

CHAPTER 15

MEDICAL AND PUBLIC HEALTH SERVICES

“Health of people is the foundation up on which all their happiness and all their powers depend” said Benjamin Disraeli, the British Prime minister. In this chapter, how is Public Health planned and executed in Bidar district is discussed. The Bidar district is the northern most part of Karnataka state. Bidar district is constituted by five taluks namely Aurad, Basavakalyan, Bhalki, Bidar and Humnabad. Recently three more new taluks viz Kamalnagar, Hulsoor and Chitaguppa were created. Bidar is the head quarters of the district. When we think of the individuals, personal health measures (Nutrition, Hygiene, Treatment, etc) are to be adopted, whereas when it comes to society, Public Health measures will have to be implemented. A Country, State or District can be recognized for doing people activity with the help of recognizing its public Health activity. It is very clear now (since a Century) what constitutes public health, how to improve public health etc. Details of State and Central health policies are given here.

Public Health Policies: The practice of public health has been dynamic in India and has witnessed many hurdles in its attempt to affect the lives of the people of this country. Challenge confronting the Public Health: 1) There is a raising burden of chronic non communicable diseases and it

is known as epidemiological transition, 2) There is increase in the elderly population and it is known as demographic transition 3) There is the burden of environmental changes 4) There is an unfinished agenda of maternal and child mortality, HIV/AIDS pandemic and other communicable diseases 5) Silent epidemics: The tobacco attributable deaths range from 8,00,000 to 9,00,000 per year leading to a huge social and economics losses. Mental, neurological and substance abuse disorders also cause a large burden of diseases and disability 6) The rising toll of road deaths and injuries (2-5 million hospitalization) over 1,00,000 deaths in 2005 7) Remerging communicable and non communicable diseases 8) Drug resistant TB, Malaria, SARS, avian flu, H1N1 Pandemic 9) Inadequate financial resource for health sector and inefficient utilization result in inequalities in health 10) Issues such as Trade Related Aspects of Intellectual Property Rights continue to be debated in international forums and health system will face new pressures on the issue of globalization which leads to health inequality 11) Health inequality lie in the social, economic spheres and political mechanisms lead to social stratification according to income, education occupation, gender, and race or ethnicity 12) Lack of programme for acquiring of social determinants of health leading to glaring failure of public health.

Addressing the Public Health Issues

- 1) Revitalizing the primary Health care based on the principles outlined in the Alma Ata declaration in 1978.
- 2) Universal access and coverage, equality, and community participation.
- 3) Implementing health agendas and intersectoral approaches to health.
- 4) Lesson from Health for all, Millennium Development Goals to be completed.
- 5) Disease prevention and control of population with informed choices to society.

However the role of the Government is crucial for addressing these challenges and achieving health equality. The Ministry of Health and Family Welfare (MOHFW) play a key role in guiding Indian public health system.

Role of Government within health system: Health system strengthening: The important issues that the health system must confront are lack of financial and material resources, health work force issues and

the challenge of implementing pro equity health policies in a pluralistic environment. The National Rural Health Mission (NRHM) launched by the govt of India is a leap forward in establishing effective integrating and convergra of health services. **Health information system:** The integrated disease surviellance project was set up to give information regarding disease occurrence so that prevention can be taken up. Government is expected to publish health profile of the people.

Public Health Laboratories: To support the governments diagnostic and research activities on health mechanisms, to monitor epidemiological challenges like mental health, occupation health and environmental risks.

Health research system: There is a need for strengthening research infrastructure in the department of community medicine.

Regulation and enforcement of public health: A good system of regulation is fundamental to the successful public health outcomes. It reduces exposure to diseases through enforcement of sanitary crodes eg. water quality monitoring, slaughter house hygiene and food safety. **Health promotion:** Stopping to spread of STD's and HIV/AIDS. Helping youth to recognize the dangers of tobacco smoking and promoting physical activity. Health promotion activity to be extended to rural areas.

Human resource development and capacity building: Establish training facility for public health specialist. The public Health foundation of India is a positive step. Changes in the under graduate curriculum and to include geriatric care, adolescent health and mental health, need to increase the number of paramedical workers and training institution in India. **Implementation Policy :** Identification of health objectives and targets that can be used by states, communities, professional organization, and all sections eg "Better health for all" 'school health', 'mental health', 'referral system', urban health, etc.

The intersectoral Co-Ordination: The ministry of health needs to form stronger partnership with other agents involved in public health. **Social determinants of health** – investments in basic education public health and primary care. **Improving Living conditions:** Provision of safe drinking water, sewerage and solid waste management is essential. This would reduce 70-80 per cent of the burden of community diseases. Urban planning water

supply, sewage disposed, social waste management is equally important for the urban polulence. The Jawaharlal Nehru Urban Renewal mission in 35 cities to be expanded to cover the entire country. Urban poverty alleviation, promotion of agricultural mechanization improving efficiency of investments, rationalization subsidies.

Education: Right to children to compulsory and Free Education. Nutrition priority for improving the nutrition of children integrated child Development services (ICDS) to be strengthened and child malnutrition to be eradicated with urgency.

Social security measures: Mahatma Gandhi Rural Employment Guarantee scheme has a potential to change condition of rural India. Horticulture, laying roads horticulture, rain harvesting, will be seriously attended too. Food security measures improving the public distribute system cannot be ignored. Insurance for unorganized sector, National old age pension scheme should be implemented with all the seriousness.

Population stabilization: Gender mainstreaming, women specific intervention in all policies, programmes and system protecting women for domestic violence, Reducing the impact of climate change and disaster on health, Visualization, implantation, availability of resources for community participate. The principles of implementation of Public Health has been spelt out very clearly. But its implementation may not follow the same pattern though it is suffice to implent in spirit. The evolution of the Public Health System is briefly given here.

Public Health from the early times in Bidar: Ayurveda system of health has been in existence since several centuries. Ayurvedic doctors (Vaidyas) were noted for their knowledge of herbs, plants etc. Those required plants were available there in Bidar and simple remedies, which were efficacious were made. One ayurvedic doctor was there in almost all the villages. Common people had considerable faith in that system.

Advent of Muslims: In the 14th century, Unani system of medicine was introduced in India from rulers of several countries. But this did not displace the practice of ayurveda. But the Unani system did not penetrate into the rural areas. Unani Doctors (Hakims) practiced in towns and enjoyed the patronage of the Muslim aristocracy and many Hindus

also. The Bahamani King Alaud – din Ahmed II (1436-1458 AD) ordered construction of a splendid hospital known as Shafa Khana at Bidar. Both Hindus And Muslim Physicians were appointed to look after the hospital. In Shafa Khana not only unani, but ayurvedic medicines were also given. The treatment was free. Khwaja Mahmud Gawan the renowned scholar and the Prime minister of Bahamani Sultan in the 15th Century greatly encouraged Unani system of Medicine. In 1890 AD, a separate department of Unani Medicine was formed by the Nizam's government for expansion of Unani systems to bigger towns.

Beginning of Western System of Medicine: When British East India Company and the British officers came to India, They brought western system of medicine, Nasir-ud-doula the sixth Nizam, ushered in the allopathic system in the Hyderabad state. A medical department was created in the year 1844. It offered only curative treatment except one preventive treatment; smallpox vaccination. This continued till 1912. There were many epidemics of cholera, plague, causing health mortality but govt concentrated only on sanitation by making it one of the duties of the local bodies. The health service in the urban areas was poor and much worse in the rural areas. Village planning, Sanitary reform, housing schemes Medical and Maternity relief was totally inadequate to meet the needs of the people.

Rapid Developments: In 1913, head of the medical department was given an additional charge of sanitation and he was called as sanitary commissioner. The same year travelling dispensaries for districts were started and were headed by Assistants Surgeons called as district sanitary assistants. In 1922 compulsory primary vaccination of Children between 6-12 months was introduced in the state and the same year Department of Public Health was introduced.

In 1927, Nationaly with the assistance of Rockefeller Foundation of America, a detailed survey of the hook worm infestation was taken up and it showed the problem was widespread and immense. As a result in 1928, the rural sanitation campaign was taken up for prevention and control of hook worm infestation in the state. The project worked in several districts and its aim was education about hookwarm, prevention of hook worm infestation and its treatment, provision of latrines in the village. In 1934,

a separate Deputy Director of Public Health was put in charge of Public Health matters of the state and assist the Director of Medical and public health department. Meanwhile the unani units were continued to be under a separate Unani Medical Department. In 1935, a district hospital was inaugurated at Bidar. Then came the dispensaries at same taluk head quarters. Sanitation was given more importance.

After the advent of the community development schemes and after the establishment and new local bodies, more importance was given to Sanitation. Health Centres were established for preventive and creative treatments in rural areas, Village panchayats also have taken up rural sanitation work by constructing drains, soak pits, hand flush latrines etc. Rural water supply scheme was being implemented for supply of wholesome water. In 1950, a scheme was taken up and practitioners of western and Indian system of medicine were given small subsidies as an inducement to settle down in selected villages and to set up private medical practice there. The cost of medicine and the contingent charges were met by the local boards concerned. The practitioners were supposed to give free treatment to patients. The Practitioners could accept fees for medical attendance and treatment from well to do patients. These dispensaries was maintained entirely from the funds to the local bodies.

Mile Stones of Public Health: The mile stones in the history of Public Health that have had a telling effect on millions of lives.

- Launch of expanded programme of Immunization 1974.
- Primary Health Care enunciated at Alma Ata in 1978
- Eradication of Smallpox in 1979
- Launch of Polio eradication in 1988
- FCTC ratification in 2004 and cot PA act of 2005.
- New Patent policy accepted. 2005

1971-72, 72-73 was the famine year in the district. Dysentery, Gastroenteritis, Deficiency diseases specially Vitamin A and Vitamin B were reported, timely treatment was given. To check the growth of these diseases, two mobile medical units were started, one at the head quarters Humnabad for taluks of Basavakalyan, Bidar and Humnabad and the other at Bhalki as its headquarter for the taluks of Bhalki and Aurad.

