

Third

# Common Review Mission

State Report

## Bihar



# **COMMON REVIEW MISSION III**

## **Bihar Report**

**4<sup>th</sup> November to 9<sup>th</sup> November 2009**

### **Introduction**

In pursuance to achieve the overall objectives of NRHM, the teams of Common Review Mission (CRM) - III for different states were briefed at the National level on 3rd November 2009, by NRHM and different Programme Divisions highlighting the state specific issues.

The team members of the Common Review Mission (CRM) III to Bihar consisted of Dr. Deoki Nandan, Director, NIHFV; Dr. J.N.Sahay, Adv, NHSRC; Dr. Sunil Nandraj, WHO, Dr. K. Pappu, NIPI, Dr. P.K. Srivastava, Joint Director, NVBDCP and Dr. B.Kishore, Asst. Commissioner, MOHFW.

The team visited the state from 4<sup>th</sup> November to 9<sup>th</sup> November 2009. On 4<sup>th</sup> November 2009, the Team had a meeting at State Health Society, Bihar (SHSB). Detailed presentations were made by Sri Ravi Parmar, the Executive Director, SHSB, Patna regarding the activities undertaken and planned by the SHSB. The meeting was also attended by Sri Sanjay Priyadarshi, AO, SHSB, Dr. Varsha Singh, Consultant (MCH), SHSB, Dr. A. K. Tiwari (I/c IDSP & Infrastructure), Dr. Gopal Krishna (I/c State Immunization Division), Ms. Rashi Jaiswal, SPM, SHSB, and Mr. Ranjit Samaiyar, Consultant, NRHM, SHSB.

The team visited districts Kagariya and Nalanda as per schedule. The members of team formed two groups to cover both the districts simultaneously.

- Team – A comprising of Dr. Deoki Nandan, Director, NIHFV; Dr. J.N.Sahay, Adv, NHSRC & and Dr. B. Kishore, Asst Comm, MOHFW visited Nalanda District. The team was accompanied by Dr. A.K.Tiwary, SHS Bihar.
- Team– B comprising of Dr. Sunil Nandraj, WHO; Dr. K. Pappu, NIPI, Dr. P.K. Srivastava, Joint Director, NVBDCP visited district Khagariya. The team was accompanied by Mr. Ranjit Samaiyar, Consultant, NRHM, SHSB.


The teams visited the Medical College Hospital/s, the District Hospital/s, Sub District Hospital/s, CHCs/Block PHCs, APHCs & Sub Centres and had interaction with village communities in villages in their respective districts. Details of Health Facilities visited are given below:

<b>District</b> <b>Nalanada</b>	<b>District Khagaria</b>
<ul style="list-style-type: none"> <li>• District Sadar Hospital.</li> <li>• Sub District Hospital</li> <li>• Block PHC &amp; Add PHC               <ol style="list-style-type: none"> <li>1. Chandi,</li> <li>2. Noorsarai,</li> <li>3. Rajgir (refrral Hospital),</li> <li>4. Pawapoori,</li> <li>5. Nalanda</li> </ol> </li> <li>• ANM Training School Bihar Sharif – located at District Hospital</li> <li>• Health Sub Centre               <ol style="list-style-type: none"> <li>1)Ghosarama,</li> <li>2) Dashrathpur,</li> <li>3) Lahuar,</li> <li>4) Nalanda,</li> <li>5) Naroonna</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Sadar Hospital</li> <li>• Referral Hospital ;Gogri PHC cum Referral Hospital               <ol style="list-style-type: none"> <li>1. Block PHC &amp; Add PHC</li> <li>2. Mansi PHC</li> <li>3. Beldaur PHC</li> <li>4. APHC- Mahesh Khunt</li> <li>5. APHC – Pirnagara.</li> </ol> </li> <li>• Community visit:               <ol style="list-style-type: none"> <li>1. Village Pirnagara</li> <li>2. Village Sisba</li> </ol> </li> </ul>

