

District Health Society Nawada

District Health Action Plan 2009-2010



Developed & Designed

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Foreword

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

The District Health Action Plan of Nawada district has been prepared keeping this vision of mind. The DHAP aims at improving the existing physical infrastructures, enabling access to better health services through hospitals equipped with modern medical facilities, and to deliver with the help of dedicated and trained manpower. It focuses on the health care needs and requirements of rural people especially vulnerable groups such as women and children. The DHAP has been prepared keeping in mind the resources available in the district and challenges faced at the grass root level. The plan strives to bring about a synergy among the various components of the rural health sector. In the process the missing links in this comprehensive chain have been identified and the Plan will aid in addressing these concerns. The plan has attempts to bring about a convergence of various existing health programmers 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 programmers. The medical personnel and staff of DH/PHCs/APHCs/HSCs gave vital inputs which were incorporated into this document.

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

(Yogendra Bhakta)
(IAS)

District Magistrate-Cum-
Chairperson, DHS, 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. Launching Muskan- Ek Abhiyan 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 of even poor and illiterate rural women. Like wise 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, ACOMO, 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. (Smt)Savitri Sharma
Chief Medical Officer
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Introduction

1.1 Background

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

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

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

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

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

Stakeholders in Process

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

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 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

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

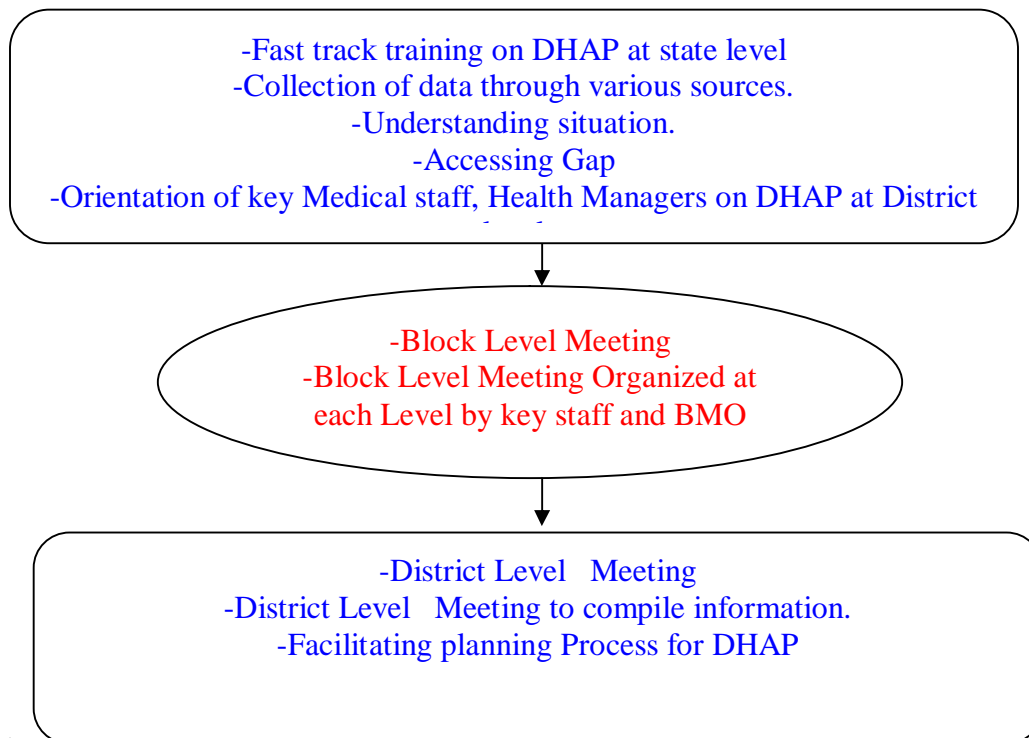
Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersectoral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the 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 Vaishali 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, ACO (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 come from participants it has added then finalized. The field staffs of the department too have played a significant role. District officials have provided technical assistance in estimation and drafting of various components of this plan.

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



DISTRICT HEALTH ACTION PLAN PLANNING PROCESS

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Chapter 2

District Profile

History

Nawada situated in the lap of magadh section of division enjoys its glorious past with historical imminence. King vahdrath had founded the magadh empire. Where so many dynasties like vahdrath, 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 fought 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.

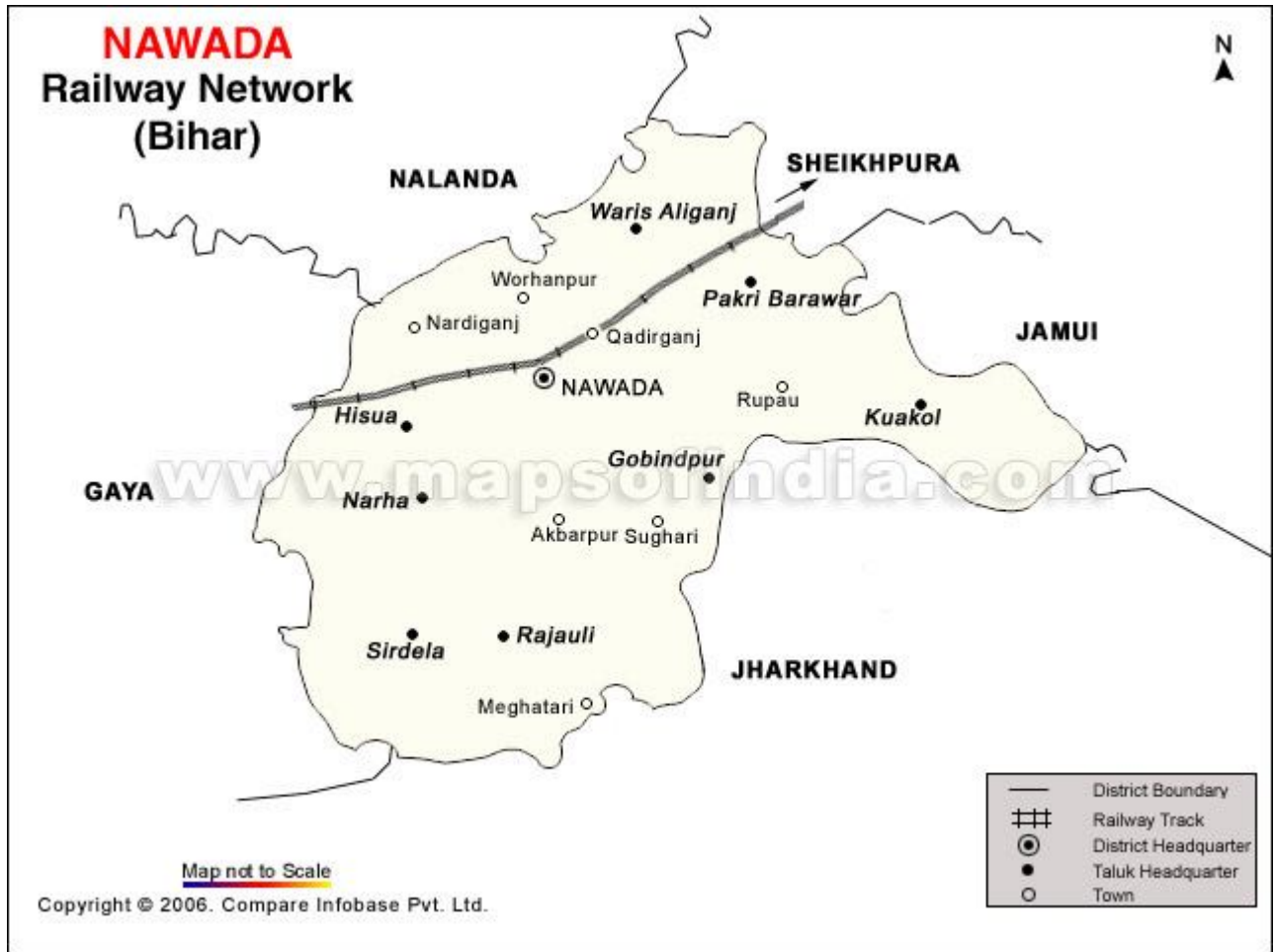
Great Lord Budha and Lord Mahavir who are regarded, as the first lights of Asia loved this place very much. The king Bimbisar was one of the most beloved disciples.