Each of these units consisted of one male medical officer, one lady medical officer, one junior health inspector, one pharmacist and one Auxiliary Nurse-Midwife. These mobile medical units were well equipped and treated the patients on the spot. An amount of Rs.1,28,284 was spent on drugs, diets etc, during the two recent famine years with two mobile units.

Reorganization of the department: After the 1st Nov 1956, a separate post of District Health was created who was posted to be in charge administration of all curative and preventive health services in the district. In 1965, the medical and public health department were amalgamated. In 1977, an officer designated as Director of Health and Family Planning services was asked to take charge of department of Health and family welfare service instead of family planning services. At the district level, two independent officers were appointed (1) District surgeon in charge and District Headquarters Hospital and (2) District Health and Family planning officer.

The District Health and Family Planning officer, Bidar is in charge of public health and family planning wing of the department at the district level. He deals with administrative issue, control of epidemics, malaria eradication, maternity and child welfare, vital statistics, sanitation, health education and laboratory work associated with public health. As a family planning officer, he goes for, propaganda of family planning, supply of contraceptives, conducting the camps for vasectomy and tubectomy operations and loop insertions. In addition curative health service, preventive health services, technical guidance to local bodies on matters of public health are attended by him. He is also in overall incharge of all the medical institutions at the taluk level in the district. He gets assistance for the family planning programme. Laboratory work by laboratory technicians. For maternity and child health programme also he gets assistance.

Vital statistics: In 1915-16 rules regarding, securing better registration of births and deaths were revised, and as a result revenue officers were to finalise the registers maintained by village officers. In 1918, a new regulation was issued which laid down that the birth and deaths were to be certified by technical officer. This was supervised at Bengaluru by Directorate of Economics and Statistics.

In 1969, a new legal measure called the registration of births and deaths was brought into force in order to streamline the system. New live births, still births, deaths and other related statistics were registered by the village Patels in rural areas and they are called as registrars. They have to send the monthly report to Tahsildars of the taluk. Deputy commissioners will supervise it at District level and he maintains District Register for Births, Death and Marriages. It is the director of Demography who looks after the implementation of rules in the state. In the urban areas, the Health and sanitary Inspectors of the Municipalities collect these statistics and send them to Chief Registrar. At the national level, Registrar General of India maintains the records as given by state officers from time to time.

The rise and fall in the population of an area can be attributed to some extent to the condition of health and well being of the people, medical facilities available, standard of living, attitude towards family planning etc. *Crude birth and Death rate:* Is defined as the number of births per thousand of midyear population in any given year. Similarly crude death rate is defined as the number of death per thousand of midyear population in any given year. But it is found that the statistics manual are not adequate according to Directorate of Economics and statistics.

Year	No. of births report	No. of deaths report
1970	4,481	2,147
1971	4,787	1,950
1972	6,218	2,172
1973	5,795	4,645
1974	6,480	3,121
1975	8,511	3,041

The district public health planning and implantation is becoming collaborated and this can be seen in the implementation of various programmes. Infant and maternal mortality, still birth rate, prenatal rate and postnatal rate are the components and other related indicators of infant mortality. Infant mortality was considerably high in the districts in the early decades of the century. The main causes for such deaths are prematurity, bronchitis, diarrhoea, dysentery, fevers convulsions, sepsis and respiratory diseases. The infant mortality rate has been considerably reduced in the recent years with the introduction of modern system of

midwifery and other schemes. The statistics of infant still births and infant deaths from 1971 to 1975 is given in the table

Year	No. Of Still births reports	No. Of Infant deaths reported
1971	80	144
1972	313	142
1973	205	200
1974	197	329
1975	247	294

Source: Chief registrar of Birth, Death and Marriages

The main cause for maternal deaths are anaemia, haemorrhage, eclampsia and difficult labour. As in the case of infant mortality, the rate of maternal mortality which was high in the earlier decades has been reduced in the recent years. This is because of the increased facilities provided or the pre natal and post natal treatments in the several hospitals and health centres in the district. The statistics of maternal deaths is given here.

Year	No. of maternal death reported
1971	14
1972	8
1973	10
1974	12
1975	22

Common diseases treated: The common diseases treated in health centres and dispensaries in the district are fevers, diarrhoea, dysentery and respiratory diseases, pneumonia, typhoid, digestive diseases, gastro enteritis, worms, ulcers, anaemic, skin diseases etc. The table below shows the number of deaths caused by some diseases in the district from 1971 to 1975 as furnished by the chief registrar of Births and Deaths and Marriage.

Year	Deaths Due to			
	Plague	Cholera	Malaria	Small pox
1971	1	19	985	193
1972	1	16	74	3
1973	1	26	160	15
1974	1	3	79	19
1975	1	6	59	4

The reasons are insanitary conditions, use of unprotected water, under nutrition and malnutrition, etc.

Cholera: Is one of the dreaded communicable diseases. However there is decrease in the incidence. Wherever an outbreak is reported, health staff are rushed to the place for anti cholera inoculations. It is found difficult to eradicate because of the polluted environment and unprotected water from 1972 to 1975.

Year	Attacks	Deaths	Inoculations made
1972	402	Nil	1,50,730
1973	490	406	1,80,434
1974	41	Nil	1,85,330
1975	15	1	52,281

Small pox: The incidence of the disease was high during the pre independence days, but gradually declined in the later years. It was achieved through vaccination programme only. Now World Health Organization has declared, that smallpox is eradicated from all the countries of the world.

Plague: This disease is almost controlled in this district.

Typhoid: This is often seen and it causes deaths too. Wherever typhoid case is reported, health authorities administer TAB inoculations, chlorination of drinking water is undertaken.

Malaria: National malaria eradication programme is the biggest in the world against a communicate disease. It was completed in 1986. However incidence of malaria came down but not completely. The programme was taken up in all the five taluks of Bidar. Later surveillance activity was also taken up.

Primary Health Centres and Units: Achieving Public Health necessitates opening of Primary Health Centres (PHC's) in the rural areas for a populations of fixed numbers as suggested by World Health Organization. This suggestion was implemented in India, including Karnataka. PHC's and Units were established in the rural parts of the Bidar district during the successive five year plan periods. In 1975 there were eight PHC's of the government of India type covering a population of about 60 thousand each on an average. There were six beds in each PHC's and two beds in each Primary Health Units for the treatment of inpatients. The basic health

services rendered to the rural people through these health centres and health units are:

- 1) Curative services.
- 2) Control of communicable diseases such as malaria, small pox, cholera, tuberculosis.
- 3) Family planning, maternity and child health service.
- 4) Health Education.
- 5) School Health Service.
- 6) Collection of Vital statistics.
- 7) Environmental sanitation.

The staff attached to each of the Karnataka type health units comprise of an Assistant Medical Officer of Health, A junior Health Inspector, A Pharmacist, three Midwives and Three members of class IV staff. Under the malaria eradication programme, there is a Medical Officer of Health, an Assistant Unit Officer, a Senior Microscopist, 17 Junior Microscopist, 4 senior Malaria Inspectors, 4 Junior Malaria Inspectors, 3 Malaria Surveillance workers, 4 superior field workers and ten field workers. All these staff work under the control of the district Health and Family Planning officer.

Family Planning: A State branch and the Family Planning Board has been functioning since 1957. An extended family planning programme was started in 1965. When a separate District Family Planning Bureau was established for better coordinator, The District Health Officer was redesignated as District Health and Family planning officer. Eight PHC's have been provided with a vehicle for facilitating, family planning work. Maternity cum Sterilization wards were established. The Bidar region was considered as an area of moderate growth rate of population since the population increased by 24-26% in the decades 1961-71 in this district as against 24.22% in Karnataka state during that period.

Formerly the family planning programme was being implemented on the basis of clinical approach. This was found to be inadequate for rural areas. Hence the extension approach was adopted where in the education and service facilities were extended to the door step of the rural community and the entire population, both urban and rural, was brought under the

extended reorganized family programme in 1965. In 1965, District Family Planning unit was started and a survey of eligible couples for practicing Family Planning was done and there was one lakh people eligible for Family Planning methods. The District Family Planning Bureau was managing the programme operations with the help of the (1) Mobile sterilization unit (2) Mobile IUCD unit (3) Education and information Division (4) Field operation and evaluation division and (5) Administrative Division.

All those people who work in these programmes were effectively trained. *Vasectomy and Tubectomy*: Facilities have been provided in all bigger medical institution in the district to conduct vasectomy and tubectomy operation, such operations are also being done at camps in rural areas arranged for the purpose under the Medical Officer of Health. Wherever possible, service of the private practitioners are also sought. Private practitioners who render family planning serves in their own clinics or Nursing Home can claim Rs.30 per case of Vasectomy and Rs.40 per case towards Tubectomy and Rs.11 per case of IUCD insertion, provided they render free services to the patients and attend to any complication noticed letter.

The person who is motivated to use IUCD is given Rs. 3 and the motivator is also given Rs. 3. Nirodh is being issued free of charge at the medical institutions and by the health workers during their domiciliary visits. In addition, it was being sold at subsidized rate at selected medical shops and commercial shops. Intensive propaganda through lectures film shows, exhibitions, publicity, literature etc were done throughout the district in order to educate the people.

Year	Sterilization achievement			IUD inserts	
	Target	Vasectomy	Tubectomy	Target	Auto
1969-70	400	817	331	1000	131
1972-73	3540	18,624	776	600	43
1975-76	4050	-	-	810	472

Family Planning Action committee comprises of Deputy Commissioner, Divisional Family Planning Action Committee, District Health and Family Planning Officer, District Surgeon, Several Non-Officials meet once a quarter year and plan and review the programme. Professional organization like IMA Bidar Branch, Social Service organizations like Rotary and Lions club have been involved in this work.

Medical Institutions of Bidar: In 1974-75, the following were there in Bidar. District Hospital at Bidar, General Hospital at Basavakalyan, Eight primary Health centres and one Police Health Centres, Five Civil Dispensaries, one local fund dispensary. A hospital is being maintained by the Gurudwara Sahib Nanak Jaira Known as Guru Nanak Hospital. In addition to these, there is a National Malaria Eradication Programme centre, A district T.B Center, District Health Laboratory, and a National Leprosy Control Centre. The civil dispensaries are situated in 1) Humnabad 2) Chitguppa, 3) Mannaekhed 4) Aurad and 5) Bhalki. They have Bed Strength of 20, 18, 12, 10, and 10 respectively. The general Hospital at Basavakalyan has a strength of 25 only with an x-ray unit attached.

