DISTRICT HEALTH SOCIETY
KHAGARIA
DISTRICT HEALTH ACTION PLAN
2009-2010

Developed & Designed

By

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Foreword

National Rural Health Mission aims at strengthening the rural health infrastructures and to improve the delivery of health services. NRHM recognizes that until better health facilities reaches the last person of the society in the rural India the social and economic development of the nation is not possible.

The District Health Action Plan of Khagaria district has been prepared keeping this vision of mind. The DHAP aims at improving the existing physical infrastructures, enabling access to better health services through hospitals equipped with modern medical facilities, and to deliver with the help of dedicated and trained manpower. It focuses on the health care needs and requirements of rural people especially vulnerable groups such as women and children. The DHAP has been prepared keeping in mind the resources available in the district and challenges faced at the grass root level. The plan strives to bring about a synergy among the various components of the rural health sector. In the process the missing links in this comprehensive chain have been identified and the Plan will aid in addressing these concerns. The plan has attempts to bring about a convergence of various existing health programmes and also has tried to anticipate the health needs of the people in the forthcoming years.

The DHAP has been prepared through participatory and consultative process wherein the opinion the community and other stakeholders have been sought and integrated. I am grateful to the Department of Health, Government of Bihar for providing the leadership in the preparation of this plan and also in the implementation of other health programmes. The medical personnel and staff of DH/PHCs/APHCs/HSCs gave vital inputs which were incorporated into this document.

I am sure the DHAP and its subsequent implementation would inspire and give new momentum to the health services in the District of Khagaria.

(Mr. Abhay Kumar Singh)
District Magistrate-cum-
Chiarperson, DHS, Khagaria

About the Profile

Even in the 21st century providing health services in villages, especially poor women and children in rural areas, is the bigger challenge. After formation of National Rural Health Mission, we are doing well in this direction. Launching Muskan- Ek Abhiyan we are try to achieve 100% immunization and Anti Natal Care. Janani Evam Bal Suraksha Yojana is another successful program that is ensuring safe institutional delivery of even poor and illiterate rural women. Like wise several other programs like RNTCP, Pulse Polio, Blindness control and Leprosy eradication are running and reaching up to last man of society. But satisfaction prevents progress. Still, we have to work a lot to touch miles stones. In this regard sometime, I personally felt that planning of any national plan made at center lacks local requirements and needs. That is why, despite of hard work, we do not obtain the optimum results. The decision of preparing District Health Action Plan at District Health Society level is good.

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

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block. I am grateful to the DHS consultants, ACMO, MOICs, MOs, Block Health Managers, Grade'A' Nurse, ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Khagaria District.

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

Dr. Uday Chandra Mishra
Civil Surgeon-Cum-
Member Secretary, DHS, Khagaria

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Chapter-1

Introduction

1.1 Background

Keeping in view health as major concern in the process of economic and social development revitalization of health mechanism has long been recognized. In order to galvanize the various components of health system, National Rural Health Mission (NRHM) has been launched by Government of India with the objective to provide effective health care to rural population throughout the country with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The mission aims to expedite achievements of policy goals by facilitating enhanced access and utilization of quality health services, with an emphasis on addressing equity and gender dimension. The specific objectives of the mission are:

- Reduction in child and maternal mortality
- Universal access to services for food and nutrition, sanitation and hygiene, safe drinking water
- Emphasis on services addressing women and child health; and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care
- Revitalization local health traditions and mainstreaming of AYUSH

One of the main approaches of NRHM is to communities, which will entail transfer of funds, functions and functionaries to Panchayati Raj Institutions (PRIs) and also greater engagement of Rogi Kalyan Samiti (RKS). Improved management through capacity development is also suggested. Innovations in human resource management are one of the major challenges in making health services effectively available to the rural/tribal population. Thus, NRHM proposes ensured availability of locally resident health workers, multi-skilling of health workers and doctors and integration with private sector so as to optimally use human resources. Besides, the mission aims for making untied funds available at different levels of health care delivery system.

Core strategies of mission include decentralized public health management. This is supposed to be realized by implementation of District Health Action Plans (DHAPs) formulated through a participatory and bottom up planning process. DHAP enable village, block, district and state level to identify the gaps and constraints to improve services in regard to access, demand and quality of health care. In view with attainment of the objectives of NRHM, DHAP has been envisioned to be the principle instrument for planning, implementation and monitoring, formulated through a participatory and bottom to up planning process. NRHM-DHAP is anticipated as the cornerstone of all strategies and activities in the district.

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

tkeholder in Proce

- Member of tte nd Ditrict Helth Miion
- Ditrict nd Block level progrmme mnger, Medicl Officer.
- tte Progrmme Mngement Unit, Ditrict Progrmme Mngement Unit nd Block Progrm Mngement Unit tff
- Member of NGO nd civil ociety group (in ce thee group re involved in the DHAP formultion)
- upport Orgnition – PHRN nd NHRC

Beide bove referred group, thi document ill lo be found ueful by public helth mnger, cdemicin, fculty from trining intitute nd people engged in progrmme implementtion nd monitoring nd evlution.

1.2 Objectives of the Process

The aim of this whole process is to prepare NRHM – DHAP based on the framework provided by NRHM-Ministry of Health and Family Welfare (MoHFW). Specific objectives of the process are:

- ⇨ To focus on critical health issues and concerns specifically among the most disadvantaged and under-served groups and attain a consensus on feasible solutions
- ⇨ To identify performance gaps in existing health infrastructure and find out mechanism to fight the challenges
- ⇨ Lay emphasis on concept of inter-sect oral convergence by actively engaging a wide range of stakeholders from the community as well as different public and private sectors in the planning process
- ⇨ To identify priorities at the grassroots and curve out roles and responsibilities at block level in designing of DHAPs for need based implementation of NRHM

1.3 Process of Plan Development

1.3.1 Preliminary Phase

The preliminary stage of the planning comprised of review of available literature and reports. Following this the research strategies, techniques and design of assessment tools were finalized. As a preparatory exercise for the formulation of DHAP secondary Health data were complied to perform a situational analysis.

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

The Government of the State of Bihar is engaged in the process of re – assessing the public healthcare system to arrive at policy options for developing and harnessing the available human resources to make impact on the health status of the people. As parts of this effort present study attempts to address the following three questions:

1. How adequate are the existing human and material resources at various levels of care (namely from sub – center level to district hospital level) in the state; and how optimally have they been deployed?
2. What factors contribute to or hinder the performance of the personnel in position at various levels of care?
3. What structural features of the health care system as it has evolved affect its utilization and the effectiveness?

With this in view the study proceeds to make recommendation towards workforce management with emphasis on organizational, motivational and capacity building aspects. It recommends on how existing resources of manpower and materials can be optimally utilized and critical gaps identified and addressed. It also commends at how the facilities at different levels can be structured and organized.

The study used a number of primary data components which includes collecting data from field through situation analysis format of facilities that was applied on all HSCs and PHCs of Khagaria district. In addition, a number of field visits and focal group discussions, interviews with senior officials, Facility Survey were also conducted. All the draft recommendations on workforce management and rationalization of services were then discussed with employees and their associations, the officers of the state, district and block level, the medical profession and professional bodies and civil society. Based on these discussions the study group clarified and revised its recommendation and final report was finalized.

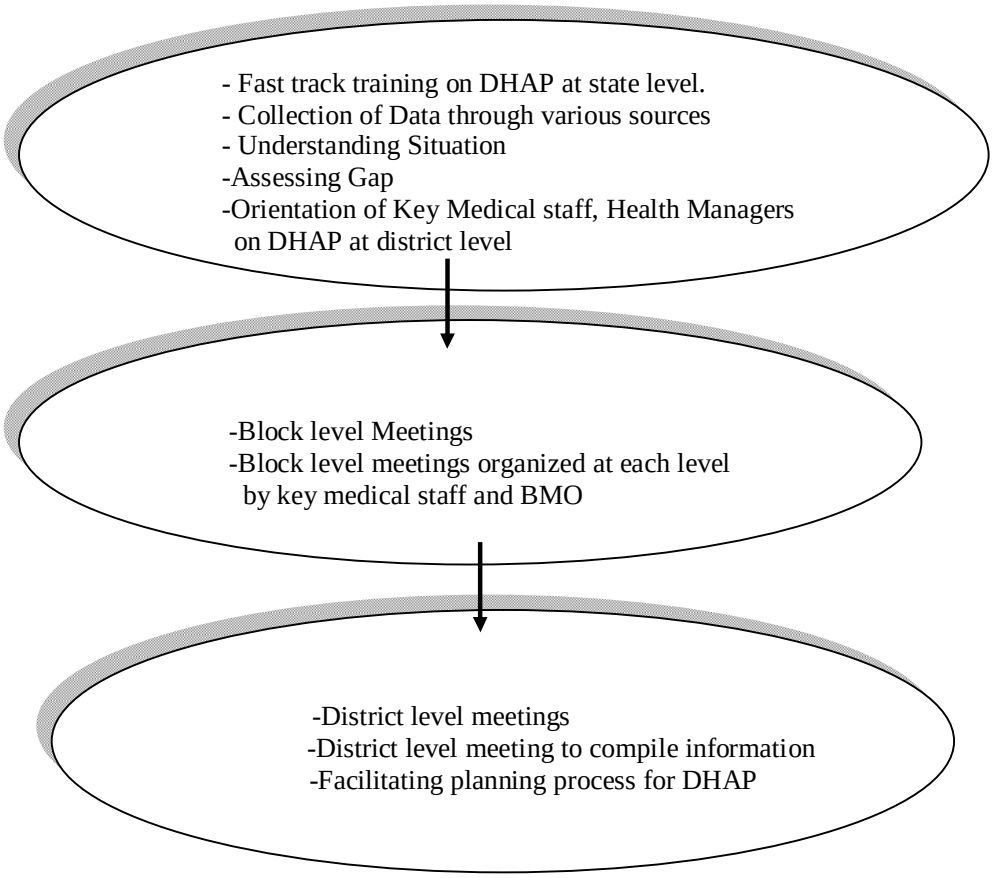
Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersect oral as well as intra sect oral coordination.

To translate this into reality, concrete planning in terms of improving the service situation is envisaged as well as developing adequate capacities to provide those services. This includes health infrastructure, facilities, equipments and adequately skilled and placed manpower. District has been identified as the basic coordination unit for planning and administration, where it has been conceived that an effective coordination is envisaged to be possible. This Integrated Health Plan document of Khagaria district has been prepared on the said context.

1.3.3 Preparation of DHAP

The Plan has been prepared as a joint effort under the chairmanship of District Magistrate of the district, Civil Surgeon, ACMO (Nodal officer for DHAP formulation), all program officers and NHSRC/PHRN as well as the MOICs, MOs, Grade'A' Nurse, Block Health Managers, ANMs, AWWs and community representatives as a result of a participatory processes as detailed below. After completion the DHAP, a meeting is organized by Civil Surgeon with all MOIC of the block and all programme officer. Then discussed and displayed prepared DHAP. If any comment has came from participants it has added then finalized. The field staffs of the department too have played a significant role. District officials have provided technical assistance in estimation and drafting of various components of this plan.

After a thorough situational analysis of district health scenario this document has been prepared. In the plan, it is addressing health care needs of rural poor especially women and children, the teams have analyzed the coverage of poor women and children with preventive and promotive interventions, barriers in access to health care and spread of human resources catering health needs in the district. The focus has also been given on current availability of health care infrastructure in pubic/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.



Chapter 2

District Profile

History

Khagaria, as a district, is only twenty seven years old. Earlier, it was a part of the district of Munger, as a subdivision. The sub-division of Khagaria was created in the Year 1943-44. It was upgraded as district, with effect from 10th May 1981, vide Government of Bihar notification no. 7/T-1-207/79 dated 30th April 1981. As a sub-division of the old district of Munger, Khagaria was the youngest, in terms of creation of sundivision, before independence. The other three older subdivisions were Munger sadar, Begusarai and Jamui. The Jamui sub-division was created on 22nd July, 1864 and Begusarai sub-division on the 14th February 1870.

Khagaria was created as a separate sub-division mainly because of the difficulties arising out of a lack of easy means of communications. Railways were a very old means of communication in this district. As per the Gazetteer of 1960,this Sub-division had three railway lines - the north Eastern Railway, passing west to East had four Stations – Khagaria, Mansi, Maheshkhunt and Pasraha . One branch Line shot off from Khagaria passing through Olapur and Imli, while another branch line shot off from Mansi, which went up to Saharsa. This Mansi- Saharsa branch line, during that period was however disturbed during rains between Katyani Asthan and Koparia, a distance of 6 miles, which had to be covered by boats. Apart from railways, the other means of communication was roads, which were in a very bad shape. The only metalled road at that time was 22 mile long Maheshkhunt- Aguawani ghat road, which was still under construction. During that period Khagaria- Parihara- bakhri Road was also under construction and National Highway linking Moakamaghat to Assam were under contemplation.

This district is well connected to other parts of Bihar and the country through railways as well as roads. New Delhi – Gauhati railway lines passes through Khagaria. Other prominent stations are Mansi, Maheshkhunt and Pasraha. From Mansi, one branch line goes towards Saharsa, while from Khagaria, one branch line goes towards Samastipur. Both these branch lines are still meter- gauge. Between Khagaria and Mansi, both broad gauge and meter gauge railway lines run parallel. Mansi had been an important place from the point of view of railways, since it used to be the headquarters of an Engineering district of railway but now most of important offices of railways have shifted from this place to other places, and mostly to Khagaria or Barauni, which falls in Begusarai district.

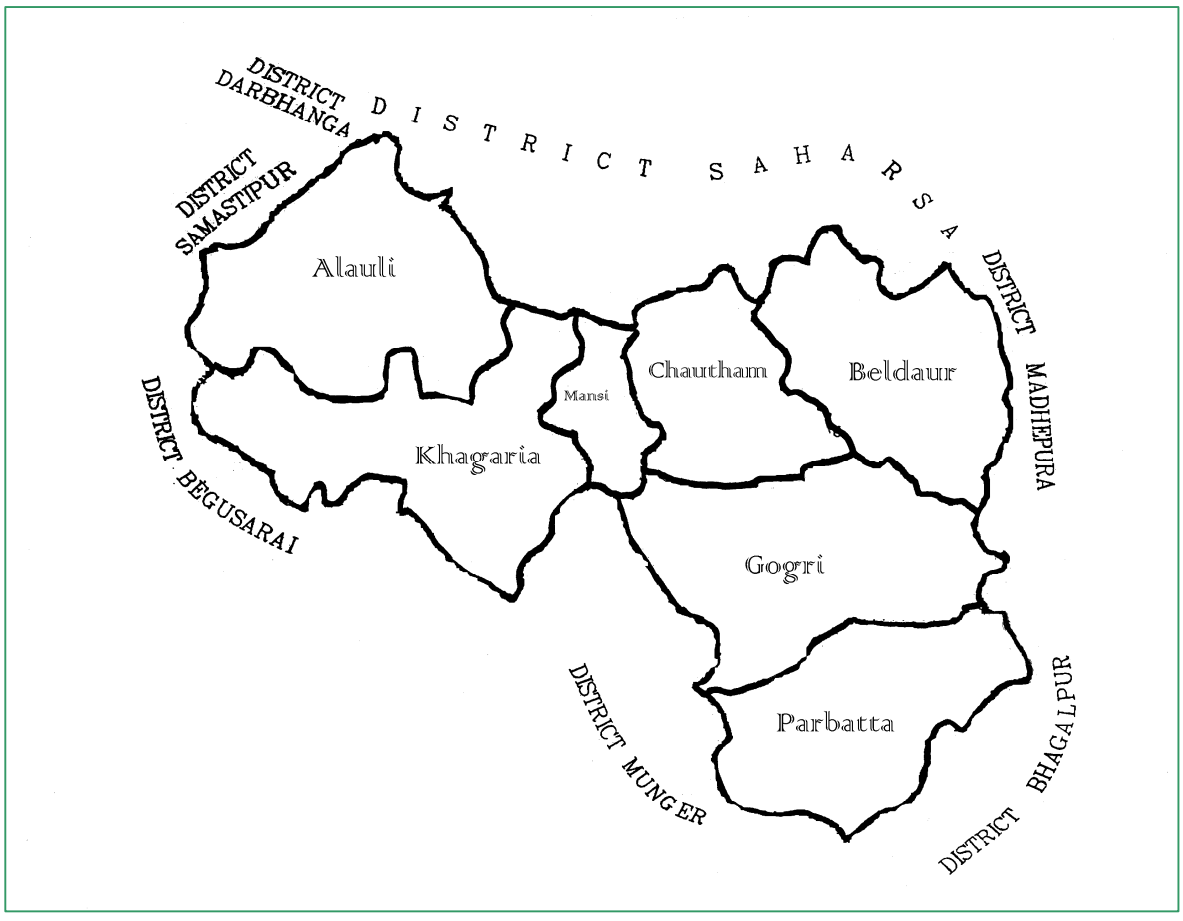
National Highway No. 31 passes through the district almost parallel to the railway line in west-east direction, the intersection of the two existing at a place called Chukati, eight kms. Eastward from Khagaria. Almost 46 Km. of NH- 31 falls within the jurisdiction of Khagaria district. NH-31 goes right upto Gauhati and is an important road link of Bihar to the north – eastern part of the country and to Northern Bengal. From Maheshkhunt, on NH-31, branches off one road to Saharsa district. It is maintained by Road Construction Department of Government of Bihar.

Apart from National highway, the condition of other roads in the district is not very good. Historically also the situation had been the same. Excessive rains and water logging coupled with poor maintenance account for this. Prominent roads of the district, which are maintained by Road Construction department are Maheshkhunt- Chautham- Beldaur Road (26 Km.), Maheshkhunt – Gogari- Parvatta- sultanganj ghat Road (32 Km.), Khagaria- Alauli Road (18 Km.), Khagaria – Parihara- Bakhri Road (19 Km.), Khagaria- Munger ghat Road (6.5 Km.), Khagaria- Sonmankhi Road (6.5 Km.) and Pansalwa – Baijnathpur Road (11 Km.).

The condition of other roads, some maintained by Rural Engineering organisation and some by Block and Panchayats are also worse. Due to existence of several rivers and rivulets, all weather

communication in the interiors of the district would require huge investment in bridges and culverts, the lack of which makes large part of country side accessible by boats only during the rainy season.

MAP OF KHAGARIA DISTRICT



(a) Administrative profile

A perusal of the history of local self-government reveals that District Board of Munger was established in 1887, under Bengal local self Government Act, 1885. The Board originally consisted of 25 members. The District Magistrate was an ex-officio member of the Board and was invariably its Chairman; there were six other ex-officio members, and twelve were elected and six nominated by the Government. From the constitution of the Board in 1887 till 1917 the European District Magistrates used to be invariably the chairman of the Board; the first being I.E.Kaunshead.The first two Indian chairmen were Rai Bahadur G.C.Banarjee (1918) and Raja Deoki Nandan Prasad (1922). Non-official Chairmen presided over the board, for the first time after 1924,when the District Boards were reconstituted on an elective basis under the provisions of the Bihar and Orissa local self-Government (Amendment) Act of 1924-25.Under the District Boards of Munger, there were four local Boards, situated at the subdivisional headquarters. While the Local Boards at Munger, Jamui and Begusarai were formed in 1887 that at Khagaria was established in 1948. Initially the Local Board at Khagaria consisted of eight members six elected and two nominated. The Local Board used to get allotment of funds from the District Board for maintenance of village roads, upkeep of pounds, water supply and village sanitation. Under the District Board, there were eight Union Committees, one of them being Khagaria. Under the Municipal Act, four of these, including Khagaria was converted into Notified Area Committees. Khagaria Union Committee was converted into the Notified Area Committee in 1950, with 12 members. Khagaria became a municipality in the year, while Gogri was converted into a notified area committee in the year.

After independence, Bihar Panchayat Raj Act, 1947 brought a great leap towards local self-government in the form of panchayats, which were initially formed with a population of around 2000 persons. In 1957-1958, in the entire Munger district, there were 159 panchayats. Later on a three-tier panchayat system was established.

