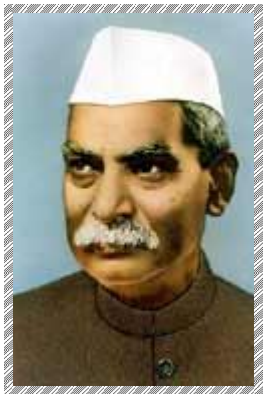
DISTRICT ACTION PLAN



DISTRICT HEALTH SOCIETY

SARAN

Foreword

Importance of better human life exists only in better Health Care Management system in a democratic setup for socio economic development of the society. Govt. of India recognized this fact and launched National Rural Health Mission in 2005 to rectify anomalies exists in Rural Health Care System and to achieve an optimum health standard for 18 State & Union Territory.

The District Health Action Plan (DHAP) is one of most key instrument to achieve NRHM goals based on the needs of the district.

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

I need to congratulate the department of Health of Bihar for its dynamic leadership of the health sector reform programme and we look forward to a rigorous and analytic documentation of their experiences so that we can learn from them and replicate successful strategies. I also appreciate their decision to invite consultants (NHSRC/ PHRN) to facilitate our DHS regarding preparation the DHAP. The proposed location of HSCs,PHCs and its service area reorganized with the consent of ANM, AWW, male health worker and participation of community has finalized in the block level meeting.

I am sure that this excellent report will galvanize the leaders and administrators of the primary health care system in the district, enabling them to go into details of implementation based on lessons drawn from this study.

Lokesh Kumar Singh
DM-CUM-CHAIRMAIN
District Health Society, Saran

ABOUT THE PROFILE

Under the National Rural Health Mission this District Health Action Plan of Saran 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 capacity building aspects. It recommends on how existing resources of manpower and materials could 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 state level consultants (NHSRC/PHRN), ACMOs, MOICs, Amit Anand (DAM) , Mritunjay Prasad(District Nodal Monitoring & Evaluation Officer), Jay Prakash (IDSP), Block Health Managers like Basant Kumar, RamNarayan and Data operator(DHS) Gaurav Kumar and Santosh Kumar from their excellent effort we may be able to make this District Health Action Plan of Saran District.

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

Dr. Dharmdev Singh
Civil Surgeon-Cum-Member Secretary
District Health Society, Saran

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Centre
APL	Above Poverty Line
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy
BCC	Behaviour Change Communication
BDC	Block Development Committee
BPL	Below Poverty Line
CBO	Community Based Organization
CDPO	Child Development Project Officer
CHC	Community Health Centre
CMO	Chief Medical Officer
DDC	Drug Distribution Centre
DAP	District Action Plan
DF	Deep Freezers
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Directly Observed Treatment Short-course
EmOc	Emergency Obstetric Care
FGD	Focus Group Discussion
FRU	First Referral Unit
FTD	Fever Treatment Depot
GP	Gram Panchayat
HMS	Health Management Society
ICDS	Integrated Child Development Services
IDSP	Integrated Disease Surveillance Project
IEC	Information Education And Communication
ILR	Ice-lined Refrigerators
IOL	Intra-Ocular Lens
IUD	Intra-uterine Devices
IPHS	Indian Public Health Standards
LHV	Lady Health Visitor
MDT	Multi Drug Therapy
MMU	Medical Mobile Unit
MOIC	Medical Officer In-Charge
MPW	Multi Purpose Worker
MSG	Mission Steering Group
NBCP	National Blindness Control Programme
NGO	Non Government Organization
NLEP	National Leprosy Eradication Programme

NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
PHC	Primary Health Centre
PPC	Post Partum Centres
PRI	Panchayati Raj Institution
RCH	Reproductive And Child Health
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infections
SC	Sub-centre
SC/ST	Scheduled Caste/ Scheduled Tribe
SHG	Self Help Group
SNP	Supplementary Nutrition Programme
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOT	Training of Trainers
UFWC	Urban Family Welfare Centre
VHC	Village Health Committee
VHSC	Village Health and Sanitation Committee
ZP	Zila Parishad

List of Abbreviations

I. ACKNOWLEDGEMENTS

The commitment to bridge the gaps in the public health care delivery system, has led to the formulation of District Health Action Plans. The collaboration of different departments that are directly or indirectly related to determinants of health, such as water, hygiene and sanitation, will lead to betterment of health care delivery, and to make this collaboration possible actions are to be outlined in the District Health Action Plan. Thus this assignment is a shared effort between the departments of Health and Family Welfare, ICDS, PRI, Water and Sanitation, Education to draw up a concerted plan of action.

The development of a District Action Plan for Saran district of Bihar entailed a series of Consultative Meetings with stakeholders at various levels, collection of secondary data from various departments, analysis of the data and presentation of the existing scenario at a District-level workshop. The District level Workshop was organized to identify district specific strategies based on which the District Action Plan has been prepared by the District & Block Program Management Unit.

We would also like to acknowledge the much needed cooperation extended by the District Magistrate and Deputy Development Commissioner without whose support the conduct of the of district level workshop would not have been possible. Our thanks are due to All the Program officers and Medical officers of the district for their assistance and support from the inception of the project. The involvement of the all the Medical officers played a vital role throughout the exercise enabling a smooth conduct of consultations at block and district levels.

The present acknowledgement would be incomplete without mentioning the participation of representatives and officials from department of Integrated Child Development Services, Panchayati Raj Institution, Education and Water and Sanitation, who actively participated in consultations with great enthusiasm. Without their inputs it would not have been possible to formulate the strategic health action plan for the district. The formulation of this plan being a participatory process, with inputs from the bottom up, the participation of community members at village level proved very helpful. These consultations at grassroots level supplemented the deliberations at block and district levels, adding value to the planning process.

Finally, we would like to appreciate the efforts and supports of all those including PHRN Bihar, Team who were associated with the team for accomplishment of this task and brought the effort to fruition.

Additional Chief Medical Officer
(**Dr. Kumkum Sinha**)

Civil Surgeon cum CMO
(**Dr. Dharmdev Singh**)

II. INTRODUCTION

The National Rural Health Mission launched for the period of seven years (2005-12), aims at providing integrated comprehensive primary health care services, especially to the poor and vulnerable sections of the society. NRHM is projected to operate as an omnibus broadband programme by integrating all vertical health programmes of the Department of Health and Family Welfare including Reproductive and Child Health Programme-II, National Vector Borne Disease Control Programme, Revised National Tuberculosis Control Programme, National Blindness Control Programme and National Leprosy Eradication Programme. The Mission envisions effective integration of health concerns, with determinants of health like hygiene, sanitation, nutrition and safe drinking water through decentralized management at district level. In order to make NRHM fully accountable and responsive, the need for formulation of a District Health Action Plan (DHAP) 2009-10 has been recognized The DHAP intends to provide a guideline to develop a viable public health delivery system through intensive monitoring and ensuring performance standards. It reflects the convergence of different aspects of health like potable water, sanitation, women and child development and school level education.

As a first step towards planning process, identification of performance gaps was attempted by carrying out a situational analysis. The public health infrastructure in the district indicates under-equipped health facilities with vacant staff positions. From the convergence point of view involvement of ICDS and PRI within the framework of health is significant. Intervention by PRI through the constitution and activation of Village Health & Sanitation Committees is still in process, and in the meantime, ICDS workers integrate with health workers at village level through Anganwadi centre to ensure better accessibility to and availability of health services.

The formulation of the DHAP envisages a participatory approach at various levels. To make the plan more practicable and to ensure that grass root issues are voiced and heard, the initial stages of process of plan development included consultations at village and block levels. As NRHM emphasizes community participation and need-based service delivery with improved outreach to disadvantaged communities, village and block level consultations provided vital information to guide the district health action plan. The consultations endeavored to reach a consensus on constraints at community level and engender feasible solutions/intervention strategies. Priorities were set based on discussions on both demand and supply side concerns in the blocks. Furthermore, a district level workshop was conducted to share findings of the village and block level process with a larger stakeholder group, and to finalize a strategic action plan.

During district level consultations involving a range of stakeholders from different levels, strategies have been formulated to achieve identified district plan objectives. For effective implementation, specific activities have been identified for each strategy and a time frame assigned for each activity.

To provide equitable reproductive and child health services with the objective of bridging the spatial variations and achieving the goals of the Mission, a comprehensive approach has been suggested through partnerships with private institutions, initiatives by other departments like ICDS, Education and civil society. Involvement of elected Panchayat representatives and community participation at large have specified for addressing and reducing gender discrimination issues (viz. advocacy on age at marriage, denial of sex-selection, equality of immunization etc). For enhancing availability, accessibility and acceptability of services, increase in female literacy, improved IEC for behavior change and strengthening of health services as well as service providers are envisaged as major tools which can mitigate cultural, institutional and functional constraints.

The infrastructural scenario indicates that appointment of ASHAs, under NRHM, is not yet completed. Training for ASHAs is still pending. Rogi Kalyan Samitis are not full functional at all. The findings of the facility survey suggest that each & every Health facilities need to be upgraded as per IPHS. To make the health care mechanism more accountable, health institutions should be upgraded with adequate availability of staff and equipment and drugs. As a part of NRHM it is proposed to provide each health facility with an untied grant for maintenance and local health action. Thus the present work plan suggests proper monitoring and directions for use of the maintenance grant. It is also proposed to improve outreach activities in un-served and underserved areas, especially in those inhabited by vulnerable populations, through provision of Mobile Medical Units.

In conformity with the innovations expected in NRHM, mainstreaming of AYUSH for strengthening primary health delivery is also suggested.

For improving the performance indicators for child immunization, strengthening of the service delivery infrastructure and increase in manpower has been suggested. Additionally there is need for in-service training programmes for skill development of field staff. To increase immunization coverage, more outreach camps should be organized for better access by the underserved and un-served populations. NGOs and PRI are envisioned as playing a role in improving service delivery efficiency and effecting behavior change.

Under National Disease Control Programmes, to improve the performance of NVBDCP (specifically indicator of Kala-azar & malaria) improvement in surveillance activities have been suggested for epidemic preparedness and response. Sensitization of the community (BCC) and social mobilization can be achieved effectively by involving Panchayat members. In addition, there is need for strengthening and upgrading the epidemiological capabilities of laboratories Moreover, inter-sectoral collaboration between the health department, water and sanitation department, PRI, education department, ICDS and NGOs has been envisaged for effective intervention.

For achieving the targets for RNTCP in the span of next one year increased BCC activities are suggested for higher acceptance of services and self reporting by patients. Infrastructural strengthening is also recommended with increased manpower and close monitoring. Moreover, the role of private practitioners is envisaged for IEC activities and for the sensitization of the community.

As evident from the situational analysis, all most all the posts are lying vacant for specialists. Thus filling vacant posts would be one of the activities for strengthening service delivery. To improve access to rural/ tribal or underserved areas more outreach camps should be organized. There should be adequate procurement, distribution and assurance of quality equipment and drugs. School health camps should be organized to target children 10-14 years of age for refractive errors. Further there is need for promotion of outreach activities by effective communication.

Existing knowledge and awareness about leprosy call for increased BCC activities to eliminate misconceptions and beliefs associated with the disease. This could be achieved by successful intervention of the Panchayat through activation of village health committees. Moreover there is need to reinforce the service delivery mechanism by providing quality services for counseling, diagnosis and treatment.

To make the system more accountable, the District Health Action Plan proposes close monitoring and evaluation with continuous integration at each level (village, block and district). This will not only ensure streamlining of strategies but also check for effective collaboration of services related to immunization and institutional delivery, AYUSH infrastructure, supply of drugs, up gradation of PHCs to CHCs as per IPHS, utilization of untied funds, and outreach services through operationalization of the mobile medical units. The PRIs, RKSs, Quality Assurance Committees at the District level, District Health Missions, are to be the eventual monitors of the outcomes.

THE CONTEXT

The importance of health in economic and social development for improving the quality of life has long been recognized. In order to energize the various components of health system, Government of India has launched the National Rural Health Mission (NRHM). This was launched in April 2005, to provide effective health care to the 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 the achievement of policy goals by facilitating enhanced access and utilization of quality health services, with emphasis on the equity and gender dimensions.

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

NRHM will facilitate transfer of funds, functions and functionaries to PRIs and also the greater engagement of RKS, hospital development committees or user groups. Improved management through capacity development is also planned. Innovations in human resource management constitute a major challenge in making health services available to the rural/tribal population. Thus, NRHM aims at the availability of locally resident health workers, multi-skill training of health workers and doctors, and integration with the private sector for optimal use of human resources. The Mission aims to make untied funds available at different levels of the health care delivery system.

Core strategies of the Mission include decentralized public health management. This will be realized by implementation of District Health Action Plans (DHAPs), which will be the principal instrument for planning, implementation and monitoring, and which will be formulated through a participatory and bottom-up planning process. DHAP enable village, block, district and state levels to identify the gaps and constraints in order to improve services with regard to access, demand and quality of health care. NRHM-DHAP is anticipated to form the cornerstone of all strategies and activities in the district.

The District Health Action Plan integrates the various interrelated components of health to facilitate access to services and ensure quality of care. These different components are as detailed below:

- Resources: health manpower, logistics and supplies, community resources and financial resources, voluntary sector health resources.
- Access to services: public and private services as well as informal health care services; levels of integration of services within public health system.

- Utilization of services: outcomes, continuity of care, factors responsible for possible low utilization of public health system.
- Quality of care: technical competence, interpersonal communication, and client satisfaction, client participation in management, accountability and redress mechanisms.
- Community: needs, perceptions and economic capacities, PRI involvement in health, existing community organizations and modes of involvement in health.
- Socio-epidemiological situation: local morbidity profile, major communicable diseases and transmission patterns, health needs of special social groups (e.g. Adivasis, migrants, very remote hamlets)

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, partnerships with NGO and the private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving programme functionaries and community representatives at district level.

