Summer Training at
State Health Society Bihar
(April - June, 2013)

HEALTH SCENARIO IN BIHAR UNDER NRHM" AND QUALITY ASSESSMENT TO LABOR ROOM (HUMAN RESOURCE, BIO, MEDICAL WASTE AND INFECTION CONTROL) IN KOSI DIVISION BIHAR

By
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Post Graduate Diploma in Hospital and Health Management
2012-2014

Institute of Health Management Research,
Jaipur
2013

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Certificate

This to certify that **Dr. Keshav Sharma**, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur, Batch 17th has successfully undergone summer training in State Health Society, Bihar on the topic on **"Health Scenario in Bihar under NRHM" and "Quality assessment of Labor Room (Human Resource, Bio Medical Waste and Infection Control) in Kosi division, Bihar** from April 8th to June 7th 2013.

The candidate has successfully carried out the study assigned to him during summer training and his approach towards the study was sincere, scientific and analytical.

We wish him success in all his future endeavors.

Dr. Santosh Kumar
Associate Professor,
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Sanjay Kumar, IAS
Secretary, Health
-cum-
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संजय कुमार, भा०प्र०से०
सचिव, स्वास्थ्य
-सह-
कार्यपालक निदेशक

Letter no:...4710...

Dated:...07/06/13...

To Whom It May Concern

This is to certify that Dr. Keshav Sharma, student of Institute of Health Management Research, Jaipur, has done his summer training in State Health Society Bihar from 8th April to 7th June 2013. He has worked and submitted a project report on "Health scenario in Bihar under NRHM". He is a hardworking, sincere and committed student and we wish him very best for all his future endeavours.

7/6/2013
(Sanjay Kumar)

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I am also highly thankful to my mentor **DR. SANTOSH KUMAR** at IIHMR Jaipur & **MR. RANJEET SAMAIYAR** Consultant, NRHM, my guide for this summer internship program, for the guidance, support, facilitation & coordination which I have received from them and also an opportunity given to me to have a look of health system at various levels.

I am also grateful to District Health Society, Patna under the leadership of **DR. LAKHINDAR PRASAD**, Civil Surgeon Patna who gave us an opportunity to have the exposure to ground realities and provided with necessary support and guidance during my field visit.

I would also like to convey our heartfelt gratitude to all State Programme Officers for making me familiar with various programs which has helped me tremendously to enhance my knowledge and understanding.

I would like to extend my thanks to the Heads of developmental partners - UNICEF, BTAST, PCI, JANANI, IIHMR PATNA, ZIQITZA HEALTH CARE PVT LTD for the support and help they have provided to me for the field trip as Ill as orientation.

Last but not the least almighty God who gave me courage & strength to perform my duties efficiently. I thank everybody again.

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EXECUTIVE SUMMARY

Bihar has come a long way since implementation of NRHM in the state. This is what data on various health indicators suggest. The objective of the study is to get firsthand account of the existing health scenario in the state under NRHM. The methodology applied was first to get the top view of the health system which included reviewing the SPIP and Financial Guidelines and interaction with State Program Officers at the State Health Society, then moving down to various levels of health delivery system in the form of field visits in and around the state capital, interacting with health functionaries at different levels and finally getting a view from the bottom through the eyes of the community. We also got an opportunity to visit some of the development partners working in the state and got to know how they are supporting the state government in achieving public health objectives. While planning is done meticulously taking into account needs of every district and funds are released periodically along with guidelines, the implementation at the ground level somehow lacks wholehearted effort by those responsible for execution of various plans. The very idea with which a program is launched seems to get lost somewhere in transition from planning to execution. Infrastructure and human resource are the prime areas of concern and is going to remain so for the next few years. Intersectoral convergence is one aspect which can dramatically change the face of public health in the state if implemented in letters and spirit. Though the sight of people crowding at government hospitals is an indication that faith of people has been reinstated in the health institutions and more and more people are utilizing the services provided by them, a careful observation suggests that the crowd consist mainly of women and children. The whole activities of these hospitals are oriented towards providing maternity and child health services and gives an impression that these hospitals are functioning more like Maternity Centers than hospitals. This may be due to government's thrust upon reducing the MMR and IMR through various incentive based programs like JBSY and JSSK in order to achieve the Millennium Development Goals which is also the first goal of the NRHM. But for the long run the public health institutions must be strengthened and equipped to provide good quality comprehensive healthcare as well as emergency medical care to the community. Also, the incentives given under these programs are significantly more than the incentives given under Family Planning programs, which implies that people are being encouraged to produce more children. This strategy may help in achieving the immediate goal of reducing the MMR and IMR,

but in the long run this may affect the overall goal of development. ASHAs are the backbone of the NRHM on which the success of many programs depends. Capacity building of ASHAs will ensure increased awareness among community members which in turn will lead to better health seeking behavior. The need has also been felt to sensitize the community about various health related issues, their entitlements towards good health and adopting healthy lifestyle through massive IEC and BCC campaign using every channel of communication particularly electronic media. There are scores of development partners and NGO's working on different projects in the state. They are supporting the state government in implementation of various health programs and development of health infrastructure both technically and financially. However, it was observed during the field visit that some of the infrastructure facilities developed by them were languishing without proper care and maintenance after being handed over to the government. There is a need to fix accountabilities of both the service providers and the community in order to save government health institutions from the 'tragedy of public goods' and also to enhance the managerial capabilities of those responsible for running the health institutions so that instead of complaining of lack of funds and human resources they start optimum utilization of available resources. The private health sector in the state is highly unorganized and needs to be regularized. There is also need to increase participation of private players in public health delivery system through Public Private Partnership, though there have been some initiatives by the state government in this direction and some ventures are running successfully on this model.

There are many indicators to measure the achievements and progress made in the public health. But the real indicator is the smile on the face of people which erupts as a result of healthy and disease free life.

CONTENT

INTRODUCTION

My summer internship at SHSB started with literature review of State Programme Implementation Plan (SPIP) for NRHM 2012-2013 and financial guidelines. This helped me to know the basic concepts of the all the programmes under NRHM, proposed plan by the Government of Bihar required fund requisites and gaps in various departmental activities like infrastructure and human resource. The plans were prepared on the needs identified and has addressed lots of critical issues and district specific innovations or requirements to implement the programme. The data given in the SPIP has been used extensively in preparing our report. SPIP 2012-13 provides the roadmap for the actual implementation of this programme for the next financial year 2012-13.

Financial guidelines provided to me the knowledge on how the funds and plans are disseminated to the district level and how the guidelines are to be followed, where and how to use the fund released. I went through each programme specific guidelines and fund allocation procedure.

Next was my interaction with all the state programme officers who gave me an overview about the different programmes they were looking after, i came to know the process of microplaning, strategies, their implementation, monitoring and evaluation, how they provide information to the district level, how the services are provided at ground level. I were acquinted with the new initiatives in programmes and changes in coming SPIP.

After the field visits and ground situation analysis, concepts got much better horizon and enhanced the knowledge gained through SPIP and Financial guidelines. I was able to correlate the services to be provided at health facilities, the protocols to be followed, incentives given to beneficiaries. It was a fruitful learning for me. Similarly the interaction with developmental partners also gave me an insight into the situation from the other side of the coin. The triad formed by the government as service provider, developmental partners and beneficiaries coming together gave a real picture of the situation.

The whole learning of SPIP, Financial guidelines and orientation for four weeks was really a great help for me, it enhanced my knowledge and i was able to grasp more from field visits. Finally the working of NRHM, its components and intersectoral convergence gave me the broader and actual picture of how things function.

STATE HEALTH SOCIETY- BIHAR

State Health Society, Bihar came into existence after NRHM had been launched. It is the head body in the state for NRHM functioning in Bihar. Headed by Executive Director who reports to the Principal Secretary Health-cum-Chief Executive Officer, GoB. This body is meant for providing the needed health care benefits to the people of Bihar by guiding its functionaries towards receiving, managing, disseminating and account for the funds and the state specific programmes and instruction as per guidance from the Ministry of Health & Family Welfare, Government of India.

As per decision of GoB the state health society functions as resource centre in making any policies, developing operational guidelines, collaboration with developing patners, NGO's, Public private partnership, district wise fund disbursement, Human resource recruitment, infrastructure development, procruments of drugs and instrument.

State health society have different department for proper functioning of programmes headed by State Programme Officers, the department includes–Reproductive and Child Health, Planning, Monitoring and Evaluation, Infrastructure and Accreditation, Disease control and Surveillance, Training and Institutional Strengthening , Finance, Procurement, Administration, Additionalities.

It organizes training, meeting, conferences, policy review studies / surveys, workshops and inter-state exchange visits for deriving inputs for improving the implementation of NRHM in the Bihar.

State health society is committed towards promoting the right of every citizen to enjoy a healthy life. Society is targeting to make health care accessible to the public by meeting the unmet demands of target population and assuring equal and responsive quality services.

Tab 1: - Interaction with State Officials at State Health Society Bihar

SN	Name	Designation & Department	Date(s) of visit	L
1	Sh. Sanjay Kumar	Executive Director	07.06.2013	
2	Dr. D.K. Raman	RCH - Additional Director	26 .04.2013	Procurement of Drugs
3	Mr. Arvind Kumar	Deputy Director – Drug	26.04.2013	Tender & bidding of drugs
4	Sh. Ashok Kumar Singh, BAS	Administrative Officer	26.04.2013	Administrative Management issues & their management as Hospital Manager
5	Sh. R.B.P. Yadav	Consultant- Infrastructure	24.04.2013	Infrastructure gaps & work plan to fill a gap.
6	Sh. Kumar Anuj	HR, Radiology & Pathology	23.04.2013	HRM with Out sourcing concept, HRIS system
7	Dr. N.K. Sinha	State Immunization Officer	26.04.2013	Impact of monitoring & evaluation in immunization.
8	Mr. Ram Ratan	State Programme Officer- RI & Polio	26.04.2013	JE Immunization
9	Dr. A.K. Tiwari	State Surveillance Officer- IDSP	17.04.2013	IDSP & Generic drug
10	Dr. Ragani Mishra	State Entomologists	16.04.2013	Data collection from ground
11	Mr. Rajesh Kumar	Consultant- Finance	29.04.2013	Finance management under different project heads
12	Dr. M.P. Sharma	State Programme Officer	29.04.2013	ARSH, School Health Program, WIFS, Ambulance services
13	Dr. N.K. Mishra	State Programme Officer	25.04.2013	Operationalization of NRC & PCPNDT act implementation.
14	Dr. A.K. Shahi	State Programme Officer	22.04.2013	Unmet need & Family Planning

15	Mr. Subodh Jaiswal	Deputy Director- FP	17.04.2013	Status of Family planning in Bihar
16	Mr. Atul Verma	Data Officer-Data Centre, Grievance Redressal & NRHM Reporting	24.04.2013	NRHM – MIS reporting system
17	Dr. Y.N. Pathak State	Programme Officer-ANM/GNM School	18.04.2013	Nursing gap & strategy used to fill these gap in Bihar
18	Ms. Rashi Jayaswal	State Programme Manager	16.04.2013	State Planning process, District Health Action Plan & State PIP planning in Bihar.
19	Mr. Santosh Kumar	Planning (Assistant)	16.04.2013	Planning formats
20	Mr. Ranjeet Samaiyar	Consultant- NRHM	08.04.2013 til end	VHSND program implementation & training
21	Mr. Gaurav Kumar	Deputy Director-MCH	16.04.2013	MCH challenges & key innovative initiatives in Bihar
22	Ms. Jayati Srivastava	Deputy Director-Training	25.04.2013	Making of Training calendar
23	Ms. Vasudha Gupta	Team Leader- ARC	22.04.2013	ASHA
24	Mr.Tarun Kumar Ranjan	Conslt.-Communication & Documentation-ARC	22.04.2013	How ASHA play a role in community mobilization.
25	Ms. Jyoti Verma Deputy	Director- Monitoring & Evaluation	22.04.2013	Monitoring & Evaluation, QMS
26	Mr. Arvind Kumar	System Analysist-cum-Data Officer	18.04.2013	HMIS, DHIS2, MCTS, HRIS
27	Mr. Ranjan Kumar	Software Developer-cum- Server Administrator	22.04.2013	Data Analysis & Data Quality

