



REPORT OF THE SIXTH COMMON REVIEW MISSION – BIHAR



02nd Nov – 09th Nov 2012

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CHAPTER 1

After launch of National Rural Health Mission (NRHM) on 12th April 2005, annual Common Review Mission (CRM) to selected states is one of the important monitoring and hand holding mechanisms under the NRHM. Sixth CRM visited the State of Bihar between 2nd November to 9th November 2012. The state has been included in all past CRMs except the third CRM. State level briefing was conducted at State Health Society Bihar (SHSB) on 03rd November 2012, when Shri Sanjay Kumar IAS, Executive Director SHSB & Secretary Health, Govt of Bihar provided an overview of the Mission in the state with major gains and constraints faced by the state. After useful interaction with State Programme Officers and functionaries of State Programme Management Unit (SPMU), the CRM team got divided into two groups – one group to Banka district and the second group to Gopalganj district. The SHSB deputed two senior officials from state to accompany the each team for the facilitatory support.

Team Leader – Dr Ajay Khara, Deputy Commissioner (Child Health), MoHFW, GOI

Banka District		Gopalganj District	
Name	Organisation	Name	Organisation
1. Dr J N Srivasrava	NHSRC	1. Dr Renu Shaharawat	NIHFW
2. Ms. Sabina Bindra Barnes	DFID	2. Shri Ajit Kumar Dungdung	MoHFW
3. Shri Sanjeev Gupta	FMG, MoHFW	3. Dr Sai Subhasree Raghavan	SAATHII
4. Dr Manoj Patki	PHFI	4. Dr Neha Kashyap	MoHFW
5. Shri Rajeev Agarwal	MoHFW	5. Shri Anisur Rehman	MoHFW
6. Dr S A Pasha	Dept of AYUSH	6. Shri Dushyant Meher	Planning Commission
7. Dr G P Verma (State Rep.)	SHSB	7. Shri Ranjeet Samaiyar (State Rep.)	SHSB

The teams travelled to respective districts on 04th Nov 2012, and after interacting with District Magistrates, Civil Surgeons, Members of District Programme Management Units and other functionaries of district administration, the teams visited Health facilities, Anganwadi Centres, outreach locations. The team members interacted with ASHAs, AWW, beneficiaries, Mukhiya (PRI) and Block Managers as well. It was endeavour of each team to maintain cordiality and informality, without losing sight of overall objective of the Mission. On 09th November 2012, a presentation of key findings and recommendations was presented to the Principal Secretary Department of Health & Family Welfare, the Executive Director SHSB, members of the State Health Society and other stakeholders.

CHAPTER 2

DISTRICTS AND FACILITIES VISITED

6 th Common Review Mission			
District Gopalganj			
District Headquarters		DHS Gopalganj	
District Magistrate		Shri Pankaj Kumar	
Civil Suregon/ Chief Medical Officer		Dr. Shankar Jha	
Health facilities Visited			
SN	Name Address/Location	Level(SC/PHC/CHC/ Other)	Name of the person in charge
1	Sadar Hospital Gopalganj	District Hospital	Dr. Vimal Kumar
2	Sub district Hospital Hathua	Sub District Hopital	Dr. Sudhir Kumar
3	Referral Hospital Bhore	FRU	Dr. Shahid Nazmi
4	Referral Hospital Phulawaria	FRU	Dr. Premchand Prabhat
5	PHC Manjha	PHC	Dr. Shakti Kumar Singh
6	PHC Uchkagaon	PHC	Dr. Ram Lakhan Prasad
7	PHC Thave	PHC	Dr. T.N. Singh
8	APHC, Miraganj	PHC	Dr. F. Ansari
9	HSC, Miraganj	SC	Malti kumari
10	HSC, Hussepur	SC	Nilam srivastava
11	HSC, Basadila	SC	Laxmi kumari
12	HSC, Dahibhata	SC	Binda Prabha
13	HSC, Paithanpatti	SC	Smt. Sharda Kumar Gupta
14	HSC, Batarde	SC	Sunita Tiwari
15	AWC, Basadila	AWC	
16	Dhanwantri Rath	Mobile Medical Unit	
17	102 Ambulance	EMRI	

District Banka			
District Headquarters			
Name of District Magistrate		Shri Dipak Aanand, IAS	
Name of Civil Surgeon		Dr N. K. Vidyarathi	
Health facilities Visited			
SN	Name and Location	Facility	Name of the person in charge
1	Sadar hospital , Banka	District Hospital	Dr. Sunil KumarJha
2	Referral Hospital, Amarpur	FRU	Dr Abhay Prakash Chaudhary
3	Referral Hospital, Katoriya	FRU	Dr. Yogendra Prasad Mandal
4	Referral Hospital, Baunsi	FRU	Dr. Bhagwan Das
5	PHC Chanan	PHC	Dr. Ranjan Kumar Ghose
6	PHC Dhouraiya	PHC	Dr. Binay Kumar
7	PHC Barahat	PHC	Dr. Pradeep Kumar Jha
8	APHC Ahiro	PHC	Ms. Pushp Lata Kumari & Dr Jamaluddin (AYUSH)
9	HSC, Sultanpur	SC	Mrs. Sunita Kumari & Mrs Kanchan Kumari
10	HSC, Bhairuganj	SC	Smt Pushpa Kumari Smt Rekha Kumari
11	HSC, Mirzapur	SC	Smt. Parmila Devi
12	HSC, Shyam Bazaar	SC	Smt. Niva Kumari
13	HSC, Kadhar	SC	Smt. Alis Murmu
14	HSC, Jaipur	SC	Smt Varonica Murmu
15	Villages Inavaran, Letwa and Kunta	VHND	Smt. Alis Murmu
16	AWC Kunata	AWC	Smt Bindu Bala

CHAPTER 3

INTRODUCTION



State Profile

Bihar is located in the eastern part of the country (between 83°30' to 88°00' longitudes). It is an entirely land-locked state, lies mid-way between the humid West Bengal in the east and the sub humid Uttar Pradesh in the west. Its geographical location provides the state with a transitional position in respect of climate, economy and culture. It is bounded by Nepal in the north and by Jharkhand in the south. The Bihar plain is divided into two unequal halves by the river Ganga which flows through the middle from west to east.

The state of Bihar has an area of 94,163 sq. km. and a population of 10.38 million. Population density of state is 1102 per sq. km. which is higher than national average 382. The state has the third highest population in the country and the growth rate is 25% which exceeds the national average of about 17%. Sex ratio of 916 per 1000 males and literacy level of 63.82%. There are 9 divisions, 38 districts, 101 sub divisions, 534 blocks and 45,098 villages in the State.

Demographic Profile

Indicator	Bihar	India
1. Total population (Census 2011) (In Crore)	10.38	121.01
2. Decadal Growth (Census 2011) (%)	25.07	17.64
3. Sex Ratio (Census 2011) (per 1000 males)	916	940
4. Child Sex Ratio (Census 2011)	933	914

5. Schedule Caste population (In Crore)	1.3	16.6
6. Schedule Tribe population (In Crore)	0.076	8.43
7. Total Literacy Rate (Census 2011) (%)	63.82	74.04
8. Male Literacy Rate (Census 2011) (%)	73.39	82.14
9. Female Literacy Rate (Census 2011) (%)	53.33	65.46

In state of Bihar Gopalganj and Banka districts have been chosen for the review. Out of two visited districts by the CRM teams, Gopalganj district adjoins Kushinagar district in Uttar Pradesh and National Highway (NH – 28) traverses through the district, while Banka district borders the state of Jharkhand.

Gopalganj is situated between 20° 12" and 26° 39" ; North latitudes and 83° 54" to 84° 55"; East longitudes, in the northern part of the state while Banka is situated south east state of the state. Sex ratio of Gopalganj is 892/1000 while for Banka, the sex ratio is 978/1000 (Source AHS 2011). The overall literacy level of the state is 64% while literacy rate of Gopalganj is higher than state at 67%.

Indicator	Gopalganj	Banka	Bihar
1. Total population (Census 2011)	25,58,037	20,29,339	10,38,04,367
2. Growth rate (NHSRC- HMIS analysis 2011-12)	18.83	26.14	25.07
3. Population density (NHSRC- HMIS analysis 2011-12)	1258/square km	672/square km	1,102/square km
4. Sex Ratio per 1000 males (NHSRC- HMIS analysis 2011-12)	892	978	919
5. Literacy Rate (census 2011)	67.04	60.12	63.82

Health Indicators

The state is showing encouraging trend in Infant Mortality rate (IMR), which used to be 61 deaths per 1000 live births in 2005 at time of launch of the NRHM. Now as per latest SRS data, IMR of the state has been reported to be 44 deaths / one thousand live births and is at par with the country's IMR. But regrettably, under-5 mortality rate in the state remains at 64, which does not compare well with the country's under-5 mortality. It is a pointer that after child's first birthday, considerable efforts are required for improving their health status of under-5 children. Performance of the State in terms of other health indicators like MMR, TFR and CBR has a long way to go in order to catch up with the rest of the country.

Indicators	Bihar	India
1. Infant Mortality Rate (SRS Bulletin 2012)	44	44
2. Maternal Mortality Rate (Per 100000 live births) (NRHM State wise Progress as 30.06.2012)	261	212
3. Total Fertility Rate (AHS 2010-11)	3.7	2.5
4. Neonatal Mortality Rate (NRHM State wise Progress as 30.06.2012)	31	33
5. Birth Rate (SRS Bulletin 2012)	27.7	21.8
6. Death Rate (SRS Bulletin 2012)	6.7	7.1

Neonatal mortality rate of Banka district is 30 against 35 of the state. MMR of the both districts are toward higher side than state that is 306 of Gopal ganj and 321 of Banka against 261 of the state. Percentage of institutional delivery and children fully immunized between ages 12-23 months are much higher in both districts against state indicators.

Indicator	Gopalganj	Banka	Bihar
1. Infant Mortality Rate (AHS 2010-11)	51	48	44 (SRS 2012)
2. Neonatal Mortality Rate (AHS 2010-11)	38	30	31(NRHM State wise Progress as 30.06.2012)
3. Under Five Mortality rate (AHS 2010-11)	66	63	64(NRHM State wise Progress as 30.06.2012)
4. MMR (Per 100000 Live births) (NHSRC HMIS Analysis 2011-12)	306	321	261(NRHM State wise Progress as 30.06.2012)
5. Mother who received 3 or more ANC checkups (AHS 2011)	39.6	36.1	34
6. Institutional Deliver (AHS 2011)	53.6	59.5	47.7
7. Children aged 12-23 months and fully immunized (AHS 2011)	74.8	67.9	64.5

Public Health Infrastructure

There are 6 Medical Colleges, 36 district hospitals, 70 CHC, 1863 PHC and 9696 Sub centre in state. Out of 9696 subcentres, only 4848 are running in Govt building and rest are running in rented building out of which 2616 are under construction.

CHAPTER 4

KEY FINDINGS

I. PROGRAMME MANAGEMENT

State of Bihar has been one of first few states to form a state health society (SHSB) immediately after the launch of NRHM. Executive Director SHSB is also State's Mission Director. Though the society structure in the state is functioning well, the State has not been able to operationalise the State Health Systems Resource Centre (SHSRC). In the past, the functioning of SHSRC was out-sourced to a consulting organisation, which was not successful.

There are many development partners (DPs), who are working within the state to provide technical assistance to the SHSB. There could be overlaps among DPs with regards to domains and expertise, which could perhaps be harnessed better by putting a coordination structure in the state.

Staff against sanctioned posts at SPMU and DPMU have been recruited except for absence of DPMs in four districts and District Community Mobilisers in sixteen districts (22/38). However availability of hospital managers and accountant at FRUs is a cause of concern with availability of approx. 41% of staff. The state may like to launch a recruitment drive for filling the vacant posts.

It was informed that a large number of contractual appointments could not be made because of non-availability of appropriately qualified candidates within the reserved category as per state's statute. It was also informed that in spite of having a policy of 'walk-in' interviews for doctors and specialists, the state has not been able to recruit candidates, who would be willing to serve at PHCs, FRUs and District Hospitals. Even those, who join at these institutions, their attrition rates are high.

However, the CRM team also met few exceptionally devoted professionals, who had decided to serve in remote locations, in a challenging environment. For instance, Dr Prem Raj Bahadur, MBBS, MD (JIPMER), DGO is one such professional at PHC Dhauriya. He chose to take-up the contractual appointment at the PHC to serve his natives because he belongs to that region. He is performing LSCS and first trimester MTP.

Though it was found that programme management structure is adequately manned at different levels, the health delivery system, below the level of PHC, is not functioning optimally.

State does not have in-house capacity for technical support for various programs. Technical support is being provided by development partners and management consultancies on project bases, which is not sustainable. State should build up its capacity in term of state resource centre.

- The State has developed TOR for the District programme Management Unit that clearly states the roles and responsibilities, reporting relationships and place of posting of various DPMU staff and Regional Program management unit staff. The staff reported clarity on the job roles and responsibilities.
- The District PIP is almost single handedly prepared by the District Planning coordinator. The Civil surgeon and the CMO are not involved much in the preparation

of the PIPs. The Planning process is not preceded by an elaborate gap analysis due to the paucity of time and lack of capacity at the district to carry need based planning.

- The Monitoring at district level is conducted by the regional programme managers and the Regional Accounts Managers, 5 in all. They are required to make 4- 5 monitoring visits per month. The monitoring plans are made in advance and the tour plans are duly approved at the state level in the beginning of the month. They maintain reports for the monitoring visits conducted and submit them to the State.

Issues:

- Lack of commitment and ownership of programme officers at district level
- Strengthening of the monitoring system, supportive supervision and follow-up visits by regular staff and as well as of DPMU.

Recommendations –

1. SHSB may seek approval of appropriate authority in the state for filling of reserved vacancies with suitably qualified general candidates, if repeated sincere efforts have not resulted into successful selection of candidates for the reserved posts.
2. Supportive supervision / hands-on support to facilities and maintenance of advisory notes (for improvement) at the facilities for follow-up action . Need for a dedicated 2-3 teams of MOs/ Ayush MO and proactive ANM at block level who can visit once a week as per the roster to APHCs/SCs, observe and hand-hold ANMs in provision of quality ANC services(BP, Hb, Wt measurement), immunization services along-with proper filling-up of MCH registers, MCP cards.
3. The State and District Program Units should go with a dedicated checklist(GOI integrated RCH checklist can be adopted) for comprehensively monitoring RCH services at health facilities. This should be backed by a tour report with clear timelines for the district to fill the gaps within the set time period.
4. Differential compensation package with performance based incentives for contractual staff in 'difficult terrain'.
4. Rationalisation of work-schedule for ANM (May decrease frequency of the ANM meeting from weekly to fortnightly schedule).

II. INFRASTRUCTURE DEVELOPMENT

The State has made considerable progress in improving its health infrastructure. Till recently the state has been dependent upon the building department for the planning and execution of the work, which has not always resulted into the most beneficial utilisation of resources. Now, the state has constituted Bihar Medical Services and Infrastructure Corporation Limited (BMSICL) for addressing specific needs of Healthcare infrastructure. It is expected to result into substantial improvement in execution of the work, as well as 'better value for the money'.

State has a different hierarchy of public health institutions vis-a-vis with other states. In Bihar Additional PHC corresponds to PHC elsewhere for an average of 20-30 thousand population. The PHC in Bihar located for 1 lakh population and has six indoor beds and it strives to provide BEmONC services. There is urgent need of increasing indoor capacity of these PHCs as well to meet the increased load, after launch of the NRHM. Mothers are not staying for 48 hours after delivery because of non availability of beds. There are 399 Community Health Centres (CHCs), sanctioned in the state. CHC, also known as Referral Hospital, is a 30-bedded facilities and the state is committed to upgrade all Referral Hospitals to FRU for providing at least level 3 RCH services.

Construction of Generic Medicine Shops within the premises of the health facility is one of the appreciable initiatives, taken up by the State Government where 209 Generic Medicine Shops are already constructed and construction of 19 shops are under progress.

The team witnessed proper directional signage's for the health facilities, even in remote and tribal blocks, which is a good initiative of the state for facilitating access to facilities by general public.

The state has a total of 16,576 Subcentres sanctioned, out of which 4848 sub centres are functional in the Govt Building (Source: RHS 2011). In order to meet the shortfall, construction of 3362 sub centres are in progress.

1. Development -

Type of facility	Sanctioned	Under Construction	Constructed
1. PHCs	533	135	94
2. CHCs	399	399	-
3. Subcentres	16576	3362	962
4. DHs	36	12	8

Progress Report of Health Facilities					
S.No	Name of Works	No. of works Taken up	Works Completed	Works in Progress	Not Started
1	Construction 12 Sadar Hospital in new districts.	12	8	4	-
2	Construction of Newly created 21 Sub-Div. Hospital (75 Bedded)	21	14	7	-
3	Up gradation of 15 Reff. Hospital to Sub-Div. Hospitals	15	11	2	-
4	Renovation of 22 Sub-Div. Hospitals	22	19	-	3
5	Renovation of 25 Sadar Hospitals	25	23	1	1
6	(A) Construction of 12 Civil Surgeon office	12	7	4	1
	(B) Construction of 15 Civil Surgeon Residence cum office	15	8	5	2
7	Up gradation of 201 PHC (6 bed) to CHC (30 Bed)	201	0	0	201
8	Construction of Generic Medicine Shop	249	209	19	21

Geographic location of Health Facilities – Conventionally, geographic location of health facilities has been planned in term of population, served by each type of facility. While planning for new facilities, due consideration should also be given to terrain and travel time to reach the facility. For example, a sub centre should be located in such an area, so as to ensure that each household would be able to reach the sub centre, at least within 30 minutes of walking time. In Banka district, 4.8% of the population is tribal with major concentration in three blocks, which are hard to reach as well. Hence, it is suggested that instead of going by population norms, state should plan for further facilities in difficult areas, in term of travel time to avail the care.

Residential Accommodation - The residential accommodation for essential staff is either not available within the premises or there has considerable deterioration of the buildings. For

instance, at RH Amarpur (Banka District), there are five quarters available for the staff, however, none of the doctors are staying within the campus.

Availability of appropriate and liveable residential accommodation within the facility or nearby would contribute immensely providing the services on 24x7 basis besides motivating the staff in staying in difficult and hard to reach locations.



Figure 1: Dilapidated Condition of Residences at RH Amarpur (05th Nov 2012)

District Hospitals & SDH –

- a. Inadequate secondary care beds specially in District Hospitals. None of the district hospital has beds to meet the norm of 200 secondary care beds per 10 lakh population. Some of the district hospitals even have less than 100 beds, which does not meet IPHS criteria of being called as 'District Hospital'.
- b. Utilization pattern in secondary care hospitals is invariably Sub –Optimal. The Bed Occupancy Rates in the Public health Facilities has been found in the range of 30 to 70 percent. The Facility incharges may be advised to look into the distribution of beds among different departments, so as to optimise utilisation of beds, more so for immediate post natal care.