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 revealed for the first time here.

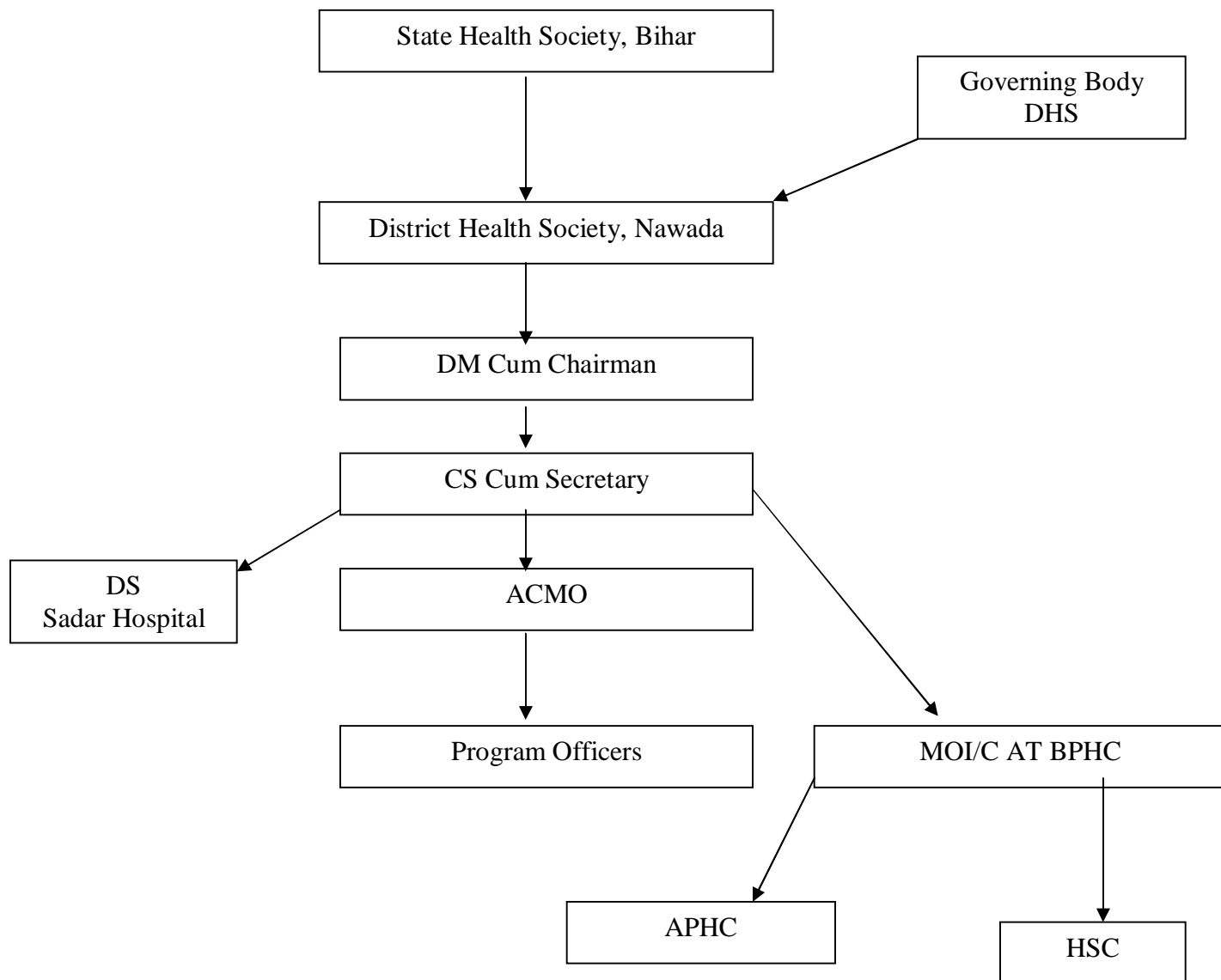
The village Dariyapur Parvati in the Nawada District situated six miles north of Warisaliganj . There are ruins and relic of Kapotika Bodh Bihar . In the centre stands a famous temple of Avalokiteshwer. King Aditaysen founded the historical monuments in the village Apsar that is visible even today. Kurkihar 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. Rajendra 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 back 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.

