DISTRICT HEALTH ACTION PLAN

2012-2013

(DISTRICT JAMUI)

NATIONAL RURAL HEALTH MISSION

GOVERNMENT OF BIHAR

Civil Surgeon cum Secretary
District Health Society, Jamui.

District Magistrate cum Chairman
District Health Society, Jamui.

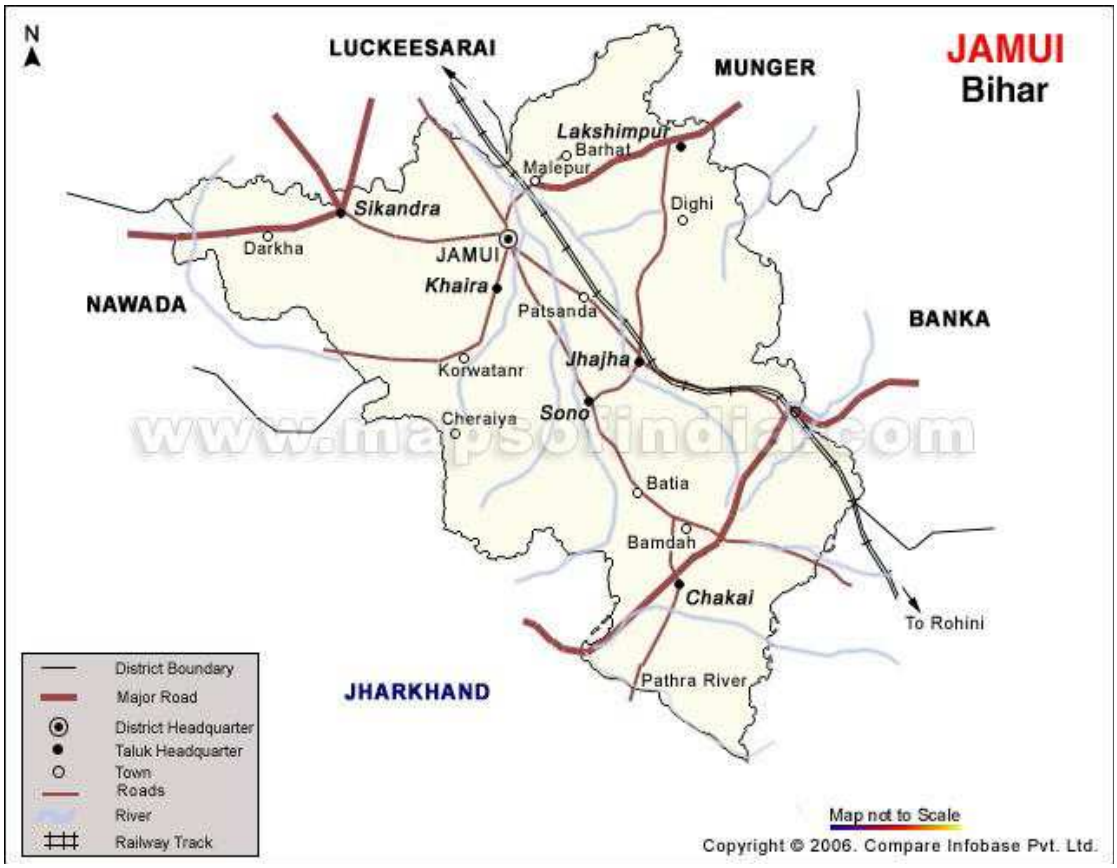
ACKNOLEDGEMENT

It is our pleasure to present the District Health Action Plan for Jamui District for the2012-13. The District Health Action Plan seeks to set goals and objectives for the district health system and delineate implementing processes in the present context of gaps and opportunities for the Jamui district health team.

National Rural Health Mission was introduced to undertake architectural corrections in the public Health System of India. District health action plan is an integral aspect of National Rural Health Mission. District Health Action Plans are critical for achieving decentralisation, interdepartmental convergence, capacity building of health system and most importantly facilitating people's participation in the health system's programmes. District health Action planning provides opportunity and space to creatively design and utilise various NRHM initiatives such as flexi–financing, Rogi Kalyan Samiti, Village Health and Sanitation Committee to achieve our goals in the socio-cultural context of Jamui.

We are very glad to share that the team of District Health Society and its concerning all the MOICs and BHMs of the district along with key district level functionaries participated in the planning process. The plan is a result of collective knowledge and insights of each of the district health system functionary. We are sure that the plan will set a definite direction and give us an impact to embark on our mission.

MAP OF JAMUI DISTRICT



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1. INTRODUCTION

The National Rural Health Mission (NRHM) is a comprehensive health programme launched by Government of India to bring about architectural corrections in the health care delivery systems of India. The NRHM seeks to address existing gaps in the national public health system by introducing innovation, community orientation and decentralisation. The mission aims to provide quality health care services to all sections of society, especially for those residing in rural areas, women and children, by increasing the resources available for the public health system, optimising and synergising human resources, reducing regional imbalances in the health infrastructure, decentralisation and district level management of the health programmes and community participation as well as ownership of the health initiatives. The mission in its approach links various determinants such as nutrition, water and sanitation to improve health outcomes of rural India.

The NRHM regards district level health planning as a significant step towards achieving a decentralised, pro-poor and efficient public health system. District level health planning and management facilitate improvement of health systems by 1) addressing the local needs and specificities 2) enabling decentralisation and public participation and 3) facilitating interdepartmental convergence at the district level. Rather than funds being allocated to the States for implementation of the programmes developed at the central government level, NRHM advises states to prepare their perspective and annual plans based on the district health plans developed by each district.

The concept of DHAP recognises the wide variety and diversity of health needs and interventions across the districts. Thus it internalises structural and social diversities such as degree of urbanisation, endemic diseases, cropping patterns, seasonal migration trends, and the presence of private health sector in the planning and management of public health systems. One area requiring major reforms is the coordination between various departments and vertical programmes affecting determinants of health. DHAP seeks to achieve pooling of financial and human resources allotted through various central and state programmes by bringing in a convergent and comprehensive action plan at the district level.

2. DISTRICT PLANNING PROCESS

The Planning process began with the constitution of a four member team from the district on the behest of State Health Society Bihar. This team consisted of ACMO(Nodal officer) DPM, DAM, DM&E, DPC, &DCM.

A decentralized participatory planning process has been followed in development of this District Health Action Plan. The health facilities in the block viz. HSCs, APHCs, PHCs and, FRUs were surveyed using the templates developed at the aforementioned workshop. The inputs from these Situation Analysis & "facility" surveys were taken into account while developing the District Health Action Plan. The findings of the DLHS – 3 have also been used to analyse the present situation in the district.

The District Planning Team (DPT) provided technical oversight and strategic vision for the process of development of District Health Action Plan. The members of the DPT had also taken the responsibility of contributing to the selected thematic areas such as RCH, Newer initiatives under NRHM, immunization etc. Assessment of overall situation of the District and development of broad framework for planning was done through a series of meetings of the DPT.

- Extensive District consultations of various interests groups/stakeholders and their feedback.
- Resources availability recommendations of stakeholders at all levels.
- Formation of District level core group to further the planning process.
- Participation of Block & VHC level functionaries ANM, ASHA, AWW in the planning process.
- District level consultation processes with workshops, meetings and discussions.
- Feedback & Consultative meetings with various allied Departments.
- The major thrust areas in the NRHM namely, Reproductive & Child Health, Immunization, Control of Communicable Diseases, Strengthening & Mainstreaming & Establishing the Public Health Standards in the Health System have been taken into account while developing the District Health Action Plan

3. HISTORICAL PERSPECTIVE

Various literatures indicate the fact that Jamui was known as Jambhiyaagram. According to Jainism, the 24th Tirthankar lord Mahavir got divine knowledge in Jambhiyagram situated on the bank of river named Ujjihuvaliya. Another place of a divine light of Lord Mahavir was also traced as "Jrimbhikgram" on the bank of Rijuvalika river which resembles Jambhiyagram Ujjhuvaliya.

The Hindi translation of the words Jambhiya and Jrimbhikgram is Jamuhi which is developed in the recent time as Jamui. With the presage of time, the river Ujhuvaliya/Rijuvalika is supposed to be developed as the river Ulai and as such both the place are still found in Jamui. The Ulai river is still flowing nearby Jamui. The old name of Jamui has been traced as Jambhubani in a copper plate which has been kept in Patna Museum. This plate clarifies that in the 12th century, Jambubani was nothing but today's Jamui. Thus the two ancient names as Jambhiyagram and Jambubani prove that this district was important as a religious place for Jains and it was also a place of Gupta dynasty in the 19th century, the historian Buchanan also visited this place in 1811 and found the historical facts. According to other historians Jamui was also famous in the era of Mahabharata. According to available literature, Jamui was related to Gupta and Pala rulers before 12th century. But after that this place became famous for Chadel rulers. Prior to Chandel Rai, this place was ruled by Nigoria, who was defeted by Chandels and the dynasty of Chandels founded in 13th century. The kingdom of Chandels spread over the whole of Jamui. Thus Jamui has a glorious history.

4. DISTRICT PROFILE

Jamui was formed as a District on 21st February, 1991 as a result of its separation from Munger. It is located at a Longitude of 86º-13'E and the latitude is 24º-55'N

Boundary

North	South	East	West	North
Munger and Lakhisarai District	Giridih District of Jharkhand	Deoghar and Banka District	Nawada District	Munger and Lakhisarai District

Administrative Units

S.No.	Administrative Units	No of Unit
1	No. of Police District	**1**
2	No. of Sub-Divisions	**1**
3	No of Police Subdivisions	**2**
4	No. of Blocks	**10**
5	No. of Circles	**10**
6	No. of Police Stations	**12**

PHYSIOGRAPHICAL DIVISION

Most of the part of the district has hilly topography. Western portion of Jamui like Sikandra Jamui & a little part of Khaira has plain area. Sikandra block is situated in alluvial zone. A sizeable part of the district comprises plains which are paddy-growing lands. Sourthern part of the district is covered with hills and forest characteristically reminiscent of the Chhotanagpur plateau in physical features. Hills of the district are considered to be the out –laying extension of Vindhya Range. Southwest part of the district has another block of hills known as Gidheswar Pahar.

RIVER & DRAINAGE SYSTEM

Kuil and Ulai River are the chief rivers of the district. Beside these rivers, tributaries and sub tributaries, rainy rivers flow in scattered way. There are two irrigation dams Nagi & Nakti Dam situated in the southern hilly terrain of the district. Both Dam are declared as Bird Sanctuary.

CLIMATE

- Winter season - November to February
- Summer season - March to May
- Monsoon season - June to September
- Autumn - October to November

TEMPERATURE

Like another part of Bihar temperature changes from season to season. However the minimum temperature in the district ranges between 30^0 to 5^0 Celsius in winter season whereas the maximum temperature ranges between 38^0 to 42^0 Celsius in summer season.

RAINFALL

The monsoon usually breaks in the second half of June and lasts till September. The average rainfall in the district is approximately 1000 mm. The average maximum rainfall is usually recorded in August. Chakai. Sono and Jhajha get rainfall more than the district average.

SOIL

Jamui has a typical topography. The soil pattern of the district differs widely due to topography of the region. Important soil is sandy soils and alluvial soil of heavy texture having natural or alkaline reaction. Jhajha, Khaira, Sono, Chakai & Laxmipur block contain forest soil. A sizeable part of the plain of northern side of the district lies in the Basin of Kiul River & its tributaries.

LAND USE PATTERN

As above-mentioned Jamui has variable nature of topography, according to 1981 only 58.49% area is cultivable. Following table shows total area cultivable area and growing main staple food in the district:-

ABOUT JAMUI

Description	2011	2001
Actual Population	**1,756,078**	**1,398,796**
Male	914,368	729,138
Female	841,710	669,658
Population Growth	**25.54%**	**32.90%**
Area Sq. Km	3,098	3,098
Density/km2	**567**	**452**
Proportion to Bihar Population	1.69%	1.69%
Sex Ratio (Per 1000)	**921**	**918**
Child Sex Ratio (0-6 Age)	956	963
Average Literacy	**62.16**	**42.43**
Male Literacy	73.77	57.06
Female Literacy	49.44	26.32
Total Child Population (0-6 Age)	**313,455**	**276,379**
Male Population (0-6 Age)	160,287	140,775
Female Population (0-6 Age)	153,168	135,604
Literates	**896,670**	**476,261**
Male Literates	556,264	335,723

Female Literates	340,406	140,538
Child Proportion (0-6 Age)	**17.85%**	**19.76%**
Boys Proportion (0-6 Age)	17.53%	19.31%
Girls Proportion (0-6 Age)	18.20%	20.25%

Description	Rural	Urban
Population (%)	**91.76 %**	**8.24 %**
Total Population	**1,611,431**	**144,647**
Male Population	838,318	76,050
Female Population	773,113	68,597
Sex Ratio	**922**	**902**
Child Sex Ratio (0-6)	957	937
Child Population (0-6)	**291,047**	**22,408**
Male Child(0-6)	148,716	11,571
Female Child(0-6)	142,331	10,837
Child Percentage (0-6)	**18.06 %**	**15.49 %**
Male Child Percentage	17.74 %	15.21 %
Female Child Percentage	18.41 %	15.80 %
Literates	**803,379**	**93,291**
Male Literates	502,282	53,982

Female Literates	301,097	39,309
Average Literacy	**60.84 %**	**76.32 %**
Male Literacy	72.84 %	83.72 %
Female Literacy	47.73 %	68.06 %

Area & Density: Jamui district occupies a total of 3098.26 sq. km. There are approximately 576 people per sq. km.

S.NO.	Name of the Blocks	Aria in (Sq. km.)	Population 2011	Density
1	Aliganj	172.89	142127	836
2	Barhat	232.16	93383	409
3	Chakai	774.04	234832	308
4	Gidhaur	71.11	76165	1089
5	Jamui	173.91	227512	1330
6	Jhajha	427.39	270603	644
7	Khaira	418.71	222216	540
8	Laxmipur	251.77	124115	501
9	Sikandra	184.01	153808	850
10	Sono	392.27	211270	548
Total Density of Jamui District		3098.26	11756078	576

Literacy: Average literacy figures of the Jamui District are as follows:

S.NO.	Name of the Blocks	Literacy
1	Aliganj	44.77
2	Barhat	45.54
3	Chakai	36.11
4	Gidhaur	49.39
5	Jamui	52.51
6	Jhajha	43.16
7	Khaira	42.68
8	Laxmipur	37.45
9	Sikandra	42.74
10	Sono	34.1
Total Density of Jamui District		42.845

Wells in District:

S.NO.	Name of the Blocks	No. of Wells
1	Aliganj	1764
2	Barhat	1424
3	Chakai	5667
4	Gidhaur	547
5	Jamui	1005
6	Jhajha	2292
7	Khaira	2848
8	Laxmipur	2300
9	Sikandra	2903
10	Sono	2037
Total No. of Well in Jamui District		22787

NUMBER OF APHC & HSC

S.NO.	Name of the Blocks	No. of APHC	No. of HSC
1	Aliganj	3	24
2	Barhat	4	16
3	Chakai	7	40
4	Gidhaur	2	13
5	Jamui	4	25
6	Jhajha	6	39
7	Khaira	7	38
8	Laxmipur	4	21
9	Sikandra	4	26
10	Sono	7	37
Total No. of APHC in Jamui District		48	279

HSC Building Status

S.NO.	Name of the Blocks	No. of HSC In Government Building	No. of HSC In Panchayat Bhawan	No. of HSC In Rented Building
1	Aliganj	7	0	14
2	Barhat	2	7	0
3	Chakai	8	10	5
4	Gidhaur	7	6	0
5	Jamui	10	5	9
6	Jhajha	4	2	18
7	Khaira	8	11	3
8	Laxmipur	4	11	1
9	Sikandra	6	0	18
10	Sono	9	6	8
Total No. of APHC in Jamui District		65	58	76

NUMBER Of AWC

S.NO.	Name of the Blocks	No. of RURAL AWC	No. of URBAN AWC
1	Aliganj	111	0
2	Barhat	71	0
3	Chakai	180	0
4	Gidhaur	59	0
5	Jamui	108	69
6	Jhajha	163	37
7	Khaira	177	0
8	Laxmipur	94	0
9	Sikandra	117	0
10	Sono	166	0
Total		1246	106

NUMBER Of ANM & ANMR

S.NO.	Name of the Blocks	No. of RURAL ANM	No. of URBAN AWC
1	Aliganj	11	15
2	Barhat	17	20
3	Chakai	26	16
4	Gidhaur	9	3
5	Jamui	14	24
6	Jhajha	29	23
7	Khaira	17	22
8	Laxmipur	17	11
9	Sikandra	22	23
10	Sono	25	15
Total		187	172

