

District Health Action Plan

2010-2011



**District Health Society
Munger**

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Foreword

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system.

This District Health Action Plan (DHAP) is one of the key instruments to achieve NRHM goals. This plan is based on health needs of the district.

After a thorough situation 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 public/NGO/private sector, availability of wide range of providers. This DHAP has been evolved through a participatory and consultative process, wherein community and other stakeholders have participated and ascertained their specific health needs in villages, problems in accessing health services, especially poor women and children at local level.

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 and Family Welfare and State Health Society of Bihar for their 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.

**ARVIND KR. SINGH, IAS
(DM, MUNGER)**

About the Profile

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

The information related to data and others used in this action plan is authentic and correct according to my knowledge as this has been provided by the concerned medical officers of every block. I am grateful to the state level consultants (NHSRC/PHRN), ACO, MOICs, Block Health Managers and ANMs and AWWs from their excellent effort we may be able to make this District Health Action Plan of Vaishali District.

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

Dr. Abbid Hussian
ACMO
Munger

Dr. K.C.singh
Civil Surgeon
Munger

Chapter-1

Introduction

1.1 Background

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

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

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

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

For effective programme implementation NRHM adopts a synergistic approach as a key strategy for community based planning by relating health and diseases to other determinants of good health such as safe drinking water, hygiene and sanitation. Implicit in this approach is the need for situation analysis, stakeholder involvement in action planning, community

mobilization, inter-sectoral convergence, partnership with Non Government Organizations (NGOs) and private sector, and increased local monitoring. The planning process demands stocktaking, followed by planning of actions by involving program functionaries and community representatives at district level.

Stakeholders in Process

- ❑ *Members of State and District Health Missions*
- ❑ *District and Block level programme managers, Medical Officers.*
- ❑ *State Programme Management Unit, District Programme Management Unit and Block Program Management Unit Staff*
- ❑ *Members of NGOs and civil society groups*
- ❑ *Support Organisation – PHRN and NHSRC*

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

1.2 Objectives of the Process

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

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

1.3 Process of Plan Development

1.3.1 Preliminary Phase

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

1.3.2 Main Phase – Horizontal Integration of Vertical Programmes

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

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

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

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

Government of India has launched National Rural Health Mission, which aims to integrate all the rural health services and to develop a sector based approach with effective intersectoral as well as intrasectoral coordination. To translate this into reality, concrete planning in terms of improving the service situation is envisaged as well as developing adequate capacities to provide those services. This includes health infrastructure, facilities, equipments and adequately skilled and placed manpower. District has been identified as the basic coordination unit for planning and administration, where it has been conceived that an effective coordination is envisaged to be possible.

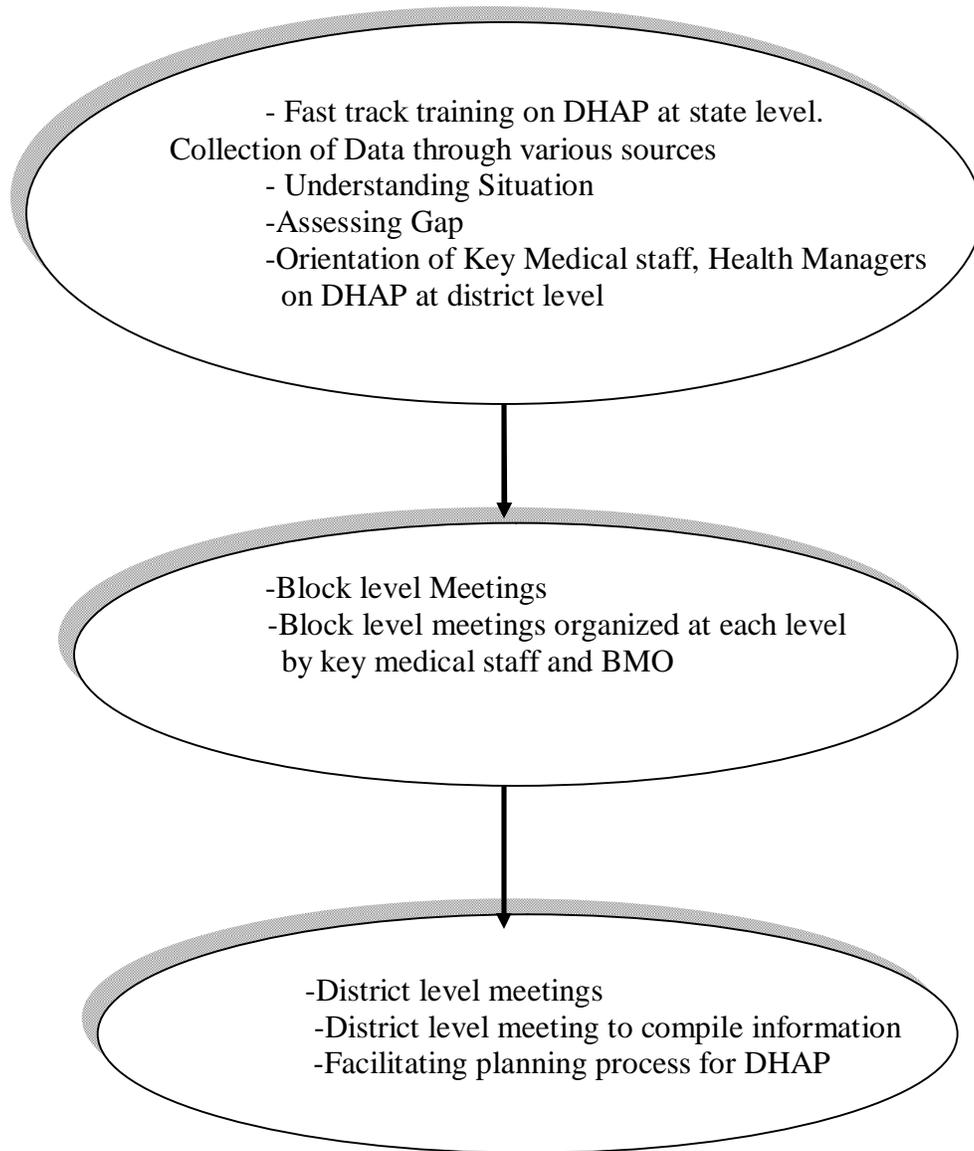
This Integrated Health Action Plan document of Vaishali district has been prepared on the said context.

1.3.3 Preparation of DHAP

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

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

District Health Action Plan Planning Process



MUNGER – Historical Pointers

The territory included within the district of Munger (famously Monghyr) formed part of the Madhya-desa as “Midland” of the first Aryan settlers. It has been identified with Mod-Giri a place mentioned in the Mahabharata, which was the capital of a kingdom in Eastern India near Vanga and Tamralipta. In the Digvijaya Parva of Mahabharata, we find the mention of Mod-Giri, which seems similar to Mod-Giri. Digvijaya Parva suggests that it was a monarchical state during early times. A passage in the Sabha-Parva describes Bhima’s conquest in Eastern India and says that after defeating Karna, king of Anga, he fought battle at Modagiri and killed its chief. It was also known as Maudal after Maudgalya, a disciple of Buddha, who converted a rich merchant of this place into Buddhism. Buchanan says that it was the hermitage of Mudgala Muni and this tradition of Mudgal Rishi still persists. Munger is called “Modagiri” in the Monghyr copperplate of Devapala. The derivation of the name Munger (Monghyr) has found the subject of much speculation. Tradition ascribes the foundation of the town to Chandragupta, after whom it was called Guptagars a name which has been found inscribed on a rock at Kastaharni Ghat at the north-western corner of the present fort. It is insisted that Mudgalrishi lived there. Tradition ascribes the composition of various sukta of the 10th Mandala of the Rigveda to Rishi Mudgal and his clan. However, General Cunningham had strong suspicion when he connects this original name with Mons as Mundas, who occupied this part before the advent of the Aryans. Again Mr. C.E.A. Oldham, ICS, a former collector suggests the possibility of Munigihā, i.e., the abode of the Muni, without any specification which later corrupted to Mungir and later became Munger.

At the dawn of history, the present site of the town was apparently comprised within the Kingdom of Anga, with the capital Champa near Bhagalpur. According to Pargiter, Anga comprises the modern districts of Bhagalpur and Munger commissionerary. The Anga dominion at one time included Magadha and the Shanti-Parva refers to an Anga king who sacrificed at Mount Vishnupada. In the epic period Modagiri finds mention as a separate state. The success of the Anga did not last long and about the middle of the sixth century B.C. Bimbisara of Magadha is said to have killed Brahmadatta, the last independent ruler of ancient Anga. Hence the Anga became an integral part of the growing empire of Magadh. As epigraphic evidence of the Gupta period suggests that Munger was under the Guptas. To the reign of Buddhagupta (447-495 A.D.) belongs a copper plate of A.D. 488-9 originally found at Mandapura in the district.

HIUEN TSIANG’S ACCOUNT: However the first historical account of the district appears in the Travels of HIUEN TSIANG, who visited this area towards the close of the first half of the seventh century A.D. Hiuen Tsiang observed “The country is regularly cultivated and rich in produce flowers and fruit being abundant, the climate is agreeable and manners of the people simple and honest. There are 10 Buddhist monasteries with about 4,000 priests and few Brahminical temples occupied by various sectaries”. The pilgrim’s “I-lan-ha-po-fa-to” country is identified as this area. He had to pass through thick forest and strange mountains into the country of Hiranayaparvat. The capital Hiranayaparvat, lay, on the southern bank of Ganga, and closed to it stood Mount Hiranya, which “belched masses of smoke and vapour that obscured the light of the sun and the moon”. The position of this hill is determined from its proximity to the Ganga, to be Munger and though no smoke now comes from any peak, the numerous hot springs in the hills point to famous volcanic action. These hot springs are also mentioned in Hiuen Tsiang’s Account. General Cunningham identified the hot springs being those of Bhimbandh and its offshoots. Other authorities refer to it as Uren in present Lakhisarai District.

Unfortunately, there is a historical gap of almost two centuries when we find its fresh mention in the Munger copper plate of Devapala discovered at Munger about 1780. We learn from this copper plate about Dharampala (c.770-810) who preceded far beyond Kanauj in his military campaigns. It refers to a campaign of Dharampala along the foot of the Himalayas. Tripartite struggle between the Palas, Rashtrakutas and Gurjar-Pratihars for supremacy over Kanauj was a dominant factor in the history of northern India. We find mention of Pala king Gopal, his son Dharampala & Devapala. Munger prominence is also corroborated by the Nawlagarth inscriptions of Begusarai. The Bhagalpur plate of Narayanpala, executed at Munger, shows their policy of religious tolerance and their patronage to the worshippers of Shiva & Sakti cults.

Till the advent of the Turkish rule in India, Munger was under sway of the Karnatak dynasty of Mithila. However Bakhtiyar Khilji took possession of Territory any of Munger in AD1225. Thus Munger in possession of the Khilji ruler Gyasuddin. After a tussle and aftermath a peace treaty Munger came under the control of Sultan of Bengal between 1301-1322, which is corroborated by the Lakhisarai Inscription. Munger came under the possession of Muhammad Bin Tugular who annexed Munger to Delhi for some time. In 1342 the whole of north India witnessed the turmoil and Late Spasmodic Ilyas Shah of Bengal taking advantage of the opportunities established his sway over Bihar. An interesting description of the Bengal sultan still exists in Lakhisarai. Inscription bearing a date corresponding to 1297 which mentions Rakmuddin Kalawao (c1296-1302) and a Governor round Ferai Hitagim. During this conflict between the Tugulaqs of Delhi and Bengal Sultan some portions of then Munger came under the possession of the Sharqils of Jaunpur.