Nawada District Communication Map



District Health Administrative Setup



AREA (Sq. Kms) :-	2494
POPULATION(CENSUS 2001)	
TOTAL :-	1809425
MALES :-	928638
FEMALES :-	880787
RURAL POPULATION	
TOTAL :-	1670101
MALES :-	
FEMALES :-	
URBAN POPULATION	
TOTAL :-	139234
MALES :-	
FEMALES :-	
POPULATION OF SCHEDULED CASTES :-	173167
POPULATION OF SCHEDULED TRIBES :-	1911
DENSITY OF POPULATION :-	726 per sqm
SEX RATIO :-	948/1000

COMPARATIVE POPULATION DATA (2001 Census)

Basic Data	India	Bihar	Nawada
Population	1027015	828787	1809425
Density	324	880	726
Socio- Economic			
Sex- Ratio	933	921	948
Literacy % Total	65.38	47.53	47.36
Male	75.85	60.32	61.2
Female	54.16	33.57	32.6

LITERACY RATE	
TOTAL :-	47.36%
MALES :-	61.2%

FEMALES	:-	32.6%
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
<u>HEALTH</u>		
DISTRICT HOSPITAL	:-	01
REFERRAL HOSPITAL	:-	02
PRIMARY HEALTH CENTRE	:-	14
ADDITIONAL PRIMARY HEALTH CENTRE	:-	24
HEALTH SUB CENTRE	:-	136
BLOOD BANK	:-	01
AIDS CONTROL SOCIETY	:-	01

2.1 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 .

2.2 Administration and Demography

Table-1

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	24
7.	No of HSCs	136
8.	No of Sub divisional hospitals	
9.	No of referral hospitals	2
10.	No of Doctors	107
11.	No of ANMs	136
12.	No of Grade A Nurse	82
13.	No of Paramedicals	82
14.	Total population	1809425
15.	Male population	928638

16.	Female population	880787
17.	Sex Ratio	948/1000
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	
24.	No. of primary schools	987
25.	No. of Anganwadi centers	1837
26.	No. of Anganwadi workers	1837
27.	No of ASHA	1671
28.	No. of electrified villages	
29.	No. of villages having access to safe drinking water	
30.	No of villages having motorable roads	

Source: Census 2001

2.3 HEALTH PROFILE

Infrastructure

2.3.1: Health Facilities in the District

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

Health Sub-centres

S.No	Block Name	Population 2009 with growth @ 2.7%	Sub-centres required Pop 5000(IPH)	Sub-centers Present	Sub-centers proposed	Further sub-centers required	Status of building		Availability of Land (Y/N)
							Owned	Rented	
1	Akbarpur	214642	43	14	23	6	3	11	
2	Govindpur	94427	19	5	8	6	2	3	Y
3	Hisua	137615	28	16	11	01	1	8	

4	Kauwakole	129187	26	12	12	2	2	3	
5	Kashichak	68400	14	13	1	0	2	11	
6	Meskaur	109211	22	8	12	2	2	6	
7	Nardiganj	123510	25	19	0	6	2	17	
8.	Narhat	108978	22	7	8	7	2	5	
9.	Pakribarawan	171938	35	9	19	7	1	1	
10.	Rajauli	159757	32	18	10	4	2	2	
11.	Roh	153729	31	9	18	1	6	3	
12.	Sadar PHC	195626	39	18	5	16	5	8	
13.	Sirdala	136369	28	9	18	1	6	3	
14.	Warisaliganj	187000	38	18	10	8	3	15	Y
	Total	1990389	402	175	155	67	39	96	

Additional Primary Health Centers (APHCs)

No	Block Name	Population 2009 with growth @ 2.7%	APHCs required (After including PHCs) (IPH)	APHCs present	APHCs proposed	APHCs required	Status of building		Availability of Land
							Own	Rented	
1	Akbarpur	214642	8	3	4	2	2	2	Y
2	Govindpur	94427	3	0	2	3	--	--	
3	Hisua	137615	5	3	2	2	1	0	
4.	Kauwakole	129187	5	2	3	3	1	2	N
5.	Kashichak	68400	3	0	3	3	--	--	--
6.	Meskaur	109211	4	1	3	3	1	0	Y
7.	Nardiganj	123510	5	3	2	2	---	--	Y
8.	Narhat	108978	4	2	2	2	1	1	Y
9.	Pakribarawan	171938	6	1	5	5	--	1	Y
10.	Rajauli	159757	6	4	2	2	--	--	--
11.	Roh	153729	5	0	5	5	--	--	--

12.	Sadar PHC	195626	5	4	1	1	---	2	-----
13.	Sirdala	136369	6	2	4	4	1	1	-----
14.	<u>Warisaliganj</u>	187000	6	3	3	3	2	1	Y
	Total	1990389	71	28	41	43	9	10	---

Primary Health Centers

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	<u>Warisaliganj</u>	187000	1	0	0
	Total	1990389	14	1	0

CHC Required

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.	<u>Warisaliganj</u>	187000	1	0	0
	Total	1990389	14	1	0

Sub-Divisional Hospital

No	Name of sub division	Population	Sub- Divisional Hospital Present	Sub- Divisional Hospital required	PHCs proposed
1.	Rajauli	977113	0	1	0
	Total	977113	0	1	0

District Hospital

No	Name of District	Population	District Hospital Present	District Hospital required	PHCs proposed
1.	Nawada	1809425	1	0	0
	Total	1809425	1	0	0

2.3.2 Human Resources and Infrastructure

Sub-centre database

No. of Sub - Center present	No. of Sub center required	Gaps in Sub centers	ANMs (R)/(C) posted formally	ANMs (R)/(C) posted required	Gaps in ANMs(R)/(c)	Building owners hip (Govt)	Required Building (Govt)	Gaps in Buildings (Govt.)	ANM residing at HSC area (Y/N)	Condition of residential facility (+++/++/+/#)	Status of furnitures	Status of Untied fund
129	402	273	253/136	402/402	uncomplete	39	367	367	y	+++	N/A	unexpensed

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

Additional Primary Health Centre (APHC) Database: Infrastructure

No	No. of AP HC present	No. of APH C required	Gaps in APH C	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	28	43	15	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

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

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 Supply: Available -A/Not available -NA, Intermittently available-I

Primary Health Centres: Human Resources

	No. of PHC	Doctors		ANM		Laboratory Technician		Pharmacist/Dresser		Nurses		Specialists		Store keeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	14													