28	Sh. Pramod Kumar	Additional Director-Finance	29.04.2013	Financial Management in NRHM
29	Sh. K.L. Das	Finance Manager	29.04.2013	Same as above
30	P J Joseph	Director, Radiation Safety	30.04.2013	Radiology & its importance in Hospital for patient safety.
31	Ms. Rupali tripathi	Consultant-ARSH	29.04.2013	Implementation of ARSH
32	Md.Imtiazuddin	Consultant- School Health Programme	30.04.2013	Implementation of School Health Program
33	Prof. Jeetendra Mohan Deewan	SIHFW	30.04.2013	Introduction about SIHFW & various training conducted by it.
34	Mr. Saurav	Consultant- NCD	30.04.2013	GoI strategies for NCD management

District Health Society (DHS) PATNA

INTRODUCTION

Patna the capital city of Bihar is spread in an area of 3202 km square has a population of approximately 58 lakhs and is the most thickly populated city of the state with a density of 1803/sq km, it is divided into 6 subdivisions which is further subdivided into 23 blocks. There are 23 block PHC's and 60 additional PHC's & 393 HSC's. The city does not have any district hospital but has 6 sub-divisional hospitals. There are 331 Gram Panchayats, 1,451 revenue villages and 3,652 anganwadi centres. In order to deliver health services the district has 523 regular ANM's and 378 contractual ANM's. 17 grade A nurses and about 1,187 paramedical staffs. The ground level health workers include 2,882 ASHA's, 3233 AWW's. The whole health network is working under the umbrella of DHS which is being looked and managed by Civil Surgeon. There are 3 units in the society:

1. DPMU – Headed by Dist. Programme Manager, assisted by Dist. Programme Coordinator, Dist. Monitor & Evaluator, Dist. Accounts Manager.
2. DSU – Dist. Epidemiologist, Dist. Data Operater, Dist. Data Manager
3. ARC – Dist.Community Mobilizer, Dist Data Assistant.

Tab 2: - VISITS TO HEALTH FACILITIES

S.NO	TOPIC	DATE
1.	Introduction and orientation to District health society, Patna	06.05.2013
2.	Facilities visited	
	a) Day 1- NRC & Skill lab, GGS, Patna City.	06.05.2013
	b) Day 2- PHC, Khagaul.	07.05.2013
	c) Day 3- SDH, Danapur.	08.05.2013
	d) Day 4- PHC, Mokama and Goswari.	09.05.2013
	e) Day 5- PHC, Fathua	10.05.2013
3.	Reporting at DHS, Patna	11.05.2013

Tab 3: - HEALTH FACILITIES VISIT & KEY LEARNINGS

SN.	Facility / Name / Designation	Date(s) of visit	Key Learning
1	NRC at Guru Govind Singh hospital, (Patna)	06.05.2013	How to deal with SAM children & what should be diet for them.
2	Skill laboratory, Gosh, (Patna)	06.05.2013	SHSB initiatives for skill development of paramedical & medical staff.
3	ANM meeting: at PHC, Khagaul	07.05.2013	How health programs & administrative information is conveyed to ANM through meeting at PHC level.
4	Sub-Divisional Hospital, Danapur, (Patna)	08.05.2013	Optimum utilization of hospital resources with team effort & various innovations.
5	PHC Mokama (Patna)	09.05.2013	Under utilization of resources.
6	PHC Goswari (Patna)	09.05.2013	PHC was functioning in HSC infrastructure & also taking maximum effort to provide health services in limited resources.
7	PHC Fatuha (Patna)	10.05.2013	Well managed PHC among our field visit.
8	VHSND site at Anganwadi Center, Fathua (Patna)	10.05.2013	There was gap in the knowledge about VHSND among ASHA/AWW/ANM
9	RKS meeting, PHC Fathua (Patna)	10.05.2013	How ….. • RKS meeting is conducted • Problems are discussed • Group solution is taken for problems.

NRC AT GURU GOVIND SINGH HOSPITAL, PATNA CITY

OBSERVATION:

Nutritional Rehabilitation Center (NRC) is located in the premises of Guru Govind Singh Hospital, Patna City, which is established on PPP model and run by ‘’Citizens Foundation’ Ranchi, a Jharkhand based NGO. It runs a batch of 20 severe acute malnourished (SAM) children for 21 Days. Criteria for selection of a child to NRC admission includes Z score below 3 standard deviation, Mid Upper Arm Circumference (MUAC) less than 115mm, presence of nutritional edema and the child should be betIen the age group of 6 months to 5 years.

The batch has three sets of nutritional days:-

- Day 1 to Day 7 – Phase 1 – F 75
- Day 8 & Day 9 – Phase 2 – F 100
- Day 10 to Day 21 – Phase 3 – F 100 & Mix of various nutritional foods, excluding salt.

First early morning (06.June.2013) I reported to the DHS, Patna then I was accompanied with Mr. Santosh (DCM, Patna) and started my visit to NRC. Around 10am I reached to the NRC , NRC was well kept and maintained, at the entrance gate security entry register was maintained. I had a complete round of NRC; few of the observation are as the diet was given as per schedule to the children and to mothers on time. The staff laid stress on the interactive counseling session in evening so as to help mothers in understanding the basic hygiene and food supplementation method.

The premises had a large number of informative and educative IEC materials displayed showing that proper communicational channel was being maintained. Due to the small size of rooms there was overcrowding in the wards. Some of the children Ire accompanied by their grandmother instead of mother. Cleaning have to be maintained on regular basis.

SKILL LABORATORY, GGSH, PATNA CITY

OBSERVATION:

Same day (06.June.2013) in late afternoon we visited the Skill Laboratory, GGSH, Patna city. Initially this skill laboratory was managed by UNICEF later on handed over to GoB for Capacity Building of Medical officers, Nurses and ANM's.

There are six fixed Stations and about twenty four mobile stations which is being utilized as per requirement. Each batch contains five participants with one demonstrator. The total strength of batch is thirty. Well established, spacious & equipped laboratory with all ultra modern facilities are available for the training purpose.

Pre Test & Post Test assessment tools were being used to check the efficiency of training. Participatory method of training is being implemented, during our visit we just noticed that there was lack of cleanliness and maintenance both of infrastructure and equipment is leading to damaging the assets as well as inadequate utilization of resources. Training in the skill lab was happening only for 6 month so it needs to be utilized for whole 12 month.

PHC, KHAGAUL (PATNA)

JAPANEES ENCEPHALITIS CAMPAIGN

OBSERVATION:

Special J.E. Immunization campaign was conducted in two high focused districts of Bihar (Patna, Jahanabad) between 22nd April and 16th May 2013 in which children between 1 year & 15 years of age were being vaccinated. The target population in Patna is approximately 17 lakhs. The J.E.vaccines is imported from China.

Site First Rajkiya Madhya Vidhyalaya, Sah Sankul Sansadhan Kendra, Rupaspur- Jalalpur, Danapur. - J.E. Immunization done till time of visit – 245

Site Second - Primary School, Tes Lal Verma Nagar, Danapur. J.E. Immunization done till time of visit – 162

Lack of planning, preparedness and transmission of message to the ground level workers results in confusion. There are migrant populations so it becomes difficult to get all children at one place. Emergency Drug Kit was not well maintained. Inadequate distribution of vials resulted in incomplete vaccination at few sites.

ANM MEETING: AT PHC, KHAGAUL

OBSERVATION :

There is provision for weekly ANM meeting to be conducted at PHC every Tuesday Meeting at PHC Khagaul was presided over by MOIC and BHM, which was attended by all the ANM's of that Block. Few of ANM were not able to attend the meeting because of J.E. campaign. Monitoring format of malnourished children was distributed to all ANM's then discussion was initiated on issues related to HMIS reporting, immunization Planning, VHSND etc. The ANM's were told about the importance of timely submission of HMIS reports in proper format. They were asked for the various problems faced by them in field. MOIC and BHM were briefed about all the rules & regulations. The changes made in micro plan for R.I. which was scheduled for next day was discussed and analyzed.

SUB-DIVISIONAL HOSPITAL, DANAPUR (PATNA)

OBSERVATIONS :

One of the six sub-divisional hospitals located in Patna district is SDH-Danapur a sixty bedded hospital (sanctioned) but only 38 beds were functional, catering about one lakh twenty three thousand population and average daily OPD of 500 and about 400 to 500 deliveries per month in which 12 are cesarean section.

The hospital has 20 doctors, 8 paramedics, 28 support staffs. There are 2 ambulances available with an efficient back up of 102 and 108 services. Out of 50 posts sanctioned for grade 'A' nurses 44 were vacant. The hospital has14 MAMTA's to assist and support post natal care. This hospital is also working to get affiliation of FFHI standards.

The hospital has separate administrative building with separate MCH facility equipped building. Semi Auto analyzer was purchased through RKS fund to help & support pregnant ladies for quick and speedy service delivery. Quality Assurance team has been formed for better utilization of recourses & meeting is held every Wednesday to take decision on problems on priority basis. Blood Storage facility was present but non functional because of expiry of contract. Inadequate sitting arrangement for patients in the campus has led to patients and attendants standing outside. Corridors were not having the natural light sources. Work is hampered due to inadequate nursing staff. Canteen services are not being provided according to the guidelines but the efforts were made to provide food to in patients. No master plan for constructing and expanding building. Medicine supply was irregular. Ambulance services were not able to meet the community demand.

PHC MOKAMA (PATNA)

OBSERVATION:

Located at a distance of 100 km from head quarter, PHC Mokama is designated as Referral Hospital to cater the population of 158,363.

The hospital has bed strength of 30. It has two beds in labor room and two additional beds for extra delivery procedure. The Hospital also contains NBCC with Photo Therapy unit, Oxygen Concentrator, radiant Warmer. Family planning Counseling center, ARSH clinic is running in the premises.

PHC Mokama covers 4 APHC & 12 HSC under its referral umbrella.

Inadequate cleanliness due to inefficient housekeeping from outsourced agency is leading to unhygienic environment. Cold chain is maintained properly, ILR & DF running at its maximum potential. ARSH clinic was running but not as per guidelines and take away materials were unavailable. There was no sitting arrangement for patients in OPD. Improper storage of syringes & other materials. Despite of having the status of referral Hospital, Caesarian section was not performed. 108 & 102 services was not functioning properly and was not been provided to the patients. Labor room did not have hot water supply. Necessary medicine in emergency drug kit was not available. Registration counter did not have shades for the patients.

PHC GOSWARI (PATNA)

OBSERVATION:

PHC, Goswari is located in a remote area of block Mokama & caters a huge population, it has six sanctioned beds but only 2 are functional because of lack of infrastructure and space. Human Resource at PHC is - 1 MOIC, Medical Officer (4 MBBS + 1 AYUSH) and 6 ANMs**.** The PHC has a Labor load of 5-6 delivery daily. Inadequate space as compared to demand & supply ratio depending on patient load. NBCC is not present, poor sanitation & hygiene, poor autoclaving and sterilization services, inadequate resources and lack of facilities for patients are few of its drawbacks.

This PHC is working on an infrastructure of a Health Sub Centre. Thus, it demands a proper infrastructure for its smooth functioning.

PHC FATUHA (PATNA)

OBSERVATION:

PHC,Fatuha caters the population of 1,96,130 (urban-51000, rural-1,45,130). It is the referral centre for 2 APHC and 16 sub centers.Average OPD load is about 300 to 400 patients / month. Delivery load crosses 300 per month. There are six sectioned beds but actual functional beds are 19 because of huge demand of community due to quality of services provided at PHC level. There was separate male and female registration counters. Well equipped NBCC with proper IEC materials & posters both for beneficiaries and providers of services. Beds with concept of "Satrangi Chadar Program" rainbow sheets. Labor room & Operation room was well maintained. Proper utilization of Untied Fund & RKS Fund as mentinoed by MOIC. Family Register Concept for ASHA can be up scaled in future. Block Mapping & Block profile displayed in the room for help in planning & implementation strategies.

VHSND SITE AT ANGANWADI CENTER, FATHUA (PATNA)

OBSERVATION:

Village Health, Sanitation & Nutrition Day (VHSND) is one of the best strategy of NRHM which gives a holistic approach and covers routine Immunization, mother & child care, ANC, PNC, child health, growth monitoring, counseling session (Family Planning, Sanitation, Hygiene, Health), Adolescent health, meeting & discussion. Providing IFA tablets to pregnant women & adolescent girls, this is the program which completely focuses on health services at village level. Inadequate Space or the area chosen could not support the VHSND session. Ground staff was not able to distinguish between RI and VHSND so laid more focus on RI. VHSND was not conducted as per the Guidelines.