- c. As mentioned earlier, laboratory services are delivered through PPP model which is not functioning properly. At most of the places below district hospital level, outsourced agency has set up only collection centres. This leads to prolonged turn-around time and reporting time. The services were contracted out to provide those diagnostic test, which are not conducted at the facilities' lab. However, now PPP labs are conducting same tests, which are done by the in-house lab. This has led to under utilization and even dysfunction of in-house labs, leaving the govt. lab technicians without their professional work and is being sub-optimally.
- d. Though SNCUs have been sanctioned for all District Hospitals, only 4-5 SNCUs are functional. Equipments have been procured, but have not been put to use.
- e. The State does not have capacity for the hospital planning. Though state has developed considerable infrastructure in terms of new facilities and expansion of existing facilities, structure are not planned scientifically leading to inefficient and poor quality services.
- f. Emergency services are not well organised. They are not prepared for mass casualty and disaster. In many of the district hospital even there is no dedicated infrastructure for Accident and Emergency Services.
- g. System for medical records maintenance is non-existent in the state. There are no standardized formats for clinical records. Medical records departments are yet to be established in secondary care hospitals. There is no cadre for medical records technicians in the state.
- h. Intensive care services (ICUs) are mandated at each district hospital. Though building and equipments are available at many district hospitals, they have still not been operationalized. The main constrains are human resource and skills.
- i. Safe abortion services are not available at most of the facilities. Though according to IPHS, MVA can be done at PHC level. There are hardly any MTP procedure done at PHC, CHC and SDH level. Even at district hospital level, number of procedures are minimal.
- j. Quality of ANC services leaves much to be desired. Separate ANC clinics are not available at most of the facilities. They are shared with general female OPD. Mandatory service package for ANC as per national guidelines cannot be availed due to poor diagnostic services and already over burdened female OPD. As no ANC record maintained separately continuity of care cannot be ensured.

Organisation of Health Facilities - There is also a need to develop doctor's chambers, duty room for hospital staff & night duty personnel, patients amenities, etc within the health facilities. For instance, it was observed at Dhauriya PHC that two doctors simultaneously share a common room to conduct their OPD clinics, which compromises privacy and confidentiality. Medical Officer Incharge was advised to do the needful for creation of partition. Following are common observations at many locations –

1. **Amenities for conduct of OPD clinic** – Examination table, steps for climbing, side screen or curtains, hand-washing facilities, x-ray view box, weighting scale in OPD
2. **Amenities for patients** – sitting chairs in adequate number, fan, availability of safe potable drinking water, and clean toilets.
3. **Access to Emergency Services** – Availability of ramp, wheel chairs, stretcher trolleys, etc
4. **Organisation of Emergency Department (life saving drugs and functional equipments)** – availability of Emergency Drug Tray / crash cart, functional suction machine, nebulizer, Oxygen cylinder (For instance, at Emergency Dept of Banka Sadar Hospital, Oxygen cylinder was not functional.), periodical training of hospital staff in emergency procedures). Separate and ear marked area for triage is required for Triage in case of mass casualties.
5. **Amenities for ASHAs** – Very often ASHAs stay at health facility till conduct of labour, duration of which may vary. It may not be always possible for ASHAs to travel back to their residences in night either due to non-availability of Public Transport system or personal safety issue. Hence, it would be important that a designated place for ASHAs/ ANMs are created within health facilities.
6. **Diagnostic Services** - The state has outsourced diagnostic services under PPP, as per following details -

Status of functional Radiology & Pathology Centres in the state under PPP mode(PHCs to DHs)	
Ultrasound	40
X-Ray	303
Pathological Lab	34
Pathological Sample Collection Centre	252

However, instead of strengthening of Public Health System, outsourcing has resulted into closure of hospital laboratory and X-ray facilities at almost every facility. Thus, the regular staff (laboratory technician, x-ray technician/ radiographer) has become redundant. Following are few of the other problems, which are cause of concern and the state may look into –

- a) Personnel managing x-ray machines and laboratory services are not qualified as per prescribed norms. As a result accuracy and reliability of test results is doubtful.
- b) Personal safety is not being adhered to. E. g. Usage of TLD badges and lead aprons.
- c) X-ray machines are non-compliant to AERB norms.
- d) Site approval for Radiology Departments are not available
- e) Kidney function tests and liver function tests are paid services at the visited facilities for all categories of beneficiaries.
- f) Long turn around time.

Blood Bank –

(For year 2012 – 13)

Total no of Camps in the state	Total no of voluntary Donation	Total no. of Replacement	Total units Collected
288	7705	3971	10054

Till the year 1991, Banka has been a subdivision of erstwhile Bhagalpur district, where a State Govt Medical College is located. At Sadar Hospital Banka, there is Blood storage Unit and the Mother Blood Bank is located at the Medical College Bhagalpur. However, in the year 2011, a total of 31 units of blood was provided by the Medical College Blood Bank and in the current year (01st Jan 2012 to 31st October 2012) only 08 units of the blood has been supplied to Sadar Hospital's Blood unit. Thus complete requirement of the blood is not being met at the Designated FRU (Level 3 Services). On further enquiry, it was revealed that the Medical College Blood Bank is asking for donors or blood donation cards for meeting the requirement. The state may kindly look into the issue urgently.

8. Availability of Essential Drugs –

The state has an Essential Drug List (EDL) with a system of its periodic review and updation.

Essential Drug list		
Health Facilities	No of OPD Drugs	No of IPD Drugs
Six Medical College Hospitals	65	120
DHs to APHC	33	112

At the time of visit to the health facilities, most of the medicines were found available in the OPD and labour rooms. However differential EDL based on the type of facilities and services offered have not been prepared

9. Biomedical Waste Management –

Common treatment facilities have been set up in Patna, Muzaffarpur, Bhagalpur and the 4th CTF is under construction in Gaya. At the time of visit, handling of Bio Medical Waste was as per the guidelines. Liners and bins were available at the point of generation of bio medical waste.

10. Equipment Maintenance Plan – The state needs to undertake requisite actions to ensure –

- All newly purchased equipment are covered under the extended comprehensive 'on-site' warranty (with provision of spare parts by the supplier)
- Old equipments are under comprehensive AMC.
- 'Write-off' action is started for BER (Beyond Economic Repair) equipments to clear junk from hospital premises.

11. Implementation of JSSK –

- a. Free food to JSSK beneficiaries is available only at the Sadar Hospital. At other level 2 and level 3 facilities (in District Banka), there is no provision of food to beneficiaries.
- b. It was also noticed that free drop-back facilities are not available to approx. 60% of the beneficiaries.
- c. During interaction with beneficiaries, it was observed that no out of pocket expenditure on drugs was borne by them.
- d. Laboratory and Ultrasound services are provided free of cost to all pregnant women.
- e. Each Block is supported by 1 basic ambulance which is not sufficient to cater to a population of 2 lakh. Significant no. of pregnant women are not able to avail free RT services both Home to facility and Drop Back because of either non-availability of ambulance or the response time of less than 30 minutes is not adhered to. Hence most beneficiary in the interior blocks of Banka District incurred out of pocket expenses for reaching the hospital.

APHC & Subcentres -

The state has made good progress in improving Infrastructure at District Hospitals, SDH and Referral Hospitals. However, APHCs and Subcentres continue to have many deficiencies such as dilapidated building, absence of light source, non-availability of water, quarter for ANM, rusted examination table or its non-availability, non-functional toilets.



Figure 2: Examination Table at Bhainrojanj (Block – Chandan)

Recommendations –

1. **Hospital Planning Cell –** Formation of Bihar Medical Services and Infrastructure Corporation is a step in right direction. However, in order to ensure its effectivity, the cell should have its own hospital planning cell and manned by hospital planner, architect and

civil engineer. The ToR of the proposed cell include undertaking gap analysis, schematic diagram of proposed civil work and renovations and preparation of architectural brief.

2. **Accommodation Facility**-Each facility, providing 24x7 RCH delivery services should have overnight accommodation for ASHAs and ANMs.
3. **Reorganisation of Health Facilities** – Layout of Health Facilities may be re-organised by minor civil work/ re-appropriation to improve access, privacy and space utilisation.
4. **Condemnation of un-used articles/ BER¹ items** – A large number of visited facilities are faced with space constraints and regrettably, junk & condemned article occupy considerable patient care space. The state may support Civil Surgeons and Facility Incharges in this task by issuing appropriate guidelines/ directives.
5. **Actions for Repair of BLR items** – It was observed that at many facilities, there are unserviceable equipment, which could not be repaired locally and put to use because of non-availability of expertise for its repair in the local market. It is proposed that the all district hospitals and SDH may please be advised to prepare a list of such repairable items and a state level intervention should be in order to repair such equipments
6. **Strengthening of Emergency Services** – Emergency services at most of facilities have been found to have deficiencies. The state may plan for revamping of Emergency Services including preparedness of the facilities for disaster services. In the first phase, all district hospitals and SDH may be taken-up by BMSICL. The key issues to be looked into would be (a) Access of Emergency Department – Signage, Motorable Roads, Ramp, Stretchers, Trolleys, etc (b) Infrastructure – organisation of Patient Care and availability of life saving equipments such as suction machine, ECG machine, supporting lab services, crash cart, availability of blood, access to new born care unit (c) Training of available staff in life saving procedures and emergency care.
7. **Diagnostic Facilities**
 - a. The Hospital’s own diagnostic services may please be made functional. Only those investigations may be outsourced, which the state is unable to manage from its resources.
 - b. Quality control norms should form part of the outsourced services
 - c. Compliance to AERB norms should form part of the contract, more so in areas of qualification, radiation safety.
 - d. A system of periodical calibration of laboratory’s measuring equipment may be introduced.
8. **Ambulance Services** – The facilities should be backed by appropriate Emergency Response and Patient Transport System. Observation of CRM has been dwelled into in Chapter 4 (Section V).

102 Ambulance Service Average cost of transportation to Beneficiaries			
Months	Total invoice raised	Beneficiary Load	Average Cost per beneficiary
May-12	30149588	21269	1418
Jun-12	48349312	49437	978
Jul-12	55078569	68826	800
Aug-12	56410444	76673	736
Sep-12	57013874	76920	741
Oct-12	Invoice not	79132	-

¹ BER – Beyond Economic Repair

	raised		
Total	847001787	372257	

Emergency Referral Transport 108

- 50 Ambulances
- 38 Districts
- Patient Load from April'12 – September'12

Months	Patient Load
April'12	2631
May'12	2838
June'12	2908
July'12	2475
August'12	2987
September'12	2892
Total	13839

102 (old) and 1911 Call Centre

Patient Load – April'12 – July'12						
S.No	Name of Division	No. of Calls	Enquiry	Conference Service with Doctor	Doctor Service at Home	Patho Service at Home
1	Patna	1438	59	1979	0	0
2	Gaya	1215	0	1215	0	0
3	Bhagalpur	1050	57	993	0	0
4	Saran	149	33	116	0	0
5	Muzaffarpur	1095	82	1013	0	0
6	Purnia	685	38	647	0	0
		5632	269	5363	0	0

III. HUMAN RESOURCES IN HEALTH - Numbers, Skills, Performances

I. Present Status

After launch of the NRHM, the state has taken actions for creating and filling of the vacancies for effective and meaningful implementation of NRHM interventions.

The State has tried to overcome the shortage of staff of different categories like Medical Officers, Nurse "A" Grade, ANM, Lab Technicians, OT Assistants etc at district, sub division hospitals and PHCs which is evident from the following initiatives that have been taken up:

- Reorganizing of Existing Manpower to provide 24 X 7 hour services at the PHCs
- Recruitment of Doctors, ANM, Nurse 'A' Grade, and Support Staff at various Health Facilities is being done on massive scale through recruitment drive in order to meet the shortage of staff.
- 1757 Doctors recruited against 2497 posts.
- 233 Private Specialists have been inducted in specialties like Eye, ENT, Orthopedics, Pediatrics, Obs & Gynae and Surgery, they are provided Rs. 500/day as honorarium to meet the shortage of specialists at all levels of health facilities.
- 1092 ANMs recruited against 1,358 vacant sanctioned posts
- 5979 ANM (R) recruited against vacancies of 11964 posts till November, 2008 under NRHM.
- 477 Block Health Managers selected against a vacancy of 533. Selection of remaining vacancies will also be filled up very soon.
- Recruitment of 317 Block level Accountants against vacancies of 505 has been completed
- Appointment of 1544 Ayush Doctors for APHC is in process
- 3810 new nurse grade 'A' post have been created in 1905 APHC (2 in each APHC) under NRHM. Out of 3810 posts 2374 have been recruited so far.

HR status for various position as on 17.10.2012

SL	Name of the post	Sanctioned	Position	Shortfall
1	Accountant (FRU)	149	60	89
2	ANM(Contractual)	11264	8146	3118
3	ANM(Regular)	11794	9419	2375
4	ASHA	86489	83211	3278
5	Ayush doctors	1704	1318	386
6	BAM	517	480	37
7	BCM(ASHA)	509	368	141
8	BHM	521	468	53
9	DAM	38	38	0

10	Data Entry Operator(IDSP)-I	38	26	12
11	Data Entry Operator(IDSP)-II	2	22	(+20)
12	Data Entry Operator(Kala-azar)	31	22	9
13	DCM (ASHA)	1	22	(+21)
14	DDA (ASHA)	38	38	0
15	Dist Child & Health Manager	38	9	29
16	District Plg.. Coordinator	38	30	8
17	Doctors (Contractual)	2435	1584	851
18	Doctors (regular)	5145	2461	2684
19	DPM	38	34	4
20	Epidemiologist	38	21	17
21	Financial and Logistic Assistant	31	12	19
22	FP Counsellors	153	97	56
23	Grade 'A' Nurse(Contractual)	3393	1541	1852
24	Grade 'A' Nurse(Regular)	3318	406	2912
25	Hospital Manager	143	65	78
26	KTS Supervisors	183	157	26
27	LHV (Regular)	1168	431	737
28	M&E Officer	38	34	4
29	MAMTA	4541	4287	254
30	MPW	1963	743	1220
31	VBD Consultant	31	29	2

SL	Name of the District	Nos of SC, conducting deliveries	Total SC with two ANMS
1	Araria	0	199
2	Arwal	1	64
3	Aurangabad	0	216
4	Banka	1	265
5	Begusarai	0	287
6	Bhagalpur	1	258
7	Bhojpur	2	302
8	Buxar	2	147

9	Champanan- E	2	327
10	Champanan –W	1	368
11	Darbhanga	3	259
12	Gaya	0	440
13	Gopalganj	2	195
14	Jamui	1	279
15	Jehanabad	0	92
16	Kaimur	0	183
17	Katihar	5	330
18	Khagaria	0	171
19	Kishanganj	1	136
20	Lakhisarai	2	102
21	Madhepura	1	272
22	Madhubani	2	434
23	Munger	1	151
24	Muzaffarpur	2	480
25	Nalanda	2	374
26	Nawada	1	325
27	Patna	1	387
28	Purnia	2	334
29	Rohtas	2	186
30	Saharsa	2	152
31	Samastipur	0	362
32	Saran	0	413
33	Sheikhpura	3	85
34	Sheohar	2	29
35	Sitamarahi	3	212
36	Siwan	1	367
37	Supaul	7	178
38	Vaishali	3	335
	Total	59	9696

Measures taken by the State to attract and retain skilled professionals and also assess work performance

- GOB has already initiated regularization of the contractual health posts of doctors, nurses and ANMs against sanctioned posts.
- A policy of stable tenure is followed in the Government and contracts are signed for three years.
- There is a plan to bring legislation to protect health professionals and medical institutions in the event of violence.
- HR policy has been approved by governing body of SHSB for the contractual manpower working under SHSB and HSC. HR Section Part A is the responsible section.
- Dynamic ACP for Medical Education and Bihar State Health Service.
- The monitoring of performance of employees are done through review meetings by state and the District Monitoring Teams. Nodal Officers have been identified in each district for the purpose. Additionally Development Partners under NRHM have been given 2-3 focus districts for monitoring and facilitation CSR is filled annually by the concerned authorizes for the regular posts.
- Performances of contractual employees are being done through Performance appraisal against benchmarks. Renewal of the contract is based on the performance.

Innovations in workforce management

- Every Monday Walk-in-interviews are being conducted across the State and the vacancies are advertised on the official SHSB website.
- Online doctors, ANM, Grade A nurse appointment management system.
- Online applications are submitted-facilitates transparency in recruitment
- Online monthly recruitment of doctors, Nurses etc in the district.
- About 200 retired and Medical teachers from other states selected for appointment on contract
- Doctors have been sent to MPH programmes in IIPH and to various workshops across the country from time to time.
- Medical Protection and Clinical Establishment Act passed by the state.
- Draft "Bihar Medicare Service Institutions and Persons (Prevention of violence and damage to property) Bill is at the final stage and is likely to be tabled during the forthcoming budget session of the state legislature.

Action taken on 5th CRM recommendations

5th CRM Recommendations	SHSB Compliance Status
Consider monetary and non monetary incentives for postings in difficult areas	Direction has been given to the district authorities to make provision of financial incentives in the 2012-13 District Action Plan
Enforce the policy of additional points for post graduate studies, for those who serve in difficult areas	Under consideration.
Need for active recruitment of trained cadres such as ANMTC from local schools	Under consideration.
Rationalizing work load- Lab. Tech, BHE	Under consideration
Expand the base of training organizations by involving Medical Colleges, NGOs etc	Their support is being taken by involving them in training programmes
Set up skill labs in DH and BPHCs	Already under process
Create a team of mobile trainers for on-site supervision and mentoring	Under consideration
Promotion of skilled and better performing staff	Under consideration
Use of innovative pedagogical methods – that are able to more rapidly scale up training, such as interactive AV aids	Under consideration
Intra-block transfers for contractual staff (after a set period of time) as an incentive	Under consideration
Find ways to retain managerial as well clinical cadres	Salary hike as well as other facilities are being provided for retaining the managerial as well as clinical staff
Team based performance incentives	Noted
Performance incentives linked to workload	Under consideration
Timeliness in payment of salaries to be ensured	Full effort is being made for timely payment of salaries to contractual staff
Consider the use of external HR agencies to	Hiring of external HR agency for fast

facilities and fast track recruitment	track recruitment is under process. One HR agency is already in the system
Building a culture of supportive supervision, appreciative enquiry and team building across the state	Efforts are being made for the same

III. Issues

However, the SHSB is faced with many challenges in recruiting quality HR and retaining them. Few of important reasons for the prevailing HR problem are given below -

1. Non-availability of qualified candidates to fill-in reserved contractual posts -

The state has a large number of reserved contractual posts lying vacant because of non-availability qualified candidates and also their unwillingness to join the NRHM posts. The matter needs to be examined by higher decision making authority to find out a solution within the rules. The state may also examine possibility of making short-term contractual appointments to such posts and simultaneously continues with its search of candidates from the reserved category.

2. Issue of Parity with regular cadre staff – During course of interaction with the NRHM staff, issue of parity of contractual staff vis-à-vis regular cadre staff noticed, which may a cause of discontentment and at time friction. Considerable efforts are required for team building and creating homogeneity with some kind of collective responsibility in not only DPMU/SPMU, but the district and state as a whole.