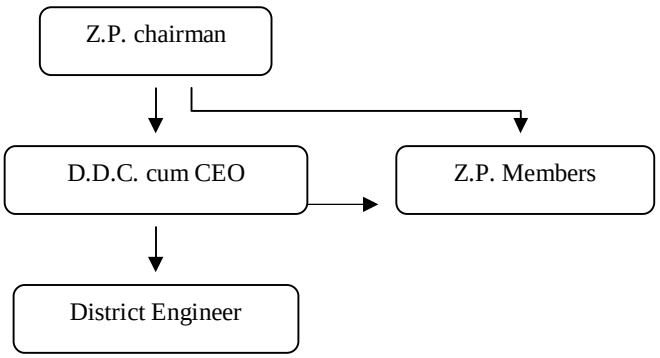
The local self government in rural areas was reorganised vide Bihar Panchayati Raj Act, 1994. Under the new act, Khagaria has 129 panchayats, 185 panchayat Samiti members, 1859 Gram Panchayat ward members and 18 Zilla Parishad members. However the elections could not be held till 31st Dec.1999. The last panchayat elections were held in Bihar in the year 1978.

Administrative Profile of District Khagaria

Administrative levels	Description/Number
District headquarter	Khagaria / 01
Parliamentary constituencies (no.)	01
Assembly constituencies (no.)	04
Number of tehsils / taluks	02
Number of Blocks (CD Blocks)	07
Number of Gram Panchayats	129
Number of villages (Revenue villages) Inhabited villages Uninhabited villages	305 241 64

THREE-TIER PRI

TIER I



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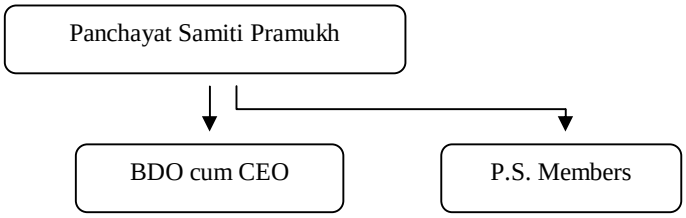
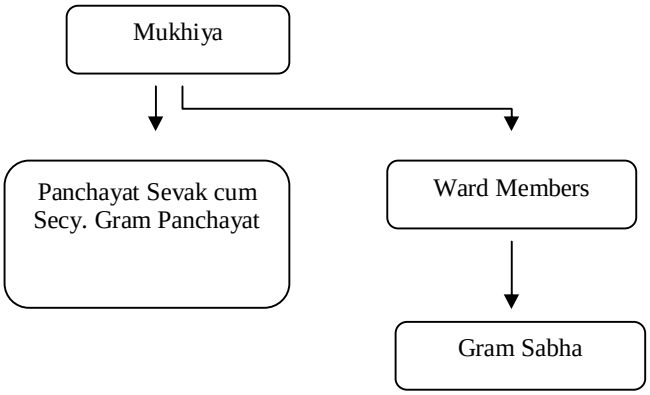


TIER III



(b) Geography and Climate

Before the construction of embankments along the Ganga, the Bagmati, the Burhi Gandak and the Kosi, namely karachi badlaghat embankment, Badla- Nagarpara embankment, Burhi Gandak protection embankment and Gogri- Narayanpur embankment, the vast tract of present Khagaria district was flat alluvial plain and was abound in marshy and swampy land.

The major part of the alluvial plain comprising this district, at present, is mainly a saucer- shaped depression, the center of which was innundated during the rains by the over flow of the rivers and for the rest of the year was full of marshy hollows. The inundation has decreased after construction of embankments but still a large part in the north eastern part of the district, contained in west by Gogri-Maheshkhunt – Saharsa Road, in the north by the Koshi and in the south by the Ganga is completely inundated during rainy season except for the National Highway and the New Delhi – Gauhati Railway line.

The climate of the district may be said to form a medium between the dry, parching heat of the up country and the close moist atmosphere of the south valley of Bengal. The heat is often intense but is very favourable during the rains because of law humidity. The seasons are the same as in the other parts of Bihar. The summer begins towards the middle of march and continues upto the end of June, when the rainy season begins, The months of April and May combine heat with high humidity relieved by intermittent rain falls. The rainy season continues upto October , while the water logging due to rain water continues in some areas up to the end of December. The winters are quite pleasant in this area.

In contrast to the southern portions of the old district of Munger, this district, lying north to the Ganga does not comprise of any forest of Sal or other large trees. However ever growing jungles of Kash and Pater is found in the northern areas in the belt of the Koshi and its tributaries. At most of the places, there are luxuriant gardens of mango and litchi, for which this district is mostly famous. Apart from these, Babul, Neem, Sirish and Sisho are also found. Not the least valuable product is thatching grass. It is grown on low land subject to inundation which retains water too long to enable the villagers to sow a cold weather crop upon it.

In the whole district, there is no hill and no mineral is found in this district. As far as the land use pattern is concerned, wheat is the prominent rabi crop in the district. Due to floods and water logging, the paddy production is very low, except in the southern part of the district. Maize is grown abundantly almost through out the district, while banana cultivation as a cash crop, has grown into prominence in last two decades. Banana cultivation is done mostly in Choutham, Gogari and Parbatta blocks.

Apart from these mango and litchi orchards are abundant in this district and are found almost through out the entire area. The study of old gazetteers shows that these orchards have been in existence since long.

The economy of the district is dependent entirely on agriculture and its two main allied activities, namely horticulture and dairy. Industrialisation is completely absent. This district has potential for agro- based industries because of large production of banana and maize, but so far no industry has come-up. The development of Barauni district of Begusarai, as a prominent industrial area, has also pre-empted any industrialization in this district as entrepreneurs move towards Barauni or to the upcoming town of Silliguri in West Bengal, rather than investing in this district. Another reason is lack of surplus capital in this district because of historical reasons, as mentioned earlier. Agriculture was never so profitable here, as to generate surplus capital. Small business is the only non agricultural economic activity in this district.

(c) Demographic profile

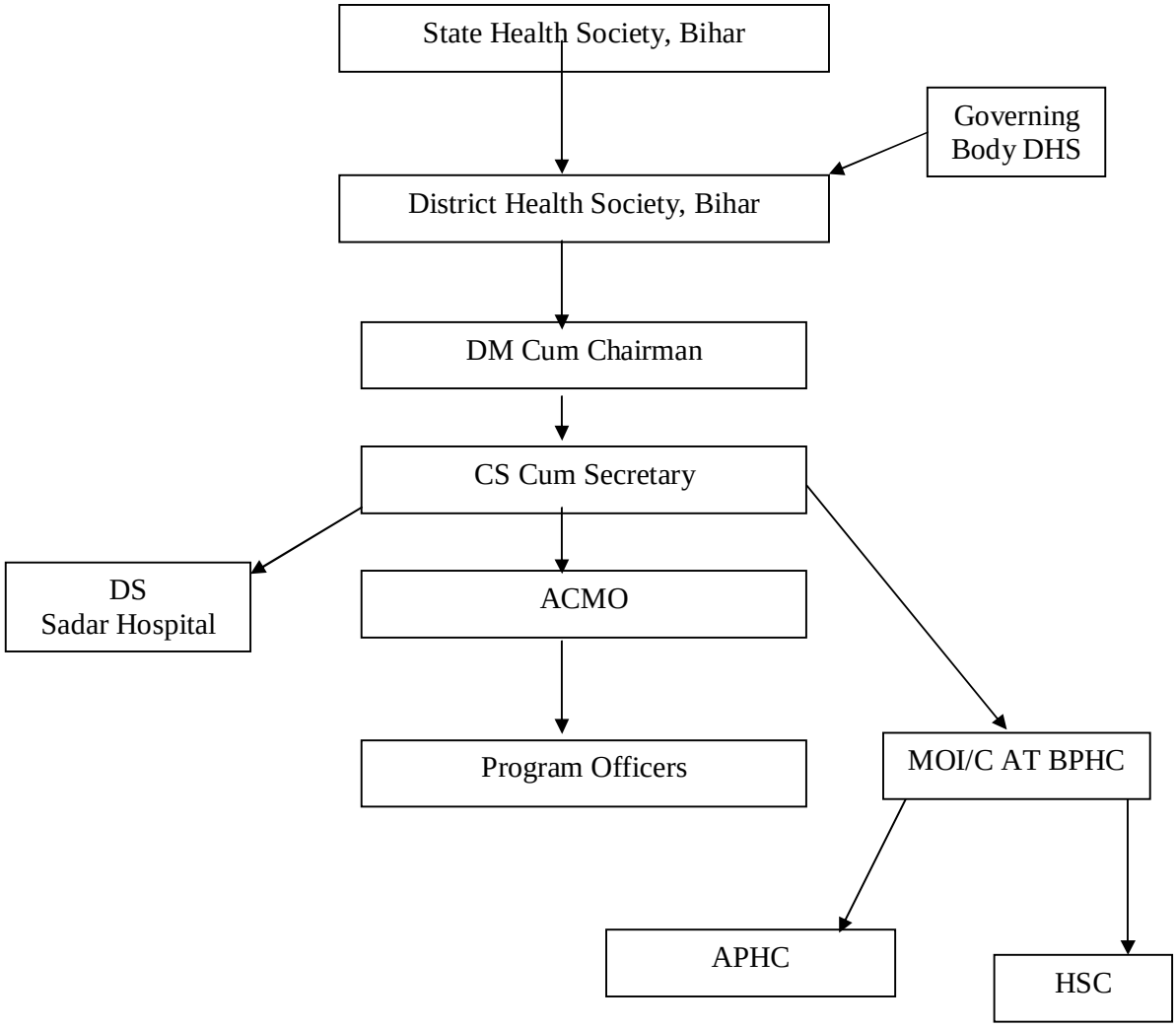
The population of Khagaria is merely 1.55% of the state of Bihar. A total number of 12, 80,354 persons are there in the district. Around 14% of the total population in this district has been estimated as scheduled caste whereas a negligible proportion, i.e, 0.03% of the total population has been counted as scheduled tribe. The district is predominantly rural as 94% of the total population live in villages in this district. The literacy rate in the district is also far below the state average.

Demographic profile of District Khagaria

Source: census 2001

Indicators	District	State
Population		
Males	679267	43153964
Female	601087	39724832
Total	1280354	82878796
Urban	76327	
Rural	1204027	
Scheduled Castes	185122	
Scheduled Tribes	332	
Population growth rate	2.5%	2.5%
Vital statistics		
Crude Birth rate	30.7	
Crude Death Rate	7.9	
Sex Ratio	1130	921
Literacy		
Literacy among Males	46.12%	60.32%
Literacy among Females	20.16%	33.57%
Total	32.35%	47.53%

District Health Administrative Setup



KHAGARIA – AT A GLANCE

AREA (Sq. Kms)	:-	1474.46
POPULATION(CENSUS 2001)		
TOTAL	:-	1280354
MALES	:-	679267
FEMALES	:-	601087
RURAL POPULATION		
TOTAL	:-	1204027
MALES	:-	644384
FEMALES	:-	559643
URBAN POPULATION		
TOTAL	:-	76327
MALES	:-	41444
FEMALES	:-	34883
POPULATION OF SCHEDULED CASTES	:-	185122
POPULATION OF SCHEDULED TRIBES	:-	332
DENSITY OF POPULATION	:-	859
SEX RATIO	:-	890

COMPARATIVE POPULATION DATA (2001 Census)

Basic Data	**India**	**Bihar**	**khagaria**
Population	1027015	828787	1280354
Density	324	880	859
Socio- Economic			
Sex- Ratio	933	921	890
Literacy % Total	65.38	47.53	32.35%
Male	75.85	60.32	46.12%
Female	54.16	33.57	20.16%

LITERACY RATE		
TOTAL :- 32.35%		
MALES :- 46.12%		
FEMALES :- 20.16%		
REVANUE VILLAGES		
TOTAL :- 206		
INHABITED:- 141		
UNINHABITED:- 65		
PANCHAYATS	:-	129
SUB-DIVISION	:-	01
BLOCKS	:-	07
REVENUE CIRCLES	:-	07
TOWNS	:-	02
NAGAR PARISHAD(Khagaria, Gogri)	:-	02
NAGAR PANCHAYAT	:-	01
M.P CONSTITUENCY	:-	01
M.L.A. CONSTITUENCY	:-	04
HEALTH		
DISTRICT HOSPITAL	:-	01
REFERRAL HOSPITAL	:-	01
PRIMARY HEALTH CENTRE	:-	07
ADDITIONAL PRIMARY HEALTH CENTRE	:-	24
HEALTH SUB CENTRE	:-	193
BLOOD BANK	:-	01
AIDS CONTROL SOCIETY	:-	01

2.1Administration and Demography

Table-1

No.	Variable	Data
1.	Total area	**1474.46** Sqr Km
2.	Total no. of blocks	07
3.	Total no. of Gram Panchayats	129
4.	No. of Revanue villages	306
5.	No of PHCs	07
6.	No of APHCs	24
7.	No of HSCs	193
8.	No of Sub divisional hospitals	0
9.	No of referral hospitals	01
10.	No of Doctors	76
11.	No of ANMs	326
12.	No of Grade A Nurse	52
13.	Total population	**1522340**
14.	Male population	**807648**
15.	Female population	**714692**
16.	Sex Ratio	1000/933
17.	SC population	**185122**
18.	ST population	332
19.	No. of Anganwadi centers	1276
20.	No. of Anganwadi workers	1254
21.	No of ASHA	1017
22.	No. of electrified villages	30
23.	No. of villages having access to safe drinking water	152
24.	No of villages having motorable roads	32

Source: Census 2001

2.3 HEALTH PROFILE

Infrastructure

2.3.1: Health Facilities in the District

Data below indicating the present status of HSC, APHC, PHC, CHC, Sub-divisional hospital & District Hospital.

Health Sub-centres

S.No	Block Name	Population 2008 with growth @ 2.7%	Sub-centres required Pop 5000(IPH)	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)
							Own	Rented	
1	Alauli	254262	51	37	0	14	8	29	
2	Beldaur	175325	35	26	0	9	8	18	
3	Chautham	135262	27	23	0	4	7	19	
4.	Gogri	289287	57	34	0	23	6	28	
5.	Khagaria	351325	70	37	0	33	14	13	
6.	Mansi	88339	18	11	0	7	3	8	
7.	Parbatta	228540	46	25	0	21	12	13	
	Total	**1522340**	**304**	**193**	**0**	**111**	**58**	**128**	

Additional Primary Health Centers (APHCs)

No	Block Name	Population 2008 with growth @ 2.7%	APHCs required (After including PHCs) (IPH)	APHCs present	APHCs proposed	APHCs required	Status of building		Availability of Land
							Own	Rented	
1	Alauli	254262	8	6	0	2	0	6	
2	Beldaur	175325	6	2	0	4	0	2	
3	Chautham	135262	5	3	0	2	0	3	
4.	Gogri	289287	10	3	0	7	1	2	
5.	Khagaria	351325	12	3	0	9	0	3	
6.	Mansi	88339	3	2	0	1	1	2	
7.	Parbatta	228540	8	5	0	3	2	3	
	Total	**1522340**	**52**	**24**	**0**	**28**	**4**	**21**	

Primary Health Centers

No	Block Name/sub division	Population	PHCs Present	PHCs required @ Pop 80000 - 120000 (IPH)	PHCs proposed
1	Alauli	254262	1	3	0
2	Beldaur	175325	1	2	0
3	Chautham	135262	1	1	0
4.	Gogri	289287	1	3	0
5.	Khagaria	351325	1	4	0
6.	Mansi	88339	1	1	0
7.	Parbatta	228540	1	2	0
	Total	**1522340**	7	16	0

CHC Required

No	Block Name/sub division	Population	CHCs Present	CHCs required @ Pop 1200000 and above(IPH)	PHCs proposed
1	Alauli	254262	0	0	0
2	Beldaur	175325	0	0	0
3	Chautham	135262	0	0	0
4.	Gogri	289287	0	0	0
5.	Khagaria	351325	0	0	0
6.	Mansi	88339	0	0	0
7.	Parbatta	228540	0	0	0
Total		**1522340**	0	0	**0**

Sub-Divisional Hospital

No	Name of sub division	Population	Sub- Divisional Hospital Present	Sub- Divisional Hospital required	PHCs proposed
1.	Gogri	289287	0	1	1
	Total	289287	0	1	1

District Hospital

No	Name of District	Population	District Hospital Present	District Hospital required	PHCs proposed
1.	Khagaria	1522340	1	1	0
	Total	1522340	1	1	0

2.3.2 Human Resources and Infrastructure

Sub-centre database

No. of Subcenter present	**No. of Subcenter required**	**Gaps in Sub centers**	**ANMs (R)/(C) posted formally**	**ANMs (R)/(C) posted required**	**Gaps in ANMs(R)/(c)**	**Building ownership (Govt)**	**Required Building (Govt)**	**Gaps in Buildings (Govt.)**	**ANM residing at HSC area (Y/N)**	**Condition of residential facility (+++/++/+/#)**	**Status of furnitures**	**Status of Untied fund**
193	**304**	**111**	**174/152**	**29/41**	**130/152**				**y**	**+++**		**unexpensed**

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

Additional Primary Health Centre (APHC) Database: Infrastructure

No	No. of APHC present	No. of APHC required	Gaps in APHC	Building ownership (Govt)	Building Required (Govt)	Gaps in building	Building condition (+++/++/#)	Condition of Labour room (+++/++/#)	No. of rooms	No. of beds	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulance/ vehicle (Y/N)
1	24	52	28	5	19		#	#			#	N		Y

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

Primary Health Centres : Infrastructure

No	No. of PHC present	No. of PHC required	Gaps in PHC	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. Places where rooms > 5	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1	**07**	**16**	**9**	**7**	**0**	**0**	**7**	**7**	**+++**	**0**	**6**	**A**	**++**	**+**

Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

Primary Health Centres: Human Resources

	No. of PHC	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	**07**	**114**	**53**	**406**	**326**	**7**	**0**	**6**	**6**	**67**	**52**	**7**	**0**	**6**

Referral Hospital/CHC : Infrastructure

No	No. of Referal/CHC present	No. of Referal/CHC required	Gaps in Referal/CHC	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. Places where rooms > 5	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1	**1**	**1**	**0**	**1**	**0**	**0**	**2**	**A**	**++**	**2**	**30**	**A**	**++**	**++**

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

Referral Hospital: Human Resources

	No. of /Referral/ CHC	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	**1**	**4**	**4**	**0**	**0**	**1**	**0**	**1**	**0**	**4**	**2**	**4**	**1**	**1**

District Hospital: Infrastructure

No	No. of Sadar Hospital present	No. of Sadar Hospital required	Gaps in Sadar	Building ownership (Govt)	Building Required (Govt)	Gaps in Building	No. of Toilets available	Functional Labour room (A/NA)	Condition of labour room (+++/++/#)	No. of beds	Functional OT (A/NA)	Condition of ward (+++/++/#)	Condition of OT (+++/++/#)
1	**1**	**1**	**0**	**govt**	**0**	**0**	**3**	**A**	**+++**	**80**	**A**	**++**	**+**

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

District Hospital: Human Resources

	N0. of DH	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	**1**	**13**	**12**	**17**	**16**	**1**	**1**	**2**	**2**	**9**	**4**	**5**	**4**	**1**

2.3.3 Indicators of Reproductive Health and Reproductive Child Health

Table

Variables Description	Khagaria	Bihar	India
Percentage girls marrying below legal age at marriage	**39.5**	**51.5**	
Percentage of households with low standard of living	78.1	**66.3**	
Percentage of households using adequate iodized salt (15ppm)	24.8	**29.6**	
Birth order 3 and above	46	**54.4**	
Percent women know all modern method	44.4	**52.2**	
Percent husbands know NSV (No scalpel vasectomy)	40.3	**35.6**	
Percent women/husbands using any family planning method	24.0	**31**	
Percent women/husbands using any modern method of family planning	20.4	**27.3**	
Unmet need for family planning	39.7	**36.7**	
Percent women received at least three visits for ANC	33.4	**19.6**	
Percent women received full ANC	4.3	**5.4**	
Percentage of Institutional delivery	33.5	**23**	
Percentage of delivery attended by skilled personnel	41.7	**29.5**	
Percentage of children (age12-23 months) received full immunization	52.4	**23**	
Percentage of children (age12-23 months) did not received any immunization	12.9	**49.4**	
Percent women aware of HIV/AIDS	34.2	**28.8**	
Percent husbands aware of HIV/AIDS	**68.9**	**62.1**	