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RKS MEETING, PHC FATHUA (PATNA)

OBSERVATION:

Rogi Kalyan Simiti (RKS) has been established from APHC till Medical college hospital level. **Rogi Kalyan Samiti (RKS) or Patient Welfare Committee or Hospital Management Society (HMS)** is present and plays a vital role. This committee, which is a registered society, acts as a group of authorized people who are entitled to manage the affairs of the hospital. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local Elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRU's / RKS / PHC/ APHC. HMS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services. It may consist of the following members:-

1. Peoples representatives MLA/MP
2. Health officials (including an AYUSH doctor)
3. Local district officials
4. Leading members of the community
5. Local Health Facility in-charge as MOIC, Superintendent.
6. Representatives of the Indian Medical Association
7. Members of the local bodies and Panchayati Raj representative
8. Leading donors.

Meeting was held in a cordially environment with almost all the members taking active part in discussion and decision making. Issues discussed were scanned, all pros and cons were studied and a final decision was made unanimously. Proper recording of minutes of the meeting was done and before the meeting got over every member of meeting was asked to sign it. Utilization certificate for previous month's untied fund was discussed and passed by committee.

SECTION-5

- ✓**INTRODUCTION**
- ✓**DEVELOPMENTAL PARTNERS**

DEVELOPMENTAL PARTNER IN BIHAR

INTRODUCTION

In order to deliver better health services Government of Bihar & State Health society have given an opportunity and platform to various developmental partners to meet the unmet health needs of public as well as also help in overcoming the challenges and issues of public health. Some of the developing partners that are playing a major role in Health structure of Bihar are :

Tab 4 : - DEVELPOMENTAL PARTNERS WORKING WITH SHSB

S.N.	Developmental partners	S.N.	Developmental partners
1	World Health Organization (WHO)	**11**	JANANI
2	Bill & Melinda Gates Foundation (BMGF)	**12**	DFID- BTAST
3	United Nations International Children's Emergency Fund (UNICEF)	**13**	Path Finder
4	Cooperative for Assistance and Relief Everywhere(CARE)	**14**	I – Pass
5	United Nations Population Fund (UNFPA)	**15**	FRHS
6	Johns Hopkins Program for International Education in Gynecology and Obstetrics (Jhpiego)	**16**	BBC WST's
7	Norway India Partnership Initiative (NIPI)	**17**	World Health Partners (WHP)'s
8	Project Concern International (PCI)	**18**	International Finance Corporation (IFC)'s
9	PLAN India	**19**	Bhoomika Organisation.
10	IIHMR, Patna	**20**	Others

PROJECT CONCERN INTERNATIONAL (PCI)

Project Concern International, an international not for profit organization of Washington is working in South East Asia in 16 about countries. In Bihar PCI is working on PARIVARTAN Project with main stress on 'positive community impact'. PARIVARTAN is a part of ANANYA project which is supported by Bill and Melinda Gate Foundation in eight innovation districts of Bihar: East Champaran, West Champaran, Gopalganj, Begusarai, Khagaria, Samastipur, Patna and Saharsa in partnership with PATH which works on the training aspect, Foundation for Research in Health System (FRHS) on research aspect, BBC is working on mass media campaign on behavior change communication, Population Service International (PSI) works on sustainable sanitation solution and NIDAN. PARIVARTAN focuses on identifying the gaps of service delivery at block level, capacity building, advocacy and networking. The goal of the project is to catalyze collective community action to promote shifts in social norms and behavior change to increase adoption of key family health and sanitation practices, and enhance accountability and equity of health and sanitation services across Bihar by 2016. Parivartan works to address inequities by ensuring that the poorest of the poor enjoy full access to the same services. Parivartan intends to foster and strengthen community structures in the eight districts to improve family health and sanitation practices, strengthen accountability for health, sanitation and welfare services through community structures that work to advance equity, service access, quality and utilization; establish a knowledge base of successful approaches to scale up community mobilization and build partnerships and mechanisms to support state-wide scale up and sustainability of community mobilization interventions. Target group for Ananya Project are vulnerable groups and community susceptible group such as **Dalit, Maha Dalit, Schedule Caste, Pashmanda Muslims**, focusing on pregnant women, children, adolescent girls. The main strategy is to mobilize them and bring them together by reducing the economic, social, political barrier in reaching the site and utilize the services. On a common platform their need and problem are discussed and collective actions are taken for solution. Parivartan works on institutional building at different levels and creating multiple layers of platform, which are community group at tola and street level, village organization at revenue village level. These vulnerable groups will be provided with basic health and sanitation by PCI.

Parivartan will focus on delivering the 8 family health behaviors aligned with Ananya as well as 4 water and sanitation behaviors

WATER AND SANITATION-

- ✓ Hand washing with water and soap at critical moments
- ✓ Safe storage and handling of portable water
- ✓ Access and usage of toilets (potentially CLTS-Community led total sanitation behaviors)
- ✓ Safe disposal of waste.

FAMILY HEALTH

- ✓ Deliveries that occur in a facility and mothers who have access to basic emergency obstetric services (EmOC).
- ✓ Safe delivery at home (including a skilled birth attendant, clean delivery, birth preparedness and care-seeking plan in case of complication and/or emergency.
- ✓ Preventive postnatal care services and practices for newborns and mothers (including clean cord care, immediate breast feeding and early follow-up of the mother and child.
- ✓ Practice of skin-to-skin care (ST/SC) Kangaroo mother care (KMC) for newborns.
- ✓ Practice of early and exclusive breastfeeding of infants during the first six months of life
- ✓ Age appropriate complementary feeding for children between 6-23 months
- ✓ Postpartum family planning among women who want to space and limit future births
- ✓ Compliance for recommended schedules of immunization for children up to age two

Later on village organization will be merged with JEEVIKA under Bihar Rural Livelihood Programme for sustainability. Till now PCI is working and providing more efforts on formation of community groups, formation of village organization is yet to do work for them. They have vision that village organization activities will be merged with village health sanitation and nutrition committee by forming community health sanitation committee which will represent the community at panchayat level.

Sahelis are community cadre from the same vulnerable community, they will be provided with 7 health and sanitation modules, 2 on advocacy and CG and VO and 1 module on introduction and village entry all this modular training is provided by PATH. After training of sahelis they will train community group members.

Parivartan is working closely with Government of Bihar, specifically the Departments of Public Health, Social Welfare, Women and Child Development and Rural Development, to ensure communities increase the access and uptake of various services

UNITED NATIONS CHILDREN'S FUND

For the past 60 years, UNICEF has represented the needs and rights of children everywhere. It has worked across national and social divides to provide integrated services for children and their families. In the new millennium – and in the context of a revitalized and reformed United Nations – UNICEF pledges to strengthen all its partnerships to accelerate achievements of the world's youngest citizens. UNICEF has a long history in Bihar, having worked there for 30 years in all major development areas for women and children. With the reduction of child malnutrition rates as one of its priorities, UNICEF has supported the Dollar Strategy and demonstrated significant improvements in nutritional status of children by encouraging early and exclusive breastfeeding, debunking myths about colostrum, and providing information on adequate nutrition for nursing mothers and older children. Similarly UNICEF supported the Sankalp programs to ensure school enrollment and regular attendance of all out-of-school children.

UNICEF is also supporting the statewide introduction of key child survival and maternal health initiatives like routine immunization for childhood diseases, zinc and oral rehydration salts for diarrhoea treatment, water & sanitation and the training of skilled birth attendants. Core working areas of UNICEF are following four as : -

A. Child Survival
B. Education
C. Child Protection
D. Emergency Preparedness and Response

UNICEF working way :- Every programme of UNICEF made in a logical framework, then is approved by GoI & State Government, then implemented on some focused area as pilot project.

UNICEF with GoB / SHSB :

1. Immunization and Village health sanitation & nutrition day :

a) System strengthening:

- ✓ Identify bottlenecks and gaps in the RI and share with Government for further action
- ✓ HR Technical support to the state and district for strengthening monitoring systems
- ✓ Strengthen system for monitoring the management of diarrhoea using ORS & Zn, and RI

b) Community mobilization :

- ✓ Develop a model for mobilization of community for RI/VHSND through mid media campaign (10 blocks in 5 districts)
- ✓ Monitoring support, media communication workshops for Measles second opportunity Catch up campaigns in select districts (as decided nationally) of the state.
- ✓ Promote the use of ORS & Zinc in the diarrhoea management.

2. Child Health: System strengthening :

- ✓ Strengthening IMNCI supportive supervision at the field in the 5 districts.
- ✓ Develop and share with the SHSB, strategic document identifying the challenges of SBA training and deployment of trained personnel.
- ✓ Technical support to the SHSB on rolling out IMNCI training, implementation and supportive supervision
- ✓ Facilitate implement QA mechanisms in the SNCUs, NBCCs of the state

3. Maternal Health:

a) System strengthening:

- ✓ Implement QA mechanisms in the labor rooms & OTs for deliveries
- ✓ Facilitate BEmOC & CEmONC functions through FFHI accreditation of the institutions in 5 districts
- ✓ Facilitate operationalization of the L1 Centers for maternal health in 5 districts
- ✓ Provide technical support to SHSB and districts for quality AntiNatal services and newborn care as part of the continuum of care.

b) Capacity Building:

- ✓ Enhance the quality of MCH services in the institutions through skills laboratories in the 5 districts.
- ✓ Develop capacity of partners on emergency, preparedness, coordination and Response.
- ✓ Technical support for improving the ANM schools.
- ✓ Technical assistance to develop comprehensive SBCC strategy & plan for the implementation of it on NRHM related programs.

4. Other initiatives of UNICEF :

- ✓ Supportive role in IEC activities, BCC activities, Dus Ka Dum, Micronutrient Initiative
- ✓ Technical support of UNICEF- For improving quality of care in all NBCCs in Bihar (QA- FBNC model), FFHI in selected facilities of 5 districts, Setting up of skill labs.
- ✓ Support for the first half year for the external monitoring for quality improvement of SCNU & NBCC (QA-FBNC model)
- ✓ UNICEF for Supervision and Monitoring of activities, especially in the initial period of management of NRCs & 2 NRCs were operationalized in the districts of Muzaffarpur and East Champaran during August-September 2007 in 2 flood affected districts by UNICEF.
- ✓ SHSB has piloted a coordinated effort with ICDS (department of social welfare) with
- ✓ Technical support of UNICEF to ICDS (department of social welfare) & SHSB for pilot project in one district in 2010 for registration and distribution of IFA syrup/small tablets to preschool (6-59 months) children by using AWCs as a point of distribution through 'Muskan Diwas' and Village Health and Nutrition Day (VHND).
- ✓ Financial as well as technical support to all nursing schools and Govt of Bihar in the field of nursing.

- ✓ Social Mobilizations and IEC activity for Polio & R.I.
- ✓ Technical support of Iodine deficiency program in Bihar.

Tab 5 :- Maternal & Child key initiatives by UNICEF

UNICEF			
MATERNAL		**NEW BORN**	
A.1	BEmOC	B.1	QA OF FBNC
A.2	CEmOC	B.2	Facilitating SNCU / NBSU Accredation.
A.3	Facilitate L1 Center	B.3	Promotion of ORS & ZINC
A.4	QA in Labor & OT room	B.4	IMNCI & HBNC supportive supervision.
A.5	SKILL LAB	B.5	Capacity Development of care provider on Critical Services.
A.6	Support in rolling out of MDR in focus District.	B.6	POST CARD BASED TRACKING OF New Born, discharged from SNCU
A.7	PMTCT Integration IN MNCH Facilities.	B.7	NUTRION - NRC, IFA, VIT A Supplementation.