3. Effective Deployment of Available H R –

a. Historically programme management structure was created to supplement their efforts of programme implementation. This also included besides making contractual appointment, new modalities of managing the services were introduced. For instance, in the State of Bihar, Diagnostic services were outsourced to ensure availability of those investigation facilities, which the health system was not able to provide and also to reduce out of pocket (OOP) expenditure. However, over the period of time, the out-sourced laboratories and x-ray departments are also providing those services, which were being provided by the hospital's own laboratories. At present, regular cadre laboratory technicians are without the work.

b. The team observed at Additional PHC Ahiro that there were two ANMs, One Grade I nurse and one Ayush Doctor. However, other than conduct of routine OPD by ANM and issue of Homeopathic prescription by Ayush doctor, no value added services and investigations were being provided. Hence it is proposed that either range of services is increased at the APHC or the staff is deployed at other high case load health facilities where they are needed.

4. **Incentivisation of contractual staff** – In the programme implementation, contractual staff are the ‘key-drivers’. Hence, it would be essential in the interest of programme that high performers in the programme are recognised and suitable monetary and non-monetary incentives may given to them.
5. Setting measurable targets (KPI) at time of annual appraisal, providing enabling support and measurement of performance against KPI
6. Revision of Honorarium / contractual salary for fresh recruits, based on market conditions
7. Hard area incentives for all cadre in term of
 - a) Availability of liveable residences, even for contractual staff
 - b) Monetary benefits – The state could be divided into four zones – Major cities, Not so developed towns, rural and hard areas. Compensation package for each category should be different.
 - c) Benefits of earned leave, gratuity and Medical Insurance could be extended to contractual staff, on completion of 2 – 3 years of service.

8. It was observed at 9696 sub centres two ANMs are in position. However, delivery services are being provided only at 59 sub centres (0.61%). The State could launch multiple strategies for promoting institutional deliveries – Developing those subcentres, which have good infrastructure, ANM staying in sub centre quarter, responsive transport services.

9. This strategy of initiating delivery services at SCs and APHCs will help to bring down the delivery load at the higher referral centre. The State needs to look into this very seriously and can train AYUSH MOs and ANMs in SBA Training, provide necessary resources at identified SCs for making them functional as Delivery Points.

10. Human resource generation (2005-2012)

There has been no change in number of State Medical Colleges or in the number of seat at existing medical colleges. Three new medical colleges are in pipeline, besides operationalisation of AIIMS Patna.

The State has operationalised one College of Nursing in Govt Sector. But number of GNM and ANM training centres is static. In Private Sector, GNM, ANM and Post basic Institutes have been added after 2005. However, quality of the education at these institutions is a cause of concern.

Type of Nursing Institute	2005				2012			
	Government		Private		Government		Private	
	No of Institute	Seats	No of Institute	Seats	No of Institute	Seats	No of Institute	Seats
1. BSC Nursing					1	40	1	40
2. GNM	6	376	-	-	6	370	6	290
3. Post Basic	-	-	-	-	-	-	1	40

IV. Key Recommendations

- 3 New Medical Colleges needs to be operationalized at the earliest possible.
- Rational Deployment of manpower based on the work load

- Operationalization of GNM schools needs to be fast tracked.
To overcome the shortage of LHVs, possibilities of training the senior ANMs to promote them to LHVs may be considered.
 - Multiple health workers at grass root level with overlapping of their job work, with overlapping of job responsibilities. Work/responsibilities of every worker need to be finalized and notified at the earliest.
 - Capacity building needed at every level, followed by institutionalized system for planning, implementation and reporting of supportive supervision from bottom-up i.e. block, district and State
 - To overcome the shortage of Epidemiologists, feasibilities of collaborating with NICD, PHFI etc for training may be considered.
 - Strengthen the HR Cell for Planning, Performance Review and policy reforms
-

IV. OUTREACH SERVICES & REFERRAL TRANSPORT

The Emergency Referral Transport services was introduced in the State in the month of May, 2012. The programme component is at the nascent stage and requires time for proper review. However, it was attempted to understand how it is implemented and identify the gaps which can be addressed as earlier as possible. It is estimated that 1 EMRI is currently catering to around 1,67,000 population (in reference to 2011 provisional Census data) .

There are two types of ambulances in the State according to their reach and operation.

- a) 108 (toll free) – which is stationed at the District Headquarters can travel in the State. There are 50 such ambulances.
- b) 102 (deployed at health facilities) – 504 Ambulances in number. The number of BPL patients out of the total beneficiaries who availed services is low. These are all GPS enabled. The 102 ambulances are well equipped as seen in Gopalganj district. The vehicles are used primarily for referral of pregnant women followed by sick newborns as per the state data. However, these are not supposed to provide inter-district services. They are stationed at the Block PHC level.

Out of 554 Ambulances in the State, the number of Ambulances with Advanced Life Support is 5 and Ambulances with Basic Life Support are 549 in number.

Observations:

- The 102 are well equipped and have emergency drugs and are GPS fitted. They have a centralized call center at Patna that directs the ambulances nearest to the site to reach the beneficiary. Each of the PHCs visited had an ambulance. The records for the ambulance and its usage were being maintained.
- The general perception on the concept of Emergency Referral Transport was generally good amongst the people who are aware of the service. However, the awareness level about the service and how to access was missing amongst general public.
- Expectant women are transported to health facility for delivery and sometimes two or more patients were being dropped back together to home after the deliveries. The average number of visits/trips that an ambulance makes was found to be 4- 5 in most of the PHCs.
- The beneficiary response for the utilization of referral transport was however, poor. Women in the ward were questioned the means they used to reach the hospital or PHC and private vehicle was the main and prime mode of transport. Some of the reasons they cited were response time of the ambulance, denial particularly during night hours and also awareness about the availability of referral transport was poor amongst beneficiaries.
- The State has carried out the study to ascertain the cost per patient of the RT vehicle and have been able to bring down the cost from Rs. 1418 to Rs. 741 per patient in a period of 4 months.

Mobile Medical Unit, Dhanwantri Rath:

No MMU in Banka District. The Gopalganj district had 1 MMU. It was being implemented through PPP mode and the agency was recently blacklisted rendering the MMUs non

functional. Apart from this, an MMU dedicated to providing services to the Mahadalit Tolas was operational in the district. The following were the services provided and observations made during the visit to Dhanwantri rath.

- It's being operated on PPP mode.
- Facilities provided are - X-ray, Lab services- (HB, Unrine, Suger, SGOT, Blood urea, etc.), culture and lipid profile was not being done.
- Advance route was available duly approved by RPMU.
- Follow up visit at the same site after three months.
- Medicine was dispensed for three days. There after they were asked to take medicine from nearest PHC.
- Total available HR- 9 (Doctors, SN, Pharmacist, Lab Tech, X-Ray tech, Coordinator etc.)
- IEC through audio-visual tool but not audible to people outside.
- As per available records- they cater 80-90 patients per day.
- Regarding the services ASHAs and AWW informed the community.
- Services were mostly availed by women and children including pregnant women. Maximum beneficiaries were females of the age of 50-80 years, who has come to consult their old age related ailments.

Issues and Recomendations:

Issues	Recommendations
<ul style="list-style-type: none"> • Low utilization of EMRI. 	<ul style="list-style-type: none"> • There is a need to improve the response time and awareness about the referral transport.
<ul style="list-style-type: none"> • Low Awareness of EMRI services 	<ul style="list-style-type: none"> • Need to do extensive IEC for increasing the awareness of the availability of referral transport services amongst the beneficiaries as well ASHAs.
<ul style="list-style-type: none"> • State share of 60%, 40 % and 20 %, unavailability for state funds sometimes is a problem. 	
<ul style="list-style-type: none"> • Reported unavailability of the vehicles in the night and refusal of services to places in far flung areas 	<ul style="list-style-type: none"> • Monitoring from the centralized call center required to see that ambulances do not refuse calls
<ul style="list-style-type: none"> • The number of ambulances is around 1 / 1, 67 , 000 of population 	<ul style="list-style-type: none"> • There is a need to procure more EMRI vehicles and the state should ensure including the same in PIP for the year 2013- 14.
<ul style="list-style-type: none"> • The response time of the EMRIs is sometime as high as 1.5 hour post call. 	<ul style="list-style-type: none"> • State needs to look into measures to improve the availability and efficiency of the EMRIs. There could be special provision of EMRIs to cater to the

	load in hard to reach areas.
<ul style="list-style-type: none"> The MMUs in the districts are non functional. 	<ul style="list-style-type: none"> There is a need to resume services of the MMUs in the district as it is essential for provision of services in the hard to reach areas.

Village Health, Sanitation and Nutrition Days:

Key Observations

Gopalganj : VHSND at Subcenter Paithanpatti was providing the Family planning Counselling , ANC Check ups alongwith routine immunization services. The subcenter had three rooms and privacy during the ANC check ups was ensured. There was no provision for electricity , water in the subcenter. Tally sheets for the beneficiaries were being maintained and the MCP cards were being given to the beneficiaries. The ANM was resourceful and was SBA trained. MCTS registrations register was being maintained but the ANM hadn't received any MCTS generated workplan till now. Drugs were being dispensed but the subcenter had only 5 of the Essential drugs out of the Kit A and Kit B drugs. Since the MCTS workplan is not available at the subcenter, the ANM has to depend on the AWW records to understand the beneficiaries for vaccination due in a particular month. the workload of the ANM was high as the attendance for the VHSND was nearly 25-35 patients. The Hb and urine examination was not being done as the ANM does not have a Hb meter or urine exam dipsticks in both the districts.

At Banka : VHSNDs are essentially providing immunization services only. Full range of services like ANC examination, counselling not being provided during VHNDs

No evidence to show that missed out cases of ANC, Immunization services being brought at VHND days.

No monitoring tool developed at district and Block level to monitor the VHND services.

V. COMMUNITY PROCESSES & MONITORING- Community Process Including ASHA, PRI, VHNSC, CRM and NGO

A. ASHA

Current Status

Enrolment and Retention: The state has successfully enrolled 97% of the required ASHA (84,140 /87,315) and maintains a rigorous database, which is updated quarterly at block level. The annual attrition rate is low at 3-4% and reasons for attrition include transition of villages into urban areas and selection of ASHA as PRI and as part of Shiksha Mitra. ASHAs were vibrant, empowered and were happy in their role and working with their respective health facility staff.

Current tasks performed: The ASHA delivers following services in the state and these include:

- Registration of pregnant women at the health facility
- Motivating women to visit health facility for pre, perinatal and post natal visits.
- Ensuring that women receive TT injections, immunization and iron and folic acid tablets
- Helping women to obtain transport for reaching the health facility for institutional delivery.
- Accompanying women to the hospital for institutional delivery, overnight hospital stay as required and accompanying them back home after delivery.
- Home based visits during antenatal and post natal period for providing education on health, nutrition and family planning; ensuring adherence to prescribed medications; motivating women to visit health facility for required visits; distributing contraceptives and iron and folic acid tablets and ensuring women receive TT injection and other immunizations.
- Social marketing of contraceptives
- Motivating family members to visit health facilities for required immunization of the children
- Ensuring adherence to TB medications
- Participation in the ASHA Divas and VHNSC meetings

However not all services are provided and also not delivered as care continuum in coordination with ANM and AWW to all mother-infant pairs.

- For e.g. only 50% of the women interviewed at the PHC and less than 30% at the district hospital, used state provided free transport, to reach the health facility for delivery.
- Even though home visits are made by ASHA, coordinated visits along with ANM are not taking place, which are critical for, preparing the mother for delivery, monitoring her for potential complications and adequate weight gain, ensuring adherence to iron and folic acid tablets among others.

- Only in some cases ASHA stays overnight at the health facility even in absence of ASHA GHAR. Majority of the time women are discharged within 6-12 hours of duration not requiring her overnight stay. Lack of ASHA GHAR facilities is another critical reason for not staying overnight with the mothers.
- There is also lack of coordination and ownership among ASHA, ANM and AWW in tracking of mother-infant pairs for timely uptake of all the services and monitoring of pregnancy and birth outcomes and growth and development of the child. ASHA also likely to focus on individual visits where she likely to receive incentives.
- Poor health seeking behaviour, illiteracy and pre, peri and post natal visits occurring in separate blocks or districts due to cultural practices are some of the reasons for lack of adherence mother-infant pairs to hospital visits and prescribed vaccines, prophylaxis and treatments.
- Documentation by ASHA is limited to those activities associated with obtaining incentives.
- ASHAs are not familiar with and engaged in tracking, documentation, review and reporting of infant and maternal deaths.
- ASHAs are not actively involved in line listing, tracking and follow-up of severely anemic, sick and malnourished infants and children in coordination with ANM and AWW.
- Linkage between Mamta and ASHA for ensuring continuous counselling on optimal infant feeding both at the facility and in the community is lacking

Training: The state is lagging behind in training of ASHA specifically in certain districts (Table 1). Even though 78% were trained on module 1, only 61% were trained on module 2-4 and 48% on module 5-7. Training is contracted to four NGOs including Janani, PHRN, PFI and Caritas India, who are responsible for monitored the quality of training. All trainings are monitored through written tests and skill and practice sessions.

Table 1: District Wise Training Status of ASHA

District	Target	Module Wise Progress (Percentage Trained)			
		Module 1	Module 2-4	Module 5-7 (Phase I)	Module 5-7 (Phase II)
Araria	2376	85	0	35	0
Arwal	773	84	0	89	19
Aurangabad	2160	73	71	79	0
Banka	1820	84	86	86	0
Begusarai	2629	81	79	31	0
Bhagalpur	2311	85	76	23	0
Bhojpur	2264	78	72	41	0
Buxar	1493	93	68	43	0
Champan (E)	4326	62	55	39	0
Champan (W)	3206	88	88	78	18

Darbhanga	3550	68	61	51	0
Gaya	3514	75	77	37	0
Gopalganj	2371	82	0	47	0
Jamui	1520	98	79	95	57
Jehanabad	871	88	0	99	63
Kaimur	1462	85	83	49	0
Katihar	2549	72	91	13	0
Khagaria	1412	60	0	96	35
Kishanganj	1368	82	82	0	0
Lakhisarai	802	69	68	87	0
Madhepura	1711	85	78	73	0
Madhubani	4046	68	0	9	0
Munger	961	98	95	31	0
Muzaffarpur	3984	79	78	52	0
Nalanda	2365	94	76	3	0
Nawada	1959	100	76	11	0
Patna	3233	71	74	86	0
Purnia	2723	81	0	61	0
Rohtas	2490	78	74	52	2
Saharsa	1622	41	38	64	0
Samastipur	3835	81	80	46	0
Saran	3459	78	78	52	0
Sheikhpura	520	83	80	12	0
Sheohar	580	82	84	78	0
Sitamarhi	2965	67	80	0	0
Siwan	3008	84	85	16	0
Supaul	1928	78	0	98	77
Vaishali	2969	87	77	90	15
	87135	78	61	48	5

Supportive Structures: While the State Health Society is staffed with young, energetic and committed leadership to oversee the ASHA components, support structures at the district level are lacking in around 40% of the districts and in 30% of the blocks (Table 2). However at the village level majority of vacancies are filled for ASHA facilitators.

Table 2: Vacancies in Supportive Structures

	Target	Vacancies	
		Number	%
State Level	6	0	0
Regional Level	9	0	0
District level (DCM)	38	16	42
District level (DDA)	38	8	21
Block Level (BCM)	534	164	31
Village level	4150	230	6

State, district, block and village level teams listed above carry supportive supervision of ASHA. In the blocks where BCM is placed (e.g. GopalGunj districts), there is clarity of role with specific reference to planning, implementation and monitoring.

ASHA Divas is held once in a month and used for sharing health updates and also changes in national guidelines and policies.

Payments:

Incentives are paid through cheques or bank advice and 96% of the ASHA are in possession of bank accounts. In certain districts ASHA receive their incentives through mobile money transfer. Incentives are mainly for JBSY, immunization, family planning, ASHA Divas and Home based care. The average take home for ASHA is Rs 600 as per the evaluation carried out by NHSRC in the year 11-12. Three to six months backlog of payment of incentives were reported in the districts visited.

In addition to the financial incentives, ASHAs were given two saris, umbrella and torch in the previous financial years. Majority of the ASHA interviewed requested regularization of pay.

Monitoring:

Performance based monitoring using ten indicators was only recently initiated.

Grievance Redressal Mechanism:

There are no formal grievance mechanisms in place, however ASHA Divas is used for addressing the grievances at the village level, whereas the civil surgeon and district magistrate addresses district level grievances. State ARC addresses the issues concerning policy level with guidance from state mentoring group and NHSRC.

ASHA Rest Rooms and ASHA Ghar: There are no living facilities for ASHA for over night stay when they accompany women for delivery. While there is access to clean rest rooms at some of the PHC, rest room facilities are lacking at the sub center level.

Drug Kits: Drug kits are provided to 99% of ASHA, however they are not replenished. Procurement of HBNC kits is underway and communication kits have been distributed only to all those trained on Modules 5-7.

- **Career progressions:** ASHAs are very keen to undertake advance training, which will enable them to apply for ANM positions. Majority of the ASHAs are interested in undergoing advanced training for transitioning towards ANM positions

Promising practices:

- The state has:
 - Good rate of recruitment and retention of ASHA and these ASHAs are vibrant and happy with their respective health facilities, providers and administration.
 - Comprehensive data base which is updated at the block level quarterly.
 - Enthusiastic and committed staff supporting ASHA program at the state, district and block level.
 - Made good progress in engaging ASHAs in family planning counselling, social marketing of contraceptives, immunization and home based follow-up
 - Honours 3 ASHAs from each block with cash awards of Rs. 1000, 500, 300 and a certificate at the district level ASHA Sammellan
 - Assisting around 1000 ASHAs in enrolling with National Open Schools or IGNOU for completion of 10th grade.
 - Piloted mobile money transfer in Sheikhpura district in collaboration with NIPI and SBI for streamlining the payments of incentives to ASHAs.

Recommendations:

- The state has to take rigorous and time sensitive steps towards
 - Filling the vacancies for DCM, DDA, BCM and ASHA facilitators
 - Completing all pending trainings with focus on districts where less than 50% of the trainings are completed.
 - Ensuring timely payments of incentives in all blocks
 - Updating and disseminating the guidelines
 - Ensuring access to clean rest rooms to ASHA at all health facilities
 - Building ASHA GHAR where immediately feasible and resources permit.
 - Strengthening supportive supervision at the state, district, block and village levels
 - Replenishing and/or distribution of drug kits, HBNC and communication kits
 - Operationalizing the tracking of performance based indicators
 - Establishing formal grievance redressal mechanisms and tracking and addressing the grievance on real time basis.

