National Rural Health Mission (NRHM)
Government of India
New Delhi

7TH COMMON REVIEW MISSION

VISIT REPORT: BIHAR

11TH -17TH NOVEMBER 2013

SEVENTH COMMON REVIEW MISSION
STATE VISIT REPORT: BIHAR (NOVEMBER, 2013)

1. INTRODUCTION

A Common Review Mission led by Dr. Sushma Dureja, Deputy Commissioner (Adolescent Health) MoHFW GoI, senior officers from MoHFW, development partners and consultants visited Bihar during November 11-17, 2013 to review the implementation of NRHM. Details of mission members are in Annex-1.

The main objective of 7th CRM was to review the functioning of NRHM/NHM vis-à-vis its goals and objectives, identify the changes that have occurred in last eight years, assess the health care delivery system in the States especially to find out what has worked and what hasn't and explore the main reasons for successes and failures, document the lessons learnt and suggest a way forward.

The team did an in-depth desk review of the documents and data available including the State PIP, Record of Proceedings of NPCC, HMIS data and variance analysis report before heading for the State. Mr. Sanjay Kumar, Secretary Health cum Mission Director NRHM, Government of Bihar, chaired the briefing meeting on 11th November 2013, which was attended by officers and consultants of DoHFW. After the opening remarks by Dr. Sushma Dureja, DC (AH), GoI, on the objectives of 7th CRM, a detailed presentation was made by Mr. Sanjay Kumar, Mission Director, Bihar and other programme officers of the State highlighting the progress, status of main programmes under NRHM and the new initiatives being taken by the State.

The CRM team visited two districts, Vaishali and Purnea. The details of the facilities visited are in Annex 2.

The Mission had a debriefing session on November 17, 2013 chaired by Mission Director NRHM, Government of Bihar. List of persons who were present in debriefing meeting is provided in Annex 3
The team would like to sincerely express appreciation and thank the officials of the Government of Bihar, staff of SHSB, Directorate and staff of the facilities visited by the CRM for facilitating the review, openly responding to various issues raised by the CRM members and hospitality provided.

Structure of the report

The Structure of this report is as follows:

- Chapter 2 provides a summary
- Chapter 3 gives background of the State based on the desk review.
- Chapter 4 is based on the field findings of the CRM. The chapter is structured into 10 thematic areas of the 7th CRM. For each theme, the State scenario or current status, followed by team's observations in the districts and issues or areas of improvement has been provided.
- Chapter 5 provides the overall recommendations.

2. EXECUTIVE SUMMARY

Bihar has come a long way since 2005. Bihar has made good progress in terms of some goals and outcomes:

- IMR has reduced from 61 (SRS 2005) to 43 (SRS 2012)
- MMR has reduced from 312(SRS 2004-06) to 261(SRS 2007-09)
- Full Immunization has gone up from 11.6% (NFHS 1998-99) and 19.0 % (CES 2005) to 49.0% (CES 2009) and 64% (WHO concurrent evaluation 2012-13)
- ANCs registered within first trimester has more than doubled (from 15.3% DLHS-2, 2002-04 to 33.2% CES 2009)
- Deliveries taking place in public facilities 18.8% (DLHS-2, 2002-04) to 48.9% (CES 2009)

The State has also tried to build up and strengthen NRHM structures by inducting program managers, service delivery staff and ASHAs:

- State has established program management units at all levels and has more than 1400 posts of program managers: State-42, division - 45, district- 190, FRU-149 and block level- 1066
- State has added 1409 doctors (from state budget), 1384 AYUSH MOs, 1512 staff nurses, 8529 ANMs on contract in addition to the regular staff. In total, Bihar has 16,167 posts of contractual service delivery staff approved under NRHM against 13,800 regular and contractual staff supported by State.
- State has selected 84860 ASHAs. ASHAs are supported by supervisory posts at every level: 533 community mobilizers at block, 38 at district and 9 at divisional levels. State also has 4405 Mamtas.

Other notable initiatives include:

- Availability of free drugs in all public health facilities
- Revival of ANM schools in the State majority of which were closed for 15 years
- Development of HRIS web portal to capture personnel/HR information
- Ranking of districts and divisions based on on-line dashboard system for monitoring progress
- Piloting of mobile kunji, a job aid which helps frontline health workers deliver high quality inter personal communication during their home visits
- Government to Person (G2P)Payment Project comprising an online system called Health Operations Payment Engine (HOPE) and last mile delivery of G2P Payments
- Establishment of Bihar Medical Services & Infrastructure Corporation to procure drugs and equipments and also build quality health infrastructure

Bihar received recognition for its efforts and was declared winner in five categories among EAG states based on (1) % change in Under 5 mortality rate, (2) % reduction in Infant Mortality Rate, (3) % change in the 3 ANC Checkup+ Institutional delivery, (4) increase in Number of IPD attendance/1000, (5) % increase in OPD attendance/1000 population

State has also provided much required stability of tenure to the Mission Director, NRHM thereby ensuring that long term decisions are taken, implemented and consolidated.

The desk review, discussions with State, divisional and district officials, field visits, and interactions with community revealed that there was absolute lack of service delivery prior to NRHM. Because of

this high unmet need public health facilities got an overwhelming response when government hospitals started providing services and free drugs. However now the system is reaching a plateau- it is quite evident in institutional delivery and even in OPD and IPD the rate of increase has slowed considerably.

Given the above background of progress, the 7th CRM tried to find out reasons that have prevented Bihar in sustaining a faster rate of progress particularly in RCH and disease control programs especially Kala-azar, providing better quality of services and getting results commensurate with the resources invested.

Even after 8 years of NRHM, there are considerable challenges in infrastructure, HR deployment, performance monitoring, referral transport, supervision and capacity building. The data and the field visits show that:

- Huge infrastructure gaps still remain. As per population norms Bihar still requires 795 CHCs, 2130 PHCs and 11064 Sub-centres. As per 'time to care' criteria numbers are more.
- Block PHCs having 6-9 beds are catering to a population of approximately 2 lakhs which is highly inadequate. With an average 15-20 delivery per day in some of the BPHCs, mothers and newborns are being kept out in open.
- Only 204 out of 1330 APHCs i.e. 15% are serving as level 1 facility and conducting more than 10 normal deliveries a month. Other APHCs are largely providing only OPD services, thus people have to visit the block PHCs or other higher facilities for any primary IPD services. (The APHC are the actual PHCs as per GoI norms which caters to 30-50000 population in Bihar)
- Overcrowding at BPHCs and DHs coupled with less number of beds makes it impossible to provide quality services. 48 hours stay becomes a remote possibility. All India average is one government hospital bed for 879 people where as in Bihar it is about 6000 people per bed.
- With only 127 gynecologists, 58 anesthetists, and 119 pediatricians in government system, availability of specialists remains a problem. State is yet to design an incentive package to attract specialists.
- Rational posting of existing specialists and EmOC/LSAS doctors has improved. However, HR data shows that 5% (9 gynecologists, 2 anesthetists, 4 pediatricians) are still posted in APHCs where they can never be utilized. Another 30% are posted in the BPHCs. Similarly 20% of EmOC and LSAS trained MOs(10 EmOC and12 LSAS trained MO)s are posted in non-FRUs. More worrisome is non-performance and lack of performance monitoring by the State/district. Only 44% of LSAS and 22% of EmOC trained MOs are performing.
- State has 567, "dial 102": all Basic Life Saving (BLS) ambulances, 50 "dial 108": 5 Advanced Life Support (ALS) +45 BLS ambulances. Number of ambulances is inadequate for 102 as it has to cater to a population of almost 2 lakhs. Ambulances are currently catering to 26 % of PW coming for institutional deliveries for pick-up and only 24 % for drop back. Absence of a centralized single number (state has three number: 102,108 and 1099 each catering to specific needs) creates confusion in public.
- Frontline supervision is almost non-existent with only 432 LHVs left (to monitor 17726 ANMs) in the system, mostly on the verge of retirement. The only LHV School in the State is closed since 1992. There is no alternate supervisory cadre in place. Interaction during field visit shows that supervision by officials and MOs in regular cadre is rare and ad-hoc.
- State has added almost 2000 program managers/supervisory staff. Recently majority of them have started conducting regular field visits and the checklists are uploaded on the website. However, follow up action is non –existent. Lack of adequate empowerment and State's backing is rendering such monitoring visits ineffectual.

- Another problem is weak capacity building system especially in-service training. SIHFW has only 4 regular staff. There are no district training centres. The choice of trainee at district level is ad-hoc. There is no orientation training, refresher trainings are rare. Pace of programmatic training is very slow.

Given the above scenario Bihar now needs to concentrate on much faster up gradation of infrastructure, increase bed capacity, ensure optimal utilization of available HR, take steps to make monitoring effective and develop a robust system for capacity building.

The areas of priority action may include:

- Differential facility/block/district plan and its speedy execution especially infrastructure at BPHCs and APHCs
- Strong and responsive capacity building system which can take care of the dynamic requirements of the health system, reviving SIHFW, exploring PPP in training
- Empowerment of staff for effective monitoring and supervision and ensuring follow up action
- Long term systemic changes in terms of comprehensive HR policy which explores absorption of contractual staff and building up a public health cadre

Past CRMs have also highlighted similar issues however pace of implementation in the State seems to be slow. Many of the studies/plan and decisions recommended last year are still under consideration.

In spite of the gaps, the performance/achievement of Bihar in terms of goals and outcomes in the last five years in some areas has been impressive. The recognitions bestowed on Bihar also acknowledge the fact that the State has really performed well and is moving in the right direction. The achievements have primarily been possible for the high commitment of the numerous people working at various levels within the health system who have faced the challenges and ignored all odds (some of whom we met during the CRM visit) to improve the health situation. However the pace needs to be much faster so that in the coming years the momentum itself can sustain the rate of progress.

3. DESK REVIEW

Introduction to Bihar

Bihar has 38 districts with a total population of 1038 lakhs (Census, 2011). The population density is 1100 per sq. km. Almost 12 % of the total population in Bihar lives in urban areas.

Demographic Profile

Indicator	BIHAR	India
Total population (In Crores) (Census 2011)	10.38	121.01
Crude Birth Rate (SRS 2011)	27.7	21.6
Sex Ratio (Census 2011)	916	940
Child Sex Ratio (Census 2011)	933	914
Total Literacy Rate (%) (Census 2011)	63.82	74.04
Per capita income(2011-12)	24,681	60,972
% of BPL Population (2011-12)(Planning Comm)	33.7	21

NRHM: Goals and Achievements

RCH

The State's MMR at 261(SRS 2007-09) has improved from 312; but is still way above the national average of 212. The IMR (SRS 2012) is at 43. TFR at 3.6 (SRS 2011) is higher than the national average of 2.3 and nowhere close to the target of 2.1.

INDICATOR	BIHAR		INDIA	
	Trend (year & source)		Current status	NRHM goal
Maternal Mortality Ratio (MMR)	312 (SRS 2004-06)*	261 (SRS 2007-09)	212 (SRS 07-09)	<100
Infant Mortality Rate (IMR)	61 (SRS 2005)	43 (SRS 2012)	42 (SRS 2011)	<30
Total Fertility Rate (TFR)	4.3 (SRS 2005)	3.6 (SRS 2011)	2.3 (SRS 2011)	2.1

*MMR as per AHS 2010-11 is 305, and AHS 2011-12 is 294.

DLHS & AHS figures

(All figures are in %)

Indicators	DLHS -3 (2007-08)	AHS (2010-11)
Mothers who had 3 or more Ante Natal Check-ups	26.4	34.0
Mothers who had full Ante Natal Check-up	4.6	5.9
Institutional delivery	27.7	47.7
Children 12-23 months fully immunized	41.4	64.5
Total unmet need for family planning	37.2	39.2

National Disease control Programmes:

Parameter	State Target for 2013-14	Outcome of the Mission in the State (Up to June 2013-14)
Annual Blood Exanimate Rate (ABER) i.e. persons screened annually for Malaria	0.10	0.16
Annual Parasite Incidence (API) i.e. Malaria cases per 1000 population annually	<1	0.02
Annualized new smear positive case detection rate(%) for Tuberculosis	70%	44%
Success rate of new smear positive patients (%)	90%	88%
Leprosy prevalence rate	<1	1.21
Cataract Operation (in lakhs)	2.85	0.19
Number of IDSP units functional	38	38

Financial Progress under NRHM

- More than Rs.6077.26 crores has been released far for Bihar under NRHM
- For the year 2013-14, allocation under NRHM for Bihar is Rs. 1396.63 Crores.

Base line of the public health system in the State

Health Infrastructure

District Hospital (DH)	:	36
Sub Divisional Hospital (SDH)	:	38
Community Health Centres (CHCs)	:	70 (known as Referral Hospital in the State)
Block Primary Health Centre (BPHC)	:	533
Additional Primary Health Centres (APHC)	:	1330
Health Sub Centres (HSC)	:	9696

High Priority Districts

Out of 38 districts in Bihar, 10 are high priority districts (Jamui, Saharsa, Purnea, Sitamarhi, Sheohar, Purbi Champaran, Araria, Katihar, Kishanganj & Gaya).

The CRM team covered one high priority district i.e. **Purnea** and one better performing district i.e. **Vaishali.**

Health System Strengthening

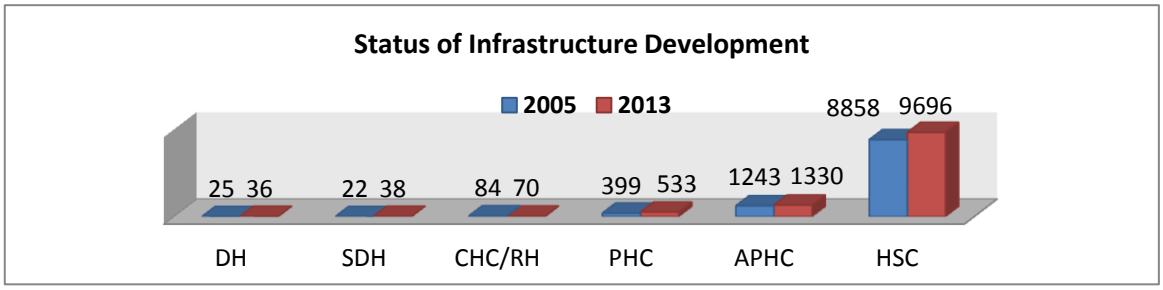
Sl. No	Activity	Status
1	24x7 PHC	On a baseline of zero 24X7 PHCs in 2005, 496 more PHCs are functional as 24X7 basis during 2005-06 to 2013-14.
2	Functioning as FRUs	On a baseline of zero FRUs in 2005, 66 facilities (36 DHs, 19 SDHs and 11 CHCs) are working as FRUs in 2013-14.
3	ASHAs Selected	On a baseline of 36488 ASHAs selected in 2005-06 , 84541 ASHAs selected up to 2013-14, 60386 ASHAs trained in Round-1& 36853 ASHAs trained in round 2 of the 6 th & 7th Modules.
4	ANMs at SCs	In Bihar, out of 9696 SCs, 5676 SCs are functional with 2nd ANMs.
5	Contractual appointments	In Bihar, 13520 health human resources have been supported (1601 Doctors, 273 Specialists, 1384 AYUSH Doctors, 1491 Staff Nurses, 414 Paramedics & 8357 ANMs are positioned).
6	Rogi Kalyan Samiti	On a baseline of 487 RKS registered in 2007-08, out of 1969 health facilities, 1918 facilities (36 DH, 68 CHCs, 35 Other than CHCs, 481 PHCs & 1298 other than SC) have registered under RKS up to 2013-14.
7	Village Health Sanitation & Nutrition Committees (VHSNCs)	On a baseline of zero VHSNCs in 2005-06, 8295 VHSNCs constituted at Panchayat level in 44874 villages up to 2013-14
8	MMUs	On a baseline of zero VHSNCs in 2005-06, 34 MMUs are operational in 24 districts in 2013-14.
9.	ERS(108 type)	In Bihar, 567 ambulances (517 BLS and 50 Advanced) are operational.
9	VHNDs	On a baseline of 2.12 lakhs VHNDs held in 2007-08, 9.08 lakhs VHNDs were held in 2012-13 and a total of 16.9 lakhs VHNDs were up to June 2013.
13	Drugs	In Bihar, more than Rs. 95 Crores have been allocated for Drugs under NRHM in 2012-13 & more than, Rs. 164 crores have been allocated in 2013-14.

4. FINDINGS OF 7TH CRM IN THE STATE

I. Service Delivery

Adequacy of Facilities

- After the implementation of NRHM, the number of public health facilities in the State has increased. As shown below the increase is seen in all categories of public health facilities except CHC/ referral hospitals[1]:



(Source: RHS 2012, DoHFW Govt. of Bihar)

However huge gap remains in terms of facilities as well as number of functional beds:

Type of Health Facility	Required as per population (2011 Census)	Sanctioned	Available (as RHS 2012)	Actual Gap	No. of Beds Sanctioned	No. of Beds Working	Avg no of beds /facility
Medical College & Hospital	21	12	10	11	7300	5587	559
District Hospital	38	36	36	2	4897	4308	120
Sub Divisional Hospital	63	55	38	25	3607	1546	41
Community Health Centre	865	469	70	795	2070	1877	27
Primary Health Centre (PHC) block	533	533	533	0	3204	3122	6
Additional Primary Health Centre (APHC)	3460	2787	1330	2130	16722	927	0.7
Health Sub Centre	20760	16623	9696	11064	0	0	0

[1]Some of the Referral hospitals have been upgraded to Sub-divisional hospitals, hence the decrease in number.