The local Social Service Organization and the international agencies like UNICEF, FAO, and WHO are also associated with it. Department of Horticulture, Fisheries, Animal Husbandry Health Services, Education, Social Welfare, Panchayat Raj, Yuvaka Mandalas, Mahila Mandals etc cooperate in carrying out the programme. The UNICEF provides financial assistance for the training programme and for equipment while the FAC and WHO provide technical assistance. In the district, the applied nutrition programme was started in Aurad, Basavakalyan and Bidar Taluks in 1968 and subsequently it was extended to the other taluks of Humnabad and Bhalki in 1969 and 1970 respectively.

In order to improve the existing dietary pattern, special measures have been taken – Education of the people about proper nutrition, Health worker and community development block staff give practical demonstration, continue follow up in taluks, and discuss, show films and conduct exhibitions. Educational materials are distributed. The Mid-Day-Meals scheme organized by the department of Public instructions is closely associated with this programme. At the end of 1975, there were 365 centres including Primary Schools, Balwadis and Mahila Mandals catering to 14,738 school children and 13,862 pre-school children in the district.

Special Nutrition programme: 25 centres in operation in the urban slum areas. As in 1975, there were ten centres for this programme in Basavakalyan Taluk only catering to 160 children and 440 mothers. Cereals were given to them in the form of gruel, uppittu etc. The supplement given under this programme include about 300 calories and 12 grams of protein.

The world food programme which is in operation in the district, provide Mid Day Meals to school students coming from nearby villages. About 717 inmates of 14 hostels run by the social welfare department also benefited under this programme.

Health Education: The health workers are to give health education to rural people. They have to utilize every opportunity to talk to them about 'vision health' subjects and give them practical demonstration regard to personal cleanliness, environmental sanitation, chlorination of water, vaccinations, DDT spraying etc. The department also arranges for the observance of World Health Day, Leprosy Day, Anti Fly Week, Family Planning fort night etc. They have to give talk, hold exhibition on health topics, screen films on various subjects in village and towns.

School Health Service: The aim is to give comprehensive health care to school children comprising medical examination, treatment, correctional treatments etc. The school children are guided to have good habits, and practice, in order to promote their best growth. Under this programme, children in the age group of 6-11 are being immunized against disease such as diphtheria, polio and whooping cough. Medical examination of students is done at least two times during a school year. Children are made to under go Eye check up, Dental Check up and Examination to find out malnutrition. In 1974-75 Eight, primary health centres were doing school health services in Bidar district. An estimate of School health expenditure is as follows:

Year	No. of Children covered			Expenditure
	Boys	Girls	Total	
1971-72	8,071	573	8,044	8,614
1972-73	7,266	460	7,726	7,726
1973-74	7,727	606	8,333	8,333
1974-75	8,244	659	5,903	8,903

Leprosy Control: It was roughly estimated that about 7,700 person were affected by leprosy in Bidar district. Many Crippled and disabled patients were living with stigma of leprosy in the society. With a view of controlling the leprosy in the district, a National Leprosy subsidiary centre was started in Bidar in 1959 with the aim of doing survey, education and treatment. The same centre was upgraded into a National Leprosy

Control centre in 1972. At the beginning, the centre was started with one medical officer and one medical social worker. Later the centre had, one medical officer, one senior non medical supervisor, one junior non medical supervisor and about 15 paramedical workers. The department of Health Services is also required to make sanitary arrangement during fairs and festivals when people gather in large numbers. Treatment of leprosy case is arranged at weekly clinics at important places where the Medical officer of Health examines the cases. In addition, treatment is also given by rural medical practitioners and range health inspectors in several places. The National leprosy control centre has now four subsidiary centres at Bhalki, Bidar, Kamthana and Halbarga. It has seven sub centres at Bidar, Janawada, Chillargi, Kamthana, Manhalli, Badgal and Ranjolkheni (all in Bidar taluk) and Eight sub centre in Bhalki, Bhatambra, Saigon, Dadgi, Khatak, Chincholi, Nittur, Halbarga and Byalhalli (all in Bhalki taluk).

The table gives some information on Leprosy

Calendar year	No. of outpatients treated	Financial year	Exp. In Rs.
1966	1,675	1966-67	20,704
1970	2,524	1970-71	41,212
1975	5,017	1975-76	1,19,806

District Tuberculosis Centre: The Tuberculosis chest clinic in Bidar in 1956 was converted into the present District Tuberculosis Centre in 1972. The chest clinic had limited its functions to the District head quarters of Bidar only. Consequent on its conversion into the district T.B Centre, preventive and curative activities namely home to home BCG Bacillus Calmette Guerin Vaccination and domiciliary treatment were being offered. At present, there are twenty referring centres over the district which after diagnosing the disease provide treatment and also refer the cases for x-ray and sputum examination on, to the centre. Attached to the centre, there is a small laboratory. The BCG Vaccination is given to the persons in the age group and 6 to 20 years. It acts as a preventive support against tuberculosis. There is a team of seven B.C.G technicians and a non medical team leader in Bidar District which goes from place to place for vaccinating the eligible's. The following table given some particulars of the District Tuberculosis Centres, Bidar.

Year	No. of Patients	BCG Programme		
	Treated	Registration	Vaccination	Expenditure
1973	517	1,47,568	31,945	88,600
1974	1,023	1,69,046	53,883	1,38,926
1975	641	1,31,490	40,988	1,01,910

District Health Laboratory: A district health laboratory was set up at Bidar in 1971. Various tests (Blood, Urine, Sputum, stools) were made there by analysing the samples received from various medical institutions of the district. In 1975, the laboratory made 7,405 tests of various kinds as against 6,384 in 1971. At present it has a medical officer of health, three senior laboratory technicians and four laboratory attenders.

District Hospital: A District Hospital was started at Bidar in the year 1935. It had periodical expansions and in 1975 it had a bed strength of 215 and the following sections were there (1) Medical (2) Surgical (3) Maternity and Child Health (4) X-ray (since 1963) (5) Dental (Since 1968) (6) V.D. Clinic (Since 1970) (7) Blood Bank (since 1970), (8) Eye Clinic (1972), (9) Urban Family Planning Centre (Since 1965) and (10) a laboratory (Since 1974). There was also provision for training nursing Students, Auxiliary Nurse Midwives, lady health visitors, and for doing house surgery after medical graduation. Beside the district surgeon, who is the head of the hospital, there were in 1975, 14 Assistant surgeons of class II cadre, three Nursing Superintendents out of whom one was of grade I and the other grade II, Two nursing tutors, 31 nurses, three midwives, three pharmacists and about 141 class IV officials.

There is a provision to give treatment to T.B. cases both as in patients and out patients in this hospital, which has a separate ward with 20 beds for the purpose. In 1975, the number of T.B inpatients and out-patients that were treated was 202 and 1,401 respectively as against 199 and 1302 in 1974. The number of in patients and out patients who were treated for various other diseases in 1975 was 13,353 and 4,75,486 as against 13,261 and 4,55,691 respectively in 1974. The total number of major and minor operation that were done in the hospital in 1975 was 69 and 410 as against 551 and 169 respectively in 1974. The number of labour cases that were attended in the hospital in 1975 was 2,092 as against 2,200 in 1974. The number of X-rays taken was 120, screenings 930, and bariums

20 in 1975 as against 698 x-rays, 8,113 screenings and 13 bariums in 1974. The number of Vasectomy cases were 51, tubectomy 393 and IUCD 278 in 1975, while it was 13 Vasectomy, 282 Tubectomy and 153 I.U.C. D cases in 1974. The hospital was manufacturing some medicines such as glucose, glucose-saline, normal saline, distilled water, and ACD Solutions. The expenditure incurred on the hospital in 1974-75 was Rs. 19,75, 472 whereas it was Rs. 16,57,533 in 1973-74.

Methodist Hospital, Bidar: It is a charitable institution, was founded in 1903. It had periodical expansion and had 25 beds in the beginning while the present bed strength is 50 only. It provides patient care in medicine, surgery, paediatrics, obstetrics and gynaecology with a separate eye department. Besides a chief medical officer (who is the head of the institutions) it has two doctors, 19 nurses, three para-medical staff and 33 ministerial staff in 1975. The number of in-patients and out patients that were treated was 1,040 and 9,541 respectively as against 942 and 6,350, in 1974. The number of labour cases that were attended to in the hospital in 1975 was 250 as against 225 in 1974. The total number of major and minor operations that were conducted in 1975 was 35 and 85 respectively as against 27 and 53 in 1974. The number of family planning cases attended to by the institutions in 1976 was 112 as against 34 in 1975 and 23 in 1974. The total number of x-ray screenings taken in 1976 was 210 as against 100 in 1975 and 85 in 1974. The expenditure incurred on the hospital in 1974-75 was Rs.1,73,719 as against Rs.2,05,905 in 1973-74.

General Hospital, Basavakalyan: A civil dispensary which was started at Basavakalyan in 1952 was upgraded into a General Hospital in 1970. It had medical, surgical and maternity sections, Leprosy and Tuberculosis cases. Patients were treated also in the out patient department of the hospital. In 1975, the bed strength of the hospital was 25. There is a medical officer, a lady medical officer, two pharmacists, five nurses and seven members of the class IV staff. The total number of inpatients and outpatients treated in 1975 was 429 and 53,728 compared to 117 and 54,576 respectively in 1974. The total number of operations done in 1975 was 170 as against 233 in 1974. The number of maternity cases which received attention in 1975 was 334 as against 262 in 1964. There is a

separate section for family planning where in eleven tubectomy cases, eight IUCD cases and four vasectomy cases were attended in 1975, as against thirteen tubectomy and three IUCD cases in 1974. The expenditure on this hospital which was Rs. 79,244 in 1974-75 had increased to Rs.94,055 in 1975-76.

