

National Health Policy 2001

The Way Forward

Agenda for Health Sector Reform



December 2001

Ministry of Health
Government of Pakistan

Table of Contents

Foreword

| | | |
|------------------|---|----|
| 01. | Key Features of the policy | 1 |
| 02 | Overall Vision | 1 |
| 03. | Concretizing the Vision: Ten specific area of Reforms | 2 |
| 04 | Key areas | 3 |
| Key Area No. 1: | To Reduce the Widespread Prevalence of Communicable Diseases (i.e. EPI cluster of childhood diseases, TB, Malaria, Hepatitis -B and HIV -AIDS | 3 |
| Key Area No. 2: | To Address Inadequacies in Primary/Secondary Health Care Services | 4 |
| Key Area No. 3: | To Remote Professional and Managerial Deficiencies in District Health System | 6 |
| Key Area No. 4: | To Promote Greater Gender Gender Equity in the Health Sector | 8 |
| Key Area No. 5: | To Bridge the Basic Nutrition Gaps in the Target-population i.e. children, women and vulnerable population groups | 9 |
| Key Area No. 6: | To Correct Urbal Bias in the Health Sector Implementation Modalities. | 9 |
| Key Area No. 7: | To introduce required Regulation in the Private Medical Sector | 10 |
| Key Area No. 8: | To Create Mass Awareness in Public Health Matters | 10 |
| Key Area No. 9: | To Effect Improvements in the Drug Sector with a View to Ensuring the Availability, Affordability and Quality of Drugs in the Country | 11 |
| Key Area No. 10: | Capacity Building for Health Policy Monitoring in the Ministry of Health | 12 |
| Annex-I | Projected Health Indicators | |
| Annex-II | Public Sector Expenditure on Health 1995/200 | |
| Annex-III | Three Year Planned Public Programme & Ten year Vision | |

Foreword

It is a matter of privilege for me to present the new National Health Policy 2001 of the Ministry of Health, which was endorsed by the Federal Cabinet on June 11, 2001. The new Health Policy takes forward the agenda for the health sector, espoused by the Government of Pakistan. However, the new Health Policy has adopted a focused approach by identifying ten key strategies for the health sector, which have the potential to bring about a major improvement in the delivery of health care and the overall health status of the population of Pakistan.

The new Health Policy provides an overall national vision for the Health Sector based on “Health for All” approach. Under the new Health Policy, health sector investments are being viewed a part of the Government’s Poverty Alleviation Plan; priority attention has been accorded to the primary and secondary tiers of the health sector; and good governance is seen as the basis for health sector reforms to achieve quality health care.

The key to the success of the new Health Policy lies in its implementation. This is not an easy task but is by no means impossible. The new Health Policy has outlined implementation modalities and has set targets and a time frame for each of the key areas identified that would be implemented over a 10-year period. These have to be implemented in partnership between the federal Ministry of Health and the provincial Departments of Health, and in close collaboration with the district health set-up under the Local Government structure. The private health sector would also be taken on board while implementing the key policy initiatives.

The support provided by the provincial Department of Health in the formulation of the policy has been praiseworthy. The Multi-donor Support Unit, Social Action Program, provided valuable technical assistance in the preparation of the new Health Policy. I am happy to present this document to the public at large.

**Dr. Abdul Malik Kasi,
Federal Ministry of Health
Government of Pakistan
Islamabad**

June 12, 2001

NATIONAL HEALTH POLICY, 2001

Ministry of Health Government of Pakistan

1. KEY FEATURES OF THE POLICY

The new policy has the following key features

- 1.1 Health sector investments are viewed as part of Government's Poverty Alleviation Plan;
- 1.2 Priority attention is accorded to primary and secondary sectors of health to replace the earlier concentration on Tertiary Care;
- 1.3 Good governance is seen as the basis of health sector reform to achieve quality health care.

