Report of the 2nd Common Review Mission,

Chhattisgarh

16th December to 22nd December 2008

Team Members:

1. Dr. R S Sharma, Joint Director, NVBDCP, Govt of India.
2. Dr Kaushik Ray Barman, Senior Consultant - Public Health Planning, National Health System Resource Centre, New Delhi
3. Dr. Pavitra Mohan, Health Specialist, UNICEF India Country Office, New Delhi.
4. Dr. Joe Varghese, Senior Programme Coordinator, Christian Medical Association of India, New Delhi

Acknowledgement

The Common Review Mission Team sincerely expresses their appreciation & thanks for the courtesy, hospitality and cooperation extended by the officials of the State Mission Directorate, Government of Chhattisgarh, partners of the programme and particularly the community during this visit. We also deeply appreciate National Rural Health Mission for providing us the opportunity to participate in Common Review Mission to experience and understand the initiatives undertaken by the state in various dimensions. We appreciate the fact that the State authorities have already taken note of many of these issues positively as evident from our final debriefing with the state authorities.

Contents:

Chapter 1 INTRODUCTION

1. Introduction

Chhattisgarh was one among the newly formed state (formed in the year 2000) which had inherited some genuine constraint like weak health infrastructure, depleted human resources for health system apart from many of its areas are earmarked as conflict areas leading to compromised health indicators. Many of the basic determinants of health like water, sanitation, economic opportunities and food availability were also in a compromised situation. During its origination there was considerable inadequacy in the state's capacity for planning, implementing and monitoring health reforms. Nevertheless the political and administrative leadership of the state had identified health as one of the priorities right from the beginning and the path embarked on by the state has resulted in many remarkable achievements.

Many of the health sector reform agendas set by the state were pioneering and stood as example for improving health system and health status of people of this country. When National Rural Health Mission was rolled out in the country in the year 2005, Chhattisgarh state had already covered certain ground in many strategic sectors especially with respect to women community health worker programme. Today the state runs the largest trained network of ASHA (Mitanin) in the country.

2. Baseline of public health system in the state

2.1 Infrastructure and Human resources:

Inadequate health infrastructure and human resources has been one of the major constrain of the state. The last few programme Implementation Plans under NRHM of the state had identified this lacunae and made several proposals to correct it. As of the year 2007 the state has 85 community health centres against a requirement of 129, 467 primary health centres against requirement of 707 and 3193 sub centres against requirement of 4694. Similarly state has significant shortfall in almost all categories of human resources. For example there is as many as 1400 posts of Medical officers are vacant across the state. The shortage is also systemic in nature as the state has limited capacity in training new personnel as per requirement of NRHM. The large forest (44%) which covers the state and conflict affected regions make it even more difficult to find people for serving in this area.

2.2 Health indicators:

The health indicators of Chhattisgarh show a dismal health status and inadequate service utilization on most counts. However as per the latest SRS data available (2007) infant mortality rate especially the rural infant mortality rate has shown a considerable decline of 33 points from the period of state formation.

Table 1

S. No.	Item	Chhattisgarh	India
1	Crude Birth Rate (SRS 2007)	26.5	23.1
2	Crude Death Rate (SRS 2007)	8.1	7.4
3	Total Fertility Rate (NFHS-III)	2.6	2.7
4	Infant Mortality Rate (SRS 2007)	59	55
5	Maternal Mortality Ratio (SRS 2001 – 2003)	379	301

A comparison of the last two DLHS survey shows poor level of institutional deliveries which remain static at18.1% between two surveys. However commendable levels achievement in breast-feeding practices has been noticed.