The Interaction meetings were held with the following officials of each district during the field visit:

- District Magistrate
- Civil Surgeon
- Acting Deputy Supdt
- Staff of Health Facilities
- District EPI, Leprosy, RCH, TB and Malaria officers.
- Medical Officer I/C (CHC, PHC)
- Specialists and medical officers
- Paramedical and field staff
- ANMs
- ASHAs
- AWW
- Community (mothers of newborn)
- ANM Training School Principal Tutor and faculty

## Preamble to the overall report

- The up gradation of Block PHCs to 24x7 facilities has continued and offers increasing number of Mothers and Children access to services. Case Load of general OPD also continues to increase. General medicines and antibiotics are adequately stocked in all the facilities. Doctors & paramedical staff are generally available in the facilities. ASHAs are the one of the most visible face of the health delivery system both at the facility and in the community. Newborn care is largely missing both in the facilities and the community.
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- Two things stand out remarkably. Women coming to deliver in the facilities or coming for sterilization operations deserve respect which did not seem very evident. Secondly, the way the very impressive quantities of medicine are dumped in the stores at almost all facilities gives a feeling of no one owning or being in charge of the facility.
  - However, the larger challenges of the systemic deficiencies prevent the delivery of the planned services. The RCH Program Implementation Plan requires at least 1 consultant for each of the program components. Currently, the entire RCH program amounting to Rs. 416 crores is monitored by only 1 consultant. Additionally, the state does not have a Directorate with the usual complement of Director (RCH) supported by Additional and Joint Directors. This means the whole RCH programme is functional through the State Health Society with totally inadequate Technical Staff. Besides, in the absence of a State Health Systems Resource Centre and ASHA resource centre the SHS is bereft of an agency for HR development and skills to do concurrent evaluation of the interventions.
  - Similarly for various disease control Programme, the better coordination between the Officials of Directorate and SHS will improve the performance especially for Kala Azar which has been targeted for elimination by the year 2010 and requires all functionaries of Health delivery and monitoring system to be involved fully.
  - Bihar has an overall approved funding of 1254.70 crores for 2009-10 under the Programme Implementation Plan (PIP). This gives an average of 100 crores to be

spent on an average per month. However, till end of October 2009 the expenditure is to the tune of Rs. 250 crores averaging about 35 crores per month.

- The stores for Generic Drugs have been built but are yet to be made functional. Toilet and Water facilities are mostly poor and neglected.
- Disposal of Biomedical wastes has to be accorded priority as neither paramedical Staff nor cleaners are aware about its disposal.
- Both the overall inadequate staff strength at the state level Supervisory/technical cadre and the slow pace of expenditure have adverse effects at the district and block levels which was evident during the field visits.



## 1. Infrastructure Upgradation

The initiatives taken by State Health Society, Bihar during previous year, was appreciated by the last Common Review Mission. The portable structure for establishing generic medical stores at block PHCs was visible during this visit. It was learnt that the State Health Society has issued instructions for providing supply of drinking water by putting overhead tanks in all the health facilities. The generators provided in each PHC are functional. The pace of construction work for the PHCs and APHCs have slowed down as in some places the Contractors have run away. However, in the sites visited, general cleanliness and infrastructure is poor and needs strict monitoring by Block Health Manager and PHC Medical Officer In-charge. Residential facility not available except one referral hospital. Only some rooms or varandah are used for sitting. For ANM, it is without security which was expressed by them as Boundary wall in many facilities (including the District Hospital) is not proper.



## 2. Human Resources Planning

The human resource in health sub-centres, PHCs and district hospitals has increased substantially by pooling or deputing doctors and ANMs from additional PHCs to higher level. This has also been strengthened by the contractual

appointment of large number of doctors, nurses, ANMs and nurse Aids (Mamta). However, in many sub centres single ANMS are managing, and in around 30 to 40% 2<sup>nd</sup> ANM is in place. The coverage by ANMs is around 10,000 populations.