NUMBER Of GRADE A PARMANENT & CONTACTUAL

S.NO.	Name of the Blocks	No. of GRADE A PARMANENT	No. of GRADE A CONTACTUAL
1	Sadar Hospital	3	11
2	Aliganj	0	3
3	Barhat	0	7
4	Chakai	3	9
5	Gidhaur	0	2
6	Jamui	0	4
7	Jhajha	4	5
8	Khaira	0	4
9	Laxmipur	0	4
10	Sikandra	0	2
11	Sono	0	8
Total		10	59

NUMBER Of DOCTOR PARMANENT & CONTACTUAL

S.NO.	Name of the Blocks	No. of DOCTOR PARMANENT	No. of DOCTOR CONTACTUAL
1	Sadar Hospital	9	0
2	Aliganj	1	1
3	Barhat	2	2
4	Chakai	3	9
5	Gidhaur	0	2
6	Jamui	2	4
7	Jhajha	1	4
8	Khaira	0	4
9	Laxmipur	3	0
10	Sikandra	1	3
11	Sono	2	2
Total No. of APHC in Jamui District		24	31

NUMBER Of MAMTA TARGET & SELECTION

SI. No.	Name of the health center	MAMTA	
		TARGET	SELECTION
1	2	3	4
1	Sadar Hospital, Jamui	24	19
2	Ref., Jhajha	12	12
3	Ref., Laxmipur	7	0
4	Ref., Chakai	4	0
5	P.H.C, Sikandra	9	9
6	P.H.C, Khaira	12	12
7	P.H.C, Gidhour	3	3
8	P.H.C, Sono	4	4
9	P.H.C, Barhat	2	0
10	I. Aliganj	6	6
Total		83	65

NUMBER Of ASHA TARGET & SELECTION

SI. No.	Name of the health center	ASHA	
		TARGET	SELECTION
1	2	3	4
1	Jamui	208	203
2	Ref., Jhajha	202	212
3	Ref., Laxmipur	110	103
4	Ref., Chakai	202	206
5	P.H.C, Sikandra	122	115
6	P.H.C, Khaira	208	238
7	P.H.C, Gidhour	72	63
8	P.H.C, Sono	205	217
9	P.H.C, Barhat	72	55
10	I. Aliganj	115	115
Total		1516	1527

Status of Total no.of Beds in Health Facilities in District

Sl. No.	Name of the health center	BEDS	
		sanctioned	Functional
1	2	3	4
1	SADAR HOSPITAL JAMUI	100	100
2	Ref.Hosp,Jhajha	30	30
3	Ref.CHAKAI	30	30
4	Ref., Laxmipur	30	30
5	P. H.C JAMUI	6	6
6	P.H.C, Sikandra	6	6
7	P.H.C, Khaira	6	6
8	P.H.C, Gidhour	6	6
9	P.H.C, Sono	6	6
10	P.H.C, Barhat	6	6
11	I. Aliganj	6	6
Total		232	232

Ranking of District 2011-12

MONTH	RANKING
APRIL	22
MAY	26
JUNE	28
JULY	31
AUG	17
SEP	06
OCT	03
NOV	06

Equipments	Sanctioned	Functional	Damage
Deep freezer large	5	1	4
Deep freezer small	8	6	2
ILR Large	5	3	2
ILR Small	15	10	5
Cold Box Large	65	35	30
Cold Box Small	51	18	33
Vaccine Career	853	523	303
Ice Pack	9906	7714	2192
Voltage Stabilizer	17	12	5
Vaccine Van	1	1	0
Generator	11	11	11

5. SWOT ANALYSI of PART A, B, And C

SWOT Analysis of Part A

Strength

- Decentralized Planning and availability of Resources and Fund for program till HSC level.
- Huge pool of Human Resource working at ground level as ANM, Asha and Anganwadi workers.
- Provision of incentive money for Asha, ANM according to their performance in mobilizing community for institutional delivery ,FP etc.
- Provision of Incentive money for beneficiary under JBSY, Family Planning.
- Extension of emergency facilities in remote rural areas and posting of skilled doctors.
- Regular training program of doctors and other medical staffs for skill up gradation.
- Strong provision of IEC and BCC activity under the programs for effective program implementation and sensitizing people.
- Decentralized implementation process of the entire program.
- Involvement of people in uplifting health facilities through RKS andVHSC.

Weakness

- All PHCs are with only six bedded facility.50-60% of facilities are not adequate as per IPHS norms for providing emergency care.
- Lack of doctors and other human resource in the remote areas medical facilities
- Achievements in most of the program are far less than target.
- Slow pace of most of training like SBA and IMNCI.
- Monthly VHND is not operational as yet.
- Institutional delivery is still less than 50% in the district.
- No NRC has been made operational in the district.
- Seat for contractual medical officer and specialist, ANM and Asha are still vacant.

- Achievements in Family Planning and IUD insertation are far less than targets.
- Insensitivity of Doctors and other health staffs for patients.
- Unavailability of doctors and staffs in hospital at the time of duty.
- No timely procurement of equipments and drug in the remote health facilities.

Opportunity

- All the time support from state health society for all financial and logistics requirements for program implementation
- Scope for involving Private partner like Surya clinic for timely achievement of targets.
- Scope of getting full support from people through their participation in RKS and VHSC.
- Favourable political and administrative environment for program implementation
- Increasing literacy and awareness among public to support Family planning and institutional deliveries.
- Better coordination and support from other line departments like ICDS, Municipality etc

Threat

- Large scale poverty becomes the cause of nutritional deficiency leading to health problems.
- In case of remaining without practice for long time health staff training become useless.
- Extending services in remote rural areas is still a challenge in achieving targets of MCH and FP, RI.
- Traditional and religious attitude of public is hindrance for increasing Institutional deliveries, Family planning etc.

SWOT Analysis of Part B

Strength

- Asha support system with DCM and BCM has been made functional in the district.
- Motivational program for Asha like Umbrella distribution is completed in time.
- Formation of VHSC has been completed in most villages of the district.
- Deployment of BHM and Hospital Managers is complete at all the vacant places in the district.
- Services of advanced life saving ambulance (108) is started in the district
- Contractual AYUS doctors have been placed in APHC.
- Decentralized planning at HSC level has been started from this year in the district

Weakness

- Asha Selection is not 100% complete
- Utilization of untied fund in most of the health centers is very less.
- Replenishment of Asha kit and drugs is not timely and complete.
- Construction of HSC, APHC, PHC buildings and staff quarters moving with very slow pace.
- ISO certification process of health facilities is still to start in the district.
- Pathology and Radiology services under PPP initiatives are not properly functional at most of the health facilities.
- Lack of orientation among members of RKS regarding their scope of works for Health facilities.

Opportunity

- Participation of Mukhiyas and Surpanch in Asha selection process to expedite the process and also proper and complete utilization of Untied fund for health facility development.
- Favourable administrative and political condition for program implementation.
- Availability of fund from both NRHM and State funding for development of health infrastructure.

Threat

- Corruption and ill intention in construction of buildings and selection process of employees.
- Lack of people interest and support for proper maintenance of health infrastructure and quality of services.
- Less knowledge and sensitivity for work among Asha and other contractual employees.
- Not immediately filling vacant positions Specialist Doctors of.

SWOT Analysis of Part C- Routine Immunisation

Strength

- Properly and timely formation of block microplan of RI.
- Availability and involvement of large human work force in form of ANM and Asha.
- Functioning of one separate dept. in health sector to look after RI.
- Timely availability of vaccines.
- Abundance of fund for all kind of review meeting and supervion og the program.

Weakness

- Low achievement against the fixed targets.
- Poor cold chain maintenance.
- Handling of cold chain-deep freezers by untrained persons.
- Poor public mobilization by ANM and Asha.
- Poor or false reporting data from block and sub centers.
- Quarterly review meeting at district and blocks are not happening regularly.
- Unavailability or non use of RI logistics like red/black bag, twin bucket etc

Opportunity

- Support from UNICEF and other development agencies in RI.

- Proper coordination and support from Anganwadi –ICDS dept.
- Growing awareness among people regarding immunization.

Threat

- Sudden outbreak of epidemic.
- Corruption in program implementation.

6. MATERNAL HEALTH

Goal: - Reduction of the Maternal Mortality Ratio

Objectives:-

- To increase ANC and PNC coverage
- To reduce anemia among pregnant mothers
- To increase institutional deliveries
- To increase access to emergency obstetric care
- To reduce incidence of RTI/STI cases

Strategies

- Case management of pregnant women to ensure that they receive all relevant services by ASHAs and ANMs
- Providing ANC along with immunisation services on immunisation days Providing ANC along with immunisation services on immunisation days (**VHSND-**Village Health Sanitation and Nutrition Day observation fortnightly at all AWCs will help giving manifold services at one point as well as strengthen our health system).
- Effective monitoring and support to HSCs for ANC by APHC.
- Strengthening ANC services at the Sub centre level and at all AWCs by ensuring availability of appropriate infrastructure, equipment and supplies, particularly carrying Hub cutters, Needle cutter, and Blood Pressure Machines by all ANMs
- Provision of quality Antenatal and Postpartum Care to pregnant Women
- Increase in Institutional deliveries
- Quality services and free medicines to all the deliveries in the health facilities.
- Availability of safe abortion services at all CHCs and PHCs
- Increased coverage under Janani Bal Suraksha Yojna
- Strengthening the Maternal, Child Health and Nutrition (MCHN) days
- Improved behaviour practices in the community
- Referral Transport
- Organizing RCH Camps.

Present Status:-

- In the Jamui District there are three functional FRU and need renovation, establishment and construction work.

- Equipment for the three Blood Storage Unit are available
- There are 48 APHCs sanctioned in the district but only 27 are running.
- More than half of the SHCs are providing facilities at the level but need to be upgraded and capacitate for the better services

Activities

- Ensuring availability of fully functional and equipped labour rooms, maternal wards, ambulance services and blood storage facilities.
- Training of ASHAs for counselling of eligible couples for early registration and the use of the home based pregnancy kit.
- Regular updating of the ANC register.
- Preparation of the due list with the dates for Ante Natal Checkups for every pregnant woman in the Sub centre area.
- Ensure delivery of ANC services through strengthening of health sub-centres,APHCs and PHCs.
- Form inter-sect oral collaboration to increase awareness, reach and utilization of ANC services
- Promote institutional delivery through reinforced network of APHCs, PHCs/Referral Hospitals, Sub-divisional Hospitals and District Hospitals.
- Promote institutional delivery by involving private sector/NGO providers of EmOC.
- Ensure safe delivery at home.
- Revamp existing referral system for emergency deliveries.
- Form inter-sectoral collaboration to increase awareness regarding safe delivery and referral.
- Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs.
- Provision of weighting machines to all Sub centres and AWCs.
- Availability of IFA tablets.
- Training of personnel for Safe motherhood and Emergency Obstetric Care.
- Developing the CHCs and PHCs for quality services and IPHS standards.
- Availability of Blood Bank at the District Hospital.
- Certification of the Blood Storage Centres.
- Improving the services at the Sub centres.

7. CHILD HEALTH

Objectives

- Ensuring that children of (0-6 months old) are exclusively breastfed.
- Increase in percentage of children (12-23 months) fully immunised (BCG, 3 doses of DPT, Polio and Measles)
- Ensuring initiation of complementary feeding at 6 months of children.
- Increasing the percentage of children with diarrhoea who received ORS.
- Increasing the percentage of children with ARI/fever who received treatment from.
- Ensuring monthly health checkups of all children (0-6 months) at AWC.
- Ensuring that all severely malnourished children are admitted, receive medical attention, and are nutritionally rehabilitated.
- Reduction in IMR
- Ensuring in the Treatment of 100% cases of Pneumonia in children
- To strengthen school health services

Strategies

- Promote immediate and exclusive breastfeeding and complementary feeding for children.
- Improving feeding practices for the infants and children including breast feeding.
- Counselling mothers and families to provide exclusive breastfeeding in the first 6 months.
- Convergence with WCD Department for implementation of Rajiv Gandhi Creche Scheme at NREGA worksites to enable exclusive breastfeeding and child care by women workers.
- Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months.
- Eradication of Poliomyelitis.
- Increase early detection and care services for sick neonates in select.

Activities

- Meeting with WCD officials to review the status of implementation of the Rajiv Gandhi Creche scheme.
- Training by Health Department of crèche workers on nutrition and child care.
- Organising health checkups at AWC for children in the 0-6 year age group on the 2nd Monday of every month.
- Referral of severely undernourished sick children to Nutrition Rehabilitation Centre (NRCs)
- Use mass media (particularly radio) to promote breastfeeding immediately after delivery.
- Birth (colostrums feeding) and exclusively till 6 months of age.
- Increase community awareness about correct breastfeeding practices through
- Build capacity of immunisation service providers to ensure quality of immunization services.
- Form inter-sect oral collaboration to increase awareness, reach and utilization of immunisation services.
- Strengthen Supervision and monitoring of immunization services.
- Promotion of health seeking behaviour for sick children and Community based As per Intensified Pulse Polio Immunisation Campaign (IPPI) based on ongoing Supplementary Immunisation Activities (SIAs).

8.Family Planning Population Stabilization

Objectives

- Fulfilling unmet need for family planning services at the community level
- Increasing the use of any modern method of family planning from 35% to 50%
- Increasing male sterilisation rates from 0.5% to 2%
- Increasing the utilization of condoms as the preferred choice of contraception from 2.7% to 8%.
- Reduction in Total fertility Rate from 2.5 to 2.4Increase in Contraceptive Prevalence Rate to 70 %
- Decrease in the Unmet need for modern Family Planning methods to %
- Increase in the awareness levels of Emergency Contraception from 60% to 80%

Strategies

- IEC/BCC at community level with the help of ASHAs, AWW.
- Addressing complications and failures of family planning operations.
- Training male peer educators to increase awareness amongst men about the importance of contraception and the ease of spacing methods.
- ASHAs to have a stock of contraceptives for distribution.
- Training of MOs in NSV & Female Sterilization.
- Raise awareness and demand for Family Planning services among women, men and adolescents.
- Availability of all methods and equipments at all places.
- Increase access to and utilization of Family Planning services (spacing and terminal methods)
- Increasing access to terminal methods of Family Planning.
- Increased awareness for Emergency Contraception and 10 yr Copper T
- Decreasing the Unmet Need for Family Planning.
- Expanding the range of Providers.

Activities

- Selecting and training male peer educators (1 for every 500 persons) in 5 blocks to counsel men for the adoption of spacing methods.
- Interpersonal counseling of eligible couples on family planning choices by ASHAs and male peer educators.
- Family planning day at all health facilities every month.
- ANM and ASHA to report complications and failure cases at community to facility.
- Quick facility level action to address complications and failures.
- Extensive campaign using multiple channels to raise awareness and demand for Family Planning.
- Broad inter-sect oral collaboration to promote small family norm, late marriage and childbearing.
- Promotion of Family Planning Services at community level through peer educators.
- Each APHC and PHC will have one MO trained in any sterilization method 6. Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives.
- Increase utilization of Family Planning services through provision of incentives to acceptors and private providers FP services.

Urban RCH

Goal – Promote quality primary health care services in the urban area

Objectives:-

- To promote quality RCH services in the urban area
- To provide free OPD services and drug
- To promote immunization, institutional delivery and family planning in the urban area

Strategies:-

- Fictionalization of the two urban RCH in the JAMUI in PPP mode

Present Status:-

- Not any urban RCH center is running

Gap Analysis:-

- Need urban RCH center in the district

Activities Planned:-

- Two urban RCH will be functionalize in PPP mode
- Ensure quality services at the urban RCH Centre
- Service provision such as family planning, immunization and institutional delivery

Plan for vulnerable groups

Goal – Reduce mortality and morbidity in the vulnerable section of the society

Objectives:-

- To promote primary health care services for the Mahadalits

Strategies:-

- Organizing health camps in Mahadalit Tolas IEC/ BCC

Present Status:-

- A large number of Mahadalits are not accessing to the health care facilities

Gap Analysis:-

- Mahadalits are not accessing to the health care facility properly due to lack of awareness, illiteracy and other social barriers
- Activities Planned:-
- Organize health camps in the Mahadalit Tola
- Printing and distribution of health card for Mahadalit
- Organize immunization session in the Mahadalit Tola
- Free drug distribution during health camps
- Interpersonal communication by health personnel in the camp

Iinnovations/PPP/NGO

Objectives:-

- To sensitize the people on PCPNDT and sex ratio
- To make two DH viz. Pilgrim and L E Z Hospital Gaya family friendly hospital

Strategies:-

- Organzing workshop on PCPNDT and sex ratio at the district and bloc
- IEC/BCC
- Family Friendly Hospital

Present Status:-

- Few people are aware on the issue

Gap Analysis:-

- A large number of people are not sensitized on the issue of the PCPNDT and sex ratio specially in the rural area
- Many ultrasonic centre are running and providing sex selection services illegally that affection adversely on the sex ratio
- Need for proper implementation of the PCPNDT and MTP act

Activities Planned:-

- Organizing sensitization workshop (Beti Bachao Karyashala) on PCPNDT and Sex Ratio at the district level with the support of state health society. Resource person will come from SHSB
- Organizing sensitization workshop (Beti Bachao Karyashala) on PCPNDT and Sex Ratio at the Block level
- IEC on the issue will be distributed in the workshop and also among the community
- Pilgrim and L E Z hospital will become family friendly hospital as per norms

9. Adolescent Reproductive and Sexual Health

Objectives

- Improve sex ratio 921 -> 924
- Increase the knowledge levels of Adolescents on RH and HIV/AIDS
- Enhance the access of RH services to all the Adolescents.
- Improvement in the levels of Anaemia.