Some inscriptions found in Munger speak of the conflict between the Jampur rules and the Bengal Sultan which resulted in former’s defeat and finally resulted in peace. Here we came across the name of prince Danyal who held the post of Governor of Bihar. It was prince Danyal who had repaired the fortification of Munger and built in 1497 the vault over the shrine of Shah Nafah. This is also known by the inscription but up by Danyal on the eastern wall of the Dargah just within the southern gate of the fort.

Nasrat Shah succeeded Hussain Shah in Bengal in 1590. His brother-in-law Makhduin Alam took possession of Munger Fort and entrusted its responsibility to one of his general named Kutub Khan who made Munger the head quarters of Bihar army of the rulers of Gaur. Bahar in his memoir mention that when he invaded Bihar, Munger was under the charge of a prince. After the Battle of Ghagra, Babar sent envoys to Nusarat Shah later Kutub Khan was defeated and killed by Shur Shah. In 1534 again a powerful army in command of Ibrahim Khan moved out to Munger, The battles took place in the narrow plains of Surajgarha in which Ibrahim Khan was routed and slain and Sher Shah firmly placed himself to Kingship. Thus during the Humayun-Sher Shah conflict Munger proved strategic ground. During the subsequent war between Sher Shah and Humayun Munger was the seat of battle between, the Afghan and the Empires in which Sher Shah captured Dilawar Khan son of Daulat Khan Lodi. Mughal rule was substituted for Afghan rule. During Akbar’s period when the great Bengal military revolts started. Munger was for some time the headquarters of Akbar’s officers in their expeditions against the rebels. It was in this year that Raja Todarmal took possession of Munger and tried to deal with three refractory powerful semi-independent Zamindars of

Akbar's time viz. Raja Gajapati of Hajipur, Raja Puran Mal of Ghidhaur and Raja Sangram Singh of Kharagpur. The last two belonged to the district of Munger. Gajapati was totally ruined. After the final occupation of Bihar, Raja Man Singh was appointed as the Governor and on the basis of Akbarnama. It can be said that Raja Man Singh succeeded well in his administration. Kharagpur at that time was a great principality extending from the south of Munger to the south of Bhagalpur and Santhal Paragans. Sangram Singh remained loyal to the Mughal rule till Akbar's death in 1605. But the accession of Jahangir and the rebellion of Prince Khusru led him to make a final attempt to recover his independence. He collected his forces, which, according to Jahangir's memoirs, consisted of about four thousand horses and a large army of foot soldiers.

The Mughal army under Jahangir's Kuli Khan Lala Beg, Governor of Bihar, valiantly opposed him and a gun shot in 1606 killed Sangram Singh. Sangram Singh's son succeeded in gaining favour of Jahangir but had to wait till 1615 when, on his conversion to Islam, he was allowed to return to Bihar. He known in history as Rozafzun (ie. Daily growing in power). He remained faithful to the Emperor and in 1628 when Jahangir died he was a commander of 1500-foot soldiers and 700 horses. When Shahjahan became the Emperor, Rozafzun entered into active Mughal services and accompanied Mahabat Khan in his Kabul expedition. He was a brave soldier and had to his credit his participation in the Siege of Parendah and was promoted to the higher ranks and became the commander of 2000-foot soldiers and 1000 horses. He died in 1635 and was succeeded by his son Raja Bihruz who was also a great fighter and held the rank of 700-foot soldier and 700 horses, under Shahjahan. He extended his territory, got many grants specially the Chakla Midnapur, in which he built a town and named it Kharagpur. A ruined palace built by him is there; adjoining it is a three-domed mosque. There is still a marble slab, which gives the date of building in 1656 A.D. But this brave Kharagpur ruler died in 1656. During the civil (1657-58) amongst the sons of Shahjahan, Shah Shuja, the second son of the Emperor was governor of Bengal. On hearing of the serious illness of his father in 1657 he raised the standard of revolts and claimed the throne. Though his capital was at Rajmahal, Munger the centre from which he direct his preparations and here he returned in 1658 after his defeat. In June 1658, Aurangzeb made an attempt to conciliate Shuja by granting him the province of Bihar in addition to Bengal. Munger came into great prominence during this period of the civil war. Prof. Quanungo writes that after the March of Imperial Army Shuja wrote to Dara asking for the grant of Munger, which formed the part of Dara's province of Bihar. Dara was also prepared to give away the Fort of Munger on the condition that the present fortress was dismantled and Shuja's son did not reside there. We also get a reference of Murad's letter in which the designs of Dara to deprive Shuja of Munger has been hinted at. Shuja took shelter at Munger to face the Imperialists. In course of this conflict Dara was compelled to send urgent letters to his son to make peace with his uncle. As a result of this treaty of 1685 Munger was added to Shuja's viceroyalty but he was not allowed to reside there. In 1659 Daud Khan took charge of the province of Bihar. Mir. Jumla and Prince Muhammad pursued Shuja up to Munger. Shuja was forced by the treachery of Raja Bihruz Khan of Kharagpur and Khaza Kamal of Birbhum to abandon Munger in 1659. It was in this connection that Raja Bihruz was made In charge of the whole area of Munger. We also find a mention of a Aevastative famine during the reign of the Governor, Ibrahim Khan which continued from 1670-72. The Dutch traveller, De Graafe, who travelled from Munger to Patna in November 1670 gives a graphic picture of the horrible scnes. Marshall also mentions very interesting details about Munger. He inspected Shah Suja place built on the west side of the Fort. He describes it, "as a very large house where the king (Suja) lived, walled next to the river, for about one and half Kos with bricks and stones, with a wall fifteen yards high". He entered the first gate but was stopped at the other within which he saw two elephants carved in stone and very large and handsomely". The inside palace was so strictly guarded that two Dutch men De Graafe and Oasterhoff were imprisoned for their antiquarian interest as they were taken as spies. They were released after seven weeks of imprisonment in November , 1670 by paying a fine of one thousand rupees to the Nawab of Patna. Marshall found a great garden and, at the south end, he saw several thatched and many tombs and mosques.

He further writes "the town stands upon an ascent, the river bank by it being 8 or 10 yards high, the brick wall by the river side at the south end of Munger was about 5 yards high and 20 yards long with a little tower at each end and each wall is a fortification to place the gun on it. Towards the close of the 18th Century we find that Munger was merely station of "Power Magazine" established there...." For most vivid lightning often about Munger attracted by the iron ore which abounds in the neighboring hills and if it fell upon the magazine, the while Fort could certainly be destroyed by the explosion". We find mention in the travel account of R.Heber in his book "Narrative of Journey Through the Upper Province of India (1827)" that Munger was noted for its good climate and Warren Hastings also speaks of the delightful change of atmosphere from that of Bengal. Heber further wrote "Munger presents an imposing appearance.... The Fort is now dismantled. Its gates, its battlements etc. are all of Asiatic architecture and very much similar to the Khitairagorod of Moscow." Miss Emily Eden was also much struck by the inland tables and boxes and expressed surprise on such curious workmanship (Miss Eden-Up the Country quoted in Munger Gazetteer 1960). The remark of Miss Eden is also attested in the writing of Fanny Parkes who wrote "Among the articles manufactured here the black vases for flowers turned into while wood and lacquered whilst in the Lathe with scaling wax are pretty". Joseph Hooker also speaks highly of Munger, "By far the prettiest town, Munger was celebrated for its iron manufacture, especially of muskets, in which respect it is the Birmingham of Bengal".

When we come down to the early Mughal period we get a few references to the district in the famous book "Ain-I-Akbari" prepared by Abul Fazl. According to it Sarkar Munger consisted of 31 mahals or Parganas, paying a revenue of 10,96,25 981 dams (40 dams equal to One Akbar Shahi rupee). It is also mentioned that Sarkar Munger furnished 2150 horses and 50,000 foot soldiers. Raja Man Singh who is said to have reconquered Bengal and Orissa had for some time Munger as his residenoc. During the reign of Aurangzeb we find mention of Munger inconnection with the death and burial at Munger of the poet Mulla Mohammad Saiyed, who wrote under the nom-de-plume of Ashraf. The poet Ashraf stood in high favour with prince Azim-Us-Shah, Aurangzeb's grand son, who happened to be the Governor of Bihar. The poet Ashraf had also been for a long time the teacher of Zebunissa Begum, Aurangzeb's daughter who was herself a poetess of rupute. It 1704 while on his way from Bengal to Mecca, the poet died at Munger where his tomb is still pointed out. Nicholas Graafe, a Dutch physician who visited in the beginning of the century was struck with admiration at the sight of its white wall, towers and minarets. But by 1745 when Mustafa Khan, a rebellious General of Alivardi Khan advanced against it in his march northwards the fort was a ruinous fortification which the Governor and his little garrison tried to put up some Defence but failed miserably.

The besieger got upon the wall and seized the fort though the leader was killed by a stone that fell upon him. Mustafa Khan, however, following the custom of those days, had music played to celebrate his success, he also took some guns and ammunition from the fort and after a halt for a few days marched off towards Patna. During the period of the disintegration of Mughal Empire Munger had to witness new changes. Bihar came to be joined to the Suba of Bengal, which had practically become independent of Delhi. Alivardi, who was the Fauzdar of Rajmahal had now become the District Governor of Munger.

Munger was politically and strategically so important that it did not escape even the Maratha expedition. The second Maratha invasion under Raghujee Bhonsla occurred in 1743.

Balaji Maratha entered into Bihar and advancing through Tekari, Gaya, Manpur, Bihar and Munger. It is also mentioned that during the 4th Maratha invasion in 1744 Raghujee passed through the hills of Kharagpur. When British force was pursuing Jean Law, the French adventurer and partisan of siraj-ud-duala, who was flying northwards after the Battle of Plassey, Major Coote reached Munger late at night on 20th July, 1757 and requisitioned a number of boats which the Governor of Munger supplied. But Munger Fort was in such a good condition that he was not allowed to enter the Fort and when he approached the walls he found that garrison was ready to fire. Coote wisely resumed his march without any attempt to enter the Fort. Nearly three years after in the spring of 1760 the army of Emperor Shah Alam marched out of the District when he was being pursued by Major Caillaud and Miran. The Emperor had been defeated by Caillaud and Miran at Sirpur on the 22nd February, 1760. This time Johan Stables, who had succeeded Caillaud was given charge of Munger. It was he who directed to attack the Kharagpur Raja who had openly defied the authority of the new Nawab, Kasim Ali Khan.

The modern history of Munger came again into Prominence in 1762 when Kasim Ali Khan made it his capital instead of Murshidbad in Bengal. The new Nawab removed his treasure, his elephants and horses and even the gold and silver decorations of the Imam Bara from his old capital. He favored General Gurghin (Gregory) Khan, an Armenian of Ispahan, re-organized the army and had it drilled and equipped after English model. He also established an arsenal for the manufacture of fire-arms and it is from this time that Munger can trace back its importance for the manufacture of guns. Even today that glorious tradition is being carried on by hundreds of families who specialize in the manufacture of guns.

Two days a week he sat in a public hall of audience and personally dispensed justice. He listened patiently to the complaints and grievances of everyone and gave his impartial order. The Nawab, indeed, was a terror both to his enemies and to wring doors. He also honored learning and the learned and welcomed scholars and savants to his court and he surely earned the respect and admiration of both friends and foes alike. Unfortunately, however, destiny did not help him and Mir Kasim Ali soon came into confrontation with the English.