2. Overall Vision.

- 2.1 The overall national vision for the health sector is based on "Health-For-All" approach. The new health policy aims to implement the strategy of protecting people against hazardous diseases; of promoting public health; and of upgrading curative care facilities.
- 2.2 A series of measures, programmes and projects have been identified as the means for enhancing equity, efficiency and effectiveness in the health sector through focused interventions.
- 2.3 The present policy document is a blueprint of planned improvements in the overall national health scenario. It will require commensurate investments and interventions by the Provincial Governments for improving health infrastructure and healthcare services. The Federal Government will continue to play a supportive and coordinative role in key areas like communicable disease control programmes.

3. Concretizing the vision: 10 Specific Areas of Reforms

3.1 In order to concretize the above vision, 10 specific areas have been identified.

These are:

- 3.1.1 Reducing widespread prevalence of communicable diseases;
- 3.1.2 Addressing inadequacies in primary/secondary health care services;
- 3.1.3 Removing professional/managerial deficiencies in the District Health System;
- 3.1.4 Promoting greater gender equity;
- 3.1.5 Bridging basic nutrition gaps in the target-population;
- 3.1.6 Correcting urban bias in health sector;
- 3.1.7 Introducing required regulation in private medical sector;
- 3.1.8 Creating Mass Awareness in Public Health matters;
- 3.1.9 Effecting Improvements in the Drug Sector;
- 3.1.10 Capacity-building for Health Policy Monitoring.

3.2 In each of these areas, strategic objectives have been identified and implementation modalities determined. The new health policy has developed a clear view of what is required to be done in key areas, and the measures to be taken to achieve the envisioned goals. The succeeding paragraphs will spell out both the strategy and the implementation modalities in tandem. The policy also incorporates essential aspects like an appropriate time frame for implementation and indication of targets wherever possible.

3.3 The National Health Policy, 2001 will act as a collective frame work and provide guidelines to the Provinces while implementing plans in the health sector in accordance with their requirements and priorities.

4. Key Areas:

KEY AREA No.1: *To reduce Widespread Prevalence of Communicable Diseases (i.e. EPI cluster of childhood diseases, TB, Malaria, Hepatitis-B and HIV-AIDS.*

1.1 Implementation Modalities

- 1.1.1 The protective and promotive health programmes will be implemented as National Programmes with clear-cut Federal/Provincial spheres of responsibility. The Federal Government authorities will assist in planning, monitoring, evaluation, training and research activities while the Provincial Governments will undertake service delivery.
- 1.1.2 The National Programme on EPI will be expanded through introduction of Hepatitis-B vaccine with effect from July 2001.
- 1.1.3 Routine EPI facilities in the Provinces, especially cold -chain equipment will be strengthened through GAVI's grant assistance over the next 5 years.
- 1.1.4 National Immunization Days against Poliomyelitis will continue to be observed annually to ensure WHO Certification by 2005.
- 1.1.5 A National Programme for immunizing mothers against Neonatal Tetanus will be implemented in 57 selected High-Risk Districts of the country over 3 years.
- 1.1.6 A new national programme will be introduced against Tuberculosis based on DOTS (Directly Observed Treatment Short Course) mode of implementation. The main features of this are - training of federal, provincial and district level managers; case detection through sputum smear technology; observed treatment of patients; standardized drug regime; and operational research.
- 1.1.7 A new national malaria control programme will be implemented, focusing on malaria microscopy through upgraded basic health facilities; and early diagnosis with prompt treatment. Mass spraying will be replaced by selective sprays only.
- 1.1.8 The current PC-I on HIV-AIDS will be enlarged to incorporate the following components - prevention of HIV transmission through health education; surveillance system; early detection of Sexually Transmitted Infections (STIs); Improved Care of the Affected Persons; and promotion of safe Blood

Transfusion. A uniform law will be enacted to set up Blood Control Authorities in the Provinces.