Source: DLHS (2007-2008)

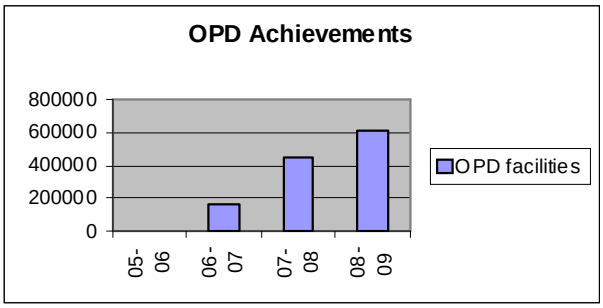
2.3.4 Achievements: STATUS OF PREGRESS IN DIFFERENT HEALTH PROGRAMS

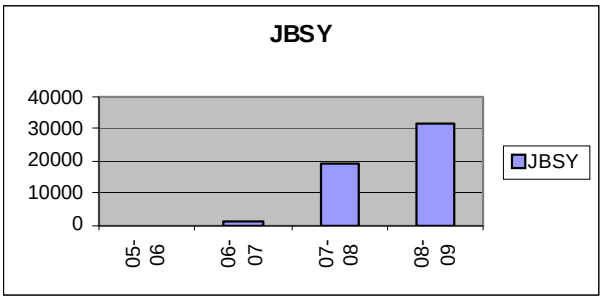
Table. Treatment provided in previous four financial years

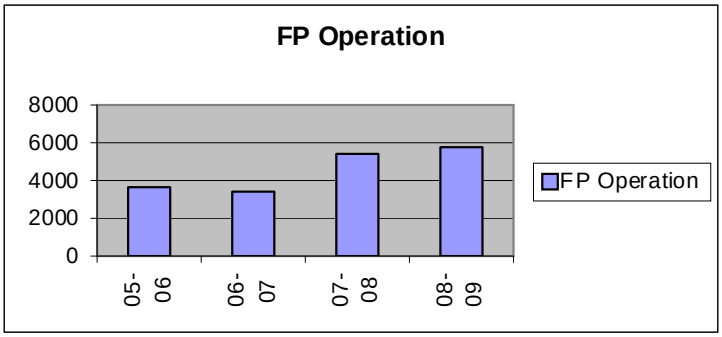
Sl. No.	Program	2005-06	2006-07	2007-08	2008-09
01.	OPD facilities	NA	169279	454921	618622
02.	JBSY	NA	1131	19336	31779
03.	FP Operation	3626	3435	5464	5783
04.	Full immunized child	19431	22632	29503	38271
05.	Leprosy	143	213	289	346
06.	Malaria	4	4	2	1
07.	Kala-zar	268	293	508	475
08.	TB	NA	455	828	1116
09.	Blindness	NA	78	1076	1377
10.	Vitamin A	NA	116867	199532	203664

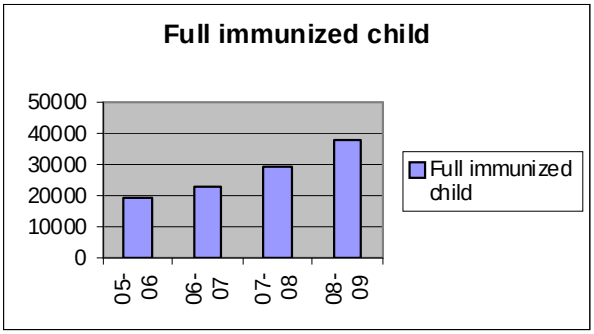
Source: District Health Society, Khagaria

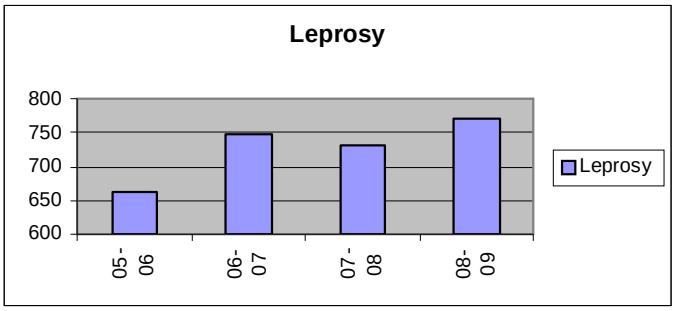
Chart representation of achievements in different programs in last four financial years

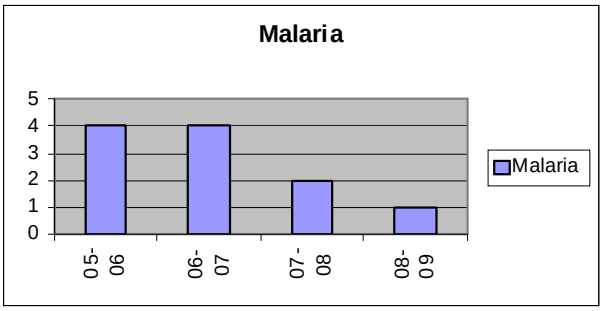


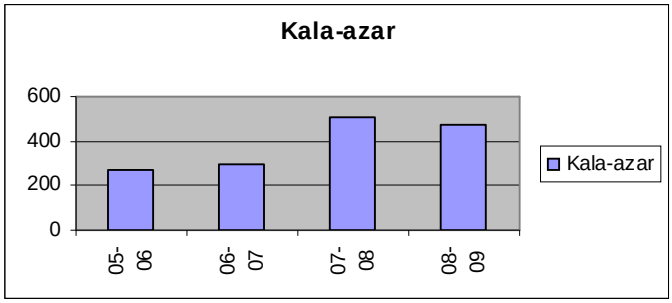


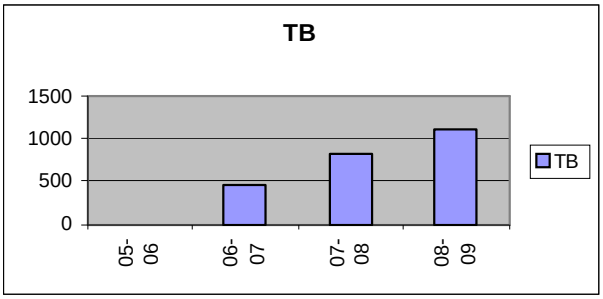


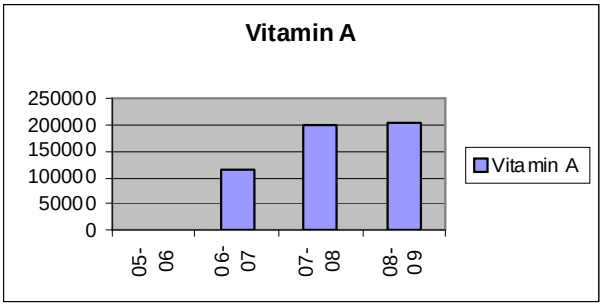






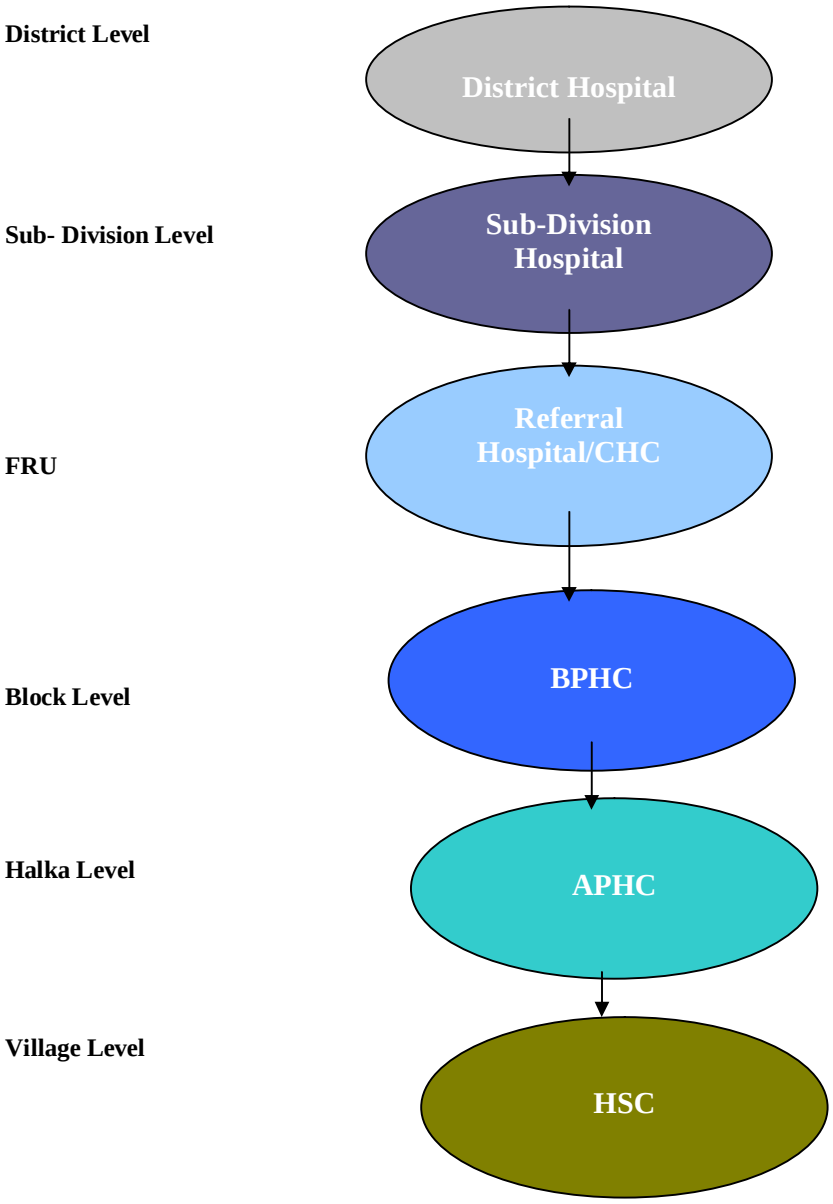






Chapter 3
Situation Analysis & Budget for HSC, APHC, BPHC & DH

On different level, there are various institutions in the health system from where health facilities are being provided to the people. The IPH standard specifies the properties, requirements and service specifications of all institutions. In the network of health system of a district, there are following hierarchy of institutions at different level-:



In the present situational analysis of Khagaria district, we will try to find out answer of the following questions-

- Is there sufficient no. of HSC, APHC, BPHC, CHC, Sub-divisional hospital & District Hospital sanctioned as per IPH standard?
- What are the gaps between no. of required and sanctioned institutions?
- Whether all institutions have resources, manpower and infrastructure as per IPH norms or not?
- Whether all institutions are providing the health services as per IPH norms or not?
- Is there sufficient fund allotment for institutions and programs?
- What are the activities that will improve the quality of services and will make it more reliable?

The situation analysis on the basis of no. of institutions, infrastructure, manpower, services and budget is given below

3.1 Health Sub Center

: Health Sub Center is the first line service deliverable institutions from where different types of services are provided to women and children. The objectives of IPHS for Sub-Centre's 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.

No. of Institutions (Health Sub Center)

As per IPH standard at every 5000 population one HSC has to be established.

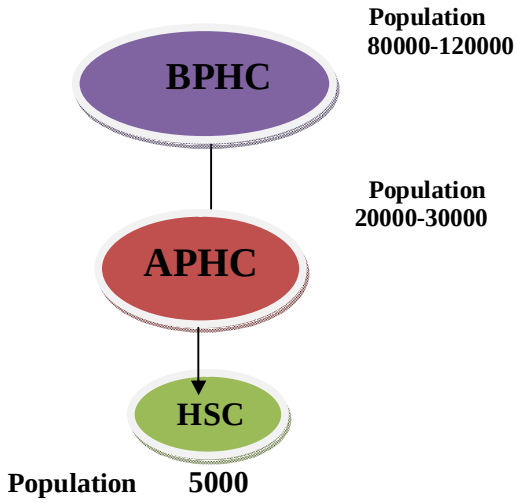
District Population (2008)	Maximum HSC required as per IPH Norms @ 5000 people	No. of Sub center already sanctioned/established	Gaps in No. of HSC
1522340	304	193	111

To obtain 100% IPH standard -: Need to sanction 111 new HSC to achieve 100% IPH standard.
Task for 2009-10 -:

- **Out of 193 sanctioned HSC 42 HSC are not established so far. So, in financial year 2009-10, the first priority should be given to these non-functional HSC.**

3.1.1 Infrastructure

GAPS IN INFRASTRUCTURE:



First contact point with community

Introduction:

Health Sub Centre is very important part of entire Health System. It is first available Health facility nearby for the people in rural areas.
We are trying to analyze the situations at present in accordance with Indian Public Health Standards.

1. Infrastructure for HSCs:

IPHS Norms:

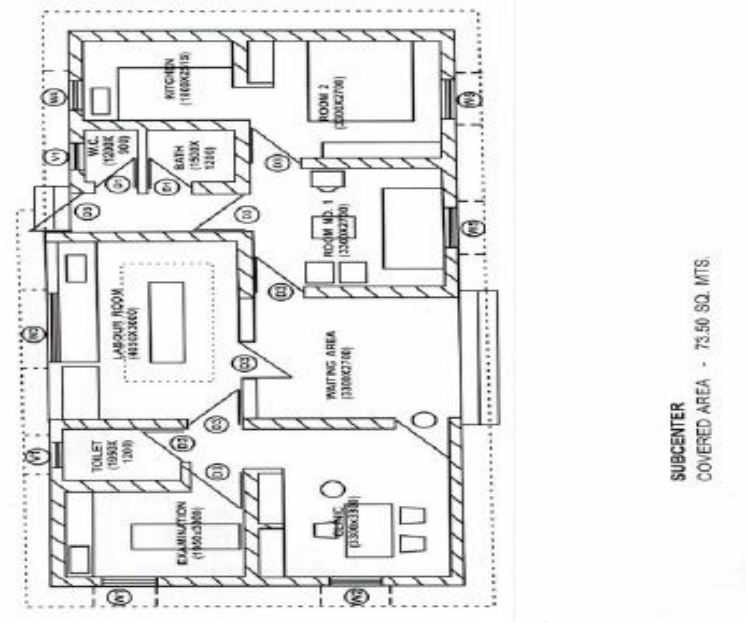
A Sub-centre should have its own building. If that is not possible immediately, the premises with adequate space should be rented in a central location with easy access to population.

i. Location of the centre: The location of the centre should be chosen that:

   a. It is not too close to an existing sub centre/ PHC
   b. As far as possible no person has to travel more than 3 Km to reach the Sub centre
   c. The Sub Centre Village has some communication network (Road communication/Public Transport/Post Office/Telephone)
   d. Accommodation for the ANM/Male Health Worker will be available on rent in the village if necessary. For selection of village under the Sub Centre, approval of Panchayats as may be considered appropriate is to be obtained.

ii. The minimum covered area of a Sub Centre along with residential Quarter for ANM will vary from 73.50 to 100.20 sq mts. depending on climatic conditions(hot and dry climate, hot and humid climate, warm and humid climate), land availability and with or without a labor room. A typical layout plan for Sub-Centre with ANM residence as per the RCH Phase-II National Programme implementation Plan with area/Space Specifications is given below

Typical Layout of Sub- Centre with ANM Residence



Waiting Area	:	3300mm x 2700mm
Labour Room	:	4050mm x 3300mm
Clinic room	:	3300mm x3300mm
Examination room	:	1950mm x 3000mm
Toilet	:	1950mm x 1200mm

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

Room -1 (3300mm x 2700mm)
Room-2(3300mm x 2700mm)
Kitchen-1(1800mm x 2015mm)
W.C.(1200mm x 900mm)
Bath Room (1500mm x 1200mm)

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

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2009-10	Budget for (2009-10)
Physical Infrastructure	The minimum covered area of a Sub Center along with residential Quarter for ANM will vary from 73.50 to 100.20 sq meters.	304 (Max. HSC as per IPHS)	58 (Already having building)	248	135	135 X 1300000 =17,55,00000
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI guideline is not prepared				
Furniture	Examination Table 1 Writing table 2 Armless chairs 3 Medicine Chest 1 Labour table 1 Wooden screen 1 Foot step 1 Coat rack 1 Bed side table 1 Stool 2 Almirahs 1 Lamp 3 Side Wooden racks 2 Fans 3 Tube light 3 Basin stand 1	1X 304 = 304 2X 304 = 608 3X 304 = 912 1X 304 = 304 1X 304 =304 1X304 = 304 1X 304 =304 1X 304 = 304 1X 304 =304 2X 304 = 608 1X 304 = 304 3X 304 = 912 2X 304 = 608 3X 304 = 912 3X 304 = 912 1X 304 = 304	**193 HSC are sanctioned that need all these furniture. Some HSC have some furniture but worth deposable.**	**304**	All sanctioned/established HSC i.e. 193	193X 12000= 2316000 386X 8000 = 3088000 579X2000= 1158000 193X 5000= 965000 193X 8000= 1544000 193X 1000= 193000 193X 200 = 38600 193X 1000 = 193000 193X 500 = 96500 386X 300 = 115800 193X12000= 2316000 772 X 200= 154400 386 X 1500= 579000 772X 1500= 1558000 772X 250= 193000 193x 1500= 289500 **Total-14797800**
Equipment	Basin Kidney 825 ml Tray instrument Jar Dressing	2X304=608 1X304=304 1X304=304	**193 HSC are sanctioned that need all**	**304**	All sanctioned/est	

	Hemoglobin meter ForcepsTissue160 mm Forceps sterilizer Scissors surgical Reagent strips for urine Scale, Infant metric Sterilization kit Vaccine Carrier Ice pack box Forceps Suture needle straight Suture needle curved Syringe Disposable gloves Clinical Thermometer Torch weighing (baby) weighing (Women) Stethoscope	1X304=304 1X304=304 1X304=304 1X304=304 1X304=304 2X304=608 8X304=2432 20X304=6080 12X304=3648 12X304=3648 12X304=3648 20X304=6080 1X304=304 20X304=6080 1x 304= 304 1x 304= 304 1X304= 304 1X304= 304 1X304= 304	**these equipments.**		ablished HSC i.e. 193	**Total - 2,2500000 (Approx.) (To provide all listed Equipments to all working 193 HSC)**
Drugs	**Kit A** ORS IFA Tab. (large) IFA Tab. (small) Vit. A Solution(100 ml) Cotrimoxazole Tab(child) **Kit B** Tab. Methylergometrine Maleate (0.125 mg) Paractamol (500 mg) Inj.Methylergometrine Maleate Tab.Mebendazole(100 mg) Tab.Dicyclomine HCl. (10 mg) Ointment Povidone Iodine 5% Cetrimide Powder Cotton Bandage Absorbant Cotton (100 gm each)	150X304= 15000X304= 13000X304= 6X304= 1000X304= 480X304= 500X304= 10X304= 300X304= 180X304= 5X304= 125X304= 120X304= 10X304=	**193 HSC are sanctioned that need all these drugs.**	**304**	All sanctioned/established HSC i.e 193	**Total - 2,2500000 (Approx.) (To provide all listed Medicine to all working 193 HSC)**
Support Services						
Laboratory	Minimum facilities like estimation of haemoglobin by using a approved **Haemoglobin Colour Scale**, urine test for the presence of protein by using **Uristix,** and urine test for the presence of sugar by using **Diastix** should be available. **Haemoglobin Colour**	1X304=304	**193 HSC are sanctioned that need all these equipments.**	**304**	All sanctioned/established HSC i.e 193	**Total = 19,30,000 (Approx.) (To provide three listed Equipments**

	Scale **Uristix** **Diastix**	1X304=304 1X304=304				**of laboratory to all working 193 HSC)**
Electricity	Wherever facility exists**,** uninterrupted power supply has to be ensured for which inverter facility / **solar power** facility is to be provided. **Solar power set**	1X304=304	**193 HSC are sanctioned that need Solar power sets.**	**304**	All sanctioned/established HSC i.e 193	193X20000= **38,60,000**
Water	Potable water for patients and staff and water for other uses should being adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	7PHC 24APHC 1SDH 1Sub Div				33x15000=495000
Telephone	Where ever feasible, telephone facility / cell phone facility is to be Provided. **Mobile phone**	1X304=304	**193 HSC are sanctioned and need Mobile Phone**	**304**	All sanctioned/established HSC i.e 193	193X1500= **289500**

3.1.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2009-10	Budget 2009-10
Health worker (female)	2	2X304=608	152	456	193X2=386 Total=386	386X6000X12 = **2,77,92,000**
Health worker (male)	1 (funded and appointment by the state government)	1X304=304	0	304	193	193X4000x12 = **92,64,000**
					Total	**3,70,56000**

3.1.3 Services And others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2009-10)
Infrastructure	**Out of 135 only 58 HSC have its own building, remaining are running in rented building.**	**1**. Non payment of rent **2.** Land availability for new building	**1.** Ensuring payment of rent till own buildings are not constructed. **2.** Involvement of DM to arrange land.	**1.** Budget to construct 135 HSC is given above. Construction of building is time taking process. So, timely payment of rent is needed **2.** DM should instruct the CO to arrange land for HSC.	**Rent for HSC** 135X500X12= 8,10,000
	Lack of Equipments, Drugs, Furniture , Power	**HSC are working but without resources**	Purchasing Equipments, Drugs, Furniture, Power etc. as per IPH standard.	No, excuse. There is no other way except purchasing all required resources.	**Detail budget has been given above.**

	Formats/Registers and Stationeries (Untied fund)	**Always it is found that HSC is lacking stationeries**	Arrangements of fund for these miscellaneous expenses.	Untide fund are available but problem in handleling. Untide fund is operated jointly by ANM & PRI people but they have no proper knowledge to handle it. Only one PRI e.i Mukhiya (Pradhan) should be authorized for joint account and then proper orientation should be given them.	**193X10,000= 19,30,000**
Services of HSCs	**No institutional delivery at HSC level**	Skilled staff to perform institutional delivery is available but lacking resources.	Arrange all required resources to perform institutional delivery.	Purchase Drug, equipments, furniture as per IPHS. Arrangement of Ambulance at APHC & PHC level to quickly send patients in bigger hospital in case of complications.	**Detail budget has been given above**.

