State Programme Implementation Plan

RCH-II

2005-06 to 2009-10

BIHAR

Department of Health and Family Welfare
Government of Bihar

1. SUMMARY

This State Project Implementation Plan for the Reproductive Child Health Programme- Phase II for Bihar provides the roadmap for the actual implementation of this programme for the next five years (2005-06 to 2009-10). It follows in essence, form and content, the ”GoI guidelines for SPIP" and the “Suggestive Guidelines Manual for Development of SPIP”. As the states are supposed to develop their respective plans within the overall framework of RCH II at the national level, this document also draws heavily from the National PIP. Efforts have been made to plan based on evidence, consult all stakeholders, incorporate lessons learnt from RCH I, set realistic objectives, develop synergies between different vertical programs, and strengthen and decentralize programme management.

Organization of the Document

This document is divided into two broad parts. *Part One*, comprising of Sections One to Six, sets the stage by providing background information and in-depth analysis of broad health development issues in the state, in general and of the implementation of RCH I, in particular. *Part Two* outlines the state's vision for the implementation of RCH II with details of technical objectives, strategies, activities and resources involved in this implementation.

Part One begins with Section Two, which outlines the wide consultative process that was undertaken to develop this plan document. It also provides a chronological overview of this process that began in early 2003. Section Three delineates the time-line for the implementation of the planned interventions. Section Four provides the background information of the state such as its demographic and socio-economic features and Administrative divisions and details of the current status of broad issues such as RCH outcomes and service utilization, its Public as well as Private and NGO health infrastructure and current donor-assisted programs in the state. It also describes institutional arrangements for RCH I and identifies the critical issues and gaps in these arrangements. Finally, this section discusses the programme finances for RCH I and analyses the availability of budget and expenditure, including timeliness. Building on the information provided in the previous section, Section Five, analyses the situation to identify the core issues that affect the major programme components (Maternal, Child, Urban and Adolescent Health and Family Planning and cross-cutting areas like logistics, HMIS and human resource development). It also analyses regional and district-wise variations in terms of the key health indicators. Section Six attempts to lists out the major impediments identified during the implementation of RCH I in the state and also provides the lessons learnt to be used in developing the plan of action for RCH II.

In Part Two, Section Seven contains the vision statement for RCH II in Bihar. It sets out the specific, objectives, strategies and activities for the key programme components of RCH, namely, Maternal Health, Child Health, Family Planning, Adolescent Health and Urban Health. Further, it outlines specific objectives, strategies and activities for the crosscutting areas such as Health Facilities and Personnel, Training, NGOs and Public-Private Partnership, and Behavior Change Communication. Section Eight provides the details of programme management structure that will be in place at the state, district and sub-district levels to implement RCH II. Section Nine discusses the Monitoring and Evaluation component of RCH II, whereas Section Ten provides detail of the budgetary provisions required for RCH II.

Background and Current Status for RCH II Planning in Bihar

Bihar with a population of 82.9 million is the second most populous state in India, next only to Uttar Pradesh. Despite efforts in the last few decades to stabilize population growth, the state's population continues to grow at a much faster rate (28.43%) than the national population (21.34%). The state is densely populated with 880 persons per square kilometer as against the country average of 324. The sex ratio of the state at 919 is also less favorable than the national average of 933.The state has 38 districts divided into 9 administrative divisions. In addition, the state has 101sub-divisions, 534 community development blocks, 9 urban agglomerations, 130 towns and 37,741 villages.

Background and current status data suggest that Bihar is one of the poor performing states in terms of RCH I outcomes. This is reflected in the four key indicators namely MMR, IMR, NMR and TFR. RCH I remained a virtual non-starter in the state for a variety of reasons leading to poor availability, accessibility and utilization of RCH services. Of the four key health indicators, the state's performance is below normal for three indicators namely, MMR, NMR and TFR. Only the reported IMR in the state is better than national average. (Refer Table 1.1).

Table 1.1: RCH Outcomes and Service Utilization: Current Status

Outcomes Indicators	State	India		
	Current Status	Current Status	Goal	
			2006-07	2009-10
MMR[1]	452	407	200	<100
IMR[2]	62	66	45	<30
NMR[3]	46.5	45	26	20
TFR[1]	3.4	3.2	NA	2.1

Source: [1] MMR & TFR: (NFHS II 1998-99, [2] IMR: (SRS 2001), [3] NMR: (SRS1998)

Public Health Infrastructure

Although the state has a fairly extensive network of public health facilities it remains grossly inadequate compared to GoI/GoB norms. Furthermore, even the existing facilities lack the basic minimum infrastructure needed for their optimal functioning. As per information available with the state directorate, only 23 of the 38 districts in the state have a district hospital. Similarly, of 101 sub-divisional headquarters, only 23 have a sub-divisional hospital. The CHC/ Referral Hospital Network are virtually non-existent with the state having only 101 CHCs/Referral Hospitals (70 functional). The state has only 398 PHCs that suggests that each PHC covers an average of 2 lakh population as against the norm of 30,000. A similar situation prevails with regard to facilities at the Health Sub-Center level, where the state has 9140 Health Sub-Centers i.e. an average of one Health Sub-Center for 9000 population as against the norm of 5000.

Similar to the situation with physical infrastructure, districts face acute shortages in health personnel as well. As per the data available with the state, a large number of posts of Medical Officers and frontline health workers remain vacant. Specific personnel data indicate that against the sanctioned strength of 5124 MOs there are only 3860 medical officers are working in the state, leaving close to 22% post vacant. In case of frontline health workers such as ANM, LHV, MHWs, staff nurses and AWW, situation is almost similar or even worse. For example, in case of ANMs, against the sanctioned posts of 11294, the state has only 10055 ANMs (i.e. a shortage of about 11%), whereas there are only

1298 MHWs against the sanctioned strength of 2552 (about 49% posts vacant) and 662 LHVs against the sanctioned number of 1126 (shortage of more than 40%). In case of Staff Nurses 195 out of 451 sanctioned posts are vacant. Similarly, despite being critical to high profile programs like, RCH & ICDS, almost 4000 posts of Anganwadi Workers continue to remain vacant.

Private and NGO Health Services/ Infrastructure

The State has a relatively wide network of private health facilities providing RCH services. However, exact data on the number these health facilities are not available with the State. This non-availability of data related to private health facilities also shows that these individuals/organizations are not necessarily registered with the Department of Health & Family Welfare, GoB, making it difficult to regulate these facilities.

Existing data suggest that the RCH program has not being able to develop a wide network of NGOs for RCH in the state. The state has only 12 mother NGOs were covering 22 districts of Bihar. For rest of the districts (16) there are no NGO working as mother NGOs. With regard to functioning of MNGOs, it's difficult to comment, as the state does not have a structured procedure to assess the working of MNGOs.

Donor-assisted Programs

There are mainly two development partners working in Bihar, UNICEF,WHO and the European Commission (EC). Support from the partners was sought given their respective strengths and the need for technical support to enhance the quality of programme implementation and efficient utilization of resources. During the period under discussion, the EC provided financial assistance under the Sector Investment Programme to assist in health sector reforms and UNICEF support to the state was in the area of strengthening immunisation and nutrition services.The

Institutions Involved in RCH

Given the broad scope of RCH and the range of services planned, the program envisaged involvement of all relevant stakeholders from government and non-governmental sectors. Functional synergies were sought with key governmental departments such as ICDS, PWD and PRIs. Active co-operation was also sought from non-governmental organizations, private sector and developmental partners. The key partners are Department of Family Welfare, ICDS, PWD, PRIs, NGOs / Private sector and Development Partners (UNICEF and EC)

Situation Analysis

Maternal Health

The major issues affecting maternal health services in Bihar are listed below.

- Paucity of skilled frontline health personnel (ANM, LHV) to provide timely and quality ANC and PNC services.
- Lack of public health facilities providing obstetric and gynecological care at district and sub-district levels.
- Inadequate and erratic supply of essential items such as BP machines, weighing scales, safe delivery kits, Kit A and Kit B, etc.
- Shortage of gynecologists and obstetricians to provide maternal health services in peripheral areas.
- Dearth of skilled birth attendants to assist in home-based deliveries

- Virtually non-existent referral network for emergency medical and obstetric care services
- Lack of awareness about antenatal, perinatal and post natal care among the community especially in rural areas.
- Low levels of female literacy
- Significantly high levels of malnutrition (anemia) among women in the reproductive age group
- Poor communication because of bad roads and a dismal law and order situation.

Child Health

The specific issues affecting child health in the state are listed below.

- High levels of maternal malnutrition leading to increased risk pre-term and low -birth weight babies that in turn increase risk of child mortality.
- Low levels of female literacy, particularly in rural areas.
- Failure of family planning programme in delaying and spacing births leading to significantly high mortality among children born to mothers under 20 years of age and to children born less than 24 months after a previous birth.
- Failure of programme to effectively promote breastfeeding immediately after birth and exclusive breastfeeding despite almost universal breastfeeding practice in the state
- High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socioeconomic groups leading to a disproportionate increase in under five mortality
- Persistently low levels of child immunisation primarily due to non-availability of time and quality immunisation services
- Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI, Diarrhea, etc.
- Inadequate and erratic availability of essential supplies such as drugs, ORS packets, weighing scales, etc.
- Lack of knowledge of basic child health care practices amongst health care providers at the and the community
- Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children

Family Planning

The major issues affecting the implementation of the Family Planning programme in Bihar are as follows.

- Role ambiguity resulting in dilution of roles, responsibilities and accountability amongst programme personnel both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth
- Inability of the program to alter preference for son of eligible couples through effective behavior change communication (BCC)
- Lack of health facilities, both in terms of physical infrastructure and skilled human resources to deliver quality family planning services
- Inability of the program to up-scale family planning services to cater the enhanced demand for family planning leading to significantly high level of unmet need
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups.

- Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups.
- Weak public-private partnerships to promote and deliver family planning services

Adolescent Health

Adolescents constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health program. However, in Bihar, this realization has remained confined to the level of mere rhetoric and has not yet been translated into practice. This is evident from the fact that the existing RCH programme does not have separate planning of health services to address the specific needs of adolescents of the state.

District / Sub-district Variations

Key indicators related to Maternal and Child Health (MCH) and Family Planning clearly show the poor status of RCH in Bihar. However, close examination of data reveals that there exist wide inter-district variations for almost all the key indicators. Analysis of the data suggests that districts generally closer to the state capital and not flood-prone have better health indicators.

Training

The status of training facilities in the state (both in terms of infrastructure and human resources) remains far from satisfactory at all levels. At the state level, there is only one training institute, the State Institute of Health and Family Welfare (SIHFW) that imparts training to health personnel. In the private sector Surya Clinics and MGMNH are giving training to the health personnel. The SIHFW is facing a severe shortage of faculty. At the regional level, too there is an acute shortage of good training centers. There is one LHV Training School at Patna City in the state. Of the nine administrative divisions in the state only six have Regional Training Centers. Only 21of the 38 districts have ANM training centers. These training centers are not undertaking training courses due to change in training policy as well as shortage of training infrastructure and skilled trainers. Apart from the huge number of vacancies, lack of clarity regarding staff roles and responsibilities, ad hoc transfers and postings of key personnel and a weak performance appraisal system characterize the human resource management system of state.

Logistics

There is no systematic structure either at the state, regional or district levels to manage the logistical aspects of RCH. Most logistical activities are dealt with in an ad hoc manner. The state does not have mechanisms for proper estimation of key supplies, their indenting and/or procurement, and their warehousing and transportation. The bulk of essential supplies in RCH come directly to districts from GoI and often the state is not even aware of the content and delivery schedule of these consignments. This state of affairs often results in irrational and erratic supplies, negatively affecting programme delivery.

HMIS

The RCH program in Bihar is characterized by a health management information system wherein collection, collation and analysis of information are inadequate. The existing HMIS system basically comprises the nine different forms

developed by GoI. The health facilities at both district and sub-district levels delay submission of their respective forms. In turn, this leads to lack of timely and comprehensive information about the status of the program at the state level. There is shortage of physical infrastructure and skilled manpower for HMIS.

Programme Finances

Analysis of the money received by the state under RCH I clearly indicates that utilization of money earmarked for RCH has been abysmally low. The audited expenditure report for last four years clearly shows that the highest utilization of RCH funds was in year 2003-04 when the state used about 33.70% of the money received form GoI. Close analysis of expenditure under RCH I by the state suggests that though the expenditure by the state were made under the broad areas suggested by GoI, the state has not been consistent with any activity/intervention throughout the program period.

Lesson Learnt from RCH I

In light of the experiences of RCH I implementation in the state, the major lessons learnt are outlined below.

(1) Management and Institutional

- Restructuring both at the state and district levels to clearly demarcate roles and responsibilities of key officials involved in the RCH programme along with their reporting relationships.
- Make SCOVA/ SHSB fully functional with all administrative and financial resource.
- Involve personnel with requisite financial management skills (CA / MBA Finance) and experience of large-scale government finances
- Impart ongoing, structured training to enhance managerial and technical capacity of DoH&FW officials involved with RCH II at different levels
-
- Develop alternate Strategies for hiring manpower/consultants
- Decentralize authority, processes and modalities at all levels of service delivery
- Institute innovative methods for motivating the service providers at all levels.

(2) Coordination

- Outline clear roles and responsibilities of all collaborating departments and mechanisms to ensure coordination for the implementation of RCH plan of action.
- Develop mechanism for partnership with NGOs, CBOs and PRIs in the plan process.

(3) Strategic Inputs and Systems

- Assess major procurement and logistical bottlenecks and develop specific plans to address them
- Develop user friendly computerized monitoring and evaluation system for all levels.
- Strengthen State and district level mass media cells. Develop tailor-made BCC strategies for RCH and various services under it.

(4) Quality and Infrastructure

- Clearly earmark adequate resources, for strengthening of emergency medical services at district and sub-divisional hospitals and operationalisation of FRUs, along with adequate referral backup in the RCH plan
- Build more public health facilities (referral hospitals, PHCs and SHCs) according to population as per GoI norms.
- Provide resources to ensure proper physical infrastructure, essential supplies and requisite staff to the health facilities identified for upgradation as FRUs in the RCH plan.

Objectives and Strategies for RCH II

In line with the vision for the improved maternal and Child health scenario in the State, Department of Health and Family Welfare, has set specific goals for key RCH outcome indicators. The goals have been set for both Medium-term (2007-08) and Long-term (2009-10) and are in **sync with GoI goals for EAG states.**

The Medium-term (2006-07) RCH II program goals are as follows:

- Reduce the Maternal Mortality Rate in the state by about 17% (from 452 to 375)
- Lower the Infant Mortality Rate in the state by about 15% (from 62 to 52)
- Reduce the Neonatal Mortality Rate in the state by about 15% (from 46.5 to 39)
- Decrease TFR from 3.4 to 3.0 (reduction of about 11%)

The Long-term **(2006-07)** RCH II program goals are as follows:

- Reduce the Maternal Mortality Rate to 275 (reduction of about 40% from present level)
- Reduce the Infant Mortality Rate by about 44% to 35
- Lower the Neonatal Mortality Rate by about 45% to a level of 25
- Fertility Rate down to 2.25 from existing level of 3.4 (reduction of about 37%)

Table 7.2.1: RCH Outcomes in the State: Goals

Outcomes Indicators	State			India		
	Current Status	Goal		Current Status	Goal	
		2006-07	2009-10		2006-07	2009-10
MMR[1]	452	375	275	407	200	<100
IMR[2]	62	52	35	66	45	<30
NMR[3]	46.5	39	25	45	26	20
TFR[1]	3.4	3.0	2.25	3.2	NA	2.1

Source: [1] MMR & TFR: (NFHS II 1998-99, [2] IMR: (SRS 2001), [3] NMR: (SRS1998)

These goals clearly indicate that the State is planning to drastically upscale availability, accessibility and utilization of RCH services. Given the State's less than encouraging experience during RCH I, there might be some skepticism about its ability to achieve these goals. However, the key stakeholders who have been involved in setting these goals have done so based on the realization that in view of the ambitious targets set by GoI for RCH II, which in turn are guided by The Millennium Development Goals (MDGs), the Tenth Plan Goals and Immediate and Medium Term Goals of the National Population Policy 2000, Bihar has no option but to bring all resources at its disposal to achieve these goals.

Objectives and Strategies for Maternal Health

Objective 1: To improve coverage of timely and quality ANC services

Strategies

[1.1] Increase availability of ANC services through reinforced network of frontline ANC service providers

[1.2] Strengthen supervisory network to support network of frontline ANC service providers

[1.3] Ensure delivery of ANC services through strengthening of health sub-centers, APHCs and PHCs

[1.4] Ensure timely and adequate supply of essential equipment and consumables with frontline ANC providers (ANMS and LHVs) and health facilities (HSCs, APHCs and PHCs)

[1.5] Build capacity of frontline ANC service providers (ANMs and LHVs)

[1.6] Form inter-sectoral collaboration to increase awareness, reach and utilization of ANC services

Objective 2: Strengthen maternal health services to ensure safe delivery

Strategies

[2.1] Promote institutional delivery through reinforced network of PHCs, CHCs/Referral Hospitals, Sub-divisional Hospitals and District Hospitals

[2.2] **Promote institutional delivery by involving private sector/NGO providers of EmOC in un-served and under-served areas**

[2.3] Ensure safe delivery at home

[2.4] Revamp existing referral system for emergency deliveries

[2.5] Form inter-sectoral collaboration to increase awareness regarding safe delivery and referral

Objective 3: Increase community awareness about need and benefits of ANC, Institutional delivery and PNC services

Strategies

The specific strategies to achieve this objective have been discussed in the previous two objectives

Objectives and Strategies for Child Health

Objective 1: Promote immediate and exclusive breastfeeding and complementary feeding for children

Strategies

[1.1] Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrum feeding) and exclusively till 6 months of age.

[1.2] Increase community awareness about correct breastfeeding practices through traditional media

Objective 2: Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months

Strategies

[2.1] Conduct fixed day and fixed-site immunisation sessions according to district microplans.

[2.2] Build capacity of immunisation service providers to ensure quality of immunization services

[2.3] Form inter-sectoral collaboration to increase awareness, reach and utilization of immunisation services

[2.4] Strengthen Supervision and monitoring of immunization services

Objective 3: Eradication of Poliomyelitis

Strategies

[3.1] As per Intensified Pulse Polio Immunisation Campaign (IPPI) based on ongoing Supplementary Immunisation Activities (SIAs).

Objective 4: Increase early detection and care services for sick neonates in select districts through the IMNCI strategy in select districts

Strategies

[4.1] Build state IMNCI training pool

[4.2] (Re)train health and ICDS staff in IMNCI protocols

[4.3] Ensure implementation of IMNCI clinical work following training

Objective 5: Improve curative care services for children under three years of age for minor ARI and diarrhea

Strategies

[5.1] Upgrade the capacity of PHC/FRUs to delivery quality pediatric services

[5.2] Involvement of private facilities to accept emergency referrals for BPL children

[5.3] Raise awareness about early recognition of childhood illnesses, home-based care and care-seeking

Objectives and Strategies for Family Planning

Objective 1: Raise awareness and demand for Family Planning services among women, men and adolescents

Strategies

[1.1] Extensive campaign using multiple channels to raise awareness and demand for Family Planning

[1.2] Broad inter-sectoral collaboration to promote small family norm, late marriage and childbearing

[1.3] Promotion of Family Planning Services at community level through peer educators (satisfied acceptor couples)

Objective 2: Increase access to and utilization of Family Planning services (spacing and terminal methods)

Strategies

[2.1] Provide quality Family Planning Services through expanded network of health facilities and frontline health workers

[2.2] Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives

[2.3] Increase utilization of Family Planning services through provision of incentives to acceptors and private providers of FP services.

Objectives and Strategies for Adolescent Health

Objective 1:
Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.

Strategies

[1.1] Create conducive environment to promote adolescent health needs among health service providers and community at large.
[1.2] Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents.
[1.3] Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.
[1.4] Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers.

Objective 2: Improve micronutrient service for adolescents primarily to reduce anemia.

Strategies

[2.1] Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents.
[2.2] Increase availability and distribution of micronutrient supplements to adolescents at grassroots level primarily through health and education networks.

Objectives and Strategies for Urban RCH

Objective 1: Improve delivery of timely and quality RCH services in urban areas of Bihar

Strategies

[1.1] Identify health service providers of both public and private sectors (including NGOs) in urban areas and plan delivery of RCH services through them
[1.2] Strengthen facilities of both public and private sectors (including NGOs) in urban areas
[1.3] Strengthen outreach RCH services in urban areas through involvement of both public and private sector service providers
[1.4] Delivery of RCH services through periodic camps in urban areas, primarily in urban slums

Objective 2: Increase awareness about Maternal and Child health and Family Planning services in urban areas of the state

Strategies

[2.1] Multiple channels for delivery of key RCH messages in urban areas

[2.2] Broad inter-sectoral coordination to increase awareness and knowledge of key messages under the RCH programme.

Strategies for Institutional Strengthening: Crosscutting Areas

Health Facilities and Human Resources

State level Facility Survey and Mapping of Health Facilities

A facility survey will be conducted with technical support of Development Partners in the state to access the existing infrastructure, manpower, and equipment status. Information from the facility survey will be used to take evidence-based decisions on issues such as developing new facilities, upgrading and rationalizing existing ones, provision of appropriate equipment and supplies for all facilities, recruitment of additional personnel and their capacity building to enable them to perform at optimal levels. To further encourage evidence-based planning, supervision and monitoring, Village-based mapping using appropriate Geographical Information System (GIS) tools will be undertaken in two districts (Vaishali and Nalanda).

Health Facilities

[1] Health Sub-Centers (HSCs): All the existing 9140 HSCs will be refurbished. In addition, 7440 more HSCs will be built.

[2] Primary Health Centers (PHCs): The existing 1333 APHCs will be upgraded as PHCs, and 1212 new PHCs will be built. The existing 398 PHCs will be refurbished.

[3] First Referral Units (FRUs): 190 existing health facilities (five facilities in each district including the district hospital) will be upgraded and operationalised as FRUs

[4] Urban Health Centers (UHCs): The existing 12 UHCs will be refurbished and an additional 111 new UHCs will be built.

Personnel

[1] ANMs: 1239 vacant ANM posts will be filled and an additional 5286 ANMs will be recruited

[2] MHWs (Male): 1264 vacant MHW posts will be filled and an additional 2412 MHWs will be recruited

[3] LHVs: 564 vacant LHV posts will be filled and an additional 2190 LHVs will be recruited

[4] Staff Nurse: 195 vacant Staff Nurse posts will be filled and additional Staff Nurse will be recruited according to need

Training

The State Institute of Family Welfare (SIHFW) is the nodal training agency for RCH II at the State level. It will be strengthened both in terms of additional personnel as well as physical infrastructure. At the regional level, the existing Regional Health and Family Welfare Training Centers (RHFWTCs) will be refurbished and new RHFWTCs will be constructed on need assessment. The existing 21 ANM Training Centers (ANMTCs) across the State will be refurbished. In order to build both managerial and technical capacity of staff at all levels of program implementation, a detailed training plan has been envisaged which will be carried out in a phased manner during the plan period.

NGO and Public-Private Partnership

As per GoI norms, the existing network of 12 MNGOs will be strengthened to effectively support implementation of various planned activities under RCH II. A network of 19 MNGOs will be put in place and their capacity will be built to enable them to develop a wide network of FNGOs.

A variety of innovative and feasible activities for involvement of NGOs and Public-Private Partnership in delivery of RCH II services and awareness generation has been planned.

Behavior Change Communication (BCC)

To effectively implement action plans for BCC in RCH II, the IEC bureaus at state and district levels will be strengthened. Additionally emphasis will be on capacity building of frontline health workers to support BCC initiatives under RCH II at community levels. Further, a broad inter-sectoral collaboration with departments such as ICDS, Education, PRIs, etc and Civil Society Organizations has been planned.

Programme Management Structure

A reorganised programme management structure at the state, district and sub-district levels is being put in place. Towards this, the two separate Departments of Health and Family Welfare have been merged and a Secretary heads the new department. This merger is expected to lead to better coordination at all levels. The State Health Society, Bihar is being constituted to function as the nodal agency for effective management of RCH II programm. At the district level too, the formation of District Health Societies is being planned, which will function as the nodal agency for RCH II in their respective districts. To strengthen management capacity at facility level, Hospital Management Committees will be constituted. The operational guidelines for these bodies at state, district and facility levels have been developed.

Monitoring and Evaluation

Monitoring and Evaluation function will be strengthened. A user-friendly, computerized HMIS system up to PHC level will be put in place and the necessary provisions for equipment and skilled personnel have been made in the plan. The input, process and out come indicators, including key financial indicators will be monitored.

For this mid term and end term evaluation will be conducted by an independent external agency.

2. PROCESS OF PLAN PREPARATION

The Bihar State Project Implementation Plan (PIP) for RCH II follows in essence, form and content, the "GoI guidelines for SPIP" and the "Suggestive Guidelines Manual for Development of SPIP". As the states are supposed to develop their respective plans within the overall framework of RCH II at the national level, this document also draws heavily from the National PIP. Efforts have been made to plan based on evidence, consult all stakeholders, incorporate lessons learnt from RCH I, set realistic objectives, develop synergies between different vertical programs, and strengthen and decentralize programme management.

The process of development of SPIP began at the end of the year 2002 following the letter from Secretary (FW), GoI, that suggested that the state should start preparing its SPIP for RCH II to address the state-specific unique features, specific problems and the strategies to address them. It gained momentum in early 2003 with various workshops and consultative meetings held at various levels, where key stakeholders were oriented on development of SPIP for RCH II. Based on GoI directives, recommendations of various consultative workshops, inputs from stakeholders at state, district and sub-district levels and technical support from development partners such as UNICEF and EU, the state submitted a draft SPIP to the center in August-2003.

In September 2004, the state received feedback from GoI on the draft SPIP with instructions to incorporate logframe approach for the development of SPIP. This was followed by a further set of guidelines and manuals from GoI. In response to the feedback received, in January 2005, GoB constituted a state-level design team in consultation with UNICEF, under the supervision of Joint Secretary, FW, and GoB. The design team comprised of members drawn from the state Health and Family Welfare Directorate, GoI personnel supporting RCH programme in the state, select health officials from district and sub-district levels, officials of other departments such as ICDS and PRI, Professional bodies such as IMA, FOGSI, representatives of NGOs, CBOs, FBOs, SMU consultants and development partners (UNICEF and EU).

The team participated in a three-day workshop in March 2005 to review GoI feedback on draft SPIP submitted by the state and developed a plan of action to re-develop the SPIP according to the revised GoI guidelines. Paucity of reliable data was identified as one of the major limitations for development of the SPIP. Therefore, a thorough exercise was undertaken to identify collate all possible relevant data sources. The following information sources were utilized for this purpose – National Family Health Survey I and II, Rapid Household Survey I (Phase I and II) and II (Phase I), SRS and Census 2001. The various data sets were analyzed and examined for consistency in determining the current status of RCH/FP outcomes. These indicators were taken as baseline figures for the state.

The state held consultations with a cross section of stakeholders and determined the goals as well as the feasibility of achieving the goals within a given timeframe. The consultations also took into consideration the resource requirement and encompassed financial, human, institutional and infrastructure resources. Finally, with UNICEF support, the SMU finalized the set of figures that can be taken as the goals for the state to achieve.

The design team worked on various sections of SPIP in close consultation with UNICEF in the months of April and May 2005. Finally, the revised draft as per GoI guidelines was submitted to the center by in Mid-June 2005.

Furthermore, in line with GoI guidelines two districts namely Vaishali and Nalanda were identified for the development of district PIP for RCH II. Select members of the state - level design team visited these districts to constitute district - level design teams. These teams were oriented about RCH II and briefed on development of district level PIP for RCH II. The state team also provided specific support for data collection and collation. These districts are scheduled to submit their respective PIPs by the end of August 2005 and would be then annexed with final draft of RCH II State level Project Implementation Plan. In addition, these two-district PIPs would serve as the model DPIP for other districts to follow.

Chronology of SPIP Development

December 9, 2002	Letter from Secretary (FW), GoI, (letter no. D.O.No.M-15012/4/2001-RCH (DC) Pt.) to Secretary (FW), GoB stating that a project development team has been put in place to draft the NPIP and asked the state to develop a State Specific Project Implementation Plan for RCH II to address the state specific unique features, problems and the strategies to address them.
February, 2003	Government officials attended the Health Sector Reform workshop hosted by the EC in Goa where the approach to the preparation of the SPIP was explained by the national design team for RCH II.
April 2003	Presentation of draft PIP was made by EPOS Health Consultants at the Department of Family Welfare,GoI. The Secretary Department of ME, FW& IM and representative of the UNICEF, Patna Office had attended the presentation.
May 2003	The draft PIP was presented to the Minister (ME, FW& IM). The Secrtary, officials of the department and the representative of the UNICEF had attended the presentation.
June, 2003	Government officials attended the cluster level workshop on RCH II in Kolkata, which explained the logframe aspect of the RCH II programme.
August, 2003	Final SPIP was submitted by the State to the DoFW,GoI
March 31, 2004	Letter from Secretary (FW), GoI, (D.O.No.M.15012/4/2001-RCH (DC)) regarding the status of SPIP preparation. The state was asked to indicate its willingness to work with and identify a development partner in the state to facilitate the design and logframe formulation. A sample logframe was attached.
August 12, 2004	Letter from the Secretary (FW), GoI, (D.O.No.L.2567/Secy (FW)/2004) regarding preparation of the state RCH plan and the appraisal criteria. The state was asked to submit its plan by Sept.2004. A compendium of all past and present guidelines on state planning was enclosed.

September 16, 2004	Letter from the Secretary (FW), GoI, (D.O.No.23011/45/2004-Ply/EAG) to the Secretary (FW), GoB asking the state to adopt the CMP strategy as an approach to focus on interventions and implement it within the RCH guidelines.
September 21, 2004	Comments of the DoFW, GoI on Bihar's SPIP was received.
November 25, 2004	Letter from GoB (no.12/P-03-11/04 1787 (FW)/Health) to Civil Surgeons and ACMOs regarding preparation of the District Action Plans along with the GoI format.
December 15, 2004	Letter from Dy.Sec. (ME, FW & IM), GoB to Project Officer (Health) (F.No.12/P-3-11/2002/Part 190 (FW)), informing UNICEF to extend assistance in preparing the SPIP as per the revised GoI guidelines and feedback on draft SPIP.
January 31, 2005	The state level design team was constituted in consultation with UNICEF to facilitate the redevelopment of SPIP as per the revised GoI guidelines.
February 7, 2005	Letter from Health & FW Secretary, GoI to Secretary (FW), GoB (D.O.No.344/Secy (H&FW)/2005) emphasizing preparation of SPIP. A checklist to ensure quality assurance of State PIP was enclosed.
March 3, 2005	Order by the Joint Secretary (file no.12/P-3-11/2004 (Part) 213 (FW) identifying the core design team with the nodal officer, and asking them to submit the SPIP by the end of March 2005.
March 9-11, 2005	A design workshop with different stakeholders (GoI officials, GoB officials, Govt. health functionaries, RCH consultants and UNICEF, Patna and New Delhi) was held for preparing the SPIP.
June, 2005	Submission of the SPIP by the State design team to Secretary, (H & FW), GoB for approval and submission to GoI.

3. TIME FRAME

The timeframe envisaged for the implementation of RCH II program is from April 2005 to March 2010. The activity wise timeline is enclosed in Annexure-I.

BACKGROUND AND CURRENT STATUS

4. BACKGROUND AND CURRENT STATUS

4.1. Demographic and Socio-Economic Features at State and District Levels

Bihar with a population of 82.9 million is the second most populous state in India, next only to Uttar Pradesh. Despite efforts in the last few decades to stabilise population growth, the state's population continues to grow at a much faster rate (28.43%) than the national population (21.34%). The state is densely populated with 880 persons per square kilometre as against the country average of 324. The sex ratio of the state at 919 is also less favourable than the national average of 933.

Table 4.1.1: Bihar: Demographic, Socio-Economic and Health Indices

Characteristics	Bihar	India
Area	94,163 Sq. Km	
Demographic Indicators		
Population	828.8 Million	1027.0 Million
Population Density (Population / km^2)	880	324
Sex Ratio	919	933
% decadal growth rate	28.43%	21.34%
Socio-Economic Indicators		
Per Capita Income (Rs.) for year 2003-04		
At constant1993-94 prices	3707	10964
At current prices	6861	20292
% decadal growth in Per capita Income	~ zero	~ 45%
Proportion of population below poverty line	42%	26%
Level of Urbanization	10.5%	27.8%
Literacy	47.5%	65.4%
Health Indicators		
Maternal Mortality Rate (MMR)	452	407
Infant Mortality Rate (IMR)	62	66
Total Fertility Rate (TFR)	3.49	2.85
Crude Birth Rate (CBR)	31.9	25.8
Crude Death Rate (CDR)	8.8	8.5
Full ANC Coverage	8.2	32
Institutional Delivery	13.8	34
Full Immunization	11	54

Source: Census 2001, Ministry of Statistics and Program Implementation: http://mospi.nic.in

People in Bihar are among the poorest in India. Bihar has the lowest per capita net domestic product of all the Indian states (per capita income of Rs. 4992/- in Bihar as compared to Rs. 12183/- at the all India level). As per the NSSO survey (1999-2000) 42.6% of the population in Bihar were below poverty line. Per capita income at Rs 3707 (1993-94

prices) is also the lowest in the country with almost zero % decadal growth rate as against the country level growth of around 45%. The level of urbanisation is also low and of the total population, and only 10.5% of the population lives in urban areas. Literacy at 47.5% too continues to be lower than the national average of 65.4%. Moreover, the literacy rate among women in rural areas in the state is as low as 30.03%.

In terms of key health indicators, Bihar is among the low performing states. Though the state fares reasonably well in terms of its Infant Mortality Rate (62) as against the national average (68), it continues to be among the poorer performing states in terms of other indicators such as MMR (452), TFR (3.49), NMR (46.5) and CBR (31.9). These outcomes are perhaps a reflection of poor health service indicators. The Full ANC Coverage in the state is 8.2 against the national average of 32. Institutional Delivery is 13.8% as against 34% in the country and Full Immunisation coverage is 11% as compared to the national average of 54%.

Among the 38 districts of the state, West Champaran is the largest in terms of area (5228.00 sq. km) while the smallest is Sheikhpura (605.96 sq. km). In terms of population, Patna is the largest at 4.72 millions followed by East Champaran that has a population of 3.94 millions. Sheohar and Sheikhpura have the smallest population of 0.52 millions and 0.53 millions respectively. In terms of Sex Ratio, while districts such as Siwan (1031) and Gopalganj (1001) have a favourable ratio, other districts like Munger (872), Patna (873) and Bhagalpur (876) have a less favourable ratio.

Bihar has total SC population of around 15.07%. However, SC population in certain districts like Gaya (29.6%) and Nawada (24.1%) is much higher than the state average. On the other hand, districts such as Kishanganj (6.6%) and Arwal (8.9%) have a relatively low proportion of SC population. After the bifurcation of the state in 2002, most of the areas with large ST population have been included in the state of Jharkhand. Therefore, the state has only 1% ST population. However, districts such as Banka, Jamui, Katihar, Purnea and Kishanganj have an average of around 5% ST population.

In terms of socio-economic indices too the district level variation is obvious. For literacy rates, districts such as Arwal (26%), Jehanabad (29.3%), Kishanganj (31.1%), Araria (35%) and Katihar (35.1%) are much below the even state average of 46.4%. However, there are districts - Aurangabad (57%), Bhojpur (59%), Munger (59.5%), Patna (62.9%) and Rohtas (61.3%) -that have performed better than the state average with literacy rates close to 60%. Similarly performance of districts on percentage of people living below the poverty line is varied with districts such as Araria faring the worst at 80.3%. Other poorly performing districts are Bhagalpur, Madhubani, Purnea, Sitamarhi, Supaul and Sheohar, where close to 70% of the population continues to live below the poverty line. Despite such a large number of districts having a significant proportion of their population living below poverty line, the state average of 46.2% (among the lowest in the country) is largely due to the fact that there are some districts such as Kaimur, Saharsa, Samastipur, Arwal and Jehanabad and Gopalganj where close to 80% of the population are living above the poverty line. *(See table 4.1.2 for district-wise detailed data)*.