OBJECTIVES OF THE DHAP

The aim of the present study is to prepare DHAP based on the broad objective of the NRHM. Specific objectives of the process are:

- To identify critical health issues and concerns with special focus on vulnerable /disadvantage groups and isolated areas and attain consensus on feasible solutions.
- To examine existing health care delivery mechanisms to identify performance gaps and develop strategies to bridge them
- To actively engage a wide range of stakeholders from the community, including the Panchayat, in the planning process
- To identify priorities at the grassroots level and set out roles and responsibilities at the Panchayat and block levels for designing need-based DHAPs
- To espouse inter-sectoral convergence approach at the village, block and district levels to make the planning process and implementation process more holistic

METHODOLOGY

Planning process started with the orientation of the different programme officers, MOICs, Block Health Manager and our health workers. Different group meetings were organized and at the same time issues were discussed and suggestions were taken. Simple methodology adopted for the planning process was to interact informally with the government officials, health workers, medical officers, community, PRIs and other key stake holders.

Data Collection:

Primary Data: All the Medical Officers were interacted and their concern was taken in to consideration. Daily work process was observed properly and inputs were taken in account. District officials including CMO, ACMO, DIO, DMO, DLO, RCHO and others were interviewed and their ideas were kept for planning process.

Secondary Data: Following books, modules and reports were taken in account for this Planning Process

- RCH-II Project Implementation Plan
- NRHM operational guideline
- DLHS Report
- Report Given by DTC
- Report taken from different programme societies e.g. Blindness control, District
- Leprosy Society, District TB Center , District Malaria Office
- Census-2001
- National Habitation Survey-2003
- Bihar State official website

Tools:

Main tools used for the data collection were:

- Informal In-depth interview
- Group presentation with different district level officials
- Informal group discussions with different level of workers and community representative
- Review of secondary data

Data Analysis:

Primary Data: Data analysis was done manually. All the interviews were recorded and there points were noted down. After that common points were selected out of that.

Secondary Data: All the manuals books and reports were converted in to analysis tables and these tables are given in to introduction and background part of this plan.

SWOT ANALYSIS OF DISTRICT

STRENGTHS – WEAKNESSES – OPPORTUNITIES – THREATS:

✓ STRENGTHS

1. **Involvement of C.S cum CMO**: - C.S cum CMO take interest, guide. In every activity of Health programme and get personally involved.

2. **Support from District Administration**: - District Magistrate and Deputy Development Commissioner take interest in all health programmes and actively participate in activities. They provide administrative support as and when needed. They make involvement of other sectors in health by virtue of their administrative control.

3. **Support from PRI (Panchayati Raj Institute) Members**: - Elected PRI members of District and Blocks are very co-operative. They take interest in every health programmes and support as and when required. There is an excellent support from Chairman of Zila Parishad They actively participate in all health activities and monitor, it during their tour programme in field

4. **Well established DPMU and BPMU**: - Since one year, all the posts of DPMU & BPMU are filled up. Facility for office and automation is very good. All the members of DPMU & BPMU work harmoniously and are hardworking.

5. **Effective Communication**: - Communication is easy with the help of Internet facility at block level and land line & Mobile phone facility. This is incorporated in most of PHCs of the district.

6. **Facility of vehicles**: - Under the Muskan Ek Abhiyan programme. Every Block has the vehicles for monitoring.

7. **Support from media**: - Local newspapers and channel are very co-operative for passing messages as and when required. They also personally take interest to project good and worse things which is very helpful for administration to take corrective measures.

✓ WEAKNESS

1. **Lack of Consideration in urban area**: - Urban area has got very poor health Infrastructure to provide health services due to lack of manpower. Even Urban Slum is not covered under Urban Health scheme (Urban Health Scheme is not implemented by the GOB for Saran district) which cover urban Population.

2. **Non availability of specialists at Block level**: - As per IPHS norms, there are Vacancies of specialists in most of the PHCs. Many a times only Medical Officer is posted, they are busy with routine OPD and medico legal work only. So PHC do not fulfill the criteria of ideal referral centers and that cause force people to avail costly private services.

3. **Non availability of ANMs at PHCs to HSCs level**: - As per IPHS norms, there are vacancies of ANMs in most of the HSCs . Out of 644 Sanctioned posts of contractual ANMs only 210 ANMs are selected. So HSCs do not fulfill the criteria of ideal Health Sub Centre and that cause force people to travel up to PHCs to avail basic health services.

4. **Apathy to work for grass root level workers**: - Since long time due to lack of Monitoring at various level grass root level workers is totally reluctant for work. Even after repeated training, desired result has not been achieved. Most of the MO, Paramedics, Block Health Managers & workers do not stay at HQ. Medical Officers, who are supposed to monitor the daily activity of workers, do not take any interest to do so. For that reason workers also do not deliver their duties regularly and qualitatively.
   Due to lack of monitoring & supervision some aim, object & program is suffering.

5. **Lack of proper transport facility and motarable roads in rural area**: - There are lacks of means of transport and motarable roads in rural areas. Rural roads are ruled by '**Jogad**', a hybrid mix of Motor cycle and rickshaw, which is often inconvenient mean of transport. The fact that it is difficult to find any vehicle apart from peak hours is still the case in numerous villages.

6. **Illiteracy and taboos**:-The literacy rate in rural area has still not reached considerable mark. Especially certain communities have constant trend of high illiteracy. This causes prevalence of various taboos that keep few communities from availing benefits of health services like immunization or ANC, institutional delivery etc.

✓ OPPORTUNITIES

1. Health indicator in Saran district is not satisfactory. Services like Institutional delivery, Complete Immunization, Family Planning, Complete ANC, School Health activity, Kala-azar eradication may required to be improved. So there is an opportunity to take the indicator to commendable rate of above 75+% by deploying more efforts and will.

2. **Introduction of PPP Scheme:** Through introduction of PPP Scheme we can overcome shortfall of specialist at Block level.

3. **Involvement of PRIs:** - PRI members at district, Block and village level are very co-operative to support the programmes. Active involvement of PRI members can help much for acceptance of health care deliveries and generation of demand in community.

4. **Improvement of infrastructure:** - With copious funds available under NRHM, there is good opportunity to make each health facility neat and clean, Well Equipped and Well Nurtured.

✓ **THREATS**

1. Flow of information if not properly channeled to the grass root stakeholder

2. Natural calamities like every year flood adversely affected the progress of Health Programme.

AN OVERVIEW OF DISTRICT SARAN

Saran is also known as Chapra. It is district headquarters also the Divisional headquarter of Saran Division.

History

In ancient days, Modern Saran Division formed a part of KOSALA country. The history of Saran Division is bound to be history of Kosala which included portions other than present limit of Saran Division. The kingdom of Kosala was bounded on the west by Panchala, by the river Sarpika(sai) in the south, on the east by Gandak and on the north by Nepal. The Kosala consisted of modern Fyzabad, Gonda, Basti, Gorkhapur, Deoria in UP and Saran in Bihar.The historical background of the district- as available in the Ain-e- Akbari records Saran as one of the six Sarkars (Revenue Divisions) Constituting the province of Bihar. At the time of grant of Diwani to the East India company in 1765, there were eight Sarkars including Saran and Champaran. These two were later combined to form a single unit named Saran. Saran (along with Champaran) was included in the Patna Division when the Commissioner's Divisions were set up in 1829. It was separated from Champaran in 1866 when it (Champaran) was constituted into a separate district. Saran was made a part of Tirhut Division when latter was created in 1908. By this time there were three subdivisions in this district namely Saran, Siwan and Gopalganj. In 1972 each subdivision of the old Saran district became an independent district. The new Saran district after separation of Siwan and Gopalganj still has its headquarters at Chapra. Various hypotheses have been put forward about the origin of the name SARAN. General Cunningham suggested that Saran was earlier known as SARAN or asylum which was a name given to a stupa (Pillar) built by emperor Ashoka. Another view holds that the name SARAN has been derived from SARANGA- ARANYA or the deer forest, the district being famous for its wide expanses of forest and deer in prehistoric times. The earliest authentic historical fact or record concerning this district may perhaps be related to 898 AD, which suggests that the village of Dighwara dubauli in Saran had supplied a copper plate issued in the reign of king Mahendra paldeva.

Saran has ancient and mythical history. Maharshi Dadhichi belongs to Saran who had donated his bone to Gods for manufacturig of arms. Cottage of Dronacharya was also situated in Saran. Gautamasthan, 8 km from chapra town, is used to be Maharshi Gautam's ashrama. Lord Rama has provided Devi Ahiylya, wife of Maharshi Gautam who become stone due to a curse (by her mistake), her life back. Currently, there is a temple and Vishnupad preserved.The fight of "Gaj" (Elephant) and "Grah" (Corcodial) was held at Sonepur in Saran district. Presently It (Sonpur) is well known for Asia's biggest cattle Fair on Kartik Purnima(October-November) every year. Ambica Sthan (Ami,Dighwara) another important place of the district is famous for the worship of Goddess Durga. The famous Ashoka Pillar is located about 33 km from Chapra town (5 km from Maker Village). This is the place where Lord Buddha made his 13th stop on his way to attaining 'Nirvana'. He converted "Amrapali" - a local courtesan/powerful prostitute into a saint. This is now a major tourist attraction for Buddhists from all over the world and is well maintained by the archaeological survey of India.At Chirand near Chapra ancient (primitive) bones were found and are placed in the Chapra Museum. It is famous for King Maurayadhwaj who was ready to sacrifice his only son to Vaman Avatar
Lord Vishnu.

It is also famous for its Bhojpuri heritage .The famous "Bhikhari Thakur" is a famous person from Saran, and is often referred to as the "Shakespeare of Bhojpuri". "Mahendra Misir" also a famous person in Bhojpuri Folk songs. He had specially invented the "Purvi" a style of Bhojpuri Folk song. He was the master in playing of several types of instruments. **Bhojpuri is dialect of this place.** Ara (Arrah), Ballia (Balia), Chapra and Deoria, the Bhojpuri heartland, are known as "ABCD" of India due to their people congruence of language and culture. People of this "ABC" region has taken Bhojpuri across the Indian boarder to far away places in Fiji, Mauritius, Trinidad & Tobago, Surinam and Guyana when their forefathers were settled there as indentured labourer by Imperial forces. They have adopted there new homeland but still have Bhojpuri in their blood.

Location

The district of Saran has an area of 2641 Sq. Kms and is situated between 25°36' & 26°13' North latitude and 84°24' & 85°15' East longitude in the southern part of Saran Division of North Bihar. The Ganges constitute the Southern boundary of the district beyond which lie the districts of Bhojpur and Patna. District Siwan and Gopalganj lie on the north of district Saran. The Gandak forms the dividing line with Vaishali and Muzaffarpur district in the east. To the west of Saran lies Siwan and Balia in Uttar Pradesh, river Ghaghra is the natural boundary between Saran and Ballia.


SARAN
Bihar
N
To Baikunthpur
Gandak
SIWAN
MUZAFFARNAGAR
To Duraundha
Masrakh
Bhagwanpur Hat
Taraiya
Tajpur
Bishanupur
Baniapur
Ekma
Marhaura
Amnaur
Maker
VAISHALI
Daudpur
Nagra
Sobhepur
Bhelidi
Parsa
Khaira
To Ballia
Manjhi
Saria
Garkha
Dariapur
UTTAR PRADESH
CHHAPRA
Sirpal Basant
Revelganj
Nayagaon
To Desri
Dighwara
Ghaghara
Sonpur
PATNA
BHOJPUR
To Danapur
District Boundary
Major Road
District Headquarter
Taluk Headquarter
Town
Roads
River
Railway Track
Map not to Scale
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Turkaulia
MOTIHARI
CHAMPARAN
Kateya
Kuchai Kot
GOPALGANJ
GOPALGANJ
Bhore
Madhuban
Chakia
Manjha
Barauli
Hathua
Barharia
Goreakothi
Sahebganj
Sahnpur
SIWAN
Mairwa
SIWAN
Baruraj
Gothini
Pachrukhi
Maharajganj
Mashrakh
MUZAFFAR
Darauli
Duraundha
Taraiya
Raghunathpur
Ganga pur Siswan
Ekma
Baniapur
SARAN
Vaishali
Rasra
BALLIA
Bansdih
Manjhi
Parsa
Revelganj
BALLIA
CHHAPRA
Dighwara
Simri
Barhra
Darapur
Barhampur
Shahpur
Buxar
Maner


Bihar
Pashchim Champaran
Purba Champaran
Sitamarhi
Gopalgani
Sheohar
Madhubani
Kishan ganj
Siwan
Muzaffarpur
Supaul
Araria
Darbhanga
Saran
Madhepura
Vaishali
Samastipur
Saharsa
Purnia
Buxar
Patna
Khagaria
Bhojpur
Begusarai
Katihar
Rohtas
Jehanabad
Nalanda
Lakhisarai
Bhagalpur
Sheikhpura
Munger
Kaimur (Bhabua)
Nawada
Jamui
Aurangabad
Gaya
Banka

Physiography

The district is entirely constituted of plains but there are quite a few depressions and marshes, which cause the formation of three broad natural divisions, namely:

a) The alluvial plains along the big rivers, which are subjected to periodic inundation and prone to floods.
b) The region of uplands away from the rivers and not subject to floods.
c) The Diara areas in the beds of the great rivers.

The soil of the district is alluvial. No mineral of economic value is found in the district.

Climate

The climate of the district is generally tropical in nature with hot summer and cold winter. Summer climate is hot and dry, with blowing westerly winds during the month of March to June touching the mercury temperature up to 45 degree Celsius till the onset of rain. The winter sets in from middle of November to February with temperature touching at 7 degree Celsius during the month of January. The district enjoys a pleasant climate between Novembers to February.

Rainfall

The monsoon breaks sometime in the later half of June. The rainy season lasts till the end of September. Maximum rainfall occurs in the month of July & August. It will be seen that the normal rainfall in the district is 1140 mm.