	Poor ANC	1. In compare to delivery there are poor percentage of pregnant women registration. 2. Minimum three antenatal check-ups	1. Make community aware about the merit of ANC 2. Make system more reliable.	1.Need to aware village women through orientation program. Regular supply of TT & IFA. 2. Ensure availability of drug and equipments necessary for check up	**Detail budget has been given above**.
	Poor Post Natal Care	1.A minimum of 2 postpartum home visits 2. Initiation of early breast-feeding within half-hour of birth 3. Counseling on diet & rest, hygiene, contraception, essential new born care, infant and young child feeding.	Ensuring minimum 2 postpartum visits at home. Ensuring counseling on early breath feeding, on diet & rest, hygiene, contraception, essential new born care	Strict rule to compel ANM to visit at home. Orientation & Training program of ANM over early breath feeding, on diet & rest, hygiene, contraception, essential new born care	**No need of extra Budget. Orientation & Training program can be organized from Untied fund.**

	Family Planning and Contraception	1. Education, Motivation and counseling to adopt appropriate Family planning methods 2. Provision of contraceptives such as condoms, oral pills, emergency contraceptives. 3. IUD insertions	Increase No. of FP operation & promotion of the use of contraceptives	1.Tubectomy operation is going good but to increase the no. of vasectomy operation counseling of male are necessary. 2. Ensure the availability contraceptives such as condoms, oral pills, emergency contraceptives 3. Training of ANM on IUD Insertion is required.	**No need of extra Budget. Orientation & Training program can be organized from Untied fund.**
	No MTP	Counseling and appropriate referral for safe abortion services (MTP) for those in need.	Start MTP Services at HSC level.	First purchase the essential equipments and drugs listed above. Training/refreshing course of suitable ANM.	**Detail budget of equipments and drugs has been given above**
	RNTCP	Eradication of TB	Easy availability of drugs & referral of patients.	Referral of suspected symptomatic cases to the PHC/Microscopy center • Provision of DOTS at sub centre and proper documentation and follow-up	**Budget will be given under RNTCP head**

	AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	Eradication & Control	Making people aware about these disease	IEC activities to enhance awareness and preventive measures about AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	**For IEC 193X5000= 9,65,000**
	Child Immunization	1. No 100% child immunization 2. Drop out cases 3. Shortage of vaccine.	Working at various levels to obtain 100 % child immunization.	1. Preparation of micro plan at PHC level. Special Plan for hard to reach area. 2. Proper monitoring. 3. Filling up immunization card to follow up. 4. Vaccine is supplied from state that is irregular. So, ensure availability of all vaccine to increase reliability. 5. To control drop out cases if possible new vaccine like **Easy 5** and **MMR** should supply.	**Vaccine is supplied from state. So, no need to prepare the budget at district level.**

3.1.4 Budget Summery (Health Sub Center)

2009-10

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	17,55,00000	For State Govt.
	Furniture	1,47,97,800	
	Equipments	2,2500000	
	Drugs	2,2500000	
	Laboratory	19,30,000	
	Electricity	38,60,000	
	Telephone	2,89,500	
Manpower	Health worker (female)	2,77,92,000	
	Health worker (male)	92,64000	
Services of HSC	Infrastructure (Rent)	8,10,000	
	Untide Fund	19,30,000	
	IEC	9,65,000	
	Total	**60,238,539**	

3.2 Additional Primary Health Center (APHC):

Additional Primary Health Center are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-center for curative, preventive and promotive health care. A typical Primary Health Center covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 sub-center and refer out cases to PHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.

The objectives of IPHS for APHCs are:

I. To provide comprehensive primary health care to the community through the Additional Primary Health Center.

ii. To achieve and maintain an acceptable standard of quality of care.

iii. To make the services more responsive and sensitive to the needs of the community.

No. of Institutions (Additional Primary Health center)

As per IPH standard at every 30,000 population one APHC has to be established.

District Population (2008)	Maximum APHC required as per IPH Norms @ 30,000 people	No. of APHC already sanctioned/established	Gaps in No. of HSC
1522340	**52**	**24**	**28**

To obtain 100% IPH standard -: Need to sanction 55 new APHC to achieve 100% IPH standard.

Task for 2009-10 -:

- **Out of 24 sanctioned APHC 10 APHC are not established so far. So, in financial year 2009-10, the first priority should be given to these non-functional APHC.**
- **25% of gaps i.e. 14 APHC can be sanctioned more to minimize the gaps.**

3.2.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2009-10	Budget for (2009-10)
Physical Infrastructure	It should be well planned with the entire necessary infrastructure. It should be well lit and ventilated with as much use of natural light and ventilation as possible. The plinth area would vary from 375 to 450 sq. meters depending on whether an OT facility is opted for.	52 (Max. APHC as per IPHS)	5 (Already having building but requires renovation)	**48**	**20**	20 New building X 52,00000 =**11,0000000** 4 Old (renovation) X 25,00000 =**1,0000000** **Total** = **12,0000000**
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI guideline is not prepared				
Furniture	Examination table 3 Writing tables with table sheets 5 Plastic chairs 6 Armless chairs 8 Full steel almirah 4 Labour table 1 OT table 1 Arm board for adult and child 4 Wheel chair 1 Stretcher on trolley 1 Instrument trolley 2 Wooden screen 1 Foot step 5 Coat rack 2 Bed side table 6 Bed stead iron 6 Baby cot 1 Stool 6 Medicine chest 1	Maximum APHC is 52 so requirement is accordingly	**24 APHC are sanctioned that need all these furniture. Since almost all APHC are non-functional so, everywhere these furniture are required.**	**28**	All sanctioned/established APHC i.e. 24	**10,00000(Apprx) per APHC** **Total - 10,00000 X 24=** **2,40,00000** **(To provide all listed furniture to 24 working APHC)**

	Lamp 3 Shadowless lamp light (for OT and Labour room) 2 Side Wooden racks 4 Fans 6 Tube light 8 Basin 2 Basin stand 2 Sundry Articles including Linen: Buckets 4 Mugs 4 LPG stove 1 LPG cylinder 2 Sauce pan with lid 2 Water receptacle 2 Rubber/plastic shutting 2 meters Drum with tap for storing water 2 I V stand 4 Mattress for beds 6 Foam Mattress for OT table 1 Foam Mattress for labour table 1 Macintosh for labour and OT table 4 metres Kelly's pad for labour and OT table 2 sets Bed sheets 6 Pillows with covers 8 Blankets 6 Baby blankets 2 Towels 6 Curtains with rods 20 metres					
Equipment	• Normal Delivery Kit • Equipment for assisted vacuum delivery • Equipment for assisted forceps delivery • Standard Surgical Set • Equipment for New Born Care and Neonatal Resuscitation • IUD insertion kit • Equipment / reagents for essential laboratory investigations • Refrigerator • ILR/Deep Freezer • Ice box • Computer with	Maximum APHC is 52 so requirement is accordingly	24 APHC are sanctioned that need all these equipments.	52	All sanctioned/established HSC i.e 52	17,50,000(Approx) per APHC Total - 17,50,000 X 24 = 4,20,00,000 (To provide all listed equipments to 24 working

	accessories including internet facility • Baby warmer/incubator. • Binocular microscope • Equipments for Eye care and vision testing • Equipments under various National Programmes • Radiant warmer for new borne baby • Baby scale • Table lamp with 200 watt bulb for new borne baby • Phototherapy unit • Self inflating bag and mask-neonatal size • Laryngoscope and Endotracheal intubation tubes (neonatal) • Mucus extractor with suction tube and a foot operated suction machine • Feeding tubes for baby 28 • Sponge holding forceps - 2 • Valsellum uterine forceps - 2 • Tenaculum uterine forceps – 2 • MVA syringe and cannulae of sizes 4-8 • Kidney tray for emptying contents of MVA syringe • Trainer for tissues • Torch without batteries – 2 • Battery dry cells 1.5 volt (large size) – 4 • Bowl for antiseptic solution for soaking cotton swabs • Tray containing chlorine solution for keeping soiled instruments • Residual chlorine in drinking water testing kits • H2S Strip test bottles					APHC)
Drugs	Paracetamol	Maximum	24 APHC are	52	All	Total -

	Tab- 500mg per Tab. Paracetamol Syrup- 125mg/5ml-60ml Atropine - Inj. 0.6 mg per 1ml amps Ciprofloxacin - Tab 500mg/Tab Co Trimoxazole Tab 160 + 800 mg Tab Gentamycin - Inj M.D. vial (40 mg/ml)- 30ml vial Oxytocin - Inj-Amp 1 ml (5i.u./ml) 5% Dextrose 500 ml bottle B Complex Tab Gentamicin - Ear/Eye Drop 5 ml Promethazine - Inj-Amp. 2ml amps (25 mg/ml) Pentazocine Lactate Inj. Inj-Amp.- 1 ml (30 mg/ml) Diazepam - Inj-Amp. 2ml amps (5mg/ml) Cough Expectorant 100 ml pack Ampicillin 250mg Capsule Ampicillin 500mg Capsule Cetrizine Tablet - 10mg Doxycycline Capsule-100mg Etophylline & Theophylline Inj.- 2ml Fluconazole Tablet – 200mg Dicyclomine Tablets - 20mg Dexamethasone Inj.- 4mg/ml- 10ml Vial Atropine Inj. 0.6mg/ml - 1ml Ampoule Lignocaine Solution 2% Solution 2%- 30ml Vial Diazepam Tablet- 5mg Chlorpheniramine Maleate - Tablet- 4mg Cephalexin) - Capsule- 250mg Metronidazole - Tablet- 200mg	APHC is 52 so requirement is accordingly	sanctioned that need all these equipments.		sanctioned/established HSC i.e 52	4,8000000 (Approx.) (To provide all listed Medicine to all working 24 APHC)

	Ranitidine Hydochloride - Tablet 150mg Metoclopramide - Tablet- 10mg Diethylcarbamazine - Tablet- 50mg Paracetamol Dicyclomine - Tablet (500mg+20mg) Fluconazole - Tablet 50mg Diethylcarbamazine - Tablet- 100mg Xylometazoline - Drops - 0.1% (Nasal) 10ml vial. A.R.V. Theophyline IP Combn. 25.3mg/ml Aminophyline Inj. IP 25mg/ml Adrenaline Bitrate Inj. IP 1mg/ml Methyl Ergometrine Maleate 125mg/Tablet, Injection Amoxycilline Trilhydrate IP 250mg/Capsule Amoxycilline Trilhydrate IP 250mg/Dispersible Tab. Phenoxymethyl Penicillin 130mg/ml Vit K3 (Menadione Inj.) USP 100mg/ml Nalidixic Acid Tabs. 100mg/Tab Phenytoin Sodium Inj. IP 50mg/2ml Chlorpromazine Hydrochloride 25mg/ml Cephalexin /Ceptrofloxin 250mg/Tablet Sodium Chloride Inj. IP I.V. Solution 0.9w/v Gama Benzine hexa Chloride As decided by CS Plasma Volume Expander As decided by CS Inj. Magnesium Inj. 50% preparation Hydralazine Misoprostol 200mg/Tablet					

Support Services						
Laboratory	1. Routine urine, stool and blood tests 2. Bleeding time, clotting time, 3. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc. 4. Sputum testing for tuberculosis (if designated as a microscopy center under RNTCP) 5. Blood smear examination for malarial parasite. 6. Rapid tests for pregnancy / malaria 7. RPR test for Syphilis/YAWS surveillance 8. Rapid diagnostic tests for Typhoid (Typhi Dot) 9. Rapid test kit for fecal contamination of water 10. Estimation of chlorine level of water using ortho-toludine reagent	Maximum APHC is 52 so requirement is accordingly	24 APHC are sanctioned that need all these equipments.	28	All sanctioned/established APHC i.e 24	Budget for Laboratory equipments has been given above.
Electricity	Wherever facility exists, uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	Maximum APHC is 52 so requirement is accordingly	24 APHC are sanctioned that need power supply.	28	All sanctioned/established APHC i.e 24	Generator service can be out sourced. 24 X 36000 X 12= 1,03,68,000
Water	Potable water for patients and staff and water for other uses should be in adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	Safe water available everywhere				

Telephone	Where ever feasible, telephone facility / cell phone facility is to be provided.	Maximum APHC is 52 so requirement is accordingly	24 APHC are sanctioned that need Telephone facility.	**52**	All sanctioned/established APHC i.e	Total 24 X 500 X 12 = 1,14,000
Transport	The APHC should have an ambulance for transport of patients. This may be outsourced.	Maximum APHC is 52 so requirement is accordingly	24 APHC are sanctioned that need Transport facility.	**52**	All sanctioned/established APHC i.e	Ambulance service may be outsourced Total 24 X 15000 X 12 = 43,20000
Laundry and Dietary facilities	Laundry and Dietary facilities for indoor patients: these facilities can be outsourced.	Maximum APHC is 52 so requirement is accordingly	24 APHC are sanctioned that need Laundry facility.	**52**	All sanctioned/established APHC i.e	Laundry and Dietary facilities can be outsourced 10,000 per APHC per month Total 24 X 10,000 X 12 = 28,80000

3.2.3 Services And others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2009-10)
Infrastructure	**Out of 24 only 5 APHC have its own building, remaining are running in rented building.**	**1.** Non payment of rent **2.** Land availability for new building	**1.** Ensuring payment of rent till own buildings are not constructed. **2.** Involve DM to arrange land.	**1.** Budget to construct 25 APHC is given above. Construction of building is time taking process. So, timely payment of rent is needed **2.** DM should instruct the CO to arrange land for HSC.	Rent for HSC 19X1200X12= 2,73,600
	Lack of Equipments, Drugs, Furniture, Power	HSC are working but without resources	Purchasing Equipments, Drugs, Furniture, Power etc. as per IPH standard.	No, excuse. There is no other way except purchasing all required resources.	Detail budget has been given above.

	Formats/Registers and Stationeries (Untied fund)	Always it is found that HSC is lacking stationeries	Arrangements of fund for these miscellaneous expenses.	Untied fund Provision under control of RKS.	24X25,000= 600000
Services of APHC	**No institutional delivery at APHC level**	No services of delivery	Arrange all required resources and manpower to start institutional delivery.	▪ Purchase Drug, equipments, furniture as per IPHS. ▪ Hire required manpower to support this service. ▪ Arrangement of Ambulance at APHC level to quickly send patients in bigger hospital in case of complications.	Detail budget has been given above.
	Medical care	Non Functional	▪ OPD Services ▪ 24 hours emergency services ▪ Referral services ▪ In-patient services (6 beds)	▪ hours in the morning and 2 hours in the evening ▪ Minimum OPD attendance should be 40 patients per doctor per day. ▪ Appropriate management of injuries and accident, First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions ▪ Ambulance Service to support referral ▪ Provision of diet, light, laundry etc to start indoor service.	Nothing new for these services Detail budget has been given above.

	Maternal and Child Health Care	**Non functional**	▪ Antenatal care ▪ Intra-natal care ▪ Postnatal Care ▪ New Born care ▪ Care of the child	▪ start immunization properly. ▪ start JBSY at APHC level ▪ Establish lab for minimum investigations like hemoglobin, urine albumin, and sugar, RPR test for syphilis ▪ Nutrition and health counseling ▪ Promotion of institutional deliveries ▪ Conducting of normal deliveries ▪ Assisted vaginal deliveries including forceps / vacuum delivery whenever required ▪ Manual removal of placenta ▪ Appropriate and prompt referral for cases needing specialist care. ▪ Management of Pregnancy Induced hypertension including referral ▪ Pre-referral management ▪ A minimum of 2 Postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through Sub-center staff. ▪ Initiation of early breast-feeding within half-hour of birth c) Education on nutrition, hygiene, contraception, **essential new born care** ▪	Nothing new for these services Detail budget has been given above.

	Family Planning, Contraception & MTP	No FP operation at APHC level.	1. Start FP operation 2. Distribution of contraceptives such as condoms, oral pills, emergency contraceptives. 3. IUD insertions	▪ Education, Motivation and counseling to adopt appropriate Family planning methods. ▪ Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions. ▪ Permanent methods like Tubal ligation and vasectomy / NSV. ▪ Follow up services to the eligible couples adopting permanent methods ▪ Counseling and appropriate referral for safe abortion services (MTP) for Those in need. ▪ Counseling and appropriate referral for couples having infertility.	No need of extra Budget. Orientation & Training program can be organized from Untied fund.

	RNTCP	No DOT center at APHC	Treatment and Distribution of drug.	▪ All APHCs to function as DOTS Centers to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per Guidelines.	Budget will be given under RNTCP head
	Integrated Disease Surveillance Project (IDSP)	No IDSP	Need to start IDSP	▪ APHC will collect and analyze data from sub-center and will report Information to PHC surveillance unit. ▪ Appropriate preparedness and first level action in out-break situations. ▪ Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid and tests for detection of faucal Contamination of water (Rapid test kit) and chlorination level.	Budget for Computer operator and Stationary. 24X 7500X12= 21,60,000
	National Program for Control of Blindness (NPCB)	No NPCB program	Need to start NPCB Program	▪ Diagnosis and treatment of common eye diseases. ▪ Refraction Services. ▪ Detection of cataract cases and referral for cataract surgery.	Budget will be given under District Blindness program head
	National AIDS Control Program		Starting AIDS control program at APHC level	▪ IEC activities to enhance awareness and preventive measures about	Budget will be given under District AIDS

				STIs and HIV/AIDS, Prevention of Parents to Child Transmission ▪ Organizing School Health Education Programme (c) Screening of persons practicing high-risk behavior with one rapid test to be conducted at the APHC level and development of referral linkages with the nearest VCTC at the District Hospital level for confirmation of HIV status of those found positive at one test stage in the high prevalence states. ▪ Risk screening of antenatal mothers with one rapid test for HIV and to establish referral linkages with CHC or District Hospital for PPTCT services. ▪ Linkage with Microscopy Center for HIV-TB coordination. ▪ Condom Promotion & distribution of condoms to the high risk groups. ▪ Help and guide patients with HIV/AIDS receiving ART with focus on Adherence.	program head
	Leprosy, Malaria, Kala- azar, Japanese Encephalitis, Filariasis, Dengue etc and control of	Eradication & Control	Making people aware about these disease and providing treatments	▪ IEC activities to enhance awareness and preventive measures about	

	Epidemics			AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics ▪ Starting treatment of patients if reported. ▪ Referral facilities for better treatment.	