Strategies

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

Activities

- Create conducive environment to promote adolescent health needs among health service providers and community at large.
- Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents.
- Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.
- Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers.
- Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents.
- Increase availability and distribution of micronutrient Workshop to develop an understanding regarding the Adolescent health and to finalize the operational Plan.

- Supplements to adolescents at grassroots level primarily through health and education networks.
- Provision of Adolescent friendly health services at PHCs, CHCs, FRUs and district hospitals in a phased manner. Training of the MOs, ANMs on the needs of this group, vulnerabilities and how to make the services Adolescent friendly.
- Adolescent Health Clinics will be conducted at least twice in a month by the MO to provide Clinical services**,** Nutrition advice, Detection and treatment of anaemia, Easy and confidential access to medical termination of pregnancy, Antenatal care and advice regarding child birth, RTIs/STIs detection and treatment, HIV detection and counselling.
- Treatment of psychosomatic problems, De-addiction and other health concerns.
- Awareness building amongst the PRIs, Women's groups, ASHA, AWWs.
- Provision of IFA tablets to all Adolescents, deworming every 6 months,
- Vitamin A administration and Inj. TT.
- Involvement of NGOs for Environment building. One NGO per Block will be selected. NGO will select the counsellor in the villages.
- Involvement of ASHAs as counsellor and one Male & Female person of all the villages, and training of all the health personnel in the Sub centres, PHCs and CHC in the block
- There will be equal number of Male and Female counsellors and will alternate between two PHCs – one week the male counsellor is in one PHC and the female counsellor in the other and they switch PHCs in the next week so that both the boys and girls benefit.
- Facilitating group meetings.
- Organizing Counselling session once per week at the PHCs with Wide publicity regarding the days of the sessions.
- Collecting data and information regarding the problems of Adolescents Close monitoring of the under 18 marriages, pregnancies, prevalence of RTI/STDs.
-

10. District Hospital

Infrastructure of District Hospital

Objectives

- Ensure that the hospital acquires District Hospital status
- To provide quality secondary care with a special focus on BPL patients

Strategies

- Ensuring the district hospital status for the concerned hospital.
- Providing private space for all patients in general OPD
- Providing separate ward for paediatric OPD
- Ensuring IPD for general and specialist care.
- Ensuring clearing of encroachment and renovation.
- Ensuring functioning of all OTs
- Establishment of eye OT with proper equipment.
- Ensuring the power supply through Bihar state electricity board.

Activities

- Submitting the requisition for recognition of hospital in question as district hospital
- Follow-up of the process.
- Clearing the encroachment through legal process.
- Follow-up of the clearing process and up gradation of these facilities into wards.
- Curtains/ wooden separators for every doctor-patient chamber.
- Identification of specialist examination rooms.
- Requisition for recruitment of OT technicians.
- Identification of room for conversion into OT -ophthalmologic surgeries with proper equipment.
- Requisition for BSEB for speedy power connection and follow-up of the process

Equipments of District Hospital

Activities

- Identification for infrastructure to store equipment
- Creating a channel for collection of disagreed/ unrepeatable equipment from HSCs onwards.
- Entering into service contract with local/industries for servicing, replacement, and replenishment of materials required from HSCs onwards.
- Training of health workers/ worker dealing with the equipment for proper operation and minor repairs.

Drugs of District Hospital

Strategies

- Ensuring the establishment of the repair units.
- Ensuring servicing of equipment.
- Ensuring proper operation of equipment Ensuring supply of replacement and replenishment of materials.

Strategies

- Ensuring the replenishment of the drugs at the district level.
- Ensuring a system for replenishment of drugs.

Activities

- Creating a HMIS for the drug channel.
- Responding to the monthly.
- Reporting from the HSCs/APHCs/PHCs/SDHs/DH.
- Computerized management of the drugs in the health facilities.
- Advertisement for the posts of Pharmacists (M. Pharma)

11. Primary Health Centre

Objective of IPHS for PHCs are:

- To provide comprehensive primary health care to the community through the Primary Health Centres.
- To achieve and maintain an acceptable standard of quality of care.
- To make the services more responsive and sensitive to the needs of the community.

Strategies

- To phase out PHCs from blocks which already have a Referral Hospital and/or Sub-divisional Hospital so that there is no overlap of facilities providing the same level and nature of services – Jhajha, Laxmipur, Chakai.
- Strengthening all PHCs to ensure basic facilities especially functional labour rooms and OTs.
- Ensuring running water supply and drinking water supply in all PHCs
- Ensuring power supply and power back up for all PHCs
- Up gradation of PHCs into 30 bedded facilities.
- ISO certification of selected PHCs in the district.
- Strengthening of BMU
- Ensuring community participation.
- Strengthening of Infrastructure and operationalization of construction works

Activities

- Need based (Service delivery)Estimation of cost for up gradation of PHCs
- Preparation of priority list of interventions to deliver services.
- Selection of any two PHCs for ISO certification in first phase.
- Sending the recommendation for the certification with existing services and facility detail.
- Ensuring regular monthly meeting of RKS.
- Appointment of Block Health Managers in rest of the vacant place & accountants in all institutions.
- Training to the RKS signatories for account operation.
- Trainings of BHM and accountants on their responsibilities.
- Meeting with community representatives on erecting boundary, beautification etc,
- Nukkad Nataks on Citizen's charter of HSCs as per IPHS
- Monthly meetings of VHSCs, Mothers committees.

"Human Resource of Primary Health Centres:"

Activities For Rationalization of Doctors across facilities

- Reviewing current postings.
- Preparing a rationalization plan.
- Meeting to DHS to consider and approve the rationalization plan.

Filling Vacancies

- Requisition to state health department for recruitment of permanent doctor and requisition to state health society for hiring of contractual doctors.
- Requisition to state health department for recruitment of permanent Grade A nurse and requisition to state health society for hiring of contractual Grade A nurses.
- Appointment of Laboratory technicians, pharmacists, dressers and Store keepers (permanent positions
- Submission of proposal for sanction and appointment of an OT Assistant in all 7 PHCs+ 3 referral hospitals.
- Holding interviews and issuing appointment letters.

Strategies

- Rationalization of doctors across APHCs, and PHCs
- Filling vacancies of doctors by hiring doctors on contract/appointment of regular doctors – 7 PHCs+ 3 referral hospital (Khaira, Sikandra, Gidhour, Barhat, Sono, Jamui, Jhajha, Chakai, Laxmipur) would need 5 Doctors each – Medicine, Surgery, Paediatrician, Gyanecologist and Anaesthetist.
- Sanction and appointment /hiring of 7 Staff Nurses for all PHCs
- Sanction and appointment/hiring of 2 ANMs for all PHCs
- Filling vacancies of Pharmacists, Dressers, Laboratory Technicians and Storekeeper.
- Sanction and appointment of an OT Assistant in all PHCs

"Infrastructure of Primary Health Centres"

Strategies

- Fully operationalise 3 newly constructed PHCs – Gidhour, Barhat, I. Aliganj.

- To phase out PHCs from blocks which already have a Referral Hospital and/or Sub-divisional Hospital so that there is no overlap of facilities providing the same level and nature of services – Jhajha, Laxmipur, Chakai.
- Ensuring running water supply and drinking water supply in all PHCs
- Ensuring power supply and power back up for all PHCs

Activities

Fully operationalising 3 new PHCs

- I. Aliganj required new building
- **Phasing out PHCs from blocks with Referral and SDH facilities.**
- Placing a proposal for phasing out of PHCs to District Health Society.
- Sending proposal approved by DHS to State Health Society for approval.

Ensuring running water supply

- Requesting PHED to prepare a budget for provision of running water supply in all PHCs and referral hospital.

Ensuring power supply and power back up

- Hiring of generators for all PHCs and referral hospital.

"Equipment of Primary Health Centres"

Strategies

- A detailed assessment of the status of functional equipment in all PHCs as per IPHS norms.
- Rational fulfilling of the equipment required, Repair/replacement of the damaged equipment

Activities

- Monthly reporting of the equipment status, functional/non-functional.
- Purchase of essential equipment locally by utilizing the funds or through RKS funds.
- Identification of a local repair shop for minor repairs.
- Training of health worker for handling the equipment and minor repair.

"Drugs of Primary Health Centres"

Strategies

- Ensuring timely replenishment of essential drugs prescribed under IPHS standards.
- Ensuring management of adverse drug reactions
- Ensuring proper storage of the drugs.

Activities

- Block level drug replacement unit by providing fortnightly status of the drug availability/expiry in the store.
- Utilization of RKS funds for purchase of essential drugs locally.
- Providing basic training for management of drug reactions for health workers mainly Staff Nurse and refresher course for Doctors.
- Separate provision of drugs mainly for camps.
- Rationalizing the collection of user fees on drugs and utilization of these funds for purchase of essential/emergency drugs.
- Utilization of PMGY funds allotted for drugs purchase at the local level.

12. Additional Primary Health Centre

Objectives

- To ensure that jamui has 100% of functional APHCs as required by population norms
- To upgrade all APHCs as per PHC level IPHS norms and to name all APHCs as PHCs
- To operate 25% of APHCs on a 24*7 basis

Strategies

- 48 APHCs to be newly established should be set up to meet the PHC level IPHS norms. Of these 12 are proposed to be constructed in this year and 20 operationalized. The overlap is to enable initiation of services while ensuring the requisite construction of infrastructure.
- Prioritising the setting up of APHCs in all blocks. APHCs currently and also in blocks where the gaps are more than 50% namely Sono, Chakai and Jhajha. A total of 12 APHCs need to be set up in these priority.

Activities

Construction of buildings for existing & proposed APHCs

- Meeting with CO to identify available land for setting up the priority APHCs (PHCs) in the selected villages.
- Follow up the responses to the advertisement given by Bihar Govt for donation of land for setting up of APHCs HSCs.
- Village meetings to identify accessible locations for setting up of APHCs
- Finding locations for new APHCs on the basis of hard to reach areas and population. Distance between two facilities should also be considered.
- Requesting state government to revise the rent rates for APHC (PHC) building and make the grant for payment of the rent.
- Ensuring construction of APHC (PHC) building as per IPHS norm along with residence for MOs, ANM and other health staff.
- Ensuring power supply to all APHCs

"Human Resources Additional Primary Health Centres"

Strategies

- Rationalization of doctors across block facilities to ensure filling of basic minimum positions.
- If any APHC (PHCs) after rationalization is in need of more doctors then additional doctors can be deputed from PHC to run at least one day OPD. This should be considered as an interim arrangement.
- Filling vacancies by hiring doctors on contract or appointing regular doctors.

Activities For Rationalization of Doctors across facilities

- Reviewing current postings.
- Preparing a rationalization plan.
- Introducing rationalization plan in DHS meeting agenda to consider and approve the rationalization plan.

Additional charge as interim arrangement

- Preparation of the roster for deputation of Doctors at the APHC (PHC) where no doctor is available.
- Informing community about the 1 day per week OPD services at APHCs (PHCs)
- Hiring of vehicles for the movement of doctors for fixed OPD days.

Filling vacancies

- Requisition to state health department for recruitment of permanent doctor and requisition to State Health Society for hiring of contractual doctors.
- Requisition to state health department for recruitment of permanent nurses and requisition to State Health Society for hiring of contractual nurses.
- Appointment of 2 MPWs (M/F) at each APHC
- Hiring Laboratory technicians and pharmacists (permanent positions)
- Hiring of clerks/accountants.

Contract Renewal

- Renewal of contract of Grade A staff nurses for the next three years based on perform.

Grade A Nurses

- Renewal of contract of Nurses for 3 years based on performance.
- Recruitment of Nurses for newly established 48 APHCs

ANMs

- Filling of ANM vacancies
- Recruitment of two ANMs for each of the newly established 32 APHCs

MPWs

- Appointment of 2 MPWs (M/F) for all 48 APHCs

Laboratory technicians

- Filling up of vacancies of Laboratory technicians in all APHCs (PHCs)

Pharmacists

- Filling up of vacancies of Pharmacists in all APHCs (PHCs)

Accountant

- Filling up of vacancies of Accountants.

"Equipment Additional Primary Health Centres"

Strategies

- A detailed assessment of the status of functional equipment in all APHCs as per IPHS norms.
- Rational fulfilling of the equipment required Repair/replacement of the damaged equipment.

Activities

- Monthly reporting of the equipment status, functional/non-functional.
- Purchase of essential equipment locally by utilizing the funds or through RKS funds.
- Identification of a local repair shop for minor repairs.
- Training of health worker for handling of the equipment.

"Drugs Additional Primary Health Centres"

Strategies

- Ensuring timely replenishment of essential drugs prescribed under IPHS standards.
- Ensuring management of adverse drug reactions.
- Ensuring proper storage of the drugs.

Activities

- Block level drug replacement unit by providing fortnightly status of the drug availability/expiry in the store.
- Utilization of RKS funds for purchase of essential drugs locally.
- Providing basic training for management of drug reactions for health workers mainly Staff Nurse and refresher course for Doctors.
- Separate provision of drugs mainly for camps.
- Rationalizing the collection of user fees on drugs and utilization of these funds for purchase of essential/emergency drugs.
- Utilization of PMGY funds allotted for drugs purchase at the local level.

13.Health Sub Centres

Objectives

The overall objective is to provide health care that is quality oriented and sensitive to the needs of the community.

The objectives for Sub-Centres are:

- To provide basic Primary health care to the community.
- To achieve and maintain an acceptable standard of quality of care.
- To make the services more responsive and sensitive to the needs of the community.

Human Resource of Health Sub Centres

Strategies

- Renewing the contracts of the ANMs on contract Appointment of regular and contractual ANMs for the newly sanctioned HSCs

Activities

Appointment of ANMs for new HSCs

- Submission of proposal for the appointment of regular and contractual ANMs for the newly sanctioned HSCs
- Holding interviews and issuing appointment letters.

"Equipment of Health Sub Centres"

Strategies

- Assessing the equipment needs of all currently sanctioned HSCs and identifying equipment requiring repair and equipment that needs to be requisitioned.
- Acquiring permission from the state government to appoint district level agency for repair and maintenance.
- Ensuring timely supply of the equipment.
- Ensuring timely repair of the equipment by the local agency.
- Ensuring quick replacement of non-functional equipment.

Activities

- Identifying a local repairing agency.
- Training for the ANM and other health staff at the HSC in handling the equipment and conducting minor repairs.
- Setting up of a district level equipment replacement unit.

"Drugs of Health Sub Centres"

Strategies

- Ensuring timely replenishment of essential drugs prescribed under IPHS standards.
- Ensuring management of adverse drug reactions.
- Ensuring proper storage of the drugs.

Activities

- Weekly reporting of the drugs status: availability, requirement, expiry status.
- Setting up a block level drug replacement unit.
- Utilization of untied funds for purchase of essential drugs locally.
- Providing basic training for management of drug reactions.

14. ASHA

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 Jamui ASHAs have been selected in all the blocks. In most of the blocks ASHAs have completed two rounds of training, while in some of the blocks they have completed one round of training. Salient information related to ASHAs in the district can be found in the matrix below:

Situation analysis:

Out of a total target 1785 ASHAs for the District, 1494 have already been selected. The number of ASHAs to be selected has been determined on the basis of older population estimates. Given that the current estimate of district rural population is **1,756,078** .the total number of ASHAs required at the norm of 1 for every 1000 population is 1756.

Activities

- Submission of proposal for the sanction and selection of additional ASHAs
- Development of an IEC campaign on the role of the ASHA using print and folk media by Block Health Educators.
- Building partnerships with NGOs for conducting an IEC campaign on the ASHA programme.
- Monitoring of the IEC Campaign by Block Community mobilizer.
- Determining the community based selection and review process for ASHAs by DHS.
- Partnership with NGOs for implementing the community based selection and review process
- Monitoring of NGO partnership for community based selection and review of ASHAs by Block Health Educators.

