District Health Action Plan

2012-2013

बिहार सरकार

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Developed & Designed

by

Smt.Sandhya (DPM)
Mr. Amrendra Kr. Arya (DAM)
Mr. Dayanand Mishra (M&E Officer)
Smt. Mamta Rani (DPC)
Mr. Rajeev Kumar (DDA)

DISTRICT HEALTH SOCIETY, NAWADA

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 Nawada district has been prepared keeping this vision in mind. The DHAP aims at improving the existing physical infrastructure, enabling access to better health services through hospitals equipped with modern medical facilities, and better service delivery 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 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 have also given vital inputs which have been incorporated into this document.

This plan is a result of collective knowledge and insights of each of functionaries of the district health machinery.

I am sure the implementation of DHAP would inspire and give new momentum to the health services for Nawada District.

Divesh Sehara (IAS)
District Magistrate-cum-Chairman,
District Health Society, Nawada

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. we are try to achieve 100% immunization and Ante Natal Care. Janani Evam Bal Suraksha Yojana is another successful program that is ensuring safe institutional delivery especially poor and illiterate rural women likely to several other programs like RNTCP, Pulse Polio, Blindness control, 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 mile 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 Nawada 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, Block Health Managers, ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Nawada District.

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

Dr. Sudhir Kumar Mahto
C.S.–Cum- Member Secretary,
DHS, Nawada

Table of contents

Chapter-1

1.1 Introduction

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.

Stakeholders in Process

- *Members of State and District Health Missions*
- *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- *District and Block level programme managers, Medical Officers.*
- *Members of NGOs and civil society groups (in case these groups are involved in the DHAP formulation)*

Besides above referred groups, this document will also be found useful by public health managers, academicians, faculty from training institutes and people engaged in programme implementation and monitoring and evaluation.

1.2 Planning Objective:

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 District Planning Process

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 Nawada 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 Nawada 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, 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 programmed 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.

- A work shop organized in the district with MOIC BHM, BCM, Accountant to each block were trained for preparing Block Level Planning
- RPM Facilitated the workshop DPM, DPC, DAM solved the queries for there at each block a workshop was done and all members of Block PHC and ANMs were sensitized and given orientation regarding the planning. The District Programme officers in charge for the block facilitated the workshop in their Blocks.
- All blocks filed the situation analysis format and took out the gap present in their facilities
- There by district Compiled the data & added the information, goals, issues, strategies, activities and budget of the district and submitted it to State Health Society, Bihar Patna.

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Chapter 2

District Profile

2.1 History

Nawada Situated in the lap of Magadh Section of Division enjoys its glorious past with historical imminence. King Vahydrath had founded the Magadh empire. Where so many dynasties like Vahydrath, Morya, Kanah, Gupta, Palking etc. King ruled over so many the then states of middle and North India.

The might king Jarasandh Who's birthplace was Tappoban and who bought with great Pandav Bhim who was the champion among the king of the time. The history bears the testimony that Bhim has visited Pakardia village. Which is three miles away from the head quarters, Nawada.

The place Sitamarhi situated in the lap of Nawada was blessed when Sita Jee made it her above in her exile and gave birth to Lava.

The village Barat was the abode of great epic maker Balmiki. In the southern side of Rajauli sub-division of Nawada, Sapt-rishi had made the place for their abode.

Great Lord Budha and Lord Mahavir who are regarded, as the first lights of Asia loved this place very much. The king Bimbisar was one of the most beloved disciples.

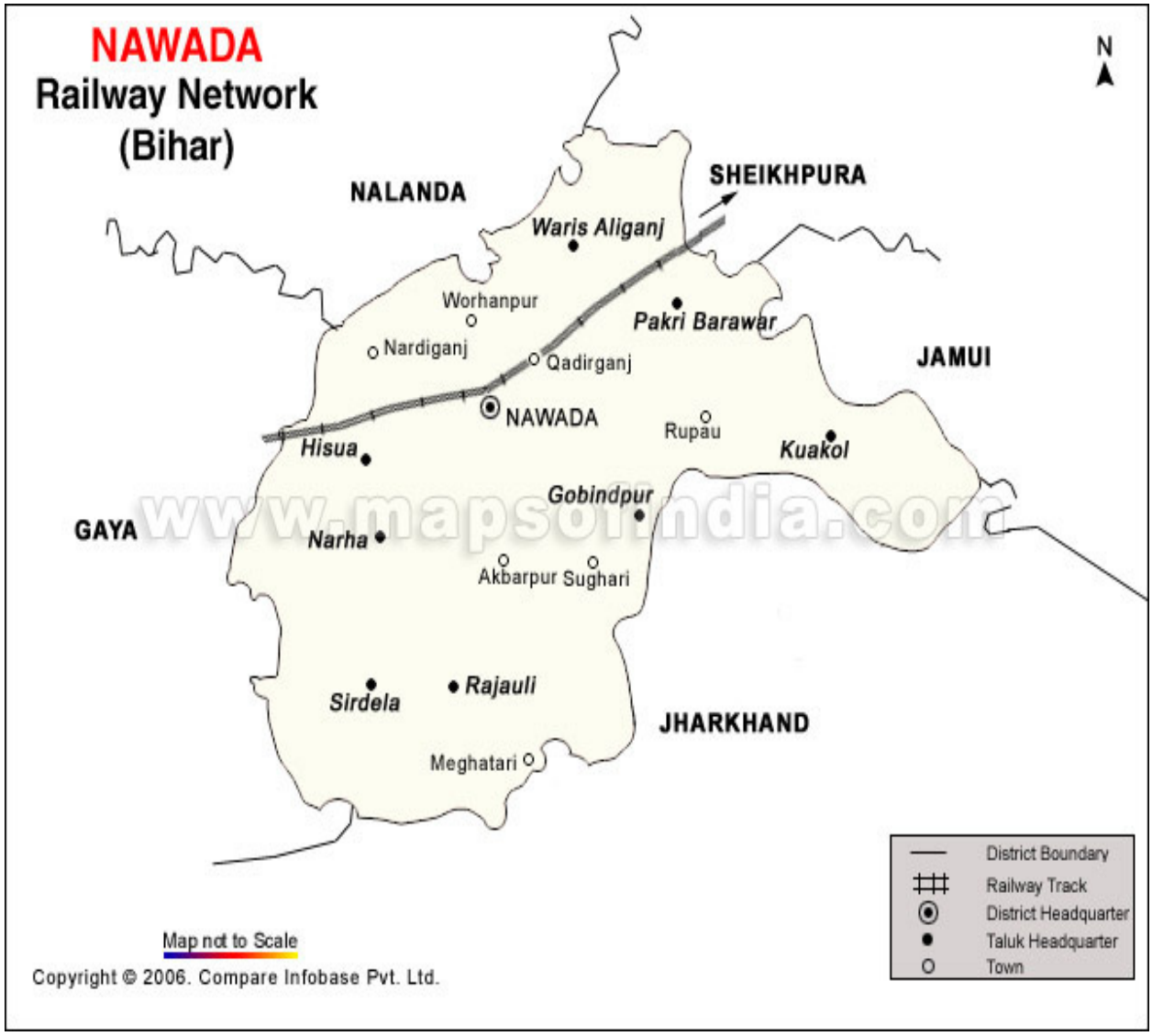
Truly every inch of this place is the witness that lord Budha and Lord Mahvir gave first priority to offer their mission to this place. The historical sermon of lord Buddha was reveled for the first time here.

The village Dariyapur, Parvati in the Nawada District situated six miles north of Warisaliganj. There are ruins and relic of Kapotika Bodh Bihar. In the centre stands a famous temple of Avalokiteshwer. King Aditaysen founded the historical monuments in the village Apsar that is visible even today. Kurkihar enjoyed its esteemed glory in the Pal dynasty. It is about three miles North East away from Warisaliganj. Which is a small town of Nawada. In 1857 the heroes of the time had captured Nawada and paved the way for freedom.

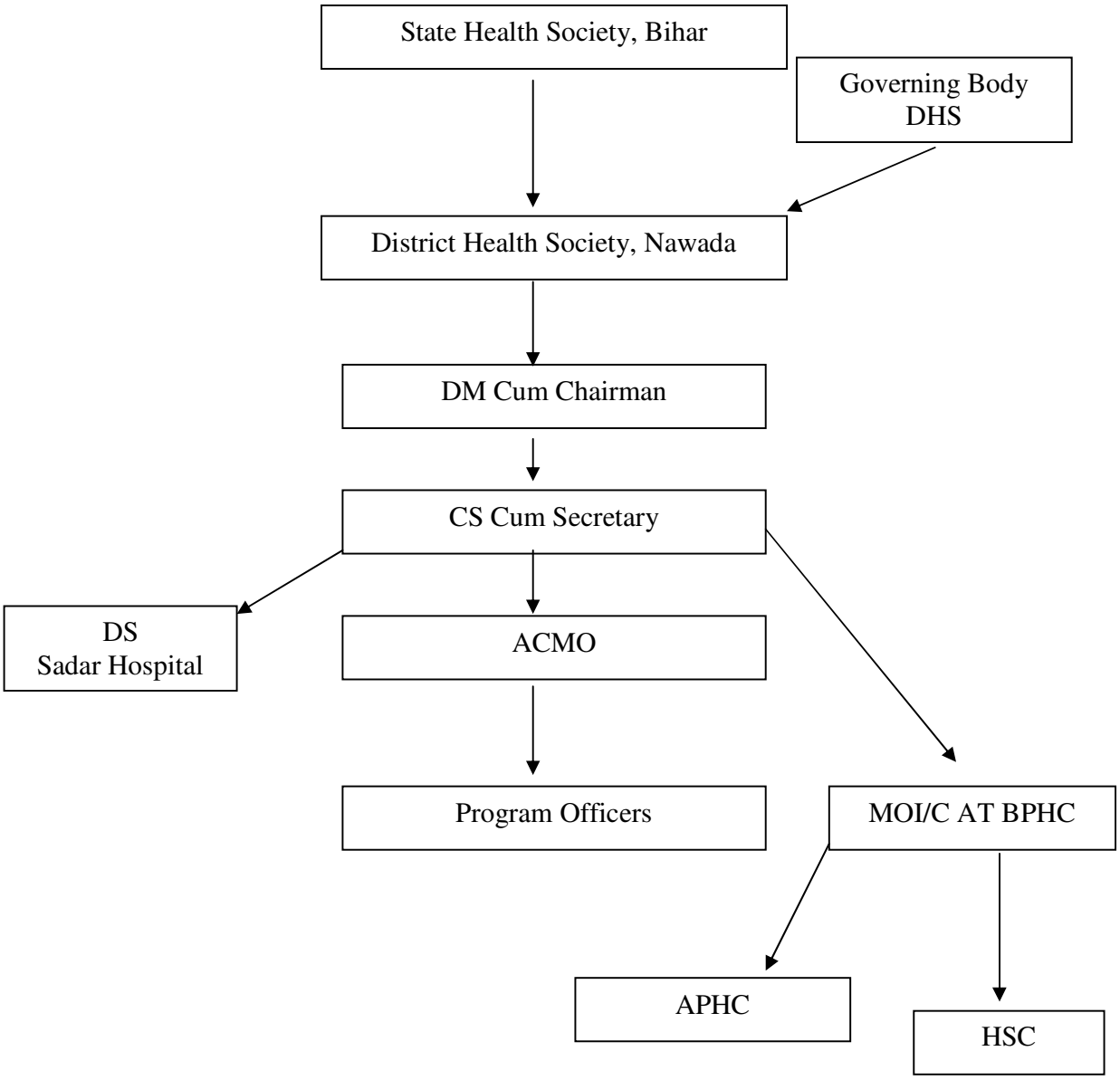
Famous "Sarvoday Asharam " is in the district of Nawada. This Asharam inaugurated by Desh Ratana Dr. Rajedra Prasad and nourished by Shree Jai Prakash Narayan has enhanced the glory of Nawada. It is situated one and half

miles away from Kawakole Police station at Village Sekhodewra .The site of the asharam is beautiful with the background of hills there are also each hills. If ones stand against the highest of the hillocks and shouts, the voice is echoed book in the same very district and human like tone. In the helm of music Nawada contribution is worth mentioning rising from Thumari to Dhrupad many great musician have raised by the glory of Nawada. Padma Bhushan Prasad, Siyaram Tiwary was the master of Dhrupad and Thumari belonged to Nawada.

2.2 Nawada District Communication Map



2.3 District Health Administrative Setup



2.4 NAWADA – AT A GLANCE

AREA (Sq. Kms)	:-	2494
POPULATION(CENSUS 2011)		
TOTAL	:-	2216653
MALES	:-	1145123
FEMALES	:-	1071530
RURAL POPULATION		
TOTAL	:-	1265.14
MALES	:-	652.32
FEMALES	:-	612.82
URBAN POPULATION		
TOTAL	:-	94.56
MALES	:-	79.93
FEMALES	:-	44.62
POPULATION OF SCHEDULED CASTES	:-	332.0
POPULATION OF SCHEDULED TRIBES	:-	1.25
DENSITY OF POPULATION	:-	889 per sqm
SEX RATIO	:-	936/1000

2.5 COMPARATIVE POPULATION DATA (2011 Census)

Basic Data	Bihar	Nawada
Population	103804637	2216653
Density	--	889
Socio- Economic		
Sex- Ratio	916	936
Literacy % Total	63.82	61.63
Male	73.39	70.49
Female	53.33	52.95

LITERACY RATE	
TOTAL	:- 61.63%
MALES	:- 70.49
FEMALES	:- 52.95%
VILLAGES	
TOTAL	:- 1099
INHABITED	:- 978
UNINHABITED	:- 121
PANCHAYATS	:- 187
SUB-DIVISION	:- 02
BLOCKS	:- 14
REVENUE CIRCLES	:- 14
TOWNS	:- 03
NAGAR PARISHAD(Nawada)	:- 01
NAGAR PANCHAYAT(Warisaliganj, Hisua)	:- 02
M.P CONSTITUENCY	:- 01
M.L.A. CONSTITUENCY	:- 05
HEALTH	
DISTRICT HOSPITAL	:- 01
REFERRAL HOSPITAL	:- 02
PRIMARY HEALTH CENTRE	:- 14
ADDITIONAL PRIMARY HEALTH CENTRE	:- 32
HEALTH SUB CENTRE	:- 160
BLOOD BANK	:- 02
AIDS CONTROL SOCIETY	:- 01

2.6 SOCIO-ECONOMIC PROFILE

Social

- Nawada district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community.
- The villages of Nawada have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden.
- 11.38% of the population belongs to SC and 0.51% to ST. Some of the most backward communities are *Mushahar, Turha,chamar* and *Dome*.

Economic

- The main occupation of the people in Nawada is Agriculture, business and daily wage labour.
- Almost 20% of the youth population migrates in search of jobs to the metropolitan cities like Kolkata, Punjab, Mumbai, Surat, Delhi etc.
- The main crops are Wheat, Paddy, Pulses, Oilseeds.
- The main cash crop are Arhar and Grounut .
- Industry Biri factory
- River Sakri

2.7 Administration and Demography

Table-1

Sl. No.	Variable	Data
1.	Total Area	2494 Sqr Km
2.	Total no. of Blocks	14
3.	Total no. of Gram Panchayats	187
4.	No. of Villages	1099
5.	No of PHCs	14
6.	No of APHCs	32
7.	No of HSCs	160
8.	No of Sub divisional hospitals	02
9.	No of referral hospitals	02
10.	No of Doctors	54+71
11.	No of ANMs	206+151

12.	No of Grade A Nurse	53 +12
13.	No of Para Medicals	82
14.	Total population	22,16,653
15.	Male population	11,45,123
16.	Female population	10,71,530
17.	Sex Ratio	936/1000
18.	No of Eligible couples	280864
19.	Children (0-6 years)	274126
20.	Children (0-1years)	73283
21.	SC population	173167
22.	ST population	1911
23.	BPL population	230548
24.	No. of primary schools	973
25.	No. of High School	5
26.	No. of women collage	05
27.	No. of Anganwadi centers	1810
28.	No. of Anganwadi workers	1810
29.	No of ASHA	1959
30.	No. of electrified villages	796
31.	No. of villages having access to safe drinking water	876
32.	No. of villages having motorable roads	905
33.	Total worker to total population (%)	49.50%
34.	Cultivators to total population (%)	36.22%
35.	Worker in HH inclustries to total worker (%)	2.05%
36.	Main worker to total population (%)	9.67%
37.	Police Station	20

Source: Census 2011

Chapter-3

HEALTH PROFILE

3.1: Health Facilities in the District

Status of HSC, APHC, PHC, CHC, Sub-divisional hospital & District Hospital.