- Ensuring that ASHA makes arrangements for transport to the health facility for institutional delivery for all women and accompany them to the hospital
- Strengthening the documentation of ASHA
- Establishing mechanisms for tracking, documenting and reporting of maternal and infant deaths by ASHA in coordination with ANM and AWW
- The state also should work towards:
 - Engaging ASHA actively in RCH camps for increasing institutional deliveries (from current 54%)
 - Evolving better role clarity and coordination among ANM, ASHA and AWW in follow-up of mother-infant pairs with specific focus on tracking of severely anaemic women and children and sick and malnourished children.
 - Strengthening ASHA capacity in line listing and tracking of women and children, facilitation of filling of MCH cards by ANM and AWW, and tracking, documenting and reporting of maternal and infant deaths
 - Establishing formal linkages between Mamta and ASHA for continuous support for IYCF

B: Rogi Kalyan Samitee

The RKS were not functional at the APHC level. The BPHCs had RKS committees in place. The Records and registers were maintained for the meetings of the committee. However, the frequency of meetings and the attendance was seen to be low. The utilization of RKS funds was being utilized well

Current Status and Positives:

Rogi Kalayan Samittees are formed at more than 96% of the health facilities as detailed below and working very well. Meetings take place regularly and minutes are recorded in the registers. The fund utilization is also as per the target and the funds are mainly used for the benefit of the beneficiaries.

Table 3: Current Status of RKS

Type of Facility	Number	Status of RKS formation and registration			
		Formed	Registered	A/F Registration	Total
APHC	1330	1324	1294	24	1318
PHC	533	481	480	1	481
RH	70	68	68	0	68
SDH	44	36	35	1	36
DH	37	37	37	0	37
MCH	6	6	6	0	6
Total	2020	1952	1920	26	1946

Recommendations:

- There is a need for a differential financing under RKS depending on the basis of case load of the facilities. Some facilities may require more funds where case load are high and some may require less funds.

C: INVOLVEMENT OF VHNSC and PANCHAYATI RAJ**Current Status****VHNSC:**

A total of 8224 (97% of the target) VHNSCs are constituted and the members of VHNSC are orientated with guidelines. The state has developed a manual entitled VIKAS KI DAGAR PER HAMARA GAON and a film on conducting VHNSC meetings towards orienting the members. Monthly meetings have been initiated recently on last Saturday of the month and minutes of meetings are recorded. Block Health Manager is responsible for monitoring of VHNSC activities.

Panchayati Raj is not actively involved at all places in the functioning of VHNSC, RKS and district health society. Where they were involved their role is limited to facilitating the space. The head of Panchayati Raj selects ASHA but may not always adhere to the guidelines. It is critical for Bihar state to engage the Panchayati Raj in NRHM activities specifically to address low institutional delivery rate, high prevalence of malnutrition and high prevalence of certain communicable diseases.

Recommendations

The state has to take rigorous and time sensitive steps towards

- Developing an outcome based vision for VHNSC
- Strengthening monitoring of VHNSC at the block, district and state level
- Increasing the fund allocation for VHNSC through state resources
- Sensitizing and engaging the Panchayati Raj in VHNSC, RKS and district health society activities.
- Working with Panchayat Rai Members in bringing convergence among health, education, nutrition, sanitation, NREG, housing and other rural development activities.

E: COMMUNITY MONITORING AND SOCIAL AUDITING**Current Status**

Community based monitoring is being piloted in five districts through PFI. Social auditing is not in place at this time. Even though social auditing was included as part of 2012-13 PIP, it was not approved and was recommended to make it part of CBPM.

Towards community monitoring the state has:

- Signed formal MOU with PFI

- Held two meetings of state advisory group on community action (AGCA) and 4 STAG meetings
- Developed modules, curricula and materials on CBPM process
- Published an expression of interest in the local newspapers inviting applications from NGO's and selected eligible NGOs and oriented them on CBPM process.
- Conducted state level TOT and block level trainings for selected NGOs
- Held review meetings of partner NGOs
- Organized district, block and village level sensitization programs
- Formed Village Planning and Monitoring Committees (VPMC) in 300 villages, trained the members in two phases and held two rounds of VHSC meetings.
- Completed the community enquiry process by the VPMC with the support from NGOS and data was compiled and shared with the village members on status of accessing health services
- Formed District and block level planning and monitoring committees, oriented the members on CBPM and conducted meetings with these committees.

Positives

- The state is going through systematic and diligent process in operationalizing CPMB.

Recommendations

- Document CPMB process to be shared with other states.
- Scale up successful, replicable and sustainable components of CPMB along with social auditing across the state through leveraging state funds.
- District vigilance and monitoring committees are not functioning and should be strengthened

VI. REPRODUCTIVE & CHILD HEALTH (RCH)

Maternal and Newborn Health:

1. Antenatal care:

Coverage of pregnant women for antenatal care (ANC) was poor. The Maternal Child Health (MCH) register at sub-center level recorded three ANC visits for majority of pregnant women, however, during interaction with beneficiaries all of them reported to have undergone at the most two antenatal visits only.

Records of pregnant women registered for ANC were maintained in the MCH register, but the ID no. for entering the details in MCTS data base was missing in the register. Only at one health facility the proper ID nos. duly entered in the MCH register were noticed. During state interaction, it was reported that due to inadequate support for data entry, it has not been possible to enter all the beneficiaries' data in MCTS. A discrepancy was also noted in number of ANC visits recorded in Mother Child Protection (MCP) cards vis a vis that recorded in MCH register.

The quality of ANC was poor, in the MCH register all the details related to weight and BP of pregnant women were entered but scrutiny of these registers showed many discrepancies. First, the weight gain over three ANC visits for most registered women ranged from 0-1 kg. Second, for all consecutive pregnant women (20-30 in no.) the BP was recorded uniformly as 120/80 mm Hg for all cases. All the health facilities (including subcenters) where ANC was being provided were having functional equipments for measurement of both weight and blood pressure. The interaction with the pregnant women revealed that during their ANC visits they are given inj. Tetanus Toxoid (TT) and 50-100 tablets of Iron Folic acid; and weight was taken sometimes only. All these women said that BP measurement and abdominal examination was not done during their ANC check-up.

Almost all referred cases with complications were coming to District hospital. Most of the cases were referred due to severe anaemia. No line listing of severely anaemic women was being done in any of the districts visited. The haemoglobin (Hb) estimation was not being done at subcenter level but for all such cases, in MCH register it was recorded as no anemia and this was reportedly on the basis of clinical examination by the ANMs.

A review of facility level deaths in past one year revealed that most of the deaths were either due to severe anemia or haemorrhage (mostly postpartum). No estimation was done at the subcenter level due to non-availability of haemoglobinometer. At Additional PHC level, though the facility for Hb estimation was there and a lab technician under RNTCP was posted there, but he was doing Hb estimation and urine examination of clients undergoing sterilization operation at that facility but not for pregnant women undergoing delivery at the same setup.

Issues and concerns	Recommendations
<ul style="list-style-type: none">ANC Coverage is poor.Quality ANC services not there (only TT, IFA and sometimes weight). For other components for which services are not being provided, entries were made in the	<ul style="list-style-type: none">ANC coverage needs to be expanded.Monitoring & technical supportive supervision for quality ANC services and for proper maintenance of

<p>register.</p> <ul style="list-style-type: none"> • Discrepancies between the no. of ANC visits recorded in MCH register and as recorded in MCP Cards and beneficiary reports (eg. MCTS id was missing) • MCH register of ANM records no anemia but Hb estimation not being done. • No line listing of severely anaemia cases as no Hb was being done • Lack of motivation and supportive supervision 	<p>records and reports.</p> <ul style="list-style-type: none"> • Hb estimation services to be provided at all delivery points (existing LTs to be utilized). • Hb services need to be provided for each pregnant women.
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2. Delivery care:

24 hour delivery services were provided upto Additional PHC level. Two subcenters in Gopalganj district were identified as delivery points, but when the team visited both of them were non-functional in terms of equipment and supplies; and no deliveries were being conducted. At additional PHC visited in Gopalganj district, there were 24x7 delivery facilities but there was no running water and no electricity back up at the facility. Labor rooms were generally clean and adequately equipped except at DH which had high delivery load incommensurate with the bed strength. There were no attached toilets at most facilities.

The assisted vaginal delivery was not being done at DH, Gopalganj and any other health facility below district level due to either non-availability or very old obsolete non-functional equipments (Ventouse/ forceps). The BeMOC services were not practiced at PHC level. Pregnant women were not getting inj. Magnesium Sulphate for eclampsia (though the team found injection Magnesium Sulphate available in the labor room in emergency tray) instead they were given inj. Diazepam and then referring cases to District hospital. Partographs were not plotted, only in case of PPH, patients were given oxytocics and referred to higher facility.

CeMOC services were available only at the District hospital, Gopalganj among out of the two districts visited by the CRM team and this resulted in huge rush of complicated cases at the DH. At SDH , Gopalganj, though the infrastructure and manpower was available to provide CeMOC services but they were non-functional due to lack of availability of blood storage facility. Though severe anaemia and haemorrhage were reportedly the primary causes of maternal death at facility level but among two districts (Gopalganj and Banka) there was only one blood bank available at DH Gopalganj. There was no blood storage unit at any level in both the districts. In DH, Gopalganj, though no anaesthetist was posted but anaesthesia was being provided by two MOs trained in LSAS. At blood bank, DH, Gopalganj, the team noticed a good practice of contribution by a civil society organization, Nirankari Sangh. The organization was donating almost 200 units of blood at one go every year. As the district did not have the capacity to absorb the donated units, most of the units were sent to state capital Patna.

Most of the caesarean sections at DH, as per OT register were due to obstructed labour. Partographs were not plotted for women undergoing vaginal delivery at any of the health facilities. Upon further probing for the reason for high number of caesarean sections due to obstructed labour, it was reported that people who were coming with obstructed labor were being injected with IV bolus dose of 2 ampoules of Syntocinon, perhaps by practitioners

outside the public health system (needs to be substantiated at the state level). The state has high MMR 261/100000 live births yet no Maternal Death Review was being done either at facility or at community level.

Most of the labor rooms were manned by SBA trained staff nurses and ANMs. The skills of staff nurses were found to be good but ANMs were lacking in many skills (during state presentation it was elaborated that the reason for poor skills of ANM was due to lack of quality training in the private ANM schools, which are mostly private in the state, but now efforts are underway to open up new ANM schools in government sector).

Post delivery stay in Health facility ranged from 6 to 24 hours. The main reasons were: a) insistence on the part of the beneficiary to go home, b) mass dropping of beneficiaries through ambulances; and, c) lack of space due to high delivery load at certain facilities.

Records were well maintained in the labor room but the APGAR score was not recorded as there was no column for recording the same. The birth weight of newborns at all facilities was recorded in interval scale of 2, 2.5, 3, 3.5 kg and so on rather than exact measurement on the SALTER scale. The team noticed the good practice of pasting the photograph of the mother and the baby in the labor room register of one of the Additional PHCs visited.

JSSK was being implemented in the state, but free diet was available only till DH and SDH level. At PHC and lower level, the main constraints for lack of provision of free diet were lack of sustainability of dietary services due to inadequate case load and Rs 50/- ceiling for diet by the state.

Most of the women who delivered in the hospital/ health facility did not avail the referral transport. The main causes were: a) lack of awareness about the free ambulance services available; b) ASHAs neither informed them about the availability of free transport nor made it available to them. When ASHAs were asked about the reasons, they said that ambulance services are not responsive in late night (either there is no response or they are told that the van is already in the field) or there is delayed response (one ASHA reported she contacted the ambulance and was told that it would reach in half an hour. She again contacted after half an hour and again after 25 minutes and eventually the family of pregnant woman had to hire a private vehicle to take her to the health institution for delivery); c) reluctance of ambulances to serve in far off areas. The availability of transport was seen best at Block PHC level where women were able to get drop back services to home as a group in the morning.

The interaction with the beneficiaries revealed that they were not making any OOP payments for availing services provided at the health facility, including drugs, diagnostics, blood etc. However, the informal payments were made to ASHA, for receiving JSY cheque, and for birth registration for beneficiaries of LAADLI scheme. The informal payments ranged from Rs. 100 to Rs 700.

The state provides free delivery services under JSSK, but many women in the state are still delivering at home. The primary reasons as reported by the ASHAs and community were: a) Expenditure incurred for an institutional delivery is high in comparison to JSY benefit received; b) Lack of transport facility to go to a health facility for delivery; c) Prevalent social custom of delivering at home. The families of women undergoing institutional delivery were making expenditure for transport, informal payments, and food. The total expenditure was substantial; the transport was mostly privately hired for reaching the health facility and charges ranged from Rs 450 to Rs 650. For drop back home, they were paying on an average Rs 100 to public or private mass transport system.

JSY payments were paid in the form of bearer cheque with pasted photograph of the delivered woman with her newborn baby. There was considerable backlog of JSY payments mainly due to insufficient supply of cheque books from the authorized bank. Most of the beneficiaries and ASHAs reported that they were not getting the JSY payments in time and sometimes this period extended up to two months. (State authorities reported that for current deliveries efforts are being made to made to deliver the cheques in time and simultaneously they are trying to cover up the remaining backlog also). At additional PHC level, women were paid JSY money on a fixed day in a week by the Accountant of the PHC to which the Additional PHC was attached. At DH, Gopalganj, every day the bank was visiting the hospital premises at fixed time in the afternoon everyday to pay cash to the beneficiaries with the result the JSY beneficiaries were getting the cash within the hospital premises itself.

Issues and Concerns	Recommendations.
<ul style="list-style-type: none"> • CeMOC services only at DH, Gopalganj. • Most C-Sections due to obstructed labour, Partographs not maintained. • Emergency drugs like Magnesium sulphate available, but not being properly used for referred cases. Assisted vaginal delivery not being practiced. • JSSK being implemented, however problems related to referral transport, diet exist. • Free diet is not being provided below district level due to lack of sustainability of the services @ Rs. 50/- per day. • Informal payments are being made by beneficiaries. • Delayed payments for both beneficiary and ASHA. • Monitoring and supervision of RCH services is weak. Poor public health capacity in terms of public health cadre (few LHV) for monitoring and supervision. • Maternal Death Review is not being done, neither facility nor at community level. • Main causes of Facility-based maternal deaths due to hemorrhage and severe anemia. Blood 	<ul style="list-style-type: none"> • CeMOC services to be extended up to Referral Hospital. • BeMOC services need to be strengthened below district level (Refresher training/ technical monitoring and supervision to be institutionalized). • Equipment for Assisted vaginal delivery (ventouse/ outlet forceps to be made available till referral hospital level to make services available at those levels) • Referral transport to be strengthened (more ambulances, other alternatives like voucher for private transport to be explored). • Dietary services to be provided at all delivery points. Dietary Entitlement may be enhanced, in absence of running kitchen at health facilities where delivery load is low, a model diet is proposed with following items available (2 pc bread, 1 boiled egg, 250 ml milk, 1 banana ≈ Rs. 14/-), it can be operationalised for a diet to be given twice a day within the budget of Rs. 50/-. • Monitoring to be strengthened and action to be taken against violators. • Streamlining of JSY payments to be done. • Supervisory cadre need to be strengthened. Utilize AYUSH doctor s for monitoring. • Maternal Death Review to be institutionalized. • Increase Blood Storage units and blood banks as appropriate for facility.

<p>availability is poor. No BSU functioning.</p> <ul style="list-style-type: none"> • Opportunities for partnership with Civil society exist. Eg. Nirankari Sangh for blood availability. • Short postnatal stay 	<ul style="list-style-type: none"> • Partnership with civil society organizations need to be strengthened and possibility of extending the partnership for other areas like referral transport need to be explored. • Postnatal stay needs to be extended through support systems like free diet and assured drop back home.
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3. Postnatal Care:

The coverage for postnatal care was poor. During postnatal period neither ANM nor ASHA's were conducting any home visits for care of the delivered woman and her newborn. While scrutinizing the records maintained by ASHA it was noticed that ASHA was keeping the record of all the children immunized, type and number of doses of vaccine received and due, but such a record for home visits for postnatal care was not available with her.

4. Newborn care:

Most labor rooms had well equipped and functional NBCCs except at Additional PHC level and Essential Newborn care was being provided. There was one NBSU unit established in district Banka and one in district Gopalganj. The NBSU unit in district Gopalganj was being used for training purposes only and not for service delivery. There was no functional SNCU in both the districts; however the building for SNCU was under construction at DH, Gopalganj. The NBCCs were manned by staff nurses and ANMs, many of whom were trained in NSSK. The skills of Staff nurses were good in newborn resuscitation but those of ANMs were poor. MAMTA's are guiding mothers in initiation of breastfeeding within one hour of birth.

Issues and Concerns	Recommendations.
<ul style="list-style-type: none"> • NBCC functional at delivery points visited and ENBC Services being provided.(Skills of ANMs not up to the mark for NSSK, good for Staff Nurses) ▪ NBSUs not established (except one at each district) and SNCUs are under process of establishment. ▪ Home based visits for PNC care are not being undertaken. 	<ul style="list-style-type: none"> ▪ NBCC to be made functional, preferably with trained staff nurses. ▪ NBSUs and SNCUs as appropriate for the facilities to be operationalised. ▪ PNC care needs to be strengthened with appropriate supervision and monitoring

5. Biomedical waste management:

The equipment and colour coded containers for biomedical waste were available at all facilities, however the practices to handle the waste were poor. Many facilities were disposing their waste through CWT facilities. The disposal practices were not appropriate where such facilities were not available. At sub-center level, the immunization waste was being sent to PHCs for disposal.

6. Safe abortion services:

There was lack of safe abortion services in public health system. The MTP services were available at District hospital level only. In Gopalganj district, two private providers were accredited by district authorities for providing safe abortion services, but the authorities were not having any record of abortion services provided by these private providers. There was general perception among the state health officials that women do not prefer to go for MTP in public health facilities due to concerns of privacy and confidentiality. This was the major reason for lack of interest in expansion of safe abortion services in public health system. The RTI and STI services were available at district level only.

7. Family Planning services:

Fixed day family planning services were provided up to Additional PHC level. The MO from Block PHC was coming to Additional PHC once a week to conduct sterilization operations, almost all of these were female sterilization through Minilap. Most of women undergoing sterilization operation had parity 3 and more. Vasectomy was almost non-existent. Though the human resource deployment showed presence of a NSV trained doctor at SDH, Gopalganj, but no NSVs were being reported in the records seen.

For IUCD insertion, the facilities were available till subcentre level and it was accepted mostly by women with parity 3 or more. ASHAs were doing social marketing of contraceptives of other spacing methods, but the acceptance of other methods of spacing was low.

Issues and Concerns	Recommendations
<ul style="list-style-type: none">Fixed day FP services provided up to APHC level, less focus on spacing methods; no FP counseling.MTP and RTI/STI services absent except at District Hospital.	<ul style="list-style-type: none">FP services focus to shift more on spacing methods. Fixed day services to be provided at Sub Centre level.Expand Safe Abortion Services in public Health system.

Nutrition:

During state presentation it was highlighted that malnutrition was widely prevalent among children. On checking the MCP cards, it was noticed that the details related to maternal care and immunization were recorded in the card, but the nutrition data for growth monitoring was not entered at all in any of the cards scrutinized.

Visit to the AWC revealed that the supplementary nutrition was being provided to children, pregnant and lactating women, and children were imparted preschool education. The growth monitoring was not being done due to non-availability of equipments to measure weight and height/length of children. Thus many of the children though who could be malnourished were not being detected at the community level.

