | | | | | |
|---|---|---|---|---|---|
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 1 | Rs.200000 | | Rs.200000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | 1 | Rs.96000 | | Rs.8000/- per month |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | **Innovations( If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)** | 1+161 | Rs.22465 | | Rs.13955/- for training |
| B.14.A | **YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services** | 1 | Rs.5000/- | | Rs.5000/- per PHC |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | Rs.93600 | | Rs.7800/- per data centre per month |
| | **Sub Total Planning, Implementation & Monitoring** | | | | |
| **B.16** | **Procurement** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | 1 | Rs.118654 | | Rs.118654/- for labour room |
| **B.16.1.1** | **General Drugs & Supplies for Health Facilities** | | Rs.500000 | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | 12000 | | |
| **Grand Total** | | | **Rs.3053719** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C .1.f | Quaterly Reveiew Meeting at Block Level | 4 | Rs.48300/- | |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C .1.h | Mobilization of Children through ASHA | | | |
| C .1.k | Developed Micro Plan at Sub Centre Level | 17 | Rs.1700/- | |
| C .1.l | Consolidated Micro Plan at Block Level | 1 | Rs.1000/- | |
| C .1. m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 1 | Rs 7800/- | |
| C .1.o | Red & Black Plastic bag etc | 3180 | Rs.6360/- | |
| C .1.q | Safety Pits For PHCs | | | |
| | Alternate Vaccine Delivery (Coorier) | 3180 | Rs.636000 | |
| **sTotal** | | | **Rs.293460** | |

s

# Block PIP

**(Year 2012-13)**

**Name of the block:-Kesath** **District:-Buxar**

**Part A RCH Flexipool**

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | Applies only if there is a referral hospital |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | 1 | Rs.25000 | | Rs.25000/- per year |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | 0 | | | |
| A.1.3.2 | Monthly Village Health and Nutrition | 28 | Rs13200/- | 1 VHND / SC | Rs13200/-,(Rs.100/-Per Person for Participating |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | Days | | | | micro planning & Capacity building program for ANM+AWW+ASHA+VHSC member & Rs.100/- for POL per block level monitors for MOIC,BHM,BCM CDPO) |
| A.1.4 | **Janani Suraksha Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | | | | |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 1100 | Rs.2200000 | --------------- deliveries | Rs.2000/- Per Institutional Delivery |
| A.1.4.2.2 | Urban | | | | |
| A.1.4.2.3 | Caesarean Deliveries | | | | |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | 15 | Rs.11250 | | Rs.750/ per MDR |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | 300 | Rs.30000 | | Rs.100/- per 3 PNC for normal baby |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | 100 | RS.20000 | | Rs.200/- per 6 PNC for Low weight baby |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 20 | Rs.100000 | | Rs.5000/- per camp management |
| A.3.1.3 | NSV camps | | | | |
| A.3.1.4 | Compensation for female sterilisation | 400 | Rs.400000 | | Rs.1000/- Per Female sterilisation case. |
| A.3.1.5 | Compensation for male sterilisation | 10 | Rs.15000 | | Rs.1500/- Per Male sterilisation case. |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 1 | Rs.15000 | | Rs.15000/- for POL |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | 3 | Rs.4500 | | Rs.1500/- Per Camp |
| | **Innovative Activity** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | 3 | Rs.414000 | | Rs.11500 per month per ANMr |
| A.8.1.1.b | Staff Nurses | 2 | Rs.480000 | | Rs.20000/- Per month per Grade A Nurse |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | | | | **Only DH & SDH** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | | | | **Only DH & SDH** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | 396 | Rs.118000 | | **Rs.200/- per session site for ASHA & Rs.100/- per session site for ANM** |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | 1 | Rs.297000 | | **Rs.18000/- per month per BHM include 10% increment** |
| A.10.4.9 | Management Unit at FRU (Hospital | | | | **Only DH & SDH** |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | Manager & FRU Accountant) | | | | |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | **Rs.5942950** | | |

**Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12**

| S. No | Activity Proposed | Physical target | Proposed Amount | Expected Output | Remarks |
|---|---|---|---|---|---|
| 1 | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | 35 | Rs.8750 | | Rs.250/per ASHA per year |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | 35 | Rs.3010 | | Rs.86/-per month per ASHA Day |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | | | | |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | 1 | Rs.191400 | Block level ASHA Resource Centre functional with staff | Rs.13200/- per month per BCM + Rs.1800/ per Asha facilitator per year + Rs.2000/ per month |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Office expenses |
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for SDH/CHC | | | | |
| B2.2.A | Untied Fund for PHCs | 1 | Rs.25000 | | Rs.25000 per PHC |
| B2.2.B | Untied Fund for APHCs | 0 | Rs.0 | | Rs.25000 per APHC |
| B2.3 | Untied Fund for Health Sub Centre | 3 | Rs.30000 | | Rs.10000 per HSC |
| B2.4 | Untied Fund for Village Health and Sanitation Committee | 15 | Rs.150000 | | Rs.10000 per revenue village |
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs | | | | |
| B3.2.A | Annual Maintenance Grant for APHCs | 0 | Rs.0 | | Rs.50000 per APHCs |
| B3.3 | Annual Maintenance Grant for HSC | 3 | Rs.30000 | | Rs.10000 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | | | | |
| B4.3 | Sub Centre Rent & Contingencies | 3 | Rs.1500 | | Rs.500 per HSC |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction , Renovation & Setting up** | | | | |
| B5.2.A | Construction of APHC | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC | | | | |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs | 1 | Rs.8000 | | Rs.8000/- Per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total Construction/Renovation & Setting up** | | | | |
| **B6** | **HMS/RKS** | | | | |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | | | | |
| B6.2 | Corpus Grant to HMS/RKS-SDH | | | | |
| B6.3 | Corpus Grant to HMS/RKS-PHCs | **1** | Rs.100000 | | Rs.100000 per PHCs |
| B6.4 | Corpus Grant to HMS/RKS-APHCs | **0** | Rs.0 | | Rs.100000 per APHCs |
| | **Innovative Activity** | | | | |
| | **Sub Total Corpus Group to HMS/RKS** | | | | |
| **B7** | **Decentralise Planning** | | | | |
| B.7 | Block, HSC & Village Health Action Plan | 1+3 | Rs.9500 | | Rs.5000/- per BHAP & Rs.1500/- |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | per HSC plan |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | 10 | Rs.15000 | | Rs.100/- for VHSC meeting & Rs.100/- for participate in VHSC meeting by Block Level Officers. |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | 10 | Rs.6500 | | Rs.100/- DA of VHSC member for participant meeting & Rs.30/- for Refreshment of VHSC member |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | 1 | Rs.240000 | | Rs.20000/- per Mo per month |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | 1 | Rs.15000 | | Rs.15000/- per PHC |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |
| **B.12** | Referral Transport | | | | |
| B.12.2.D | Referral Transport in PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 1 | Rs.200000 | | Rs.200000 per Unit for 12 month |
| B.13.3.D | IMEP- Bio-Waste Management | 1 | Rs.96000 | | Rs.8000/- per month |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | **Innovations( If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)** | 1+82 | Rs.13955 | | Rs.13955/- for training |
| B.14.A | **YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services** | 1 | Rs.5000/- | | Rs.5000/- per PHC |

| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | Rs.93600 | | Rs.7800/- per data centre per month |
|---|---|---|---|---|---|
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | 1 | Rs.118654 | | Rs.118654/- for labour room |
| **B.16.1.1** | **General Drugs & Supplies for Health Facilities** | | Rs.500000 | | |
| **B.23.A** | **Payment of monthly bill to be BSNL** | | | | |
| **Grand Total** | | | **Rs.1754079** | | |

**Part C: Immunization Strengthening Programme (2012-13)**

| S. No. | Activities | Physical Target | Proposed Budget (Rs. In Lacs) | Remarks |
|---|---|---|---|---|
| C .1.f | Quaterly Reveiew Meeting at Block Level | 4 | Rs.27500/- | |
| C.1. g | Focus on Slum & Underserved Area | | | |
| C .1.h | Mobilization of Children through ASHA | | | |
| C .1.k | Developed Micro Plan at Sub Centre Level | 3 | Rs.300/- | |
| C .1.l | Consolidated Micro Plan at Block Level | 1 | Rs.1000/- | |
| C .1. m | Pol For Vaccine & Logistics Delivery From State to district & to PHC | 1 | Rs.4800/- | |
| C .1.o | Red & Black Plastic bag etc | 396 | Rs.792/- | |
| C .1.q | Safety Pits For PHCs | 1 | 20000/- | |
| | Alternate Vaccine Delivery (Coorier) | 396 | Rs.59400 | |
| **Total** | | | **Rs.113792** | |