Overcrowding & Floor beds

- Total number of beds in public health facilities is approximately 1 bed for 6000 population which is far less than WHO standard of 1.9 beds per 1000 population and even more relaxed goals of 11th five year plan which targets 1 bed per 2000 population. With 50% of population below poverty line, for whom private sector remains out of bounds; overcrowding, patients sharing beds or being treated in the corridors, on the floor is a routine occurence.
- Due to less number of facilities, availability and accessibility remains a problem, more so in difficult to reach areas where people have to cover large distances.
- In spite of shortage of facilities, State has made good progress in reaching out to the marginalized sections through outreach activities such as VHSNDs and through ASHAs. Team visited "Mahadalit tolas" and "Mushahar community" in Purnea district and found them well aware of their entitlements especially JSY. They were found to be availing services in the VHSNDs particularly ANC and immunization.

Infrastructure

- Infrastructure development plans were available at state and district levels, but there is no prioritization of construction of infrastructure based on un-served areas, backward areas, land availability and need especially for high caseload facility. Facility up gradation/construction is not as per IPHS. Quarters for staffs are highly inadequate across the state. The pace of construction is tardy and quality of construction variable.

Overall Progress of infrastructure work under NRHM since inception:

Facility	New Constructions		Renovation/Upgradation	
	Sanctioned	Completed	Sanctioned	Completed
DH	12	11	25	24
SDH	30	16	22	19
CHC/BPHC	0	0	414	11
PHC	62	41	0	0
Other than SC	272	10	73	55
SC	3415	1028	2767	1742
Total	**3791**	**1106**	**3301**	**1851**

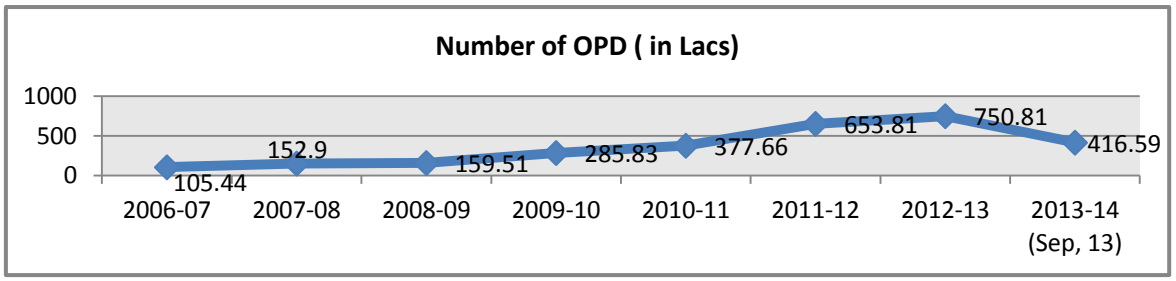
(Source: June MIS report, MoHFW)

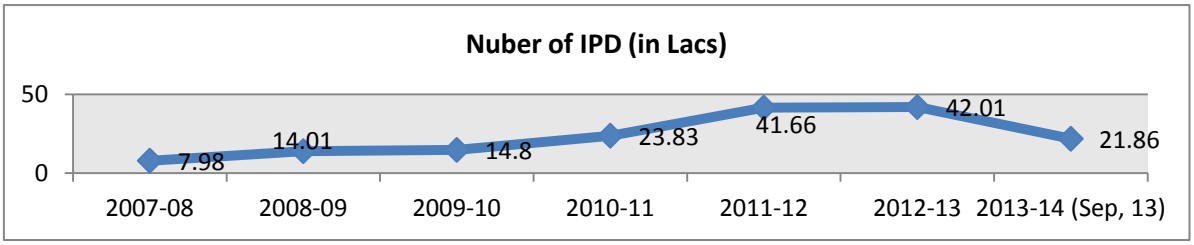
- Before year 2010 all the construction works were done through PWD. Out of 4192 sanctioned works to PWD only 1200 works have been completed till date. Bihar Medical Services Infrastructure Corporation Ltd (BMSICL) was established in 2010, however it is yet to be fully functional and some works are still pending with PWD. In addition, State has an infrastructure wing of civil works in SHSB comprising one Superintending Engineer, one Executive Engineer and two Assistant Engineers which monitors construction, up-gradation as well as maintenance of the health infrastructure

- Amongst the sanctioned construction work under NRHM and State budget, construction has not been started in 20 PHC, 320 APHC and 2089 HSC due to unavailability of land. Out of total planned construction of SNCU, trauma centre, drug warehouses, MCH wings and quarters for doctors and nurses, majority are under construction.
- In spite of all the constraints, Infrastructure and equipments were found to be adequate at the DH & SDHs of both the districts. Overall maintenance and cleanliness too was satisfactory. The DHs have all the departments and can be developed into medical colleges.
- There is serious mismatch of infrastructure especially at the delivery points (except DH and SDH) which remain high case load facilities without adequate infrastructure, beds, seating arrangement, toilets, boundary walls etc. State has 496 functional Block PHCs working 24x7, each covering a population of approximately 1.5 to 2 lakhs but having only 6 beds. BPHC K.Nagar in Purnea had only 9 beds and is conducting 15-20 deliveries per day. Due to lack of adequate beds newborns and women are kept out in the open verandah/corridors. Similarly in BPHC Vaishali, Garoul, Bhagwanpur & Rajapakar in Vaishali district are conducting 7-9 deliveries per day, but due to less number of beds (i.e only 6 bedded PHC) 48 hrs stay of the women after delivery is not being practiced. SDH Mahua (vaishali Dist) have no regular electric connection purely depends upon generator for power supply.

Utilization of Facility Based Services:

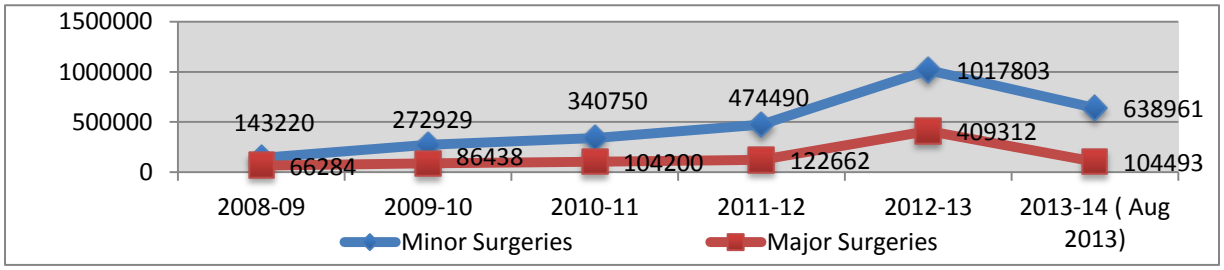
- The OPD & IPD numbers increased substantially since inception of NRHM.





(Source: HMIS data)

Major and minor surgeries:



- In both the districts, facilities have increased flow of in-patient admissions with admissions of primarily of Institutional deliveries, trauma cases, fever and cases of Kala- azar.
- State has a free drug policy. There are essential drug list for OPD & IPD patient. In both the districts, the supply of medicines was adequate. Lab Diagnostics and X ray services have been made available through PPP.
- The State has 28 functional Blood Banks and 7 Blood storage units. State is also in the process of establishing 6 new Blood Banks in Araria, Arwal, banka, East Champaran, Sheohar & Supaul district. Blood Banks were available at DH level in both the districts. In Vaishali district, no BSU is available at any of the 3 designated FRUs; hence none of the FRUs fulfills the criteria of fully functional first referral unit. Therefore all the complicated cases are being referred to either district hospital Hazipur or PMCH Patna.
- There are 1330 AYUSH co- located heath facilities, all of which are Additional Primary Health facilities (APHCs). AYUSH medical officers are posted in these Additional Primary Health Centers to mainstream AYUSH services. Patients flow: average- 35-40 patients/ per day in OPD at all APHCs. No IPD services for AYUSH are functional at any APHC. No OPD services for AYUSH available at District Hospital, SDH & BPHC level. AYUSH doctors are being utilized in the National Health Programmes like School Health, WIFS at APHC level.
- In Purnea district, AYUSH drugs have not been supplied after 2011, though in FY 2013-14 an amount of Rs. 585 Crores have been sanctioned for AYUSH drugs for co-located AYUSH health facilities by Department of AYUSH. This is forcing the AYUSH MOs to prescribe allopathic drugs. At many APHCs the AYUSH MOs are managing the APHCs with the help of ANMs/SNs with 30-35 patients in OPD per day without any allopathic MO.
- CRM teams found that the limitations of infrastructure were a limiting factor in IPD/ bed occupancy. In Vaishali district the lack of specialists was cited as a reason for referral of complicated cases to PMCH in Patna district. C section service is being provided only at DH Hajipur, since only one anesthetist is available in Vaishali district. Mahua also has Dental clinic and Yuva clinics for youths. Safe abortion services were not available in public health institutions except DH.
- The State has re-designated its facility as Level 1, Level 2, and Level 3 depending on the service delivery package being provided. Out of 941 delivery points, 389 L1, 496 L2 & 56 L3 health facilities are functional in the State, which makes 8.04% of the facilities functional as delivery points. The % compares well with other states however the situation needs to be analysed in terms of huge gap in infrastructure, high population density and high BPL population.
- Overall increase in funding in the past years has led to reanimation of government health care service delivery, especially when compared to pre-NRHM period by providing better infrastructure, staff, equipment, medicines and other consumables available for general public, thus expanding the services available .However, the pace needs to be much faster and can be sustained only through long term systemic changes.

Quality of Care

- Quality assurance committee is functional at State, Regional and District levels; however meeting of district level QAC needs to be regular. No mechanism is in place to ensure adherence of Standard Treatment Protocol in both the districts.
- Citizen charters are adequately displayed in Purnea but only at few places in Vaishali.
- State has reported to have Grievance redressal system in which people can register their complaints through phone, on line or SMS, but Grievance redressal mechanism was not visible in both the district. Mechanism to capture patient satisfaction level has not been found in the health facilities visited by the team. As informed by Civil Surgeon Vaishali, people's complaints are received in writing and then action is taken.
- Some of the facilities (SDH/PHCs) have no attached toilets in the labor room.
- Screens were not available in the hospital wards to ensure patient privacy in both the districts.
- There is no sitting arrangement for attendants in the ward.
- Centralized Sterile Services Department (CSSD) was not found to be functional in DHs of Vaishali and Purnea.
- Bio Medical Waste management system has been outsourced from Medical College to PHC level. In all the 38 districts up to PHC level following agencies are providing waste management services -M/s Synergy Waste Management Pvt. Ltd., New Delhi, M/s SembRamky, New Delhi and M/s S.S.Medical Systems, Bhimtal.
- Bio Medical Waste management system was found to be weak. The hospital biomedical waste is not being segregated at source as per the guidelines.. Though the State has conducted more than one round of training, the behavior change in the staff is yet to take place. The hospital staff casually disposes off the waste product in the colour-coded bins without understanding the importance of segregation.
- The plastic bags are not being placed inside the bins on regular basis; most of the bins at PHC and below level are being used without plastic bags.Also, an irregular supply of plastic bags to be kept inside the dust bins is reported
- In Purnea at SDH Dhamdaha, the collecting vehicle from M/S Synergy had two plastic drums in which all kind of biomedical wastes were being collected from the facilities defeating the very purpose of segregation and waste management.
- No mechanism was visible in Vaishali and Purnea districts to ensure Biomedical Waste Management at APHC & HSC levels.
- Infection control measures were inadequate in most of the facilities especially BPHC and below. Use of bleaching solution and procedure of sterilization of equipments needs improvement.
- Housekeeping, laundry and diet services have been outsourced. Housekeeping services especially cleaning of toilets were not satisfactory. In DH Purnea, toilets are dirty and offensive; the team was given to understand that there was shortage of materials like phenyl & other disinfectant. The housekeeping services are not being monitored at all. The hospital staff also complained about non-cooperative behavior of housekeeping staff at DH Purnea. In District Hospital Purnea, old maternity ward doesn't have functional toilet; new ward has four functional toilets, however three remains locked and reserved for hospital staff. Diet for the IPD patients is being provided up to Block PHC level.

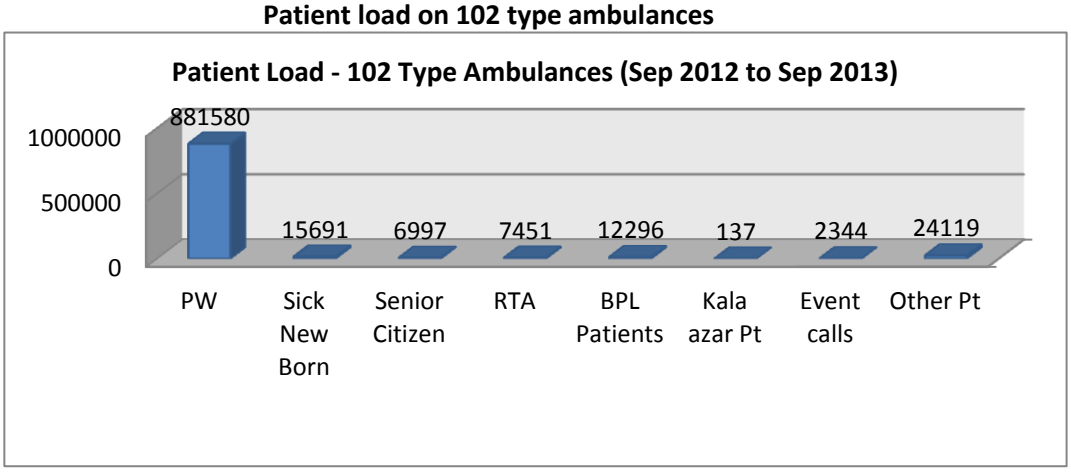
Subcontracting/PPP

- Following services are being provided through PPP mode in the State: MMU, BMW management,lab diagnostics,Xray, ultrasound, dental clinics, dietetics, housekeeping, laundry Generator.
- All the services being provided through PPP mode are free for all the patients coming to the Government health facilities. Non availability of doctors has been found at the some health facilities for generating radiology reports (as mandated in contract). The payment is not being made to IGEMS (the outsourced agency entrusted for radio-diagnosis) staff for the last 4 months in Purnea district.
- The service delivery through outsourcing has made services available and increased accessibility of to health services in far flung areas, which is one of the major factors of increase in the number of patient inflow to the public health facilities. Outsourcing ensured better cleanliness in most of the hospitals e.g. SDH Mahua, BPHC Vaishali. Power back up provided through generators in all facilities up Block PHC level ensures the night stay of patients in the health facilities.
- Purnea DH has outsourced advanced dental clinics to private dentists which is very popular among the clients in spite of the charges (fixed charges as set by State is charged and is well displayed). It is free for BPL patients and the amount is reimbursed by the State. However the district is reconsidering such clinics as their own dental clinics are not running well. State needs to provide adequate services to public, even through PPP and may get a study conducted through third party before taking any decision.