Table 4.1.2: Bihar: Key Demographic and Socio-economic Indicators of Districts										
Sl No	Districts	Area in Sq. Km	Population			BPL (%)	SC (%)	ST (%)	Sex Ratio	Literacy Rates
			Rural	Urban	Total					
1	2	3	4	5	6	7	8	9	10	11
1	Araria	2830.00	2026257	132351	2158608	80.3	13.6	1.4	913	35.0
2	Aurangabad	3305.00	1842998	170057	2013055	61.7	23.5	0.1	934	57.0
3	Arwal	761.12	659270	52458	711728	23.36	8.9	0.05	929	26.0
4	Banka	3019.56	1552353	56420	1608773	63.4	12.4	4.7	908	42.7
5	Begusarai	1918.00	2241743	107623	2349366	65.4	14.5	0.1	912	48.0
6	Bhagalpur	2569.44	1970745	452427	2423172	70.2	10.5	2.3	876	49.5
7	Bhojpur	2474.17	1930730	312414	2243144	55.3	15.3	0.4	902	59.0
8	Buxar	1623.83	1273422	128974	1402396	46.6	14.1	0.6	899	56.8
9	Champaran (E)	3968.00	3688687	251086	3939773	54.1	13.0	0.1	897	37.5
10	Champaran (W)	5228.00	2733907	309559	3043466	47.4	14.3	1.5	901	38.9
11	Darbhanga	2279.00	3028441	267348	3295789	60.0	15.5	0.0	914	44.3
12	Gaya	4976.00	2997479	475949	3473428	69.8	29.6	0.1	938	50.4
13	Gopalganj	2033.00	2022048	130590	2152638	37.6	12.4	0.3	1001	47.5
14	Jehanabad	807.88	743433	59154	802587	26.34	10.0	0.05	929	29.3
15	Jamui	3098.27	1295552	103244	1398796	63.4	17.4	4.8	918	42.4
16	Kaimur	3361.90	1247299	41775	1289074	15.4	22.2	2.8	902	55.1
17	Katihar	3057.00	2174361	218277	2392638	49.1	8.7	5.9	919	35.1
18	Khagaria	1486.00	1204027	76327	1280354	48.8	14.5	0.0	885	41.3
19	Kishanganj	1884.00	1167340	129008	1296348	58.0	6.6	3.6	936	31.1
20	Lakhisarai	1299.01	684485	117740	802225	62.3	15.8	0.7	921	48.0

Sl.No.	Districts	Area in sq.k.m	Population			BPL (%)	SC (%)	ST (%)	Sex Ratio	Literacy Rate
			Rural	Urban	Total					
1	2	3	4	5	6	7	8	9	10	11
21	Madhepura	1788.00	1458679	67967	1526646	55.4	17.1	0.6	915	36.1
22	Madhubani	3501.00	3450736	124545	3575281	72.4	13.5	0	942	42.0
23	Munger	1418.76	819950	317847	1137797	53.0	13.3	1.6	872	59.5
24	Muzaffarpur	3372.00	3398361	348353	3746714	55.9	15.9	0.1	920	48.0
25	Nalanda	2367.00	2016899	353629	2370528	53.8	20.0	0.0	914	53.2
26	Nawada	2494.00	1671253	138443	1809696	62.0	24.1	0.1	946	46.8
27	Patna	3202.00	2757060	1961532	4718592	48.1	15.5	0.2	873	62.9
28	Purnia	3229.00	2321544	222398	2543942	70.0	12.3	4.4	915	35.1
29	Rohtas	3851.10	2123942	326806	2450748	56.8	18.1	1.0	909	61.3
30	Saharsa	1701.65	1383015	125167	1508182	14.2	16.1	0.3	910	39.1
31	Samastipur	2904.0	3271338	123455	3394793	19.5	18.5	0.1	928	45.1
32	Saran	2641.0	2950064	298637	3248701	54.1	12.0	0.2	966	51.8
33	Sheikhpura	605.96	444189	81313	525502	59.5	19.7	0.0	918	48.6
34	Sheohar	442.99	494699	21262	515961	69.8	14.4	0.0	885	35.3
35	Sitamarhi	2200.01	2529407	153313	2682720	67.1	11.8	0.1	892	38.5
36	Siwan	2219.0	2564860	149489	2714349	51.0	11.4	0.5	1031	51.6
37	Supaul	2410.35	1644370	88208	1732578	74.6	14.8	0.3	920	37.3
38	Vaishali	2036.00	2531766	186655	2718421	41.1	20.7	0.1	920	50.5
State Total		**94363.00**	**74316709**	**8681800**	**82998509**	**46.2**	**15.07**	**0.9**	**919**	**46.4**

Source

4.2 Administrative Divisions

Bounded by Uttar Pradesh in the west, West Bengal on the east, Nepal on the north and Jharkhand on the south, Bihar covers an area of 94,363 square kilometers. The state has 38 districts divided into 9 administrative divisions. Tirhut and Patna divisions have 6 districts each whereas the Bhagalpur Division comprises of only two districts.

Table 4.2.1: Administrative Divisions

Sl no.	Divisions	Districts
1	Patna	Patna, Nalanda, Bhojpur, Rohtas, Kaimur, Buxar
2	Magadh	Gaya, Jehanabad, Arwal, Aurangabad, Nawada
3	Tirhut	Muzaffarpur, Sitamarhi, Vaishali, Champaran East, Champaran West, Sheohar
4	Saran	Saran, Siwan, Gopalganj
5	Darbhanga	Darbhanga, Madhubani, Samastipur
6	Munger	Begusarai, Jamui, Khagaria, Lakhisarai,Munger, Sheikhpura
7	Kosi	Saharsa, Madhepura, Supaul
8	Bhagalpur	Bhagalpur, Banka
9	Purnea	Purnia, Araria, Kishanganj, Katihar

In addition, the state has 101sub-divisions, 534 community development blocks, 9 urban agglomerations, 130 towns (125 statutory towns and 5 non-statutory census towns) and 37,741 villages.

Table 4.2.2: Community Development Blocks

Sl No	Districts	Community Development Blocks	
		Total	Block Name
1	Araria	9	Narpatganj, Forbesganj, Bhargama, Raniganj, Araria, Kursakatta, Sikti, Palasi, Jokihat
2	Arwal	3	Karpi, Kurtha, Makhdumpur
3	Aurangabad	11	Daudnagar, Haspura, Goh, Rafiganj, Obra, Aurangabad, Barun, Nabinagar, Kutumba, Deo, Madanpur
4	Banka	11	Shambhuganj, Amarpur, Rajaun, Dhuraiya, Barahat, Banka, Phulidumar, Belhar, Chanan, Katoria, Bausi
5	Begusarai	18	Khudabandpur, Chhorahi, Garhpura, Cheria Bariarpur, Bhagwanpur, Mansurchak, Bachhwara, Teghra, Barauni, Birpur, Begusarai, Naokothi, Bakhri, Dandari, Sahebpur Kamal, Balia, Matihani, Shamho Akha Kurha
6	Bhagalpur	16	Narayanpur, Bihpur, Kharik, Naugachhia, Rangra Chowk, Gopalpur, Pirpainti, Colgong, Ismailpur, Sabour, Nathnagar, Sultanganj, Shahkund, Goradih, Jagdishpur, Sonhaula
7	Bhojpur	14	Shahpur, Arrah, Barhara, Koilwar, Sandesh, Udwant Nagar, Behea, Jagdishpur, Piro, Charpokhari, Garhani, Agiaon, Tarari, Sahar
8	Buxar	11	Simri, Chakki, Barhampur, Chaugain, Kesath, Dumraon, Buxar, Chausa, Rajpur, Itarhi, Nawanagar
9	E. Champaran	27	Raxaul, Adapur, Ramgarhwa, Sugauli, Banjaria, Narkatia, Bankatwa, Ghorasahan, Dhaka, Chiraia, Motihari, Turkaulia, Harsidhi, Paharpur, Areraj, Sangrampur, Kesaria, Kalyanpur, Kotwa, Piprakothi, Chakia(Pipra), Pakri Dayal, Patahi, Phenhara, Madhuban, Tetaria, Mehsi

Sl No	Districts	Community Development Blocks	
		Total No.	Block Name
10	Champaran W	18	Sidhaw, Ramnagar, Gaunaha, Mainatanr, Narkatiaganj, Lauriya, Bagaha, Piprasi, Madhubani, Bhitaha, Thakrahan, Jogapatti, Chanpatia, Sikta, Majhaulia, Bettiah, Bairia, Nautan
11	Dharbhanga	18	Jale, Singhwara, Keotiranway, Darbhanga, Manigachhi, Tardih, Alinagar, Benipur, Bahadurpur, Hanumannagar, Hayaghat, Baheri, Biraul, Ghanshyampur, Kiratpur, Gora Bauram, Kusheshwar Asthan, Kusheshwar Asthan Purbi
12	Gaya	24	Konch, Tikari, Belaganj, Khizirsarai, Neem Chak Bathani, Muhra, Atri, Manpur, Gaya Town CD Block, Paraiya, Guraru, Gurua, Amas, Banke Bazar, Imamganj, Dumaria, Sherghati, Dobhi, Bodh Gaya, Tan Kuppa, Wazirganj, Fatehpur, Mohanpur, Barachatti
13	Gopalganj	14	Katiya, Bijaipur, Bhorey, Pach Deuri, Kuchaikote, phulwaria, Hathua, Uchkagaon, Thawe, Gopalganj, Manjha, Barauli, Sidhwalia, Baikunthpur
14	Jahanabad	12	Arwal, Kaler, Sonbhadra Banshi Suryapur, Ratni Faridpur, Jehanabad, Kako, Modanganj, Ghoshi, Hulasganj
15	Jamui	10	Islamnagar Aliganj, Sikandra, Jamui, Barhat, Lakshmipur, Jhajha, Gidhaur, Khaira, Sono, Chakai
16	Kaimur	11	Ramgarh, Nuaon, Kudra, Mohania, Durgawati, Chand, Chainpur, Bhabua, Rampur, Bhagwanpur, Adhaura
17	Katihar	16	Falka, Korha, Hasanganj, Kadwa, Balrampur, Barsoi, Azamnagar, Pranpur, Dandkhora, katihar, Mansahi, Barari, Sameli, Kursela, Manihari, Amdabad
18	Khagaria	7	Alauli, Khagaria, Mansi, Chautham, Beldaur, Gogri, Parbatta
19	Kishanganj	7	Terhagachh, Dighalbank, Thakurganj, Pothia, Bahadurganj, Kochadhamin, Kishanganj
20	Lakhisarai	6	Barahiya, Pipariya, Surajgarha, Lakhisarai, Ramgarh Chowk, Halsi
21	Madhubani	21	Madhwapur, Harlakhi, Basopatti, Jainagar, Ladania, Laukaha, Laukahi, Phulparas, Babubarhi, Khajauli, Kaluahi, Benipatti, Bisfi, Madhubani, Pandaul, Rajnagar, Andhratharhi, Jhanjharpur, Ghoghardiha, Lakhnaur, Madhepur
22	Madhepura	13	Gamharia, Singheshwar, Ghailarh, Madhepura, Shankarpur, Kumarkhand, Murliganj, Gwalpara, Bihariganj, Kishanganj, Puraini, Alamnagar, Chausa
23	Munger	9	Munger, Bariarpur, Jamalpur, Dharhara, Kharagpur, Asarganj, Tarapur, Tetiha Bambor, Sangrampur
24	Muzaffarpur	17	Sahebganj, Baruraj (Motipur), Paroo, Saraiya, Marwan, Kanti, Minapur, Bochaha, Aurai, Katra, Gaighat, Bandra, Dholi (Moraul), Musahari, Kurhani, Sakra
25	Nalanda	20	Karai Parsurai, Nagar Nausa, Harnaut, Chandi, Rahui, Bind, Sarmera, Asthawan, Bihar, Noorsarai, Tharthari, Parbalpur, Hilsa, Ekangarsarai, Islampur, Ben, Rajgir, Silao, Giriak, Katrisarai
26	Nawada	14	Nardiganj, Nawada, Warisaliganj, Kashi Chak, Pakribarawan, Kawakol, Roh, Gobindpur, Akbarpur, Hisua, Narhat, Meskaur, Sirdala, Rajauli

Sl No	Districts	Community Development Blocks	
		Total	Block Name
27	Patna	23	Maner, Dinapur-Cum-Khagaul, Patna Rural, Sampatchak, Phulwari, Bihta, Naubatpur, Bikram, Dulhin Bazar, Paliganj, Masaurhi, Dhanarua, Punpun, Fatwah, Daniawan, Khusrupur, Bakhtiarpur, Athmalgola, Belchhi, Barh, Pandarak, Ghoswari, Mokameh
28	Purnia	14	Banmankhi, Barhara, Bhawanipur, Rupauli, Dhamdaha, Krityanand Nagar, Purnia East, Kasba, Srinagar, Jalalgarh, Amour, Baisa, Baisi, Dagarua
29	Rohtas	19	Kochas, Dinara, Dawath, Suryapura, Bikramganj, Karakat, Nasriganj, Rajpur, Sanjhauli, Nokha, Kargahar, Chenari, Nauhatta, Sheosagar, Sasaram, Akorhi Gola, Dehri, Tilouthu, Rohtas
30	Saharsa	10	Nauhatta, Satar Kataiya, Mahishi, Kahara, Saur Bazar, Patarghat, Sonbarsa, Simri Bakhtiarpur, Salkhua, Banma Itahri
31	Samastipur	20	Kalyanpur, Warisnagar, Shivaji Nagar, Khanpur, Samastipur, Pusa, Tajpur, Morwa, Patori, Mohanpur, Mohiuddinagar, Sarairanjan, Vidyapati Nagar, Dalsinghsarai, Ujiarpur, Bibhutpur, Rosera, Singhia, Hasanpur, Bithan
32	Saran	21	Mashrakh, Panapur, Taraiya, Ishupur, Baniapur, Lahladpur, Ekma, Manjhi, Jalalpur, Revelganj, Chapra, Nagra, Marhaura, Amnour, Maker, Parsa, Dariapur, Garkha, Dighwara, Sonepur
33	Sheikhpura	6	Barbigha, Shekhopur Sarai, Sheikhpura, Ghat Kusumbha, Chewara, Ariari
34	Sitamarhi	17	Bairgania, Suppi, Majorganj, Sonbarsa, Parihar, Sursand, Bathnaha, Riga, Parsauni, Belsand, Runisaidpur, Dumra, Bajpatti, Charaut, Pupri, Nanpur, Bokhara
35	Sheohar	5	Purnahiya, Piprarhi, Sheohar, Dumri Katsari, Tariani Chowk
36	Siwan	19	Nautan, Siwan, Barharia, Goriakothi, Lakri Nabiganj, Basantpur, Bhagwanpur Hat, Maharajganj, Pachrukhi, Hussainganj, Ziradei, Mairwa, Guthani, Darauli, Andar, Raghunathpur, Hasanpura, Daraundha, Siswan
37	Supaul	11	Nirmali, Basantpur, Chhatapur, Pratapganj, Raghopur, Saraigarh, Bhaptiyahi, Kishanpur, Marauna, Supaul, Pipra, Tribeniganj
38	Vaishali	16	Vaishali, Paterhi Belsar, Lalganj, Bhagwanpur, Goraul, Chehra Kalan, Patepur, Mahua, Jandaha, Raja Pakar, Hajipur, Raghopur, Bidupur, Desri, Sahdai Buzurg, Mahnar

4.3 RCH Outcomes and Service Utilization

Bihar is one of the poor performing states in terms RCH I outcomes as is reflected in the four key indicators namely MMR, IMR, NMR and TFR. RCH I remained a virtual non-starter in the state for a variety of reasons leading to poor availability, accessibility and utilisation of RCH services. Of the four key health indicators, the state's performance is below normal for three indicators namely, MMR, NMR and TFR. Only the reported IMR in the state is better than national average. This clearly suggests that if Bihar were to improve its key health indicators as per mid-term (2006-2007) as well as medium term goal (2009-2010) set by GoI, it has to drastically upscale availability, accessibility and utilisation of RCH services. *(Refer Table 4.3.1).*

Table 4.3.1: RCH Outcomes and Service Utilization: Current Status

Outcomes Indicators	State	India		
	Current Status	Current Status	Goal	
			2006-07	2009-10
MMR[1]	452	407	200	<100
IMR[2]	62	66	45	<30
NMR[3]	46.5	45	26	20
TFR[1]	3.4	3.2	NA	2.1

Source: [1] MMR & TFR: (NFHS II 1998-99, [2] IMR: (SRS 2001), [3] NMR: (SRS1998)

However, status of maternal and child health indicators in urban areas are better. Though, the MMR for Urban areas is not available, IMR, NMR and TFR are significantly lower than both State and Country average. *(See table 4.3.2).* This is perhaps reflection of better availability, accessibility and utilisation of RCH services in urban areas of the state. Other factors, which might have helped in improving these indicators in urban areas are better literacy rate particularly, the female literacy, extensive network of private health facilities providing RCH services and more awareness among community about need and availability of RCH services.

Table 4.3.2: Urban RCH Outcomes and Service Utilization: Current Status

Outcomes Indicators	State	
	Urban	Overall
MMR[1]	NA	452
IMR[2]	54.6	62
NMR[3]	35.3	46.5
TFR[1]	2.75	3.4

Source: [1] MMR & TFR: (NFHS II 1998-99, [2] IMR: (SRS 2001), [3] NMR: (SRS1998)

There is a realization that it is imperative for the state to emulate GoI goals. However, given the experience of RCH I in the state, it would be more prudent to set achievable targets rather than simply taking GoI targets, that may not be possible to achieve in the current scenario.

In addition, current status of key process indicators for MMR, IMR, NMR and TFR reflect the overall poor status of RCH services in the state. A close examination of process indicators for Maternal Health suggests that for a majority of women in the state, particularly those in living in rural areas and belonging to the SC community, adequate maternal health services was not available. For example, according to NFHS - 2 data, only 9.5% of pregnant women in the state received three or more antenatal check-ups, whereas the corresponding figure for rural women is even lower at 8.8%. 63% of the women did not receive any ANC. The percentage of pregnant women receiving two doses of Tetanus Toxoid injections at 57.8% is one of the few relatively better indicators for maternal health in the state. However, this too is much below the national average. The percentage of institutional delivery in the state is only 15% and for the SC community the figure is alarmingly low at 8%. Of the overall institutional delivery, public health facilities accounted for only 4%. RCH I envisaged that given the fact that institutional deliveries will continue to be low, non-institutional deliveries should be conducted under the supervision of a skilled birth attendant. However, this figure too is abysmally low at 23.3%. Similarly, the percentage of women who received PNC within two months of birth is at 10%. 63.4% women reportedly suffer from moderate to severe anaemia. *(See Table 4.3.2 for further details on current status of Maternal Health in the state).*

Table 4.3.2: Indicative Format for Current Status: Maternal Health

Process/Intermediate indicator	Current status (1998-99)
(1) % of pregnant women getting registered in first trimester	
Overall	15.1
SC	
Urban/Rural	38.2/12.9
(2) % of pregnant women receiving 3 or more antenatal checks	
Overall	9.5
SC	NA
Urban/Rural	17.1/8.8
(3) % of pregnant women receiving 2 doses of tetanus toxoid injections	
Overall	57.8
SC	50.3
Urban/Rural	78/55.9
(4) % of pregnant women receiving 100 tablets of IFA	
Overall	24.1
SC	18
Urban/Rural	46.1/22
(5) % of eligible women with no ANC	
Overall	63
SC	70.7
Urban/Rural	30.6/65.6
(6) % of women with moderate/severe anemia	
Overall	63.4
SC	67
Urban/Rural	59.6/63.7
(7) % of institutional delivery	
Overall	15
SC	8
Urban/Rural	40.1/12.1
(8) % of delivery in a public health facility	
Overall	4
SC	2.5
Urban/Rural	11.9/3

(9) % of delivery in a private health facility	
Overall	11
SC	5.5
Urban/Rural	27.3/8.9
(10) % of deliveries by skilled birth attendants (doctors, nurses, ANMs)	
Overall	23.3
SC	17.7
Urban/Rural	51.9/20.6
(11) % of pregnancies with complications which need and received EMOC	
Overall	NA
SC	NA
(12) % with PNC within 2 months of birth	
Overall	10
SC	9.2
Urban/Rural	10/10.1
(13) Number of facilities operationalised to provide 24 hours delivery and Basic EMOC services	
Sub-divisional Hospitals (23)	23
PHCs (398)	NA
(14) Number of facilities operationalised in a sustained manner as per GoI norms for providing Comprehensive Emergency obstetric care, Cesarean section and blood storage/banking facilities	
District hospitals (25)	NA
Sub-divisional Hospitals (23)	NA
FRUs (101)	NA
(15) % of ever married women who have heard about AIDS	
Overall	11.7
SC	7
Urban/Rural	42/8.2
(16) % of ever married women who have heard about HIV/AIDS but don't know ways to avoid AIDS	
Overall	49.6
SC	55.4
Urban/Rural	47/51

One of the key goals of RCH I was to improve the Child Health Status of the state particularly in terms of reduced NMR and IMR. However, NFHS - 2 data clearly indicates that the programme has not been able to achieve expected outcomes. Though IMR has decreased to 62 per 1000 (as against the national average of 66) the pace of this progress has been slow. The NMR at 46.5 continues to be worryingly high. Scrutiny of process indicators related to Child Health suggests that the status of key child health interventions, both preventive as well as curative is far from satisfactory. For example, though culturally there are few impediments to breastfeeding, the percentage of neonates who were breastfed on day one of life was only 20.7% and the percentage of children who were exclusively breastfed till 3 months and 6 months of age are 55.2% and 36% respectively.The practice of breastfeedind beyond six months is also high. This clearly shows that messages related to timing and exclusivity of breastfeeding is not reaching a large number of mothers. Immunisation, which is one of the proven interventions for reduction in morbidity and mortality among children from vaccine preventable diseases, is in a bad shape, with full immunisation at as low as 11%. Antigen -wise coverage too is no better with BCG coverage at 37.7%, DPT (3 doses) at 24.2%, OPV (3 doses) at 41.0% and Measles at 16.6%. Only 10.2% of children aged 12-35 months received one dose of vitamin A. The high NMR is probably reflected by the fact that, of children under 3 years of age with diarrhoea only 50.3 % and with ARI only 58.2% were taken to a health facility/provider. Although the state has made some progress in reducing malnutrition among children, it continues to have a large proportion of

children (53.7%) who are chronically under-nourished. (See Table 4.3.3 for further details on current status of Child Health in the state).

Table 4.3.3: Indicative Format for Current Status: Child Health	
Process/Intermediate indicator	**Current status 1998-99**
(1) % of neonates who were breastfed on day one of life	
Overall	20.7
SC	22.5
Urban/Rural	21.8/20.6
(2) % of children who were exclusively breastfed	
till 3 months of age	55.2
till 6 months of age	36
(3) % of children in the age group of 12-23 months who received vaccination	
BCG	37.7
DPT (3 doses)	24.2
Polio (3 doses)	41.0
Measles	16.6
Fully immunized	11
(4) % of children aged 12-35 months receiving at-least 1 dose of vitamin A	
Overall	10.2
SC	8.6
Urban/Rural	19.4/9.3
(5) % of children under age 3 years with diarrhea taken to a health facility/provider	
Overall	50.3
SC	49.5
Urban/Rural	38.9/51.3
(6) % of children under age 3 years with ARI taken to a health facility/provider	
Overall	58.2
SC	54.2
Urban/Rural	63.3/57.7
(7) Nutritional Status of the children in the age group of 6-35 months	
% of Children with moderate/severe anemia	54.4
% of Children chronically undernourished	53.7

Given that is the second most populous state of the country, the focus of RCH I was to decelerate the population growth in the state. This has clearly not been achieved as is evidenced by the persistently high TFR of 3.49%. The key process indicators are suggestive of this dismal state of affairs. In terms of knowledge, only 39.75 of among currently married women have heard or seen family planning messages. With practice related process indicators, only 27.6% of currently married women have ever used any contraceptive method. Among the contraceptive methods female sterilisation continue to be the most preferred method accounting for about 19.2% of the total. However, there exists a strong unmet need for family planning as reflected in the differentials between the existing TFR and wanted TFR, which is 1. Interestingly, this differential remains almost the same across different population sub-groups such as urban/rural and SC and non-SC. *(*See Table 4.3.4 for further details on current status of Family Planning in the state).

Table 4.3.4: Indicative Format for Current Status: Family Planning	
Process/Intermediate indicator	**Current status 1998-99**
(1) Total fertility rate	
Overall	3.49
SC	3.91
Urban/Rural	2.75/3.59
(2) Total wanted fertility rate	
Overall	2.58
SC	2.8
Urban/Rural	1.84/2.68
(3) Total demand of family planning services among currently married women age 15-49	
Overall	49.1
SC	46.7
Urban/Rural	61.9/47.6
(4) % of currently married women who have heard or seen any message about family planning	
Overall	39.7
SC	30.6
Urban/Rural	71.7/36.1
(5) % of currently married women who have discussed family planning with husband/relatives /friends etc	
Overall	19.8
SC	16.8
Urban/Rural	23.2/19.5
(6) % of currently married women age 15-49 who have ever used any contraceptive method	
Any method	27.6
Any modern method	25.3
Pill	3.9
IUD	0.9
Condom	1.8
Female sterilization	19.2
Male sterilization	1.0
Any traditional method	3.6
Rhythm/safe period	2.6
Withdrawal	1.8
Other Method	1.0
(7) % of current users of modern methods of family planning	
who told about the side effects of the method	15.8
Who received follow-up services	77.1
(8) % of currently married women age 15-49 with unmet need for family planning	
Overall	24.5
SC	27.2
Urban/Rural	23.1/24.7
(9) % of currently married women age 15-49 with met need for family planning	
Overall	24.5
SC	19.5
Urban/Rural	38.9/22.9

In context of the high proportion of the population in the age group of 15-19 years, policy makers have increasingly recognised that adolescents are critical to improve the overall reproductive and sexual health status of the community. This is particularly relevant for states like Bihar, where early marriage and child bearing are common. However current status indicates large gaps exist in the area of adolescent health. Knowledge of family planning in this age segment at 41.1% is only marginally higher as compared to the overall figure of 39.7%. However, translation of this knowledge into practice namely, use of any contraceptive methods is alarmingly low at 4.45 as compared to the overall state average of 27.6%. The importance of this age group for prevention of HIV/AIDS is well documented. Thus, to prevent HIV/AIDS it is important to increase awareness among adolescents about the diseases, modes of transmission and methods of prevention. However, the percentage *of ever-married women age 15-24 years who have heard about AIDS* is 11.4% and of these and about half (48.4%) know how to avoid HIV/AIDS. *(See Table 4.3.5 for further details on current status of Adolescent Health in the state).*

Table 4.3.5: Indicative Format for Current Status: Adolescent Health

Process/Intermediate indicator		**Current status 1998-99**
(1) % of Household population in the age group of 15-19 years		
Male		9.5
Female		10.0
Total		9.7
(2) Marital status of household population in the age group of 15-19 years		
	Male	Female
Never married	89.7	54
Currently married	5.4	36.5
(3) % of ever-married women age 15-24 years who have heard or seen any message about family planning (by specific media source)		
Any Sources		41.1
Radio		26.5
Television		19.3
Cinema/film show		7.5
Newspaper/magazine		8
Wall painting/hoarding		23
Drama/Folk dance		3.2
(4) % of currently married women age 15-19 years who have ever used any contraceptive method (by specific method)		
Any method		4.4
Any modern method		2.5
Pill		1.4
IUD		0
Condom		0.9
Female Sterilization		0.2
Male Sterilization		0
Any traditional method		2.1

Process/Intermediate indicator	Current status 1998-99
(5) % of ever-married women age 15-24 years who have heard about AIDS (by specific source)	
Total	11.4
Radio	57.5
TV	80.8
Cinema	12.1
Newspaper/ magazine	18.7
Poster/hoarding	2.1
Health worker	0.8
Adult Education Programme	0
Friend/Relative	16.8
School teacher	0.4
Other sources	1.7
(6) % of ever-married women age 15- 24 years who have heard of AIDS and believe that it can be avoided (by specific method)	
Overall	48.4
Abstain from sex	16.4
Use condoms	18.8
Have only one sex partner	25.4
Avoid sex with commercial sex workers	9.7
Avoid sex with homosexuals	2
Avoid blood transfusions	9.3
Avoid injections/use clean needles	13
Avoid IV drug use	4.6
Other ways	12
(7) % of ever-married women age 15-19 years having iron-deficiency	
	64.2

4.4 Public Health Infrastructure

4.4.1 Physical Facilities

Although the state has a fairly extensive network of public health facilities it remains grossly inadequate compared to GoI norms. Furthermore, the existing facilities are devoid of basic minimum infrastructure needed for their optimal functioning. Only 23 of the 38 districts in the state have a district hospital. Similarly, of 101 sub-divisional headquarters, only 23 have a sub-divisional hospital. The Referral Hospital Network is also inadquate with the state have only 101 Referral Hospitals (70 functional) against almost 400, as per GoI norms. The state has only 398 PHCs that reveals that each PHC covers an average of 2 lakh population as against the norm of 30,000. A similar situation prevails with regard to the Health Sub-Center, where the state has 9140 Health Sub-Centers i.e. an average of one Health Sub-Center for 9000 population as against the norm of 5000. To address the problem of inadequate PHCs, the State Government has established 1333 Additional PHCs that are merely up-graded Health Sub-Centers with 2 doctors and paramedical staffs. Besides the shortage of health facilities at the district and sub-district levels, the number of available beds in the public health sector is also inadquate. The State has about 3363 beds in all its district hospitals while the bed strength at sub-divisional hospitals is 1307. In the Referral Hospitals , the bed strength is about 2130, while at the PHCs it is 2388.

However, more than the inadequate number of facilities, it is the non-availability of minimum infrastructure and supplies at these facilities which are responsible for sub-optimal delivery of health services. Most of the district and sub-divisional hospitals do not have adequate numbers of bed strength. Buildings of a large proportion of the hospitals at district and sub-divisional levels are in a dilapidated condition due to lack of maintenance and repair. Furthermore, there is a severe shortage of essential supplies, thereby hampering the delivery of basic health services. The situation at A PHC and Health Sub-Centers is even worse as a fairly large number of PHCs and Sub-Centers do not have a building . (For district-wise details see Table 4.4.1)

4.4.2 Personnel

Similar to the situation with physical infrastructure, the districts face acute shortages in health personnel as well. A large number of posts of Medical Officers and health workers remain vacant. Specific personnel data indicate that against the sanctioned strength of 5124 MOs there are only 3860 medical officers are working in the state, leaving close to 22% post vacant. In case of frontline health workers such as ANM, LHV, MHWs, staff nurses and AWW, the situation is similar . For example, in case of ANMs, against the sanctioned posts of 11294, the state has only 10055 ANMs (i.e. a shortage of about 11%), whereas there are only 1298 MHWs against the sanctioned strength of 2552 (about 49% posts vacant) and 662 LHVs against the sanctioned number of 1126 (shortage of more than 40%). In case of Staff Nurses 195 out of 451 sanctioned posts are vacant. Similarly, despite being critical to pro-poor programs like, RCH & ICDS, almost 4000 posts of Anganwadi Workers continue to remain vacant (56524/60587).

Table 4.4.1: Bihar: Public Health Infrastructure - Physical Facilities														
Sl No	Districts	District Hospital	SD Hospital	Referral Hospitals		PHCs	Addl. PHCs	HSCs	No. of Beds					
									Dist. Hospital	SD hospital	Referral Hospitals	PHCs	Addl. PHCs	Total Beds No(s)
		No(s)	No(s)	No(s)	Func	No(s)	No(s)	No(s)	No(s)	No(s)	No(s)	No(s)	No(s)	
1	Araria		1	3	3	9	32	200		52	90	54	192	388
2	Aurangabad	1		5	3	11	55	207	117		90	66	330	603
3	Arwal				1	3	25	55			30	18	150	198
4	Banka		1	2	2	10	22	227		58	60	60	132	310
5	Begusarai	1		2	2	11	27	288	176		60	66	162	464
6	Bhagalpur		1	4	3	13	37	306		30	90	78	222	420
7	Bhojpur	1		2	2	12	27	331	147		60	72	162	441
8	Buxar		1	1	0	7	18	158		32	0	42	108	182
9	Champaran E	1		5	2	20	46	315	100		60	120	276	556
10	Champaran W	1	1	3	3	16	30	398	254	30	90	96	180	650
11	Darbhanga			3	2	13	37	272			60	78	222	360
12	Gaya	1		2	2	18	66	550	140		60	108	396	904
13	Gopalganj	1	1	3	3	10	22	186	74	100	90	60	132	456
14	Jehanabad		1	4	2	4	23	70		35	60	24	138	257
15	Jamui		1	1	3	7	24	170		36	90	42	144	312
16	Kaimur		1	2	2	9	17	107		32	60	54	102	248
17	Katihar	1		4	3	11	29	258	100		90	66	174	430
18	Khagaria	1		1	1	6	15	150	52		30	36	90	208
19	Kishanganj		1	2	1	7	9	129		33	30	42	54	159
20	Lakhisarai		1	1	1	4	12	94		42	30	24	72	168
21	Madhepura	1		1	0	7	17	191	40		0	42	102	184
22	Madhubani	1	1	5	3	18	57	423	110	50	90	108	342	700
23	Munger	1		3	1	6	10	123	162		30	36	60	288
24	Muzaffarpur	1		2	1	14	45	475	218		30	84	270	602
25	Nalanda	1	1	4	3	12	33	302	160	30	90	72	198	550
26	Nawada	1		3	2	10	24	129	120		60	60	144	384
27	Patna		3	5	4	16	66	425		496	120	96	396	1108

Sl No	Districts	District Hospital	SD Hospital	Referral Hospitals		PHCs	Addl. PHCs	HSCs	No. of Beds					
									Dist. Hospital	SD hospital	Referral Hospitals	PHCs	Addl. PHCs	Total Beds No(s)
		No(s)	No(s)	No(s)	Func	No(s)	No(s)	No(s)	No(s)	No(s)	No(s)	No(s)	No(s)	
28	**Purnia**	1		2	2	11	27	278	260		60	66	162	598
29	**Rohtas**	1	1	3	1	13	37	186	120	67	30	78	222	517
30	**Saharsa**	1		3	0	7	18	152	239		0	42	108	389
31	**Samastipur**	1	3	1	1	14	49	354	110	92	30	84	294	610
32	**Saran**	1		4	3	15	42	412	176		90	90	252	608
33	**Sheikhpura**		1	1	1	3	22	78		32	30	18	132	212
34	**Sheohar**		1	1	0	3	7	39		30	0	18	42	90
35	**Sitamarhi**	1		3	2	13	36	212	109		60	78	216	463
36	**Siwan**	1		4	2	15	32	425	59		60	90	192	401
37	**Supaul**		1	1	1	9	20	178		30	30	54	120	234
38	**Vaishali**	1		4	2	11	33	339	130		60	66	198	454
State Total		**23**	**23**	**100**	**70**	**398**	**1148**	**9192**	**3173**	**1307**	**2100**	**2388**	**6888**	**16106**

Table 4.4.2: Bihar: Public Health Infrastructure - Personnel													
Sl. No	Districts	MO		ANM		LHV		MHW		Staff Nurse		AWW	
		Sanct.	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working
1	**Araria**	117	98	273	177	41	12	102	40	17	9	1778	1631
2	**Aurangabad**	188	91	342	319	23	17	110	75	12	3	1430	1390
3	**Arwal**	62	24	78	105	4	4	59	34	0	0	631	631
4	**Banka**	97	84	275	213	45	25	124	49	12	6	1352	1044
5	**Begusarai**	117	73	352	351	24	16	33	11	8	8	1314	1296
6	**Bhagalpur**	162	127	387	385	48	27	34	32	8	8	1512	1347
7	**Bhojpur**	132	105	370	368	26	20	106	42	8	1	1658	1646
8	**Buxar**	89	77	212	212	15	11	42	19	2	2	1139	1139
9	**Champaran (E)**	237	135	364	355	35	23	48	28	12	1	2901	2895
10	**Champaran (W)**	145	74	427	308	43	19	60	5	19	15	2263	2252
11	**Darbhanga**	172	152	363	296	29	19	131	96	8	5	2563	2315
12	**Gaya**	231	197	575	563	41	33	245	159	8	1	2427	2385
13	**Gopalganj**	106	95	250	249	20	8	30	3	12	2	1816	1592
14	**Jehanabad**	119	92	59	56	5	5	31	18	13	8	604	599
15	**Jamui**	85	61	222	222	25	12	70	31	12	8	1156	1138
16	**Kaimur**	93	74	146	146	19	11	64	20	19	9	996	993
17	**Katihar**	121	106	238	211	56	31	33	1	12	7	1716	1637
18	**Khagaria**	73	61	190	191	31	18	18	5	4	2	967	965
19	**Kishanganj**	56	37	169	115	31	15	64	27	11	5	1052	963
20	**Lakhisarai**	72	51	131	131	20	14	40	28	10	9	671	608
21	**Madhepura**	81	51	223	93	35	9	22	4	4	0	962	588
22	**Madhubani**	233	124	487	380	37	15	54	43	34	16	3437	2852
23	**Munger**	141	91	157	157	30	28	51	30	23	23	645	644
24	**Muzaffarpur**	241	223	594	592	29	21	140	82	4	4	2822	2610
25	**Nalanda**	178	167	402	402	30	30	36	21	0	0	1785	1761
26	**Nawada**	115	87	207	207	24	11	30	21	25	17	1249	1235
27	**Patna**	289	205	434	434	32	30	49	6	16	13	2481	2465
28	**Purnia**	126	100	356	275	56	29	126	67	8	2	1464	1424
29	**Rohtas**	158	129	286	270	29	12	136	48	20	10	1712	1628
30	**Saharsa**	97	55	192	169	33	15	18	1	26	21	932	825
31	**Samastipur**	192	183	475	470	30	20	29	18	4	4	2692	2512
32	**Saran**	185	133	512	386	33	29	46	17	27	10	2455	2218

Sl. No	Districts	MO		ANM		LHV		MHW		Staff Nurse		AWW	
		Sanct.	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working	Sanct.	Working
33	**Sheikhpura**	53	36	109	109	16	6	18	4	4	1	357	339
34	**Sheohar**	52	34	46	26	4	1	38	13	9	1	265	265
35	**Sitamarhi**	147	127	299	289	27	9	130	82	17	13	2064	1920
36	**Siwan**	151	126	465	298	31	25	102	56	13	9	2099	1934
37	**Supaul**	85	70	206	111	44	8	60	34	2	0	1376	1230
38	**Vaishali**	126	105	421	414	25	24	33	28	8	3	1844	1608
State Total		**5124**	**3860**	**11294**	**10055**	**1126**	**662**	**2562**	**1298**	**451**	**256**	**60587**	**56524**

4.5 Private and NGO Health Services/ Infrastructure

The State has a wide network of private health facilities in the urban areas providing RCH services. In general, these private health facilities are run either by individuals/organizations for profit or by Non-profit Charitable organization/NGOs. However, exact data on the number of these health facilities are not available with the State as in the State registration of private clinics and nurshing homes are not being done. Presently these health facilities are also not regulated by the DoH & F.W. However under PNDT Act the private clinics and nurshing homes undertaking ultra sonography have been regulated and these facilities are being monitored.There is an urgent need to create a comprehensive database for private health service providers and develop appropriate regulatory mechanism for them.

NGOs involved with the RCH Program in the State

RCH I envisaged large-scale involvement of NGOs and CBOs to ensure efficient delivery of services especially in urban and hard-to-reach areas. However, existing data suggest that the program has not been able to develop a effective network of these organizations. The state has only 12 Mother NGOs (MNGOs) covering 22 of the 38 districts of Bihar. However the state does not have a structured procedure to assess the working of MNGOs.There is a need to improve coordination between the NGOs and the Government at all levels i.e. state, districts and sub-district levels in order to make them effective.

Further analysis of information related to NGOs in the state revealed that there are many NGOs that are engaged in the health service delivery. Although no atempts have been made to assess the functioning of these NGOs, it is important to take initiative to develop efficient NGO network in the State for RCH programme.