# Block PIP

**(Year 2012-13)**

**Name of the block:-Sadar Hospital** **District:-Buxar**

## Part A RCH Flexipool

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| **A.1** | **MATERNAL HEALTH** | | | | |
| A.1.1.1 | Creating FRUs | | | | |
| A.1.1.2 | Operationalise 24*7 PHC (MCH Centre-APHC) | | | | |
| A.1.3 | **Integrated outreach RCH services** | | | | |
| A.1.3.1 | Conducting RCH Outreach Camps, for awareness generation on FP, MH, CH, Adolescent Health with services like ANC, FP (OCP, condom, Copper T), counselling services on MH, Newborn care, CH, Exclusive Breast Feeding, Nutrition, on Adolescent Health) | | | | |
| A.1.3.2 | Monthly Village Health and Nutrition Days | | | | |
| A.1.4 | **Janani Suraksha** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **Yojana / JSY** | | | | |
| A.1.4.1 | Home Deliveries | 2000 | 1000000 | | Rs. 500*2000 |
| A.1.4.2 | Institutional Deliveries | | | | |
| A.1.4.2.1 | Rural | 6500 | 13000000 | | 6500*2000 |
| A.1.4.2.2 | Urban | 800 | 800000 | | 800*1000 |
| A.1.4.2.3 | Caesarean Deliveries | 400 | 600000 | | 400*1500 |
| A.1.4.3 | Other activities (JBSY) | | | | |
| A.1.5.1 | Maternal Death Audit | | | | |
| | **Innovative Activity** | | | | |
| | | | | | |
| | **Sub-total Maternal Health** | | | | |
| **A.2** | **CHILD HEALTH** | | | | |
| A.2.1.3 | Home Based Newborn Care to ASHA/AWWs 3 PNC for Normal Baby | | | | |
| A.2.1.4 | Home Based Newborn Care to ASHA/AWWs 6 PNC for Low Birth Baby | | | | |
| | **Innovative Activity** | | | | |
| | **Sub-total Child Health** | | | | |
| **A.3** | **FAMILY** | | | | |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| | **PLANNING** | | | | |
| A.3.1 | **Terminal/Limiting Methods** | | | | |
| A.3.1.2 | Female Sterilisation camps | 24 | 1200000 | | 24*5000 |
| A.3.1.3 | NSV camps | 5 | 25000 | | 5*5000 |
| A.3.1.4 | Compensation for female sterilisation | 2000 | 2000000 | | 2000*1000 |
| A.3.1.5 | Compensation for male sterilisation | 150 | 225000 | | 150*1500 |
| **A.3.2** | **Spacing Methods** | | | | |
| A.3.2.2 | IUD services at health facilities / compensation | | | | |
| **A.3.3** | POL for Family Planning/ Others | 10 | 100000 | | 10*1000 |
| **A.3.5.4** | Provide IUD Services at health facility (IUD Camps) | | | | |
| | **Innovative Activity** | | | | |
| | **Sub-total Family Planning)** | | | | |
| **A.8** | **INFRASTRUCTURE & HUMAN RESOURCES** | | | | |
| A.8.1.1.a | ANMs | | | | |
| A.8.1.1.b | Staff Nurses | | | | |
| A.8.1.2 | Laboratory Technicians in (Blood Bank) | 3 | 360000 | | **10*3*12** |

| FMR Code | ACTIVITY | Physical Target | PROPOSED AMOUNT (Rs. in Lakh) | EXPECTED OUTPUT | Remarks |
|---|---|---|---|---|---|
| A.8.1.5 | Medical Officers at CHCs/PHCs (Salary of MOs in Blood Bank) | 2 | 840000 | | **35000*2*12** |
| A.8.1.7 | Contractual Staff "FP Counsellor" | 1 | 180000 | | **15000*12** |
| A.8.1.8 | Incentive/Awards etc. to SN,ANM etc (Muskan Program-Incentive to ASHA & ANM) | | | | |
| **A.10** | Programme Management Costs | | | | |
| A.10.3 | Strengthening of Block PMU | | | | |
| A.10.4.9 | Management Unit at FRU (Hospital Manager & FRU Accountant) | 2 | 540000 | | **30000*12=360000**<br>**15000*12=180000**<br>**540000** |
| | **Innovative Activity** | | | | |
| | **GRAND TOTAL RCH II** | | | | |

**Part B: SUMMARY OF MISSION FLEXIPOOL (MFP) PIP 2011-12**

| S. No | Activity Proposed | Physical | Proposed | Expected | Remarks |
|---|---|---|---|---|---|

| | | target | Amount | Output | |
|---|---|---|---|---|---|
| 1 | **Decentralization** | | | | |
| B1.1.2 | Procurement of ASHA Drug Kit & Replenisment | | | | |
| B1.1.3 | Other Incentive to ASHAs (TA/DA for ASHA Divas) | | | | |
| B1.1.4.A | Best Performance Award to ASHAs at Block Level | | | | |
| B1.1.2 | ASHA Resource Centre/ ASHA Monitoring Group at Block Level | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total ASHA-Decentralisation** | | | | |
| **B2** | **Untied Funt** | | | | |
| B2.1 | Untied Fund for DH/SDH/CHC | 1 | 50000 | | Rs. 50000 per SDH |
| B2.2.A | Untied Fund for PHCs | | | | |
| B2.2.B | Untied Fund for APHCs | | | | |
| B2.3 | Untied Fund for Health Sub Centre | | | | |
| B2.4 | Untied Fund for Village Health and Sanitation | | | | |