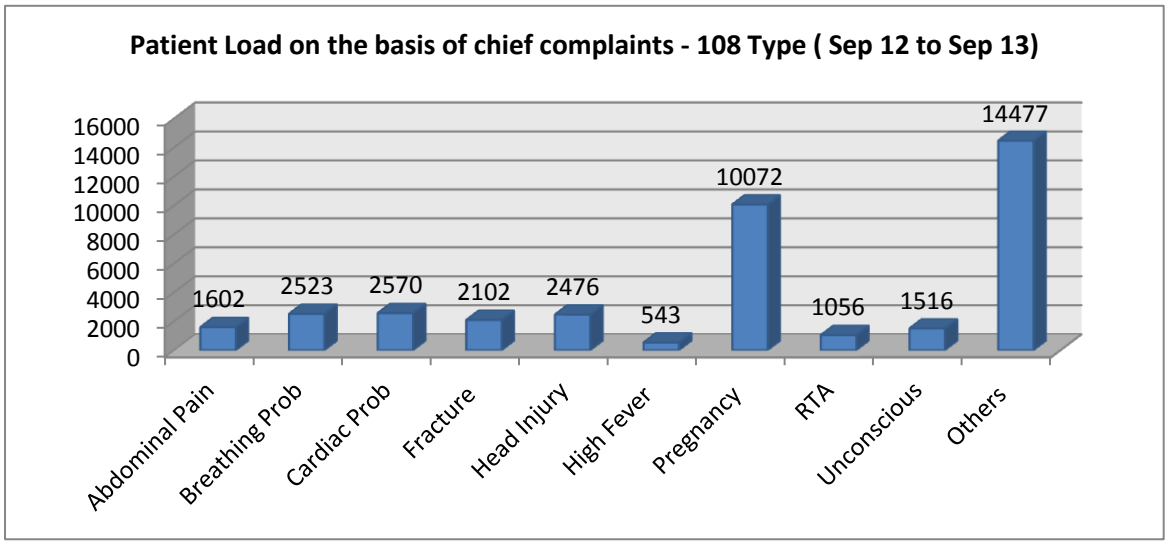
Ambulance & Referral Services

- State has 517 (dial 102) BLS ambulances & 50 (dial 108) ambulances, out of which 5 are ALS & 45 are BLS are functional. In the FY 2013-14, 391 new BLS ambulances and 44 Disaster ambulances (ALS type) have been given to the State. Each block has been given one 102, and each district one 108, one 1099 and one mortuary van.
- The utilization of the vehicles is low-average 5 visits per day- mileage 80-100 kms. Community awareness about referral transport was found very low in both the districts.
- State has reported to have initiated the process to adhere the National Ambulance Service conditionality, but in both the districts non adherence was noted.
- Most facilities reported repeated break-downs of vehicles lasting for few days to three months (Rajapakar, Patepur). Condition of many of 102 ambulances is deplorable and the drugs and supplies are either unavailable or inadequate. Delayed or no response of ambulance services reported by community and ASHAs.
- The 102 ambulance services are not being optimally utilized in both the districts. AC is also not functional in many of the ambulances of Purnea & Vaishali.
- Delay of 5-6 months reported in payments –in BPHC Vaishali payments

Patient load on 102 type ambulances



Patient load on 108 type ambulances:



(Source: State Health Society Bihar Portal)

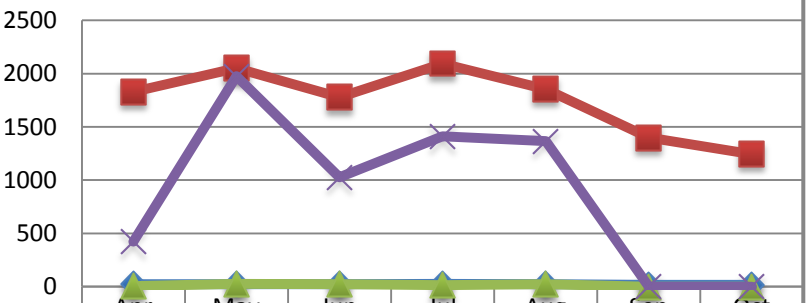
- The patient load on 102 type ambulance service mainly of pregnant women (92%). The present available ambulances are not being optimally utilized to meet the demand from the community, also drop back facility also not assured. As per the norm, there should be 1 ambulance for 1 lakh population, whereas there are only 567 functional BLS & ALS ambulances are available in the State, hence the state should consider to operationlize the newly sanctioned 391 ambulances across the state besides ensuring adequate utilization of existing ones.
- The three types of ambulances and three numbers to call: 102,108 and 1099 is quite confusing for general public. State informed that 102 is for PWs within the block, 108 is ambulance service for all and is used for inter-district referral, whereas 1099 is for disaster management but at other times is to be used as ambulance.

Mobile Medical Unit

- Mobile Medical Units are functional under PPP mode namely Aarogya Rath & Dhanwantari Rath in the State. There are 34 MMUs are functional in 24 districts. MMU is functional in both the districts. In Vaishali district one MMU (Aarogya Rath) is functional through Jain Studios ltd (operating agency) & in Purnea district one MMU (Dhanwantari Rath) is functional through Jagran Studios (operating agency). State has not adhered to the Conditionalities as per the guidelines of National MMU Services.
- The MMU operates as per route plan prepared by the District Health Society for the remote and hard to reach areas where health infrastructure is quite poor. Apart from an MBBS doctor, a lab technician, X-ray technician, MMU Coordinator, ANM and two support staffs are deployed in MMU.On an average the MMU has an OPD of 50-60, 10-20 lab investigations per session . Medicines which are required in MMU are decided at the State level and the list and all medicines are available in the MMU. Medicines are procured by the agency itself. The MMU has lab facilities including examination for sugar, urine and routine blood investigation. X-Ray and ECG facilities are also available in the MMU and found to be working. The MMU has audio-visual aids on immunization and AIDS control provided by the SHS. These materials are displayed during the MMU camps in villages on LED TV.

- The MMU operates as per the tour plan and the ANM and ASHAs of the concerned area mobilize and manage the population at the camp site. However, monitoring mechanisms of MMU services were found to be very weak. The report simply mentions number of patients treated/screened and number of investigations done. The information of patients screened/treated for diseases/ailments is not categorized. Due to which trends in morbidity at the district and State levels is not known and hence strategies cannot be prioritized. Further, the initiative lacks ownership at the District level as the MMUs are outsourced to private party by State Health Society

MMU Service Delivey Data, FY 2013-14



	Apr	May	Jun	Jul	Aug	Sep	Oct
Vaishali Number of Camps	23	24	22	25	23	18	16
Vaishali OPD Patients	1828	2051	1777	2095	1854	1399	1244
Purnea Number of Camps	6	25	24	14	22	0	0
Purnea OPD Patients	421	1975	1027	1410	1365	0	0

(Source: SHSB portal, Govt. of Bihar)

- As per the service delivery data the MMU in Purnea district was not functional in the months of September and October. The number of OPD patients attended by MMU has also decreased from month of july to October in Vaishali district.
- It has also been reported by the community members that no prior information is being given to the prospective community about arrival of MMU.
- In Purnea, the vehicle used as MMU has non- functional AC, Inverter, Mike, Speaker and TV. The vehicle was found unfit for use
- Kit-based investigations viz. MP, Hep-B, Urine Pregnancy Test etc.are available in. LT was not competent enough to perform all listed investigations. Further, he was also not aware with different kind of instruments kept in the vehicle to conduct other bold investigation (e.g. - Blood Sugar).
- The biomedical waste management practices are not being followed at all; used syringes are being disposed off in open field which is a potential health hazard to the street children.

IEC/BCC

- IEC material well displayed in majority of the health facilities, however more emphasis is required on Family Planning IEC (Vaishali). There is no display of information regarding free diagnostic facilities available in Vaishali district.
- No IEC programme is being done to propagate the AYUSH system in both the District. The display of IEC material below PHC level is not so visible. There is no specific initiative has been taken by State to address the issue of declining sex ratio. No IEC/BCC could be seen at village level in any of the districts visited.

II. Reproductive and Child Health

Planning

- Though the State is planning for next three years with the help of development partners and started with the gap analysis, currently there are no detailed facility/block/district level plans for ensuring availability, accessibility and adequacy of quality RCH services. Implementation for RCH is being done on the basis of targets/budget given by the district/State. There is still a mismatch between what is required at the facility/block level and what is being proposed and approved in the district PIP/RoP.
- No prioritization was found in district plans based on gaps for delivery points to provide assured RCH services. The planning seems to be ad hoc and state driven rather than actual requirement at facility/block or district.

Care of Mother and Child

- JSSK seems to have picked up at least for all the in-hospital services. The beneficiaries told the teams that they were satisfied with the services as the out of pocket expenditure is nil.
- Most of the ANMs/ GNMs were found to be trained in SBA in Purnea (though not so in Vaishali), However, except in DH purnea , partographs are not used during the labor, though the GNM correctly explain all component of partograph.
- Mechanisms to ensure quality of care in institutional delivery and EmOC were found to be very weak. In Purnea both SDHs Dhamdaha and Banmankhi had good infrastructure and good case load but availability of anesthetist is an issue. District hospital Purnea had no designated antenatal room, no separate wards for high risk mothers (Eclampsia, APH). Hospital stay post delivery is 12- 24 hours. Beds are inadequate at block PHCs and mothers have to share the beds or use floor beds. Safe abortion services were available only at the district hospital & that too for the clients undergoing sterilization operations
- Some of the essential drugs like Magsulf were not available at Vaishali BPHC & Mahua SDH since 2 months in Vaishali district.
- In Purnea all the facilities had adequate (3-5) clean labour table. The same was found in Vaishali but there were a few exceptions too where rusted labour table without bed sheets were in use. There were no mattresses on the labour tables in majority of cases.There was no display of baby resuscitation algorithm in the labor room which can be very useful to handle asphyxiated baby. The newborn was covered with blanket used by the mother and there was no training to use “Kangaroo Method” to prevent hypothermia of the newborn. Exclusive breast feeding was advised to all mothers. None of the places visited had warm cloth wrapping for newborn after delivery to prevent hypothermia.
- Functional radiant warmers were seen at most of the delivery points. In District hospital the SNCU has 5 Radiant warmers and 2 photo therapy machine. It was managed by qualified nurse. One pre mature baby was admitted in SNCU. The SNCU is adjacent to labor room and seemed well maintained. The SNCU at Vaishali is a model SNCU and worth emulating.

Facility Based New Born Care	2005-06	2013-14
Sick New Born Care unit (SNCU)	0	12
New Born Stabilization Unit (NBSU)	0	16
New Born Care Corner (NBCC)	0	496

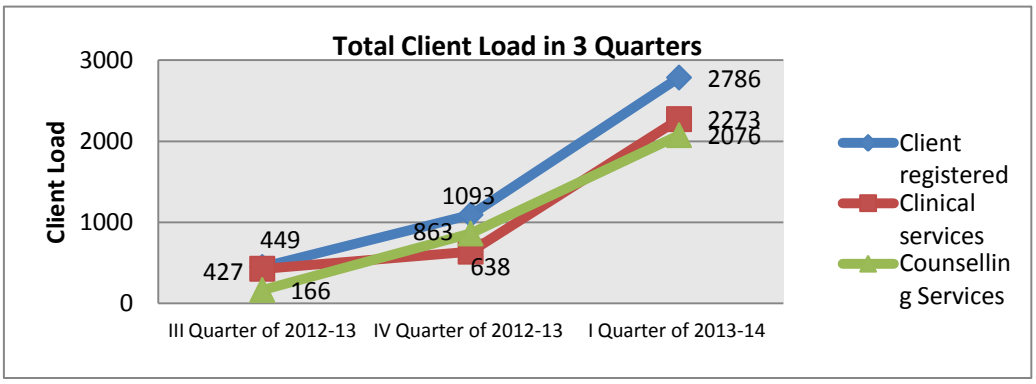
- Delivery point at APHC and HS- team visited one APHC (Akbarpur) and HSC sandip which are delivery points. In APHC average monthly deliveries was 15 and in HSC average 2-3 delivery /

day. The institution has separate labour room with 2-3 beds. There was no electricity and solar power was being used with inadequate power supply. There is no running water supply. Although the efforts for increasing institutional delivery are commendable, however adequate facilities and emergency referral facilities should be made available in such health institutions.

- Nutritional Rehabilitation Centre (NRC) is available in both the district. The NRC in SDH, Dhamdaha (Purnea district) is run by Savera (an NGO); though there are adequate beds and space, there is no Pediatrician available at NRC. The designated staff at NRC needs training as there is knowledge gap in treating the child admitted. NRC situated at SDH Mahua (Vaishali district) is run by NGO NIdaan and does not have staff as per the ToR. Feeding facilitators do not have the required qualifications.Also, the public entitlement have not been displayed prominently.
- Line listing of severely anemic pregnant women and LBW babies was not found.

ARSH & School Health

- RBSK is not fully implemented in the State, as of now School health programme is named as Nayi Pidhhi Swasthya Guarantee Karyakarm. However from the current financial year guidelines has been changed and the programme is to be renamed as Rashtriya Bal Swasthya Karyakram (RBSK).
- State has received the sanction for 1086 AYUSH doctors, 534 ANMs and 534 Pharmacists for 534 teams for 534 blocks under RBSK in the FY 2013-14, the recruitment process has been started and targeted to be completed by the end of Dec, 2013.
- Under Nayi Pidhhi Swasthya Guarantee Karyakarm, a total of 27250 camps were held which covered 29.71 Lakhs children, out of which 1.98 Lakhs children have Lab test done and 0.37 Lakhs children have been referred to the health facilities for further treatment up to 2nd Qtr.
- State has planned to construct DEIC at nine health zones namely Patna, Magadh, Tirhut, Bhagalpur, Darbhanga, Koshi, Munger, Purnea and Saran, however construction work not started yet. Convergence with education department is in place. School health card is being developed under Nayi Pidhi Swasthya Guarantee Yojna (School Health Programme).
- 58 Yuva clinics are functional in 23 districts. Average client load has increased from 19 in FY 2012-13 to 49 in FY 2013-14.



(Source: SHSB, Govt. of Bihar)

- Under WIFS programme, state has nominated the nodal officers from Education dept, ICDS and health dept. Master trainers has also been nominated but district and block level training has not been started yet.

- District Vaishali have 3 Yuva clinics at Jandaha, Lalganj and Mahua. SDH Mahua is well performing, having good IEC material displayed at the clinic, ANM was also fine aware about the programme. No Yuva clinics in Purnea.

Community level Care Arrangements

- Community level care arrangements were not visible except VHSNDs. The post natal check-up at the community level are not done specially after home deliveries by ANMs. The AWW do not have adequate knowledge on screening of children, there is deficiency on documentation of weight in growth chart.

Family Planning

- The family planning services at all the health institutions visited are available Family planning counselor available at District hospital only.

Services	06-07 MIS	07-08 MIS	08-09 MIS	09-10 MIS	10-11 MIS	11-12 HMIS	12-13 HMIS	13-14 HMIS
Male Sterilisation	428	400	1537	6539	10367	6675	5145	364
Female sterilisation	161943	300918	325185	398202	500463	490227	441106	31695

- The PPIUCD trained ANMs was posted in some of the health institutions. In Purnea average 2-3 PPIUCD insertion per month was done in both SDH and PHC. Even in APHC, the GNM posted are inserting 2-3 PPIUCD in a month.
- The female sterilization operation was conducted on regular interval at Bhawanipur PHC as the MO incharge is trained in sterilization.
- In the District there is no separate programme officer for maternal health and family planning and civil surgeon is looking after the programme. We could not see any IEC on family planning in any of the health institutions visited. The distribution of condom and OCP was not recorded by the institution and ASHA were unable to showed us the figure of distribution of Condom and OCPs.
- The State is yet to overcome the huge seasonality in FP. Majority of sterilizations still take place between Nov-March.

Janani Suraksha Yojna (JSY)

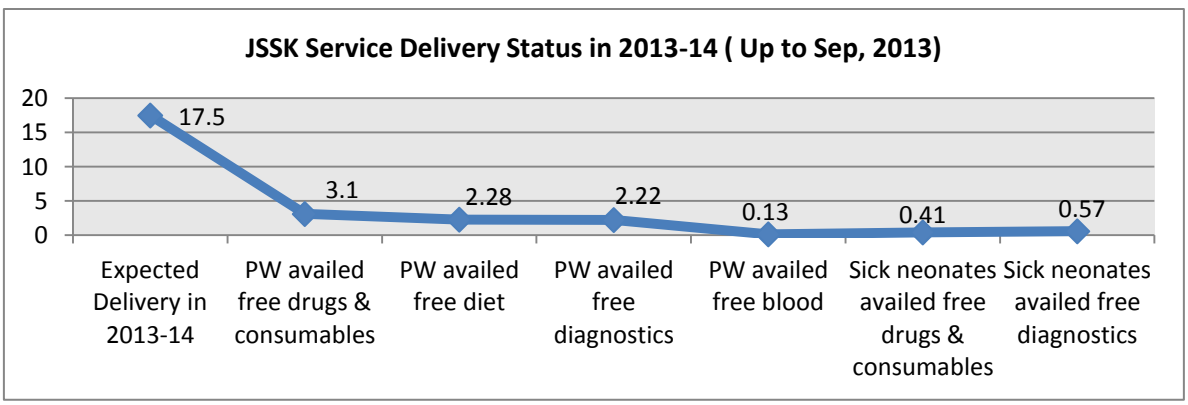
- JSY continues to be the driving force for the women to access delivery care services as community awareness about the JSY scheme found to be very high. Its success is corroborated with the fact that the number of JSY beneficiaries in Bihar rose from 89839 in 2006-07 to 1829916 in 2012-13 which is a 20 times increase. In Bihar, the scheme is named as Janani Bal Suraksha Yojana (JBSY). In all the facilities visited JSY entitlements were found displayed at prominent places such as ANC/PNC wards and at the main entrance of the facility in local language.
- The scheme is one of the most successful strategies which led to increased utilization of public health facilities. The team found that majority of women have MCP card which is duly filled as regards ANCs and immunization status. However, it is also noted with concern that

many MCP cards did not have a mention of MCTS ID No. of the mother. There is a well established monitoring mechanism where 5% of JSY beneficiaries are randomly verified by District/state level authorities every month.

