Morang
District Profile
&
Annual Report

2061/62
Fiscal Year

Editor
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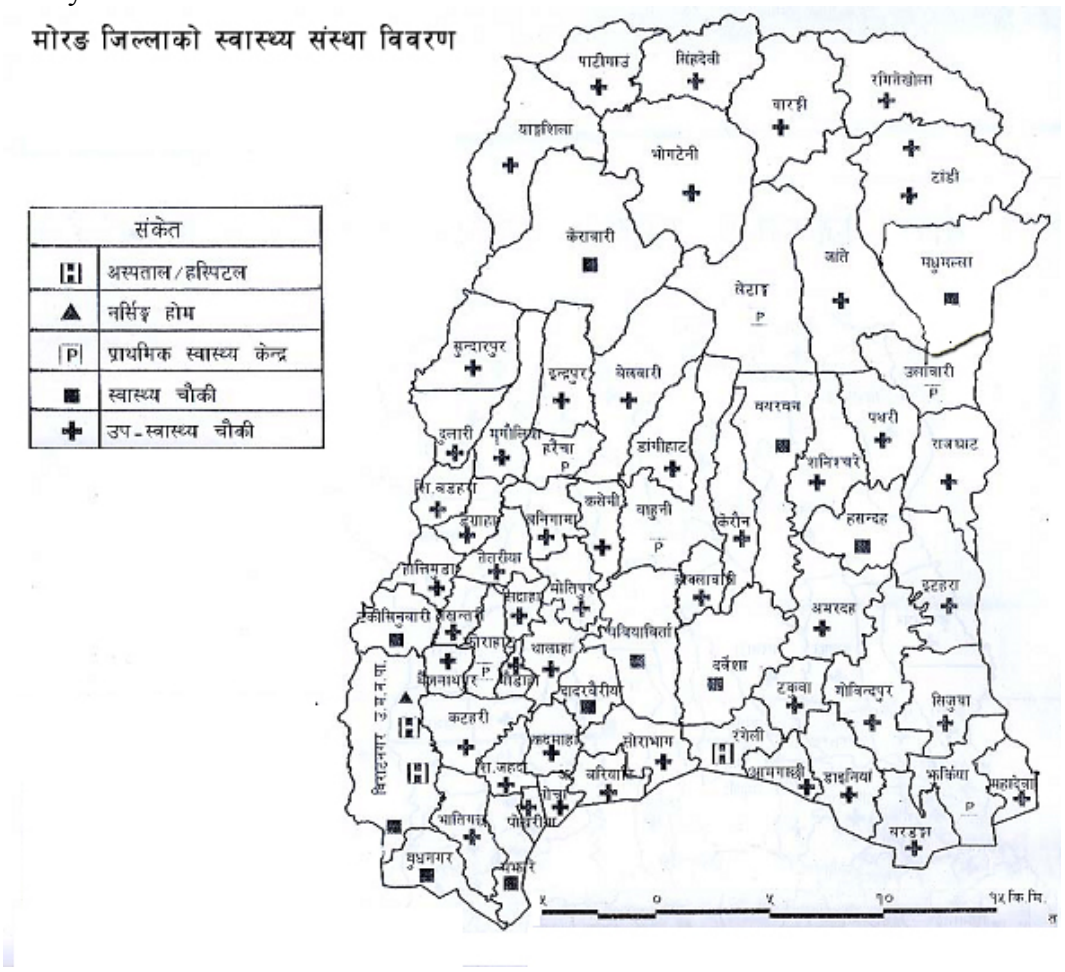
Ministry of Health
Department of Health Services
Eastern Regional Heath Directorate
District Public Health Office
Morang, Nepal

CHAPTER 2

INTRODUCTION

MORANG: General Background

Historically, Morang district has been derived from *Mawarang,* the name of *Kirati* administrative zone during regime of *Kirati* king *Hang*.[1] *Gograha* was its older name of present Biratnagar; headquarter of the district and Koshi zone, coined during *Ranna* regime which is connected with the name of King *Birat* of *Mahabharat* era. Now people believe that the capital of King *Birat* of that Mahabharat era was located at present Budhanagar V.D.C. which is 10 Km south east from Biratnagar. Morang district is one of the Eastern Terai district comprising 65 VDCs where 66 governmental health institutions are available for providing Primary Health Care services.



Geographical Location

- Eastern Terai district
- Adjoining districts: Panchthar, Ilam, Jhapa, Sunsari, Dhankuta
- Area : 1,855 S.Km.
- Total Population: 914,799
- Biratnagar Sub-metropolitan Population: 181,000
- Number of VDCs : 65
- Sub-Metropolitan City : 1
- Number of Ilakas : 17
- Electoral Constituencies : 7

Health Institutions

- Hospitals: 2 (Koshi Zonal, Rangeli Hospital)
- Primary Health Care Centres: 6
- (Jhorahat, Haraicha, Mangalbare, Letang, Bahuni, Jhurkia)
- Health Posts: 11
- (Babiyabirta, Bayarban, Rani, Ranjani, Budhnagar, Dadarbairiya, Hasandaha, Kerabari, Madhumalla, Majhare, Tankisinwari)
- Sub Health Post: 49
- FCHV: 655 (VDCs=585, Biratnagar Sub metro=70)
- TBAs= 336, EPI-ORC= 303
- PHC-ORC= 281 (Fund raised Rs. 33,718.00)
- Ayurvedic= 2, Nursing Home: 7, Pvt. Hospital =2

MORANG: Human Development Indicators 2001[2]

S.No.	Indicators	Morang	National
1.	Life Expectancy	67.28 Yrs	60.98 Yrs
2.	Life Expectancy (Female)	67.78 Yrs	61.5 Yrs
3.	Life Expectancy (Male)	66.85 Yrs	60.5 Yrs
4.	Adult Literacy	52.3%	48.6%
5.	Adult Literacy (Female)	39.9 %	34.9%
6.	Adult Literacy (Male)	64.9%	62.7%
7.	Human Development Index (HDI)	0.531	0.471
8.	Proportion of Malnourished Children under 5 years	41.5%	50.5%
9.	Access of Safe drinking water	94.07%	20.48%
10.	Proportion of below poverty line	34.4%	39.6%
11.	Average duration of School stay		
12.	Average duration of School stay (Female)	2.58 Yrs	1.95 Yrs
13.	Average duration of School stay (Male)	4.31 Yrs	3.56 Yrs
14.	Proportion of Income (Female)	0.363	0.345
15.	Proportion of Income (Male)	0.527	0.485
16.	Gender Development Index	0.511	0.452
17.	Gender Development Index/Human Development Index	0.963	0.959
18.	Women involvement in local level election	18.78%	19.33%
19.	Women involved in any occupation	18.38%	18.78%
20.	Women involved in administration sector	15.01%	12.71%
21.	Proportion of women income	0.271	0.302
22.	Gender Empowerment Measurement	0.399	0.391
23.	Gender Empowerment status of Morang in country	20th position	
24.	Number of Factory	2961	
25.	Organizations for social service	912	
26.	Per Capita Income (in market value)	21871 ($297)	
27.	Social Empowerment Index	0.451	0.406
28.	Economic Empowerment Index	0.506	0.337
29.	Political Empowerment Index	0.919	0.646
30.	Human Empowerment Index	0.625	0.463
31.	Human Empowerment Index Order in the country	5th	

As per Human Development Indicators published by UNDP, Morang district is found in first position in Eastern development region.

CHAPTER 2

ANNUAL REPORT (F.Y. 2061/62)

Table 1 Target Population (Programme wise)

Population:	914799
Male:	458772
Female:	456027
Under 1 year's population:	22870
Under 3 year's population:	70352
Under 5 year's population:	118289
MWRA:	174510
Expected Pregnancy:	34945

Major Achievements

1. CHILD HEALTH

1.1 Expanded Programme on Immunization (EPI)

1.1.1 Background:

EPI is a priority national programme of HMG/N which has been running nation wide since 1989. Active surveillance system is weak; therefore it is difficult to measure the impact of the programme. However, there is no doubt that the programme has contributed significantly towards reduction of infant and child mortality as evidence by reduction of IMR and U5MR over the last decade[3]. According to the Annual Report published by Ministry of Health, Department of Health Services[4] noted that measles vaccine coverage rate of Rauthahat was 120 percent, National 85 percent, Eastern development region 88 percent and Morang 95 percent in FY 2060/61. However the BCHIMES[5] survey conducted in early 2000 and DHS survey 2001[6] indicate that the actual coverage is lower than the reported coverage by 5-10%. The Multi Year Plan of Action 2002-2007 (MYPOA) has set six objectives: 1) increasing routine immunization coverage to >90% and maintain the level; 2) eradication of poliomyelitis by 2005; 3) elimination of MNT by 2005; 4) reduction of measles cases and deaths; and 5) introduction of Hep-B vaccine and 6) promotion of safe injection practices in immunization programme.

1.1.2 Objectives:

- To eliminate neonatal tetanus (less than 1 cases per 1000 live births) by the year 2005;
- To reduce measles cases by 90% and measles death by 95% from the previous level by the year 2005.
- To obtain certificate of poliomyelitis eradication by the year 2005.
- To introduce new vaccine (Hepatitis B).

1.1.3 Targets:

The target population for BCG, DPT, OPV, and Measles vaccines is all infants under one year (12 months) of age. For TT+, the target population is all pregnant women. The EPI covers all the 16 districts in eastern region. It aims to have uniform coverage in all the districts and sustain high levels of coverage (i.e. at least 80% for BCG, DPT 3, OPV 3, and Measles in children under one year and 80% coverage for TT+ vaccine in pregnant women.

1.1.4 Strategies:

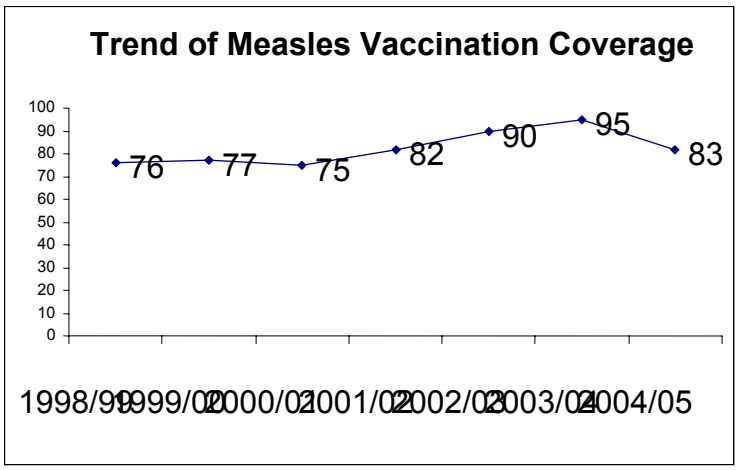
- Immunization service delivery mainly through outreach sessions, provision of immunization services by conducting 3-5 sessions per VDC per month, in the district.
- Use of all fixed sites to increase immunization coverage. EPI services provided through fixed health facilities including Hospitals, PHC, HP, SHP and other health clinics.
- Supplementary immunization activities (NIDs, SNIDs, Mopping up) for polio eradication and MNTE activities for maternal and neonatal tetanus elimination.
- Control of outbreak of VPDs through appropriate interventions.