Health Sub-centres

Sl. No	Block Name	Population 2009 with growth @ 2.7%	Sub-centres required Pop 5000(IPH)	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building	
							Own	Rented
1	Akbarpur	214642	43	16	23	6	3	13
2	Govindpur	94427	19	6	8	6	2	4
3	Hisua	137615	28	11	11	01	2	9
4	Kauwakole	129187	26	11	12	2	2	9
5	Kashichak	68400	14	11	1	0	2	19
6	Meskaur	109211	22	8	12	2	2	6
7	Nardiganj	123510	25	11	0	6	3	8
8.	Narhat	108978	22	7	8	7	2	5
9.	Pakribarawan	171938	35	9	19	7	4	5
10.	Rajauli	159757	32	13	10	4	3	10
11.	Roh	153729	31	9	18	1	5	4
12.	Sadar PHC	195626	39	17	5	16	5	12
13.	Sirdala	136369	28	9	18	1	5	4
14.	Warisaliganj	187000	38	20	10	8	5	15

Additional Primary Health Centers (APHCs)

Sl. No	Block Name	Population 2009 with growth @ 2.7%	APHCs required (After including PHCs) (IPH)	APHCs present	APHCs proposed	APHCs required	Status of building	
							Own	Rented
1	Akbarpur	214642	8	4	4	2	1	3
2	Govindpur	94427	3	2	2	3	1	1
3	Hisua	137615	5	1	2	2	1	0
4.	Kauwakole	129187	5	3	3	3	1	2
5.	Kashichak	68400	3	3	3	3	3	0
6.	Meskaur	109211	4	1	3	3	1	0
7.	Nardiganj	123510	5	2	2	2	0	2
8.	Narhat	108978	4	3	2	2	1	2
9.	Pakribarawan	171938	6	1	5	5	1	0
10.	Rajauli	159757	6	1	2	2	0	1
11.	Roh	153729	5	2	5	5	0	2
12.	Sadar PHC	195626	5	3	1	1	0	2
13.	Sirdala	136369	6	2	4	4	0	2
14.	Warisaliganj	187000	6	4	3	3	2	2

Primary Health Centers

Sl. No	Block Name/ Sub division	Population	PHCs Present	PHCs required @ Pop 80000 – 120000 (IPH)	PHCs proposed
1	Akbarpur	214642	1	1	0
2	Govindpur	94427	1	0	0
3	Hisua	137615	1	0	0
4.	Kauwakole	129187	1	0	0
5.	Kashichak	68400	1	0	0
6.	Meskaur	109211	1	0	0
7.	Nardiganj	123510	1	0	0
8.	Narhat	108978	1	0	0
9.	Pakribarawan	171938	1	0	0
10.	Rajauli	159757	1	0	0
11.	Roh	153729	1	0	0
12.	Sadar PHC	195626	1	0	0
13.	Sirdala	136369	1	0	0
14.	Warisaliganj	187000	1	0	0
Total		**1990389**	**14**	**1**	**0**

As per census 2001

CHC Required

Sl. No	Block Name/sub division	Population	CHCs Present	CHCs required @ Pop 1200000 and above(IPH)	PHCs proposed
1	Akbarpur	214642	1	1	0
2	Govindpur	94427	1	0	0
3	Hisua	137615	1	0	0
4.	Kauwakole	129187	1	0	0
5.	Kashichak	68400	1	0	0
6.	Meskaur	109211	1	0	0
7.	Nardiganj	123510	1	0	0
8.	Narhat	108978	1	0	0
9.	Pakribarawan	171938	1	0	0
10.	Rajauli	159757	1	0	0
11.	Roh	153729	1	0	0
12.	Sadar PHC	195626	1	0	0
13.	Sirdala	136369	1	0	0
14.	Warisaliganj	187000	1	0	0
Total		1990389	14	1	0

As per census 2001

3.2 Human Resources and Infrastructure

Sub-centre database

Name of PHC	No. of working Medical Officer	No. of working Dentist	No. of working Grade A. Nurse	No. of working ANM (R)	No. of working Ayush	No. of working Asha	No. of working Asha facilitator
Akbarpur	3	1	8	12	4	228	11
Govindpur	2	1	0	6	2	95	4
Hisua	2	1	4	3	1	128	5
Kauakole	1	1	1	9	2	153	7
Kashichak	2	1	4	8	2	74	4

Meskaur	2	1	1	5	0	107	5
Nardiganj	2	1	5	15	2	108	5
Narhat	2	1	2	4	3	97	5
Pakriwarma	2	1	1	7	1	175	8
Roh	1	1	0	12	2	145	7
Rajauli	0	1	3	11	0	170	8
Sirdala	3	1	-	-	1	117	6
Sadar PHC	0	1	-	-	4	146	7
Warisaliganj	0	0	4	19	4	160	9

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	32	43	11	9	34	34	#	#			#	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

Infrastructure

Additional Primary Health Centre (APHC) Database: Human Resources

No	No. of APHC	Doctors		ANM		Laboratory technician		Pharmacists / dresser		Nurses A Grade		Accnt/Peons/Sweeper/Night Guards	Availability of specialist
		Sanction	In Position	Sanction	In position	Sanction	In position	Sanction	In position	Sanction	In Position		
1	43	86 43(A)+43 (Ay)	17	86	35	43	1	43	3	43	11	33/110	0

Primary Health Centres : Infrastructure

Sl. 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	14	0	0	11	3	3	0	13	++	11	6	A	++	+

Good condition +++/ Needs major repairs++/Needs minor repairs-less that Rs10,000-+/ needs new building-#; Water S upply: 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	14	243	48	430	344	21	5	52	20	257	59			

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	2	14	12	10	4	4	5	A	++	2	30	A	++	++

A ANM(R)- Regular/ ANM(C)- Contractual; Govt- Gov/ Rented-Rent/ Pan –Panchayat or other Dept owned; Good con dition +++/ 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	
2	12	2	7	5	2	0	2	0	2	1	8	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	+++	60	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

	No. 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	9	1	1	1	1	2	2	4	4	5	4	1

Chapter-4

Situational Analysis

Situational Analysis of Key RHC Indicators 8-09

A. Maternal Health

Improving the maternal health scenario by strengthening availability, accessibility and utilization of maternal health services in the district is one of the major objectives of RCH. However, the current status of maternal health in the district clearly shows that the programme has not been able to significantly improve the health status of women. There are a host of issues that affect maternal health services in district . The important ones are listed below:

• Shortage of skilled frontline health personnel (ANM, LHV) to provide timely and quality ANC and PNC services.

• The public health facilities providing obstetric and gynecological care at district and sub-district levels are inadequate.

• Mismatch in supply of essential items such as BP machines, weighing scales, safe delivery kits, Kit A and Kit B, etc and their demand.

• Shortage of gynecologists and obstetricians to provide maternal health services in peripheral areas.

• Inadequate skilled birth attendants to assist in home-based deliveries

• Weak referral network for emergency medical and obstetric care services

• Lack of knowledge about antenatal, perinatal and post natal care among the community especially inrural areas

• Low mean age of marriage resulted in pregnancy and difficult deliveries.

• Low levels of female literacy resulted unawareness on maternal health services.

• High levels of prevalence of malnutrition (anemia) among women in the reproductive age group

• Poor communication because of bad roads and a law and order situation.

One of the very good things happen to maternal health is introduction of JBSY.

B. Child Health

The child health indicators of the state reveal that the state's IMR is lower than the national average but the NMR is disproportionately high. Morbidity and mortality due to vaccine-preventable diseases still continues to be significantly high. Similarly, child health care seeking

practices in the case of common childhood diseases such as ARI and Diarrhoea are not satisfactory. The child health scenario is worse for specific groups of children, such as those who live in rural areas, whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households is particularly appalling. Issues affecting child health are not only confined to mere provision of health services for children, but other important factors such as maternal health and educational status, family planning practices and environmental sanitation and hygiene have enormous bearing on child health. This is more than evident in the case of Bihar where child health continues to suffer not only because of poor health services for children but due to issues such as significantly high maternal malnutrition, low levels of female literacy, early and continuous childbearing, etc. The specific issues affecting child health in the state are listed below.

C. Maternal Factors

• High levels of maternal malnutrition leading to increased risk pre-term and low -birth weight babies thatin turn increase risk of child mortality.

• Low levels of female literacy, particularly in rural areas.

D. Family Planning Services

The Family Planning programme has partially succeeded in delaying first birth and spacing births leading to significantly high mortality among children born to mothers under 20 years of age and to children born less than 24 months after a previous birth.

E. Child Health Services

The programme has not succeeded fully in effectively promoting colostrums feeding immediately afterbirth and exclusive breastfeeding despite almost universal breastfeeding practice in the state. In the State majority of mother breast feed children beyond six months. However both State and Unicef have taken initiative to generate awareness among mothers for exclusive breast feeding.

F. NRHM STATE PROGRAMME IMPLMENTATION PLAN- 2008-09

• High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socio-economic groups leading to a disproportionate increase in under five mortality.

• Persistently low levels of child immunization primarily due to nonavailability of timely and quality immunization services.

• Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI,
Diarrhea, etc.
• Inadequate supply of drugs, ORS packets, weighing scales, etc.
• Lack of knowledge of basic child health care practices among the
community.
• Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children.
IMNCI Training: IMNCI training has successfully started in the District . In 2012-13, DHS Nawada proposes to establish Nutritional Rehabilitation Centre in Nawada district . In this project special nutritious food provided to the severel malnutrition children.

G. Family Planning

RCH emphasizes on the target-free promotion of contraceptive use among eligible couples, the provision to couples a choice of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programmes vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it has increased in NFHS-3 and is far from the replacement level. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average The persistently high fertility levels point to the inherent weakness of the state's family planning programme as well as existing socio demographic issues. High TFR is reflected by a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies.
The major issues affecting the implementation of the Family Planning programme in Bihar are as follows.
• Lack of integration of the Family Planning programmes with other RCH
components, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.

• Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.

• Inability of the programme to alter fertility preferences of eligible couples through effective behavior change communication (BCC).

• Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. Use rates for the pill, IUD, and condoms remain very low, each at 1 percent or less).

• Due to high prevalence of RTI/STD, IUDs are not being used by majority of women.

• Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups.

• Weak public-private partnerships, social marketing to promote and deliver family planning services.(Public Private Partnership is improved since 2008- 09.

6 Nursing homes in districts are accredited to conduct Family planning

operations. The issues mentioned above are closely interlinked with the existing socio demographic conditions of the women, specially rural, poor and illiterate.

Comprehensive targeted family planning programme as well as intersectoral coordination on an overall female empowerment drive is needed to address the factors responsible for persistently high fertility levels in Bihar.

H. Adolescent Reproductive & Sexual Health

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

Although it is a transitional phase from childhood to adulthood, it is the time that the adolescents experience critical and defining life events – first sexual relations, first marriage, first childbearing and parenthood. It is a critical period which lays the foundation for reproductive health of the individual's lifetime.

Therefore, adolescent reproductive and sexual health involves a specific set of needs distinct from adult needs. The reproductive health needs of adolescents as a group has been largely ignored to date by existing reproductive health services.

Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron deficiency anemia. The prevalence of early marriage in India poses serious health problems for girls, including a
significant increase of maternal or infant mortality and morbidities during
childbirth. The following facts will help understand the situation objectively.

• The median age of marriage among women (aged 20 to 24) in India is 16 years.

• In rural India, 40 percent of girls, ages 15 to 19, are married, compared to only 8 percent of boys the same age.

• Among women in their reproductive years (ages 20 to 49), the median age at which they first gave birth is 19.

• Nearly half of married girls, ages 15 to 19, have had a least one child.

• India has the world's highest prevalence of iron-deficiency anemia among women, with 60 percent to 70 percent of adolescent girls being anemic. Underlying each of these health concerns are gender and social norms that constrain young people –especially young women's – access to reproductive health information and services. Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher levels of morbidity and mortality. Early child bearing continues to bean impediment to improvements in the educational, economic and social status of women in India. Overall for young women, early marriage and
early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life. In many societies, adolescents face pressures to engage in sexual activity.

Young women, particularly low income adolescents are especially vulnerable. Sexually active adolescents of both sexes are increasingly at high risk of contracting and transmitting sexually transmitted diseases, including HIV/AIDS; and they are typically poorly informed about how to protect themselves.

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

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

Being a sensitive and often, controversial area, adolescent reproductive and sexual health issues and information are very often difficult to handle and disseminate. Furthermore, the contents do not only deal with factual and knowledge-based information but more importantly, need to deal with attitudinal and behavioral components of the educational process. Thus it can be conclusively stated that adolescents are a diverse group, and their diversity must be considered when planning programs. Adolescents, the segment of the population in the age

group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health programme, as it would remain in the reproductive age group for more than two decades. Early marriages seem to be still a key problem. Percentage of boys who are married before attaining 21 years in consistently high in most districts. The mean age of marriage for girls is 16.9. 25% pregnant mothers in the state are in the age group of 15-19 years. This is due to the reason that most of the girl's married before18 years. The various anecdotal evidences emerging from the community level participatory planning exercises and opinions voiced by the various levels of health officials during consultation exercise indicate that there is lack of a cohesive ARSH strategy at the state level. Possibility of bifurcating the total target into school going and out of school going adolescents have not been examined as a strategy option. Hence the current school health program by and large lacks any adolescent oriented interventions. The possibility of convergence between the RCH II program priorities and NACP priorities require to be integrated.

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

the state health department to prepare itself to tackle the problems / issues of this important segment.

I. Health Infrastructure and Facilities of Nawada

District Hospitals: Nawada district has one District Hospital which is situated in District head quarter Nawada. As per IPHS norms there is a some shortage of manpower like specialties doctors and Paramedics. Dispite all constraints sadar hospital is providing all health facilities.

Sub District Hospitals: At present there are Two Sub Divisional Hospital in Nawada district namely ***Nawada*** and the ***Rajauli.***

Referral Hospitals: There are 2 referral Hospitals in Nawada District namely as Kauakole and Warisaliganj. These referral hospitals get patient from PHCs, APHCs and are covered by specialised services.

Block PHCs: At present there are 14 in the district. These upgraded new PHC require proper building infrastructure as per IPHS norms.

Additional PHCs: The total no. of Additional PHC is 32. These Additional PHCs only provide OPD services. All these APHCs require functionalizing the inpatient for providing deliver services and reduce the load of Block PHCs.

HSCs: At present there are 370 HSCs in the district. Half of the HSCs are running from the rented place or Panchayat office. Mostly these HSCs are manned by one ANM only.

Infection Management and Environmental Plan:

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

The DHS Nawada is in the process of establishing the Biomedical Waste

Management system for all the hospitals of Nawada district.