Sl No	District	Mother NGOs
1	**Aurangabad**	Daudnagar Organization for Rural Development Badi Masjid, Old Town, Daudnagar Aurangabad
2	**Bhagalpur**	Arthik Atma Nirbharta Samajik Vikas Pradhikaran Swami Sahjanand Bhawwan Vidyapati Marg, Patna - 800 001
3	**Buxar**	Bhagwan Buddha Vikas Sewa Samiti, Mother TeresaSchool Campus, North Mandiri, South of Kali Mandir, Bansghat, Patna-800 001
4	**Champaran- E**	Rajinder Institute of Education & Social Welfare, halimpur P.O. – Dumri Kala, Sitamarhi-843315
5	**Champaran -W**	Rajinder Institute of Education & Social Welfare, halimpur P.O. – Dumri Kala, Sitamarhi -843315
6	**Darbhanga**	Mahila Bal Utthan Kendra, Sahu Road Muzaffarpur – 842 001
7	**Gaya**	Adithi, 2/30 State Bank Colony, bailey Road, Patna
8	**Jahanabad**	Adithi, 2/30 State Bank Colony, bailey Road, Patna
9	**Jamui**	Gram Nirman Mandal, Sarvodaya Ashram, P.O. – Shokhodewra, Nawada-805 106
10	**Kaimur**	Daudnagar Organisation for Rural Development, Badi Masjid, Old Town, Daudnagar, Aurangabad
11	**Khagaria**	Adarsh Mahila Kala Kendra, Samastipur
12	**Muzaffarpur**	Mahila Bal Utthan Kendra, Sahu Road, Muzaffarpur – 842 001
13	**Nalanda**	Bihar Voluntary Health Association, Near LCT Ghat Near Ganga Apartment, Mainpura, Patna
14	**Nawada**	Gram Nirman Mandal, Sarvodaya Ashram, P.O. – Shokhodewra, Nawada-805 106
15	**Patna**	Bihar Voluntary Health Association, ear LCT Ghat Near Ganga Apartment, Mainpura, Patna

Sl No	District	Mother NGOs
16	**Purnia**	Arthik Atma Nirbharta Samajik Vikas Pradhikaran Swami Sahjanand Bhawwan Vidyapati Marg, Patna
17	**Saharsha**	Adarsh Mahila Kala Kendra, Samastipur
18	**Samastipur**	Millat Educational Society, Station Road P.O. & Dist. – Samastipur 848 101
19	**Saran**	[1] Scientific Educational Promotion & Medical Aid Foundation 1-Niti Bagh, P.O. – BV College, Patna 800 014
20	**Sheikhpura**	[1] Shantidoot, Gharpar, Udantpur, Biharshareef Nalanda 803 101
21	**Sitamarhi**	[1] Millat Educational Society Station Road P.O. & Dist. – Samastipur 848 101
22	**Siwan**	[1] Scientific Educational Promotion & Medical Aid Foundation 1-Niti Bagh, P.O. – BV College, Patna 800 014

4.6 Donor Assisted Programs in the State

There are three development partners working in Bihar, UNICEF, WHO and the European Commission (EC). Support from these partners was sought given their respective strengths and the need for technical support to enhance the quality of programme implementation and efficient utilization of resources. The EC provided financial assistance under the Sector Investment Programme to assist in health sector reforms, UNICEF supported the strengthening of immunisation and nutrition services. The WHO extended support in servillance of Pulse Polio programme. A detailed description of the support areas, objectives and outcomes is given below.

European Commission: EC contributed resources under the Sector Investment Programme(SIP) to support the health sector reforms in the State. The Sector Investment Programme aims to supplement and strengthen the reforms initiatives of the state government with a view to make theRCH investmant more fruitful. SIP in particular, aims to enhance State's capacity for policy analysis, institutional strengthening at state and district levels, decentralization of decision making , rationalisation of infrastructure, manpower and financial mechanisms. It also supports the state's endeavour for bringing improvements in technical, financial and managerial capacity of programme managers at the state, district and hospital levels.

UNICEF: Under its flagship program of Reproductive and Child Health (RCH), UNICEF's key activities in the state are centered around the acceleration of routine immunisation and outreach services, and the elimination/eradication of certain vaccine-preventable diseases. The programme supports efforts to improve access, demand and use for immunisation, micronutrient supplementation, birth registration, injection safety and facilitate introduction of new antigens (Hepatitis B). UNICEF also facilitates micro planning for routine immunisation through fixed sub-center and outreach sessions, including at least one such session per month in all hard-to-reach villages. It promotes community participation to improve attendance at outreach sessions, facilitate dropout tracking, and monitor the quality of services. Support for cold-chain maintenance and spare parts are also provided. Lessons in micro planning from the highly successful mobilization efforts for polio eradication have been captured at state, district, block, and village level to strengthen routine immunisation programme.

4.7 Institutional Arrangements and Organizational Development

4.7.1 Institutions Involved in RCH

RCH and the range of services planned, RCH envisaged involvement of relevant stakeholders from government and non-governmental sectors for service delivery. Functional synergies were sought with governmental departments such as ICDS, PWD and PRIs. Active co-operation was also sought from non-governmental organisations, private sector and developmental partners. The roles and responsibilities of each key institution involved in RCH are discussed below.

(1) Department of Family Welfare

The Department of Family Welfare has been entrusted to implement the program according to GoI norms and goals set by the state government. It has also been entrusted to function as the nodal agency to co-ordinate between GoI and the state government and with other government departments, NGOs, private sector and development partners. It is responsible for overall planning, implementation and effective supervision and monitoring. Timely release of funds to districts through SCOVA and effective utilisation of these funds are another key responsibility.

(2) Integrated Child Development Scheme (under DWCD/DSW)

In order to capitalise on the vast reach and active community involvement of ICDS. The RCH envisaged the active co-operation of ICDS functionaries for community mobilisation and delivery of MCH services. ICDS was also entrusted to support planned activities enhance nutritional status of women and children.

(3) Public Works Department

The department has been entrusted to carry out all minor and major civil works under the RCH programme on advice of Department of Health and Family Welfare. It was to ensure timely completition of all civil works referred to it under this programme.

(4) PRIs

The 73rd and 74th constitutional amendments have entrusted the responsibility of local governance to the PRIs. For RCH PRIs has been entrusted with tasks of community mobilisation, demand generation and supervision and monitoring at grassroots level.

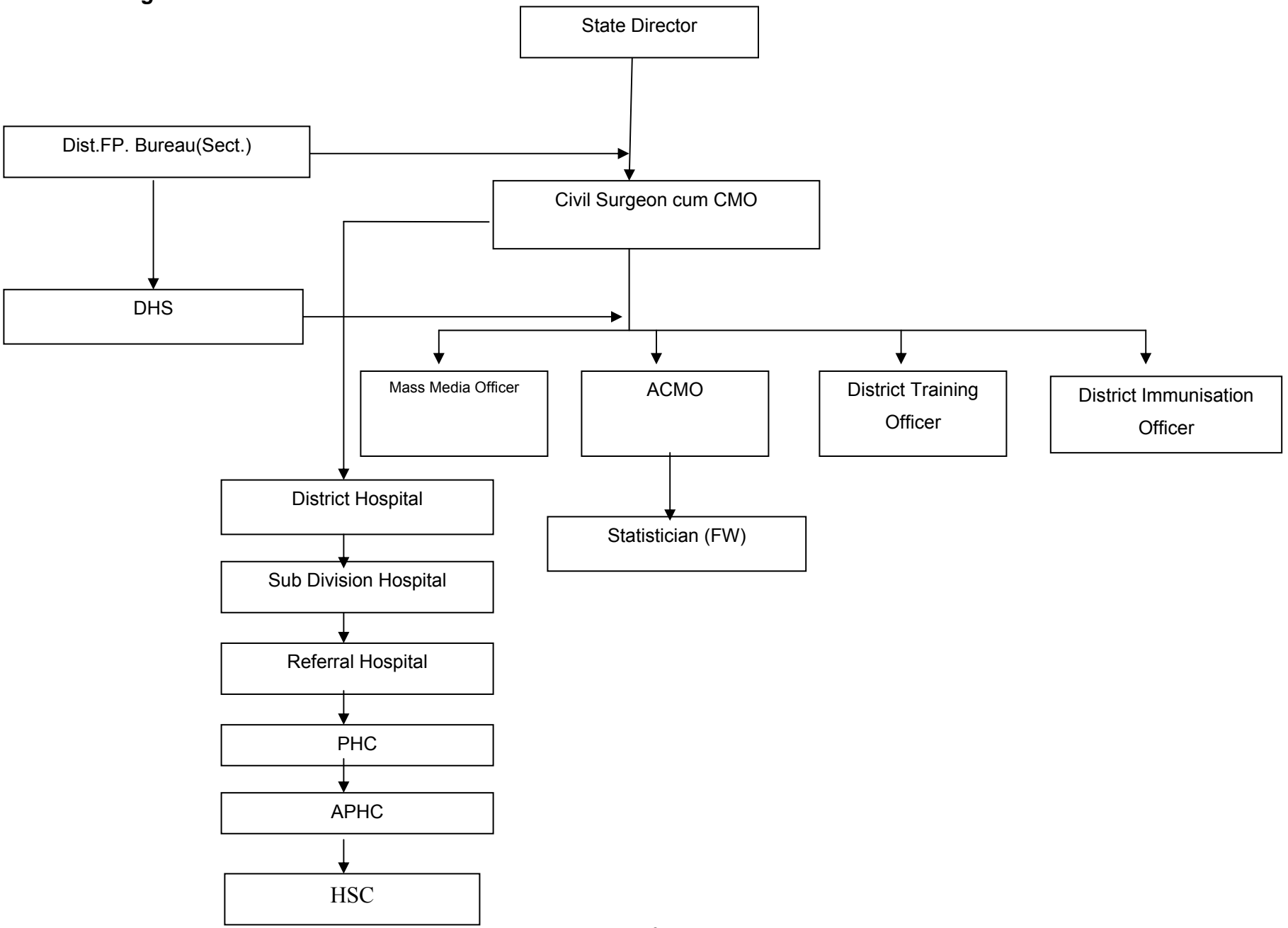
(5) NGOs / Private sector

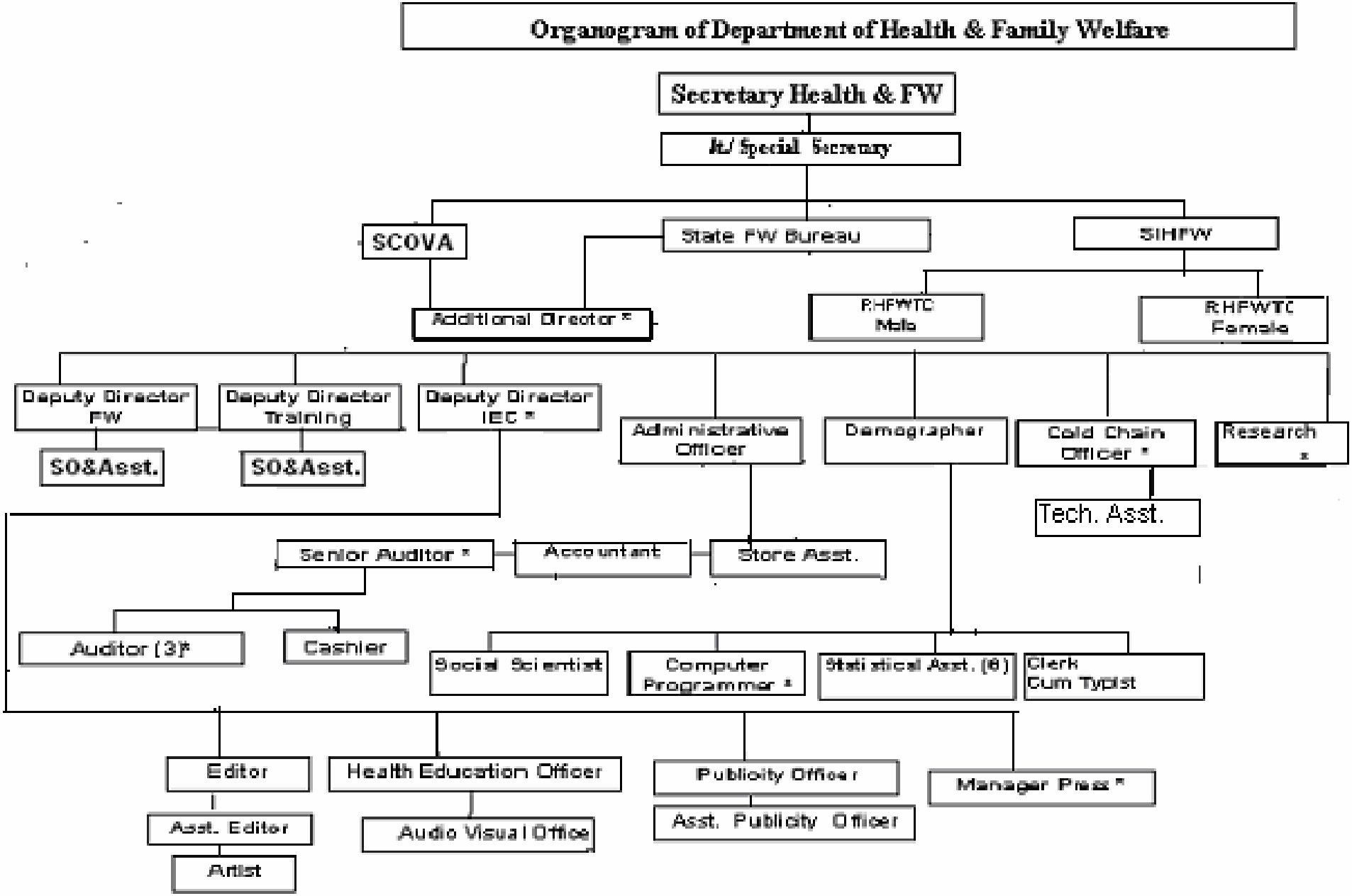
NGOs and the private sector have been extensively involved to increase access of RCH services in un-served and under-served areas. The programme sought to establish a large network of NGO partners that would deliver quality RCH services at community levels. Mother NGOs have been appointed for each district they are required to develop and support a network of NGOs in their respective districts. They were also to support in IEC and community mobilisation efforts.

(6) Development Partners (UNICEF, WHO and EC)

To enhance quality of programme implementation and efficient utilisation of resources, need-based technical support was envisaged from the state's active developmental partners, namely UNICEF, WHO and EC. EC is providing financial and technical assistance under the Sector Investment Programme to implement the health sector reforms. UNICEF supporting the state in the area of strengthening immunisation and nutrition services. WHO is extending support in Pulse Polio Surveliance.

4.7.2 Current Organizational Structure




Organogram of Department of Health & Family Welfare
Secretary Health & FW
Jt/ Special Secretary
SCOVA
State FW Bureau
SIHFW
Additional Director *
RHFWTC Male
RHFWTC Female
Deputy Director FW
Deputy Director Training
Deputy Director IEC *
Administrative Officer
Demographer
Cold Chain Officer *
Research *
SO&Asst.
SO&Asst.
Tech. Asst.
Senior Auditor *
Accountant
Store Asst.
Auditor (3)*
Cashier
Social Scientist
Computer Programmer *
Statistical Asst. (6)
Clerk Cum Typist
Editor
Health Education Officer
Publicity Officer
Manager Press *
Asst. Editor
Audio Visual Office
Asst. Publicity Officer
Artist

4.7.3 Training

The status of training facilities in the state remains unsatisfactory at all levels. At the state level, there is one training institute, the State Institute of Health and Family Welfare (SIHFW) that imparts training to health personnel. However, this institute is facing a shortage of faculty. At the regional level, too there is an acute shortage of good training centers. Pesently in the state there are six Regional Training Centers and 21 ANM training centers. In the ANMTCs Tirhut division has maximun percentage of seats (26.75) followed by Patna division(17.20) however Magadh and Kosi divisions have about 6 and 4 percent of seats respectively. In these training centers no admission has been taken since 2004 due to changes in the selection policy for admission of the ANMs in the state.The state government has decided to recruit the ANMs centrally through joint admissin tests.

Table 4.7.31: Training Facilities at various levels in Bihar

At the divisional Level	Name	Availability of Training Institute	Functional status
State	Bihar	Present	
Division /Region	Patna	Available	Presently training courses are being not organizes since 2004 due to change in selection policy of the state.
	Magadh	Available	
	Tirhut	Available	
	Saran	Available	
	Darbhanga	Available	
	Munger	Available	
	Koshi	Available	
	Bhagalpur	Available	
	Purnea	Available	
District	Araria	Not Available	
	Arwal	Not Available	
	Aurangabad	Not Available	
	Banka	Not Available	
	Begusarai	Available	
	Bhagalpur	Available	
	Bhojpur	Available	
	Buxar	Not Available	
	Champaran-E	Available	
	Champaran-W	Available	
	Darbhanga	Not Available	
	Gaya	Available	
	Gopalganj	Available	
	Jehanabad	Not Available	
	Jamui	Not Available	
	Kaimur	Not Available	

	Katihar	Available	
	Khagaria	Not Available	
	Kishanganj	Available	
	Lakhisarai	Not Available	
	Madhubani	Available	
	Madhepura	Not Available	
	Munger	Not Available	
	Muzaffarpur	Available	
	Nalanda	Available	

4.7.4 Logistics

The arrangeent at the state, regional or district levels to manage the logistical aspects of RCH has been weak. Most logistic related activities are dealt with in an ad hoc manner. The State's mechanisms for proper estimation of supplies, their indenting procurement, warehousing and transportation have been weak. The bulk of supplies for RCH have been coming directly to districts from GoI and many times the state head quarter was not aware of the delivery schedule of the consignments. This state of affairs results in erratic supplies, and adversily affect the service delivery.

4.7.5 HMIS

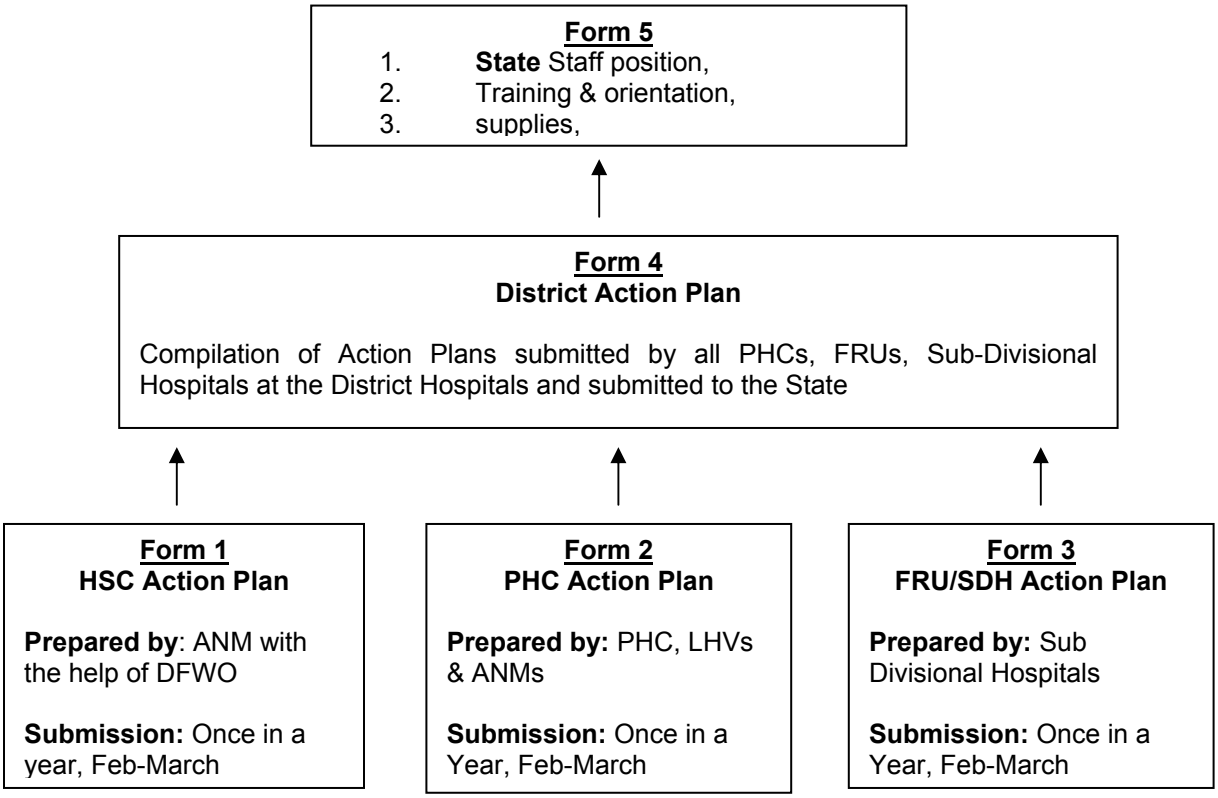
A well-developed Health Management Information System is critical for effective management, supervision and monitoring of a health program. However, the RCH program in Bihar is characterized by a health management information system wherein collection, collation and analysis of information are inadequate. The existing HMIS system basically comprises the nine different forms developed by GoI. (See Table 4.7.5.1 for details of each form). These forms are designed to effectively capture the relevant program data,and need to be filled and analyzed manually, at various levels of service delivery. As a result, health facilities at both district and sub-district levels delay submission of their respective forms. This leads to paucity of timely and comprehensive information about the status of the program at the state level.

As the health facilities at the district and sub-district levels do not use computers to enter data, the state receives a huge volume of paper forms that it cannot analyze and put to use for improvement of the programme. At the state level too, there is shortage of resources, both physical infrastructure and skilled manpower support a comprehensive health management information system.

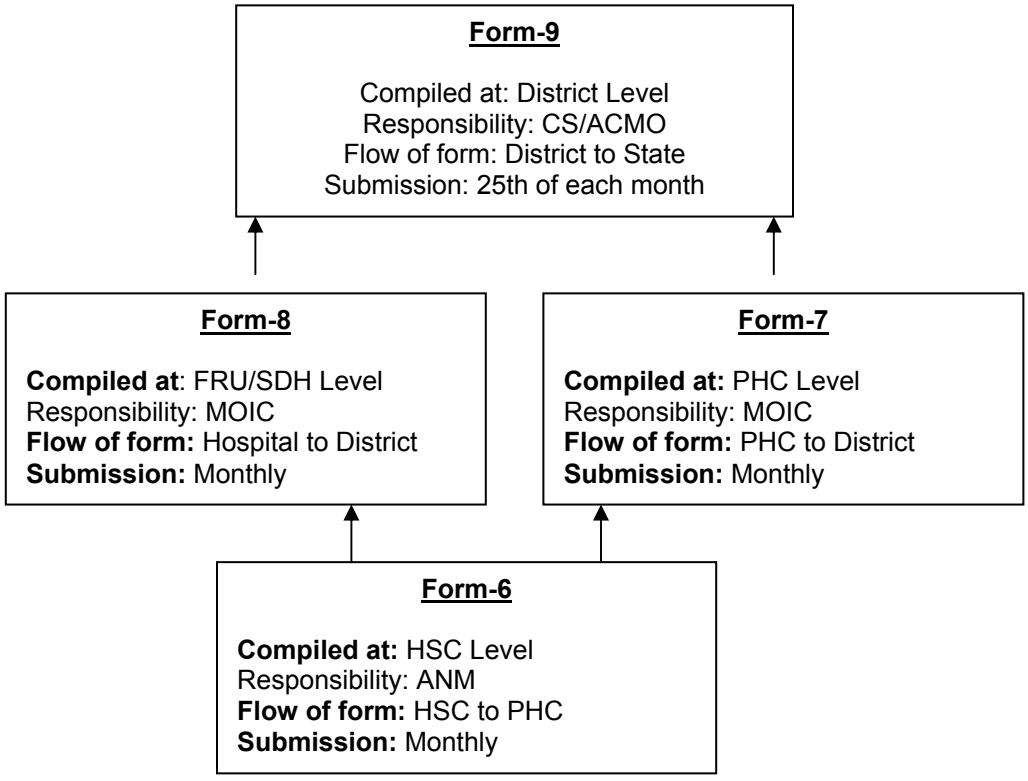
Table 4.7.5.1: HMIS Forms

Form No.	Information	Filled by
Form No.1	General information, no. of births, Cases of complicated pregnancies and deliveries, sick newborns , RTI/STD cases, oral rehydration performance data [action plan by ANM or SC]	ANM
Form No. 2	Deliveries, MTPs ,RTI/STD, Immunization, need assessment of individual ANMs [action plan for PHC]	PHC level
Form No. 3	Sterilization, ,immunization, services in obstetric care STI/RTI [action plan for FRU/Subdivision/DH]	Sub division level
Form No. 4	District action plan	District
Form No. 5	State action plan	State level
Form No. 6	Monthly report by ANM	ANM
Form No. 7	Monthly report by PHC	PHC
Form No. 8	Monthly report by FRU/Subdivision	FRU
Form No. 9	Monthly report by District	District

Action plan Forms



Reporting Forms



4.8 Programme Finances

4.8.1 Analysis of budget availability in RCH I

Analysis of the money received by the state under RCH I clearly indicates that utilization of money earmarked for RCH has been low. The audited expenditure report for last four years clearly shows that the highest utilization of RCH funds was in year 2003-04 when the state used about 33.70% of the money received form GoI. During other financial years, utilization was as low as 2.51% (year 2000-01) and 9.94% (year 2002-03). In the financial year 2001-02 utilization was relatively better at 22.78%.

Table 4.8.1.1: Programme Finances: Analysis of Budget availability in RCH - I

Year	Activity / Schemes	Grant Received	Expenditure	% Utilized
2000-01	**RCH**			
	GOI	37233400	1354164	3.64
	NIHFW	16642060		
	TOTAL	**53875460**	**1354164**	**2.51**
	IPPI			
	GOI	224216424	175478576.5	78.26
	WHO	62844219	20347629.05	32.38
	TOTAL	**287060643**	**195826205.52**	**68.22**
	GRAND TOTAL	**340936103**	**197180369.52**	**57.83**
2001-02	**RCH**			
	GOI	59753700	13613884.20	22.78
	TOTAL	**59753700**	**13613884.20**	**22.78**
	IPPI			
	GOI	158532650	113074612.25	71.33
	WHO	43408074	62624997.40	144.27
	TOTAL	**201940724**	**175699609.65**	**87.01**
	GRAND TOTAL	**261694424**	**189313493.85**	**72.34**
2002-03	**RCH**			
	GOI	143978250	14317236.93	9.94
	TOTAL	**143978250**	**14317236.93**	**9.94**
	IPPI			
	GOI	165789485	147753657.62	89.12
	WHO	11391292	22367078.85	
			1292873.65	
	TOTAL	**177180777**	**171413610.12**	**96.75**
	GRAND TOTAL	**321159027**	**185730847.05**	**57.83**
2003-04	**RCH**			
	GOI	83375000	28097646.24	33.70
	TOTAL	**83375000**	**28097646.24**	**33.70**
	IPPI			
	GOI	290960156	262151480.81	90.10
	WHO	0		
	TOTAL	**290960156**	**262151480.81**	**90.10**
	GRAND TOTAL	**374335156**	**290249127.05**	**77.54**

4.8.2 Analysis of expenditures and key reasons for shortfalls

Close analysis of expenditure under RCH I by the state suggests that though the expenditure by the state were made under the broad areas suggested by GoI, the state has not been consistent with any activity/intervention throughout the program period. Expenditure data of last four financial years indicates that apart from Administrative expenses head there were only four heads (Minor Civil Work, Awareness Generation Training, Cold Chain, and Dai Training) where some expenditures were made in three out of four years under report. Under five broad areas, namely, Zilla Saksharta Samiti, Target Free Approach, IEC Family Planning, SST and Mobility Support, expenditures were made only once during the four years under discussion.

Table 4.8.1.1: Programme Finances: Analysis of expenditures in RCH - I

RCH	Year			
Head of Expenditure	**2000-01**	**2001-02**	**2002-03**	**2003-04**
Zilla Saksharta Samiti	628000			
Target Free Approach	726164			
Minor Civil Work		7112684	2555536	5008696
Awareness Generation Training		64345	43132	1955089
Cold Chain		1379587	1346515.2	809876.8
Dai Training		711319	1918565	1292997
RCH Camp		179628		2795186.9
Integrated Skill Development (RCH)		2829720.2		
Eligible Couple Register		190000		
Boundary Wall		810598		
P.N.D.T			591253	311724
Integrated Skill Development			1818915	8443892
Empowered Action Group			4762972.73	6276350.64
RCH Meeting			76059	
Repair & Maintenance			279500	
Training of MO & Vaccinator			251850	
IEC Family Planning				577200
SST				103830
Mobility Support				66755
Administrative Expenses		336003	672939	456048.9
TOTAL	**1354164.00**	**13613884.20**	**14317236.93**	**28097646.24**
IPPI	**Year**			
Zilla Saksharta Samiti	628000			
IEC	34088005.75			293651.6
Fuel & Transport	36934939.49			
Booth Management	98398750.73			911060
Mop Up Round	20347629.05	62624997.40		2312354.95
Panch Sammelan	5428880.5			
Other Activity For Immunization		113074612.25	170120736.47	257646944.26
Advertisement Expenses			1277873.65	
Telephone Expenses			15000	
Regional Director NPSP				987470
TOTAL	**195826205.52**	**175699609.65**	**171,413,610.12**	**262151480.81**

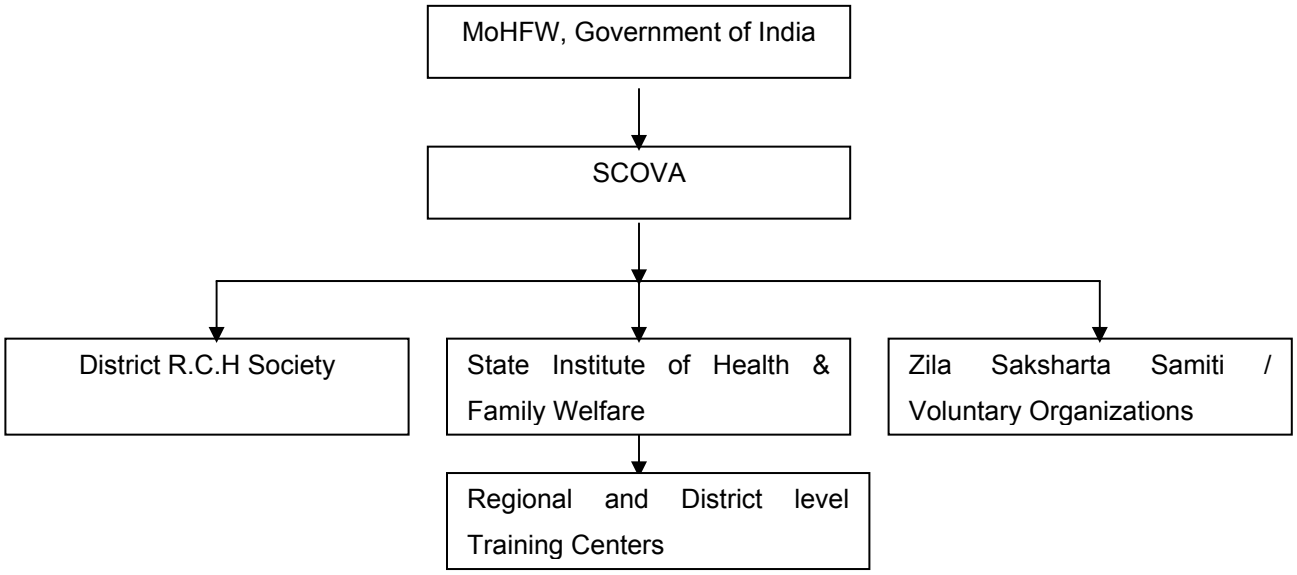
Source: Audit Report GoB

4.8.3 Issues of overlap

There has been no issue of overlap due to low level of fund utilization in RCH I. However, some implementing units and/or program area did receive fund from more than one sources/agencies. For example, ZSS has got fund under RCH and IPPI programme for IEC activities from Govt. of India and WHO, similarly money has been allocated for Cold Chain maintenance from UNICEF.

4.8.4 Fund flow mechanisms in RCH I

For RCH I program the fund flow mechanism was as follows:



Timeliness of RCH funds availability with GoB: One the major problems experienced during RCH I program was lack of timeliness of funds received by the state from Government of India. The data on funds received from GoI clearly indicates that in almost all the years of the program, the state received a major proportion of resources allocated under RCH during the third and fourth quarters. This not only affected the program implementation capacity of the state 5government but also affected funds availability at district and Sub-districts level, thereby affecting the entire program.


SITUATIONAL
ANALYSIS

5. SITUATION ANALYSIS

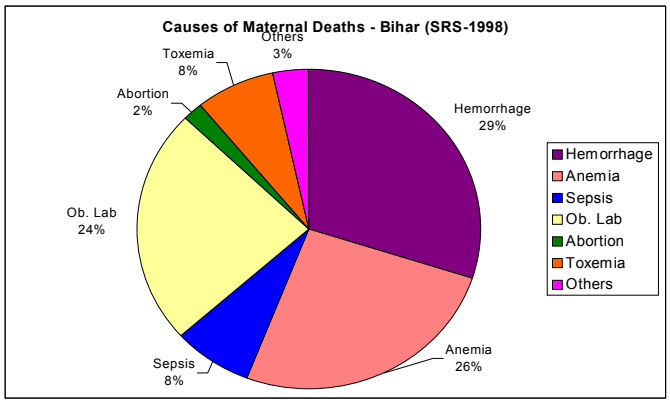
5.1 Maternal Health

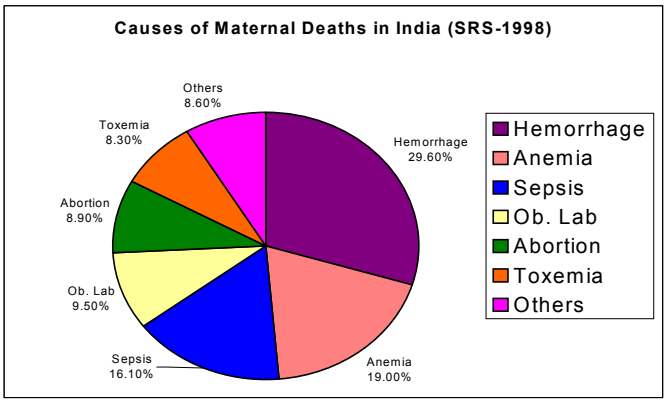
Improving the maternal health scenario by strengthening availability, accessibility and utilization of maternal health services in the state is one the major goals of RCH. However, the current status of maternal health in the state clearly shows that the programme has not been able to significantly improve the health status of women. There are a host of issues that affect maternal health services in Bihar. The important ones are listed below.

- Paucity of skilled frontline health personnel (ANM, LHV) to provide timely and quality ANC and PNC services.
- The public health facilities providing obstetric and gynaecological care at district and sub-district levels are unadequate.
- Mis match in supply of essential items such as BP machines, weighing scales, safe delivery kits, Kit A and Kit B, etc and their demand.
- Shortage of gynaecologists and obstetricians to provide maternal health services in peripheral areas.
- Inadquate skilled birth attendants to assist in home-based deliveries
- Weak referral network for emergency medical and obstetric care services
- Lack of knowledge about antenatal, perinatal and post natal care among the community especially in rural areas.
- Low levels of female literacy
- High levels of prevelance of malnutrition (anaemia) among women in the reproductive age group.
- Poor communication because of bad roads and a law and order situation.

These issues have continued to impread maternal health services in the state. It has been envisaged that RCH I would improve the status of maternal health services,however, due to in adquate infrastructure, manpower and weak managerial systems maternal health care continues to be poor. Presently the maternal health services that are mainly available in the urban area of the State are being provided by the private sector.

Causes of Maternal Deaths: Bihar and India





5.2 Child Health

The child health indicators of the state reveals that the state's IMR is lower than the national average but the NMR is disproportionately high. Furthermore, the state is at the bottom in terms of immunisation coverage, both antigen-wise as well as full immunisation. Given this low level of immunisation, morbidity and mortality due to vaccine-preventable diseases continues to be significantly high. Similarly, child health care seeking practices in the case of common childhood diseases such as ARI and Diarrhoea are not satisfactory. Although at the state level, the child health scenario (except for immunisation) is comperatively better, the same for specific groups of children, such as those who live in rural areas, whose mothers are illiterate, who belong to Scheduled Castes, and who are from poor households is particularly appalling.

Issues affecting child health are not only confined to mere provision of health services for children, but other important factors such as maternal health and educational status, family planning practices and environmental sanitation and hygiene have enormous bearing on child health. This is more than evident in the case of Bihar where child health continues to suffer not only because of poor health services for children but due to issues such as significantly high maternal malnutrition, low levels of female literacy, early and continuous childbearing, etc. The specific issues affecting child health in the state are listed below.

Maternal Factors

- High levels of maternal malnutrition leading to increased risk pre-term and low -birth weight babies that in turn increase risk of child mortality.
- Low levels of female literacy, particularly in rural areas.

Family Planning Services

- The Family Planning programme has partially succedded in delaying first birth and spacing births leading to significantly high mortality among children born to mothers under 20 years of age and to children born less than 24 months after a previous birth.

Child Health Services

- The programme has not succedded fully in effectively promote chostrum feeding immediately after birth and exclusive breastfeeding despite almost universal breastfeeding practice in the state. In the State majority of mother brest feed children beyond six months.

- High levels of child malnutrition, particularly in rural areas and in children belonging to disadvantaged socioeconomic groups leading to a disproportionate increase in under five mortality.
- Persistently low levels of child immunisation primarily due to non-availability of time and quality immunisation services.
- Lack of child health facilities, both infrastructure and human resource, to provide curative services for common childhood ailments such as ARI, Diarrhea, etc.
- Inadequate supply of drugs, ORS packets, weighing scales, etc.
- Lack of knowledge of basic child health care practices among the community.
- Failure to generate community awareness regarding essential sanitation and hygiene practices that impact on the health of children.

Since these factors are inter-linked and synergistic, any effort to improve the health of the children in the state needs to address child health issues in a holistic manner.

5.3 Family Planning

RCH emphasizes the target-free promotion of contraceptive use among eligible couples, the provision to couples of a choice of various contraceptive methods (including condoms, oral pills, IUDs and male and female sterilization), and the assurance of high quality care. It also encourages the spacing of births with at least three years between births. Despite RCH and previous programs vigorously pursuing family planning objectives, fertility in Bihar continues to decline at much lower rates than the national average. Although the total fertility rate has declined by about half a child in the six-year period between NFHS-1 and NFHS-2, it remains quite high and far from the replacement level. At current fertility levels, women in the state will have an average of 3.5 children each throughout their childbearing years. Furthermore, certain groups such as rural, illiterate, poor, and Muslim women within the population have even higher fertility than the average.