1.1.5 Analysis:

Table 2 Target Vs Achievement

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
BCG	Person	22550	21451	94	75.8	1. Measles Campaign, 2. Frequent training for health workers due to piloting programmes, 3. Shortage in supply of vaccine for 3 months.
DPT3	,,	22550	16704	73		
Polio3	,,	22550	18368	82		
Hep-3	,,	22550	20593	91		
MEASLES		22550	18363	81		
TT2		35006	21673	62		
Cold Chain training	Times	1	1	100		
Micro Planning/ DDC Orientation	,,	1	1	100		

Graph 1 Trend of Measles vaccination coverage



Trend of measles vaccination seems running above 75 percent over past 7 years. This year coverage was dropped to 82 percent due to measles campaign, frequent movement of health workers due to series of trainings, and shortage of vaccine supply for three months.

Table 3 VDC wise BCG coverage in Morang

S.N.	VDCs	Taget	Achievment	%
1	Aamgachhi	137	313	228
2	Rangeli	406	733	181
3	Nocha	104	137	132
4	Dainiya	328	407	124
5	Bardanga	265	318	120
6	Budhanagar	327	383	117
7	Jhurkiya	267	305	114
8	Sorabhag	278	316	114
9	Warangi	92	104	113
10	Amahibariyati	163	183	112
11	Thalaha	205	227	111
12	Sis. Jahada	194	213	110
13	Sub Metro Brt	4540	4932	109
14	Pokhariya	75	81	108
15	Dadarbairiya	215	229	107
16	Majhare	242	249	103
17	Dangraha	136	139	102
18	Tandi	265	270	102
19	Yangsila	182	186	102
20	Baijanathpur	122	122	100
21	Belbari	530	529	100
22	Sijuwa	308	305	99
23	Sis. Badahara	130	128	99
24	Letang	456	447	98
25	Hoklabari	127	124	97
26	Dulari	277	267	96
27	Kadmaha	195	188	96
28	Hattimuda	215	207	96
29	Bhatigachha	306	289	94
30	Banigama	218	200	92
31	Jhorahat	131	116	88
32	Kerabari	425	369	87
33	Lakhantari	109	93	86
34	Hasandaha	292	248	85
35	Madhumalla	522	436	84
36	Mahadewa	122	102	84
37	Urlabari	698	583	84
38	Tankisinuwari	447	369	83
39	Singdevi	74	61	82
40	Katahari	509	417	82
41	Bhaudaha	168	137	81
42	Tetariya	151	122	81
43	Keroun	337	272	81
44	Bayarban	549	441	80
45	Indrapur	465	374	80
46	Govindapur	406	324	80
47	Motipur	141	112	80
48	Rajghat	345	275	80
49	Takuwa	198	156	79
50	Sanischare	642	506	79
51	Darbesha	453	355	78
52	Jante	196	153	78
53	Haraicha	172	133	78
54	Dangihat	526	397	76
55	Mirgouliya	350	261	75
56	Amardaha	384	282	73
57	Itahara	422	297	70
58	Pathari	586	412	70
59	Babiyabirta	393	276	70
60	Bahuni	333	232	70
61	Pati	65	44	67
62	Sundarpur	423	278	66
63	Ramitekhola	86	53	61
64	Kaseni	195	119	61
65	Sidraha	102	58	57
66	Bhogteni	150	83	55
District		22870	21477	94

BCG coverage is heterogeneous which ranges from Aamgachi 222 percent to Bhogteni 55 percent in the district.

Table 4 VDC wise DPT 3 Coverage in Morang district

S.N.	VDCs	Taget	Achievment	%
1	Aamgachhi	137	287	210
2	Jhurkiya	267	329	123
3	Sorabhag	278	339	122
4	Mahadewa	122	133	109
5	Rangeli	406	436	108
6	Dainiya	328	348	106
7	Nocha	104	110	106
8	Thalaha	205	210	102
9	Dadarbairiya	215	219	102
10	Majhare	242	246	102
11	Kadmaha	195	197	101
12	Dangraha	136	133	98
13	Bardanga	265	259	98
14	Pokhariya	75	73	97
15	Amahibariyati	163	151	92
16	Baijanathpur	122	112	92
17	Belbari	530	459	87
18	Lakhantari	109	94	86
19	Budhanagar	327	278	85
20	Sis. Jahada	194	159	82
21	Banigama	218	177	81
22	Sub Metro Brt	4540	3663	81
23	Sijuwa	308	244	79
24	Sis. Badahara	130	102	79
25	Bhatigachha	306	240	78
26	Tankisinuwari	447	345	77
27	Dulari	277	207	75
28	Keroun	337	250	74
29	Letang	456	328	72
30	Indrapur	465	332	71
31	Darbesha	453	319	70
32	Tetariya	151	106	70
33	Mirgouliya	350	245	70

S.N.	VDCs	Taget	Achievment	%
34	Kerabari	425	295	69
35	Bhaudaha	168	113	67
36	Jante	196	130	66
37	Warangi	92	60	65
38	Jhorahat	131	85	65
39	Katahari	509	326	64
40	Hoklabari	127	81	64
41	Hasandaha	292	180	62
42	Yangsila	182	112	61
43	Haraicha	172	105	61
44	Takuwa	198	120	61
45	Tandi	265	158	60
46	Bayarban	549	318	58
47	Sanischare	642	370	58
48	Motipur	141	81	58
49	Hattimuda	215	122	57
50	Pati	65	37	57
51	Babiyabirta	393	222	57
52	Kaseni	195	108	55
53	Bhogteni	150	82	55
54	Madhumalla	522	284	54
55	Pathari	586	317	54
56	Rajghat	345	186	54
57	Govindapur	406	217	53
58	Itahara	422	225	53
59	Sidraha	102	54	53
60	Singdevi	74	39	53
61	Ramitekhola	86	44	51
62	Dangihat	526	259	49
63	Bahuni	333	160	48
64	Amardaha	384	181	47
65	Sundarpur	423	197	47
66	Urlabari	698	318	46
District		22870	16716	73

DPT 3 coverage is heterogeneous which ranges from Aamgachi 210 percent to Urlabari 46 percent in the district.

Table 5 VDC wise Measles vaccine coverage in Morang

S.N.	VDCs	Taget	Achievment	%
1	Aamgachhi	137	247	180
2	Warangi	92	144	157
3	Sorabhag	278	422	152
4	Mahadewa	122	142	116
5	Belbari	530	601	113
6	Amahibariyati	163	181	111
7	Jhurkiya	267	294	110
8	Jante	196	215	110
9	Rangeli	406	440	109
10	Dadarbairiya	215	230	107
11	Pokhariya	75	79	105
12	Yangsila	182	187	102
13	Hoklabari	127	129	101
14	Baijanathpur	122	121	99
15	Banigama	218	214	98
16	Hasandaha	292	287	98
17	Kadmaha	195	187	96
18	Bardanga	265	254	96
19	Letang	456	436	96
20	Dainiya	328	311	95
21	Nocha	104	98	94
22	Dangraha	136	128	94
23	Sis. Badahara	130	122	94
24	Dulari	277	259	94
25	Hattimuda	215	198	92
26	Kerabari	425	391	92
27	Rajghat	345	317	92
28	Keroun	337	306	91
29	Majhare	242	215	89
30	Mirgouliya	350	304	87
31	Thalaha	205	175	85
32	Tetariya	151	128	85
33	Bayarban	549	463	84

S.N.	VDCs	Taget	Achievment	%
34	Bahuni	333	280	84
35	Bhaudaha	168	139	83
36	Tankisinuwari	447	368	82
37	Ramitekhola	86	71	82
38	Sanischare	642	518	81
39	Sis. Jahada	194	156	80
40	Lakhantari	109	86	79
41	Sub Metro Brt	4540	3572	79
42	Bhogteni	150	116	77
43	Bhatigachha	306	235	77
44	Pati	65	50	77
45	Tandi	265	200	76
46	Madhumalla	522	393	75
47	Indrapur	465	347	75
48	Pathari	586	430	73
49	Jhorahat	131	96	73
50	Sijuwa	308	224	73
51	Urlabari	698	497	71
52	Katahari	509	356	70
53	Budhanagar	327	224	68
54	Dangihat	526	354	67
55	Govindapur	406	271	67
56	Babiyabirta	393	257	65
57	Singdevi	74	47	63
58	Takuwa	198	119	60
59	Itahara	422	253	60
60	Amardaha	384	223	58
61	Kaseni	195	110	56
62	Darbesha	453	250	55
63	Sidraha	102	54	53
64	Haraicha	172	86	50
65	Sundarpur	423	200	47
66	Motipur	141	63	45
District		22870	18870	83

DPT 3 coverage is heterogeneous which ranges from Aamgachi 180 percent to Motipur 45 percent in the district.

Measles Campaign 2061

Measles campaign 2061 was introduced first time in the country. Campaign was three week long. Many rumors raised during campaign by which programme was affected. DPHO Morang, health workers, volunteers, teachers, students, civil society, human right activist, NGOs and media played important role. Overall coverage of measles vaccination was 85% in the district.

Table 6 VDCs Categorized with Problems and priority 2060/61

Category 1 Low Drop Out Rate (<10) High Coverage (>80)	**Category 2** High Drop Out Rate (>10) High Coverage Rate (>80)	**Category 3** Low Drop Out Rate (<10) Low Coverage Rate (>80)	**Category 4** High Drop Out Rate (>10) Low Coverage Rate (<80)
Bhaudaha, Bahuni, Bayarban, Tetariya, Mirgouliya, Keroun, Kerabari, Hattimuda, Dulari, Sis. Badahara, Dangraha, Letang, Kadmaha, Hasandaha, Banigama, Baijanathpur, Madhumalla, Hoklabari, Yangsila, Pokhariya, Dadarbairiya, Jante, Jhurkiya, Amahibariyati, Belbari, Mahadewa, Sorabhag, Warangi, (28 Health Facilities)	Thalaha, Majhare, Nocha, Dainiya, Bardanga, Rangeli, Aamgachhi, District (7 Health Facilities)	Sidraha, Kaseni, Babiyabirta, Pathari, Indrapur, Pati, Bhogteni, Lakhantari, Sanischare, Ramitekhola, Tankisinuwari (11 Health Facilities)	Motipur, Sundarpur, Haraicha, Ranjani, Amardaha, Itahara, Takuwa, Singdevi, Govindapur, Dangihat, Budhanagar, Katahari, Urlabari, Sijuwa, Jhorahat, Tandi A+B, Bhatigachha, Rani, Siswani Jahada, (20 Health Facilities)
No Problem	**Priority 3**	**Priority 2**	**Priority 1**

About half of VDCs of Morang district is having coverage more than 80 percent and drop out rate less than 10 percent. District average falls under the category 2.