- By and large, payments are regular and made timely to the mothers except a few facilities where backlog for the past two months was observed. The backlog in payments is primarily due to non-availability of cheque books from the banks and also because of early discharge of mothers from the facility. In some cases mothers hardly stayed for three hours after delivery due to scarcity of beds and poor transport services.
- Payment to mothers is made through bearer cheque as a rule and before her discharge from the facility. In order to minimize the scope of leakages, photograph of mother and ASHA (if present) is kept in the JSY payment register along with other documents. Another copy of the same photograph is pasted on the backside of cheque and her signatures/thumb impression is verified by the Medical Officer. This practice has been universally followed in all the health facilities in Bihar where payments are being made. ASHA payments are made electronically in the entire State. However, ASHA payments are highly irregular and being made once in a quarter.
- As regards Direct Benefit Transfer (DBT) implementation, there is hardly any progress made and even in the identified DBT districts of Arwal, Sheohar and Sheikhpura very few payments have been made so far. State to expedite the process of DBT/ account payee cheque payments considering the huge number of JSY beneficiaries. Once operationalised, this initiative will decrease the administrative work of the account staff in a big way apart from ensuring transparency and keeping a check on fraudulent payments. District Vaishali is one of the pilot districts where IMGSY (Indira Gandhi Matritva Suraksha Yojana) scheme of Women and Child Department is under implementation. The IMGSY provides Rs. 6000/- to pregnant and lactating mothers in two installments through bank or post office accounts; however due to poor coordination with WCD, bank/postal account details of beneficiaries is not being tapped by the Department of Health & Family Welfare.

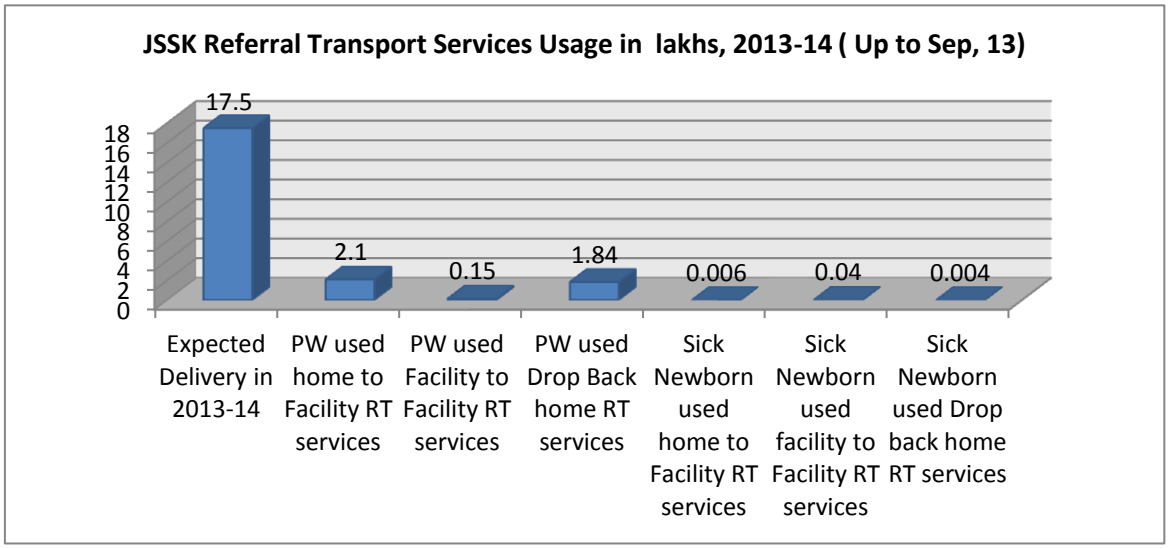
Janani Shishu Suraksha Karyakram (JSSK)

- Bihar has launched JSSK and has issued G.O for implementation of free entitlements under JSSK. Free drugs, diagnostics, diet and referral is being provided to the beneficiaries in both the districts, however assured referral is an issue in the State due to shortage/lack of optimal utilization of dedicated ambulances for JSSK at block level, till date only one Ambulance is provided to each block to cater all the PW, trauma, complicated, neonatal cases.
- State Nodal Officer and District Nodal persons in place for all the 38 districts in the state. State & district Grievance Redressal Officer also nominated for all 38 districts.
- Free drugs and Free Diagnostics are being implemented fully in the State. However, free diet is being implemented at DH, SDH, RH & PHC level only and is planned for implementation for the APHCs and HSCs also (which are the delivery points).



(Source: HMIS, Govt. of Bihar Data)

- Referral transport remains the weakest link in JSSK. As per JSSK reports (2012-13), Home to facility is 25% and drop back is reported to cater to only 25% of PW. In the FY 2013-14 (up to 2nd Qtr) only 12% of expected PW has availed the home to facility referral services.



(Source: HMIS, MoHFW)

- Field visits have indicated that Grievance Redressal system is very weak in both the districts, Signage displayed at health facilities, but people have little awareness on JSSK entitlements.

Maternal & Infant Death Review

- Maternal Death Review System is not established in the state. No Maternal Death Reviews or Child Death Reviews are being currently conducted in Vaishali district.In Purnea only few deaths are being reviewed.
- State is Irregular in submission of Monthly Reports: 7 out of 12 reports submitted in 2011-12 and 3 out of 6 submitted for 2012-13
- Quality of reports below par- veracity of data doubtful (discrepancies in nos., wrong figures for nos. associated with anemia, blank columns, deletion of columns etc). More than 90% of reported deaths assigned under "OTHERS". Poor quality review confined to medical causes and lack of focus on identification of systemic gaps and follow up corrective action.
- There is no sharing on Status of proportion of maternal deaths out of total reported deaths in the state from High mortality districts (as per AHS 2010) e.g. Araria, Kishanganj, Purnea, Katihar etc.
- Status of implementation of CBMDR, FBMDR, and constitution of FBMDR committees in all identified health facilities is not shared by the State.

Immunization Services

- The acceptance of Routine immunization especially for newborn and under one year children is considerably high.

Immunization Coverage

(All figures are in %)

	NFHS 2	NFHS 3	Coverage Evaluation Survey		
Year	1998-99	2005-06	2005	2006	2009
Fully Immunized	11.6	32.8	19.0	37.7	49.0
BCG	36.0	64.7	52.8	75.2	82.3
OPV 3	42.2	82.4	27.1	47.6	61.6
DPT 3	24.9	46.1	36.5	49.0	59.3
Measles	16.2	40.4	28.4	46.0	58.2

- Immunization activities are being conducted at regular interval in all health institutions and VHNDs. However at places, microplans could not be seen. The due list although prepared by ANMs, AWW and ASHA the child tracing is poor.
- The vaccines and logistic storage in all cold chain points are in functional ILRs. However at places temperature monitoring is not done due to non functional thermometers. The distribution of vaccines and logistics to the districts from State vaccines stores need careful planning.
- At places the birth dose immunization are given in separate building.
- No IEC on immunization is seen in any of the ANC or PNC ward
- There is no shortage of vaccines except for BCG and Hep. B in past. Immunization points are adequate and alternate vaccine delivery mechanisms are in place.
- The vaccine vans are less in number. Also the new vaccine vans supplied by GoI are small and would require many more trips to get the vaccine requirement of the district/block and also add to POL costs.

National Iodine Deficiency Disorders Control Program (NIDDCP)

- As per the NFHS-3, 63% of the households consume adequately iodized salt. Bihar is striving to achieve universal access to iodized salt and has reinstituted legal ban on un-iodized salt on 17th May 2006**.** Salt Testing Kits have been distributed and IEC material on benefits of Iodized salt has been disseminated. Coordination with department of ICDS and education is required in creating demand and producing awareness in the common people for use of iodized salt.

III. Disease Control Programmes:

Communicable Disease Control Programme

Integrated Disease Surveillance Program (IDSP)

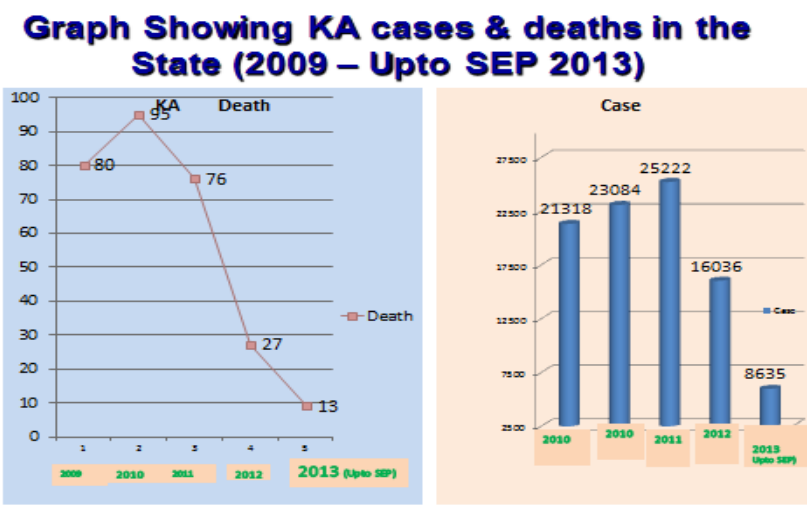
- Data is being collected regularly in both the districts and there is 100% reporting of PL form. Information was available on out breaks. Media alerts and subsequent action taken found to be well documented in Purnea.
- Weekly and monthly reports are shared with the concerned MOICs/CS and DM at the scheduled meetings. Minutes are documented, but feedback/action taken report on recommendations is not being documented properly. E.g.: Jalalgarh block showed 28 presumptive enteric fever cases; as per laboratory reports there were no confirmed cases, but field investigation details have not been documented.
- IDSP activities more active at State level viz. Monsoon Health alert day celebrated on 19th August 2013 targeting vector & food & water borne diseases (especially for AES/JE and Dengue outbreaks)
- In Purnea, IDSP District DEO post is vacant. Trainings for all cadres is pending
- Referral lab not working and district priority lab is yet to be set up in Purnea. No significant Private sector/NGO involvement found towards same in the district.
- IT infrastructure available for data management, but Video Conferencing (VC) not being conducted.

National Vector Borne Disease Control Program (NVBDCP)

- Among NVBDCP diseases, Kala- azar is a major problem in the state. Dengue and AES/JE have emerged as problems in recent years. While Malaria cases seem to be under control, Filariasis has wider presence (with low endemicity) in the State.

Kala-azar

- State action plan is available. A declining trend in number of cases (47%) and deaths (50%) upto October 2012, compared to same period in 2003 is appreciable. Sufficient number of drugs & diagnostic are available in blocks.
- Across State, 33 districts are endemic, among them 425 are endemic blocks, out of these 5 blocks are having more than 10 cases per lakh population.

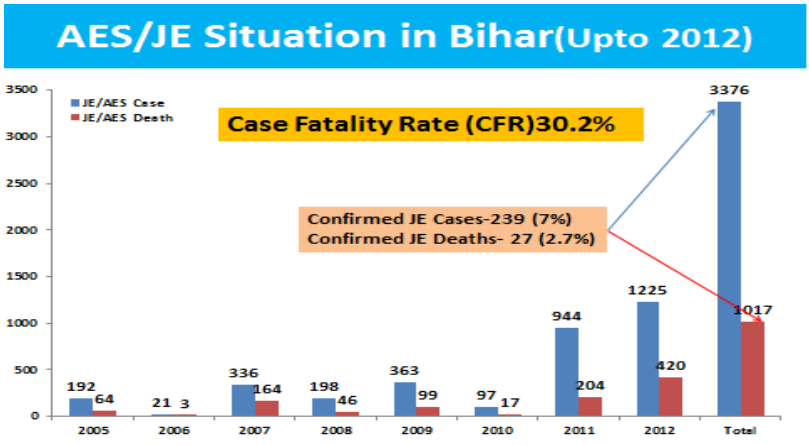


- Poor staffing position is weakening the program across the state. Out of six sanctioned posts of Kala azar technical Supervisor (KTS) in the district only 4 KTS are in position
- Infrastructure of the district offices needs attention. At the DMOs office, no storage, tables, chairs and other facilities could be found. Mobility for staff available only during IRS.

- Delay in SOE/UC submission from districts. Delay in payment of salary to the contractual staff is also observed.
- The 2nd round spray started late by 4 months (in month of October). During concurrent IRS visit in Patepur and Madurapur PHC (Vaishali) the quality of IRS is poor. Advance information for spray was given to community. Few BCC posters were found at block and village but refusal rate is high and quality of spray is poor.
- The supervision by peripheral staff is poor. Minimal role of Block medical officer noticed during the visit. The BHI is active.
- No personal protection clothes were found with spray worker and spray instruments not in good condition in Purnea.
- ASHAs were given one day special training on KA IEC/BCC in Patepur block, yet very minimal / no role of ASHA was observed towards community mobilization in Vaishali. Incentives to patients: given properly, regularly, however incentive to ASHA is irregular in Purnea.
- MSF is working in Hajipur Hospital having KA ward, treating cases with Ambisome. Raghopur Block needs special attention as service delivery is poor due to inaccessible roads and villages are mostly cut off during rainy season and floods.

AES/Japanese Encephalitis, Dengue & Chikungunya

- JE is an emerging problem. 14 confirmed JE cases with no death reported in state upto October 2013 but none reported in CRM districts of Vaishali and Purnea. Guidelines for treatment of AES for field workers as well as State level SOPs on management of AES cases have been developed and circulated.



- All six medical colleges and hospitals are equipped with ELISA reader and functional as Sentinel sites.
- Malathion fogging has been carried out in 13 districts
- Total confirmed cases of Dengue is 1657 (upto October 2013) with 3 confirmed deaths. Free drugs and ambulance (102) available for suspected cases of Dengue. However Dengue was not reported in CRM district Vaishali.
- Chikungunya has not been reported so far.

Malaria

- Malaria is not a major problem, No deaths due to Malaria reported since 2011. State ABER is poor i.e. only 0.2%. Seven districts are reporting cases. District Vaishali is not reporting malaria cases. There is continuous decline in number of Malaria positive cases including Pf for the last four years in the state.
- State action plan not yet ready, district action plans also not in place.
- Man power is not adequate, only around 10% of staffs in position (particularly consultants, field staffs, data entry operators).Passive and active surveillance needs to be strengthened. Also all the trainings were pending and only LT trainings carried out recently.

- Trainings done for ASHA at district level. No other state level trainings done for BHI, BHWs, and MOICs.
- During IRS, micro plan and other field activities happening even with shortage of pumps, poor quality existing spray pumps and less support from the health facilities. Even the operational cost given for spray is not adequate
- No specific BCC activities documented, IEC not adequate.
- SOEs, UCs available at district and state. Logistics are available, but not equally distributed.
- 1st round IRS completed. 2nd round is undergoing.
- Sufficient quantities of antimalarial drugs are available in Blocks and district.

Filariasis

- Minimal involvement of the officers associated with LF. There is no district action plan in place. No state level meeting of state task force and state technical advisory committee. Besides no trainings/re orientation happened- under planning.
- Funds have not been released to districts.. State RRT nodal officer not identified yet.
- Proper line listing and mapping of lymphoedema and hydrocele cases has not been found in both the districts. Microfilaria rate (Mf %) in Vaishali district is 1.03.
- 3986 Hydrocele operation conducted in Vaishali district this year.
- MDA was organized in 2013 but coverage report is pending.

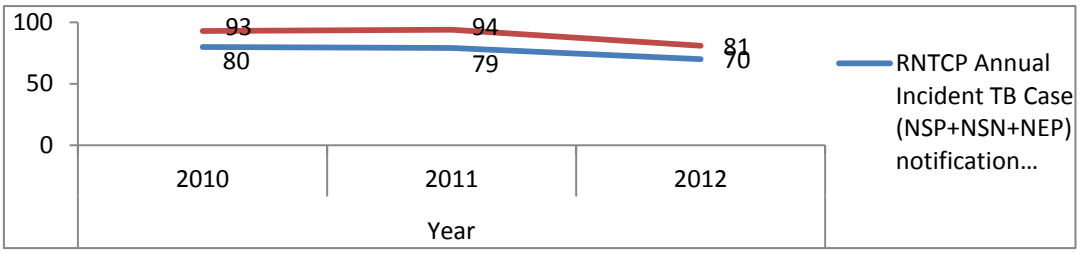
Revised National Tuberculosis Control Program (RNTCP)

Vaishali

- Chronic gaps exist in the key RNTCP position of all the 5 STS (Senior Treatment Supervisor), Data Entry Operator and 2 STLS (Senior Lab supervisor another 3 vacancies will arise after 31st Dec 2013.).As a result supervision is lacking and after 31st Dec 2013 RNTCP in the district will come to a standstill with no one to record, report and supply consumables/reagents to the microscopy centres.
- As per the RNTCP Population norms in place of 36 DMCs (Designated Microscopy Centres) only 17 DMCs are functional. Sub optimal involvement of the ANMs in the supervisory activities. No plan exists for the alignment of the TU at the block level.
- Nikshay entry only 33 cases entered out of 1811 TB Cases registered in 2013. Not a single TB Case notified.
- TB and RNTCP are rarely discussed in ANM/ASHA meetings. As a result treatment cards are not regularly updated and patients don't get informed about scheduled follow-up visits. All health facilities (including APHCs) not regarded as PHIs and monthly report are not

Case Finding Activities

- RNTCP Annual Incident TB Case (NSP+NSN+NEP) notification rate/lakh population (10, 11, 12) & RNTCP Annual Total Case notification rate/lakh population (10, 11, 12).



- Only 9 Medical Officers have been trained on Programmatic Management of Drug Resistant TB (PMDT). DR TB Centre Coordinator is untrained in PMDT.
- No normative guidance on the diagnosis of paediatric TB. There is no link between the supply and demand of Tuberculin.