The PMU is staffed by DMP, Accountant, data manager and 2 DE operators but to facilitate and play a more active role for all health programmes, their capacity needs to be improved.

### **3. Assessment of the case load being handled by the Public System**

Efforts have led in increasing the number of patient care facilities and in utilization of Public Health Services provided. The increased utilization of services is reflected in increased number of persons provided every type of service that is available – be it outpatient care, be it in patient care, be it institutional delivery services or be it emergency services, or surgical services, laboratory services etc. The main reasons for this are in the improved human resources deployed, drugs availability and JSY incentives. Every PHC visited has, doctors regular and contractual. And the doctors are largely present at least during duty hours with at least one or two being available in the nights – along with one or two ANMs or nurses. APHCs are created and being made functional with initiating the OPD and making the medicines available

### **4. Preparedness of facilities for patient care services**

The PHCs at the Block are mostly 6 bedded facilities and can only handle normal deliveries. However, the ambulance services have been seen to be better organized to respond to inter institutional transfer. The generators are functional. Infrastructure development is visible in different stages of construction/progress, however till the new constructed sites are functional, the distance between ward and labour rooms need to be minimized as in some case the patient has to cross the road to go to ward.

ICTC centre functional at District Hospital and Sub District Hospital. The basic utilities (toilet and running water) in the observed facilities were very poor and are not conducive for the women to stay for long after delivery. Even the condition of wards especially in Khagaria was not hygienic.

The only operational blood bank in District Khagaria used to be at the district hospital. This was discontinued since a new unit was to be operated by Red Cross. This has left no FRU in the public health system in the entire district with the blood bank facility.

### **5. Outreach activities of Sub-centre**

Sub-centres are functioning with ANM but their involvement in utilization of untied grant need to be enhanced for grassroot planning and management. RI is done in catchment area. Drugs are available in adequate quantity.

Mobile Medical services have been planned and are likely to be started through a private agency/NGO selected through a state level process. This will cater to about 1.5 lakh vulnerable and difficult to reach population. The service is yet to start.

## 6. Utilisation of untied fund

Utilization of untied grant need to be enhanced as a lot of balance is available at every facility visited. This needs to be monitored not only by submission of SOE but by timely utilization of funds for the activities and available balance. This system is not seen as at state and district level, the release was the major concern. In Gogri PHC, funds released in September have not been deposited in Bank which was brought out by the CRM members and labled as serious lapse.

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These funds, at least at the level of the HSC level, seem to have been tied! In the blocks visited the authority has taken the decision to buy some furniture and fixtures for all the SHC with the ANMs untied fund for ease of accounting, procuring and based on what was perceived by the MOIC to be needed in the SHC. ANM was clear how she would want to spend the untied funds money for improving the quality of her services.

## 7. Thrust on difficult areas and vulnerable social groups

Pop of about 1.5 lakhs has been identified as mahadalit under vulnerable groups but no specific activity is started yet

## 8. Quality of services provided

The patient handling by doctors is good but pre and post management need improvement viz., crowd management, wards, lab our rooms. Even the food is not available in many places and where ever it is available its quality is poor which may be due to the rate fixed of Rs.25/- (for breakfast, lunch, tea and dinner) is less.

General cleanliness is poor. The services provided under RCH are given separately.



## 9. Diagnostics

Basic laboratory facilities are available in referral and district hospitals but needs management. Capacity of Lab. Technicians is poor as test done with rk39 for Kala Azar is shown in the register as aldehyde test. The diagnostic services, even though outsourced, are likely to close down because of non payment.

## **10. Logistics & Supply chain management**

The monitoring of procurement, storage, supply, consumption and replenishment needs to be geared up as the whole process is poorly managed. Even at district hospital the coordination between Dy. Suptd., CMO and the store keeper did not seem proper. The accountability should be clear and problems in receipt & stock taking should be resolved on priority.

## **11. Decentralized Planning**

The district plans are made and District Collector is monitoring it but the awareness among district level health officials seems to be poor which need to be strengthened.