Strategies

- Sanction of additional ASHAs

- Facilitate selection through a community process focused on creating awareness about the role of the ASHA as a community mobiliser and activist and her positioning as a representative of the community.
- Community based review of existing ASHAs for performance and replacement of non-functional ASHAs.
- Partnership with local, active voluntary organizations with a background in community health work in the community based selection and review process.

ASHA Training

- Situation Analysis: Out of 1520, 1494 ASHAs have received only the first round of training.

Strategies

- Conducting 12 days of camp based training for all ASHAs
- Conducting 30 days of field based training for 30% of ASHAs in the district.

Supportive Supervision Activities

- Monthly cluster level meetings of ASHAs, ANMs, AWWs, VHSC members and ASHA trainers.
- Monthly block level trainer's meeting
- Monthly district level trainer's meeting
- Development of simple monitoring formats to be filled out by ASHA trainers, and District Resource Persons to review the functionality of the programme
- Organising an ASHA mela every year at the District level to create a sense of solidarity and support amongst ASHAs
- ASHA Helpline to be managed by the ASHA helpdesks
- Selecting active ASHAs with leadership qualities to be ASHA trainers

Strategies

- Timely release of monetary incentives to ASHAs Instituting social incentives for ASHAs

Activities

- Advertising for an ASHA coordinator at the district levelRecruitment of ASHA coordinator Health educators at the block level to support in ASHA training

15. Nutrition Rehabilitation Centres (NRCs)

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 than 50 % of child deaths worldwide. The Consequences of malnutrition are serious leading to stunting, mental and physical retardation, weak immune defence 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 diarrheal and pneumonia.

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

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, diarrheal 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 counselling to identify the nutrition and health problems in their child.

16.Rogi Kalyan Samitis & Untied Funds

Rogi Kalyan Samitis & Untied Funds for Health Sub-Centre, APHC & PHCs

"Health Sub Centre"

Strategies

- Ensuring that HSCs receive untied funds

Activities

- Opening Bank Accounts
- Ensuring timely release of funds to HSCs

"Additional Primary Health Centre"

Strategies

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

Activities

- Ensuring that all APHCs receive untied funds as per the NRHM guidelines

"Primary Health Centre"

Strategies

- Ensuring timely release of funds to HSCs
- Ensure that RKS is registered in all PHCs.
- Ensure UCs are sent regularly.
- Utilisation of RKS funds to pay for outsourced services
- Ensuring that HSCs receive untied funds
- Opening Bank Accounts

Activities

- Training of RKS office bearers on documentation of meetings as well as of the potential of the RKS

- Training of block level accountants in preparation of the utilization certificates
- Monthly review meeting of block level accountants by District Accounts Manager to strengthen the documentation process
- Developing a check list for review

17. Immunization

Objectives

- 100 % Complete Immunization of children (12-23 month of age)
- 100 % BCG vaccination of children (12-23 month of age)
- 100% DPT 3 vaccination of children (12-23 month of age)
- 100% Polio 3 vaccination of children (12-23 month of age)
- 90% Measles vaccination of children (12-23 month of age)
- 100% Vitamin A vaccination of children (12-23 month of age)

Activities

- Organising regular routine immunisation training for ANM and AWW and IPC/IEC/BCC trainings for ASHA and AWWs.
- Organising immunisation camps at every Sub centre level on every Wednesday and at the AWCs on every Saturday.
- Regular house to house visits for registration of pregnant women for ANC and children for immunisation.
- Developing tour plan schedule of ANM with the help of BHM and MOIC.
- Timely payment to MOICs to arrange transportation of vaccines from district hospital to PHCs.
- Regular disbursement of funds from the DIO to MOs for providing incentives to ANMs.
- Regular disbursement of funds for ANMs to provide incentives to AWWs and ASHA workers.
- Providing per diem for health workers, mobilisers, supervisors and vaccinators and alternative vaccinators.
- Maintaining the disbursement records.
- Visits by MOIC, CDPO, BHM, LHV and health educator to monitor the progress of immunisation schedule and prepare report.
- Ensuring the unrestricted movement of the monitoring team with fuel for vehicle and funds for hiring of the vehicle.
- Maintaining continuous power supply at PHC level for maintaining the cold chain.
- Applying for acquisition of ILR and deep freezer for the 1 PHCs which do not have ILR at present.
- Applying to State Heath society for the funding for Vaccine van to get timely stock of vaccines for the districts.

- Timely and regular requests from district to state as well as blocks to district to replenish the supply of DPT and syringe.
- Rationalisation 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.
- Reviewing the contract of Voltas Cooling Company, currently responsible for repair and maintenance.
- Submitting a proposal to the state health society to acquire power of issuing maintenance and repair contract for cold chain equipment from district.
- Procure stock of hub cutters for all the PHCs for safe disposal of needles and syringe.

18.Vitamin A Supplementation Programme

Situation Analysis:

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 mechanism 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

- Updation of Urban and Rural site micro –plan before each round.
- Improving inter-sectional coordination to improve coverage.
- Capacity building of service provider and supervisors.
- Bridging gaps in drug supplies.
- Urban Planning for Identification of Urban sites and urban stakeholders.
- Human resource planning for Universal coverage.
- Intensifying IEC activities for Community mobilization.
- Strengthening existing MIS system and incorporating 9 doses of Vitamin-A in existing reporting structure.
- Strong monitoring and supervision in Urban areas.

Activities

- Orientation , stationary, data compilation, validation and updating.
- Constituting district level task force and holding regular meetings.
- Organising meeting of block coordinators.
- Training and capacity building of service providers.
- Strategy planning meetings, orientation of stakeholders, resource planning and site management for urban centre and orientation of urban supervisors.
- Ensuring availability of immunisation cards
- Procurement of Vit A Syru

19.National Disease Control Programme

"Tuberculosis"

Strategies

- Detection of New cases.
- House to House visit for detection of any cases.
- IEC for awareness regarding the symptoms and effects of TB.
- Prompt treatment to all cases.
- Rehabilitation of the disabled persons.
- Distribution of Medicine kit and rubber shoes.
- Honorarium to ASHA for giving DOTs.

Activities

- Participation of ASHAs and AWWs for providing DOTS so as to reach services close to the patients for decrease default rate.
- Ensure proper counselling of the patient by the health workers.
- Organizing awareness campaign and community meetings to aware people about the TB and DOTS.
- Sensitization of MOTCs/MOs at the Peripheral health facilities to ensure every TB suspect
- undergo Sputum Smear examination (at least 2% of Total New OPD patient)
- Sensitization of all Lab Technician for Correct Sputum Smear Microscopy(5%-15% positivity is expected among patients examined for diagnosis)
- Ensuring 3 sputum smear examinations for TB patients.
- Participation of ASHA and Community Volunteers to provide effective DOTS.
- Incentive to ASHA and Volunteers for timely Sputum smear microscopy Collection and follow-up.
- Initiation of treatment of New Smear Positive (NSP) patients within a weak of diagnosis.
- To control spared of infection in Group.
- Proper Monitoring/Supervision to ensure regular and interrupted DOTS as per guidelines.

"Proper counselling of patients by the DOTS provider and supervisory staffs".

- Maintenance/ Replacement of defective Binocular microscopes.
- Establishment of new DMC as per need and repairing/renovation of closed DMCs with proper electricity connection and water supply.
- Refreshment training of Lab Staffs specially Lab Technician for maintenance of microscopes.
- Ensure regular and adequate supply of laboratory consumables to DMCs from |District TB Centre(DTC)
- Recruitment of Counsellor at PHC level.
- Active participation of community specially ASHA and AWW.
- Capacity building of ASHA.
- Remuneration to ASHA/Community volunteer for providing DOTS will be paid timely.
- New recruitment for lacks in staffs i.e., Lab Technician, STS, STLS, TBHV and other.

"National Leprosy Elimination programme"

Objective

- To reduce the leprosy disease prevalence rate to.

Strategies

- Currently disease prevalence rate per 10,000 population is.
- New patients registered .
- Awareness in urban areas.

Activities (Improving case detection)

- House to house visits for tracing cases of Leprosy, by health workers (BHWs, ASHA, ANM)
- Detected cases are to be taken to hospital for proper counselling, by professional counsellors.
- The cases detected are to be monitored and followed up by health workers, mainly by BHWs/ASHA to detect deformity.

IEC/BCC to create awareness

- Awareness creation among community by having hoardings, pamphlet, advertisements in the news papers.
- Sensitization of AWW.
- School quiz contest.

- Awareness in the community through Gram- Goshti.
- Organizing 2 Health camps in each block.
- Rally to create awareness.

Strengthening Facilities

- Increasing availability of fuel, vehicle, stationary and medicine at facility level.

Human Resources

- Walk-in interview for filling of all required staff at the district level.
- Continued training for all health workers.
- Training of all health workers specifically in counselling patients and the family about the disease.
- Contracting of services that are essential for management of cases.
- Contracting of a consoler at least at the PHC level.

"Malaria Control Programme"

Situation Analysis:

District faces lack of laboratory technicians and facilities at the APHC/PHC level. This has proved to be a hurdle in prompt diagnosis of the cases. All BHW, BHI, ANM are responsible for collecting the BS of the suspected cases. The exact burden of disease in Jamui is not known as reports from private sector is not collected or not reported. The BCC activities in the district are also limited. There is also shortage of mosquito bed nets but anti-malarial drugs are in abundant.

Strategy

- Ensuring registration of all private laboratories.
- Filling-up of all vacant posts.
- Enhancing BCC activities.
- Ensuring adequate supply of mosquito bed nets.

Activities

- Meeting with DM for issuing an order for all old and new laboratories to register with DHS.
- Following their registration, they would be expected to report all the disease specific cases to the DHS.
- All HWs would also be then requested to collect the reports.
- Training of all health workers in BCC.

"Filaria Control Programme"

Situation Analysis

Similar to Malaria lack of laboratory technicians and facilities at the APHC/PHC level continues to pose a challenge for an effective filarial control programme in the district. In case of Filaria specifically the exact burden of disease is not known because reports from the private sector are not collected or not reported. BCC activities in the district are limited. There is a shortage of chemically treated bed nets. Mass Drug Administration has been carried out in the population where cases have been detected.

Strategy

- Early diagnosis and prompt treatment.
- Ensuring registration of all private laboratories.
- Filling all vacant posts.
- Enhancing BCC activities.
- Ensuring adequate supply of mosquito bed nets.
- Ensuring adequate supply of drugs.

Activities

- House to house visits for tracing cases of Filariasis, by health workers (BHWs, ASHA, ANM)
- Collection of reports from local private practitioners and laboratories in the village.
- Following their registration, they would be expected to report all the disease specific cases to the DHS.
- All HWs would also be then requested to collect the reports.
- Training of all health workers in BCC.
- District level procurement of drugs for MDA, with funds from respective department.

"National Blindness Control Programme"

Strategy

- Prompt case detection.
- Ensuring proper treatment.

Activities

- Screening of all children in the schools Including Optometrists in Mobile medical unit's visits to camps in villages.
- Fortnightly visit by optometrist opthometrician to health sub-centres and weekly visit to APHCs.
- Contracting of ophthalmologist services.
- Distribution of spectacles from the health facilities.
- Conducting in-hospital minor surgeries for cataract.
- Conducting surgeries in the NGO run hospitals and follow-up.
- Distribution of spectacles for BPL population undergoing surgery in private sector.

"Kala Azar"

- Jamui District is free from Kala Azar

"Integrated Disease Surveillance Programme (IDSP)"

Situation Analysis

(The programs with major surveillance components include):

- The National Anti-Malaria Control Program.
- National Leprosy Elimination Program
- Revised National Tuberculosis Control Program
- Nutritional Surveillance
- National AIDS Control Program.
- National Polio Surveillance Program as part of the Polio eradication initiative
- National Programme for Control of Blindness (Sentinel Surveillance)

- Surveillance activities of all these vertical programs of Malaria, Tuberculosis, Polio, and HIV are functioning independently leading to duplication of Surveillance efforts. Surveillance has been ineffective due to
- There are a number of parallel systems existing under various programs which are not integrated
- The existing programs do not cover non-communicable diseases

- Medical colleges and large tertiary hospitals in the private sector are not under the reporting system as well as for utilization of laboratory facilities.
- The laboratory infrastructure and maintenance is very poor
- Presently, surveillance is sometimes reduced to routine data gathering with sporadic response systems thereby leading to slow response to Epidemics,
- Information technology has not been used fully for information and to analyze and sort data so as to predict epidemics based on trends of the reported data.
- In response to these issues the Integrated Disease Surveillance Programme was launched in Bihar in 2005 to provide essential data to monitor progress of on going disease control programs and help in optimizing the allocation of resources.

- IDSP includes 22 diseases/ conditions (Malaria, Acute diarrhoeal disease-Cholera, Typhoid, Jaundice, Tuberculosis, Acute Respiratory Infection, Measles, Polio, Road Traffic Accidents, Plague, Yellow Fever, Meningoencephalitis /respiratory distress, etc.,(HIV, HCB, HCV) and 5 state specific diseases (Thyroid diseases, Cutaneous Leishmaniosis, Acid Peptic Diseases, Rheumatic Heart Diseases).
- Establishing of District Surveillance unit.
- Rapid response teams have been established at District levels.
- DSUs (District Surveillance Units) have been established in all districts.
- Regional Lab has been proposed for specialized test.

Objectives

- Improving the information available to the government health services and private health care providers on a set of high-priority diseases and risk factors, with a view to improving the on-the-ground responses to such diseases and risk factors.
- Establishing a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health actions can be initiated in response to health challenges in the country at the state and national level.
- Improving the efficiency of the existing surveillance activities of disease control programs and facilitate sharing of relevant information with the health administration, community and other

stakeholders so as to detect disease trends over time and evaluate control strategies.

Activities

- Strengthening of the District Surveillance Unit (DSU), established under the project,
- Training of the Unit In charge for epidemiology – {DMO)
- Hiring of Administrative Assistant.
- Training of contract staff on disease surveillance and data analysis and use of IT.
- Providing support for collection and transport of specimens to laboratory networks.
- Provision of computers and accessories
- Provision of software of GOI
- Notifying the nearest health facility of a disease or health condition selected for community-based surveillance
- Supporting health workers during case or outbreak investigation
- Using feedback from health workers to take action, including health education and coordination of community participation.

20. DEMAND GENERATIO, IEC/BCC

Situation Analysis

- There is lack of awareness and good practices amongst the community due to which they neither avail the services nor take any positive action. There is lack of awareness regarding the services, schemes including the Fixed Health days.

The following issues need special focus:

- Importance of 3 visits for ANC, advantages of institutional delivery, Post natal care.
- Availability of skilled birth attendants, balanced diet during pregnancy, anaemia, misgivings about IFA, kitchen garden.
- Importance of complete immunization, disadvantages of drop outs, nutritional requirements of infants and children, malnutrition, exclusive breastfeeding.
- Problems of adolescents, drugs addiction, malnutrition, problems of sexuality, age at marriage, tendency to take risks in sexual matters.
- DOTS programme for TB, location of microscopy centres, cardinal symptoms of TB,
- High risk behaviour in the community in relation to water born diseases, heart diseases and lung diseases, and HIV/AIDS, STDs
- Evil of drugs addiction affecting adolescents,
- High prevalence of RTIs, including STDs,
- Issues of malaria spread and prevention and also other diseases
- JSY, Fixed Health days, availability of services.
- The personnel have had no training on Interpersonal communication

Objectiv

- Widespread awareness regarding the good health practices
- Knowledge on the schemes, Availability of services

Strategy

- Information Dissemination through various media,
- Interpersonal Communication.
- Promoting Behaviour change.

Activity

- Awareness on Fixed MCHN days
- Designing of BCC messages on exclusive breast feeding and complimentary feeding, ANC, Delivery by SBA, timely referral, PNC, FP, Care of the Newborn,
- Gender, hygiene, sanitation, use of toilets, male involvement in the local language.
- Consistent and appropriate messages on electronic media – TV, radio.
- Use of the Folk media, Advertisements, hoardings on highways and at prominent sites.
- Training of ASHA/AWW/ANM on Interpersonal communication and Counselling on various issues related to maternal and Child health.
- Display of the referral centres and relevant telephone numbers in a prominent place in the village.
- Promoting inter-personal communication by health and nutrition functionaries during the Fixed health & Nutrition days.
- Orientation and training of all frontline government functionaries and elected representatives.
- Integration of these messages within the school curriculum.
- Mothers meeting to be held in each village every month to address the above mentioned issues and for community action.
- Kishore Kishori groups to be formed in each village and issues relevant to be addressed in the meetings every month
- Meetings of adult males to be held in each village to discuss issues related to males in each village every month and for community action.
- Village Contact Drives with the whole staff remaining at the village and providing services, drugs , one to one counselling and talks with the Village Health & Water Sanitation Committee and the Mother's groups
- Developing Nirdeshika for holding Fixed Health & Nutrition days to be distributed to all MOs, ANMs, AWWS, LS, PRIs,
- Monthly Swasthya Darpan describing all the forthcoming activities and also what happened in the month along with achievements
- Bal Nutrition Melas 4 times at each Sub centre
- Wall writings.
- Pamphlets for various issues packed in an envelope.