The state reportedly has a large number of SAM children but does not have the adequate capacity to treat all of them. The main reason is that the facility based management of SAM through NRCs though effective was very costly thus making it unsustainable. The cost of running one NRC that admitted 20 children for 21 days costed Rs. 215000/- and the average cost of treatment comes out to be approx. Rs. 10000/- per child per month. (The NRC visited

by the team was clean and well managed through PPP mode and treatment was effective but the state was apprehensive of its cost, sustainability and inability to cover large number of SAM children in the state through NRCs).

A community based management of SAM children was being implemented in one of the districts in the state on a pilot basis with the help of an international organization, but the team could not visit it as it was not being implemented in the districts chosen for CRM visit. However, the team observed the high cost of treatment and inability of facility based management to effectively cover large number of SAM children and was of the view that community based management needs to be evaluated for its effectiveness and if found effective, should be considered as one of the viable options to treat SAM children in Bihar especially in view of resource constraints and magnitude of the problem in the state.

It is suggested that as the coverage of immunization among children is good, the VHND should be utilized as an opportunity to measure weight and height/length by AWW of children undergoing immunization and record it in the MCP card as well as updating in AWW's records. Widely prevalent malnutrition among children demands that this option be practiced and more and more children detected in the age group when the malnutrition is setting in and when the children are not going to AWCs i.e below the age of 3 years.

The situation of malnutrition was becoming graver in the state due to lack of safe water supply and common occurrence of diarrhoea among children in the region visited. There is need for IEC to improve sanitation and hygiene practices, and inter-sectoral coordination for provision of safe drinking water. The team saw Mobile Kunji which is being given by Pathfinder to AWWs and ASHAs to deliver IPC. The concept of Mobile Kunji was found to be novel and had following unique features: (a) it is a standardized tool to deliver IPC to women (b) it is the integrated package to impart IPC on various issues relating to maternal health, child health, nutrition, immunization, sanitation & hygiene and family planning etc. (C) it delivers the message in the local language. The system operates through mobile phone and the component of IPC could be chosen as per need of the woman. The system is conceptually good in design, it is recommended by the team that effectiveness of this intervention post- implementation needs to be evaluated and if found effective then it should be scaled up at the programme level.

Issues and Concerns	Recommendations.
<ul style="list-style-type: none"> • Malnutrition prevalent (Growth monitoring not being performed. Safe water is not available to one and all, diarrhoea is very common) • Nutrition data is not being entered in the MCH card. • Mobile Kunji (supplied by Pathfinder to ASHAs and AWWs). Features: Standardized tool for IPC, integrated message on various topics, facility to deliver in local language 	<ul style="list-style-type: none"> • AWC to be equipped and monitored for growth monitoring. • VHND days to be utilized for integrated MCHN services (AWW to take wt. and ht. of all the children undergoing immunization) • Every immunized child to be weighed and height measured by AWW, AWW worker to fill the nutrition part of the card on VHND day. • Mobile Kunji Needs to be evaluated in future for effectiveness; and if found effective to be adopted at programme level.

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| | <ul style="list-style-type: none"> • IEC for improving sanitation and hygiene practices, provision of safe drinking water. IYCF training of health workers. |
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Good practices:

- Transparent and accountable mechanism of JSY payments in form of bearer cheque with the photograph of mother and baby pasted on it.
- Facilitation of JSY payments to beneficiaries through bank visiting the hospital premises on daily basis at fixed hours in the afternoon for encashing the cheques.
- Initiative of Civil Society Organization in Gopalgunj district for Blood Donation. The organization donates almost 200 units of blood every year at one go at District hospital Gopalgunj which due to lack of capacity at district level to absorb was being sent to state capital. Partnerships need to be explored with these locally based organizations for possibility of blood donation on quarterly basis. Possible collaboration in other areas like referral transport could be explored with these locally based organizations.
- MAMTA's are performing well for early initiation of breast feeding, however their sustainability in the health system and expanding their role in strengthening IYCF practices in the state needs to be worked out.
- Mobile Kunji to ASHA and AWW-This is an integrated standardized tool for IPC to be given by ASHA and AWWs. The messages are in local language and include a variety of topic. Post-evaluation, if found effective then to be adopted at programme level.

CHILD HEALTH

The state has a tremendous improvement in the health indicator of IMR which has reached to 44/1000 in 2011 from 61. In last three years, there is the highest fall in the trend of IMR. The urban infant mortality rate is 40 while rural infant mortality rate is 52. All Newborns in the state receive home visits through IMNCI and HBNC trained workers at the community. Essential Newborn Care (ENC) services are provided at all the PHCs. It was evident during the visit that Breastfeeding initiated in all newborns within one hour. Initiation of breastfeeding has gone upto 79% from 72%. Health workers and MOs are trained in IPC skill for early initiation of breastfeeding.

In the state, the total 464 New Born Care Corner are established in which 124(27%) are fully functional, 314(68%) are partially and 26(5%) are Non functional. State level Newborn Care Committee is formed which is headed by Health secretary. In the parallel line, District Newborn Care Committees are formed in all the districts for coordination.

State government has taken an initiative to make the provision of Newborn Kit (Baby Shirt, Baby Bed Sheet, Baby Blanket, Baby Napkin, and Sanitary Pads for mother) to all mothers in government hospitals.

NRC has been established in all the 38 districts to control severe acute malnutrition in the children in the age group between 7-60 months. The ICDS/ASHA/ANM of the selected block

does screening of the SAM children. Till date 8233 SAM children are admitted in which 6052 (73.51%) are cured. Data showed that 84.83% of cured children were SC/EBC/OBC.

Child Sex ratio in the State is area of concern as it has reached to 933(Census 2011) from 951(census 1991) girls per 1000 boys in 0-6 age group.

Under Integrated Management of Neonatal and Childhood Illness (IMNCI), trained health workers visit the home of a new born for Post Natal Care at least three times. This training to the health professionals help them identifying signs of distress among children and give them appropriate treatment. More than 55,000 workers are trained in 8 days IMNCI package.

The Routine Immunisation percentage in Bihar has gone upto 66.8% which is better than the National average of 61%. The reinvigorated programme which was launched in 2005 as part of Swasthya Bihar Campaign ensured that every child is vaccinated against six fatal and debilitating childhood infections. These include tuberculosis, diphtheria, tetanus, whooping cough, polio and measles. Hepatitis B vaccines have been included in RI since 2011. Vaccines to prevent Encephalitis have also been introduced in several districts as part of RI activities. The state is also Polio-free for the last 18 months as no polio cases have been reported.

Nayee Pidhi Swasthya Guarantee Karyakram: Under this programme which was launched in 2011, children from zero to fourteen of age are provided health cards and adolescent girls from 15 to 18 are given Adolescent Girls Health Cards and referral facilities. Under this programme, comprehensive health check up is being done. As per need, referral slips to children with congenital anomalies and other complications, which can be corrected, are being issued for specialised treatment. Under this initiative, 61,830 health camps have so far been organised in which 1,52,40,033 children have undergone health check up and 2,88,059 children with congenital abnormalities have been referred to health centres specialised treatment.

Vitamin A Supplementation Programme: State Health Society is organizing Vitamin A programme twice every year at the interval of six months. In December 2011, Vitamin A supplementation round, 13.3 million children out of 14.4 million were administered Vitamin A doses.

PREVENTION, DIAGNOSIS AND TREATMENT OF MALNUTRITION

Malnutrition is one of the major contributing factors of infant and maternal mortality in Bihar and thus it remains a high priority for all the concerned departments. Even though the state has made considerable progress in addressing both prevention and treatment of malnutrition, there remain many challenges, which are detailed below along with recommendations.

A. Prevention of malnutrition among adolescent girls:

The state has begun rolling out ARSH clinics in ten districts and school health camps and weekly distribution of IFA supplement across the states. However all three programs are in the initial stages and required additional efforts by the state as detailed below.

- Rapid recruitment of Ayush doctors and district level adolescent health educators

- Development of database for tracking of diseases and conditions identified during school health screenings and ARSH clinics including malnutrition
- Establishment of formal linkages between school health programs and health facilities for treatment of identified diseases and conditions including malnutrition
- Immediate procurement and distribution of weekly iron and folic acid supplements
- Establishment of formal linkages with ICDS for providing food rations for girls with sub-optimal nutritional status.

B. Prevention of low weight gain during pregnancy:

The state has functional weighing scales at all the delivery points. However the weight is not measured and documented accurately, as a result the facilities are losing a golden opportunity to track and address problems related to low weight gain during pregnancy. To address this issue

- ANMs have to be capacitated and monitored for accurate measurement and documentation of weight during all ANC visits.
- ANMs and ASHAs have to be capacitated to help educate mothers on optimal weight gain during pregnancy and also ensure access to adequate food supply through ICDS and other sources.

C. Prevention of Anaemia among pregnant mothers:

Mechanisms are in place for distribution of iron and folic acid tablets to all registered pregnant women but not for diagnosing anemia. The state has to put in rigorous and time sensitive efforts towards:

- Procuring and placing Haemoglobinometers at the all the delivery points
- Capacitating and monitoring all health care providers in accurate measurement of haemoglobin
- Ensuring uninterrupted supply of iron and folic acid supplementation
- Capacitating ANM and ASHA on educating the women about the importance of adhering to iron and folic acid supplementation.
- Establishing mechanisms for documenting adherence to iron and folic acid supplementation in the medical records

D. Early Initiation of Breast Feeding (Promising Practice)

The state has done commendable job with regard to early initiation of breast feeding through establishment of MAMTA program.

MAMTA is responsible for;

- Providing moral support to women in labor room and maternity ward,
- Assisting mother in initiation of breast-feeding within the first hour and correct positioning of breast feeding
- Cleaning and wrapping of newborns to keep them warm

- Weighing of the newborn
- Immunization
- Ensuring immediate medical attention for sick newborns

Currently there are 4405 MAMTA workers placed at all delivery points and incentives are borne by the Health Department of Bihar. All the mothers interviewed at the health facilities reported to have received all the above services. The following are the bottlenecks, which need to be addressed by the state and also NRHM in order to ensure quality services by MAMTA

- The state has to work with health department in ensuring timely payments for MAMTA, which are delayed by few months.
- NRHM to allocate funding for training of MAMTA and also for non-monetary incentives in the 2012-13 PIP.
- The state has to establish formal linkages between ASHA and MAMTA for following up on IYCF counselling and support

E. Prevention and treatment of mild and moderate malnutrition among infants and young children

Even though AWW, ANM and ASHA work together, often growth of the child is not tracked or documented accurately losing a golden opportunity to identify and treat malnutrition at early stages. To address this:

- The state has to engage chief Ministers office in ensuring convergence among health, nutrition and rural development department.
- Integrated health, nutrition and rural development services should work towards
 - Measuring and documenting growth accurately
 - Increasing the food rations for the families with malnourished children
 - Educating the family members on use of locally available food
 - Tracking of distribution and consumption of supplements by the children

F. Treatment of severe acute malnutrition among children (promising practice)

The state has done a commendable job once again in addressing the SAM. The state has set a goal of reducing the SAM prevalence grade III and IV from 8.33% to 1% .Towards this the state has

- Established NRCs in all districts except of Aurangabad, Madhibani and Bhojprui in collaboration with NGOs. Eleven out of 38 NRCs are located at sub district health facilities.
- Established a total of 760 beds for treatment of severe acute malnutrition among children of 7-60 months of age.
- To date, the state admitted 8233 children in 421 batches, and out of these 74% of them were successfully treated. Not surprisingly 60% of the children admitted were

female and 84% were from SC, EBC and OBC background. Eighty eight percent of the children were between 0-36 months and 12% were between 37-60months of age, reiterating the importance of nutrition interventions in the first three years of life.

AWW, ANM and ASHA are responsible for screening the children at the block level and referring to the NRCs. However due to limited bed strength, only 20 of them are admitted in each batch and treatment lasts for 21 days. During the admission, the children are monitored for their weight and treated with diet and medicines and mothers are educated on nutrition, hygiene and health. The children are followed every fifteen days after the discharge.

Even though NRCs are functioning well and effective, they are expensive, not meeting the demand and unsustainable. Some of the measures the state can take to address the demand include;

- Decentralize treatment of SAM to the PHC level through capacity strengthening of health care providers.
- Streamline screening and referrals and limit NRC admission to only those that require medical attention along with nutrition supplements
- Reduce the time required for in-patient treatment if feasible and follow the children through OPD.
- Establish nutrition OPD at sub-divisional hospitals, FRUs and PHCs where children without medical problems can be followed and treated in collaboration with AWCs.
- Evaluate other alternative approaches such as community based nutrition programs that are being piloted in Bihar for cost effectiveness, feasibility, sustainability and large-scale replication.
- Optimal utilization of the funds available for NRCs for 2012-13
- Strengthening of the linkages between NRC and NBCC

SCHOOL HEALTH PROGRAMS

The state has conducted school health camps in financial year 2011-12 and screened 1,52,40,033 children. However there were no activities undertaken after these camps. The changes suggested by 5th CRM team for school health cards were implemented.

The state has considerable work to do make school health programs meaningful in tracking, screening, diagnosing and treating of child hood illnesses. Some of the immediate actions to be implemented by the state include:

- Recruitment of 456 AYUSH doctors and 38 district level adolescent health coordinators.
- Procurement of equipment for school health camps
- Development of vision, guidelines and implementation framework which will be used by the AYUSH doctors and adolescent health coordinators
- Finalization of data base for tracking health status of children screened in the financial year 2012-2013
- Establishing referral mechanism between school health camps and health facilities for diagnosis and treatment of conditions identified during screening.

- Implementation of school health programs on ongoing basis as opposed to one time event in camp mode.
- Involvement of children in planning, implementing and monitoring of school health programs as part of their academic curriculum.

VII. PROMOTIVE HEALTH CARE, SOCIAL DETERMINANTS & EQUITY

Even though the state has progressed well towards display of IEC materials at the district, sub-divisional levels facilities and PHCs, it has considerable work to do with regard to IEC display at sub-centers and also in designing and implementing comprehensive BCC campaign for general masses. Recognizing the need, the state has commissioned Population Council to conduct situational analysis of BCC campaign for the state in the past year. This was a comprehensive well-conducted study and key observations of this report are:

- BCC continues to be a vertical program, campaigns are short, and few stakeholder have integrated BCC in their programs
- Majority of the rural population in Bihar is out of reach from any mass media including newspaper, radio or television, where as 57 percent of women have met an ASHA at least once during their last pregnancy
- Health sector's media unit and its sub-system in districts and blocks are too weak to implement an effective BCC strategy for all target audiences.
- There are no rigorous evaluations of BCC campaigns' impacts, and most development partners work in isolation with little or no sharing with other stake holders. Each of the development partners has developed its own package of messages and BCC tools with little standardization of themes.
- Implementation of different health sector components is a shared responsibility; the state health department needs to involve other departments for implementing the BCC strategy with a broader health sector mandate.

Recommendations that emerged during this study which are in concurrence with the CRM team observations and recommendations include:

- The state health society has to
 - Develop a vision for bringing desired health practices in collaboration with ICDS, PHED, SHG and Mahadalit Vikas
 - Revamp the media unit and related human resources at all levels.
- The state's BCC strategy should be focused on
 - Four ANC visits, institutional delivery, iron and folic acid supplementation, and complete immunization
 - Postnatal care (PNC) for mother and newborn,
 - High impact, simple behaviours such as early breastfeeding initiation, clean cord care, skin-to-skin care, timely seeking health care after danger signs, and contraceptive use
 - Appropriate complementary feeding, adequate and balanced diet, Vitamin A consumption, and use of iodized salt
 - Improving hygienic practices and removing open defecation
 - Communicable diseases those are widely prevalent in Bihar.
 - Suggested media strategies to be employed include

- Interpersonal communication with ASHAs, however ensure that content and quality of counseling by ASHAs is improved and ensure that ASHA reach Below Poverty Line (BPL) families, scheduled castes, and minorities living in cluster/hamlets
- Mid-media such as wall paintings, posters, and leaflets for clients or counseling aids
- Potential partners in implementing the health sector BCC strategy include
 - ICDS which has the most overlapping health sector responsibilities and address the same audiences including pregnant women, adolescent girls, and children under six years of age
 - PHED which manages a key health component by ensuring access to safe drinking water and sanitation, without which the health burden on the family cannot be significantly reduced.
 - SHGs provide captive audiences of about 1.07 million families and MahadalitVikasMission to about 2.2 million families, who belong to the poorest and most disadvantaged groups without access to information and services, even from ASHAs.
 - The Panchayatis responsible for planning and local governance of all development programs in villages, conceived to fulfill the key role of providing supportive supervision, bringing the programs under community monitoring, and facilitating convergence of various programs at the VHSND forum.

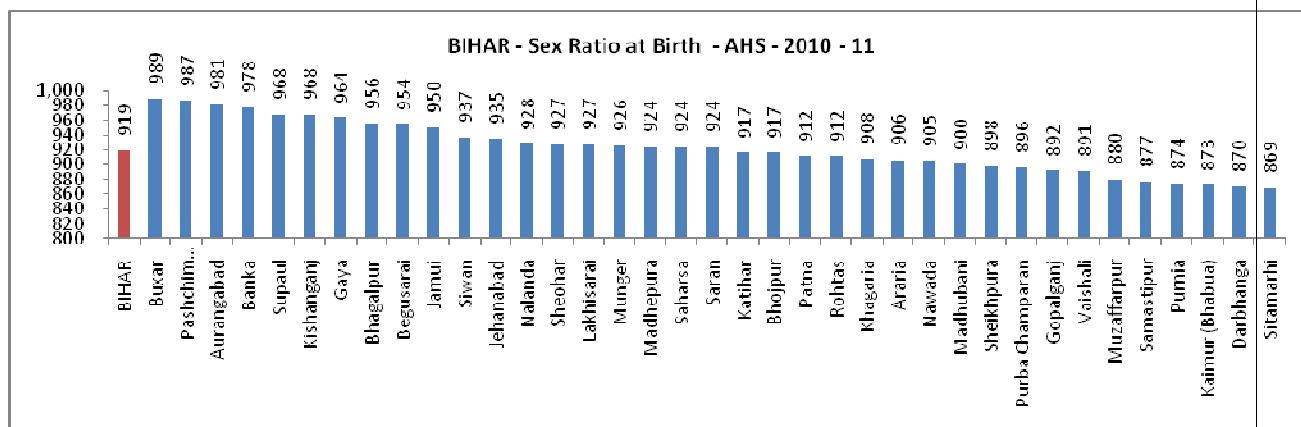
VIII. PC-PNDT ACT

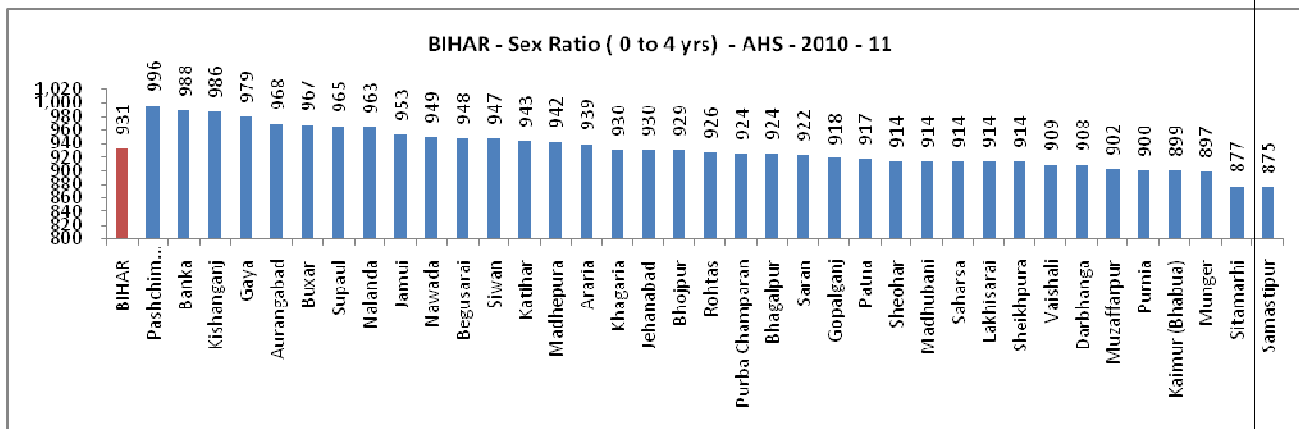
PC & PNDT Act is an Act to provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith or incidental thereto.