1.1.6 Problems/Constraints And Action To Be Taken

Problem/Constraints	**Action to be Taken**	**Responsibility**	**Time Frame**
Shortage of vaccine supply for 3 months	Requested RMS and LMD	DPHO, EPIS	ASAP
Frequent *Bandhs* affected vaccine supply			
Frequent trainings affected service flow	Action has taken to minimize the effect	DPHO	ASAP

1.2 Nutrition

1.2.1 Background:

Malnutrition is a major health problem among the children and women of childbearing age in the country. Growth monitoring, micro-nutrients distribution, de-worming, Vitamin "A" distribution, promotion of breastfeeding and control of anemia are being carried out in order to promote health of child and women under the nutrition program.

1.2.2 Objectives:

- To reduce protein malnutrition among the children under 3 years of age through multi sartorial approach.
- To eliminate Iodine deficiency disorder and vitamin a deficiency by 2005;
- To reduce prevalence of anemia to less than one third by the year 2010;
- To reduce the incidence of low birth –weight to less than 10% of all births by the year 2005.

1.2.3 Target:

- Reduction of sever and moderate malnutrition among children under 3 years of age to half of the 1990 level by the year 2005;
- Reduction of iron deficiency anemia of expected pregnancies by one third of the 1990; Level by the year 2005.
- Reduction of vitamin "A" deficiency among children under five years of age by 90% in all districts by preventive measures by the year 2005.

1.2.4 Strategies:

- Promote, facilitate and utilize community participation and involvement for all nutrition activities.
- Integrate/incorporate EPI/FP/MCH and related activities in the nutrition plans.

1.2.5 Analysis:

Table 7 Nutrition: Target Vs Achievement

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Growth Monitoring	Person	70352	35369	50	75	1. Measles Campaign, 2. Frequent training for health workers due to piloting programmes
Deworming	,,	93862	106230	100		
Anemia	,,	29755	17372	58		
Vitamin "A" Distribution	,,	105595	120643	100		
Treated by Vitamin "A"	,,	10560	2191	21		
Albendazole Distribution for Pregnant Mother	,,	10501	8774	84		
Supervision	Time	2	2	100		
Nutrition Review meeting	,,	3	0	0.0		
Logistic Supply	,,	2	2	100		
Breast Feeding week celebrate	,,	1	1	100		
Iodine month Celebration	Time	1	1	100		

Table 8 VDC wise New growth monitoring in Morang

S.N.	VDCs	Taget	Achievment	%
1	Dulari	852	1314	154
2	Singdevi	228	300	132
3	Motipur	432	539	125
4	Hasandaha	899	1055	117
5	Yangsila	561	629	112
6	Dangraha	418	450	108
7	Banigama	670	678	101
8	Aamgachhi	421	404	96
9	Kaseni	601	571	95
10	Thalaha	631	590	94
11	Tandi	814	749	92
12	Babiyabirta	1209	1109	92
13	Amahibariyati	502	455	91
14	Mahadewa	375	336	90
15	Majhare	743	649	87
16	Sis. Badahara	399	348	87
17	Warangi	282	229	81
18	Rajghat	1061	848	80
19	Bhogteni	462	350	76
20	Bahuni	1024	761	74
21	Amardaha	1181	877	74
22	Tankisinuwari	1375	1006	73
23	Pokhariya	231	169	73
24	Budhanagar	1007	733	73
25	Urlabari	2148	1545	72
26	Hoklabari	392	279	71
27	Nocha	320	206	64
28	Darbesha	1393	880	63
29	Hattimuda	661	412	62
30	Jhurkiya	821	502	61
31	Dadarbairiya	660	401	61
32	Jante	603	364	60
33	Pati	201	120	60

S.N.	VDCs	Taget	Achievment	%
34	Tetariya	464	270	58
35	Madhumalla	1604	910	57
36	Sis. Jahada	596	330	55
37	Belbari	1630	894	55
38	Kadmaha	600	326	54
39	Dainiya	1009	537	53
40	Dangihat	1616	831	51
41	Sundarpur	1303	664	51
42	Sorabhag	856	427	50
43	Bhaudaha	517	252	49
44	Indrapur	1432	688	48
45	Bardanga	815	388	48
46	Letang	1403	668	48
47	Ramitekhola	266	123	46
48	Mirgouliya	1077	482	45
49	Takuwa	608	261	43
50	Keroun	1037	439	42
51	Jhorahat	404	159	39
52	Baijanathpur	375	140	37
53	Bayarban	1688	628	37
54	Sijuwa	947	338	36
55	Kerabari	1307	452	35
56	Lakhantari	334	108	32
57	Govindapur	1249	397	32
58	Haraicha	528	166	31
59	Katahari	1567	473	30
60	Bhatigachha	941	283	30
61	Itahara	1298	387	30
62	Sanischare	1974	485	25
63	Pathari	1801	439	24
64	Sidraha	313	70	22
65	Rangeli	1247	215	17
66	Sub Metro Bir	13965	2298	16
District		70348	35386	50

New growth monitoring coverage is heterogeneous which ranges from Dulari 154 percent to Biratnagar 16 percent in the district.

Growth monitoring for 0-3 yr. children was done by 60 percent. Likewise, 0-5 yrs. children were covered by 100 percent in Vitamin A and deworming. Prevalence of anaemia under three year children was 58 percent in the district. According to Nepal Micro Nutrient Survey 1998[7], the prevalence of current night blindness was high among pregnant women (6.1%) with the highest rates recorded in East Terai (13.4%) and East hills (9.3%). The survey noted that more than 1% of all school aged children had night blindness with the prevalence increasing with age. There has been little improvement in the nutritional status of children as measured by stunting over the last 23 years. The prevalence of stunting among 6-59 months has reduced by only 15.3 percentage points, from 69.4% to 54.1%. Thus, it is clear that past programmes and policies have not been sufficient and/or appropriate.

Iodine Month Observed

Iodine Month was observed in the district in the collaboration with partners. Awareness programmes such as displaying banners, posters, producing pamphlets, conducting orientations, use of print and electronic media were held as a part of the programme. DPHO Morang was joined by Salt Trading Corporation, Nursing Campus, Aama Milan Kendra, Red Cross, Help Group, BNMT and Plan Nepal during Iodine month.

Breast Feeding Week Observed

Breast feeding week was observed in the district with different women groups and mother groups. *Sancharika Samuha,* a women journalists group which is active in awareness programme and income generation programme in Biratnagar sub-metropolitan ward number 15. Articles were published in local newspapers and FM programme was also conducted awareness programme on the breast feeding week.

1.2.6 Problems/Constraints and Action to be Taken

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
Shortage of Weighing machine in HIs	Requested Supporting partners	DPHO	ASAP
Inadequate supervision	DPHO supervisors and supervisors from supporting partners attempted	DPHO	ASAP

1.3 Control of Diarrhoeal Disease (CDD)

1.31 BACKGROUND:

Diarrhoeal disease is one of the major public health problems among under 5 years of children in the region and holds 3rd. position in OPD visit. Death rate is also quit high among less than 5 years of age. Case management service is provided through all health facilities. Community volunteers are serving as primary ORS providers at the community level. ORT corners are being established gradually in PHC/HP/SHP.

1.3.2 OBJECTIVES:

- To reduce the mortality due to diarrhoea and dehydration (from estimated 30000 deaths per year) to a minimum and
- To reduce morbidity from 3.3 episodes per child per year to a minimum.

1.3.3 TARGETS:

- To reduce mortality rate due to diarrhoeal disease by 50% in under 5 years of children
- To reduce morbidity rate due to diarrhoeal disease by 20% in under 5 years of children.
- To raise accessibility of ORS to target population by 90%.
- To raise awareness about ORS use in the treatment of diarrhoea

1.3.4 STRATEGIES:

- By increasing awareness in the community through mobilization of community health workers and volunteers.
- By ensuring availability of ORS packets and antibiotics.
- By establishing ORT corners in all peripheral health institutions.

1.3.5 ANALYSIS OF ACHIEVEMENT BY MAJOR ACTIVITIES:

Control of diarrhoeal diseases is one of the priority programmes. Table 3 indicates treatment of diarrhoeal cases has exceeds its target. U5 children are estimated to get sick from diarrhoea three times a year. Targets are set accordingly. Table suggests good access to health care. FCHVs working at every ward of VDCs are to be accounted for the good result.

Table 9 Target Vs Achievement

Program/ Activities	Unit	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Treated of Diarrhea cases/ Supervision	Person	20522	41695	100		
ORS Purchase	Pkt.	93760	48000	51		
ORS Supply	,,	93760	37000	39		

DPHO Morang failed to achieve the target to purchase ORS. It has taken initiative for purchasing ORS from Royal Drugs Limited (RD) in time. But RD and its suppliers informed inability of supply very late. After getting the report from RD and its suppliers, DPHO Morang adopted another option of purchasing ORS from free market. Suppliers from open market also proved to be unable for supplying the full requirement of ORS. We asked for support from Logistic Management for additional supply. Nepal Family Health Programme (NFHP) played important role by supporting to maintain the EOP level of store located in all institutions around the year. With the help of NFHP we took 5000 packets of ORS from

District Health Office Sunsari to maintain the buffer stock of ORS. Under these circumstances, DPHO Morang issued letters to all under health institutions to maintain their EOP level by purchasing ORS by their CDP programme as per required. Health institutions used to buy ORS from market as a part of CDP programme following its regulation.

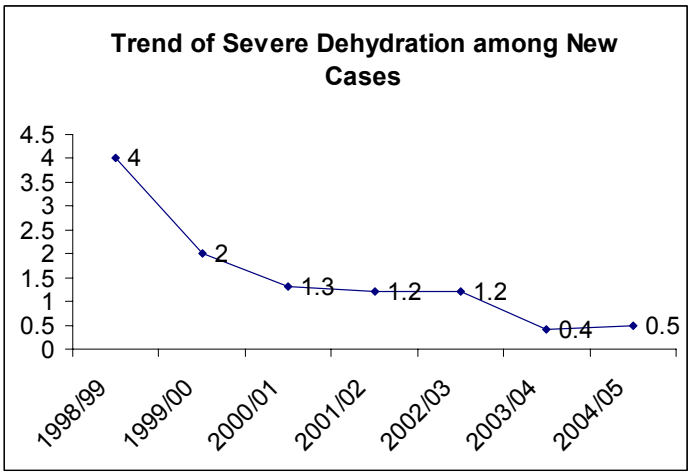
Coverage

Table 10 Incidence of CDD

Indicators	2059/060	2060/061	2061/062
Incidence of Diarrhea/1,000	349	398	385
% of Severe Dehydration among new cases	1.2	0.4	0.5

It is noted that incidence of diarrhoeal diseases per 1000 population and percentage of severe dehydration among new cases is in decreasing trend in Morang district. In FY 2060/61, Morang was second highest in reporting Incidence of diarrhoea per 1000 U5 population and was lowest in reporting percentage of severe dehydration among new cases[8]. This indicates the good level of awareness on control of diarrhoeal diseases in community.