1.2 Targets and Time Frame:

- 1.2.1 Immunization coverage will be increased to 80% by 2005 and full coverage reached by 2010.
- 1.2.2 Polio cases will be reduced to less than 100 by end 2001 with WHO Certification achieved by 2005.
- 1.2.3 Hepatitis-B Coverage will be available in 70% of districts by 2002 and 100% by 2003 providing 17.3 million doses annually over next 5 years.
- 1.2.4 Full DOTs coverage of TB will be achieved in all districts of the country by 2005. The detection rate will be 70% and cure rate 85% by then. It will reduce TB prevalence by 50% by 2010.
- 1.2.5 Malaria cases also will be reduced by 50% by 2010. Plasmodium Falciparum cases will be kept at less than 40% of all malaria infections.

Key Area No.2: *To address inadequacies in primary/secondary health care services*

The main inadequacies are identified as the deficient state of equipment and medical personnel at BHU/RHC level. Absenteeism is common. At the district/tehsil level hospitals there are major shortcomings in emergency care, surgical services, anesthesia and laboratory facilities. There is no referral system in operation.

2.1 Implementation Modalities:

- 2.1.1 Trained Lady Health Workers will be utilized to cover the un-served population at the primary level. This would ensure family planning and primary healthcare services at the doorstep of the population through an integrated community-based approach.
- 2.1.1 58,000 Lady Health Workers under Ministry of Health and 13,000 Village-based Family Planning Workers under Ministry of Population Welfare will be integrated from 1st July 2001 to create a cadre of 71,000 Family Health

Workers under the National Programme for Family Planning and Primary Health Care. This cadre will be increased to 100,000 by the year 2005.

2.1.3 Provinces undertake improvement of District/Tehsil Hospitals under a phased plan. A minimum of 6 specialties (Medicine, Surgery, Pediatrics, Gynae, ENT and Ophthalmology) will be made available at these facilities.

2.1.4 District and Tehsil Hospitals will be upgraded to the desired standard through Provincial Master Plans. The Provincial Governments have prepared the following hospital upgradation plan over 5 years:

Punjab: 25 District Hospitals and 52 Tehsil Hospitals at a cost of Rs. 1665 million.

Sindh: 11 District Hospitals and 44 Tehsil Hospitals at a cost of Rs. 330 million.

NWFP: 19 District Hospitals and 11 Tehsil Hospitals at a cost of Rs. 989 million.

Balochistan: 3 District Hospitals and 30 Tehsil Hospitals at a cost of Rs. 540 million.

2.1.5 The performance of RCHs/BHUs will be specially reviewed and only those facilities will be upgraded which can actually serve the population. Adequately functioning facilities will be strengthened by filling up of staff positions and allocation of financial resources based on performance/utilization. Poorly functioning facilities will be contracted out to the private sector or other alternative uses explored.

2.1.6 Foreign assistance for the primary/secondary sectors as per above priorities will be sought by all concerned authorities including Economic Affairs Division and Planning and Development Division.

2.1.7 A model referral system in selected districts of each Province will be developed by 2002 to be replicated countrywide by 2005.

2.1.8 Appointments against vacant posts of staff in rural facilities will be facility specific on contractual basis.

2.2 Targets and Time Frame:

- 2.2.1 100,000 Family Health Workers will be recruited and trained by 2005 to cover the entire target population.
- 2.2.2 Rationalization study of RHCs/BHUs will be completed by 2002.
- 2.2.3 58 District and 137 Tehsil Hospitals will be upgraded over a period of 5 years.

Key Area No. 3: *To Remove Professional and Managerial Deficiencies in District Health System.*

The main deficiencies have been identified as the ineffectiveness of the district health office to supervise health services in a district. DHOs generally lack in essential qualifications and management skills.

A large number of posts of male and female doctors and paramedics at the primary and secondary health facilities are vacant, as well as specialist positions in district and tehsil hospitals. Mega-hospitals are managed in an adhoc manner.