Forest

The district of Saran, which in the remote past was densely wooded and presumably derived its name from its forest, is completely devoid of any forest now. The land is fertile and there is a large population to be supported and therefore virtually no space has been left for wild growth. The cultivated land is dotted over with bamboo groves, palm trees & mango orchids.

Agriculture

The district has very good potential for Agriculture and allied activities. Agriculture has continued to be the main occupation in the district and also the main source of livelihood of the people. Rainfall still controls the agriculture economy of the district. Conditions have however improved to some extent to meet the situation caused by the failure of monsoon through some irrigation projects.

Rice and Maize is the main crop of the district. It accounts for about 47.1% of the net sown area; wheat covers nearly 10.53% of the net sown area, while sugarcane is grown in only 0.95% of the area. Maize is produced through mix cropping with Potato.

Irrigation

The question of irrigation in the district of saran involves watering of fields on one hand and draining of water logged on the other. In the pre-Independence Day requirement of irrigation received some attention at the hands of erstwhile zamindars. The British Government as such paid little or no attention to the irrigation needs of the district. It was only in the post independence period that government has realized this need. Several schemes executed by the govt. are following:-

- Saran canal Irrigation
- Daha Canal Irrigation
- Naina Bandh Flood control
- Saran embankment Flood control
- Ghaghra embankment Flood control
- Mahi river embankmet Flood control
- Gandak embankment Flood control
- Sondh embankment Flood control
- Kurimal Bandh Flood control

To drain water from the water logged field there are **118 sluice gates in the above mentioned embankments.** The irrigation division Chapra is looking after these embankments. Rains are the main source of irrigation and the outcome of crops largely depends on the adequacy and its even distribution throughout the agricultural operations. However, rainfall cannot be depended upon as an unfailing source of irrigation. Therefore artificial irrigation supplements rainfall in varying degree to meet the requirement of water for agriculture.

Animal Husbandry

Livestock is very important in the district like saran with predominantly agricultural economy. Cattle of local breeds though handy and suited to the climate are generally of a poor variety. Buffalos are sometimes are employed for ploughing the land, especially when deep mud is prepared for the transplantation of paddy. Goats are bred in almost every village and pigs of omnivore's kind are kept by certain section of people. The quality of livestock has improved considerably through the efforts of the government and responses of farmers. In order to protect the livestock from various diseases and epidemic and also to improve the breed, the animal husbandry department of the state government has taken some useful and concrete measures. It has established veterinary hospital, sub-centers, and artificial insemination center in the district.

Industry

There are no large-scale industries or heavy industry worth mentioning in the district. According to the previous records, among the large industrial establishment of the district mentions may be made of **Marhura confectionary of M/s C. E. Mortorn India Ltd., the Saran Engineering Company Ltd, the Cawnpur sugar works Ltd & Cawnpur Sugar Mills distillery at Marhuara.** But at present they all are closed.

Minerals

No minerals of any economic importance are found in the district.

River System

The district is shaped like a triangle with its apex at the confluence of boundary of Gopalganj district and Gandak-Ganga River. **There are three rivers namely the Ganga, Ghaghra, Gandak** that encircle the district from southern, northern, eastern and western side respectively. Out of twenty blocks in the districts, **six blocks viz Sonepur, Dighwara, Revelganj, Chapra, Manjhi and Dariyapur are flood prone**. **There are six partially flood affected blocks Viz. Garkha, Parsa, Marhoura, Amnaur, Jalalpur, and Ekma. The remaining blocks are free from floods.**

Road & Transport

The district of Saran is well served by a network of roads. The district headquarter Chapra is situated on the **National Highway 19**, which provides road link between east and west (Hazipur to Gazipur).

Administrative Divisions

There are **3 subdivisions** with **20 blocks**. The district has **330 Gram Panchayats** constituting **1767 villages**. Out of this **1566 are inhabited** and **201 are uninhabited**. The district has 5 numbers of statutory towns with **one Nagar Parishad and 4 Nagar Panchayats.**

- **Subdivision:- Chapra, Marhaurah and Sonepur**
- **Blocks:- Chapra, Manjhi, Dighwara, Rivilganj, Parsa, Baniapur, Amnaur, Taraiya, Sonepur, Garkha, Ekma, Dariyapur, Jalalpur, Marhaura, Masarakh, Maker, Nagra, Panapur, Isuapur, Lahladpur.**

The police system comprises of network of police station and town out-posts headed by Superintendent of Police (SPs) and supported by Dy. SPs. The judicial system in the district is headed by district & session Judge

Tourisms Places in Saran

Saran district has been a hub of interfaith interaction with all the religion, resulting in places of tourist interests and cultural fairs. Few places of tourist interest are as below:

1. Aami: The place is situated over 37 Kms east of Chapra and 4 Kms west of Dighwara. It is said that in the ancient times, there was a Dirgh dwar near the Dighwara Railway Station and place came to be known as Dighwara.

In Aami there is an old temple known as Amba Sthan. Near the temple there is a garden and a broad well in which water remains all over the year and it never dries up. The believers from far off come to pay oblation established in her memory over this *Yagya Kund*. The believers from far off places also come to offer oblation in the Navratra of April & October.

2. Sonepur: Internationally famous for the large fair held on the occasion of Kartik Purnima, it is also the head quarters of Sonepur Anchal. Sonepur is a Nagar Panchayat and is noted for its Railways platform which is one of the largest in India. So far as religious aspect of Sonepur Mela is concerned, special significance is owing to the temple of shree

Hariharnath and the site of the battle of Gaj-Grah and rescue of the former by Hari During Kartik Purnima Ganga Snan or ceremonial bathing in the Ganga is held by Hindus to be unusually efficacious. On the day of full moon (Kartik Purnima) immense crowd assembles and take bath. The Mela commences on that day and lasts for more than a fortnight.

The Shiva temple, Kali temple and other temples and historical religious monuments are situated here and social and economical activities are at the highest peak during the Mela period. People come here to pay their oblation to the lords and thus its importance is not within Sonepur of Bihar rather it is of India and world fame.

3. **Dhorh Ashram:** This place is situated towards north of ParsaGarh, where Many exhibits of archeological importance can be seen. This place has got Religious importance due to the **Gigantic shivling of stone** of Bhagwan Dhadheswar Nath.

4. **Gautam Asthan:** The Ashram of Gautam Rishi is situated 5 Kms west of Chapra. As per religious belief **purification Devi Ahilya was meted out here**.

5. **Chirand:** Chirand is situated 11 Kms south east of district headquarter near Doriganj Bazaar at the north bank river Ghagra. The result of the excavation reveals about 4000 yrs developed culture of Pasan age. **Inhabitants of Chirand were engaged in animal husbandry, agriculture and hunting.** In whole of India, **new pashan age culture was first revealed here.**

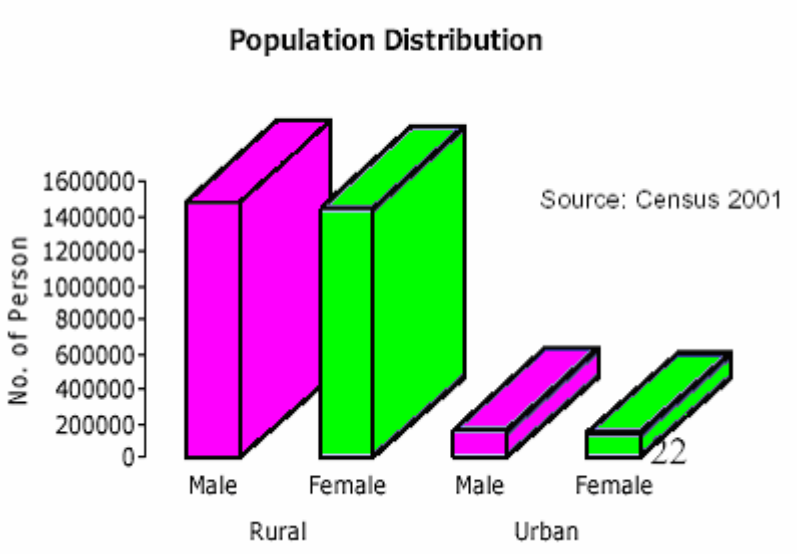
6. **Silhauri: -** This is an important place as per the child Episode of Shiv Puran and Ram charitra Manas. The mohbhan of Narad depicts the place to be here. This ancient place is 28 km away from Marhowra. On every Shivratary mela is organized here during which the devotes of Baba Shilanath come to pay their obeisances.

Data Analysis of few Parameters of Demography

Population

Population Distribution

As per the census 2001 the total population of the Saran District stands at **32, 48,701**. The majority chunk of the population resides in rural area of the district, as evident from the chart.



The **average population density per square kilometer is 1231.** In context of the social composition of the population of saran district, it can be district, as evident from the chart.
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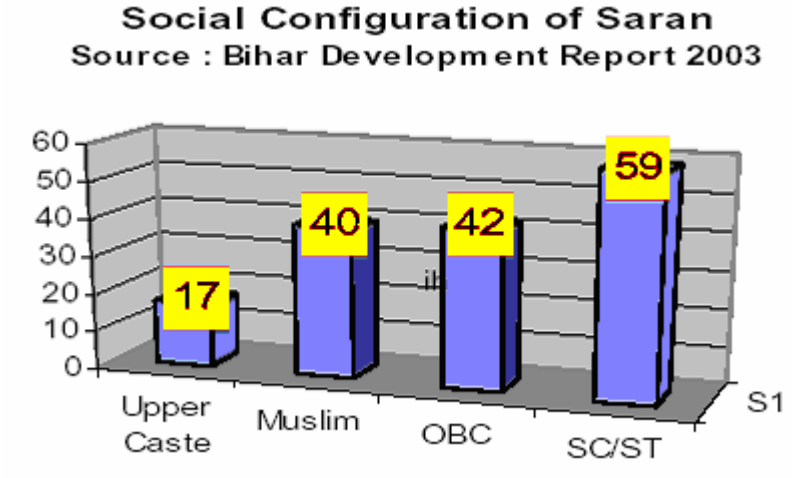
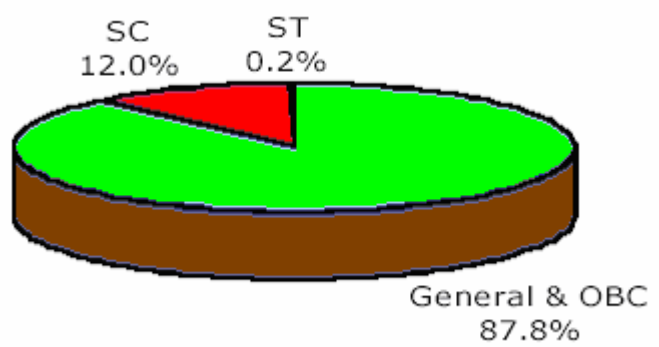


Social Composition of Saran



Seen from the chart below that **12% of total population belongs to Schedule caste category**. Schedule Tribe population is almost negligible and stands at 0.2% only. The census 2001 does not give detail on the size of OBC population but it forms the major chunk of district's population. Analysis of the social composition of the district population is important because studies have revealed significant links between social identity and poverty.

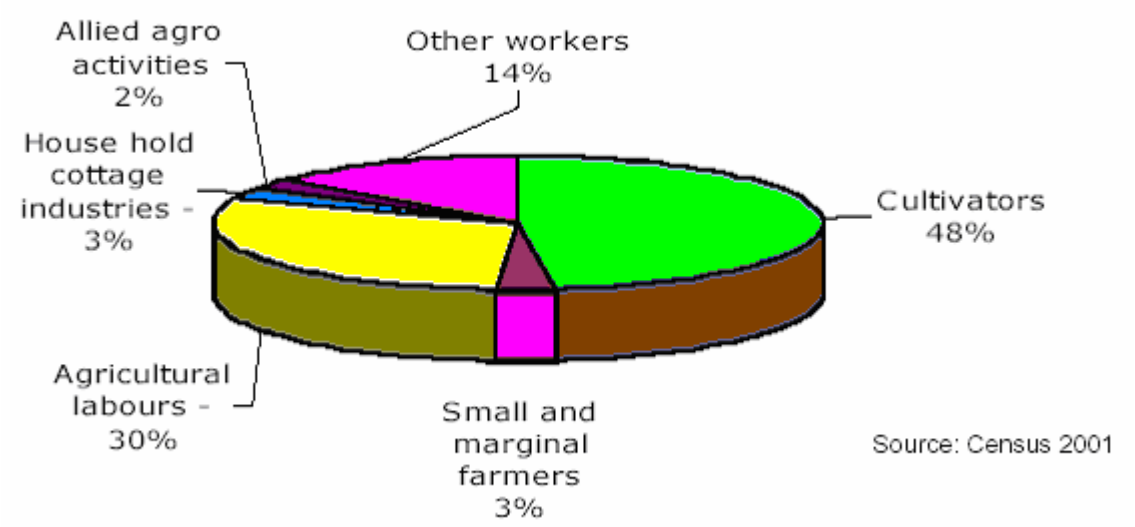
Analysis of the incidence of poverty among social group has shown that poverty is dominantly present across social groups, which are traditionally termed as "backward" in caste configuration of Bihar's social fabric. The Bihar Development Report 2003 has shown that the incidence of poverty among SC/STs groups is 59% and among OBC category it is 42%.

This would mean that a sizeable SC & OBC population of Saran district comes under the category of poor or below poverty line status.
This would therefore form an important indicator for designing development intervention in the district.

Occupation

Analysis of the occupation pattern in the district presents an interesting picture. As per the census 2001, out of the 636014 working population, the distribution of work force is as depicted in the chart below. It can be seen that the major part of the work force is directly dependent on

Occupation Pattern in Saran



farm sector for generating livelihood. Around 80% is directly related to agriculture, where 30% generate their income through agriculture labor. This points towards important aspects that **despite of agriculture being the primary occupation almost half of workers don't have land or fall in the marginal farmers' category.** This should be kept as an important bearing in mind while designing any intervention based on occupation sector (Capacity building, support etc).