MIR KASIM AND HIS CONFLICT WITH THE ENGLISH: The first quarrel appears to have been caused by the tactless conduct of Mr. Ellis, who was in charge of an English factory at Patna. Mr. Ellis had received a vague report that two English deserters were concealed at Munger. A long dispute followed and it was finally compromised by Mr. Ironsides, the Town Major of Calcutta, who conducted the search of the Fort with the due permission of the Nawab. No deserters were found inside the Fort, the only European in the place being an old French invalid. In April, 1762 Warren Hastings was sent from Calcutta to arrange the terms between the Nawab and Mr. Ellis. The Nawab received him well but Ellis refused to meet Warren Hastings and stayed in his house at Singhia, 15 miles away from Munger. Beside this personal rancor, serious trade disputes arose between the Nawab and East India Company. The East India Company had been enjoying exemption from heavy duty transit levied on inland trade. After the battle of Plassey the European servants of the Company began to trade extensively on their own account and to claim a similar exemption for all goods passing under company's flag and covered by Dastak or certificate signed by the Governor or any agent of the factory. Great abuses followed when the English in some cases lent their names to Indians for a consideration and the latter used the same Dastak over and over again or even began forging them.

Warren Hastings in 1762 says that every boat he met on the river bore the company's flag and became aware of the oppression of the people by the Gumashtas and the Company's servant. Mir Kasim bitterly complained that his source of revenue had been taken away from him and that his authority was completely disregarded. Eventually in October, 1762, Mr. Vansittart, the Governor left Calcutta in order to try and conclude a settlement between the two parties. He found the Nawab of Munger smarting under the injuries and insults he had received. But at length it was agreed that servants of the company should be allowed to carry on the inland private trade, on payment of a fixed duty of 9% on all goods - a rate much below that paid by the other merchants. The dastak also remained with a new provision that it should also be countersigned by the Nawab's collector. Mir Kasim agreed to these terms but, of course, very unwillingly. Sair-ul-Mutakharin gives a detailed account of the visit of Vansittart. The Nawab advanced six miles to meet Vansittart and arrange for his residence in the house which Gurghin Khan had erected on hill of Sitakund (Pir Pahar).

Vansittart returned to Calcutta in January 1763 after a week long stay at Munger but he was sorry to find that the agreement concluded with the Nawab has been repudiated. The Nawab, however, had honestly sent the copies of the Governor's agreement to all of his officers for its immediate implementation. The result was that English goods then in transit, were stopped and duty claimed upon them. The English council reacted sharply and wanted that the English dastak should pass free of duty. The Nawab on the other hand protested at this breach of faith and passed orders abolishing all transit duty and thereby, throwing open the whole inland trade free from any custom duty. The English regarded this as an act of hostility and preparations for war began but English decided first to send a deputation headed by Messrs. Amyatt and Hay to arrange fresh terms with the Nawab. Mr. Ellis was also informed of this development and was warned not to commit any act of aggression even if the mission failed and Amyatt and Hay were well out of the Nawab's power.

The members of the mission reached Munger on the 14th May, 1763 and opened up negotiations, but it was soon found that they were undocked. The Nawab who was offended at the rough and over bearing manner in which he was addressed by the English linguist and refused to speak to him. At subsequent interviews also the Nawab tried to avenge the English insult and refused to come to any terms. The Envoys were kept under strict supervision and when some of the party wished to ride out from Munger they found their way barred by the Nawab's soldiers with lighted matches ready to fire. Just at this tense moment English cargo boats for Calcutta were detained at Munger and 500 Muskets intended for the factory at Patna were found out hidden under the cargo. The Nawab, naturally, became suspicious of the English move which might have been to seize the fort and the city at Patna. He wanted, therefore, a thorough check-up by his own troops otherwise he would declare war. In the mean time he permitted Mr. Amyatt and others of the party to leave for Calcutta, but detained Mr. Hay and Mr. Gulson as hostages for the safety of his officers who had been arrested by the English.

As regards the final rupture between the English and Bengal Nawab it was precipitated by the action of Mr. Ellis who believed that war was in any case inevitable, and seized the city of Patna on hearing the news that the detachment was advancing from Munger to reinforce the Nawab's garrison. The Nawab also retaliated promptly, reinforcements were hurried up and the Fort quickly recaptured. This news of the success gave Kasim Ali the keenest delight. Even though it was mid-night, he immediately ordered music to strike and awakened the whole town of Munger. At day-break the doors of the public halls were thrown open and every one hastened to offer him congratulations. He, now, proclaimed the outbreak of war and directed his officers to put the English to sword wherever they were found. In pursuance of this general order Mr. Amayat was killed at Murshidabad and the factory at Cossim (Kasim) Bazar was stormed. The survivors surrendered and were sent to Munger to join their unfortunate companions from Patna.

The British force under Major Adams quickly advanced against the Nawab and defeated his troops at Suti. On hearing of his defeat, he sent his Begums and children to the fort at Rohtas and set out himself accompanied by Gurgin Khan to join his army that was now concentrated on the banks of the Udhua Nullah near Rajmahal. Before leaving Munger, however, he put to death a number of his prisoners including Raja Ram Narayan, till lately Deputy Governor of Bihar, who was thrown down into the river below the fort with a pitcher filled with sand bound to his neck. Gurgin Khan not satisfied with this butchery also urged the Nawab to kill his English prisoners but this the Nawab refused to do. Jagat set Mahtab Rai and Sarup Chand, two rich bankers of Murshidabad who had been brought from that place by Mir Kasim Ali as they were believed to favour the British cause also appears to have escaped. Though as the tradition says they were also drowned at the same time. This story is, however, contradicted by the author of Sair-UI-Mutakharin who says that they were hacked to pieces at Barth. The exact location of the tower of castle of Munger from where Jagat Seth and others were thrown down has not yet been located.

Before the Nawab could join his army at Udhua Nullah he heard of a second decisive defeat that he had sustained and thereafter returned to Munger. He stayed there only for two or three days and marched to Patna with his prisoners like Mr. Hay, Mr. Ellis and some others. On the way Mr. Kasim halted on the bank of Rahua Nullah, a small stream near Lakhisarai. It was here that Gurgin Khan met his death and was cut down by some of his own troopers who were demanding arrears of their pay. A scene of wild confusion followed. Makar, another Armenian General, fired off some guns, the thought that the English were upon them and fled in terror, Mir Kasim himself flying on an elephant. There was great confusion in the army because of this false alarm but Mir Kasim marched on the next day to Patna.

In the meantime the British army moved on rapidly towards Munger and at this time Munger was placed under the command of Arab Ali Khan, who was a creature of Gurgin Khan. On the first of October 1763 the main body of the army arrived on batteries that had been thrown up and were immediately opened. For two days heavy fire was maintained but in the evening the Governor capitulated and surrendered himself and his garrison. The English at once set to work to repair the breaches and improve the defences.

The Fort was left under the command of Captain John White who was further directed to raise locally another battalion of sepoys. This news of the capture of Munger infuriated the Nawab who as soon as he heard of it gave order that his English prisoners at Patna should be put to death. This order was carried out by the infamous Samru and is known in history, as the 'Massacre of Patna'.

There years later in 1766 there was a mutiny of the European officers of Bengal army because of the reduction of "bhatta" which was an extra monthly sum to cover the increased expenses when the soldiers were on active military duty. After the battle of Plassey Mir Jafar Khan had granted an extra-allowance, called "double bhatta" which had continued during the role of Mir Kasim also. But the Directors of the companies now passed order that this allowance should be abolished except for the grant of half-bhatta to the troops stationed at Patna and Munger. This curtailment was bitterly resented by the army officers and on the first of May, 1766 a memorandum to this effect was signed by officers of the first brigade stationed at Munger under Sir Robert Fletcher who transmitted it to Lord Clive at Murshidabad.

Clive lost no time and proceeded to Munger in person by forced marches and in the mean time sent forward some officers to deal with the situation as well as they could. When arrived at Munger late at night on the 12th May, the army heard too much of drums beating and going further to Robert Fletcher's quarter they found the European regiment drinking, singing and beating drums. Next morning two of them went to Kharagpur and returned with two battalions to Munger. But we learn that on 14th the European battalion broke out in open mutiny and Captain Smith seized the saluting batteries which were situated upon hillock. The hillock was known as Karn Choura hill. Captain Smith gained possession of the hill and was successful in suppressing the rebellion. In short, Munger was recaptured by the prompt and brave action of Captain Smith and Sir Robert Fletcher.

Clive had already reached Munger and he held a parade of troops. He explained the circumstances under which the "bhatta" had been withdrawn and he further applauded the loyal conduct of the sepoys and condemned the conspiracy of some officers. They were further threatened that the ring leaders would get the severest penalties under Martial Law. After his address, the brigade gave their hearty cheers and marched off quietly to the barracks and the lines. Thus, the rebellion of the British officers at Munger was successfully suppressed. For some time John Maccabe was a Deputy Commissioner, Government of Munger before 1789.

The subsequent history of the district is uneventful with the extension of the British dominions, the town of Munger ceased to be an important frontier post. There was no arsenal, no regular garrison was kept up and no attempt was made to bring the fortification up-to-date. Munger, however, was still important for its fine situation and salubrious air and was used as a sanatorium for the British troops. So great a resort that it was the journey up the Ganga followed by a stay was regarded as healthy as a sea voyage. We find that a trip to Munger was prescribed for the wife of Warren Hastings when she was in ill health and in 1781 when Warren Hastings was on his way to meet Chait Singh at Banaras he left his wife here for the benefit of her health. But during the early part of the 19th century Munger was degraded to a lunatic asylum for sepoys where there was also a depot for army clothing and it became an invalid station for British soldiers.

Munger District is located in the southern part Bihar and its headquarters are located on the southern bank of river Ganges. The district is spread over 1419.7 Sq. km. accounting for 3.3% of the area of Bihar . It lies between 24⁰ 22 N to 25⁰ 30 N latitude and 85⁰ 30 E to 87⁰ 3 E longitude. From administrative and development point of view,Munger is divided into three subdivisions namely Munger,Kharagpur, and Tarapur. There are nine developmental blocks namely Munger, Bariarpur, Jamalpur, Dharahara, Kharagpur, Tetia Bambar,Tarapur Asarganj and Sangrampur. There are about 903 villages in the district. The Munger district on an average is 30 to 65 mtrs above sea level. The average annual rainfall is 1231 mm.

FORMATION OF THE DISTRICT

The existence of Munger as a separate executive centre dates from the year 1812, It appears from a letter dated the 15th July of that year, that Mr. Ewing was appointed to have charge of Munger Criminal Court, called the court of Joint Magistrate of Munger and that he was made subordinate to the Magistrate of Bhagalpur and worked like a sub-divisional officer.

A letter also from Mr. Dowdeswell, Secretary to the Government, dated the 22nd October, 1811 proves that at that time no magisterial authority existed at Munger except that of the Magistrate of Bhagalpur to whom it was addressed : “I am directed”, it runs, to acquaint you that his Excellency the Vice-President in council considers it of importance that you should revert to the practice which formerly existed holding the Kachari during a part of the year at Munger, and that he desires that you will make necessary arrangement for the purpose”. But the extent of the Munger jurisdiction is not mentioned in the local records till September, 1814 when it is clearly stated to comprised five Thanas or police divisions, viz. Munger, Tarapur, Surajgarha, Mallepur and Gogri.

No change seems to have been made in the powers or jurisdiction of the Munger court till 1832 when it was made revenue-receiving Centre under the name of a Deputy Collectorship. This new office was conferred on the joint Magistrate. From this time officer exercised most of the power of a full Magistrate-Collector. He had now power to correspond directly with the chief Executive and the Revenue authority as an independent authority.