The persistently high fertility levels point to the inherent weakness of the state's family planning programme. This failure is reflected in a dismal picture of women in Bihar marrying early, having their first child soon after marriage, and having two or three more children in close succession by the time they reach their late-20s. At that point, about one-third of women get sterilized. Very few women use modern spacing methods that could help them delay their first births and increase intervals between pregnancies.

The major issues affecting the implementation of the Family Planning programme in Bihar are as follows.

- Lack of integration of the Family Planning programs with RCH, resulting in dilution of roles, responsibilities and accountability of programme managers both at state and district levels.
- Failure of the programme to effectively undertake measures to increase median age at marriage and first childbirth.
- Inability of the program to alter fertility preferences of eligible couples through effective behavior change communication (BCC).
- Lack of health facilities, both in terms of physical infrastructure and skilled human resources to deliver quality family planning services.
- Inability of the program to up-scale family planning services to cater the enhanced demand for family planning leading to significantly high level of unmet need.
- Over emphasis on permanent family planning methods such as, sterilization ignoring other reversible birth spacing methods that may be more acceptable to certain communities and age groups. (Overall, sterilization accounts for 82 percent of total contraceptive use. Use rates for the pill, IUD, and condoms remain very low, each at 1 percent or less).
- Continued use of mass media to promote family planning practices despite evidently low exposure to mass media in Bihar, leading to lower exposure of family planning messages in the community, particularly among rural and socio-economically disadvantaged groups.
- Weak public-private partnerships to promote and deliver family planning services.

These issues clearly indicate an urgent need to design and implement an effective family planning programme in the state. Such a programme would not only deliver benefits leading to limitation of population size, but also favorably impact the status of maternal and child health.

5.4 Adolescent Health

Adolescents, the segment of the population in the age group of 15 -19 years, constitute about 23% of the population of the state. This group is critical to the success of any reproductive and sexual health program, as it would remain in the reproductive age group for more than two decades. The health needs of this age group are different from that of the general population so there is a need for a tailor made public health programs to address the key issues related to adolescent health. However, in Bihar, this realization has not yet been translated into practice. This is evident from the fact that the existing RCH programme does not have separate planning of health services to address the specific needs of adolescents of the state.

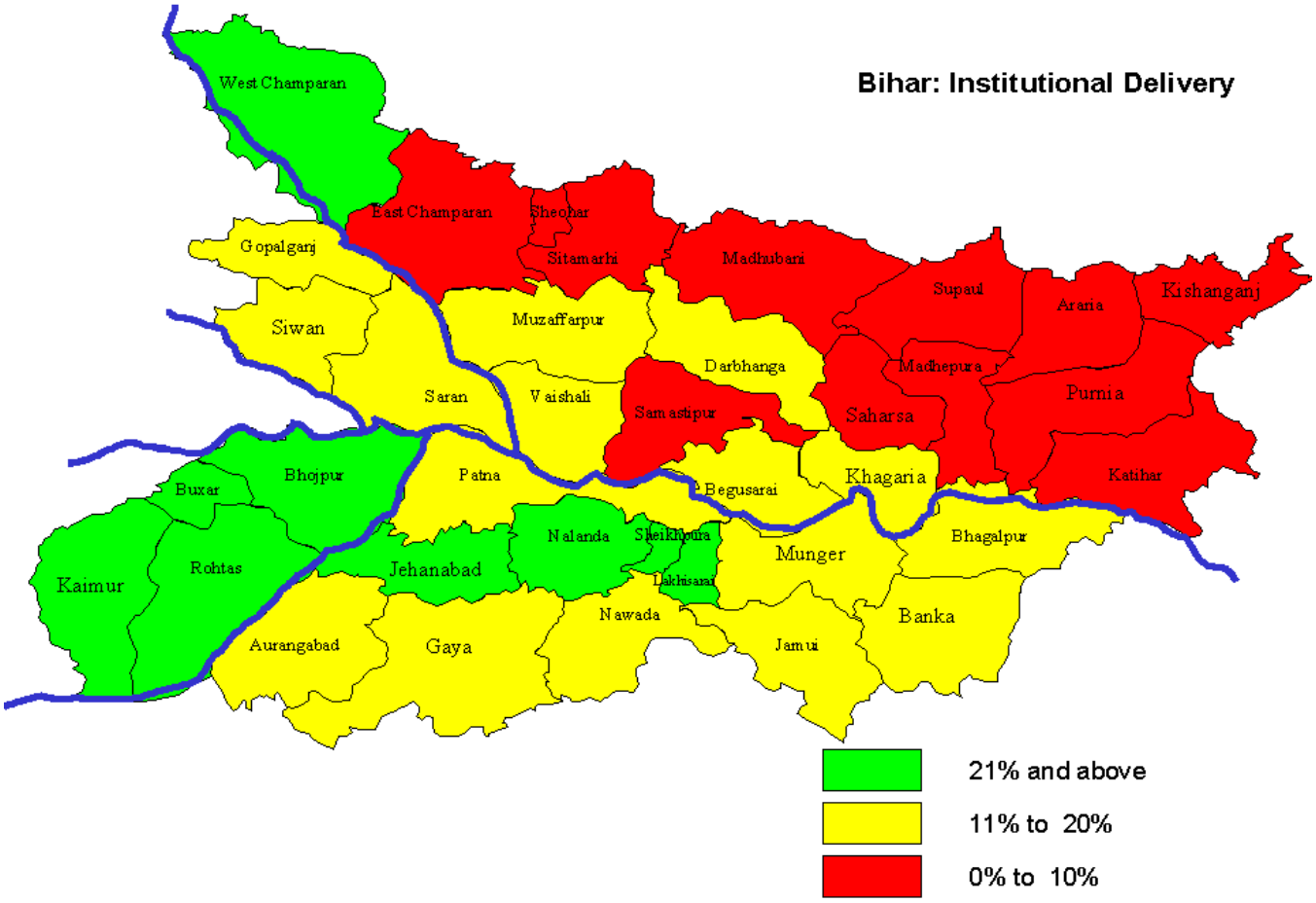
Ideally, a program for adolescent should promote reproductive care and hygiene practices, encourage delayed marriage and child bearing, educate young people about safe sex practices. In addition, the program should also sensitise young people about gender discrimination and sexual violence. Particular emphasis should be paid to strategies such as counselling and inter-personnel and behaviour change communication. Moreover, such a program should also be designed in a manner that would sensitise health care providers about the unique health care needs of this group.

5.5 District / Sub-district Variations

Key indicators related to Maternal and Child Health (MCH) and Family Planning clearly show the poor status of RCH in Bihar. However, close examination of data reveals that there exist wide inter-district variations for almost all the key indicators. Listed below is the top five and lowest five performing districts for select key indicators. Data related to institutional delivery suggests that West Champaran has the highest rate of institutional delivery of 43.7%, the same for districts like Purnia and Katihar is 5.3% and 6.1% respectively. Even among the top performing districts, variations are wide and the second best performing district has a differential of more than 10 percentage points. Geographical analysis of these districts indicates that four out of five best performing districts are closer to the state capital and are not affected by. Among the low performers, four out of five districts are located at the periphery and the only nearby district (Samastipur) is extremely flood prone.

Table 5.5.1: District Level Variations in Institutional Delivery

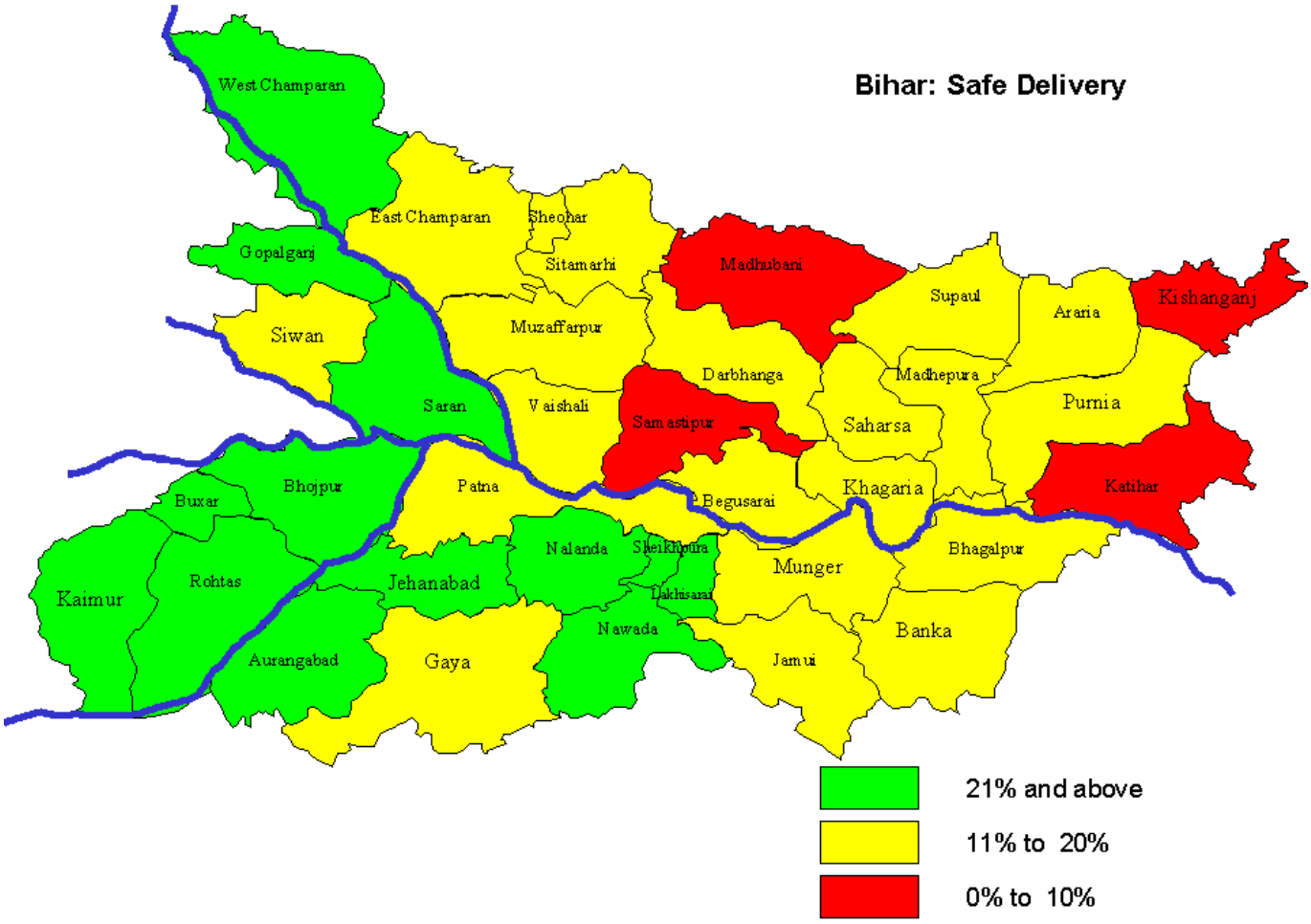
	Good Performing District	%	Poor Performing District	%
Institutional Delivery	West Champaran	43.7	Purnia	5.3
	Bhojpur	31.9	Katihar	6.1
	Buxar	28.3	Samastipur	6.6
	Jehanabad	26.0	Kishanganj	6.7
	Nalanda	23.2	Araria	6.8



In terms of safe delivery too the top performing districts remain similar to those who featured in as best performing districts for institutional delivery, perhaps indicating that overall delivery services in these districts are relatively better. Among the poor performing districts too, except for one, the districts remain the same as in the previous section. Madhubani, the only district that did not feature in the previous list of poor performing districts for institutional delivery, but ranked here as one of the poor performing districts for safe delivery (9.8%), also shares the geographical characteristics of other districts in this category i.e. peripheral and highly flood prone.

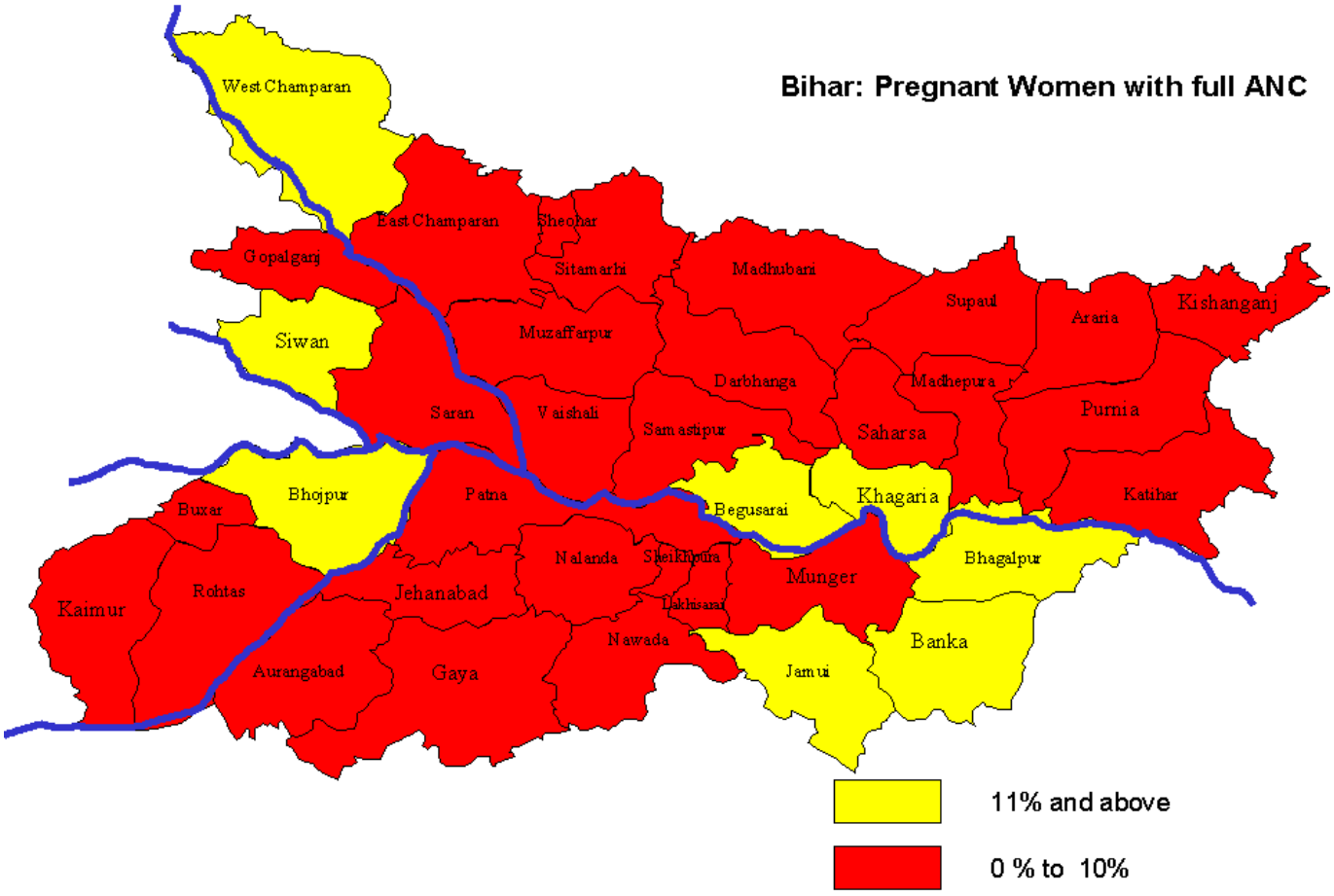
Table 5.5.2: District Level Variations in Safe Delivery

	Good Performing District	%	Poor Performing District	%
Safe Delivery	West Champaran	48.0	Samastipur	7.6
	Bhojpur	40.1	Katihar	8.0
	Buxar	29.7	Kishanganj	8.2
	Jehanabad	28.0	Madhubani	9.8
	Nalanda	27.1	Araria	10.2


Bihar: Safe Delivery
West Champaran
East Champaran
Sheohar
Sitamarhi
Madhubani
Supaul
Araria
Kishanganj
Gopalganj
Siwan
Muzaffarpur
Darbhanga
Madhepura
Purnia
Saran
Vaishali
Samastipur
Saharsa
Bhojpur
Buxar
Patna
Begusarai
Khagaria
Katihar
Nalanda
Sheikhpura
Munger
Bhagalpur
Rohtas
Kaimur
Jehanabad
Lakhisarai
Nawada
Banka
Aurangabad
Gaya
Jamui
21% and above
11% to 20%
0% to 10%

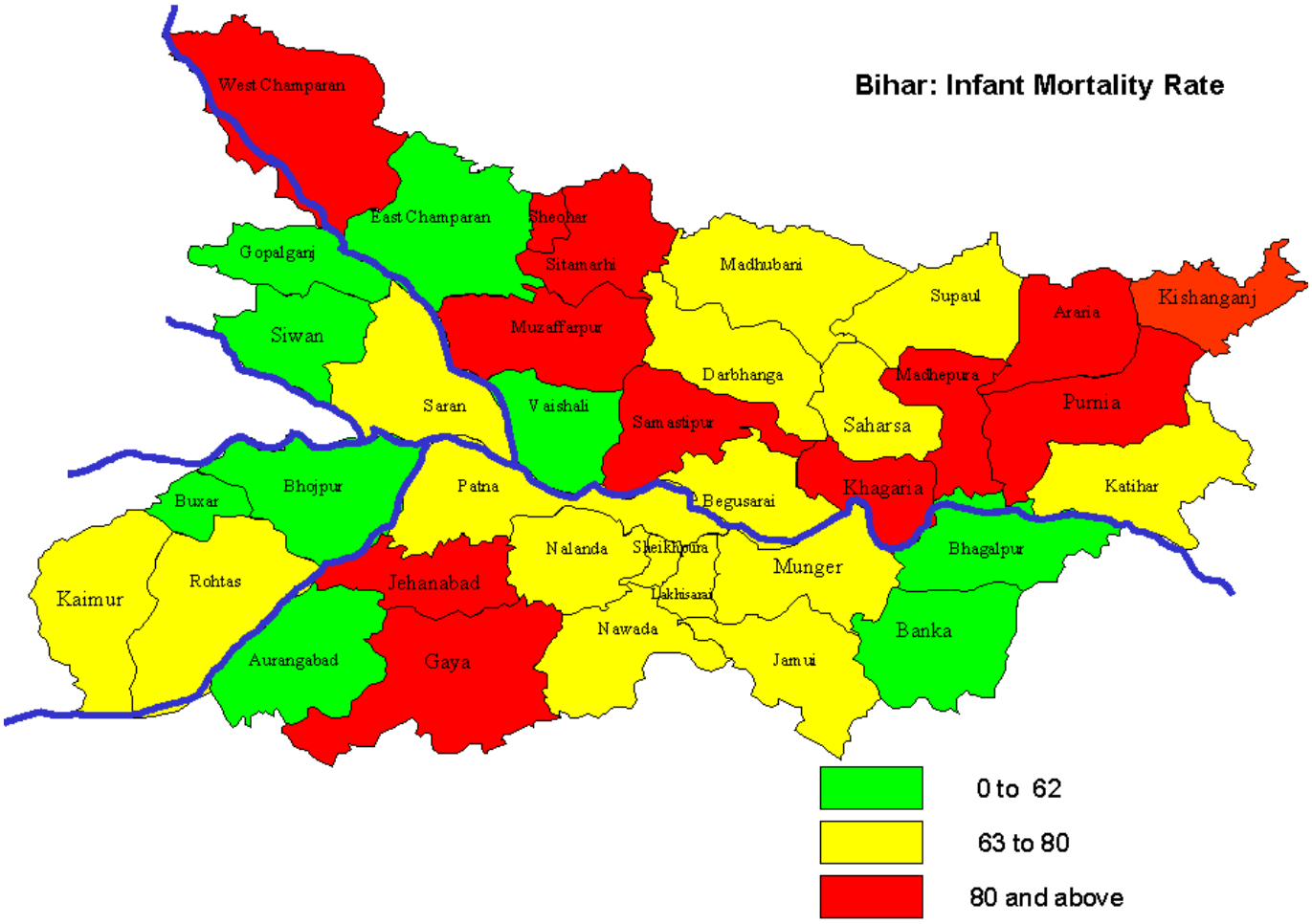
The general performance in terms of ANC services in the state is abysmally low, reflecting the poor condition of public health services for women in the reproductive age group. Even the best performing district viz West Champaran is at 15.3%, which is low compared to national average. The coverage rate in the low varies between 3.3% to 4.6%.

Table 5.5.3: District Level Variations in % of Pregnant Women with full ANC				
	Good Performing District	**%**	**Poor Performing District**	**%**
% of Pregnant Women with full ANC	West Champaran	15.3	Sitamarhi	3.3
	Begusarai	12.5	Samastipur	3.4
	Siwan	11.8	Madhepura	3.8
	Bhojpur	11.1	Purnia	3.9
	Bhagalpur	10.4	Aurangabad	4.6



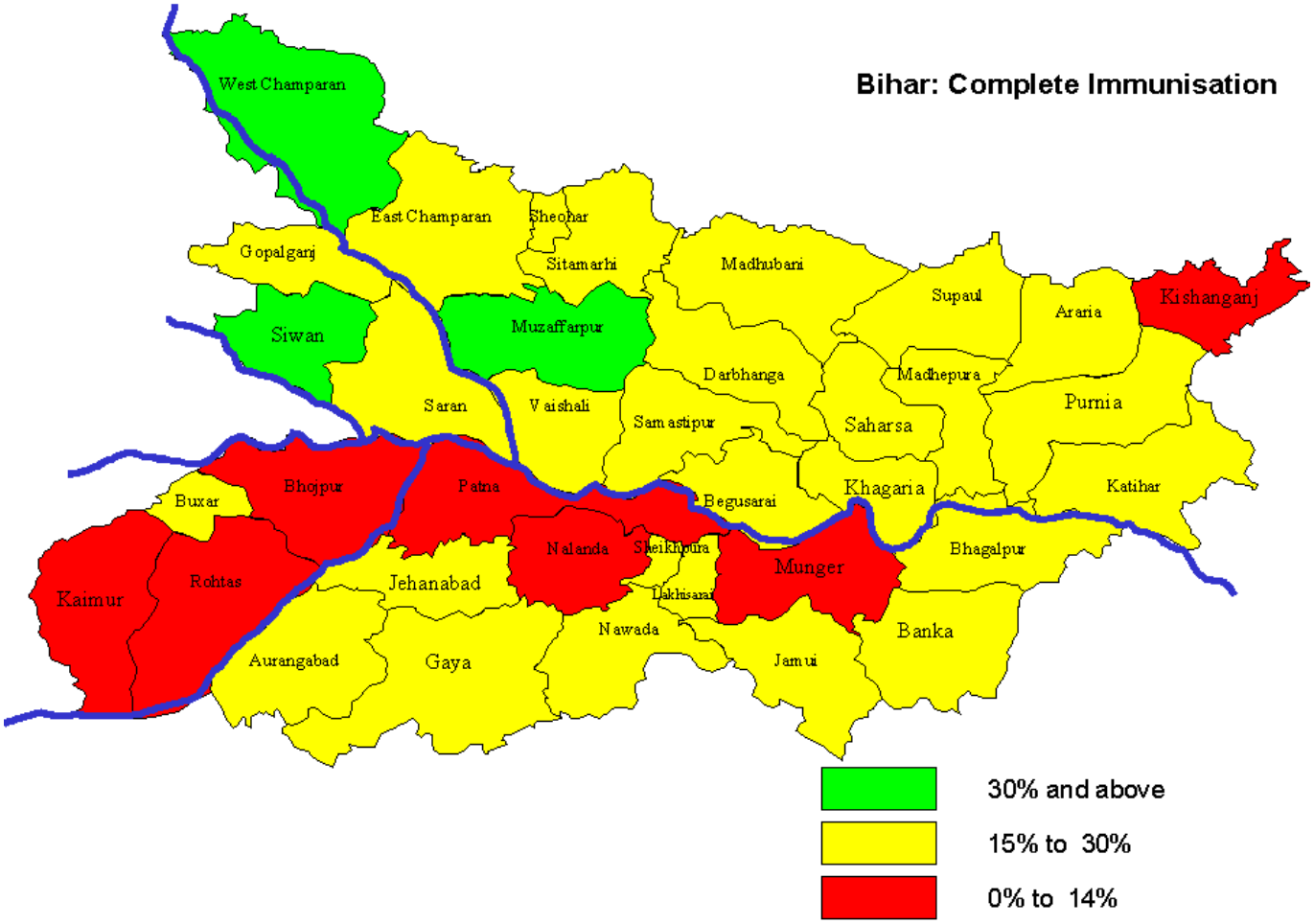
Though the performance of the state in terms of IMR is above the national average, a large proportion of districts continues to report significantly high IMR than the state averages. Geographical analysis suggests that most of these districts such as Kishanganj, Araria, Purnea, Samastipur, and Khagaria with high IMR are either peripheral or highly prone to floods.

Table 5.5.4: District Level Variations in IMR				
	Good Performing District	**%**	**Poor Performing District**	**%**
IMR	Siwan	43	Kishanganj	113
	Vaishali	46	Araria	102
	Gopalganj	53	Purnia	89
	Bhojpur	55	Samastipur	87
	Buxar	55	Khagaria	85



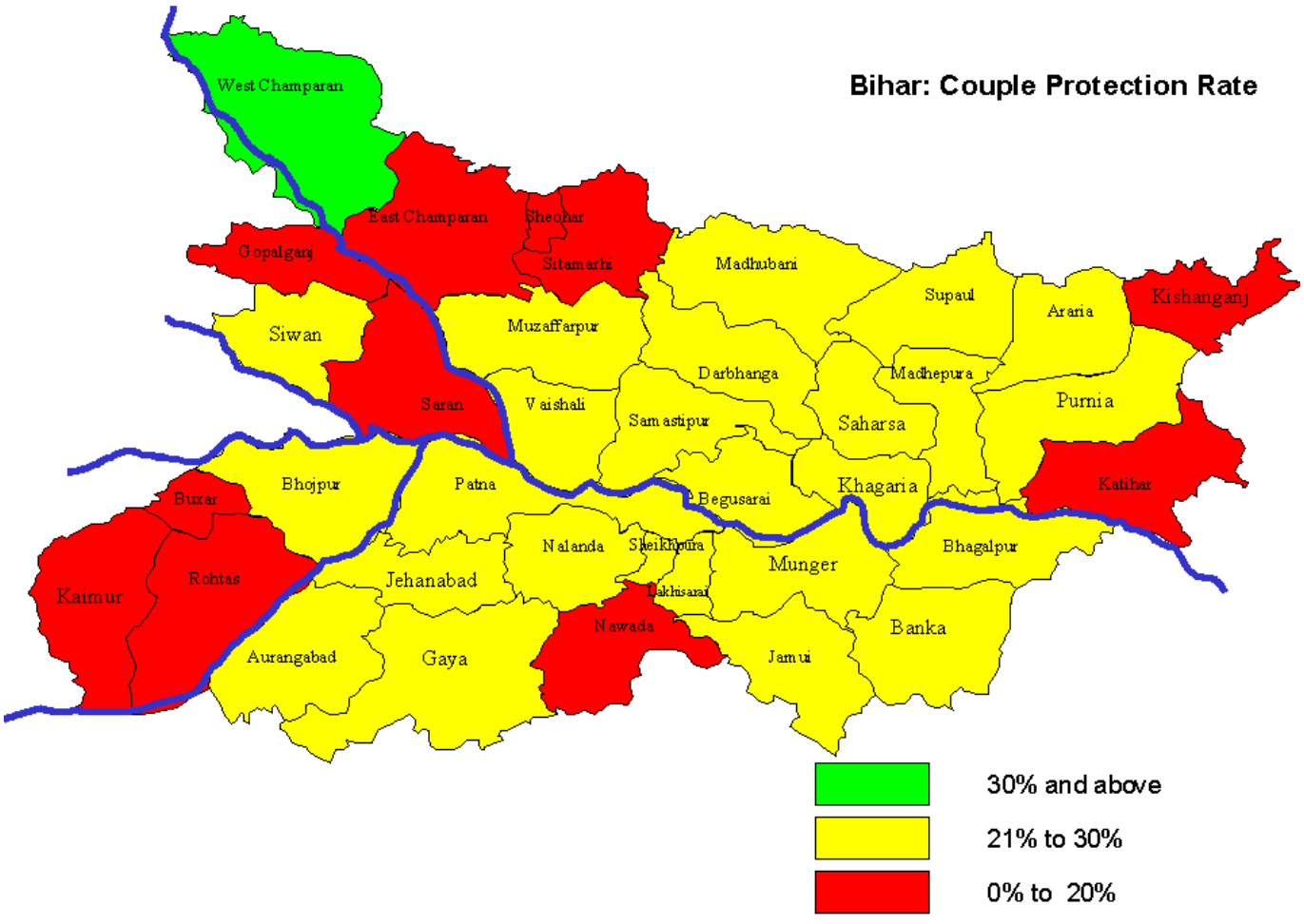
As Bihar features at the bottom of all the states in terms of immunisation coverage, all the districts continue to report very low immunisation coverage, both antigen-wise and full immunisation. In the best performing districts such as West Champaran, Siwan, Muzaffarpur, Nawada and Jehanabad, full immunisation coverage ranges from 36.8% to 27.1%. On the other hand, among the low performing districts such as Rohtas, Munger, Kishanganj, Bhojpur and Nalanda, this ranges close to a single digit figure (8.4% to 13.2%).

Table 5.5.5: District Level Variations in Complete Immunization				
	Good Performing District	**%**	**Poor Performing District**	**%**
Complete Immunization	West Champaran	36.8	Rohtas	8.4
	Siwan	30.8	Munger	11.0
	Muzaffarpur	30.1	Kishanganj	11.4
	Nawada	28.7	Bhojpur	12.0
	Jehanabad	27.1	Nalanda	13.2



Performance indicators for family planning in the state are not very different from those of maternal and child health. The Couple Protection Rate, one of the key indicators for family planning continues to be significantly lower than the national average. Here too, the performance of districts are varied and while districts such as West Champaran, Saharsa, Khagaria, Araria and Darbhanga report CPR in the range of 35.3% to 25.2%, the low performers such as Gopalganj, Kishanganj, Sitamarhi, Katihar and Saran have CPR in the range of 14.5% to 17.5%.

Table 5.5.6: District Level Variations in CPR				
	Good Performing District	**%**	**Poor Performing District**	**%**
CPR	West Champaran	35.3	Gopalganj	14.5
	Saharsa	27.7	Kishanganj	15.5
	Khagaria	26.8	Sitamarhi	16.6
	Araria	26.5	Katihar	17.2
	Darbhanga	25.2	Saran	17.5



The poor state of Family Planning services in the state is also evident in the high Crude Birth Rate. Unlike other indicators discussed previously, the Crude Birth Rate is one of the few indicators for which inter-district variation is relatively less. Across the state, it ranges from a high of 40.7% to a low of 32.6%, for a majority of the districts (22 out of 38) , the range is between 35 and 37.

Table 5.5.7: District Level Variations in CBR				
	Good Performing District	**%**	**Poor Performing District**	**%**
CBR	Patna	32.6	West Champaran	40.7
	Madhubani	33.6	Katihar	39.5
	Jehanabad	33.7	Araria	38.8
	Nalanda	34.3	Purnia	38.1
	Muzaffarpur	34.9	Kishanganj	37.4

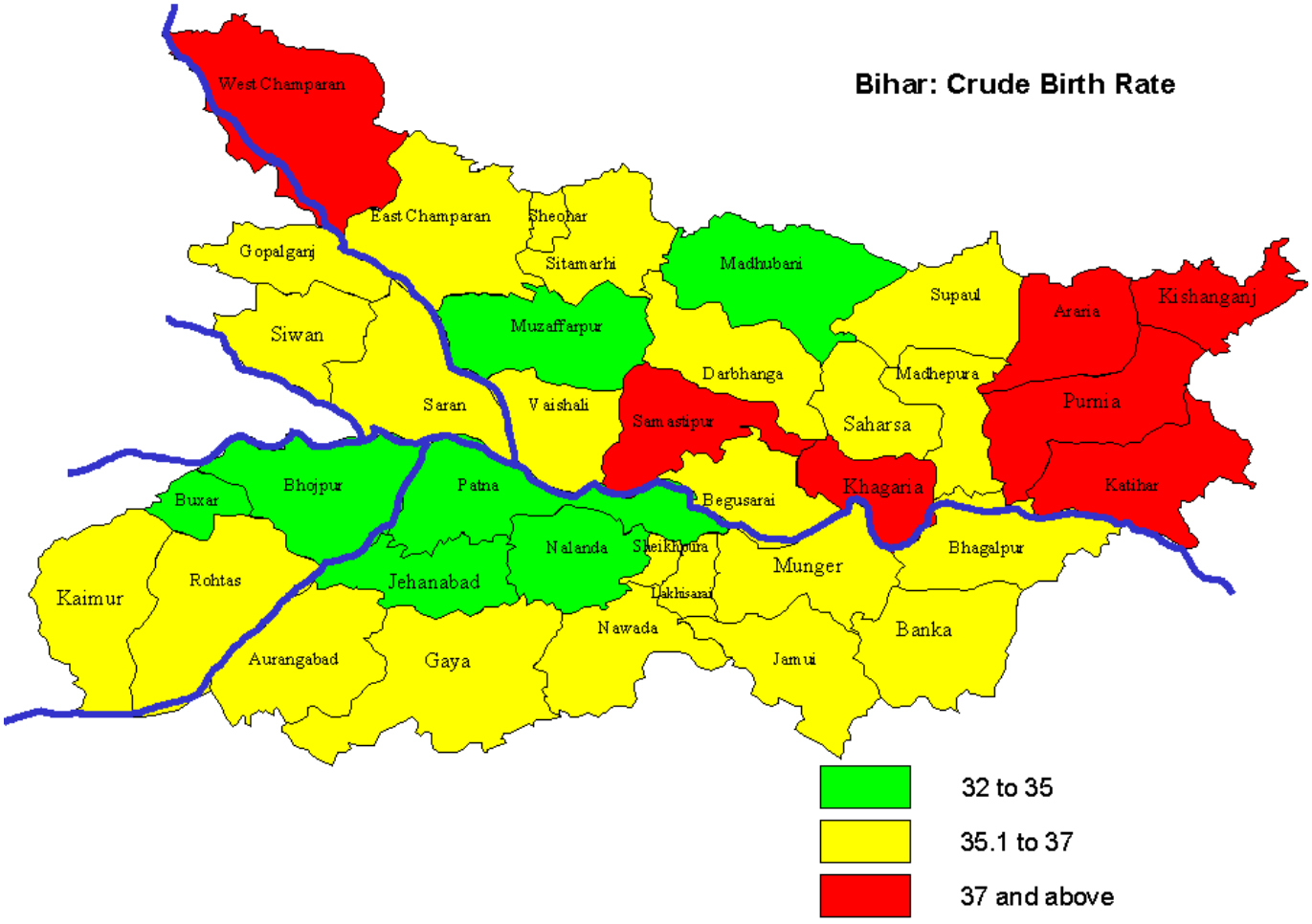


Table 5.5.8: Ranking of Districts based on key health Indicators

SL NO	District	Maternal Health (RHS - I, 1998-1999)					Rank	Child Health		Complete Immz. (RHS-I)	Rank	Family Planning		CBR (PFI)	Rank
		% of institutional delivery	Rank	% of safe delivery	Rank	% of preg. Women with full ANC		IMR (PFI)	Rank			CPR (RHS-I, IIPS 98-99)	Rank		
1	Araria	6.8	26	10.2	26	7.0	19	102	37	20.4	15	26.5	4	38.8	35
2	Aurangabad	18.8	7	22.5	8	4.6	26	62	10	18.3	19	21.1	17	35.8	18
3	Banka[1]							62	9					35.8	17
4	Begusarai	15.7	11	19.0	12	12.5	2	76	22	16.4	22	21.9	14	36.0	22
5	Bhagalpur	14.1	14	18.5	15	10.4	5	62	8	25.2	8	24.7	6	35.8	16
6	Bhojpur	31.9	2	40.1	2	11.1	4	55	6	12	27	22.9	11	35.0	7
7	Buxar	28.3	3	29.7	3	6.9	21	55	5	24.1	10	19.4	24	35.0	6
9	Champaran E	9.6	21	12.1	23	8.4	10	60	7	15.4	24	19.3	25	35.9	19
37	Champaran W	43.7	1	48.0	1	15.3	1	83	32	36.8	1	35.3	1	40.7	37
8	Darbhanga	12.0	18	14.2	20	8.6	9	77	24	21.8	12	25.2	5	35.3	14
10	Gaya	12.1	17	14.9	18	6.7	22	81	30	24.3	9	21	18	36.5	28
11	Gopalganj	17.0	10	20.4	10	7.5	15	53	4	21.2	13	14.5	30	36.0	21
12	Jamui[1]							70	18					35.3	13
13	Jehanabad	26.0	4	28.0	4	7.1	18	81	29	27.1	5	20.6	20	33.7	3
14	Kaimur[1]							67	14					36.3	25
15	Katihar	6.1	29	8.0	29	7.0	20	77	23	25.7	7	17.2	27	39.5	36
16	Khagaria	10.4	20	16.9	17	10.4	6	85	34	26.3	6	26.8	3	37.3	31
17	Kishanganj	6.7	27	8.2	28	6.5	24	11.3	1	11.4	28	15.5	29	37.4	33
18	Lakhisarai[1]							70	17					35.3	12
19	Madhepura	9.0	23	11.5	24	3.8	28	82	31	15.8	23	24.4	8	36.6	29
20	Madhubani	7.4	25	9.8	27	5.9	25	65	12	17.9	20	21.8	16	33.6	2
21	Munger	17.9	8	19.4	11	8.0	12	70	16	11	29	21.9	15	35.3	11
22	Muzaffarpur	10.6	19	17.4	16	7.7	14	84	33	30.1	3	24.7	7	34.9	5
23	Nalanda	23.2	5	27.1	5	9.6	7	73	21	13.2	26	23.9	9	34.3	4
24	Nawada	17.8	9	22.4	9	7.4	16	79	25	28.7	4	19.7	23	35.8	15
25	Patna	12.4	16	14.5	19	7.8	13	80	26	14.2	25	20.8	19	32.6	1
26	Purnia	5.3	30	12.5	22	3.9	27	89	36	17.3	21	22.6	12	38.1	34
27	Rohtas	21.1	6	26.3	7	9.3	8	67	13	8.4	30	20	22	36.3	24
28	Saharsa	9.4	22	13.6	21	6.7	23	72	20	20.1	16	27.7	2	36.4	27
29	Samastipur	6.6	28	7.6	30	3.4	29	87	35	19.6	17	22	13	37.4	32
30	Saran	14.8	12	26.7	6	8.4	11	64	11	20.9	14	17.5	26	36.1	23

31	Sheikhpura[1]							70	15					35.1	8

Table 5.5.8: Ranking of Districts based on key health Indicators

SL NO	District	Maternal Health (RHS - I, 1998-1999)					Rank	Child Health		Complete Immz. (RHS-I)	Rank	Family Planning		CBR (PFI)	Rank
		% of institutional delivery	Rank	% of safe delivery	Rank	% of preg. Women with full ANC		IMR (PFI)	Rank			CPR (RHS-I, IIPS 98-99)	Rank		
32	Sheohar[1]							81	28					35.3	10
33	Sitamarhi	8.2	24	11.5	25	3.3	30	81	27	18.6	18	16.6	28	35.3	9
34	Siwan	14.4	13	18.8	14	11.8	3	43	2	30.8	2	20.4	21	36.0	20
35	Supaul[1]							72	19					36.4	26
36	Vaishali	13.9	15	19.0	13	7.3	17	46	3	22	11	23.1	10	36.8	30

*1: At the time of RHS - I, 1998-99, these districts (*Banka, Jamui, Kaimur, Lakhisarai, Sheohar and Supaul) *were part of other districts so no district specific RHS data.*

5.6 Human Resources Development including Training

Given the scale of operations and the technical nature of the RCH programme, a well-structured human resource management system is critical. However, even at the end of the RCH-I, a human resource management system has not been developed. This has resulted in a situation characterised by a huge number of vacancies, lack of clarity regarding staff roles and responsibilities, ad hoc transfers and postings of key personnel and a weak performance appraisal system. The state also does not have a comprehensive and consistent training policy for medical and para-medical staff. The major issues pertaining to human resource management for RCH in the state are as follows.