## **12. Decentralised Local health action**

Though at the PHCs and grass-root, the services and programme implementation is being done as per instructions of district officials, a formal planning at grass root will give the ownership to the community.

## **13. Community Processes under NRHM**

Village health and sanitation committees have been formed but not started up, however, it was learnt that the bank accounts are being opened and it is likely to start functioning immediately after the funds are transferred.

**The Rogi Kalyan Samiti** has been formed up to the PHCs level in a majority of the places. They meet irregularly and did not have specific activities outlined for themselves. There is a feeling that it is a redundant body even before it is up and running. A case in point is a cheque for the society drawn on September 28<sup>th</sup> has not been deposited till the 5<sup>th</sup> November, the day of the CRM member's visit! Overall, it is not surprising that only 61.66 lakhs have been spent out of the total of 853 lakhs allotted for the RKS or less than 10%!

### **Village Health and Sanitation Committee:**

Currently, the VHSC is **Co-opted** by "Lok Swasthya, Pariwar Kalyan Avm Gramin Swakchta Samiti" of PRI where the ANM is the Secretary of committee and Selected member of Panchayat is the President and this is at the Revenue Village level. As of

now the funds are being released to RV level with 'Nigrani Committees' is being established at the village level. Guidelines relating to this have been sent in July.

Strategically, the cooption has the potential of involving PRIs in the improvement of health facilities but I it is being at the RV it is distant from the village and does not make the villagers feel part of the ownership process which this VHSC is supposed to do. There were members that were met in the villages when told about the community ownership through village level committees who showed a lot of enthusiasm for more information and action.

The NGOs did not appear to have been able to create space for themselves or have not been given any specific role except for centrally selected NGOs for taking on the responsibility of Mobile Medical Van. So, Community Monitoring has not been found to have been done anywhere.

#### **14. ASHA**

ASHAs have been very articulate; their grasp of the basic child care has been satisfactory. Ironically, training for most of them has not proceeded beyond the first module still. The continuous engagement with the facilities where they bring the women for delivery and the sector meetings seem to have given them a working knowledge of maternal and child health care. This has to be now reinforced immediately through the training on the rest of the 4 modules. VHND days are not operationalized anywhere in the district visited.

The critical support structures needed for ASHAs to be effective are not available. The institutional structure starting from ASHA Resource Centre at the State Level and district and block coordinators and ASHA facilitators are not in place. The kit and its refillment, the second support is also not evident at the district and sub district level. The critical support the payment of incentive on time was not seen anywhere. There is a big backlog and understandably a lot of frustration amongst the ASHAs met. A nodal person, the Block Accounts Officer, could be identified as the person to interface with ASHA for all payments and preferably through cheque. ASHA can maintain a diary for recording her activities for which incentive is due to her countersigned by ANM which the nodal person at the block can take in to account to make payments.

## 15. National Disease Control Programmes

### 15.5 Overall Effectiveness of NDCPs

All national disease control programs are being implemented by the state. Kala Azar Elimination remains high priority for Bihar which has been targeted for elimination by the year 2010 and requires all functionaries of Health delivery and monitoring system to be involved fully.

### 15.6 NVBDCP

Among vector borne diseases, malaria, filaria and kala-azar are the major disease prevalent in the state, however, kala-azar Bihar contributes to more than 80% of kala-azar burden in the country and 31 out of 38 districts of Bihar report kala-azar. Being a disease affecting the poorest of the poor, improved kala-azar cure reflects effective reach of public health services to the poor. The slow progress made by Bihar remains the major issue for National KA elimination goal set for 2010 by GOI. Kala-azar control, has two aspects:

- **Effective case management** by promptly diagnosing all suspected cases using rapid diagnostic kits (RDK) and provide complete treatment so that these cases get cured and remain non-infective to others; and
- **Vector control** by identifying high risk villages reporting KA cases and undertake two rounds of high quality in-door residual spray (IRS) with DDT during the months of March/April and June/July every year. Active case search in these villages is also important to identify new cases as well as those who still remain infective after treatment.