Graph 2 Trend of Severe Dehydration among New Diarrhoeal Cases



Trend of severe dehydration among new diarrhoeal cases is in decreasing trend over past seven years in Morang district.

1.2.6 Problems/Constraints and Action To Be Taken

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
ORS supply was inadequate to meet demand	Support taken from LMD	DPHO	ASAP

1.4 Acute Respiratory Infection (ARI) Program:

1.4.1 Background:

Acute Respiratory Infections are one of the commonest causes of death in children under 5 years of age. It is also a major public health problem and control of ARI is an integral part of primary health care. The program recognizes an important role of mothers and caretakers in Identification, Home care and Referral of pneumonia cases. Clinical experience and intervention studies have indicated that early treatment with antibiotics can reduce mortality from pneumonia. Many pneumonia deaths occur at home, some after only a few days of illness. The key to reducing ARI mortality is to ensure better access to and timely use of

correct case management of pneumonia. Morang has got community based pneumonia program, where FCHVs treat the pneumonia cases with first line drug (Cotrimoxazole Pad. Tabs) and if child had any danger signs they would refer to the nearest Health facilities.

1.4.2 Objectives:

- To improve the situation of child health in Nepal by reducing mortality and morbidity due to ARI among under 5 years of children.

1.4.3 Targets:

- To reduce mortality from pneumonia in under 5 years of children.
- To reduce morbidity due to ARI in under 5 years of children.

1.4.4 Strategies:

- Raising public awareness through mobilization of community health workers and volunteers by ensuring availability of antibiotics.

1.4.5 Analysis of Achievement by Major Activities:

Table 11 Target Vs achievement

Program/ Activities	Unit	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Treated of Pneumonia Cases	Person	11417	30498	100.0	64.6	

Like CDD programme, the achievement of treated Pneumonia cases is higher than its target. A reason of this is access of service provided by FCHV at community level. It is clear that community based pneumonia can be done, and in Nepal, has resulted in a dramatic increase in the percent of expected cases treated. There is good evidence showing that quality of care is good, that misdiagnosis is unlikely, that correct treatment is usual, and that referral patterns improve. It also appears that the model used for this programme is likely to establish a foundation, which will allow community based treatment to be sustained. The relationship between the community workers providing the treatment and the communities they serve becomes strong, providing an incentive for the worker and ongoing service to the community.[9]

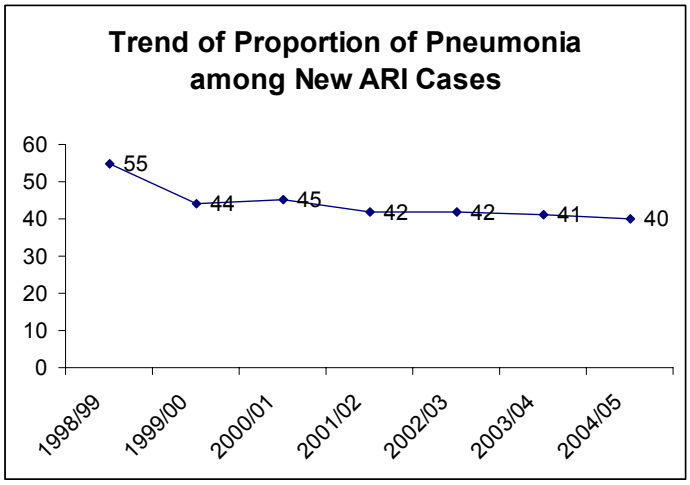
Coverage

Table 12 Incidence of ARI and Pneumonia

Indicators	2059/060	2060/061	2061/062
Incidence of ARI/1000	591	657	648
% of pneumonia among new cases	1.0	0.8	0.8

Both incidence of ARI and percentage of Pneumonia among new cases are in decreasing trend in Morang district. The contribution of FCHV in this programme has been felt and appreciated by community in Morang.

Graph 3 Trend of Proportion of Pneumonia among New ARI Cases



ARI is one of the major causes of child morbidity and mortality in the district. FCHV are playing vital role in serving ARI suffering children in the community. FCHV are trained for diagnosis and treatment of ARI. FCHV examines a child with her timer by counting respiration rate. She offers counseling for home treatment or treats with Cotrimoxazole or refers to health institutions.

1.5 Neonatal Health Programme or Morang Initiative for Neonatal Intervention (MINI)

Of the 130 million babies born every year, about 4 million die in the first 4 weeks of life-the neonatal period. A similar number of babies are stillborn.[10] The time has come for these health interventions for newborn babies to be integrated into maternal and child health programmes, which in turn need to be strengthened and expanded. Proven cost-effective interventions, delivered through a continuum-of-care approach, can prevent millions of needless deaths and disabilities. In Nepal 3-4 neonates dies every hour.[11] Direct causes for neonatal deaths in Nepal are Infection, Birth Asphyxia trauma, Pre-maturity and Hypothermia. DPHO Morang is proud to note that the district has been selected for piloting for Neonatal health intervention. Since, Infant mortality rate still high in the country and major proportion of its has been comprised by Neonatal deaths. So, infant mortality will be down until and unless decrease in neonatal mortality. Reviews of literatures and researches have established the strategy as Neonatal intervention. Ministry of Health has formulated policy and guidelines for neonatal health programmes in the country. The success of Morang district's neonatal health programme opens horizon for replication of the programme in other district of the country. DPHO Morang has made joint effort in collaboration with JSI R&T under Morang Innovative Neonatal Intervention (MINI) since 2004.

Of course, to treat a neonate is challenging. Programmes demands hard working of health workers and FCHVs. Health workers are offering additional effort for home treatment. The treatment with Gentamycin has cured infected neonates. Community has paid due recognition to the service providers. Community is also getting aware even to take out their neonates from the home for treatment. However, FCHVs are taking this programme as both opportunity and challenge. Series of trainings at different levels completed. Health workers and FCHVs are now well trained for neonatal health care. The preliminary data analysis explains its effectiveness and acceptance.

1.6 Community Based –Integrated Management of Child Illness (CB-IMCI)

The IMCI intervention is integrated case management of the five most important causes of childhood deaths – ARI, Diarrhoea, Measles, Malaria and Malnutrition. The strategy includes a range of other preventive and curative interventions, which aim to improve practices both in the health facilities and at home.

Ten batches of twenty peoples in each batch training concluded resulting more than 200 trained health workers for IMCI. Plan Nepal supported financially. NEPAS and Koshi Zonal Hospital supported technically for the training. Evaluation of the training was also concluded with the help of NEPAS and Plan Nepal.

The result of the training is expected to be reflected into the quality care of U5 children. It can be measured by qualitative method and takes time. However, recommendation from the evaluation noted that there is still room to improve the practices of health workers.

1.2.6 PROBLEMS/CONSTRAINTS AND ACTION TO BE TAKEN

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
More time of HWs was consumed by trainings	Tried to minimized the effect	DPHO	ASAP

2. Reproductive Health

2.1 Family Planning

2.1.1 BACKGROUND:

The main thrust of the National Health Policy (1991) related to the National Reproductive Health and Family Planning (RH/FP) Programme is to expand and sustain adequate quality family planning services to the community level through all health facilities. The policy also aims to encourage NGOs, social marketing organizations, as well as private practitioners to complement and supplement government efforts. Community-level volunteers (TBAs, FCHVs) are to be mobilized to promote condom distribution and re-supply of oral pills. Awareness on RH/FP is to be increased through various IEC/BCC intervention as well as active involvement of FCHVs and MGs as envisaged by the National Strategy for FCHVs.

In this regard, FP services are designed to provide a constellation of contraceptive methods that reduce fertility, enhance maternal and neonatal health, child survival, and contribute to bringing about a balance in population growth and socio-economic development, resulting in an environment that will help the Nepalese people to improve their quality of life.

2.1.2 OBJECTIVES:

Within the context of RH, the main objectives of FP Programme are to assist individuals and couples to:

- Space and/or limit their children;
- Prevent unwanted pregnancies;
- Manage infertility and
- Improve their overall reproductive health.

2.1.3 TARGETS:

- To reduce TFR from 4.1 per women to 3.5 by the end of 10th Five Year Plan and to 3.05 in 2017
- To rise the CPR to 47% by the end of 10th 5 Year Plan period and to 58.2% by 2017.
- To achieve approx. 2,293,000 couples using modern contraception by end of 10th Five Year Plan.
- To achieve approximately 536,288 Family Planning Current Users and 23,025 Voluntary Surgical sterilizations cases in Eastern development region in 2060/61

2.1.4 STRATEGIES:

- Increasing the knowledge and understanding of the benefits of delayed marriage, birth spacing, and a well planned family norm across the region through integrated RH/ FP/IEC and BCC activities;
- Increasing accessibility and availability of RH/FP services through a combination of approaches;
- Expanding regular year-round and mobile VSC outreach services;
- Expanding IUCD services with special emphasis on thorough counseling and follow-up services;
- Training service providers in collaboration with NHTC;
- Improving the quality of care in accordance with the NMS for contraceptive services;
- Establishing management & treatment services for complications of abortion, including FP services;
- Ensuring adequate supply & distribution of contraceptives at regional, district & below district level;
- Strengthening HMIS for better management of FP programmes;
- Ensuring effective monitoring and supervision of FP programmes and
- Re-supplying pills and distributing condom through FCHV.

2.1.5 ANALYSIS OF ACHIEVEMENT:

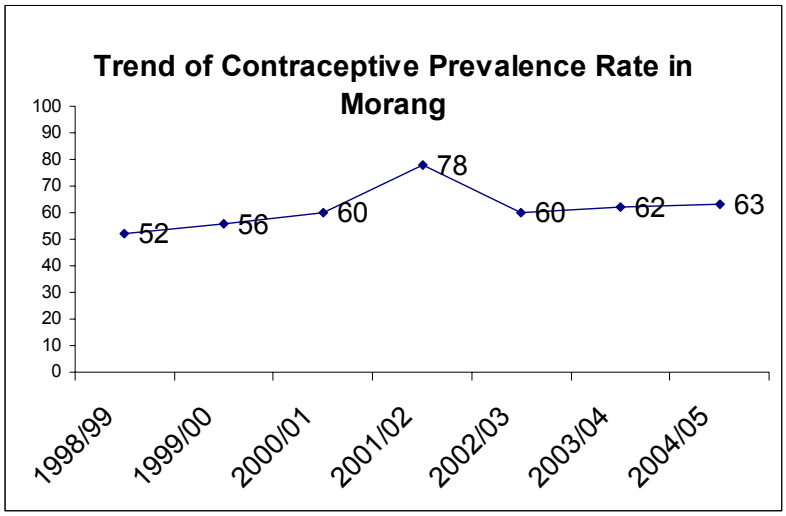
Table 13 Achievement of Programme

Program/ Activities	Unit	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Current users	Person	146000	110487	75.7	66.1	
Sterilization	,,	6840	8160	100.0		

Table 14 Trend of Family Planning Programme Coverage

Indicators	2059/060	2060/061	2061/062
Contraceptive Prevalence Rate (CPR as % of MWRA)	65.0	62.94	63.3
Condom(%CPR Method Mix)	2.7	2.1	2.0
Pills(%CPR Method Mix)	5.02	3.16	3.1
Depo(%CPR Method Mix)	14.70	12.39	11.9
IUCD(%CPR Method Mix)	1.10	1.42	1.6
Norplant(%CPR Method Mix)	1.52	1.81	1.4
VSC(%CPR Method Mix)	40.0	42.0	44.7
Total number of VSC	7456	8270	8160
Male	182	167	120
Female	7272	8103	8040
Total number of VSC in GO sector	3183	3622	3314
Total number of VSC in NGO sector	4273	4848	4846

Graph 4 Trend of Contraceptive Prevalence Rate



CPR of Morang which is third highest in Nepal and highest in EDR which is reached 63 percent in FY 2061/62.