I. Human Resource Development including Training

Human Resource Development forms one of the key components of the overall architectural corrections envisaged by both the RCH II and NRHM programs. Though the district has reasonable number of MBBS doctors, there is an acute shortage of specialized medical manpower. The shortage of specialists like obstetricians and Anesthetists are obstructing the district plans to operationalise all hospitals at full swing.

Trainings as per GoI guidelines on Immunization, IMNCI, EmOC, LSAS, SBA and Minilap/MVA etc have been taken up with full vigor. It is proposed to continue these trainings in 2010-11.

J. Inequity and Gender

Ensuring Gender Equity

One of the broad indicators for measuring gender disparity is the sex ratio. The sex ratio in Bihar is unfavorable to women. Analysis of other indicators on the basis of gender reveals widening gaps between the sexes. While NMR for females is marginally higher than that of males, it widens further for the IMR, and even further for the under-five Mortality Rate. In conditions of absolute poverty, where resources to food and health care are severely limited, preference is given to the male child, resulting in higher female malnutrition, morbidity and mortality.

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among women in the marginalized sections of society have a major impact on the health and well being of families. Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society. Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NFHS data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the concern of women, and female sterilization accounts for 19% of FP methods used as against male sterilization, which is as low as 1%. In terms of nutritional status too, a large proportion of women in Bihar suffers from

moderate to severe malnutrition. Anemia is a serious problem among women in every population group in the state, with prevalence ranging from 50% to 87% and is more acute for pregnant women.**MENTATION PLAN- 2008-09**

K. Urban Slums

Urban health care has been found wanting for quite a number of years in
view of the fast of urbanization leading to growth of slums and population as more emphasis is given in rural areas. Most of the Cities and Towns of Bihar have suffered due to lack of adequate primary health care delivery especially in the field of family planning and child health services.

L. Logistics

Validation of equipments and drugs procurement is within the domain of
state level decision making. The Districts generally purchase the requirements and distributed to the other Health institutes mostly Block PHCs. However stock out of drugs still a problem for concern and require insurability of drug availability in the health institutes. There should provision of contingency funds for emergency drugs at the district level and health facilities. Under NRHM there is scope for huge and rapid flow of materials from the MOHFW, GOI and the State level.RCH Kit A & Kit B are being supplied by MOHFW, GOI.

District and the peripheral institutions need to be strengthened through
capacity building for enhancing their capabilities of indenting, procurement, inventory management and distribution of drugs and supplies and maintenance of medical equipment and transport. Cold Chain Vans are available in the districts for distribution of Vaccines to PHCs/ HSCs during vaccination programs and camps.

Generally PHC vehicles are used to collect the drugs and supplies from the district store. Currently local purchase of drugs and supplies are not approved. Drugs, consumables, and vaccines are directly supplied by the districts for HSCs, PHCs and other facilities very irregularly. There is need to streamline the process for estimation and indenting of vaccines, drugs and supply of consumables. The supply system would ensure smooth flow of indented materials as per guidelines from state to all levels of utilization.

M. HMIS and Monitoring & Evaluation

The National Rural Health Mission has been launched with the aim to

provide effective health care to rural population. The programme seeks to decentralize with adequate devolution of powers and delegation of responsibilities has to have an appropriate implementation mechanism that is accountable. In order to facilitate this process the NRHM has proposed a structure right from the village to the national levels with details on key functions and financial powers. To capacitate the effective delivery of the programme there is a need of proper HMIS system so that regular monitoring, timely review of the NRHM activities should be carried out. The quality of MIES in districts is very poor. Reporting and recording of RCH formats (Plan and monthly reporting) are irregular, incomplete, and inconsistent. Formats are not filled up completely at the sub center level. There information is not properly reviewed at the PHC level. No feedback is provided upon that information. For overall management of the programme, there is a Mission Directorate and a State Programme Management Unit in the state. .At district level, there is a District Health Society who will be responsible for the data dissemination from the sub-district level to the district level. District M & E Officer at the district level and Accountant cum M& E Officer at block level will be responsible for management of HMIS.As such, there is a Monitoring Team constituted district level as well as block level to monitor the implementation of the NRHM activities.

There is a Hospital Management Committee/Rogi Kalyan Samiti at all PHCs and CHCs. The PHC / CHC Health Committee will monitor the performance of HSC under their jurisdiction and will submit the report and evaluate the HSC performance, and will be submitted to the District, which will compile and sent it to the State.

N. Behaviour Change Communication

The district does not have any comprehensive BCC strategy. All the programme officers implement the BCC activity as per their respective programmes. The IEC logistic is designed, developed and procured at the district level and distributed to the PHC in an adhoc manner. However some activity is done at the state level. There is no credible study available to identify the areas / region specific knowledge, attitudes and practices pertaining to various focus areas of interventions like breast feeding, community & family practice regarding handling of infants, ARSH issues etc. At present there is no impact assessment of the IEC and BCC activities. It's very important to assess the impact of IEC/BCC activities, resources and methods to undertake mid way corrective measures.

O. Convergence/Coordination

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

There are 179 PRIs in Nawada district. VH & SC are constituted in all panchayat.

P. Progress from RCH II Implementation of 2005-09

Major achievements during 2005-09

1. District Health Societies formed & registered.

2. ASHA: A total of 1903 ASHAs selected against the total revised target of 1959

3. DPM & BPMU: The district DPMU staff (DPM, DAM, D M&E, DPC, DCM, DDA) & block BPMU (HM, BCM & Accountant) have been recruited. The orientation training for all has been completed.

4. Free drug distribution of essential drugs started 24 hours presence of doctors ensured in all facilities up to PHC Level resulting in unprecedented increase in OPD patients. Performance of last three is as below:-

Sl. No.	Year	No. Of OPD
1	2006-07	469279
2	2007-08	654921
3	2008-09	851400
4	2009-10	
5	2010-11	
6	2011-12 (upto Nov,11)	

5. Routine Immunization:- Immunization Details is as below-

Sl. No.	Year	BCG	DPT	Polio	Measles	Vit-A
1	2006-07	57329	55536	54929	53151	16863
2	2007-08	53026	50780	43497	44679	11685

3	2008-09	50879	39812	45966	44538	23048
4	2009-10	48689	54003	53468	45236	9867
5	2010-11	48731	41384	35958	38313	16736
6	2011-12 (upto Nov,11)	5493	26427	19905	29519	-

6. Institutional Delivery has increased manifold:-

Sl. No.	Year	No. Of Delivery
1	2006-07	3514
2	2007-08	15602
3	2008-09	-
4	2009-10	24013
5	2010-11	28603
6	2011-12 (upto Nov,11)	19933

7. No. Of Family Planning in District:-

Sl. No.	Year	No. Of Family Planning
1	2006-07	6112
2	2007-08	7831
3	2008-09	6877
4	2009-10	6464
5	2010-11	13115
6	2011-12 (upto Nov,11)	3034

8. Rogi Kalyan Samitis (RKS) formed in all health facilities till PHC level, registration of RKS completed:-

9. Establishment of labour room with latest equipment is under progress.

10. Operationalisation 24x7 details in as follow:-

Sub Divisional Hospital		**CHCs**		**PHCs**		**APHCs**	
Total No.	No. Of SDH with	Total No.	No. Of CHS with	Total No.	No. Of PHC with	Total No.	No. Of APHC with

	24x7 facilities		24x7 facilities		24x7 facilities		24x7 facilities
1	1	2	2	14	14	32	0

11. Contractual Appointment:-

Sl. No.	Name of Post	Sanctioned Post	In Working
1	DPM	1	1
2	DAM	1	1
3	M & E	1	1
4	DPC	1	1
5	DCM	1	1
6	DDA	1	1
7	Office Assistant	1	1
8	Office Assistant (Account)	1	1
9	DEO/Assistant	2	1
7	Hospital Manager	2	2
8	BHM	14	14
9	BCM	14	11
10	BAM	14	14
11	Doctor	45	21
12	Dental Doctor	15	14
13	Staff Nurse	82	53
14	ANM	223	151
15	ASHA	1959	1903
16	Mamta	101	101

12. Constitution of VHSC in district – There are 179 panchyat in Nawada district. VHSC is constituted in all 179 panchyat.

Chapter 5

Budget For HSC, APHC, BPHC & DH

5.1 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-Centres are:

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

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
2256755	451	327	167

To obtain IPH standard -: Need to sanction 121 new HSC to achieve IPH standard.

5.1.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13	Budget for (2012-13)
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.	451 (Max. HSC as per IPHS)	160 (Already having building)	291	50	50 X 950000 =47500000
Furniture	Examination Table 1 Writing table 2 Armless chairs 3 Medicine Chest 1 Labour table 1	1X 451 =451 2X 451 = 902 3X 451 = 1353 1X 451 = 451 1X451 =451 1X 451 = 451	432 HSC are sanctioned that need all these furniture.	451	All sanctioned/ established	330X 12000= 3960000 660X 8000 = 5280000 990X2000= 1980000

	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 451 = 451 1X 451 = 451 1X451 = 451 2X 451 = 902 1X 451 = 451 3X 451 = 1353 2X 451 = 902 3X 451 = 1353 3X451 = 1353 1X 451 = 451	Some HSC have some furniture but worth deposable.		HSC i.e 330	330X 5000=1650000 330X 8000= 2640000 330X 1000=330000 330X 200 = 66000 330X 1000 = 330000 330X 500 = 165000 660X 500 = 330000 330X16000= 5280000 990 X 200= 198000 660 X 1500= 990000 990X 1500= 1485000 990X 250= 247500 330x 1500= 495000 Total- 49,929000
Equipment	Basin Kidney 825 ml Tray instrument Jar Dressing 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	2X451=902 1X451=451 1X451=451 1X451=451 1X451=451 1X451=451 1X451=451 1X451=451 2X451=902 8X451=3608 20X451=9020 12X451=5412 12X451=5412 12X451=5412 20X451=9020 1X451=451 20X451=9020 1x451= 451 1x 451= 451 1X451= 451 1X451= 451 1X451=451	330 HSC are sanctioned that need all these equipments .	451	All sanctioned/ established HSC i.e 330	Total - 5,0000000 (Approx.) (To provide all listed Equipments to all working 330 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)	150X451= 15000X451= 13000X451= 6X451= 1000X451= 480X451= 500X451= 10X451= 300X451 180X451= 5X451= 125X451= 120X451= 10X451=	330 HSC are sanctioned that need all these drugs.	451	All sanctioned/ established HSC i.e 330	Total - 5,0000000 (Approx.) (To provide all listed Medicine to all working 330 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. Hemoglobin Color Scale Uristix Diastix	1X451=451 1X451=451 1X451=451	330 HSC are sanctioned that need all these equipments .	451	All sanctioned/ established HSC i.e 330	Total = Total = 43,20,000 (Approx.) (To provide three listed Equipments of laboratory to all working 330HSC)
Electricity	Wherever facility exists, uninterrupted		330 HSC are sanctioned that need	451	All sanctioned/	

	power supply has to be ensured for which inverter facility / solar power facility is to be provided. Solar power set	1X451=451	Solar power sets.		establi shed HSC i.e 330	330X20000= 6600000
Water	Potable water for patients and staff and water for other uses should bein 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 everywher e				
Telephone	Where ever feasible, telephone facility / cell phone facility is to be provided. Mobile phone	1X451=451	330 HSC are sanctioned and need Mobile Phone	451	All sancti oned/ establi shed HSC i.e 330	330X1500= 495000

5.1.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpow er	Gaps	For 2012-13	Budget 2012-13
Health worker (female)	2	2X451=902	136+195 =331	571	330X2=660 32(APHC)X2=7 24	724X6000X12 = 52128000
Health worker (male)	1 (funded and appointme nt by the state governme	1X451=451	0	451	330x1=330	330X4000x12 = 15840000

	nt)					
					Total	67968000

5.1.3 Services and others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2012-13)
Infrastructure	Out of 330 only 39 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. Involve DM to arrange land.	1. Budget to construct 12 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 169X500X12= 1014000
	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 (Untide fund)	Always it is found that HSC is lacking stationeries	Arrangements of fund for these miscellaneous expenses.	Untied fund are available but problem in handling. Untied 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.	330X10,000= 330000
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 visit 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.
	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 330X5000= 1650000
	Child Immunization	1. No 100% child immunization 2. Drop out cases 3. Shortage of vaccine.	Working at various level 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.

5.1.4 Budget Summery (Health Sub Center)

2012-13

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	475,00,000	
	Furniture	49,929000	
	Equipments	5,0000000	
	Drugs	5,0000000	
	Laboratory	43,20,000	
	Electricity	66,00000	
	Telephone	49,5000	
Manpower	Health worker (female)	52128000	
	Health worker (male)	15,840000	
Services of HSC	Infrastructure (Rent)	10,14000	
	Untied Fund	33,00000	
	IEC/BCC	16,50000	
	Total	28,27,76,000	

5.2 Additional Primary Health Center (APHC):

Additional Primary Health Center are the cornerstone of rural health services- a first step 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 primitive 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 in remote areas.

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 (2011)	Maximum APHC required as per IPH Norms @ 30,000 people	No. of APHC Present	Gaps in No. of APHC
2256755	76	32	44

To obtain IPH standard -: Need to sanction 54 new APHC to achieve IPH standard.
Task for 2012-13 -:

- Out of 54 sanctioned APHC 32 APHC is established so far. So, in financial year 2012-13, the first priority should be given to these non-functional APHC.

5.2.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13	Budget for (2012-13)
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.	76 (Max. APHC as per IPHS)	9 (Already having building but requires renovation)	67		35 New building X 53,15,000 =18,60,25000 9 Old (renovation) X 25,00000 **=2,25,00,000** _____ **Total- 21,38,40,000**
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	Maximum APHC is 76 so requirement is accordingly	32 APHC is present that need all these equipments.	76	All sanctioned/ established HSC i.e 32	Total - 8,80,00000 (Approx.) (To provide all listed Medicine to all working 32 APHC)

	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 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	Maximum APHC is 76 so requirement is accordingly	32 APHC are sanctioned that need all these equipments.	76	All sanctioned/ established APHC i.e 32	Budget for Laboratory equipments has been given above.

	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					
Electricity	Wherever facility exists, uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	Maximum APHC is 76 so requirement is accordingly	32 APHC are sanctioned that need power supply.	76	All sanctioned/ established APHC i.e 32	Generator service can be out sourced. 32 X 36000 X 12= 13,824000
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 76 so requirement is	32 APHC are sanctioned that need Telephone facility.	76	All sanctioned/ established	Total 32 X 500 X 12 = 192000

		accordingly			APHC i.e	
Transport	The APHC should have an ambulance for transport of patients. This may be outsourced.	Maximum APHC is 76 so requirement is accordingly	32 APHC are sanctioned that need Telephone facility.	76	All sanctioned/ established APHC i.e	Ambulance service may be outsourced Total 32 X 15000 X 12 = 57,60000
Laundry and Dietary facilities	Laundry and Dietary facilities for indoor patients: these facilities can be outsourced.	Maximum APHC is 76 so requirement is accordingly	32APHC are sanctioned that need Telephone facility.	76	All sanctioned/ established APHC i.e	Laundry and Dietary facilities can be outsourced 10,000 per APHC per month Total 32 X 10,000 X 12 = 38,40000

5.2.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13	Budget 2012-13
Medical Officer MBBS – 1 Ayush - 1	2	2X76=152	17	203	2X55=110	110X20,000 X12= 2,64,00000
Pharmacist	1	1X76=110	3	107	1X55=55	55X6000X12= 39,60,000
Nurse-midwife (Staff Nurse)	3	3X76=228	11	319	3X55=165	165X7500X12= 1,48,50,000
Health workers (F)	1	1X76=76	1	109	1X55=55	55X6000X12= 39,60,000
Health Educator	1	1X76=76	23	87	1X55=55	55X8000X12= 52,80,000
Health Asstt (Male & Female)	2	2X76=152	35	185	2X55=110	110X4000X12= 52,80,000
Clerks	2	2X76=152	30	190	2X55=110	110X8000X12= 1,05,60,000
Laboratory Technician	1	1X76=76	1	109	1X55=55	55X6000X12= 39,60,000

Driver	outsou rced					
Class IV	4	4X76=252	33	407	4X55=220	220X4000X12= 52,80,000
					Total	7,95,30,000

5.2.3 Services and others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2012-13)
Infrastructure	Out of 55 only 12 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 43X1200X12= 6,19,200
	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 (Untide fund)	Always it is found that HSC is lacking stationeries	Arrangements of fund for these miscellaneous expenses.	Untide fund provision under control of RKS.	55X25,000= 13,75,000

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 Untide 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)			▪ 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.	
	National Program for Control of Blindness (NPCB)			▪ 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 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	Budget will be given under District AIDS program head

				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.	
	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.	
	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 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	Budget will be given under District AIDS program head

				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.	
	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.	