A very small size of the working population is related to cottage industry. This point towards the fact that **cottage industries have received very low priority in the district as a source of occupation/livelihood**. It is also evident from the occupation distribution that industry based employment is non-existent in the district.

DISTRICT PROFILE SARAN (THROUGH FIGURES)

(Figures based on Census 2001)

Population (Census 2001)	Total	Person	3248701
		Male	1652661
		Female	1596040
	Rural	Person	2950064
		Male	1494636
		Female	1455428
	Urban	Person	298637
		Male	158025
		Female	140612

Density of the population per sq km.	1231
Sex ratio (Number of females per 1000 males)	966

Literacy Rate (Census 2001)	Total	Person	51.80
		Male	67.30
		Female	35.82
	Rural	Person	50.29
		Male	66.28
		Female	33.98
	Urban	Person	66.12
		Male	76.50
		Female	54.29

Area in Sq. Km	2641
No. of Subdivisions	3
No. of C.D. Blocks	20
No. of Villages	
(a) Total	1767
(b) Inhabited	1566
(c) Uninhabited	201
No. of Statutory Towns	5

Most populous village in the district	Sabalpur	23499
Least populous village in the district	Asgharpur	6
Most populous C.D. Block	Chapra	363036
Least populous C.D. Block	Lahladpur	70078

C.D Block having highest literacy rate	
Total	Chapra-61.50
Female	Chapra -48.30
C.D Block having lowest literacy rate	
Total	Panapur - 42.75
Female	Panapur -26.36
Town having highest literacy rate	
Total	Chapra (M)-70.84
Female	Chapra (M)-61.05
Town having lowest literacy rate	
Total	Maraura (NA)-51.47
Female	Maraura (NA)-35.36

CLASSIFICATION OF WORKERS

(a) Cultivators -	306413
(b) Small and marginal formers -	19353
(c) Agricultural labours -	188507
(d) House hold cottage industries	18112
(e) Allied agro activities -	15103
(f) Other workers -	88526

DISTRICT AND BLOCK INFORMATION

Number of Blocks –	20
Number of Revenue circles -	20
Number of subdivisions -	03
Number of Towns -	05
Nagar Parishad -	01
Nagar Panchayat –	04
Police Stations (Thana) -	30
Railway Thana -	02
O. P. –	04
T.O.P. –	15
Police District –	01
M.P. Constituency –	02
MLA Constituency –	10
Z.P. Members -	47
Gram Panchayat Mukhiya	330

EDUCATION

Primary Schools -	1265
Middle Schools -	341
High Schools -	117
Inter College(10+2) –	06
Teacher's training College	03
I.T.I. -	01

COLLEGES

(a) Constituent -	11
(b) Affiliated –	03
Govt. Residential Schedule cast High Schools	01
Number of Research organization –	02
Navodaya Vidyaalaya –	01
Central School -	03

HOSPITALS

District Hospital -	01
Referral Hospital -	03
Primary Health Centre -	15
Additional Primary Health Centre -	43
Health Sub Centre -	412
Woman Hospital (Sitab Diyara)	1

ROAD'S

National High Way	192 Km
PWD Road -	298 Km
Kachhi Road	1052 Km
Pakki Road	119 Km
Brick Soling Road	225 Km

RAILWAYS

Length of Rail Road	91.04 Km

POST OFFICES

GPO	02
Sub- Post Office	54
Branch Post Office	312

ENERGY AND ELECTRICITY

(i) Length of Distribution Network (in KM)	
(a) High Tension 11 KV Line	2008.64
(b) Low Tension 11 KV Line	2538.77
(ii) Town Electrified	
a) Number	05
b)Percentage of Total No of Town Electrified	100 %
(iii) Village Electrified	
(a) Number of Village	1635
b)Percentage of Total No of Village Electrified	74 %
(iv) Industrial Connection	
(a) Rural	422
(b) Urban	512

FINANCIAL INSTITUTIONS

Name of the Lead Bank	Bank of India
No. of Branches of lead Bank	17
No. of Other Scheduled Banks	12
No. of Branches of the other Scheduled Banks	72
Name of Regional Rural Bank	**Saran K.G. Bank**
No. of Branches of Regional Rural Banks	64
No. of Branches of Co-Operative Banks	18
No. of Branches of LDB's	06

IRRIGATION (IN HECTARE)

Net Irrigated area	101611
Canal	22320
State Tube Well Private Tube Well	72135
Others	7156

CO- OPERATIVE SOCIETY

No. of branches of Co-Operative Banks	17
No. of Packs	183
Vyapar Mandal	16
Fisheries Co- Operative Society	14

Other's	13

AGRICULTURE

Net Sown Area	199300 (hec)
Cropping pattern	Paddy, Wheat, Maize, Arhar,Gam, Lentil, Linseed, Petil
Cropping intensity	200%
Agricultural Production Yields Rates(Kg/Hectare)	573000 MT
Wheat	2500
Paddy	2000
Maize	2500
Gram	1000
Lentil	1100
Pea	1200
Arhar	1100
Linseed	800
Til	600

ANIMAL HUSBANDRY

Plough Animals	158185
Dairy Animals	
(i) Cow	82499
(ii) Buffaloes	109414
(iii) Sheep/ Goat	234640
(iv) Poultry	90000

DETAILS OF HEALTH INFORMATION

District Health Profile of Saran District		
1	Male-Female Ratio	965 Per thousand
2	Birth Rate	33.75 Per thousand
3	Growth Rate	2.1
Total No. of Health Centers in Saran District		
1	District Sadar Hospital	1
2	Referal Hospital	3
3	Primary Health Center	15
4	Add. Primary Health Center	43
5	Health Sub Center	412
6	Woman Hospital, Sitabdiyara	1

List of P.H.C./Add. P.H.C.

Sl. No.	Name of Primary Health Center	Name of Add. Primary Health Center
1	SONEPUR	1. Nowdiha, 2.Nayagaon 3. Sabbalpur
2	DIGHWARA	1 Goriepur

3	DARIYAPUR	1 Fatehpur 2.Salempur 3. Derni 4.Darihara
4	PARSA	1. Sarsouna 2. Maker 3. Bheldi
5	GARKHA	1. Dhanowra 2. Basant
6	MARHOWRAH	1. Olhanpur 2. Pojhi 3. Narharpur 4. Goura
7	AMNOUR	1. Lakshi Ketuka 2. Koreiya 3.Jhakhra 4.Katsa
8	MASHRAKH	1. Panapur
9	TARAIYA	1. Chhapia 2. Kumhaila 3. Gangoi
10	BANIYAPUR	1. Kateiya 2. Janta Bazar 3.Bhithi 4. Sohaie Gajan
11	JALALPUR	1. Raghunathpur
12	MANJHI	1. Daudpur 2.Mubarkpur
13	EKMA	1. Mukundpur 2.Mane 3.Chhitrawalia 4. Parshagadh 5. Mohhabat Nath ke Mathiya
14	REVELGANJ	1. Sitabdiyara
15	SADAR BLOCK	1. Chirand 2. Kutubpur 3.Goldinganj 4.Badalu Tola 5. Baluwa

List of Sub Centre Under Primary Health Center

SL.NO	NAME OF PRIMARY HEALTH CENTER	NO. OF SUB CENTER
1	JALALPUR	34
2	TARAIYA	32
3	BANIYAPUR	39
4	SONEPUR	26
5	MASHRAKH	34
6	DARIYAPUR	29
7	AMNOUR	26
8	SADAR BLOCK	25
9	PARSA	25
10	REVELGANJ	14
11	DIGHWARA	14
12	MANJHI	33
13	MARHOWRAH	28

14	GARKHA	27
15	EKMA	27
Total		413

Information Related to of R.N.T.C.P. Programme in Saran district

Sl.No	NAME OF CENTER	PLACE
1.	DISTRICT T.B. CENTER	Chapra
2.	ADD. T.B. CENTER	Marhowrah
3.	TUBERCULOSIS UNIT	1.District T.B. Center,
		2.Referral Hospital, Sonepur
		3.Refrral Hospital, Taraiya
		4.P.H.C.,Manjhi
		5.P.H.C., Amnour
		6.Referral Hospital,Baniyapur
4.	MICROSCOPIC CENTER	16 Working
		15 Under process

HUMAN RESOURSE				
Sl. No.	NAME OF POST	Sanction Post	In Position	Vacant
01	Civil Surgeon	01	01	
02	ACMO	01	01	
03	District RCH Officer	01	01	
04	D. M. O	01	01	
05	Dist. Training Officer	01	01	
06	Dist. T.B. Officer	01	01	
07	Dist. Leprosy Officer	01	01	
08	Dist. Mass Media & E officer	01	--	1
09	Deputy Officer	01	01	
10	Medical Officer	178		
11	Block Extension Education	16	01	15
12	Health Educator	30		
13	Health Worker(ANM)	512	367	145
14	ANM Contractual		112	

14	Health Worker(M)	169	75	94
15	Sanitary Inspector	16		
16	Pharmacist	62	11	51
17	Lab. Technician	52	12	40
18	X-Ray Technician	4	2	2
19	PHN	5	1	4
20	Nurses A Grade			
21	Sister Tutors			
22	Lady Health Visitor	33	29	4
23	Computer	16	11	5
24	Malaria Inspector	15	3	12
25	Statistician	1	1	

SITUATION ANALYSIS

The three tiers of the Indian public health system, namely village level Sub centre, Additional Primary Health Centre and Primary Health Centres were closely studied for the district of Saran on the basis of three crucial parameters:

1) Infrastructure
2) Human resources and
3) Services offered at each health facility of the district.

The Indian Public Health System (IPHS) norms define that a Village **Health Sub centre** should be present at the level of 5000 population in the plain region and at 2500-3000 population at the hilly and tribal region. As all the HSC of Saran District is situated in the plain terrain, the norm of Sub centre per 5000 population is expected to be followed. A sub centre is supposed to have its own building with a small OPD area and a room for check up. Sub centres are served by an ANM, lady health volunteer and male multipurpose health worker and supported by the Medical Officer at the APHC. Sub centres primarily provide community based outreach services such as immunisation, antenatal care services (ANC), natal and post natal care, and management of mal nutrition, common childhood diseases and family planning. It provides elementary drugs for minor ailments such as ARI, diarrhoea, fever, worm infection etc. The Sub centre building is expected to have provisions for a labour room, a clinic room, an examination room, waiting area and toilet. It is expected to be furnished with essential equipments and drugs for conducting normal deliveries and providing immunisation and contraceptive services. In addition equipment for first aid and emergency care, water quality testing and blood smear collection is also expected to be available.

The **Primary Health Centre (PHC)** is required to be present at the level of 30,000 populations in the plain terrain and at the level of 20,000 populations in the hilly region. A PHC is a six bedded hospital with an operation room, labour room and an area for outpatient services. The PHC provides a wide range of preventive, promotive and clinical services. The essential services provided by the PHC include attending to out-door patients, reproductive and child health services including ANC check-ups, laboratory testing during pregnancy, conducting normal deliveries, nutrition and health counseling , identification and management of high risk pregnancies and providing essential new born care such as neonatal resuscitation and management of neo natal hyperthermia and jaundice. It provides routine immunisation services and tends to other common childhood diseases. It also provides 24 hours emergency services, referral and in- patient services. PHC is headed by MOIC and served by two doctors. According to IPHS norms every 24 *7 PHC is supposed to have three full time nurses accompanied by 1 lady health worker and 1 male multipurpose worker. NRHM stipulates PHC to have a block health manager, accountant, storekeeper and a pharmacist/dresser to support the core staff.

According to IPHS norms, a **Community Health Centre** (CHC) is based at one lakh twenty thousand populations in the plain areas and at eighty thousand populations for hilly and tribal region. Community health Centre is a 30 bedded health facility providing specialized care in medicine, obstetrics & gynecology, surgery, anaesthesia and paediatrics. IPHS envisage CHC as an institution providing expert and emergency medical care to the community.

In Bihar, CHCs are absent and PHCs serve at the population of one lakh while PHCs are formed to serve at the population levelof 30,000. The absence of CHC and the specialised health care it offers has put a heavy toll on PHCs as well as district and sub district hospitals. Moreover various emergency and expert services provided by CHC cannot be performed by PHC due to non availability of specialised services and human resources. This has led to negative outcomes for the overall health situation of the state.