Tab 6 :- Field Visits by UNIICEF : -

SN	**Health Institute**	**Detail**
1.	ANM, ASHA & AWW meeting at Primary Health Center (PHC) at Desari, Vaishali District	Administrative issue, Field issues & problems, specific topic orientation program (diarrhoea management)
2.	DMCH, Darbhanga	SNCU operation
3.	HSC, Jorja , Darbhanga	Labor room set up, Delivery at HSC
4.	VHSND visit	Village health sanitation & nutrition day celebration.
5.	Additional Primary Health Center	Nimathi, Block Baheri, Darbhanga
6.	Primary Health Center (PHC) at Goraul (ISO certified), Vaishali	

FIELD VISIT:

DAY 1: An overview of all the work done by UNICEF in the state.

DAY 2: Field visit to Primary Health Center (PHC) at Desari, Vaishali, we observed the ANM, ASHA & AWW meeting, Headed by MOIC of PHC. The meeting was organized for the field issues faced by ANM, AWW, and ASHA and to understand the level of their knowledge on various programmes. Participatory & interactive meeting, empowerment of ground staff were a few positive steps taken by the PHC. They were well aware about the importance of their work which was a very good sign. On the same day we went to DMCH, Darbhanga, there we observed the SNCU unit – how SNCU operations are managed on a day to day basis. What are the challenges faced & how they plan to overcome it. As SNCU at DMCH, Darbhanga was well planned, well spacious & well maintained by using standard guidelines still it needs to be renovated.

Health sub Center (HSC), Jorja, Dharbhanga was the first exposure for us to see a Health Sub Center having a functional labor room which was maintained according to standard guidelines. We also interacted with the beneficiaries there, she was very happy about the services provided by government. Important thing which we observed was the dedication of the staffs for their work. Friendly behaviour with the patients & records was maintained properly, all these experiences at government facilities was eye opener for us. From there we visited site of Village Health Sanitation & Nutrition Day (VHSND) under the same HSC. We observed the way an ANM organizes the VHSND at the village, as we know that there are various challenges at ground level but she was able to manage the VHSND site well. As we know that VHSND is in its initial phase and still needs lot of improvement to achieve the ideal VHSND plan at the village. Then from there we started travelling to next health facility site – Additional Primary Health Center, Nimathi, Block Baheri, Darbhanga. As in our team most of us had never visited APHC before so we were a bit curious. We found that APHC was well established, well spacious maintained by two Medical Officers but even with the good space they did not have labor room facility. Then after completing from there we started moving to next Health Facility - Primary Health Center (PHC), ISO certified at Goraul, Vaishali. Late in the afternoon around 4.00 pm we reached the facility, then we had an orientation by MOIc of PHC, he briefed us about his vision for the hospital, then he did mention about the challenges faced for an ISO standardization of the PHC & briefed about his experience.

At the end of the field visit we understood the supportive role of UNICEF in development of Health facilities in Bihar , but after UNICEF developed a few units as an standard such as SNCU, Hajipur, Vaishali but when it handed over to Government Authority, same facility was not maintained up to the standard guidelines.

Bihar Technical Assistant Support Team (B- TAST)

Bihar technical assistant support team, is located in the campus of SHS Bihar, providing technical support to Bihar Government. B-TAST is being appointed by DFID providing up to £145 million (£120m Financial Aid, and £25m Technical Cooperation) over six years. Other agencies are IP global,CARE, Options (UK based) to departments of Health (DoH), Social Welfare (SWD) and Public Health Engineering (PHED), to help the Government of Bihar improve health, nutrition and water and sanitation outcomes through the Sector Wide Approach to Strengthening Health (SWASTH) (SWASTH - means 'good health' in Hindi) programme,

It's a six year programme initiated in June 2009. In initial year of this programme diagnostic or snap shot test was done to find out the gaps and was analysed. Mile stone to be achieved was decided after the gap analysis and accordingly money was distributed to the 3 departments- 40% to health, 40% social welfare and rest 20% to PHED department and in 2010 june implementation of this programme was started. Financial assistant is decided every year by GoI as the fund for financial assistant comes through ministry of external affairs (GOI). In all 38 district of Bihar district programme officers and IT consultant are supporting district health society. Mile stone on which B-TAST is working are labor room strengtning, family friendly hospital initiative accreditation, family planning corner, cold chain strengthening, outreach RI, NBCC, NBSU, SCNU, respectful care at birth, training, skill lab, kala azar training in 31 endemic district. Bihar constitutes 70% of global burden for kala azar, target achieved is around 1/1000 per block till 2015 this programme will work with convergence between social welfare and self help group to enhance the positive health behavior. Vouchers will be given to SHG when they will fulfill the required activity like residual spray, social mobilization, case search accordingly. It will be starting as a pilot study either in Muzaffarpur or Purnea. WATSAN is another programme by SWASTH working closely with the PHED which works on addressing the critical gaps in rural sector, quality management of Bihar and improving and strengthening the gaps in water quality management and sanitation in Bihar, the current sanitation coverage in Bihar is less than 25%. Open defecation is the most preferred option in villages of Bihar cutting across caste gender and social status, most of the rural household in Bihar is at the bottom of the sanitation ladder. SWASTH's technical and financial performance is assessed on a six-monthly and annual basis. The Joint Annual reviews (comprising of representatives from the Government of Bihar, Government of India and DFID) monitor progress against the programme logframe/milestones matrix, and to agree the milestones for subsequent funding.

IIHMR, PATNA

The **S HMIS B "** project is being implemented by the Institute of Health Management Research, Patna in collaboration with the State Health Society with the technical and financial support of UNFPA since October 2009. The head office of IIHMR is in Jaipur which is a WHO Collaborating Centre for District Health Systems based on primary health care, and identified by the Ministry of Health and Family Welfare, GoI as Institute of Excellence in training. It has been recognized as a Research Institution by Department of Scientific and Industrial Research (DSIR), Government of India, also from Ministry of Finance, Government of India.

Health Management and Information System (HMIS) is one of the critical elements of managing various public health programs. Properly organized, implemented and used, it can contribute significantly in improving program performance. To ensure quality of data recording, analysis and use for decision-making, the Government of Bihar through UNFPA has entrusted IIHMR, Jaipur to undertake capacity building of health staff at different levels on HMIS including basic training and follow-up to ensure implementation of HMIS.

IIHMR is implementing the project through its zonal offices located in every division and headed by a zonal officer. The project has undertaken various activities such as development of training materials, conducting training sessions of grassroot functionaries at Health Sub-Centre and at Block levels on HMIS formats and providing handholding support during monthly review meetings. The project had been divided into three phases.

Phase-I (Oct 2009 to Sep 2011): - The first phase focused on capacity building, hand holding and supportive supervision of the grassroot health functionaries. It included development of training manuals which was designed based on the findings of a snap gap analysis, a kind of situation analysis, carried out in two districts – Saran and Supaul – one good performing and another not so good performing respectively. A total of 17,943 health personnel were trained on HMIS including ANMs, LHVs, BHMs, BAMs/ BHEs, DEOs, MOICs, CSs, ACMOs, DTOs, DPMs, district M&E Officers and State Resource Persons in 459 batches. Apart from other aspects of HMIS, knowledge on every data elements and its correct compilation procedures was given to them so as to improve data quality generated through the monthly reporting system.

Phase-II (Oct 2011to Nov 2012): - The second phase of the project was focused on establishing the mechanism of review and feedback besides consolidating the progress made in first phase and follow-up of trainings. The specific objectives of Phase-II of the project were: to build the capacity of Regional M&E Officers, Regional M&E Supervisors, District M&E Officers, BHMs, and DEOs on data analysis; to oversee the quality of data (correctness and completeness) generated at different levels (HSC, PHC, District and State); to facilitate use of data in planning, monitoring, evaluation and decision making; and to establish a system of feedback and suggest measures for improvement at different levels.

During this period the project also started the analysis of key program indicator and sharing the same with Regional and District M&E Officers, identifying and organizing special capacity building sessions, monthly field visits as per the individual operational plan, monthly project review meetings, monitoring and supporting the districts and PHCs to organize review meetings, monitoring the use of auto compilation (XL) sheet (which was stopped later after the start of facility wise reporting) and APHC and HSC wise data upload on DHIS2 etc.

Phase III (Dec 2012 to Dec 2013): - The third is focused on the sustainability of the work done in the previous phases after the project is over in December 2013. For this purpose suitable personnel from the state authorities are being identified to whom the learning can be transferred.

Achievement: - The first and second phase of the project is over and it is at present in its third phase. The project has been successful in organizing all planned activities during the project period. Analysis of the HMIS data from the web-portal before and after the project implementation period showed improvement in the quality of HMIS data in terms of timely reporting, completeness and increasing trend in qualifying validation checks.

JANANI

INTRODUCTION

Janani is an Indian not for profit organization providing family planning and comprehensive abortion care services. It is affiliated to DKT-International, a NGO based in Washington D.C. and is one of the largest and most cost-efficient social marketing organizations in the world. Gopi Gopalakrishnan (founder of Janani) was the editor in 'The Times Of India' at Delhi. The trend of increasing population growth in Bihar caught his eyes and he felt the need of an organization which could work on family planning and control the population growth rate in the state. This brought Janani into existence. Janani has been working in Bihar since 1996 and continues to expand its programs. Today it has added its presence in three other states- Jharkhand, Uttar Pradesh and Madhya Pradesh.

Janani is working with the Indian government to deliver its products under the Contraceptive Social Marketing Programme (CSMP) of the Ministry of Health & Family Welfare. On the other hand the services offered by the organization is assisted by the state government.

RANGE OF PRODUCTS :

Janani delivers through social marketing of contraceptives and abortion care products. They are as follows:

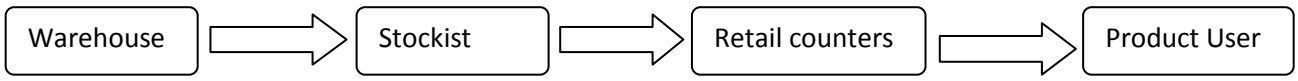
- ✓ Apsara – oral contraceptive pill
- ✓ Mithun, Plan X & Style – condom
- ✓ Post pill – emergency contraceptive pill
- ✓ Pari – contraceptive injection (depot)
- ✓ Safe-T kit – medical abortive tablet
- ✓ Urvashi – intra uterine contraceptive device (Cu 375mm)

HEALTH SERVICES : - Janani delivers services through..

- ❖ Surya clinics – These are clinics with provision for admitting the clients undergoing an operative procedure.
- ❖ The forms of Surya clinics in the state are:
  - ✓ Janani owned clinics (JOCs) – owned and run by Janani
  - ✓ Janani franchised clinics (JFCs) – only the franchise remains with Janani and the services are offered by private providers.
- ❖ Outreach family planning services at government facilities
- ❖ Rural health services by Surya health promoter (formely known as Titli Centres)
- ❖ Janani also provides trainings to doctors and nurses and help them in upgrading their skills.

PRODUCT DELIVERY CHAIN

The range of contraceptive and abortive products follow a very easy and simple delivery pattern and thus can be easily available to the end users. The first point, where all the final products are stocked is the warehouse of the organization. Next, from the warehouse the products are sent to the respective stockists and from the stockists to the wholesale and retail stores. From here it is made available to the users. The sales officer is the person responsible to deliver the products from one point to another.



There are two divisions in the products of Janani:

(a) Schedule H drugs – drugs which can be sold through chemists shops with a drug licence. Pari, Safe-T kit and Urvashi comes under this schedule.

(b) Schedule K drugs – drugs can also be sold through non traditional outlets(NTOs). Apsara, Mithun, Plan-X, Style and Post pill comes under this schedule.

FIELD VISITS

Field visit - Surya clinic (Janani owned clinics) at Hajipur & Patna.

1. **Surya clinic, Hajipur** – It is a 30 bedded clinic cum hospital and only clients of female sterilization are admitted here. Total manpower of the hospital is 11 staffs (including counselor, lab tech, attendants, ANM etc) and a doctor on pay roll basis. They also have 3 doctors and 4 anesthetists on call basis. All the services are being provided here at the clinic such as female sterilization, male sterilization (very few cases are observed), IUD insertion, MTP under Yukti yojana launched by GoB, contraceptive injectables under Dimpa project launched by GoI, counseling services related to family planning etc. The system of bio medical waste disposal is well maintained at the clinic and the treatment of the waste is in partnership with 'M/s Semb Ramky' New Delhi with a plant at Muzaffarpur (Bihar). Register of each and every activity at the clinic has been well maintained by the staffs.