5.2.4 Budget Summery (Additional Primary Health Center)

2012-13

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	265965000	
	Drugs	11,0000000	
	Electricity	2,37,60,000	
	Telephone	3,30,000	
	Transport	99,00000	
	Laundry/Diet	66,00000	
Manpower	For all	7,95,30,000	Details break up given above
Others Services of APHC	Rent	6,19,200	
	Untide fund	13,75,000	
	IDSP	49,50,000	

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

- New building for PHC, Pakribrawa.
- 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 (2011)	Maximum PHC required as per IPH Norms @ 1,00,000 people	No. of PHC already sanctioned/established	Gaps in No. of PHC
2216653	22	14	8

To obtain IPH standard -: Need to sanction 7 new PHC to achieve IPH standard.

Task for 2012-13 -:

- Out of 14 sanctioned PHC all 14 PHC are established and functioning. So, in financial year 2012-13, 25% of gaps i.e 2 PHC can be sanctioned more to minimize the gaps.

Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13	Budget for (2012-13)
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.	21 (Max. PHC as per IPHS)	14 PHC are functional out of which 3 have no building. (Existing buildings require renovation)	7	1new building	01 New building X 2,0000000 =2,0000000 11 Old building (renovation) X 50,00000 =5,50,00000 Total = 8,50,00000
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines,	Working in 14 PHC & RH & DHS				17x85929= 1460793
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	Working PHC is 14 so requirement is accordingly	14 PHC are sanctioned that need all these furniture.	7	All sanctioned/ established PHC i.e 14	10,00000(Approx) per PHC Total – 10,00000 X 14 = 1,40,00000 (To provide all listed furniture to 14 working PHC)

	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 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	Working PHC is 14 so requirement is accordingly	14 PHC are sanctioned that need all these equipments.	7	All sanctioned/ established PHC is 14	17,50,000(Approx) per PHC Total – 17,50,000 X 14 = 2,45,00,000 (To provide all listed equipments to 14 working PHC)

	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 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	Maximum PHC is 14 so requirement is accordingly	14 PHC are sanctioned that need all these equipments.	7	All sanctioned/ established PHC i.e 14	Total – 5,0000000 (Approx.) (To provide all listed Medicine to all working 14 PHC)

	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 14 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 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	Maximum PHC is 14 so requirement is accordingly	14 PHC are sanctioned that need all these equipments.	7	All sanctioned/ established PHC i.e 14	Budget for Laboratory equipments has been given above.

	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					
Electricity	Wherever facility exists, uninterrupted power supply has to be ensured for which Generator and inverter facility is to be provided.	Maximum PHC is 14 so requirement is accordingly	14 PHC are sanctioned that need power supply.	7	All sanctioned/ established PHC i.e 14	Generator service can be out sourced. 14 x 36000 x 12= 60,48,000
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.	14 PHC is existing so requirement is accordingly	14 existing PHC have telephone.	7	4 Newly PHC equire new	Total 14 X 500 X 12 = ,84,000

					conne ction	
Transport	The APHC should have an ambulance for transport of patients. This may be outsourced.	14 PHC is existing so requireme nt is accordingly	14 existing PHC have Ambulance.	7	All sancti oned/ establi shed PHC	Ambulance service may be outsourced Total 14 X 15000 X 12 = 25,20,000
Laundry and Dietary facilities	Laundry and Dietary facilities for indoor patients: these facilities can be outsourced.	14 PHC is existing so requireme nt is accordingly	All sanctioned PHC requires this facility.	7	All sancti oned/ establi shed PHC i.e	Laundry and Dietary facilities can be outsourced 10,000 per PHC per month Total 14 X 10,000 X 12 = 16,80,000
Boundry Wall	Boundry Wall in 10 PHC					10x100000= 1000000
Residence Quarter for Staff Nurse	14 PHC					14x7720000= 108080000

5.3.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13	Budget 2012-13
General Surgeon	1	14X1=14	2	12	12	12X35000X12= 50,40,000
Physician	1	14X1=14	1	13	13	13X35000X12= 54,60,000
Obstetrician/ Gynecologist	1	14X1=14	2	12	12	12X35000X12= 50,40,000
Pediatrics	1	14X1=14	2	12	12	12X35000X12= 50,40,000
Anesthetist	1	14X1=14	0	14	14	14X35000X12= 58,80,000
Health Manager	1	14X1=14	14	0	0	14X22000X12= 36,96,000
Eye surgeon	1	14X1=14	1	13	13	13X35000X12= 54,60,000
Nurse-midwife	9	14X9= 126	16	110	110	110X12000X12= 1,58,40,000
Dresser	1	14X1=14	3	11	11	11X6000X12= 7,92000
Pharmacist/ compounder	1	14X1=14	2	12	12	12X7500X12= 10,80,000
Lab. Technician	1	14X1=14	0	14	14	14X6500X12= 10,92,000
Radiographer	1	14X1=14	0	14	14	14X7500X12= 12,60,000
Ophthalmic Assistant	1	14X1=14	1	13	13	13X8000X12= 12,48,000
Ward boys/ nursing orderly	2	14X2= 28	0	28	28	28X5000X12= 16,80,000
Sweepers	3	19X3= 42	0	42	42	42X4000X12= 20,16,000
Chowkidar	1	14X1=14	0	14	14	14X4000X12= 6,72,000
OPD attendant	1	14X1=14	0	14	14	14X5000X12=

						8,40,000
Statistical Assistant/ Data entry operator	1	14X1=14	0	14	14	14X7500X12= 12,60,000
OT attendant	1	14X1=14	0	14	14	14X6000X12= 14,08,000
Registration clerk	1	14X1=14	0	14	14	14X5000X12= 8,40,000
Accountant	1	14X1=14	14	0	0	14X15000X12= 25,20,000
BCM	1	14x1=14	11	3	14	14x19200x12= 32,25,600
					Total	**7,13,89,600**

5.3.3 Services and others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2012-13)
Infrastructure	Out of 14 only 13 PHC have its own 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 3 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.	Rent for HSC 3X3000X12= 108000
	Lack of Equipments, Drugs, Furniture, Power	PHC 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 (Untide fund)	Always it is found that HSC is lacking stationeries	Arrangements of fund for these miscellaneous expenses.	Untide fund provision under control of RKS.	14X50,000= 7,00,000

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 haemoglobin, 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.	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 Laproscopic 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 Untide 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)		IDSP is started from Feb, 2011	▪ 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	Budget will be given under District AIDS program head

				of 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.	

5.3.4 Budget Summery (Primary Health Center)

2012-13

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	8,50,00000	
	BoundryWall	1000000	
	ANM Quator	108080000	
	Furniture	1,40,00000	
	Equipments	2,45,00,000	
	Drugs	5,0000000	
	Waste Disposal	1460793	
	Electricity	60,48,000	
	Telephone	84,000	
	Transport	25,20,000	
	Laundry/Diet	16,80,000	
Manpower	For all	7,13,89,600	Details break up given above
Others Services of APHC	Rent	1,08,000	

Untide fund	SDH	50000	
	PHC	350000	
	APHC	1325000	
	Sub- Center	1690000	
	VHSC	9560000	
	HSC Untide fund	7,00,000	
Total		**36,65,70,393**	

5.4 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 overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the people of the district. The specific objectives of IPHS for DHs are:

i. To provide comprehensive secondary health care (specialist and referral services) to the community through the District Hospital.

ii. To achieve and maintain an acceptable standard of quality of care. To make the services more responsive and sensitive to the needs of the people of the district and the hospitals/centers from which the cases are referred to the district hospitals

No. of Institutions (Sadar Hospital)

As per IPH standard one District Hospital at every district.

District Population	Maximum DH required as per IPH Norms	No. of DH already sanctioned/established	Gaps in No. of DH

(2011)			
2216653	1	1	0

To obtain IPH standard -: Need to strength sanction 7 new PHC to achieve IPH standard.

Task for 2012-13 -:

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

5.4.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2012-13	Budget for (2012-13)
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	300 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	For working 1 District Hospital as per	1 DH is sanctioned and working and need all	1	All sanctioned /established PHC i.e 1	10000000 (Apprx)

	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 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	requirement	these furniture.			(To provide all listed furniture to 1 working PHC)

	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	Working DH is 1 so requirement is accordingly	1 DH is sanctioned that need all these equipments.	1	One sanctioned /establishe d DH	20000000 (Apprx) (To provide all listed equipments to 1 working DH)

	▪ 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 – 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					Total - 2,0000000 (Approx.) (To provide all listed Medicine to working 1 DH)

	Cetrizine Doxycycline Ampicillin & Cloxacilin Etophylline & Theophylline Dopamine Hydrochloride Adrenaline Sodium Bicarborate Tinidazole Fluconazole Clotrimazole Cream Dicyclomine Tablets 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 /establishe d 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 everywher e				
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 2 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

5.4.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2012-13	Budget 2012-13
Hospital Superintendent	1	1X1=1	1	0	0	State
Hospital Manager in FRU		1x2=2	2	0	0	2x30000x12= 7,20,000
Medical Specialist	3	3X1=3	1	2	2	2X35000X12= 8,40,000
Surgery Specialists	3	3X1=3	1	2	2	2X35000X12= 8,40,000
O&G specialist	6	6X1=6	2	4	4	4X35000X12= 16,80,000
Psychiatrist	1	1X1=1	0	1	1	1X30000X12= 3,60,000
Dermatologist / Venereologist	1	1X1=1	1	1	1	1X30000X12= 3,60,000
Pediatrician	3	3X1=3	1	2	2	2X35000X12= 8,40,000
Anesthetist (Regular / trained)	6	6X1= 6	0	6	6	6X35000X12= 25,20,000
ENT Surgeon	2	2X1=2	1	1	1	1X35000X12= 4,20,000
Ophthalmologist	2	2X1=2	1	1	1	1X35000X12= 4,20,000
Orthopedic an	2	2X1=2	1	1	1	1X35000X12= 4,20,000
Radiologist	1	1X1=1	0	1	1	1X35000X12=

						4,20,000
Casualty Doctors / General Duty Doctors	20	20X1= 20	2	18	18	18X30000X12= 64,80,000
Dental Surgeon	1	1X1=1	0	1	1	1X20000X12= 2,40,000
Health Manager	1	1X1=1	1	0	1	1X20000X12= 2,40,000
AYUSH Physician	4	4X1=4	0	4	4	4X15000X12= 7,20,000
Pathologists	2	2X1=2	1	1	1	1X30000X12= 3,60,000
Staff Nurse	20	20X1=20	4	16	16	16X12000X12= 23,04,000
Hospital worker (OP/ward +OT+ blood bank)	20	20X1=20	7	13	13	13X3000X12= 4,68,000
Ophthalmic Assistant	2	2X1=2	1	1	1	1X7500X12= 90,000
ECG Technician	1	1X1=1	0	1	1	1X6000X12= 72,000
Laboratory Technician (Lab + Blood Bank)	4	4X1=4	1	3	3	3X6500X12= 2,34,000
Maternity assistant (ANM)	4	4X1=4	4	4	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	**2,18,64,000**

5.4.3 Services and others

As per IPHS norms

5.4.4 Budget Summery (District Hospital)

2012-13

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	12,00000	

	/Cleaning		
Manpower	For all	2,18,64,000	Details break up given above
Others Services of DH	Untied fund	2,00,000	
	Disaster handling fund	10,00,000	
	Total	**7,58,23,000**	

CHAPTER – 6

DISTRICT LEVEL PROGRAMMES ANALYSIS & BUDGET

6.1 Strengthening of District Health Management

Situation Analysis/ Current Status	The District Health Mission and Society have formed been registered in Nawada. 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 behaviour 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

<table>
<tr><td></td><td colspan="2">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.
8. Quarter for All DHS Staff.
9. As per direction given by the Chairman cum DM, Nawada to provide medical assistance to each & every human being. It is must to monitor whether medical officer is available or not in their respective health center. For this we must have a provision in next year FY 2012-13 financial budget for 24x7 help line service with toll free no. in DHS.
10. Mobile for All DPMU Unit (DPM, DAM, M&E, DPC, DCM, DDA) Staff.
11. Laptop for DPC & DDA.
12. Four Wheeler for Asha Resource Center, Nawada for the Monitoring of All PHCs.
13. Two Wheeler for the BCM.
14. Mobile for BHM, BCM.
15. Provision for DEO in all Asha Resource Center, Bihar.</td></tr>
<tr><td>Support required</td><td colspan="2">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.</td></tr>
<tr><td>Timeline</td><td colspan="2">2012-13
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</td></tr>
<tr><td rowspan="4">Budget</td><td>Activity / Item</td><td>2012-13</td></tr>
<tr><td>Orientation Workshop</td><td>50,000</td></tr>
<tr><td>Issues based Workshops</td><td>3,25,000</td></tr>
<tr><td>Mobility for Monitoring</td><td>50,000</td></tr>
<tr><td></td><td>Total</td><td>4,25,000</td></tr>
</table>

6.2 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 M & E 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. The DPC is responsible for all microloans and supporting hand to DPM. She is also responsible for District Health Action Plan. 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 proper implementation of NRHM. 2. Capacity building of the personnel 3. Change of designation of District Data Assistant as a District M & E Officer because even after holding the District Level Post to DPM, DAM & M & E 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, M&E, DPC, DCM and CHS Officer 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	2012-13 • Selection of District level consultants, their capacity building and infrastructure • Development of an operational Manual 2012-13 • 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 2012-13
Honorarium DPM,DAM, M&E Officer Consultants	16,97,328
DPC	2,88,000
DCM & DDA	6,72,000
District Epidemiologist, District Data Manager & DEO	6,86,400
Officer Assistant	3,69,600
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	2,00,000
Workshops for development of the operational Manual at district and Block levels	1,00,000
Untied Fund	5,00,000
Joint Orientation of Officials and DPM, DAM, M&E, DPC, DCM, DDA	1,50,000
Management training workshop of Officials	75,000
Training of DPM and Consultants	1,10,000
Review meetings @ Rs 1000/ per month x 12 months	12,000
Office Expenses @ Rs 20,000/month x 12 months for district	2,40,000
Annual Maintenance Contract for the equipment	80,000
Total	**73,40,328**

6.3 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 2011 3. 70% Institutional deliveries by 2011 4. 90% deliveries by trained /Skilled Birth Attendant by 2011 5. 95% women to get improved Postnatal care by 2011 6. Increase safe abortion services from current level to 80 % by 2011
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	2012-13
	Tracking Bags @ Rs 300/ bag x AWCs 3200 and refilling	9,60,000
	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 60480)	12,09,60,000
	Total	12,27,70,000