21. PROGRAM MANAGMENT

Situation Analysis

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

Objective

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

Strategies

- Capacity building of the members of the District Health Society regarding the programme, their role, various schemes and mechanisms for monitoring and regular reviews.
- Establishing Monitoring mechanisms.
- Regular meetings of Society.
- Bimonthly meetings of Health,ICDS and PHED (as role of water and sanitation will play an important role in providing better health)

District Programme Management Unit

Status

- In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for

planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers.

- In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager District planning coordinator M&E District community mobilizer District data asistent Officer have being provided in each district.
- These personnel are there for providing the basic support for programme implementation and monitoring at district level under DHS.
- The District Programme Manager is responsible for all programmes and projects in district under the umbrella of NRHM and the District Accounts Manager (DAM) is responsible for the finance and accounting function of District RCH Society including grants received from the state society and donors, disbursement of funds to the implementing agencies, preparation of submission of monthly/ quarterly/ annual SOE, ensuring adherence to laid down accounting standards, ensure timely submission of UCs, periodic internal audit and conduct of external audit and implementation of computerised FMS.
- The District Nodal Monitoring and Evaluation Officer (M&E Officer) has to work in close consultation with district officials, facilitate working of District RCH Society, maintain records, create and maintain district resource database for the health sector, inventory management, procurement and logistics, planning and monitoring & evaluation, HMIS, data collection and reporting at district level.
- There is a need for providing more support to the Civil Surgeon office for better implementation especially in light of the increased volume of work in NRHM, monitoring and reporting especially in the areas of Maternal and Child Health, Civil works, Behaviour change and accounting right from the level of the Sub centre.

- The Civil surgeon's office is located in the premises of the only General hospital in the district. The office of all the Deputy Civil Surgeons is also in hospital premises.

Activities

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

Capacity building of the personnel

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

Development of total clarity in the Orientation workshops and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities:

- Disease Control
- Disease Surveillance
- Maternal & Child Health
- Accounts and Finance Management
- Human Resources & Training
- Procurement, Stores & Logistics
- Administration & Planning
- Access to Technical Support
- Monitoring & MIS
- Referral, Transport and Communication Systems
- Infrastructure Development and Maintenance Division

- Gender, IEC & Community Mobilization including the cultural background of the Meos
- Block Resource Group
- Block Level Health Mission
- Coordination with Community Organizations, PRIs
- Quality of Care systems

Provision of infrastructure for officers, DPM, DAM, M&E Officer and the consultant of the District Project Management Unit. Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, etc;

Use of Management principles for implementation of DistrictNRHM

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

- Financial management training of the officials and the Accounts persons. jurisdiction of the Civil Surgeon
- **Strengthening the Block Management Unit**: The Block Management units need to be established and strengthened through the provision of :
- Block Programme Managers (BPM), Block Accounts Managers (BAM) and Data Operators (DO) for each block. These will be hired on contract.
- Office setup will be given to these persons
- Accountants on contract for each PHC since under NRHM Sub centres have received Rs 10,000 also the village committees will get Rs 10,000 each,besides the funds for the PHCs.
- Provision of Computer system, printer, Digital Camera will be provided for BHM

Convergence of various sectors at district level

- Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon
- Monitoring the Physical and Financial progress by the officials as well as independent agencies
- Yearly **Auditing** of accounts

<u>Strategies</u>

- Support to the Civil Surgeon for proper implementation of NRHM.
- Capacity building of the personnel
- Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities
- Provision of infrastructure for the personnel
- Training of District Officials and MOs for management
- Use of management principles for implementation of District NRHM
- Streamlining Financial management

22.CAPACITY BUILDING AND TRAINING

Situation Analysis

SBA Trainings- 138 contractual ANMs Have received SBA Training.

EMOC Training- Only 2 medical officer from the district has received EmOC training.

IMNCI- No medical officers(MBBS) have received IMNCI ToT.

Family Planning – No any doctors have received Non scalpel Vasectomy training. No Minilap training has been organized in the district.

Strategy

- SBA training to Sub centre ANMs.
- SBA training to all three staff nurses from 32 APHCs
- Building capacity of 2 staff nurses from each of 7 PHCs, 3 RH, 1 SDH and district hospital. Facility
- Establishing district level training centres for regular trainings of the district staff

Activities

- SBA trainings has to be given ANMs posted at Sub centre and APHC. Total number of ANMs=442. Therefore 74 batches each comprising of 6 ANMs has to be trained.
- Staff nurses from each of 6 PHCs, 3 RH, 1 SDH and district hospital. Total number of SNs to be trained=22. So total 4 batches need to be trained.
- LHV from each PHC and RH. total number of LHV=9. So 2 batches for training.

EMOC-

- 2 medical officers from District hospital, SDH and 3 RH.
- 1 MO from each PHC
- 1 MO from 32 priority APHCs.
- Total number of MOs to be trained= 44. Total 8 batches to be trained.

Safe abortion services training

- 2 medical officer s from District hospital, SDH and 3 RH.
- 1 MO from each PHC
- 1 MO from 32 APHCs.

Total number of MOs to be trained-44. Total number of batches=8.

Anaesthetics skill training-

- 1 MO from each functional PHC and 1 each from 3 RH, 1 SDH and 1 DH. Total number of MOs to be trained=11. Total number of batches=2.

NSV training

- 1 MO from each block PHC and 3 RH. So two batches of 6 participants each.

STI/RTI training-

- 1 MO from each functional PHC and 1 DH, 1 SDH and 3 RH. So two batches of 6 participants each.

MINLAP training

- 1 MO from each functional PHC and 1 DH, 1 SDH and 3 RH. So two batches of 6 participants each.

Training on Family Planning choices and IUD insertion

- 1 ANM from each of 32 APHC
- 1 ANM from 6 functional PHC
- 1 ANMs from 3 RH, 1 SDH and DH. So total number of ANM=43. So total 8 batches to be trained.

ARSH training

- 1 MO each from 6 PHCs, 3 RH, 1 SDH and DH. Total number of MOs to be trained=11. So two batches of 6 participants each

SNCU training-

- 2 MOs from 3 RH, 1 SDH and DH. Total number of MOs to be trained
  So two batches of 6 participants each.

<u>Programme management training</u>-

Basic computer skills for clerical staff at DPMU, DHS, District hospital, SDH, referral and PHCs and DPMSU.
District health planning and management for DPMSU and DPM.

23. MONITORING AND EVALUATION

Situation Analysis

Monitoring is an important aspect of the programme but it is not happening effectively and regularly. Each officer and the MOIC, MO, BHM at PHCs are supposed to make regular visits and monitor the progress and check on the activities and also the data provided by the ANMs. The reports have to be submitted and discussed in the monthly review meetings at the entire forum. The District Health Society is not monitoring the progress and neither are the committees at the Block and Gram Panchayat levels. No proper Check-lists exist for monitoring. Also analysis is not done of the visits and any data collected No Verbal Autopsies (Maternal, Neo-natal, Infant & Child Death audits) are carried out any levels. The Role & Functioning of the Sub centre level Committee, PHC level Committee,RKS at PHC and VLC need to be clearly defined. There is no system of concurrent Evaluation by independent agencies so that the district officials are aware regarding the progress and the lacunae.

Strategies

- Developing the system for visits, reporting and review
- Developing a system of Concurrent Evaluation

Activities

- Fixing the dates for visits, review meetings and reports.
- Development of Checklist for Monitoring.
- Software for the checklist and entry of the findings in the checklist.
- MOIC, MOs & BHM to make at least 5% facility visits and also of the villages.
- Quality assessment of all health institutions.
- Maternal Mortality Audit by MO and by involving ANM AWW for reporting of maternal deaths,

24.BIO-MEDICAL WASTE MANAGEMENT

Situation Analysis

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

Objectives

- Stopping the indiscriminate disposal of hospital Waste from all the facilities by 2011-12

Strategies

- Capacity Building of personnel
- Proper equipment for the disposal and disposal as per guidelines
- Strict monitoring and Supervision

Activities

- Review of the efforts made for the Biomedical Waste Interventions
- Development of Microplan for each facility in District & Block workshops

Capacity Building of personnel

- One day reorientation workshops for District & Block levels
- Training to two persons for Plasma Pyrolysis Plant. The company persons will impart this training.

- Biomedical Waste management to be part of each training in RCH and IDSP
- Proper equipment for the disposal
- Plasma Pyrolysis Plant to be installed
- Installation of the Separate Colour Bins/containers and Plastic Bags for the bins
- Segregation of Waste as per guidelines
- Partnering with Private providers for waste disposal
- Proper Supervision and Monitoring
- Formation of a Supervisory Committee in each facility by the MOs and the Supervisors

Year 2012-13

Block PIP

Name of the block I. Aliganj **District Jamui**

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	168000	12 outreach camps in a year	
A.1.3.2	Monthly Village Health and Nutrition Days	No. of SC x 12 months	2500	1 VHND / SC	

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
A.1.4	**Janani Suraksha Yojana / JSY**				
A.1.4.1	Home Deliveries	10% more than previous years	116000	deliveries	
A.1.4.2	Institutional Deliveries				
A.1.4.2.1	Rural	15% more than previous year	4864000	---------- deliveries	
A.1.4.2.2	Urban	15% more		---------- deliveries	
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		15-15% more than previous year	
A.1.5	Other strategies/activities		750		
A.1.5.1	Maternal Death Audit				The GoI guidelines on Facility and Community based MDR should be followed.
	Sub-total Maternal Health (excluding JBSY)				
	Sub-total (including) JBSY				

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
A.2	**CHILD HEALTH**				
A.2.1	IMNCI Training	------ ANMs and Health Educator (HE) s to be trained		------ ANMs and HEs to be trained	IMNCI advocated only for ANMs and health workers
A.2.2	Facility Based Newborn Care/FBNC	----- MOs to be trained	25000	----- MOs to be trained	State may implement F-IMNCI which has FBNC
A.2.4	School Health Programme	------- Schools to be covered; -------- students of ---- ---- classes ----, ----, & ----- covered	248000	------- Schools to be covered; -------- students of ---- ---- classes ----, ----, & ----- covered, ----- boys & ----- girls covered	The programme may concentrate on un-served and under-served areas.
A.2.6	Care of Sick Children and Severe Malnutrition	Establishment of Nutritional Rehabilitation Centre at PHC		Nutritional Rehabilitation Centre established at PHC	
A.2.7	Management of Diarrhoea, ARI and Micronutrient Malnutrition		32000	------ girls & ---boys aged 0 1- 14 years treated for ARI, Diarrhoea	
	Sub-total Child Health		**5456250**		

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
A.3	**FAMILY PLANNING**				
A.3.1	**Terminal/Limiting Methods**				
A.3.1.1	Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services	All MOs, ANMs, ASHAs given first round of dissemination	45000	All MOs, ANMs, ASHAs given first round of dissemination	
A.3.1.2	Female Sterilisation camps	-------- camps to be held in a year, ------- female sterilisations to be conducted	532000	-------- camps to be held in a year, ------- female sterilisations to be conducted	
A.3.1.3	NSV camps	-------- camps to be held in a year, ------- NSVs to be conducted	20000	-------- camps to be held in a year, ------- NSVs to be conducted	
A.3.1.4	Compensation for female sterilisation	For 20-30% more female sterilisations from last year		For 20-30% more female sterilisations from last year	
A.3.1.5	Compensation for male sterilisation	For 20-30% more male sterilisations from last year		For 20-30% more male sterilisations from last year	
A.3.1.6	Accreditation of private providers for			----- Private providers	

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
	sterilisation services			accredited	
A.3.2	**Spacing Methods**				
A.3.2.1	IUD camps	1 camp / SC x 12 months	12000	1 camp / SC x 12 months held	
A.3.2.2	IUD services at health facilities / compensation	------ cases to be inserted at PHCs, APHCs and SCs		------ 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.3.2.4	Social Marketing of contraceptives				Physical target to be provided by the State
A.3.2.5	Contraceptive Update seminars	All MOs, Staff, ANM, ASHAs, HEs to be given first round of updates on contraceptives		All MOs, Staff, ANM, ASHAs, HEs given update on contraceptives	
A.3.3	POL for Family Planning/ Others				This could also be for bringing poor clients from hard to reach areas. Also for mobilising clients and transporting doctors and surgical teams

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
A.3.4	Repairs of Laparoscopes				
A.3.5.	Other strategies/activities				For FP mobile vans for far flung / hard to reach area; to provide some cash reward to 2 best ANMs, and ASHAs and 2 AWWs and 2 self help group member per quarter for mobilising clients for NSV / Vasectomy and IUCD insertion
	Sub-total Family Planning (excluding compensation)		**609000**		
	Sub-total Sterilisation and IUD compensation & NSV camps				
A.4	**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**				
A.4.1	Adolescent services at health facilities.	Orienting all MOs, ANMs, ASHAs, HE on ARSH		all MOs, ANMs, ASHAs, HE oriented on	

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
				ARSH	
A.4.2	Other strategies/activities	To establish ARSH Corner at PHC		A dedicated ARSH corner established at PHC	Through Roster, an ANM to be posted every day in the corner and basic counselling and clinical services to be provided to the adolescents – this should be separately for male and female adolescents (confidentiality to be maintained)
	Sub-total ARSH				
A.8	**INNOVATIONS/ PPP/ NGO**				
A.8.1	PNDT and Sex Ratio	All staff, MOs, ANMs, ASHAs and relevant stakeholders at block level to be oriented on PCPNDT act		____staff, MOs, ANMs, ASHAs and relevant stakeholders at block level to be oriented on PCPNDT act	
A.8.2	Public Private				

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
	Partnerships				
A.8.3	NGO				
A.8.4	Other innovations (if any)				
	Sub-total Innovations/ PPP/ NGO				
A.9	**INFRASTRUCTURE & HUMAN RESOURCES**				
A.9.1	**Contractual Staff & Services**				
A.9.1.1	ANMs	____ new ANM hired	5934000	____ new ANM posted	
A.9.1.2	Laboratory Technicians	------ new Lab tech hired	120000	------ new Lab tech posted	
A.9.1.3	Staff Nurses	---- new staff Nurse needed	1440000	---- new staff Nurse posted	
A.9.1.4	Medical Officers and Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons, Physicians)	----- specialists needed	840000	----- specialists in place	
A.9.1.5	Others - Computer Assistants/ BCC Co-ordinator/ ASHA Link Worker etc		308400		
A.9.1.6	Incentive/ Awards etc. to ASHA Link worker/ SN/ MOs				The block can decided if it wants to

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
	etc.				award, provide some incentives for MH, CH, FP, for example for VHND work etc.
A.9.3	**Minor civil works**				
A.9.3.1	Minor civil works for operationalisation of FRUs				
A.9.3.2	Minor civil works for operationalisation of 24 hour services at PHCs, APHCs and SCs	------- done at PHC, ----- APHCs repaired, ------ SCs repaired		PHC, ____APHCs and ____SCs repaired	
A.9.4	**Operationalise IMEP at health facilities**				
A.9.5	**Other Activities**				
	Sub-total Infrastructure & HR		**8682400**		
A.10	**INSTITUTIONAL STRENGTHENING**				
A.10.3	Monitoring & Evaluation / HMIS				
A.10.4	Sub Centre Rent/Contingencies	----- SCs are well furnished and		----- SCs are well furnished	For rents for SCs and other contingency, like furniture

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
		operational			(table chairs, electric work, genset charges, curtain, up keep (operational expenses) etc.)
A.10.5	Other strategies/ activities	------ visits conducted by PHC staff to field		------- field visits conducted by PHC staff	For supervisory visit of MOICs, MOs, BHMs to SCs, Muskan sites, VHND sites and other community based activities like community interactions etc. @ 4 visits / month – include POL charges
	Sub-total Institutional Strengthening		**735600**		
A.11	**TRAINING**				
A.11.3	**Maternal Health Training**				
A.11.3.1	Skilled Birth Attendance / SBA	----- ANMs trained		----- ANMs trained	
A.11.3.2	EmOC Training	----- MOs, ----- ANMs to be		------ MOs ----- ANMs	