Guru Nanak Hospital, Bidar: It was started in March 1970 by the Gurudwara Sahib Nanak Jhira. This is a charitable hospital, treatment is free to all irrespective of caste and creed. It is equipped with an operation theatre and x-ray plant, E.C.G, and pathology lab. The bed strength of the hospital in 1970 was 15. It had a medical officer, a lady medical officer, two nurses, two pharmacists and a radiographer. The total number of in-patients and out patients treated in 1975 were 102 and 80,687 as composed to 54 and 47,276 respectively in 1974. The total number of operations conducted from the date of its establishment up to the end of 31st December, 1975 is only 197. The total expenditure incurred by the hospital in 1975-76 was Rs. 1,59,438 as against Rs. 1,21,125 in 1974-75.

Medical Personal in Bidar: In 1977, there were six physicians with postgraduate qualifications, nine graduate surgeons, 67 graduate physicians and a graduate dentist. The ayurvedic and Unani Physicians numbered 35 and 25 respectively. There were 34 pharmacists, four nurses two health technicians, 125 auxiliary nurse mid wives, 456 Para Medical staff, five Unani vaid (tabeebs), 33 ministerial staff and 79 class IV officer. The total number of registered medical practitioners practicing allopathy, ayurveda, unani were 71,10,324 respectively. There are three traditional bone setters and messagists at Bidar.

Chemists and druggist: According to the figures furnished by the State Drugs Control, there were in 1975, 23 chemists and druggists and 29 qualified pharmacists in the district.

Medical Association: There is a branch of Indian Medical Association at Bidar which was started in 1969. In 1976, it had 22 members consisting of doctors of modern medicine in government service and Private Practice including Specialists. The activities of the Association include organization of periodical professional meetings of doctors educating of the public on matters of health, conducting antenatal, prenatal and child guidance clinics

and family planning motivation. Under the school health programme, health of about 500 children was being looked after by the association. Short term refreshers courses which were useful for doctors working in the moffusil areas to get their knowledge, were held every year. The government of Karnataka was encouraging holding of such courses by deputing doctors to attend them and by giving substantial grants for conducting the courses, sometimes the meeting of the Association were held at the taluk headquarters also.

Health and Nutrition: Health is considered as one of an essential requirement of human resource development. Low life expectancy, malnutrition and diseases are considered important factors contributing to underdevelopment. The link between nutrition and human development has been brought out clearly in the international conference on nutrition (ICN) held in Rome in 1992. The growth rate of the population during 2001-2011 is 1,338 which is below the state average of 1,567. The growth rate is lowest in Bhalki taluk i.e 7.90 per cent and maximum in Bidar taluk. The district shares 2.78 per cent of population of the states. The growth rate is 25.15 per cent. The slow urbanization trend indicates lack of diversification and modernization and existence of traditional and backward economy.

Sex ratio: When the govt takes up empowering women and save the girl child, the women number increases. But at other times the low sex ratio indicates the increasing number of missing women. This also supports the fact that the gender inequality exists in the society and the status of women in the family and society continues to be low, despite of the empowerment programmes undertaken by the Government.

Sex ratio in the taluks

Sl. No.	Taluks	Sex ratio 2001	Sex ratio 2011	Sex ratio 0-6/2001	Sex ratio 0-6/2011
1	Aurad	950	956	946	950
2	Basavakalyan	960	959	928	934
3	Bhalki	947	959	942	934
4	Bidar	938	949	943	938
5	Humnabad	950	962	949	955
Total		949	952	941	942

Source: District at a Glance Bidar

Declining sex ratio is on account of high female maturity or female infanticide: In spite of the introduction of PCPNDT act in 1994 the female foeticide in Bidar has not reduced. There is a need to promote female literacy and women need to be provided adequate knowledge about health care delivery during pregnancy and child birth. The anganwadi centres and the self help groups have to work more effectively in this regard. Now the health department under NRHM has adopted behavioural change communication (BCC) approach to attain the delivered outcomes in infant mortality, child mortality, malnutrition and anaemia. It is a process that motivates people to adopt and sustain the healthy behaviours and lifestyles. Sustaining healthy behaviour usually requires continuing investment in BCC, helps in understanding the dynamics of health issues in terms of its various dimensions. But the implementation of these programme, is very slow in the district as adequate trained, field staff is not available, therefore the outcomes are not satisfactory.

Bidar district has entered into the third stage of demographic transition, therefore, control of population may help to promote human development. The minimum age of marriage is 18 and therefore the total fertility is still very high. High fertility rate affects the reproductive health of women and the health of children also. It is one of the major causes of anaemia and malnutrition among women and children. There is a need to generate awareness among men and women about the small family norm and adequate spacing and the availability of birth control measures.

The couple protection rate is usually expressed as per cent of women in the age group of 15-45 years protected from pregnancy and child birth in the year under consideration for a specific area. The major factors affecting the couple protection rate are availability of various types of birth control measures that are effective and user friendly, the supply and distribution pattern of these contraceptives, counselling and follow ups centres, literacy and awareness among the users—it is largely influenced by social, psychological and behavioural pattern among the users. It is largely influenced by social, psychological and behavioural pattern of men and women in the region. The traditional societies and the rigid customs and traditions as well as illiteracy do not facilitate the use of contraceptive methods.

In a patriarchal society like Bidar, family planning has always been a female domain. Women lead a main role in contraception where as men's job is supportive in nature. Gender issues, lack of awareness, misconception about male methods compounded by pragmatic factors with expensive weightage to female methods have lead to reduced utilization of male contraceptives. The international conference on population and development held in Cairo in 1994 emphasized the need to gender equality in reproduction and sexual health. Men should be sensitized about reproductive health issues and womens reproductive rights. Many studies in India have shown the inadequate involvement of men in family planning programmes. The participation of men in family planning requires social and behavioural changes. This is to be brought through adequate gender sensitization and awareness. The role of men assumes even more significance with the emergence of HIV/AIDS. Female sterilization continue to be the main method of family planning in the district and the responsibility of the spacing between the births of two children also falls on women. The female sterilization cases are about 99% in all taluks. All these factors explain the low couple protection rate in the district. It is 54.5%, the rate is below 50% in rural areas. Is only 60% in Bidar taluk though a large part of the taluk is urban in character.

Talukwise Population 2011

Sl.No	Taluk	Population	Male	Female	Growth rate
1	Aurad	2,78,400	1,42,309	1,36,091	13.5
2	Basavakalyan	3,45,247	1,76,223	1,69,024	15.12
3	Bhalki	2,77,350	1,41,603	1,35,717	7.90
4	Bidar	4,69,941	2,41,095	2,28,846	15.88
5	Humnabad	3,32,362	1,69,435	1,62,927	12.83
District Total		17,03,300	8,70,665	8,32,635	13.38

Sex ratio 1901-2011

	1901	1911	1921	1931	1941	1951
Bidar	980	929	968	959	949	980
Karnataka	983	981	969	965	960	966
	1961	1971	1981	1991	2001	2011
Bidar	971	963	968	952	949	952
Karnataka	959	957	963	960	965	968

Infant mortality, Child mortality and Maternal Mortality in Bidar District

Taluks	IMR	CMR	MMR
Aurad	34	44	44
Basavakalyan	25	33	186
Bhalki	52	68	99
Bidar	23	31	119
Humnabad	21	28	206
District	31	35	134
State	35	40	144

Couple Protection rate

Taluks	Mean age at marriage	Couple protection rate	Vasectomy	Tubectomy
Aurad	17.5	56	16	2306
Basavakalyan	18	55	18	3111
Bhalki	17.5	52	21	2028
Bidar	19	54	18	2728
Humnabad	18	59	0	2484
District	18	54.5	73	12657

Infrastructure and Health care personnel Community Health Centre

Health care covers not merely medical care but also all aspects preventive care also. Health care at its essential core is widely reorganized to be a public good. Its demand and supply cannot therefore be left to be regulated solely by the invisible hand of the market. Hence the states intervention in the provision of these facilities is essential as their provision through market may lead to exclusion of the poor and marginalised groups including women. An efficient and equity based health care system should satisfy four criteria. 1) Universal access and access to adequate level of facilities, 2) Access without excessive financial burden, and 3) Efficient provision of quality services ensuring. competence, empathy, accountability, pursuit of quality care and cost effective use of the results of relevant research. Special attention to be given to vulnerable groups such as children, women disabled marginalize and the aged.

The health status of the people depends signification on availability of health facilities, access to these, and functioning of these facilities. The state provision and the health care services is made through a set of health institutions that includes Primary Health Centres, Primary Health

Units, Sub Centres, the Community Health Centres and the Government Hospitals and Hospitals belonging to the Indian System of Medicine, Dispensaries etc. In urban and Semi urban areas the private clinics and Nursing Homes are also available to meet the health needs of the people. The Karnataka Government is on a mission to increase accessibility, affordability and availability of quality health care in the state. As part of this, the government has undertaken rapid expansion of health facilities in the state. The availability of health infrastructure facilities in Bidar District is indicated in the following table.

Health Infrastructure in the District.

Taluks	Hospitals	PHC's	CHC's	Private Hospitals	Sub-Centre
Aurad	3	11	2	22	54
Basavakalyan	3	12	2	37	54
Bhalki	2	11	1	26	55
Humnabad	4	10	3	50	54
Bidar	5	07	0	162	53
District	17	51	8	297	270

Source: DHO Bidar

There is concentration of Private Hospitals in Bidar Taluk mainly in the Bidar city. There is no CHC in Bidar taluk. There is a general hospital with 100 beds at each taluk place. Only the hospital at Bidar has 850 beds. There are 51 PHC's and 8 CHC's and 270 subcentres in the district. There are 297 private hospitals in the district and out of them 55% are concentrated in Bidar Taluk, mainly Bidar city.

Indicators of availability of access to Health facility

Taluka	Population per PHC	Villages Per PHC	Population bed ratio	No. of doctors (10000) population	Population ambulance Ratio
Aurad	33182	13.7	1395	0.66	24887
Basavakalyan	39859	9.3	1654	1.74	40443
Bhalki	27341	11.8	1610	0.55	37259
Bidar	25869	17.7	738	0.57	84833
Humnabad	33124	8.2	1409	0.69	38202
District	31675	11.74	1356	0.72	46325

Source : DHO Bidar

The adequacy of these facilities is measured with respect to the population norm. The population per PHC is above 25,000 in all the taluks. Then the availability of PHC is inadequate. This is also evident from the fact that the villages served by PHC are 11.7 in the district. In Aurad taluk one PHC serves about 13.7 villages. The inadequate and occupancy ratio and patient visit ratio, road transport facilities further reduce the access to the health facilities.