6.4 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 Nawada 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	2012-13
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	Compone nt on training
Supply of Diagnosis and treatment protocols (chart booklets) for IMNCI & IMCI strategy	
Supply of medicine kit for IMNCI	State

6.5 Family Planning

Situation Analysis/ Current Status

Indicators	No. or Rate
Eligible Couple	5,50,770
% 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 3 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 75 subcentres. • All the ANMs at 75 subcentres will be given a practical hands on training on insertion of IUD • 4. 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 • 9. 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

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>Support required</td><td>• 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</td></tr>
<tr><td>Timeline</td><td><table><tr><td></td><td>2012-13</td></tr><tr><td>Training of MOs for NSV</td><td>10 MOs</td></tr><tr><td>Training of MOs for Minilap</td><td>5 MOs</td></tr><tr><td>Training of Specialists for Laparoscopic Sterilization</td><td>3 MOs</td></tr><tr><td>Sterilization Camps (Persons)</td><td>15000</td></tr><tr><td>Accreditation of private institutions for sterilization</td><td>10</td></tr><tr><td>Supply of Copper T – 380</td><td>5000</td></tr><tr><td>Emergency Contraception</td><td>3000</td></tr></table></td></tr>
<tr><td>Budget</td><td><table><tr><td>Activity / Item</td><td>2012-13</td></tr><tr><td>NSV @ Rs. 1500 per person X 1000 cases</td><td>15,00000</td></tr><tr><td>Sterilization @ 1000 X 14000 cases</td><td>1,40,00000</td></tr><tr><td>Copper T-380 @ Rs 50 / piece x 5000</td><td>2,50,000</td></tr><tr><td>Emergency Contraception @ Rs10/2 tabs</td><td>25,000</td></tr><tr><td>IEC</td><td>1,50,000</td></tr><tr><td>Total</td><td>1,59,25,000</td></tr></table></td></tr>
</table>

6.6 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. 1,500.00 per month. In district Nawada 1959 ASHAs have been selected and 1871 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

<table>
<tr><td></td><td>healthcare.
3. To address the unmet needs.</td></tr>
<tr><td>Strategies</td><td>1. Selection and capacity building of ASHA.
2. Constant mentoring, monitoring and supportive supervision by district Mentoring group.</td></tr>
<tr><td>Activities</td><td>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 Saree, Umbrella, Raincoat again to ASHAs.
5. Provision for Vehicle & Mobile of Asha Facilitator.
6. Provision for Mobile of all ASHA.
7. Formation of a District ASHA Mentoring group to support efforts of ASHA and problem solving
8. Review and Planning at the Monthly sector meetings
9. Periodic review of the work of ASHAs through Concurrent Evaluation by an independent agency</td></tr>
<tr><td>Support required</td><td>1. Timely Payments to ASHA.
2. Proper training.
3. Capacity Building.
4. Increase Incentive Payment for ASHA.</td></tr>
<tr><td>Timeline</td><td><table>
<tr><td>Activity</td><td>2012-13</td></tr>
<tr><td>Total ASHAs</td><td>1959</td></tr>
<tr><td>Training of new & untrained ASHAs</td><td>1959</td></tr>
<tr><td>Reorientation of the initial ASHAs</td><td>0</td></tr>
<tr><td>District ASHA Mentoring group</td><td>2</td></tr>
</table></td></tr>
<tr><td>Budget</td><td><table>
<tr><td>Activity / Item</td><td>2012-13</td></tr>
<tr><td>Training of Asha at District Level</td><td>99,62,821</td></tr>
<tr><td>ARC</td><td>41,58,170</td></tr>
<tr><td>District mentoring group – meetings, travel @ Rs 10,000 per month x 12 months</td><td>1,20,000</td></tr>
<tr><td>Incentive for ASHAs on ASHA Day</td><td>24,21,324</td></tr>
<tr><td>Asha Drug Kit & Replenishment</td><td>53,87,25</td></tr>
<tr><td>Motivation of ASHA</td><td>25,00,000</td></tr>
<tr><td>Total</td><td>1,91,62,315</td></tr>
</table></td></tr>
</table>

6.7 Immunization

Situation Analysis/ Current	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

Status	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**	**2012-13**
	Mobility support for alternative vaccine delivery Rs. 50 per session for 1 planned sessions per week at each Sub centre village for 12 months = Rs. 50x1 sessionsx4 weeks/mthx12 monthsx SCs	15,36,000
	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	7,29,600
	Mobility Support Mop up campaign @ Rs 10000 per PHC (Including travel, vaccine delivery, IEC) x 6 rounds/ year x PHCs	11,40,000
	Mobilization of Children by Social Mobilizers @ Rs. 100/ session x4 sessions per month X session sites x12month	30,72,000
	Contingency fund for each block @ Rs.1000/month x 14 blocks x 12 months	1,68,000
	Pit Formation for disposal of AD Syringes and broken vials (@ Rs. 2000 per pit per Subcentre and PHC	13,18,000
	Printing of Immunization 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 months	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	72,000
	Total	**95,95,600**

6.8 RNTCP (Revised National Tuberculosis Control Programme)

Situation Analysis/ Current Status

Indicators	No. / Rate
New Sputum Positive cases (NSP)	1291
Annualized new case detection rate per one lakh population	42.10/Lakhs
Total No. of patient put on treatment	3462
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 2005 in Nawada. Under this programme in District Nawada Tuberculosis Unit at microscopic centers were setups.

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
6.

Support required

Timely supply of medicines

Timeline

2012-13

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**	**2012-13**
	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/PPP support	5,00,000
	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 @ 8000 per person X 2 X 12	2,11,200
	STS @ 12000 per person X 5 X 12	7,92,000
	STLS @ 12000 per person X 5 X 12	7,92,000
	LT @ 8500 per person X 12 X 12	13,46,400
	Data Entry Operator @ 85000 per person X 1 X 12	1,12,200
	Accountant @ 4000 per person X 1 X 12	52,800
	MO @ 28000 per person X 1 X 12	3,69,600
	Total	1,16,45,779

6.9 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	2012-13 House to house detection Wide publicity Rigorous follow-up	
Budget	Activity / Item	2012-13
	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**

6.10 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 Nawada 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. Folloing are the descriptions of man power status.

Post Name	Sanctioned	In position	Vacant	Remarks
DMO	1	0	1	All these posts come under state cadre
AMO	1	0	1	
Malaria Inspector	6	2	4	
Lab Technician	19	1	18	
Clerk	2	1	1	
BHI	19	2	17	
BHW	53	6	47	
Driver	2	0	2	
Mechanic	1	0	1	
Motor Cleaner	2	0	2	
SFW	2	1	1	
FW	4	1	3	
Peon	2	1	1	
Sweeper	1	1	0	

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

<table>
<tr><td></td><td>
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
</td></tr>
<tr><td>Support required</td><td>
Availability of supplies
Filling up of vacancies
Supply of health Education material
</td></tr>
<tr><td>Timeline</td><td>
<table>
<tr><th>Activity / Item</th><th>2012-13</th></tr>
<tr><td>Hiring Contractual Staff</td><td>x</td></tr>
<tr><td>Purchase of Jeep</td><td>x</td></tr>
<tr><td>Fogging & Spraying</td><td>x</td></tr>
<tr><td>Hoardings</td><td>14 PHC, 1 SH
25 APHC</td></tr>
<tr><td>IEC activities</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Budget</td><td>
<table>
<tr><th>Activity / Item</th><th>2012-13</th></tr>
<tr><td>Salary Contractual staff</td><td>84,12,000</td></tr>
<tr><td>Travel expenses @ Rs 6000 per month x 12 months</td><td>72,000</td></tr>
<tr><td>Office expenses @ Rs 5000 per month x 12</td><td>60,000</td></tr>
<tr><td>Jeep and truck maintenance</td><td>80,000</td></tr>
<tr><td>Training</td><td>5,00000</td></tr>
<tr><td>Board hoarding: Twenty 8’x 12’ at 20 sites initially at the PHC and Sadar hospitals @ Rs 25,000/-</td><td>5,00000</td></tr>
<tr><td>Board hoarding: Fifty five 5’x3’ at 25 sites initially at the APHC@ Rs 10,000/-</td><td>2,50,000</td></tr>
<tr><td>Total</td><td>98,74,000</td></tr>
</table>
</td></tr>
</table>

Description of Contractual Staff salaries

Post Name	Unit	Unit cost	Months	Amount
AMO	1	1 X 30000	12	360000
Malaria Inspector	4	4 X 12000	12	576000
Lab Technician	14	14 X 8500	12	1428000
Clerk	1	1X8000	12	96000
BHI	17	17X8000	12	1632000
BHW	47	47X7000	12	3948000
Driver	2	2X4000	12	96000
Mechanic	1	1X4000	12	48000
Motor Cleaner	2	2X4000	12	96000
SFW	1	1X7000	12	84000
FW	3	1X 4000	12	144000
Peon	1	1X4000	12	48000
Total				**8556000**

6.11 BLINDNESS CONTROL PROGRAMME

D-5. BLINDNESS CONTROL PROGRAMME

Situation Analysis/ Current Status

Indicators	No.
Total Cataract surgery performed	4467
Cataract surgery with IOL	1567
School going children screened	0
Children detected with refractive error	0
Children provided with free corrective spectacles	0

Eye Care is being provided through the Sadar Hospital, There are 1 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 21 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 Nawada. 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

<table>
<tr><td></td><td>3. Reduce the backlog of blindness
4. Development of institutional capacity for eye care services</td></tr>
<tr><td>Activities</td><td>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
<table><tr><td>Eye Care centre</td><td>Vision Centre</td><td>Screening</td></tr><tr><td>Eye Surgeon</td><td>Primary Eye Care</td><td>Identify Blind</td></tr><tr><td>Treatment of eye conditions and follow-up</td><td>Vision Test</td><td>Maintain Blind Register</td></tr><tr><td>Training</td><td>Screening Eye Camps</td><td>Motivator</td></tr><tr><td>Supervision</td><td>Referral for surgery</td><td>Referral</td></tr></table>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</td></tr>
<tr><td>Support required</td><td>Procurement of latest equipment for hospitals by GOI
Timely Repair of equipment</td></tr>
<tr><td>Timeline</td><td>2012-13
Health Mela
Development of PHCs as Vision Centres
Development of Sadar Hospital Nawada as Eye Unit
School Screening
Cataract Camps</td></tr>
<tr><td>Budget</td><td>Activity / Item</td><td>2010- 11</td></tr>
</table>

	Health Mela	2,00000
	IEC	3,42,500
	School Eye Screening	220000
	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	**36,72,500**

6.12 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 : 2012 -13

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	14 PHC and 2 Urban Units= 16 units	16	1000	16000
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	14	14	1500	21000
III.	Capacity Building				
	Training and Capacity Building of Service Providers	14 PHC and 2 Urban Units= 16 units	16	5000	80000
IV.	Urban Health Intervention Strategy				
	Strategy Planning Meetings, Orientations of Stakeholders & Volunteers, Resource Planning, Site-management	3 Municipal Area	3	5000	15000
	Orientation of Urban Supervisors	1 Municipal Area	1	2500	2500
V.	Human Resource				
	Honorarium to Urban vaccinators	150 Urban sites	150	100	15000
	Honorarium to Volunteers, AWWs, ASHA to function as service provider	2618 AWWs/ASHAs/ and 10% of AWC-Volunteers= (2618+2618*10%)	2880	100	288000
	Honorarium to the Urban Supervisor	1 Supervisor / 10 sites	15	400	6000
VI.	Management Information System for Monitoring VAS Program				
	Availability of Immunization cards [JBR Cards ,Reporting Formats, Record & Registers,	14 PHC & 2 urban area	16	10000	160000
VI.	Logistics and Procurement				
	Need Assessment and Procurement of Vitamin-A Syrup [Children 9m-5yrs =4,000,00 children	8000 VA bottles	8000	52	400000
	Mobility Support for Carrying Vitamin A bottles from district to PHCs	14 PHC & 2 urban area	16	3000	48,000
VII.	IEC/BCC				
	Posters, Banners, Flexes, etc	14 PHC & 2 Municipal area urban area	16	10000	160000
IX.	Program Monitoring and Review				
	Mobility Support : Hiring of Vehicles & POL	14 PHC & 2 urban area	16	6000	96000

TOTAL	1312500

Expenses on conducting 1 Biannual Round = Rs . **13,12,500**

Expenses on conducting 2 Biannual Rounds = Rs. 13,12,500 X 2= 26,25,000

CHAPTER 7

District Budget (2012-13)

7.1 TOTAL BUDGET AT-A-GLANCE (2012-13)

Sl. N	Heads	Budget 2012-13
1	Sub center	28,27,76,000
2	Additional PHC	79,31,93,400
3	PHC	37,95,45,393
4	District Hospital	2,18,64,000
6	DPMU	73,40,328
7	Maternal Health & JBSY	12,27,70,000
9	Family Planning	1,59,25,000
10	ASHA	1,91,62,315
11	Immunization	95,95,600
12	RNTCP	1,16,45,779
13	Leprosy	5,71,000
14	Malaria	98,74,000
15	Blindness	36,72,500
16	Vitamin A	26,25,000
18.	IDSP	9,39,400
19.	Failiaria	13,11,662
	Total	**1,68,28,11,377**

NRHM Part-A

Annexure 2

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Remarks	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)			
A	**RCH Flexipool**																
A.1	**MATERNAL HEALTH**																
A.1.1	**Operationalise Facilities**																
A.1.1.1	**Operationalise FRUs-**																
A.1.1.1.1	Dissemination Workshop for FRU Guidelines																
A.1.1.1.2	Monitor Progress and Quality of Service Delivery							4	12500	10000	13000	13500	13500	50000			
A.1.1.2	Operationalise 24x7 PHCs (Mch Center-Aphc)							14	25000	70000	91000	94500	94500	350000		for running of 24x7 service in 14 APHC	
A.1.1.3	MTP Services at Health Facilities																
A.1.1.4	RTI/STI Services at Health Facilities																
A.1.1.5	Operationalise Sub-Centres (MCH Center-Hsc)							28	50000	560000	840000	0	0	1400000		for running of 24x7 service in 28 HSC	
A.1.2	***Referral Transport***																
A.1.3	**Integrated Outreach RCH Services**																
A.1.3.1	RCH Outreach Camps/ Others							28	7700	43120	56056	58212	58212	215600			
A.1.3.2	Monthly Village Health and Nutrition Days							1810	540	195520	254176	263952	263952	977600			
A.1.4	**Janani Suraksha Yojana / JSY**																
A..1.4.1	Home Deliveries							300	500	30000	39000	40500	40500	150000			
A_1.4.2	**Institutional Deliveries**																
A.1.4.2.A	Institutional Deliverie-Rural							33600	2000	16800000	16800000	16800000	16800000	67200000	**2200000**	**(Comm. Exp. for FY 2011-12**	
A.1.4.2.B	Institutional Deliveries-Urban							460	1200	110400	143520	149040	149040	552000			