Referral Hospital/CHC : Infrastructure

No	No. of Referral/CHC present	No. of Referral/CHC required	Gaps in Referral/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 condition +++/ Needs major repairs++/Needs minor repairs-less than Rs10,000-+/ needs new building-#; Water Supply: Available –A/Not available –NA, Intermittently available-I

	No. of /Referral/ CHC	Doctors		ANM		Laboratory Technician		Pharmacist/ Dresser		Nurses		Specialists		Storekeeper
		Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	Sanction	In Position	
1	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 than 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

2.3.3 Indicators of Reproductive Health and Reproductive Child Health

Table

Variables Description	Nawada	Bihar	India
Percentage girls marrying below legal age at marriage	65.3	51.5	
Percentage of households with low standard of living	87.1	66.3	
Percentage of households using adequate iodized salt (15ppm)	20.8	29.6	
Birth order 3 and above	51.6	54.4	
Percent women know all modern method	46.1	52.2	
Percent husbands know NSV (No scalpel vasectomy)	40.3	35.6	
Percent women/husbands using any family planning method	24.3	31	
Percent women/husbands using any modern method of family planning	21.9	27.3	
Unmet need for family planning	39.9	36.7	
Percent women received at least three visits for ANC	23.6	19.6	
Percent women received full ANC	3.3	5.4	
Percentage of Institutional delivery	31.1	23	
Percentage of delivery attended by skilled personnel	38.7	29.5	
Percentage of children (age12-23 months) received full immunization	48.9	23	
Percentage of children (age12-23 months) did not received any immunization	15.7	49.4	

Percent women aware of HIV/AIDS	23.2	28.8	
Percent husbands aware of HIV/AIDS	48.7	62.1	

Source: DLHS (2007-2008)

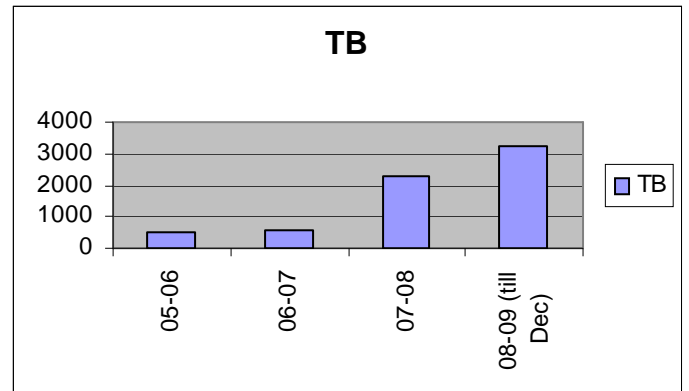
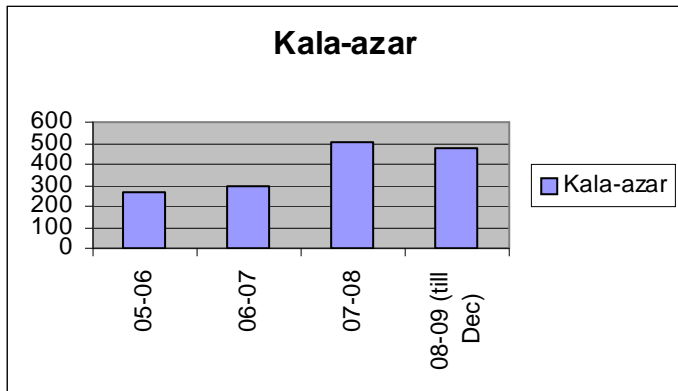
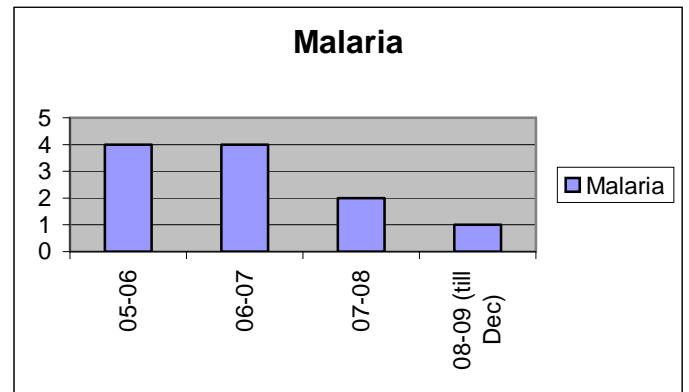
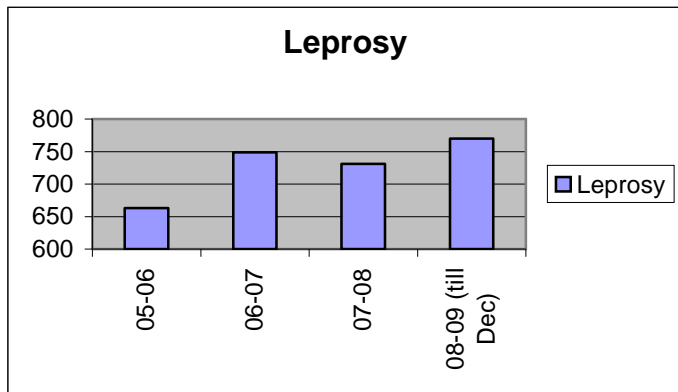
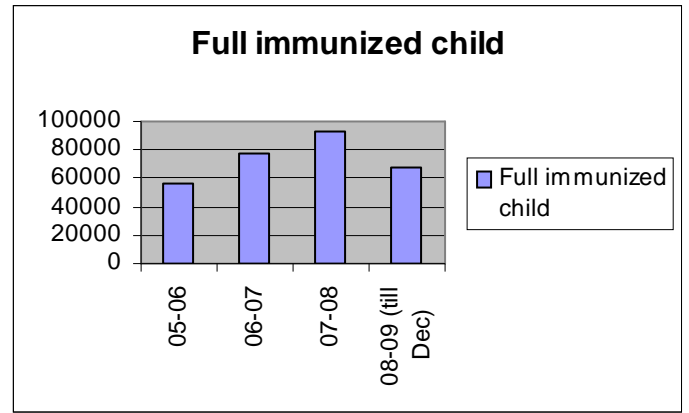
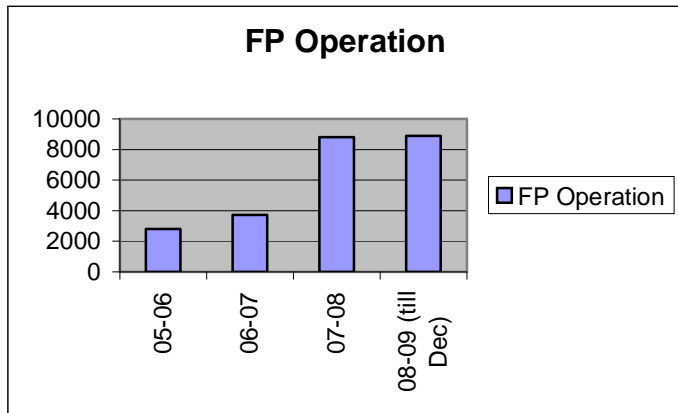
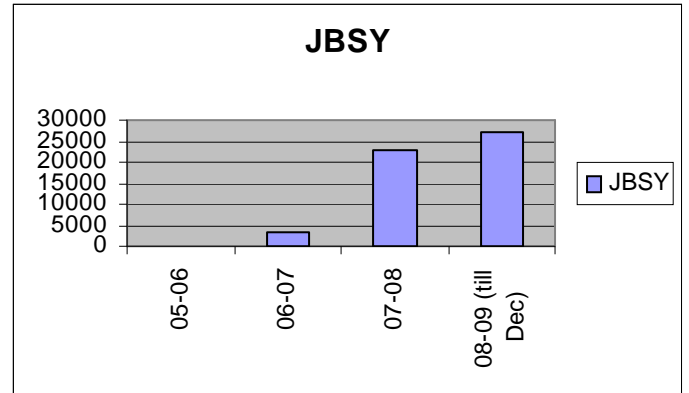
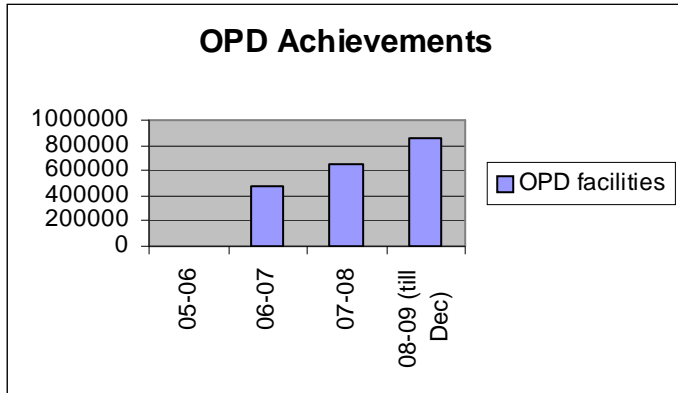
2.3.4 Achievements: STATUS OF PROGRESS IN DIFFERENT HEALTH PROGRAMS