3.1 Implementation Modalities:

- 3.1.1 Adequate financial and administrative powers will be given to the district health office under the Devolution plan to effectively manage priority programs at district level.
- 3.1.2 DHO will be appointed on merit-based criteria, with a Masters in Public Health or equivalent as minimum qualification. District health managers will undergo compulsory in-service training courses at health academies.
- 3.1.3 A package to improve the working/living conditions of doctors, nurses and paramedics in rural areas will be developed. A proposal embracing Rural Area Compensatory Allowance, Non-Practicing Allowance, Anesthesia Allowance and Nursing Allowance has been submitted to the Pay and Pension Committee for consideration. Improvements in living conditions may also be funded through Poverty Alleviation Programme.
- 3.1.4 Posting policy will ensure presence of doctors at primary and secondary levels in a district. Medical graduates after completing their House Job will have to be posted on vacant posts in primary and secondary facilities for a minimum period of one year. Medical graduates will be selected for such appointment in an order of priority involving, inter-alia, place of domicile (village, tehsil and

district) and quota availed for entry to medical college. Such medical graduates will receive only provisional registration from PMDC and will be eligible for permanent registration only after completing the mandatory period or rural medical service.

- 3.1.5 In-service officers belonging to Mos cadre will be required to serve for a minimum period of two years in primary and secondary health facilities by way of compulsory rural medical service to become eligible for promotion from BPS-17 to BPS-18.
- 3.1.6 Specialists in non-teaching hospital will serve for a minimum period of 2 years in rural medical service before being considered for promotion from BPS-18 to BPS-19.
- 3.1.7 As an incentive, preference will be given to those Medical Officers and Medical Graduates to enter postgraduate programmes who have completed 2 years rural medical service.
- 3.1.8 Medical Officers and health workers working in district and tehsil hospitals will be given hands-on training in anesthesia and obstetrics to address the acute shortage of trained staff in these priority areas. This measure will improve the availability and quality of emergency services in hospitals.
- 3.1.9 Mega-hospitals under autonomy arrangements will be institutionalized. Their Chief Executives will be appointed on prescribed criteria through a transparent selection process. Administrative and financial powers will be properly notified. Autonomy will be linked to revenue generation through rational user-charges and quality service delivery criteria. A system of monitoring the performance of autonomy-based mega-hospitals will be established.
- 3.1.10 Private practice of specialists will be replaced by the system of Institutional Practice in mega-hospitals. Rules will be framed for this purpose by the respective governments.

Key Area No. 4: *To promote greater gender equity in the health sector.*

4.1 Implementation Modalities:

- 4.1.1 Focussed reproductive health services to childbearing women through a life cycle approach will be provided at their doorsteps. This will ensure provision of Safe Motherhood facilities to the majority of mothers, thereby enhancing child survival rates.
- 4.1.2 Access to primary health services will be provided to the majority of women by expanding the Lady Health Workers Programme at the grassroots level. A cadre of 100,000 community-based trained lady health workers will provide basic services to the family at the household level.
- 4.1.3 Emergency Obstetric Care facilities will be provided through the establishment of “Women-Friendly-Hospitals” in 20 districts of Pakistan under Women Health Project.
- 4.1.4 A referral system between the village level and the Health Care facilities upto District Hospital level will be established under the Women Health Project.
- 4.1.5 More job opportunity will be provided to women as LHWs under the above programme. Additionally enrolment of midwives, LHVs and Nurses will be progressively increased in Nursing Schools, Midwifery Schools and Public Health Schools.
- 4.1.6 All vacancies in Government Sector of WMOs, Nurses, LHVs and Women cadres will be filled up on priority basis.

4.2 Targets and Time Frame:

- 4.2.1 By 2005, 100,000 Family Health Workers will be duly trained as community workers and developed in the field.
- 4.2.2 The number of nurses will increase from 23,000 to 35,000 by 2005 and 55,000 by 2010.

Key Area No. 5: *To bridge the Basic Nutrition Gaps in the target-population i.e. children, women and vulnerable population groups.*

5.1 Implementation Modalities:

- 5.1.1 Vitamin-A Supplementation will be provided annually to all, under-5 children (about 30 million) along with OPV on National Immunization Days through EPI network.
- 5.1.2 Provision of iodized salt will be ensured along with introduction of fortified flour and vegetable oil by addition of micro-nutrients like Iron and Vitamin-A.
- 5.1.3 Nutrition Project through PSDP will ensure a food fortification programme in coordination with local food industry.
- 5.1.4 Provision of Health Nutrition Package through 100,000 Family Health Workers which included Vitamin-B Complex Syrup, Ferrous Fumerate and Folic Acid to deserving persons, especially childbearing women and sick family members.
- 5.1.5 Mass awareness/health education programmes will be run through multi-media.