The Ministry of Health & Family Welfare, Govt. of India is the nodal agency for implementation of PC & PNDT Act in States/ UTs. It has been observed that the status of implementation of the Act at the ground level is poor as various indicators viz. constitution/ reconstitution of statutory bodies, meetings, inspection visits, sealing/ seizures, case filing etc. are not being executed up to the mark. The utilization of funds pertaining to activities of PNDT has not been done adequately by States/ UTs. States/ UTs send their quarterly progress report on status of implementation of PC & PNDT Act.

Status of implementation in Bihar:

S. No.	Indicators	Total numbers
1	Registered facilities	1317
2	Registered Govt. facilities	63
3	Suspension/ cancellation of registration of clinics	64
4	Inspection done by Appropriate Authorities/ inspection committees	305
5	USG machine sealed/ seized	5
6	Renewals of registration	170
7	Ongoing court cases under PC & PNDT Act	10
8	No. of conviction secured	0
9	No. of medical licenses cancelled	0





Observations during visit:

1. Major gaps in implementation of the PC & PNDDT Act were observed and require strengthening at state/district level. Effective monitoring and inspections of facilities/clinics offering diagnostic services require to be scaled up. The State has reported nil convictions and very few inspections by the Appropriate Authorities.
2. Out of 38 districts in the State, majority of districts have non-functional Advisory Committees and; their reconstitution as per the Act has not yet been initiated.
3. No dedicated PNDDT cell has been formed in the state/districts. Though budget has been approved for the same in current financial year.
4. The overall understanding about the implementation of PC & PNDDT Act amongst various stakeholders reflects general lack of clarity of the law. Capacity building/training workshops of implementing bodies including SAA, DAA, State/District Advisory Committees is the need of the hour.
5. Inspection of ultrasound clinic has revealed that the mandated F-Forms are not being maintained as per the Act. Given that non-maintenance of records is also a cognizable offence under the Act; this gap requires focussed action for carrying out surprise inspections, awareness generation and capacity building of service providers. Compliance regarding display of registration certificate inside the room also needs to be enforced by the Appropriate Authorities.
6. Implementation of PC & PNDDT Act needs to be brought centre- stage to address the declining sex ratio.
7. Registration of ultrasound centres under the Act to be strictly monitored and swift action against unregistered facilities under amended Rule 11 (2) of the PNDDT Rules.

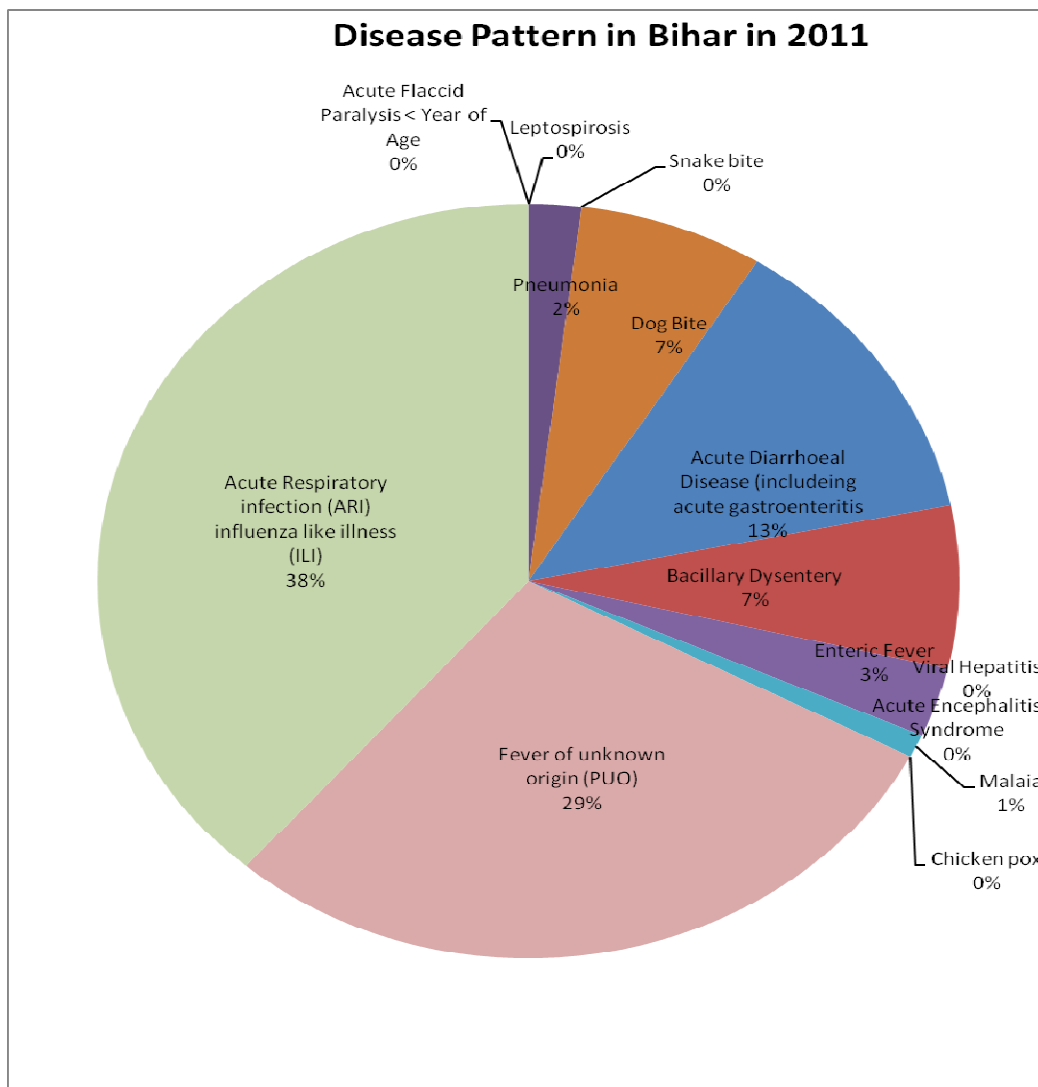
Recommendations:

1. Constitution/ reconstitution of statutory bodies viz. State Supervisory Board, State Inspection & Monitoring Committee, District Advisory Committees to be done immediately.
2. The State Inspection and Monitoring Committee (SIMC) to be constituted including with representatives from Health, Legal Affairs, Civil society, State Women's Commission was also discussed during the meeting.
3. Periodic meetings of State Inspection and Monitoring Committee and State Appropriate Authority to be ensured.

4. A state level orientation programme to be organized for all Stakeholders working at State/ Districts.
5. PC & PNDT Cell to be constituted at State & District level with required HR and infrastructure in order to facilitate the reporting process.
6. Comprehensive mass media and IEC campaign involving both electronic and print media.

IX. NATIONAL DISEASE CONTROL PROGRAMMES

Disease control is a part of NRHM but it doesn't seem to be a focus in the state as well as the districts that the CRM team visited. Disease control is not treated as a preventive proactive measure rather than it is reactive. In the district Banka the ACMO who holds charge for all disease control programme as well as family welfare is overburdened. The posts for District Disease Control Programme Officer have not been sanctioned. At the community level it was not clear if ASHA were involved /incentivised to cover communicable diseases. In Banka where thematic ASHA divas (Day) is observed mission was informed that communicable disease was covered periodically in the discussions. *NCD* were totally neglected area and not using the AYUSH doctors posted at the PHC for covering NCD is a lost opportunity. No preventive and promotive work on NCD was seen though short term care is provided in the general hospital. The state, should pilot covering NCD at the CHC and districts as other states like MP have done.

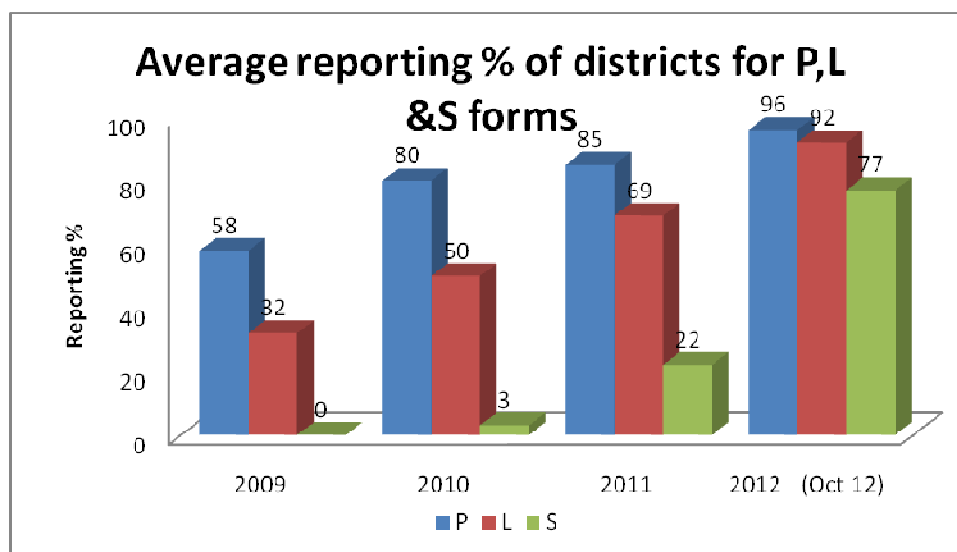


1. Integrated Disease Surveillance Programme

IDSP has been marked by improvements in reporting. The state reports 85% reporting on “P” form in 2011 compared to 58% in 2009. There is 69% reporting on “L” form in 2011 which was 32% in 2009. Reporting on the “S” form has improved up to 22% compared to 0% in 2009.

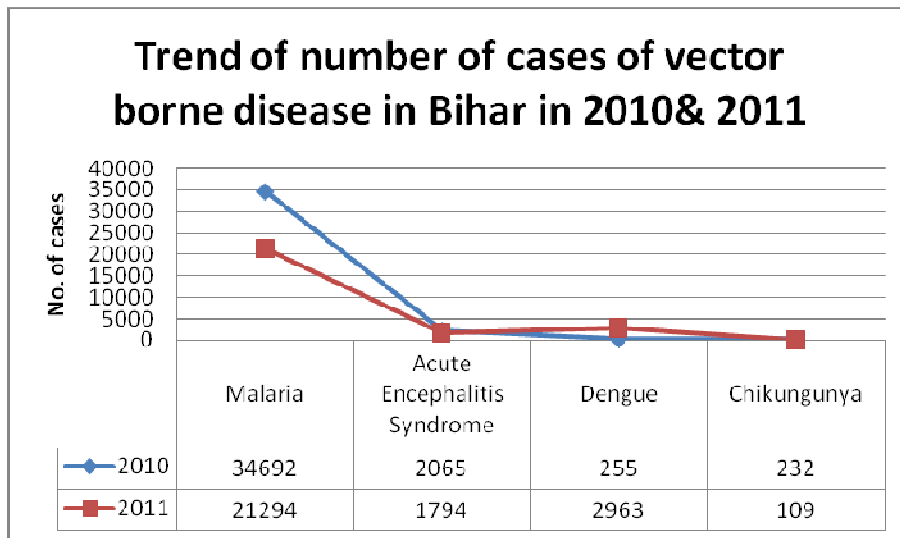
IDSP Data is being collected at all the districts and reported on time. However the data collection is only from the facilities and not all cases are captured. There is no active surveillance carried out at the community level. Some data for non-communicable diseases was being collected but it was only self-reported and at the facilities. Also no evidence of use of this data for planning was seen at the district or state level except for KL, TB and HIV and these needs to be expanded to other diseases including NCD. IEC activities need to be strengthened in all the PHCs regarding commencement of IRS for the June Round; availability of anti-malarial and diagnostic facilities at village level.

Banka District has reported 17,240 cases of unknown origin of fever since Jan-Oct 2012, 173 cases of Malaria and 3 for Dengue and none Chikengunya & JE. This is despite presence of disease carrying vector in abundance, in and around the district including amplifying host for certain viral diseases. It would be useful for the district to analysis the cases and intensify active surveillance in the community.

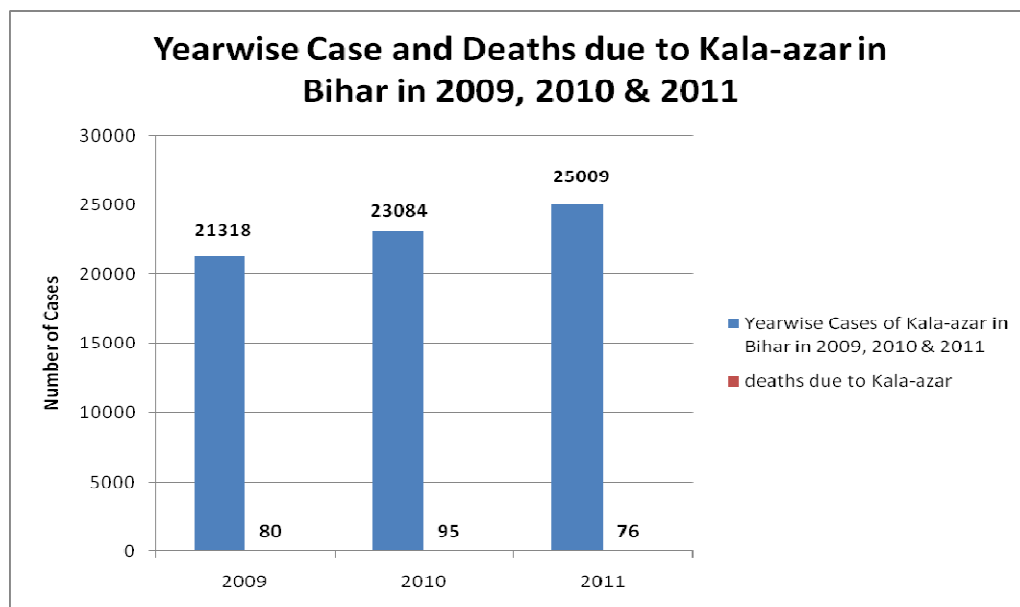


2. National Vector Borne Disease Control Programme

National Vector Borne Disease Control Programme (NVBDCP) covers six diseases namely Malaria, Kala-azar, Dengue, Filaria, Japanese Encephalitis (JE) and Chikengunya. The programme is not well integrated in the health system. There is lack of IEC/ BCC for the disease control programs including at community level. Mobility support to VBD Consultant for effective implementation of NVBDCP activities is lacking or not used properly.



A. *Kalazar* is in elimination stage but one doesn't see the mission mode for the same at the state and district level. Bihar has majority of KL cases 75% and death cases 95% in the country with 32 of 38 districts being endemic. The programme is in treatment/control mode with passive case detection and needs to be geared up to elimination mode, with a common target for all KA stakeholders. Considerable work needs to be carried out on IEC activities to increase community, ASHA and in some cases Medical Officer basic awareness of KA. Death rate has decreased from 177 in 2007 76 in 2011 as per the HMIS. For Vector control IRS is very important but it is not being done properly and community is not informed on time. Deficiency of drugs for Kala-azar was seen across the state due to delayed procurement. But this is *due to low supply from the Centre and Centre needs to expedite procurement processes for these drugs.*

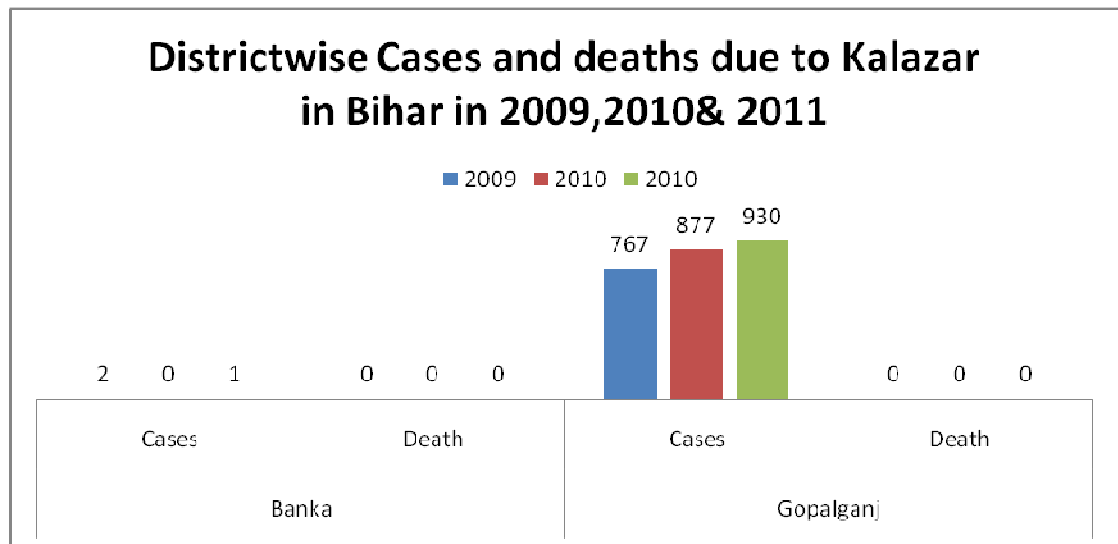


Lack of MO at the block and PHC level in supervision and monitoring of IRS is a big concern. High attrition rate of consultants is seen which can be taken care by paying the consultants on time and paying salaries at par with NRHM. *This needs to be considered at the national level.*

For KL to be eliminated from the state following is a must

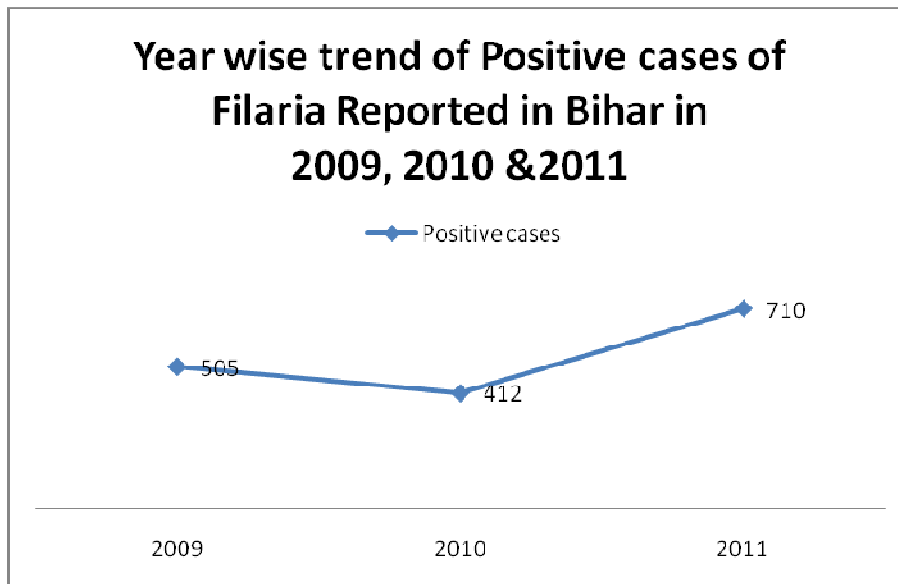
- a) Intensified project coordination with NRHM will be required along with close monitoring and supervision by MOs at the district, block and PHC level.
- b) IRS needs to be in campaign mode, accompanied by intensified supervision and household informed in advance.
- c) BCC needs to be intensified. State needs to provide involve ASHA to provide information on the cause of disease and availability of treatment to the community.