3.2.4 Budget Summery (Additional Primary Health Center)

2009-10

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	12,0000000	
	Furniture	2,40,00000	
	Equipments	4,20,00,000	
	Drugs	4,8000000	
	Electricity	1,03,68,000	
	Telephone	1,14,000	
	Transport	43,30000	
	Laundry / Diet	28,80000	
Manpower	For all	2,17,44,000	Details break up given above
Others Services of APHC	Rent	2,73,600	
	Untide fund	600000	
	IDSP	49,50,000	
		180,059,701	

3.3 Primary Health Center (PHC):

Primary Health Centers exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

Objectives

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure you just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

No. of Institutions (Primary Health center)

As per IPH standard at every 1,00,000 population one PHC has to be established.

District Population (2008)	Maximum PHC required as per IPH Norms @ 1,00,000 people	No. of PHC already sanctioned/established	Gaps in No. of PHC
1522340	**15**	**7**	**8**

To obtain 100% IPH standard -: Need to sanction 8 new PHC to achieve 100% IPH standard.

Task for 2009-10 -:

- **Out of 7 sanctioned PHC all 7 PHC are established and functioning. So, in financial year 2009-10, 25% of gaps i.e. 2 PHC can be sanctioned more to minimize the gaps.**

3.3.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2009-10	Budget for (2009-10)
Physical Infrastructure	The PHC should have 30 indoor beds with one Operation theatre, labour room, X-ray facility and laboratory facility. It should be well lit and ventilated with as much use of natural light and ventilation as possible. The plinth area would vary from 375 to 450 sq. meters depending on whether an OT facility is opted for.	15 (Max. PHC as per IPHS)	7 PHC are functional (Existing buildings require renovation)	**8**		6 Old building (renovation) X 50,00000 =3,00,00000
Waste	Waste disposal should be	Nothing to do				

Disposal	carried out as per the GOI guidelines, which is under preparation	because GOI guideline is not prepared				
Furniture	Examination table 3 Writing tables with table sheets 5 Plastic chairs 6 Armless chairs 8 Full steel almirah 4 Labour table 1 OT table 1 Arm board for adult and child 4 Wheel chair 1 Stretcher on trolley 1 Instrument trolley 2 Wooden screen 1 Foot step 5 Coat rack 2 Bed side table 6 Bed stead iron 6 Baby cot 1 Stool 6 Medicine chest 1 Lamp 3 Shadowless lamp light (for OT and Labour room) 2 Side Wooden racks 4 Fans 6 Tube light 8 Basin 2 Basin stand 2 Sundry Articles including Linen: Buckets 4 Mugs 4 LPG stove 1 LPG cylinder 2 Sauce pan with lid 2 Water receptacle 2 Rubber/plastic shutting 2 meters Drum with tap for storing water 2 I V stand 4 Mattress for beds 6 Foam Mattress for OT table 1 Foam Mattress for labour table 1 Macintosh for labour and OT table 4 metres Kelly's pad for labour and OT table 2 sets Bed sheets 6 Pillows with covers 8 Blankets 6	Working PHC is 7 so requirement is accordingly	**7 PHC are sanctioned that need all these furniture.**	**7**	All sanctioned/established PHC i.e 7	10,00000(Approx) per PHC Total - 10,00000 X 7 = 70,00000 (To provide all listed furniture to 7 working PHC)

	Baby blankets 2 Towels 6 Curtains with rods 20 metres					
Equipment	• Normal Delivery Kit • Equipment for assisted vacuum delivery • Equipment for assisted forceps delivery • Standard Surgical Set • Equipment for New Born Care and Neonatal Resuscitation • IUD insertion kit • Equipment / reagents for essential laboratory investigations • Refrigerator • ILR/Deep Freezer • Ice box • Computer with accessories including internet facility • Baby warmer/incubator. • Binocular microscope • Equipments for Eye care and vision testing • Equipments under various National Programmes • Radiant warmer for new borne baby • Baby scale • Table lamp with 200 watt bulb for new borne baby • Phototherapy unit • Self inflating bag and mask-neonatal size • Laryngoscope and Endotracheal intubations tubes (neonatal) • Mucus extractor with suction tube and a foot operated suction machine • Feeding tubes for baby 28 • Sponge holding forceps - 2 • Valsellum uterine forceps - 2 • Tenaculum uterine forceps – 2 • MVA syringe and cannulae of sizes 4-8 • Kidney tray for emptying contents of	**Working PHC is 7 so requirement is accordingly**	**7 PHC are sanctioned that need all these equipments.**	**7**	All sanctioned/established PHC is 7	17,50,000 (Approx) per PHC Total - 17,50,000 X 7 = 1,22,50,000 (To provide all listed equipments to 7 working PHC)

	MVA syringe • Trainer for tissues • Torch without batteries – 2 • Battery dry cells 1.5 volt (large size) – 4 • Bowl for antiseptic solution for soaking cotton swabs • Tray containing chlorine solution for keeping soiled instruments • Residual chlorine in drinking water testing kits • H2S Strip test bottles					
Drugs	Paracetamol Tab- 500mg per Tab. Paracetamol Syrup- 125mg/5ml-60ml Atropine - Inj. 0.6 mg per 1ml amps Ciprofloxacin - Tab 500mg/Tab Co Trimoxazole Tab 160 + 800 mg Tab Gentamycin - Inj M.D. vial (40 mg/ml)- 30ml vial Oxytocin - Inj-Amp 1 ml (5i.u./ml) 5% Dextrose 500 ml bottle B Complex Tab Gentamicin - Ear/Eye Drop 5 ml Promethazine - Inj-Amp. 2ml amps (25 mg/ml) Pentazocine Lactate Inj. Inj-Amp.- 1 ml (30 mg/ml) Diazepam - Inj-Amp. 2ml amps (5mg/ml) Cough Expectorant	Maximum PHC is 7 so requirement is accordingly	7 PHC are sanctioned that need all these equipments.	**7**	All sanctioned/established PHC i.e. 7	Total - 2,2500000 (Approx.) (To provide all listed Medicine to all working 7 PHC)

	100 ml pack Ampicillin 250mg Capsule Ampicillin 500mg Capsule Cetrizine Tablet - 10mg Doxycycline Capsule-100mg Etophylline & Theophylline Inj.- 2ml Fluconazole Tablet – 200mg Dicyclomine Tablets - 20mg Dexamethasone Inj.- 4mg/ml- 10ml Vial Atropine Inj. 0.6mg/ml - 1ml Ampoule Lignocaine Solution 2% Solution 2%- 30ml Vial Diazepam Tablet- 5mg Chlorpheniramine Maleate - Tablet- 4mg Cephalexin) - Capsule- 250mg Metronidazole - Tablet- 200mg Ranitidine Hydochloride - Tablet 150mg Metoclopramide - Tablet- 10mg Diethylcarbamazine - Tablet- 50mg Paracetamol Dicyclomine - Tablet (500mg+20mg) Fluconazole - Tablet 50mg Diethylcarbamazine - Tablet- 100mg Xylometazoline - Drops - 0.1% (Nasal) 10ml vial. A.R.V. Theophyline IP Combn. 25.3mg/ml Aminophyline Inj. IP 25mg/ml Adrenaline Bitrate Inj. IP 1mg/ml Methyl Ergometrine Maleate 125mg/Tablet, Injection Amoxycilline Trilhydrate IP 250mg/Capsule Amoxycilline Trilhydrate					

	IP 250mg/Dispersible Tab. Phenoxymethyl Penicillin 130mg/ml Vit K3 (Menadione Inj.) USP 100mg/ml Nalidixic Acid Tabs. 100mg/Tab Phenytoin Sodium Inj. IP 50mg/2ml Chlorpromazine Hydrochloride 25mg/ml Cephalexin /Ceptrofloxin 250mg/Tablet Sodium Chloride Inj. IP I.V. Solution 0.9w/v Gama Benzine hexa Chloride As decided by CS Plasma Volume Expander As decided by CS Inj. Magnesium Inj. 50% preparation Hydralazine Misoprostol 200mg/Tablet					
Support Services						
Laboratory	1. Routine urine, stool and blood tests 2. Bleeding time, clotting time, 3. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc. 4. Sputum testing for tuberculosis (if designated as a microscopy center under RNTCP) 5. Blood smear examination for malarial parasite. 6. Rapid tests for pregnancy / malaria 7. RPR test for Syphilis/YAWS surveillance 8. Rapid diagnostic tests for Typhoid (Typhi Dot) 9. Rapid test kit for fecal contamination of water 10. Estimation of chlorine level of water using ortho-toludine reagent	Maximum PHC is 7 so requirement is accordingly	7 PHC are sanctioned that need all these equipments.	**7**	All sanctioned/established PHC i.e 7	Budget for Laboratory equipments has been given above.

Electricity	Wherever facility exists**,** uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	Maximum PHC is 7 so requirement is accordingly	7 PHC are sanctioned that need power supply.	**7**	All sanctioned/established PHC i.e. 7	Generator service can be out sourced. 7 X 36000 X 12= 30,24,000
Water	Potable water for patients and staff and water for other uses should be in adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, Chlorination, etc. as per the suitability of the center.	Safe water available everywhere				
Telephone	Where ever feasible, telephone facility / cell phone facility is to be provided.	7 PHC is existing so requirement is accordingly	7 existing PHC have telephone.	**7**		Total 7 X 500 X 12 = 42,000
Transport	The APHC should have an ambulance for transport of patients. This may be outsourced.	7 PHC is existing so requirement is accordingly	7 existing PHC have Ambulance.	**7**	All sanctioned/established PHC i.e. 7	Ambulance service may be outsourced **Total 7 X 15000 X 12 = 12,60,000**
Laundry and Dietary facilities	Laundry and Dietary facilities for indoor patients: these facilities can be outsourced.	7 PHC is existing so requirement is accordingly	All sanctioned PHC requires this facility.	**7**	All sanctioned/established PHC i.e. 7	Laundry and Dietary facilities can be outsourced 10,000 per PHC per month **Total 7 X 10,000 X 12 = 8,40,000**

3.3.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2009-10	Budget 2009-10
General Surgeon	1	7X1=7	0	7	7	**7X25000X12= 21,00000**
Physician	1	7X1=7	6	1	1	**1X25000X12= 3,00000**
Obstetrician/ Gynecologist	1	7X1=7	1	6	6	**6X25000X12= 18,00000**
Pediatrics	1	7X1=7	1	6	6	**6X25000X12= 18,00000**
Anesthetist	1	7X1=7	5	2	2	**7X25000X12= 21,00000**
Health Manager	1	7X1=7	7	0	7	**7X12000X12= 1008000**
Eye surgeon	1	7X1=7	0	7	7	**7X20000X12= 16,80,000**
Nurse-midwife	9	7X9= 63	10	53	53	**53X7500X12= 47740000**
Dresser	1	7X1=7	7	0	0	**7X6000X12= 5,04000**
Pharmacist/ compounder	1	7X1=7	7	0	0	**7X7500X12= 6,30,000**
Lab. Technician	1	7X1=7	1	6	6	**7X6500X12= 5,46,000**
Radiographer	1	7X1=7	0	7	7	**7X7500X12= 630000**
Ophthalmic Assistant	1	7X1=7	0	7	7	**7X6500X12= 5,46,000**
Ward boys/ nursing orderly	2	7X2= 14	0	14	14	**14X4000X12= 6,72,000**
Sweepers	3	7X3= 21	5	16	16	**16X4000X12= 768,000**
Chowkidar	1	7X1=7	0	7	7	**7X4000X12= 336000**
OPD attendant	1	7X1=7	0	7	7	**7X5000X12= 420000**
Statistical Assistant/ Data entry operator	1	7X1=7	7	7	7	**7X6000X12= 5,04,000**
OT attendant	1	7X1=7	0	7	7	**7X6000X12= 5,04,000**
Registration clerk	1	7X1=7	0	7	7	**7X5000X12= 4,20,000**
Accountant	1	7X1=7	7	7	7	**7X8000X12= 6,72,000**
					Total	**6,56,80,000**

3.3.3 Services and others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2009-10)
Infrastructure	Out of 7 only 15 PHC have its own building, remaining are running in rented building.	**1**. Non payment of rent **2.** Land availability for new building	**1.** Ensuring payment of rent till own buildings are not constructed. **2.** Involve DM to arrange land.	**1.** Budget to construct 4 PHC is given above. Construction of building is time taking process. So, timely payment of rent is needed **2.** DM should instruct the CO to arrange land for HSC.	
	Lack of Equipments, Drugs, Furniture, Power	PHC are working but without resources	Purchasing Equipments, Drugs, Furniture, and Power etc. as per IPH standard.	No, excuse. There is no other way except purchasing all required resources.	Detail budget has been given above.
	Formats/Registers and Stationeries (Untied fund)	Always it is found that HSC is lacking stationeries	Arrangements of fund for these miscellaneous expenses.	Untied fund Provision under control of RKS.	7X50,000= 3,50,000
Services of PHC	Delivery at PHC level	Delivery services but with poor resources	Arrange all required resources and manpower to improve the quality of institutional delivery.	▪ Purchase Drug, equipments, furniture as per IPHS. ▪ Hire required manpower to support this service.	Detail budget has been given above.

	Medical care		▪ Care of routine and emergency cases in surgery ▪ Care of routine and emergency cases in medicine ▪ ▪ New-born Care ▪ ▪ 24 hours emergency services ▪ Referral services ▪ In-patient services (6 beds)	▪ hours in the morning and 2 hours in the evening ▪ Minimum OPD Attendance should be 40 patients per doctor per day. ▪ Appropriate management of injuries and accident, First Aid, Stabilization of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions ▪ Ambulance Service to support referral ▪ Provision of diet, light, laundry etc to start indoor service.	Nothing new for these services Detail budget has been given above.

	Maternal and Child Health Care	**Non functional**	▪ 24-hour delivery services including normal and assisted deliveries ▪ Essential and Emergency Obstetric Care ▪ Antenatal care ▪ Intra-natal care ▪ Postnatal Care ▪ New Born care ▪ Care of the child	▪ improve quality of JBSY at PHC level ▪ Establish lab for minimum investigations like hemoglobin, urine albumin, and sugar, RPR test for syphilis ▪ Nutrition and health counseling ▪ Promotion of institutional deliveries ▪ Conducting of normal deliveries ▪ Assisted vaginal deliveries including forceps / vacuum delivery when ever required ▪ Manual removal of placenta ▪ Appropriate and prompt referral for cases needing specialist care. ▪ Management of Pregnancy Induced hypertension including referral ▪ Pre-referral management ▪ A minimum of 2 Postpartum home visits, first within 48 hours of delivery, 2nd within 7 days through Sub-center staff. ▪ Initiation of early breast-feeding within half-hour of birth c) Education on nutrition, hygiene, contraception, essential new born care ▪	Nothing new for these services Detail budget has been given above.

	Family Planning, Contraception & MTP	FP operation at PHC level.	1. Full range of family planning services including Laparoscopic Services 2. Safe Abortion Services 3. Distribution of contraceptives such as condoms, oral pills, emergency Contraceptives. 3. IUD insertions	▪ Education, Motivation and counseling to adopt appropriate Family Planning methods. ▪ Provision of contraceptives such as condoms, oral pills, emergency Contraceptives, IUD insertions. ▪ Permanent methods like Tubal ligation and vasectomy / NSV. ▪ Follow up services to the eligible couples adopting permanent methods ▪ Counseling and appropriate referral for safe abortion services (MTP) for Those in need. ▪ Counseling and appropriate referral for couples having infertility.	No need of extra Budget. Orientation & Training program can be organized from Untied fund.
	RNTCP	DOT center at PHC	Treatment and Distribution of drug.	▪ All PHC function as DOTS Center to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per Guidelines.	Budget will be given under RNTCP head

	Integrated Disease Surveillance Project (IDSP)	No IDSP	Need to start IDSP	▪ PHC will collect and analyze data from sub-center and will report information to PHC surveillance unit. ▪ Appropriate preparedness and first level action in out-break situations. ▪ Laboratory services for diagnosis of Malaria, Tuberculosis, Typhoid and tests for detection of faucal contamination of water (Rapid test kit) and chlorination level.	Budget has been given above.
	National Program for Control of Blindness (NPCB)	No NPCB program	Need to start NPCB Program	▪ Diagnosis and treatment of common eye diseases. ▪ Refraction Services. ▪ Detection of cataract cases and referral for cataract surgery.	Budget will be given under District Blindness program head
	National AIDS Control Program		Starting AIDS control program at PHC level	▪ IEC activities to enhance awareness and preventive measures about STIs and HIV/AIDS, Prevention of Parents to Child Transmission ▪ Organizing School Health Education Programme (c) Screening of persons practicing high-risk behavior with one rapid test to be conducted at the PHC level and development of referral linkages with the nearest VCTC at the District Hospital level for confirmation of HIV status of those found positive at one test stage in the high prevalence states. ▪ Risk screening of	Budget will be given under District AIDS program head

				antenatal mothers with one rapid test for HIV and to establish referral linkages with District Hospital for PPTCT services. ▪ Linkage with Microscopy Center for HIV-TB coordination. ▪ Condom Promotion & distribution of condoms to the high risk groups. ▪ Help and guide patients with HIV/AIDS receiving ART with focus on Adherence.	
	Leprosy, Malaria, Kala- azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	Eradication & Control	Making people aware about these disease and providing treatments	▪ IEC activities to enhance awareness and preventive measures about AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics ▪ Starting treatment of patients if reported. ▪ Referral facilities for better treatment.	

3.3.4 Budget Summery (Primary Health Center)

2009-10

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	15,50,00000	
	Furniture	1,90,00000	
	Equipments	3,32,50,000	
	Drugs	5,0000000	
	Electricity	82,08,000	
	Telephone	1,14,000	
	Transport	34,20,000	
	Laundry / Diet	22,80,000	
Manpower	For all	6,56,80,000	Details break up given above
Others Services of APHC	Rent	96,000	
	Untied fund	9,50,000	
		64,398,261	

3.4 District Hospital:

District Health System is the fundamental basis for implementing various health policies and delivery of healthcare, management of health services for define geographic areas. District hospitals is an essential component of the district health system and functions as a secondary level of health care which provides curative, preventive and promotive healthcare services to the people in the district.

The overll objective of IPH i to provide helth cre tht i ulity oriented nd enitive to the need of the people of the ditrict. The pecific objective of IPH for DH re:

i. To provide comprehenive econdry helth cre (pecilit nd referrl ervice) to the community through the Ditrict Hopitl.

ii. To chieve nd mintin n cceptble tndrd of ulity of cre. To mke the ervice more reponive nd enitive to the need of the people of the ditrict nd the hopitl/center from hich the ce re referred to the ditrict hopitl

No. of Institutions (Sadar Hospital)

As per IPH standard one District Hospital at every district.

District Population (2008)	Maximum DH required as per IPH Norms	No. of DH already sanctioned/established	Gaps in No. of DH
1522340	**1**	**1**	**0**

To obtain 100% IPH standard -: Need to strength sanction 8 new PHC to achieve 100% IPH standard.