Table 2

	DLHS 3 (2007-08)			DLHS 2 (2002 – 04)		
	T	R	U	T	R	U
Institutional delivery	18.1	13.2	48.4	18.1	10	50.4
Mother's who had three or more ANC%	51.2	47.3	75.9	44.4	37.7	71.4
Children 12-23 months fully immunized %	59.3	57.2	71.4	56.9	52.9	73
Children under three years breastfed within one hour of birth	50.1	50.2	49.3	29.5	27.4	38
Children 0-5 months exclusively breastfed	78.3	79	73.4	NA	NA	NA

2.3 Status of PRI framework:

With the initiation of NRHM new institutional mechanisms are in place for the proactive involvement of PRIs in the health sector.. Over the last few years the state had made several initiatives to involve PRIs in the planning for health and implementation of health programmes (like Swasth Panchayat Scheme initiated for placing health into the agenda of panchayats). The present thrust seem to be more towards ensuring PRI participation in planning and implementation rather than devolution of power, facilities and finances to PRIs.

3. The second Common Review Mission team members

1. Dr. R S Sharma, Joint Director, NVBDCP, Govt of India.
2. Dr Kaushik Ray Barman, Senior Consultant - Public Health Planning, National Health System Resource Centre. New Delhi
3. Dr. Pavitra Mohan, Health Specialist, UNICEF India Country Office. New Delhi.
4. Dr. Joe Varghese, Senior Programme Coordinator, CMAI, New Delhi.

4. List of facilities visited by the team

Table 3: Name of the institution visited in Chhattisgarh (16th-22nd Dec 2008)

	State/ Dist Raipur	District Bilaspur	District Dhamteri
Sub centre		1. Gobripat (Kota) 2. Keonchi 3. Dahi Bahra (Gaurela) 4. Bacharwar (Pendra)	1. Bhakhara 2. Koliari 3. Megha
Primary Health Centre		1. Ganiari (Takhatpur) 2. Kargikalan (Kota) (Mitanin Camp) 3. Keonchi (Gaurela) 4. Andhiarpur (Gaurala) 5. Amadand (Pendra)	1. Bhakhara (Kurud) 2. Megha (Magarload) 3. Bare Kareli (Magarload)

			4. Dugali (Nagri)
Community Health Centre	1. Abhanpur	1. Kota 2. Senetorium (Gaurela) 3. Pendra	1. Kurud 2. Nagri
District Hospital		1. Dist Hospital, Bilaspur	1. Dist Hospital, Dhamteri
Other Institution (state/ District level)	1. Medical college, Raipur 2. SIHFW 3. RDHFW 4. SPMU 5. Directorate	1. CMO office & DPMU 2. JSS rural hospital (NGO) 3. Keonchi AWC 4. AYUSH Disp (Pendra) 5. F W Camp (Seepat PHC) 6. RFWTC	1. ANMTC

Table 4:

2nd Common Review Mission				
Name of State		Chhattisgarh		
Names of Districts visited				
Sno	Name	District HQ	Name of DM	Name of CMO
1	Bilaspur	Bilaspur	Mr. Sonmani Borah	Dr. S.K.Pambhoi
2	Dhamtari	Dhamtari	Mr. Tyagi	Dr. O.P.Dubey
3	Raipur	Raipur	--	--
Health Facilities visited During 2nd CRM (16th-22nd Dec 2008)				
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
District Bilaspur				
1	SC, Gobripat (CHC Kota)	Gobripat, Kota	SC	Dr. Awdheshwar Sai
2	SC, Kenwachi (CHC Gourella)	Keonchi, Gourela	SC	Dr. Amar Singh Sendram
3	SC, Dahibahra (CHC Gourella)	Dahibahra, Gourela	SC	Dr. Amar Singh Sendram
4	SC, Bacharwar (CHC Pendra)	Bacharwar, Pendra	SC	Dr. D.S. Paikra
5	PHC, Ganiyari (CHC Takhatpur)	Ganiyari, Takhatpur	PHC	Dr. Pramod Tiwari, BMO-Takhatpur
6	Kargikala, Mitanin Training 10th Round	Kargikala, Kota	PHC premises	Mr. Satyaprakash Sahu, Mitanin Co-coordinator
7	PHC, Kenonchi (CHC Gourela)	Keonchi, Gourela	PHC	Dr. Amar Singh Sendram
8	PHC, Amadand (CHC Pendra)	Amadand, Pendra	PHC	Dr. D.S. Paikra