There is no death report in both district visited due to Kala azar in 2009, 2010 and 2011.



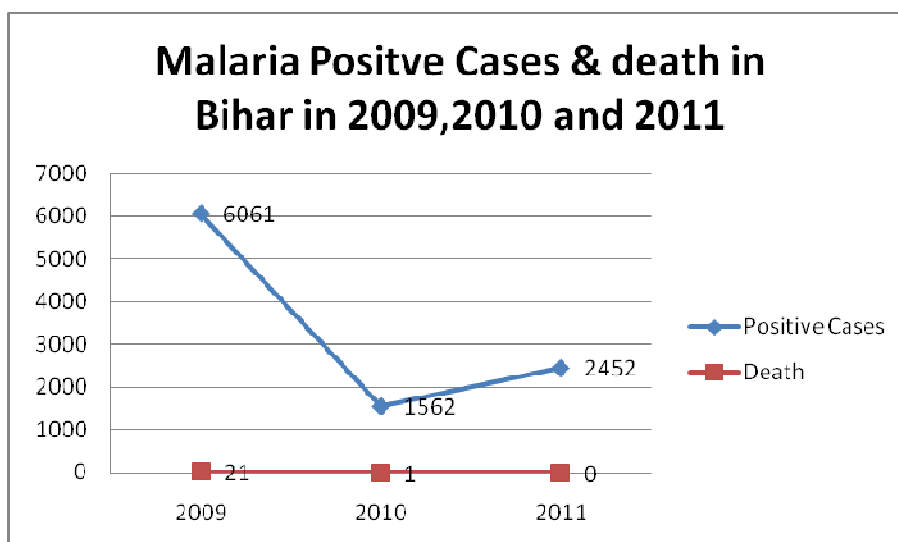
B. Japanese Encephalitis: No case is reported from the Banka district. As no diagnostic are available for JE with only clinical diagnosis conducted which is a concern and mostly AES cases being reported. The team was told that Diagnostic is available at nearby district of Purnia. Mission was informed that vaccination for JE carried out only in endemic districts.

C. Filaria: MDA 2012 schedule is 26th November for the state for which all preparation have been undertaken and Albendazole procured. However DEC 110 mg is not available in adequate quantity and this could push forward the date.



D. *Chikengunya/Dengue*: For diseases like JE, Chickengunea, Dengue, diagnostic kits not available at facility and are purchased only when there is a breakout.

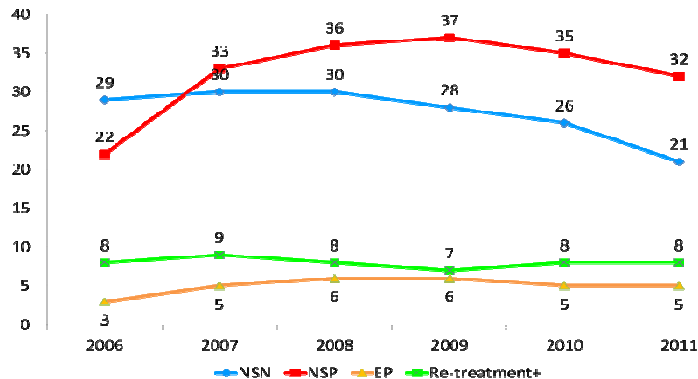
E. *Malaria*: Number of malaria cases reported in the district increased in 2011. In Banka district we observed presumptive treatment being carried out. There was Malaria officer in charge and no independent post in the district. Nor was there VBD consultant or malaria inspector. Neither the ANM nor the ASHA were being used in making slides. The treatment is given on clinical diagnosis and the effort for lab confirmation is not in practice. LLN and Incentives for Malaria have not been introduced to the district. IEC activities need to be strengthened in all the PHCs regarding commencement of IRS for the various Rounds and availability of anti malarial and diagnostic facilities at village level should be ensured with the facility level workers trained to use the same.



2. Revised National Tuberculosis Control Program

RNTCP Chronic gaps in key position at the state and district level

Ownership of RNTCP is weak at the district level and needs to supervise more closely. The ANMs are not working in case finding and case holding supervision. TB case finding is not optimal in the state and although case finding has improved slightly it is still very low, see graph below. MDR-TB patients diagnosed across the state but drugs are not available to treat all those who are diagnosed.



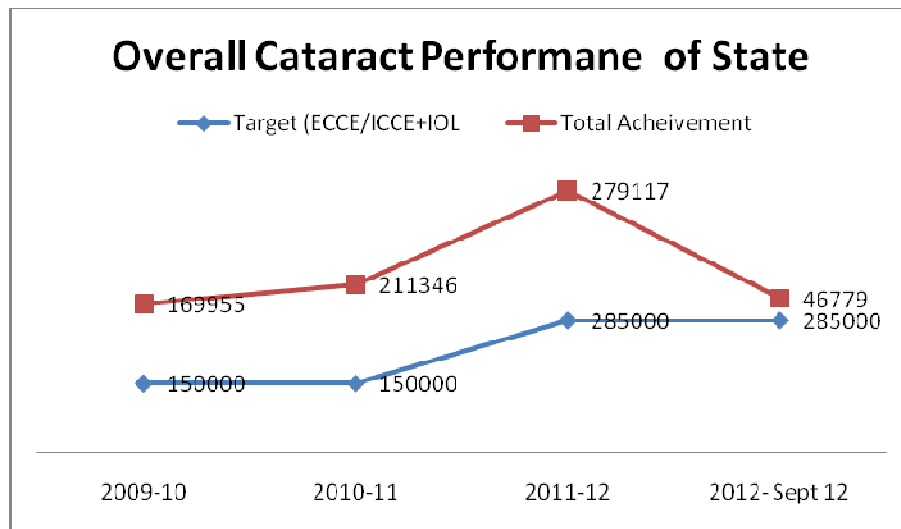
Funds are getting released for programme from SHS in time. Financial Management guidelines of NRHM shared with programme officers. RNTCP officers are called for review meetings. A) The general health system needs to be activated and involved for case findings and public referral. B) The state needs to initiate provision of incentivising the ANMs and ASHAs to support case findings. C) The role of private sector is very important in TB control as most of the people go to the private sector and pay out of pocket and once they are drug resistant and unable to pay fees they are send to the public sector. D) from private sector needs to be strengthened and E)health providers beyond public sector both formal and informal need to be actively engaged in the programme

F) There is urgent need to arrange for treatment of identified MDR cases so far 88 identified in the state out of which 5 cases are identified at Gopalganj and being treated but in Banka there were cases identified and were not being treated.

3. Blindness Control

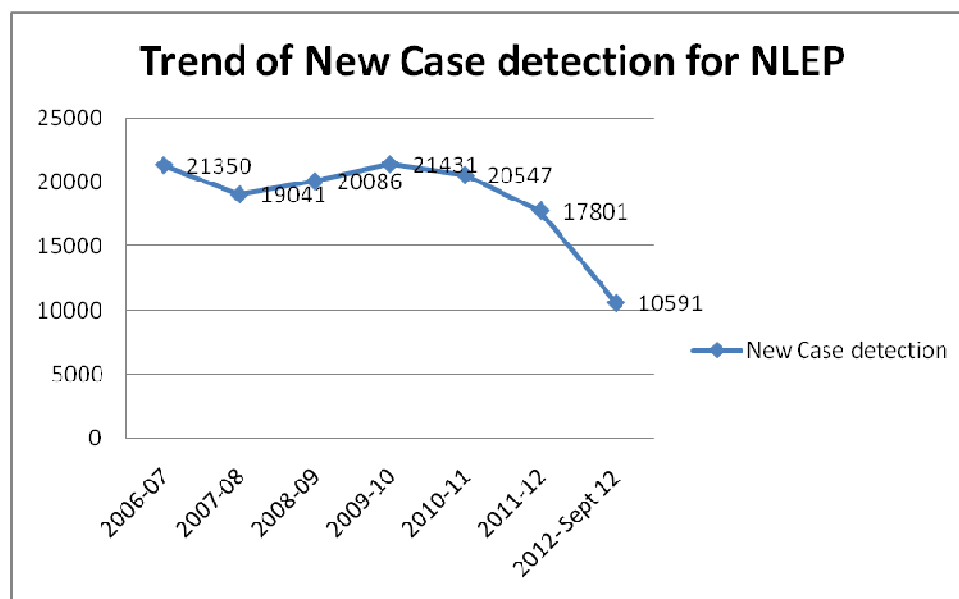
Only two districts have contractual eye surgeons posted in the state and in 15 districts para medical OAs have been contracted. The state has achieved only 16% (46779 out of 2,85,000) target for ECCE/ICCE and IOL upto September 2012. The state needs to gear up to take up this as they were able to achieve 98% last year. The post of OA is also vacant in many districts. In Gopalganj screening was taking place and select patients

were being operated with the help of NGOs. There was no link with the school health programme.



4. Others.

- There was no tracking carried out for *Iodine deficiency* in both the districts visited.
- 10591 cases of *leprosy* were detected in 2012-13 till Sept. Although numbers of new cases detected have been gradually decreasing the numbers are still large and prevalence has slightly increased for present year. The incentive for ASHA sensitisation and case detection has not been spent well and this needs to be expedited. Similarly IEC /BCC activities for stigma reduction have not been undertaken and there is gross under spend. Drugs are available at every PHC for treatment as per the disability.
- Screening programs for Thalassemia, Sickle Cell Anaemia and Genetic Disorders were not present in both the districts visited.



X. LOGISTICS & PROCUREMENT:

- **Current status:** The State Health Society Bihar is the State Purchase Organisation and it finalises the purchase rates through tender to buy specific drugs/hospital equipments/instruments in all the Government Hospitals and makes these rates available to all civil Surgeons and the DHS for their purchase, as per their requirement.
- The SHSB invites tenders directly from the pharmaceutical manufacturers / direct importers for making rate contract of all essential drugs. The lowest bidder qualifies and is given rate contract for all essential drugs, which is then informed to all the civil surgeons and Chief Medical officers. The purchase orders are placed directly to the rate contracted agency by the Civil Surgeon cum Chief Medical Officer depending on their requirements for six months. The Agency gives the Civil Surgeon a proforma invoice with the due date for supply. The Purchaser receives the indented supplies directly from the supplier on making full payment to them, Thus purchases are made on Cash and Carry mechanism.
- The DHS makes the indent and forecasts the requirement in the next six months based on the consumption of drugs in the last three years. The next order is placed 3-4 Months after the stock is received, keeping a buffer stock of 2-3 months so that there is no scarcity of drugs in any Govt Hospital.
- The State is in the process of setting up procurement MIS which is an online drug management system wherein the District Civil Surgeon / CMO would be able to directly place a purchase order to the suppliers shortlisted by the State and providing a particular drug, depending upon the district requirement. This has not been operationalised as yet and would be operationalised tentatively in the next four months.
- To ensure the quality of drugs made available
- At the PHC level, the MOs are given a flexibility to make the emergency purchases if required.

Observations:

- The EDL has been rationalised and is available on the website of Bihar State Health Society and available with the facility incharges. They were displayed at few and not all facilities for public viewing.
- The drug availability at the District hospital was good. It was reported that not all the essential drugs were available at the PHCs and subcentres. However, it was acknowledged that the availability of drugs has improved considerably over time.
- During the facility visits it was observed that the free distribution of drugs is being done at all the sub-centers, PHCs and District Hospitals and the beneficiaries did not incur any out of pocket expenditure on the medicines purchase.

Issues and Concerns:

- The availability of essential drugs at the subcenter level was not good. At subcentres in Gopalganj, only 5 out of the 14 essential drugs were available.
- The ANMs at the subcentres were not clear about the means to get these drugs from the PHCs.
- The PHCs also reported some shortage of drugs. Record keeping such as stock registers maintenance was poor. There were no indenting procedures being followed at the PHCs or APHCs

XI. HMIS & MCTS

Key Observations

- a. Facility wise reporting has started from May 2012 on the DHIS 2 site.
- b. HMIS Being the single source of reporting is a very good strategy of the state in building towards a stronger and more authentic HMIS system for effective planning and decision making.
- c. The District Health Ranking system has been introduced by the state on some of the key indicators which is a good innovation to ascertain the performance of different districts on a monthly basis
- d. The LAN connectivity was a problem in one of the PHCs in Gopalganj district, which leads to overburdening of the data entry operator who needs to work on the data entry at cyber cafe. There were errors in the entry of the MCTS data as filled by the ANMs that warranted the urgent need of training of ANMs in data entry and format filling.
- e. Currently, the ANMs were not receiving any micro plans made by the MCTS software to work on. Considering that the MCTS in Bihar is in initial phase, It was acceptable and expected that the same would be functional in sometime.
- f. The ANM needs to fill the data on an MCTS formats and MCTS register at the sub-center. The forms are sent to the PHC and are uploaded by the Data entry operator into the server. The forms are then returned to the ANM with the 18 digit registration number for the beneficiary. It was however seen that many of the forms that were sent back to the sub-centres did not still have the registration number on the form or on register.
- g. The ANM needs to fill two similar formats for the same beneficiary which leads to duplication of work for her but does avoid the error that may creep in when the ANM sends the register to the PHC and enters the data only when the register is returned.
- h. Seeing the amount of data to be uploaded in the server both for MCTS and HMIS, their is a need for an addition DEO at the Block level for timely entry of data.
- i. The District Health Ranking system has been introduced by the state on some of the key indicators which is a good innovation to ascertain the performance of different districts on a monthly basis
- j. A new method of getting complete registration has been thought of. The Mobile phone of ANMs will have a mobile application installed having the MCTS format in Hindi. The ANMs could enter the data through mobile which will be uploaded directly in the server.
- k. ANMs need to be trained in MCTS. The training of MCTS for ANMS was reported to be over by December.

Recommendations :

- a) There is a need for utilizing the District Ranking on health indicators for ascertaining the bottlenecks in some of the programs vis-a-vis HR availability, service delivery and infrastructure availability.
- b) Need for a additional hand for data entry at block level
- c) Generation of MCTS Work plan and its utilization by the field level functionaries in missed out ANC and immunization cases.

XII. MAINSTREAMING OF AYUSH

The main objective of the Mainstreaming of AYUSH is to co-locate the AYUSH facilities at Primary Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs). The visiting team found that the AYUSH facilities are not co-located at PHCs, CHCs and DHs.

Group Observation:

- a. It was noted that 1384 Medical Officers under AYUSH stream of medicine have been appointed/posted at APHCs as replacement of GDMOs.
- b. These AYUSH doctors are not practicing AYUSH stream of medicine due to non-availability of AYUSH medicines and required support mechanism and infrastructure.
- c. They were found to be running OPD without medicines and at some places were involved in some of National program. Thus, the very purpose of mainstreaming of AYUSH under NRHM is defeated.
- d. The TOR of AYUSH doctors defined by the State Health Society says that they are involved to supervise/monitor ANMs, Sub-Centres and participate in Immunization programme. But the visiting team in both the Districts of GopalGunj and Bnkadid not found their involvement. It is also told that they are involved in School Health Programme.
- e. The State should endeavour to provide opportunities for AYUSH doctors to practice AYUSH stream of medicine by providing them separate space in the health facility (PHCs, CHCs and DHs) with requisite equipment and furniture.
- f. AYUSH medicines and required Para medical staff (Pharmacist and attendant) should be made available in all health facilities having AYUSH doctor.
- g. Provision of funds for procurement of AYUSH medicine needs to be taken up with the Directorate of AYUSH in the State and Department of AYUSH, Ministry of Health and F.W, Government of India.
- h. Availability of AYUSH doctors in health facilities should be announced to the public by providing signboards with names of the doctors and the system of medicine they are practicing. They may also be involved in all National programmes and in supervising/monitoring the field staff at sub-centre and village level.
- i. AYUSH doctors who are providing antenatal, intra-natal and post-natal services should be recognized and their services may be made more professional by giving them BeMONC and SBA training.
- j. At all District Hospitals, Speciality wing of Panchkarma in Ayurveda and Ilaj Bit Tadbeer (RegimenalTherapy) in Unani system may be established which are more effective in Non-Communicable diseases in both preventive and curative aspects. In addition to this the number of standalone AYUSH dispensaries may be increased. The Administrative structure of Directorate of AYUSH may be strengthen at state, regional and district level to facilitate the effective monitoring of AYUSH systems in the state.

XIII. FINANCIAL MANAGEMENT: BIHAR

Good Practices

- ✓ Books of accounts were properly maintained in Tally ERP-9 software as well as manually at District /CHC/ PHC level.
- ✓ Bank Reconciliation Statement was prepared at all levels.
- ✓ Timely reporting was observed from Block level to District health society.
- ✓ Uniform accounting practice is being followed by District Health Society.
- ✓ Concurrent Audit implemented in financial year 2011-12 and 2012-13.
- ✓ JSY registers is properly maintained and all the JSY records and photographs of beneficiaries maintained properly at CHC/ PHC level.
- ✓ NDCPs accountant are properly maintaining books of accounts at District Health Society level.
- ✓ Smooth Electronic transfer of funds up to PHC level.

Key observations regarding financial management at the State level were as follows:

Budget Vs Expenditure

The total approved budget of the State for financial year 2012-13 Under NRHM is Rs.1421.32 crore against which the expenditure has incurred by the State up to Sep 2012 is Rs. 327.65 crore equivalent to 23% of approved PIP. The State has only 53% expenditure under RCH flexible pool against the approved SPIP of Rs.412.43 crore and only 13% expenditure reported under Mission Flexible pool against the approved SPIP of Rs. 512.42 crore. The committed liabilities are Rs. 110.53 crore in RCH and Rs. 165.39 crore in Mission Flexi Pool for FY 2011-12. The reasons for low utilization is low expenditure was reported during FY 2012-13 by state in Maternal Health, Family Planning Services, ARSH, PNDT Activities, Training, vulnerable Groups and JSSK in RCH and Hospital Strengthening, New Construction, Panchayati Raj Initiative, Mobile Medical Units, New Initiatives, Support Services in Mission Flexi Pool and advances outstanding at various agencies.