Task for 2009-10 -:

- **Need to provide required manpower, resources, drugs and equipments to minimize the gaps.**

3.4.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2009-10	Budget for (2009-10)
Physical Infrastructure	An area of 65-85 m^2 per bed has been considered to be reasonable. The area will include the service areas such as waiting space, entrance hall, registration counter, etc. In case of specific requirement of a hospital, flexibility in altering the area be kept.	1	1	0	500 beds hospital is already proposed so need to complete it.	**For proposed hospital budget has been already sanctioned.**
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI guideline is not prepared				
Furniture	Doctor's chair Doctor's Table Duty Table for Nurses Table for Sterilization use Long Benches Stool Wooden Stools Revolving Steel Cup-board Wooden Cup Board Racks -Steel – Wooden Patients Waiting Chairs Attendants Cots Office Chairs Office Table Foot Stools Filing Cabinets (for records) M.R.D. Requirements (record room use) Pediatric cots with railings Cradle Fowler's cot Ortho Facture Table Hospital Cots Hospital Cots Pediatric Wooden Blocks Back rest	For working 1 District Hospital as per requirement	1 DH is sanctioned and working and need all these furniture.	**1**	All sanctioned /established PHC i.e. 1	10000000 (Apprx) (To provide all listed furniture to 1 working PHC)

	Dressing Trolley Medicine Almirah Bin racks ICCU Cots Bed Side Screen Medicine Trolley Case Sheet Holders with clip Bed Side Lockers Examination Couch Instrument Trolley Instrument Trolley Mayos Surgical Bin Assorted Wheel Chair Stretcher / Patience Trolley Instrument Tray Assorted Kidney Tray Assorted Basin Assorted Basin Stand Assorted Delivery Table Blood Donar Table O2 Cylinder Trolley Saline Stand Waste Bucket Dispensing Table Wooden Bed Pan Urinal Male and Female Name Board for cubicals Kitchen Utensils Containers for kitchen Plate, Tumblers Waste Disposal - Bin / drums Waste Disposal - Trolley (SS) Linen Almirah Stores Almirah Arm Board Adult Arm Board Child SS Bucket with Lid Bucket Plastic Ambu bags O2 Cylinder with spanner ward type Diet trolley - stainless steel Needle cutter and melter Thermometer clinical Thermometer Rectal Torch light Cheatles forceps assortted Stomach wash equipment Infra Red lamp Wax bath Emergency Resuscitation Kit- Adult Enema Set					

Equipment	**As per IPHS norms** • Imaging Equipment • X-ray room accessories • Cardiac equipments • Labor ward equipments • Equipment for New Born Care and Neonatal Resuscitation ▪ ENT equipment ▪ Eye equipment ▪ Dental Equipment ▪ Laboratory equipments ▪ OT equipment ▪ Surgical equipment ▪ Physiotherapy equipments ▪ Endoscopes equipments ▪ Anesthesia equipments • IUD insertion kit • Equipment / reagents for essential laboratory investigations • Refrigerator • ILR/Deep Freezer • Ice box • Computer with accessories including internet facility • Baby warmer/incubator. • Binocular microscope • Equipments for Eye care and vision testing • Equipments under various National Programmes • Radiant warmer for new borne baby • Baby scale • Table lamp with 200 watt bulb for new borne baby • Photo therapy unit • Self inflating bag and mask-neonatal size • Laryngoscope and Endotracheal intubations tubes (neonatal) • Mucus extractor with suction tube and a foot operated suction machine • Feeding tubes for baby 28 • Sponge holding forceps - 2 • Valsellum uterine forceps - 2 • Tenaculum uterine forceps –	Working DH is 1 so requirement is accordingly	1 DH is sanctioned that need all these equipments.	**1**	One sanctioned /established DH	20000000 (Approx) (To provide all listed equipments to 1 working DH)

	2 • MVA syringe and cannulae of sizes 4-8 • Kidney tray for emptying contents of MVA syringe • Trainer for tissues • Torch without batteries – 2 • Battery dry cells 1.5 volt (large size) – 4 • Bowl for antiseptic solution for soaking cotton swabs • Tray containing chlorine solution for keeping soiled instruments • Residual chlorine in drinking water testing kits • H2S Strip test bottles					
Drugs	Dicyclomine Inj- Atropine - Inj. Norfloxacin- Tab Ciprofloxacin - Tab Ciprofloxacin - Tab Co Trimoxazole Tab Amoxicillin- Cap Gentamycin - Inj Albendazole Alprazolam - Tab Ranitidine - Inj Oxytocin - Inj-Amp Methyl Ergometrine Glibenclamide 5% Dextrose 5% Dextrose + 0.9% B Complex Silver Sulphadiazine oint - Promethazine - Inj-Amp. Pentazocine Lactate Inj. Diazepam - Inj-Amp. Cough Expectorant Ampicillin Ciprofloxacin Thiopentone Cetrizine Doxycycline Ampicillin & Cloxacilin Etophylline & Theophylline Dopamine Hydrochloride Adrenaline Sodium Bicarborate Tinidazole Fluconazole Clotrimazole Cream Dicyclomine Tablets					Total - 2,0000000 (Approx.) (To provide all listed Medicine to working 1 DH)

	Dexamethasone Digoxin Metformin Atropine Lignocaine Solution 2% Cetrimide Concenterated Diazepam Diclofenac Sodium Carbamazepine Carbamazepine Cephalexin Metronidazole Metronidazole Cefotaxime Atenolol Furosemide Ranitidine Hydochloride Metoclopramide Isosorbide Dinitrate Diethylcarbamazine Ciprofloxacin Metronidazole Cefotaxime Enalapril Enalapril Chloramphenicol Alprazolam Tramadol Dexamethasone Cefotaxime Amlodipine Erythromycin Stearate Cetrizine Omeprazole Prednisolone Diethylcarbamazine Ampicillin Sodium Atenolol Hydroxy progesterone acetate Xylometazoline Prednisolone Betamethasone Chloram Phenicol Bupivacaine Hydrochloride Succinyl Choline Intermediate acting insulin Lente/NPH Insulin Insulin injection (Soluble) - Inj. 40IU/ml premix insulin (30/70 Human) A.S.V.S. ARV					

Support Services						
Electricity	Wherever facility exists**,** uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	1 District Hospital	1 DH is sanctioned that need power supply.	**1**	All sanctioned /established DH i.e 1	Generator service can be out sourced. 1 X 2200 X 365 days = 8,03,000
Water	Potable water for patients and staff and water for other uses should be in adequate quantity. Towards this end, adequate water supply should be ensured and safe water may be provided by use of technology like filtration, chlorination, etc. as per the suitability of the center.	Safe water available everywhere				
Telephone	Where ever feasible, telephone facility / cell phone facility is to be provided.	3 Telephone connections required	1 telephone is existing.	**1**	2 new connection required	Total 3 X 1000 X 12 = 36,000
Transport	The APHC should have an ambulance for transport of Patients. This may be outsourced.	3 ambulance & 1 Vehicle required	1 ambulance existing.	**1**		Ambulance service may be outsourced Total X 15000 X 12 = 7,20,000
Laundry, Dietary and Cleaning facilities	Laundry, Dietary and cleaning work can be outsourced.	For 1 existing District Hospital	One existing DH requires this facility.	**1**		Laundry, cleaning and Dietary facilities can be outsourced 1 lakh per month Total 1 X 1,00000 X 12 = 12,00000

3.4.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2009-10	Budget 2009-10
Hospital Superintendent	1	1X1=1	1	0	0	**State**
Medical Specialist	3	3X1=3	1	2	2	**2X25000X12= 6,00000**
Surgery Specialists	3	3X1=3	1	2	2	**2X25000X12= 6,00000**
O&G specialist	6	6X1=6	1	5	5	**5X25000X12= 15,00000**
Psychiatrist	1	1X1=1	0	1	1	**1X20000X12= 2,40,000**
Dermatologist / Venereologist	1	1X1=1	0	1	1	**1X20000X12= 2,40,000**
Pediatrician	3	3X1=3	1	2	2	**2X25000X12= 6,00000**
Anesthetist (Regular / trained)	6	6X1= 6	1	5	5	**5X25000X12= 15,00000**
ENT Surgeon	2	2X1=2	1	1	1	**1X20000X12= 2,40,000**
Ophthalmologist	2	2X1=2	1	1	1	**1X20000X12= 2,40,000**
Orthopedic an	2	2X1=2	1	1	1	**1X20000X12= 2,40,000**
Radiologist	1	1X1=1	1	1	1	**1X20000X12= 2,40,000**
Casualty Doctors / General Duty Doctors	20	20X1= 20	4	16	16	**16X20000X12= 38,40,000**
Dental Surgeon	1	1X1=1	1	1	0	**0**
Health Manager	1	1X1=1	0	0	1	**1X12000X12= 1,44,000**
AYUSH Physician	4	4X1=4	0	4	4	**4X15000X12= 7,20,000**
Pathologists	2	2X1=2	0	1	1	**1X20000X12= 2,40,000**
Staff Nurse	20	20X1=20	9	11	11	**11X7500X12= 9,90,000**
Hospital worker (OP/ward +OT+ blood bank)	20	20X1=20	8	12	12	**12X3000X12= 4,32,000**
Ophthalmic Assistant	2	2X1=2	0	0	0	**1X6000X12= 72,000**
ECG Technician	1	1X1=1	0	1	1	**1X6000X12= 72,000**
Laboratory	4	4X1=4	1	3	3	**3X6000X12=**

Technician (Lab + Blood Bank)						**2,16,000**
Maternity assistant (ANM)	4	4X1=4	4	0	0	**0**
Radiographer	2	2X1=2	0	2	2	**2X6000X12= 1,44,000**
Pharmacist[1]	6	6X1=6	2	4	4	**4X6000X12= 2,88,000**
Physiotherapist	2	2X1=6	0	2	2	**2X12000X12= 2,88,000**
Statistical Assistant	1	1X1=1	0	1	1	**1X8000X12= 96,000**
					Total	**1,37,82,000**

3.4.3 Services and others

As per IPHS norms

3.4.4 Budget Summary (District Hospital)

2009-10

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	0	
	Furniture	1,0000000	
	Equipments	2,0000000	
	Drugs	2,0000000	
	Electricity	8,03,000	
	Telephone	36,000	
	Transport	7,20,000	
	Laundry/Diet /Cleaning	12,00000	
Manpower	For all	1,37,82,000	Details break up given above
Others Services of DH	Untied fund	2,00,000	
	Disaster handling fund	10,00,000	
	Total	**51,341,065**	

CHAPTER – 4
DISTRICT LEVEL PROGRAMMES ANALYSIS & BUDGET

4.1 Strengthening of District Health Management

Situation Analysis/ Current Status	The District Health Mission and Society have formed been registered in Khagaria. There are 8 members with the District Magistrate as the chairman, the DDC as the vice-chairman and the Civil Surgeon as the member secretary of the society. The others members are the ACMO, RCH officer, superintendent Sadar hospital, CEO nagar parishad, IMA secretary and District Welfare Officer. The Governing body meetings are held monthly under the chairmanship of the DM. Although the DHS formed and meetings conducted regularly but it needs proper training on planning and management.	
Objectives / Milestones/ Benchmarks	District Health Society to make functional and empower to plan, implement and monitor the progress of the health status and services in the district.	
Strategies	1. Capacity building of the members of the District Health Mission and District Health Society regarding the program, their role, various schemes and mechanisms for monitoring and regular reviews 2. Establishing Monitoring mechanisms 3. Provide ASHA as link workers to mobilize the community to strengthen health seeking behavior and to promote proper utilization of health services.	
Activities	1. Orientation Workshop of the members of the District health Mission and society on strategic management, financial management & GoI/GoH Guidelines. 2. Issue based orientation in the monthly Review and planning meetings as per needs. 3. Improving the Review and planning meetings through a holistic review of all the programmes under NRHM and proper planning. 4. Formation of a monitoring Committee from all departments. 5. Development of a Checklist for the Monitoring Committee. 6. Arrangements for travel of the Monitoring Committee 7. Sharing of the findings of the committee during the Field visits in each Review Meeting with follow-up of the recommendations.	
Support required	1. Technical and financial assistance needs to be imparted for orientation and integration of societies. 2. A GO should be taken out that at the district level each department should monitor the meetings closely and ensure follow-up of the recommendations. 3. Instructions & directions from GoH for proper functioning of the societies and monitoring committee. 4. Funds to maintain society office & staff.	
Timeline	2009-10 1.Orientation Workshops of the members of the District Health Mission and District Health society 1. Issues based workshops will be organized. 2. Formation of the monitoring Committee and will start the monitoring visits. 3.Reorientation Workshops 4.Workshops as per need 5.Strengthening of the Monitoring Committee	
Budget	**Activity / Item**	**2009-10**
	Orientation Workshop	**50,000**
	Issues based Workshops	**3,25,000**
	Mobility for Monitoring	**50,000**
	Total	**4,25,000**

4.2 District Programme Management Unit

Status	In NRHM a large number of activities have been introduced with very definite outcomes. The cornerstone for smooth and successful implementation of NRHM depends on the management capacity of District Programme officials. The officials in the districts looking after various programmes are overworked and there is immense pressure on the personnel. There is also lack of capacities for planning, implementing and monitoring. The decisions are too centralized and there is little delegation of powers. In order to strengthen the district PMU, three skilled personnel i.e. Programme Manager, Accounts Manager and Data Assistant have being provided in each district. These personnel are there for providing the basic support for programme implementation and monitoring at district level. The District Programme Manager is responsible for all programmes and projects in district 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 computerized FMS. The District Data Assistant (DDA) 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 CMHO 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, Behavior change and accounting right from the level of the Sub center. The Civil surgeon's office is located in the premises of the only General hospital in the district due to which the hospital cannot expand and take on additional patients. The office of the District Family Welfare officer and other district health officials is also in hospital premises.
Objectives	Strengthened District Programme Management Unit
Strategies	1. Support to the Civil surgeon for proper implementation of NRHM. 2. Capacity building of the personnel 3. Change of designation of Data Assistant as a District Data Manager because even after holding the PG degree similar to DPM and DAM, they have gotten Assistant designation. It affects their moral. 4. Development of total clarity at the district and the block levels amongst all the district officials and Consultants about all activities 5. Provision of infrastructure for the personnel 6. Training of district officials and MOs for management 7. Use of management principles for implementation of District NRHM 8. Streamlining Financial management 9. Strengthening the Civil Surgeon's office 10. Strengthening the Block Management Units 11. Convergence of various sectors

Activities	1. **Support to the Civil surgeon** for proper implementation of NRHM through proper involvement of DPMU and more consultants for support to civil surgeon for data analysis, trends, timely reports and preparation of documents for the day-to-day implementation of the district plans so that the Civil Surgeon and the other district officers: • Finalizing the TOR and the selection process • Selection of consultants, one each for Maternal Health, Civil Works, Child health, Behavior change. If properly qualified and experienced persons are not available then District Facilitators to be hired which may be retired persons. **2. Capacity building of the personnel** • Joint Orientation of the District officers and the consultants • Induction training of the DPM and consultants • Training on Management of NRHM for all the officials • Review meetings of the District Management Unit to be used for orientation of the consultants 3. **Development of total clarity in the Orientation workshops** and review meetings at the district and the block levels amongst all the district officials and Consultants about the following set of activities: • Disease Control • Disease Surveillance • Maternal & Child Health • Accounts and Finance Management • Human Resources & Training • Procurement, Stores & Logistics • Administration & Planning • Access to Technical Support • Monitoring & MIS • Referral, Transport and Communication Systems • Infrastructure Development and Maintenance Division • Gender, IEC & Community Mobilization including the cultural background of the Meos • Block Resource Group • Block Level Health Mission • Coordination with Community Organizations, PRIs • Quality of Care systems 4. **Provision of infrastructure for officers**, DPM, DAM, DDM and the consultants of the

	District Project Management Unit. • Provision of office space with furniture and computer facilities, photocopy machine, printer, Mobile phones, digital camera, fax, Laptop etc; **5. Use of Management principles for implementation of District NRHM** • 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 • Provision of Rs. 500000 as Untied funds at the district level under the jurisdiction of the Civil Surgeon • Compendium of Government orders for the DC, Civil surgeon, district officers, hospitals, CHCs, PHCs and the Subcentres need to be taken out every 6 months. Initially all the relevant documents and guidelines will be compiled for the last two years. 6. **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 Block Data Assistants (BDA) for each block. These will be hired on contract. For the post of BPM and the BAM retired persons may also be considered. • Office setup will be given to these persons • Accountants on contract for each PHC since under NRHM Subcentres have received Rs 10,000, also the village committees will get Rs 10,000 each, besides the funds for the PHCs. • Provision of Computer system, printer, Digital Camera with date and time, furniture **7. Convergence of various sectors at district level** • Provision of Convergence fund for workshops, meetings, joint outreach and monitoring with each Civil Surgeon 8. **Monitoring the Physical and Financial progress** by the officials as well as independent agencies 9. **Yearly Auditing** of accounts
Support from state	1. State should ensure delegation of powers and effective decentralization. 2. State to provide support in training for the officials and consultants. 3. State level review of the DPMU on a regular basis. 4. Development of clear-cut guidelines for the roles of the DPMs, DAM and District Data Manager. 5. Developing the capacities of the Civil Surgeons and other district officials to utilize the capacities of the DPM, DAM and DDA fully. 6. Each of the state officers Incharge of each of the programmes should develop total clarity by attending the Orientation workshops and review meetings at the district and the block levels for all activities.
Time Frame	2009-10 • Selection of District level consultants, their capacity building and infrastructure • Development of an operational Manual 2009-10 • Selection of Block management units and provision of adequate infrastructure and office automation • Capacity building up of District and Block level Management Units • Training of personnel • Reorientation of personnel

Budget		Activity	Year 2009-10
		Honorarium DPM,DAM,DDA Consultants	**6,72,000**
		Honorarium Consultants Maternal Health, Civil Works, Child health, Behavior change each @ 40,000 per month X 12X 4	**19,20,000**
		Travel Costs for DPMU @ Rs 20,000/ per month x 12 months	**2,40,000**
		Infrastructure costs Laptop, fax, Projector, Photostat machine, Digital Camera	**2,00000**
		Workshops for development of the operational Manual at district and Block levels	**1,00000**
		Untied Fund	**5,00000**
		Joint Orientation of Officials and DPM, DAM, DDM	**25,000**
		Management training workshop of Officials	**50,000**
		Training of DPM and Consultants	**50,000**
		Review meetings @ Rs 1000/ per month x 12 months	**12,000**
		Office Expenses @ Rs 10,000/ month x 12 months for district	**1,20,000**
		Annual Maintenance Contract for the equipment	**50,000**
		Total	**39,39,000**

4.3 Maternal Health & JBSY

Objectives	1. 100% pregnant women to be given two doses of TT 2. 90% pregnant women to consume 100 IFA tablets by 2010 3. 70% Institutional deliveries by 2010 4. 90% deliveries by trained /Skilled Birth Attendant by 2010 5. 95% women to get improved Postnatal care by 2010 6. Increase safe abortion services from current level to 80 % by 2010
Strategies	1. Provision of quality Antenatal and Postpartum Care to pregnant women 2. Increase in Institutional deliveries 3. Quality services in the health facilities 4. Availability of safe abortion services at all APHC and PHC 5. Increased coverage under JBSY 6. Strengthening the Maternal, Child Health and Nutrition (MCHN) days 7. Improved behavior practices in the community
Activities	1. Identification of all pregnancies through house-to-house visits by ANMs, AWWs and ASHAs 2. Fixed Maternal, Child Health and Nutrition days • Once a week ANC clinic by contract LMO at all PHCs and CHCs • Development of a microplan for ANMs in a participatory manner • Wide publicity regarding the MCHN day by AWWs and ASHAs and their services • A day before the MCHN day the AWW and the ASHA should visit the homes of the pregnant women needing services and motivate them to attend the MCHN day • Registration of all pregnancies • Each pregnant woman to have at least 3 ANCs, 2 TT injections and 100 IFA tablets • Nutrition and Health Education session with the mothers 3. Postnatal Care • The AWW along with ANM will use IMNCI protocols and visit neonates and mothers at least thrice in first week after delivery and in total 5 times within one month of delivery. They will use modified IMNCI charts to identify problems, counsel and refer if necessary 4. Tracking bags • Provision of tracking bags for the left outs and the dropout Pregnant mothers • Training of ANMs and AWWs for the use of Tracking bags