The earliest record of value in the collectorate appears to be the letter from the

CENSUS OF INDIA 2001

State/District/C.D Block	Literacy rate								
	Total			Rural			Urban		
	Persons	males	females	Persons	males	females	Persons	males	females
MUNGER DISTRICT	60.11	70.7	47.97	53.35	65.3	39.69	76.87	84	68.64
Munger	67.97	75.7	58.96	54.66	63.9	43.72	75.44	82.2	67.48
Bariarpur	53.84	65.40	40.07	53.84	65.40	40.07	--	--	--
Jamalpur	75.09	83.6	65.36	63.93	73.8	52.59	84.39	91.7	75.98
Dharhara	50.98	63.5	36.73	50.98	63.5	36.73	--	--	--
Kharagpur	51.39	64.4	36.74	50.28	64.10	34.79	57.83	66.2	48.19
Asarganj	52.00	62.7	39.71	48.68	59.8	35.88	81.44	88.6	73.34
Tarapur	53.34	66.1	39.44	53.34	66.1	39.44	--	--	--
Tatia Bombar	51.00	64.9	34.75	51.00	64.9	34.75	--	--	--
Sangrampur	53.66	65.8	40.01	53.66	65.8	40.01	--	--	--

Commissioner of Bhagalpur to the Secretary to the Sadar Board of Revenue. At Fort William, dated the 29th May, 1850. He writes-“It appears from the record that the native town and Bazar of Munger have for a long period been considered government property. This though constituting one Mahal, was divided into 13 Tarafs, Viz. (1) Bara Bazar, (2) Deochi Bazar, (3)

Goddard Bazar, (4) Wellesly Bazar, (5) Munger Bazar, (6) Gorhee Bazar, (7) Batemanganj Topekhana Bazar, (8) Fanok Bazar, (10) Dalhatta Bazar, (11) Belan Bazar, (12) Rasoolganj and (13) Begampur”.

Population, Literacy Rate Blockwise.

CENSUS OF INDIA 2001

State/District/C.D Block	Population			Child population in the age - group 0-6			Literates			
	Persons	males	females	Persons	males	females	Persons	males	females	
MUNGER DISTRICT	Total	1135499	604662	530837	197144	102928	94216	564043	354611	209432
	Rural	818913	435774	383139	150156	78809	71347	356799	233051	123748
	Urban	316586	168888	147698	46988	24119	22869	207244	121560	85684
Munger	Total	296950	159243	137707	48399	25084	23315	168940	101494	67446
	Rural	109639	58869	50770	20323	10555	9768	48817	30891	17926
	Urban	187311	100374	86937	28076	14529	123547	120123	70603	49520
Bariarpur	Rural	92431	49632	42799	17015	8630	8385	40604	26816	13788
Jamalpur	Total	181571	96522	85049	28735	14829	13906	114768	68267	46501
	Rural	84912	45260	39652	15447	8079	7368	44411	27434	16977
	Urban	96659	51262	45397	13288	6750	6538	70357	40833	29524
Dharhara	Rural	103919	55197	48722	19601	10295	9306	42986	28509	14477
Kharagpur	Total	181008	96183	84425	30683	16619	14064	77249	51253	25996
	Rural	154098	81942	72156	25872	14196	11676	64470	43428	21042
	Urban	26910	14241	12669	4811	2423	2388	12779	7825	4954
Asarganj	Total	59562	31620	27942	11276	5832	5444	25108	16175	8933
	Rural	53856	28609	25247	10463	5415	5048	21123	13876	7247
	Urban	5706	3011	2695	813	417	396	3985	2299	1686
Tarapur	Rural	84341	44060	40281	16311	8531	7780	36289	23470	12819
Tatia Bombar	Rural	57622	30869	26753	10796	5586	5210	23882	16395	7487
Sangrampur	Rural	78095	41336	36759	14328	7522	6806	34217	22232	11985

Geography & Economy

Physical Features and Natural Resources

The district of Munger is hemmed among the Ganges in the north, Bhagalpur district in the east, Barh district in the west and the district of Jamui in the south. It covers almost 14 Development Blocks. The total area is 3301.70 Km² and the total population is 1,924,317, vide 1991 census. The density of population per Km² was 583 in 1991.

Relief Feature

Plain Lands in the North:

The Northern plain of Munger district has two facets of landscape i.e. diaras north of the Gangatic levee and tal lands south of the levee. Some of the Gangetic levee and tal lands south of the levee. Some of the important diaras are Maheshpur, Heru, Bahadurpur,

Kalarampur, Budhwa and Taufir diaras. These diaras suffer from annual inundation along with the erosion and deposition of soils. This is the area of food hazards with the sedimentary rocks.

The area south of the Gangetic levee is known as Tal lands. Some of the important tals are Barhiya tal, Mainma tal, Bilya tal, Bariarour tal and others. Some of the important rivers e.g. Kiul Harohar, Dakranal and Baduar deposit soil in their flood plains. Tal lands also suffer from annual inundation, water loggings and deposition of soil.

Mineral Water

Munger district has long been famous for its mineral waters and hot water springs, There is a belt of thermal springs along a Zone from the Kharagpur hills to the Rajgir hills of the Patna district. There are altogether seven groups of thermal springs in this district. These are:-

1. Bharari (Chormara Group)
2. Bhimbandth Group
3. Hingania Group
4. Remeshwar-Lakshmishwar –Bhowrah Kunds groups.
5. Rishikund groups.
6. Sitakund – Phillips-kund group and
7. Sringirishi group

CLIMATE

Munger district is a part of Zone – III with sub-zone in South Bihar Plains. The zone is located on south of river Ganges and comprises districts of Munger, Bhagalpur, Gaya, Aurangabad, Rothas, Bhojpur, Patna and Nalanda. It is sub humid and much drier as compared to zone-I and III. It has monsoon sub-tropical climate ranging from sub-dry and sub-humid conditions. There are three district seasons in this zone viz., summer, monsoon and winter.

SUMMER (MARCH TO MAY)

The summer season is characterized by gradual rise in temperature, occasional thunder showers and hail storm, high velocity westerly during this season is very dry resulting in sunstroke deaths at times. The maximum temperature rises up to 45o C.

MONSOON (JUNE TO SEPTEMBER)

It starts from middle of June and continues up to end of September. Monsoon is characterized by cloudy weather, high humidity, frequent rains and weak variable surface wind. Maximum rainfall occurs during July and August.

WINTER (OCTOBER TO FEBRUARY)

Winter season is characterized by gradual decrease in temperature which comes to a minimum in the first week of January. Thereafter, the temperature starts increasing. The minimum temperature varies from 3.50 C to 90 C.

RAINFALL

The rainfall under this zone is mainly influenced by the south-west monsoon which sets in the second week of June and continues up to end of September. Sometimes cyclonic rain also occurs. The average annual rainfall of this zone is 1078.7 mm. The rainfall distribution is marked seasonal in character. Greatly limiting water availability in certain times of the year and requiring disposal of excess water in some weeks during monsoon also occur. The average annual rainfall of Munger district is 1146.4mm (53year average), out of which 80% is received during monsoon season and the rest (more than5%)in summer season. In case of Munger district, the temporal variation annual rainfall was recorded at a maximum of 2181.6 mm in 1971 and a minimum of 481.6 mm in 1972 with annual coefficient of variation of 27.2%. July

and August received maximum monthly rainfall in the district. The monthly co-efficient of variation of rainfall for monsoon from June to September was 68.5%, 44.3% and 51.8% respectively for Munger.

SOIL

Soil of Munger district is grey to dark grey in color, medium to heavy in texture, slightly to moderately alkaline in reaction, cracks during summer (1 cm to more than 5 cm wide and more than 50 cm deep) becomes shallow with onset of monsoon, with clay content nearly 40% to 50% throughout the profile. Slickenside along with the wedge shaped structural aggregates absorb soil are found in level land or depression. Soil becomes bonding during summer and remains inundated rains. The clay minerals found are smectites followed by hydrous mica. The soil has a good fertility status. Diara land soils are light textured and well drained with free calcium carbonate (CaCO_3) that varies between 3% to 8% but seldom exceeds 10% particularly no genetic low zone gives a coarse stratification micro relief, udic moisture regime clay. Minerals found are hydrous mica, smectite, kaolinite and chloride. The nature of sediments deposited in Diara land can be generally stated as those near the streams are coarser in texture i.e., sand which gradually becomes finer with distance a grade to heavy texture of clay in the central part of the meander, these being always layers of sand at varying department which generally do not go deeper than 40 cm to 60 cm of surface deposited as a result of changing course of the current. These Diaras are either:

Islands between river streams or

The place of the abandoned Dhar in the flood plains.

4.4 Child Health

Logical Framework

Sl.	Goal	Sl.	Impact indicators						
1	To improve Child health & achieve child survival	1.1	Reduction in IMR						
		1.2	Child performance in the school - enrolment, attendance and dropout						
Sl.	Objectives	Sl.	Outcome indicators	Sl.	Strategy	Sl.	Output indicators		
1	To increase ORS distribution from 51%(DLHS3) to 80%	1.1	% increase of ORS distribution .	1.1 .1	<i>IMNCI, Home Based Newborn Care/HBNC</i>		% of PHC initiated IMNCI and HBNC training.		
2	To increase treatment of diarrhoea from 77.1% to 90% within two weeks		% increase of treatment of diarrhoea within two weeks						
3	To increase treatment of ARI/Fever in the last two weeks from 82.2%(DLHS3) to 95%		% increase of treatment of ARI/Fever in the last two weeks						
4	To increase of infant care with in 24hr of delivery from 29.7%(DLHS3) to 50%		% increase of infant care with in 24hr of delivery .					Strengthening of Facility Based Newborn Care/FBNC and trained workers on using equipments.	No of PHC initiated FBNC with trained MAMTA on facility based new born care..
5	To increase % of breastfeeding from 33.8% to 70% within 1 hr of birth		% increase of breastfeeding within 1 hr of birth .	1.1 .2				Infant and Young Child Feeding/IYCF	No of training organised in PHC on IYCF
6	To increase initiation of complimentary feeding among 6 month of children from 88.3% to 90%		% increase of complimentary feeding among 6month of children.						
7	To increase exclusive breastfeeding among 0-6 month of children from 36.4% to 80%		% increase of exclusive breastfeeding among 0-6 month of children .						
8	To increase immunization coverage from 53.3% to 70%		% increase of full immunization coverage .						
9	To increase vit A coverage of received atleast one dose (9month to 35 months) from 67.3% to 80% and include up to 5 years.		To increase Vit A reported adequate coverage among (9m to 5ys)	1.1 .3				Management of diarrhea, ARI and Micronutrient Malnutrition through Child survival months	Two round of Child survival Month organised in one financial year.
10	To decrease Malnutrition form 58%(NFHS III state) to 30% of the age group of (0 to 5 yrs)			% of decrease Malnutrition age group of (0 to 5 yrs)				1.1 .4	Care of Sick Children and Severe Malnutrition and strengthen VHND at all AWCs
		2.1		2.1 .1	School Health Programme	No Of school health programme organised in the PHC			
Sl.	Strategy		Gaps		Activities	Unit Cost	Budget		
	<i>IMNCI, Home Based Newborn Care/HBNC</i>		<i>Training Gaps(AWW-2328/2476,ASHA-0,ANM-377/401,MPW-</i>		<i>Assessment of Training load and prepare calendar of training</i>	NA	0		