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
		trained		trained	
A.11.3.3	Life saving Anaesthesia skills training	----- MOs, ----- ANMs to be trained		------ MOs, ----- ANMs trained	
A.11.3.4	MTP training	----- MOs, ----- ANMs to be trained		------ MOs, ----- ANMs trained	
A.11.3.5	RTI / STI Training	----- MOs, ----- ANMs to be trained		----- MOs, ----- ANMs trained	
A.11.5	**Child Health Training**				
A.11.5.1	IMNCI	Covered in child health			
A.11.5.2	F-IMNCI and SNCU	---- MOs, & ---- ANMs to be trained on SNCU		---- MOs, & ---- ANMs trained on SNCU	F-IMNCI covered unde Child Health
A.11.5.5	Other CH Training (NSSK)	____ MOs, ____ ANMs to be trained			As per GoI and GoB guidelines
A.11.6	**Family Planning Training**				
A.11.6.2	Minilap Training	----- MOs, ----- ANMs to be trained		----- MOs, ----- ANMs trained	
A.11.6.3	NSV Training	----- MOs, ----- ANMs to be trained		----- MOs, ----- ANMs trained	
A.11.6.4	IUD Insertion	----- MOs, -----		----- MOs, -----	

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
	Training	ANMs to be trained		ANMs trained	
A.11.6.5	Contraceptive Update Training	Covered under FP			
A.11.7	**ARSH Training**	Covered under ARSH			
A.11.8	**Programme Management Training**				
A.11.8.1	BPMU Training				
	Sub-total Training				
A.12	**BCC / IEC**				
A.12.4	**Other activities**	------- community based Health Education (HE) sessions conducted by ANMs and ASHAs (@ 2 / month by every ASHA)		------- HE sessions conducted by ANMs and ASHAs	ANMs and ASHAs to hold 2 community meetings for awareness generation on MH, CH, FP and ARSH
	Sub-total BCC/ IEC				
A.13	**PROCUREMENT**				
A.13.1	**Procurement of Equipment**				
A.13.1.1	Procurement of equipment: MH				Some budget to be earmarked for emergencies – for commonly

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
					sued equipments
A.13.2	**Procurement of Drugs and supplies**				
A.13.2.1	Drugs & supplies for MH			MVA sets	Some budget for contingency to be earmarked
A.13.2.3	Drugs & supplies for FP			5 NSV sets, 5 minilap sets	Some budget for contingency to be earmarked
A.13.2.5	General drugs & supplies for health facilities				Some budget for contingency
	Sub-total Procurement				
A.14	**PROGRAMME MANAGEMENT**				
A.14.2	**Strengthening of BPMU**		50000		
A.14.3	**Strengthening of Financial Management systems**		180000		For hiring of additional hands for handling finances
A.14.4	Other activities (Program Management Expenses at Block level, Mobility				

FMR Code	ACTIVITY	Physical Target	PROPOSED AMOUNT (Rs. in Lakh)	EXPECTED OUTPUT	Remarks
	support, etc.)				
	Sub-total Programme Management				
	Total RCH II Base Flexi Pool				
	Total RCH II Demand Side				
	GRAND TOTAL RCH II		**230000**		

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

S. No	Activity Proposed	Physical target	Proposed Amount	Expected Output	Remarks
1	**Decentralization**				
1.13	ASHA Support System at Block Level		158400	Block level ASHA Resource Centre functional with staff	
1.14	ASHA Trainings	ASHAs to be trained		ASHAs trained	
1.15	ASHA Drug Kit & Replenishment	ASHA kits to be procured		ASHA kits procured	
1.16	Motivation of ASHA	ASHAs provided utility items	13500	ASHAs provided with 2 Sarees 1 Umbrella; and Performance Awards distributed	
1.17	Capacity Building/Academic Support programme				For example: ASHAs enrolled into 10th Grade/ Bach Preparatory prog, IGNOU
1.18	ASHA Divas		99072		TA/DA for ASHA Divas @ Rs. 86 per ASHAs per month *12
	Sub Total ASHA-Decentralisation		**270972**		
1.2	Untied Fund for Health Sub Center, Additional Primary Health Center and Primary Health Center	Untied Funds to SCs, APHC and PHCs	101000	Untied Funds to SCs, APHC and PHCs	Approved. Untied Funds @ Rs. 0.10 lakh per SC; @ Rs. 0.25 lakh per PHC / APHC
1.21	Village Health and Sanitation Committee	VHSCs formed	62000	VHSCs formed and % of last years budget spent	
1.22	Rogi Kalyan Samiti	RKS fund released to PHC	300000	90% allotted RKS fund spent	
	Sub Total Decentralization		**463000**		

2	**Infrastructure Strengthening**				
2.1	Construction of HSCs	New SCs to be constructed		SCs constructed	
2.2 B	Construction of new residential quarters in at PHC, APHCs SCs for Doctots, ANMs and Staff Nurses.	New staff quarters to be constructed		staff quarters constructed	
2.3	Upgradation of PHCs to CHC				Decision to be made in consultation with DHS
2.4	Upgrading District Hospitals and Sub-Divisional Hospital as per IPHS	1 PHC, ----APHC and ------- SCs to be upgraded as per IPHS standard	20000	1 PHC, ----APHC and ------- SCs upgraded as per IPHS standard	
2.5	Annual Maintenance Grant	AMG for PHC, APHc and SCs	300000		@ Rs. 1 lakh per SDH/RH; @ Rs. 0.50 lakh per PHC, Rs. 25,000 / APHC and @ 15,000/SC
	Sub Total Infrastructure Strengthening		**500000**		
3	**Contractual Manpower**				
3.1	Mobile Phone Facility for health personnel		6000		Purchased 38 Handsets with SIM, Recurring charges
3.2	Block Programme Management Unit		405360		For salary etc.
	Sub Total Contractual Manpower		**4113601**		
	PPP Initiatives				
4	**Referral & Emergency Transport-**				

4.4	Referral Transport in Districts				Operational cost / POL etc.
	Sub Total Referral & Emergency Transport				
5	American Association of Physicians of Indian Origin (AAPIO)				
6	Services of Hospital Waste Treatment and Disposal in all Government Health facilities up to PHC in Bihar (IMEP) (Budgeted in Part-A)				One time cost and recurrent cost for disposal pit construction and waste management
9	Outsourcing of Pathology and Radiology Services from PHCs to DH				
10	Operationalising MMU				
11	Monitoring and Evaluation (State, District, Block Data Centre)				For block data cell and HMIS related work (some budget for travel expenses to field)
12	Hospital Maintenance	Covered under annual maintenance grant			
14	Strengthening of Cold Chain		25000		For making, transporting icepacks, genset charges etc.
15	Mainstreaming of AYUSH under NRHM				Salaries field visit expenses of AYUSH doctors
16	Procurement and Logistics				
18	RCH Equipment/Instrument Procurement				

19	De-centralised Planning				Funds for block level NRHM PIP Planning and development
	Sub- Total (5-21)		**25000**		
21	ANMs				Budget for hiring new ANMs (including their salaries)
22	Intersectoral Convergence				For Muskan Project
	Sub- Total (21-22)				
Grand Total					

C: Immunization Strengthening Programme (2011-12)

	Activities	**Proposed Budget (Rs. In Lacs)**		
1.	Mobility support for Supervision and Monitoring at districts and state level.			
2	Cold chain maintenance			
3	Alternate Vaccine Delivery to Session sites			
4	Focus on urban slum & underserved areas			
5	Social Mobilization by ASHA /Link workers			
7	Computer Assistants support at district level			
	Printing and dissemination of immunization cards, tally sheets, charts, registers, receipt book, monitoring formats etc.			
1	Quarterly review meeting at block level			
1	District level Orientation for 2 days ANMs, MPHW,LHV			
1	To develop micro plan at sub-centre level			
1	For consolidation of micro plan at block level			
21	Red/Black bags, twin bucket, bleach/hypochlorite solution			
2	Alternative vaccinator hiring for urban RI			
2	POL of Generators for cold chain			
2	Catch up Campaigns for flood prone areas			
Total				

Part D: Approval under the National Disease Control Programmes

Revised National Tuberculosis Control Programme (RNTCP)

Sr. No.	Activity Proposed	Proposed Budget	Expected Output	Remarks
1	Civil works			
2	Laboratory materials		1) Sputum of TB Suspects Examined per lac population per quarter; 2) All districts subjected to IRL OSE and Panel Testing in the year; 3) IRLs accredited and functioning optimally;	Output to be checked with RNTCP staff
3	Honorarium		1) All eligible Community DOT Providers to be paid honorarium in all districts in the FY;	
4	IEC/ Publicity		1) All IEC/ACSM activities proposed in PIP completed; 2) Increase in case detection and improved case holding;	
5	Equipment maintenance		1) Maintenance of Office Equipments at Block Level	
6	Training		1) Induction training, Update and Re-training of all cadre of staff;	
7	Vehicle maintenance		1) All 4 wheelers and 2 wheelers in the Block to be kept in running condition and maintained	
8	Vehicle hiring			
9	NGO/PP support		1) Contribution of NGOs/PPS in case detection and provision of	

			DOT	
10	Miscellaneous		1) All activities proposed under miscellaneous head in PIP	Check with RNTCP
11	Contractual services		1) Contractual staff in place	Check with RNTCP
12	Printing			
13	Research and studies			
14	Medical Colleges			
15	Procurement –vehicles			
	Total			

National Vector Borne Disease Control Programme

(NVBDCP)

			(Rs. in Lakh)	
SI. No	**Budget head**	**Proposed Budget**	**Expected output**	**Remarks**
1	**DBS (Domestic Budgetary Support)**			
1.1	**Malaria**			To be checked with Malaria Section
	MPW contractual-salary			
	ASHA			
	IEC			
	Training			
	M&E including NAMMIS			
	Bed Nets (ITBNs)			
	Total			
1.2	**FILARIASIS**			
	Training of MOs			
	IEC AT STATE LEVEL			
	Meeting of Coordination Committee			
	Office Expenses at State level			
	Offfice expenses at distrcit / PHC level			
	POL at State Level			
	Meeeting at District levels			
	IEC at district level			

	Training of Mos at district level			
	Training Paramedical staff			
	Linelisting			
	POL at district level			
	Night Blood Survey			
	Training for drug distributors			
	Incentive to drug distributors			
	Training for trainers at district level			
	Incentives to supervisors			
	Total ELF			
1.3	**Dengue / Chikungunya**			
			Identify the high risk areas	
	3.Epidenmic preparedness (logistic+operational cost) State level			
	4-Training/workshop, state level			
	Dengue Total			
1.4	**AES / JE**			

	Diagnotics & Management, (ANMMCH Gaya , & PMCH ,Patna)			
	Training (At State Level)			
	IEC(At State Level)			
	Technical Malathion			
	Monitoring & Evaluation(At State Level)			
	Lab Support & Equipment Supply (ANMMCH Gaya , & PMCH ,Patna)			
	Lab Support (Furnishing of Virology Lab& Equipment Supply) At PMCH ,Patna			
	Staff for strengthening of Lab at PMCH			
	Other Chatges(Contengency)			
	AES/JE Total			
2	**Kala-azar**			
	DBS support- Operational cost including wages, IEC, transportation of DDT			
	Kala azar (World Bank support)			
	Human resource		Strengthening of KA elimination activity	

	Supervision			Mobility support for supervision
	State Office Strengthening			
	Training		Improved capacity	
	World Bank total			
	Kala Azar Total			
	Total Cash (VBD)			
3	**Cash for decentralized commodities**			
	Grand Total Cash for NVBDCP			
4	Commodity for malaria + Filaria			
	Grand Total Cash + Commodity			

National Programme for Control of Blindness

(NPCB)

(Rs. in Lakh)

S	Particulars	Proposed Amount	Approved Amount	Remarks
1	Review Meeting			
2	Flexi pool fund (for staff remuneration & other)			
3	TA/DA for Staff			
4	POL/Vehicle Maintenance			
5	Stationary and Consumables			
6	State level Workshop			
	Total			
	Grant in Aid other components-			
1	Recurring GIA for Eye Donation			
2	Vision Centre (50 @ 50,000/- per vision centres)			
3	Eye Bank 2 @ 15 Lakh			
4	Eye Donation Centre 2 @ 1 lakh			
5	Non-Recurring Grant to NGO for strengthening /expansion of eye care unit on 1: 1 sharing basis 2 @ 30 lakh			
6	Training of Ophthalmic & support Man power			
7	IEC – Annex.1			
8	GIA for free Cataract Operation for 38/ DHS-Blindness Division – Annex-2			
9	GIA for School Eye Screening for 38 DHS-Blindness Division			

10	Support towards salaries of Ophthalmic Manpower to States			
	1.Ophthalmic surgeon in district Hospitals for 10 dist. @ 35000/- per month			
	2. Ophthalmic Assistant in district Hospital in 20 dist. @ 12000/-			
	3. Eye Donation Counselors in eye bank in Government and NGO sector in 2 dist. @ 15000/- per month			
11	Strengthening /setting up of Regional Institutes of Ophthalmology (Non Recurring Assistance)			
12	Strengthening of Medical Colleges @ 40 Lakh for 6			
13	Strengthening of District Hospitals @ 20 Lakhs for 7 dist.			
14	Grant-in-aid to District Health Societies (Recurring Assistant) @ 5 Lakhs			
	Back lock dues in dist.(Approx.)			
	Total:- Rupees Twenty One Crore Ten Lac(s) Seventy Eight Thousand Seven Hundred Fifty Only.			

National Leprosy Eradication Programme

(NLEP)

(Rs. in Lakh)

S. No.	Activity proposed	Proposed Amount	Approved Amount	Expected Outcome	Remarks
1)	**Contractual Services**	15.00	15.00	Functional leprosy cell at state/district level	
	State - SMO, BFO cum AO, DEO, Administrative Assistant, Driver				
	District - Drivers (19)				
2)	**Services through ASHA/USHA**	30.00	25.00	Increase in percentage of cases reported by ASHA	
	Honararium to ASHA, sensitization of ASHA				
3)	**Office expenses & Consumables**	12.82	12.80	Functional leprosy cell at state/district level	
4)	**Capacity building**	24.16	24.00	Improvement in skills in diagnosis & treatment of leprosy	
	4 days training of newly appointed MO (rural & urban)				
	3 days training of newly appointed health worker & health supervisor				
	2 days refresher training of MO				
	5 days training of newly appointed Lab. Technician				
5)	**Behavioral Change Communication**	40.16	40.00	Better self reporting as a result of increased	Programmes IEC needs to be integrated with other
	Quiz,folk show,IPC workshop,Meeting of opinion leaders,Health melas				

	Wall painting,Rallies,Hoardings etc			awareness	programme IEC activities under NRHM
6)	**POL/Vehicle operation & hiring**	30.20	30.20	Improvement in mobility of SLOs & DLOs	
	2 vehicles at state level & 1 vehicle at district level				
7)	**DPMR**	24.44	24.00	Decrease in recurrence of foot ulcers and reduction in grade II disability through RCS	
	MCR footwear, Aids and appliances, Welfare allowance to BPL patients for RCS, Support to govt. institutions for RCS				
8)	**Material & Supplies**	20.06	20.00	Management of reaction cases	
	Supportive drugs, lab. reagents & equipments and printing forms				
9)	**Urban Leprosy Control**	18.24	18.00	Better diagnosis & treatment of leprosy in urban areas	
10)	**Supervision, Monitoring & Review**	8.00	6.00	Better, supervision & monitoring of programme	
	Review meetings and travel expenses				
11)	**Cash assistance**	30.00	10.00	Better, supervision & monitoring of programme	
	TOTAL	**253.08**	**225.00**		

National Leprosy Eradication Programme

(NLEP)

(Rs. in Lakh)

S. No.	Activity proposed	Proposed Amount	Approved Amount	Expected Outcome	Remarks
1)	**Contractual Services**	15.00	15.00	Functional leprosy cell at state/district level	
	State - SMO, BFO cum AO, DEO, Administrative Assistant, Driver				
	District - Drivers (19)				
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4)	**Capacity building**	24.16	24.00	Improvement in skills in diagnosis & treatment of leprosy	
	4 days training of newly appointed MO (rural & urban)				
	3 days training of newly appointed health worker & health supervisor				
	2 days refresher training of MO				
	5 days training of newly appointed Lab. Technician				
5)	**Behavioral Change Communication**	40.16	40.00	Better self reporting as a result of increased awareness	Programmes IEC needs to be integrated with other programme IEC activities under
	Quiz,folk show,IPC workshop,Meeting of opinion leaders,Health melas				
	Wall painting,Rallies,Hoardings etc				