Section A: INFRASTRUCTURE

Health Sub-centres

S.No	Block Name	Population 2008 with growth @ 2.7%	Sub-centres required Pop 5000	Sub-centers Present	Further sub-centers required	Status of building		Availability of Land
						Own	**Rented**	
1	**JALALPUR**	270797	54	**34**	21	**6**	**28**	3
2	**TARAIYA**	294528	59	**32**	27	**11**	**21**	2
3	**BANIYAPUR**	327235	65	**39**	26	**8**	**31**	2
4.	**SONEPUR**	253293	51	**26**	25	**12**	**14**	2
5.	**MASHRAKH**	309107	62	**34**	28	**4**	**30**	2
6.	**DARIYAPUR**	258690	52	**29**	23	**10**	**19**	3
7.	**AMNOUR**	195526	39	**26**	13	**7**	**19**	2
8.	**SADAR BLOCK**	210323	42	**25**	17	**5**	**20**	2
9.	**PARSA**	231734	46	**25**	21	**7**	**18**	1
10.	**REVELGANJ**	118561	24	**14**	10	**7**	**7**	0
11.	**DIGHWARA**	124201	25	**14**	11	**6**	**8**	1
12.	**MANJHI**	263063	53	**33**	20	**7**	**26**	2
13.	**MARHOWRAH**	278474	56	**28**	28	**5**	**23**	2
14.	**GARKHA**	268465	54	**27**	27	**26**	**1**	0
15.	**EKMA**	216696	43	**27**	16	**10**	**17**	1
15.	**SADAR URBAN**	206171						
Total		**3826864**	**725**	413	**313**	**131**	**282**	25

Referral Hospital

No	Name of Referral	Population	Referral Present	Referral Hospital required	PHCs proposed
1.	**TARAIYA**	294528	1		
2.	**BANIYAPUR**	327235	1		
3.	**SONEPUR**	253293	1		0
	Total	875056	3	0	0

District Hospital

No	Name of District	Population	District Hospital Present	District Hospital required	PHCs proposed
1.	Saran	206171	1	1	0
	Total	**206171**	**1**	**1**	**0**

Section B – Human Resource

Health Sub Centre

	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 ownership (Govt)	Required Buildin g (Govt)	Gaps in Buildings (Govt.)	ANM residing at HSC area (Y/N)	Condition of residential facility (+++/++/+/#)	Status of furniture's	Status of Untied fund
1	413	725	312	487/210	512/644	25/434	131	594	463	N	#	#	unexpended

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

No	No. of APHC present	No. of APHC required	Gaps in APHC	Building ownership (Govt)	Buldi ng Re quire d (G ovt)	Gaps in building	Building condition (+++/++/#)	Condition of Labour room (+++/++/#)	Condition of residential facility (+++/++/+/#)	MO residing at APHC area (Y/N)	Status of furniture	Ambulance/ vehicle (Y/N)
1	43	121	78	43	78	78	#	#	#	N	#	N
Total	43	121	78	43	78	78	#	#	#	N	#	N

Additional PHC

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

Primary Health Centre

B.4 **Equipment, Drugs and Supplies**

Equipment

No.	Name of facility	Equipment required
1	Family Planning	BP Blade, BP Handle, Forceps, Scissors, Catguts etc.
2	JBSY	Labor Table, Mattress, Labor conducting for forceps etc.
3	Immunization	Deep Freezer, ILR etc.
4	Pulse Polio	Vaccination Carrier etc.
5	Filaria	Vehicles etc.

Drugs

No.	Name of facility	Drugs required
1	Family planning	Atropine, Catamin, Diagipam injection, Antibiotics etc.
2	JBSY	Matharzin injection & Tab., Antispasmodic injection. Etc.
3	Immunization	Hub Cutter etc.
4	Filaria	MDA, DEC

HEALTH SERVICES

Name of the District:			
No.	Service	Indicator	District Data
1	***Child Immunisation***	% of children 9-11 months fully immunized (BCG+DPT123+OPV123+Measles)	8172+9927+16861+2378=37338
		% of immunization sessions held against planned	100%
2	***Child Health***	Total number of live births	5959
		Total number of still births	
		% of ARI cases treated	
3	***Maternal Care***	Number of pregnant women registered for ANC	1484
		% of pregnant women registered for ANC in the 1st trimester	NA
		% of pregnant women with 3 ANC check ups	1238
		% of pregnant women with anaemia	
		% of pregnant women who received 2 TT injections	1419
		Number of RTI/STI cases treated	
		% of female sterlisations	

5	***RNTCP***	% of TB cases suspected out of total OP	3%
		Proportion of New Sputum Positive out of Total New Pulmonary Cases	825
		Annual Case Detection Rate (Total TB cases registered for treatment per 100,000 population per year)	55%
		Treatment Success Rate (% of new smear positive patients who are documented to be cured or have successfully completed treatment)	73%
		% of patients put on treatment, who drop out of treatment	94%
6	***Vector Borne Disease Control Programme***	Annual Parasite Incidence	0.00019
		Annual Blood Examination Rate	0.61
		Plasmodium Falciparum percentage	NIL
		Slide Positivity Rate	0.032
		Number of patients receiving treatment for Malaria	7
		Number of patients with Malaria referred	NIL
		Number of FTDs and DDCs	1
7	***National Programme for Control of Blindness***	Number of cases detected	7200
		Number of cases registered	6200
		Number of cases operated	5653
		Number of patients enlisted with eye problem	21000
		Number of camps Organized	40
8	***National Leprosy Eradication Programme***	Number of cases detected	776
		Number of Cases treated	776
		Number of default cases	79
		Number of case complete treatment	697
		Number of complicated cases	6
		Number of cases referred	4
9	***Inpatient Services***	Number of in-patient admissions	66253
10	***Outpatient services***	Outpatient attendance	865231

C. Community Participation, Training & BCC

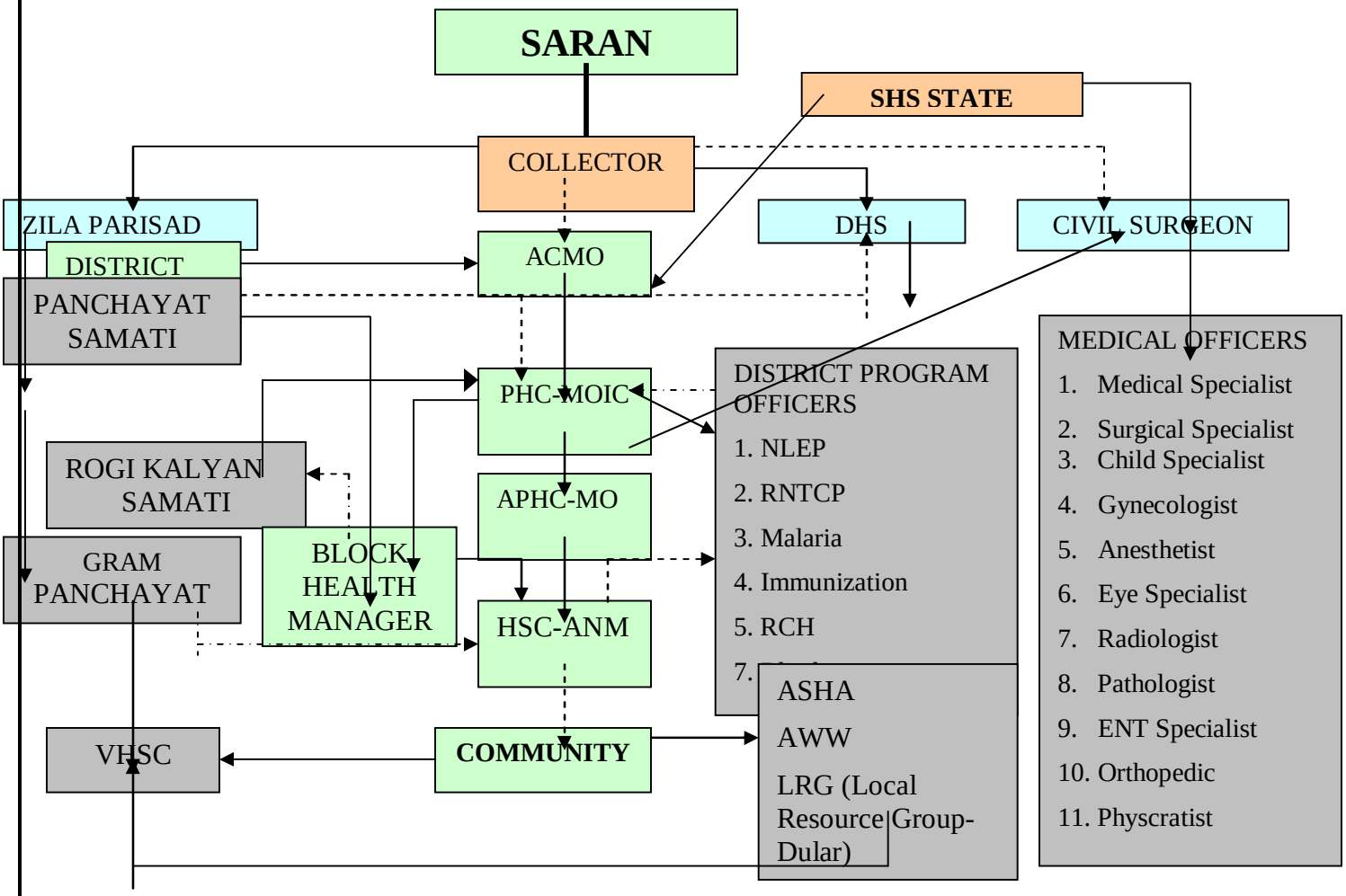
C.1 Community Participation

S.No	Name of Block	No. VHSC formed	No. of VHSC meetings held in the block		Total amount released to VHSC from untied funds	No. of ASHA's	Number of ASHA's trained	Number of meetings held between ASHA and Block offices	Total amount paid as incentive to ASHA	
							Round 1	Round 2		
1	**AMNOUR**	-	-	-	-	175	168	-		
2	**BANIYAPUR**	-	-	-	-	211	208	-		
3	**SADAR BLOCK**	-	-	-	-	200	200	-		
4	**DARIYAPUR**	-	-	-	-	200	200	-		
5	**DIGHWARA**	-	-	-	-	80	80	-		
6	**EKMA**	-	-	-	-	154	154	-		
7	**GARKHA**	-	-	-	-	252	201	-		
8	**JALALPUR**	-	-	-	-	222	166	-		
9	**MANJHI**	-	-	-	-	210	210	-		
10	**MARHOWRAH**	-	-	-	-	189	185	-		
11	**MASHRAKH**	-	-	-	-	252	219	-		
12	**PARSA**	-	-	-	-	209	209	-		
13	**REVELGANJ**	-	-	-	-	62	62	-		
14	**SONEPUR**	-	-	-	-	160	160	-		
15	**TARAIYAN**	-	-	-	-	177	160	-		
	TOTAL					**2753**	**2582**			

C.3 BCC campaigns

No.	Name of Block	BCC campaigns / activities conducted
1	**AMNOUR**	Community meetting, Mahila Mandal Meetting, I.E.C., etc.
2	**BANIYAPUR**	Do
3	**SADAR BLOCK**	Do
4	**DARIYAPUR**	Do
5	**DIGHWARA**	Do
6	**EKMA**	Do
7	**GARKHA**	Do
8	**JALALPUR**	Do
9	**MANJHI**	Do
10	**MARHOWRAH**	Do
11	**MASHRAKH**	Do
12	**PARSA**	Do
13	**REVELGANJ**	Do
14	**SONEPUR**	Do
15	**TARAIYAN**	Do

ADMINISTRATIVE MAP OF DHS



Priorities as per Background and Planning Process

PRIORITIES AS PER BACKGROUND AND PLANNING PROCESS

National Rural Health Mission encompasses a wide range of health concerns including the determinants of the good health. Though there is a significant increase in resource allocation for the NRHM, there can never be adequate resources for all the health needs and all that needs to be done for ensuring good health of all the people. It is therefore necessary to prioritize the areas where appropriate emphasis needs to be given.

Based on the background and the planning process following are the overall priorities of this District:

1. Repair and new construction of buildings of health institutions
2. To upgrade the health facilities as per IPHS
3. Significant increase in institutional deliveries
4. Increased male participation in family planning
5. To take steps to combat malaria and anaemia
6. To promote early initiation of breastfeeding and exclusive breastfeeding up to six months
7. To ensure 100% fully immunized children
8. To take effective anti-tobacco measures
9. Increased BCC / IEC measures
10. To take effective steps to increase sex ratio
11. To take measures to promote ARSH
12. To provide 100% medicines in Govt. Health institutions
13. To increase facilities for welfare of patients
14. To increase EmOC facilities
15. E-governance of health system


Goals

GOALS

The National Rural Health Mission will strive to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children and will achieve the following goals:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

INDICATOR	Current	Goals 2009-10
Reduction in Infant Mortality Rate (IMR)	**46**	**30**
Reduction in Birth Rate	**21.3**	**19**
Reduction in Total Fertility Rate	**2.3**	**2.1**
Reduction in Death Rate	**7**	**6.5**
Increase in Ante-Natal Care as defined	**60.1%**	**90%**
Increase Proportion of Pregnant Women getting IFA tablets	**26.8%**	**75%**
Increase Proportion of Pregnant Women getting 2 TT Injections	**97.7%**	**99%**
Increase Institutional Deliveries	**41.9%**	**60%**
Increase Contraceptive Prevalence Rate	**53.7%**	**62%**
Increase Complete Immunisation of children (12-23 month of age)	**55.3%**	**85%**

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAM

Revised National T.B Control Programme

Tuberculosis (TB) is a communicable disease caused by Mycobacterium Tuberculosis, which spreads from a diseased person to a healthy one. Germs of TB spread through air when untreated patients cough or sneeze. TB mainly affects the lungs; but it can also affect other parts of the body (Brain, Bones, Glands, etc.).

Tuberculosis (TB) remains a major public health problem in India. Every year approximately 18 lakh people develop TB and about 4 lakh die from it. India accounts for one fifth of global incidence of TB and tops the list of 22 high TB burden countries. Unless sustained and appropriate action is taken, approximately 20 lakh people in India are estimated to die of TB in next five years.
TB kills more adults in India than any other infectious disease.

In India, EVERY DAY:

- ☐ More than 40,000 people become newly infected with the tubercle bacilli
- ☐ More than 5000 develop TB disease
- ☐ More than 1000 people die of TB (i.e. 1 death every 1½ minutes)

The best way to diagnose lung TB is by examining the sputum under a Binocular Microscope. Germs of TB can be seen with a Binocular Microscope.

Despite the existence of a National Tuberculosis Control Programme since 1962, the desired results had not been achieved. On the recommendations of an expert committee, a revised strategy to control TB was pilot tested in 1993 in a population of 2.35 million, which was then increased in phased manner

The Revised National Tuberculosis Control Programme (RNTCP) aims to stop the spread of TB by curing patients. The key of this strategy is to cure TB through Directly Observed Treatment at a time and place convenient to the patient.