2.1.6 PROBLEMS/CONSTRAINTS AND ACTION TO BE TAKEN

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
Shortage of Medical doctors for VSC	Requested RHD and FHD for doctors	DPHO	ASAP

2.2 Safe motherhood

2.2.1 BACKGROUND:

The MoH's Safe Motherhood Programme is the HMG's main thrust to reduce maternal and neonatal mortality by addressing the high rates of death and disability caused by the complications of pregnancy and childbirth. The past strategy of carrying out FP/MCH in an integrated manner, promoting attendance birth through TBAs and promoting ANC visits were not adequate in addressing the issues of MMR. Experience also showed that the avoidance of the three delays was imperative to achieve goal of reduction of maternal mortality. Recognizing that every pregnancy is at risk, two major strategies have been adopted, providing around the clock emergency obstetric care (either comprehensive or basic) and ensuring the presence of skilled attendants at deliveries, especially in the home setting.

However, because the majority of women do not have access to maternal healthcare services due to social, economic, and political factors, medical interventions alone are not sufficient to reduce MMR. Specific non-health approaches are needed. Therefore, the Safe Motherhood Programme takes a multi-sectoral approach to include both health and non-health interventions that promote access to and utilization of services. The long-term goal of the 15-year National Safe Motherhood Plan (2002-2017) envisages establishment of BEOC and CEOC services in all 75 districts, skilled attendance of births & increased access to emergency fund & transport services.

2.2.2 OBJECTIVES:

- To reduce the mortality and morbidity among pregnant women and new born during childbirth and the postnatal period through the adaptation of a combination of health and non-health related measure.
- To improve the quality of antenatal, natal, postnatal and neonatal care through appropriate training of health personnel, including emergency obstetric care.
- To advocate and raise public awareness about safe motherhood related issues.
- To strengthen referral care.
- To improved legal and socio-economic status of women.

2.2.3 TARGETS:

- To contribute to the reduction of the maternal mortality rate from estimated rate of 539/100000 live birth to 300/10000 live birth end of Tenth Five year plan.
- To reduce neo-natal mortality rate from 39-to32 per1000 live births by the end of Tenth five year plan.
- To increase delivery by health workers to 18% by the end of Tenth plan.
- To increase % of woman attending antenatal care 4 times to 25% by end of Tenth plan.

2.2.4 STRATEGIES:

- Promoting inter-sect oral collaboration at regional district and community level.
- Strengthening and expanding basic maternal care services.
- Supporting activities that raise the status of women.

2.2.5 ANALYSIS OF ACHIEVEMENT:

Table 15 Achievement of Safe motherhood programme

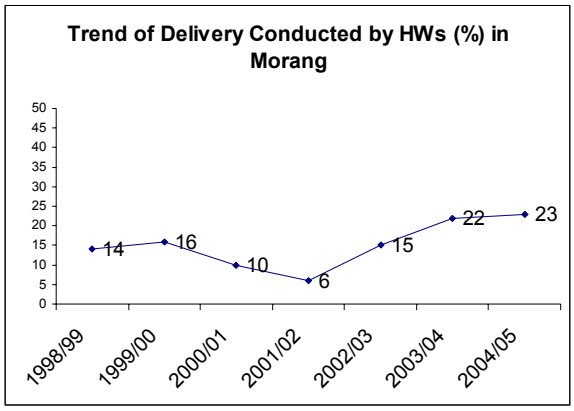
Program/ Activities	Unit	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
ANC New visit (56%)	Person	19603	26938	100.0		
Delivery trend HW (16%)	,,	5284	7468	100.0		
PNC first visit (18%)	,,	5945	13131	100.0		

Table 16 Coverage of Safe motherhood programme

Indicators	2059/060	2060/061	2061/062
ANC first visit as a % of expected pregnancy	79.4	72.2	77.1
% of women with 4th visit among 1st visit	40.0	54.0	35.4
% of delivery conducted at health institutions (Hospital/PHCC/HP/SHP)	7.5	15.5	16.9
Number of delivery conducted in Hospital	1371	3050	4350
Number of delivery conducted in PHCC	941	1045	1562
% of home delivery attended by HW	9.2	6.7	4.5
Delivery conducted by Health Workers	15	22	23
PNC first visit as % of expected pregnancy	32.2	40.4	38.4

Trend of del
workers is 1
trend which
coming year

Graph 5 Trend of Delivery conducted by Health Workers



Trend of delivery conducted by health workers is 22 percent which is in increasing in Morang district.

Table 17 VDC wise status of 4 ANC visits in Morang

S.N.	VDCs	ANC First	4 visit	%
1	Rangeli	196	352	180
2	Govindapur	254	287	113
3	Lakhantari	86	93	108
4	Amahibariyati	251	242	96
5	Tankisinuwari	264	250	95
6	Kadmaha	249	205	82
7	Rajghat	128	104	81
8	Darbesha	207	168	81
9	Dangraha	208	165	79
10	Letang	485	369	76
11	Banigama	285	212	74
12	Amardaha	278	196	71
13	Jhurkiya	454	309	68
14	Ramitekhola	145	98	68
15	Budhanagar	347	233	67
16	Bhogteni	125	65	19
17	Bardanga	268	164	61
18	Dainiya	338	199	59
19	Warangi	103	60	58
20	Dangihat	203	116	57
21	Belbari	621	353	57
22	Jante	83	45	54
23	Hattimuda	280	151	54
24	Pokhariya	126	67	53
25	Pati	244	123	50
26	Hasandaha	444	223	50
27	Thalaha	380	189	50
28	Bhatigachha	208	99	48
29	Kerabari	408	194	48
30	Mahadewa	95	45	47
31	Sanischare	563	265	47
32	Yangsila	50	22	44
33	Nocha	105	46	44
34	Sijuwa	549	234	43
35	Indrapur	371	157	42
36	Jhorahat	350	147	42
37	Aamgachhi	194	79	41
38	Sis. Badahara	251	96	38
39	Haraicha	454	173	38
40	Tandi	217	82	38
41	Pathari	339	128	38
42	Tetariya	100	37	37
43	Sundarpur	199	72	36
44	Itahara	338	122	36
45	Dadarbairiya	549	180	33
46	Sis. Jahada	156	50	32
47	Sub Metro Brt	4383	1390	32
48	Mirgouliya	253	78	31
49	Madhumalla	391	117	30
50	Hoklabari	119	35	29
51	Bahuni	919	268	29
52	Dulari	529	154	29
53	Takuwa	211	60	28
54	Keroun	216	61	28
55	Bhaudaha	184	51	28
56	Baijanathpur	141	39	28
57	Katahari	326	86	26
58	Majhare	812	209	26
59	Sidraha	68	17	25
60	Urlabari	2788	608	22
61	Motipur	299	59	20
62	Singdevi	97	19	20
63	Kaseni	202	38	19
64	Bayarban	1007	187	19
65	Sorabhag	709	131	18
66	Babiyabirta	491	76	15
District		26693	10949	41

Status of 4 ANC visits in VDCs of Morang district is heterogeneous which ranges from Rangeli 180 percent to Babiyabirta 15 percent in the district.

Table 18 VDC wise status of Delivery conducted by Health Workers in Morang

S.N.	VDCs	Taget	Achievment	%
1	Jhurkiya	408	283	69
2	Urlabari	1067	692	65
3	Biratnagar	6937	4327	62
4	Pokhariya	115	50	44
5	Amahibariyati	249	87	35
6	Darbesha	692	217	31
7	Haraicha	262	74	28
8	Kadmaha	298	69	23
9	Rangeli	620	135	22
10	Bahuni	509	110	22
11	Thalaha	313	57	18
12	Aamgachhi	209	36	17
13	Letang	697	119	17
14	Hasandaha	447	76	17
15	Dangraha	208	35	17
16	Dadarbairiya	328	53	16
17	Sorabhag	425	68	16
18	Motipur	215	32	15
19	Bhogteni	229	34	15
20	Tetariya	230	29	13
21	Jante	300	36	12
22	Sijuwa	471	56	12
23	Nocha	159	17	11
24	Lakhantari	166	17	10
25	Govindapur	620	63	10
26	Pati	100	9	9
27	Budhanagar	500	43	9
28	Dainiya	501	43	9
29	Dulari	423	33	8
30	Kerabari	649	49	8
31	Baijanathpur	186	14	8
32	Tankisinuwari	683	50	7
33	Bayarban	838	61	7

S.N.	VDCs	Taget	Achievment	%
34	Tandi	404	28	7
35	Sis. Jahada	296	18	6
36	Warangi	140	8	6
37	Majhare	369	21	6
38	Sis. Badahara	198	11	6
39	Hoklabari	195	10	5
40	Mahadewa	186	9	5
41	Sundarpur	647	31	5
42	Ramitekhola	132	6	5
43	Madhumalla	797	32	4
44	Mirgouliya	535	21	4
45	Bardanga	405	13	3
46	Banigama	333	9	3
47	Belbari	810	21	3
48	Sidraha	155	4	3
49	Yangsila	279	6	2
50	Kaseni	298	6	2
51	Pathari	895	17	2
52	Babiyabirta	600	11	2
53	Singdevi	113	2	2
54	Rajghat	527	8	2
55	Takuwa	302	4	1
56	Sanischare	980	12	1
57	Amardaha	587	7	1
58	Dangihat	803	8	1
59	Keroun	515	5	1
60	Bhatigachha	467	4	1
61	Indrapur	711	5	1
62	Bhaudaha	257	1	0
63	Hattimuda	328	1	0
64	Katahari	778	0	0
65	Jhorahat	201	0	0
66	Itahara	645	0	0
District		34945	7413	21

Status of delivery conducted by health workers is heterogenous which ranges from Jhurkia 69 percent to Katahari, Jhorahat, Itahara, Hattimudha and Bhaudha 0 percent in the district.