					NRHM
6)	**POL/Vehicle operation & hiring**	30.20	30.20	Improvement in mobility of SLOs & DLOs	
	2 vehicles at state level & 1 vehicle at district level				
7)	**DPMR**	24.44	24.00	Decrease in recurrence of foot ulcers and reduction in grade II disability through RCS	
	MCR footwear, Aids and appliances, Welfare allowance to BPL patients for RCS, Support to govt. institutions for RCS				
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	Supportive drugs, lab. reagents & equipments and printing forms				
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	Review meetings and travel expenses				
11)	**Cash assistance**	30.00	10.00	Better, supervision & monitoring of programme	
	TOTAL	**253.08**	**225.00**		

District Health Society, Jamui (Bihar)

Integrated District Health Action Plan 2012-2013

Budget Sheet

FMR CODE NO.	Activities	Component Code (only at state level)	Output 2012	Activity Plan													Budget Plan											
				2011-2012 FY				2012-2013 FY																					
				Activity planned (X)	Base line / Current Status (As per Oct2011)	Variance (X~Y)	Reasons for Variance	Unit of Measure (In Words)	Special efforts to overcome constraints (Process to be adopted)	Physical Target					Tentative Unit Cost (In Rs)	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 (In Rs.)	Financial Requirement (In Rs)					Commited Fund If Required (If any)	Budgetary Source (other than NRHM source)	Remarks
										Q1	Q 2	Q 3	Q 4	Total No of Unit						Q1	Q2	Q3	Q4	Annual Propose d Budget			
A	RCH - TECHNICAL STRATEGIES & ACTIVITIES (RCH Flexible Pool)					-										-			-						-			
A.1	MATERNAL HEALTH					0										0			0									
A.1.1.1.2	Monitoring Progress and Quality of service delivery in FRU			4	0			Four		1	1	1	1	4	12500	50000	50000	0	50000	12,500	12,500	12,500	12,500	12,500	50,000			Rs.12500/- for quaterly meeting of FRU
A.1.1.2	Operationalise 24*7 PHCs (MCH Centre - APHC)			10	0			Ten		3	3	4	0	10	25000	250000	250000	0	250000	30,000	90,000	90,000	120,000	-	300,000			Rs.30000/- Per APHC
A.1.1.5	Operationalise Sub Centre (MCH Centre - HSC)			2	0			Three		1	1	1	0	3	50000	100000	100000	0	100000	60,000	60,000	60,000	60,000	-	180,000			Rs.60000/- Per HSC
A.1.3	Integrated outreach RCH services															0			0					-	-			
A.1.3.1	RCH Outreach Camps / Others.			19	0			Tweenty		5	5	5	5	20	7000	133000	147000	0	133000	7,000	35,000	35,000	35,000	35,000	140,000			Rs.7000/- Per RCH Camp.

A.1.3.2	Monthly Village Health and Nutrition Days			1397	0			One Thousend Three Hundred Ninety Seven		1397	1397	1397	1397	1397	543.76	759636.911	763900	35800	723836.911		770,000				770,000			
A.1.4	Janani Suraksha Yojana / JSY															0			0						-			
A.1.4.1	Home Deliveries			195	0			Two Hundred		100	50	50	0	200	500	97500	95000	0	97500	500	50,000	25,000	25,000	-	100,000			Rs.500 Per Home Delivery
A.1.4.2	Institutional Deliveries-:															0			0						-			
A.1.4.2.a	Rural			17713	16920			Thertey Thousend		10000	10000	5000	5000	30000	2000	35426000	39970716	2439855 0	11027450	2,000	20,000,000	20,000,000	10,000,000	10,000,000	60,000,000			
A.1.4.2.b	Urban			583	1444			Three Thousend		1000	1000	500	500	3000	1200	699600	660000	265000	434600	1,200	1,200,000	1,200,000	600,000	600,000	3,600,000			
A.1.4.2.c	Ceasarean Deliveries			30	30			Fifty		20	10	10	10	50	1500	45000	195813	25500	170313	1,500	30,000	15,000	15,000	15,000	75,000			Rs.1500/.Per Ceasarean Deliveries
A.1.4.3	Administrative Expences			0	0			One		1	1	1	1	4		493516	493516	0	493516	126,879	126,879	126,879	126,879	126,879	507,515			
A.1.5	Other strategies/Activities															0			0						-			
A.1.5.1	Institution based death review/Community based MDR			111	0			Hundred		25	25	25	25	100	750	83250	80850	0	83250	750	18,750	18,750	18,750	18,750	75,000			Rs.750/- Per MDR case.
A.2	CHILD HEALTH															0			0						-			
A.2.1.1	Implementation of IMNCI activities in district			1	1			One		0	1	0		1	50000	50000	50000	0	50000	50,000	-	50,000			50,000			Rs.50000/- Per District
A.2.1.3	Incentive for HBNC to ASHA/AWWS 3 PNC for normal baby			4837	0			Four Thousend Eight Hundred Eightty		1210	1210	1210	1210	4840	99.99	483651.63	470354	0	483651.63	100	121,000	121,000	121,000	121,000	484,000			Rs.100/- per case
A.2.1.4	Incentive for HBNC to ASHA/AWWS 6 PNC for low birth baby			1972	0			One Thousend Nine Hundred Seventy Two		493	493	493	493	1972	200	394400	383446	0	394400	200	98,600	98,600	98,600	98,600	394,400			Rs.200/- Per case

A.2.2	Facility based New born care / FBNC			1	0			One		1	0	0	0	1	77500	775000	775000	0	775000	775,000	775,000	-	-	-	775,000			Rs.775000/- per FBNC establishment
A.2.6	Management of Diarrohea, ARI and Micronutrient Malnutrition (Nutritional Rehablitation Centre)			1	1			One						1	4E+06	3644100	3644100	534000	3110100	361000	1,644,000	1,444,000	1,444,000	1,444,000	5,976,000			Total 17 Batch Plan 12-13 For NRC
A.3	FAMILY PLANNING															0			0						-			
A.3.1	Terminal/Limiting Methods															0			0						-			
A.3.1.1	Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services			1	1			One		1	0	0	0	1	20000	20000	20000	0	20000	20,000	20,000	-	-	-	20,000			
A.3.1.2	Female Sterilisation camps			288	27			Two Hundred Eighty Eight		72	72	72	72	288	5000	1440000	1560000	15650	1424350	5,000	360,000	360,000	360,000	360,000	1,440,000			Rs.5000/- per Camp
A.3.1.3	NSV camps			4	2			Four		2	2	0	0	4	5000	20000	20000	0	20000	5,000	10,000	10,000	-	-	20,000			Rs.5000/- per Camp
A.3.1.4	Compensation for female sterilisation			7410	1522			Seventeen Thousend Five Hundred Sixtey		4390	4390	4390	4390	17560	1000	7410000	8535000	2942799	4467201	1,000	4,390,000	4,390,000	4,390,000	4,390,000	17,560,000			Rs.1000/- per case
A.3.1.5	Compensation for male sterilisation			187	1			One Hunderd Eighty Eight		47	47	47	47	188	1500	280500	309000	77400	203100	1,500	70,500	70,500	70,500	70,500	282,000			Rs.1500/- per case
A.3.1.6	Accreditation of private providers for sterilisation services			1873	447			Three Thousend		1000	1000	500	500	3000	1500	2809500	3090000	51000	2758500	1,500	1,500,000	1,500,000	750,000	750,000	4,500,000			Rs.1500/- per case for Private Hospital
A.3.2	Spacing Methods															0			0						-			
A.3.3	POL for Family Planning/others				0			Ten		3	3	2	2	10	17000	0	187000	0	0	17,000	51,000	51,000	34,000	34,000	170,000			
A.3.5.4	Provide IUD Services at health facility (IUD Camps)			31	0			Therty		10	10	5	5	30	1515	46965	51500	3000	43965	1,500	15,000	15,000	7,500	7,500	45,000			Rs. 1500/- Per IUD Camp

A.7																								-			
A.7.2	Other PNDT Activities (Monitoring of Sex Ratio at Birth)			1	0			Four		1	1	1	1	4	100000	100000	100000	0	100000	25,000	25,000	25,000	25,000	25,000	100,000			Rs.100000/- Per district for Monitoring
A.8	INFRASTRUCTURE (Minor Civil Works) & HUMAN RESOURCES (Except AYUSH)															0			0						-			
A.8.1.1	ANMs, Staff Nurse,Supervisory Nurse (Salary of Contractual ANM/Contractual Staff Nurse)			153	153			Two Hundred Sixty Six						266	170400	26071200	26071200	6696604	19374596	31,500	10,783,500	10,783,500	10,783,500	10,783,500	43,134,000			
A.8.1.2	Laboratory Technicians (in Blood Bank)			3	0			Three						3	120000	360000	360000	180000	180000	30,000	90,000	90,000	90,000	90,000	360,000			Rs.10000/- per month per Lab Technician
A.8.1.5	Salary of Medical Officer in Blood Bank			1	0			One						1	420000	420000	420000	235000	185000	35,000	105,000	105,000	105,000	105,000	420,000			Rs.35000/- per month
A.8.1.7	Salary of Contractual Staff "Family Planning" Counsellor			2	0			Two						2	135000	270000	270000	0	270000	30,000	90,000	90,000	90,000	90,000	360,000			Rs.15000/- Per Month Salary Per FP Counsellor
A.8.1.8	Incentive/ Awards etc. to ASHA Link worker/ SN/ MOs etc. (Incentive for ASHA & ANM for Muskan Ek Abhiyan)			34236	0			Therty Four Thousend Two Hundred Therty Six						34236	59.7	2043889.2	2043889.2	2346900	-303010.8	-	510,000	973,350	510,000	513,929	2,507,279			
A.9	TRAINING															0			0						-			
A.9.3	Maternal Health Training															0			0						-			
A.9.3.1	Skilled Birth Attendance / SBA			6	4			Twoelve		3	3	3	3	12	88110	528660	592350	186000	342660	88,110	264,330	264,330	264,330	264,330	1,057,320			Rs.88110/- Per Batch for SBA training at District Level (for 6 participant)
A.9.3.4	MTP training														23280	0	116400	0	0						-			
A.9.3.	Other MH Training			2	0			Two		1	1	0	0	2	5750	115000	230000	0	115000	135,0	135,00	135,00	-	-	270,000			Rs.75000/-

7	(Training of MO & Paramedicals at sub centre level														0					00	0	0						per batch for MO & Rs.60000/- per batch for Paramedicals
A.11.5	Child Health Training															0			0						-			
A.9.5.1	IMNCI			32	15			Fourty		10	10	10	10	40	146151	4676817.6	5261420	1065000	3611817.6	134,760	1,347,600	1,347,600	1,347,600	1,347,600	5,390,400			Rs. 134760/- per batch (24 participant in a batch)
A.9.5.5.3	NSSK Training (SN/ANM)			4	0			Four		2	0	2	0	4	52900	211600	211600	0	211600		52,990	158,610			211,600			Rs.52900/- per batch
A.11.6	Family Planning Training															0			0						-			
A.9.6.2	Minilap Training			1	0			One		0	1	0	0	1	70240	70240	70237	0	70240	70,240	-	70,240	-	-	70,240			Rs.70240/- Per batch for 4 doctores.
A.9.6.3	NSV Training																								-			
A.9.6.4.1	Trainingof MO in IUD insertion			1	0			One			1	0	0	1	55300	55300	55289	42104	13185	55,300	-	55,300			55,300			Rs. 55300/- per batch (10 participant in a batch)
A.9.6.4.2	Trainingof ANMs/LHVs/SNs in IUD insertion			3	0			Three		1	1	1	0	3	29425	88275	88260	61835	26425	29,425	29,425	29,425	29,425	-	88,275			Rs.29425/- per batch (10 participants in a batch)
A.9.8.2	DPMU Training			1	0			One		1	1	0	0	1	50000	50000	50000	0		50,000	50,000	-	-	-	50,000			Rs. 50000/- Per district for DPMU Training.
A.10	PROGRAMME / NRHM MANAGEMENT COSTS																								-			
A.10.1.5	Mobility Support (District Malariya Office)														180000	0	180000	0	0						-			
A.10.2.1	Contractual Staff for DPMU recruited and in Position			9				Nine						4	395428	3558852	1186284	609000	2949852	183,420	550,260	550,260	550,260	550,260	2,201,040			Rs.35200/- Per Month Salary for DPM, Rs.29700/- Per Month

																												Salary for DAM, Rs.25300/- Per Month Salary for MEO Rs.22000/- Per Month Salary For DPC Rs.12000/- Per Month Salary Of Office Assistant/Office Assistant Account &Data Operator 10 % increament.
A.10.2.2	Provision of equipment/furniture & Mobility support for DPMU Staff			1				One							986000	986000	986000	341000	645000	60,000	180,000	180,000	180,000	180,000	720,000			Salary of Office Assistan DEO ,Office Assistant Account,& Assistant Of Data Entry Opprator.Budgeted in FMR Code 10.2.1
A.10.3	Strengthening of Block PMU			10	10			Ten						10	735600	7356000	8091600	2698978	4657022	800,966	2,402,897	2,402,897	2,402,897	2,402,897	9,611,587			Rs.21780/- Per Month Salary for BHM, Rs.14520/- Per Month Salary for BAM with 10 % increament. Recurring Expenses.
A.10.4.2	Renewal (Upgradation)			1	0			One		1				1	8100	8100	8100	8100	0	8,100	8,100	-	-	-	8,100			Rs.8100/- Renewal & Upgradation of Tally
A.10.4.3	AMC (State,Regeonal & DHS)			1	0			One		1				1	22500	22500	22500	0	22500	22,500	22,500				22,500			Rs.22500/- for AMC

A.10.4.9	Management Unit at FRU (Hospital Manager & FRU Accountant)			2	2			Two						2	225000	450000	900000	262461	187539	91,111	273,333	273,333	273,333	273,333	1,093,332			Rs.30250/- Per FRU Manager per Month with increament & Rs.15000/- per month Per FRU Accountant
A.10.5.1	Annual audit of the programme (statutory Audit)			4	2			Four			4	0	0	4	9000	36000	36000	0	36000	12,000	-	48,000	-	-	48,000			Rs.12000/- Per Unit Cost
A.10.6	Concurrent Audit (State & District)			1	0			One		1	1	1	1	1	240000	240000	240000	27000	213000	20,000	120,000	60,000	60,000	60,000	300,000	60,000		Commited expenditure 60000
	NRHM-A															0			0						-			
	Grand Total of RCH II (NRHM-A)														9E+06	10323005 3.3	10949332 4.2	4310868 1	60222159 .34	3,393,561	48,488,164	47,335,073	35,000,073	34,769,577	165,592,888			
	NRHM-B																								-			
B1	ASHA															0			0						-			
B.1.1.1	Selection & Training of Asha			1520	1476			One Thousend Seven Hundred Fifty						1750	4623.3	7027461.6	6902637	0	6902637	4,624	2,023,000	2,023,000	2,023,000	2,023,000	8,092,000			Rs.4624/- Per Asha Training Cost
B.1.1.2	ASHA Drug Kit & Replenishment			1520	1476			One Thousend Seven Hundred Fifty						1750	250	380000	380000	0	380000	250	437,500	-	-	-	437,500			Rs.250/- Per Asha Per Drug Kit twice in a year.
B.1.1.3	ASHA Diwas			1520	1476			One Thousend Seven Hundred Fifty						1750	1032	1568640	1568640	592950	975690	125	656,250	656,250	656,250	656,250	2,625,000			Rs. 125/- Per Asha Per Asha Day.
B.1.1.4A	Best Performance Award to ASHAs at District Level			10	0			Ten		0	0	0	10	10	2000	20000	22000	0	20000	2,000				20,000	20,000			Rs.3000/- Per PHC
B.1.1.4C	ASHA Identity Card			75	0			Two Hundred Therty		230	0	0	0	230	20	1500	200	0	1500	50	11,500	-	-	-	11,500			Rs.50/- per Asha Identity Card.
B.1.1.5	Asha Resource Centre / Asha Mmentoring Group			83	0			Ninety Five						95	31115	2582564.92	2551450	438550	2112900	299,100	899,100	899,100	899,100	899,100	3,596,400			Rs. 24200/- Per month DCM Salary Rs.18150/- Per Month DDA Salary,with