Recruitment / Selection of Personnel

The Bihar Public Service Commission (BPSC), the nodal agency for recruitment of all government staff in the state is also the nodal agency for the recruitment of staff in the RCH programme. However, due to procedural delays selection process of the BPSC often recruitment of personnel gets inordinately delayed. This has led to a large number of vacancies at all levels, ranging from 10% to 50%, severely affecting the programme implementation.

Roles and Responsibilities of Health Personnel

In the absence of a human resource management system, confusion prevails at all levels of staff regarding their specific roles and responsibilities including the reporting structure within the RCH programme. This leads to dilution of accountability of the key officials involved in the programme.

Transfer and Posting of key Personnel

Guidelines regarding posting and transfer of key personnel within the RCH programme are not clearly laid down. These are usually done on an ad hoc basis. This results in irrational deployment of staff wherein generalists are placed in specialist posts and vice versa.

Performance Appraisal

The existing performance appraisal system for the RCH programme personnel in the state is inconsistent, and outdated. Promotions are time-bound and not based on performance. This is one of the major de-motivating factors for the staff.

Training

Although the lack of both managerial and technical skills of staff at all levels of the RCH programme has been identified as one of the major impediments for effective programme implementation, the state does not have a comprehensive training policy to enhance skills of programme personnel. The lack of resources both physical infrastructure and skilled personnel for training translates into a situation where staff do not receive either pre-service or in-service training required to perform their duties at optimal level.

5.7 Inequity/Gender

Data obtained from sources such as RHS (I & II) and NFHS (II) on Bihar, shows wide disparities in health indicators revealing an inequity based on socio-economic class and gender. Health indicators are invariably the worst for women, illiterates, people living in rural areas, Scheduled Castes and Muslims. Relatively higher levels of fertility, infant mortality, malnutrition, and reproductive health problems characterise these groups. The underlying causes of these differentials are complex and myriad and are both internal and external to the communities involved. While the various factors are outlined separately below, they are in reality, often closely inter-linked and synergistic.

Gender

One of the broad indicators for measuring gender disparity is the sex ratio. The sex ratio in Bihar is unfavorable to women. Analysis of other indicators on the basis of gender reveals widening gaps between the sexes. While NMR for females is marginally higher than that of males, it widens further for the IMR, and even further for the under-five Mortality Rate. In conditions of absolute poverty, where resources to food and health care are severely limited, preference is given to the male child, resulting in higher female malnutrition, morbidity and mortality.

Gender discrimination continues throughout the life cycle, as well. Women are denied access to education, health care and nutrition. While the state's literacy rate is 47.5%, that for women in rural areas is as low as 30.03%. Abysmally low literacy levels, particularly among women in the marginalised sections of society have a major impact on the health and well being of families. Low literacy rate impacts on the age of marriage. The demand pattern for health services is also low in the poor and less literate sections of society.

Women in the reproductive age group, have little control over their fertility, for want of knowledge of family planning methods, lack of access to contraceptive services and male control over decisions to limit family size. According to NHFS-II data, for 13% of the births, the mothers did not want the pregnancy at all. Even where family planning methods are adopted, these remain primarily the

concern of women, and female sterilisation accounts for 19% of FP methods used as against male sterilization, which is as low as 1%.

In terms of nutritional status too, a large proportion of women in Bihar suffers from moderate to severe malnutrition. Anaemia is a serious problem among women in every population group in the state, with prevalence ranging from 50% to 87% and is more acute for pregnant women.

Rural/Urban

Rural-urban differentials in access to health care and resultant outcomes in fertility, mortality and morbidity in Bihar mirror those of the rest of the country. For example, NHFS-II data reveals that 50% of girls between the age group 15-19 in rural areas already married as against 24% in urban areas. This disadvantage that rural populations in the state face in terms of access to care is further compounded by other geographical features such as distance from the state capital and vulnerability to annual flooding. It is the socially disadvantaged - Scheduled castes and Muslims who often inhabit such areas.

Ethnicity

Muslims and Scheduled Caste populations in the state are characterized by lower incomes and literacy levels. Not surprisingly, they also report consistently higher fertility, morbidity and mortality rates. Muslim women (50%) are more likely to have reproductive health problems than Hindu women (43%). Deep-rooted social discrimination and lack of cultural sensitivity of the health providers towards them, effectively excludes them from seeking care.

Economic Class

Health outcomes are determined by a number of factors outside of health services, such as poverty, which increase exposure and reduces resistance to disease. A majority of the state's rural poor have little access to curative public health facilities. Private care is beyond their reach and even utilization of health facilities that are free at the point of contact involves invisible charges that they cannot bear, effectively denying them even the most basic health services. Higher fertility in this group is directly related to higher IMR, as well as the economic contribution of additional children to the family's income.

5.8 Logistics

Inadequate supplies of drugs, consuables ,equipments etc, at different levels have been identified as one of the major bottlenecks. However, as discussed in the Background and Current Status section of this document, there is no logistics management system either at the state and/or regional/district levels to support logistics of the RCH program. This has adversely affected the program implementation at different levels. The major issues related to the logistics management system for RCH are outlined below.

Forecasting

Since RCH is a target -free programme, biannual forecasting of essential supplies is to be based on assessment of actual community needs using standard CNA tools for RCH. However, in Bihar this assessment is often partial and not completed on time. This leads to a situation where the forecasting at the state level is based on past trends and informed guesswork. In the absence of a sound forecasting mechanism, the state often encounters over-supply and/or under-supply of items.

Indenting and Procurement

The bulk of essential supplies in RCH come directly to districts from GoI, since the state/districts do not have a proper indenting mechanism, the state/district is not aware about the delivery schedule of these consignments. Under the RCH programme, certain items are to be procured by the State/District for which purchase committees have been constituted for this purpose. However, due to ambugity in the rules and regulations for the purchase, there are usually inordinate delays in procurement of essential items.

Record-keeping

Although detailed records of stocked items are kept at all levels of the RCH programme, these are done entirely manually. These documents are stored poorly and unsystematically, making easy retrieval of information difficult, in most cases.

Transportation, Warehousing and Inventory Management

There is no structured system in the state for transportation and proper storage of supplies of the RCH programme, particularly at district and sub-district levels. Since there is no allotment of funds for transportation of supplies the programme managers often have to use their official vehicles for this purpose. However, due to lack of adequate POL support, this option is also not always available and supply remains inadquate. Similarly, the state does not have adequate warehousing facilities and it has to manage with one state level and two regional warehouses. At the district and sub-district levels there is no warehouse for storage of supply. The storekeepers are also not trained in scientific warehousing techniques.

5.9 HMIS

A well developed, health management information system (HMIS) is essential to support evidence-based decision making for program planning, implementation and supervision & monitoring. However, the RCH program in Bihar is characterised by a health management information system, which consists only of manual and fragmented collection and collation of program data using the nine forms discussed earlier. Therefore, the HMIS in the state merely collects, collates and reports data with no mechanism in place to analysis and provide feedback to the program managers.

At all levels, there is acute shortage of physical infrastructure and skilled personnel for HMIS. At the state level, the State Demographic Cell is staffed by a State Demographer, five Statistical Assistants (as against the sanctioned posts of 8) and one clerk-cum-typist. Other sanctioned posts that are vacant at the state cell are of one Social Scientist, three Computer Programmers and one Assistant. However, as the state Demographic Cell lacks even a single computer data continues to be collected, collated and reported manually. Similarly at the district level, the HMIS of the RCH program continues to suffer due to a shortage of physical infrastructure and skilled human resources. The data suggests that against the 27 sanctioned posts each of Statisticians and Computer Clerks for the office of the ACMO across the state, only 12 posts are filled. For the Office of District RCH officer, there are again 27 sanctioned posts of Statistical Assistants of which only 6 have been filled. Though computers have been supplied to most districts, all remain virtually unused in the absence of skilled personnel and/or other issues such as lack of power, unavailability of proper infrastructure etc. The situation at the PHC level is worse. As per the available data, there are 394

sanctioned posts of Computer Personnel for 398 PHCs in the state. However, of the 394 posts only 328 have been filled. All data entry at the PHC level too is done manually.

Apart from the shortage of physical infrastructure and skilled personnel for HIMIS in the state, the other major issues affecting HMIS functioning are as follows:

- Often health facilities at districts and sub-district do not have the reporting forms (form 1 to 9)
- Generally, district and sub-district health facilities do not submit their data on time and usually the forms submitted by them are not correctly and/or fully filled
- Due to usual procedural delays in collection, collation and reporting of CNA, district and state level plans are not based on actual community needs
- Frontline health workers are overburdened with filling up too many forms, which often also involve a great deal of duplication. Frequent changes in formats and contradictory instructions, add to their confusion and misery

It appears that the key reason for most of the weaknesses in the existing HMIS of the state is the lack of a Systems Approach. Therefore, the HMIS in the state needs to be strengthened to ensure provision of required information at each level of management at the right time and in the right formats.


LESSONS LEARNT
FROM RCH I
IMPLEMENTATION

6. LESSONS LEARNT FROM RCH I IMPLEMENTATION

6.1 Project Summary of RCH I

RCH I primarily aimed to bring about integration of all interventions of fertility regulation, maternal and child health with reproductive health. In a radical departure from previous family planning programs, RCH I envisaged services to be provided based on the needs of the community arrived at through decentralized participatory planning and a target free approach. Services were planned to be client-centered, demand-driven and of high quality. The programs also envisaged up-gradation of facilities for providing various interventions and quality of care. The access of the community to essential services was also to be improved particularly through improvement in outreach services.

Summary of Programme Interventions

- Child survival interventions as under CSSM programme
- Safe motherhood interventions as under CSSM programme
- Facilitation for operationalisation of Target Free Approach
- Institutional Development
- Integrated training package
- Modified Management Information System
- IEC activities & counseling on health, sexuality and gender
- District sub-projects under Local Capacity Enhancement
- RTI/ STI clinics at district hospitals
- Facility for safe abortions at PHCs
- Enhanced community participation

The RCH I programme achievement wsa poor in Bihar due to reasons discussed below. Low level of achievement is reflected in the pattern of utilisation of funds allotted by GoI. However, the state was able to implement certain components of the programme that are outlined below.

RCH Camps

Funds were released to 11 districts and 480 RCH Camps were held. While it is recognised by the service providers that these camps have a positive impact in terms of increasing access in un-served and under-served areas as well as in increasing acceptance.

IEC

IEC activities were implemented through Zilla Saksharta Samitis in 12 districts (Jamui, Araria, Banka, Bhojpur, Khagaria, Lakhisarai, Madhubani, Munger, Saharsa, Siwan, Supaul, and Vaishali).

Outreach service and 24 hours Delivery

Rs.89.76 lakhs were allocated for the RCH outreach scheme for 17 districts.

Training

Training of key health care providers was a critical component of RCH I and comprised of trainings of ANM, LHV, MO, MHW and Dais. Training was also planned for Awareness generation and skill development. Funds for conducting Dai Trainings were released to 23 districts and 5969 dais have been trained. Training for New-Born Care was also held in Patna, Nalanda and Madhubani, though essential equipment for new-born care was not supplied. In-service training of frontline health staff such as ANM, LHV, MO, MHW has been conducted ,however only 29%, 15.98%, 20.20% and 8.02% of the total strength of each cadre having received training respectively. In terms of Specialised Skill Training in procedure such as MTP, Minilap, NSV and IUD about 9.09%, 11.87%, 9.85% and 0% of providers being trained. For Specialised Management training, only 37.16% of trainings were conducted, however for Specialised Communication training, only 21.35% trainings were held.

In service Training											
ANM			LHV			MO			HW (M)		
Load	Trained	% Trained	Load	Trained	% Trained	Load	Trained	% Trained	Load	Trained	% Trained
8781	2547	29	876	140	15.98	792	160	20.20	3664	294	8.02

Specialized Skill Training											
MTP			Minilap			NSV			IUD		
Load	Trained	% Trained	Load	Trained	% Trained	Load	Trained	% Trained	Load	Trained	% Trained
396	36	9.09	396	47	11.87	396	39	9.85	9647	0	0

Specialized Management training			Specialized Communication training		
Load	Trained	% Trained	Load	Trained	% Trained
55	148	37.16	120	562	21.35

NGO Involvement

NGOs were to be involved in both community mobilization and service delivery for RCH I. 12 MNGOs working in 22 districts were selected by GoI. However, the MNGO program and MNGOs were involved only in community mobilization rather than in service delivery.

Incentive Schemes

Under Community Incentive Scheme, Department of Family Welfare, Government of India, released Rs.70 lakhs to Bihar in 2001 – 2002 to encourage involvement of village communities for population stabilization and improving the overall health conditions of people in villages through the involvement of village Panchayats.

6.2 Lessons Learnt

As mentioned earlier, the achievement of RCH I was low in the state, though few components that were successful and could be recommended for continuation or expansion. However, poor planning and implementation provide important lessons which need to be incorporated in RCH II. These are outlined below.

Table 6.2.1: Lessons Learnt

	Impediment	Lesson Learnt
Management and Institutional	Inadquate management structure at the state and district levels with regard to the RCH programme.	Rework the Organogram for both the state and district levels to clearly demarcate roles and responsibilities of key officials involved in the RCH programme along with their reporting relationships
	Low performing SCOVA resulted in poor programme management.	Make SCOVA/ SHSB fully functional with all administrative and financial resource.
	Lack of financial management capacity leading to under-utilization of funds.	Involve personnel with requisite financial management skills (CA / MBA Finance) exposure to large-scale government finances
	Lack of adequate skills and capacity - technical and managerial and also inadequate capacity building initiatives	Impart ongoing, structured training to enhance managerial and technical capacity of GoB officials involved with RCH II at different levels
	Low level of ownership and commitment to RCH	Ensure active involvement of state in RCH planning, implementation, supervision and monitoring.
	Large number of sanctioned posts vacant.	Develop alternate Strategies (contract) for hiring personnel/consultants
	Centralization of authority, processes and modalities	Decentralize authority, processes and modalities at all levels of service delivery
	Lack of motivation and accountability among service providers for RCH	Institute innovative methods for reward and punishment for service providers at all levels.

Coordination	Weak inter-departmental collaboration	Outline clear roles and responsibilities of all collaborating departments and mechanisms to ensure coordination for the implementation of RCH plan of action.
	Non-involvement of communities, NGOs, and PRIs in planning, management and supervision and monitoring of the programme.	Develop mechanism for workable partnership with NGOs, CBOs and d PRIs in the plan process.
Strategic Inputs and Systems	Lack of timely supply of kits, drugs and other supplies and consumables	Assess major procurement and logistical bottlenecks and develop specific plans to address them
	Weak monitoring and evaluation system, including lack of mobility support	Develop user friendly monitoring and evaluation system for all levels. Ensure adequate provision to ensure mobility support for all levels.
	Limited use of mass-media, communication channels and inter-personal communication to increase awareness about RCH	Strengthen State and district level mass media cells. Develop tailor-made BCC strategies for RCH and various services under it.
Quality and Infrastructure	Poor emergency care and referral backup particularly in rural areas	Clearly earmark adequate resources, for strengthening of emergency medical services district and sub-divisional hospitals and operationalisation of FRUs, along with adequate referral backup in the RCH plan
	Insufficient public health facilities including bed strength at all levels and particularly at sub-district levels (RH, PHC and SHC)	Build more public health facilities (RH, PHC and SHC) according to population as per GoI norms.

	Non operationalisation of FRUs due to weak infrastructure, poor accessibility, lack of essential supplies and absence of staff with requisite skill sets.	Provide resources to ensure proper physical infrastructure, essential supplies and requisite staff to the health facilities identified for upgradation as FRUs in the RCH plan.

RCH II PROGRAM OBJECTIVES AND STRATEGIES

7. RCH II PROGRAMME OBJECTIVES AND STRATEGIES

7.1 Vision Statement

The State envisages to undertake proven strategies and activities to bring a paradigm improvement in the status of Reproductive and Child Health of the people in general and disadvantage sections in particular.

7.2 Technical Objectives, Strategies (or Interventions) and Activities

In line with the vision for the improved maternal and Child health scenario in the State, Department of Health and Family Welfare, has set specific goals for key RCH outcome indicators. The goals have been set for both Medium-term (2007-08) and Long-term (2009-10) and are in sync with GoI goals for EAG states.

The Medium-term (2007-08) RCH II program goals are as follows:

- Reduce the Maternal Mortality Rate in the state by about 17% (from 452 to 375)
- Lower the Infant Mortality Rate in the state by about 15% (from 62 to 52)
- Reduce the Neonatal Mortality Rate in the state by about 15% (from 46.5 to 39)
- Decrease TFR from 3.4 to 3.0 (reduction of about 11%)

The Long-term (2009-10) RCH II program goals are as follows:

- Reduce the Maternal Mortality Rate to 275 (reduction of about 40% from present level)
- Reduce the Infant Mortality Rate by about 44% to 35
- Lower the Neonatal Mortality Rate by about 45% to a level of 25
- Fertility Rate down to 2.25 from existing level of 3.4 (reduction of about 37%)

Table 7.2.1: RCH Outcomes in the State: Goals

Outcomes Indicators	State			India		
	Current Status	Goal		Current Status	Goal	
		2006-07	2009-10		2006-07	2009-10
MMR[1]	452	375	275	407	200	<100
IMR[2]	62	52	35	66	45	<30
NMR[3]	46.5	39	25	45	26	20
TFR[1]	3.4	3.0	2.25	3.2	NA	2.1

Source: [1] MMR & TFR: (NFHS II 1998-99, [2] IMR: (SRS 2001), [3] NMR: (SRS1998)

7.2.1 Maternal Health (including MMR, RTI/STI)

Goals and Objectives

The over-arching goal for maternal health is to reduce MMR in the State by about 17% (from 452 to 375) by the year 2006-07 and by about 40% from present level (275) by the year 2009-10, with emphasis on the SC community, socially economically and geographically deprived communities specially in rural areas.

The specific RCH II program objectives for Maternal Health are as follows:

- Improve coverage of timely and quality ANC services
- Strengthen maternal health services to ensure safe delivery
- Increase community awareness about need and benefits of ANC, Institutional delivery and PNC services

Strategies and Activities

Objective 1: To improve coverage of timely and quality ANC services

The strategies and activities to improve coverage of timely and quality ANC services for pregnant women are briefly outlined below:

[1.1] Increase availability of ANC services through reinforced network of frontline ANC service providers

- Fill vacant ANM posts by the end of 2005-06 and appoint additional ANMs in a phased manner to achieve GoI norm of one ANM for 5000 population by the year 2009-10. *(For details refer to section 7.3.1.3)*
- Issue necessary departmental instructions to re-emphasize provision of ANC services in the job description of ANMs.
- Utilize network of ASHAs (as and when available).

[1.2] Strengthen supervisory network to support network of frontline ANC service providers

- Fill vacant LHV posts by hiring LHVs on contract basis by the end of 2006-07 and appoint additional LHVs in a phased manner to achieve GoI norm of one LHV for every five-health sub-center by the year 2008-09. *(For details refer to section 7.3.1.3)*
- Issue necessary departmental instructions to re-emphasize that supervision of RCH related activities is one of the major tasks of PRIs.

[1.3] Ensure delivery of ANC services through strengthening of health sub-centers, APHCs and PHCs *(For details refer to section 7.3.1.2)*

- Strengthen network of existing health sub-centers (9140) and PHCs (398) to ensure at least one weekly ANC clinics at all levels by the end of 2006-07.
- Expand network of health facilities at sub-district level in a phased manner to achieve GoI norms of one health sub-center for 5000 population and one PHC for every 30,000 population by the year 2009-10 by building additional Health Sub-centers and upgrading APHCs to PHCs.

[1.4] Ensure timely and adequate supply of essential equipment and consumables with frontline ANC providers (ANMS and LHVs) and health facilities (HSCs, APHCs and PHCs)

- Supply BP instruments and weighing scales to all ANMs and LHVs in phased manner.
- Ensure timely and adequate supply of essential consumables such as Kit A and Kit B at health sub-centers. Supply required reporting formats and stationary to frontline ANC providers and health facilities.

[1.5] Build capacity of frontline ANC service providers (ANMs and LHVs) *(For details refer to section 7.3.2.2)*

- Provide comprehensive skill upgradation training to frontline ANC service providers to ensure delivery of quality ANC services
- Conduct training to build capacity of LHVs for effective supervision and monitoring.

[1.6] Form inter-sectoral collaboration to increase awareness, reach and utilization of ANC services

- Develop working arrangements with ICDS, Social Welfare Department and PRIs to ensure coordination at all levels
- Involve Anganwadi Workers, PRIs, ASHAs, etc. to identify pregnant women in the community and motivate them to avail ANC services
- Involve ICDS, NGOs and PRIs, ASHAs networks in behavior change communication for ANC. *(For details refer to section 7.3.4)*

Expected Results

The expected results of the interventions planned for ANC Services are:

- Increased timely registration of pregnant women for ANC coverage from 15% to 55%
- Increased full ANC coverage (3 or more) for pregnant women from 9.5% to 40%
- Increased TT injection and IFA Tabs coverage for pregnant women to 80% from the present levels of 57.8% & 24.1% respectively.
- Decreased percent of women with moderate/severe anemia to a level of 30% from the present level of 63.4%.

Objective 2: Strengthen maternal health services to ensure safe delivery

The strategies and activities to strengthen maternal health services to ensure safe delivery are briefly outlined below:

[2.1] Promote institutional delivery through reinforced network of PHCs, CHCs/Referral Hospitals, Sub-divisional Hospitals and District Hospitals, Medical College Hospitals.

- Provision of 24 -hour delivery and basic emergency services at PHC level.Doctors conducting delivery at PHCs between 7 P.M. and 7 A.M. will get an incentive of Rs. 500/ per delivery; the nurse will get rs 200/; and female assistant rs 100/ per delivery. *(For details refer to section 7.3.1.2)*
- Provision of comprehensive EmOC including caesarian section and blood storage facilities at 190 FRUs that are to be operationalised in a phased manner by the year 2009-10. *(For details refer to section 7.3.1.2)*
- Impart refresher training to Gynecologists and Obstetricians on safe delivery practices and referral procedures. (For details refer to section 7.3.2.2)
- Provide resources to FRUs (Referral Hospitals, Sub-divisional Hospitals and District Hospitals) for hiring of services of Anesthetists from the private sector for caesarian sections (@ Rs. 500 per case).

[2.2] Promote institutional delivery by involving private sector/NGO providers of EmOC in un-served and under-served areas

- Pay incentives for every institutional delivery, (@Rs 500 for normal delivery and Rs 2000 for caesarian section) of BPL families conducted by private sector and NGO providers contracted through the MNGO network, in identified un-served and under-served areas.

[2.3] Ensure safety of deliveries at home

- Ensure availability of Disposable Delivery (DD) kits with AWW/ANMs/TBAs and LHVs.
- Train all ANMs, LHVs and Nurses in safe delivery practices and PNC services in a phased manner. *(For details refer to section 7.3.2.2)*
- Train Traditional Birth Attendants (TBAs) in safe delivery practices and PNC services in a phased manner through NGOs and frontline health workers. *(For details refer to section 7.3.2.2)*
- Supply adequate DD kits to TBAs through ANMs, LHVs and/or NGO networks.

[2.4] Revamp existing referral system for emergency deliveries

- Train all ANMs, LHVs, Nurses and TBAs in identification of danger signs during delivery, referral procedures and PNC services. *(For details refer to section 7.3.2.2)*
- Provide resources under Janani Surksha Yojna (JSY) to ANMs and ASHAs to facilitate referral of emergency cases of BPL families (@ Rs. 500 per case)
- Provide resources at PHC level for contracting out transport for referral of EmOC cases @ Rs.500 per case for BPL families.

[2.5] Form inter-sectoral collaboration to increase awareness regarding safe delivery and referral

- Involve NGOs, ICDS, PRIs and ASHA network network to raise community awareness and knowledge about importance of institutional delivery, safe delivery practices at home, referral and PNC services.
- Involve PRIs to supervise utilization of resources under JSY for referral support to BPL families.

Expected Results

The expected results of the interventions planned for safe delivery are:

- Increased institutional deliveries from 15% to 40%
- Increased percentage of deliveries by skilled birth attendants (doctors, nurses, ANMs) from 23.3% to 55%
- 1551 PHCs operationalised to provide 24 hours delivery and Basic EmOC as per GoI norms
- 190 FRUs operationalised to provide comprehensive Emergency obstetric care, Caesarian section and blood storage/banking facilities according to GoI norms
- Increased coverage of PNC services from 10% to 25%

Objective 3: Increase community awareness about need and benefits of ANC, Institutional delivery and PNC services

The specific strategies and activities to achieve this objective have been discussed in the previous sections of 1.6 and 2.5

Expected Results

The expected results of the interventions planned for raising community awareness and knowledge of maternal health services are:

- Increased community awareness about need and benefits of ANC, Institutional delivery and PNC services

(Note: For year-wise details of expected results of planned interventions to improve Maternal Health services, refer Table 7.2.1.1)

Table 7.2.1.1: Specific Year-wise Objectives for Maternal Health						
Process/Intermediate indicator	**Current status**	**Yearly Objectives**				
	1998-99	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
(1) % of pregnant women getting registered in first trimester						
Overall	15.1	20	26	34	45	55
SC						
Urban/Rural	38.2/12.9					
(2) % of pregnant women receiving 3 or more antenatal checks						
Overall	9.5	13	17	22	30	40
SC	NA					
Urban/Rural	17.1/8.8					
(3) % of pregnant women receiving 2 doses of tetanus toxoid injections						
Overall	57.8	65	72	80	80	80
SC	50.3	57.5	68	75	80	80
Urban/Rural	78/55.9					
(4) % of pregnant women receiving 100 tablets of IFA						
Overall	24.1	30	40	52	65	80
SC	18	24	35	47	60	75
Urban/Rural	46.1/22					
(5) % of eligible women with no ANC						
Overall	63	55	50	45	40	35
SC	70.7	62	55	48	42	35
Urban/Rural	30.6/65.6					
(6) % of women with moderate/severe anemia						
Overall	63.4	55	47.5	40	35	30
SC	67	60	54	47.5	40	34
Urban/Rural	59.6/63.7					
(7) % of institutional delivery						
Overall	15	18	22	27	33	40
SC	8	10	13	17	22	30
Urban/Rural	40.1/12.1					

Process/Intermediate indicator	Current status	Yearly Objectives				
	1998-99	2005-06	2006-07	2007-08	2008-09	2009-10
(8) % of delivery in a public health facility						
Overall	4	5	6	7.5	9	11
SC	2.5	3	4	5.5	7	10
Urban/Rural	11.9/3					
(9) % of delivery in a private health facility						
Overall	11	13	16	19.5	24	29
SC	5.5	7	9	11.5	15	20
Urban/Rural	28.2/8.9					
(10) % of deliveries by skilled birth attendants (doctors, nurses, ANMs)						
Overall	23.3	28	33	40	47.5	55
SC	17.7	20	25	32	40	52
Urban/Rural	51.9/20.6					
(11) % of pregnancies with complications which need and receive EmOC						
Overall	NA	20	24	29	35	40
SC	NA	10	13	17.5	23	30
Urban/Rural	NA					
(12) Number of facilities operationalised to provide 24 hours delivery and Basic Emergency Obstetric Care according to						
Sub-divisional Hospitals (23)	23	23				23
PHCs (398)	NA	398	898	1550	2100	2500
(13) Number of facilities operationalised in a sustained manner as per GOI norms for providing Comprehensive Emergency obstetric care Caesarian section and blood storage/banking facilities						
District hospitals (25)	18	25				25
Sub-divisional Hospitals (23)	NA					23
FRUs (101)	0					190
(14) % with PNC within 2 months of birth						
Overall	10	12.5	15	18	21	25
SC	9.2	11	13	16	20	25
Urban/Rural	10/10.1					

7.2.2 Child Health (including IMR, NMR)

Goals and Objectives

The over-arching goal for Child health is to reduce IMR and NMR in the State by about 15% (from 62 to 52) and 15% (from 46.5 to 39) respectively by the year 2006-07. The long-term goal is to reduce IMR and NMR by about 44% (35) and 45% (25) respectively by the year 2009-10. Like maternal health, even for child health emphasis has been on improving the health status of children from SC community and those living in rural areas.

The specific RCH II program objectives for Child Health are as follows:

- Promote immediate and exclusive breastfeeding and complementary feeding or children
- Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months
- Eradication of Poliomyelitis
- Increase early detection and care services for sick neonates in select districts through the IMNCI (Integrated Management of Neonatal and Childhood Illnesses) strategy
- Improve curative care services for children under three years of age for minor ARI and diarrhea

Strategies and Activities

Objective 1: Promote immediate and exclusive breastfeeding and complementary feeding for children.

The strategies and activities to promote immediate and exclusive breastfeeding and complementary feeding for children till 6 months of age are briefly outlined below:

[1.1] Use mass media (particularly radio) to promote breastfeeding immediately after birth (colostrum feeding) and exclusively till 6 months of age. *(For details refer to section 7.3.4)*

- Production and broadcast of radio spots, jingles, folk songs and plays promoting importance of correct breastfeeding practices
- Production and broadcast of TV advertisements and plays on correct breastfeeding practices
- Publication of newspaper advertisements and stories on correct breastfeeding practices

[1.2] Increase community awareness about correct breastfeeding practices through traditional media

- Train frontline Health workers, Anganwadi Workers, PRIs, TBAs, local NGOs and CBOs in correct breastfeeding and complementary feeding practices *(For details refer to section 7.3.2.2)*
- Involve frontline Health workers, Anganwadi Workers, PRIs, TBAs, local NGOs and CBOs in promoting correct breastfeeding and complementary feeding through IPC, group meetings, folk media and wall writing.
- Educate adolescent girls about correct breastfeeding and complementary feeding practices through school -based awareness campaign. *(For details refer to section 7.3.4)*

Expected Results

The expected results of the interventions planned for promoting immediate and exclusive breastfeeding and complementary feeding for children are:

- Increased percentage of neonates breastfed on day one of life from 20% to 55%
- Increased proportion of children who are exclusively breastfed till 6 months of age from 36% to 60%

Objective 2: Increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months

[2.1] Conduct fixed day and fixed-site immunisation sessions according to district microplans.

- Fill vacant ANM posts by the end of 2005-06 and appoint additional ANMs in a phased manner to achieve GoI norm of one ANM for 5000 population by the year 2009-10. *(For details refer to section 7.3.1.3)*
- Update district microplan for conducting routine immunization sessions
- Ensure timely and adequate supply of vaccines and essential consumables such as syringes, equipment for sterilisation, *Jaccha-Baccha immunisation cards*, reporting formats at all levels.
- Supply AD Syringes to conduct outreach sessions in select areas.
- Provide mobility support to ANMs @ of Rs. 50 per session for collection of vaccines from PHCs and conduct outreach sessions and to Districts for collection of vaccines

from state/regional depot and supply to PHCs on weekly basis @ Rs.1000 per PHC per month.

- Enlist help of AWWs in identification of new-borns and follow-up with children to ensure full immunisation during sessions
- Replace all Cold Chain equipment, which is condemned, or more than five years old in a phased manner by the year 2006-07 and supply new Cold Chain equipment based on analysis of actual need of the health facilities
- Facilitate maintenance of Cold Chain equipment through annual maintenance contract with a private agency with adequate technical capacity.
- Provide POL support to State and Regional WIC/WIF facilities @ Rs. 15000 per month and @ Rs. 5000 per PHC per month to each PHCs for running of Gensets and minor repair
- Issue necessary departmental instructions to re-emphasize provision of ANC services in the job description of Anganwadi Workers.

[2.2] Build capacity of immunisation service providers to ensure quality of immunization services *(For details refer to section 7.3.2.2)*

- Provide comprehensive skill upgradation training to immunisation service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.
- Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunisation services
- Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment

[2.3] Form inter-sectoral collaboration to increase awareness, reach and utilization of immunisation services

- Develop working arrangements with ICDS and PRIs to ensure coordination at all levels
- Involve Anganwadi Workers and PRIs to identify children eligible for immunisation, motivate caregivers to avail immunisation services and follow-up with dropouts.
- Involve ICDS and PRI networks in behavior change communication for immunisation *(For details refer to section 7.3.4)*

[2.4] Strengthen Supervision and monitoring of immunization services

- Build capacity of Medical Officers, MOICs and DIOs in supervision and monitoring of implementation of immunisation services as per the micro-plan*(For details refer to section 7.3.2.2)*
- Provide mobility support to MOICs and DIOs for supervision and monitoring of implementation of immunisation services @ Rs. 1600 per MOIC per month and @ Rs. 3000 per DIO per month
- Develop effective HMIS to support supervision and monitoring of implementation of immunisation services
- Coordinate with representatives of PRI to strengthen supervision and monitoring of immunization services

Expected Results

The expected results of interventions to increase timely and quality immunisation service and provision of micronutrients for children in the age group of 0-12 months are:

- Increased antigen-wise Immunisation coverage for children in the age-group of 0-1 year to 60%
- Increased full Immunisation for children in age-group of 0-1 year from 11% to 30%
- Increased Vitamin A coverage from 10.2% to 60%
- Reduced percentage of children chronically undernourished from 53.7% to 30%

Objective 3: Eradication of Poliomyelitis

[3.1] As per Intensified Pulse Polio Immunisation Campaign (IPPI) based on ongoing Supplementary Immunisation Activities (SIAs).

Expected Results

The expected result of the Polio Eradication campaign is:

- No transmission after December 2005.

Objective 4: Increase early detection and care services for sick neonates in select districts through the IMNCI strategy in select districts.

The strategies and activities to increase early detection and care services for sick neonates in select districts through the IMNCI strategy are briefly outlined below:

[4.1] Build state IMNCI training pool *(For details refer to section 7.3.2.2)*

- Identify key persons to join IMNCI master training pool
- Form institutional contracts with key partners for training activities (e.g. IAP, NNF)
- Train members of master trainer pool in national level course

[4.2] (Re)train health and ICDS staff in IMNCI protocols *(For details refer to section 7.3.2.2)*

- Identify districts / training sites with adequate clinical material for training
- Recruit and train district trainers (using state master trainer pool)
- Train all health and ICDS staff in a phased manner

[4.3] Ensure implementation of IMNCI clinical work following training *(For details refer to section 7.3.1.2)*

- Implementation of IMNCI clinics in all HSCs of IMNCI districts
- Supply equipment and drugs as required per IMNCI protocols.

Expected Results

The expected results of interventions to increase early detection and care services for sick neonates in select districts through the IMNCI strategy are:

- 90% IMNCI district's villages have IMNCI trained workers
- 80% of IMNCI trained workers correctly following protocols
- 80% of new-borns visited 3 times within 10 days of birth
- 90% of IMNCI village workers with adequate supplies

Objective 5: Improve curative care services for children under three years of age for minor ARI and diarrhea

The strategies and activities to improve curative care services for children under three years of age for minor ARI and diarrhea are briefly outlined below:

[5.1] Upgrade the capacity of PHC/FRUs to delivery quality pediatric services

- Install New-born corners in FRU/PHC facilities *(For details refer to section 7.3.1.2)*
- Refresher training for PHC/MO on neonatal care *(For details refer to section 7.3.2.2)*
- Contract employment of paediatrician in all FRUs, if required following rationalisation of existing staff

[5.2] Involvement of private facilities to accept emergency referrals for BPL children

- Assess and accredit private neonatal facilities
- Formulate fee roster and referral / voucher system
- Reimburse claims and assess quality of private services delivered

[5.3] Raise awareness about early recognition of childhood illnesses, home-based care and care seeking*(For details refer to section 7.3.4)*

- Involve frontline health workers and Anganwadi workers to impart health education to community on early recognition of childhood illnesses, home-based care and care-seeking
- Use multiple mass media channels such as radio, TV, local cable networks, print media (local newspapers) to propagate early recognition of childhood illnesses, home-based care and care-seeking.