Bed-Patient Ratio and Occupancy Ratio and Patient visit Ratio in PHC/Sub Centre 2010-11.

Taluks	Bed population Ratio (1 bed per lakh of population)	Bed occupancy Ratio	Average patient visit ratio to PHC (for 1 PHC per day)
Aurad	60.5	16.6	12.5
Basavakalyan	71.2	68.9	14
Bhalki	53	37.4	11
Bidar	6	41.5	16
Humnabad	63.5	110.5	11.5
District	65	89.6	12

Number of Community Health Centres is 8 only (there should be one CHC for four Centres as per the norm. These are 51 PHC's but there are only 8 CHC's (Required number is 13) and three of them are in Humnabad taluk. This indicates acute shortage of referral institutions in the district.

The bed population ratio is very low in the district. It is 65 per lakh of population. It is lowest in Bhalki (53) and Aurad (60.5) taluks. But the bed occupancy rate is also low due to inadequate availability of other facilities. It is less than 25 in Aurad taluk. The average patients visiting the PHC's is about 12-15 per day in all the taluks. Thus the Primary Health Centres are underutilized in all the taluks. It is recorded that there is a significant improvement in the provision of health care services after the implementation of NRHM programme. All the PHC's are inadequately equipped with staff and equipments. Still there is shortage of health personnel and it is at critical level.

ANC Coverage and anaemia among the pregnant woman. The antenatal care services are being implemented effectively under NRHM Programme. In the district, Antenatal Care Services include 1) ANC registration, 2) ANC check up by health functionary, 3) Admission of tetanus toxoid doses, 4)

Provision of iron and folic acid tablets, 5) Postnatal care services involving completion of three check ups.

Under NRHM, The state has taken up measures to increase the access of pregnant women to health services. ASHAs were introduced at the village level for motivating the pregnant woman to utilize the antenatal care services provided by the government health facilities. ASHAs play the role of connecting bridge between community and first level government health sector. There groups of health care providers along with Anganwadi Workers (AWW) build the base line of rural health services in the district. As a result of this, ANC registration has improved significantly in the district.

Percent of Pregnant Women Registered and Received ANC

Taluks	% of pregnant women registered and received ANC	% of pregnant women received full ANC (3 ANC visits + 90 IFA tab + TT	% of pregnant women who are anaemic	% of pregnant women who are provided with nutrition
Aurad	94	89	64.52	71
Basavakalyan	95	94	59.68	68
Bhalki	95	92	63.1	78
Humnabad	96	92	62.67	65
Bidar	100	100	54.25	71
District	95.5	93.8	54	68

Source: DHO Bidar

Antenatal check up and treatment is essential for reducing the MMR and Undernutrition in the newborn child. The percentage of women with full ANC is 95% in all the taluks. It is 100% in Bidar Taluk. However the percent of pregnant woman who registered for ANC and got three ANC check up is about 94% in the district. The percent of women with anaemic is also high in the district. It ranged between 64% in Aurad and 63% in Bhalki and 63% in Humnabad. It is also high in Bidar and Basavakalyan taluks. The double burden of work and lack of adequate nutrition as well as low spacing are the major causes for the same. Women are the residual eaters and the poverty does not provide them a nutritious food. The high fertility rates, more number of children and inadequate spacing among them also leads to anaemia. 76 per cent of the pregnant women are covered by Anganwadi Centres for provision of nutrition. Despite of the implementation of NRHM programme and women health specific programmes, the women health status continues to remain at low level. This is evident from the above table.

Institutional Delivery: The promotion of institution delivery is essential to ensure safe motherhood and reduce the maternal and child mortality rates. The Nanjundappa Committee in its report in 2002 reported that institutional deliveries constitute only 48% of the total deliveries in this part of the state. But the situation has changed now with the introduction of ASHA and 24/7 PHC services, under NRHM programme, the percent of institutional deliveries has increased to 99.0% in Aurad and Humnabad taluk, but it is still 98% in Basavakalyan, Bhalki and Bidar taluks. It is 98% at the district level. However the field studies have reported that home deliveries are still observed in Hamlets, Tandas and remote villages.

Institutional Deliveries

Taluks	percentage of Institutional deliveries	Percent of by ANM/LHV	Percentage by trained Dias
Aurad	99	0	1
Basavakalyan	98	0	2
Bhalki	98	0	2
Bidar	98	0	2
Humnabad	99	0	1
District	98	0	2

Source: DHO Bidar

Immunization of Children: Immunization prevents under five deaths from vaccine preventable diseases in India. Immunization is a cost effective and relatively inexpensive public health intervention for improving child survival. Under the national immunization programme, infants are immunized against 7 Vaccine preventable diseases-namely diphtheria, pertussis, tetanus, polio, hepatitis B, tuberculosis and measles. There is a need to improve the coverage with a focus on quality of the health care services.

Immunization status of children below 1 year

Taluks	Percent of children immunized	Percent of children immunized against DPT 2 and Measles
Aurad	95	95
Basavakalyan	97	97
Bhalki	98	98
Bidar	99	99
Humnabad	98	98
District	97	97

Source: DHO Bidar

The immunization programme is one of the key interventions for protection of children from life threatening conditions which are preventable. It is one of the largest immunization programme in the world and a major public health intervention in the country. Immunization programme in India was introduced in 1978 as expanded programme of Immunization (EPI). It has provided guidance and support for expanding coverage by standardizing immunization schedules, promoting safe injection technologies, improving the stocking and availability of vaccines and protecting vaccines preservancy through cold chain management. Its aims at having 80% of children in each district to receive three doses of diphtheria, pertussis, tetanus (DPT) Vaccine.

In Bidar district, the Anganwadi workers and the Health Workers are involved in the immunization programme along with other Health Department staff. Outreach immunization is undertaken to make the universal immunization programme more effective. Thursday is the immunization day. The coverage of children under full immunization is about 97 per cent. The district is nearing to target of 100 per cent immunization.

The percentage of immunization has increased in the district significantly. This is on account of the implementation of NRHM programme. The Anganwadi worker and the ASHA form a group to generate awareness among the women about importance of immunization. The percent of children immunized against DPT 3 and measles in 95 per cent in Aurad and 99 per cent in Bidar. Thus progress achieved has helped to reduce the IMR and CMR in recent years.

Malnutrition, Underweight Children and BMI Ratio: Nutrition is a significant input that determines the health standards of the people, specially women and children. Nutrition depends on the consumption and composition of the food. In the district for a large majority of the poor, the food is Jawar Roti and Dal (Red gram). The consumption of fruits, milk and vegetables is very low. Even this Jawar Roti and Dal is not adequately available to women and girl children. Due to strong religious beliefs and gender bias, women take food at the end and consume only the left overs. As a result, the level of nutrition is very low in women. The percent of mothers with adequate folic acid and iron is only 46.29 per cent in the district. Low female literacy and lack of awareness and knowledge about nutrition are some of the major causes of undernutrition among children.

Malnutrition and anaemia are common among woman and children. The percent of children with malnutrition is very high in the district. The percent of children born underweight in the district is 8.40 per cent but it varies between 5.23 per cent in Aurad to 14.18 per cent in Bhalki taluk. The percent of malnourished children is very high in Bidar taluk. This is also confirmed from a micro level study. Poverty, gender discrimination, early marriage, high fertility, low spacing, low female literacy, lack of awareness are major causes of undernutrition. The anganwadi centres started under the integrated child development scheme to cater to the nutrition needs the children, in the age group of 0-6 years and also the pregnant women. There are now 1890 anganwadi centres working in the district, their distribution and coverage of children is indicated in the following table.

Anganwadi Centres and coverage of children 2012-13

Taluks	Anganwadi-Centres	Children Covered 0-3 yr	3-6 years	Total	Average children per centre
Aurad	351	12202	15760	27962	80
Basavakalyan	410	20184	12018	32202	78
Bhalki	338	18036	13118	31154	92
Bidar	466	23610	15821	39431	84
Humnabad	325	14487	10990	25477	78
District	1890	88519	67707	156226	83

Source : DD, women and child development Dept. 2013-14

The per cent of children covered in the age group of 0-3 is maximum in Bidar and it is lowest i.e., 12,202 in Aurad taluk. The number of average children per anganwadi are 83. The number is more in Bhalki and Bidar taluks. There are difficulties in expansion of coverage due to scarcity of resources. The studies conducted by the students of women's studies and social work department indicate the effective working of these centres in rural areas and the anganwadi worker is the first consultant and advisor for the majority of women in rural areas. The anganwadi centres are being strengthened with building and other infrastructure facilities under the Backward Region Grant Fund Programme (Earlier the scheme was called Rashtreeya Sam Vikas Yojane (RSVY) and other programmes.

Communicable diseases

Communicable diseases are also known as infectious diseases. They

spread from one person to another, that is a healthy person may catch it from a patient. Communicable diseases spread through air, water, food and contacts. Influenza, Measles, Typhoid mumps, Polio, Chickenpox, Tuberculosis, AIDS are some of the major communicable diseases.

Communicable Diseases

Taluks	% of HIV Patients	% of patients with communicable diseases	Percent of patient with non communicable diseases
Aurad	0.1	0.02	1.79
Basavakalyan	4.6	0.20	0.80
Bhalki	1.2	0.09	0.15
Bidar	3.2	0.07	1.47
Humnabad	0.03	0.20	1.00
District	1.81	1.16	5.20

Source: District Health Office, Bidar

Performance of Various Health Schemes: The government both central as well as the State had introduced various schemes for improvement of health status of the people. The performance of some of the major schemes is analysed here.

National Rural Health Mission (NRHM): This programme was introduced in April 2005. It focuses on woman and child health in rural areas. It is directed at provision of accessible, affordable, accountable, effective and reliable primary health care facilities for the poor people in and especially women in rural areas. Reducing maternal and child mortality is a crucial agenda before NRHM. Different innovative schemes have been undertaken under the programme to achieve these goals.