9	PHC, Andhiarpur (CHC Gourela)	Andhiarpur, Gourela	PHC	
10	CHC, Kota	Kota	CHC	Dr. Awdheshwar Sai
11	CHC, Pendra (CHC Pendra)	Pendra	CHC	Dr. D.S. Paikra
12	Sanatorium and Eye hospital (CHC Gourella)	Gourela	FRU/ CHC	Dr. Amar Singh Sendram
13	AYUSH Dispensary	Pendra	AYUSH Instt.	Dr. D.S. Paikra
14	District Hospital, bilaspur	Bus stand, Bilaspur	DH	Dr. Amar Singh Thakur
15	PHC Seepat – F W Camp (CHC Masturi)	Seepat, Masturi	PHC/ camp	Dr. Sanyal
16	Regional FW Training Center, Bilaspur	Sarkanda, Bilaspur	Training Center	Ms. Madhulika Singh
17	CMHO Office	Shanti Nagar Bilaspur	District Office	Dr. Surendra Pambhoi, CMHO
18	DPMU, Bilaspur	Shanti Nagar Bilaspur	District Office	Mr. Utkarsh Tiwari, DPM – NRHM
19	Keonchi, Anganwadi centre	Gourela	AWC	-
20	Jan Swasthya Sahyog Kendra, Ganiyari, (CHC Takhatpur)	Ganiyari, Takhatpur	Other	Dr. Yogesh Jain
District Dhamteri				
1	SC, Bhakhara	Bhakhara, Block - Kurud	SC	Pushpa Bangare (ANM) & Leela Ram Dewangan (MPW-M)
2	SC, Koliari	Koliari, Block - Kurud	SC	Smt. Manju Sahu (ANM)
3	PHC, Bhakhara (Kurud)	Bhakhara, Block- Kurud	PHC	MO post Vacant Dr. U.S. Navratan, BMO (Incharge)
4	PHC, Megha (Magarload)	Megha, Block- Magarlod	PHC	MO post Vacant Dr. T.R. Dhruw, BMO
5	PHC, Bade Kareli (Magarload)	Bade Kareli, Block - Magarlod	PHC	MO post Vacant Dr. T.R. Dhruw, BMO
6	PHC, Dugali (Nagri)	Dugali , Block - Magarlod	PHC	Dr. Hemant Kumar Nag
7	CHC, Kurud	Teh.-Kurud	CHC	Dr. U.S. Navaratan (BMO)
8	CHC, Nagri	Teh.-Nagri	CHC	Dr. D.R. Thakur (BMO)
9	Dist Hospital, Dhamteri	Civilines, Dhamtari	Dist Hospital,	Dr. R.K. Saxena (CS)
10	ANMTC	Civilines	ANMTC	Smt. L.J. Issac (Principal)

1	CHC, Abhanpur	Block, Abhanpur, Raipur	CHC	BMO, Abhanpur
2	Medical college, Raipur	Raipur		
3	SIHFW	Raipur		Director, SIHFW
4	RDHFW	Raipur		Regional Director
5	SPMU	Raipur		SPM
6	Directorate of H & F W	Raipur		All Directors

Chapter 2 Mandate of CRM & Adopted methodology

2.1 Mandate of CRM

The Common Review Mission (CRM) is constituted with a mandate to review by undertaking concurrent evaluation of the National Rural Health Mission implementation in the state of Chhattisgarh. The CRM is also an occasion for the state to share and review experiences, discuss with wide range of stakeholders and carry out mid course corrections if required.