| | Committee | | | | |
|---|---|---|---|---|---|
| | **Innovative Activity** | | | | |
| | **Sub Total Untied Fund** | | | | |
| **B3** | **Annual Maintenance Grant** | | | | |
| B3.2 | Annual Maintenance Grant for PHCs | | | | |
| B3.2.A | Annual Maintenance Grant for APHCs | | | | |
| sB3.3 | Annual Maintenance Grant for HSC | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B4** | **Hospital Strengthening** | | | | |
| B4.2.A | Installation of Solar Water System in FRU & PHCs | 1 | 150000 | | 150000 Per SH |
| B4.3 | Sub Centre Rent & Contingencies | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total Annual Maintenance Grant** | | | | |
| **B5** | **Construction** , | | | | |

|  |  |  |  |  |  |
|---|---|---|---|---|---|
|  | **Renovation & Setting up** |  |  |  |  |
| B5.2.A | Construction of APHC |  |  |  |  |
| B5.2.B | Construction of residential Quarters for Doctor & Staff Nurse in APHC |  |  |  |  |
| B5.2.C | Refurbishment of existing cold chain room for district stores & earthling & wiring of existing Cold Chain Rooms in all PHCs |  |  |  |  |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total Construction/Renovation & Setting up** |  |  |  |  |
| **B6** | **HMS/RKS** |  |  |  |  |
| B6.1 | Corpus Grant to HMS/RKS-District Hospital | **1** | **1500000** |  | 500000Per DH*3 |
| B6.2 | Corpus Grant to HMS/RKS-SDH |  |  |  |  |
| B6.3 | Corpus Grant to HMS/RKS-PHCs |  |  |  |  |
| B6.4 | Corpus Grant to HMS/RKS-APHCs |  |  |  |  |
|  | **Innovative Activity** |  |  |  |  |
|  | **Sub Total Corpus Group to HMS/RKS** |  |  |  |  |
| **B7** | **Decentralise Planning** |  |  |  |  |

| | | | | | |
|---|---|---|---|---|---|
| B.7 | Block, HSC & Village Health Action Plan | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total Decentralise Planning** | | | | |
| **B8** | **Panchayati Raj Institution** | | | | |
| B.8.1 | Constitution & Orientation of Community Leader & Of VHSC,SHC,PHC,CHC etc. | | | | |
| B.8.2 | Orientation Workshop, Training & Capacity Building of PRI at PHC | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total PRI** | | | | |
| **B.9** | **Mainstreaming of AYUSH** | | | | |
| B.9.1 | Salary of AYUSH MO | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total AYUSH** | | | | |
| **B.10** | **BCC/IEC Strategy** | | | | |
| B.10.1 | BCC/IEC Activities | | | | |
| | **Innovative Activity** | | | | |
| | **Sub Total of BCC/IEC** | | | | |
| **B.12** | Referral Transport | | | | |

| | | | | | |
|---|---|---|---|---|---|
| B.12.2.D | Referral Transport in PHCs | | | | |
| | **Innovative Activity** | | | | |
| | **Sub- Total Referral Transport** | | | | |
| B.13 | PPP/NGO | | | | |
| B.13.3.B | Outsourcing of Pathology & Radiology Services at PHCs | 3 | 3600000 | | 100000Per SH *3*12 |
| B.13.3.D | IMEP- Bio-Waste Management | 1 | 500000 | | 500000Per SH |
| B.14 | **Innovative Activity** | | | | |
| B.14.A | YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services | 1 | 5000 | | 5000 Per DH |
| B.15 | **Planning, Implementation & Monitoring** | | | | |
| B.15.3.1A | Data Centre of DH,SDH & Blocks | 1 | Rs.94368 | | Rs.7864/- per data centre per month |
| **B.16.1.1** | **Procurement of Equipment: MH (Labour Room)** | | | | |
| **B.16.1.1** | **General Drugs & Supplies for Health Facilities** | 1 | 6000000 | | 6000000 Per DH |
| **B.23.A** | **Payment of monthly bill to be BSNL** | 1 | 30000 | | 30000per Dh |
| | **Grand Total** | | **32754368** | | |