		11/83,MO-47/146,CDPO-05/16,ICDS Super-05,Health supervisors-27,NGOs-06)	Incorporate ASHA in IMNCI training team	NA	0
		No ASHA is trained on IMNCI	ASHA kit regular supply and incorporate use of ASHA Kit in training curriculum.		
		Inadequate monitoring of this activity at field level	Division of area among all trained supervisors for revision of IMNCI activity in their area.	NA	0
			BHM will be responsible for review of health supervisor sand LS(ICDS)on given format.Unicef staff will support in devloping review mechanism in PHC.	NA	0
			Incorpate IMNCI reports in HIMS formate	NA	0
			Encouraging mother regarding child care.in VHND	NA	0
			Frequent checkups of babies by Paediatrician. Distribute teliphone number to AWW and ANM of respective doctors those who are supervising them in the field.	NA	0
			Wednesday could be fixed a day for IMNCI related work at HSC level	NA	

					Community based Monitoring support system develop with SHG in one PHC Training of Group members seed money to SHG for referral services and other need based services.	Rs 10 00 00 for one PHC	100000
	Facility Based Newborn Care/FBNC		only eight institutions have baby warmer machines but maintenance of machine is not up to the mark and district having referral six bedded SNCU		All PHCs should be equipped with baby warmer machines.	Mobilizing nine units from UNICEF	0
			ANMs and Doctors are not trained to operate these machines		Training of Doctors and ANMs to operate baby warmer machine.	Rs 50 00/- for demonstration at District level	5000
			There is no provision of stay of mothers of neonates at PHC.		Organize training programme for newborn care for the nurses in the district hospitals	One Nurse from each PHC Cost will be 50 00/-	5000

				District level Supporting supervisory team should be developed with the responsibility of nonfunctioning of neonatal care unit. Training of team on monitoring of NCU	Rs. 5000/- for one time training	5000
			<i>Neonatal Care Unit not up to mark.</i>			
			<i>Non availability of "MAMTA" at PHC level.</i>	<i>Training of Mamta and staff nurse on logistics of New born Care units. by district level supervisory Team.</i>	Rs 1500 for team members for each PHC per month	342000
	Infant and Young Child Feeding/IYCF		Non awareness of breast feeding and proper diet of young children.	Colostrum feeding and breast feeding inclusively for six months. Through IMNCI Training.	NA	0
				Baby friendly hospital Training of one doctor from each Nursing hospital at District Level	Rs. 20000 for training programme	20000
				Two days training of one staff nurse from each private hospital on counselling skill.	Rs 20000/- for training programme	20000

			Accreditation of nursing home and facility according to norms of baby friendly hospital initiatives	NA	0
		Poor knowledge regarding new born care and child feeding practices	Development and Printing of BCC materials	Rs 5 per unit for 10 00 0 units	50000
			Preparing adolescent and pregnant mother on IYCF by IPC through AWW, LRP and ASHA	NA	0
			Linking JBSY with colostrums feeding	NA	0
		Myths and misconceptions about early initiation of breast feeding, exclusive breast feeding and complementary feeding	Counselling and orientation of local priests, opinion leaders, fathers, mother in laws by ICDS/ Health functionaries in mothers meetings and VHSCs meetings	NA	0
			Folk performance to promote exclusive breast feeding	Included in maternal health	0
			Uniform message on radio from state head quarter	State budget	0
		Lack of awareness on importance of appropriate and timely	Organize social events through VHSCs	NA	0

			IYCF	Strengthening of <i>Mahila Mandal</i> meetings- fortnightly with involvement of adolescent girl	NA	0
				Organize healthy baby shows, healthy mother / pregnant woman.	Rs 20 00 per month per PH C	456000
				Appreciation and reorganization of positive practices in community. For this purpose hiring a documentation specialist.	Rs 10 00 00 for the whole district on community wise sample basis	100000
				Celebration of “Annaprashan(Muhjutthi) Day” at AWC	NA	0
				Demonstration of recipes.	Rs 25 0 per month per AWC(Under MUKSHAN program)	0

					Exposure visits to existing NRCs to observe different models in the country	Rs 50 00 0 for the district	50000
	Care of Sick Children and Severe Malnutrition		There is not a single unit in the district where severely malnourished children could be treated.		Establish rehabilitation center in district hospital, FRU and one PHC and promote locally available food formula for nutritional Therapy as Hadrabad Mix	Rs 10 00 00 0 per unit	4000000
	Management of diarrhea, ARI and Micronutrient Malnutrition		There is high prevalence of PEM and anemia among children because of Child nutrition is least priority among service providers.		Procurement of ,ORS , Vitamin A supplementation(9m to 5 years children) with De-worming pediatric IFA syrup.	10 00 00 00 OR S packets at the rate of Rs 5 per packet. (If OR S is not provided in Kit A) IFA syrup for 80 00 00 children at rate of Rs	3700000

						4 per child ren	
					Include coverage of Vitamin A and IFA, children in New HIMS format.	NA	0
					Insure two round of Vitamin A and deworming for the age group of (9m to 5 yrs) & (2 yrs to 5 yrs) respectively in the month of April And Oct as per GOI guide line.	Rs 15 00 00 0 per rou nd into two rou nds (If Vit A is not pro vid ed in Kit A)	3000000
					Involvement of ICDS, school teachers and PRI for monitoring and evolution	NA	0
	School Health Programme		No Pre School Health checkup & complete Immunization card.		Half yearly health checkup camp for children in schools should be organized.	Rs 20 00 per PH C	38000
					Training of school teacher by the medical personnel with support of administrative person.	Bu dg et inc orp ora ted in ad ole sce nt	0

No training of school teacher for basic health

				health	
		No regular health checkup camp at school.	Quarterly meetings of VEC representatives by attending existing meetings of VECs representatives at block level by the concerned MOICs and BHMs.	NA	NA
		No Training & Screening of school's teacher for eye sight test.	Linking existing 7 ophthalmic paramedics with this program and developing school wise calender.	Mobility support of Rs 10000 per PHC for moving other blocks and hard to reach areas.	190000
		No other specific program has been formulated in the district.	School health anemia control programme should be strengthened with biannually de worming .	Budget incorporated in adolescent health	0

			Organizing competitions/Debates/Painting competitions/Essay/demonstration and model preparation of nutritional food and health.	Rs 20000 per PHC	380000
			Half yearly Health checkups and health card of all school going children.	Printing of Health Card at the rate of Re 1 per card for the children of class 6 to 10	100000
			Films shows on health, sanitation and nutrition issues	Use LCD projector in this activity.	0
			Social science Lab activities.	Included in adolescent health	0

			Rally and Prabhat Phery in epidemic areas. (Kala-azar & Malaria)	Local contribution/ Untied Fund/ VH SC	0
			Referral system for the school children for higher medical care.	From RK S fund	0

Total

12561000



Ministry of Health and Family Welfare
Government of India

**District Level Household and Facility Survey
under Reproductive and Child Health Project (DLHS-3)**

District Fact Sheet

2007-08



Bihar
Munger



International Institute for Population Sciences
(Deemed University)
Mumbai - 400 088

For further information, please contact:

Additional Director General (Stat.)
Ministry of Health and Family Welfare
Government of India
Nirman Bhavan
New Delhi - 110 011
Telephone: 011-23061334
Fax: 011-23061334
E-mail: adg-mohfw@nic.in

Chief Director (Stat.)
Ministry of Health and Family Welfare
Government of India
Nirman Bhavan
New Delhi - 110 011
Telephone: 011-23062699
Fax: 011-23062699
E-mail: cdstat@nic.in

Director/ Project Coordinator (DLHS -3)
International Institute for Population Sciences (IIPS)
Govandi Station Road, Deonar
Mumbai - 400 088
Telephone: 022- 2556 3254/5/6
Fax: 022- 2556 3257, 2555 5895
E-mail: rchpro@iips.net, director@iips.net
Website: <http://www.rchiips.org>

About DLHS - 3:

The District Level Household Survey (DLHS) was initiated in 1997 with a view to assess the utilization of services provided by government health care facilities and people's perception about the quality of services. The District Level Household Survey (DLHS -3) is the third in the series of district surveys, preceded by DLHS-1 in 1998-99 and DLHS-2 in 2002-04. As in DLHS-3, the International Institute for Population Sciences (IIPS) was the nodal agency to conduct DLHS-1 and DLHS-2. DLHS-3, like other two earlier rounds, is designed to provide estimates on important indicators on maternal and child health, family planning and other reproductive health services. In addition, DLHS-3 provides information on important interventions of National Rural Health Mission (NRHM). Unlike other two rounds in which only currently married women age 15-44 years were interviewed, DLHS -3 interviewed ever-married women (age 15-49) and never married women (age 15-24).

The sample size among the districts in the country varies according to their performance in terms of Ante-Natal Care (ANC), institutional delivery, immunization, etc. and it was fixed based on information related to such indicators from DLHS-2. For low performing districts, 1500 Households (HHs), for medium performing districts, 1200 HHs and for good performing districts, 1000 HHs were fixed as sample size. In case of Munger, sample size was 1000 households with 10% additional HHs to take care of non-response/refusal, etc.

The survey used two-stage stratified random sampling in rural and three-stage stratified sampling in urban areas of each district. The information from 2001 Census was used as sampling frame for selecting primary sampling units (PSUs). In rural areas, all the villages in the district were stratified into different strata based on population /HH size, percentage of SC/ST population, female literacy (7+), etc. The required number of villages from each strata was selected with probability proportional to size (PPS). In selected primary sampling units (villages), household listing was done and required numbers of households were selected using systematic random sampling.

For larger villages (more than 300 HHs) segmentation was carried out. In case of 300 to 600 HHs, two segments of equal size were made and one was selected using PPS. For PSUs having more than 600 HHs, segments of 150 HHs were created depending on the size and then two segments were selected using PPS. In case of urban areas, number of wards were selected using PPS at first stage. In a selected ward, one enumeration block from 2001 census was selected again using PPS. Procedure for segmentation, household selection, etc. was same as in the case of rural PSUs.

The uniform bilingual questionnaires, both in English and in local language, were used in DLHS-3 viz., Household, Ever Married Women (age 15-49), Unmarried Women (age 15-24), Village and Health facility questionnaires.

In the household questionnaire, information on all members of the household and the socio-economic characteristics of the household, assets possessed, number of marriages to usual members of the household since January 2004 and deaths in the household since January 2004 etc. was collected. In case of female deaths, attempts were made to assess maternal death. The household questionnaire also collected information on respondent's knowledge (seen/read/ heard) about messages related to various government health programmes being spread through media and other sources.

The ever married women's questionnaire consisted of sections on women's characteristics, maternal care, immunization and child care, contraception and fertility preferences, reproductive health including knowledge about HIV/AIDS.

The unmarried women's questionnaire contained information on her characteristics, family life education and age at marriage, reproductive health-knowledge and awareness about contraception, HIV / AIDS, etc.

The village questionnaire contained information on availability of health, education and other facilities in the village and whether the health facilities are accessible throughout the year.

For the first time, population-linked facility survey has been conducted in DLHS-3. In a district, all Community Health Centres (CHCs) and District Hospital (DH) were covered. Further, all Sub-centres (SC) and Primary Health Centres (PHC) which were expected to serve the population of the selected PSU were also covered. There were separate questionnaires for SC, PHC, CHC and DH. They broadly include questions on infrastructure, human resources, supply of drugs & instruments, and performance.

Note:

DLHS-2: information is based on data collected from currently married women 15-44 years.

DLHS-3: information is based on data collected from ever married women 15-49 years.

DLHS-2: In total percentage is adjusted for indicators considering over sampling of urban PSUs in DLHS-2. This adjustment is done in those districts where urban percentage is less than 30.

DLHS-2: includes tap (inside residence/yard/plot), tap (shared/public), hand pump/borewell, well-covered.