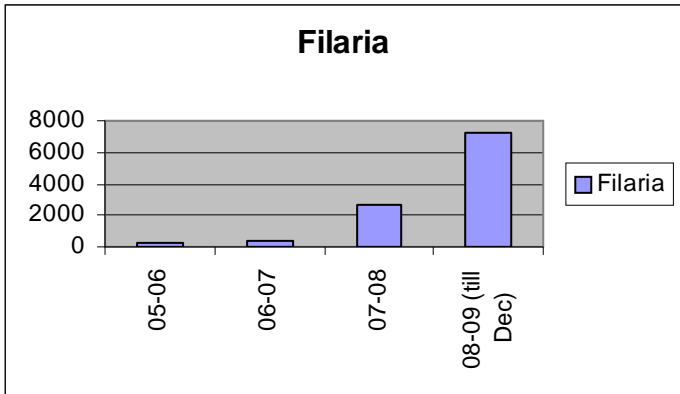
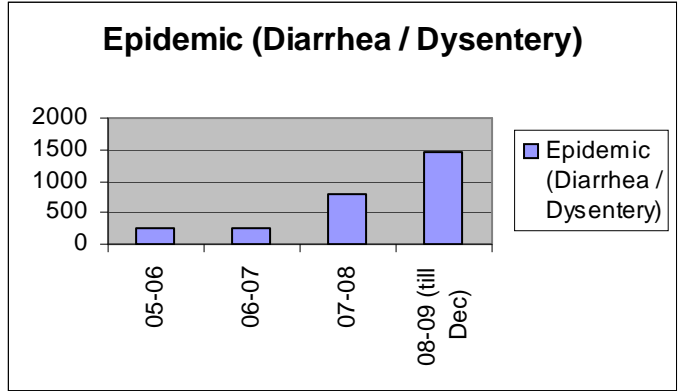
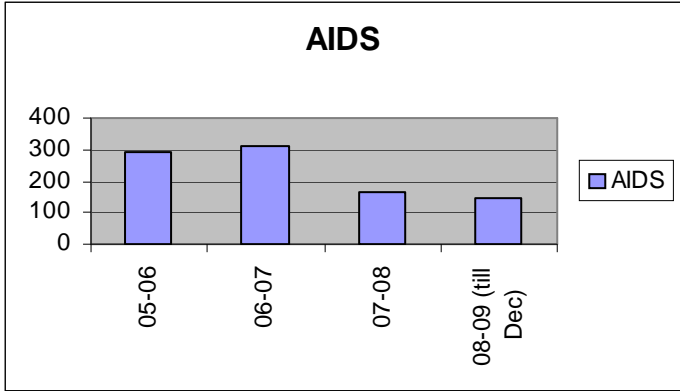
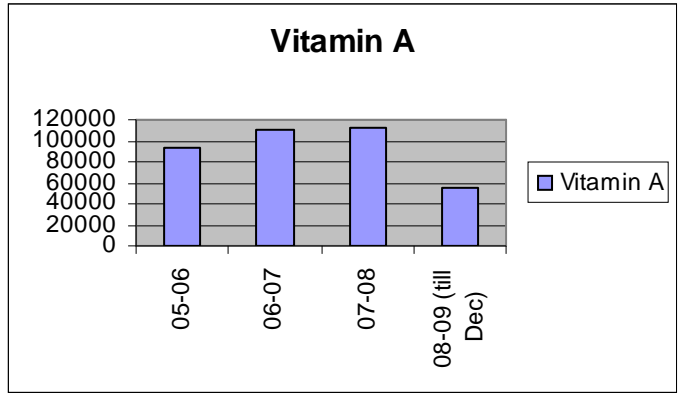
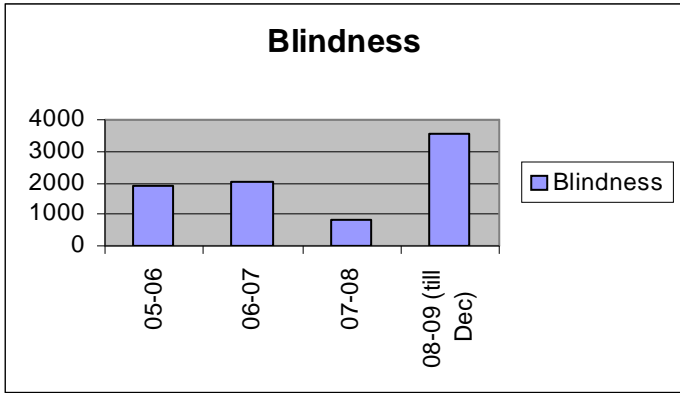
Table. Treatment provided in previous four financial years