# Rogi Kalyan Samiti, Chougai (Buxar)

## Integrated Block Health Action Plan 2012-13

## Budget Sheet

| FM R CODE NO. | Activities | Component Code (only at state level) | Output 2012 | Activity Plan | | | | | | | | | | Budget Plan | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2011-2012 FY | | | | 2012-2013 FY | | | | | | 2011-2012 FY | | | | | 2012-2013 FY | | | |
| | | | | Activity planned (X) | Activity Executed (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 | under or over-utilised Budget {(B~D} =E | Tentative Unit Cost (F) | Budget Planned (including spill over amount) {(AP x A) ± E} = BP | Budgetary source (other than NRHM source) | Remarks |
| | | | | | | | | | | Q1 | Q2 | Q3 | Q4 | | | | | | | | | |
| A | RCH - TECHNICAL STRATEGIES & ACTIVITIES (B130) | | | | | - | | | | | | | | | - | | - | - | | - | | |
| A.1 | MATERNAL HEALTH | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.1 | Operationalise facilities (only dissemination, monitoring, and quality) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.1.1 | Operationalise FRUs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.1.2 | Operationalise 24x7 PHCs | | | 1 | 0 | 1 | | 1 | | 0 | 0 | y | 0 | 25000 | 25000 | 25000 | 0 | 25000 | 25000 | 25000 | | |
| A.1.1.3 | MTP services at health facilities | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.1.4 | RTI/STI services at health facilities | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.1.5 | Operationalise Sub-centres | | | 1 | 0 | 1 | | 1 | | 0 | y | 0 | 0 | 50000 | 50000 | 50000 | 0 | 50000 | 50000 | 50000 | | |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.1.2 | Referral Transport | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.3 | Integrated outreach RCH services | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.3.1 | RCH Outreach Camps | | | 2 | 0 | 2 | | 12 | | y | y | y | y | 7000 | 14000 | 14000 | 0 | 14000 | 7000 | 84000 | | |
| A.1.3.2 | Monthly Village Health and Nutrition Days | | | 41 | 41 | 0 | | 50 | | y | y | y | y | 22800 | 22800 | 22800 | 2840 | 19960 | 19200 | 19200 | | 117 (50 AWW+50 ASHA+12 ANM+5 VHSC MEMBER)*2*50+5 (MOIC,CDPO,BCM,BHM,PHED Er.)*5*3 |
| A.1.4 | Janani Suraksha Yojana / JSY | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.4.1 | Home Deliveries | | | 0 | 0 | 0 | | 100 | | y | y | y | y | | 0 | | 0 | 0 | 500 | 50000 | | |
| A.1.4.2 | Institutional Deliveries | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.4.a. | -Rural | | | 1500 | 651 | 849 | | 1600 | | y | y | y | y | 2000 | 3000000 | 3000000 | 1161200 | 1838800 | 2000 | 3200000 | | |
| A.1.4.b. | -Urban | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.4.c | Caesarean Section | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A1.4.3 | Administrative Expenses | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.4.4 | Incentive to ASHAs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.1.5 | Maternal Death Review/Audit | | | 8 | 0 | 8 | | 8 | | y | y | y | y | 750 | 6000 | 6000 | 0 | 6000 | 750 | 6000 | | |
| A.1.6 | Other Activities | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.2 | CHILD HEALTH | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.2.1 | IMNCI | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.2.1.3 | Incentive for HBNC to ASHA/AWWs(State Iniative) 3 PNC for Normal Baby | | | 225 | 0 | 225 | | 1560 | | y | y | y | y | 100 | 22500 | 22500 | 0 | 22500 | 100 | 156000 | | |
| A.2.1.4 | Incentive for HBNC to ASHA(State Iniative) 6PNC for Low Birth Baby | | | 92 | 0 | 92 | | 1560 | | y | y | y | y | 199.33 | 18338 | 18338 | 0 | 18338 | 200 | 312000 | | |