Table 19 VDC wise status of PNC 1st Visits in Morang

S.N.	VDCs	Taget	Achievment	%
1	Kadmaha	298	258	86.6
2	Jhorahat	201	149	74.2
3	Amahibariyati	249	183	73.4
4	Jhurkiya	408	289	70.9
5	Sorabhag	425	299	70.3
6	Dadarbairiya	328	223	68
7	Urlabari	1067	724	67.9
8	Tankisinuwari	683	448	65.6
9	Dangraha	208	132	63.6
10	Sub Metro Brt	6937	4391	63.3
11	Belbari	810	482	59.5
12	Budhanagar	500	296	59.2
13	Thalaha	313	182	58.1
14	Lakhantari	166	93	56
15	Mahadewa	186	99	53.1
16	Ramitekhola	132	70	53.1
17	Babiyabirta	600	314	52.3
18	Pokhariya	115	60	52.2
19	Bhatigachha	467	243	52
20	Aamgachhi	209	98	46.8
21	Dulari	423	185	43.7
22	Pati	100	41	41.1
23	Darbesha	692	268	38.7
24	Sanischare	980	377	38.5
25	Sis. Badahara	198	74	37.4
26	Banigama	333	123	36.9
27	Nocha	159	58	36.5
28	Tetariya	230	82	35.6
29	Sijuwa	471	165	35.1
30	Majhare	369	128	34.7
31	Bahuni	509	176	34.6
32	Motipur	215	73	34
33	Sidraha	155	52	33.5

S.N.	VDCs	Taget	Achievment	%
34	Katahari	778	250	32
35	Hoklabari	195	61	31
36	Hasandaha	447	136	30
37	Kerabari	649	183	28
38	Rangeli	620	166	27
39	Hattimuda	328	86	26
40	Warangi	140	36	26
41	Jante	300	74	25
42	Letang	697	170	24
43	Keroun	515	124	24
44	Sundarpur	647	155	24
45	Itahara	645	150	23
46	Haraicha	262	59	23
47	Mirgouliya	535	110	21
48	Pathari	895	183	20
49	Tandi	404	78	19
50	Baijanathpur	186	34	18
51	Dainiya	501	89	18
52	Bardanga	405	70	17
53	Dangihat	803	130	16
54	Bhaudaha	257	40	16
55	Bhogteni	229	33	14
56	Madhumalla	797	105	13
57	Sis. Jahada	296	37	12
58	Singdevi	113	14	12
59	Govindapur	620	76	12
60	Kaseni	298	36	12
61	Takuwa	302	35	12
62	Bayarban	838	95	11
63	Indrapur	711	73	10
64	Rajghat	527	41	8
65	Yangsila	279	8	3
66	Amardaha	587	16	3
District		34945	13788	39

Status of delivery conducted by health workers is heterogenous which ranges from Kadmaha 87 percent to Yangsila, Amardaha 3 percent in the district.

2.1.6 PROBLEMS/CONSTRAINTS AND ACTION TO BE TAKEN

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
ANC check up with counseling is poor	Refresher Training given	DPHO	ASAP

2.3 Adolescent health

With the help of supporting partners Aama Milan Kendra five VDCs are taken as conducting piloting Youth friendly clinics in the districts. Health workers have given training for organizing separate clinics in different days for boys and girls in the health institutions. Now, hopeful results are coming.

3 DISEASES CONTROL

3.1 National Tuberculosis Programme

3.1.1 BACKGROUND:

Tuberculosis is one of the major public health problems in Nepal and is a leading cause of death in adults. Introduction of treatment by Directly Observed Treatment Short Course (DOTS) has already reduced the number of deaths in Nepal from 8000-11000 to 5000-7000. Expansion of this cost-effective and highly successful treatment strategy, which already has proven its efficacy in Nepal, will have a reflective impact on mortality and morbidity. The National Tuberculosis Programme's (NTP), long term goal is to reduce the transmission of TB to such a level that it is no longer a public health problem. The NTP operates its diagnostic and treatment services within the general health services of the country. The basic unit of management for diagnosis and treatment of TB patients is the district hospital and the Primary Health Centre. Health Post acts as sub-centre for supervision of patients on DOTS in selected health posts in different districts. Region provides support in managing TB control activities of the districts.

3.1.2 OBJECTIVES:

- To achieve 85% cure rate in new smear positive pulmonary tuberculosis
- To achieve 70% case detection ratio in new pulmonary tuberculosis
- To implement the DOTS activities in phased manner in all districts

3.1.3 TARGET:

- 85% cure rate in new smear positive cases
- 80% conversion rate in new smear positive cases
- 70% case detection rate
- Expansion of DOTS in all districts

3.1.4 STRATEGIES:

- To promote early case detection of infectious pulmonary cases through sputum smear examination
- To ensure effective chemotherapy
- Involvement of community for planning, Implementation and monitoring of T.B. control services.

3.1.5 ANALYSIS OF ACHIEVEMENT BY MAJOR ACTIVITIES:

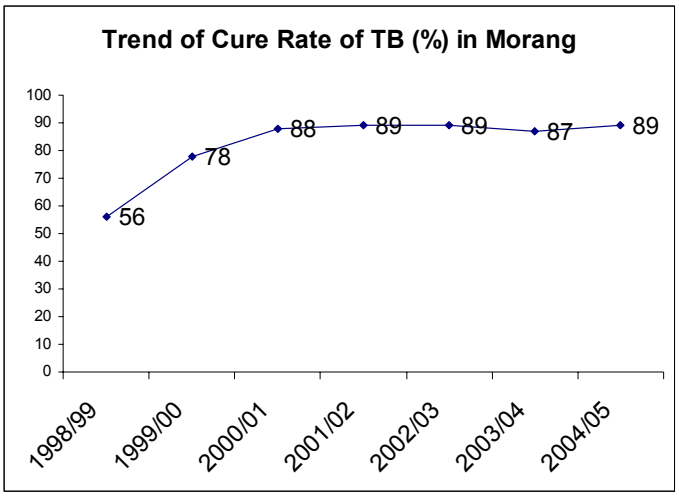
Table 20 Achievement of TB programme

Program/ Activities	Units	Target	Achievement	% Ach	% expenditure wrt released budget	Reasons for not achieve 100%
Sputum examination for Suspected cases.	Per.	6000	5866	97.8		
New sputum examination	Slide	18000	17291	96.1		
Follow up sputum examination	Slide	2804	2639	94.1		
New sputum +ve	Per.	600	574	95.7		
New sputum -ve	,,	480	340	70.8		
Extra pulmonary	,,	125	294	100.0		
Retreatment case		137	98	71.5		
TB Pts to Pts family health Ed. on DOTS	,,	150	150	100.0	74.3	
Dhami Jhakri orientation	,,	20	20	100.0		
DOTS center evaluation Workshop	Times	6	6	100.0		
World TB day	,,	1	1	100.0		
Supervision	,,	60	36	60.0		
School Health programme	School	25	17	68.0		
TB/DOTS orientation for social Workers	No.	20	20	100.0		
TB/DOTS orientation for Mothers group	,,	20	20	100.0		

Table 21 Performance Indicators of TB programme

Indicators	2059/060	2060/061	2061/062
Case Detection Rate	56	64	63
Cure Rate on DOTS	90	88	89
Treatment Success Rate (Cured+Completed)	89	88	90
Sputum Conversion Rate	87	87	93

Graph 6 Trend of TB Cure Rate



TB Cure rate is in increasing trend in Morang.

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
Problem in Urban DOTS	Operational research conducted with BNMT	DPHO/BNMT	ASAP

3.2 Leprosy

3.2.1 BACKGROUND:

Leprosy is one of the major public health problems of eastern region. It is aimed to provide diagnostic and therapeutic services of leprosy within the general health services. MDT service is available in all health institutions of the region. Leprosy burden is high in Terai district where as low or eliminated in hill districts. The regional prevalence rate of leprosy is continually in decreasing trend but the new case detection rate is not declined as expected. In 1982 leprosy PR was 17.3 per 10000 populations and finally this value reduced to 2.81. This indicates the achievement of reduction is 83.76% and leprosy elimination is in the positive trend.

3.2.2 OBJECTIVES:

- Elimination of leprosy by the year 2005 AD (Prevalence rate below 1 cases per 10,000 population) at national level
- Provision of MDT to all registered cases
- Prevention of disability by early detection and treatment of cases
- Reduction of social stigma by increasing awareness about the disease

3.2.3 TARGET:

- To reduce the present registered prevalence rate to < 1 per 10000 population by the middle of FY 062/063 (end of December 2005)
- To reduce impairment and disability due to leprosy resulting reduction of WHO defined disability proportion around 5%
- To prevent leprosy transmission by early case detection and increase patient volunteer submission more than 90%

3.2.4 STRATEGY:

- High priority will be given to undetected cases and treatment
- Increased co-operation and coordination between HMG and I/NGOs will be maintained

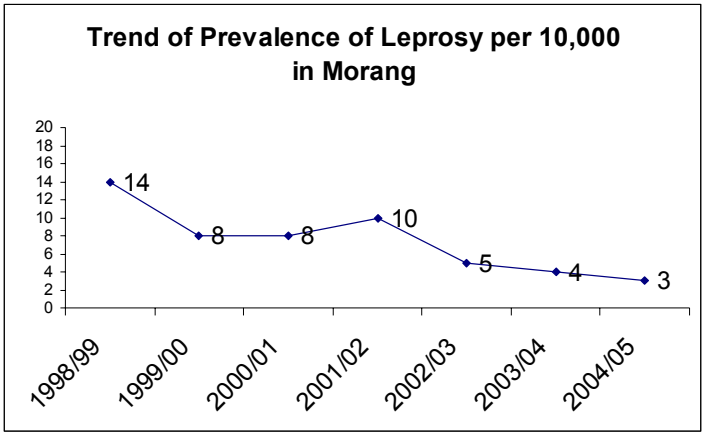
3.2.5 ANALYSIS OF ACHIEVEMENT BY MAJOR ACTIVITIES:

Table 22 Performance of Health Education Programme

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
School Health education	Times	17	17	100.0		
Rapid inquiry survey	VDC	10	10	100.0	95.5	
Supervision	Times	40	40	100.0		

S.N.	*Indicators*	*MB*			*PB*		
		2059/60	2060/61	2061/62	2059/60	2060/61	2061/62
1.	New Case Detection Rate	2.6	2.6	1.1	4.1	3.1	1.3
2.	RFT	91.8	87.0	98.9	98.7	94.0	100.0
3.	Prevalence Rate	3.15	2.5	2.1	2.09	1.29	1.5

Graph 7 Trend of Leprosy Prevalence Rate



Trend of prevalence rate of Leprosy is in decreasing trend but still far from its elimination stage.