5.2 Targets & Time Frame:

- 5.2.1 Reduce Low Birth Weight babies from 25% to 15% by 2010.
- 5.2.2 Vitamin-A Supplementation to approximately 30 million children a year.

Key Area No. 6: *To correct urban bias in the health sector.*

- 6.1 Every Medical College, both in the public and private sectors will be required to adopt at least one district/ tehsil hospital or primary health facility in addition to the Teaching Hospital affiliated to it. This will entail mandatory visits on rotation basis by faculty/medical students to spend more time in rural settings while helping to provide selective specialist cover to the beneficiary population. Detailed schemes on these line will be chalked out by the Provincial Government / Boards of management of medical colleges.

- 6.2 The compulsory rural service of new medical graduates selected to fill up available vacancies in Government health institutes in rural areas will further contribute in promoting rural orientation.

Key Area No. 7: *To introduce required regulation in the private medical sector with a view to ensuring proper standards of equipment and services in hospitals, clinics and laboratories as well as private medical college and Tibb/Homeopathic teaching institutions.*

7.1 Implementation Modalities:

- 7.1.1 Draft laws/regulations on accreditation of private hospitals, clinics and laboratories have been circulated to all Provincial Governments and stakeholders. These will be finalized and submitted to the Federal Cabinet.
- 7.1.2 A law to ensure that private medical colleges adhere to PMDC approved standards before they start admitting students has been circulated as above. This will be submitted to the Federal Cabinet after necessary processing.
- 7.1.3 The existing law on Tibb and Homeopathy will be amended to recognize degree and postgraduate level courses in Traditional Medicine thus removing the existing lacuna on this account. The amendments will be submitted to the Federal Cabinet.
- 7.1.4 Each Provincial Government will develop an appropriate framework for encouraging private-public cooperation in the health sector, especially for operationalizing un-utilized or under-utilized health facilities through NGOs, individual entrepreneurs or doctors' groups.

Key Area No. 8: *To create mass awareness in public health matters.*

8.1 Implementation Strategy:

- 8.1.1 Optimal use will be made of multimedia to disseminate health and nutrition.
- 8.1.2 TV/Radio Authorities will be asked to air programmes dedicated to health and nutrition, in close coordination with Health & Education Ministries, and institutions like National Institute of Health, Health Services Academy and National Programme Authorities of Anti-TB, Malaria and HIV-AIDS Control Projects.

- 8.1.3 A Nutrition Cell will be established in the Ministry of Health through the Nutrition Project with required nutrition experts and mass communication specialists.
- 8.1.4 Appropriate interpersonal skills' training will be imparted to Family Health Workers as well under the Family Planning and Primary Health Care training programmes.
- 8.1.5 Greater participation of NGOs and civil society in Mass Awareness programmes.

Key Area No. 9: *To Effect improvement in the Drug Sector with a view to ensuring the availability, affordability and quality of drugs in the country.*

9.1 Implementation Modalities:

- 9.1.1 Local manufacture of required drugs, both by multinational and national companies will be encouraged to engender maximum market competition.
- 9.1.2 Imported drugs found to be in chronic short supply will be prioritized for local manufacturing.
- 9.1.3 Balanced and fair pricing policies will be pursued to encourage investment in the pharmaceutical sector.
- 9.1.4 The Drug Control Organization's Capacity for market surveillance and quality control will be strengthened by posting additional staff, and upgrading laboratories at Karachi and NIH, Islamabad.
- 9.1.5 While the availability of Life-Saving drugs will be specially monitored in the market, the provision of free Life-Saving drugs in the public sector hospitals will be limited to areas like emergency/casualty. The mustahikeen will however be eligible to free treatment, including drugs, through the Zakat system. The Family Health Workers' Health Package will also be available to the target population free of charge.