A full-fledged programme was started in 1997 and rapidly expanded in a phase manner with excellent results.

By March 2004, Saran district has been covered under RNTCP

The RNTCP is an application in India of the WHO-recommended Directly Observed Treatment, Short Course (DOTS) the most effective strategy to control TB.

Role of the District TB Control Society / District TB Centre

The TB programme will provide orientation, training, technical assistance, quality assurance of laboratory services, and supervision and monitoring of activities. It will also refer tuberculosis patients with serious complications who require hospitalization.

First time Saran district is under Target zone after RNTCP launched. The cure rate is increased upto 85 %. That is due to good performance of all the TUs. They maintain the track records of High Detection and High cure rate upto 85 %.

Saran District maintained the NSP case detection rate through out the years and improved it cure rate. The percent of positive cases detection is increased and also the cure rate has improved.

At every 100000 Population there is a provision to establish one Designated Microscopy Unit.

There are 24 Sanctioned Designated Microscopy Unit in Saran , out of 24 DMC only 16 are functional,

8 DMCs are non-functional due to lack of Microscopist/Microscope and Lab technician

Deliberations at grassroots level (village and block level) gave an idea about perceptions and level of awareness/ stigma attached to tuberculosis. Within the community, tuberculosis is recognized as a contagious disease. Due to prevailing beliefs associated with the disease it is socially stigmatized. Because of fear of segregation from the community, individuals hide the disease thereby resulting in delayed treatment. According to the members of the community, socio-economic deprivation, unhygienic living conditions and excessive smoking are factors contributing to the occurrence of infection. TB is suspected when cough persists for more than three weeks. No home treatment is practiced for curing TB. Knowledge about DOTS is low.

The preventives suggested for TB were to reduce smoking, have a nutritious diet and ensure protection from cold.

Most of the respondents spoke of the need for information dissemination about modes of transmission and prevention that could be adopted at village level. AWW, ASHA, ANM, Panchayat Members and community groups have been earmarked for this role of information dissemination.

GOAL-
To achieve and maintain the cure rate of atleast 85% among newly detected infectious (New sputum smear positive cases)
To achieve and maintain detection of at least 70% such cases in the population.

S. No.	Priority areas	Activity planned under each priority area
1	To achieve and maintain more than 85% cure rate and 90% conversion rate	1) Intensified field supervision
		2) To have a regular monthly meeting with PHI MOs and PHI staff for strictly implementation of DOTs strategy and RNTCP guidelines
		3) To have a in time necessary corrective measure to reduce death,defaulter, and failure rate
		4) Intensive supervision and timely initial home visit and providing basic health education for regular and complete treatment along with follow-up sputum examination as per schedule
		5) Providing training and refresher training to PHI staff and DOTS providers.
2	To achieve and maintain case detection rate more than 70%	(1) To have all efforts to increase reference rate more than 2-3% out of new adult O.P.D. to DMC for early diagnosis and prompt treatment
		(2) To have all efforts that all TB suspects go for 3 sputum examination and all Cat III patients have sputum re-examination.
		(3) To involve more Private Practitioner and social workers for referral of TB suspect to DMCs
		(4) To involve more and more NGOs and Public leading persons to increase reference of TB suspects to nearby DMCs
		(5) Strength IEC activity for create awareness about sign and symptoms of TB and importance of sputum examination and where to go for diagnosis
3	IEC activity	(1) To increase awareness at community level to know about the sign, symptoms, diagnosis and DMCs, treatment and DOT centres where all facilities are available free.
		(2) To have more and more Patient Provider, Community leader and group meeting.
		(3) IEC material displayed at public places
4	Maintains of contractual staff under RNTCP	(1) As and post lies vacant , will be fulfilled by available waiting list or by fresh recruitment
5	Training of newly recruited health staff	(1) Arrange training session at district or state level as per RNTCP guideline by making schedule as early as possible.
6	Strengthening the Involvement of NGOs and PPs	(1) Involve more and more NGOs and PPs and encourage them to sign the scheme of RNTCP and provide them training, material and feedback.
		2) Continous medical education and meeting with IMA.
7	Strengthening DTC/DMC/DMU	1. Maintenance and new construction of building
		2. Lab Construction.

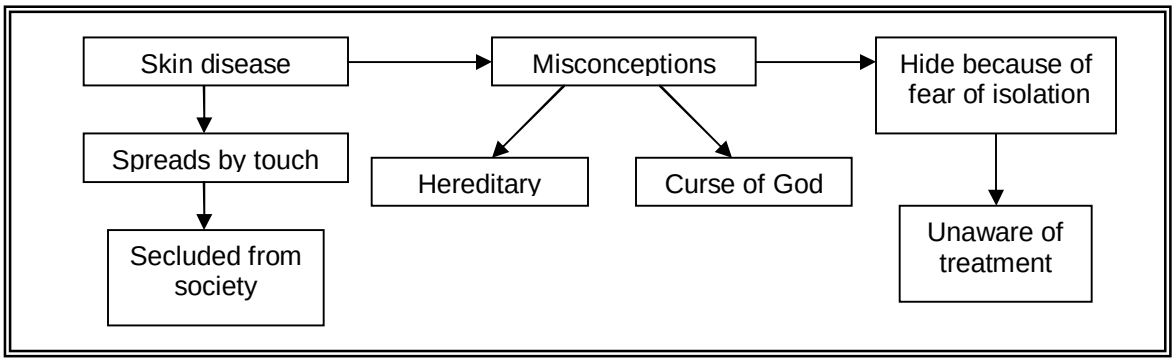
NATIONAL LEPROSY ERADICATION PROGRAME

B.2 National Leprosy Elimination Programme

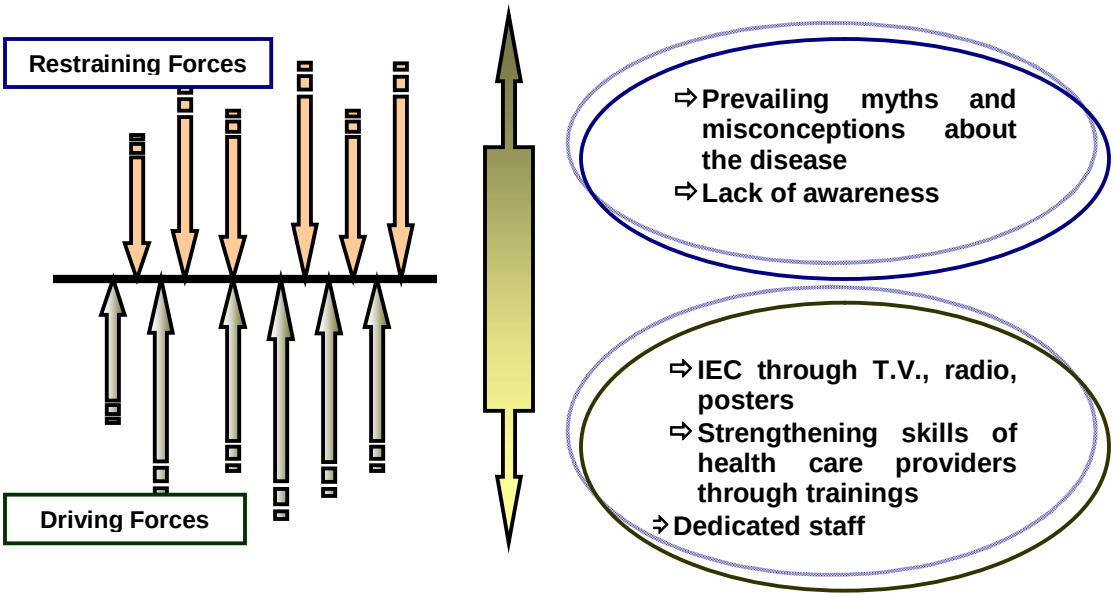
Leprosy is a chronic infectious disease caused by M. Leprae, an acid-fast, rod shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract and also the eyes, apart from some other structures. Leprosy has afflicted humanity since time immemorial. It once affected every continent and it has left behind a terrifying history and human memory of mutilation, rejection and exclusion from society.

The Govt. of India started the National Leprosy Elimination Programme in 1983 and Multi-Drug Therapy (MDT) was introduced in a phased manner district by district. The Prevalence Rate of leprosy (PR) was 21.1 in the year March-1985 which has come down to 0.89 by June-2006. World Bank assisted National Leprosy Elimination Programme (NLEP) phase-2 has been initiated since 2001.The goal of NLEP phase-2 was to eliminate leprosy by March-2005 by reducing the prevalence rate of leprosy to below 1 per 10,000 populations. The strategy of the 2nd phase of NLEP was to detect leprosy patients from high endemic districts and urban slums through Special Action Plan for Elimination of Leprosy (SAPEL).

According to the community, leprosy is a hereditary skin disease. It is believed to be curse of God. The patient is secluded from society. Initially individuals hide the symptoms because of fear of isolation from the society. There is a general notion that the disease spreads by touch. Very few are aware that the disease is curable or have heard about MDT. Prevailing erroneous beliefs and lack of awareness have been identified as the main factors which hinder the progression of the eradication programme. (Table (IV) annexed in annexure-II).



The main restraining and driving forces for leprosy are set out below



To lower the burden of leprosy and to eliminate it from the list of public health problems the programme (NLEP) aims at providing quality leprosy services through the general health care system. To strengthen the programme more effectively following strategies have been suggested.

PRIORITY AREAS:

- Regular programme review with special reference to high and medium priority blocks and PHCs
- Strategic plan for High Priority Blocks
- Supervision & monitoring of NLEP indicators monthly by all BHOs
- Active surveillance at regular interval
- Strengthening the already existing Integration of NLEP with GHS
- Strengthening of supervision at all levels by DLO & District Nucleus MOs every month
- Coordination support service for general health care staff from district technical support team
- Detailed plan for IEC with focus on high endemic and urban areas
- Coordination with local IMA / NGOs
- Monthly review of elimination activities by DLO
- POD camps in all Blocks (Taluka)/PHCs
- Capacity building of General Health Care Staff
- Urban Leprosy Control planning and implementation in urban area with multiple service providers
- Optimal utilization of allotted funds for allocated activities under the programme
- Staff orientation to calculate, interpret and use essential NLEP indicators

- Training to all newly appointed Medical Officers/Health supervisors/MPHW (M&F) / ICDS worker

- Refresher modules for all functionaries trained earlier
- Guidelines on NLEP counseling to be available at all Health Centres. Review in monthly meetings at PHC for field staff and at District Level for PHC Medical Officers
- A comprehensive IEC communication strategy for NLEP has been developed indicating suitable methods and media for high, medium and low endemic blocks
- Streamline MDT Stock Management & Supply
- Focus on adequate availability of MDT at each level viz. District, PHCs, Govt. and Non Govt. Hospitals.
- Regular monitoring of MDT stock
- Avoidance of overstocking & expiry of MDTs
- Avoidance of shortage & effect on service delivery
- Quality of storage
- Careful validation of 25 % of the newly detected cases and regular review of registers
- Regular follow up of cases under treatment with proper counseling.
- Top priority to urban area leprosy elimination activities.
- Implementation of Simplified Information System
- Availability of SIS Guidelines at all health facilities.
- Complete and timely reporting as per SIS.

Work Plan for NLEP

To achieve the programme objectives, certain strategies and intervention approaches are planned on the basis of suggestions obtained during consultative meetings.

✓ **Strategy 1**: Increase awareness among the community about the disease Leprosy is known to be one of the most socially stigmatized diseases because of little knowledge on causes and cure. Thus increasing awareness about the disease among the members of the community is the foremost strategic intervention. By improved BCC patients can be motivated to self report at the onset of suggestive symptoms. Further promotion of IEC activities can help reducing the social stigma.

✓ **Strategy 2**: Involvement of Panchayat for motivation to patients Involvement of the Panchayat can be the paramount force for motivating patients to seek treatment and eradicating misconceptions attached to his disease. By orientation of health committees and community leaders, influential members or Panchayat members can be educated on the issue.

✓ **Strategy 3**: BCC plan to mitigate stigma for increasing treatment responsiveness and eradicating fallacious beliefs associated with the disease there is need for behavior change in the community. This can be achieved by assessing the area-specific need for BCC and development of BCC materials for effective implementation.

- ✓ **<u>Strategy</u> 4:** Reinforcement of service delivery for ensuring effective service delivery there should be provision of quality diagnosis and treatment. Intense and continuous monitoring for regular supply of drugs can strengthen the service delivery mechanism. In addition, by means of counseling it is necessary to ensure that treatment is completed.

OBJECTIVE	STRATEGIES	ACTIVITY
Increase awareness among the community about the disease	BCC to motivate patients having suggestive symptoms to go for self reporting	Using ASHA and AWW to disseminate information during VH&N day
	IEC activities to reduce the social stigma	Interpersonal communication by health workers IPC Training (4 batch of 40 each)
	Involving Village committee as link agencies	Orientation of village Health & Sanitation committee
To develop BCC plan to mitigate stigma	Involvement of Panchayat for motivation to patients	Orientation of community leaders on village & health committees Development of BCC material Development of IEC material
To provide the quality treatment	Quality diagnosis and treatment	Quality diagnosis and treatment indicators to be finalized
	Intense monitoring for regular supply of drugs	Intense monitoring during sub centre days
	Appropriate counseling of patients to prevent deformities	Monitoring indicators will be developed to ensure counseling is effective

NATIONAL
VECTOR BORNE DISEASE
CONTROL PROGRAM

National Vector Borne Disease Control Programme

The NVBDCP was initiated in the year 2003-2004. It is an umbrella programme for prevention and control of vector borne diseases including Malaria, Filaria, Kala-azar and Dengue. Under the programme comprehensive and multi sectoral public health activities are implemented. Districts teams should review incidence and prevalence data available for these diseases in the district through surveillance activities and plan as per national strategy adapted to address local needs. Vector borne diseases like Malaria, Kala-azar , Dengue and Japanese encephalitis are outbreak prone diseases and therefore during formulation of the district health plan, epidemic response mechanism should also be outlined.