A.1.4.2.C	Institutional Deliveries-C-Sections							150	1500	45000	58500	60750	60750	225000			
A.1.4.3	Administrative Expenses							1	640000	128000	166400	172800	172800	640000			
A.1.4.4	Incentive to ASHAs																
A.1.5	Maternal Death Review							10	750	1500	1950	2025	2025	7500			
A.1.6	Other Strategies/Activities (ICTC for HIV Testing of ANC Cases)																
Total Maternal Health										**17993540**	**18463602**	**17655279**	**17655279**	**71767700**	**22000000**		
A.2	**CHILD HEALTH**																
A.2.1	**IMNCI**																
A.2.1.1	Implementation of IMNCI Activities in Districts							1	50000	11000	14300	14850	14850	55000			
A.2.1.2	Monitor Progress Against Plan; Follow Up with Training, Procurement, Etc																
A.2.1.3	Incentive for HBNC to ASHA/AWWs(State Iniative) 3 PNC for Normal Baby									134322	174619	181335	181335	671612			
A.2.1.4	Incentive for HBNC to ASHA(State Iniative) 6PNC for Low Birth Baby									109503	142354	147829	147829	547516			
A.2.2	Facility Based Newborn Care/FBNC (Operationalise 40 NBSUs)							1	775000	155000	201500	209250	209250	775000			
A.2.3	Home Based Newborn Care/ HBNC																
A.2.4	Infant and Young Child Feeding/ IYCF																
A.2.5	Care of Sick Children and Severe Malnutrition																
A.2.6	Management of Diarrhoea, ARI and Micronutrient Malnutrition (Nutritional Rehabilitation Centres)							1	464535	92907	120779	125424	125424	464535			
A.2.7	Other Strategies/activities (Vitamin A Biannual Round)							120106	42.32	2541443		2541443		5082885.92			
A.2.8	Infant Death Audit																
A.2.9	Incentive to ASHA Under CH																
Total Child Health										**3044176**	**653552**	**322013**	**678689**	**7596549**			

											2					
A.3	**FAMILY PLANNING**															
A.3.1	**Terminal/ Limiting Methods**															
A.3.1.1	Dissemination of Manuals on Sterilisation Standards & QA of Sterilisation Services						1	20000	0	10000	10000	0	20000			
A.3.1.2	Female Sterilisation Camps						28	5000	28000	36400	37800	37800	140000			
A.3.1.3	NSV Camps						15	5000	15000	19500	20250	20250	75000			
A.3.1.4	Compensation for Female Sterilisation						16637	1000	3327400	4325620	4491990	4491990	16637000			
A.3.1.5	Compensation for Male Sterilisation (Compensation for NSV Acceptance)						150	1500	45000	58500	60750	60750	225000			
A.3.1.6	Accreditation of Private Providers for Sterilisation Services						1	1800000	360000	468000	486000	486000	1800000			
A.3.2	**Spacing Methods**															
A.3.2.1	IUD Camps															
A.3.2.2	IUD Services at Health Facilities															
A.3.2.3	Accreditation of Private Providers for IUD Insertion Services															
A.3.2.5	Contraceptive Update Seminars															
A.3.3	POL for Family Planning (for District Level + State Level Monitoring)						15	17000	63750	63750	63750	63750	255000			
A.3.4	Repairs of Laparoscopes															
A.3.5	**Other Strategies/ Activities**															
A.3.5.1	State Level Worshop/Review for FP															
A.3.5.2	Orientation															
A.3.5.3	Family Planning Incentive/Award to Best Performer District/other Personel															
A.3.5.4	Provide IUD Services at Health Facility (IUD Camps)						14	1500	0	6300	8400	6300	21000			
	Provide IUD Services at District Level						3	2000	0	1800	2400	1800	6000			
A.3.5.	Social															

5	Marketing of Contraceptives																
Total Family Planning										**3839150**	**4989870**	**5181340**	**5168640**	**19179000**			
A.4	**ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH / ARSH**																
A.4.1	Adolescent Services at Health Facilities (ARSH Corners in 3 DHs and PHCs)																
A.4.2	School Health Programme							1	3673600	918400	918400	918400	918400	3673600			
A.4.3	Other Strategies/ Activities (Menstrual Hygiene)																
Total ARSH											**918400**	**918400**	**918400**	**3673600**			
A.5	**URBAN RCH**																
A.5	URBAN RCH(Urban Health Center Through PPP)																
A.6	**TRIBAL RCH**																
A.6	TRIBAL RCH																
A.7	**PNDT & Sex Ratio**																
A.7.1	Support to PNDT Cell																
A.7.2	Other PNDT Activities (Monitoring of Sex Ratio at Birth)							1	100000	25000	25000	25000	25000	100000			
Total PNDT										**25000**	**25000**	**25000**	**25000**	**100000**			
A.8	**INFRASTRUCTURE (Minor Civil Works) & HUMAN RESOURCES (Except AYUSH)**																
A.8.1	**Contractual Staff & Services**																
A.8.1.1	ANMs (Salary of Contractual ANM/ Contractual SN)							223	138000	7693500	7693500	7693500	7693500	30774000			
	Staff Nurses (Salary of Contractual ANM/ Contractual SN)							82	240000	4920000	4920000	4920000	4920000	19680000			
	Supervisory Nurses (Salary of Contractual ANM/ Contractual SN)									0	0	0	0	0			
A.8.1.2.1	MPW																
A.8.1.2	Laboratory Technicians/(LT in Blood Banks)							6	120000	180000	180000	180000	180000	720000			
A.8.1.3	Specialists (Anaesthetists, Paediatricians, Ob/Gyn, Surgeons,																

	Physicians, Dental Surgeons, Radiologist, Sonologist, Pathologist, Specialist for CHC)																
A.8.1.4	PHNs at CHC, PHC Level									22000	28600	29700	29700	110000			
A.8.1.5	Medical Officers at CHCs / PHCs (Salary of MOs in Blood Banks)							2	420000	210000	210000	210000	210000	840000		SDH Rajauli & Sadar nawada	
A.8.1.6	Additional Allowances/ Incentives to M.O. of PHCs and CHCs																
A.8.1.7	Others - FP Counsellors							2	180000	90000	90000	90000	90000	360000		SDH Rajauli & Sadar nawada	
A.8.1.8	Incentive/ Awards Etc. to SN (Muskaan Programme-Incentive)																
	Incentive/ Awards Etc. to ANMs Etc. (Muskaan Programme-Incentive)																
	Incentive/ Awards Etc. to (Muskaan Programme-Incentive to ASHA)							1959	2400	1175400	1175400	1175400	1175400	4701600			
	Incentive/ Awards Etc. to (Muskaan Programme-Incentive to AWW)							1810	2400	1086000	1086000	1086000	1086000	4344000			
	Incentive/ Awards Etc. to (Muskaan Programme-Incentive to ANM)							429	1200	128700	128700	128700	128700	514800			
A.8.1.9	Human Resources Development (Other Than Above)																
A.8.1_10	Other Incentives Schemes (Pl. Specify)																
A.8.2	**Minor Civil Works**																
A.8.2.1	Minor Civil Works for Operationalisation of FRUs																
A.8.2.2	Minor Civil Works for Operationalisation of 24 Hour Services at PHCs																

	Total Civil Work									**15505600**	**155122 00**	**155133 00**	**155133 00**	**62044400**			
A.9	**TRAINING**																
A.9.1	**Strengthening of Training Institutions (Repair/renovation of Training Institutions)**																
A.9.1	Strengthening of Training Institutions (Repair/renovation of Training Institutions)																
A.9.2	**Development of Training Packages**																
A.9.2	Development of Training Packages																
A.9.3	**Maternal Health Training**																
A.9.3.1	Skilled Attendance at Birth							10	88110	220275	220275	220275	220275	881100			
A.9.3.2	Comprehensive EmOC Training (Including C-Section)																
A.9.3.3	Life Saving Anaesthesia Skills Training																
A.9.3.4	MTP Training							12	43470	130410	130410	130410	130410	521640			
A.9.3.5	RTI / STI Training							2	65000	32500	32500	32500	32500	130000			
A.9.3.6	BEMOC Training																
A.9.3.7	Other MH Training (Any Integrated Training, Etc.)-Training of MOs and Paramedics at Sub-District Level (Convergence with BSACS)							2	50000	25000	25000	25000	25000	100000			
A.9.4	IMEP Training																
A.9.5	**Child Health Training**																
A.9.5.1	IMNCI										3398945	3398945		6797890			
A.9.5.2	F-IMNCI																
A.9.5.3	Home Based Newborn Care																
A.9.5.4	Care of Sick Children and Severe Malnutrition A.9																
A.9.5_5	**Other CH Training (Pl. Specify)**																
A.9.5.5.1	TOT on FBNC																
A.9.5.5.2	Training on FBNC for Medical Officers																
A.9.5.5.3	NSSK Training (SN/ANM)										75647	78557		290950			

A.9.6	**Family Planning Training**																
A.9.6.1	Laparoscopic Sterilisation Training																
A.9.6.2	Minilap Training							1	70240	17560	17560	17560	17560	70240			
A.9.6.3	NSV Training							1	33900			33900		33900			
A.9.6_4	**IUD Insertion Training**																
A.9.6.4.1	Training of Medical Officers in IUD Insertion							2	55300		55300	55300		110600			
A.9.6.4.2	Training of ANMs / LHVs/SN in IUD Insertion							3	32362		48543	48543		97086			
A.9.6.5	Contraceptive Update																
A.9.6_6	**Other FP Training (Pl.SSpecify)**																
A.9.6.6.1	Post Partum Family Planning (With Emphasis on IUCD Insertion) Master Trainers at All 38 Districts Hospitals																
A.9.6.6.2	Training of Family Planning Counsellors																
A.9.7	ARSH Training (MOs, ANM/Nurses, Nodal Officers)																
A.9.8	**Programme Management Training**																
A.9.8.1	SPMU Training																
A.9.8.2	DPMU Training							1	40000		20000	20000		40000			
A.9.9	**Other Training (Pl. Specify)**																
A.9.9.1	Continuing Medical and Nursing Education																
A.9.9.2	Post Graduate Diploma in Family Medicine for MO																
A.9.9.3	DNB in Family Medicine for MO																
A.9.9.4	PGD in Public Health Management for MO (IIPH)																
A.9.9.5	PGD in Public Health Management for Health and Management Personnel (IIPH at SIHFW)																
A.9_10	**Training (Nursing)**																
A.9.10.1	Strengthening of Existing Training Institutions/																

	Nursing School																
A.9.10.2	New Training Institutions/ School																
A.9_11	**Training (Other Health Personnel)**																
A.9.11.1	Promotional Training of Health Workers Females to Lady Health Visitor Etc.																
A.9.11.2	Training of ANMs, Staff Nurses, AWW, AWS																
A.9_11_3	**Other Training and Capacity Building Programmes**																
A.9.11.3.1	Training of Faculty / Post Basic B.Sc / Basic B.Sc																
A.9.11.3.2	Community Visit for Students & Teachers																
A	RCH Flexipool																
	Total Training									**425745**	**4024180**	**4060990**	**425745**	**9073406**			
A_10	**PROGRAMME / NRHM MANAGEMENT COSTS**																
A.10.1	**Strengthening of SHS/ SPMU (Including HR, Management Cost, Mobility Support, Field Visits)**																
A.10.1.1	Liability on Current Staff at Prevailing Salary																
	Supervisory post							393	20000	1965000	1965000	1965000	1965000	7860000			
	4th Grade							72	10000	180000	180000	180000	180000	720000			
	Doctor for APHC Level & PHC Level							64	30000	480000	480000	480000	480000	1920000			
A.10.1.2	Additional Manpower Under SHSB																
A.10.1.3	State Monitoring Cell for Blood Banks/BSUs																
A.10.1.4	Provision of Equipment/furniture and Mobility Support for SPMU Staff																
A.10.1.5	Mobility Support (District Malaria Office)							1	180000	45000	45000	45000	45000	180000			
A.10.1.6	Strengthening of Directorate																
A.10.1.7	Liability on Various New Posts Approved																

	in PIP 2010-11, Already Advertised and Shortlisting Underway																
A.10.2	**Strengthening of DHS/ DPMU (Including HR, Management Cost, Mobility Support, Field Visits)**																
A.10.2.1	Contractual Staff for DPMU Recruited and in Position																
	DPM Salary							1	514776	128694	128694	128694	128694	514776			
	DAM Salary							1	431244	107811	107811	107811	107811	431244			
	M&E Salary							1	359364	89841	89841	89841	89841	359364			
	DPC Salary							1	264000	66000	66000	66000	66000	264000			
	Data Operator Salary for DPC							1	120000	30000	30000	30000	30000	120000			
	Office Assistant Salary							2	120000	60000	60000	60000	60000	240000			
	Data Operator Salary							2	120000	60000	60000	60000	60000	240000			
	Laptop for DPC							1	35000	35000	0	0	0	35000			
	Mobile Recharge for DPC							1	6000	1500	1500	1500	1500	6000			
	Night Gurd for DHS Office							2	60000	30000	30000	30000	30000	120000			
	Puen for DHS Office							2	60000	30000	30000	30000	30000	120000			
	Office Exp.							1	360000	90000	90000	90000	90000	360000			
A.10.2.2	Provision of Equipment/furniture and Mobility Support for DPMU Staff							1	1084600	271150	271150	271150	271150	1084600			
A.10.3	Strengthening of Block PMU							14	516160	1806560	1806560	1806560	1806560	7226240			
A.10.4	**Strengthening (Others)**																
A.10.4.1	Tally Purchase for DAM																
A.10.4.1	Tally Purchase for FRU							2	17100		34200			34200			
A.10.4.1	Computer Purchase for 2 FRU & 1 Sadar Block							3	50000		150000			150000			
A.10.4.2	Renewal (Upgradtion)							1	8910		8910			8910			
A.10.4.3	AMC (State, Regional & DHS)							1	24750	24750				24750			
A.10.4.4.	AMC (Block Level)																
A.10.4.5	Training on Tally							1	25000			25000		25000			
A.10.4.6	Training in Accounting Procedures																
A.10.4.7	Capacity Building & Exposure Visit of Account Staff																
A.10.4.8	Regional Programme Management Unit																
A.10.4.9	Management Unit at FRU (							4	42500	42500	42500	42500	42500	170000			

	Hospital Manager & FRU Accountant)																
A.10.5	**Audit Fees**																
A.10.5.1	Annual Audit of the Programme (Statutory Audit)							18	9000	40500	40500	40500	40500	162000			
A.10.5.2	Internal Auditor																
A.10.5.3	TA for Internal Auditor																
A.10.5.4	Training of Internal Audit Wing																
A.10.6	Concurrent Audit (State & District)							1	240000	60000	60000	60000	60000	240000			
A.10.7	Mobility Support to BMO/ MO/ Others																
Total Management Cost										**5644306**	**5777666**	**5609556**	**5584556**	**22616084**			

TOTAL NRHM Part-A										**46477517**	**49446070**	**51265596**	**45051209**	**192377139**	**22000000**		

Note:- As per direction given by the Chairman Cum DM, Nawada to provide Medical assistance to each and every human beings. It is must to monitor wether Medical Officer is available or not in their respective Health Center. For this we must have a provision in next year (FY 2012-13) financial budget for 24x7 help line services with toll free no. in DHS.