																												2 Increament, Rs.5000/- Per Month Office Expenses at Dist Level, Rs.14520/- Per month Per BCM Salary with 2 Increament, Rs.1050 per month per Asha Facilitator, Rs.2000/- Office Expenses at Block Level
B.2	Untied Fund																								-			
B.2.1	Untied Fund for District Hospital & Sub Divisional Hospital			1	1			One		1				1	50000	50000	100000	0	100000	50,000	50,000	-	-	-	50,000			Rs.50000/- Per Unit
	Untied Fund for FRU							Three		3				3						50,000	50,000	-	-	-	50,000			
B.2.2A	Untied Fund for Primary Health Centre			10	10	10		Ten		10				10	25000	250000	275000	29352	245648	25,000	25,000	-	-	-	25,000			Rs.25000/- Per Year for PHC
B.2.2B	Untied Fund for Additional Primary Health Centre			48	0	0		Fourty Eight		10				48	25000	1200000	700000	3845	696155	25,000	25,000	-	-	-	25,000			Rs.25000/- Per Year for APHC
B.2.3	Untied fund for Health sub centre			279	0			Two Hundred Seventy Nine		279				279	10000	2790000	2790000	247473	2542527	10,000	2,790,000	-	-	-	2,790,000			Rs. 10000/- Per Year for HSC.
B.2.4	Village Health and Sanitation Committee			1506	1506			One Thousend Five Hundred Six		1506				1506	10000	15060000	8190000	1002562	1405743 8	10,000					-			Rs. 10000/- Revenue Village Per Year.
B.3	Annual Maintenance Grant																								-			
B.3.1	Annual Maintenance Grant for FRU			3	0			Three		1	1	1		3						100,000	100,000	-	-	-	100,000			
B.3.1A	Annual Maintenance Grant for Dist Hospital			1	1			One		1	0	0	0	1						500,000	500,000	-	-	-	500,000			Rs.500000/- Per Year for Dist

																												Hospital.
B.3.2A	Annual Maintenance Grant for PHCs			7	0			Ten		3	3	2	2	10	50000	350000	350000	139724	210276	50,000	150,000	150,000	100,000	100,000	500,000			Rs.50000/- Per Year for PHC.
B.3.2B	Annual Maintenance Grant for APHCs			48	0			Therty Two		16	16	0	0	32	50000	2400000	900000	0	900000	50,000	800,000	800,000	-	-	1,600,000			Rs.50000/- Per Year for APHC.(Total APHC in govt building are 32)
B.3.3	Annual Maintenance Grant for HSC			279	0			Sixty Five		30	35	0	0	65	10000	2790000	800000	34214	765786	10,000	300,000	350,000	-	-	650,000			Rs.10000/- Per Year for HSC (Total HSC in govt building are 65)
B.4	Hospital Strengthening																								-			
B.4.2A	Installation of Solar Water System in PHC			5	0			Five		5	0	0	0	5	141000	705000	282000	0	282000	38,500	192,500	-	-	-	192,500			Rs.38500/- Per PHC
B.4.3	Sub Centre Rent & Contigencies							Sixty Five						65	6000	0	480000	34214	445786	500	390,000	390,000	390,000	390,000	1,560,000			Rs.500/- Per Month Per HSC.
B.5	Renovation & Setting up																								-			
B.5.2C	Strengthening of Cold Chain Room			1	0			One		1	0	0	0	1	80000	80000	800000	0	800000	800,000	800,000				800,000			Rs.700000/- Per Year For Dist & 100000 Need Based
B.6	Rogi Kalyan Samiti																								-			
B.6.1	Rogi Kalyan samiti for Dist Hospital			1	1	11		One						1	500000	500000	500000	283490	216510	500,000	500,000	-	-	-	500,000			Rs.500000/- Per Year for Dist Hospital.
B.6.2	Rogi Kalyan samiti for FRU			3	3	3		Three						3	100000	300000	100000	0	100000	100,000	300,000	-	-	-	300,000			Rs.100000/- Per Year for FRU
B.6.3	Rogi Kalyan samiti for PHC			10	10			Ten		10				10	100000	1000000	1100000	1371439	-271439	100,000	100,000	-	-	-	100,000			Rs.100000/- Per Year for PHCs
B.6.4	Rogi Kalyan samiti for APHC			27	0			Therty Two		32	0	0	0	32	100000	2700000	2800000	0	2800000	100,000	3,200,000	-	-	-	3,200,000			Rs.100000/- Per Year for APHCs
B.7	Decentarlise Planning																								-			
B.7.1	District Health Actiona Plan (Including BHAP &			290	290	290		Two Hundred Ninety			290			290	1713.9	497022.3	296500	8000	288500	518,500		518,500			518,500			Rs.50000/- for DHAP For Two

	HSC Plan)																											Workshop, Rs.5000/- for Per BHAP & Rs.1500/- for Per HSC Plan
	Innovative Activity																								-			
	Loptop for DPC							One		1				1						35,000	35,000				35,000			Rs.35000/- for Loptop.
	Planning Cell at district level-1 Computer Assistant							One						1						72,000	72,000				72,000			Rs.6000/- per month
B.8	Panchayati Raj Initiative																								-			
B.8.1	Constitution and Orientation of Community Leader & of VHSC,HSC,PHC,CHC etc.			153	153			One Hundred Fifty Three						153	1500	229500	213000	0	213000	200	229,500	-	-	-	229,500			
B.8.2	Orientation Workshop, Training and Capacity Building of PRI at DHS, CHC, PHC			10+153				One Hundred Sixty Three						163	614.05	#VALUE!	93950	17480	76470		100,950	-	-	-	100,950			
B.9	Mainstreaming of AYUSH																								-			
B.9.1	Mainstreaming of AYUSH- Medical Officer only AYUSH			22	22	22		Therty Two						32	220000	4840000	4840000	1658054	3181946	20,000	192,000	192,000	192,000	192,000	768,000			Rs.20000/- Per Month Per AYUSH MO (21)
B.10	IEC-BCC NRHM																								-			
B.10.1	Development of State BCC/IEC Strategy							Eleven						11	38750	0	465000	82806	382194		89,320	89,320	89,320	89,320	357,280			Rs.207280/- for Dist Level & 15000/- for PHC
B.10.3	Health Mela (Leprosy)			1	0			One		0	1	0	0	1	4000	4000	4000	0	4000	5,000	-	5,000		-	5,000			Rs. 5000/- for Health Mela
	Honorarium of IEC Consultant							One						1						15,000	45,000	45,000	45,000	45,000	180,000			Rs.15000/- Per Month Salary for IEC Consultant
B.11	Referral Transport																											

B.11	Mobile Medical Units			1	1			One						1						468,000	1,404,000	1,404,000	1,404,000	1,404,000	5,616,000			Rs.468000/- Per Month For MMU
B.12.2.A	Emergency Medical Service 102																											
B.12.2.C	Advanced Life saving Ambulance (Call 108)			1	1			Eleven						11	2E+06	1560000	1560000	718000	842000	142,142	4,690,686	4,690,686	4,690,686	4,690,686	18,762,744			Rs.142142/- Per Month for 108 Ambulance
B.12.2.D	Referral Transport in Districts			6				Six						6	78000	468000	858000	0	858000	13,000					-	1,000,000		Committed expinditure for 2010-11
B.13	NGO / PPP																								-			
B.13.3.B	Outsourcing of Pathology & Radiology Services from PHCs to DH			7	4			Ten						10	200000	1400000	3800000	1687338	2112662	20,000	600,000	600,000	600,000	600,000	2,400,000			Rs.200000/- Per Year Per Unit.
B.13.3.D	IMEP (Bio-Waste Management)			14	0			Fourteen						14	105231	1473230.64	1368000	0	1368000		366,000	366,000	366,000	366,000	1,464,000			
B.14.A	Rajiv Gandhi Scheme for Empowerment of Adolecent Girls or SABLA														177.13	0	216636	0	216636						-			
B.14.B	YUKTI Yojana of Public & Private Sector for Providing Safe Abortion Services			471	0			Five Hundred		100	100	200	100	500	339.26	159791.46	160471	0	160471	339	33,900	33,900	67,800	33,900	169,500			Rs.160469.98/- for YUKTI.
B.15	Planning, Implementation & Monitoring																								-			
B.15.3.1.A	State,District,Divisional,Block Data Centre.			12	12	12		Twoelve						12	90000	1080000	1080000	379191	700809	10,000	360,000	360,000	360,000	360,000	1,440,000			Rs.10000/- Per Month Per Data Centre
B.15.3.2.A	MCTS & HRIS			10				Ten						10	28702	287016.2	226913	0	226913		268,329	-	-	-	268,329			
B.15.3.2.B	RI Monitoring			10		10		Ten						10	130000	1300000	130000	0	130000	130,000	65,000		65,000		130,000			Rs.130000/- Mobility for DIO
B.15.3.3.A	Strengthening of HMIS			1				One							4000	4000	4000	0	4000	28,900	28,900				28,900			
B.15.3.3.B	Plans for HMIS supportive Supervision and Data Validation.														230000	0	230000	2000	228000	21,800	21,800				21,800			Rs.21800/- Mobility for DM&E, Resource Pool.
B.16	Procurement																								-			

B.16.1.1	Procurement of equipment: MH (Labour Room)			11				Eleven						11	118654	1305194	1542502	0	1542502	125,000	-	1,375,000			1,375,000			Rs.125000/- Each Labour Room.
B.16.1.2	Procurement of Equipment: CH (SCNU & NBCC equipment)			92				Ninety Two						92	20564	1891850.28	2056359	155000	1901359		2,201,177						2,201,177			Rs. 2201177/- for SNCU & NBCC Equipments.
B.16.1.3A	Procurement of Minilap Set: FP			50	0	50		Fifty		25	0	25	0	50	3000	150000	165000	0	165000	3,000	75,000		75,000		150,000			Rs.3000/- Per Kit
B.16.1.3B	Procurement of NSV Kit : FP			5	0	5		Five		5				5	1100	5500	5500	0	5500	1,100	5,500	-	-	-	5,500			Rs.1300/- Per Kit
B.16.1.3C	Procurement of IUD Kit : FP (PHCLevel)			1	0			One			1			1	15000	15000	15000	0	15000	15,000		15,000			15,000			Rs.15000/- Per IUD Kit.
B.16.1.5A	Dental Chair Procurement			6	0			Six		6	0	0	0	6	339474	2036841	1357894	0	1357894	226,315	1,357,890			-	1,357,890			Rs.226315/- Per Dental chair
B.16.1.5C	A.C.1.5 Ton Window in Blood Bank			1	0			One		1				1	25000	25000	25000	0	25000	25,000	25,000				25,000			Rs.25000/- for AC
B.16.2.1A	Parenatal Iron Sucrose (1V / 1M) as therapeutic measure			1				One		1					500000	500000	500000	0	500000	500,000	500,000				500,000			Rs.500000/- for Parental Iron Source
B.16.2.1B	IFA Tablets for Pregnant & Lactating Mothers							One Lakh Fourty Thousend Nine Hundred Eighty SIX		140986				1E+05	14.21	0	990584	0	990584	769,786	769,786				769,786			
B.16.2.2A	IFA Small Tablets & Syrup for Children (6-59 Months)			224235				Two Lakh Twenty Four Thousend Two Hundred Therty Five		224235				2E+05	5.68	1273654.8	1233137	0	1233137	1,275,608	1,275,608				1,275,608			
B.16.2.2B	IMNCI Drug Kit			3456				Three Thousend Four Hundred Fifty Six		3456				3456	250	864000	888000	0	888000	250	864,000				864,000			Rs.250/- Per IMNCI Drug Kit.

B.16.2.5	General Drugs & Supplies for health facilities			1756078				Seventeen Lakh Fifty Six Thousend Seventy Eight		1756078				2E+06		0	7411100	0	7411100		1458815 0				14,588,150			
B.22.4	Support Strengthening RNTCP			12				Twoelve						12	18000	216000	126000	0	126000	18,000	54,000	54,000	54,000	54,000	216,000			Rs.216000/- for RNTCP Staff.
B.23.A	Payment of monthly bill to be BSNL			11	7			Eleven							3405	37455	23835	0	23835	3,405	37,455	-	-	-	37,455			Rs.37455/- frp BSNL Bill.
	Grand Total of Additionalities (NRHM-B)														0	#VALUE!	63478308	8885682	61461926	7,287,494					-			
C	IMMUNISATION																								-			
C.1.a	Mobility support for Supervision and Monitoring at districts and state level.			120				One Hundred Twoenty		30	30	30	30	120	50000	6000000	50000	25000	5975000	50,000	12,500	12,500	12,500	12,500	50,000			Rs. 50000/- Per Year for DIO
C.1.c	Printing and dissemination of immunization formats, tally sheets, monitoring formats etc.(@ Rs.5/- per beneficiaries) + 10% extra.			60558	0	6		Sixty Thousend Fifve Hundred Fifty Six		15139	15139	15139	15139	60556	5	302790	294443	0	302790	5	75,695	75,695	75,695	75,695	302,780			Rs.323890/- for Printings of RI formats.
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.			4				Four		1	1	1	1	4	5500	22000	22000	0	22000	5,000	5,000	5,000	5,000	5,000	20,000			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.			4				Four		1	1	1	1	4	111900	447600	447600	37650	409950	147,300	147,300	147,300	147,300	147,300	589,200			Rs.50/- Partricipants travel & Rs.50/- Per participants meeting expenses (Total ASHA-1473*4 meeting)
C.1.g	Focus on slum & underserved areas in urban areas / alternate Vaccinator for slums.			948				Nine Hundred Eighty Four		237	237	237	237	984	276.08	261723.84	304800	66700	195023.84	200	47,400	47,400	47,400	47,400	189,600			Rs.189600/- for Slum & Underserved areas.
C.1.h	Mobilization of children through ASHA under Muskan Ek Abhiyan			34236				Therty Four Thousend Two Hundred Therty Six						34236	15.3	523810.8	425952	0	523810.8		130,955	130,955	130,955	130,955	523,820			Rs.200/. Per Month Per Asha/Volunteer
C.1.i	Alternate Vaccine Delivery in hardto reach areas.			350				Three Hundred Fifty						350						100	105,000	105,000	105,000	105,000	420,000			
C.1.j	Alternate Vaccine Delivery in other areas.			2932				Two Thousend Nine Hundred Therty Two						2932	51.98	152405.36	1447200	632000	-479594.64	52	439,800	439,800	439,800	439,800	1,759,200			
C.1.k	To develop micro plan at sub-centre level			371				Three Hundred Seventy ONE						371	100	37100	29500	0	37100	100	37,100	-	-	-	37,100			Rs.100 /- Per HSC microplan,
C.1.L	For consolidation of micro plan at District & block level.			10				Eleven						11	1181.8	11818.1	13000	7500	4318.1	1,000	12,000	-	-	-	12,000			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.			10				Ten						10	7090.9	70909	78000	37005	33904	7,100	19,650	19,650	19,650	19,650	78,600			Rs.78600/- for POL for Vaccine Delivery.
C.1.n	Consumables for computer including provision for internet access for RIMs Rs.400 per month per district.			1				One						1	4800	4800	4800	0	4800	4,800	1,200	1,200	1,200	1,200	4,800			Rs.400/- per month per district.

C.1.o & p	Red/Black Plastic bags etc. Bleach / Hypchlorite Solution/twin bucket.			2868				Two Thousend Eight Hundred Sixty Eight						2868	26.37	75629.16	61530	0	75629.16	26	18,806	18,806	18,806	18,806	75,224			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.			3				Three						3	5277	15831	21108	0	15831	3,958	3,958	3,958	3,958	3,958	15,832			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 cases investigation for every district.			5				Five						5	3000	15000	15000	0	15000	5,000	5,000	5,000	5,000	-	15,000			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 .
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	120000	120000	120000	60000	60000	11,000	33,000	33,000	33,000	33,000	132,000			Rs.11000/- 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.			471				Four Hundred Seventy One						471	1543.3	726899.01	669800	22650	704249.01	1,550	181,875	181,875	181,875	181,875	727,500			Rs727000/- for Ri Training.
C.3.d	One day cold chain handlers trainings			20				Twenty						20	1228.5	24569	13513	10467	14102	12,400	12,400				12,400			Rs.12400/- for Cold Chain Handler training.
C.3.e	One day training of block level date handlers.			10				Ten						10	1228.5	12284.5	13513	0	12284.5	12,535	12,535				12,535			Rs.12535/- for block level data Handler training.
C.4	Cold Chain Maintenance			10				Ten						10	5833.3	58333.3	70000	0	0		19,750	19,750	19,750	19,750	79,000			Rs.79000/- per district.

C.6	Pulse Polio			4				Four						4							1,274,412	1,288,162	52,143	2,548,824	5,163,541			
																									-			
	Grand Total of Immunization (NRHM-C)															8883503.07	4101759	898972	7926197.77	262,126	2,595,336	2,535,051	1,299,032	3,790,713	10,220,132			
D	IDD			10				Ten						10		0			0	3,536	35,360				35,360			
E	IDSP			1				One						1		0			0		392,480	392,480	392,480	392,480	1,569,920			
GT	Grand Total (A+B+C)															#VALUE!	177,073,391	52,893,335	129,610,283						-			