Problem/Constraints	Action to be Taken	Responsibility	Time Frame
Prevalence rate is still high in Morang	Awareness campaign conducted in municipality with the help of NLR	DPHO/NLR	ASAP

3.3 Malaria Program

3.3.1 Background:

Malaria eradication program was started in the year of 1962 in this region and was continued up to the year 1977. But since the year of 1978 eradication program eventually become Malaria Control Program as recommended by WHO. At present, this program is carried out in all districts except Solukhumbu district in the region.

3.3.2 OBJECIIVES:

- Prevention of mortality due to malaria.
- Reduction in malaria morbidity.
- Prevention and control of P. Falciparum epidemics

3.3.3 TARGETS:

- To reduce the annual parasite incidence to 3 cases/1000 population

3.3.4 STRATEGIES:

- Early diagnosis and prompt treatment of malaria cases through health facilities
- Selective application of indoor residual spraying in case of epidemic prone areas
- Promotion of personal protective measures
- Improving target setting of blood slide collection and lab facilities for strengthening early diagnosis of malaria in service outlets of malaria endemic districts
- Training for increased competence of puerperal level health staff in malaria control

3.3.5 ANALYSIS OF ACHIEVEMENT BY MAJOR ACTIVITIES:

Table 23 Malaria: Target Vs Achievement

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Slide collection	No.	6000	14662	100.0	96.5	
Malaria Spraying	Times	2	2	100.0		

Table 24 Malaria Incidence

Indicators	2059/060	2060/061	2061/062
Malaria Parasite Incidene/1,000	0.2	0.2	0.1
Slide Positively Rate	2.5%	1.6%	1.2%
% of PF	15.2	9.9	12.4
Clinical Malaria Incidence Per/1,000 risk population	3.7	5.2	5.7

3.3.6 Problem/Constraints and Action to be taken

SN	Problem/ Constraints	Action to be taken	Responsibility	Deadline
2	Increasing SPR	Re-activate the PCDV Programme.	EDCE/DoHS	ASAP
3	Delay budget release	Requested DoHS	DoHS	ASAP

3.4 Kala-azar Program

3.4.1 Background:

Kala-azar has been reported from six districts in this region. This disease is also a public health concern due to high case fatality rate among the infected cases. It is mostly prevalent in rural area with low socio economic group of the people.

3.4.2 Objectives:

- To reduce morbidity and mortality due to Kala – azar.
- To prevent epidemic due to Kala – azar.

3.4.3 Targets:

- To reduce the Kala – azar incidence in the region.
- Prevention of epidemic.

3.4.4 Strategies:

- Early diagnosis and prompt treatment of Kala–azar through strengthening of referral services at the peripheral health Institution.
- Early detection and timely containment of epidemics.
- Protection of risk population with indoor residual spraying.

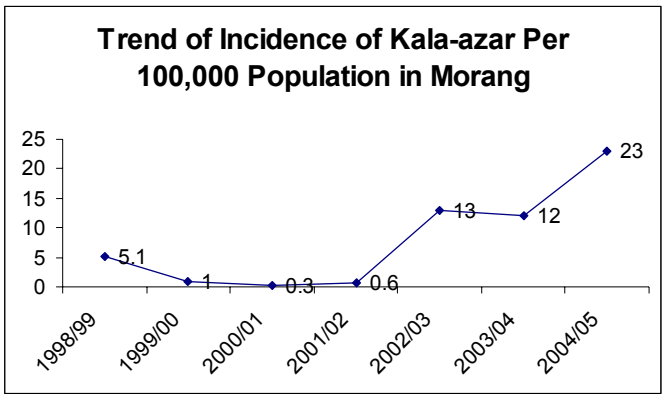
3.4.5 Analysis Of Achievement By Major Activities:

Table 25 Target Vs Achievement

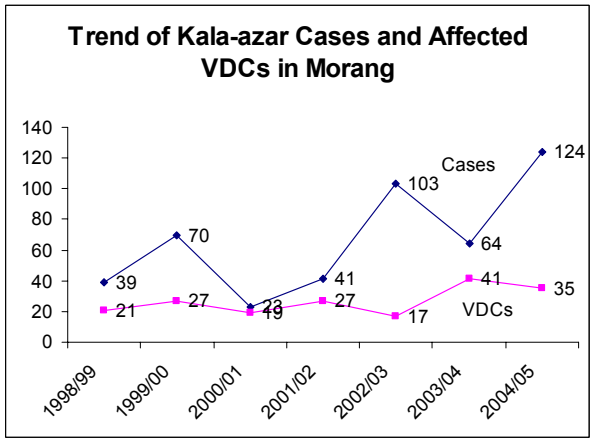
Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt	Reasons for not achieve 100%
Spraying	Times	2	2	100.0		

Target 26 Incidence of Kala-azar

Indicators	2059/060	2060/061	2061/062
Case Incidence/10000 of Population	13.7	12.4	11.4
Number of death due to Kala-azar	1	1	2



Graph 8 Kala-azar is in increasing trend in Morang district.



Graph 9 The trend of Kala-azar, is increasing. Total 41 VDCs are being affected by Kala-azar.

3.5 JE Program

Table 27 Target Vs Achievement

Program/ Activities	Unit	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Spraying, Fogging	time	2	2	100		

Table 28 Incidence of JE

Indicators	2059/060	2060/061	2061/062
Case Incidence/100000	6.6	6.4	3.0
Number of death due to JE	6	8	3

3.6 AIDS and STDs Programme Targeted Activities.

Table 29 Performance in HIV/AIDS programme

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
HIV/AIDS day	time	1	1	100	NA	
DACC meeting	time	2	2	100	NA	

World AIDS day was observed in Morang in collaboration with DDC, Schools and NGOs on 1st December 2004.

Morang	Male	Female	Total
HIV/AIDS	196	112	308
IDU	-	-	558

3.7 Curative Service through OPD Service

3.7.1 BACKGROUND:

Curative health services aims to provide appropriate diagnosis, treatment and referral through the network of PHC outreach to specialized hospitals. It is one of the important and highly demanded services. Services are provided through all health facilities.

3.7.2 OBJECTIVES:

- To provide curative services to all patients reporting to the health facilities or PHC outreach sites to reduce duration of illnesses, mortality and improved quality of life.

3.7.3 TARGETS:

- To provide service to all clients attending health facilities with appropriate diagnosis, treatment and/or referral to specialized facilities.

3.7.4 STRATEGIES:

- Establishment and service delivery through of SHP in all the VDCs.
- Establishment and service delivery through PHCs in all electoral constituencies.
- Establishment of 3-5 out reach clinics in all VDCs for EPI and PHC-ORC.

3.7.5 ANALYSIS OF ACHIEVEMENT BY MAJOR ACTIVITIES:

Table 30 Coverage of OPD

Indicators	2059/060	2060/061	2061/062
Total OPD visits as % of total population	17.6	18.9	19.18

3.8 Epidemics control

Table 31 Epidemics or Out breaks

Epidemics	Number of VDCs	Affected Number	Episode
Measles, Diarrhoea, Skin	5	200	5

4. SUPPORTING PROGRAMMES

4.1 Partners Defined Quality

Table 32 Partners defined quality

Supporting Partners	No. of Health Institutions	Benefited Participants	Outcome
SCF US	50	500	HFMC strengthened

4.2 HMIS

4.2.1 BACKGROUND:

To develop skill in record keeping, analysis and use of information for planning and supervision, integrated HMIS implementation strategies started in 1993. Efforts are being done to utilize HMIS information in planning, monitoring, supervision and evaluation at regional and district level.

4.2.2 OBJECTIVES:

- To monitor the coverage, continuity and quality of the health services and to assist service provider and managers to use the data at the service delivery level.
- To assess the progress of district health programmes.
- To help districts in preparation of work plan.

4.2.3 STRATEGIES:

- Collection of information, analysis and use for planning, monitoring and management.
- Initiate bottom-up planning.
- To organize programme performance review meeting.

4.2.4 ANALYSIS OF ACHIEVEMENT OF MAJOR ACTIVITIES:

- Monthly reports are monitored and feed back given to the concerned VDCs or HIs.
- District level programmes performance review workshop completed.
- Work plan and integrated supervision plan was prepared to cover all 17 Ilakas.

Table 33 HMIS Reporting Status by Institutions (%) FY 2059/060-2061/062

FY	District	Hosp	PHC	HP	SHP	PHC /ORC	FCHV	NGO
059/060	100	33	100	100	99	95	96	98
060/061	100	100	100	100	99	92	920	98
061/062	100	100	100	100	98	86	95	98

Table 34 Status of number of Monthly Meeting conducted FY 2061/062.

Number of monthly meeting conducted at district level based on the Monthly Monitoring sheets FY 2061/062	Name of District	Number of Meeting
	Morang	12

Table 35 Average number of People Served by type of health facilities per months

FY	District	Hosp	PHC	HP	SHP	PHC/ORC	FCHV	NGOs
059/060	40	184	963	663	206	30	24	409
060/061	57	187	1009	706	238	27	34	422
061/062	51	192	1311	584	248	29	43	432

S.N.	Problems/ constraints	Action to be taken	Responsibility	Deadline
1	Delay reporting from Health Institutions	Feedback given to concerned institutions	Incharges of HIs	ASAP
2	Incomplete and Inconsistent reporting	-Proper person not always involved in report making -Feedback given	Health Institutions Incharges	ASAP
3	Lack of training for newly recruited health workers.	Provision of basic and refresher training.	MD/ NHTC/ DoHS	ASAP

4.3 LMIS

Table 36 Reporting Status by Institutions (%) FY 2061/062

District	Hospital	PHCC/HC	HP	SHP
100.0%	75.0%	100.0%	100.0%	98.5%

Table 37 Health Institutions wise ASL, EOP of Essential Commodities

F.Y.	Health Institution	Condom		Depo		Pills		ORS		Vita. A		Cotrim		Iron tablets	
		ASL	EOP	ASL	EOP	ASL	EOP	ASL	EOP	ASL	EOP	ASL	EOP	ASL	EOP
2060/61	PHC/HP/ SHP	139715	27943	23530	4706	18325	3665	54445	10889	102355	20471	313305	62661	572275	114455
	District	279430	83829	47060	14118	36650	10995	108890	32667	204710	61413	626610	187983	1144550	343365
2061/62	PHC/HP/ SHP														
	District														

4.4 Female Community Health Volunteer (FCHV)

4.4.1 Background:

To acquire support and active participation of the community in primary health services, the FCHV programme was initiated in the year of 1988/89 At present FCHVs are involved in the distribution of condoms, pills, Vitamin "A" Capsules, ORS and also initial management of ARI cases in selected district. They are also responsible for the dissemination of information and education in the community on FP, EPI, Nutrition and Sanitation.

4.4.2 Objectives:

- To empower rural women with basic knowledge and skill.
- To develop in every word at least one FCHV as a health resource person who is knowledgeable, trained and well supported by local mothers.

4.4.3 Strategies:

- Training of FCHVs basic and refresher.
- Review meeting for FCHVs trimester.
- Orientation of VDCs members for selection of FCHVs.