The main objectives of NVBDCP are:

- To reduce mortality and morbidity due to Malaria
- To reduce percentage of PF cases.
- To control other vector borne diseases like Kala azar, Dengue, Filaria, Chikungyniea etc.

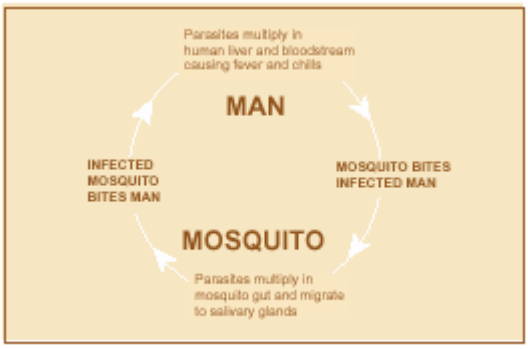
Saran is a Kala azar & Malaria prone district of Bihar .

B.3.1 MALARIA

Malaria is a life-threatening parasitic disease transmitted by mosquitoes. It was once thought that the disease came from fetid marshes, hence the name mal aria, (bad air). In 1880, scientists discovered the real cause of malaria a one-cell parasite called plasmodium. Later they discovered that the parasite is transmitted from person to person through the bite of a female Anopheles mosquito, which requires blood to nurture her eggs.

Today approximately 40% of the world's population mostly those living in the world's poorest countries are at risk of malaria. The disease was once more widespread but it was successfully eliminated from many countries with temperate climates during the mid 20th century. Today malaria is found throughout the tropical and sub-tropical regions of the world and causes more than 300 million acute illnesses and at least one million deaths annually.

There are four types of human malaria Plasmodium vivax, P. malariae, P. ovale and P. falciparum. P. vivax and P. falciparum are the most common and falciparum the most deadly type of malaria infection.



Man and mosquito play complementary roles in the malaria cycle.

The malaria parasite enters the human host when an infected Anopheles mosquito takes a blood meal. Inside the human host, the parasite undergoes a series of changes as part of its complex life-cycle. Its various stages allow plasmodia to evade the immune system, infect the liver and red blood cells, and finally develop into a form that is able to infect a mosquito again when it bites an infected person. Inside the mosquito, the parasite matures until it reaches the sexual stage where it can again infect a human host when the mosquito takes her next blood meal, 10 to 14 or more days later.

Malaria symptoms appear about 9 to 14 days after the infectious mosquito bite, although this varies with different plasmodium species. Typically, malaria produces fever, headache, vomiting and other flu-like symptoms. If drugs are not available for treatment or the parasites are resistant to them, the infection can progress rapidly to become life-threatening.

Malaria can kill by infecting and destroying red blood cells (anaemia) and by clogging the capillaries that carry blood to the brain (cerebral malaria) or other vital organs.

Malaria, together with HIV/AIDS and TB, is one of the major public health challenges undermining development in the poorest countries in the world.

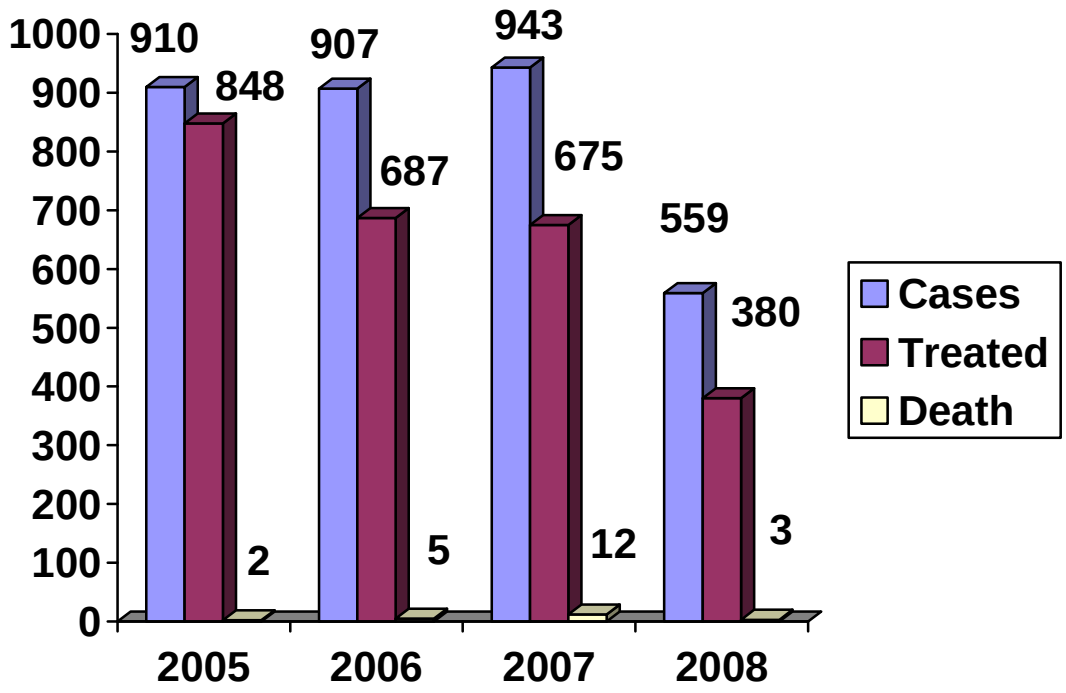
Goal- To reduce mortality and morbidity due to Malaria

OBJECTIVES	CONSTRAINTS	STRATEGIES	ACTIVITIES
Early Case Diction and Prompt Treatment	Lack of Knowledge about malaria prone areas	Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment	House to house survey by ASHA/AWW/MHW etc
	Lack of Human resources such as Malaria inspector , Lab Technician	Appointment of L.T and Malaria inspector on Contract basis	Publication of vacancies
			Recruitment & selection of H.R
	Lack of FTDs & DDC	For complete surveillance of fever cases identification and treatment, role of FTDs and DDCs are very important Establishments of FTDs and DDCs	Appointment of Malaria link workers on contract basis
			Training of Malaria link workers
			Establishment of Fever Testing depots at every 5000 Population
			Establishment of Drug distribution center at every 5000 Population.
		Follow MAP treatment policy	Strictly follow the MAP treatment guidelines for diagnosis & treatment of malaria cases
			Procurement of Rapid diagnosis sticks for PF cases.
			Procurement and timely supply of necessary equipments and lab reagents
			Procurement & supply of essential drugs
Strengthening institutional infrastructure	Lack of Infrastructure for District Malaria Office such as office , vehicle and store	Construction / hire building on rent for District Malaria office and store	Construction of building for District Malaria office & Store
			Hire building on rent for District Malaria office & Store
			Provision for Vehicle for DMO for better monitoring
Preventive Vector Control	**Lack of Biological control (Hatchery)**	**Establishment of hatchery at every block**	Establishment of hatchery for larvivours fishes at district level as well as at block level.
			Introduction of fishes at breeding places at least once in every six months

	Improper and poor spraying	**Indoor Residual Spray**	Timely and proper IRS in high risk area according to MAP guidelines
		To reduce man mosquito contact	To reduce man mosquito contact distribution of Impregnated Mosquito Net in high risk area.
To increase the knowledge about the sign , symptoms and treatment of Malaria	**Lack of awareness and knowledge about the malaria in masses**	Emphasize upon Behavioral Change communication and social mobilization	Awareness generation towards adopting personal prophylactic measures to control Malaria
			Awareness towards service delivery centers for treatment of Malaria
			Awareness generation towards the spray

B.3.2 Kala-Azar

Saran is a Kala-azar prone area in the State. Studies reveals that the ST and SC community especially Mushhar community are vulnerable towards the epidemic due to their poor living conditions.



Kala-azar scenario at Saran

Goal

To contribute to improving the health status of vulnerable groups and at-risk population living in kala-azar-endemic areas by the elimination of kala-azar so that it is no longer a public health problem.

Targets

To reduce the annual incidence of kala-azar to less than one per 10,000 population at district by 2010.

- Reduce case fatality rates
- Prevent the emergence of Kala azar/HIV/AIDS, and TB co-infections

Objectives	Constraints	Strategies	Activities

Early Case Diction and Prompt & complete Treatment	Lack of Knowledge about Kala-azar prone areas	Identify pockets populations at risk to have increased access to early diagnosis and prompt treatment	House to house survey by ASHA/AWW/MHW etc
	Lack of Human resources such as Lab Technician	Appointment of L.T on Contract basis	Publication of vacancies
			Recruitment & selection of H.R
	Lack of FTDs & DDCs	For complete surveillance of Kala-azar cases identification and treatment, role of FTDs and DDCs are very important. Use of FTDs and DDCs of Malaria for Kala-azar cases	Appointment of link workers on contract basis
			Training of link workers
			Establishment of Fever Testing depots at every 5000 Population
			Establishment of Drug distribution center at every 5000 Population.
	Lack of equipment & Drugs, reagents	Timely diagnosis and treatment	Strictly follow the treatment guidelines for diagnosis & treatment of Kala-azar cases
			Procurement of K-39 testing kits .
			Procurement and timely supply of necessary equipments and lab reagents
			Procurement & supply of essential drugs
Provide better living condition	Lack of Pucca houses for vulnerable community	Convergence to welfare and DRDA for availability of pucca houses under Indira Awas Yojna	Meeting with public representatives and PRIs
			Meeting with DDC and DRDA director
			Meeting with Block program officer (DRDA)
To make preventive measures to eradicate Kala-azar	Improper & poor spraying of DDT	Indoor Residual Spray	Timely IRS in high risk area and vulnerable area.
			Monitoring of spraying by MOIC & Block Health Managers
			Capacity building programme for sprayer for DDT spray to ensure that every corner of the house is properly spray up to height of six feet from the ground level.
		To reduce man mosquito contact	To reduce man mosquito contact by distribution of Impregnated Mosquito Net in high risk area and vulnerable community/people
	Myths and misconception about the spray	To conduct IEC/BCC activities	Awareness generation about the DDT Spray for Kala-azar
			FGD with vulnerable people

			about the spraying
			One to one meeting by ASHA with vulnerable households on spraying
		Emphasize upon Behavioral Change communication and social mobilization	Awareness generation towards adopting personal prophylactic measures to control Kala-azar
			Awareness towards service delivery centers for treatment of Kala-azar
			Awareness generation towards the spray

B.3.3 Filaria control Programme

The National Filaria Control Programme was launched in 1555 for the control of filariasis. Activities taken under the programme include: (i) delimitation of the problem in hitherto unsurveyed areas, and (ii) control in urban areas through recurrent anti-larval measures and anti parasite measures. Man, with micro Filaria in the blood is the main reservoir of infection. The disease is not directly transmitted from person to person, but by the bite of many species of mosquitoes which harbor infective larvae. Important vectors are species of Culex, Anopheles, Mansonia and Aedes. The incubation period varies, and micro-Filaria appears in the blood after 2-3 months in B. malayi after 6-12 months in W. bancrofti infections.

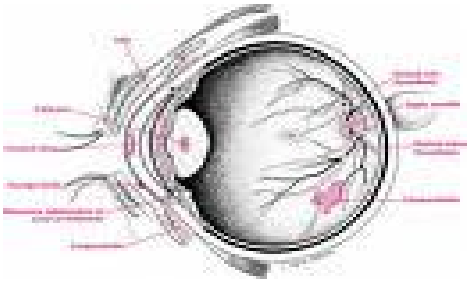
Constraints

- It affects mainly the economically weaker sections of communities
- Result in low priority being accorded by governments for the control of lymphatic filariasis.
- Low effectiveness of the tools used by the control programme
- The chronic nature of the disease and that

Suggestions

- Single dose DEC mass therapy once a year in identified blocks and selected DEC treatment in filariasis endemic areas.
- Continuous use of vector control measures.
- Detection and treatment of micro-Filaria carriers, treatment of acute and chronic filariasis.
- IEC for ensuring community awareness and participation in vector control as well as personal protection measures.