Sl. No.	Program	2005-06	2006-07	2007-08	2008-09 (till Dec)
01.	OPD facilities	NA	469279	654921	851400
02.	JBSY	NA	3514	22639	27226
03.	FP Operation	2810	3722	8816	8888
04.	Full immunized child	55691	77683	93007	67969
05.	Leprosy	663	749	731	770
06.	Malaria	4	4	2	1
07.	Kala-azar	268	293	508	475
08.	TB	483	581	2314	3235
09.	Blindness	1926	2025	855	3582
10.	Vitamin A	93669	110424	112256	55078
11.	AIDS	289	314	165	145
12.	Epidemic (Diarrhea / Dysentery)	250	250	803	1456
13.	Filaria	315	365	2686	7194

Source: District Health Society, Nawada

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

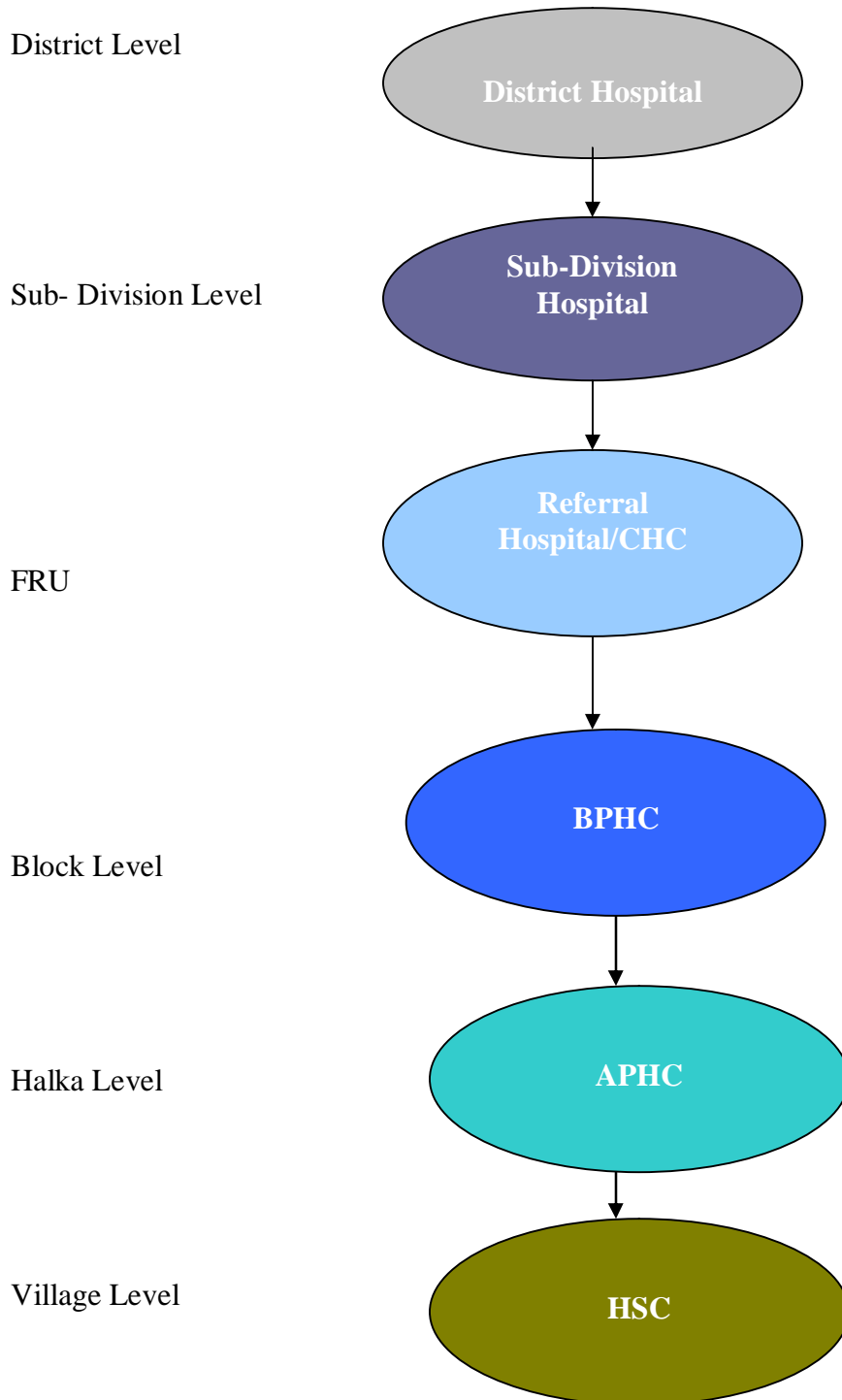




Chapter 3

Situation Analysis & Budget For HSC, APHC, BPHC & DH

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



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

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

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

3.1 Health Sub Center: Health Sub Center is the first line service deliverable institutions from where different type 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	201/129	121

To obtain 100% IPH standard -: Need to sanction 121 new HSC to achieve 100% IPH standard.