Introduction of ASHA: ASHA, a female voluntary health activist at the village level for every 1000 women. Under the programme, 26 PHC are converted into 24/7 and the rate of deliveries has increased. The Rogi Kalyan samithis are established. The village health and sanitation committees are formed. The total expenditure under the programme is 14.55 crores during 2015-16.

- National Aids Control Programme (NACP) is to control spread of HIV/AIDS.
- The Revised National Tuberculosis Control Programme (RNTCP) is implemented using Dots to control Tuberculosis

- National Vector borne Disease Control Programme (NVBDCP) is being implemented for prevention and control of vector borne diseases like malaria, filariasis Kala uzar, dengue and chikoongunya.
- National programme for control of Blindness (NPCB) and National Leprosy Eradicating Programme to eradicate leprosy are being implemented in the district.

Health Department Programmes

Thayi Bhagya: In order to reduce IMR and MMR in the backward district of Bidar, Yadgir, Raichur, Koppal, Bagalkot and Chamarajnar, empanelled private hospitals are given an incentive of Rs. 3 lakhs for every 100 deliveries conducted including surgeries with treatment being free to the patients. 4,321 beneficiaries have availed the facility in this district.

Arogya Kavacha (108): This programme with the help of ambulance and its staff provides free first aid and referral transport incase of medical emergency. The average number of calls per day fall between 100-150. Of the calls attended, 48 per cent are pregnancy related. 15 ambulances have been deployed under this programme in the district of Bidar and 28,517 patients have received the benefits.

Suvarna Aarogya Chaitanya: This is a unique programme being implemented for the first time in the country. In this programme, about one crore school children in the government as well as private schools are medically examined and, children suffering from ill health are given treatment including surgeries free of cost in emancipated hospital.

Madilu: It is one of the schemes started by the state government to provide postnatal care for the mother and the child. The objective of the scheme is to encourage poor pregnant women to deliver in health centres and hospitals in order to considerably reduce maternal and infant mortality in the state. Under this programme a kit is provided to women from below poverty line families delivering in government Hospitals. The benefit is limited to two live deliveries. 12,466 kits are distributed under the scheme during 2012-2013.

Prasooti Araike: This scheme was introduced in six 'c' category districts of Bidar, Raichur, Koppal, Bijapur and Bagalkot for the benefit of pregnant women belonging to below poverty line of SC and ST families. This has now been extended to all below poverty line at all the districts.

The women of below-poverty line will get Rs.1000 (for first two deliveries) during her antenatal care to get nutritious food. All these programmes have contributed significantly to increase the institutional delivery, reduction in IMR/ CMR/ and MMR.

Health Insurance: The coverage of people under various health insurance schemes of the government is increasing in the district. This is desirable. Only government supported health insurance scheme, is considered desirable. **Per capital Analysis of Health Expenditure:** The total expenditure on various health schemes is presented in the following table.

Expenditure as various health schemes 2012-13

Programme Name	Aurad	B.Kalyan	Bhalki	Bidar	Humnabad	Dist.
NRHM	76,91,096	70,01,427	72,73,011	8,005,632	7,22,81,331	13,13,21,322
RCH	1,31,17,205	1,05,32,428	1,21,23,730	1,18,77,298	1,42,46,355	1,03,28,865
Immunization	4,77,000	5,12,050	563070	8,40,686	4,91,700	7,89,900
Other D.C programme	0	0	0	0	0	79,57,586
KHSDRP	0	0	0	0	0	1,31,16,062
Total	2,12,85,301	1,80,45,905	1,99,59,812	2,07,23,616	2,19,66,386	4,35,13,735

Source: District Health Office- Bidar

The total expenditure on various health programmes is 14.54 crores. Aurad and Humnabad have spent more on health issues. There is a need to increase the utilization of funds and complete the works within the scheduled time period. This expenditure as compared to the population of the district falls short of the need of the people. The per capita expenditure on health ranges from Rs.106 in Aurad taluk and as 101 in Basavakalyan taluk to Rs 73 in Bidar Taluk.

Per Capital Expenditure on Health

Sl.No	Taluk	Expense capital (Rs)
1	Aurad	105.9
2	Basavakalyan	81.7
3	Bhalki	101.4
4	Bidar	73.6
5	Humnabad	95.6
	District	98.6

Source : Estimated from the total expenditure

Per capital expenditure is very low in the district. It should be minimum 5 per cent of GDP to provide to the people according to WHO.

Malnutrition amongst children: India bears a high burden of malnutrition among children. Despite of the fact that ICDS programme is working in India and Karnataka since 1975, yet 70 per cent children are anaemic. Undernutrition among children below five years has a significant impact on growth of the body and mind and morbidity during childhood. It also affects the nutritional status in adolescents and adult life. Malnutrition including micro nutrient deficiencies often lead to permanent damage including impairment of physical growth and mental development. The basic causes of malnutrition in general, identified in several studies are poor diets with incidence of infections, poor maternal nutritional status, female disempowerment, high socio-economic inequality pervasive poverty, poor health services, very poor sanitation and weak governance, inadequate knowledge and high female illiteracy etc.

Specific Causes of malnutrition in Bidar based on micro level study poverty

- 1) Poverty:** The major occupation of the households is agriculture labour, trade and business. The income level is very low. There is concentration of the households in the monthly income groups of less than 5,000 rupees. The average income of the household is Rs.3,254. The per capita income is Rs. 542. The households are not able to meet their daily needs, they are not able to purchase fruits, vegetables, milk etc. The expenditure on health and other religious functions is more, therefore, the family is unable to meet the nutritional requirement of the children.
- 2) Indebtedness:** About 78.45 per cent of the households are indebted. The debt is incurred either to finance the health expenditure and emergency requirements of the family like death in the home, marriage or religious ceremony. Quite often the money spent is to finance the debt.
- 3) Lack of reproductive choices for woman:** 62 per cent of the women reported are anaemic and have related health problems like tiredness in the evening, backache, headache, etc. The reasons often are early marriage, no spacing between children, low health status of mother etc.

- 4) Lack of awareness about nutrition:** Women have no awareness about hygienic, health and nutrition.
- 5) Lack of adequate employment:** There is excess labour phenomena in day land agriculture. Single season, more crop, system of cultivation leads to inadequate employment.
- 6) Social factor:** Value system associated with a pregnant women prohibits woman from eating certain fruits and vegetables. The new born is often not fed immediately after birth. children are not fed at regular intervals.
- 7) Gender discrimination:** In a patriarchal society the status of the women is low in family and society. There is discrimination and as a result incidence of malnutrition is high in women SC/ST/Muslims.
- 8) Lack of adequate care of the children:** Mothers have very less time to look after the children. This due to heavy work load (12-14 hrs a day)
- 9) Lack of Effective functioning of anganwadi centres:** The centres do not monitor the weight properly and periodically.

Health status and women: Women have double or triple burden of work. They work within the house, collect fuel and fodder from outside and also work in the fields. They do not have any leisure time.

Summer of Public Health Situation in Bidar

- Bidar district has now entered into the third stage of demographic transition.
- IMR / CMR / MMR are changing slowly
- Institutional deliveries are increasing
- Immunization of children is also increasing
- However malnutrition and anaemia in women is a cause for concern
- Percentage of children born with low birth weight is also cause for concern
- Delivery of health services is not adequate.

Annexure-1

Word Meaning

Ayurveda: The traditional Hindu system of medicine (incorporated in AtharvanaVeda, the last of the four Vedas), which is based on the idea of balance in bodily systems and uses diet, herbal treatment, and yogic breathing.

Anaemia: Is usually defined as a decrease in the total amount of red blood cells (RBCs) or hemoglobin in the blood. It can also be defined as a lowered ability of the blood to carry oxygen. When anaemia comes on slowly, the symptoms are often vague and may include feeling tired, weakness, shortness of breath or a poor ability to exercise. Anaemia that comes on quickly often has greater symptoms, which may include confusion, feeling like one is going to pass out, loss of consciousness or increased thirst. Anaemia must be significant before a person becomes noticeably pale. Additional symptoms may occur depending on the underlying cause.

Barium X-ray, Is a radiographic (X-ray) examination of the gastrointestinal (GI) tract. Barium X-rays (also called upper and lower GI series) are used to diagnose abnormalities of the GI tract, such as tumors, ulcers and other inflammatory conditions, polyps, hernias and strictu. These procedure are done less often presently became of other procedures.

Curative care or curative medicine, is the health care given for medical conditions where a cure is considered achievable, often such treatment only is available with some doctors instead of comprehensive care which include Preventive, Curative and Rehabilitative treatments.

Child mortality, also known as under-5 mortality or child death, refers to the death of infants and children under the age of five or between the age of one month to four years depending on the definition. Many deaths in the majority of the world go unreported since many poor families cannot afford to register their babies in the government registry.

Convulsion, Is a medical condition where body muscles contract and relax rapidly and repeatedly, resulting in an uncontrolled shaking of the body. Because a convulsion is often a symptom of an epileptic seizure, the term convulsion is sometimes used as a synonym for seizure. However, not all epileptic seizures lead to convulsions, and not all convulsions are

caused by epileptic seizures. Convulsions are also consistent with an electric shock.

Critical illness Dreaded disease: A disease is known as dreaded disease. It causes deaths as a result of that people fear. Eg: Cholera, Measles etc. Crude birth rate is the number of live births occurring among the population of a given geographical area during a given year per 1,000 mid-year total population of the given geographical area during the same year.

Crude death rate – the total number of deaths per year per 1,000 people. As of 2014 the crude death rate for the whole world is 7.89 per 1,000.

DDT : Dichloro dipheny ltrichloroethane is a colorless, crystalline, tasteless, and almost odorless organochlorine known for its insecticidal properties and environmental impacts. First synthesized in 1874, DDT's insecticidal action was discovered by the Swiss Chemist Paul Hermann Müller in 1939. It was used in the second half of World War II to control malaria and typhus among civilians and troops. After the war, DDT was also used as an agricultural insecticide and its production and use duly increased.

DOTS (Directly Observed Treatment, Short Course). This is in reference treatment of tubercles in India.