Expected Results

The expected results of interventions to improve curative care services for children under three years of age for minor ARI and diarrhea are:

- 70% of designated FRU/PHC with functional new-born care corner
- 70% of designated FRU with paediatrician
- 90% of PHC with MO trained in neonatal care within last 3 years
- Increased percentage of children under 3 years of age taken to a health facility/provider for treatment of minor ARI and Diarrhoea from present levels of about 60% to 80%

(Note: For year-wise details of expected results of planned interventions to improve Child Health services, refer Table 7.2.2.1)

Table 7.2.2.1: Specific Objectives for Child Health						
Process/Intermediate indicator	**Current status**	**Yearly Objectives**				
	1998-99	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
(1) % of neonates who were breastfed on day one of life						
Overall	20.7	25	30	37.5	45	55
SC	22.5	25	30	37.5	45	55
Urban/Rural	21.8/20.6					
(2) % of children age 0-3 months who were exclusively breastfed						
till 3 months of age	55.2	60	65	72	80	80
till 6 months of age	36	40	45	50	55	60
(3) % of children in the age group of 12-23 months who received vaccination						
BCG	37.7	40	45	50	55	60
DPT (3 doses)	24.2	27.5	32	40	47.5	60
Polio (3 doses)	41.0	45	50	55	60	60
Measles	16.6	20	30	40	50	60
Fully immunized	11	20	25	30	40	50
(4) % of children 12-35 months receiving at-least 1 dose of vitamin A						
Overall	10.2	15	25	40	50	60
SC	8.6	12	20	30	40	55
Urban/Rural	19.4/9.3					
(5) % of children under age 3 years with diarrhea taken to a health facility/provider						
Overall	50.3	55	60	65	70	80
SC	49.5	50	57.5	65	70	75
Urban/Rural	38.9/51.3					
(6) % of children under age 3 years with ARI taken to a health facility/provider						
Overall	58.2	*60*	*65*	*72*	*80*	*80*
SC	54.2	*60*	*65*	*72*	*80*	*80*
Urban/Rural	63.3/57.7					
(7) Nutritional Status of the children in the age group of 6-35 months						
% of Children with moderate/severe	*54.4*	*50*	*45*	*40*	*35*	*30*
% of Children chronically	*53.7*	*50*	*45*	*40*	*35*	*30*

7.2.3 Family Planning (TFR)

Goals and Objectives

The over-arching goal for Family Planning program in Bihar is to reduce the Total Fertility Rate by about 11% (from 3.4 to 3.0) by the year 2006-07and that by 37% (from 3.4 to 2.25) by the year 2009-10. Given the fact that in Bihar, close to 90% population is in rural areas virtually all strategies will be focused on the needs of rural areas.

The specific RCH II program objectives for Family Planning are as follows:

- Raise awareness and demand for Family Planning services among women, men and adolescents
- Increase access to and utilization of Family Planning services (spacing and terminal methods)

Strategies and Activities

Objective 1: Raise awareness and demand for Family Planning services among women, men and adolescents

The strategies and activities to raise awareness and demand for Family Planning services among women, men and adolescents are briefly outlined below:

[1.1] Extensive campaign using multiple channels to raise awareness and demand for Family Planning *(For details refer to section 7.3.4)*

- Plan communication campaign to promote Family Planning through different media using multiple approaches such as TV, Radio, Folk Media, Wall Painting, Print Materials and IPC, etc.
- Produce pre-tested and tailor-made IEC materials for various audience segments (adolescents, women, rural audiences, religious groups etc.
- Broadcast/ distribute AV and print IEC materials through various channels
- Organize biannual health mela at all blocks to promote Family Planning Services through Field NGOs.

[1.2] Broad inter-sectoral collaboration to promote small family norm, late marriage and childbearing

- Form partnership with NGO and civil society networks, religious organisations and leaders, PRIs, ICDS, Education, General Administration, Corporate Associations and Professional bodies (IAP, IMA) to promote Family Planning *(For details refer to section 7.3.4)*
- Orient and sensitize partners through annual district level workshops conducted by Mother NGO
- Orient and sensitize block-level partners through biannual district level workshops conducted by Field NGOs
- (Re) train frontline health workers, Anganwadi Workers and PRIs as motivators and counselors for family planning services through IPC and counseling *(For details refer to section 7.3.2.2)*
- Involve Registered Medical Practitioners (RMPs) and Practitioners of Indian Systems of Medicine (ISM) in the state to promote the small family norm, late marriage and child bearing.
- Advocate inclusion of promotion of small family norm, late marriage and child-bearing in school curriculum to orient school-going adolescents*(For details refer to section 7.3.4)*
- Explore and implement innovative approaches to promote Family Planning methods among men, through barbers, tea-shops, pan-shops, sports organizations etc. *(For details refer to section 7.3.4)*

[1.3] Promotion of Family Planning Services at community level through peer educators

- Identify acceptor couples to act as link couples to promote Family Planning services in select high fertility districts *(For details refer to section 7.3.4)*
- Select link couple /ASHA to work in the rural areas.

Expected Results

The expected results of interventions to raise awareness and demand for Family Planning services among women, men and adolescents are:

- Decreased Total Wanted Fertility Rate by about 42% (from 2.58 to 1.50).
- Increased demand for planning services by about 50% (from 49.1% to 75%).

- Increased awareness among women, men and adolescents about family planning services late marriage and childbearing

Objective 2: Increase access to and utilization of Family Planning services (spacing and terminal methods)

The strategies and activities to increase access to and utilization of Family Planning services (spacing and terminal methods) are briefly outlined below:

[2.1] Provide quality Family Planning Services through expanded network of health facilities and frontline health workers

- Strengthen and expand health facilities network at district and sub-district level and fill vacant posts for frontline health workers. *(For details refer to section 7.3.1.2 and 7.3.1.3)*
- (Re) train existing and newly appointed frontline health workers in various Family Planning methods, cafeteria approach for counseling various FP options available and on follow-up of acceptor couples. *(For details refer to section 7.3.2.2)*
- Impart technical skill-enhancement training to existing and newly appointed frontline health workers on provision of various spacing (Oral contraceptive, condom, IUD insertion, emergency contraception) and terminal (female and male sterilization) methods of Family Planning. *(For details refer to section 7.3.2.2)*
- Train doctors in various reversible and terminal FP procedures (MTP, Minilap , NSV and IUD) *(For details refer to section 7.3.2.2)*
- Ensure adequate and timely supplies of contraceptives, medical equipment and reporting formats at health facilities at all levels.
- Conduct monthly Family Planning clinics to provide terminal and spacing services at all district hospitals/SDHs, FRUs and PHCs.
- Organize biannual Family Planning Camps at all blocks (along with awareness raising health melas) to provide spacing and terminal FP services.

[2.2] Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives *(For details refer to section 7.3.4)*

- Collaborate with Bihar State AIDS Control Society (BSACS) to further promote marketing of condoms and also to promote other contraceptives.
- Collaborate with NGOs involved in Social Marketing of contraceptives in the state (Janani and PSI) to increase availability of contraceptives at grassroots levels
- Reinforce social marketing system of contraceptives through networks of MNGOs and FNGOs
- Use networks of frontline health workers (ANMs), Anganwadi workers, RMPs, SHGs, and PRIs to function as depot holders for community based distribution of contraceptives.

[2.3] Increase utilisation of Family Planning services through provision of incentives to acceptors and private providers of FP services.

- Provide incentive @ Rs. 500 to women if hospitalization for delivery is followed immediately by tubetomy/laproscopy, under the Janani Suraksha Yojana.
- Provide incentive @ Rs. 500 to women who on their own accord chose to undergo sterilization after a maximum of third live birth, under the Janani Suraksha Yojana.

Expected Results

The expected results of interventions to increase access to and utilization of Family Planning services (spacing and terminal methods) are:

- Increased contraceptives use by currently married women in the age-group of 15-49 by about 80% (from 27.45 to 50%)
- Reduced percentage of currently married women age 15-49 with unmet need for family planning by about 50% (from 24.5% to 12.5%)

(Note: For year-wise details of expected results of planned interventions to improve Family Planning Services, refer Table 7.2.3.1)

Table 7.2.3.1: Specific Objectives for Family Planning						
Process/Intermediate indicator	**Current status**	**Yearly Objectives**				
	1998-99	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
(1) Total wanted fertility rate						
Overall	2.58	2.5	2.25	2.00	1.75	1.50
SC	2.8	2.75	2.50	2.25	2.00	1.75
Urban/Rural	1.84/2.68					
(2) Total demand of family planning services among currently married women age 15-49						
Overall	49.1	55	60	65	70	75
SC	46.7	50	55	60	65	70
Urban/Rural	61.9/47.6					
(3) % of currently married women who have heard or seen any message about family planning						
Overall	39.7	45	52	60	67.5	75
SC	30.6	35	40	45	52	60
Urban/Rural	71.7/36.1					
(4) % of currently married women who have discussed family planning with husband/relatives/friends/neighbor etc						
Overall	19.8	22	25	27.5	30	35
SC	16.8	19	22	25	27.5	30
Urban/Rural	23.2/19.5					
(5) % of currently married women age 15-49 who have ever used any contraceptive method						
Any method	**27.6**	30	34	39	45	50
Any modern method	25.3					
Pill	3.9					
IUD	0.9					
Condom	1.8					
Female sterilization	19.2					
Male sterilization	1.0					
Any traditional method	3.6					
Rhythm/safe period	2.6					
Withdrawal	1.8					
Other Method	1.0					

Process/Intermediate indicator	Current status	Yearly Objectives				
	1998-99	2005-06	2006-07	2007-08	2008-09	2009-10
(6) % of current users of modern methods of family planning						
who told about the side effects of the	15.8					
who received follow-up services	77.1	80	80	85	85	90
(7) % of currently married women age 15-49 with unmet need for family planning						
Overall	24.5	22	20	17.5	15	12.5
SC	27.2	25	22	20	17.5	15
Urban/Rural	23.1/24.7					
(8) % of currently married women age 15-49 with met need for family planning						
Overall	24.5	33	40	47.5	55	62.5
SC	19.5	25	33	40	47.5	55
Urban/Rural	38.9/22.9					

7.2.4 Adolescent Health

Goals and Objectives

The over-arching goal for Adolescent Health in Bihar is to improve reproductive health and nutrition of adolescents.

The specific RCH II program objectives for Adolescent are as follows:

- Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.
- Improve micronutrient service for adolescents primarily to reduce anemia.

Strategies and Activities

Objective 1: Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.

The strategies and activities to raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing are briefly outlined below:

[1.1] Create conducive environment to promote adolescent health needs among health service providers and community at large.

- Annual orientation of all health service providers at state and district levels on adolescent health needs through state, district and block level workshops
- Sensitise community leaders, school teachers, PRIs, NGO networks, Anganwadi Workers, towards the health needs of the adolescents through annual block level workshops

[1.2] Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents. *(For details refer to section 7.3.4)*

- Plan BCC campaign to promote late marriage and childbearing among adolescents through mass media and tailor-made IEC materials
- Promote small family norm, late marriage and childbearing through school curriculum and classroom talks to orient school-going adolescents.

- Use NGO networks to propagate safe reproductive health practices and FP among adolescents primarily through inter-personal communication.

[1.3] Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.

- Form partnership with NGO and civil society networks, religious organisations and leaders, PRIs, and Education department to promote safe reproductive health practices and family planning among adolescents. *(For details refer to section 7.3.4)*
- (Re) train frontline health workers and schoolteachers as motivators and counselors for safe reproductive health practices and family planning among adolescents through IPC and counseling *(For details refer to section 7.3.2.2)*

[1.4] Provide RTI/STI curative services for adolescents through expanded network of health facilities and frontline health workers.

- (Re) train frontline health workers to provide RTI/STI curative services for adolescents *(For details refer to section 7.3.2.2)*
- Conduct monthly clinic to provide RTI/STI curative services for adolescents at health facilities at all level. *(For details refer to section 7.2.3)*

Expected Results

The expected results of interventions to raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing are:

- Decreased proportion of married females in the age group of 15-19 by about 60% (from 36.5% to 15%)
- Increase median age at first childbearing by 20%
- Increased awareness about Family planning methods among married females in the age group of 15-24 years by 70% (from 41.1% to 70%)

Objective 2: Improve micronutrient service for adolescents primarily to reduce anemia.

The strategies and activities to improve micronutrient service for adolescents primarily to reduce anemia are briefly outlined below:

[2.1] Targeted BCC campaign using multiple channels to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine among adolescents *(For details refer to section 7.3.4)*

- Implement targeted BCC campaign to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine through school curriculum and classroom talks to orient school-going adolescents.
- Implement extensive BCC campaign through different media using multiple approaches such as IPC, TV, Radio, Folk Media, Wall Painting and Print Materials, etc for out of school adolescents and community at large to promote good nutritional practices and micronutrients.

[2.2] Increase availability and distribution of micronutrient supplements to adolescents at grassroots level primarily through health and education networks.

- Use networks of frontline health workers (ANMs), Schoolteachers, Anganwadi workers, RMPs, SHGs, to function as depot holders for storage and distribution of micronutrient supplements among adolescents, particularly female adolescents.
- Use NGO/ASHA network in un-served and under-served areas to promote, store and distribute micronutrient supplements among adolescents, particularly female adolescents.

Expected Results

The expected results of interventions to improve micronutrient service for adolescents are:

- Reduce severe and chronic malnutrition among adolescents in the age group of 15-19 years by 40%

(Note: For year-wise details of expected results of planned interventions to micronutrient service for adolescents primarily to reduce anemia, refer Table 7.2.4.1)

Table 7.2.4.1: Specific Objectives for Adolescent Health						
Process/Intermediate indicator	**Current status**	**Yearly Objectives**				
	1998-99	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
(1) % of Household population in the age group of 15-19 years						
Male	9.5					
Female	10.0					
Total	9.7					
(2) Marital status of household population in the age group of 15-19 years						
Male						
Never married	89.7					
Currently married	5.4	**4.5**	**3.5**	**2.5**	**1.5**	**1**
Female						
Never married	54					
Currently married	36.5	**35**	**30**	**25**	**20**	**15**
(3) % of ever-married women age 15-24 years who have heard or seen any message about family planning (by specific						
Any Sources	41.1	45	55	60	65	70
Radio	26.5					
Television	19.3					
Cinema/film show	7.5					
Newspaper/magazine	8					
Wall painting/hoarding	23					
Drama/Folk dance	3.2					
(4) % of currently married women age 15-19 years who have ever used any contraceptive method (by specific method)						
Any method	4.4	7.5	12.5	20	25	30
Any modern method	2.5					
Pill	1.4					
IUD	0					
Condom	0.9					
Female Sterilization	0.2					
Male Sterilization	0					
Any traditional method	2.1					

Process/Intermediate indicator	Current status	Yearly Objectives				
	1998-99	2005-06	2006-07	2007-08	2008-09	2009-10
(5) % of ever-married women age 15-24 years who have heard about AIDS (by specific source)						
Heard about AIDS	11.4	15	20	27.5	35	45
Radio	57.5					
TV	80.8					
Cinema	12.1					
Newspaper/ magazine	18.7					
Poster/hoarding	2.1					
Health worker	0.8					
Adult Education Programme	0					
Friend/Relative	16.8					
School teacher	0.4					
Other sources	1.7					
(6) % of ever-married women age 15- 24 years who have heard of AIDS and believe that it can be avoided (by specific						
Overall	48.4	55	60	65	70	75
Abstain from sex	16.4					
Use condoms	18.8					
Have only one sex partner	25.4					
Avoid sex with commercial sex workers	9.7					
Avoid sex with homosexuals	2					
Avoid blood transfusions	9.3					
Avoid injections/use clean needles	13					
Avoid IV drug use	4.6					
Other ways	12					
(7) % of ever-married women age 15-19 years having iron-deficiency						
	64.2	55	50	45	40	35

7.2.5 Urban RCH (Maternal, child and Adolescent Health, Family Planning)

Goals and Objectives

The over-arching goal for Urban RCH is to reduce MMR in the State to a level of 325 by the year 2006-07 and to 225 by the year 2009-10. The goal for Child health is to reduce IMR and NMR in urban areas across the state by about 8.5% (from 54.6 to 50) and 15% (from 35.3 to 30) respectively by the year 2006-07. The long-term goal is to reduce IMR and NMR by about 41% (32) and 44% (20) respectively by the year 2009-10. Similarly, the goal for Family Planning is to reduce the Total Fertility Rate by about 10% (from 2.75 to 2.50) by the year 2006-07and that by 27% (from 2.75 to 2.00) by the year 2009-10. *(Refer Table 7.2.5.1 for year-wise Urban RCH goals)*

Table 7.2.5.1: Urban RCH outcomes : Goals

Outcomes Indicators	State			India		
	Urban - Current Status	Goal		Current Status	Goal	
		2006-07	2009-10		2006-07	2009-10
MMR[1]	NA	325	225	407	200	<100
IMR[2]	54.6	50	32	66	45	<30
NMR[3]	35.3	30	20	45	26	20
TFR[1]	2.75	2.50	2.00	3.2	NA	2.1

Source: [1] MMR & TFR: (NFHS II 1998-99, [2] IMR: (SRS 2001), [3] NMR: (SRS1998)

The specific RCH II program objectives for Urban Health are as follows:

- Improve delivery of timely and quality RCH services in urban areas of Bihar
- Increase awareness about Maternal and Child health and Family Planning services in urban areas of the state

Strategies and Activities

Objective 1: Improve delivery of timely and quality RCH services in urban areas of Bihar

The strategies and activities to improve delivery of timely and quality RCH services in urban areas of Bihar are briefly outlined below:

[1.1] Identify health service providers of both public and private sectors (including NGOs) in urban areas and plan delivery of RCH services through them

- Map existing providers of RCH services of both public and private sectors (including NGOs).
- Develop Micro-plans for each urban area for delivery of RCH services, both outreach and facility based.

[1.2] Strengthen facilities of both public and private sectors (including NGOs) in urban areas

- Strengthen public sector health facilities in urban areas by upgrading Urban Health Centers, FRUs (district hospitals and SDHs), and medical colleges for delivery of quality RCH services *(Refer to section 7.3.1.2 for details).*
- Establish partnerships with select private health facilities for delivery of facility-based RCH services e.g. institutional delivery, permanent methods of FP, curative MCH service, etc.
- Collaborate with health facilities managed by large public sector undertakings such as Railways, ESIS, CGHS and Military to provide RCH services to general population from identified urban areas.

[1.3] Strengthen outreach RCH services in urban areas through involvement of both public and private sector service providers

- Deliver outreach services planned under RCH through reinforced network of frontline health service providers (ANMs, LHVs)
- Develop partnerships with NGOs based in urban areas and particularly in urban slums to deliver outreach services e.g. ANC, immunisation, community based distribution of contraceptives, etc,
- Expand outreach of RCH services by adoption of identified under-served or un-served urban areas by facility-based providers (e.g. adoption of a particular slum by a medical college or private health institute)

[1.4] Delivery of RCH services through periodic camps in urban areas, primarily in urban slums

- Organise biannual RCH camps in identified urban areas
- Involve health service providers from both public and private sector and professional bodies such as IMA, IAP, FOGSI, etc for successful implementation of the camps.

Expected Results

The expected results of interventions to improve delivery of timely and quality RCH services in urban areas of Bihar are:

ANC Services

- Increased timely registration of pregnant women for ANC coverage from 38.2% to 75%
- Increased full ANC coverage (3 or more) for pregnant women from 17.1% to 65%
- Increased TT injection and IFA Tabs coverage for pregnant women to 90% from the present levels of 78% & 46.1% respectively
- Decreased percent of women with moderate/severe anemia to 30% from the present level of 59.6%

Safe Delivery and PNC Services

- Increased institutional delivery from 40.1% to 65%
- Decreased percentage of deliveries by skilled birth attendants (doctors, nurses, ANMs) from 51.9% to 35%
- Increased coverage of PNC services from 10% to 25%

Immunisation Plus Services

- Increased antigen-wise Immunisation coverage for children in the age-group of 0-1 year to 60%
- Increased full Immunisation for children in age-group of 0-1 year from to 30%
- Increased Vitamin A coverage from 19.4% to 60%

Curative Care Services for Minor ARI and Diarrhoea

- Increased percentage of children under 3 years of age taken to a health facility/provider for treatment of minor ARI and Diarrhoea from present levels of about 60% to 80%

Utilisation of Family Planning Services

- Increased contraceptives use by currently married women in the age-group of 15-49 by about 80% (from 27.45 to 50%)
- Reduced percentage of currently married women age 15-49 with unmet need for family planning from 23.1% to 10.0%

Strategies and Activities

Objective 2: Increase awareness about Maternal and Child health and Family Planning services in urban areas of the state

The strategies and activities increase awareness about Maternal and Child health and Family Planning services in urban areas of the state are briefly outlined below:

[2.1] Multiple channels for delivery of key RCH messages in urban areas

- Utililise various channels of mass media with extensive reach in urban areas such as TV, local cable networks, radio (particularly FM channels), cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.
- Extensively use print media such as newspapers (particularly local newspapers), journals and magazines for dissemination of key RCH messages.

[2.2] Broad inter-sectoral coordination to increase awareness and knowledge of key messages under the RCH programme

- Involve representatives from Urban Local Bodies (municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organisations for intensive inter-personal communication and community-based awareness campaigns.
- Use NGO network (MNGOs and FNGOs) with RCH to deliver key messages planned under RCH through IPC and community-based activities in urban areas, particularly in urban slums.
- Implement school-based awareness campaign for RCH services with emphasis on adolescent health.

Expected Results

The expected results of interventions to increase awareness about Maternal and Child health and Family Planning services in urban areas of the state are:

Awareness and Knowledge of Maternal Health Services

- Increased community awareness about Maternal Health Services particularly among adolescents and women in the reproductive age-group

Breastfeeding Practices

- Increased percentage of neonates breastfed on day one of life from 21.8% to 60%

Demand for Family Planning Services

- Decreased Total Wanted Fertility Rate from 1.84 to 1
- Increased demand for planning services from 61.9% to 80%
- Increased awareness about family planning services among women in the reproductive age-group

(Note: For year-wise details of expected results of planned interventions to improve Urban RCH services, refer Table 7.2.5.2)

Table 7.2.5.2: Specific Objectives for Urban RCH						
Process/Intermediate indicator	**Current status**	**Yearly Objectives**				
	1998-99	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
Maternal Health						
(1) % of pregnant women getting registered in first trimester	38.2	45	55	65	70	75
(2) % of pregnant women receiving 3 or more antenatal checks	17.1	20	30	40	50	65
(3) % of pregnant women receiving 2 doses of tetanus toxoid injections	78	80	80	85	90	90
(4) % of pregnant women receiving 100 tablets of IFA	46.1	50	57.5	65	75	90
(5) % of eligible women with no ANC	30.6	27.5	22	17.5	15	12
(6) % of women with moderate/severe anemia	59.6	55	47.5	40	35	30
(7) % of institutional delivery	40.1	45	50	55	60	65
(8) % of delivery in a public health facility	11.9	14	16	18	20	22
(9) % of delivery in a private health facility	28.2	31	34	37	40	43
(10) % of deliveries by skilled birth attendants (doctors, nurses, ANMs)	51.9	52	50	45	40	35
(11) % with PNC within 2 months of birth	10	12	15	20	25	30
(12) % of ever married women who have heard about AIDS	42	50	57.5	65	70	80
(13) % of ever married women who have heard about HIV/AIDS but don't know ways to avoid AIDS	47	40	32	25	20	15
Child Health						
(1) % of neonates who were breastfed on day one of life	21.8	25	30	40	50	60
(2) % of children in the age group of 12-23 months who received vaccination in Urban Areas						
BCG	NA	40	45	50	55	60

DPT (3 doses)	NA	27.5	32	40	47.5	60
Process/Intermediate indicator	**Current status**	**Yearly Objectives**				
	1998-99	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
Polio (3 doses)	NA	45	50	55	60	60
Measles	NA	20	30	40	50	60
Fully immunized	NA	15	17.5	20	25	30
(3) % of children 12-35 months receiving at-least 1 dose of vitamin A	19.4	25	30	40	50	60
(4) % of children under age 3 years with diarrhea taken to a health	38.9	47.5	55	60	70	80
(5) % of children under age 3 years with ARI taken to a health facility/provider	63.3	70	75	80	80	80
Family Planning						
(1) Total wanted fertility rate	1.84	1.75	1.50	1.25	1.25	1
(2) Total demand of family planning services among currently married	61.9	65	70	75	80	80
(3) % of currently married women who have heard or seen any massage about family planning	71.7	75	80	85	90	95
(4) % of currently married women who have discussed family planning with husband/relatives/friends/neighbor etc	23.2	25	30	35	40	45
(5) % of currently married women age 15-49 with unmet need for family	23.1	21	19	17.5	15	10
(6) % of currently married women age 15-49 with met need for family planning	38.9	44	51	57.5	65	70

7.3 Institutional Strengthening

7.3.1. Health Facilities and Human Resources

7.3.1.1 State Facility Survey and Mapping of Health Facilities.

A facility survey will be conducted with technical support of Development Partners in the state to access the existing infrastructure, personnel, and equipment status. The survey would also assess the specific requirements of each facility in terms of physical infrastructure, equipment, essential supplies and personnel. With regard to personnel, the training needs would be assessed in order to enhance their capacity, both managerial and technical. Information from the facility survey will be used to take evidence-based decisions on issues such as developing new facilities, upgrading and rationalising existing ones, provision of appropriate equipment and supplies for all facilities, recruitment of additional personnel and their capacity building to enable them to perform at optimal levels.

7.3.1.2 Health Facilities

Health Sub-Centers (HSCs)

There are 9140 functional HSCs i.e. one HSC for about 9070 people against the GoI norm of one HSC for a population of about 5000. This clearly indicates that there is an urgent need to expand network of health sub-centers in a phased manner to have one health sub-center for 5000 population by the year 2009-10. Thus, during the RCH II plan period massive efforts will be taken to strengthen the HSC network in the State. For this, based on the state population of 8.29 million, about 5700 more HSCs will be built during the plan period. *(Refer Table 7.3.1.2.1 for year-wise plan)* In addition, based on the facility survey, the existing 9140 HSCs will also be refurbished and provisoin will be made for their repair and maintenance. It is envisaged that by year 2009-10, the State will have about 14840 fully functional HSCs.

Table7.3.1.2.1 Strengthening of Health Sub-Centers (HSCs)

Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Existing No. of HSCs	9140	9520	9900	11900	13900
Construction of new HSCs	380	380	2000	2000	940
Total	**9520**	**9900**	**11900**	**13900**	**14840**

Primary Health Centers (PHCs)

There are 398 PHCs in the state, which is significantly less than the requirement as per the GoI norms. Against the GoI norm of one PHC for population of about 30000, the State has one PHC for about 2 lakhs population. Add to this, the existing PHCs are also in bad shape and need elaborate refurbishment,repair and maintenance. To fill the big gap in number of PHCs the State has a network of 1153 Additional PHCs. Now, to develop the PHC network as per the GoI guidelines and deliver the interventions planned under RCH II, the state will expand the existing PHC network with two pronged strategy i.e. upgrade all 1153 APHCs to PHCs, construct 1212 new PHCs and refurbish repair and maintain the existing 398 PHCs based on facility survey recommendation. *(Refer Table 7.3.1.2.2 for year-wise plan).*

Table7.3.1.2.2 Strengthening of Primary Health Centers (PHCs)

Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Existing PHCs	398	898	1551	2151	2763
Upgrade all APHCs to PHCs	500	653			
Construction of new PHCs using State resources received from planning commission.			600	612	
Total	**898**	**1551**	**2151**	**2763**	**2763**

First Referral Units (FRUs)

Bihar is among the few States where first referral system is virtually non-existent. During RCH I 78 health facilities, including district and sub-divisional hospitals were selected to be operationalised as FRUs. However, none of these health facilities could have been operationalised. Now, to develop the First referral system, it is planned that during next five years, 190 health facilities (five facilities in each district), including the district hospital will be upgraded and operationalised as FRUs. *(Refer Table 7.3.1.2.3 for year-wise plan).* Thus there will be five functional FRUs in each districts, four of which will be in district periphery. Selection of the health facilities to be taken for upgradation as FRUs will be done on the basis of facility survey report.

Table7.3.1.2.3 Operationalisation of First Referral Units (FRUs)					
Activity	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Upgradation & operationalisation of District or Sub-Divisional Hospital as FRUs	1 each in all 38 districts				
Upgradation & operationalisation of Referral Hospital/PHC as FRUs		1 each in all 38 districts	1 each in all 38 districts	1 each in all 38 districts	1 each in all 38 districts
Total	**38**	**38**	**38**	**38**	**38**
Cumulative No. of FRUs	**38**	**76**	**114**	**152**	**190**

As per the GoI guidelines, in the FRUs 5 MOs (surgeon, obstetrician, physician, paediatrician, MBBS doctor trained in life saving anaesthetic skills for EmoC) and 4 paramedical workers trained in obstetric care, new born care, blood storage and laboratory services is required. Personnel requirement for the FRUs will be met with rationalisation of existing personnel with department of Health and Family Welfare, GoB.

Urban Health Centres (UHCs)

At present, there are 12 Urban Health Centres (UHC) in the state. Provision for their repair and maintenance needs to be done on a priority basis. However, as per the GoI guidelines, there should be one UHC for 50,000 population (outpatient).During the next five years, based on the above criteria, additional 111 UHCs will be established in buildings taken on rent. *(Refer Table 7.3.1.2.4 for Urban areas wise proposed UHCs).* With this, it is envisaged that the State will have around 123 Urban Health Centres to form the First Tier of the Urban Health facility network by year 2009-10. The staff at each UHC will comprise of 1 Medical Officer (MO), 1 PHN/LHV, 2 ANMs, 1 Lab Assistant and 1 Staff clerk with computer skills. To meet the staff requirement possible redeployment of existing staff will be pro-actively considered and short-fall, if any will be met through appointment of staff on contract basis. For the Second *tier* referral services Medical College hospitals/District hospitals/Sub-divisional hospitals will serve as referral units for urban population. In un-served and under served areas, Private/NGO run centres will be encouraged.

Table7.3.1.2.4 Strengthening of First Tier Health Facilities in Urban Areas (UHCs)				
Sl No	**District**	**City/Town**	**Total**	**No. of proposed Urban Health Posts**
Population between 50000 to 100000				
1	Araria	Araria	60594	1
2	Aurangabad	Aurangabad	79351	2
3	Begusarai	Begusarai	93378	2
4	Buxar	Buxar	82975	2
5	Gopalganj	Gopalganj	54418	1
6	Jamui	Jamui	66752	1
7	Kishanganj	Kishanganj	85494	2
8	Jehanabad	Jehanabad	81723	2
9	Lakhisarai	Lakhisarai	77840	2
10	Madhubani	Maharani	66285	1
11	Munger	Jamalpur	96659	2
12	Nawada	Nawada	82291	2
13	Patna	Mokameh	56400	1
14	Paschim Champaran	Bagaha	91383	2
15	Patna	Phulwarishariff	53166	1
16	Samastipur	Samastipur	55590	1
17	Sitamarhi	Sitamarhi	56769	1
18	Supaul	Supaul	54020	1
Population between 100000 to 300000				
1	Katihar	Katihar	175169	4
2	Munger	Munger	187311	4
3	Paschim Champaran	Bettiah	116692	2
4	Patna	Dinapur Nizamat	130339	3
5	Purba Champaran	Motihari	101506	2
6	Nalanda	Biharsharif	231972	5
7	Bhojpur	Arrah	203395	4
8	Darbhanga	Darbhanga	266834	5
9	Purnia	Purnia	171235	3
10	Rohtas	Dehri	119007	2
11	Rohtas	Sasaram	131042	3
12	Saharsa	Saharsa	124015	2
13	Saran	Chapra	178835	4
14	Siwan	Siwan	108172	2
15	Vaishali	Hajipur	119276	2
Population > 300000				
1	Bhagalpur	Bhagalpur (M. Corp)	340349	7
2	Gaya	Gaya	383197	8
3	Muzaffarpur	Muzaffarpur	305465	6
4	Patna	Patna	1376950	28
			Grand Total	**123**

7.3.1.3. Health Personnel

For successful implementation of the planned interventions under RCH II, it is essential that the health facilities be adequately staffed. The data suggest that there are many vacant posts at different levels and with new planned facilities at Health Sub-centre, PHCs and FRUs levels, there will be requirement for more health staff. To address this increased need of health staff, the State plan to aggressively recruit health staff at all levels primarily on contract basis.

ANMs

At present, in the State, there are 11294 sanctioned posts of ANMs, of which 10055 are filled. There is an urgent need to fill these vacancies. However, even if all vacant posts are filled up the ANM population ratio will be about 1:7340. Thus, to achieve GoI norm of having one ANM for a population of about 5000, the State plans to recruit additional 5922 ANMs to be taken on contract in a phased manner by the year 2009-10. the State plan to fill all 1239 vacant ANM posts. In addition, about 380 new ANMs will also be recruited on contractual basis this year. It is planned that with the proposed yearly recruitment of ANMs for next 5 years, the State will have 17216 ANMs. The recruitment of ANMs will be primarily done on contract basis. (*Refer Table 7.3.3.1 for year-wise ANMs recruitment plan).*

Table7.3.3.1 Status of ANMs

Status	Year 1	Year 2	Year 3	Year 4	Year 5
Existing ANMs	10055	11734	12174	14234	16276
Vacancy	1239				
Recruitment of ANMs					
Contrauctual Appointment of ANMs for the new HSCs	380	380	2000	2000	940
Contractual appointments of ANMs for the new UHCs.	60	60	60	42	-
Total	**11734**	**12174**	**14234**	**16276**	**17216**

MHWs (Male)

In Bihar close to 50% of existing MHWs posts (2562) are vacant. However, the State plans to fill these vacancies on priority basis. In addition, the State also plans to appoint 1710 more MHWs, so that total number of MHWs goes up to 4272, adequate to have one MHW each in about 30% of the HSCs in the State. These MHWs will be posted in the select 30% of the geographically tough HSCs, to support ANMs. The 30% of such HSCs will be selected with input from the proposed facility survey. (*Refer Table 7.3.3.2 for year-wise MHWs recruitment plan)*

Table7.3.3.2 Statusof MHWs					
Status	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Existing MHWs	1298	2904	3246	3588	3930
Vacant Posts	1264				
Recruitment of MHWS Cotractual Appointment of new MHWs	342	342	342	342	342
Total	**2904**	**3246**	**3588**	**3930**	**4272**

LHVs

LHVs play the vital role in program supervision & monitoring at grass-root level. At present there are 1126 posts sanctioned for LHVs, of which 662 are filled. To strengthen the program supervision & monitoring, the State plans to recruit more LHVs so that there is one LHV for every 5 HSCs. Thus, an additional 1251 LHVs will be contractually appointed in a phased manner to achieve GoI norm by the year 2008-09. (*Refer Table 7.3.3.3 for year-wise LHVs recruitment plan)*

Table7.3.3.3 Status of LHVs					
Status	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Existing LHVs	662	1232	1338	1768	2189
Vacant Post	464				
Recruitment of LHVs Contractual appointment of LHVs at UHCs	30	30	30	21	-
Contractual appointment of LHVs for supervising ANMs posted at newly created HSCs	76	76	400	400	188
Total	1232	1338	1768	2189	2377

Staff Nurse

At present there are 256 staff nurses working at the district level as against the sanctioned 451 posts. The 195 vacancies need to be filled and depending on need, more nurses will be appointed particularly to ensure smooth operationalisation of FRUs. In the Medical Colleges of the State, there are 1063 sanctioned posts of staff nurses of which 971 are filled up. The remaining 92 posts will be filled up by the State Goverment.

Lab technicians

Lab technicians would be contractually appointed in APHCs being upgraded to PHCs. Initially 500 LTs would be taken in the first year and 653 would be taken in year two.

7.3.2 Training

Successful Implementation of any programme depends on the capacity building of the personnel engaged.

In RCH – II also ,human resource base will be created by enhancing the capacities through training .The sensitization of health personnel towards various RCH interventions is one of the major focus of the capacity building initiatives under RCH - II . Various trainings will be provided to State and district level managers, medical officers, nursing staff, ANMs, AWWs , ASHA and others .

The training will be provided at the State Institute of H & FW , Regional training Institutes , ANM training schools , District hospital ,PHCs and also in Railways , ESI ,private sector hospitals where there is enough case load for a proper training . Some of the trainings will be contracted out to the NGOs and private players also , so that any limitation of State infrastructure is overcome easily .[Available in detail in NGO chapter]. As BCC will be a major training aspect ,it has been dealt in a separate chapter.

All the technical training programmes will ensure that.along with the theoretical inputs, proper practical exposure is also provided. Apart from this each training programme will stress on the managerial aspect and on the communication with the clients.

The TOTs will ensure that the trainers not only master the contents of the training topic but also aquire skills as teachers/trainers or facilitators and motivators.

The state official, trainers, professionals and functionaries who excel in implementing training programmes will be recognized through awards and citations.

A rational selection criteria will be used to select the trainees for the trainings where the no. of trainees are limited.

Moreover promotion and posting policy will be linked to training and the functionary will have to undergo training to avail the promotion. There will be provision for proper rational posting so that the personnel trained, utilize their training in their day to day work.

A feedback system will be developed to assess the quality of the training . From time to time, presence of state/regional observers will be ensured to assess the quality of district level trainings and workshops.

Detailed Records and data about personnel undergone training should be available with all concerned at all levels. SIHFW will coordinate and monitor this with the help of district Data Officers

7.3.2.1 Training Institutes

SIHFW

The State Institute of Health and Family Welfare (SIHFW) is the premier training institute in the state of Bihar. SIHFW needs to be further strengthened as the apex institute in the state of Bihar for co-ordination and implementation of all capacity building initiatives under RCH II program. SIHFW has the required infrastructure and facilities, which need to be reinforced further so that it can conduct the various training programs on continuous basis.

As the nodal agency for training activities in the State, SIHFW will have following major tasks:

- To develop annual training calendars based on the district action plans in close co-ordination with RHFWTCs and ANMTCs.
- To conduct clinical and non-clinical training programs for medical officers.
- To support RHFWTCs and ANMTCs to conduct timely induction and refresher training programs for ANMs and LHVs.
- To facilitate ongoing assessment of training needs of functionaries at all levels
- Co-ordinate and implement integrated skill development and specialised skill development training programs.
- Conducting TOTs with RHFWTCs and ANMTCs
- To co-ordinate with SCOVA/SHSB for need based hiring of resource persons for the training programs

At present, out of the 14 sanctioned posts of faculty at SIHFW, only 4 faculties are in position. They are for Management/OB, Communication, Gynaecologist and Paediatrician. The State propose to fill following positions at SIHFW at earliest:

- One faculty each, for three areas - Human Resources Development, Monitoring and Evaluation, & Behaviour Change Communication Strategies.