Purnea

- DTO in charge and the team is working in good manner, DTO in charge regularly attending the OPD, maintaining the Reports, visiting the field often, and supporting the new initiatives like private provider TB Notifications.
- Purnea is the one of the better performing district in the State, also started TB notification from Private Providers.
- Maintenance of records (Treatment cards, Treatment Register and Lab register) is not up to the mark. Particularly Treatment cards was not updated properly, even without Medical officers sign in the outcome report column, since 1Q13 (e.g.: in Dhamdaha TU DMC)
- Data Entry operator not placed at DTC (since his appointment, he was placed at DM office, so all the data entry has been always delayed. NIKSHAY entry not up to date. Only 70% registered cases were entered in NIKSHAY as on 3rd Q13 and Private sector TB notification not yet entered, even though district started receiving notification from private sector since last 4 months.)
- Monitoring and supervision is not evident in the field.
- TB HIV coordination: Not all the TB Patients were referred for HIV Testing (In 2012 only 42% were tested for HIV and in 2013, as on 3Q, only 39% were tested for HIV), even some of the major centres do not have HIV testing centres (e.g.: Dhamdaha Sub divisional Hospital, All the TB patients and ANC mothers found it difficult to travel 25-30 km distance to other centres where HIV testing is available).
- ANMs and ASHA were not aware about common symptoms for suspecting TB and when to refer the patients for sputum examination to detect TB. Also there is no proper counselling of patients (e.g.: A Patient in metha tola south, dhamgara village, due to vomiting of two days during the intensive phase, stopped the medicine and then after few days of interval taking the same medicine from private doctor remaining medicine boxes kept with the patient.)

National Leprosy Elimination Program (NLEP)

- 18 districts yet to achieve elimination i.e. PR <1/10,000 population.
- ASHA Payment irregular in districts, due to no proper data available at district level.
- Non availability of IEC plan for reduction of stigma and discrimination in both the districts.
- New Case Detection Rate trend is decreasing in Vaishali and Purnea. In Purnea, treatment completion rate: 2012-13: 91.2, PR: 1.48 (oct13), MCR: 98 available & RCS: 5. ANCDR more than 10 per lakh in 3 blocks: banmanki, K.Nagar, Kasba. Disability register: 442 patients line listed, total no cases: 2011/12:630, 2012/13:678..

- Reports submission happening from PHCs, Treatment cards available at PHC level but not at Sub center level. Sub center level case identification not happening.
- No IPC during Field visits on Leprosy, Involvement of PRIs and village leaders not evident.
- Infrastructure: few kms away from sadar hospital, office running in old building which may collapse at any time, no proper furniture, storage, logistics arrangements, no computer,
- Fund for NLEP was not utilized in last financial year and current year fund not yet released in Purnea.

Non- Communicable Disease control Programmes

- Except Diabetic Screening, screening for Cancer, Cardiovascular disease and stroke yet to be initiated in the State.
- For NPCDCS, 7 districts were chosen as pilots i.e. Muzaffarpur, E. Champaran, W. Champaran and Kaimur started the work and Vaisali & Rohtas under process to start. Procurement of Infrastructure, equipment and consumables as per NPCDCS to be initiated**.**
- Cardiac care units yet to start under the pilot program in the 7 districts
- Training: 50 MOs trained at state level under NPCDCS. Training materials and modules not available adequately to train state and district level persons. For Cancer screening, 30 Medical officers have been trained in Mahveer Cancer Hospital, Patna.
- Supply of Glucometer and strips to the districts still not properly happening (Quick expiry gluco-strips have been supplied with increased risk of expiry of the gluco-strips before utilization). Limited fund flow to purchase glucometer, strips and lancets at the district level. No proper specification to procure the clinical equipments. Also adequate number of persons not trained at central level.

National Tobacco Control Program (NTCP)

- Bihar stands 6th from top among current tobacco user state. Tobacco prevalence in Bihar is 53.5% v/s 34.6% for India. Male Users: 66.2 %, Female Users; 40.1 %, Smoking form - 5 %, Smokeless form - 49 %. Use of KHAINI is highest in Bihar - 51 %.
- Almost 110 Assistant Drug Controllers and Drug Inspectors have been trained on fine mechanism in Patna. In Purnea, number of spot fine challans issued: 188, fine collected: Rs. 7300 under section 4, COPTA 2003. No IEC materials found in the facilities and community.
- On the occasion of World No Tobacco Day 31st May 2013 the STCC, SHSB has published the advertisement in all local dailies on Tobacco Advertising Promotion and Sponsorship (Section 5 of COTPA) of Bihar.

IV. Human Resource & Training

Generation of Human Resources

- Getting the required trained manpower has always remained a challenge in Bihar. To address the increasing requirements of MBBS doctors 3 Medical Colleges: Medical College & Hospital VIMS, Pawapuri, Nalanda, IGIMS, Patna and GMCH, Bettiah (West Champaran) were established after 2005 which increased the MBBS seats by 200. Two more private medical colleges have also been set up. State has also successfully set up AIIMS like institution in Patna, with 50 seats which is likely to be increased to 100. Though the number medical college and MBBS seats have increased their impact on increasing the HR in health system is yet to be seen.

Number of Medical colleges and number of MBBS Seats				
	2005-06	**2012-13**	**Increase**	**% increase**
No. of Government Medical Colleges	6	10	4	66.7
No. of MBBS seats	540	790	250	46.3
No. of Private Medical Colleges	2	4	2	100.0
No. of MBBS seats	200	400	200	100.0

- State has made Herculean effort to restart the closed ANM schools (Pre-NRHM 10 government ANM schools were closed) and has successfully restarted 21 government ANM schools.

Sl. No.	Name of Institutions	No. of Institutions	No. of Seats as per GoB*	No. of Seats approved by INC #
1	ANM (Govt.)	21	1490	423
2	ANM (Private)	49	2370	1470
3	GNM (Govt.)	7	396	266
4	GNM (Private)	6	290	310
5	Post Basic – Kurji (Pvt.)	1	40	40
6	B.Sc. Nursing (Govt.)-IGIMS	1	40	Not renewed (2012-13)
7	B.Sc. Nursing (Private)	1	40	40
	TOTAL	86	4666 (G-1926 P-2740)	2589 (Govt-689; Pvt-1900)

Source: BNRC #(Indian Nursing Council

- Para Medical Courses (Diploma in Pharmacy, B. Pharma, B. Sc. Physiotherapy, B.Sc. Occupational, and Diploma in Lab. Tech etc.) are conducted in all Medical Colleges, Patna Dental College and Public Health Institute, Patna. B.Sc Course in Para Medical (Ophthalmology technology, Radio Imaging Technology, Lab Technology, OT technology) has also been started in Public Health Institute, Patna.
- In spite of the efforts to increase the seats in medical and paramedical courses the number of seats and availability of quality trained HR remains a problem for Bihar especially for Specialists, MBBS doctors, staff nurses and ANMs.
- Many private colleges of Nursing and ANMs have come up in recent past but the quality of training given in such institutions remains a big question mark. The CRM team in Vaishali visited a private ANM school but was denied the entry into its premises
- In order to overcome the gap, the State has started recruiting AYUSH doctors. State has 3 Government AYUSH colleges (one each for Homeo, Unani and Ayurved) and 9 private college

- The availability of paramedical HR has increased because of private schools but the quality remains variable.
- CRM teams visited the government schools in both the districts and found the schools to be well equipped and adequately staffed. Teams learnt that INC has progressively decreased the number of seats in the Vaishali government ANM School in past two years from 90 to 40.

Availability

- With the launch of NRHM, the state has taken steps for filling up the vacancies for effective and meaningful NRHM implementation. The HR position has improved considerably since 2005, after hiring of contractual staffs but there is still substantial ground to cover.
- Responding to the emerging needs of Human Resource, Government of Bihar through government resolutions has increased sanctioned posts for nurses, ANM, doctors etc. as per IPH standard. However it is yet to appoint HR against the newly sanctioned posts.

HR availability (critical service delivery staff):

Sl. No.	Category of manpower	Sanctioned	In position		Total
			Regular	Contractual	
1.	MO – (MBBS)	4905	1522	1409	2931
2.	MO – AYUSH	-	105	1213	1318
3.	MO – Dental	-	5	361	366
4.	Specialist (Anes.)	718	42	16	58
5.	Specialist (Ped.)	652	99	20	119
6.	Specialist (Ob.G)	739	97	30	127
7.	Staff Nurse	4688	353	1309	1662
8.	ANM	23134	9209	8517	17726
9.	Lab. Tech.	-	265	867	1132
10.	Pharmacist	-	325	67	392
	Total		12022 (46.5%)	13809 (53.5%)	25831

Source: SHSB

- Staffs in Regular gazetted and non-gazetted posts are appointed by the State Government. Contractual Doctors, ANMs, SNs are appointed by District Health Society. Other positions are filled up by State Health Society, Bihar through online recruitment process / walk in interview mode.
- Some of the contractual positions have very high vacancies. For the post of MOs and staff nurses, availability of skilled HR is a problem however high vacancies for the positions of community mobilizer indicate the delay in the recruitment process.

Sl.No.	Contractual positions	In position/Sanctioned	% of vacancies
1.	Contractual Doctors	1409/2375	41%
2.	Nurse Grade A	1512/3395	55%
3.	ANM	8529/11433	25%
4.	Epidemiologist	23/38	39%
5.	District Community Mobilizer	23/38	39%
6.	Block Community Mobilizer	328/533	39%

- State could not furnish the ToR and Job description for regular staff. The entire focus of getting things done in NRHM is through contractual staff and regular staff seems to be outside this ambit.
- State has set cadre rules for different positions. Initial steps are being taken to absorb the contractual service delivery staff in the regular cadres and weightage is given to contractual staffs while filling up the regular position. However similar steps for managerial cadre are yet to be taken.

Deployment

- Rational posting of specialists and trained MOs especially LSAS and EmOC has improved over the years. State through a letter by Principal Secretary in 2010, asked the civil surgeons to post all the specialists and EmOC/LSAS trained doctors in appropriate facilities. As a result the majority of specialists and LSAS/EmOC trained doctors were posted in DH, SDH and FRUs however, 5% of specialists are still posted in APHCs and 20% of EmOC and LSAS trained doctors are posted in non-FRUs where there is no requirement of specialists.
- To ensure effective and rational deployment of staffs, State intends using caseload (Based on HMIS data). However the current deployment is not as per caseload. Similarly though the State intends to saturate the delivery points first with adequate HR, there are excess HR in some of the Non-delivery points.
- There is no provision of differential payments to any category of staff posted in difficult or hard to reach facilities.

Workforce Management

- Absenteeism among health staff has long been a problem, hence state is pro-actively tracking the attendance of doctors.
- HRIS web portal has been developed and being used to capture personnel information including service history of all employees of Health. Data have been uploaded and data verification and validation process is on.
- District Magistrates of both the districts visited conduct regular reviews with District Health Society staff. In Vaishali district, NRHM review is done by District Magistrate every Friday at 4 p.m. and on last Friday, there is an entire district review where all BPHC Mo i/c, BHM, BCM, DCM and PMU staff participate.
- Annual performance appraisal is a mandatory requirement for all the contractual staff, which is done by the supervisory authority after the staff, does a self-appraisal. Annual increment is allowed only after the acceptance of performance appraisal. Though DCM and BCM are given three years contract, they also need to submit their self appraisal every year. Each staff needs to give justification as to why s/he should be given continuation.
- However the whole appraisal system is seen as mechanism for renewal of contract and getting the normative 5-10% increment. Though the State informed the CRM team of some decisions to discontinue services of some contractual staff; instances of rating at least a few staff exceptional and giving them higher increment/reward was not found.
- The CRM team came across many instances of salary cuts/holding of salary of contractual staff for not being able to meet the targets set by district/programme officer. E.g. there were instances of contractual staff being fired because of lapse in duty but no such action is taken against the regular staff or their supervisor who are also at fault.
- Many policies (e.g. comprehensive HR policy, rational posting policy, incentive policy for hard to reach/difficult area, 360 degree performance appraisal) are in the pipeline for more than a year. Several policies to attract staffs and to retain them in their place of posting are still in the formulation phase

- Preparation to meet the conditionalities given by GoI also seemed to be weak. The team could not find any evidence of preparation for base-line assessment of competencies and performance monitoring system.
- Many information/data required for better analysis could not be provided by the HR cell. It is a matter of concern as it indicates lack of adequate monitoring and analysis of problem at the state level.
- One of the ANMs met in field never gets a holiday on a Sundays. Similarly another ANM had continuous day duty and night duty before she goes for VHND/immunization the next day. A person who has been working the previous day and the night in continuity CANNOT be expected to perform a task well and is liable to make mistakes. Duty roasters need to be carefully planned by trained people ideally with help of an LHV/SN/ANM.
- Most of the staff whom CRM team met in the field right from ANMs to AYUSH doctors are sincerely trying to serve the public in spite of several constraints. HR and administration would have to ensure that they get proper working conditions.

Training and Capacity Building

- Training is quite weak in Bihar. A 2-3 person cell is looking after training where as the nodal agency SIHFW with only 4 regular staff remains passive.
- The pace of training is very slow for most of the training programmes. In last 6 months of the financial year, the state's achievement is much less than expected 50%.

Training	Personnel	Upto March 2013	Target for 13-14	Performance upto last month 2013-14
Skill Birth Attendant (SBA)	Staff Nurses	402	150	18
	ANM	4853	1784	362
BEmOC	MO	133	100	25
EmOC	MO	114	32	13
LSAS	MO	139	32	15
MTP	MO	704	201	47
IMNCI	ANM/LHV	62902	3792	48
	MO	1335	384	96
	Staff Nurses	0	96	12
NSSK	MO	700	2040	350
	SN/ANM/LHV			
Adolescent Health (ARSH)	MO	324	543	261
	ANM/LHV	1320	1890	461

- Major reason, what was recorded in the field that most of the training is directly coordinated by the state with very less participation of districts. E.g. in SBA training, state can regularly use Sadar Hospital to train ANMs on SBA (as sadar hospital has enough case load) but this is not practiced in all the districts. State has to urgently revisit the training plan to expedite the training so as to meet the target set for the year 2013 -14.
- Quality of training and the post training follow up is also inadequate. Some of the trained staff is not performing but there is no hand-holding from district/State. Many SBA trained ANM could not answer basic question related to delivery. Selection of trainees at times was done without much situational analysis. ANMs on the verge of retirement or with serious ailments have been nominated for training in past.
- EmOC and LSAS trained doctors are largely placed in appropriate facilities though their performances are hardly monitored by DHS.

V. Community Processes and Convergence

Panchayat Raj Institutions (PRI)

- As mandated by NRHM to ensure involvement of Panchayati Raj Institutions (PRI) representatives' state has put representatives of PRI in VHSNCs, RKS and DHS. Many VHSNCs have woman elected member of the gram panchayat (panch) as its chairperson.
- However, field visit reveals that PRI members are not actively involved in the functioning of VHSNC and RKS. Their participation in the meetings needs to be improved. In Vaishali district, the ANMs of the Sub Centers (which were visited) could not make any expenditure of the untied grant of VHSNC until the present District Magistrate of Vaishali took an initiative to engage PRIs and because of his pro-active role, in the year 13-14, the VHSNCs have started booking expenditure.

Village Health, Sanitation and Nutrition Committees (VHSNCs)

- In the year 2008, Government of Bihar (GoB) co-opted the Panchayat Committee namely "Lok Swasthya Pariwar Kalyan evam Gramin Swaschata Samiti" as "Village Health Sanitation and Nutrition Committee". It consists of 5 members including Chairperson (panch/woman member of the Panchayat) and Secretary (ANM). VHSNCs have been formed at the level of gram panchayat covering several revenue villages.
- There is a joint bank account in the name of Chairman and Secretary for VHSNC and each VHSNC gets Rs. 10,000/- per year as untied fund. The untied grant is a resource for community action at the local level.
- Based on the utilization pattern of VHSNC grant, the top up financial grant is provided to the VHSNC in the next year. In the year, 13-14, each VHSNC was given top up grant amounting Rs. 6018/- per committee because VHSNC's fund utilization for the year 2012-13 was less than 100%.
- The state has formed 8,224 VHSNCs (97%) against the target of 8,462 at the panchayat level as in May 2013. These will cover approximately 41,000 revenue villages. The number of VHSNC in Vaishali district is 290. VHSNC monthly meeting is scheduled at every month on last Saturday and the minutes of the meetings are to be recorded. The Block Community Mobilizer is responsible for monitoring of VHSNC activities. Checklist has been prepared in Vaishali district for effective monitoring of VHSNC meeting.
- Discussions with VHSNC members revealed that they are not very clear about their roles and responsibilities, which is emerging as obstacle in performing their role effectively. The members of VHSNC and community are not clear about the amount of fund available and purpose for which the funds are to be used.
- The register of minutes of many VHSNCs was not found updated during field visit.