In view of the elimination target, GOI is providing 100% financial support for this programme including the spray wages and other inputs such as RDKs, anti KA drugs and other consumables. The following observations during the field visits:

1. The anti KA drugs are available adequately. In the facilities visited, compensation for lost wage is being paid and records of payment are seen. At district hospital, diet services are also being provided to the patient and one attendant during the hospitalization.
2. The inconsistency in treatment protocols was observed as the drug was changed from SAG to miltefosine due to poor monitoring of supply chain management and replenishment of stock.
3. Capacity of Lab. Technicians is poor as test done with rk39 for Kala Azar is shown in the register as aldehyde test.
4. In the districts visited, only one round of spray operation was undertaken and the quality was poor due to lack of adequate supervision. The spray wages was not paid; therefore the second round of IRS could not be undertaken.

## 15.7 RNTCP

The lab Technicians of RNTCP at PHC were maintaining the records properly and during the visit it was seen that they have received instructions to provide the services for other programmes which is yet to start.

## 16. RCH (Maternal Health, Child Health and Family Planning Activities)

The up gradation of Block PHCs to 24x7 facilities is going on to offer number of services to Mother and Children of the areas. The increase in Case Load at general OPD, availability of Doctors & paramedical staff and adequate drugs have been noticed. ASHAs are playing their role sincerely and have been recognized by the community as well as the institutions. The Newborn care is found to be neglected both in the facilities and the community. The other observations not very encouraging were the women coming to facilities for delivery or coming for sterilization operations deserve respect and non availability of Emergency contraceptives in spite of huge stock of drugs dumped in the stores without proper inventory. NSV is also not being done at the health centres. Even safe abortions methods including MVAs/EVAs/DNCs were not available.

### I. Institutional Deliveries:

The Institutional deliveries have seen a steady rise over the years and the district hospitals cater to about a quarter of these deliveries. The PHCs have their share of increased deliveries. However, except for the district hospitals most of the maternity beds were found to be unoccupied, indicating a short retention period. This short retention period which is on an average is about 4 to 6 hours does not lend itself to any meaningful post natal care in the crucial first 48 hours. An example of the poor understanding for the need for institutional delivery is the fact that the District hospital visited does not administer BCG and 0 dose polio after delivery to the newborn because they want it to be done at the PHC from where the women had come- missing out on a golden opportunity.

There was a big backlog of incentive payments to be made both to the ASHAs and the Mothers may affect the institutional deliveries. As of now there is no grievance redressal cell in any of the facilities.

There is a tremendous scope of initiating post partum counseling services because of the increased number of deliveries and also the same being attended to by Mamtas.

The nursing staff is under stress responding to the tremendous increase in the institutional deliveries but they feel the need for some drastic measures to improve the basic infrastructure, hygiene and privacy in the labour rooms to aid the mother in having a safe delivery and in a dignified way.

Increasing number of women are using the health services even if it is to get the monetary benefit from the JSY scheme, nevertheless this provides a great opportunity to re-establish the positive image of the public health system and the sensitivity to the

needs of the women and a respectful attitude to them. This will go in some way to ameliorate the discomfort they may have with the current stressed health delivery system.

Safe abortion including MVAs/EVAs/DNCs- training has been initiated with the help of a technical agency. However, the skills will be soon lost since it was observed at the facilities that they are not practicing these skills which they have learnt during the training.

To cope with the increasing institutional deliveries and especially the referrals including caesarians and assisted deliveries, accreditation of Private Health Facilities as an alternative, has not been explored, which is to be done on an immediate basis

## **II. Child Health:**

Muskan has been successful in enabling the ANM, AWW and ASHA to come together for improving the coverage of immunization. The measure for payment has been recently changed to number of children getting immunization shots and accordingly the incentive for 5 to 10, 11 to 15, 16 to 20 and 21 and above getting differential incentive starting from Rs 50. This new system of incentive payment is seems to have better chances of success and has to be reviewed in a years' time.