DLHS-3: includes pipe into dwelling, piped to yard/plot, public tap/standpipe.

Unmet need for spacing

Unmet need for spacing includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and who want more children after two years or later and are currently not using any family planning method. The women who are not sure about whether and when to have next child are also included in unmet need for spacing.

Unmet need for limiting

Unmet need for limiting includes the proportion of currently married women who are neither in menopause or had hysterectomy nor are currently pregnant and do not want any more children but are currently not using any family planning method.

Unmet need

Unmet need refers to unmet need for limiting and spacing.

Correct knowledge of HIV/AIDS

The women who heard about HIV/AIDS and have correct knowledge about transmission of HIV/AIDS and knowledge of prevention from HIV/AIDS.

Bihar		DLHS-3		District : Munger	
District Indicators, Munger, (2001 Census)					
Indicators			Census 2001		
Population (in thousands)			1136		
Decadal Growth Rate (1991-01)			20.3		
Sex Ratio*			878		
Percent Urban population			27.9		
Percent SC population			16.7		
Percent ST population			2.3		
Female Literacy Rate (7 years and above)			48.0		
Male Literacy Rate (7 years and above)			70.7		
Sample outcome, DLHS -3, 2007-08					
Category		No. covered	Response Rate		
Households		1024	93.1		
Ever Married Women (15-49 years)		1033	88.4		
Unmarried Women (15-24 years)		214	83.6		
Sub Centres (SC)		27	84.4		
Primary Health Centres (P H C)		9	100.0		
Community Health Centres (C H C)		1	100.0		
District Hospital (D H)		1	100.0		
Population and Household Characteristics, 2007-08					
Background Characteristics	DLHS - 3		DLHS - 2		
	Total	Rural	Total	Rural	
Percent total literate Population (Age 7 +)	70.5	65.8	-	-	
Percent literate Male Population (Age 7 +)	80.5	76.9	-	-	
Percent literate Female Population (Age 7 +)	60.1	54.7	-	-	
Percent girls (age 6-11) attending Schools	99.1	98.8	-	-	
Percent boys (age 6-11) attending Schools	99.5	99.6	-	-	
Have Electricity connection (%)	53.2	43.1	25.4	15.8	
Have Access to toilet facility (%)	40.4	25.5	40.4	28.6	
Use piped drinking water (%)	1.7	0.3	6.3	0.9	
Use LPG for cooking (%)	16.6	3.5	13.3	8.4	
Live in a pucca house (%)	26.4	15.9	27.6	17.3	
Own a house (%)	95.2	97.9	-	-	
Have a BPL card (%)	23.2	28.2	-	-	
Own Agriculture Land (%)	35.0	43.4	-	-	
Have a television (%)	30.6	18.6	30.0	21.6	
Have a mobile phone (%)	28.3	21.9	-	-	
Have a Motorized Vehicle (%)	9.0	6.9	11.3	9.4	
Standard of Living Index					
Low (%)	61.7	75.3	57.5	68.0	
Medium (%)	18.9	15.1	26.5	23.3	
High (%)	19.3	9.6	16.1	8.7	
* Number of Females per 1000 Males					
					3

Bihar	DLHS-3		District : Munger		
	Indicators	DLHS - 3		DLHS - 2	
		Total	Rural	Total	Rural
Marriage and Fertility, (Jan 2004 to 2007-08)					
Percentage of girls marrying before completing 18 years	30.5	32.6	50.4	61.2	
Percentage of Births of Order 3 and above	42.6	44.4	50.0	51.4	
Sex Ratio at birth	125	135	-	-	
Percentage of women age 20-24 reporting birth of order 2 & above	61.5	66.2	-	-	
Percentage of births to women during age 15-19 out of total births	15.6	17.2	-	-	
Family planning (currently married women, age 15-49)					
Current Use :					
Any Method (%)	41.4	39.6	38.6	36.8	
Any Modern method (%)	33.9	33.2	30.7	28.4	
Female Sterilization (%)	30.3	29.7	26.4	25.8	
Male Sterilization (%)	0.4	0.5	0.1	0.2	
IUD (%)	0.9	0.9	0.7	0.4	
Pill (%)	1.2	1.3	0.7	0.3	
Condom (%)	1.1	0.8	2.6	1.5	
Unmet Need for Family Planning:					
Total unmet need (%)	31.6	32.9	35.3	35.1	
For spacing (%)	14.9	15.4	16.1	16.5	
For limiting (%)	16.7	17.5	19.3	18.6	
Maternal Health:					
Mothers registered in the first trimester when they were pregnant with last live birth/still birth (%)	39.6	35.3	-	-	
Mothers who had at least 3 Ante-Natal care visits during the last pregnancy (%)	36.8	35.8	22.5	17.3	
Mothers who got at least one TT injection when they were pregnant with their last live birth / still birth (%) [#]	75.2	78.5	38.0	29.3	
Institutional births (%)	48.6	43.5	38.8	29.8	
Delivery at home assisted by a doctor/nurse /LHV/ANM (%)	10.5	10.9	14.4	11.2	
Mothers who received post natal care within 48 hours of delivery of their last child (%)	46.7	46.8	-	-	
Child Immunization and Vitamin A supplementation:					
Children (12-23 months) fully immunized (BCG, 3 doses each of DPT, and Polio and Measles) (%)	36.3	34.7	27.6	21.6	
Children (12-23 months) who have received BCG (%)	84.3	84.0	51.9	44.6	
Children (12-23 months) who have received 3 doses of Polio Vaccine (%)	50.1	49.5	36.8	31.1	
Children (12-23 months) who have received 3 doses of DPT Vaccine (%)	60.2	59.7	41.0	29.7	
Children (12-23 months) who have received Measles Vaccine (%)	60.6	63.9	37.7	33.8	
[#] It is adjusted according to DLHS-3 definition					

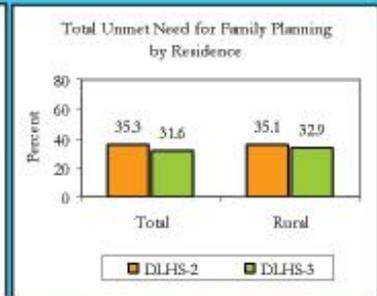
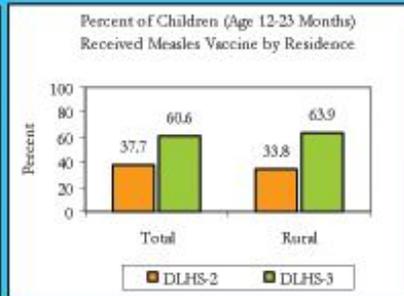
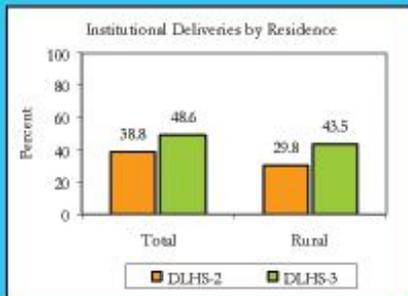
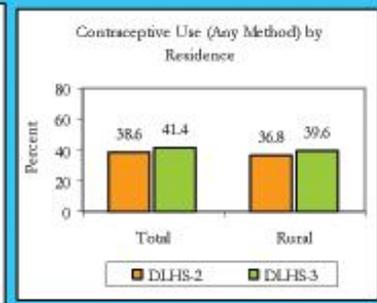
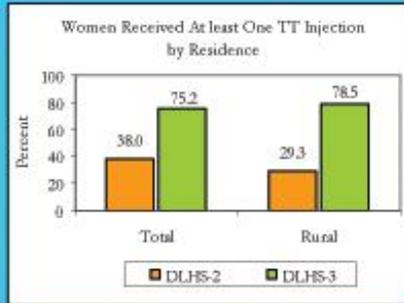
Bihar	DLHS-3	District : Munger				
		Indicators	DLHS - 3		DLHS - 2	
			Total	Rural	Total	Rural
Child Immunization and Vitamin A supplementation: (Contd...)						
Children (9-35 months) who have received at least one dose of Vitamin A (%)	64.2	67.4	-	-		
Children (above 21 months) who have received three doses of Vitamin A (%)	11.2	10.6	-	-		
Treatment of childhood diseases (children under 3 years based on last two surviving children)						
Children with Diarrhoea in the last two weeks who received ORS (%)	33.0	19.1	47.1	46.0		
Children with Diarrhoea in the last two weeks who were given treatment (%)	73.8	69.4	100.0	100.0		
Children with acute respiratory infection/fever in the last two weeks who were given treatment (%)	72.4	68.5	-	-		
Children had check-up within 24 hours after delivery (based on last live birth) (%)	41.6	40.6	-	-		
Children had check-up within 10 days after delivery (based on last live birth) (%)	42.1	40.6	-	-		
Child feeding practices (Children under 3 years)						
Children breastfed within one hour of birth (%)	19.3	19.5	-	-		
Children (age 6 months above) exclusively breastfed (%)	14.2	13.5	-	-		
Children (6-24 months) who received solid or semisolid food and still being breastfed (%)	82.3	81.6	-	-		
Knowledge of HIV/AIDS and RTI/STI among Ever married Women (age 15-49)						
Women heard of HIV/AIDS (%)	53.6	45.8	36.7	26.9		
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	24.5	22.2	20.2	21.1		
Women having correct knowledge of HIV/ AIDS (%)	92.6	92.9	-	-		
Women underwent test for detecting HIV/ AIDS (%)	4.4	3.5	-	-		
Women heard of RTI/STI (%)	58.6	49.4	96.7	95.9		
Knowledge of HIV/AIDS among Un-married Women (age 15-24)						
Women heard of HIV/AIDS (%)	79.0	74.5	-	-		
Women who knew that consistent condom use can reduce the chances of getting HIV/AIDS (%)	31.5	29.2	-	-		
Women having correct knowledge of HIV/ AIDS (%)	95.6	93.9	-	-		
Women underwent test for detecting HIV/ AIDS (%)	0.0	0.0	-	-		
Women heard of RTI/STI (%)	51.5	43.0	-	-		
Women facilitated/motivated by ASHA for						
Ante-natal Care (%)	8.0	9.8	-	-		
Delivery at Health Facility (%)	12.1	14.9	-	-		
Use of Family Planning Methods (%)	2.5	3.5	-	-		

Bihar		DLHS-3		District : Munger	
Village (N=36)					
Indicators				Number	
Villages that have implemented Janani Suraksha Yojana (JSY)				34	
Villages with Health & Sanitation Committee				0	
Villages with Rogi Kalyan Samiti (RKS)				9	
Villages where PRI aware of untied fund by Government				2	
Health facility within village-ICDS (Anganwadi)				31	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-ICDS (Anganwadi)				2	
Health facility within village- Sub-Centre				15	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Sub-Centre				16	
Health facility within village- PHC				0	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-PHC				30	
Health facility within village- Block PHC				0	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Block PHC				29	
Health facility within village- Govt. Dispensary				2	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Government Dispensary				18	
Health facility within village- Private Clinic				3	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-Private Clinic				28	
Health facility within village- AYUSH Health Facility				1	
If health facility is not in the village, whether accessible to the nearest health facility throughout the year-AYUSH Health Facility				28	
Facility Survey					
Indicators		Number	Indicators		Number
Community Health Centre (CHC) N = 1					
Infrastructure :			Performance :		
CHC having Personal Computer	0		In-patients admission in last one month	294	
CHC having Operation Theater	1		Referred cases for serious ailments from CHC to higher centre during last one month	4	
CHC having Labour Room	1		Deliveries performed in last one month	184	
CHC having Blood Storage Facility	0		Blood transfusion done in last one month	0	
CHC having large deep freezer	0		Sterilization conducted in last one month	243	
CHC prepared a CHC plan for the current year	1				
CHC having water supply for 24 hours	1				
CHC having Ambulance on road	1				
					6