Village Health, Sanitation and Nutrition Day (VHSND)

- Village Health, Sanitation and Nutrition Day (VHSND) is an effective platform to ensure outreach services and to provide health care services to women (delivered and expected), children and adolescents. ASHA, AWW & ANM jointly organize health day in every village once in a month.. On the day of VHSND, health related issues like nutrition, personal hygiene; care during pregnancy, importance of antenatal & postnatal care, institutional deliveries, immunization, etc are discussed.
- In Bihar, VHSND is being conducted twice a week (Wednesday and Friday). The CRM team visited aganwadi center and met with mothers and children in presence of ANM, AWW and

ASHAs. It was reported that ASHAs mainly help in informing community / target group about the VHSND and also in mobilizing them to attend the VHSND.

- The range of services provided in the VHSND include, registration of pregnant women, ANC check up of pregnant women registered, immunization of children, weighing of children, child growth monitoring, distribution of family planning product, ORS Packet, Iron and de-worming tablets, distribution of supplementary nutrition to underweight children and organizing kishori samooh for health education and need based counseling.
- Convergence with other line department like education, ICDS, PHED and PRIs is found to be an issue in the field. The involvement of PHED is restricted in installing hygienic latrine to the identified households.
- Checklists are being used to monitor VHSND, but no analysis is done and so no further action is taken. District/State should ensure analysis of these checklists.

ASHA Training and Performance

- In both districts, most of the ASHAs are seen as a resource who has close links with the health system. ANMs also recognize the role of ASHAs.
- Most of the ASHAs met, were found enthusiastic about their work and seem to spend about three to four hours daily in visiting households. Some ASHA demanded regular training and few demanded regularization of their services.
- In Bihar, every 21st ASHA was selected as ASHA Facilitator. Clubbing two adjacent panchayats, a cluster was formed, from the cluster, among all the ASHAs, the highest qualified, and the most acceptable ASHA was selected as ASHA Facilitator.
- ASHA Facilitators are expected to extend handholding (on the job) support to ASHAs. They also conducts sector meeting at Sub Centre with ASHAs and provide them necessary support. Each ASHA Facilitator gets Rs. 150 per day for maximum 20 days per month for making field visits to support ASHAs. Thus, each ASHA Facilitator gets Rs. 3000 per month. As they are still working as ASHA, so they also get performance based incentive. However they find this balancing act quite difficult. Also there are issues with ASHAs accepting one ASHA as Facilitator and earning much more than others.

Enrolment and attrition

- The state has enrolled 84,860 ASHAs against the target of 87,135 (97.3%). However the state has a database of 75,133 out of 84,860 ASHAs. Till date, 3,995 ASHA facilitators are enrolled against the target of 4,150 in the state.
- State assured that the selection of remaining ASHAs and ASHA Facilitators will be done very shortly. There is 3-4% (approximately) attrition of ASHAs reported by the state. Out of many reasons removal of ASHA by district due to conversion of village panchayat into urban, selection of ASHA as PRI member, Shiksha Mitra, etc. and realization that it is not a government job are prime ones.

ASHA Training on Modules 5, 6 and 7

- ASHA Training of Module 5, 6 & 7 is a fully residential training comprising of 24 days spread into 4 phases (6 days for each phase). Training is imparted with the support of state master trainers deputed by 4 State Training Agencies (STA) namely Janani, PHRN, PFI & Caritas India.
- So far 85 % ASHAs have been trained in Round 1(6 days), 62% in 2nd round (6 days) and 4% in 3rd phase of HBNC training. In 19 out of 38 districts, 1st and 2nd Phase training of Module 5, 6 & 7 have been completed.

- Monitoring of the quality of training, and supportive supervision is done by State Training Agencies, District, Regional, state officials and NHSRC team.
- Field visit report reveals that ASHAs are also conducing home visits as envisaged under HBNC guideline. They make 07 visits in case of home delivery (Day 1, 3, 7, 14, 21, 28 and 42)) and 06 visits in case of Institutional Delivery (Day 3, 7, 14, 21, 28 and 42). ASHAs have been receiving home visit incentive of Rs. 250/- from the PHCs, as reported by ASHAs. But ASHAs do not have HBNC kit with them, as they are yet to get kit.
- As the ASHAs have not been given HBNC kit, they are not able to perform many of the activities, which are to be done during home visit. ASHAs reported that they use mercury thermometer to see the temperature but in the training they were taught how to use digital thermometer. Moreover, many of the ASHAs do not have even mercury thermometer. For taking weight, they said that they use adult weighing scale, which theoretically sounds correct but does not seem practically happening as revealed during community meeting. One ASHA said that to get the weight of the newborn (using adult weighing scale), they take the weight of the mother and then again take weight of the mother with the newborn. Thereafter, subtracting the weight of the mother from the weight of the mother with newborn, she gets the weight of the baby. This process is not followed by all the ASHAs during home visit, as revealed. So, ASHAs are to be provided HBNC kit immediately to ensure quality home visits are made by ASHAs.
- While looking at the HBNC forms, it was seen that there were errors in the format. In many cases either temperature, weighing was not recorded. These errors could not be shown to ASHAs by District / Block Community Mobilizer who received the records from ASHAs as they are not trained on Module 6 & 7. So, it is suggested that the DCM / BCM are to be trained urgently so that they can also give handholding support to ASHAs through ASHA Facilitators on filling up forms. Wrong filling up of forms indicate that proper home visits are not made and this will not yield any positive result.
- Though few ASHAs were found with good HBNC skills but a section of ASHAs were found very poor in performing HBNC skills. So, it is strongly suggested that the on job supportive supervision has to be strengthened through DCM / BCM / ASHA Facilitators so that ASHAs get adequate HBNC skills. Performing the HBNC skills perfectly is critical to the success of reducing neonatal mortality.
- Non-availability of printed HBNC format was also reported by ASHAs.
- Delayed HBNC payment is another area, which needs to be looked at urgently.

ASHA involvement in RCH priorities (HBNC, WIFS, PPIUCD, contraceptives distribution)

- Team was informed that ASHAs do the mobilization for PPIUCD but they do not get any incentive for this activity. ASHA delivers contraceptive (condoms, OCP, ECP) at the doorstep of clients through social marketing. ASHAs, who were interviewed in Vaishali informed that people do take it from them. However, they don't pay for it. At many SCs in Vaishali, ASHA were not even aware of the availability of OCPs & condoms meant for home delivery of contraceptives. Only Free supplies could be seen at these facilities. Also, replenishment of these supplies was reported to be inadequate & erratic
- Field visit report reveals that 10 indicators based performance monitoring of ASHAs is not in operation correctly. The indicators, as suggested by the MoHFW have not been followed. DCM / BCM / AFs are not very clear about the indicators. So, it is suggested to give retraining to DCM/BCM/AF so that capturing of ASHA Performances can be done using 10 indicators.

Supply of ASHA Drug and equipment kits

- In Financial Year 2010-2011, 83,624 ASHAs were provided with ASHA Drug Kit. The replenishment of drug kit is done but not in a kit form. It is replenished with the drugs available at PHCs / SCs. Communication kit has been distributed to all ASHAs during the training of Module 5, 6 & 7 (Phase 1). Many of ASHA did not have their kits replenished for last two years
- HBNC Kit - Till date HBNC Kit is supplied by KAPL in 15/38 districts. The Process of Payment and verification is under processed in these districts. After verification, kit will be distributed among selected ASHA during Training of Module 5, 6 & 7.

ASHA Incentives and Support System

- Till date 81,924 ASHAs are having Bank Accounts (96.54 %). All types of incentives given to ASHA through Cheques /Bank transfer/ RTGS in their accounts.
- Field visit report reveals that though ASHAs have long list of items, where from they are likely to get incentive but they get incentive mostly from JBSY, Immunization, Family Planning, ASHA Diwas, Home visit as per HBNC etc. Most of the ASHAs shared that on an average they get Rs. 1000 – Rs. 4000 monthly. ASHAs opined that it takes time to get money as DOTS provider and also for other disease control programs.

Status of ASHA Grievance redressal mechanism

- Though, it is reported that ASHA Grievance Redressal mechanism is placed at Panchayat, blocks, districts and state but no proper documents on redressal mechanism could be seen. No data was shared to understand how many complaints were registered and how many of them were addressed

Career progression plan for ASHA

- ASHAs with 8th pass and who wish for higher education are encouraged to get enrolled for 10th grade through National open schools. In FY 2012-13, 472 ASHAs were enrolled for 10th grade in state. In FY 13-14, 2,136 ASHAs i.e. 4 from each Block are targeted to be enrolled for 10th grade. ASHA`s having higher degree and are interested to become ANM, seats reservation at ANM Schools is also proposed for eligible ASHAs.

Community Monitoring

- The bedrock of the programme is the strengthening of VHSNC. However, since in Bihar, the VHSNC is constituted at the Gram Panchayat level, the CBPM programme has formed Village level Planning and Monitoring Committees (VPMC) to further take the programme down to the grassroots i.e village level.
- As none of the districts visited had community monitoring in place, CRM could not assess its effectiveness.

Convergence

- State has not been able to ensure effective convergence beyond holding of VHSND, where occasionally members of PRI, Education, ICDS, PHED attend. It is expected that once the VHSNC and RKS members are trained then the situation of convergence will improve at state / district / block, which will ensure quality program implementation.

VI. Information and Knowledge

Infrastructure and Human Resources for Monitoring and Evaluation

- The staffing situation for Monitoring and Evaluation staff is fairly good at the state, district, and facility level. However, at the state level some vacancies do exist. Seven of the nine HMIS supervisors and 33 of the 38 District M&E Officers are in place. The district and block level staff reported to have received training in Health Management Information System (HMIS) as well as the Maternal and Child Tracking System (MCTS). All facilities have a well-equipped data center with computer, printer, scanner, camera, telephone and a functional internet facility. In most cases the equipment is operational on generator as there is no/erratic supply of electricity.

Health Management Information System (HMIS)

- Bihar has made progressive gains in rolling out the data collection, reporting, entry, analysis and feedback through the District Health Information System (DHIS) Web Portal. Since November 2008 data are reported online from the district level, from November 2009 from the Block level and from May 2012 from the Health Sub-Centre (HSC) level. Very recently (October 2013), all 38 districts are also reporting facility based data. The HMIS is the single source of data that is being used for Program monitoring and planning at all levels in Bihar. The progress of the districts is tracked through a set of 21 indicators, at the monthly meeting at all levels from State to Block PHC level.
- By and large the data are reported on a timely basis and loaded on the DHIS2 web portal. Latest by the 3rd of the month the ANM has to report the data at the PHC, while on 5th the Block PHC has to report aggregated data, and by the 10th the sub-district and district level data has to be reported to the State. Usually at the BPHC, sub-district and district level these data are reviewed by the CS/MOIC and Block Manager/ prior to uploading on the DHIS2. Also, once they are loaded, the DPMU reviews these and seeks clarifications within 7th and 10th of each month, so that the reporting units can make the necessary modifications prior to the system getting locked on 10th at the reporting unit level.
- Even though there has been progress, the completeness of data is an issue with only 68 percent of the data being complete. The reasons for lack of completeness of data include lack of reporting on stock of drugs, death reports, etc.
- Based on various data sources such as the Annual Health Survey and the Sample Registration System, the Expected Level of Achievement (ELA) have been worked out and communicated by the State to all districts. Similarly, the districts have worked out ELA for each of the blocks. The progress of the HMIS data is tracked in comparison to the ELAs in most facilities that were visited.
- Review meetings are reportedly regularly held on Tuesdays at the BPHC level. The HMIS reports are used to discuss HSC performance by the MOIC and the Block Manager during one of the weekly meetings every month in which the MOIC, Block Health Manager, Accountant, DCO, and ANMs are present. There are no minutes available for these meetings.
- Similarly at the district level, on every Friday the District Magistrate, the Civil Surgeon and all the program managers have a meeting to monitor the progress in the District. On last Friday of every month, the District M&E Officer of district hospital, sub-district hospital, BPHCs, VHN, and Accountants also join the review meeting where the HMIS reports are discussed along with the expected level of achievement. At this meeting specific areas where each facility needs to focus on is highlighted. The district also shares the ranking of the performance of the block, vis-à-vis other blocks. The HMIS data are the core set of data that are used for the discussions.

- Few monitoring visits were undertaken by the DPMU staff to review the accurateness of the HMIS data. These visits are documented and a data validation tool is utilized. During the field-visits it was found that on few occasions the MOIC and the Block Health Manager also verify the HMIS reports with the ANM Register during field-visits. System is being put in place to verify and validate the data at all levels through the State, Regional, District and Block Committees. Feedback is provided on data quality to ANMs during the Weekly Review Meetings performed at PHC by the Block Health Manager and MOIC. A data quality audit process is being institutionalized at the block level especially for assessing quality of RMNC+A indicators.

Mother and Child Tracking System

- MCTS has been operationalized since April 2012 across the state and all 38 districts are reporting. Due to limited capacity, the MCTS is able to register only about 59.4 percent of pregnant mothers and 46.3 percent of children. Pregnant women and children accessing either no services or private sector services are missed out.
- In most facilities completeness of the MCTS was calculated based on percentage of mothers and children who received antenatal or immunization services in the public health facilities and were registered under the MCTS rather than the expected level of achievement of the district.
- The data related to services delivered to pregnant women and children is not being updated in the MCTS due to which the primary objective of case specific monitoring of pregnant woman and children is not achieved. Thus, MCTS is not serving the desired purpose of supporting achievement of universal coverage for maternal care and immunization services.
- The flow of information in MCTS needs strengthening and the system be made real time and dynamic for tracking service delivery and health outcomes. There is lack of coordination between the Data Centre Operator and the ANM. There is no system in place to ensure registration number for the mother/child is reflected on MCH Register maintained by the ANM and the MCP card of the beneficiary. Once the DCO generates the registration number for the mother/child, there is no mechanism to ensure timely communication of this to the ANM, and the updation of this in the MCH Register and the beneficiary's MCP card. For instance, at the time of institutional delivery if a woman doesn't bring a MCP card reflecting the registration number or comes to the facility without a MCP card, there is no way of tracking the antenatal care services she may have received and thus it is not possible to link antenatal services to delivery outcomes.
- The workplans generated for antenatal care, delivery care, post natal care and immunization services for the facility and providers are currently at best being used to track ANM performance by the MOIC and Block Manager at the weekly meetings. As the MCTS is not capturing data on services provided to the pregnant women and children on a real time basis, the ANMs continue to rely on the manual duty register maintained by them. This duplication of effort can be avoided only once there is 100 percent registration of pregnant women and children and MCTS data are regularly entered and the flow of information between the DCO and the ANM is streamlined.
- All facilities mentioned that the server was slow at times and usually down on 4-5 days in a month. This was corroborated by the fact that some of the facilities couldn't generate any MCTS reports at the time of the site visit as the server was slow/ hanging.
- The other issue is that of providing a mobile number as several women don't have a mobile phone and some have a mobile but don't know their numbers and use it only for receiving calls. In some cases where the mother doesn't have a mobile phone, providing the mobile number of a neighbour appears to be working.

- The norm of having one data entry operator per 200,000 populations needs to be reviewed for Bihar because of the high number of pregnant women and children that need to be tracked in MCTS. To augment the capacity, Bihar is in the process of recruiting additional block level data entry personnel exclusively for MCTS and is also exploring the options of mobile based data reporting by equipping each ANM with a mobile phone. The recruitment is expected to be completed within a month.

State Health Systems Resource Centre

- There is no SHSRC at the State level. The State Health Society is providing technical support along with several development partners especially supporting the RMNCH+A implementation in high focus districts in Bihar. These include the Bill and Melinda Gates Foundation, UNFPA, NIPI, UNICEF, and DFID. BMGF is helping establish a State RMNCH+A Unit which is expected to be functional by end November 2013 and will help coordinate technical and thematic expertise. In addition, WHO provides technical support for tuberculosis?

State Institute of Health and Family Welfare

- SIHFW has reasonably good physical infrastructure and is located close to the State Project management Unit. There are several vacancies that exist and SIHFW has been utilizing the expertise of visiting faculty.
- During 2012-13, SIHFW has been engaged in the training of SBA for MOs/SN/ANM, IUDs for MOs/SN, ARSH for MOs/ANMs/LHVs, RI for MOs, IMNCI for ANM/LHV/AWWs, NPCSCS, FP Counselors, and Contraceptive Update for MOs, Cold Chain Handlers-TOT, Measles SIA-TOT, MAMTA-TOT, and Menstrual Hygiene for MOs.
- SIHFW has the experience of conducting very few studies in the past.

Innovations: District and Divisional Ranking

- Bihar has institutionalized impressive on-line dashboard system for monitoring progress across districts and divisions through a set of 34 indicators including service delivery, maternal and child health, family planning, public health as well as financial and administrative indicators (http://bihar.dashboardmonitoring.com/).
- The graphical coding provides visual ease for tracking overall progress as well as comparative progress across districts and regions.