4.4.4 Analysis of Achievement:

Table 38 Performance of FCHV programme

Program/ Activities	Units	Target	Ach	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
HFI quarterly meeting	Times	3	2	66.7	72.7	
Quarterly review meeting	Person	1755	1170	66.7		
TBA refresher meeting	,,	405	342	84.4		
FCHV Day	Times	1	1	100.0		

Table 39 Service Indicators

Indicators	2059/060	2060/061	2061/062
Average number of Mothers Group meeting held in a year per FCHV	9	11	10
No of Pills cycle distribution by FCHV	10766	18436	26576
No. of person receiving Condoms	51204	54381	196584
No. of ORS Pkt. distribution by FCHV	31781	43824	48476

Problems / Constraints and Action to Be Taken

S.N.	Problem/ Constraints	Action to be taken	Responsibility	Deadline
1	Delay Release of Budget	Provision of release of budget on time	FHD/DoHS	ASAP
2	Inadequate encouragement & motivational scheme for FCHV	Establish linkage with DDC, VDC hospitals & supporting partners and develop appropriate motivational scheme (district/center)	DHO/DPHO	ASAP

4.5 PHC Outreach- clinic Programme.

4.5.1 Background:

Primary Health Care (PHC) Out reach Services are extension of primary health care from PHC/HP/SHP to the community level. Services are provided to clients / patients at per determined time and place once in a month in three to five places of each VDCs. It aims to provide services to people residing in remote areas with community involvement.

4.5.2 Objectives:

- To improve access and coverage of primary health care through a network of 3 to 5 out reach clinics per VDC per month.

4.5.3 Strategies:

- Operation of outreach clinics by place and schedule involving community with basic minimum servile package.
- Utilize the services of VHWs and MCHWs.
- Increase community involvement.

4.5.4 Analysis of Achievement:

Table 40 Target Achievement of PHC-ORC

Program/ Activities	*Unit*	*Target*	*Achievement*	*% Achieved*	% expenditure wrt released budget *%*	*Reasons for not achieve 100%*
Clinic conducted	time	3372	2913	86.4		
Management committee reorientation	time	1	1	100	SCF support	

Table 41 Performance Indicators of PHC-ORC

Indicators	**2059/060**	**2060/061**	**2061/062**
% of PHC/ORC clinic conducted	95.2	92.0	86.4
Average number of clients served per clinic	30	27	29

4.6 Community Drug Programme (CDP)

4.6.1 Background

CDP programme in Morang district has been started since 2057/58 with the help of UNICF. Now UNICEF has no programme for monitoring of this programme in the district. BNMT has its programme on Drug Scheme Programme but only limited VDCs are taken so far till now. But by the end of FY 2061/62 district has got data of all 66 health institutions with 10 million rupees in their respective funds in Morang district.

5.6.2 Objective

- To make essential drugs available round the year with the participatory cost sharing approach.
- To ensure poor and disadvantaged patient with free drugs when needed.

5.6.3 Strategies

- Drug management committee will ensure all indent and procurement as per needed.
- Committee will be responsible for overall management including auditing budget.

5.6.4 Analysis of the achievement

Graph 10 Trend of the CDP fund

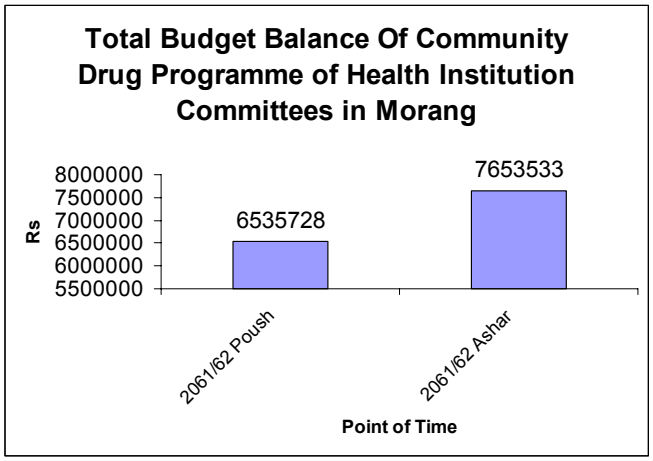


Table 42. Status of Fund of Community Drug Programme		
Ilaka	**2061/62 Poush**	**2061/62 Ashar**
Jhurkiya	349810	400532
Haraicha	686648	766707
Mangalbare	617875	713294
Letang	70472	158696
Bahuni	525825	631714
Jhorahat	476117	589295
Rani	266537	272879
Babiyabirta	222830	280538
Ranjani	463242	419340
Budhnagar	45311	199498
Dadarbairia	587121	622277
Hasandaha	258057	290307
Kerabari	648790	724412
Madhumalla	512786	504342
Majhare	60770	298967
Tanki	234127	267155
Bayarban	509410	513580
Total	6535728	7653533

4.7 Training Activities

4.7.1 Background:

Information Education Communication is one of the important components for the supporting health program. Since 1994, IEC activities have been decentralized and districts are involved in preparing in work-plan and developing IEC materials locally as per guideline of NHEICC.

4.7.2 Objectives:

- To raise health awareness of the people as to promote improved health status.
- To prevent disease through the effort of people themselves and through utilization available resources.

4.7.3 Strategies:

- Promotion of IEC activities in all governmental and non-governmental agencies.
- Dissemination of information, education and communication on health issues through health and health related workers.
- Use of individual group and mass media in health education, information and communication.

4.7.4 Analysis of Achievement of Major Activities:

Table 43 Target Achievement of Training Programme

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
FCHV (Biratnagar Municipality)	person	70	70	100	BRT M.	
Neonatal Health	HWs	400	400	100	MINI	
Neonatal Health	FCHVs	585	585	100	MINI	
CB-IMCI	HWs	110	110	100	Plan Nepal	

4.8 National Health Information Education & Communication Programme Target Activities.

4.8.1 Annual Activities assigned by Centre

Table 44 Target Achievement of IEC

Program/Activities	Unit	Target	Achievement	% Achieved	% expenditure wrt released budget	Reason for not ach. 100%
Gender awareness workshop for health worker	No.	1	0	0.0		
Slide shows in cinema halls	Times	910	310	34.1		
Health education exhibition in Community	,,	3	1	33.3		
Street drama	,,	9	2	22.2		
FM Radio programme	,,	180	195	100.0		
School Health Programme	,,	173	69	39.9		
Interaction programme between press and concerning personal	,,	16	12	75.0	46.0	
District Health Education review	Dist.	1	1	100.0		
Health education material distribution	Times	3	2	66.7		
IEC material production	Piece	20000	20000	100.0		
Health education materials publication/prize	,,	2	2	100.0		
Health education Corner	times	53	38	71.7		
Health Ed. promotion campaign	,,	53	53	100.0		

S.N.	Problems/ constraints	Action to be taken	Responsibility	Deadline
1	Delay release of budget		MoH, DoHS	ASAP
2	Distributed targets were not achieved by HIs	Delay reporting resulted poor performance	District, HIs	ASAP

4.8.2 Health Related Special Days Observed

Table 45 Special days observed in the collaboration with partners round the year

	Special days	Date
1.	World Population day (DPHO Morang stood first position in this occasion on district wide stall competition organized by UNFPA and Purbanchal University at Biratnagar)	July 11
2.	World Breast Feeding Week	August 1-7
3.	Malaria Control Day	August 20
4.	National FCHV day	October 1
5.	World Leprosy day	January 25
6.	Iodine Deficiency Disaoder Month	February
7.	World TB day	March 24
8.	World Health Day	April 7
9.	World No Tobacco day	May 31

4.9 Laboratory Services

Table 46 Laboratory Services

Program/ Activities	Units	Target	Achievement	% Achieved	% expenditure wrt released budget	Reasons for not achieve 100%
Malaria Slides	Each	45740	9425	21		

4.10 Financial Management

Table 47 Budget Expenditure

Programme /Activities	Allocated Budget	Budget Released	Budget Expenditure 2061/062	% of Irregularities Clearances
Health Education	529	245	245	
Leprosy	66	63	63	
CDD/ARI	570	368	368	
Nutrition	189	141	141	
NHTC	652	473	473	
Family Planning	3960	3277	3277	70.82
Integrated Supervision	578	449	449	
Malaria	940	907	907	
TB	150	112	112	
EPI	432	327	327	
Integrated Supervision	578	449	449	
Total----->	8644	6811	6811	

4.11 Human Resources Situation

Table 48 Human Resources (Note: S=Sanctioned post, F= Fulfilled Posts)

Category	DHO/DPHO		PHCC		HP		SHP	
	S	F	S	F	S	F	S	F
DPHO/Officers	2	2	6	1	.	.	.	.
District Assistants	14	14	-	-	-	-	-	-
Nurse/ANM	-	-	24	21	11	11	-	-
HA/AHW	-	-	18	18	33	33	49	49
Lab. personnel's	3	3	6	6	-	-	-	-
VHW/MCHW	-	-	6	4	11	10	98	97
Adm/General staffs	12	12	12	11	22	22	-	-

4.12 Piloting Programmes in Collaboration with EDPs

1 Neonatal Health Programme (JSI R&T)
2 Health Insurance Programme (Ministry of Health)
3 Partners Defined Quality, PDQ (Save the Children)
4 FM Radio Programme Production and Broadcasting (Koshi and Saptakoshi FM)

SECTION 3

3 Supporting Partners

3.1 Governmental: Koshi Zonal Hospital, Rangeli Hospital, Biratnagar Sub metropolitan city, district level line offices from Education, Agriculture, Veterinary, and Women development.

3.2 Non Governmental and Private Sector

3.2.1 List of INGO/NGO working in collaboration with DPHO in Morang

1. Merry Stopes Clinic
2. Nepal Red Cross, BRT
3. Help Group
4. CBR Project, Biratnagar
5. Aama Milan Kendra, BRT
6. Birat Nursing Home
7. NATA, BRT
8. FPAN, BRT
9. Adarsa Nirman Mandir, BRT

3.2.2 External Development Partners

EDPs	Supporting Areas
UNICEF BRT	Immunization campaigns
UNFPA, BRT	HMIS, RH
Polio Eradication(WHO),	Polio and disease surveillance
BNMT, BRT	RH, ED, ID, TB
NFHP, BRT	RH, IMCI
NLR , BRT	Leprosy
SCF(US), BRT	PHC-ORC, LQS, PDQ
Plan Nepal, BRT	CB-IMCI, Cold chain
MINI, BRT	Neonatal Health

3.3 List of Private Hospital/Nursing Homes.

1. Birat Nursing Home.
2. Eye Hospital
3. Abadh Narayan Nursing Home.
4. Koshi Nursing home
5. Purbanchal Nursing Home.
6. Neuro Diagnosis Nursing Home
7. MS Nursing Home.
8. Adarsa Nirman Mandir, Biratnagar

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