- Support staff such as one librarian, one accountant and one accounts assistant, one office assistant, one stenographer cum typist, one driver, three helpers, one housekeeper for hostel, and two security guards will be appointed preferably, on contract basis.

In addition, adequate provisions will be made for the institute to hire need based services of electricians, plumbers, carpenters, etc. on contract basis.

RHFWTCs

There are Eight Regional Health and Family Welfare Training Centers (RHFWTCs) in the state – Three for male and Five for female health staff. All the sanctioned posts of trainers at these institutes are filled. However, functioning of all RHFWTCs is severely affected due to lack of proper infrastructure. The State proposes to use the facility Survey to do a detailed assessment of the needs of these training centers. Based on the report of the facility survey, adequate resources will be provided to all RHFWTCs to upgrade their respective infrastructure and maintenance support.

Location of the RHFWTCs in the State:

RFWTC Male	RFWTC Female
Patna (non residential) Muzaffarpur Bhagalpur	Patna Gaya Muzaffarpur Saran Purnea

The Facility Survey will also assess the need for new Regional Health and Family Welfare Training Centers (RHFWTCs) in the state.

ANMTCs

There are 21 ANMTCs in Bihar, the trainingcapacity of these institutes varies from 60 to 90 participants per batch. However, most of these training centers are functioning sub-optiminaly in absence of proper infrastructure and other essential support. As in the case of RHFWTCs, the proposed facility survey will assess the needs of all the ANM training centers. Based on the report of the facility survey, adequate resources will be provided for all ANMTCs to upgrade their respective infrastructure and maintenance support. Further status of faculty positions/trainers and their requirements at ANMTCs would be assessed incourse of facility survey and then adequate provisions will be made to address their needs.

7.3.2.2 Key Training Activities

The wide range of training activities to be conducted under RCH II program by various agencies and training institutes is outlined below:

Maternal Health

- Provide comprehensive skill upgradation training to frontline ANC service providers (ANMs and LHVs) to ensure delivery of quality ANC services
- Conduct training to build capacity of LHVs for effective supervision and monitoring.
- Train Anganwadi Workers and PRI members would help in identification and motivation of pregnant women for healthy antenatal care practices and for utilization of ANC services.
- Impart refresher training to Gynecologists and Obstetricians on safe delivery practices and referral procedures.
- TOT for NGOs and frontline health workers for TBAs' training.
- Train Traditional Birth Attendants (TBAs) in safe delivery practices and PNC services in a phased manner.
- Train all ANMs, LHVs, Nurses and TBAs in identification of danger signs during delivery, referral procedures and PNC services.
- Train NGOs, Anganwadi Workers and PRI members in raising community awareness and knowledge about importance of institutional delivery, safe delivery practices at home, referral and PNC services.

Child Health

- Train frontline Health workers, Anganwadi Workers, PRIs, TBAs, local NGOs and CBOs in correct breastfeeding and complementary feeding practices
- Provide comprehensive skill upgradation training to immunisation service providers (LHVs/ANMs), particularly in injection safety, safe disposal of wastes and management of adverse effects.
- Conduct training to build capacity of Medical Officers, MOICs and DIOs for effective management, supervision and monitoring of immunisation services
- Train Cold Chain handlers for proper maintenance and upkeep of Cold Chain equipment

- Train Anganwadi Workers and PRI members in identification of children eligible for immunisation, in motivation of caregivers to avail immunisation services and in follow-up of dropouts
- Identify key persons to join IMNCI master training pool
- Train members of master trainer pool in national level course
- Recruit and train district trainers (using state master trainer pool)
- Train all health and ICDS staff in a phased manner
- Train frontline health workers and Anganwadi workers in health education techniques to build community capacity for early recognition of childhood illnesses, home-based care and care-seeking

Family Planning

- Train partners such as NGO and civil society networks, religious organisations and leaders, PRIs, ICDS, Education, General Administration, Corporate Associations and Professional bodies (IAP, IMA) in promotion of Family Planning, at state, district and block levels
- (Re) train frontline health workers, Anganwadi Workers and PRIs as motivators and counselors for family planning services through IPC and counseling
- Impart technical skill-enhancement training to existing and newly appointed frontline health workers on provision of various spacing (Oral contraceptive, condom, IUD insertion, emergency contraception) and terminal (female and male sterilization) methods of Family Planning.
- Train doctors in various reversible and terminal FP procedures (MTP, Minilap , NSV and IUD).

Adolescent Health

- Conduct annual orientation and training of all health service providers on adolescent health needs at state, district and block levels
- Train/sensitise community leaders, school teachers, PRIs, NGO networks, Anganwadi Workers, towards the health needs of the adolescents
- Train NGO and civil society networks, religious organisations and leaders, PRI members and teachers in promotion of safe reproductive health practices and family planning among adolescents.

- (Re) train frontline health workers and schoolteachers as motivators and counsellors for safe reproductive health practices and family planning among adolescents through IPC and counselling
- (Re) train frontline health workers to provide RTI/STI curative services for adolescents

Urban Health

- Train representatives from Urban Local Bodies (municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organisations in techniques for intensive inter-personal communication and community-based awareness campaigns.
- Train NGO network (MNGOs and FNGOs) with RCH in health education for RCH through IPC and community-based activities in urban areas, particularly in urban slums.

7.3.2.3 Training

Sr. No.	Name of the Training (Indicating its objective)	Target Group	Duration	Broad Course Content	Inicators/ Mechanisms for assessment of Wuality/ Impact
1.	Skill upgradation Training for delivery of Quality MH Services	ANM, LHV, Staff Nurses	5 days	ANC, PNC, Safe Delivery, danger signs during delivery, referral procedure	MMR, Quality Assessment Survey, No. of ANCs, PNCs and safe deliveries. No, of reerrals
2.	Skill upgradation, Training for quality services	ANM, LHV, Staff Nurse	5 days	FP councelling, on all spacing and terminal methods, IUD insertion, Emergency contraception (OCP, condoms, Injectables, IUDs, sterilizations, NSVs)	Quality assessment, survey of councelling sessions, client satisfaction surveys, No. of IUDs inserts. No. of ECs provided
3.	Training for effective supervision and monitoring to LHVs	LHVs	1 day	Basics of supervision, monitoring, management, preparation of workplan, work filling up of CNAA forms, effective field visits	ANMs performance
4.	Training on IPC for MH services to PRI, AWW, CBO, NGOs	PRI, AWW, ABO, NGO	3 days	IPC, MH services- ANC, PNC, safe delivery, referral services, Institutional delivery	Community awareness
5.	Training on IPC for FP services	PRI, AWW, CBO, NGO	3 days	FP Services- spacing methods, Terminal methos, Emergency contraception, Need of small family	% of FP services utilized. % of awareness about FP services in community.
6.	Training oon IPC for CH and AH services for PRI, AWW, CBO, NGO	PRI, AWW, CBO, NGO	3 days	Exclusive breast feeding, colostrums diarrhea, ARI, Immunization, Home-base neo natal care, Referral Services, Sensitization towards AH needs.	IMR, % Exclusive breast fed infants, increase in full immunization %, % referral cases, Awareness % of ARI, about ORS
7.	Refresher training for MH to gynecologists/ obstetrician	Gynecologists or obstetrician	5 days	Safe delivery, caesarean section, EmOC referral	% of safe deliveries, institutional deliveries, %

				services	reduction in MMR, % increase in FP services.
8.	Training on NSVs to MOs	Medical officers	5 days	NSV- councelling, IPC and NSV-technique	No. of NSVs done, client satisfaction survey
9.	ToT on safe delivery to NGOs for TBA training	MNGOs	3 days	Safe delivery, IPC, Inputs on how to train effectively	Survey of TBA who will receive training on the spot. Quality assessment of training given by NGOs to TBAs
10.	Training on safe delivery to TBAs through NGOs	TBAs	3 days	ANC, safe delivery, early detection of danger signs, referral services	% of safe delivery MMR
11.	Training for effective Mtg, supervision and monitoring for MO	MO	2 days	Basics of effective management, supervision monitoring, effective field visits, filling up of CNAA forms	Quality assessment surveys, client satisfaction surveys
12.	ToT for effective mtg, supervision, monitoring to MOICs and IOs	MOIC, DIO	2 days	How to provide effective trg, trg tools, basics of effective Mtg.	Quality assessment surveys, client satisfaction surveys
13.	Training for maintainance of cold chain equipments	Cold Chain handlers	2 days	Maintainance of cold chain, basic functioning, repair	% of cold chain equipment in working condition
14.	ToT for state level trainers in IMNCI	Distt level master trainers	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
15.	ToT for district level trainers in IMNCI	Distt. Level master trainers	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
16.	Training in IMNCI to ANMs, LHVs, Nurses	ANMs, LHVs, Nurses	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
17.	Training of IMNCI to AWWs	AWWs	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.

18.	Training in IMNCI to MOs	MOs	10 days	Basic training tools and techniques, IMNCI including home based new born care	IMR, Decrease in deaths due to diarrhea, ARI, increase in breast feeding.
19.	Orientation Training for IPC for urban local bodies, NGOs, voluntary Org	Representatives of Urban local bodies, NGOs, Voluntary org. etc.	2 days	IPC, brief knowledge of MH, FP, CH and AH	% improvement in utilization of health services in urban areas
20.	Training to district level PMU	DPMs, DAMs, DM, CMOs, ACMOs, DIUs	3 days	Roles and responsibilities, brief knowlwdge about programme an its aspets MH, FP, CH, AH	Better monitoring at district level
21.	Training of state level PMU/SMU	SMU	3 days	State specific programme details, roles and responsibilities, results expected	Better monitoring at state level
22.	Experience sharing/ Inter state visit	SMU	7 days	Visit to a state where RCH is successfully implemented to study its implementation, problem- solving	Better monitoring at state level
23.	Training of CNAA form documentation to ANM, MPW, LHV	ANM, LHV, MPW	3 days	CNAA forms, filling up, cross checking	Better monitoring at HSC level
24.	Orientation training in AH to school teachers	School teachers			AH sensitization
25.	Training on CNAA forms for statistical personnel	statistical personnel	3 days	CNAA forms, cross checking, collation	Better monitoring at all levels

7.3.3 NGO and Public-Private Partnership

The RCH I programme symbolized a paradigm shift from previous health and population programs in the country, in that it moved away from earlier provider-focussed intervention to increased community participation. Participation of communities was reflected firstly in the target-free approach, community needs analysis and extensive involvement of NGOs and the private sector. Involvement of NGOs and private sector has been sought primarily because of their rapport with communities, innovative approaches, flexibility and adaptability to changing situations and their relative efficiency as compared to government health systems. In RCH II also, the NGOs are expected to contribute to state efforts in both awareness generation and actual service delivery especially in un-served and under-served areas.

Role of NGOs and Private Sector in Awareness Generation

NGOs are expected to be involved in generating awareness about various program components, social marketing of RCH related products and services, facilitating community needs assessment and contributing in behavior change interventions in the community.

Role of NGOs and Private Sector in Provision of Services

Under-served and un-served areas are those socio-economically backward areas, where government health services are either minimal or entirely absent. These could be in Scheduled Caste Communities or urban slums. These may also include areas where the post of MO, ANM and LHV have been vacant for more than a year; where the PHC is not equipped with minimal infrastructure and performance on critical RCH indicators is poor. To address this issue, in RCH II, the State plans to develop extensive network of NGOs and involve them in delivery of select services planned in these areas.

7.3.3.1 NGO Network in the State for RCH II

GoI laid down specific norms regarding the establishment of a network of Regional Resource Centers (RRCs), Mother NGOs (MNGOs) supported by Field NGOs (FNGOs) across the state for both awareness generation and service delivery. Their specific levels of operation and activities are outlined in the table below. NGOs like, IPAS, BVHA, JANANI etc. will be roped in for service delivery in various feilds of maternal and childcare.

Regional Resource Centers (RRCs)

At the regional level, RRCs are to be primarily involved in the induction and in-service training of MNGOs, to provide technical and managerial support to MNGOs and FNGOs, to document best practices, liaise between the State government and MNGOs

Mother NGOs (MNGOs)

Covering an area of about two districts, MNGOs are expected to be primarily involved in identification and capacity building of NGOs in their districts. For the capacity building of Field NGOs in their area, MNGOs are to assist FNGOs in identification of RCH problems in target areas, formulation of innovative project proposals, hands on training and supervision and monitoring. They are also expected to deliver select RCH services and be involved in general awareness raising and advocacy. These can be done either by the MNGOs alone, in conjunction with their FNGOs or entirely through their FNGOs. For the latter, MNGOs can produce their own print and audiovisual IEC and training materials for dissemination in target areas through FNGOs.

Field NGOs (FNGOs)

With the support of their MNGOs, each district is to have three or more FNGOs that would primarily assist district and sub-district health staff in carrying out tasks outlined for the NGOs in RCH II. The common tasks envisaged under RCH II for FNGOs are creating awareness for ANC services, developing RMP networks, distributing DD kits and training of TBAs, supporting immunisation and micronutrients activities, promoting FP services, etc.

Service NGOs:

Service NGOs can be engaged in areas such as family planning (setting up of IUD clinics), Adolescent Reproductive Health, Maternal and Child Health and RTI/STD.Additionally, they can takeup other areas such as MTP services and Dai Training.

7.3.3.2 NGO Activities in the State for RCH II

The wide range of activities to be performed by NGOs and the private sector service providers in service delivery, awareness generation ands capacity building under the different programme areas of RCH II in the State are outlined below:

Maternal Health

Strategy and Activities

Objective 1: To improve coverage of timely and quality ANC services

[1.1] Increase availability of ANC services through reinforced network of frontline ANC service providers

- NGOs along with ICDS, PRI and ASHA networks to undertake behavior change communication for ANC.

Objective 2: Strengthen maternal health services to ensure safe delivery

[2.1] Promote institutional delivery by involving private sector/NGO providers of EmOC in un-served and under-served areas

- Private sector providers and NGO, contracted through the MNGO network, in identified un-served and under-served areas, to disburse incentives for every institutional delivery, (@Rs 500 for normal delivery and Rs 2000 for caesarian section) of BPL families conducted

[2.2] Ensure safety of deliveries at home

- NGOs and frontline health workers to train Traditional Birth Attendants (TBAs) in safe delivery practices and PNC services in a phased manner
- NGO networks, along with ANMs and LHVs, to distribute DD kits to TBAs through
- NGOs along with ICDS, PRIs and ASHA networks to raise community awareness and knowledge about importance of institutional delivery, safe delivery practices at home, referral and PNC services.

Child Health

Strategy and Activities

Objective 1: Promote immediate and exclusive breastfeeding and complementary feeding for children.

[1.1] Increase community awareness about correct breastfeeding practices through traditional media

- NGOs, along with frontline Health workers, Anganwadi Workers, PRIs, TBAs, local and CBOs, to be trained in correct breastfeeding and complementary feeding practices
- NGOs, along with frontline Health workers, Anganwadi Workers, PRIs, TBAs, local and CBOs, to promote correct breastfeeding and complementary feeding through IPC, group meetings, folk media and wall writing.

Family Planning

Strategy and Activities

Objective 1: Raise awareness and demand for Family Planning services among women, men and adolescents

[1.1] Extensive campaign using multiple channels to raise awareness and demand for Family Planning

- NGOs to organize biannual health mela at all blocks to promote Family Planning Services

[1.2] Broad inter-sectoral collaboration to promote small family norm, late marriage and childbearing

- NGO and civil society networks partnerships to promote Family Planning to be formed
- Mother NGOs to orient and sensitise partners through annual district level workshops
- Field NGOs to orient and sensitise block-level partners through biannual district level workshops
- Network of about 20,000 Registered Medical Practitioners (RMPs) and Practitioners of Indian Systems of Medicine (ISM) in the state to promote the small family norm, late marriage and child bearing.
- New partners such as barbers, tea-shops, pan-shops and CSOs to promote Family Planning methods among men at grassroots level

Objective 2: Increase access to and utilisation of Family Planning services (spacing and terminal methods)

[1.1] Increase availability of contraceptives through Social Marketing and community-based distribution of contraceptives.

- NGOs involved in Social Marketing of contraceptives in the state (Janani and PSI) to increase availability of contraceptives at grassroots levels.
- Networks of MNGOs and FNGOs to implement social marketing system of contraceptives.
- Networks of RMPs and SHGs to function as depot holders for community based distribution of contraceptives.

Adolescent Health

Strategy and Activities

Objective 1: Raise awareness and knowledge among adolescents about Reproductive Health and Family Planning services with emphasis on late marriage and childbearing.

[1.1] Create conducive environment to promote adolescent health needs among health service providers and community at large.

- NGO networks, along with community leaders, school teachers, PRIs, Anganwadi Workers, to be sensitised towards the health needs of the adolescents through annual block level workshops.

[1.2] Targeted BCC campaign using multiple channels to raise awareness about safe reproductive health practices and Family Planning among adolescents.

- NGO networks to propagate safe reproductive health practices and FP among adolescents primarily through inter-personal communication.

[1.3] Partnerships with key stakeholders and major networks to promote safe reproductive health practices and Family Planning among adolescents.

- NGO and civil society networks, along with religious organisations and leaders, PRIs, and Education department to promote safe reproductive health practices and family planning among adolescents.

Objective 2: Improve micronutrient service for adolescents primarily to reduce anemia.

[2.1] Increase availability and distribution of micronutrient supplements to adolescents at grassroots level primarily through health and education networks.

- Networks RMPs and SHGs to function as depot holders for storage and distribution of micronutrient supplements among adolescents, particularly female adolescents.
- NGO network in un-served and under-served areas to promote, store and distribute micronutrient supplements among adolescents, particularly female adolescents.

Urban RCH

Strategy and Activities

Objective 1: Improve delivery of timely and quality RCH services in urban areas of Bihar

[1.1] Identify health service providers of both public and private sectors (including NGOs) in urban areas and plan delivery of RCH services through them.

- NGOs and private sector providers, along with public health providers, of RCH services to be mapped.

[1.2] Strengthen facilities of both public and private sectors (including NGOs) in urban areas.

- Private health facilities to deliver facility-based RCH services e.g. institutional delivery, permanent methods of FP, curative MCH service, etc.
- Health facilities managed by large public sector undertakings such as Railways, ESIS, CGHS and Military to provide RCH services to general population from identified urban areas.

[1.3] Strengthen outreach RCH services in urban areas through involvement of both public and private sector service providers.

- NGOs based in urban areas and particularly in urban slums to deliver outreach services e.g. ANC, immunisation, community based distribution of contraceptives, etc.
- facility-based providers (such as medical colleges or private health institutes to expand outreach of RCH services by adoption of identified under-served or un-served urban areas.

Objective 2: Increase awareness about Maternal and Child health and Family Planning services in urban areas of the state

[2.1] Broad inter-sectoral co-ordination to increase awareness and knowledge of key messages under the RCH programme.

- Representatives from commercial associations, sports bodies, and voluntary organisations to implement intensive inter-personal communication and community-based awareness campaigns.
- NGO network (MNGOs and FNGOs) with RCH to deliver key messages planned under RCH through IPC and community-based activities in urban areas, particularly in urban slums.

Public Private Partnership

Public health facilities like Patna city hospital will be strengthened and developed into Centre for Excellence for Maternal Health. This will be done through institutional collaboration with leading and established hospitals/nursing Homes in Bihar.

7.3.4 BCC

Behavior Change Communication can play an important role in improving maternal, child and adolescent health and in achieving family planning. The selection and implementation of an appropriate set of behavior change interventions can help to directly improve a wide range of family care-giving and care-seeking practices, and enhance supportive environments for improved household health practices at community, institutional and policy level. Individual, family and community health outcomes are influenced by many factors. A comprehensive approach to behavior change recognizes that individual behavior change does not result from improved knowledge alone, and cannot be promoted in isolation from the broader social context in which it occurs. A behavior change approach explores the full range of factors that must be addressed to effectively change behaviors at multiple levels. Change interventions may include strategies – Mass Media, Inter-Personal Communication, Social Mobilization, Advocacy, and Community Participation. This section briefly outlines the components of behavior change communication required in the state's RCH programme.

7.3.4.1 Strengthening of IEC Bureau for BCC

State level

An IEC Bureau is functional in the State to support the mass media, IEC and BCC components of the RCH programme. However, it needs to be strengthened to ensure that it performs at the optimal level. At present, the functioning of the state level IEC Bureau is severely hampered due to shortage of staff and other facilities. The current status of staffing at the IEC Bureau at State level is given below. (*Refer Table 7.3.4.1.1).*

Table 7.3.4.1.1 IEC Bureau at State Level

Sl No	Designation	Sanctioned	Filled	Vacancy	Remarks
1.	Dy. Dir. (IEC)/State IEC Officer*	1	1	x	Officiating
2.	Asst. Dir. (Press Publication)**	1	1	x	
3.	Health Education Officer (non-	1	x	1	
4.	Audio-Visual Officer**	1	x	1	
5.	Publicity Officer**	1	x	1	
6.	Asst. Editor	1	1	x	Asst. Editor
7.	Asst. Publicity Officer	1	x	1	
8.	Artist cum Photographer	1	1	x	

To strengthen the functioning of State IEC Bureau, the State proposes to fill these positions, through contractual appointments/promotion of existing staff, by the end of year 2005-06. A BCC consultant has been appointed to further strengthen the capacity of the IEC Bureau at State level. This Consultant is to support the planning, implementation and monitoring of BCC activities. A decision has also been taken to hire the services of a professional agency to provide need-based support to the Bureau for:

- Training the state level BCC task force comprising of staff from SHSB and other departments such as ICDS, Education and PRIs.
- Implementation support for BCC activities planned under RCH II through development of messages and their pre-testing; media selection and buying; campaign development and co-ordination; and monitoring and impact assessment of BCC interventions.

District and Sub-district levels

The staffing structure of the District Family Welfare Bureau's IEC division according to GoI norms provides for adequate personnel required to plan, design and implement BCC activities at district and sub-district levels. However, the current status of Bureau's IEC Division suggests that there is a severe shortage of staff and infrastructure at district and sub-district levels, as against sanctioned posts. *(Refer Table 7.3.4.1.3).* Moreover, even the sanctioned posts do not

cover all the 38 districts and 534 blocks in the state. In addition, there is also a scheme for the formation of Mahila Swasthya Sangh (MSS) that was launched in 1990 with the aim of involving rural women in the family welfare programme. According to data available with the state, there are about 3868 MSSs spread over 21 districts across the state. However, most of these MSSs are non-functional and need to be revived. Therefore, in order to rejuvenate the IEC network at district and sub-district levels for implementation of BCC activities under RCH II, the state proposes to fill all the sanctioned posts by the end of the year 2005-06. Further, more posts will be created and personnel recruited to cover the remaining districts and blocks. Special emphasis will be given to revival of the existing MSS network and to expand it to other remaining blocks in the state.

Table 7.3.4.1.2 District Family Welfare Bureau - IEC Division

Sl No	Designation	Sanctioned	Filled	Vacancy	Remarks
1.	DEMO	27	1	26	ACMOs are working as
2.	Dy. DEMO - Male	27	9	18	BEEs are officiating
3.	Dy. DEMO - Female	27	8	9	Graduate LHVs are
4.	Projectionist cum	22	19	3	
5.	Artist cum	11	4	7	
6.	Projectionist	6	4	2	
7.	Block Extension	394	151	243	
8.	Family Level Worker	1669	1295	347	
9.	Mahila Swasthya	--	3138	--	

7.3.4.2 Activities of IEC Bureau for BCC

The wide range of BCC activities to be implemented by the IEC division of the State Family Welfare Department in close co-ordination with other departments and partners are outlined below:

Behaviour Change Communication

The Perspective Plan for BCC incorporates elements of Annual Work Plan & Budget of BCC for the year 2004-05 approved by GoI and is in consonance with the National Communication Strategy for RCH Programme.

BCC will focus on bringing about:

(i) **Knowledge Change** - an increase in knowledge among the target audience about the benefits of healthy living and the facilities available in their vicinity; help remove myths and misconceptions related to RCH

(ii) **Attitudinal Change -** an increase in perception of personal risk so as to bring about behavioural change and develop health seeking behaviour; a change in

attitude/sensitization of the authorities towards the needs of the target population and provide services as per norms, inculcate a sense of commitment in them, etc.

(iii) **Environmental Change -** bringing about a change in environment which is conducive for the beneficiaries to avail the benefits and services at the facility centers.

The following diagram depicts the seven steps to social change:

The goal of communication strategy for the RCH II programme will be to encourage individuals, families, and communities to make informed decisions concerning reproductive and child health through a programme of health communication which facilitates behaviour change.

Objectives:

To build an environment favoring health seeking practices, preferably through low cost and no cost interventions, especially for the disadvantaged and the marginalized sections of society. This outlook will set the tone and tenor of the mobilization process for effectuating a positive change in the existing socio-cultural mores, systems and processes.

To foster a cultural resurgence through integration of rich folk traditions of the various linguistic zones of Bihar will be made use of. The environment-building-exercises may initiate concerted awareness campaigns against gender-bias, ignorance, lethargy, alienation, insensitivity, with special focus on RCH related issues such as reduction of MMR, IMR, TFR, increase in breast feeding, awareness about PNDT Act, etc.

Strategies for Implementation:

The planning of the communication strategy for this Programme will put strong emphasis on evidence-based decisions, a combination of mass media, social mobilisation and inter-personal communication (IPC). This strategy will rely heavily on the use of such multiple channels. Experience in communication suggests that mass media by themselves are rarely effective in changing attitudes or behaviour. However, when used in conjunction with social mobilisation and tactics aimed at generating word-of-mouth discussion, such media are very effective in context setting and reinforcing behaviour. This strategy will be used to communicate with the community as well as the service providers in a planned manner to strengthen IPC.

Community's Need Assessment Approach (CNAA)

Before planning any strategy to bring about a behaviour change in the community, a baseline assessment study will be conducted so as to be able to asses the following:

- Knowledge, awareness level, attitude, practices
- Myths and misconceptions related to RCH prevailing in the society
- Information, treatment seeking behaviour
- Influence of groups, community leaders, religious leaders, service providers
- Current communication activities, efforts
- Media habits, etc.

Inter-sectoral Collaboration, Networking, Linkages

No programme can be run in isolation and it is truer in case of BCC and IEC activities. BCC strategy calls for new ways of working and partnering with a wide number of sectors including the corporate sector, NGOs, private healthcare providers and several development sectors such as nutrition, education, rural development and women's development. A well-concerted effort aimed at behaviour change amongst provider community, recipients of medical services and policy makers/opinion leaders will be planned. Need based hiring of BCC agents, NGOs, communicators, folk artists will be done.

For mass media such as radio, television and print media will be done centrally by the PMU facilitated by the state level expert group, to ensure economies of scale. Hiring of folk media will be done at district level. Printing of IEC materials, preparation and putting up of posters would be done through outsourcing.

Developing of messages and strategies addressing each selected audience segment for each selected BCC objective – The BCC Team and expert at the state level, in close association with district level BCC Team and experts will develop message sets and strategies targeting the audience segment group associated with each behavioural change objective and will pre-test the same for comprehension, acceptability and impact leading to finalization. Particular attention will be given to developing district specific strategies and their rapid piloting before wider adoption.

Selection of media and preparation of media plan – The BCC Team at state and district level will collectively select appropriate media and appropriate persons for implementation of BCC strategies such as for interpersonal communication, group meetings, mass and folk media, coordination with inter-sectoral partner functionaries etc. Efforts will be made to briefly test the cost-effectiveness of the selected media before wider usage.

Development of media specific prototypes and their pre-testing including pre-testing of BCC strategies will be coordinated by the state level BCC Team supported by the expert group in close association with the district level BCC Team and expert teams. Graphic, photography and production services will be outsourced by the expert group for this purpose.

Media related activities – Implementation of annual action plans will begin with production of content for each selected media as per agreed strategy and development of protocols for implementation of BCS strategies including roles and responsibilities for each functionary of the health department and partner departments/organisations/institutions. The state level expert group will outsource the production work to professional agencies and commercial production houses based on detailed briefs and prototypes as well as protocols as appropriate.

Quarterly Magazine - A magazine 'Kalyani' will be brought out on a regular basis from the state level. Besides being the mode of spreading knowledge and information, it will carry successful stories and good practices.

Workshops, Seminars, Exhibitions, Meals, Camps, etc. - Workshops, Seminars, Exhibitions, Meals, Camps will be organized from time to time to bring about awareness among the beneficiaries.

World Population Day, Mother's Day, etc. will be observed. This will provide an opportunity to the service providers to disseminate relevant messages to the community.

Inter-personal Communication (IPC) - The one channel of communication uniformly recognised as being important in all strategies has been that of interpersonal communication (IPC). The RCH programmes have relied heavily on 'frontline workers' engaging in face-to-face communication with their clients. Interpersonal communication and other media need to work in synchrony: the latter provide the trigger and the reinforcement while IPC is the cause of behavioural change. The ANMs, AWWs, and ASHA after being given proper training can become the resource persons for IPC.

Advocacy: Behaviour change normally requires encouragement and support at the community and family level. Since desirable health seeking behaviour tends to be different from existing patterns, obstacles to change arise within the family and the community. To remove such obstacles, as well as to generate support for strategies and service providers advocating change, effective communication programmes include in their target groups community leaders, opinion makers and functionaries of related programmes. The importance of such advocacy (aimed at formal leadership) and social mobilisation (aimed at opinion makers and functionaries) has been recognised in some communication strategies but these efforts needs to be backed by orchestrated implementation.

District level – The District Management Unit with the help of District IEC Bureau will support the PMU and State IEC Bureau in the implementation of the programme and will work in accordance with the plans prepared for the district and on lines similar to that of the PMU. It will plan strategies in a way that it will be able to reach the last beneficiary in the area.

7.3.4.4 IEC Advisory Committee: State, District and Block level

An Advisory Committee also known as Technical Resource Group (TRG) should be formed at the State, District, and Block level to advise and support and if need be to monitor the programme implementation. The committee would consist of 7-9 members from various cross-sections of society such as from the govt. and non-Govt. Depts. The committee may include members from electronic media, - television, radio, print media, communication training institute, communication specialists, NGO representatives esp. of those working in the health sector and involved in IEC activities, women's organizations, ICDS, WDC, etc. relevant others may attend the meeting as special invitees.

Specific activities to be taken up with a view to bring about behavioural change among the target group in the field of Maternal Health, Child Health, Adolescent Health and Family Planning are being elucidated below:

Maternal Health

Strategies and Activities

- Plan communication campaign to promote ANC services, Safe delivery and Referral practices through different media using multiple approaches such as TV, Radio, Folk Media, Wall Painting, Print Materials and IPC, etc.
- Produce pre-tested and tailor-made IEC materials for various audience segments (adolescents, women, rural audiences, religious groups etc.
- Broadcast/ distribute AV and print IEC materials through various channels
- Design, produce and disseminate materials for BCC for ANC to be used by NGOs and PRI networks.
- Plan and implement communication strategy for NGOs, ICDS and PRI networks to raise community awareness and knowledge about importance of institutional delivery, safe delivery practices at home, referral and PNC services.

Child Health

Strategies and Activities

- Production and broadcast of radio spots, jingles, folk songs and plays promoting importance of correct breastfeeding practices
- Production and broadcast of TV advertisements and plays on correct breastfeeding practices
- Publication of newspaper advertisements and stories on correct breastfeeding practices
- Produce prototypes and implementation strategy for IPC, group meetings, folk media and wall writing involving frontline Health workers, Anganwadi Workers, PRIs, TBAs, local NGOs and CBOs in promoting correct breastfeeding and complementary feeding through.
- Develop curriculum components for correct breastfeeding to educate adolescent girls about and complementary feeding practices through school -based awareness campaign.
- Design, produce and disseminate materials for BCC to be used by NGOs and PRI networks for promoting immunisation

- Use multiple mass media channels such as radio, TV, local cable networks, print media (local newspapers) to propagate early recognition of childhood illnesses, home-based care and care-seeking

Family Planning

Strategies and Activities

- Plan communication campaign to promote Family Planning through different media using multiple approaches such as TV, Radio, Folk Media, Wall Painting, Print Materials and IPC, etc.
- Produce pre-tested and tailor-made IEC materials for various audience segments (adolescents, women, rural audiences, religious groups etc.
- Broadcast/ distribute AV and print IEC materials through various channels
- Conduct publicity campaign to promote biannual health melas at all blocks for Planning Services.
- Produce IEC materials to be used by NGO and civil society networks, religious organisations and leaders, PRIs, ICDS, Education, General Administration, Corporate Associations and Professional bodies (IAP, IMA) to promote Family Planning
- Develop appropriate BCC materials for orientation and sensitization of partners through annual district and block level workshops
- Develop curriculum components for promotion of the small family norm, late marriage and child-bearing for school-based campaign to orient school-going adolescents
- Explore and implement innovative approaches to promote Family Planning methods among men, through barbers, teashops, pan-shops, and sports organizations. etc.

Adolescent Health

Strategies and Activities

- Develop appropriate IEC materials to be used for sensitisation of community leaders, school teachers, PRIs, NGO networks, Anganwadi Workers towards the health needs of the adolescents through annual block level workshops
- Plan BCC campaign to promote late marriage and childbearing among adolescents through mass media and tailor-made IEC materials

- Develop curriculum components for small family norm, late marriage and child-bearing to orient school-going adolescents through school curriculum and classroom talks
- Produce IEC materials to be used by NGO networks to propagate safe reproductive health practices and FP among adolescents primarily through inter-personal communication.
- Implement targeted BCC campaign to promote good nutritional practices and micronutrients such as Iron Folic Acid and Iodine through school curriculum and classroom talks to orient school-going adolescents.
- Implement extensive BCC campaign through different media using multiple approaches such as TV, Radio, Folk Media, Wall Painting and Print Materials, etc for out of school adolescents and community at large to promote good nutritional practices and micronutrients.

Urban RCH

Strategies and Activities

- Utilize various channels of mass media with extensive reach in urban areas such as TV, local cable networks, radio (particularly FM channels), cinema halls, billboards at strategic locations, etc to propagate messages related to key programme components of RCH.
- Extensively use print media such as newspapers (particularly local newspapers), journals and magazines for dissemination of key RCH messages.
- Produce IEC materials to be used by representatives from Urban Local Bodies (municipal corporations and municipalities), commercial associations, sports bodies, voluntary and religious organisations for intensive inter-personal communication and community-based awareness campaigns.
- Design and disseminate publicity materials to be used by NGO network (MNGOs and FNGOs) with RCH to deliver key messages planned under RCH through IPC and community-based activities in urban areas, particularly in urban slums.
- Develop curriculum components for RCH services with emphasis on adolescent health for school-based awareness campaign.

7.3.5 Financial Management

An integrated Financial Management System (FMS) will be developed. The purpose of FMS will be to:

- Make accurate fund flow projection
- Identify utilization rates and trends
- Monitor expenditure patterns against sanctions and allotments
- Identify areas of under utilization of funds

All concerned staff at State level will be (Re) trained to ensure compliance of the operational guidelines of financial management system of RCH II.

7.3.5.1 Fund Flow Mechanism

Against the submission and approval of the PIP, Department of Family Welfare, Government of India will release funds to the SHSB. The funds released and the future installments will be against achieving of benchmarks as mentioned in the Budgets section. SHSB will maintain a separate identifiable bank account for the purpose of receipt and release of funds under RCH II.

GoI to SHSB

An MOU will be signed between the SHSB and DoH&FW, GoI with clearly laid down benchmarks. Release of instalments from DoH&FW, GoI to SHSB will be based on the benchmarks achieved. All disbursements will be on the basis of Statement of Expenditures accompanied by necessary and complete documentation.

SHSB to DHS

SHSB will release funds to District Health Societies (DHSs) based on the annual action plans along with annual budgets submitted within the prescribed format. Disbursement of installments will take place against achievements of benchmarks specified in the budget and agreed upon between the respective DHSs and SHSB. For release of second and other installments of fund to DHSs, Statement of Expenditure and Utilization certificates need to be accompanied with statement and report of achievement of the benchmark. District Health Societies will follow the disbursal, receipt of utilization and reporting norms as specified within the financial management system set up for RCH II.

7.3.5.2 Financial Audit

Regular and timely internal and statutory audits will be done as per the norms of the GoB and GoI. Qualified and reputed Chartered Accountancy Firms will be appointed for this purpose. The appointment will be done in consultation with GoI. Statutory audit will be complete within six months of the end of the financial year. SHSB and the accounts of all the District Health Societies will be subject to audit as per the existing norms. Standardized formats for audit statements, Statement of Expenditures made available by Government of India will be used for this purpose. **Detailed work plan stating objectives, strategies,& activities is being developed separately.**

7.3.6 Logistics Strengthening

Government of India procures drugs, vaccines and supplies. This will be done in close coordination with the SMU and PMU. Liasioning with the Regional – in – Charge of the Logistics Management Information Unit (LMIU) proposed to be set up at the national level under RCH II by Government of India will be done.

It is proposed that the SMU will help set up an effective logistics management system in the state in close collaboration with the PMU. Though the responsibility of procurement will be undertaken by the GOI, it will have to rely upon the personnel in the state administration and the state infrastructure - for warehousing and distribution upto the site of delivery/usage. Thirtyeight drug stores will be setup at each district head quarters. These stores will be established in collaboration with GOI public enterprises like HSCC, Hospito India. While setting up the system, some of the major points to be kept in mind by the SMU are as follows:

- ✓ Minimum time lag between indenting and procurement
- ✓ Developing specifications for quality given with indents
- ✓ Mechanisms for pre shipment and post shipment inspection
- ✓ Proper system used for returning of stocks if non-compliance is found
- ✓ Guidelines for receiving of shipments
- ✓ Proper infrastructure ,guidelines, and space available for storage
- ✓ Proper system for inventory management at the receiving and usage sites
- ✓ Record keeping and MIS at each site
- ✓ System for release of drugs and vaccines
- ✓ System for taking back unused vaccines and drugs
- ✓ System of monitoring of expiry dates and quality of drugs, vaccines, supplies including contraceptives
- ✓ Calendar of induction and refresher training programs in logistics management.