	5. Provision of Weighing machines to all Subcentres and AWCs 6. Availability of IFA tablets • ASHAs to be developed as depot holders for IFA tablets • ASHA to ensure that all pregnant women take 100 IFA tablets 7. Training of personnel for Safe motherhood and Emergency Obstetric Care (Details in Component on Capacity building) 8. Developing the APHC and PHC for quality services and IPHS standards (Details in Component Upgradation of APHC & PHCs and IPHS Standards) 9. Availability of Blood at the General Hospital and PHC • Establishing Blood storage units at GH and PHC • Certification of the Blood Storage centres 10. Improving the services at the Subcentres (Details in Component on Upgradation of Subcentres and IPHS) 11. Behaviour Change Communication (BCC) efforts for awareness and good practices in the community (Details in Component on IEC) 12. Increasing the Janani Suraksha coverage • Wide publicity of the scheme (Details in Component on BCC ...) • Availability of advance funds with the ANMs • Timely payments to the beneficiary • Starting of Janani Suraksha Yojana Helpline in each block through Swasthya Kalyan Samitis 13. Training of TBAs focussing on their involvement in MCHN days, motivating clients for registration, ANC, institutional deliveries, safe deliveries, post natal care, care of the newborn & infant, prevention and cure of anaemia and family planning 14. Safe Abortion: • Provision of MTP kits and necessary equipment and consumables at all PHCs • Training of the MOs in MTP • Wide publicity regarding the MTP services and the dangers of unsafe abortions • Encourage private and NGO sectors to establish quality MTP services. • Promote use of medical abortion in public and private institutions: disseminate guidelines for use of RU-486 with Mesoprestol 15. Development of a proper referral system with referral cards 16. Improvement of monitoring of ANM tour programme and Fixed MCHN days • Fixed MCHN days and Tour plan of ANM to be available at the PHCs with the MOs • Checklist for monitoring to be developed • Visits by MOs and report prepared on basis of checklist filled • Findings of the visits by MOs to be shared by MO in meetings 17. RCH Camps: These will be organized once each quarter through NGOs/Rotary/Lions clubs to provide specialist services especially for RTI/STD cases.
State support	1. Issue of joint letters from Health & ICDS department for joint working 2. Ensuring availability of personnel especially specialists and Public Health Nurses for the 24 hour PHCs, APHC and two ANMs at the subcenter 3. Ensuring availability of formats and funds with the ANM for JBSY and timely payments 4. Certification of PHCs as MTP centres 5. The State should closely monitor the progress of all the activities

Budget	**Activity / Item**	**2009-10**
	Tracking Bags @ Rs 300/ bag x AWCs 1276 and refilling	**3,82,800**
	Blood Storage @ Rs 3 lakhs per unit two FRU	**6,00,000**
	One day training workshop on Tracking bags at the district level and each sector	**2,50,000**
	JBSY beneficiaries @ Rs 2000/ person (Target 45527)	**9,10,54,000**
	Total	**9,22,86,800**

4.4 Newborn & Child Health

Breast feeding: As per DLHS 2002, only 11.9% mothers breastfeed their children within two hours of birth and 4.8% children were breastfed exclusively for stipulated period of 4 months. There is lack of knowledge regarding the significance of colostrums and the socio-cultural factors associated with it.

Childhood illnesses

Diarrhea: Under nutrition is associated with diarrhea, which further leads to malnutrition. According to the DLHS 2002 although three fourths of the women were aware of what was to be done when a child got diarrhea but in practice very few women gave Oral Rehydration Solution (ORS) to the child and a negligible percentage gave more fluids to drink. This shows that there is a need for more knowledge regarding the use of ORS and increased intake of fluids and the type of food to be given.

Pneumonia: There is a need to create awareness regarding the danger signs of Pneumonia since only half of the women are aware of danger signs of pneumonia as per DLHS 2002.

Newborn and Neonatal Care: There is very little data available for the newborns and the neonates. The District data shows that a negligible percentage of newborns and neonates died which is doubtful. Reporting regarding these deaths is not done properly. The various health facilities also are poorly equipped to handle newborn care and morbidity. The TBAs and the personnel doing home deliveries are unaware regarding the neonatal care especially warmth, prevention of infection and feeding of colostrum.

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

1. Improving feeding practices for the infants and children including breast feeding
2. Promotion of health seeking behavior for sick children
3. Community based management of Childhood illnesses
4. Improving newborn care at the household level and availability of Newborn services in all PHCs & hospitals
5. Enhancing the coverage of Immunization
6. Zero Polio cases and quality surveillance for Polio cases

1. Improving feeding practices for the infants and children including breast feeding
- Study on the feeding practices for knowing what is given to the children
- Education of the families for provision of proper food and weaning
- Educate the mothers on early and exclusive breast feeding and also giving Colostrums
- Introduction of semi-solids and solids at 6 months age with frequent feeding
- Administration of Micronutrients – Vitamin A as part of Routine immunization, IFA and Vitamin A to the children who are anemic and malnourished

2. Promotion of health seeking behavior for sick children and Community based management of Childhood illnesses
- Training of LHV, AWW and ANM on IMCI including referral
- BCC activities by ASHA, AWW and ANM regarding the use of ORS and increased intake of fluids and the type of food to be given
- Availability of ORS through ORS depots with ASHA
  Identification of the nearest referral center and also Transport arrangements for emergencies with the PRIs and community leaders with display of the referral center and relevant telephone numbers in a prominent place in the village

3. Improving newborn care at the household level
- Adaptation of the home based care package of services and scheduling of visits of all neonates by ASHA / AWW / ANM on the 1st, 2nd, 7th, 14th and 28th day of birth.
- In case of suspicion of sickness the ASHA / AWW must inform the ANM and the ANM must visit the Neonate

- Referral of the Neonate in case of any symptoms of infection, fever and hypothermia, dehydration, diarrhea etc;
- Training on IMNCI of ASHA / AWW / ANM / MOs on the home based Care package
- Supply of medicine kit and diagnosis and treatment protocols (chart booklets) for implementation of the IMNCI strategy
- Strengthening the neonatal services and Child care services in Sadar hospital Khagaria and all PHC. This will be done in phases.
- In all of these units, newborn corners would be established and staff trained in management of sick newborns and immediate management of newborns. For all the equipment for establishing newborn corners, a five year maintenance contract would be drawn with the suppliers. The suppliers would also be responsible for installing the equipment and training the local staff in basic operations
- The equipment required for establishing a newborn corner would include Newborn Resuscitation trolley, Ambubag and masks (newborn sizes), Laryngoscopes, Photo therapy units, Room warmers, Inverters for power back-up, Centralized oxygen and Pedal suctions
- Training of staff in Newborn Care, IMNCI and IMCI (MOs, Nurses) including the management of sick children and severely malnourished children.
- Availability of Pediatricians in all the District hospital and PHCs
- Ensuring adequate drugs for management of Childhood illnesses.

4. Strengthening the fixed Maternal and Child health days (Also discussed in the component on Maternal Health)

- Developing a Micro plan in joint consultation with AWW
- Organize Mother and Child protection sessions twice a week to cover each village and hamlet at least once a month
- Use of Tracking Bag
- Tracking of Left-outs and dropouts by ASHA, AWW and contacting them a day before the session
- Information of the dropouts to be given by ANM to AWW and ASHA to ensure their attendance
- Wide publicity regarding the MCHN days

5. Strengthening Immunization

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

Budget

Activity / Item	**2009-10**
Newborn Corner furnished with equipment	Budget for these equipments & activities has been given in HSC, APHC, PHC head.
Generator	
POL Generator	
Examination table, chair, stool, table, other equipment	
Infant Weighing Machines	
Training on IMNCI and IMCI of LHV / ASHA / AWW / ANM / MOs on the home based Care package and mgt at facilities	Component on training
Supply of Diagnosis and treatment protocols (chart booklets) for IMNCI & IMCI strategy	
Supply of medicine kit for IMNCI	State

4.5 Family Planning

Situation Analysis/ Current Status

Indicators	No. or Rate
Eligible Couple	1,75,770
% of Female Sterilization operations DLHS-03	17.2%
% of male Sterilization operations DLHS-03	0.2%
% of Couples using temporary method DLHS-03	24%

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

Currently 24% couples are using temporary methods of contraception and 17.4% have permanent sterilization (mainly Female sterilization). In temporary methods commonest use is of Condom, which has a high failure rate. Use of Copper –T is low. The community prefers female sterilization since there is gender imbalance and limited male involvement. Women also do not have decision-making power.

The reasons for the low use of permanent methods and Copper -T are due to inadequate motivation of the clients, inadequate manpower, limited skills of the ANMs for IUD insertion and also their irregular availability. The rejection rate is high since proper screening is not done before prescribing any spacing method.

Copper T-380 – 10 year Copper T has been recently introduced but there is very little awareness regarding its availability. There is a need to promote this 10 yr Copper T

Some socio-cultural groups have low acceptance for Family Planning.

Promotion efforts for Vasectomy have been very infrequent and only 222 men have undergone Vasectomy.

The current number of trained providers for sterilization services is insufficient.

Objectives

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

Strategies

1. Increased awareness for Emergency Contraception and 10 yr Copper T
2. Decreasing the Unmet Need for Family Planning
3. Availability of all methods at all places
4. Increasing access to terminal methods of Family Planning
5. Promotion of NSV
6. Expanding the range of Providers
7. Increasing Access to Emergency Contraception and spacing methods through Social marketing
8. Building alliances with other departments, PRIs, Private sector providers and NGOs

Activities

- **1.** Expanding the range of Public Sector providers for Terminal methods
- Each APHC and PHC will have one MO trained in any sterilization method.
- All the APHC/PHC will have at least one MO posted who can be trained for abdominal Tubectomy. This method does not require a postgraduate degree or expensive equipment.
- Similarly MOs will be trained for NSV
- Specialists from District hospitals and PHCs will be trained in Laparoscopic Tubal Ligation.
- At PHCs, one medical officer will be trained in NSV
- Each PHC will be a static center for the provision of sterilization services on regular basis. The Static centers will be developed as pleasant places, clean, good ambience with TV, music, good waiting space and clean beds and toilets.
- At selected PHCs where the EmOC intervention is undertaken, the medical officer will be trained for NSV.
- Equipments and supplies will be provided at APHC and PHC for conducting sterilization services.

	• A systemic effort will be made to assess the needs of all facilities, including staff in position and their training needs, the availability of electricity and water, Operation theatre facilities for District hospitals/PHC/APHC, Inventory of equipment, consumables and waste disposal facilities and the condition, location and ownership of the building. • At least three functional Laparoscope's will be made available per team, as will the equipment and training necessary to provide IUD and emergency contraception services. The existing Laparoscope's need to be replaced. For effective coverage 4 teams are required with minimum three Laparoscope's for each team. • Vacant positions will be filled in on a contractual basis. • Access to Terminal Family Planning methods • Provision of Sterilization services every day in all the hospitals • Organization of Sterilization camps on fixed days at all PHC • NSV • **2.** Formation of District implementation team consisting of DM, CS, District MEIO, Distt NSV trainer • One day Workshop with elected representatives, Media, NGOs, departments for sensitization and implementation strategy, fixing pre-camp, camp and post-camp responsibilities • Development of a Micro plan in one day Block level workshops • NSV camp every quarter in all hospitals initially and then PHCs and APHCs • IEC for NSV • Trained personnel • Follow-up after NSV camp on fixed days after a week and after 3 months for Semen analysis • Access to non-clinical contraceptives increased in all the villages • AWWs and ASHAs as Depot holders • **3.** Training in Spacing methods, Emergency Contraceptives and interpersonal communication for dissemination of information related to the contraceptives in an effective manner. • Supply of Emergency Contraceptives to all facilities • Access for the quality IUD insertion improved at all the 27 subcentres. • All the ANMs at 27 subcentres will be given a practical hands on training on insertion of IUD • Diagnosis and treatment of RTI/STI as per syndromic approach. The various screening protocols related to the IUD insertion enabling her to screen the cases before the IUD insertion. This will result in longer retention of IUDs. • Counseling of the cases • Repair of subcentres so that the IUD services can be provided and ensuring privacy and confidentiality. • IUD 380 A will be used due to its long retention period and can be used as an alternative for sterilization. • Awareness on the various methods of contraception for making informed choices • Discussed in the Component on IEC • **5.** Increasing the gender awareness of providers and increasing male involvement • Empowering women • Increasing male involvement in family planning through use of condoms for safe sex and also in Vasectomy. • BCC activities to focus on men for Vasectomy. • Gender sensitization training will be provided for all health providers in the CHC/PHC and integrated into all other training activities. • Service delivery sites for male methods by training health providers in NSV and conventional vasectomy will be expanded so that each CHC and Block PHC in the

	district has at least a provider trained in NSV. • **6.** Improving and integrating contraceptives/RCH services in PHCs and Sub-centers • Skill-based clinical training for spacing methods including IUCD insertion and removal, LAM, SDM and EC of Lady Health Visitors (LHVs) and Auxiliary Nurse Midwives (ANMs). • They will also be trained in infection prevention, counselling and follow up for different family planning methods. • MIS training will also be given to the health workers to enable them to collect and use the data accurately. • Their supervisors will be trained for facilitative supervision and MIS. • Follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers • **7.** Strengthening linkages with ICDS programme of women and child development department and ISM (Ayurveda) • A detailed action plan will be produced in co-ordination with the ICDS department for involvement of the AWWs and their role in increasing access to contraceptive services. • Department of health officials and ICDS officers will be orientated to the plan. • AWWs and their supervisors will receive technical training and training in communication skills and record keeping by Medical Officer of the PHC and LHV. • Staff of ISM department will be trained in communication and non-clinical methods to promote and increase the availability of FP methods. • **8.** Engaging the private sector to provide quality family planning services • Incentives and training to encourage private providers to provide sterilization services • Training private lady doctors in IUD insertion and promoting the provider will help to expand coverage of these services increase the total use of IUCD. • Detailed plan will be developed in consultation with the private sector for determining the amount and mode of payment, the regulation and monitoring frameworks necessary, and safeguards to ensure equity of access. • Training for the private sector will be provided as above, and approved, monitored providers will be promoted and eligible for discounted supplies. • Accreditation of private hospitals and clinics for sterilization and NSV • Role of ASHAs: • Training for provide counseling and services for non-clinical FP methods such as pills, condoms and others. • Act as depot holders for the supplies of pills and condoms by the ANMs for free distribution • Procurement of pills and condoms from social marketing agencies and provide these contraceptives at the subsidized rate • Provide referral services for methods available at medical facilities • Assist in community mobilization and sensitization. • Building partnerships with NGOs • Creating an enabling environment for increasing acceptance of contraceptive services Innovative schemes will be developed for reaching out to younger men, women, newly married couples and resistant communities. • These will be and scaled up as appropriate.
Support required	• Availability of a team of master trainers/ANM tutors and RFPTC trainers for follow up of trained LHVs and ANMs after one month and six months of training and provide supportive feedback to the service providers • A training cell will be created in the medical college for the training of the medical officers in the area of various sterilization methods

	• Availability of equipment, supplies and personnel

Timeline

	2009-10
Training of MOs for NSV	10 MOs
Training of MOs for Minilap	
Training of Specialists for Laparoscopic Sterilization	
Sterilization Camps (Persons)	15000
Accreditation of private institutions for sterilization	10
Supply of Copper T – 380	5000
Emergency Contraception	3000

Budget

Activity / Item	**2009-10**
NSV @ Rs. 1500 per person X 1000 cases	**15,00000**
Sterilization @ 1000 X 14000 cases	**1,40,000 00**
Copper T-380 @ Rs 50 / piece x 5000	**2,50,000**
Emergency Contraception @ Rs10/2 tabs	**25,000**
IEC	**1,50,000**
Total	**1,59,25,0 00**

4.6 ASHA (Accredited Social Health Activist)

Situation Analysis	ASHA is an honorary worker and will be reimbursed on performance-based incentives and will be given priority for involvement in different programmes wherever incentives are being provided (like institutional delivery being promoted under JBSY, motivation for sterilization, DOTS provider, etc.). It is conceived that she will be able to earn about Rs. 1,000.00 per month In district Khagaria 1017 ASHAs have been selected and 976 have received training.
Objectives	1. Availability of a Community Resource, service provider, guide, mobilizer and escort of community 2. Provision of a health volunteer in the community at 1000 population for healthcare 3. To address the unmet needs
Strategies	1. Selection and capacity building of ASHA. 2. Constant mentoring, monitoring and supportive supervision by district Monitoring group
Activities	1. Strengthening of the existing ASHAs through support by the ANMs and their involvement in all activities. 2. Reorientation of existing ASHAs 3. Selection of new ASHAs to have one ASHA in all the villages and in urban slums 4. Provision of a kit to ASHAs 5. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving 6. Review and Planning at the Monthly sector meetings 7. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency
Support required	1. Timely Payments to ASHA 2. Proper training.

Timeline

Activity	**2009-10**
Selection of additional ASHAs	1017
Total ASHAs	1204
Training of new & untrained ASHAs	228
Reorientation of the initial ASHAs	228

	District ASHA Mentoring group	X
Budget	**Activity / Item**	**2009-10**
	Training & kit @ Rs 5000/ ASHA	**3,25,000**
	Reorientation @ Rs 1000/ ASHA	**2,11,000**
	Expenses for the District mentoring group – meetings, travel @ Rs 10,000 per month x 12 months	**1,20,000**
	Incentive for ASHAs on ASHA Day	**18,46,800**
	Total	**25,02,800**

4.7 Immunization

Situation Analysis/ Current Status	As per DLHS 3 BCG immunization coverage is 87.1% but full immunization coverage is 52.4% only. It indicates the dropout rate is very high. This is also fact that some children belonging to upper and middle class family get immunized from private health facilities which data is not available. But still in our district some children are remaining unimmunized. Regarding Vitamin A supplement 70.3% of the children got at least one dose of Vitamin A. The reasons for children not being Immunized are related to the ignorance of the mothers on the importance of immunization, the place and time of Immunization sessions and fear of side effects. The community perceives that the Polio drops given repeatedly at the time of Pulse Polio campaign are equivalent to the complete immunization. The ANMs have to take the vaccines from the PHC headquarters resulting in them not reaching the hamlets and also the difficult areas and also the Pulse Polio campaign. Supervision is not done properly at PHC level. Also there is large gap between reported and evaluated coverage.
Objectives/ Milestones/ Benchmarks	Reduction in the IMR 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) 100% Measles vaccination of children (12-23 month of age) 100% Vitamin A vaccination of children (12-23 month of age)
Strategies	1. Strengthening the District Family Welfare Office 2. Enhancing the coverage of Immunization 3. Alternative Vaccine delivery 4. Effective Cold Chain Maintenance 5. Zero Polio cases and quality surveillance for Polio cases 6. Close Monitoring of the progress
Activities	1. Strengthening the District Family Welfare Office • Support for the mobility District Family Welfare Officer (@ Rs.3000 per month towards cost of POL) for supervision and monitoring of immunization services and MCHN Days • One computer assistant for the District Family Welfare Office will be provided for data compilation, analysis and reporting @ Rs 4500 per month. 2. Training for effective Immunization Training for all the health personnel will be given including ANMs, LHVs, FPWs, Cold chain handlers and statistical assistants for managing and analyzing data at the district. 3. Alternative vaccine delivery system (mobility support to PHCs for vaccine delivery) a. For Alternative vaccine delivery, Rs. 50 to the ANM will be given per session. It is proposed to hold one session per week per Subcentre. b. Mobility support (hiring of vehicle) is for vaccine delivery from PHC to MCHN days

	site where the immunization sessions are held for 8 days in a month 4. Incentive for Mobilization of children by Social Mobilizers • Rs.100 per month will be given to Social Mobilizers for each village for mobilization of children to the immunization session site. This money will be provided to ASHA wherever possible but if there is no ASHA then it will be given to someone nominated from the village by the PRIs. 6. Contingency fund for each block • Rs. 1000/ month per block will be given as contingency fund for communication. 7. Disposal of AD Syringes • For proper disposal of AD syringes after vaccination, hub cutters will be provided by Govt. of India to cut out the needles (hub) from the syringes. Plastic syringes will be separated out and will be treated as plastic waste. Regarding the disposal of needles, Pits will be formed at PHCs as per CPCB guidelines. For construction of the pits at PHCs a sum of Rs. 2000/ PHC has been provisioned. 8. Outbreak investigation • Rapid Action Team for epidemics will be formed • Dissemination of guidelines • Training of Rapid Action Team for investigating outbreaks who will in turn orient the ANMs during Sector meetings 9. Adverse effect following Immunization (AEFI) Surveillance: • Standard Guidelines have been developed at national level and will be disseminated to the district officials and block levels in Review meetings. 10. IEC & Social Mobilization Plans Discussed in details in the Component on IEC 11. Cold Chain • Repairs of the cold chain equipment (@ 750/- per PHC & CHC will be given each year • For minor repairs, Rs. 10,000 will be given per year. • Electricity & POL for Genset & preventive maintenance (Running Cost) of Walk in Coolers (WICs) & Walk in Refrigerators (WIF) () @ 15000/equipment per two months plus Rs. 1000 per machine for POL for Genset. • Payment of electricity bills for continuous maintenance of cold chain for the PHCs @ 300 per month PHCs (vaccine distribution centers) has been budgeted under this head. • POL & maintenance of vaccine delivery van • @ Rs. 3000/month for maintenance and POL for Vaccine delivery van for regular supply of vaccine to the PHCs.	
Support required	State to ensure the following: • Regular supply of vaccines and **Autodestruct syringes** • Reporting and Monitoring formats • Monitoring charts • Cold Chain Modules and monitoring formats • Temperature record books • Polythene bags to keep vaccine vials inside vaccine carrier • Polythene for the vaccines to avoid labels being damaged • Training of Cold Chain handlers • Training of Mid level managers	
Budget	**Activity**	**2009-10**
	Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Subcentre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 monthsx SCs	**4,63,200**