3.1.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2009-10	Budget for (2009-10)
Physical Infrastructure	The minimum covered area of a Sub Center along with residential Quarter for ANM will vary from	451 (Max. HSC as per IPHS)	39 (Already having building)	412	25% of gaps = 103	103 X 1300000 =13,390000

	73.50 to 100.20 sq meters.					
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI guideline is not prepared				
Furniture	Examination Table 1 Writing table 2 Armless chairs 3 Medicine Chest 1 Labour table 1 Wooden screen 1 Foot step 1 Coat rack 1 Bed side table 1 Stool 2 Almirahs 1 Lamp 3 Side Wooden racks 2 Fans 3 Tube light 3 Basin stand 1	1X 451 =451 2X 451 = 902 3X 451 = 1353 1X 451 = 451 1X451 =451 1X 451 = 451 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	432 HSC are sanctioned that need all these furniture. Some HSC have some furniture but worth deposable.	451	All sanctioned/established HSC i.e 330	330X 12000= 3960000 660X 8000 = 5280000 990X2000= 1980000 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	150X451= 15000X451= 13000X451= 6X451= 1000X451=	330 HSC are sanctioned that need all these drugs.	451	All sanctioned/established HSC i.e 330	

	<p>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)</p>	<p>480X451= 500X451= 10X451= 300X451 180X451= 5X451= 125X451= 120X451= 10X451=</p>				<p>Total - 5,000000 (Approx.) (To provide all listed Medicine to all working 330 HSC)</p>
Support Services						
Laboratory	<p>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</p>	<p>1X451=451 1X451=451 1X451=451</p>	<p>330 HSC are sanctioned that need all these equipments.</p>	<p>451</p>	<p>All sanctioned/established HSC i.e 330</p>	<p>Total = Total = 43,20,000 (Approx.) (To provide three listed Equipments of laboratory to all working 330HSC)</p>
Electricity	<p>Wherever facility exists, uninterrupted power supply has to be ensured for which inverter facility / solar power facility is to be provided. Solar power set</p>	<p>1X451=451</p>	<p>330 HSC are sanctioned that need Solar power sets.</p>	<p>451</p>	<p>All sanctioned/established HSC i.e 330</p>	<p>330X20000= 6600000</p>
Water	<p>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.</p>	<p>Safe water available everywhere</p>				

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 sanctioned/established HSC i.e 330	330X1500= 495000
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3.1.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2009-10	Budget 2009-10
Health worker (female)	2	2X451=902	136+195=331	571	330X2=660 32(APHC)X2=724	724X6000X12 = 52128000
Health worker (male)	1 (funded and appointment by the state government)	1X451=451	0	451	330x1=330	330X4000x12 = 15840000
Total						67968000

3.1.3 Services And others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2009-10)
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 $291 \times 500 \times 12 = 1746000$
	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.

	<p>Poor Post Natal Care</p>	<p>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.</p>	<p>Ensuring minimum 2 postpartum visit at home. Ensuring counseling on early breath feeding, on diet & rest, hygiene, contraception, essential new born care</p>	<p>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</p>	<p>No need of extra Budget. Orientation & Training program can be organized from Untied fund.</p>
	<p>Family Planning and Contraception</p>	<p>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</p>	<p>Increase No. of FP operation & promotion of the use of contraceptives</p>	<p>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.</p>	<p>No need of extra Budget. Orientation & Training program can be organized from Untied fund.</p>

	No MTP	Counseling and appropriate referral for safe abortion services (MTP) for those in need.	Start MTP Services at HSC level.	First purchase the essential equipments and drugs listed above. Training/refreshing course of suitable ANM.	Detail budget Of equipments and drugs has been given above
	RNTCP	Eradication of TB	Easy availability of drugs & referral of patients.	Referral of suspected symptomatic cases to the PHC/Microscopy center • Provision of DOTS at sub-centre and proper documentation and follow-up	Budget will be given under RNTCP head
	AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	Eradication & Control	Making people aware about these disease	IEC activities to enhance awareness and preventive measures about AIDS, Blindness, Leprosy, Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics	For IEC 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.	Vaccine is supplied from state. So, no need to prepare the budget at district level.

				<p>4. Vaccine is supplied from state that is irregular. So, ensure availability of all vaccine to increase reliability.</p> <p>5. To control drop out cases if possible new vaccine like Easy 5 and MMR should supply.</p>	
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3.1.4 Budget Summery (Health Sub Center)

2009-10

Head	Sub head	Budget	Remarks
Infrastructure	Physical Infrastructure	13,390000	For State Govt.
	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)	17,46000	
	Untide Fund	33,00000	
	IEC/BCC	16,50000	
	Total	24,9398000	

3.2 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 (2008)	Maximum APHC required as per IPH Norms @ 30,000 people	No. of APHC already sanctioned/established	Gaps in No. of APHC
2256755	76	22	54

To obtain 100% IPH standard -: Need to sanction 54 new APHC to achieve 100% IPH standard.

Task for 2009-10 -:

- Out of 54 sanctioned APHC 32 APHC are not established so far. So, in financial year 2009-10, the first priority should be given to these non-functional APHC.
- 25% of gaps i.e 14 APHC can be sanctioned more to minimize the gaps.

3.2.1 Infrastructure

Item	IPH Norms	Maximum requirement	Present Status	Gaps	Task for 2009-10	Budget for (2009-10)
Physical Infrastructure	It should be well planned with the entire necessary infrastructure. It should be well lit and ventilated with as much use of natural light and ventilation as possible. The plinth area would vary from 375 to 450	76 (Max. APHC as per IPHS)	9 (Already having building but requires renovation)	67	25% of gaps = 17	17 New building X 52,00000 = 88,400000 9 Old (renovation) X 25,00000

	sq. meters depending on whether an OT facility is opted for.					=22500000
						Total = 11,0900000
Waste Disposal	Waste disposal should be carried out as per the GOI guidelines, which is under preparation	Nothing to do because GOI guideline is not prepared				
Furniture	Examination table 3 Writing tables with table sheets 5 Plastic chairs 6 Armless chairs 8 Full steel almirah 4 Labour table 1 OT table 1 Arm board for adult and child 4 Wheel chair 1 Stretcher on trolley 1 Instrument trolley 2 Wooden screen 1 Foot step 5 Coat rack 2 Bed side table 6 Bedstead 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	Maximum APHC is 76 so requirement is accordingly	32 APHC are sanctioned that need all these furniture. Since almost all APHC are non-functional so, everywhere these furniture are required.	32	All sanctioned/established APHC i.e 32	10,00000(Apprx) per APHC Total - 10,00000 X 32 = 3,20,00000 (To provide all listed furniture to 32working APHC)