2. **Surya clinic, Patna** – It is the oldest of the Janani owned clinics and was established in 1998 as a pilot to cater clinical services. Initially, it was expected to help those suffering from STIs, but later it revamped as a one stop family planning centre offering a range of services, including first trimester abortions performed on an outpatient basis. It is a 30 bedded hospital and has doctors on pay roll as well as on call basis. All the services enlisted by Janani are being provided here. The bio medical waste disposal is done at IGIMS, Patna.

SECTION 6

- ✓ **LEARNINGS AND FEEDBACK**
- ✓ **CONCLUSION**

LEARNINGS AND FEEDBACK

During our two months' summer internship program under the aegis of the State Health Society Bihar, we went through the SPIP, various reports and guidelines, interacted with State Program Officers, visited many government health institutions, had interaction with some of the development partners and visited few private organizations which are working with the state government under PPP model in order to get an understanding of the health scenario in the state. Bihar has shown significant improvement in health care delivery system which is evident from increasing outpatient load in government facilities, sterilization cases, immunization, institutional delivery & others since implementation of the National Rural Health Mission in 2006. Despite this progress, the State also confronts issues of infrastructure & human resource gap and poor resource utilization and poor health indicators. Our learnings and feedbacks based on our understanding of various programs and brief exposure to the system during the last couple of months are as follows:

Maternal & Child Health:

Maternal and child health programs like JBSY, JSSK, NSSK, FBNC, HBNC, IMNCI etc. which are running in the state have a great impact on the community, and are detrimental for improving health status of mother & child health. During field visits we observed that Mamta plays a very important role in providing post natal care to the mother and the baby. There is a dress code prescribed for them which they are supposed to put on while on duty so that they can be easily identified and called for help by the mothers. But most of them were found not following the dress code. The delivery load in most of the health centers is very high but the sanctioned bed for PHC is only 6. Therefore, most of the women are discharged within 12 hours after delivery instead of 48 hours which is minimum requirement under JBSY guidelines. We interacted with some of the beneficiaries and found that most of them were well aware about breast feeding practices, kangaroo care & health education. Most of the health centers where deliveries are being conducted were equipped with NBCC but many of them were not being used because of lack of knowledge of the staff. There is a need for the on job training of the staff. Manuals and SOPs are required for labor rooms.

Family Planning:

This is the area, Government also should focus on this area because population stabilization is a serious concern, as population grows scarcity of natural resources also increases. As sterilization percentage increased in the state but same time when we go in depth, then a major percentage of these sterilization is happening after around 4 childerns, it means couple already affected the state fertility rate. When we have spoken to different beneficiaries as - most of the women are not the decision maker in the family, so in family planning counseling we also should think about some community awareness programs & family involvement during counseling.

As government has taken initiatives like NSV Camp & Tubectomy Camp the provision for incentive as 1100 Rs to Male & 600 Rs for Female if they utilizes the camp services. As our

observation for female 1400 Rs incentive is for delivery & 600 incentives for sterilization, when it comes to the beneficiaries they will opt for service which is providing them more incentives.

Adolescent Health:

In Bihar adolescent's population is around 24 % (census-2011). Many girls are getting married at a very young age which is leading to early pregnancy which is harmful for both mother and child's health; many unwed adolescent girls are going for abortion. There is an instant need to focus on their health. The Govt. has taken an initiative to address their health related issues by starting ARSH clinics which provides OPD services on Wednesday and Saturday along with counseling, take away IEC materials. But this clinic need to be more strengthened up as this service is being provided only in 3 districts in Bihar. WIFS programme of iron distribution and Albendazole is also a good initiative to tackle up the problem of Anemia. The new programme Rashtriya Bal Suraksha Karyakram is definitely going to be proved very beneficial.

VHSND :.

Village Health Sanitation & Nutrition Day is one of the major initiative under NRHM. According to SHSB guidelines a VHSND program covers ANC, PNC, Immunization , Growth monitoring, counseling of adolescent girls, Family planning, Eligible couple registration & other health services. During our visit to some of the VHSND sites we observed that there was lack of awareness both in the FLHWs as well as in the community. Many of the services were not being provided due to lack of proper and adequate space and equipment and intersectoral convergence was not visible. There is a need for capacity building of FLHWs and also to increase awareness in the community. Training of VHSND should be conducted in Cascade Model - Train the Trainer pattern which is cost effective & also will be well understood by all Health persons from Higher to bottom down.

Immunization:

In Bihar state currently under this head JE campaign, Polio Campaign & other immunization program is running and current immunization coverage in Bihar is 66% (By WHO monitoring Data 2012) , no cases recorded for Polio in Last 2 years , Polio coverage is 99.5% in the state .

During our field visits we visited some JE sites under different Health facilities & some observation which we had according to that we found there should be training schedule for ANM for document maintenance, we should form standard checklist for the basic items required during immunization camp like an emergency drug kit, we should follow a standard Microplan for organizing the any immunization camp that should be discussed & planned one day prior to the camp organization scheduled date. Monitoring was happening through telephonic communication so it should also be well planned. During immunization camp we should instruct guardian for taking care the child for next 30 minutes. Some of positive thing which we noticed that ANM was doing real time entry of the vial in JE camp, also an alternate vial delivery system was working & JE monitoring is happening in the field by various higher officials.

Human resource:

There is a huge gap in the manpower sector in Bihar. Either it being Doctors, grade A nurses, ANMs. There is such a shortage of nurses that one nurse and ANM have to carry the whole load of the maternity ward. NRHM henceforth introduced the step of hiring contractual manpower and this step has yielded a significant result by addressing the problem of manpower requirement. ANM, doctors are taken on contract basis, AYUSH Dr at PHC are giving their services at APHC, which was non functional before. The training for improving their skill is also being initiated and is a step forward approach to enhance the capability of the present employees so that the gap of specialist doctors can be covered up. Skill lab development and training the medical officers and staff nurses have really proved to be fruitful in this scenario. Till date under NRHM in Bihar 1600 medical doctors, 1384 AYUSH doctors, 1619 Grade A nurse, 8196 ANMs, have been recruited apart from that incentivised workers like 84365 ASHAs and 4402 Mamta worker have been recruited. But still this problem needs to be sorted out as the load on health facility is being increased day by day, so if we are thinking of providing universal health care to the last person in the community we anyhow have to improve the human resource else burden will be increased.

Infrastructure:

Although the state has a fairly extensive network of public health facilities it remains grossly inadequate compared to the Government of India (GoI) /Government of Bihar (GoB) norms. Almost 50% of the health sub-centres do not have their own buildings (Bihar SPIP 2012-13) and are functioning from rented buildings and some of the existing facilities lack the basic minimum infrastructure needed for their optimal functioning. Also we observed area space covered by health facilities was sufficient or more but all the health facilities were not made according to any master plan, so upcoming facilities at least should follow some standard guidelines related to hospital planning. Infrastructure fund allocation to Health facility should be given after understanding the need of that health facility with considering their OPD, IPD & Delivery service load of community. The state has taken significant measures for expansion and strengthening of the health infrastructure, it is still one of the major challenges for public health in Bihar.

PPP model:

A Public–Private Partnership (PPP) is a government service & private business venture which is funded and operated through a partnership of government and one or more private sector companies. SHSB have taken various PPP initiatives like Radiology services, Hospital Maintenance Services, Blood Storage Units, Blood Bank, Bio Medical Waste, MMU, Emergency Services (108 /102/1911), UHC, NRC etc. to improve the health system of Bihar. Also we should strengthen the Ambulance (108/102) monitoring maintenance services, also we should think about to increase Ambulance services due to excessive community demand & more delivery load on health facilities. Another PPP modal service is Generator services which was well working in all

health facilities which we visited during our field visits. Hospital management services like housekeeping, canteen etc. are the areas which required some focus for strengthening the hospital services for inpatients. Also we found sill there is a knowledge gap in periphery staff / ground staff in health system about Bio Medical Waste system so we should come up with some awareness activity at every facility level, same time we should make sure where ever we use BMW bins in health facility, it should have IEC material related to that so it enhances the knowledge level of periphery / ground staff on regular basis.

NRC:

Nutrition Rehabilitation Center is a good initiative in relation to child health management, as well as a good example of PPP services. In Bihar Each District has one Nutritional Rehabilitation Centres (NRCs) (except Sitamari & Madhubani). The current prevalence rate of SAM childerns in Bihar is 8.33% , GoB goal is to bring this prevalence rate under 1%. Even the Government of Bihar has a plan to come up with the Nutritional Rehabilitation Unit. During our field visit we visited the Nutrition rehabilitation Center (NRC) at SDH – Guru Govind Singh hospital in Patna City, some of our thoughts which we had after NRC visit areas : NRC ward if made more spacious can enhance the services. Counselling sessions at NRC should be made more interactive by using Audio – Visual aids. There should be more playful and educational materials for children. It will be more beneficial if the child is accompanied by mother instead of grandmother. There should be Unique Registration number for every child which will help to keep a track of every outgoing batch children and in the future. NRC program should be incorporated with MCTS. Also there is a need to create awareness at the level of outreach worker & beneficiaries about the NRC and its services.

Skill Lab:

Skill lab is a good concept in relation to the Health system of Government of Bihar because Bihar is a state with huge human resource gap , for overcome this gap state have taken several initiatives like HRIS, Skill lab. Skill lab is one of the best initiatives for skill development of human resources of the health system. During our visit we observed training was happening in skill lab but not a full year so we should have planned for proper skill lab utilization around the year with an annual budgetary allocation. Also housekeeping & maintenance should be strengthened. Skill lab platform we should use for converting single skilled worker into multiskilled worker.

Rogi Kalyaan Samithi:

Rogi Kalyan Samiti is a patient welfare committee formed at each level of the hospital. The main aim behind its formation was that the local communities should have the authority to decide the kind of services should be delivered in hospitals. In Bihar out of the 2020 (including 6 Medical College & Hospital) hospitals Rogi Kalyan Samiti have been formed in 1915 (including 6 Medical College& Hospital) hospitals. Seed money of Rs 5,00,000 is given to district hospital and Rs 1,00,000 to SDH, PHC and APHC. During our field visit we were able to visit Rogi Kalyaan

Samiti at PHC, Fathua which enlightened us with the working, procedure, recording of minutes of meeting & how the decision is made for the benefit of hospital & community. Same time we observed that if the meeting agenda would have been given prior hand would result in more fruitful discussions. A few members who were not able to make up in the meeting should be encouraged to attend in order to make it a success.

ANM / ASHA :

ANM is nodal person at the Health Sub centre level & also a secretary of the Village Health Sanitation Committee, she plays an important role in the management of Health at village level because most of the programs which are running in the state she is the key person to make the success of those programs at ground level. As we know there is ANM staff gaps in Health facilities, so there is huge pressure on them so we should also think about capacity development & skill development of ANM. Trainings should be planned according after understanding the needs of ANM.

Accredited Social Health Activist popularly known as ASHA can be called as pillars of NRHM. They are in direct contact with the beneficiaries at community level providing the preventive health care need. During our field visit we observed that ASHA was present at every facility at every service accompanying the patients, also we learned how ASHA play a role in community mobilization for health services. We have seen some ASHA which was very active & same time we also meet some ASHA which needed some skill development, also we observed that the dress material given to ASHA should be of material conducive to the climate so as to increase their efficiency during adverse climatic conditions.

Generalized Suggestions:

A quality assurance team should be constituted at every health facility level from PHC to DH with members as both doctors & others staffs also of hospitals to resolve hospital issues on a priority basis. All Quality assurance team members should have weekly meeting & minutes of the meeting should go to District Health Society. Also we should encourage comprehensive participatory management in health facilities. We should come up with the innovative award scheme at every District level to enhance innovation culture at the facility level. Satrangi Chadar Program has to be strengthened on ground level. The replenishing human resource will help in providing quality services to the patients. The tender of every health service should be floated after analysing the market price & cost analysis so that it is feasible for the service providers as well as the beneficiaries. Also we should have a Inventory of Fixed assets as well as inventory of items which needed to be repaired or discarded on quarterly basis .The sterilization services should be well strengthened at high priority specially in all Labour and OT rooms.

Project - 2

Quality Assessment (Human Resource, Bio Medical Waste & Infection Control) of Labor Room of all PHC in Kosi Division, Bihar

Kosi Division

Kosi Division is one of the 9 divisions in Bihar. It contains 3 districts. Madhepura District, Saharsa District, and Supaul District are the districts in this division. Saharsa Town is the headquarter of the division. The literacy rate is 37.47%. The female literacy rate is 22.64%. The male literacy rate is 51.02%.