Key Area No. 10: *Capacity Building for Health Policy Monitoring in the Ministry of Health.*

10.1 Implementation:

10.1.1 A policy Analysis and Research Unit is proposed to be set up in the Ministry of Health. This Unit will also be responsible for monitoring the progress of Health Policy implementation in the key areas for submission to the Chief Executive/ Federal Cabinet periodically. The unit will also provide technical facilities to Provincial Governments on need basis.

Annexures

ANNEXI-1

Projected Health Indicators

Planned Health Sector Outcomes (2001-2004 and 2010)

| indicators | 2000 | 2004 | 2010 |
|---|------|------|------|
| Infant Mortality Rate (Per 1000 live births) | 90 | 65 | 55 |
| EPI Coverage | 51% | 80% | 100% |
| No. of Polio Cases Reported | 199 | Nil | Nil |
| Prevalence of malnutrition (Pre-School) | 39% | 35% | 20% |
| Low Birth Weight Babies (LBW) | 25% | 20% | 12% |
| Contraceptive Prevalence Rate (CPR) | 28% | 39% | 50% |
| Maternal Mortality Ration (MMR) | 400 | 300 | 180 |
| DOTs Coverage for TB | 25% | 50% | 60% |
| Lady Health Workers Coverage of Target Population | 45% | 100% | 100% |

Source: Ten Year Perspective Plan Development Plan 2001-11 and Three Development Program 2001-04, Government of Pakistan, Planning Commission, September 2001.

ANNEX-11

Public Sector Expenditure on Health – 1990/2001

(Million Rs.)

| | 1995-96 | 1996-97 | 1997-98 | 1998-99 | 1999-00 | 2000-01 |
|-----------------------------------|---------|---------|---------|---------|---------|---------|
| Provinces | | | | | | |
| Current | 8601 | 8777 | 10074 | 10642 | 12305 | 12929 |
| Development | 1348 | 1211 | 1250 | 1135 | 841 | 669 |
| Total Provinces | 9949 | 9988 | 11324 | 11777 | 13146 | 13598 |
| Federal | | | | | | |
| Current | 1538 | 1644 | 1826 | 1746 | 2003 | 2106 |
| Development | 1852 | 1802 | 1581 | 2024 | 2193 | 1790 |
| Total Federal | 3435 | 3446 | 3407 | 3770 | 4196 | 3896 |
| Total Public Sector Expenditure | 13384 | 13434 | 14731 | 15547 | 17342 | 17494 |
| Expenditure on Health as % of GNP | 0.8 | 0.5 | 0.7 | 0.9 | 0.7 | 0.7 |

Source: Economic Survey 2000-2001

ANNEX-III

THREE YEAR PLANNED PUBLIC SECTOR DEVELOPMENT PROGRAMME (PSDP) 2001-04 & TEN YEAR VISION 2001-II.