	<p>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</p>					
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Equipment	<ul style="list-style-type: none"> • 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 intubation tubes (neonatal) 	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	<p>17,50,000(Apprx) per APHC</p> <p>Total - 17,50,000 X 32 = 56,000000 (To provide all listed equipments to 32 working APHC)</p>
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	<ul style="list-style-type: none"> • 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	<p>Paracetamol Tab- 500mg per Tab. Paracetamol Syrup- 125mg/5ml- 60ml Atropine - Inj. 0.6 mg per 1ml amps Ciprofloxacin - Tab</p>	<p>Maximum APHC is 76 so requirement is accordingly</p>	<p>32 APHC are sanctioned that need all these equipments.</p>	<p>76</p>	<p>All sanctioned/established HSC i.e 32</p>	<p>Total - 8,80,00000 (Approx.) (To provide all listed Medicine to all working 32 APHC)</p>

500mg/Tab Co Trimoxazole Tab 160 + 800 mg Tab Gentamycin - Inj M.D. vial (40 mg/ml)-30ml vial Oxytocin - Inj-Amp 1 ml (5i.u./ml) 5% Dextrose 500 ml bottle B Complex Tab Gentamicin - Ear/Eye Drop 5 ml Promethazine - Inj- Amp. 2ml amps (25 mg/ml) Pentazocine Lactate Inj. Inj-Amp.- 1 ml (30 mg/ml) Diazepam - Inj-Amp. 2ml amps (5mg/ml) Cough Expectorant 100 ml pack Ampicillin 250mg Capsule Ampicillin 500mg Capsule Cetirizine 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					
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Diazepam Tablet- 5mg Chlorpheniramine Maleate - Tablet- 4mg Cephalexin) - Capsule- 250mg Metronidazole - Tablet- 200mg Ranitidine Hydrochloride - 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. Theophylline IP Combn. 25.3mg/ml Aminophylline Inj. IP 25mg/ml Adrenaline Bitrate Inj. IP 1mg/ml Methyl Ergometrine Maleate 125mg/Tablet, Injection Amoxicilline Trilhydrate IP 250mg/Capsule Amoxicilline Trilhydrate IP 250mg/Dispersible Tab. Phenoxymethyl Penicillin 130mg/ml					
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	<p>Vit K3 (Menadione Inj.) USP 100mg/ml Nalidixic Acid Tabs. 100mg/Tab Phenytoin Sodium Inj. IP 50mg/2ml Chlorpromazine Hydrochloride 25mg/ml Cephalexin /Cefprozoxin 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</p>					
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Support Services

Laboratory	<p>1. Routine urine, stool and blood tests 2. Bleeding time, clotting time, 3. Diagnosis of RTI/STDs with wet mounting, Grams stain, etc. 4. Sputum testing for tuberculosis (if designated as a microscopy center under RNTCP) 5. Blood smear examination for malarial parasite. 6. Rapid tests for pregnancy / malaria</p>	<p>Maximum APHC is 76 so requirement is accordingly</p>	<p>32 APHC are sanctioned that need all these equipments.</p>	<p>76</p>	<p>All sanctioned/established APHC i.e 32</p>	<p>Budget for Laboratory equipments has been given above.</p>
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	<p>7. RPR test for Syphilis/YAWS surveillance</p> <p>8. Rapid diagnostic tests for Typhoid (Typhi Dot)</p> <p>9. Rapid test kit for fecal contamination of water</p> <p>10. Estimation of chlorine level of water using ortho-toludine reagent</p>					
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 accordingly	32 APHC are sanctioned that need Telephone facility.	76	All sanctioned/established APHC i.e	Total 32 X 500 X 12 = 192000
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
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3.2.2 Manpower

Manpower	IPHS	Maximum manpower required	Present Manpower	Gaps	For 2009-10	Budget 2009-10
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	outsourced					
Class IV	4	4X76=252	33	407	4X55=220	220X4000X12= 52,80,000
Total						7,95,30,000

3.2.3 Services And others

Sub Heads	Gaps	Issues	Strategy	Activities	Budget (2009-10)
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 $43 \times 1200 \times 12 = 6,19,200$
	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.	$55 \times 25,000 = 13,75,000$

Services of APHC	No institutional delivery at APHC level	No services of delivery	Arrange all required resources and manpower to start institutional delivery.	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ OPD Services ▪ 24 hours emergency services ▪ Referral services ▪ In-patient services (6 beds) 	<ul style="list-style-type: none"> ▪ 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.

	<p>Maternal and Child Health Care</p>	<p>Non functional</p>	<ul style="list-style-type: none"> ▪ Antenatal care ▪ Intra-natal care ▪ Postnatal Care ▪ New Born care ▪ Care of the child 	<ul style="list-style-type: none"> ▪ 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 <p>c) Education on</p>	<p>Nothing new for these services Detail budget has been given above.</p>
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	Family Planning, Contraception & MTP	No FP operation at APHC level.	<ol style="list-style-type: none"> 1. Start FP operation 2. Distribution of contraceptives such as condoms, oral pills, emergency contraceptives. 3. IUD insertions 	<ul style="list-style-type: none"> ▪ 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.
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	RNTCP	No DOT center at APHC	Treatment and Distribution of drug.	<ul style="list-style-type: none"> ▪ All APHCs to function as DOTS Centers to deliver treatment as per RNTCP treatment guidelines through DOTS providers and treatment of common complications of TB and side effects of drugs, record and report on RNTCP activities as per guidelines. 	Budget will be given under RNTCP head
	Integrated Disease Surveillance Project (IDSP)	No IDSP	Need to start IDSP	<ul style="list-style-type: none"> ▪ 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 faecal contamination of water (Rapid test kit) and chlorination level. 	Budget for Computer operator and Stationary. $32X$ $7500X12=$ 2880000

	National Program for Control of Blindness (NPCB)	No NPCB program	Need to start NPCB Program	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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 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 	Budget will be given under District AIDS program head

				<p>District Hospital for PPTCT services.</p> <ul style="list-style-type: none"> ▪ 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. 	
	<p>Leprosy, Malaria, Kala-azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics</p>	<p>Eradication & Control</p>	<p>Making people aware about these disease and providing treatments</p>	<ul style="list-style-type: none"> ▪ 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. 	

Provisional