VII. Health Care Financing

Finance and Administration

- Humans Resource: It is observed that District Accounts Manager is placed in all the districts and there is no vacancy. At Block level nearly 8 % position is vacant (43 out of 533). In Bihar, financial and administrative powers are delegated in accordance with GOI guidelines.
- However, the post of Director Finance is vacant since more than six months. As per guidelines issued by the Ministry vide letter no.A.12014/1/2008-NRHM (F) in the year 2007 the state need to appoint a Director finance on deputation form State finance Service. . Considering the size of resource envelope of the state which is Rs. 1862.17crore during the year 2013-14, it is mandatory to have Director Finance deputed from the state finance services.
- Books of Accounts: Implementation of customized version tally ERP 9.0 up to the PHC level is indeed a great success. The state is generating FMR from tally itself. The district health society is sending FMR to the state which is tally generated. Same is consolidated at state level. Although there is some problem in synchronization which is to be resolved and in order to perform the same the state has already hired a authorized partner of tally.
- The State has provided Rs100 cr. more/in excess for the State share.

Fund Flow

- E-Banking: Fund transfer is being done electronically at all levels- State to District and also from district to blocks.
- Pooling of funds: Funds from the state to district level is transferred pool wise as is the norm and not activity-wise. State has taken a decision to release funds to the district only when district reports expenditure up to 80% of available funds.
- Concurrent audit is being implemented and audit is conducted on time. Internal audit wing is well established.
- Bank Reconciliation Statement: Bank Reconciliation statement is being prepared at District level on monthly basis at DHS Purina but it is not prepared on monthly basis at PHC level .At State level also BRS is not prepared on monthly basis. It was noticed that at state level BRS was prepared up to 31.03.2013 only till the date of our visit. Later the state has sent BRS till 31.10.2013. Further it is observed that in the District Purnea Bank Reconciliation Statement for RCH flexible Bank account is not prepared in most of the facilities since inception. It is observed that there are instances of Stale cheques in BRS of both District and State Level. It is also observed that there are many outstanding which need to be look into.
- Multiplicity of Bank Account: State Health Society maintains 18 Bank Accounts for RCH, Mission, RI, IPPI and all NDCP's was conducting separate financial transactions for each programme. This multiplicity of bank accounts renders the financial management of the Mission susceptible to weak internal controls and needs urgent rationalization. The state is maintaining 3 bank accounts for state share which is against the guidelines. The state is not considering the unspent balance available under state share in their statement of funds position sent to the Ministry.
- The state has not implemented the guidelines issued by this Ministry vide letter G-270 17/21/201 O-NRHM (F) dated 23.01.2012 regarding opening of Group Bank A/c. According to the guidelines, the state need to open a Group Bank A/c in which there should be a main bank account and all funds from Government of India need to transfer into the main account. There should be sub account for all other programmes which should be linked with main bank account. Once the fund is received by the state in main bank account, the same

will be transferred to Subsidiary Bank A/c of the respective bank account of the respective programme

Accountability

- Statutory Audit: Statutory Audit Report for the year 2012-13 in respect of both districts has been taken place. The state has submitted their Audit report to GoI. It is observed that Statutory Auditor is not visiting the blocks .As per guideline the statutory auditor needs to visit at least 40% of the block. Further as per Audit report it is observed that nearly 10 PHC has not provided their books of Accounts to Auditor.
- Diversion of Funds: It is observed that there is frequent of diversion of funds from one pool to other pool which is evident from Audit report of the state.
- Financial Utilization: Utilization of funds is low in case of both RCH (9.55%) and Mission Flexible Pool (9.18%) against approved PIP up to first quarter of the year 2013-14. The Second quarter FMR is yet to be received due to non availability of physical progress.
- Advances: It is observed in the state Advance monitoring system is inadequate at all levels. Advance register is not maintained at PHCs visited by the CRM team. Advance ledger maintained at SHS is not properly maintained as adjustment of advance is not entered in advance ledger maintained by the SHS .It is observed that advance amounting to Rs. 7.83 cr (Rs.6.67cr of State and Rs. 1.16 cr of Districts) at SHS is outstanding since long and break- up of the advance is not available. Advance of Rs.130 crores is outstanding for more than three years at State level.
- The State had Rs. 362.38 crore outstanding as advances others as on 01.04.2012 which increased to Rs.389.72 crore as on 31.03.2013.
- Unspent balance under RCH-I and EC-SIP: The State has unspent balance of Rs.16.14 crore of closed programmes like RCH-I and EC-SIP which needs to be refunded to GOI.
- Delay in payment of JSY beneficiaries: It was observed that there is delay in payment to JSY Beneficiaries in the district Purnea . Total institutional deliveries in the district Purnea for the period April-October, 2013 is 43182 while total expenditure under JSY is Rs.5.45crore which 10% less than required expenditure. Further in SDH Banmankhi the payment for JSY was made for deliveries only up to August 2013 (as on Nov12th 2013, the day team visited).
- For deliveries in the September, 2013 nearly 600 cheque for beneficiaries was lying with the Accountant on the date of our visit.
- Delay in payment of ASHA: It is observed that in the district Purnea payment of ASHA incentive against institutional deliveries is made on an average after three month, and at time more. In SDH Banmankhi ASHA incentive for the period July, 2012 to March, 2013 was paid in the month of April 2013.
- Release treated as expenditure. : It is observed that in Purnea district funds released for RKS corpus grants and untied funds for VHSNC are being treated as expenditure. Further as per books of account of RKS there was substantial unspent balance was available with the RKS of the facilities. E.g. Dhamdaha has Rs.135054 as balance as on 31st Oct 2013.
- Untied fund for VHSNCs : It is observed that untied funds for VHSNC is not being transferred for the year 2013-14.Further out of 45 VHSNC under two PHC of K.Nagar and Banmankhi 17 VHSNC have less than Rs.1500 available funds as on 14.11.2013.
- AMG Grants: It is observed that in the district Purnea Annual Maintenance Grants for APHC & HSC has not been transferred since two year.
- Uncommitted Unspent balance as on 1st April 2013 reported as NIL, while available bank balance at SHS was Rs. 545.43 Cr and State has reported committed balance Rs. 429.25 Cr. Further the unspent balance at District level has not been considered for calculation of unspent balance at the time of preparing resource envelope.

- Allocation for High Priority District: Allocation to high priority districts has not been done on the basis of set norms of 1.3 times more than normal districts.
- JSSK Expenditure: It was observed that in the district purnea expenditure under JSSK,is reported for all diagnostic expenditure incurred by the facilities instead of expenditure for mother & child only which is nearly 30% expenditure of JSSK.
- Untied fund for Sub centre: In the District of Purnea untied funds for sub centre is released in the month of October, 2013 @Rs.2500 per sub centre but it is observed that subcentres have very less balance available on date of team visit.
- Cash Withdrawal: It is observed that at PHC level high cash balance as per cash book was available on the date of our visit but in actual this amount was not available at facilities. It was explained to us that amount has been paid for some activities like family planning and training but the advance was not booked in books of account. Example are as under
    a) K.Nagar : Rs.76900 (as on 12.11.2013)
    b) SDH Banamankhi: Rs.36900 (Balance since 8.10.2013 no transaction till 12.11.2013
    c) SDH Dhamdaha: Rs.203120 (as on 13.11.2013 out of which Rs.121500 is advance to CDPO since 29.03.2012)
- CPSMS: In the state CPSMS is not implemented as the State Health Society has not adopted CPSMS for transfer of funds

VIII. Medicine and Technology

Government of Bihar (GoB) has been introducing robust system of drug procurement, storage and overall supply chain management in the state. "**State Health Society Bihar (SHSB)**" has been nominated as "**State Purchase Organization**" to finalize purchase rates of drugs and medical equipments/instruments under Rule 129 of Bihar Finance (Amendment) Rules, 2005 to ensure uniformity in purchase rates and quality of drugs. As the notified State Purchase Organization, SHSB finalizes the purchase rates and suppliers through open tender to buy specific drugs/hospital equipments/instruments in all Govt. Hospitals and makes the list of rate-contracted firms available to all Civil Surgeons and DHS for their purchase, as per their requirement.

Drugs, equipments and diagnostics

- The state has notified **Essential Drug List (EDL)** vide letter no 409(12) dated 9.5.2011 issued by Department of Health:

Level of facility	Essential indoor drugs	Essential outdoor drugs
Dist Hospital to APHC	112 drugs	33 drugs
Medical College Hospital	120 drugs	65 drugs

It is yet to come up with facility specific (DH, SDH, CHC, PHC, SC), EDL.

- In all the facilities visited, at least 31 drugs were available for the OPD patients. Similarly 102 drugs were available for the IPD patients in most facilities.
- In the health facilities basic tests are done mainly HB%, routine urine examination, blood test for MP, sputum test etc. Majority of the tests are outsourced to "**CENTRAL DIAGNOSTICS**" of Patna. This diagnostic centre does 14 tests free of cost and for other tests, patient needs to bear the cost.
- The radiological diagnostics (x-ray & ultrasonography) is outsourced to an agency, namely ***IGEMS, Silvassa***. Diagnostics is free for the patient and the private party is paid by the Stat.

- In many cases, due to lack of awareness of free diagnostics many patients had already got the tests done from outside.
- The quality of the x-ray film was not very good. The patient's number was not quoted on the X-ray film, which might result wrong distribution of x-ray films among patients.

Procurement

- For timely drug procurement, the procedure of procurement is decentralized at present. SHSB invites tender directly from the pharmaceutical manufacturers / direct importers for making rate contract of all essential drugs. SHSB prepares rate contract of essential drugs directly with their qualified manufacturer of importer and the rate contract is made available to all Civil Surgeon-cum- Chief Medical Officers, Superintendents of Medical College Hospitals for purchase. Fund for the drug procurement comes to district through two routes, (i) NRHM fund (ii) treasury route.
- If the drugs cannot be supplied by the rate contracted agency then local purchase of drugs can be done by DHS for maximum of Rs. 15000, if necessary repeated purchase can be done. For local purchase, 03 quotations are invited and the lowest rate is given the supply order.
- District warehouse does not supply drugs directly to the sub centre. The sub centre requirements are projected by the concerned BPHC in its own requirement. Once, BPHC gets their drugs then from those drugs, Sub Centre is also given drugs.
- 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 drug shortage in any hospital.
- PHC/SDH/CHC/RH collects drugs from the warehouse and for carrying drugs from the district warehouse, RKS fund is used by the respective facility. Drugs for JSSK (33 items) are separately procured under DHS grant (as per rate contract).
- The state government has constituted Bihar Medical Services and infrastructure Corporation Limited (BMSICL), which is in line of TNMSC. The BMSICL shall have centralized procurement system and is about to start functioning

Storage and Supply

- In the state, out of 38 districts, 23 districts have a drug warehouse and warehouse for 15 districts is under construction. BMSICL also have three warehouses (capacity 91000 sq ft.) on lease from State warehouse corporation Limited. The drugs procured under state's pool and NRHM pool are kept together. The field visit findings reveal that the district warehouse is suffering from acute space shortage, which needs to be taken up urgently. Due to space shortage, the FIFO (First In First out) is not properly adhered to at the district warehouse. The same situation was also noticed at most of the block health facilities. State needs to address this issue to minimize drugs wastage.
- In district warehouse and in Block PHCs, storekeeper is posted and pharmacist is made responsible for maintaining the pharmacy of the Block PHC.
- The district visit report reveals that by and large supplies of maximum drugs have been uninterrupted and responsive to utilization patterns and with the functioning of BMSICL, it is expected that supply chain management will further improve.
- To improve the drug inventory management (for drug procurement and logistics MIS system), BMEDS (Bihar Medical Equipment & Drug System) has been put forwarded by

BMSICL. BMEDS is a complete web based, centralized automation solution with advantages of built in real time MIS reports.

- The Field visit reports show that the Sadar Hospitals have adequate labour room equipments, SNCU/NSU equipments and ICU equipments and most importantly, which are in use and with proper maintenance. Authorities reported that these equipments have provision for Annual Maintenance Contract (AMC) and once any equipment becomes out of order, then either it is repaired or replaced immediately. However in BPHC and APHC, delivery room equipments had poor maintenance, e.g. radiant warmer was dusty, sterilizer either non-functional or not available at all.

Quality Assurance

To ensure quality checking of drugs, the state follows the following procedure:

- Local Depot at State Level after receiving the drugs/medicines from the manufacturer, informs the local Drug Inspector about the receipt of drugs and Drug Inspector collects the samples of drugs for testing and for analyzing. These samples are sent to the NABL accredited laboratories or Govt. Laboratories.
- Same in the district, once drugs reach the district warehouse, Drug Inspector is informed by the DHS, who comes and collects five (5) samples from each new batch supply and these samples are sent to empanel laboratory accredited by NABL and Central/State Government Test Laboratory. If the samples tested by NABL accredited labs are found to be substandard drugs, the Drug Inspector takes the sample of the same batch and is sent to the Government Laboratory for test & analysis as per Drugs & Cosmetics Act, 1940 and the Rules, 1945 and further steps are taken as per the provisions of the same Act. Samples of drugs are sent to four different NABL accredited testing laboratories situated at Indore, Mumbai, Hyderabad, Chennai. Testing of most of the Non-Biological drugs are carried out by State Testing Laboratories. Generally, NABL accredited labs send their report within a month of the receipt of the samples. The field report says that it takes years to get the report and some time it does not even come. Generally, during this period of getting lab test report, drugs under this batch number get exhausted. So, practically report does not serve much purpose.
- Facility level audit of drug store management is done considering the drug supply record of the district warehouse as base versus use of drugs at the facility level.
- Rational prescriptions of drugs are encouraged. To evaluate the prescribing behavior of the prescribers and know the availability of key medicines a sample study (covering 1540 prescription and 22 health facilities) was facilitated through SHSB's technical support partner TAST .However the sample size is too small to draw any meaningful conclusion.
- At present Stock and Distribution Register are being maintained manually at each level of facility and at District level, district inventory register is maintained. By Dec'2013, state is likely to introduce Drug Inventory and OPD Registration software in all the health facilities to maintain Drug Inventory electronically and MO i/c of the health facilities is made responsible for timely updating the records. Updating the stock position is done fortnightly. As most of the storekeepers are not computer literate, so they need help of block data entry operator to update the status.

Overall Observations

- Pharmacist is placed in all drug store. Drug inventory management system is in place, which needs to be computerized;
- Records related to indenting of drugs at all levels are well maintained.
- RKS also buys emergency drugs for labour room, FP activities;

- Laboratory services and diagnostic services are outsourced;
- Differential EDL (for DH, SDH, CHC, PHC, SC) is not introduced;
- EDL is not prominently displayed in many of the facilities;
- Drug stock position is updated fortnightly in all facilities and daily in few facilities;
- District drug ware house records are well maintained;
- District drug warehouse at district and at facility have space shortage;
- Bihar State Medical Infrastructure Corporation Limited is yet to be in operation;
- Money has not been released to DHS for drugs procurement in 13-14;
- Because of not matching the drugs name with the list of drugs (33 and 112); sometimes updating is found to be an issue at the facility level.

IX. National Urban Health Mission:

- Bihar is of the most rural states in India with only about 15 percent of its population residing in urban areas. A total of 53 urban local bodies exist in Bihar.
- Bihar had taken up the mapping of slums and health facilities in 2008-09. With rolling out of NUHM, the state is planning to update the existing maps. In the first phase of the rollout of the National Urban Health Mission, 15 cities/towns with a population of over 50,000 will be covered representing two-thirds of the urban population of Bihar. The PIPs for the 15 most populous cities/towns have been prepared and submitted to MoHFW with a total resource envelope of Rs. 50 crores (75 percent Center and 25 percent State funding). Next year the remaining cities will be covered.
- Purnea has been included in the NUHM for the year 2013-14 and a total budget of Rs 411.09 Lakh is proposed. The plan intends to cover 164 slums with a total population of 72203
- None of the urban cities/towns are located in Vaishali District.

X. Governance and Management

Programme Management

- The State has a robust State Programme Management Unit (SPMU) with State level Programme Officers and Consultants. Many senior doctors from the directorate are part of the SPMU/state Health Society. State also has inducted many officers from the Bihar Public Service Commission in SHSB.
- The State has managed to provide stability of tenure to the current Mission Director who has been the Secretary and the Mission Director for last three years. This has given adequate time to take long term decisions and actions which has resulted in betterment and consolidation of programmes. However there have been frequent changes at Principal Secretary Health level with Bihar having more than 3 Principal Health Secretaries in last 3 years.
- Though there has been many programmatic advances such as JSY , increase in full immunization, Operationalisation of FRUs/increase in C-sections, long term systemic changes in public health such as differential planning for rapid infrastructure development to bridge the gap at APHC and block PHC level at high caseload facilities, Comprehensive HR policy including policy to absorb the contractual HR, service delivery as well as programme management staff , establishment of public health cadre, strengthening of SIHFW, bringing private sector in the purview of the Clinical Establishment Act, and a system of quality assurance are yet to be taken up and rolled out.
- At the start of NRHM, Bihar had the strength of integrated structures at Principal Secretary level where the reviews were not only for NRHM but entire health department. As the CEO/head of the State Health Society and as the head of the entire Health department the

integration envisaged was complete and workable in spite of a separate though sparsely staffed directorate. In last 3-5 years this system seems to have been slowly abandoned with only Mission Director looking after NRHM, and Principal Secretary looking after other issues ranging from medical education to management of state funds. Though at programmatic level the MD has managed integration, at systems level the problems still exists. SHSB being not able to provide HR data is a symptom of this deep rooted problem.