Bihar		DLHS-3		District : Munger	
Facility Survey					
Indicators		Number	Indicators		Number
Community Health Centre (CHC) (Contd...)					
Human Resource :			Supply :		
CHC having General Surgeon	0	CHC with 24 hours normal delivery services	1		
CHC having Obstetrician/ Gynecologist	1	CHC with 24 hours New born care	1		
M.O. received training of Non-Scalpel Vasectomy (NSV) during last five years	3	CHC recognized as Integrated Counseling and Testing Centre (ICTC)	0		
M.O. received training for Prevention, Care and Support for HIV/AIDS during last five years	0				
M.O. received training of basic Emergency Obstetric Care during last five years	1				
M.O. received training of Integrated Management of Neonatal and Childhood illness during last five years	1				
Primary Health Centre (PHC) N= 9					
Infrastructure :			Performance :		
PHC having Residential Quarter for Medical Officer	5	Haemoglobin tests (TLC/DLC) conducted during last one month	0		
PHC having separate Labour Room	3	Blood smear examinations for malaria parasite conducted during last one month	54		
PHC having Personal Computer	0	In-patient admissions during last one month	1,517		
PHC having Normal Delivery Kit	6	Referral cases for serious ailments from PHC to higher centres during last one month	219		
PHC having Large Deep Freezer	2	Deliveries performed during last one month	657		
PHC having regular water supply	6	Beneficiaries of JSY during last one month	534		
PHC having Neonatal Warmer (Incubator)	0	Women provided with post-natal care services during last one month	521		
PHC having Operation Theater with Boyles Apparatus	0	New born care provided during last one month	508		
PHC having Operation Theater with anaesthetic medicine	3	Infants and children immunized during last one month	6,522		
		Condoms distributed during last one month	2,552		
		PHC prepared the PHC plan for current year	9		
7					

Bihar		DLHS-3		District : Munger	
Facility Survey					
Indicators		Number	Indicators		Number
Primary Health Centre (PHC) (Contd...)					
Human Resource :			Supply :		
PHC having Lady Medical Officer (LMO)	3	PHC that received the untied fund in previous financial year	9		
PHC having Laboratory Technician	4				
PHC organized any training programme in their PHC during last year	9				
PHC having at least one MO, who received Integrated Skill Development Training for 12 days during last five years	7				
PHC having at least one MO, who received IMNCI training during last five years	4				
Sub Centre (SC) N = 27					
Infrastructure :			Performance :		
Sub Centre located in government building	11	Number of Infants and children immunized	3,403		
Sub Centre having communication facility	0				
Sub Centre having separate labour room	0				
ANM staying in Sub Centre village	5				
Sub Centre having staff quarter for ANM	0				
Sub Centre having regular water supply	15				
Human Resource :			Supply :		
Sub Centre where Male Health Worker in position	4	Sub-Centre having auto-disposable syringes	24		
ANM had Integrated Skill Development Training in last 5 years	10	Sub-Centre reporting IFA tablets out of stock for more than 10 days during last one month	17		
ANM ever been trained in Integrated Skill Development Training	21	Sub-Centre reporting Vitamin A out of stock for more than 10 days during last one month	8		
ANM trained in integrated management of neonatal and childhood illnesses (IMNCI) in last 5 years	13	Sub-Centre reporting ORS packets out of stock for more than 10 days during last one month	21		
ANM ever been trained in integrated management of neonatal and childhood illnesses (IMNCI)	19	Sub-Centre that received untied fund in previous financial year	16		
ANM who attended Skilled birth attendant (SBA) training	6				
8					

Performance at a Glance



Situation Analysis for District Health Action Plan

No	Variable	Data
1	Total Area	1419.
2	Total no. of Block	9
3	Total no of Gram Panchayats	101
4	No. of Villages	866
5	No of PHCs	99
6	No. of APHCs	2929
7	No. of HSCs	143143
8	No. of Sub divisional hospitals	Nil
9	No. of referral hospitals	Nil proposed -1
10	No of Doctors	c-31,R-51
11	No. of ANMs	R-165,C-137
12	No. of Grad A Nurse	C-18,R-20
13	No. of Paramedicals	
14	Total Population	130,70,18
15	Male Population	
16	Female Population	
17	Sex Ratio	878f/100m
18	No. of Eligible couples	
19	Children (0-1 years)	39000
20	Children (0-6 years)	
21	SC Population	170292
22	ST Population	20365
23	BPL Population	
24	No. of Primary School	439
25	No of Anganwari centers	1074
26	No of Anganwari workers	863
27	No of ASHA	812 (820 working but)
28	No. of Electrified villages	689
29	No. of villager having access to safe drinking water	NIL
30	No of villages having motorable roads	821

Section A : Health Facilities in the District

Additional Primary Health centers (APHCs)

S.No	Block Name	Population	APHCs required (After including PHCs)	APH Cs Prese nt	APHCs Propos ed	APHCs require d	Status of building		Avalabil ity of Land	
							own	Rented	Y	N
1	Sadar. Munger	126201	4	1	4	3	NA	1	NA	4
2	Jamalpur	208998	3	2	3	1	1	NA	2	1
3	Dhrarhra	119616	4	3	4	1	2	1	2	1
4	H.Kharagpur	208350	6	3	6	3	3	NA	3	3
5	Bariyarpur	106391	3	1	3	2	NA	1	NA	3
6	Tarapur	97081	1	1	NA	NA	NA	1	NA	1
7	Asarganj	68559	2	2	1	1	NA	1	1	1
8	Sangrampur	89891	2	1	2	1	1	NA	1	1
9	Tetiyabamber	66326	4	1	4	3	1	NA	1	3
Total										

Section A : Health Facilities in the District

Primary Health centers/Referral Hospital/Sub-Divisional Hospital/District Hospital

S.No	Block Name/sub division	Population	PHCs/Referral/SDH/DH present	PHCs required (After including referral/DH/SDH)	PHCs proposed
1	Sadar. Munger	126201	PHC		
2	Jamalpur	208998	PHC		
3	Dhrarhra	119616	PHC		
4	H.Kharagpur	208350	PHC		
5	Bariyarpur	106391	PHC		
6	Tarapur	97081	PHC		
7	Asarganj	68559	PHC		
8	Sangrampur	89891	PHC		
9	Tetiyabamber	66326	PHC		
Total					

Name of the PHC/Referral Hospital/SDH/DH

No	Service	Indicator	Data
1	Child Immunizations	% of children 9-11 month fully immunized (BCG+DPT1+OPV123+Measled)	67.4%
		% of Immunization sessions held against planned	97.2%

2	Child Health	Total number of live births	19784
		Total number of still births	459
		% of newborns weighed within one week	
		% of newborns weighing less than 2500 gm	1689
		Total number of neonatal deaths (within 1 month of birth)	06
		Total number of infant deaths (within 1-12 months)	03
		Total number of child deaths (within 1-5 yrs)	03
		Number of diarrhea cases reports reported within the year	
		% of diarrhea cases treated	
		Number of ARI cases reported within the year	
		% of ARI cases treated	
		Number of children with Grade 3 and Grade 4 undernutrition who were admitted	
		Number of undernourished children	
		% of children below 5 yrs who received 5 doses of vit A solution	
3	Maternal care	Number of Pregnant woman register for ANC	97.68%
		% of pregnant woman registered for ANC in the 1 st trimester	20971
		% of Pregnant woman with 3 ANC check up	
		% of Pregnant woman with any ANC checkup	1898
		% of Pregnant woman with received 2 TT injections	
		% of Pregnant woman who received 100 IFA tablets	18641
		Number of institutional deliveries conducted by SBA	12461
		% of c- sections conducted	20182
		% of Pregnancy complications managed	
		% of institutional deliveries in which JBSY fund were given	115
		% of home deliveries in which JBSY funds were given	92%
		Number of deliveries referred due to complications	115
		% of mothers visited by health workers during the first week after delivery	62%
		Number of Maternal Deaths	03
4	Reproductive Health	Number of MTPs conducted	31
		Number of MTPs conducted	31
		Number of RTI/STI case treated	
		% of couples provided with barrier contraceptive methods	151722
		% of couples provided with permanent methods	45.09%
		% of female sterilizations	5327%
			(89%)
5	RNTCP	% of TB cases suspected out of total OP	3.7%
		Proportion of New sputum positive out of total New pulmonary cases	NSP 612 Total New Pulmonary cases -1105
		Annual case detection Rate (total TB cases registered for	62.7%

		treatment per 100,000 (% population per year .	
		Treatment success Rate (% of new smear positive patients who are document to be cured or have successfully completed treatment	91.4%
		% of patients put on treatment who drop out of treatment.	2.925%
6	Vector Borne Disease Control Programme	Annual Parasite Incidence	
		Annual Blood Examination Rate	3435
		Plasmodium Falciparum percentage	11.5%
		Silde Positivity Rate	396
		Number of Patients receiving treatment for Malaria	396
		Number of Patients with Malaria referred	11
		Number of FTD and DDCs	
7	National Programme for control of Blindness	Number of cases detected	1525
		Number of cases operated	1525
		Number of patients enlisted with eye problem	65000
		Number of camps organized	43541
8	National Leprosy Eradication Programme	Number of cases deteced	252,mb-92,pb-16
		Number of cases treated	253,MB-92,PB-161
		Number of default cases	17,MB-11,PB-6
		Number of cases complete treatment	268,MB-93,PB-175
		Number of complicated cases	10,MB-8,PB-2
		Number of cases referred	4
9	Inpatient Services	Number of in-patient admissions	10454
10	Outpatient services	Outpatient attendance	636184
11	Surgical Services	Number of major surgeries conducted	5342
		Number of minor surgeries conducted	3913

Section F: Community Participation, Training & BCC

Community Participation Initiatives

S.no	Name of Block	No. of GPs	No. of VHSC	No. of VHSC	Total amount	No. of ASHA	Number of	Number of	Total amount
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formed	meeting held in the block	released to VHSC from untied funds	s Round 1	ASHAs trained Round 2	meeting held between ASHA and Block officers	paid as incentive to ASHA
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1

NIL

Training Activities:

S.No	Name of Block	Rounds of SBA Trainings held	No. of Personal SBA Training given	Rounds of IMNCI Training held	No. of Personnel given IMNCI Training	Any specific issue on which need for a training of skill building was felt but has not being given yet
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Section B : Human Resources and Infrastructure

Name of the District ,Munger

PHC Sub-center database

Name of PHC	Sub center	Pop	No of G. P at/villages served	ANM/R/C in position	Bulliding ownership (Govt/Pan/Rent)	Building condition (++++/+++/+/)	Assured running water supply (A/N A/I)	Cont. power supply (A/AN/I)	ANM residing at HSC area (Y/N)	Condition of residential facility(++++/+++/+)	Status of furnitures	Status for Un tied fund								
Sadar. Munger	24	126201	18	22	10	1	13	3	3	18≠	24	24	2	22	2	2	1	2	23	1
Jamalpur	16	208998	13	16	8		8	1	6	9≠	1	15	16	8	8	1	7	8	8	8
Dhrarhra	25	119616	13	18	10		15			9+		25	25		25			2	25	N
H.Kharagpur	10	208350	10	10	2		8			10≠	10	10		10				1	10	N
Bariyarpur	10	106391	10	7	5		5		5	5≠	10	10	4	6				1	10	N
Tarapur	17	97081	17	11	8		9		8	9≠	1	16	1	16		17		1	7	N
Asarganj	11	68559	6	5	4		7			11≠	1	10	11	11				1	6	5
Sangrampur	19	89891	12	14	5		14		7	12≠	19	19		19				1	13	6
Tetiyabamber	11	66326	6	5	7		4	1	5	5≠	11	11	3	8	1	1	9	NA	1	11