Pending Utilization Certificate

(Rs. in Crore)

Programme	2008-09	2010-11	2011-12	Total
RCH	-	-	333.91	333.91
Mission Flexi Pool	-	189.35	106.43	295.78

15 % State Contributions

State has excess contributed the State Share for the year 2011-12. State has using State contribution in NRHM activities. State has utilized Rs.55.75 crore till 31.03-2012 but could not entered in books of accounts however it will be shown in next financial year. Overall excess State share contributed by the state is as under:

(Rs. in Crore)

Year	Amounts to be contributed	Amounts Credited	Excess Contribution
2007-08	61.81	162.65	
2008-09	144.91	115.46	
2009-10	114.65	215.41	
2010-11	182.68	95.72	
2011-12	138.93	188.29	
2012-13	284.89	192.96	
Total	927.88	970.49	42.61

Human Resource (Finance)

There is no financial manpower shortage in the State .Out of 38 districts 1 positions of District Accounts Manager is vacant and vacant position of Block accountant in 35 blocks are needs to identify and fill the vacant post. Positions of Additional Director Finance, State Finance Manager and State accounts Manager and Six accountants are filled at State level However there is a need of full time Chartered Accountants is seems for financial compliance of Concurrent Audit and Statutory audit at state level.

Concurrent Audit

State has implemented the concurrent audit system in 2010-11 and 2011-12.Concurrent audit has been conducted for the 2012-13.Appointment of Concurrent audit is under process for State level and some of District Health Society for FY 2012-13.

Statutory Audit

State has submitted the statutory audit report for the year 2011-12.State is required to submit the action taken report for the audit of 2011-12.As per the audit report RCH unspent balance of Rs. 6.36 crore needs to be refund to GOI. Substantial bank balance reported by auditor as on 31.03.2012 for Rs.513 crore in State Health Society and Rs.401 crore in District Health Societies. There is opening balance differences in RCH Rs.15.90 crore and 5.6 crore in Mission Flexi Pool.

Funds Flow Mechanism

Electronic funds transfer system is being used in the State up to CHC/PHC level. Flexi Funds transferred under NRHM to District Health Society. JSY and ASHA incentive is pending for payment at District Hospital Gopal Ganj and CHC/PHC level. Funds of VHSCs have not been transferred in visited facility. Cash payment was observed in case of JSY payment and Family Planning payments. Funds are not being utilized at VHSCs in Shambuganj PHC at Villages of Kamatpur, Bhojpur and Kunta and Paithanpatti

Accounts Training

Training to accounts personnel is provided at District level and State level. CHC/PHC accountants are maintained their books of accounts on double entry system.

Tally ERP9 Software

Tally software ERP9 procured and training has been conducted up to district level. Tally software is working properly at State and District level and CHC/PHC level. Print out of tally ERP9 accounts (Cash Book) are seen at District level and CHC/PHC level.

Delegation of Financial Power

The State has issued delegation of financial powers up to Sub centre level.

Advances outstanding position as on 30-09-2012:

S.N.	Programme	Outstanding Advances 30/09/2012 (Rs. in Crore)
1	RCH	503.01
2	Mission Flexi pool	128.01
3	RI and PPI	66.38
4	NDCPs	31.29
	Total	728.69

Advance outstanding of Rs. 328 crore to Bihar Medical service corporation 13.50 crore to construction department should be monitored. Advances are booked as expenditure in case of ASHA kit payment at Banka DHS. Age –wise advance should be monitor from and advances should not be booked as expenditure.

Bank Balance as on 30-09-2011

S.N.	Programme	Outstanding Advances 30/09/2012 (Rs. in crore)
1	RCH	9.48
2	Mission Flexi pool	142.75
3	RI and PPI	16.28
4	NDCPs	24.67
	Total	193.18

Funds are available in Bank accounts of State Health Society. State has not monitored the pendency of JSY, Family Planning and ASHA incentive for funds transfer to District level.

Integration of Financial Management process with NDCPs

It was observed that the integration of finance staff at State /District Health Society level is done for reporting of expenditure purpose.

Diversion of Funds

Auditor reported that the funds have been transferred from one scheme to another scheme at District and state level during the FY 2011-12.

Implementation of Model Accounting Hand Books

State has implemented the Model Accounting Hand books, however the State has sent the books to District Health Society and District Health Society has sent the books to CHC/PHC level for implementation the Model Accounting Hand book.

TDS provisions

State and District level are following the rules of TDS deduction.

RKS Audit

The RKS auditors for the year 2012-13 have not been appointed at SHS and some of DHS. RKS meetings are not regularly held at District Hospital, Banka. RKS audit should be implemented as per ministry guideline.

Unspent Balance:

Unspent balance under mission flexi pool is Rs. 613 crore as on 30.9.2012 as per GOI release minus expenditure reported by State.

RCH I unspent balance of Rs. 6.36 crore needs to be refunded to GOI as per audit 2011-12.

Main Group Bank Account and Sub Group Bank Accounts

Bank Accounts has not been opened as per the ministry guidelines for opening of Bank Accounts in Main Group Bank accounts and Sub Group Bank accounts for integration of Bank accounts at State and District level. Banks are not providing the cheque book for timely JSY payments and Family planning payment. It was observed that some PHC was opened their bank accounts in Current Accounts. It should be in saving accounts.

Key recommendation:

- ✓ RKS meeting should be regularly held for monitoring the funds and further planning. RKS audit should be done as per guidelines of the Ministry
- ✓ State should timely compliance of audit observations for financial Management for the year 2011-12.
- ✓ BAM and BPM should monitor the funds of VHNSC.
- ✓ Timely payment to JSY beneficiary to be monitor from DHS level.
- ✓ Cheque requisition slip should be demand from concerned bank for next six month.
- ✓ Hard copy of financial report generated from Tally ERP-9 should be kept at all level duly signed.
- ✓ Cash Payment of JSY and FP is to be avoided.
- ✓ Full time Chartered Accountants is to be appointed for monitor the financial compliance of Concurrent Audit and Statutory audit at state level.

- ✓ Display/sign boards with NRHM logo about the medical and health care facilities and incentives available under various programmes of NRHM such as RCH, JSY Immunization and NDCPS may be erected at CHCs/PHCs at the earliest for general public information.
- ✓ Director Finance and State Finance Manager must visit at least two Districts in a month for monitoring and improving the financial management system
- ✓ District Accounts Manager/Accountant may also plan to visit at least two blocks in a month for supervising the working of the Accountant and submit his report to the CMHO and a copy to the concerned BMO
- ✓ Monthly meeting of DPMs/DAMs along with CMHOs may be held for monitoring the physical and financial progress of the programmes.
- ✓ MNGO and NGO monitoring system should be developed for proper utilization of funds given to MNGOs and NGOs.
- ✓ Physical and financial progress of work should be monitored and also report in FMR.

Good Practices

- Books of accounts was properly maintained in Tally ERP-9 software as well as manually at District /CHC/ PHC level.
- Bank Reconciliation Statement is prepared at all levels
- Timely reporting was observed from Block level to District health society
- Uniform accounting practice being followed by District Health Society
- Concurrent Audit implemented in Financial year 2011-12 and 2012-13
- JSY registers is properly maintained and all the JSY records and photographs of beneficiaries maintained properly at CHC/ PHC level..
- NDCPs accountant are properly maintaining books of accounts.
- Smooth Electronic transfer of funds up to PHC level.

CHAPTER 5

RECOMMENDATIONS

I. Programme Management

1. Since large number of posts against reserved category of vacant, after seeking approval of the competent authority, SHSB may fill-in these vacant posts with available candidates (irrespective of their reservation preference) as an interim measure, while search for suitable candidates belonging to reserved categories may continue.
2. The SHSB should strengthen the system of supportive supervision / hands-on support to facilities and advisory notes (for improvement) for each facility are maintained at the DPMU and as well as facility for subsequent follow-up.
3. The State and District Program Units should go with a dedicated checklist (GOI integrated RCH checklist can be adopted) for comprehensively monitoring RCH services at health facilities.
4. SHSB may explore the possibility of introducing differential compensation package with performance based incentives for contractual staff in 'difficult terrain'.
5. SHSB may undertake study for rationalisation of work among ANM, ASHA, AWW, Health worker (Male).

II. Infrastructure Development

1. While planning for new facilities or upgradation of existing health facilities, geographic location of new facilities should be thought in term 'time to reach the facility'. For example, a subcentre should be planned such that every household within its area falls within the walking time of 30 minutes. If due to some reason in difficult terrain, it is not possible to adhere to a standard timeline, the state should take considerate decision and notify so.
2. Each facility should have its own comprehensive facility development plan (no. of projected beds, availability of services, specialities, diagnostic facility, etc vis`a`vis which may be phased for a time span of 10 years period.
3. Since there is large scale construction of health facilities in progress in Bihar, the State may plan to have a Hospital Planning Cell, which would provide technical inputs for the facility development like schematic diagram, architectural brief, technical specifications, etc.
4. In the districts, where large scale construction is in progress, the a civil engineer may be positioned at DPMU.
5. Repair of residences for key personnel at the facilities may be given priority. The state may consider providing existing vacant residence to key contractual staff, whose services are essential in the interest of the programme.
6. The subcentres may be provided with source of light and availability of water on 24x7 basis.
7. The facilities may plan to undertake low cost civil work, which would have direct impact on privacy, confidentiality and physical access by patients such as ramp, partitions, wire-mesh on windows, etc. In order to get the work completed on the fast-track, such contracts may be approved by the RKS / Civil Surgeon.
8. The hospital should operationalise its own laboratories, which are practically non-functional now because of existing arrangement for diagnostic services under the

PPP mode. Out-sourced services should supplement the existing structure and public services, not become its substitute.

III. Human Resource

1. For increasing availability of doctors, the state may operationalise three new medical colleges under a time-bound programme.
2. Deployment of manpower should be based on the work load. For instance, it was observed that a large number of subcentres have two ANMs posted, without commensurate workload.
3. The state should allocate priority to operationalization of GNM schools. Simultaneously, to overcome the shortage of LHVs, senior ANMs may be trained and promoted as LHVs.
4. At the village and subcentre level, there are multiple health workers, with overlap of their job functions and responsibilities. The state may like to get the job functions of each front-line health worker examined and rationalise it among ASHAs, ANM, Health Worker (Male) and AWW. This may require coordination with Department of Women and Child Development.
5. Training need assessment (TNA) of health sector staff may be undertaken through a systemic study, and further trainings should be based on the TNA. The field staff would need considerable supportive supervision and mentoring, which need to be strengthened.
6. To overcome the shortage of Epidemiologists, SHSB may consider collaborating with NICD, PHFI etc for the training.

IV. Outreach Services & Referral Transport

1. Awareness on 102 / 108 Ambulance / Patient transport system needs to be created, more so in difficult terrain. Periodical analysis of data in term of meeting the community need of reliable transport system, response time, availability of ambulance in night, etc may please be undertaken and corrective actions are taken.
2. It was observed that one vehicle per block is not able to meet full requirement of the block, resulting into considerable out-of-pocket expenditure. Fleet of the vehicles need augmentation. As an interim measure for providing assured referral transport to pregnant women and sick neonates, the state may consider a voucher scheme for the referral transport, for supplementing the unmet needs.

V. Community Processes

1. A large number of ASHAs have not undergone module six and seven trainings. It needs to be hastened-up to impart requisite skill-sets.
2. Supportive supervision, onsite mentoring and monitoring need to be strengthened, including institution of a system of grievance redressal for ASHA'S.
3. Role clarity and coordination among ANM, ASHA and AWW need to be strengthened.
4. Policy regarding referral to the private sector (in absence of Public Health Facilities in the vicinity).
5. As far possible, ASHAs / ANMs should be provided accommodation within the facility premises, if they are staying overnight with labour cases.
6. Timely payments to ASHAs towards the incentives should be ensured.

Panchayati Raj

1. Panchayati Raj engagement in VHNSC, RKS and district health society should be strengthened. Newly elected PRI members may be formally oriented on their roles and responsibilities, including operations of the account.

VI. Reproductive & Child Health

1. The State should examine its strategy for delivery of effective RCH services. Considerable gaps exist in terms of these services meeting minimum quality norms, more so at the level of subcentres, APHCs and PHCs. Multi-pronged strategy is recommended – enhancing knowledge and skill level, traversing gaps such as Haemoglobinometer, weighing scale, etc. supportive supervision by block level teams, monitoring by district level officers and DPMU, follow-up actions on the visit reports, effective use of MCTS,
2. Availability of CeMOC services with all its full components needs to expand at facilities other than district hospitals and selected referral hospitals. Even in district hospitals, other than availability of facilities for the caesarean section, functional SNCU and Blood bank needs to be strengthened.
3. BeMOC services need to be strengthened below district level (Refresher training/technical monitoring and supervision to be institutionalized).
4. Availability of all components of JSSK needs to be ensured at all levels. The state may conduct periodical survey in small pockets to know out of pocket expenditure, if any, on drugs, transport, diet. As discussed during the CRM debrief on 09th Nov 2012, locally available vendor may be contracted for supply of diet, which is logistically feasible such as bread, boiled egg, milk, banana, etc.
5. FP services' focus should be on the spacing methods. Fixed day services may be planned at Sub Centres.
6. Availability of safe abortion services at the facilities was minimal.
7. Maternal Death Review to be institutionalized.
8. Availability of blood at Blood banks and blood storage units needs to be ensured so almost full requirement of blood is met.
9. Partnership with civil society organizations need to be strengthened and possibility of extending the partnership for other areas like referral transport need to be explored.
10. Current modality of JSY payments to beneficiaries may please be evaluated through 'process approach' and 'redundant activities' may be discarded. As far as possible, payment to beneficiaries should be made at time of discharge from the facility. .
11. NBCC to be made functional, preferably with trained staff nurses.
12. NBSUs and SNCUs as appropriate for the facilities to be operationalised.
13. PNC care needs to be strengthened with appropriate supervision and monitoring
14. AWC to be equipped and monitored for growth monitoring. Every immunized child should be weighed and height measured by AWW, AWW worker should fill-in the nutrition part of the card on VHND day. VHND days should to be utilized for delivery of integrated MCHN services.
15. M Kunji needs to be evaluated in future for its effectiveness. If it is found effective, it could be scaled-up at national level.

16. Effective IEC strategy for improving sanitation and hygiene practices, provision of safe drinking water.

VII. **Promotive Health Care, Action on Social Determinants and Equity concerns** - The state's BCC strategy should be focused on four ANC visits, institutional delivery, iron and folic acid supplementation, and complete immunization, Postnatal care (PNC) for mother and newborn, High impact, simple behaviours such as early breastfeeding initiation, clean cord care, skin-to-skin care, timely seeking health care after danger signs, and contraceptive use.

VIII. **PCPNDT ACT -**

- a. Immediate constitution/ reconstitution of the statutory bodies under the Act viz. State Supervisory Board, State Inspection & Monitoring Committee, District Advisory Committees.
- b. The State Inspection and Monitoring Committee (SIMC) to be constituted, which would also have representatives from Health, Legal Affairs, Civil society and State Women's Commission.
- c. Periodic meetings of State Inspection and Monitoring Committee and State Appropriate Authority need to be ensured.
- d. Organisation of state level orientation programme for all Stakeholders working at State/ Districts.
- e. PC & PNDT Cell to be constituted at State & District level with required HR and infrastructure in order to facilitate the reporting process.
- f. Comprehensive mass media and IEC campaign involving both electronic and print media.

IX. **National Disease Control Programme**

Kala-azar

1. Elimination would require intensified project coordination with NRHM, monitoring and supervision by the Medical Officers at the district, block and PHC level.
2. The State is faced with shortage of Kala-azar drug – Miltefosine, for which the state has been approaching National Vector Borne Disease Control Programme. The Ministry of Health & Family Welfare is requested to intervene to meet the state's requirement..
3. The state may launch a campaign on Integrated Residual Spray (IRS). At local level ASHAs could play supportive role in educating the community.

Tuberculosis

1. Sensitise the service providers on case findings and public referral
2. ANMs and ASHAs may be incentivized in case findings
3. Strengthen notification of TB cases from private sector

X. **Use of Information Technology** - The District Health Ranking system has been introduced by the state on some of the key indicators which is a good innovation to ascertain the performance of different districts on monthly basis. Currently, the ANMs were not receiving any micro plans made by the MCTS software to work on. The ANM needs to fill the data on an MCTS formats and MCTS register at the sub-centre. The forms are sent to the PHC and are uploaded by the Data entry operator into the server.

The forms are then returned to the ANM with the 18 digit registration number for the beneficiary. It was however seen that many of the forms that were sent back to the sub-centres did not still have the registration number on the form or on register. The system may strengthened.

XI. Mainstreaming of Ayush

1. APHCs, where Ayush doctors are posted may be strengthened by providing infrastructure and supporting staff.
2. Supply /availability of adequate quantity of Ayush medicine
3. Ayush doctors needs to be involved in implementation and monitoring of National programmes (TORs are defined but not implemented in the field.)
4. At CHC and District level, Ayush facilities may be co-located, so that the community makes an informed choice about the treatment system. At all District Hospitals, Speciality wing of Panchkarma in Ayurveda and Ilaj Bit Tadbeer (RegimenalTherapy) in Unani system may be established which are more effective in Non-Communicable diseases in both preventive and curative aspects. In addition to this the number of standalone AYUSH dispensaries may be increased. The Administrative structure of Directorate of AYUSH may be strengthen at state, regional and district level to facilitate the effective monitoring of AYUSH systems in the state.

XII. Financial Management

1. State should track the expenditure out of state's own contribution.
2. Concurrent audit & RKS audit should be implemented as per ministry guideline.
3. Integration of Bank Main Group and Sub- Group Account should be done at all level.
4. Statutory Audit should be implemented timely.
5. Advances in chronological order should be monitored and advances should not be booked as expenditure.
6. RCH-1 unspent balance should be refunded to Ministry of Health & Family Welfare, Government of India.
7. Difference in opening balance should be reconciled
8. Concurrent audit & RKS audit should be implemented as per MoHFW guidelines.
9. RKS meeting should be regularly held for monitoring the funds and further planning.
10. BAM and BPM should monitor the funds of VHNSC and provide hand-holding support, more in case of newly elected PRI members.
11. Timely payment to JSY beneficiaries needs to be monitored at Distirct Level.
12. If the local banks are unable to meet the full requirement of Cheque-books, the issue may be taken up with bank regional office & head office. State Health Society may also intervene.
13. Hard copy of financial report generated from Tally ERP-9 should be kept at all level duly signed.
14. RKS audit should be done as per guidelines of the Ministry of Health & Welfare.
15. Cash Payment to JSY & Family planning beneficiaries should be avoided.