	To Start Help Line services following are required:-																
	1. Telephone Connection with Internet Connection							1	5000	15000	15000	15000	15000	60000			
	2. Toll Free Connection							2	5000	30000	30000	30000	30000	120000			
	3. Staff (DEO)							3	10000	90000	90000	90000	90000	360000			
	4. Computer Set (Fixed Cost)							1	45000	45000				45000			
	5. Help Line Room (Fixed Cost)							1	60000	60000				60000			
Total:-										**240000**	**135000**	**135000**	**135000**	**645000**			

NRHM Part-B

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
B	**Mission Flexible Pool**															
B.1	**ASHA**															
B.1.1	**ASHA COST**															
B.1.1.1	Selection & Training of ASHA							1959	5086		9962821			9962821		
B.1.1.2	Procurement of ASHA Drug Kit							1959	275		538725			538725		

	& Replenishment															
B.1.1.3	Other Incentive to ASHAs (TA/DA for ASHA Divas)							1959	1236	605331	605331	605331	605331	2421324		
B.1_1.4	**Awards to ASHA's/Link Workers**															
B.1.1.4.A	Best Performance Award to ASHAs at District Level							1959				32200		32200		
B.1.1.4.B	Rechargeable Torch to ASHA															
	Miobility Exp. For BCM							14	96000	336000	336000	336000	336000	1344000		
	Miobility Exp. For DCM							1	312000	78000	78000	78000	78000	312000		
	Laptop for DCM							1	45000		45000			45000		
	Radio for ASHA							1959	700		1371300			1371300		
B.1.1.4.C	Identity Card to ASHA							1959	25			48975		48975		
B.1.1.5	ASHA Resource Centre/ASHA Mentoring Group							111		1039543	1039543	1039543	1039543	4158170		
Total ASHA										**2058874**	**13976720**	**2140049**	**2058874**	**20234515**		
B.2	**Untied Funds**															
B.2.1	Untied Fund for SDH/CHC							1	50000	50000	0	0	0	50000		
B.2.2.A	Untied Fund for PHCs							14	25000	87500	87500	87500	87500	350000		
B.2.2.B	Untied Fund for APHC							53	25000	331250	331250	331250	331250	1325000		
B.2.3	Untied Fund for Sub Centres							327	10000	817500	817500	817500	817500	3270000		
B.2.4	Untied Fund for VHSC							956	10000	2390000	2390000	2390000	2390000	9560000		
Total Untied Fund										**3676250**	**3626250**	**3626250**	**3626250**	**14555000**		
B.3	**Annual Maintenance Grants**															
B.3.1.A	SDH							1	110000		110000			110000		
B.3.1	CHCs							2	110000	55000	55000	55000	55000	220000		
B.3.2.A	APHC							32	50000	400000	400000	400000	400000	1600000		
B.3.2	PHCs							14	55000	192500	192500	192500	192500	770000		
B.3.3	Sub Centres							169	10000	422500	422500	422500	422500	1690000		
Total Annual Maintenance										**1070000**	**1180000**	**1070000**	**1070000**	**4390000**		
B.4	**Hospital Strengthening**															
B4.1	**Up Gradation of CHCs, PHCs, Dist. Hospitals to IPHS)**															
B.4.1.1	**District Hospitals**															
B.4.1.1.A	Construction of SNCU in District Hospitals							1	6430000	3215000	3215000			6430000		
B.4.1.1.B	Up Gradation of 05 DHs by Increase Number of Beds 900							1	500000	250000	250000			500000		

B.4.1.2	CHCs (Hospital Strengthening)															
B.4.1.3	PHCs (Construction of 3 Doctors & 4 Staff Nurse Quarters in 38 PHCs)\															
B.4.1.4	Sub Centres(Hospital Strengthening)															
B.4.1.5	Others (Up Gradation of 2 Health Facilities (Rajendra Nagar) Eye Hospital & Lok Nayak Jay Prakash Narayan Hospital) Into Super Speciality As Per IPHS															
B4.2.A	Installation of Solar Water System in 25 SDH, 10 RH and 150 PHC							8	42350		169400	169400		338800		
B4.2.B	Accreditation / ISO : 9000 Certification of 90 Health Facilities (15 DH+15 SDH+ 10 RH+ 50 PHC)															
B4.2	Strengthening of Districts, Sub-Divisional Hospitals, CHCs, PHCs															
B.4.3	Sub Centre Rent and Contingencies							169	6600	278850	278850	278850	278850	1115400		
B.4.4	Logistics Management/ Improvement (G2P Bihar Health Operations Payment Engine HOPE)															
	Total Hospital Strengthening									**3743850**	**3913250**	**448250**	**278850**	**8384200**		
B.5	**New Constructions/ Renovation and Setting Up**															
B.5.1	**CHC**															
B.5.1	CHC															
B5.2	**PHCs**															
B5.2.A	Construction of APHC (PHC)							35	7599000	66491250	66491250	66491250	66491250	265965000		
B5.2.B	Construction of Residential Quarters for Doctors & Staff Nurses in 38 Old APHC							14	7720000	27020000	27020000	27020000	27020000	108080000		
	Construction of Residential Quarters for Staff Nurses in PHC Level							14	8118500	28414750	28414750	28414750	28414750	113659000		
	Construction of Boundry wall & Main Gate in							10	1000000	2500000	2500000	2500000	2500000	10000000		

	PHC															
B5.2.C	Strengthening of Cold Chain (Refurbishment of Existing Cold Chain Room for District Stores and Earthing and Wiring of Existing Cold Chain Rooms in All PHCs							1	880000	220000	220000	220000	220000	880000		
B5.3	SHCs/Sub Centres							50	2000000	25000000	25000000	25000000	25000000	100000000		
B5.4	Setting Up Infrastructure Wing for Civil Works (9 Executive Eng, 38 Asst. Eng & 76 JE Under Bihar Medical Services and Infrastructure Corporation Ltd)															
B5.5	Govt. Dispensaries/ Others Renovations															
B5.6	Construction of BHO, Facility Improvement, Civil Work, BemOC and CemOC Centers\															
B.5.7	Major Civil Works for Operationalisation of FRUS															
B.5.8	Major Civil Works for Operationalisation of 24 Hour Services at PHCs															
B.5.9	Civil Works for Operationalising Infection Management & Environment Plan at Health Facilities															
B_5_10	**Infrastructure of Training Institutions**															
B.5.10.1	Strengthening of Existing Training Institutions/Nursing School(Other Than HR)- Strengthening of Nursing Education- at IGIMS Bihar															
B.5.10.2	New Training Institutions/School(Other Than HR)															
Total New Construction/Renovation and setting up										**149646000**	**149646000**	**149646000**	**149646000**	**598584000**		
B.6	**Corpus Grants**															

	to HMS/RKS															
B6.1	District Hospitals							1	550000	137500	137500	137500	137500	550000		
B6.2	CHCs (SDH)							3	110000	82500	82500	82500	82500	330000		
B6.3	PHCs - RKS							14	110000	385000	385000	385000	385000	1540000		
B6.4	Other (APHC)							32	110000	880000	880000	880000	880000	3520000		
	Total HMS/RKS								**880000**	**1485000**	**1485000**	**1485000**	**1485000**	**5940000**		
B.7	**District Action Plans (Including Block, Village)**															
B.7	District Action Plans (Including Block, Village)							175	363000		63525000			63525000		
B.8	**Panchayati Raj Initiative**															
B8.1	Constitution and Orientation of Community Leader & of VHSC,SHC,PHC, CHC Etc							956	11200	2676800	2676800	2676800	2676800	10707200		
B.8.2	Orientation Workshops, Trainings and Capacity Building of PRI at State/Dist. Health Societies, CHC,PHC							201	677		34004	102011		136015		
B.8.3	Others State Level Activities (IEC+Monitoring+Need Based Training for VHSC Members in 5 CBPM Focus Districts)															
	Total DAP+Panchayati Raj									**2676800**	**66235804**	**2778811**	**2676800**	**74368215**		
B.9	**Mainstreaming of AYUSH**															
B.9.1	**Medical Officers at DH/CHCs/ PHCs (Only AYUSH)**							38	240000	2280000	2280000	2280000	2280000	9120000		
B.9.1.A	AYUSH Specialists															
B.9.1	Medical Officers at DH/CHCs/ PHCs (Only AYUSH)															
B.9.2	Other Staff Nurse/ Supervisory Nurses (for AYUSH)															
B_9.3	**Activities Other Than HR**															
B.9.3.1	Training of AYUSH Doctors & Paramedical Staffs W.R.T AYUSH Wing and Establishment of Head Quarter Cost															
	Total Ayush									**2280000**	**2280000**	**2280000**	**2280000**	**9120000**		

B_10	**IEC-BCC NRHM**															
B.10	**Strengthening of BCC/IEC Bureaus (State and District Levels)**															
B.10.1	Development of State BCC/IEC Strategy									143902	143902	143902	143902	575608		
B_10.2	**Implementation of BCC/IEC Strategy**															
B.10.2.1	BCC/IEC Activities for MH															
B.10.2.2	BCC/IEC Activities for CH															
B.10.2.3	BCC/IEC Activities for FP															
B.10.2.4	BCC/IEC Activities for ARSH															
B.10.3	Health Mela							1	4400		4400			4400		
B.10.4	Creating Awareness on Declining Sex Ratio Issue.															
B.10.5	Other Activities															
Total IEC-BCC										**143902**	**148302**	**143902**	**143902**	**580008**		
B_11	**Mobile Medical Units (Including Recurring Expenditures)**															
B_11	Mobile Medical Units (Including Recurring Expenditures)							1	4212000	1053000	1053000	1053000	1053000	4212000		
B_12	**Referral Transport**															
B.12.1	**Ambulance/ EMRI/Other Models**															
B.12.1	Ambulance/ EMRI/Other Models															
B.12.2	**Operating Cost (POL)**															
B.12.2.A	Emergency Medical Service/102-Ambulance Service															
B.12.2.B	1911- Doctor on Call & Samadhan															
B.12.2.C	Advanced Life Saving Ambulance (Call 108)							1	2288000	572000	572000	572000	572000	2288000		
B.12.2.D	Referral Transport in Districts							14	78000	300300	300300	300300	300300	1201200		
Total Referral Transport									**6578000**	**1925300**	**1925300**	**1925300**	**1925300**	**7701200**		
B_13	**PPP/ NGOs**															
B.13.1	**Non-Governmental Providers of Health Care RMPs/TBAs**															
B.13.1	Non-Governmental Providers of Health Care															

	RMPs/TBAs															
B.13.2	Public Private Partnerships															
B_13.3	**NGO Programme/ Grant in Aid to NGO**															
B.13.3.A	Setting Up of Ultra-Modern Diagnostic Centers in Regional Diagnostic Centers (RDCs) and All Government Medical College Hospitals of Bihar															
B.13.3.B	Outsourcing of Pathology and Radiology Services From PHCs to DH							12	678546	2035637	2035637	2035637	2035637	8142546	**9700000**	
B.13.3.C	Outsourcing of HR Consultancy Services															
B.13.3.D	IMEP(Bio-Waste Management)							17	85929	365198.25	365198.25	365198.25	365198.25	1460793		
Total PPP/NGO										**2400835**	**2400835**	**2400835**	**2400835**	**9603339**	**9700000**	
B_14	**Innovations**															
B.14.A	Innovations(If Any) (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls Or SABLA)\															
B.14.B	YUKTI Yojana Accreditation of Public and Private Sector for Providing Safe Abortion Services							1	1510000	377500	377500	377500	377500	1510000		
Total Innovations										**377500**	**377500**	**377500**	**377500**	**1510000**		
B_15	**Planning, Implementation and Monitoring**															
B.15.1	**Community Monitoring (Visioning Workshops at State, Dist, Block Level)**															
B15.1.1	State Level															
B15.1.2	District Level (Purchase of 830 Mobile Handsets From BSNL/By Tender Process)															
B15.1.3	Block Level															
B15.1.4	Other															
B.15.2	**Quality Assurance**															
B15.2	Quality Assurance															

B.15.3	**Monitoring and Evaluation**							1	54000	16200	10800	13500	13500	54000		for purchase a one HDD Drive
B.15.3.1	**Monitoring & Evaluation/HMIS/MCTS (State, District , Block & Divisional Data Centre)**							14	3000	10500	10500	10500	10500	42000		For supervision of HMIS at PHC Level
	Laptop for M&E Officer							1	35000	8750	8750	8750	8750	35000		
B15.3.1.A	State, District, Divisional, Block Data Centre							33	120000	990000	990000	990000	990000	3960000		Two data centre each Site
	Call Centre for District Level							3	96000	72000	72000	72000	72000	288000		
B15.3.1.B	CBPM															
B.15.3.2	**Computerization HMIS and E-Governance, E-Health (MCTS, RI Monitoring, CPSMS)**															
B.15.3.2.A	MCTS and HRIS							15	28575	85726	128589	128589	85726	428629		
B.15.3.2.B	RI Monitoring							14	10214	35750	35750	35750	35750	143000		
B.15.3.2.C	CPSMS															
B.15.3.2.D	Hospital Management System, Telemedicine and Mobile Based Monitoring															
B.15.3.3	**Other Activities (HMIS)**															
B.15.3.3.A	Strengthening of HMIS (Up-Gradation and Maintenance of Web Server of SHSB)							1	50000		50000			50000		
B15.3.3.B	Plans for HMIS Supportive Supervision and Data Validation									58520	58520	117040	58520	292600		
Total Planning Impl.										**1277446**	**1364909**	**1376129**	**1274746**	**5293229**		
B_16	**PROCUREMENT**															
B.16.1	**Procurement of Equipment**															
B.16.1.1A	Procurement of Bed, ANC Instrument and ARI Timer															
B.16.1.1	Procurement of Equipment: MH (Labour Room)							42	130519	2740899	2740899			5481798		
B 16.1.2	Procurement of Equipment : CH (SCNU- NBCC)							1	26894	13447	13447			26894		
B.16.1.3	**Procurement of Equipment: FP**															
B16.1.3.A	Procurement of Minilap Set (FP)							70	3300	115500	115500			231000		
B16.1.3.B	Procurement of NSV Kit (FP)							5	1210		6050			6050		
B16.1.3.C	Procurement of IUD Kit (FP) (PHC Level)							1	15000		15000			15000		
B16.1.4	Procurement of Equipment:															

	IMEP															
B16.1.5	**Procurement of Others**															
B16.1.5.A	Dental Chair Procurement							10	283500	1417500	1417500			2835000		
B16.1.5.B	Equipments for 6 New Blood Banks							1	139000		139000			139000		
B16.1.5.C	A.C. 1.5 Ton Window for 28 (Running Blood Banks)							1	27500	27500				27500		
B16.1.5.E	POL for Vaccine Delivery From State to District and to PHC/CHC							15	72000	0	540000	540000	0	1080000		
B 16.2	**Procurement of Drugs and Supplies**															
B16.2.1	**Drugs & Supplies for MH**															
B16.2.1.A	Parental Iron Sucrose (IV/IM) As Therapeutic Measure to Pregnant Women with Severe Anaemia							1		137500	165000	137500	110000	550000		
B.16.2.1.B	IFA Tablets for Pregnant & Lactating Mothers							100923		286964	430447	430447	286964	1434822		
B16.2.2	**Drugs & Supplies for CH**															
B.16.2.2.A	Budget for IFA Small Tablets and Syrup for Children (6 -59 Months)							313982	6	357230	464399	482261	482261	1786150		
B16.2.2.B	IMNCI Drug Kit							6240	275	429000	429000	429000	429000	1716000		
B16.2.3	Drugs & Supplies for FP															
B16.2.4	Supplies for IMEP															
B16.2.5	General Drugs & Supplies for Health Facilities							2216653	5	2645555	2645555	2645555	2645555	10582220		
Total Procurement										**8171096**	**9121797**	**4664762**	**3953780**	**25911435**		
B_17	**Regional Drugs Warehouses (PROMIS to Be Established and Implemented in District Drug Warehouse)**															
B.17	Regional Drugs Warehouses (PROMIS to Be Established and Implemented in District Drug Warehouse)															
B_18	**New Initiatives/ Strategic Interventions (As Per State Health Policy)/ Innovation/ Projects**															