Kosi Division - District List

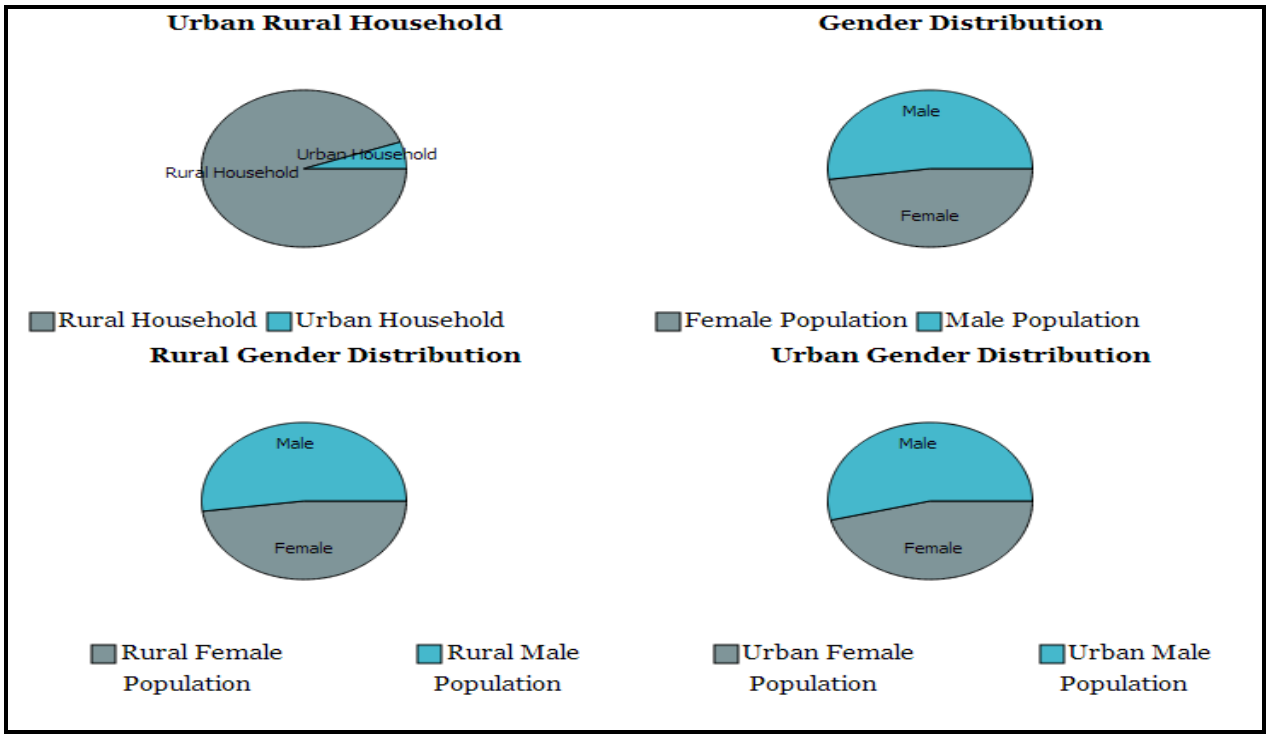
1. Madhepura District
2. Saharsa District
3. Supaul District

Demography Details - Census 2001

The number of households in Kosi is 844,085. Out of which rural household is 797,646 and the urban household is 46,439.

Female to male ratio of Kosi is 91.55%. Female to male ratio of the division is less than state's female to male ratio 91.93%. It is unsatisfactory and the people should drive some campaign to improve this. Urban female to male ratio of the division is 85.43% compared to rural female to male ratio of 91.95%.

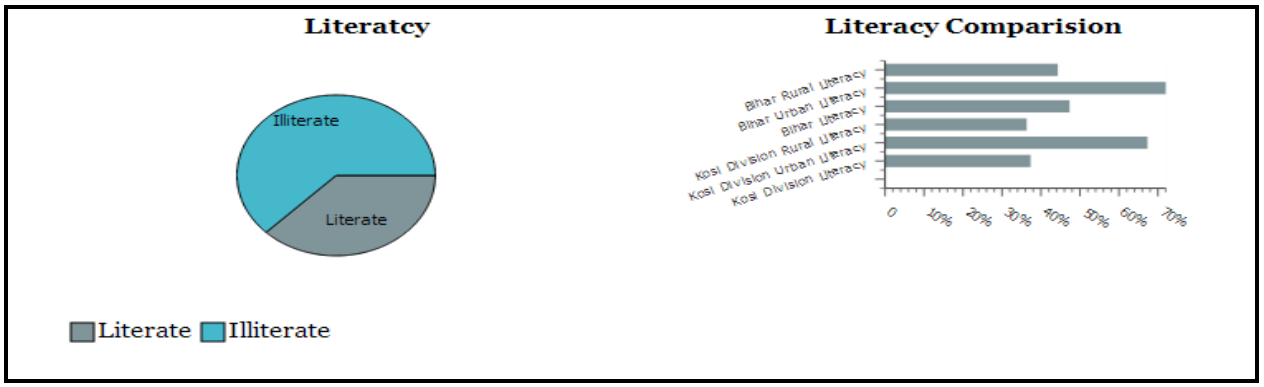
Tab: 7: House Hold Distribution (Urban / Rural and Male / Female) in Kosi division.



Kosi Division Literacy Details - Census 2001

The literacy rate of the division is 37.47% compared to the literacy rate of state 47%. The literacy rate of the division is less than state literacy rate. The rate of literacy is very low and needs immediate attention of Union and State Government. . The female literacy rate is 22.64% compared to male literacy rate of 51.02%. The rural literacy rate is 35.52% compared to urban literacy rate of 66.88%. The rural female literacy rate is 20.59% compared to urban female literacy rate of 55.04%. The rural male literacy rate is 49.24% compared to urban male literacy rate of 76.82%.

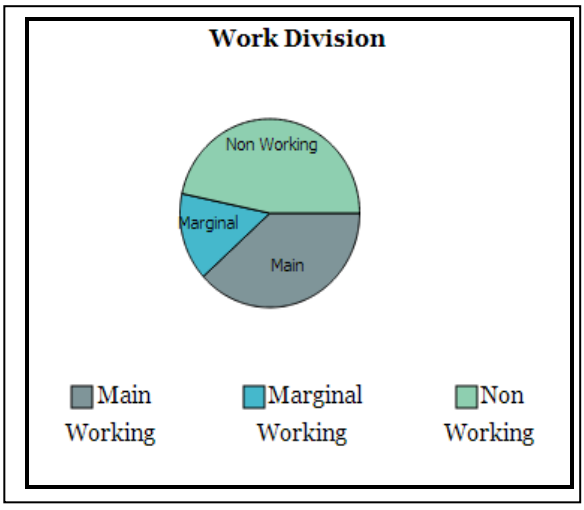
Tab: 8: Literacy Level in Kosi division



Kosi Division Working Population Details - Census 2001

The total working population is 53.34% of the total population. 63.86% of the men are working population. 41.83% of the women are working population. The main working population is 38.27% of the total population. 55.98% of the men are main working population. 18.89% of the women are main working population. While the marginal working population is 15.07% of the total population. 7.88% of the men are marginal working population. 22.94% of the women are marginal working population. The total non working population is 46.66% of the total population. 36.14% of the men are non working population. 58.17% of the women are non working population.

Tab: 9: Working Distribution in Kosi Division



Human Resource:

Tab: 10.1: Human Recourse of Labor Room of all PHC under Madhepura District.

Human Resource					
How many of the following are given Labor room duty?					
S.No.	Districts / PHC	Doctor	Grade A nurses	Nursing attendant	Sweepers
1	**Madhepura (12PHC)**				
1.A	PHC- Ghailarh	2	2	2	0
1.B	PHC-Gawalpada	2	1	2	2
1.C	PHC-chausa	2	0	2	1
1.D	PHC-Bihariganj	2	0	2	1
1.E	PHC-Uda PHC-kishunganj	2	0	2	2
1.F	PHC-Singheshwar	2	0	2	2
1.G	PHC-Gamahriya	2	1	2	2
1.H	PHC-Shankarpur	2	0	2	2
1.J	PHC-Alamnagar	1	1	0	1
1.K	PHC-Murligang	2	0	2	2
1.L	PHC-Kumarkhand	2	4	4	2
1.M	PHC-Murho	2	0	2	2

Table no 10 .1 describes about Human Recourse of Labor Room of twelve PHC under Madhepura District. Human Resources at these PHC in relation to labor room, we are taking under observation as Medical Officer, Grade A nurses, Nursing attendant and Sweepers.

Madhepura (12PHC) : In Madhepura District almost all PHC have minimum two Medical Officer placed in the hospitals. Same time there is observed unequal distribution of Grade A Nurses in twelve PHC – there are nine nurses at five PHC and seven PHC is without Grade A Nurses. Two Nursing Attendant is almost present at all PHC in Madhepura District. Seventy percentage PHC have two sweepers, twenty percentage PHC have one sweeper and one PHC do not have sweepers.

Tab: 10.2: Human Recourse of Labor Room of all PHC under Supaul District.

2	**Supaul (9PHC)**				
2.A	PHC-Marauna	4	2	0	4
2.B	PHC- Pratapgang	2	1	4	2
2.C	PHC-kishanpur	2			1
2.D	PHC- Nirmali	5	0	0	1
2.E	PHC- Pipra	1	0	0	3
2.F	PHC-Chatapur	2	0	0	2
2.G	PHC, PURAINI				
2.H	PHC-Saraigarh	1	0	0	1
2.J	PHC- Basantput	3	2		2

Table no 10.2 describes about Human Recourse of Labor Room of nine PHC under Supaul District. Human Resources at these PHC in relation to labor room, we are taking under observation as Medical Officer, Grade A nurses, Nursing attendant and Sweepers.

Supaul District (9PHC): All most all PHC under Supaul District have at least one Medical Officer available except one PHC. Medical Officers at PHC are present from one to five in number as according community demand in that area. Grade A nurses are very much less in numbers as in nine PHC only five Nurses are available which are deputed at three PHC only, so huge paramedical staff gap which effects the healthcare service delivery and same time no nurses available at six PHC. Nursing attendants are present at only one PHC as four nursing attendant remaining other eight PHC does not have any nursing attendant. At least one Sweeper present at all PHC.

Tab: 10.3: Human Recourse of Labor Room of all PHC under Saharsa District.

Human Resource					
How many of the following are given Labor room duty?					
S.No.	**Districts / PHC**	**Doctor**	**Grade A nurses**	**Nursing attendant**	**Sweepers**
3	**Saharsa (10 PHC)**				
3.A	PHC-sattarkattiya	1	1	0	0
3.B	PHC- Sonbarsa	1	4	0	1
3.C	PHC- Sourbazar	2	4	0	4
3.D	PHC- Patarghat	2	4	0	1
3.E	PHC- Sadar(PHC)	4	3	0	1

3.F	PHC- Salkhua	2		4	2
3.G	PHC- Mahishi	2	0	2	
3.H	PHC- Nauthatta	2	0	2	2
3.J	PHC- Panchgachhia	2	0	2	1
3.K	PHC- Simri bakhtayrpur	1	1	1	1

Table no 10.3 describes about Human Recourse of Labor Room of ten PHC under Saharsa District. Human Resources at these PHC in relation to labor room, we are taking under observation as Medical Officer, Grade A nurses, Nursing attendant and Sweepers.

Saharsa District (10 PHC): Minimum one Medical Officer is present at all PHC, some PHC have Medical Officers as 4 also. Seven PHC have Grade A Nurse from one to four and three PHC does not have any nurse. As same Nursing attendant also fifty percentages PHC have eleven nursing attendant and fifty percentage PHC do not have nursing attendant. Almost every PHC have sweeper posted in labor room.