- The delegation of powers to the programme management units has been done mostly in accordance to the prescribed norms; however the Regional Programme Management Units seem to be left out. Without adequate delegation of powers both administrative and financial such structures have become weak and their monitoring/supervision is not yielding necessary results.
- The training and skill development of the Public Health Managers is weak and at places almost non-existent. There is no system of orientation training for fresh managers at the time of joining. Most of the programme managers are MBAs/ Post graduates in social sciences without any exposure to health sector/government/public health and have to learn on the job (at times by committing mistakes) at their own. Similarly an MO is made Moi/c without providing administrative training. The case is same of other higher health administration posts in health in the districts as well. A large state like Bihar needs a strong public health cadre which the state is yet to be initiate.

Institutional Mechanism

- The District health societies are functioning well under the leadership of the District Magistrates who are taking interest in resolving health issues. However the District Health mission and meeting of the Governing Body of the DHS are not conducted regularly.
- District planning process is now an annual phenomenon and much better compared to the initial years of NRHM. However it is far from reaching the level where there is differential plan for each facility and where the differential is maintained even after its consolidation in the block, district and State plan.
- Field visit report reveals that most of the meetings of the RKS are need based, as and when need arises, meeting is convened. In Vaishali district, meeting of RKS at Patepur Block PHC could not take place for last 9 months due to non-fulfilment of meeting quorum. The minutes of RKS meeting were also not available for inspection.

Supervision & Monitoring

- The State has adopted the monitoring checklist recommended by GoI for various facilities and majority of the program managers are conducting regular field visits. The advanced Tour Plan and report/checklist is uploaded on the SHSB website where all stakeholders including the facilities at sub-district level can see.
- However the utility of this exercise is limited because follow- up on the part of district and facility officials is very poor. The CRM team came across many reports /letters written by program managers to various officials and facility in charges where recommended action has not been taken in spite of the reminders.
- Supervisory visits by the regular officials are very few and mostly of administrative nature. There are no reports available for such visits.

Accountability

- Social audit is a part of Community Based Participatory Monitoring (CBPM) Programme. The Nodal agency for which is PFI in Bihar. The programme is being implemented in select blocks

of Bhagalpur, Darbhanga, Gaya,Jehanabad and Nawada. Social audit is conducted by the members of Nigrani samiti/Village Planning and Monitoring Committee. The findings of the social audit are shared during the Jan Samvad/public hearing. The overall purpose is to build community awareness, give voice to general public, improve public participation. Total number of Jan Samvad conducted so far are 10.

- As Community Based Participatory Monitoring Programme is not being implemented in Vaishali and Purnea team could not assess its effectiveness.
- District Vigilance and monitoring committee: In Bihar, 37 District Level Vigilance and Monitoring Committees have been formed so far and the total number of meetings held are 45.

Regulations

- State is yet to adopt the Clinical Establishment Act. It has been pending with the State government for more than 3 years.

Progress captured in camera:

Clock-wise starting from above: Clean wards, Improved IEC, Strengthened computer lab in ANM school, Advanced Dental clininc

5. OVERALL RECOMMENDATIONS

Service Delivery	
Short Term	**Long Term**
• Adherence to the guidelines of National Ambulance Services and National MMU services on priority basis across the State. • State should ensure the availability of adequate Infrastructure and HR at all delivery points to provide the minimum assured services. • More than one ambulance should be provided to each block to ensure assured referral services from Home to Facility, Inter Facility and Drop Back in all the districts. • Urgent and focused attention to the hospital staff for proper segregation of biomedical waste products. In-house mechanism to be developed to ensure adherence to the waste disposal protocols. • Reporting by the MMU should also include reporting on the disease pattern in the area and medicines that are made available as per the prevalence of the disease. • Monitoring of MMU services by DHS officials.	• State should strengthen Grievance Redressal mechanism at all levels. • State should develop effective monitoring mechanism for biomedical waste management and other outsourced services. • Sitting arrangement with safe drinking water and toilet facility for attendants should be available in public health facilities. • Regular inspection visits by Govt. officials to be undertaken to regulate and monitor the use of ultrasound machines. • State to ensure smooth and continuous supply of essential AYUSH medicines timely.
Reproductive and Child Health	
Short Term	**Long Term**
• The Cold chain handlers need training on vaccine logistic forecasting and distribution plan. Computerized inventory is necessary. • NRC should be shifted from SDH to district Hospitals in Vaishali and Purnea dist as the Paediatrician is available in the District hospitals only. • State to ensure that JSY payments are made before the discharge of the mother from the facility and backlogs at some facilities need to be settled immediately. • JSY payments to ASHA should be made on a monthly basis. • The State should review the Mamta programme, and arrange for their training. • The Family Planning counselor should be posted in high case load facilities (>60/ month) and all Counselors must undergo comprehensive training on FP. • The immunization for newborn should be initiated at the wards through designated PP unit nurses/ ANMs	• State to move towards account payee cheques/DBT payments. • Health Institutions with high delivery load should have separate Antenatal wards with facilities to treat pregnancy complications. • The District hospital should have separate wards for keeping high risk pregnancy with separate nursing staff to address the emergency and transportation of the mother for emergency C section. • State should focus on enhancing PPIUCD and Post partum sterilization at the public health institution. • Comprehensive plan for Family Planning related IEC should be developed at State level. • Proper micro planning is needed for conducting Routine immunization in HSC , VHND with child tracking and it needs to be updated regularly.

• The District needs to plan for training of ANMs on SBA, PPIUCD, F-IMNCI and Immunization on priority basis	
Disease Control Programme	
Short Term	**Long Term**
NVBDCP	
• State should recruit a full time State Programme Officer for VBD. • DEO under NVBDCP is working with DPM, Vaishali resulting hampering of work. May be called immediately to report DMO for entering HMIS and line list data. • State should procure Paromomycine injection and Ambisome for combination treatment in identified KA districts.	• All the contractual positions funded by World Bank need to be advertised and filled up on a priority basis fast track before closing of WB project. • Computers with printers may be allotted to all VBD districts for capturing HMIS and feeding of Line listing should start so that elimination target of KA by 2015 is met. • Road map for Kala-azar developed in consultation with stakeholder should be rolled out.
IDSP	
• AHSAs should be sensitized periodically for case referral & symptom identification for epidemics. • District Priority lab need to be established on priority basis. • All the training program for all the cadres should be scheduled and conducted on a priority basis • Drugs shortage should be addressed (e.g.: Malaria)	• RRT team and public health Emergency preparedness team should sensitize the field level staff on epidemics • IEC activities should be strengthened; School health, community awareness programs, AHSA day sensitization and mass campaigns should be started • Media campaign, private sector sensitization, other departmental inter-sectoral coordination and other stake holders sensitization should be done periodically.
RNTCP	
• State should recruit district DEO in both the districts. • All the MOICs and MOTCs should be instructed to make their Tour dairy for field visit for community visits and monitoring the field staff of RNTCP and also should be instructed to monitor the programmatic activities of TB at their hospitals • Deployment of lab technicians from the general health system to operationalize the DMCs as per the RNTCP population norms. • Block level DEOs needs to be trained in Nikshay and should start entering data at the earliest.	• All the ANMs and ASHAs should be sensitized on Contract tracing, finding the TB suspects in the community and DOTS and follow up activities and TB awareness messages should be given in VHSNDs • TB HIV coordination should be looked after very seriously, all the TB patients should be tested for HIV and proper arrangements for making additional F-ICTCs should be made. • ANMs and ASHAs facilitators should be encouraged and incentivized to support case finding activities.
NLEP	
• Massive IEC / BCC (Information, Education & Communication / Behavioral Changes in Community) activities need to be done at State & district levels	• State should focus on filling up of all vacant positions across the districts • Brining down PR / ANCDR (Prevalence Rate / Annual New Case Detection Rate) to below

• Validation of all newly registered case by DNT & ILEP • Timely availability of fund to State & Districts needs to be ensured.	1/10000 and 10/100000 Population respectively by early case detection and treatment with MDT • Attention needs to be given to disability prevention, medical, Social & economic Rehabilitation of Leprosy Affected Persons.
NCD	
• Immediate action should be taken to start all the activities in the Pilot districts. • All the vacanct positions should be filled immediately. • Tobacco control activities should be incorporated in all the field activities.	• Trainings should be scheduled. • Procurement of all the logistics and instruments should be given priority
Community Process & Convergence	
Short Term	**Long Term**
• State needs to urgently plan the training of RKS and VHSNC members to appraise them about their job responsibilities and the areas on which fund could be utilized. • VHSNC and RKS should have regular meetings. • ASHAs should be provided with HBNC kit immediately to ensure quality home visits are made by ASHAs. • DCM / BCM should be trained in HBNC forms so that they can provide handholding support to ASHAs through ASHA Facilitators on filling up forms. • State / District has to ensure required printed HBNC formats at BPHC. • HBNC payment to ASHA should be made on time.	• State should re-constitute the existing VHSNC as per the new guideline. • State has to strengthen the supportive supervision and mentoring of VHSNCs and RKS. • ASHA Ghar/ Rest rooms should be constructed in the delivery points having high case load. • ASHAs should be involved in review and reporting of infant and maternal deaths. • As per new guidelines on community processes, VHSNC should have a minimum of 15 members. About 50% should be women members and SC/ST sections should be well represented. So, the SHSB needs to re-constitute the existing VHSNC as per the new guideline. • VHSNCs need orientation so that they can do situational analysis and can prioritize activities while making the expenditure. . • The State needs differential selection criteria for ASHAs in 'Mahadalit tolas'. Even for smaller villages 800 population the ASHA should be from the same community.
Information & Knowledge	
Short Term	**Long Term**
• Registration of MCTS needs to be significantly improved as only 59.4 percent of pregnant mothers and 46.3 percent of children are currently registered. • Flow of information in MCTS needs strengthening and the system needs to be made real time and dynamic for tracking service delivery and health outcomes.	• State needs to operationalize the Maternal Death Audit and Child Death Audit. • The system of regular updating of services provided to pregnant women and children needs to be put in place. • Options for improving registration and updation of MCTS services and universalization of complete package of

• Recruitment and training of additional block level data entry staff should be completed on priority with specific TORs exclusively related to MCTS. • Linking MCTS to JSBY and incentives to ASHA for full immunization • Capacity of generating actionable reports from MCTS needs to be developed at block level to track outcomes and to achieve universalization of maternal and child health services. • System of validation and verification of HMIS and MCTS data needs to be institutionalized at all levels.	maternal and child health services should be explored: – Mobile Based Data reporting from service delivery point through ANM – Involving ASHA in registration and updation of services and tracking of mothers and children to ensure delivery of complete package of services – Assigning clear responsibility to monitor implementation of MCTS and service provision utilizing MCTS at all levels • State needs to build system to ensure routine checking of data being filled by ANM during service delivery for completeness and accuracy.
Financial Management	
Short Term	**Long Term**
• Director (Finance) to be appointed on priority basis. • Bank accounts to be reconciled regularly. • ASHA payments to be made on a monthly basis; BCM, DCM need to track the performance of ASHAs and ensure that timely payments. • Ensure timely payment to all JSY beneficiaries before their discharge. • Clients undergoing sterilization operations to be paid wage loss money at the time of discharge.	• Financial Management at District level should be strengthened by way of training, regular Monitoring and Evaluation. • Funds should be transferred through CPSMS through which fund position may also be ascertained on real time basis. • Tally ERP needs to be installed at DH and SDH levels.
Medicine and Technology	
Short Term	**Long Term**
• State should adhere to the guidelines of National Drugs Services. • EDL should be prominently displayed in all health facilities. • Differential list of EDL needs to be notified for different levels of facilities. • Labeling may be done on the racks of the drug store room at district warehouse and storeroom of Block PHCs so that availability of drugs is known immediately. • Need for timely release of funds to DHS for drugs procurement; • Prescribing generic drugs have to be made mandatory at all levels of facility.	• Report submission of the sample quality check must be done within fixed time. • The outsourced agency for doing x-ray and USG needs to be asked to ensure quality production of films and also to maintain protocols of drawing films. • Additional room construction for district drug ware house needs to be taken up.

Human Resource, Training and Program Management	
Short Term	**Long Term**
• Rational deployment of HR needs to be insured at all the delivery points. • State has to expedite the filling up of vacant posts under NRHM and under GoB. • Refresher training at regular interval needs to be given to MOIC on management & financial issues. • Supportive supervision at all level is to be strengthened and most importantly action needs to be taken based on the field visit report.	• State should have a comprehensive HR policy addressing HR supply in the long term, rational posting and well thought out performance appraisal for all categories of staff. • System of mandatory induction training should be introduced. • As the state has initiated absorption of contractual specialists and doctors, the same needs to be done for other categories of HR well.

ANNEXES

ANNEX - 1

CRM TEAM FOR BIHAR

VAISHALI TEAM

S. No.	Name	Designation	Organisation	Contact details
1	Dr. Sushma Dureja (TL)	Deputy Commissioner, Adolescent Health	MoHFW, GoI	09811138931/011-23061089
2	Dr. R. K. Das Gupta	Joint Director, NVBDCP	MoHFW, GoI	09312214016
3	Ms. Sheena Chhabra	Chief, HSD	USAID	09811059143
4	Mr. Alok Vajpeyi	Head, Core Grants and Knowledge Management	Population Foundation of India	09873077550
5	Mr. Biraj Kanti Shome	Regional Coordinator, Community Mobilization	NHSRC	09435172953
6	Dr. Sanjeev Jha	Consultant, RNTCP	WHO	09304003847
7	Mr. Vipin Garg	Consultant, JSY	MoHFW	09212786892
8	Dr. Sarita Sinha	Consultant, Planning & Policy NHM	MoHFW	08750206161

PURNEA TEAM

S. No.	Name	Designation	Organisation	Contact details
1	Dr. R.S. Gupta	DDG, TB	MoHFW	09873926044/011-23062980
2	Dr. V. K. Shahi	Assistant Director - Ayurveda, AYUSH	MoHFW	09818383924
3	Dr. S. N. Bagchi	Senior Programme Manager, Health System Support Unit	PHFI	09971044553
4	Ms. Mona Gupta	Associate Director	TMSA	09377819831
5	Mr. K. Kaushal	Consultant, Finance	MoHFW	09910400611
6	Dr. Anisur Rahman	Consultant, PNDT	MoHFW	09810119488
7	Ms. Zahra Afroz	Young Professional	Planning Commission	09911252906
8	Mr. Vinod Kumar	Senior Programme Officer, UP	BMGF	07838050513

ANNEX - 2

LIST OF THE FACILITIES VISITED BY THE TEAM

Names of district visited				
Sl No.	**Name**	**District HQ**	**Name of DM**	**Name of CMO**
1.	Purnea	Purnea	Mr. M. K Verma	Dr. S.N Jha
2.	Vaishali	Vaishali	Mr. Jitendra Srivastava	Dr. Dinesh Kumar Singh

Purnea: Health Facilities visited

Sl. No.	Name	Location (Block)
1.	Sadar Hospital	Purnea
2.	ANMTC	Purnea
3.	Sub-Divisional Hospital	Dhamdaha
4.	Sub-Divisional Hospital	Banmanki
5.	BPHC	Bhawanipur
6.	BPHC	K. Nagar
7.	APHC	Sarsi
8.	APHC	Akbarpur
9.	APHC	Rangpura
10.	APHC	Sondeep
11.	APHC	Damaili
12.	Sub-Centre	Akbarpur
13.	Sub-Centre	Sondeep
14.	Sub-Centre	Supauli
15.	Sub-Centre	Gokhalpur
16.	Sub-Centre	Mirchai Badi
17.	VHSND	Dhamgarha
18.	VHSND	Badhari
19.	VHSND	Jabe
20.	VHSND	Badhi Tola
21.	VHSND	Deemapur
22.	VHSND	Damdaga Tola
23.	VHSND	Mushahar Tola
24.	VHSND	Pipra Vishanpur
25.	MMU	Matia Musehri
26.	MMU	Purnea East
27.	102/108/1099	

Vaishali : Health Facilities visited

Sl. No	Name	Address / Location
1.	Sadar Hospital	Vaishali
2.	ANMTC(Govt.)	Vaishali
3.	Private ANMTC	Vaishali

Sl. No	Name	Address / Location
4.	Sub-Divisional Hospital	Mahua
5.	BPHC	Bidupur
6.	BPHC	Goraul
7	BPHC	Rajapakar
8.	BPHC	Vaishali
9.	BPHC	Patepur
10.	BPHC	Bhagwanpur
11.	APHC	Chaksikandar
12.	APHC	Pakoli
13.	Sub-centre	Lalganj
14.	Sub-centre	Zafarpatti
15.	Sub-centre	Kutubpur
16.	Sub-centre	Bahuara
17.	VHSND	Madhurapur
18.	VHSND	Chachar
19.	VHSND	Pakri Khusua Toal
20.	MMU	Vaishali
21.	102/108/1099	
22.	Ultra Sound clinics	Hazipur
23.	SIHFW	Patna