	(Telemedicine, Hepatitis, Mental Health, Nutrition Programme for Pregnant Women, Neonatal) NRHM Helpline) As Per Need (Block/ District Action Plans)															
B.18	New Initiatives/ Strategic Interventions (As Per State Health Policy)/ Innovation/ Projects (Telemedicine, Hepatitis, Mental Health, Nutrition Programme for Pregnant Women, Neonatal) NRHM Helpline) As Per Need (Block/ District Action Plans)															
B_19	**Health Insurance Scheme**															
B.19	Health Insurance Scheme															
B_20	**Research, Studies, Analysis (Research Study to Be Conducted on Assessment of New Initiative Taken for Enhancing R.I. Coverage)**															
B.20	Research, Studies, Analysis (Research Study to Be Conducted on Assessment of New Initiative Taken for Enhancing R.I. Coverage)															
B_21	**State Level Health Resource Centre(SHSRC)**															
B_21	State Level Health Resource Centre(SHSRC)															
B_22	**Support Services**															
B.22.1	Support Strengthening NPCB															
B.22.2	Support Strengthening Midwifery Services Under															

	Medical Services															
B.22.3	Support Strengthening NVBDCP															
B.22.4	Support Strengthening RNTCP							9	19800	44550	44550	44550	44550	178200		
B.22.5	Contingency Support to Govt. Dispensaries															
B.22.6	Other NDCP Support Programmes															
B_23	**Other Expenditures (Power Backup, Convergence Etc)-**															
B.23.A	Payment of Monthly Bill to BSNL							17	3746	12735	25469	25469		63674		
Total RNTCP+BSNL										**57285**	**70019**	**70019**	**44550**	**241874**		

Total NRHM Part-B										**180990136**	**257751685**	**174432807**	**173242386**	**786417015**	**9700000**	

NRMH Part-C

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
C	**Routine Immunisation & PP**															
C.1	**Routine Immunisation**															
C.1.A	RI Strengthening Project (Review Meeting, Mobility Support, Outreach Services Etc							1	360000	90000	90000	90000	90000	360000		
C.1.C	Printing & Dissemination of Imm format, tally sheets, monitoring forms etc.							76441	6	105107	105107	105107	105107	420427		
C.1.E	Quarterly review meeting exclusive for RI at District Level							4	7700	7700	7700	7700	7700	30800		
C.1.F	Quarterly review meeting exclusive for RI at Block Level							4	161618	161618	161618	161618	161618	646470		
C.1.G	Focus on Slum & underserved areas in Urban areas/Alternate Vaccinator for slums							744	369	68640	68640	68640	68640	274560		

C.1.H	Mobilization of Children though Asha under Muskan Ek Abhiyan							27456	17	115524	115524	115524	115524	462096		
C.1.i	Alternative vaccine delivery in hard to reach areas							44	1320	14520	14520	14520	14520	58080		
C.1.J	Alternative vaccine delivery on other areas							2350	660	387750	387750	387750	387750	1551000		
C.1.K	To Devlop microplan at Sub Center Level							290	226		65400			65400		
C.1.L	For Consolidation of microplan at Block Level							14	1257		17600			17600		
C.1.M	POL for Vaccine & Logistic delivery form State to District & PHC/CHCs							14	7684	26895	26895	26895	26895	107580		
C.1.N	Consumbles for computer including internet access									1320	1320	1320	1320	5280		
C.1.o & p	Red/Black Plastic Bags							2305	30	17205	17205	17205	17205	68818		
C.1.r	Alternate Vaccinator hiring for access compromised areas, POL & Generator for Cold Chain and For Serious AEFI case							20	14685	73425	73425	73425	73425	293700		
C.2.b	Computer Assistant support of Distict Level							1	120000	30000	30000	30000	30000	120000		
C.3.a	District Level Orientation training including Hep-B./Measles, JE for 2 days ANM, MHW, LHV & ors staff etc.							441	1693	186698	186698	186698	186698	746790		
C.3.d	One day Cold Chain handlers training for block level							14	1292	4522	4522	4522	4522	18090		
C.3.e	One day Data handlers training for block level							14	1292	4522	4522	4522	4522	18090		
C.4	Cold Chain Maintenance									26675	26675	26675	26675	106700		
Total Part-C										**1322120**	**1405120**	**1322120**	**1322120**	**5371480**		

Total NRHM Part-C										**1322120**	**1405120**	**1322120**	**1322120**	**5371480**		

NRHM Part-D

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/ Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
D	IDD									5225	5225	5225	5225	20900		
Total IDD										**5225**	**5225**	**5225**	**5225**	**20900**		
Total NRHM Part-D										**5225**	**5225**	**5225**	**5225**	**20900**		

NRHM Part-E

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/ Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
E	IDSP									234850	234850	234850	234850	939400		
	Salary for Epedemologist							1	148800	37200	37200	37200	37200	148800		
	Salary for Data Manager							1	66960	16740	16740	16740	16740	66960		
	Salary for Data Entry Operator							1	42160	10540	10540	10540	10540	42160		
	Office Exp.							1	240000	60000	60000	60000	60000	240000		
	for Lab. Construction							1	400000	100000	100000	100000	100000	400000		
Total IDSP										**459330**	**459330**	**459330**	**459330**	**1837320**		
Total NRHM Part-E										**459330**	**459330**	**459330**	**459330**	**1837320**		

NRHM Part-F

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline /Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
F.1.1	**Malaria**															
F.1.1.A	MPW (F)															
F.1.1.B	ASHA Honorarium										291506	340090	340090	971685		
F.1.1.C	Operational Cost															
F.1.1.D	Monitoring , Evaluation & Supervision & Epidemic Preparedness Including Mobility										52800	35200		88000		
F.1.1.E	IEC/BCC									24750	24750			49500		
F.1.1.F	PPP / NGO Activities															
F.1.1.G	Training / Capacity Building															
F.1.1.H	Any Other Activities (Pl. Specify)															
	Total Malaria									**24,750**	**3,69,056**	**3,75,290**	**3,40,090**	**11,09,185**		
F.1.2	**Dengue & Chikungunya**															
F.1.2.A (I)	Apex Referral Labs Recurrent															
F.1.2.A.(Ii)	Sentinel Surveillance Hospital Recurrent															
F.1.2.A	Strengthening Surveillance (As Per GOI Approval)															
F.1.2.B	Test Kits (Nos.) to Be Supplied by GoI (Kindly Indicate Numbers of ELISA Based NS1 Kit and Mac ELISA Kits Required Separately)															
F.1.2.C	Monitoring/Supervision and Rapid Response															
F.1.2	Dengue & Chikungunya															
F.1.2.D	Epidemic Preparedness															
F.1.2.E	IEC/BCC/Social Mobilization															
F.1.2.F	Training/Workshop															
F.1.3	**Acute Encephalitis Syndrome (AES)/ Japanese Encephalitis (JE)**															
F.1.3	Acute Encephalitis Syndrome (AES)/ Japanese Encephalitis (JE)															
F.1.3.A	Strengthening of Sentinel Sites Which Will Include Diagnostics and Management. Supply															

	of Kits by GoI															
F.1.3.B	IEC/BCC Specific to J.E. in Endemic Areas															
F.1.3.C	Training Specific for J.E. Prevention and Management															
F.1.3.D	Monitoring and Supervision															
F.1.3.E	Procurement of Insecticides (Technical Malathion)															
F.1.4	**Lymphatic Filariasis**															
F.1.4.A	State Task Force, State Technical Advisory Committee Meeting, Printing of Forms/registers, Mobility Support, District Coordination Meeting, Sensitization of Media Etc., Morbidity Management, Monitoring & Supervision and Mobility Support for Rapid Response Team										128207			128207		
F.1.4.B	Microfilaria Survey										53900			53900		
F.1.4.C	Post MDA Assessment by Medical Colleges (Govt. & Private)/ ICMR Institutions.										11000			11000		
F.1.4.D	Training/sensitization of District Level Officers on ELF and Drug Distributors Including Peripheral Health Workers										343585			343585		
F.1.4.E	Specific IEC/BCC at State, District, PHC, Sub-Centre and Village Level Including VHSC/GKS for Community Mobilization Efforts to Realize the Desired Drug Compliance of 85% During MDA										247500			247500		
F.1.4.F	Honorarium to Drug Distributors Including ASHA and Supervisors Involved in MDA										527470			527470		
F.1.4	Lymphatic Filariasis															
Total Filaria											**1311662**			**1311662**		
F.1.5	**Kala-Azar**															
F.1.5	KALA-AZAR										11825			11825		
F.2	**Externally Aided Component (EAC)**															
F.2.A	World Bank Support for Malaria										11825			11825		
F.2.B	Human Resource															

F.2.C	Training /Capacity Building															
F.2.D	Mobility Support for Monitoring Supervision & Evaluation & Review Meetings, Reporting Format (for Printing Formats)															
F.3	**GFATM Project**															
F .3	GFATM PROJECT															
F.4	**Any Other Item (Please Specify)**															
F.4	Any Other Item (Please Specify)															
F.5	**Operational Costs (Mobility, Review Meeting,Communication,Formats & Reports)**															
F.5	Operational Costs (Mobility, Review Meeting,Communication,Formats & Reports)															
F.6	**Cash Grant for Decentralized Commodities**															
F.6.A	Chloroquine Phosphate Tablets															
F.6.B	Primaquine Tablets 2.5 Mg															
F.6.C	Primaquine Tablets 7.5 Mg															
F.6.D	Quinine Sulphate Tablets															
F.6.E	Quinine Injections															
F.6.F	DEC 100 Mg Tablets															
F.6.G	Albendazole 400 Mg Tablets															
F.6.H	Dengue NS1 Antigen Kit															
F.6.I	Temephos, Bti (for Polluted & Non Polluted Water)															
F.6.J	Pyrethrum Extract 2%															
F.6.K	Any Other (Pl. Specify)															
Total Kala-Azar											**23650**			**23650**		

Total NRHM Part-F									**24,750**	**17,04,368**	**3,75,290**	**3,40,090**	**24,44,497**			

NRHM Part-G

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
G	**NLEP**															
G.1	**NLEP**															
G.10	NGO-SET Scheme															
G.11	Supervision, Monitoring & Review															
G.12	Specific-Plan for High Endemic Districts															
G.13	Others (Maintenance of Vertical Unit, Training & TA/DA of Vertical Staff)															
G.1	Contractual Services							1		14850	14850	14850	14850	59400		
G.2	Services Through ASHA							14		5775	5775	5775	5775	23100		
G.2.2	Honorarium of Asha								220000	55000	55000	55000	55000	220000		
G.3.1	DLS									4950	4950	4950	4950	19800		
G.3.2	Office Expenses & Consumables									3850	3850	3850	3850	15400		
G.4.1	2 days moduler training of new entrant MO							1		5067	5067	5067	5067	20268		
G.4.2	1 days orientation training of supervisor, HW, AMN, LHVs & Pharmasists							2		126000	126000	126000	126000	504000		
G.5.1	School Quiz									13475	13475	13475	13475	53900		
G.5.2	Health Mela											4400		4400		
G.5.3	Wall Writing									5390	5390	5390	5390	21560		
G.5.4	Celebration of Leprosy Day in District									11000				11000		
G.6	POL/Vehicle Operation & Hiring									2063	2063	2063	2063	8250		
G.7.2	Aids & appliances									240000				240000		
G.8.1	Supprotive Medicines									50000				50000		
G.8.2	Laboratory regents & equipment									13200				13200		
G.9	Urban Leprosy Control									28500	28500	28500	28500	114000		
Total Leprosy										**579119**	**264919**	**269319**	**264919**	**1378278**		

Total NRHM Part-G										**579119**	**264919**	**269319**	**264919**	**1378278**		

NRHM Part-H

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
H	**NPCB (Blindness)**															
H.1	**Recurring Grant-in Aid**															
H.1.1	For Free Cataract Operation and Other Approved Schemes As Per Financial Norms							4000		449010	898019	449010		1796038		
H.1.2	Other Eye Diseases															
H.1.3	School Eye Screening Programme										110000	110000		220000		
H.1.4.A	Private Practitioners As Per NGO Norms															
H.1.4	Blindness Survey															
H.1.5	Management of State Health Society and Distt. Health Society Remuneration(Salary/ Review Meeting, Hiring Vehicles and Other Activities & Contingency)									45000	45000	45000	45000	180000		
H.1.6	Recurring GIA to Eye Donation Centres															
H.1.7	Eye Ball Collection and Eye Bank															
H.1.8	Eye Ball Collection															
H.1.9	Training PMOA															
H.1	Recurring Grant-in Aid															
H.1_10	IEC (Eye Donation Fortnight, World Sight Day & Awareness Programme in State & Districts)									25000	25000	25000	2500000	100000		
H.1_11	Procurement of Ophthalmic Equipment									12500	12500	12500	1250000	50000		
H.1_12	Maintenance of Ophthalmic Equipments										100000	100000	50000	250000		
H.1_13	Grant-in-Aid for Strengthening of 1 Distt. Hospitals.															
H.1_14	Grant-in-Aid for Strengthening of 2 Sub Divisional. Hospitals															
H.2	**Non Recurring Grant -in-Aid**															
H.2.1	For RIO (New)															

H.2.2	For Medical College															
H.2.3	For Vision Centre							5			275000			275000		
H.2.4	For Eye Bank															
H.2.5	For Eye Donation Centre															
H.2.6	For NGOs															
H.2.7	For Eye Ward & Eye OTS															
H.2.8	For Mobile Ophthalmic Units With Tele Network															
H.3	**Contractual Man Power**															
H.3.1	Ophthalmic Surgeon															
H.3.2	Ophthalmic Assistant															
H.3.3	Eye Donation Counsellors															
Total Blindness										**531510**	**1465519**	**741510**	**3845000**	**2871038**		

Total NRHM Part-H										**531510**	**1465519**	**741510**	**3845000**	**2871038**		

NRHM Part-I

Budgetary Proposal:

FMR Code	Budget Head/Name of activity	Baseline/ Current Status (as on December 2011)	Unit of measure (in words)	Physical Target (where applicable)					Unit Cost (in Rs.)	Financial Requirement (in Rs.)					Committed Fund requirement (if any in Rs.)	Responsible Agency (State/SHSB/Name of Development Partner)
				Q1	Q2	Q3	Q4	Total no of Units		Q1	Q2	Q3	Q4	Total Annual proposed budget (in Rs.)		
I	**RNTCP**															
I.1	**RNTCP**															
I.1	Civil Works									77451	51634	77451	51634	258170		
I.2	Laboratory Materials									68750	68750	68750	68750	275000		
I.3.A	Honorarium/Counselling Charges									82500	82500	82500	82500	330000		
I.4	IEC/ Publicity									11000	11000	11000	11000	44000		
I 5	Equipment Maintenance									8250	8250	8250	8250	33000		
I.6	Training (RNTCP)											63525	63525	127050		
I.7	Vehicle Maintenance									41250	41250	41250	41250	165000		
I.8	Vehicle Hiring									154275	154275	154275	154275	617100		
I.9	NGO/PPP Support									46750	46750	46750	46750	187000		
I.3.B	Incentive to DOTs Providers									37500	37500	37500	37500	150000		
I_10	Miscellaneous									88000	88000	88000	88000	352000		
I_11	Contractual Services									1330000	1330000	1330000	1330000	5320000		
I_12	Printing (RNTCP)									8250	8250	8250	8250	33000		
I_13	Research and Studies															
I_14	Medical Colleges															

I_15	Procurement –vehicles															
I_16	Procurement – Equipment															
I_17	Tribal Action Plan															
Total TB										**1953976**	**1928159**	**2017501**	**1991684**	**7891320**		

Total NRHM Part-I										**1953976**	**1928159**	**2017501**	**1991684**	**7891320**		

Total Budget - 2012-13

Name of Programme	Total Financial Requirement
NRHM Part-A	192377138.72
NRHM Part-B	786417014.60
NRHM Part-C	5371479.50
NRHM Part-D	20900.00
NRHM Part-E	1837320.00
NRHM Part-F	2444497.00
NRHM Part-G	1378277.50
NRHM Part-H	2871038.20
NRHM Part-I	7891320.00
TOTAL	1000608985.52