No evidence of essential newborn care was visible in the facilities. Also by discussing with the ASHAs and ANMs, the team could not get any clear indication that systematic home visit are being conducted for the first 28 days.

It was observed by the teams that Birth asphyxia management was absent in all the facilities below district level.

The Mamtas were enthusiastic but were not getting training at all places. Teams felt that this is a group which can help in facilitating retention of mothers beyond the usual 4 to 6 hours at the facility level provided the hospitals provide basic facilities like functional toilets, running water and electricity. The potential of the group is limited as of now because of lack of supervisory support.

The district facility visited in Khagaria had a Nutrition Rehabilitation Centre which was closed in 2007 and is not functional since.

## **III. Family planning**

Minilap remains the focus of family planning with NSV making a beginning in some facilities. The post operative care observed in two camps in the PHCs, require more attention to patient comfort (all women lying on the floor) and hygiene. Minilap services continue to be available through a camp approach in the Block PHCs. In two camps, it was observed that women with two and three children made up more than 60% of the cases. NSV as a FP limiting method for males has just been initiated in some block PHCs (the first one percent!). Unmet need continues to be likely because of the lack of any consistent strategy to increase the coverage for spacing.

The Institutional deliveries continue to rise from a base of 45000 in 2005 to 11 lakhs in 2009. This means postpartum family planning counseling and services (Post Placental IUCD) has a tremendous potential to be accepted. Mamtas and ASHAs will be good counselors to reach out to the mothers at the facility and the community level. Emergency contraceptive as an option for unwanted pregnancy has not been initiated in the district/ sub district level.

## **17. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health**

This is an important issue however, in the districts visited, the attention on inter-sectoral as well as intra-sectoral convergence need to be focused. The nutrition rehabilitation programmes are going on in some districts which should be expanded in some more districts.

## **18. Overall Programme management**

Program management units have been established at State Health Society, district and block level with the full time contractual appointment of a program manager and an accountant. Rogi Kalyan Samities have also been constituted and registered in most of the institutions; however, village health and sanitation committees have been constituted, but yet to be made functional. The coordination between State Health Society and Directorate of Health needs to be enhanced for consolidation of the recently achieved gains. The capacity of the Directorate of Health Service should be strengthened for planning, implementation, supervision, monitoring and evaluation of the health services. The capacity for program planning is limited at district level and needs to be strengthened. The capacity of DPM and BPM unit staff also needs to be improved for supportive supervision. Ancillary services such as ambulance, cleaning, laundry, meals etc. have been contracted out but their performance needs to be monitored. Large number of old equipment is occupying lot of space at PHC and district hospital.



## **19. Financial management**

The larger challenges of the systemic deficiencies prevent the delivery of the planned services. The RCH program of the Program Implementation Plan requires at least 1 consultant for each of the program component. Currently, the entire RCH program amounting to Rs. 416 crores is monitored by only 1 consultant. Additionally, the state does not have a Directorate with the usual complement of Director (RCH) supported by Additional and Joint Directors. This means the whole RCH programme is functional through the State Health Society with totally inadequate Technical Staff. Besides, in the absence of a State Health Systems Resource Centre and ASHA resource centre, the SHS is bereft of an agency for HR development and skills to do concurrent evaluation of the interventions.

Bihar has an overall approved funding of 1254.70 crores for 2009-10 under the Programme Implementation Plan (PIP). This gives an average of 100 crores to be spent on an average per month. However, till end of October 2009, the expenditure is Rs. 250 crores, which averages only about 35 crores per month. Both the overall inadequate staff strength at the state level Supervisory/technical cadre and the slow pace of expenditure has adverse effect at the district and block levels which was evident during the field visits.

## **20. Data Management**

Data of various programmes are being maintained by the District Data Manager except for the disease control programmes for which the concerned programme officers have to be consulted. There is a need for orientation of data managers along with district programme officers for convergence.