Disease vector, Is any agent that carries and transmits an infectious pathogen into another living organism, most agents regarded as vectors are organisms, such as intermediate parasites mosquito or microbes, but it could be an inanimate medium of infection such as dust particles. EQUITY: justice according to natural law or right specifically : freedom from bias or favouritism.

Eclampsia, is the onset of seizures (convulsions) in a woman with pre-eclampsia. Pre-eclampsia is a disorder of pregnancy in which there is high blood pressure and either large amounts of protein in the urine or other organ dysfunction. Onset may be before, during, or after delivery. Most often it is during the second half of pregnancy. The seizures are of the tonic-clonic type and typically last about a minute. Following the seizure

there is typically either a period of confusion or coma. Complications include aspiration pneumonia, cerebral hemorrhage, kidney failure and cardiac arrest. Pre-eclampsia and eclampsia are part of a larger group of conditions known as hypertensive disorders of pregnancy.

Female sterilization, is a permanent procedure in woman prevent pregnancy. It works by blocking the fallopian tubes. When women choose not to have children, sterilization can be a good option. It's a slightly more complex and expensive procedure than male sterilization (vasectomy).

Hookworm, is an intestinal parasite of humans. The larvae and adult worms live in the small intestine can cause intestinal disease. The two main species of hookworm infecting humans are *Ancylostoma duodenale* and *Necator americanus*.

Hormonal and Barrier Contraception : There are about 15 different types of contraceptives which allow you to enjoy sex without the risk of getting pregnant. These birth control methods include: condoms, the diaphragm, the contraceptive pill, implants, IUDs (intrauterine devices), sterilization and the morning after pill.

IUD (intrauterine contraceptive device): A device inserted into the uterus (womb) to prevent conception (pregnancy). The IUD can be a coil, loop, triangle, or T in shape made of plastic or metal. An IUD is inserted into the uterus by a health-care professional, and taken out after few years. IUCD- Intrauterine Contraceptive Device.

IMR (Infant mortality rate), is defined as the deaths of infants of age less than one year per thousand live births. To reduce IMR, the following steps are necessary.

- Promotion of limiting and spacing methods under family planning. Engagement of Accredited Social Health Activists (ASHA's) to generate, demand and facilitate accessing of health care services by the community.
- Village Health and Nutrition days (VHNDs) in rural areas as an outreach activity for provision of maternal and child health services.
- Home based new born care (HBNC) through ASHA to improve new born care practices in the community level and early detection of sickness and referral of sick new born babies.

- Early detection and appropriate management of diarrhoea and Acute Respiratory Diseases.
- Infant and young child feeding.
- Immunization against seven vaccine preventable diseases and supply of vitamin A Prophylaxis.
- Establishing referral systems including emergency referral transport for which the states have been given flexibility to use different models.
- Janani Shishu Suraksha Karyakaram (JSSK) has been launched on 1st June 2011 which entitles all pregnant women, delivering in public health institutions at absolutely free and no expense (delivery) including caesarean section.

Free entitlements have also been put in place for all sick newborns accessing public health institutions for treatment till 30 days after the child birth. The schemes like Janani Suraksha Yojane, Madilu etc and the working of ASHA have helped to promote the institutional delivery. But the status of the district is below the state average in all the three indicators.

Leprosy, also known as Hansen's disease (HD), is a long-term infection by the bacteria *Mycobacterium leprae* or *Mycobacterium lepromatosis*. Initially, infections are without symptoms and typically remain this way for 5 to 20 years. Symptoms that develop include granulomas of the nerves, respiratory tract, skin and eyes. This may result in a lack of ability to feel pain, thus loss of parts of extremities due to repeated injuries or infection due to unnoticed wounds. Weakness and poor eyesight may also be present.

Malaria is a potentially life threatening disease, which is transmitted by the infectious bite of the female *Anopheles* mosquito. In India, malaria has been a major public health problem since ages. The government launched the National Malaria Eradication Program (NMEP) in 1958.

Mortality rate, or death rate, is a measure of the number of deaths (in general, or due to a specific cause) in a particular population, scaled to the size of that population, per unit of time. Mortality rate is typically expressed in units of deaths per 1,000 individuals per year, thus, a mortality rate of 9.5 (out of 1,000) in a population of 1,000 would mean 9.5 deaths per year in that entire population, or 0.95% out of the total. It is distinct from "morbidity", a term used to refer to either the prevalence or incidence of a disease, and also from the incidence rate (the number of newly appearing cases of the disease per unit of time).

MORBIDITY: The condition of being diseased.

MMR (Maternal Mortality Rate) – Is the number of women who die from any cause related to or aggravated by pregnancy management excluding accidental or incidental causes, during the child birth or within 42 days of terminating of pregnancy, irrespective of the duration and site of pregnancy.

Nirodh (condom), Is a sheath-shaped barrier device used during sexual intercourse to reduce the probability of pregnancy or a sexually transmitted infection (STIs).

Public health, is defined as the science of protecting the safety and improving the health of communities through education, policy making and research for disease and injury prevention. The definition of public health is different for every person.

Private Medical Practitioners (PMPs), Or private practitioners constitute an important source of medical care in India, especially in the rural areas. They are the most preferred and considered to be the first contact person for medical care for the local community. Preference for the PMPs is observed even in the treatment of specific diseases like TB, acute respiratory tract infections, these doctors are called as general Practitioners, Registered Medical Practitioners diseased or Family Physician. These are often qualified allopathy but sometimes other system doctors also call them sellers G.I.S or Family Physicians.

Preventive care, includes things such as regular check-ups, screenings and immunizations. It may be covered without extra cost-sharing when you visit a family doctor whom you visit regularly.

Respiratory disease, is a medical term that encompasses conditions affecting the organs and tissues that make gas exchange possible in higher organisms, and includes conditions of the upper respiratory tract, trachea, bronchi, bronchioles, alveoli, pleura and pleural cavity, and the nerves and muscles of breathing. Respiratory diseases range from mild and self-limiting, such as the common cold, to life-threatening entities like bacterial pneumonia, pulmonary embolism, acute asthma and lung cancer.

Out Patient Department: Misconception about mole methods, Screening, in medicine, is a strategy used in a population to identify the possible presence of an as-yet-undiagnosed disease in individuals without signs or symptoms. Eg. Chest screening for chest disease.

X-ray screen, Is less often due because it exposes an individual for X-rays for a longer time.

Sepsis, is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion. There also may be symptoms related to a specific infection, such as a cough with pneumonia, or painful urination with a kidney infection. In the very young, old, and people with a weakened immune system, there may be no symptoms of a specific infection and the body temperature may be low or normal, rather than high. Severe sepsis is sepsis causing poor organ function or insufficient blood flow. Insufficient blood flow may be evident by low blood pressure, high blood lactate, or low urine output. Septic shock is low blood pressure due to sepsis that does not improve after reasonable amounts of intravenous fluids are given.

Tuberculosis (TB), is an infectious disease caused by the bacterium Mycobacterium tuberculosis (MTB). Tuberculosis generally affects the lungs, but can also affect other parts of the body. Most infections do not have symptoms, in which case it is known as latent tuberculosis. About 10% of latent infections progress to active disease which, if left untreated, kills about half of those infected.

Tubal ligation or tubectomy, (Also known as having one's "tubes tied") is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped and blocked or severed and sealed, either of which prevents eggs from reaching the uterus for implantation.

The World Health Organization (WHO), Is a specialised agency of the United Nations that is concerned with international public health. It was established on 7 April 1948, headquartered in Geneva, Switzerland. The WHO is a member of the United Nations Development Group. Its predecessor, the Health Organization, was an agency of the League of Nations.

The constitution of the World Health Organization had been signed by 61 countries on 22 July 1946, with the first meeting of the World Health Assembly finishing on 24 July 1948. It incorporated the Office international d'hygiène publique and the League of Nations Health Organization. Since its creation, it has played a leading role in the eradication of smallpox. Its current priorities include communicable diseases, in particular HIV/AIDS, Ebola, malaria and tuberculosis, the mitigation of the effects of non-communicable diseases, sexual and reproductive health, development, and ageing, nutrition, food security and healthy eating, occupational health, substance abuse and driving the development of reporting, publications and networking.

The WHO is responsible for the World Health Report, a leading international publication on health, the worldwide World Health Survey, and World Health Day (7 April of every year).

UNICEF, was established on 11 December 1946 by the United Nations to meet the emergency needs of children in post-war Europe and China. Its full name was the United Nations International Children's Emergency Fund.

Midday Meal Scheme, Is a school meal programme of the Government of India designed to improve the nutritional status of school-age children nationwide. The programme supplies free lunches on working days for children in primary and upper primary classes in government, government aided, local body, Education Guarantee Scheme, and alternate innovative education centres, Madrasa and Maqtabs supported under Sarva Shiksha Abhiyan, and National Child Labour Project schools run by the ministry of labour. Serving 120,000,000 children in over 1,265,000 schools and Education Guarantee Scheme centres, it is the largest such programme in the world.

Bacillus Calmette–Guérin (BCG), Vaccine is a vaccine primarily used against tuberculosis. In countries where tuberculosis is common, one dose is recommended in healthy babies as close to the time of birth as possible. Babies with HIV/AIDS should not be vaccinated. In areas where tuberculosis is not common, only babies at high risk are typically immunized, while suspected cases of tuberculosis are individually tested

for and treated. Adults who do not have tuberculosis and have not been previously immunized but are frequently exposed to drug-resistant tuberculosis may be immunized as well. The vaccine is also often used as part of the treatment of bladder cancer.

Unani Medicine, (Commonly referred to as Greeco-Arab medicine or UnaniTibb) is a traditional system of medicine practiced in Indian subcontinent. The science and art of diagnosing and treating disease or injury and maintaining health. 1. The branch of this science encompassing treatment by drugs, diet, exercise, and other nonsurgical means. 2. The practice of medicine.

Vasectomy, Is a surgical procedure for male sterilization or permanent contraception. During the procedure, the male vas deferens are severed and then tied or sealed in a manner so as to prevent sperm from entering into the urethra and thereby prevent fertilization.