Section B : Human Resources and Infrastructure

Name of the Block

Sub-center database

District Health Society, Munger

No	Sub center	Pop	No of G.P at/villages served	ANMs(R)/(C) in position	Bulliding ownershi p (Govt/Pan/Rent)	Building condition (+++/++/+)	Assured running water supply (A/NA/I)	Cont. power supply (A/AN/I)	ANM residing at HSC area (Y/S)	Condition of residential facility(++/++/+)	Status of furnitures	Status of fund
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Section B : Human Resources and Infrastructure

Name	APHC & PHC		Doctors				ANM				Laboratory technician		Pharmacists/dresser				Nurse A Grade				Accent/p eons/Swe eper/Nights Guards		Availabilit y of speciali st			
	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos	Sanc	Inpos
	P	AP	P	AP	P	A	P	A	P	A	P	A	PH	AP	PHC	AP	PHC	AP	P	A	P	A	PHC	A	PH	AP
	H	HC	H	HC	H	P	H	P	H	P	H	P	C	HC		HC		HC	H	P	H	P	HC	P	C	HC
	C		C		C	C	C	C	C	C	C	C							C	C	C	C	C	C		
Sas	1	NA	2	NA	2	N	1	N	1	N	N	N	NA	NA	NA	NA	NA	N	N	N	N	4	N	PH	AP	
Jmp	1	3	4	6	4	2	4	6	4	2	1	3	NA	NA	1/1	3/3	1/1	1/1	1	6	N	3	4	8	NA	NA
Dha	1	4	7	8	7	2	3	8	3	6	1	4	NA	NA	2/2	4/4	1/N	1/N	4	8	N	3	8	8	3	NA
Kha	1	3	6	6	4	1	4	6	4	6	1	3	1	NA	2/2	3/3	2/N	2/N	2	3	1	N	8	6	3	NA
Bar	1	3	4	6	3	N	3	6	3	N	1	3	NA	NA	1/1	3/3	NA	NA	1	3	N	N	2	1	1	NA
Tar	1	1	7	2	7	2	2	2	2	2	1	1	NA	NA	2/2	1/1	1/N	1/N	4	2	4	1	8	2	NA	NA
Asa	1	2	4	4	4	1	3	4	3	2	1	2	NA	NA	1/1	2/2	1/N	1/N	1	4	N	3	6	2	NA	NA
Sag	1	2	7	2	7	N	4	2	3	N	1	1	NA	NA	1/1	1/1	NA	NA	2	2	N	N	6	4	NA	NA
Tbam	1	1	7	2	2	2	4	2	2	1	1	1	NA		1/1	1/1	NA	NA	1	2	1	N	8	2	4	NA

Fund Allocation by SHSB & DHS
NRHM- A FY-2010-11

S.No	Name of Programme	1 st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
METERNAL HEALTH						
1	Operationalise FRU Blood storage unit	180000	180000	50000	50000	460000
2	24x7 servics.		50000	0	0	50000
3	RCH Outreach Camps in unserved/under served areas	26810	26810	26810	26820	107250
4	Janani Suraksha Yojana JSY					0
5	Home Deliveries					0
6	Rural (Inst Deliveries)@Rs.2000 per deliveries	6250000	10820375	8535185	8535190	34140750
7	Urban (Inst Deliveries)@Rs.1200 per deliveries	625000	1423547	1024273	1024272	4097092
8	Caesarean deliveries	35930	35930	35930	35930	143720
9	Others activities (JSY)	109872	109872	109872	109872	439488
CHILD HEALTH						
11	Facility Based New born Care in distirct (Training Percruitment view meeting)	63292	63292	63292	63292	253168
12	School Health Programme	648882	648882	648882	648882	2595528
FAMILY PLANNING						
14	Dissemination of manuals on uterilisation standards & quality assurance of sterilisation		25000		25000	50000
15	NSV camps organise in district @10000/-per camp	30000	30000	30000	30000	120000
16	Compensation for femal sterilization (Mini lab)	1091666	1091666	1091666	3275000	6549998
17	Compensation for mal sterilization	139731	139731	139731	139731	558924
18	Accreditation of private provider for sterilization services.	461953	461953	461953	461951	1847810
19	IUD camps	71250	71250	71250	71250	285000
20	POL for family planning for 500 below sub district facilities	12500	57500	187500	188090	445590
21	Other strategies/Activities condom and OCP dlistribution center.	1968	1969	1969	1969	7875
ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH/ARSH						
23	Adolescent services of health facilities (Youth friends clinic in urban area/university camps/market place.	25000		25000		50000
INNOVATION/PPP/NGO						
25	PNDT and Sex Ratio		331965			331965
INFRASTRUCTURE & HUMAN RESOURCES						
27	Countractual Staff & Services					
28	ANMs(Retried ANMs or hiring from other state for out reach services @5000/-m/ANM.	468750	468750	468750	468750	1875000
29	Laboratry Technicians	146250	146250	146250	146250	585000
30	Doctors and Specialities	1137039	1137039	1137039	1137039	4548156
31	Others constructul staff.	22281	22281	22281	22281	89124
32	Inscentive/award(asha per AWW @200/-m ANM per AWW @150/- m under Muskan Programme.	1341418	1341418	1341419	1341420	5365675
33	Minior civil works for operationalisation of FRUs(NBC)	125000				125000

34	Minor civil works for operationalisation of 24 hour services at PHCs @25000/-PHC (NBC)	225000				225000
35	INSTITUTIONAL STRENGTHENING					
36	Sub Center Rent and Contingencies @ No. of SCxRs.500x60 months.	138375	138375	138375	138375	553500
37	TRAINING					
38	SBA	393000	393000	393000	393000	1572000
39	MTP Training of Nurses/ANM/MO in Safe Abortion.	25000		25000		50000
40	IMNCI Training	1758754	1758754	1758754	17 587 54	5276262
41	DPMU Training	24375	24375	24375	24375	97500
42	BCC/IEC (for NRHM PART-A,B&C)					
43	Development of State BCC/IEC strategy	12500	12500	12500	12500	50000
44	Other Activities	294375	294375	294375	294375	1177500
45	PROCUREMENT					
46	Procurement of Equipmen/Instument for blood stroage	50000	50000	50000	50000	200000
47	PROGRAMME MANAGEMENT					
48	Strengthening of DHS/DPMU.	277194	277194	277194	277194	1108776
49	Strengthening of Financial Mamageent system (CA)	60000	60000	60000	60000	240000
50	Other activities (Office expnecses,mobility to state/district &block).	314754	314754	314754	314754	1259016
	Total:-	16587919	22008807	18967379	19367562	76931667

District Health Society, Munger
Fund Allocation by SHSB & DHS
NRHM- B FY-2010-11

S.No	Name of Programme	1 st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
DECENTRATION						
1	Asha support system at Distric level	15000	15000	15000	15000	60000
2	Asha support system at Block	812500	812500	812500	812500	3250000
3	Asha support system at village level	27498	27498	27498	27498	109992
4	Asha traning	200000	200000	200000	200000	800000
5	Asha Drug kit & Replenishment	553750		553750		1107500
6	Motivation of Asha	387648	387648	387648	387648	1550592
7	Asha Divas	500037	500037	500037	500037	2000148
8	United Fund for HSC,APHC & PHC	566562	566562	566563	566563	2266250
9	Village Health and Sanitation Commities	4864520	4864520			9729040
10	R.K.S	2800000		200000		3000000
INFRASTRUCTURE & STRENGTHENNG						
12	Contraction of HSC	2375000	2375000	2375000	2375000	9500000
13	Contraction of PHCs					0
14	Residential quarter of Old APHC for Stuff & Nurses	937500	937500	937500	937500	3750000
15	Construction of building of APHCwhere land available	1660937	1660937	1660937	1660937	6643748
16	Upgradation of CHC as per IPHS Standred	5000000	5000000	5000000	5000000	20000000
17	Upgradation of ANM Training School	1562500	1562500			3125000
18	Annual Maintenance Grant	468750	468750	468750	468750	1875000
Contractual Manpower						
20	Incentive for PHC DOCTORS & Staff	327095		327095		654190
21	Salaries for Contractual staff Nurses	3145426	3145426	3145427	3145427	12581706
22	Contract Salaries for ANM	2700000	2700000	2700000	2700000	10800000
23	Mobile Facility for all Health functionaries	457317	457317	457317	457317	1829268
24	Block Programe Manger Unit	2206737	2206737	2206737	2206738	8826949
25	Addl. Manpower for NRHM	146250	146250	146250	146250	585000
PPP INTITATIVE						
27	Service of Hospital Waste treatment & Disposal in all Government Health facility up to PHC in Bihar(IMEP)	556968	556969	556969	556969	2227875
28	Settingbg up to Ultra Modern Diagnostic Centre in Regonal Diagnostic centre(RDCS)	750000	750000	750000	750000	3000000
29	Opertionalising MMU(Mobile Medical Unit)	1316250	1316250	1316250	1316250	5265000
30	State District & Block Data Center Montring and Evaluation	337500	337500	337500	337500	1350000
Procurement of Supplies						
32	Delivery Kits at the HSC/ANM/ASHA(No.of ANM x Rs. 25)	69911	69912	69911	69912	279646
33	SBA Drug kit with SBA ANM/Nurses etc(No.of ANM X Rs. 25)	48905		489056		537961
34	Availability of sanitary napkin Govt. Health Facility	25000		25000		50000
35	Procurement of beds for PHC to Districts Hospitals	1449000				1449000
Procurement of Drugs						

37	Cost of IFA for pregnant lactation mothers	191184		191184		382368
38	cost fo IFA for (1-5) yeal children	326755		326755		653510
39	Cost of IFA for adolescent girls	300000		300000		600000
40	Srengthening of Cold Chain (Infrastructure Strengthening)					
41	Refurbishment of existing cold chain room for district stores	125000	250000	250000	250000	875000
42	Earthing and wiring of existing cold chain room in all PHC	162500				162500
43	Preparation of Action Plan		0			
44	Prep. Of District Health Action Plan	125000				125000
45	Mainsreaming Ayush under NRHM	1966500	1966500	1966500	1966500	7866000
46	RCH Procurement of equip					
47	Equip. For ICU	2131580				2131580
48	Equip for the labour room	2758400				2758400
49	Equip. for the SNCU & NSU	1569285				1569285
50	NSV Kits	50000				50000
51	IUD insertion kit	30000				30000
52	Minilap sets	59210				59210
Total:-		46063975	33281313	29267134	26854296	135466718

District Health Society, Munger
Fund Allocation by SHSB & DHS
NRHM- C FY-2010-11

S.No	Name of Programme	1 st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
DECENTRATION						
1	Pulse polio	3417912	3417912	3417912	3417914	13671650
2	Rutine Immunization	927025	927025	927025	927025	3708100
Total:-		4344937	4344937	4344937	4344939	17379750

District Health Society, Munger
Fund Allocation by SHSB & DHS
NRHM- D FY-2010-11

S.No	Name of Programme	1 st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
DECENTRATION						

1	Vitamin A	109050	109050	109050	109050	436200
2	MDA Falaria	185812	185812	185812	185812	743248
3	DDT-Spray Khoj Pakhwara	531125	531125	531125	531127	2124502
Total:-		825987	825987	825987	825989	3303950