MINISTRY OF HEALTH

| Name of Projects. | Allocation 2001-02 | | | Proposal for 2002-03 | | | Proposal for 2003-04 | | | Total 03 years Dev. Prog. 2001-04 | | | Total 2001-2011 | | |
|--------------------------------|--------------------|------------|-------|----------------------|------|-------------|----------------------|------|-------------|--------------------------------------|------|-------------|--------------------|-------|-------------|
| | Original | Additional | Total | Available | Gap | Requirement | Available | Gap | Requirement | Available | Gap | Requirement | Available | Gap | Requirement |
| A. (ON – GOING) | | | | | | | | | | | | | | | |
| E.P.I. | 500 | 196 | 696 | 1000 | 200 | 1200 | 1100 | 220 | 1320 | 2600 | 616 | 3216 | 13920 | 2880 | 16800 |
| N.P.F.P & P.H.C. | 1273 | 983 | 2256 | 1750 | 716 | 2466 | 1900 | 856 | 2756 | 4923 | 2555 | 7478 | 23223 | 6605 | 29828 |
| HIV/AIDS | 90 | 94 | 184 | 250 | 300 | 550 | 300 | 300 | 600 | 640 | 694 | 1334 | 4140 | 1324 | 5464 |
| Malaria | 40 | 106 | 146 | 50 | 106 | 156 | 60 | 40 | 100 | 150 | 252 | 402 | 765 | 325 | 1090 |
| Tuberculosis | 10 | 121 | 131 | 50 | 40 | 90 | 85 | 20 | 105 | 145 | 181 | 326 | 1105 | 340 | 1445 |
| w.H.P. (ADB) | 100 | 0 | 100 | 200 | 0 | 200 | 100 | 100 | 200 | 400 | 100 | 500 | 800 | 100 | 900 |
| M.N.T. | 135 | 450 | 585 | 200 | 230 | 430 | 200 | 260 | 460 | 535 | 940 | 1475 | 735 | 770 | 1505 |
| Other Projects | 468 | 0 | 468 | 790 | 0 | 790 | 800 | 80 | 880 | 2058 | 80 | 2138 | 8658 | 2232 | 10890 |
| Total (A) | 2616 | 1950 | 4566 | 4290 | 1592 | 5882 | 4545 | 1876 | 6421 | 11451 | 5418 | 16869 | 53346 | 14576 | 67922 |
| B. (NEW PROJECTS) | | | | | | | | | | | | | | | |
| Nutrition Program | 0 | 50 | 50 | 82 | 20 | 102 | 94 | 19 | 113 | 176 | 89 | 265 | 830 | 302 | 1132 |
| Reproductive H.Project | 0 | 0 | 0 | 100 | 0 | 100 | 60 | 100 | 160 | 160 | 100 | 260 | 865 | 126 | 991 |
| Measles Reduction | 0 | 0 | 0 | 100 | 15 | 115 | 120 | 50 | 170 | 220 | 65 | 285 | 1220 | 208 | 1428 |
| Mental Health | 0 | 0 | 0 | 15 | 5 | 20 | 20 | 5 | 25 | 35 | 10 | 45 | 275 | 35 | 310 |
| I.M.C.I. | 0 | 0 | 0 | 10 | 20 | 30 | 15 | 10 | 25 | 25 | 30 | 55 | 65 | 35 | 100 |
| Other Projects | 0 | 0 | 0 | 250 | 122 | 372 | 260 | 100 | 360 | 510 | 222 | 732 | 3090 | 1500 | 4590 |
| A.R.I. | 0 | 0 | 0 | 100 | 22 | 122 | 70 | 10 | 80 | 170 | 32 | 202 | 950 | 400 | 1350 |
| N.I.C.V.D. | 0 | 0 | 0 | 78 | 274 | 352 | 96 | 320 | 416 | 174 | 594 | 768 | 1074 | 306 | 1380 |
| N.I.H. | 0 | 0 | 0 | 50 | 10 | 60 | 50 | 40 | 90 | 100 | 50 | 150 | 3000 | 750 | 3750 |
| N.A.M.C.H. | 0 | 0 | 0 | 200 | 40 | 240 | 220 | 0 | 220 | 420 | 40 | 460 | 2000 | 400 | 2400 |
| Total (B) | 0 | 50 | 50 | 985 | 528 | 1513 | 1005 | 654 | 1659 | 1990 | 1232 | 3222 | 13369 | 4062 | 17431 |
| Total (A & B) | 2616 | 2000 | 4616 | 5275 | 2120 | 7395 | 5550 | 2530 | 8080 | 13441 | 6650 | 20091 | 66715 | 18638 | 85353 |
| C. (Outside PSDP) | | | | | | | | | | | | | | | |
| Hepatitis B Vaccination | 600 | 0 | 600 | 720 | 0 | 720 | 800 | 0 | 800 | 2120 | 0 | 2120 | 5000 | 5000 | 10,000 |
| Grand Total (A+B+C) | 3216 | 2000 | 5216 | 5995 | 2120 | 8115 | 6350 | 2530 | 8880 | 15561 | 6650 | 22211 | 71715 | 23638 | 95353 |