FAO : Food and agriculture organization

Health and Family welfare Statistic in Bidar District

As per the Bidar district at a glance 2015-16, The taluk level hospitals in the district are 4 and 400 beds are available. It has autonomous and teaching hospitals and 500 beds are available and other hospitals are 8 and 240 beds are available. Total 13 hospitals and 1140 beds are available in the district. In this district 75 government hospitals, 123 doctors, 1533 beds and 842 medical shops are there and only one blood bank and 60 private Nursing home hospitals are there in the district.

There are 71 Allopathy hospitals with 1492 beds are available in the district . Indian system of medicine hospitals are 3, these hospitals having 41 beds. 24 private Nursing homes are there with 60 beds. 58 primary health centers and 352 beds , 8 community health center and 240 beds are available.

In this district 35,306 D.P.T., 34,219 polio, 40,194 BCG, 33,104 measles, 39,640 T.T vaccines and 27,365 Hepatitis 'B' vaccines also given to the children. Under the family planning programme 82 Vasectomy and 8177 Tubectomy incidents registered ,6,000 IUD users, 3,594 OP users facilities are available in the district.

District has conducted the AIDS control programme and identified 258 male and female, total 472 people are identified as AIDS patients. Overall in the district 258 male and 214 female, total 472 patients are cured from AIDS. 179 male and 94 female, total 273 patients are expired from AIDS.

Under the leprosy control programme, 77 male and 69 female, total 146 people are identified as leprosy patients 85 male and 69 female, total 154 patients are cured from leprosy. Under the TB control programme, 1,084 male and 541 female, total 1625 people were identified as TB patients and 308 male and 193 female, total 501 patients are cured from TB. 42 male and 9 female, total 51 patients are expired from TB.

There are 19 numbers of 108 Ambulances are available in this district, and 15,759 patients are benefited patients. 24 hospitals are daily 24/7 days working hospitals and 5,036 delivery cases are occurred in these hospitals. The total female beneficiaries from Janani Suraksha Yojana are 12,932 and 9,653 female are benefited from Madilu kit.

**District Health and Family Welfare Office, Bidar
Maternal death report April-2015 to March-2016**

Sl.No	Months	Total Deliveries		Total deaths	Total live births	APH	PH	Anaemia	FTT	Obstr. lab	Sepsis	Abortion	IUD	Others	MMR	Audited by DC Yes/ No
		Institutional deliveries	Home deliveries													
1	Apr-15	2379	13	1	2391	0	0	0	0	0	1	0	0	0	0.42	Yes
2	May-15	2556	12	2	2566	0	2	0	0	0	0	0	0	0	0.78	Yes
3	Jun-15	2048	14	2	2059	0	1	0	0	0	1	0	0	0	0.97	Yes

4	Jul-15	2390	24	3	2411	0	2	0	1	0	0	0	0	0	1.24	Yes
5	Aug-15	2764	17	0	2781	0	0	0	0	0	0	0	0	0	0.00	Yes
6	Sep-15	3142	30	0	3172	0	0	0	0	0	0	0	0	0	0.00	Yes
7	Oct-15	2784	17	2	2799	0	1	0	0	0	0	0	0	1	0.71	Yes
8	Nov-15	3178	25	4	3199	0	1	0	0	0	0	0	0	3	1.25	Yes
9	Dec-15	2135	21	2	2154	0	0	0	1	0	0	0	0	1	0.93	Yes
10	Jan-16	2479	17	0	2496	0	0	0	0	0	0	0	0	0	0.00	Yes
11	Feb-16	2631	15	2	2644	0	0	1	0	0	0	0	0	1	0.76	Yes
12	Mar-16	2610	9	2	2617	0	0	0	0	0	0	0	0	2	0.76	Yes
Total		31096	214	20	31289	0	7	1	2	0	2	0	0	8	0.64	

**District Health and Family Welfare Office, Bidar
Maternal death report April-2014 to March-2015**

Sl.No.	Months	Total Deliveries		Total death	Total live births	APH	PPH	Anaemia	PFT	Obstrlab	Sepsis	Abortion	IUD	Others	MMR	Audited by DC Yes/No
		Institutional deliveries	Home deliveries													
1	Apr-14	2150	19	0	2169	0	0	0	0	0	0	0	0	0	0.00	Yes
2	May-14	2190	19	4	2205	0	1	0	1	0	1	0	0	1	1.81	Yes
3	Jun-14	2520	22	4	2538	0	0	0	0	0	1	0	1	2	1.58	Yes
4	Jul-14	2450	17	1	2466	0	0	0	0	0	0	0	0	1	0.41	Yes
5	Aug-14	3431	41	2	3470	1	0	0	0	0	0	0	1	0	0.58	Yes
6	Sep-14	2993	45	0	3038	0	0	0	0	0	0	0	0	0	0.00	Yes
7	Oct-14	2470	37	1	2506	0	0	1	0	0	0	0	0	0	0.40	Yes
8	Nov-14	3322	27	2	3347	0	1	1	0	0	0	0	0	0	0.60	Yes
9	Dec-14	2548	23	2	2569	0	1	0	0	0	0	0	0	1	0.78	Yes
10	Jan-15	2387	20	3	2404	0	1	0	1	0	0	0	0	1	1.25	Yes
11	Feb-15	2735	13	0	2748	0	0	0	0	0	0	0	0	0	0.00	Yes
12	Mar-15	2363	15	2	2376	0	2	0	0	0	0	0	0	0	0.84	Yes
Total		31559	298	21	31836	1	6	2	2	0	2	0	2	6	0.66	

**District Health and Family Welfare Office Bidar
Infant Death for the Month of April-2015 to March 2016**

Sl. No.	Month	Total Num-ber of live births	Total num-ber of still births	Infant Death agewise					Sex		Place of Delivery							Cause of Death																						
				0-1 day	2-3 days	4-7 days	8-28 days	29 days-1 year	Male	Female	Hospital	Home	ANM/LHV	Tr Dal	Untrained dai	Hospital	Home	Reg	Unreg	Low Wt. Bth	Pre-mature	Dianhoea	Asphyxia	Pneumonia	Tetanus	TB	Sepsis	Polio	Diphthera	Meselas	Heart disease	Jaudice	Other	Infant death Audit/Y/N	IMR					
1	Apr-15	2360	44	29	17	12	4	6	5	23	21	43	1	0	0	0	35	9	44	0	9	2	1	14	0	0	0	3	0	0	0	0	0	0	0	9	0	6	Y	19
2	May-15	2523	39	45	25	3	1	5	5	20	19	39	0	0	0	0	34	5	39	0	12	2	0	12	1	0	0	3	0	0	0	0	0	0	0	4	1	5	Y	15
3	Jun-15	2025	42	37	16	9	7	6	4	15	27	41	1	0	0	0	33	9	42	0	7	3	0	9	1	0	0	2	0	0	0	0	0	0	0	9	0	10	Y	21
4	Jul-15	2375	40	39	22	6	3	7	2	17	23	29	11	0	0	0	29	11	40	0	11	3	0	11	1	0	0	0	0	0	0	0	0	0	6	0	8	Y	17	
5	Aug-15	2738	35	26	15	6	4	6	4	18	17	34	1	0	0	0	26	9	35	0	10	0	0	11	1	0	0	0	0	0	0	0	0	0	9	0	4	Y	13	
6	Sep-15	3115	36	27	16	6	4	6	4	19	17	35	1	0	0	0	28	8	36	0	6	1	0	13	1	0	0	0	0	0	0	0	0	7	0	8	Y	12		
7	Oct-15	2784	54	24	26	11	7	7	3	29	25	51	3	0	0	0	48	6	54	0	17	1	0	20	0	0	0	0	0	0	0	0	0	6	0	10	Y	19		
8	Nov-15	3154	41	20	14	8	6	6	7	23	18	40	1	0	0	0	30	11	41	0	9	2	0	10	3	0	0	2	0	0	0	0	0	6	0	9	Y	13		
9	Dec-15	2115	26	20	13	5	2	2	4	17	9	23	3	0	0	0	23	3	26	0	9	1	0	8	1	0	0	0	0	0	0	0	0	0	0	7	Y	12		
10	Jan-16	2478	36	18	8	6	4	4	12	20	16	35	1	0	0	0	21	15	36	0	8	2	0	9	1	0	0	2	0	0	0	0	0	3	0	11	Y	15		
11	Feb-16	2861	41	15	11	2	3	8	17	18	23	40	1	0	0	0	24	17	41	0	9	1	0	10	0	0	0	6	0	0	0	0	0	6	1	8	Y	15		
12	Mar-16	2585	30	25	13	4	3	4	6	22	8	27	3	0	0	0	21	9	30	0	10	0	0	12	0	0	0	1	0	0	0	0	0	0	0	7	Y	12		
Total		30903	464	325	196	78	50	67	73	241	223	437	27	0	0	352	112	464	0	117	18	1	139	10	0	0	19	0	0	0	0	65	2	93	Y	15				

District Health And Family Welfare Office Bidar
Talukwise Immunization Progress Report For The Month Of August-2017 As Per Hims
District Health And Family Welfare Office Bidar Talukwise Immunization Progress Report for the
Month August-2017 As Per Hims

SL. No.	Name of the PHC	Measles II Dose			DPT 5 years			HEP(T)ETIS.B. Birth Dose			T.T.10 YEAR			T.T.16 YEARS			IMMUNIZATION Session		
		Target	D/M	Cumulative Total	%	Target	D/M	C. Total	%	Target	D/M	Cumulative Total	%	Target	D/M	Cumulative Total	%	Planned D/M	Held D/M
1	Aurad	5580	349	1913	34	4900	6	0	328	968	17	5484	11	34	1	5345	9	220	191
2	Bidar	9720	580	2673	28	8271	40	3	674	1752	18	9258	90	417	5	9023	95	354	243
3	Bhalki	5400	309	1601	30	4881	154	3	5400	1652	31	5464	154	175	3	5325	143	255	204
4	B.Kalyan	7200	237	1454	20	6076	13	2	7200	2052	29	6801	44	192	3	6629	63	199	185
5	Humnabad	6750	262	1767	26	5850	25	1	6750	1985	29	6548	126	290	4	6382	78	191	150
	Dist. Total	34650	1737	9408	27	29978	238	2	34650	8409	24	33555	425	1108	3	32704	388	1219	973