| A.3 | FAMILY PLANNING | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.3.1 | Terminal/Limiting Methods | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.3.1.1 | Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.3.1.2 | Female Sterilisation camps | | | 24 | 0 | 24 | | 18 | | y | y | y | y | 5000 | 12000<br>0 | 12000<br>0 | 0 | 12000<br>0 | 5000 | 90000 | | |
| A.3.1.3 | NSV camps | | | | | 0 | | 4 | | y | y | y | y | | 0 | | 0 | 0 | 5000 | 20000 | | |
| A.3.1.4 | Compensation for female sterilisation | | | 392 | 168 | 224 | | 550 | | y | y | y | y | 1000 | 39200<br>0 | 39200<br>0 | 172600 | 21940<br>0 | 1000 | 550000 | | |
| A.3.1.5 | Compensation for male sterilisation | | | 8 | 1 | 7 | | 12 | | y | y | y | y | 1500 | 12000 | 12000 | 1500 | 10500 | 1500 | 18000 | | |
| A.3.1.6 | Accreditation of private providers for sterilisation services | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.3.2.5 | Contraceptive Update seminars | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.3.3 | POL for Family Planning | | | 12 | 0 | 12 | | 12 | | y | y | y | y | 1000 | 12000 | 12000 | 0 | 12000 | 1000 | 12000 | | |
| A.3.5.4 | IUD services at health facilities | | | 3 | 0 | 3 | | 6 | | y | y | y | y | 1500 | 4500 | 4500 | 0 | 4500 | 1500 | 9000 | | |
| A.8 | INFRASTRUCTURE (MINOR CIVIL WORKS) & HUMAN RESOURCES | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.8.1 | Contractual Staff & Services(Excluding AYUSH) | | | | | 0 | | 1 | | y | y | y | y | | 0 | | 0 | 0 | 240000 | 240000 | | |
| A.8.1.1 | ANMs,Supervisory Nurses, LHVs, | | | 0 | 0 | 0 | | | | | | | | | 0 | 0 | 0 | 0 | | 0 | | |
| A.8.1.8 | Incentive/ Awards etc. to SN, ANMs etc. | | | 660 | 660 | 0 | | 696 | | y | y | y | y | 59.7 | 39402 | 39402 | 62550 | -23148 | 150 | 104400 | | |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A.8.1.9 | Human Resources Development (Other than above) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.10.2 | Strengthening of DHS/DPMU (Including HR, Management Cost, Mobility Support, Field Visits) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.10.3 | Strengthening of Block PMU (Including HR, Management Cost, Mobility Support, Field Visits) | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 735600 | 735600 | 735600 | 338798 | 396802 | 839160 | 839160 | | BHM ((21780+(21780*10/100))*12)+ BAM ((14520+(14520*10/100))*12)+ Mobility Expenses (15000*12) + Office Expenses (15000*12) |
| A.10.3a | Office assistant cum Clerk | | | | | 0 | | 2 | | y | y | y | y | | | | | | 96000 | 192000 | | 2 Office Assistant cum Clerk @ 8000/- per month |
| A.10.3b | Office Boy | | | | | 0 | | 2 | | y | y | y | y | | | | | | 60000 | 120000 | | 2 Office Boy @ 5000/- per month |
| A.10.4 | Strengthening (Others) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.10.5 | Audit Fees | | | 0 | 0 | 0 | | 1 | | | | | | | 0 | | 0 | 0 | 9000 | 9000 | | |
| A.10.6 | Concurrent Audit system | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| A.10.7 | Mobility Support, Field Visits to BMO/MO/Others | | | 0 | 0 | 0 | | 1 | | y | y | y | y | | 0 | | 0 | 0 | 180000 | 180000 | | 1 Vehicle for BMO/MO & Other @ 15000 per month |
| A.11. | Vulnerable Groups | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| Grand Total of RCH Flexible Pool (NRHM-A) | | - | - | 2,970.00 | 1,522.00 | 1,448.00 | - | 6,198.00 | - | - | - | - | - | 853,509.03 | 4,474,140.00 | 4,474,140.00 | 1,739,488.00 | 2,734,652.00 | 1,544,060.00 | 6,285,760.00 | - | |
| B | TIME LINE ACTIVITIES - Additionalities under NRHM (Mission Flexible Pool) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B1 | ASHA | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B1. | ASHA Cost: | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |

| 1 | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B1. 1.1 | Selection & Training of ASHA | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B1. 1.2 | Procurement of ASHA Drug Kit | | | 50 | 0 | 50 | | 50 | | y | y | y | y | 250 | 12500 | 12500 | 0 | 12500 | 250 | 12500 | | |
| B1. 1.3 | Performance Incentive/Other Incentive to ASHAs (if any) | | | 50 | 50 | 0 | | 50 | | y | y | y | y | 1032 | 51600 | 51600 | 24768 | 24768 | 1032 | 51600 | | |
| B1. 1.4 | Awards to ASHA's/Link workers | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 2000 | 2000 | 2000 | 2000 | 0 | 5000 | 5000 | | 1 Asha 2500 + 2nd Asha 1500 + 3rd 1000 |
| B1. 1.5 | ASHA Resource Centre/ASHA Mentoring Group | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 144000 | 14400 0 | 14400 0 | 80388 | 63612 | 158400 | 158400 | | BCM (13200*12) |
| B2 | Untied Funds | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B2. 1 | Untied Fund for CHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B2. 2 | Untied Fund for PHCs | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 25000 | 25000 | 25000 | 735 | 24265 | 25000 | 25000 | | |
| B2. 3 | Untied Fund for Sub Centres | | | 5 | 0 | 5 | | 5 | | y | y | y | y | 10000 | 50000 | 50000 | 0 | 50000 | 10000 | 50000 | | |
| B2. 4 | Untied fund for VHSC | | | 22 | 0 | 22 | | 22 | | y | y | y | y | 10000 | 22000 0 | 22000 0 | 0 | 22000 0 | 10000 | 220000 | | |
| B.3 | Annual Maintenance Grants | | | 0 | 0 | 0 | | | | | | | | | 0 | 0 | 0 | 0 | | 0 | | |
| B3. 1 | CHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B3. 2 | PHCs | | | | | 0 | | 1 | | y | y | y | y | | 0 | | 54054 | -54054 | 100000 | 100000 | | |
| B3. 3 | Sub Centres | | | 4 | 0 | 4 | | 5 | | y | y | y | y | 10000 | 40000 | 40000 | 0 | 40000 | 10000 | 50000 | | |
| B.4 | Hospital Strengthening | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B.4. 1 | Up gradation of CHCs, PHCs, Dist. Hospitals to IPHS) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B4. 1.1 | District Hospitals | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B4. 1.2 | CHCs | | | | | 0 | | 1 | | y | y | y | y | | 0 | | 0 | 0 | | 0 | | 1 Up Gradation of PHCs to CHCs |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B4. 1.3 | PHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B4. 1.4 | Sub Centres | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B4. 1.5 | Others | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B 4.2 | Strengthening of Districts , Sub Divisional Hospitals, CHCs, PHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B.4. 3 | Sub Centre Rent and Contingencies | | | | | 0 | | 4 | | y | y | y | y | | 0 | | 0 | 0 | 6000 | 24000 | | |
| B.4. 4 | Logistics management/ improvement | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B5 | New Constructions/ Renovation and Setting up | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B5. 1 | CHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B5. 2 | PHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B5. 2.C | Strengthening of Cold Chain (Refurbishment of Existing Cold Chain Room for District Stores and Earthing and Wiring of Existing Cold Chain Rooms in All PHCs | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 8000 | 8000 | 8000 | 0 | 8000 | 8000 | 8000 | | |
| B.6 | Corpus Grants to HMS/RKS | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B6. 1 | District Hospitals | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B6. 2 | CHCs | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B6. 3 | PHCs | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 100000 | 100000 | 100000 | 94225 | 5775 | 100000 | 100000 | | |
| B6. 4 | Other or if not bifurcated as above (APHC) | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 100000 | 100000 | 100000 | 0 | 100000 | 100000 | 100000 | | |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| B7 | District Action Plans (Including Block, Village) | | | 1 | 0 | 1 | | 1 | | 0 | 0 | y | 0 | 12500 | 12500 | 12500 | 0 | 12500 | 12500 | 12500 | | |
| B8 | Panchayati Raj Initiative | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B8.1 | Constitution and Orientation of Community leader & of VHSC,SHC,PHC ,CHC etc | | | 5 | 0 | 5 | | 5 | | y | y | y | y | 1500 | 7500 | 7500 | 0 | 7500 | 1500 | 7500 | | |
| B8.2 | Orientation Workshops, Trainings and capacity building of PRI at State/Dist. Health Societies, CHC,PHC | | | 5 | 0 | 5 | | 5 | | 0 | y | 0 | 0 | 650 | 3250 | 3250 | 0 | 3250 | 650 | 3250 | | |
| B8.3 | Others | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B9 | Mainstreaming of AYUSH | | | | 0 | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B.9.1 | Medical Officers at CHCs/ PHCs (Only AYUSH) | | | | | 0 | | 1 | | y | y | y | y | | 0 | | 110388 | -110388 | 240000 | 240000 | | |
| B.10 | Strengthening of BCC/IEC Bureaus (state and district levels) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B.10.1 | Development of State BCC/IEC strategy | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 15000 | 15000 | 15000 | 0 | 15000 | 15000 | 15000 | | |
| B12 | Referral Transport | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 78000 | 78000 | 78000 | 0 | 78000 | 78000 | 78000 | | |
| B13.3 | Outsourcing of Pathology and Radiology Services From PHCs to DH | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 200000 | 200000 | 200000 | 210696 | -10696 | 400000 | 400000 | | |
| B14 | Innovations( if any) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B14b | YUKTI Yojana Accreditation of Public and Private Sector for Providing | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 5000 | 5000 | 5000 | 0 | 5000 | 5000 | 5000 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Safe Abortion Services | | | | | | | | | | | | | | | | | | | | | |