PROGRAM
MANAGEMENT

8. PROGRAMME MANAGEMENT ARRANGEMENTS

Strengthening Management Systems

Issues related to management have been identified as the major impediments in RCH I implementation in Bihar. The minimal achievements and critical gaps including extreme under utilization of funds by the State are the indicators of the overall poor performance of the RCH I program in the State. *(Refer to Section 4: Background and Current Status & Section 5: Situational Analysis).* To address this issue and to ensure effective management of RCH II, a three-tier management structure (State, District and Hospital level) is proposed. In the ensuing sections the program management structure at each of these three tiers – State level, District level and Hospital level will be discussed.

8.1 State Level Management

[1] Restructuring of the Department of Health and Family Welfare

Recently, the health department in Bihar has been restructured according to the guidelines of the MoH&FW, GoI. To achieve better co-ordination and effective program management, the two departments, the Department of Health and the Department of Family Welfare have been merged as the Department of Health and Family Welfare, headed by a Secretary. This restructuring was long overdue and is a major step in the direction of better management of the Health and Family Welfare programs in the state.

2. Regional Dupty Directors.

The RDD's office has become almost redundunt over a period of time. It has been envisaged to strengthen the RDD's office at the Divigional level with a view to effective supervision of the district level program managers. The RDD's will carry out regular monitoring of the health program managers at the district level. All the reports generated at the district level will be send to the State through RDDs.The RDDs will compile and analyse the reports receiived from the districts.The Secretary DOH& F W and Director in Chief would take reports from the RDD"s on frequent intervals. This would increase the efficiency of monitoring of the health programs.

[3] Establishment of the State Health Society, Bihar (SHSB)

GoB has decided to establish the SHSB to function as the nodal agency, replacing SCOVA, for implementation of Family Welfare programs in Bihar. The Society will be responsible for planning, management , supervision and monitoring of health & family welfare programs such as RCH II and NRHM.

[3.1] Objective of the State Health Society, Bihar (SHSB):

The Society will provide managerial and technical capacity to the Department of Health & Family Welfare, Government of Bihar for the implementation of Health & Family Welfare programs such as National Rural Health Mission (NRHM) and RCH Phase –II. It may also provide need-based managerial and/or technical support to National Disease Control Programs for diseases such as tuberculosis, leprosy, blindness and vector borne diseases like malaria, kala azar, filarial, dengue and Japanese encephalitis.

[3.2] Major Tasks of the State Health Society, Bihar (SHSB)

To provide managerial and technical support to the Department of Health and Family Welfare, GoB, the SHSB will perform the following key tasks.

- Integrate the programme management posts available to the State under the 100% GoI sponsored National Family Welfare Programme [regular posts available for the State Family Welfare Bureau and the contractual positions available under the on-going RCH programme] under a single command structure.
- Mainstream staff working in contractual positions into the decision making and programme implementation process .
- Provide a optimum level of operational autonomy to the State level programme managers in the implementation of planned activities under RCH II and NRHM.

- Assist the DoH&FW to recruit need-based additional technical / managerial personnel at state and district levels.
- Receive, manage (including disbursement to implementing agencies e.g. Directorate, District Societies, NGOs etc.) and account for the funds received from the Ministry of Health & Family Welfare, Government of India.
- Manage the NGO / PPP (public–private partnership) components of the RCH-II/NRHM in the State, including execution of contracts, disbursement of funds and monitoring of performance.
- Function as a Resource Center for the Department of Health & Family Welfare in policy/situational analysis and policy development (including development of operational guidelines and preparation of policy change proposals for the consideration of Government).

- Mobilize financial / non-financial resources for complementing/supplementing the RCH-II / NRHM activities in the State.
- Organize training, meetings, conferences, policy review studies / surveys, workshops etc. for deriving inputs for improving the implementation of RCH -II / NRHM in the State of Bihar.
- Undertake such other activities for strengthening RCH-II /NRHM in the State as may be identified from time to time, including mechanisms for intra and inter-sectoral convergence of inputs and structures.

For performing the above tasks, the Society will:

- Establish and carry out the administration and management of the Society's Secretariat, which will serve as the implementation arm of the Society.
- Create administrative, technical and other posts in the Secretariat of the Society as deemed necessary.
- Establish its own compensation package and employ, retain or dismiss personnel as required.
- Establish its own procurement procedures and employ the same for procurement of goods and services.
- Make rules and bye-laws for the conduct of the activities of the Society and its Secretariat and add, rescind or vary them from time to time, as deemed necessary.

[3.3] Structure of the State Health Society, Bihar (SHSB)

The SHSB will have the three bodies namely, Governing Body, Executive Committee, and various programme committees. The Governing Body of the Society would comprise of the following members:

• Development Commissioner, GoB	Chairperson.
• Finance commissioner DoF, GoB	Deputy Chairperson.
• The Secretary DoH & FW, GoB	Chief Executive & Interim Member Secretary
• The Secretary Department of Planning ,GoB	Member
• Secretary DoME & ISM	Member
• Project Director SACS	Member
• Director ICDS	Member

The Executive Body of the Society would comprise of the following members:

- Secretary DoH&FW — Chairperson
- Secretary, DoME&AM — Member
- Deputy/Jt/Addl. Secretary in charge of FW — Member
- Director-in-Chief/Director, DoH — Member
- ED — Member Secretary
- Addl./Dy Director, DoFW — Member
- Representative of MH&FW , GoI — Member
- Representative of UNICEF — Member
- Representative of EC — Member
- Regional Director, RHFW, GoI — Member
- Members from NGOs, private sector & professional institutions to be co-opted for a term of three years

The Organogram of the State Health Society, Bihar (SHSB)

The overall governance structure of the Society will be as depicted in *Figure-1* below.

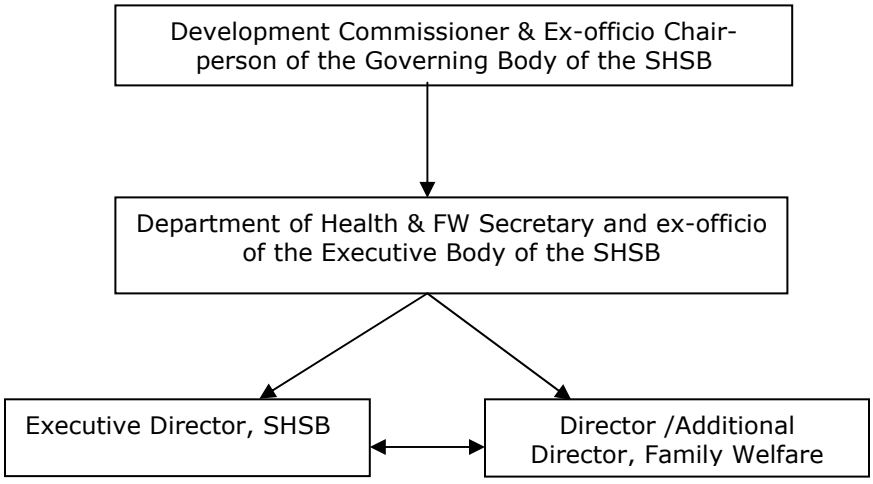


Figure-1: Governing Structure

The functional / programme divisions will be structured in a matrix type arrangement except for the Finance and Administration Division which will serve the rest of the Divisions. *Figure-2* below depicts the functional/programme divisions.

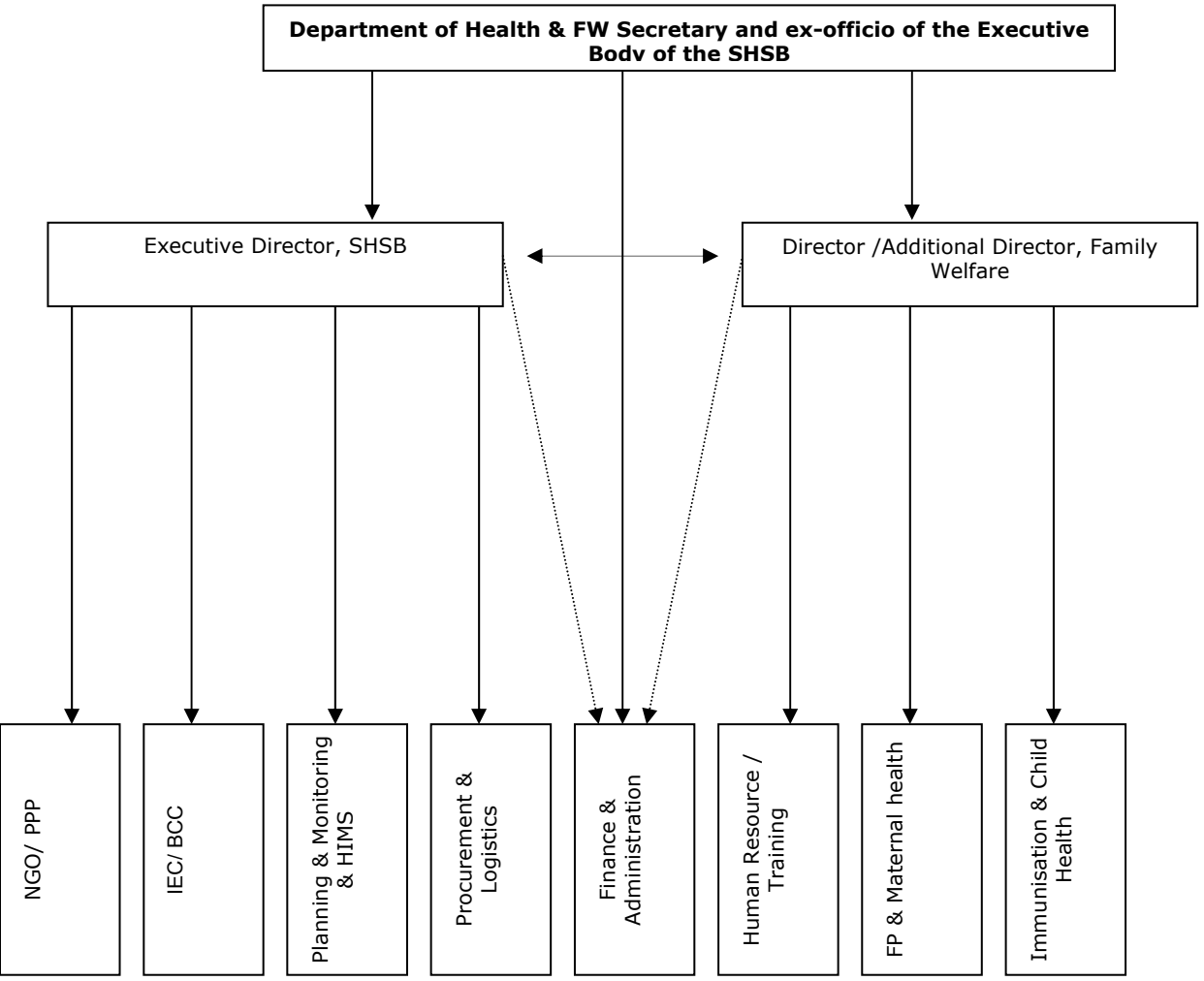


Figure-2: Functional /programme Divisions of the SHSB

Characteristics of the Organogram of the State Health Society, Bihar (SHSB)

- The proposed Organogram integrates the regular programme management posts available to the State under the National Family Welfare Programme (viz. the State FW Bureau posts) and the contractual positions sanctioned under the RCH-I.
- Each Division will be headed by an Additional / Joint Director and supported by junior experts and/or support staff. Indicative composition for each of the functional Divisions is given below, to be endorsed by the Governing Body.
- The support services like housekeeping, photocopying, local travel etc. are not considered in the Organogram as these shall be outsourced.
- The Finance and Administration Division is to serve the remaining functional units as per the decision making arrangements as set out in Section C below. Ordinarily, therefore, head of F&A Division would report both to the Executive Director as well as Director (FW). However, the overall control over the F&A Division shall rest with ex-officio Chair-person of the SHSB, i.e. Secretary (DoH&FW).
- Each of the functional Divisions (other than F&A Division) may also be assigned a geographical responsibility relating to all RCH/NRHM activities.

- ❖ The recruitment process for the State FW Bureau positions sanctioned under the National Family Welfare Programme, hitherto filled on promotion basis, would be amended as proposed below (Section D: Human Resource Policy and Procedures).
- ❖ The Organogram does not imply merger /integration of SIHFW with the SHSB. However, an eventual merger of the SIHFW with the SHSB may be considered by the Governing Body.

[3.4] Appointments of Programme Division Heads of the State Health Society, Bihar (SHSB)

The recruitment of Executive Director will be through a three-member selection committee appointed by the Governing Body.

The recruitment of the posts of Additional Director (Planning, Monitoring and Evaluation), Additional Director (NGO/PPP) and Additional Director (procurement and logistics) may also be done through the selection Committees appointed by the Governing Body:

The posts of Director, FW and Additional/Joint/Deputy Directors for the technical Divisions (Immunisation and Child Health Division, Family Planning and Maternal Health Division and Training & BCC Division) will be filled up on deputation basis from amongst officers of the Bihar State Medical Services who are eligible to be appointed as Civil Surgeons; have the requisite specialization; and have at least three years to retire. The Governing Body may resolve to declare some or all technical positions under the SHSB to be 'ex-cadre' selection posts and may decide to fill up the positions through open advertisement.

All recruitment for a period of one year or more would be finalized only by a suitable panel appointed by the executive committee. For posts with a monthly salary / consultancy fee exceeding Rs 10,000/- (Rupees ten thousand), the Executive Director would always be a member of the panel. Suitable subject experts from outside the Executive Committee would also be invited to be part of the panel. The panel would have a chairperson and at least three more members, of which two would be outside the Executive Committee. The panel's recommendations would be subject to its acceptance by the Executive Committee. All appointments would be temporary and would be made for the contract / deputation period as determined by the Governing Body.

[3.5] Appointments of Contractual Staff for SMU

All appointments for the SMU would be temporary and be made for the contract/deputation period decided by the governing body of the society. These appointments can fall in four categories:

- Short –Term Consultants
- Long Term Consultants
- Short term Assistantship / Fellowships
- Staff on Deputation from other organizations

The appointments `will be on the basis of a lump-sum compensation package to be paid on a monthly basis. However, there will be a provision for annual increments having a built-in mechanism for neutralizing inflation effect. The Governing Body may also consider providing certain other benefits to the contractual staff such as the following:

- group medical and accident insurance coverage and
- staff loans

The Governing Body shall engage appropriate expertise to formulate its own rules in the above matters which will be treated as an integral part of Society Rules after they are vetted in a subsequent meeting of the Governing Body.

Short –Term Consultants: These are consultants who have tenure of 11 months or less. It could even be for a week. They are hired for specific tasks and paid according to their assigned task as well as the rates negotiated based on the availability of options the Society has and on the consultants' experience. Their payment is related to outcomes on assigned work and there would be no restriction on what other consultancy they are undertaking. Accordingly, none of the benefits of contractual employees would be applicable to them and tax would be deducted at source as per rules.

Long Term Consultants: These are consultants who accept an assignment for over a year. Their salary is negotiated and would broadly be compatible with that which is paid to contractual employees. However, they would not be eligible for any of the benefits. Individuals whose work is required for over a year would be offered contractual employment. Long term consultancy would be permitted only if the person concerned chooses this option over contractual

employment. Whether they are full time and whether they can take up other consultancy work in parallel would form part of their initial negotiations, along with the deciding of their fees and the agreement signed would express this.

Short term Assistantship / Fellowships: Professionals interested in gaining public health / community health/ managerial, other relevant experience, newly qualified or as part of their coursework can be provided short term assistantships / fellowships for a fixed period - not exceeding six months to gain experience. They will also draw a consolidated fellowship lower than what they would normally get on full time employment at that level of qualification and experience.

Staff on Deputation from other organizations: In this case, the salary and other benefits will be paid by the Society in line with the salary policy of their parent organization, or as is applicable to contractual employees of the Society, depending on the option exercised by the concerned person.

[3.6] Functions of the Divisions of the State Health Society, Bihar (SHSB)

The key functions of the proposed eight divisions at the State Health Society, Bihar (SHSB) will be as follows

[3.6.1] Planning and Monitoring Division

[3.6.1.1] Policy Development, Planning and Co-ordination

- Develop policy for the health sector reform by undertaking situational analysis, documentation and evaluation of reform initiatives in other States.
- Develop proposals for strengthening service delivery systems in the State, including development of operational strategies for strengthening routine service delivery systems, development of strategies for improving referral services and identification of opportunities for rationalising service delivery and support infrastructure.
- Design / develop proposals for alternative service delivery systems and developing operational framework for piloting the proposals.
- Design systems and procedures for independent feedback mechanisms for assessing access to and quality of services; and participating in external evaluations by GoI / Development Partners.

- Co-ordinate formulation of State FW Plans and participate in development of new initiatives in the health sector in the State
- Collaborate with agencies in the health sector (viz. State AIDS control Society, State TB Control Society) and other departments of the State Government (Women and Child Development, Rural Development etc.).
- Act as the clearing house for new initiatives / interventions in the FW sector.

[3.6.1.2] Monitoring and Evaluation

- Manage routine reporting data received from the districts and hospitals.
- Prepare and maintain data base for other Programme Divisions (e.g. Human Resources, Finances in the Sector, Releases to and reported expenditure from district societies, procurement and supply of goods to districts, supplies received from the GoI).
- Develop and maintain Local Area Network (LAN) for SHSB.
- Collaborate with NPSP units (State and districts) for data exchange and verification etc.
- Implement independent feedback mechanisms (designed jointly with Joint Director, Planning) for assessing access to and quality of services.
- Provide miscellaneous MIS support to other Programme Divisions.

[3.6.1.3] Secretariat Functions of the SHSB

- Perform secretariat functions of the SHSB e.g. preparing agenda notes, issuing minutes and obtaining action taken reports etc.

[3.6.2] NGO/PPP Division

[3.6.2.1] NGO Co-ordination

- Manage the existing NGO schemes of the GoI and the State Government.
- Develop systems for reporting, monitoring and evaluation of NGOs and Private sector and prepare performance assessment reports through such mechanisms as may be determined by the Programme Management, Co-ordination and Policy Development Division.
- Co-ordinate with structures created for NGO partnerships by GoI.
- Develop and maintain a centralised database on collaborative projects, their progress and related service statistics.

[3.6.2.2] PPP/ Social Marketing Co-ordination

- Maintain a directory of potential partner organisations
- Assist Programme Management, Co-ordination and Policy Development Unit in developing systems, prototypes, operating tools, and guidelines for proposal development, project management, capacity building, record keeping etc.
- Manage the social marketing and social franchising interventions in the state.
- Any other job assigned from time to time.

[3.6.3] Procurement and Logistics Division

[3.6.3.1] Procurement:

- Assess the requirements of drugs, vaccines, contraceptives, kits, other consumables, equipment, other materials and services and technical assistance etc.
- Prepare annual procurement plans for goods and services.
- Organise procurement as per the procurement procedures of the Society and in accordance with the procurement plan approved by the Governing Body of the Society.
- Develop and institute system for the assessment of procurement needs at the district level (participatory and bottom up approach using empirical data).
- Develop Quality assurance and standardisation.
- Procure assets for and behalf of the Society.

[3.6.4] Finance and Administration Division

[3.6.4.1] Financial Planning:

- Assist Planning Division in budget analysis for the health sector.
- Develop proposals for improving financial management systems at State and district levels, covering all sources of funds.
- Assist the Department of Family Welfare in management of funds channeled through the treasuries; maintain database on sanctions / allotment orders issued and other related information.

[3.6.4.2] Management of Finances of the Society

- Manage Society funds, including

  (a) Disbursement of funds to implementing agencies.

  (b)Payment of salaries to the Society staff. and

  (c)preparation of Statement of Expenditure (SOE).

- Develop operational manuals for management of funds in the State Society, district societies and facility level societies (e.g. hospital management societies), including procedures for disbursement, internal control systems, delineation of financial powers and reporting standards (forms/formats, frequency) etc.
- Develop systems and procedures for efficient functioning of the State Society and develop similar 'model' guidelines for district and facility level societies.
- Train staff of the State and district societies in using operational manuals / guidelines.

[3.6.4.3] Administration

- Perform personnel management functions relating to Society staff.
- Perform secretarial functions relating to management of TA contracts.
- Undertake such other assignments, which may be assigned by the Executive Director of the Society from time to time.

[3.6.4.4] Audit:

- Organize annual audit of the SHSB State
- Organize audit of district societies.
- Develop systems for internal audit

[3.6.5] Child Health Division

[3.6.5.1] Immunisation

[3.6.5.2] New Born care, including IMNCI

[3.6.5.3] Protein calorie malnutrition management

[3.6.5.4] Diarrhea control

[3.6.5.5] ARI, Vitamin-A and micronutrients

[3.6.6] Family Planning and Maternal Health Division

[3.6.6.1] Family Planning

[3.6.6.2] maternal care including Operationalisation of FRUs

[3.6.7] IEC/BCC Division

[3.6.7.1] Management of community level BCC interventions

[3.6.8] Training & Capacity Building Division

[3.6.8.1] Manage in-service and pre-service (induction) training programs including IMNCI training and multi-skilled training of medical officers

[3.6.8.2] Co-ordinate with NIHFW, medical colleges and other training institutions that may be engaged for specific training programs

[3.6.9] Human Resource and TA Management

- Develop proposals for improving human resource management practices in the State.
- Identify technical assistance needs, including preparation of Terms of Reference.
- Support management of technical assistance inputs at State and district levels, including performance monitoring of District Programme Facilitators appointed by the Society.
- Manage human resources of the State Society, including recruitment of contractual staff and their performance assessment as per their Torso.

8.2 District Level Management

At the district level, the Governing Body of the integrated District Health Society (DHS) will perform the functions of the District Health Mission, including inter-sectoral convergence.

The DHS will be responsible for planning and managing all health and family welfare programs in the district, both in the rural as well as urban areas. There are two important implications of this requirement. Firstly, DHS's planning will have to take note of both treasury and non-treasury sources of funds, even though it may not be handling all sources directly. Secondly, its geographical jurisdiction will be greater than those of the Zilla Parishad and /or Urban Local Bodies (ULBs) in the district.

Ensuring Inter-sectoral convergence and integrated planning should be a specific task for the Governing Body of the DHS. However, the DHS is not meant to take over the executive functions of the ZP / ULBs and/or the district health administration On the contrary, DHS is meant to provide the platform where the three arms of governance – ZP, ULBs and district health administration and district programme managers get together to decide on health issues of the district and delineate their mutual roles and responsibilities.

The DHS may also be viewed as an addition to the district administration's capacity, particularly for planning, budgeting and budget analysis, development of operational policy proposals and financial management etc. Because it is a legal entity, the DHS can set up its own office which has adequate contingent of staff and experts and can evolve its own rules and procedures for hiring the staff and experts both from the open market as well as on deputation from the Government.

In other words, the DHS is not an implementing agency; it is a facilitating mechanism for the district health administration as also the mechanism for joint planning.

[1] Structure of the District Health Society (DHS)

The overall structure and composition of the Society is listed below.

Governing Body

District Magistrate, Zilla Parishad	Chairperson
District Development commissioner,	Vice-Chairman
Civil Surgeon / Chief Medical Officer	Chief Executive Officer
Executive Secretary, DHS	Member-Secretary
MPs, MLAs, MLCs from district	Member
Project Officer (DRDA)	Member
Chair-person of Hospital Management Society	Member
District Programme Managers for Health	Member
District Programme Managers for PHED	Member
District Programme Managers for ICDS	Member
District Programme Managers for Education	Member
District Programme Managers for Social Welfare	Member
District Programme Managers for Panchayati Raj	Member
Non-official Nominees	Member

Executive Committee

Civil Surgeon / Chief Medical Officer	Chairperson
Executive Secretary, DHS	Member Secretary
District Programme Managers for Health	Member
District Programme Managers for PHED	Member
District Programme Managers for ICDS	Member
District Programme Managers for Education	Member
District Programme Managers for Social Welfare	Member
District Programme Managers for Panchayati Raj	Member
Non-official Nominees	Member

[2] DHS Secretariat

Initially, the Society Secretariat will have a core team of 3 full time persons, consisting of the following:

- Executive Secretary .
- Finance / Accounts Manager, and
- Data Assistant.

Once the Society Secretariat is operationalised (that is, the above core staff is in place and the office set up), the district programme officer posts sponsored under the Centrally Sponsored Schemes[i] should be brought under the Society mechanism, as envisaged under the National Health Policy, 2002. Till this integration, existing district programme managers may be the ex-officio member-secretaries of the concerned programme committees of the Executive Committee of the DHS as provided for in the bylaws.

Eventually (that is, after integration of the posts sponsored under the Centrally Sponsored Schemes with the DHS), the DHS will have a number of functional units including technical officers belonging to State Medical Services posted on deputation to the District Society Secretariat. This will not only allow the DHS to exercise a choice in the selection of district programme managers, the tenure issue will also be addressed since all deputation postings will be for a minimum period of 3 years. The DHS secretariat will be headed by an executive secretary and will be the nodal agency for programme implementation at the district level. The specific roles and responsibilities of the executive secretary at the DHS secretariat are outlined below.

[3] Role of the Executive Secretary, DHS Secretariat

The Executive Secretary is seen as the key player not only in setting up and operationalising the DHS secretariat, but also in arranging managerial and supportive assistance to the district health administration, including general management and logistic support. It is because of the twin responsibility that s/he is been made the Member Secretary of both the Governing Body as well as the Executive Committee. In the Programme Committees, however, s/he will be a simple member.

The specific responsibilities of the Executive Secretary, DHS will include, but not be limited to the following:

Management of DHS Secretariat

- Facilitate the working of the DHS as per the bye-laws of the Society.
- Organise recruitment of personnel for the DHS.
- Maintain records of the Society.
- Organise meetings of the Governing Body and Executive Committee including preparation of agenda notes, circulation of minutes and compilation of action taken reports etc.
- Organise audit of the Society funds and preparation of annual report of the DHS as required under the bylaws.

Planning, Monitoring and Evaluation

- Create and maintain district resource database for the health sector including personnel, buildings, equipment and other support infrastructure.
- Assist the Civil Surgeon and district programme managers in developing the district work Plan based on the National & State goals.
- Undertake regular monitoring of initiatives being implemented in the district and provide regular report and feedback to the Society and others who are entitles to receive Annual Report of the Society [District Collector, Chairperson, Zilla Parishad, designated authority State Government].
- Ensure compilation, analysis & presentation of relevant information in meaningful formats and assist the Civil Surgeon in making informed discussions.
- Develop strategies/plans to improve the quality of services and present to the Society for approval.

Inventory management, Procurement & Logistics

- Facilitate preparation of District Logistics Plan for optimal allocation of resources at each facility.
- Ensure timely collection and compilation of ‘demands’ and their timely dispatch.

[4] Procedure for recruitment and appointment of contractual staff

Recruitment can be facilitated by the State Society, as this would allow economies of scale and save time. However, offer letters should be issued by the District Society on the basis of a

specimen offer letter. The recruitment of the specialists for the hospitals can be similarly organized by the State Society or the District Society. After recruitment, however, the offer letters should be issued by the Hospital Management Society.

8.3 Hospital Management Society

Aims and Objectives

The objectives of the Society will be to:

- Upgrade and modernize the health services provided by the hospital and any associated outreach services.
- Supervise the implementation of National Health Programme at the hospital and other health institutions that may be placed under its administrative jurisdiction.
- Organize outreach services / health camps at facilities under the jurisdiction of the hospita.l
- Monitor quality of hospital services; obtain regular feedback from the community and users of the hospital services.
- Generate resources locally through donations, user fees and other means.

Functions of the Hospital Management Society

To achieve the above objective, the Society shall direct its resources for undertaking the following activities / initiatives:

- Acquire equipment, furniture, ambulance (through purchase, donation, rental or any other means, including loans from banks) for the hospital.
- Expand the hospital building, in consultation with and subject to any guidelines that may be laid down by the GoB.
- Make arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipment available with the hospital.
- Improve boarding/lodging arrangements for the patients and their attendants.
- Enter into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc.
- Develop/lease out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society.

- Encourage community participation in the maintenance and upkeep of the hospital.
- Promote measures for resource conservation through adoption of wards by institutions or individuals and.
- Adopt sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water re-charging systems etc.

Structure of the District Hospital Management Societies

Governing Body

Deputy Development commissioner	Chairperson
District Magistrate	Vice –Chairperson
Medical Superintendent of the hospital	Member-Secretary
Chief Executive Officer, Nagar Nigam	Member
Up to 2 nominees of the Chairperson, Zilla Parishad	Member
Up to 3 eminent citizens nominated by DM	Member
A NGO representative nominated by DM	Member
Representative of local Medical College	Member
Representative of public sector / NGO hospitals nominated by DM	Member
An individual who makes a one time donation to DHS	Associate members
Any institution, which donates a specified amount to DHS	Institutional member

Frequency of meetings

- At least once every quarter

Regular Agenda

- Review of the OPD and IPD service performance of the hospital in the last quarter and service delivery targets for the next quarter.
- Review of the outreach work performed during the last quarter and outreach work schedule for the next quarter.
- Review of efforts in mobilizing resources from the community, trade / industry and local branches of professional associations like IMA and FOGSI etc.
- Review the reports submitted by the Monitoring Committee and direct appropriate remedial action

- Discuss the proposals from the Executive Committee

Executive Committee

Medical Superintendent of the hospital	Chair-person
Member Secretary of the Governing Body	Member Secretary
Zilla Parishad Chair-person's nominees to the Governing Body	Member
DM's nominees to the Governing Body	Member
Representatives of institutional members, if any	Member
Additional members as may be co-opted by the executive committee	Member

Frequency of meetings

- Once every month

Regular Agenda

- Review of the OPD and IPD service performance of the hospital in the last month and service delivery targets for the next month.
- Review of the outreach work performed during the last month and outreach work schedule for the next month.
- Consider reports of the Monitoring Committee for remedial action

Monitoring Committee

An Eminent person nominated by DM to the Governing Body	Chairperson
Member Secretary of the Governing Body	Member Secretary
One of the Zilla Parishad Chair-person's nominee to the Governing Body	Member
NGO representative nominated by the DM to the Governing Body	Member
Representatives of institutional members, if any	Member
Associate members, if any, who are willing to work voluntarily	Member

Tasks

- Visit hospital wards.
- Collect patient feedback through

    (a) sealed cover feedback form administered at discharge time (in-patients),

(b) complaints received through complaint boxes placed in OPD block (OPD patients) and

(c) general discussion with patients and their attendants.

- Prepare and submit monthly monitoring report to Chairperson of the Zilla Parishad, DM, Chairpersons of the Governing Body and Executive Body of the HMS, Chairperson of the Urban Local Body and Institutional members.

Structure of the Sub-District Hospital Management Societies

Governing Body

Sub-divisional Officer	Chairperson
District programme officer (deputy CMO or equivalent) in charge	Vice Chairperson
A Senior Medical Officer of the Hospital	Member-Secretary
Officer-in-charge of the hospital	Member
Block level officers of ICDS, RD, PRI, PHED, Education and Social Welfare	Member
Representative of health sector NGO working in the area	Member
An eminent citizen, nominated by DM / SDM	Member
An eminent citizen, nominated by Chairperson, Panchayat Samiti	Member
Chief Executive Officer, Nagar Nigam (if applicable)	Member
An individual who makes a one time donation to DHS	Associate members
Any institution, which donates a specified amount to DHS	Institutional member

Frequency of meetings and regular agenda

- Same as for district hospital society

Executive Committee

Officer in charge of the hospital	Chairperson
Member Secretary of the Governing Body	Member secretary
Panchayat Samiti Chair-person's nominee to the Governing Body	Member
DM/ SDM's nominee to the Governing Body	Member
Block level officers of ICDS, PHED and Education	Member
Representatives of institutional members, if any	Member

Frequency of meetings and regular agenda

- Same as for district hospital society

Monitoring Committee

Panchayat Samiti Chair-person's nominee to the Governing Body	Chairperson
Member Secretary of the Governing Body	Member Secretary
District Collector'/ SDM's nominee to the Governing Body	Member
Associate members, if any, who are willing to work voluntarily	Member

Tasks

- Same as for District Hospital Society
- Recipients of Monitoring Committee Reports to Chairperson, Zilla Parishad, DM, Chairperson, Governing Body of the HMS.

9. MONITORING AND EVALUATION

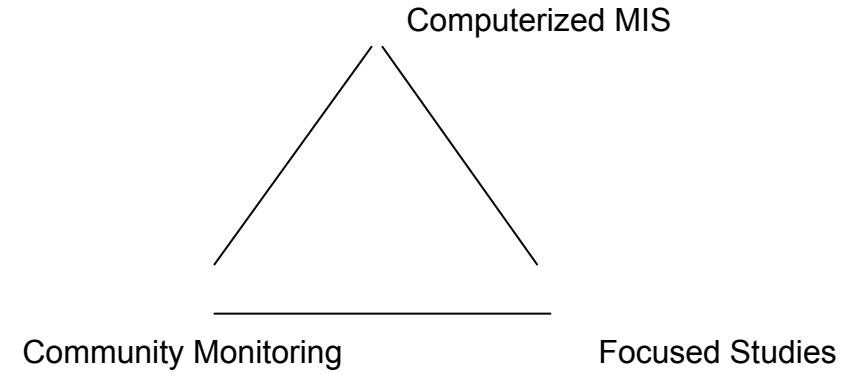
One of the major weaknesses of the RCH program in the Bihar is the absence of an effective Monitoring and Evaluation system that would provide accurate and reliable information to program managers and stakeholders and enable them to determine whether or not results are being achieved and thereby assist them in improving program performance. A triangulated process of Monitoring and Evaluation would enable cross checking and easy collection, entry, retrieval and analysis of data.

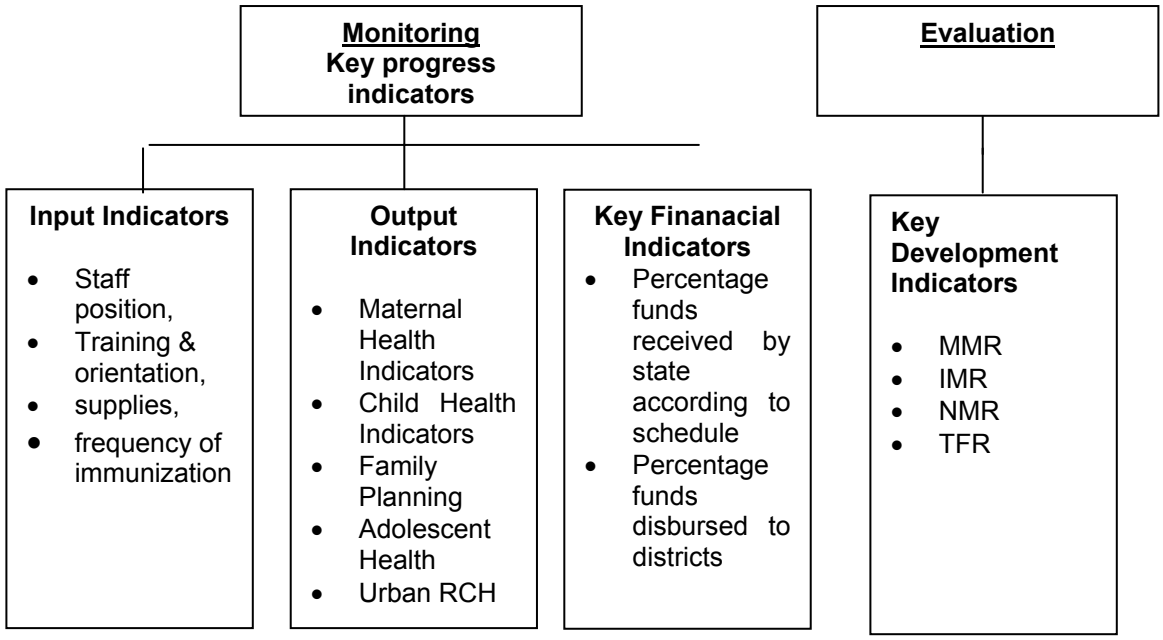
Activities

- ✓ Strengthening with up gradation of the post of state demographer at state level for monitoring and evaluation of all programs under health and family welfare as well as population studies and impact of the family welfare programme.
- ✓ Creation of Demographic and evaluation cell in district F.W bureau in each district
- ✓ Recruitment of statistical/computer personnel in the demographic cells at each level
- ✓ Mobility support
- ✓ Equipping and furnishing demographic cells
- ✓ Conducting survey and concurrent evaluation
- ✓ Formation of Databank
- ✓ Revised CNAA for all levels would be persuaded and guidelines for preparation district plans

- ✓ Web/internet based computer software for use at district and state level
- ✓ Reporting formats for providing requisite information
- ✓ Road map of each health centre for easy communication
- ✓ Triangulation of data
- ✓ Video conference used in every computer used place

Triangulation Process for Monitoring and Evaluation





9.1 Key Development Indicators

The key development indicators for measuring progress in reaching the overall project development objectives for the RCH programme in the state are as follows.

- Maternal Mortality Rate
- Infant Mortality Rate
- Neonatal Mortality Rate
- Total Fertility Rate

9.2 Key progress indicators

Key progress indicators enable the monitoring of delivery of project inputs and the achievement of project outputs.

Table 10.2.1 : Examples of Input Indicators

Institutional Strengthening: Infrastructure	Institutional Strengthening: Human Resource	Programme management	HMIS	Supervision
• No. of new facilities constructed • No. of new facilities upgraded • No. of essential equipment supplied	• No. of health personnel appointed • No. of health personnel trained for capacity building	• No. of programme managers appointed at state/district levels • No. of programme managers trained at state / district levels	• Number of operational equipment such as computers supplied to reinforce HMIS	• Number of new formats developed • Percentage of work computerized

9.3 Key financial indicators

Key financial indicators help assess the project's budgetary and financial health.

- Percentage of funds received by state according to schedule
- Percentage of funds disbursed to districts
- Percentage of funds disbursed to districts according to schedule (within 15 days)
- Percentage of utilization of funds against allocation by state / districts

10. BUDGET

The proposed annual budget to be provided by GoI for the programme Rs. 114.30 crores for the year 2005-06, Rs. 142.30 crores for the year 2006-07, Rs. 336.81 crores for the year 2007-08, Rs. 390.27 crores for the year 2008-09 and Rs. 326.88 crores for the year 2009-10. The total plan outlay for the next five years will be Rs. 1841.91 crores.
(See details attached)