	Vehicle for distribution of vaccines in remote areas @ Rs 800 per PHC for 1 times per week x 4 weeks x 12 months x PHCs	**2,68,800**
	Mobility Support Mop up campaign @ Rs 10000 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	**4,20,000**
	Mobilization of Children by Social Mobilizers @ Rs. 100/ session x4 sessions per month X session sites x12month	**9,26,400**
	Contingency fund for each block @ Rs.1000/month x 7 blocks x 12 months	**84,000**
	Pit Formation for **disposal of AD Syringes** and broken vials (@ Rs. 2000 per pit per Subcentre and PHC	**3,86,000**
	Printing of Immunisation cards @1.50 per card x 100000 cards each year	**1,50,000**
	Maintenance of Cold Chain Equipments (funds for major repair) (@ Rs.750 per PHC/CHC per month and Rs 50,000 annual for minor repairs	**2,30,000**
	POL & maintenance for Vaccine delivery van at district level @ Rs.15000/month x 12 mths	**1,80,000**
	Provision of Generator at all facilities upto PHC GH: Rs 1.5 lakhs x 1, CHCs – 5 x 0.50, PHCs – 18 x 0.5 in first year	**Out sourced Budget given above**
	Running cost of ILRs & Deep Freezers (for electricity bill) (@ 300 per month for PHCs/CHCs x 20 x 12 months	**5,04,000**
	Total	**36,12,400**

4.8 RNTCP (Revised National Tuberculosis Control Programme)

Situation Analysis/ Current Status

Indicators	No. / Rate
New Sputum Positive cases (NSP)	588
Annualized new case detection rate per one lakh population	42.10 / Lakhs
Total No. of patient put on treatment	2451
Annual total case detection rate per one lakh population	113 / Lakhs
Cure rate of New Smear Positive cases	68%
Smear Conversion Rate	81%
Defaulter cases	6%
Failure cases	1%
Source : DTO Office	

To fight Tuberculosis the Revised National Tuberculosis Control Programme based on the DOTS regime was launched in 2006 in Khagaria. Under this programme in District Khagaria Tuberculosis Unit at microscopic centers were setup.

Objectives

1. 85 % Cure rate in New Cases
2. Detection of 70% new smear positive cases once cure rate of 85% is achieved
3. Reduction in the defaulter rate to less than 5%
4. Reduction in failure rate to less than 3%

Strategies

1. Improvement in the infrastructure
2. Improvement in the quality of the intervention
3. Increasing the outreach of the programme
4. Increasing the awareness regarding Tuberculosis

Activities

1. One more DMC as per norms
2. Improvement in the quality of testing of sputum
   - Training to the RNTCP staff in the district
   - Equipment maintenance – Microscope, Computer and Others
   - Adequate supply of drugs
3. Increasing the outreach of the programme by Increasing the DOTS providers through involvement of ASHAs who will be paid Rs. 250 per caser for providing services. She will be oriented regarding DOTS. Also the AWH should be involved in reporting suspicious cases. Training will be given to ASHA for identifying the suspects.
4. Increasing the awareness regarding the various issues of Tuberculosis through involvement of Rotary clubs and the Lions clubs and NGOs. Special drive for detection of cases on World TB day through the involvement fo all departments
5. DOTS regime to be strictly monitored through the VHWSC, the PRIs and the PHC MO

Support required

Timely supply of medicines

Timeline

2009-10

1. Increasing the DOT providers through ASHAs
2. Training to RNTCP staff and ASHA
3. Awareness drives
4. Involvement of the AWW

Budget

Activity / Item	2009-10
Civil Works	3,50,000

	Laboratory Material	4,00000
	Honorarium	6,00000
	IEC/Publicity	5,86,500
	Equipment maintenance	70,000
	Training	4,82,000
	Vehicle Maintenance	1,82,354
	Vehicle Hiring	7,88,725
	NGO/PP support	60,000
	Contractual Services	34,40,000
	Printing	0
	Procurement Vehicle	60,000
	Procurement Equipment	10,000
	Miscellaneous	5,00000
	Salaries of Contractual Staff	
	TB health visitor for urban areas @ 6750 per person X 2 X 12	1,62,000
	STS @ 8625 per person X 5 X 12	5,17,500
	STLS @ 8625 per person X 5 X 12	5,17,500
	LT @ 6500 per person X 12 X 12	9,36,000
	Data Entry Operator @ 6000 per person X 1 X 12	72,000
	Accountant @ 2000 per person X 1 X 12	24,000
	MO @ 20000 per person X 1 X 12	2,40,000
	Total	**95,32,779**

4.9 LEPROSY

Objectives	Eradication of Leprosy	
Strategies & Activities	1. Detection of New cases 2. House to house visit for detection of any cases 3. IEC for awareness regarding the symptoms and effects of Leprosy 4. Prompt treatment to all cases 5. Rehabilitation of the disabled persons 6. Distribution of Medicine kit and rubber shoes 7. Honorarium to ASHA for giving MDT	
Support required	Availability of regular supply of drugs	
Timeline	**2009-10** House to house detection Wide publicity Rigorous follow-up	
Budget	**Activity / Item**	**2009-10**
	Salary to Contractual Staff	**96,000**
	Honorarium	**25,000**
	IEC for information on the disease to be spread all over the rural outposts through posters and instructional booklets.	**3,00000**
	Training	**1,50,000**
	Total	**5,71,000**

4.10 NATIONAL MALARIA CONTROL PROGRAMME

Situation Analysis/ Current Status

Issues	No.	%
Total Blood Slides Examined (BSE)	7125	
Total Positive Cases: Plasmodium Vivax (Pv): Plasmodium Falciparum (Pf):	1	
Deaths:	0	

Now the Malaria program is known as National Vector Borne Disease Control programme. Under this District malaria Working Committee has been constituted and representatives from various departments are there but there is very little help from these departments. Malaria program is in maintenance phase in Khagaria district.

The mosquito density of Anopheles Culifacies was found mainly from May to October whereas Anopheles Aegepti and Anopheles Stephensai were found throughout the year with a peak from April to Nov.

The main bottlenecks are related to shortage of manpower especially for the remote areas. Following are the descriptions of man power status.

Objectives

Reduction in SPR, API, PFR death rate

Strategies

1. Provision of additional Manpower
2. Training of personnel
3. Strengthening of Malaria clinics
4. Addressing Disease outbreak
5. Health education
6. Involvement of Private sector
7. Innovative methods of Mosquito control

Activities

1. Provision of additional Manpower
   - Hiring of personnel till regular staff in place
2. Training of personnel

The MOs, Laboratory Technicians, ANMs, ASHAs will be trained in various techniques relating to the job

3. Strengthening of Malaria clinics
   - Provision of Proper equipment and reagents – Fogging machines, sprayers,
   - Provision of Jeep,
4. Addressing Disease outbreak
   - District Outbreak teams will be created at the district headquarter
   - In the team MO, LT, one field worker
   - Provision of mobility, Lab equipments, spray equipment
5. Health education to the community through the ANMs, AWW, ASHAs, RMPs, Ayush personnel
6. Involvement of Private sector: The private practitioners will be closely involved

Support required

- Availability of supplies
- Filling up of vacancies
- Supply of health Education material

Timeline	**Activity / Item**	**2009-10**
	Hiring Contractual Staff	x
	Purchase of Jeep	x
	Fogging & Spraying	x
	Hoardings	19 PHC, 1 SH 55 APHC
	IEC activities	X
Budget	**Activity / Item**	**2009-10**
	Salary Contractual staff	**84,12,000**
	Travel expenses @ Rs 6000 per month x 12 months	**72,000**
	Office expenses @ Rs 5000 per month x 12	**60,000**
	Jeep and truck maintenance	**80,000**
	Training	**5,00000**
	Board hoarding: Twenty 8'x 12' at 20 sites initially at the PHC and Sadar hospitals @ Rs 25,000/-	**5,00000**
	Board hoarding: Fifty five 5'x3' at 55 sites initially at the APHC@ Rs 10,000/-	**5,50,000**
	Total	**1,01,74,000**

4.11 BLINDNESS CONTROL PROGRAMME

D-5. BLINDNESS CONTROL PROGRAMME

Situation Analysis/ Current Status

Indicators	No.
Total Cataract surgery performed	1377
Cataract surgery with IOL	530
School going children screened	72162
Children detected with refractive error	662
Children provided with free corrective spectacles	097

Eye Care is being provided through the Sadar Hospital, There are 3 Ophthalmic Assistants in the district posted at Sadar Hospitals and BPHC don't have Ophthalmologists. The norm for GOI is 1 eye surgeon for a population of one lakh. Hence in this district at least 32 Eye Surgeons are required. The norm for Ophthalmologist to Ophthalmic Assistant is 1: 3-4
Data is not available regarding this from Private sector.
The numbers of surgeries need to be at least triple to tackle the blindness due to Cataract.
There is no Eye Bank or Eye donation center in District Khagaria. The nearest Eye Bank is at PMCH Patna.

Objectives

1. Reduction in the Prevalence Rate of blindness to 0.5 %
2. Decrease in the Prevalence Rate of Childhood blindness to 0.6 % per 1000 children by 2010
3. Usage of IOL in 95% of Cataract operations

Strategies

1. Provision of high quality Eye Care
2. Expansion of coverage
3. Reduce the backlog of blindness
4. Development of institutional capacity for eye care services

Activities

1. Determining the prevalence of Cataract through a study by an external agency.
    - One time house-to-house survey for study of prevalence of vision defects and Cataract of entire population leading to referrals and appropriate case management including cataract surgeries
2. Increasing the number of Ophthalmologists either by hiring or through involvement of Private Sector.
3. Training in IOL to Ophthalmologists
4. Training of Paramedical staff and Teachers, NGOs, Patwaris and AWW for screening of school children and IEC activities.
5. AMC for all equipment will be done.
6. Equipment
    - Repair of Synaptophore and Operating Microscope
    - Purchase of Ophthalmic Chair, Slit Lamp, Operating Microscope, Synaptophore, A Scan biometry, Keratometer, Direct and Indirect Ophthalmoscope
7. Construction of Eye Unit in Hospitals and later PHCs
8. Supply of basic Eye medicines like eye drops, eye ointments and consumables for Primary Eye Care in PHCs / CHCs.
9. All PHCs and CHCs to be developed for vision screening and basic eye care

Eye Care centre	Vision Centre	Screening
Eye Surgeon	Primary Eye Care	Identify Blind
Treatment of eye conditions and follow-up	Vision Test	Maintain Blind Register
Training	Screening Eye Camps	Motivator
Supervision	Referral for surgery	Referral

	10. Blind Register to be filled up by the AWW, together with PRIs 11. Eye Camps with the involvement of Private sector and NGOs 12. School Eye Screening sessions 13. IEC activities	
Support required	Procurement of latest equipment for hospitals by GOI Timely Repair of equipment	
Timeline	**2009-10** Health Mela Development of PHCs as Vision Centres Development of Sadar Hospital Khagaria as Eye Unit School Screening Cataract Camps	
Budget	**Activity / Item**	**2009-10**
	Health Mela	**2,00000**
	IEC	**2,50,000**
	School Eye Screening	**3,00000**
	Blind Register	**25,000**
	Observance of Eye Donations	**25,000**
	Cataract Camps @ Rs 50,000 per camp x 20	**10,00000**
	NGO and Eye Bank @ Rs 750/IOL x 2000	**15,00000**
	POL for Eye Camps @ Rs 5000/camp x 20	**1,00000**
	Training of School teachers @ Rs 100/head x 300	**30,000**
	Training of PRIs @ Rs 100/head x 200	**30,000**
	Repair and purchase of equipment and maintenance	**2,00000**
	Total	**36,60,000**

4.12 VITAMIN-A SUPPLEMENTATION PROGRAMME

Background

The National Policy Guidelines on Vitamin-A Supplementation Program of MoH&FW, GoI recommends that children of age group 9 months to 5 years should receive two doses of Vitamin at 6 months interval which is considered adequate. These months would have intensive activities during which it was suggested that health sub-center level workers in close coordination with the ICDS workers and ASHAs will deliver services in the given month as per detailed micro-plans.

The National Workshop on Micronutrients organized by ICMR on the 24-25 November 2003 which recommended that Biannual Child Health and Nutrition Promotion Months be held, six months apart i.e. usually in April/May and October/November which would offer a package of child health & nutrition services of which Vitamin-A supplementation of target children would be an integral part.

Biannual Child Health Package of Services

1. **Vitamin-A Supplementation:** Provide prophylactic dose of Vitamin-A solution to all children between 9 months to 5 years. The recommended dosage schedule is as under:
   a. The 1st dose 1, 00,000 I.U. (1 ml or half spoon) is given with routine measles immunization at 9 months completed age;
   b. The 2nd dose 2, 00,000 I.U. (2ml or full spoon) is given with First DPT/OPV booster (16-18 months) and
   c. The next 7 doses (each dose 2 ml or full spoon) are given After every 6 months up to 5yrs of age.
2. **Promotion of Breast feeding and timely introduction of complementary feeding :** Accelerating community participation and BCC on components of breast-feeding, i.e.
   a. Early Initiation
   b. Exclusive Breastfeeding
   c. Introduction of Complimentary feeding at the age of 6 months

Coverage Pattern

The biannual round initiated in the year 2008 by the Government of Bihar, the district has reported coverage of 97.1% in June, 08 round & 92.3% in Dec, 08 round. The DLHS 3 has reported an over all coverage of 70.3 % of vitamin A within the age group of 9m-35 months.

It will continue to improve and cover more than 95% of children on a sustainable basis with 2 doses a year. It is expected to gain significant reductions in Vitamin-A Deficiency and in turn would reduce Under Five Mortality Rates (U5MR) over time.

Problematic Areas

Objective:-

1. Achieve universal coverage of 9 doses of Vitamin-A
2. Reduce the prevalence of night blindness to below 1% and Bitots spots
   To below 0.5% in children 6 months to 6 years age.
3. Eliminate Vitamin-A deficiency as public health problem.

Strategies:

1. Biannual Rounds of Vitamin-A Supplementation in fixed months, i.e. April & October every year.
2. To Cover the Children through 4 days Strategy
   Day 1- Cover children of 9m-5yrs at site i.e. AWCs/ HSCs/ APHCs/ PHCs
   Day 2- Cover children of 9m-5yrs through house to house visits
   Day 3- Cover children of 9m-5yrs at site i.e. AWCs/ HSCs/ APHCs/ PHCs
   Day 4- Cover children of 9m-5yrs through house to house visit: mopping-up

Gaps:

1. Infrastructure - Urban strategy for Identification of stakeholders and service providers in urban agglomerations, slums, notified areas to cover left out children residing in areas devoid of health & ICDS infrastructure.
2. Manpower- Lack of skilled manpower for implementation of program
3. Drugs- a) Non-supply of RCH Kit-A for ensuring first dose of Vitamin-A along with the measles vaccination at 9 months.
   b) Procurement of Vitamin-A bottles by the district for biannual rounds
4. Reporting– Lack of coordination among health & ICDS workers for report returns & existing MIS (form-VI)
5. Monitoring- Lack of joint monitoring & supervision plans & manpower

Activities:

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

PIP FOR BIANNUAL VAS ROUND : 2009 -10					
Sl.No.	Activities	Unit	Total units	Unit cost for 1 Round @ Rs.	District Budget in Rs.
1	2	3	4	5	6
I.	**Micro Planning**				
	Orientation, Stationary, Data compilation, Validation, Up-dating	7 PHC and 1 Urban Units= 8 units	8	1000	8000
II.	**Inter-sectoral Co-ordination and Convergence**				
	Constitution of District level Task Force, and organizing meetings of District coordination committee	1	1	5000	5000
	Constitutions Task Force, and organizing meetings of Block coordination committee	7	7	1500	10500
III.	**Capacity Building**				
	Training and Capacity Building of Service Providers	7 PHC and 1Urban Units= 8 units	8	5000	40000
IV.	**Urban Health Intervention Strategy**				
	Strategy Planning Meetings, Orientations of Stakeholders & Volunteers, Resource Planning, Site-management	Municipal Area	0	5000	0
	Orientation of Urban Supervisors	Municipal Area	0	2500	0
V.	**Human Resource**				
	Honorarium to Urban vaccinators	1 Urban sites	79	100	7900
	Honorarium to Volunteers, AWWs, ASHA to function as service provider	1276 AWWs/ASHAs/ and 10% of AWC-Volunteers= (1276+1276*10%)	1276	100	127600
	Honorarium to the Urban Supervisor	1 Supervisor / 10 sites	15	400	6000
Vl.	**Management Information System for Monitoring VAS Program**				
	Availability of Immunization cards [JBR Cards ,Reporting Formats, Record & Registers,	7 PHC & 1 urban area	8	10000	80000
VI.	**Logistics and Procurement**				
	Need Assessment and Procurement of Vitamin- A Syrup [Children 9m-5yrs =4,79,542 children	9221 VA bottles	9,221	52	479,542

	Mobility Support for Carrying Vitamin A bottles from district to PHCs	7 PHC & 1 urban area	8	3000	24,000
VII.	**IEC/BCC**				
	Posters, Banners, Flexes, etc	7 PHC	7	10000	70,000
IX.	**Program Monitoring and Review**				
	Mobility Support : Hiring of Vehicles & POL	7 PHC & 1 urban area	8	6000	48000
	TOTAL				**9,06,542**
Expenses on conducting 1 Biannual Round = Rs . **9,06,542**					
Expenses on conducting 2 Biannual Rounds = Rs. 9,06,542 X 2= 18,13,084					

CHAPTER 5

District Budget (2009-10)

5.1 TOTAL BUDGET AT-A-GLANCE (2009-10)

Sl. N	Heads	Budget 2009-10
1	Sub center	60238539
2	Additional PHC	64398261
3	District Hospital	51341065
4	DPMU	1759184
5	BPMU	7531970
6	Maternal Health & JBSY	45027968
7	New born & Child Health (Budget Included in HSC, APHC &PHC head)	7473419
8	Family Planning	12002763
9	ASHA	2980388
10	Immunization	17836698
11	RNTCP	4820000
12	Leprosy	417250
13	Malaria	2956820
14	Blindness	2125000
	Total	**280909325**