Bio Medical Waste:

Tab: 11.1: Bio Medical Waste of Labor Room of twelve PHC under Madhepura District.
(Filling Instruction: 1 = Yes, 2 = No)

Biomedical Waste Management													
Madhepura													
S.No.	Particular	Ghailarh	Gawalpada	chausa	Bihariganj	Uda kishunganj	Singheshwar	Gamahriya	Shankarpur	Alamnagar	Murligang	Kumarkhand	Murho
1	Heavy duty gloves	1	2	2	2	2	2	1	2	1	2	1	2
2	Bleach or bleaching powder	1	1	1	1	1	1	1	1	1	1	1	2
3	Yellow color puncture proof container	1	1	1	1	1	1	1	1	1	1	1	2
4	Red color puncture proof container	1	1	1	1	1	1	1	1	1	2	1	2
5	Blue color puncture proof container	1	2	2	2	2	1	1	1	2		1	2
6	Black color puncture proof container	1	1	1	1	1	1	1	1	1	1	1	2
7	In this labor room, do you collect different category of bio medical waste in different color container?	1	2	1	2	2	1	1	1	1	1	1	2
8	Container for the non infectious waste	1	1	1	2	1	2	1	1	1	1	1	2
9	Waste cleared within 48 hrs (check schedule for cleaning)	1	2		2	1	1	1	2	1	1	1	2
10	Bins are cleaned regularly (on a weekly basis) with soap and water	1	2		1	2	1	2	2	1	1	1	2
11	Waste is transported in closed containers (observe and mark)	1	1		1	1	1	1	2	1	1	1	2
12	Needle cutter is in working condition [For glass syringes hold needle by forceps and cut]	1	1	1	1	1	1	1	1	1	1	1	2
13	Is there bio medical waste disposal poster on top of containers?	2	2	2	2	2	2	1	2	1	1	1	2

Table no 11.1 describes about Bio medical waste of Labor Room of twelve PHC under Madhepura District. Seventy percentage of PHC have heavy Duty gloves and thirty percentage of PHC do not have heavy duty clubs. Bleaching Powder is present in almost in all PHC (eleven PHC). Same way with availability of all four type of waste disposable bag in labor room is found that Yellow, Red and Black colour waste disposal bag are commonly present in all PHC, except the blue colour waste disposal bag which is present only in five PHC. BMW posters (as IEC material) for managing the bio medical waste only were present in four PHC out of twelve PHC. In term of regular cleaning in labor room was scheduled only in seven PHC out of twelve PHC.

Tab: 11.2: Bio Medical Waste of Labor Room of nine PHC under Supaul District.

(Filling Instruction: 1 = Yes, 2 = No)

Biomedical Waste Management										
Supaul										
S.No.	Particular	PHC-Marauna	PHC-Pratapgang	PHC-kishanpur	PHC-Nirmali	PHC- Pipra	PHC-Chatapur	PHC, PURAINI	PHC-Saraigarh	PHC-Basantput
1	Heavy duty gloves	1	1	1	1	1	1	2	2	2
2	Bleach or bleaching powder	1	1	1	1	1	1	1	2	2
3	Yellow color puncture proof container	1	1	1	1	1	1	1	2	1
4	Red color puncture proof container	1	1	1	1	1	1	1	2	1
5	Blue color puncture proof container	1	2	2	1		1	2	2	2
6	Black color puncture proof container	1	1	1	1		1	1	2	1
7	In this labor room, do you collect different category of	1	1	1	1	1	1	1	2	2
8	Container for the non infectious waste	1	1	1	1		1	2	2	2
9	Waste cleared within 48 hrs (check schedule for	2	1	1	2	1	1	1	2	1
10	Bins are cleaned regularly (on a weekly basis) with	1	1	1	1		2	2	2	1
11	Waste is transported in closed containers (observe	1	1	1	1		1	2	2	2
12	Needle cutter is in working condition [For glass	1	1	1	1	2	1	1	2	1
13	Is there bio medical waste disposal poster on top of	1	2		1	2	2	2	2	1

Table no 11.2 describes about Bio medical waste of Labor Room of nine PHC under Saupaul District. Use of Heavy duty gloves and bleaching powder in labor room is present in six to seven PHC out of nine PHC.

Availability of all four type of waste disposable bag in labor room is found that Yellow, Red and Black colour waste disposal bag are commonly present in all PHC, except the blue colour waste disposal bag which is present only in four PHC. BMW posters (as IEC material) for managing the bio medical waste only were present in three PHC out of nine PHC. In term of regular cleaning in labor room was scheduled only in six PHC out of nine PHC.

Tab: 11.3: Bio Medical Waste of Labor Room of ten PHC under Saharsa District.

(Filling Instruction: 1 = Yes, 2 = No)

Biomedical Waste Management											
Saharsa											
S.No.	Particular	sattarkattiya	Sonbarsa	Sourbazar	Patarghat	Sadar(PHC)	Salkhua	Mahishi	Nauthatta	Panchgachhia	Simri bakhtayrpur
1	Heavy duty gloves	2	2	1	2	2	2	2	2	2	2
2	Bleach or bleaching powder	1	2	1	1	1	1	1	1	1	1
3	Yellow color puncture proof container	2	1	1	2	2	2	2	1	1	1
4	Red color puncture proof container	2	1	1	2	2	1	2	1	1	1
5	Blue color puncture proof container	2	1	1	2	2	1	2	1	1	1
6	Black color puncture proof container	2	2	1	2	2	2	2	2	2	2
7	In this labor room, do you collect different category of bio medical waste in different color container?	2	1	1	2	2		2	1	1	
8	Container for the non infectious waste	1	2	2	2	2	2	1	1	1	
9	Waste cleared within 48 hrs (check schedule for cleaning)	2	1	1	2	1	1	1	1	1	1
10	Bins are cleaned regularly (on a weekly basis) with soap and water	1	1	1	2	2	2	1	1	2	1
11	Waste is transported in closed containers (observe and mark)	2	2	2	2	2	2	2	2	1	2
12	Needle cutter is in working condition [For glass syringes hold needle by forceps and cut]	1	2	1	2	1	2	1	1	1	1
13	Is there bio medical waste disposal poster on top of containers?	2	2	2	2	2	2	2	1	2	2

Table no 11.3 describes about Bio medical waste of Labor Room of nine PHC under Saharsa District. Use of Heavy duty gloves in labor room is present only in one PHC out of nine PHC. Bleaching powder is present in all PHC except one PHC.

Availability of all four type of waste disposable bag in labor room is found that Yellow, Red and Blue colour waste disposal bag are present in seventy percentage PHC, except the black colour waste disposal bag which is present only in one PHC. BMW posters (as IEC material) for managing the bio medical waste only were present in one PHC out of nine PHC. In term of regular cleaning in labor room was scheduled only in six PHC out of nine PHC.

Tab: 12.1: Infection Control in Labor Room of all PHC under Madhepura District.

(Filling Instruction: 1 = Yes, 2 = No)

Infection Control													
Madhepura													
S.No.	Particular	Ghailarh	Gawalpada	chausa	Bihariganj	Uda kishunganj	Singheshwar	Gamahriya	Shankarpur	Alamnagar	Murliganj	Kumarkhand	Murho
1	How many times do you clean labor room per day?	2 time	2 times	2	2 time	3	2	2	3	1	2	10	1 time
2	Is the labour room cleaned with water, soap and	1	1	2	2	1	1	1	1	1	1	1	2
3	Do you prepare 0.5% hypochlorite solution daily?	2	2		2	2	2	2	2	1	2	1	2
4	Do you use laundary (plastic) bags to send soiled linen	2	1		2	2	2	2	2	2	2	2	2
6	Do you wear mask and cap before entering in	2	2	2	2	2	2	2	2	2	2	2	2
8	Disposable cap	2	2	2	2		2	2	2	1	2	2	2
9	Disposable mask	2	2	2	2	2	2	2	2	2	2	2	2
10	Reusable cap (cotton)	2	2	2	2	2	2	2	2	2	2	2	2
11	Reusable mask (cotton)	2	2	2	2	2	2	2	2	2	2	2	2
14	Are shoes/ slippers changed before entering in	2	2	2	2	2	2	2	2		2	2	2
15	In this labor room, does everyone wear a plastic apron	2	2	2	2	2	2	2	2			2	2
16	Do you change gloves after every per vaginal	1	2	2	2	1	1	2	1	2	2	1	2
17	Is a separate autoclave instrument set	2	2	2	2	2	2	2	2	1	2	2	2
18	Is a kidney tray used during delivery while	2	2	2	2	2	1	2	1	1	2	1	2
19	Do you recap or bent needle before disposal?	1	1	2	2	2	1	2	2	1	2	2	2
20	Are cheatle forceps kept in a dry and clean bottle?	2	1	2	2	2		2	2	1	2	2	2

Table no 12.1 describes about Infection control in Labor Room of twelve PHC under Madhepura District. Cleaning of Labor room happen on average one to two times every day, in one of PHC have a schedule of ten times in a day.

Cleaning is done with water, soap and Hydrochloride solution in nine PHC, except 3 PHC but same time when we observe the data than only two PHC prepare 0.5% Hydrochloride solution for cleaning on daily basis. Disposable laundry bag for soil linen is used only in one PHC. There is no Disposable cap / mask, reusable cap / mask, Plastic apron for delivery and separate shoes / slippers for labor room in all PHC. There is only one PHC uses separate set of autoclaved instrument for each delivery, remaining others PHC do not follow same practice during delivery services.

Tab: 12.2: Infection Control in Labor Room of all PHC under Supaul District.

(Filling Instruction: 1 = Yes, 2 = No)

Infection Control										
Supaul										
S.No.	Particular	PHC-Marauna	PHC-Pratapgang	PHC-kishanpur	PHC-Nirmali	PHC- Pipra	PHC-Chatapur	PHC, PURAINI	PHC-Saraigarh	PHC-Basantput
1	How many times do you clean labor room per day?	2 time	2 time	5-6 time		3 time	4 time	3 time		
2	Is the labour room cleaned with water, soap and hypochlorite solution?	1	1	1	1	1	1	1		1
3	Do you prepare 0.5% hypochlorite solution daily?	1	1	2		2	2	2	2	2
4	Do you use laundary (plastic) bags to send soiled linen to laundary?	1	1	1	1	2	1	2	2	2
6	Do you wear mask and cap before entering in to labor room?	1	2	2	2	1	2	2	2	2
8	Disposable cap	1	1	1	1	2	1	2	2	2
9	Disposable mask	1	1	1	1	1	1	2	2	2
10	Reusable cap (cotton)	2	2	2	2	2	2	2	2	2
11	Reusable mask (cotton)	2	2	2	2	2	2	2	2	2
14	Are shoes/ slippers changed before entering in to the labor room?	1	1	1	2	2	2	2	2	2
15	In this labor room, does everyone wear a plastic apron while conducting deliveries for any patients?	1	2	2	1	2	1	2	2	2
16	Do you change gloves after every per vaginal examination and after every delivery?	1	1	1	1	2	1	2	2	1
17	Is a separate autoclave instrument set used for each delivery?	2	1	1	1	2	2	2	2	2
18	Is a kidney tray used during delivery while giving sharp instruments to others?	1	1	1	1	1	1	2	2	2
19	Do you recap or bent needle before disposal?	1	1	2	1	1	1	2	1	2
20	Are cheatle forceps kept in a dry and clean bottle?	2	2	1		2	2	2	2	2

Table no 12.2 describes about Infection control in Labor Room of nine PHC under Supaul District. Cleaning of Labor room happen on average one to two times every day, in one of PHC have a schedule of six times in a day.

Cleaning is done with water, soap and Hydrochloride solution in eight PHC, except one PHC but same time when we observe the data than only two PHC prepare 0.5% Hydrochloride solution for cleaning on daily basis. Disposable laundry bag for soil linen is used only in five PHC. Disposable cap / mask is used in five to six PHC, reusable cap / mask not at all used in any PHC, Plastic apron for delivery and separate shoes / slippers for labor room used in three PHC. There are only three PHC uses separate set of autoclaved instrument for each delivery, remaining others six PHC do not follow same practice during delivery services.

Tab: 12.3: Infection Control in Labor Room of all PHC under Saharsa District.