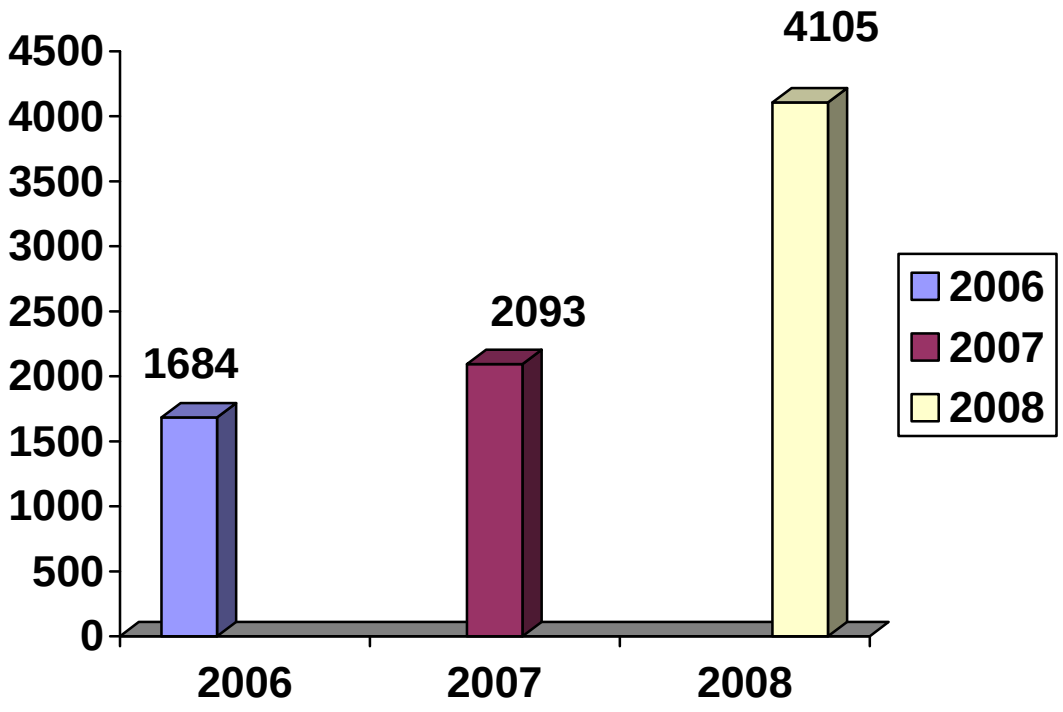
NATIONAL
BLINDNESS CONTROL
PROGRAM



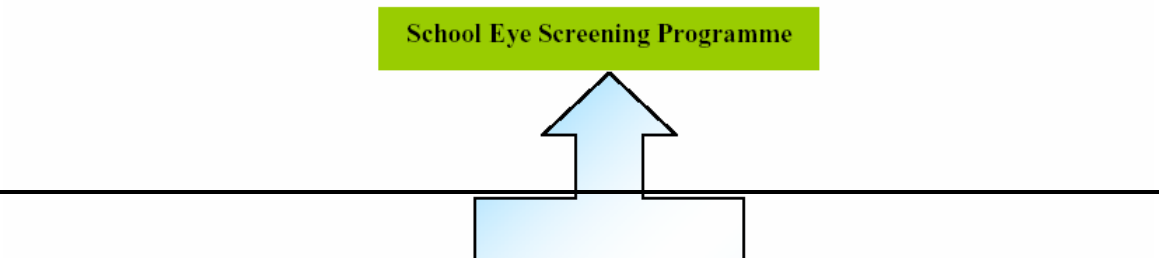
B.4 NATIONAL BLINDNESS CONTROL PROGRAMME

Blindness is a major public health problem in most developing countries where eye care facilities are still limited. Cataract is the leading cause accounting for 50% to 70 % of total blindness.
India is the first country in the world to launch blindness prevention related programme as early as 1963 i.e. National programme for trachoma control. After few changes in the names, this programme was re-designated, since 1976 as "National programme for Control of Blindness" (NPCB)

The National programme for control of blindness was launched in year 1976 with a goal for reduction in prevalence of blindness from 1.4 percent to 0.3 percent. The four-pronged strategy refers to strengthening service delivery, developing human resources for eye care, outreach activities and developing institutional capacities. All school children in the age group of 10-14 years should be screened for refractive errors. Percentage of children detected with refractive errors should be 5-7%.



Year wise no. of Cataract operation



Objectives	Constraints	Strategies	Activities
To increase cataract surgery rate	**Lack of eye surgeon & Opthalmist in the district**	Strengthening service delivery	Filling vacant posts of eye specialists
			Organizing outreach camps in rural areas & extremely backward classes tola
		Target older age groups	Identification of cases
			Increase treatment acceptance
			Follow up to treated cases
To Increase the surgery rate with IOL	**Lack of equipments and drugs**	Procurement, distribution and assurance of quality equipment and drugs	Operational mobile units (procurement of ambulance, microscope etc
			Ensure adequate supply of medicines
			Continuous availability of vitamin A
	Lack of knowledge about the new technology	**In-service training programmes**	Refresher training course for eye surgeons & opthalmists for skill up gradation (new techniques)
School Eye Screening: children in the age group of 10-14 years should be screened for refractive errors	**Lack of awareness about the refractive errors**	**School health camps**	Organization of camps for identification of children with refractive errors and prohibition of free spectacles
			Training to teachers in schools
			Snellen's Vision Box for schools
		Promoting outreach activities and public awareness	Effective communication about outreach camps
			Awareness regarding eye-care
Oral Health Screening for - Community - School children		**Promotion of Vitamin A supplementation through AWW , ANM and ASHA**	Promotion of Vitamin A supplementation
			IEC campaigning about eye donation

B.5 INTEGRATED DISEASE SURVEILLANCE PROJECT

Goal

To reduce the burden of morbidity and mortality due to various diseases in the district.

Objective

- Establishing a sustainable decentralized system of disease surveillance for timely and effective public health action.
- Integrating disease surveillance activities. To avoid duplication and facilitate sharing of information across all disease control programmes so that valid data are available for appropriate health decision.

Epidemic branch deals with Communicable Diseases, i.e. Waterborne Diseases such as Cholera, Gastroenteritis, Typhoid and Infective hepatitis, Zoonotic Diseases like, Plague and Leptospirosis, Arthropod borne diseases like, Dengue fever, Kala-azar and Malaria , Air borne disease like Meningococcal Meningitis and provides health relief services in the wake of natural calamities like heavy rain, floods, draught, cyclone etc. to prevent post calamity disease outbreak. The collection and a good analysis of data analysis of this data gives us the indication when to apply what method to stop epidemic and control it.

Strategies adopted

- Operationalization of norms and standards of case detection, reporting format.
- Streamlining the MIS system- Establishing Web based & channels for data collection within the district and transmission mechanisms to state level.
- Analyzing line listing of cases and Geographical Information Systems (GIS) mapping approach Preparation of graphs & charts on the basis of reports for planning strategies during epidemic outbreak.
- Training to all the grass root level workers, MO's & CHC staff in Data Collection, and data transfer mechanisms.

B. 6 ASHA (Accredited Social Health Activist)

ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services. She will counsel women on birthpreparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child. ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government. She will work with the Village Health & Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan. She will arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre- identified health facility i.e. Primary Health Centre/Community Health Centre/ First Referral Unit (PHC/CHC /FRU).
ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA Emphasizing evidence base decentralized village and district level health planning and management is going to be accomplished through appointment of Accredited Social Health Activist (ASHA).
The general norm was **'One ASHA per 1000 population'.** The criteria for selection were women preferably eighth pass and married/widowed of same village. She should be 'Bahu' of that particular village.

Selection of ASHA

Out of revised target of 2549 ASHA selection of 1866 ASHA has been selected and 1548 ASHA has been trained on first Module. Rest of selection and Training of remaining ASHA will be completed in the year 2009-2010.
District training team had received TOT in the year 2006. They are responsible for giving training at the block level. The TOT members who received the training will train the ASHA at the block level.

The main Constraints in proper implementation of ASHA are following:

- Poor coordination between the MOIC and Mukhias on selection.
- Lack of interest in ASHA selection amongst PRIs members

- Due to excess load of work DPMU & BPMU personnel un -deliberately do not focus on the ASHA programme. That's why all the issues related to ASHA such as selection, Training, Payment of incentives etc. are untouched.

To over come to this issue , There is a great need of a District Project Manager (ASHA) , at the district level and Block ASHA Manager at each and every block, Whose are respectively responsible for all the works related to ASHA at the District level and the Block level. Except that for helping ASHA in their work there should be a Help Desk at block level and village level in each and every block and villages.

Space for Comments

BUDGET

	Budget Head					
Slno.	1. Maternal Health	Q.1	Q.2	Q.3	Q.4	Total
1.1	Operationalise Blood Storage units in FRU	144000.00	144000.00	40000.00	40000.00	368000.00
1.2	Organise workshops on various aspects of operationalisation of 24x7 services at the facilities @ Rs. 25,000 / year / district	0.00	25000.00	0.00	0.00	25000.00
1.3	RCH Outreach Camps un-served/under served areas	0.00	7300.00	7300.00	0.00	14600.00
1.4	Home deliveries	40000.00	50000.00	58500.00	58500.00	207000.00
1.5	(A) Institutional deliveries (Rural) @ Rs.2000/- per delivery for 10.00 lakh deliveries	19496107.00	19496107.00	19496107.00	19496110.00	77984431.00
1.6	(B) Institutional deliveries (Urban) @ Rs.1200/- per delivery for 2.00 lakh deliveries	2339649.00	2339649.00	2339649.00	2339651.00	9358598.00
1.7	Incentive for MAMTA @ Rs. 100 per delivery	13500.00	13500.00	13500.00	13500.00	54000.00
1.8	Caesarean delivery	85500.00	85500.00	86126.00	86126.00	343252.00
1.9	Monitor quality and utilisation of services@ 2% of total JBSY budget	0.00	263664.19	263664.19	263664.19	790992.56
	2. **Child Health**					
	IMNCI					
2.1	Monitor progress against plan; follow up with training, procurement, review meetings etc	42378.00	42378.00	42378.00	42378.00	169512.00
2.2	School Health Programme (Details annexed)	0.00	1986795.00	1986795.00	1986834.00	5960424.00

	3. Family Planning					
3.1	Dissemination of manuals on sterilisation standards & quality assurance of sterilisation services	0.00	25000.00	0.00	0.00	25000.00
3.2	Compensation for Provide female sterilisation at PHC level in camp mode. Provide female sterilisation services on fixed days at health facilities in districts (Mini Lap)	2605000.00	2605000.00	2605000.00	7815000.00	15630000.00
3.3	Organise NSV camps in districts @Rs.10,000 x 500 camps	0.00	10000.00	30000.00	30000.00	70000.00
3.4	Compensation for NSV Acceptance @50000 cases x1500	333717.00	333717.00	333717.00	333717.00	1334868.00
3.5	Accreditation of private providers to provide sterilisation services	1082063.00	1082063.00	1082063.00	1082061.00	4328250.00
3.8	IUD Camps	0.00	60000.00	60000.00	60000.00	180000.00
3.9	Organise Contraceptive Update seminars for health providers (one at state level & 38 at district level) (Anticipated Participants-50-70)	0.00	0.00	0.00	0.00	0.00
3.10	POL for Family Planning for 500 sub-district facilities	0.00	125078.20	125078.20	125078.12	375234.52
3.11	Repair of Laproscopes	0.00	0.00	0.00	0.00	0.00
	4.Adolescent Reproductive and Sexual Health					
4.2	Disseminate ARSH guidelines. Conducting ARSH Camp in 10% of Subcentres across the	0.00	25000.00	0.00	0.00	25000.00

	state (as Village ARSH Week)					
	6. Innovations					
	PNDT and Sex Ratio					
6.1	Orientation programme of PNDT activities, Workshop at State, District and Block Level (1+38+533) Monitoring at District level and Meetings of District level Committee	0.00	139774.86	139774.86	139774.86	419324.58
6.2	Incentive for ASHA per AWW center (80000x200 per month) Incentive for ANMs per AWW center (80000x150 per month)	3203682.33	3203682.33	3203682.33	3203682.33	12814729.32
	7. Infrastructure and Human Resource					
7.1	Hiring of 1000 Retired ANMs or ANMs from other states for out reach services @ Rs. 5000 / month / ANM	0.00	500000.00	500000.00	500000.00	1500000.00
7.2	Doctors and Specialists Hiring Specialists	1924503.00	1924503.00	1924503.00	1924503.00	7698013.00
	8. Training					
8.1	SBA Training	374400.00	294400.00	294400.00	294400.00	1257600.00
8.2	MTP Training nurses/ANMs in safe abortion	0.00	25000.00	0.00	0.00	25000.00
8.3	IMNCI Training for Medical Officers (Physician) Health worker ANMs / LHVs/AWWs	1407003.75	1407003.75	1407003.75	1407003.75	5628015.00

8.4	ARSH Training for Medical Officers one day ARSH Orientation by the MOs of 25% ANMs One Day ARSH Orientation of PRI by the MOs of50% ANMs	0.00	0.00	0.00	0.00	0.00
8.5	Training of DPMU staff @ 38 x Rs.10,000	31500.00	31500.00	31500.00	31500.00	166000.00
	9. BCC/IEC					
9.1	I. Development of State BCC/IEC Strategy II. Concept and Material Development workshops by state BCC/IEC cell III. Establishment cost of the state BCC/IEC cell IV. Technical support at District Leval	12500.00	0.00	12500.00	0.00	25000.00
9.2	Other activities BCC/IEC	453750.00	453750.00	453750.00	453750.00	1815000.00
	10. Procurement of Equipments/Instruments					
10.1	Procurement of Equipments Equipments / instruments for Blood Storage Facility / Bank at facilities Equipments / instruments, reagents for STI / RTI services @ Rs. 1 Lac per district per year	33223.68	33223.68	33223.68	33223.68	132894.74
	11. Programme Management					

11.1	Contractual Staff for DPMSU recruited and in position	184796.00	184796.00	184796.00	184796.00	739184.00
11.2	Appointment of CA	60000.00	60000.00	60000.00	60000.00	240000.00

Budget Summary

Programme Name	Budget
Operationalise FRU	368000
JBSY Home Deliveries	207000
Institutional Deliveries (Rural)	77984431
Institutional Deliveries (Urban)	9358598
Caesarean Deliveries(Facility Gynec, Anesth & Paramedic)	343252
School Health Programme	5960424
Family Planning (Dissemination of manuals on Sterilization standards & Quality assurance of sterilization services	25000
Family Planning(NSV Camps) organized NSV Camps in District	70000
Family Planning (Compensation for Female Sterilization)	15630000
Family Planning (Compensation for Male Sterilization)	1334868
Accreditation of Private providers for sterilization services	4328250
Family Planning (IUD Camps)	180000
Family Planning (POL) for Family Planning	375234.52
Family Planning (Other Activities)	14341
SBA	1257600
IMNCI	5628015
BCC-IEC	1840000
Programme Management	1818526
Asha day	3222280
Untied fund for sub centre	5821000
Rogi Kalyan samiti	2600000
Constructions of HSC	7600000
Construction of Residential Quarter	3000000
Construction of Building of APHC	5315000
Up gradation of CHC	24000000
Up gradation of training school	2500000
Block Programme management unit	10863939.96
Routine Immunization (CRI)	8717005
Pulse Polio (CPP)	20358112
Monitoring and Evaluation (Data Centre)	2070000
Dial 102 Amubalance Services	492000
1911-Doctor on Call and Samadhan	136000