| B15 | Planning, Implementation and Monitoring | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B15.1 | Community Monitoring (Visioning workshops at state, Dist, Block level) | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B15.3.1A | Monitoring and Evaluation | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 90000 | 90000 | 90000 | 51466 | 38534 | 99000 | 99000 | | |
| B15.3.2A | Monitoring & Evaluation / HMIS /MCTS | | | 1 | 0 | 1 | | 1 | | 0 | y | 0 | 0 | 25773 | 25773 | 25773 | 0 | 25773 | 10100 | 10100 | | 12ANM + 1LHB + 1 DC (14*200*2)+1 Resource person @ 1000 for two day + Hall arrangement @ 2500 + 500*2 for Travelling Cost for Resource pers |
| B.16.2.4 | Supplies for IMEP | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| B.16.2.5 | General drugs & supplies for health facilities | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 500000 | 500000 | 50000 | 248247 | 251753 | 1000000 | 1000000 | | |
| B.17 | Regional drugs warehouses | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| Grand Total of Mission Flexible Pool (NRHM-B) | | 0 | 0 | 155 | 55 | 100 | 0 | 163 | 0 | 0 | 0 | 0 | 0 | 1338705 | 1690123 | 1240123 | 876967 | 811092 | 2395432 | 2774850 | 0 | |
| C | IMMUNISATION | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.1 | Pulse Polio operating costs | | | 6 | 3 | 3 | | 8 | | y | y | y | y | 36178 | 217068 | 144137 | 144137 | 72931 | 36178 | 289424 | | |
| C.2 | Routine Immunization | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2.1 | Mobility support for Supervision and Monitoring at districts and state level. | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2.2 | Cold chain maintenance | | | 1 | 0 | 1 | | 1 | | y | y | y | y | 3000 | 3000 | 3000 | 0 | 3000 | 3000 | 3000 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.2. 3 | Alternate Vaccine Delivery to Session sites | | | 0 | 0 | 0 | | 696 | | y | y | y | y | 0 | 0 | 0 | 26650 | -26650 | 42000 | 42000 | | 144 hard to reach area @ Rs. 10 & 552 Session site |
| C.2. 4A | Focus on urban slum & underserved areas | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 4B | Alternate vaccinater Honorarium for urban @ 1400 per month for 12 month for under served areas | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 5 | Social Mobilization by ASHA /Link workers Under Mukan Ek Abhiyaan | | | 660 | 0 | 660 | | 0 | | 0 | 0 | 0 | 0 | 15.3 | 10098 | 10098 | 0 | 10098 | 0 | 0 | | |
| | Social Mobilization by AWW Under Mukan Ek Abhiyaan | | | 0 | 0 | 0 | | 696 | | y | y | y | y | 0 | 0 | 0 | 0 | 0 | 100 | 69600 | | |
| C.2. 6 | Computer Assistants support at State | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 7 | Computer Assistants support at district level | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 7a | Computer Assistants support at Block level | | | | | 0 | | 1 | | y | y | y | y | | 0 | | 0 | 0 | 96000 | 96000 | | |
| C.2. 8 | Printing and dissemination of immunization cards, tally sheets, charts, registers, receipt book, monitoring | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | formats etc. | | | | | | | | | | | | | | | | | | | | | |
| C.2. 9 | Quarterly review meeting at state level | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 10 | Quarterly review meeting at District level | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 11 | Quarterly review meeting at block level | | | 4 | 1 | 3 | | 4 | | y | y | y | y | 3742 | 14968 | 14967 | 2950 | 12018 | 5375 | 21500 | | (50 AWW + 50 ASHA + 12 ANM LINK WORKER) * 25 * 4 qtr + 50 ASHA *4 Qtr. * 50 Incentive |
| C.2. 12 | District level Orientation for 2 days ANMs, MPHW,LHV | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 13 | Three days training of Mos on RI | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 14 | One day refresher training of district computer Assistant on RIMS/HIMS | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 15 | One day cold chain handlers trainings | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 16 | One day training of block level date handlers | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 17 | To develop micro plan at sub-centre level | | | 9 | 0 | 9 | | 5 | | 0 | y | 0 | 0 | 100 | 900 | 900 | 0 | 900 | 100 | 500 | | |
| C.2. 18 | For consolidation of micro plan at block level | | | 1 | 0 | 1 | | 1 | | 0 | y | 0 | 0 | 1000 | 1000 | 1000 | 0 | 1000 | 1000 | 1000 | | |
| C.2. 19 | POL for vaccine delivery from state to District and PHC/CHCs | | | 1 | 1 | 0 | | 1 | | y | y | y | y | 4800 | 4800 | 4800 | 1200 | 3600 | 14400 | 14400 | | |

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.2. 20 | Consumables for computer including provision for internet access | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 21 | Red/Black bags, twin bucket, bleach/hypochlorite solution | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 22 | Alternative vaccinator hiring for urban RI | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 23 | POL of Generators for cold chain | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 24 | Catch up Campaigns for flood prone areas | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 25 | AEFI investigation of district AEFI committee | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| C.2. 26 | Supportive supervision for 10 top priority districts | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| | | | | | | 0 | | | | | | | | | 0 | | 0 | 0 | | 0 | | |
| | Grand Total of Immunization (NRHM-C) | 0 | 0 | 682 | 5 | 677 | 0 | 1413 | 0 | 0 | 0 | 0 | 0 | 48835.3 | 251834 | 178902 | 174937 | 76897 | 198153 | 537424 | 0 | |
| GT | Grand Total (A+B+C) | - | - | 3,807 | 1,582 | 2,225 | - | 7,774 | - | - | - | - | - | 2,241,049 | 6,416,097 | 5,893,165 | 2,791,392 | 3,622,641 | 4,137,645 | 9,598,034 | - | - |