(Filling Instruction: 1 = Yes, 2 = No)

Infection Control											
Saharsa											
S.No.	Particular	sattarkatti ya	Sonbarsa	Sourbazar	Patarghat	Sadar(PHC)	Salkhua	Mahishi	Nauthatta	Panchgachhia, Inter	Simri bakhtayrp
1	How many times do you clean labor room per day?	1 time		2 time			2 time	5 time	2 time	Every	2 time
2	Is the labour room cleaned with water, soap and hypochlorite solution?	1	1	1	2	1	1	1	1	1	1
3	Do you prepare 0.5% hypochlorite solution daily?	1	2	1	2	2	2	1	1	1	2
4	Do you use laundary (plastic) bags to send soiled linen to laundary?	1	2	2	2	2	2	2	1	2	2
6	Do you wear mask and cap before entering in to labor room?	1	2	2	2	2	2	2	2	2	2
8	Disposable cap	2	1	1	2	2	2	2	2	2	
9	Disposable mask	2	2	1	2	2	2	2	2	2	
10	Reusable cap (cotton)	2	2	2	2	2	1	2	1	2	1
11	Reusable mask (cotton)	2	2	2	2	2	1	2	1	2	1
14	Are shoes/ slippers changed before entering in to the labor room?	1	2	2	2	2	2	2	1	1	
15	In this labor room, does everyone wear a plastic apron while conducting deliveries for any patients?	1	1	1	2	1	2	2	1	1	2
16	Do you change gloves after every per vaginal examination and after every delivery?	1	1	1	1	1	1	1	1	1	1
17	Is a separate autoclave instrument set used for each delivery?	2	2	2	2	2	2	2	1	1	
18	Is a kidney tray used during delivery while giving sharp instruments to others?	1	1	1	2	2	2	1	1	2	1
19	Do you recap or bent needle before disposal?	1	2	2	2	2		1	2	1	2
20	Are cheatle forceps kept in a dry and clean bottle?	2	2	2	2	2	2	2		2	1

Table no 12.3 describes about Infection control in Labor Room of ten PHC under Saharsa District. Cleaning of Labor room happen on average one to two times every day, in one of PHC have a schedule of five times in a day.

Cleaning is done with water, soap and Hydrochloride solution in nine PHC, except one PHC but same time when we observe the data than only five PHC prepare 0.5% Hydrochloride solution for cleaning on daily basis. Disposable laundry bag for soil linen is used only in two PHC. Disposable cap / mask is used in two PHC, reusable cap / mask used in three PHC, Plastic apron for delivery for labor room used in six PHC. There are only two PHC uses separate set of autoclaved instrument for each delivery, remaining others eight PHC do not follow same practice during delivery services.

CONCLUSION

Government of Bihar is working tremendously on providing better service, quality delivery system up to the last person in the community. Health department and state health society is working together to cover up all the gaps of health facilities and services. Since past few years with introduction of NRHM the health care delivery system has been revolutionized. Indicators in Bihar have shown vast improvement such as IMR is now 44 which is equivalent to the national average, MMR is 261, which is only 20% more than national average, institutional delivery have increased tremendously from 1 lakhs-14 lakhs, OPD services have increased about 200-300 per day with health facilities providing 24*7 services.

The process of institutional change has been successfully initiated and gradually will show the desired outcomes with concentrated efforts and augments. The decentralized fund allocation and release by state government in form of untied fund, annual maintenance grant, formation of Rogi kalyan samiti, all this have increased the autonomy of the health care provider for betterment of services according to the need of the local population.

The human resource insufficiency is still a major problem in Bihar faced by almost all the health facilities. To tackle this problem many training sessions and skill building initiatives are being introduced. Skill lab has been set up, BEmOC and EmOC training to the MBBS doctor to enhance there capacity have also been started

The best innovation of NRHM to tackle the accessibility and availability of health care to the grass root level is through ASHA, they are undertaking incentive wise work. ASHA are the backbone of all the programmes, they are the first contact point between Government and community. In Bihar ASHA is working quite well and are highly motivated but some where they are not happy with the delay in receiving their incentives which reduces their enthusiasm for work. Government should be very focused on the issues related to ASHA.

Gaps in infrastructure facilities needs to be addressed, many facilities were lacking proper master planning, construction is being done according to the space provided without following any master plan guidelines but it should be changed and a common FFHI guidelines should be followed to make hospitals patient friendly and also to serve the need of growing population and its demand. Fund utilization from Rogi kalyan samiti should be encouraged.

Efforts in the area of family planning have shown progressive trend in acceptance of family planning methods but still its TFR is 3.6 which is highest in country and still it is a long journey to achieve the milestone. The main hindrance in achieving better coverage family planning is low literacy rate, females here are not the decision makers in the family, it's the husband who decides the contraceptive methods, and poverty is also a reason here.

They think that more family member means more working hand and more earning in family. There is also unmet demand of couples for contraceptives. Government is providing

condoms at subsidized price, free sterilization services along with incentives. This area has to be focused more to reach the desired level.

HMIS system have increased the frequency of reporting and now the data are being generated timely and flow of data from sub centre till state health society has been improved after HMIS came into functioning. But at ground level more training and orientation should be provided to ANMs so that they are aware of the importance of reporting format of HMIS.

Improved services have also been possible due to PPP model, it is running quite successfully in area like diagnostic centers, ambulance services, blood bank, bio medical wastes. It is a system that will ensure the long run sustainability of the services, in this government reimburse costs to private providers. This model is working successfully in state, after this partnership the quality of services provided at government facilities has improved a lot.

Also the lacking of medical practitioner in Bihar is covered up by integrating the Indian system of medicine AYUSH in main stream. A progressive step has been taken by recruiting them and posting them at APHCs. They are providing their best services but the shortage of availability of medicines for them needs to be entertained immediately.

The best part of NRHM is the intersectoral convergence with different departments like PHED, ICDS, PRI and Education department. VHSND programme under NRHM is a perfect example of interlinkage providing the services at root level. SABLA project is under implementation for nutrition and health for adolescent girls, school health programme and Rastriya Bal Suraksha Karyakram is being undertaken with department of education, PHED is maintaining a safe system of water supply, water testing, and drainage system.

From point of view of building a system of health care delivery that is sustainable in long run, greater focus on providing quality service, involvement of private partnerships, timely disbursement of funds, strengthen the skills of human resource available for meeting the demand. Enthusiastic support from community is foremost important in creating sustainable health services for ensuring good health for the people of Bihar.

As from Project two Quality Assessment (Human Recourse, Bio Medical Waste & Infection Control) of Labor Room of all PHC in Kosi Division, Bihar

SECTION-7

✓APPENDIX

- **ABBREVIATIONS**
- **REFRENCES**

REFRENCES

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ABBREVIATIONS

ACMO	–	Assistant Chief Medical Officer
AFP	–	Acute Flaccid Paralysis
ALS	–	Advance life support
AMC	–	Annual Maintenance Contract
ANM	–	Auxiliary Nurse Midwife
APHC	–	Additional Primary Health Centre
ARC	–	Asha Resource Centre
ARI	–	Acute Respiratory Infection
ASHA	–	Accredited Social Health Activist
AWC	–	Aanganwadi Centre
AWW	–	Aanganwadi Worker
AYUSH	–	Ayurved Unani Siddha and Homeopathy
BCC	–	Behaviour Change Communication
BEmONC	–	Basic Emergency Obstetric Neonatal Care
BLS	–	Basic Life Support
BPL	–	Below Poverty Line
BTAST	–	Bihar Technical Assistant Support Team
CBC	–	Community Based Care
CBO	–	Community Based Organization
CBPM	–	Community Based Participation and Monitoring
CD Block	–	Community Development Block
CDPO	–	Child Development Programme Officer
CES	–	Coverage Evaluation Survey
CG	–	Community Group
CH	–	Civil Hospital
CHC	–	Community Health Centre
CMC	–	Comprehensive Maintenance Contract
CMR	–	Child Mortality Rate
CPP	–	Control Program Phase
CS	–	Civil Surgeon
CSMP	–	Contraseptive Social Marketing Programme
CSO	–	Civil Society Organization
CSR	–	Confidential Service Report
DAC	–	District Accridiation Committee
DFID	–	Department for International Development
DH	–	District Hospital
DHAP	-	District Health Action Plan
DHS	–	District Health Society
DMEO	–	District Monitoring & Evaluation Officer
DP	–	Development Partners
DPC	–	District Planning Coordinator
DPHNO	–	District Public Health Nurse Officer
DPMU	–	District Programme Management Unit
DPR	–	Detailed Program Report

DSU	–	District Surveillance Unit
EDL	–	Emergency Drug List
EHSP	–	Essential Health Services Package
EVA	–	Electronic Vacuum Aspiration
FD	–	Feeding Demonstrator
FFHI	–	Family Friendly Hospital Initiative
F-IMNCI	–	Facility Based Integrated Management of Neonatal and Childhood Illness
FLHW	–	Field Level Health Worker
FMR	–	Financial Management Report
FNGO	–	Field Non-Governmental Organization
FPP	–	Family Planning Programme
GOB	–	Government of Bihar
GOI	–	Government of India
HBNC	–	Home Based Neonatal Care
HMIS	–	Health Management Information System
HRD	–	Human Resource Development
HW	–	Health Worker
ICDS	–	Integrated Child Development Scheme
IEC	–	Information Education and Communication
IFA	–	Iron Folic Acid
IIHMR	–	Institute of Health Management Research
IMEP	–	Infection Management and Environment Protection
IMNCI	–	Integrated Management of Neonatal and Childhood Illnesses
IMR	–	Infant Mortality Rate
IPHS	–	Indian Public Health Standards
IUCD	–	Inter Uterine Contraceptive Devices
IYCF	–	Infant and Young Child Feeding
JBSY	–	Janani Evam Bal Suraksha Yojana
LHV	–	Local Health Visitor
LSAS	–	Life Saving Anesthetic Skill
MCP Card	–	Mother and Child Protection Card
M&E	–	Monitoring and Evaluation
MDG	–	Millennium Development Goals
MOHFW	–	Ministry of Health and Family Welfare
MoU	–	Memorandum of Understanding
MPH	–	Master in Public Health
MPW	–	Multi-Purpose Worker
MTP	–	Medical Termination of Pregnancy
MUAC	–	Mid Upper Arm Circumference
MVA	–	Manual Vacuum Aspiration
NACO	–	National AIDS Control Organization
NACP	–	National AIDS Control Programme
NFHS	–	National Family Health Survey
NMR	–	Neonatal Mortality Rate
NRC	–	Nutrition Rehabilitation Center
NSSK	–	Navajat Shishu Suraksha Karyakram
OBC	–	Other Backward Class

OPD	–	Outdoor Patient Dispensary
PG	–	Post Graduate
PHC	–	Primary Health Centre
PHED	–	Public Health Engineering Department
PHN	–	Public Health Nurse
PIH	–	Pregnancy Induced Hypertension
PIP	–	Programme Implementation Plan
PMU	–	Programme Management Unit
POL	–	Petrol Oil and Lubricant
PPFP	–	Post Partum Family Planning
PPP	–	Public Private Partnership
PRI	–	Panchayati Raj Institution
QAM	–	Quality Assurance Manual
RCH	–	Reproductive and Child Health
RDD	–	Regional Deputy Director
RHS	–	Rapid Household Survey
RKS	–	Rogi Kalyan Samiti
RMP	–	Registered Medical Practitioner
RMNCH+A	–	Revised maternal neonatal and child health+adolescent
ROP	–	Record of Proceedings
RTI	–	Reproductive Tract Infection
SAM	–	Severe Acute Malnutrition
SBA	–	Skilled Birth Attendant
SC	–	Scheduled Caste
SDH	–	Sub-Divisional Hospital
SGT	–	Second Generation Training
SHC	–	Sub Health Centre
SM	–	Social Mobiliser
SNGO	–	Service Non-Governmental Organization
SOE	–	Statement of Expenditure
SPMU	–	State Programme Management Unit
ST	–	Scheduled Tribe
STSC	–	Skin To Skin Care
SWD	–	Social Welfare Department
TBA	–	Traditional Birth Attendant
TFR	–	Total Fertility Rate
ToR	–	Terms of Reference
ToT	–	Training of Trainer
TT	–	Tetanus Toxoid
U5M	–	Under 5 Mortality
UIP	–	Universal Immunization Programme
UNFPA	–	United Nations Population Fund
UNCP	–	United Nations Children's Fund
UNICEF	–	United Nations International Children's Emergency Fund
UT	–	Union Territory
VHSC	–	Village Health and Sanitation Committee
VO	–	Voluntary Organization/ Village organization