2nd CRM team was given some specific mandate during briefing session at central level. The specific mandates include

a. To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
b. To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communitisation and others,
c. To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
d. To recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM

2.2 Adopted methodology

The process of CRM started with a daylong briefing session at state level with key health functionaries which provided overall state of affairs with respect to health services especially the implementation of NRHM. The team then set out for field visit in two selected districts (Bilaspur and Dhamteri) for detailed assessment of progress of NRHM with reference to the various key areas. The field visits covered facilities including the District Hospitals, CHCs, PHCs and Sub Centres as well as various relevant and associated institutions apart from the community as listed above. In these facilities the team held detailed discussions with functionaries, interacted with patients and verified various records. Another source of information was the discussion with key people associated with health sector in the state. They include officials holding key portfolios and independent observers from civil society. The team also visited Raipur medical college, State Institute of Health and Family Welfare (Raipur), Regional Training Centre (Bilaspur), Jan Swasthya Sahayog rural hospital and State Health Resource Centre, Raipur.

The team also interacted with village communities by undertaking focus group discussions, meeting with local leaders and visiting the houses of beneficiaries who had used a government health facility recently. Elaborate discussions on specific themes were held with Mitanins (ASHA) in almost of the places.

The CRM process is basically designed to provide qualitative information about areas relevant to rural health services and the progress made by the state. The team members decided to visit initial few institution collectively so that the methodology and check lists can be standardized. After that the team members visited facilities in two groups. At the end of the day, both the groups sat together to discuss various issues and made a consensus about their findings. With a specific mandate to review and document the changes in health system, to identify the key constraints and to

give specific recommendation with respect to policy and implementation of NRHM in the state, the CRM team decided to focus on few specific issues/indicators while visiting a range of institutions at the state, district, block, village level.2nd CRM team had also attempted to see the actions on the recommendations of the first CRM report such as issues related to governance of NRHM in the state, programme management unit structures & their functioning and initiatives through integrated approaches within the existing system. The team also explored the progress made on the activities planned under the state PIP 08-09 FY.

State of Chhattisgarh had embarked on the path of reform on many strategies envisaged under NRHM few years before its initiation at the national level. This was factored into the analysis of the findings while also keeping in mind the limitations of a newly formed state.

2.3 Areas covered during CRM:

- Infrastructures and Human Resources
- Mitanin, community processes and decentralisation
- Health societies, Program management units at various level
- Financial management
- Maternal, child Health and Family Planning services
- Immunization and cold storages
- JSY and its implementation
- National Disease Control Programmes
- Convergence activities
- HMIS
- Jeewan Deep Samities and Village Health and Sanitation Committee
- Untied funds
- Logistics Management and Drug procurement system
- Mainstreaming AYUSH
- Mobile Medical Units
- Training & Capacity Building through SHRC, SIHFW, training centres
- Governance issues along with planning processes

Table 5

institutional level:	Community level:
• Observation of various areas or depts. • Interaction with key functionaries. • Exit Interviews with patients. • Review of records: Stores, Log book of ambulances, Lab, X Ray dept, JDS register, OPD & IPD etc	• Discussion with Village Sarpanch and other members of PRI • Interaction with Mitanin and trainer/ coordinators • Discussions with NGO representatives. • Group discussion with community and other l personnel

Chapter 3 Findings of 2nd Common Review Mission

Findings of 2nd Common Review Mission

3.1 Institutional framework under NRHM

Village Health Sanitation Committee:	(Please refer to section 3.2.12. Community process under NRHM)
RKS:	(Please refer to section 3.2.8 Decentralization and use of untied funds)
Programme Management Units:	(Please refer to section 3.2.19.)

3.2 Change in key aspects of Health delivery system

3.2.1. Assessment of case load being handled by the Public System at all levels:

Assessment of caseload being handled by the public health system with reference to various services like OPD, IPD, Laboratory services, delivery care, ANC etc was made by analyzing the available records and interacting with providers and beneficiaries. It is well evident from the community interaction that OPD services and normal delivery is in increasing trend in many CHCs and SCs. However this trend is not seen in PHC facilities. OPD services and institutional delivery in many PHC has gone down due to non availability of doctors and Staff Nurses. The institutions where doctors are coming regularly particularly in CHCs the increase in indoor patient load is quite encouraging.

The record shows numbers of Malaria cases (P Falciparum positive cases) are quite high in many CHCs and PHCs. High numbers of malaria positive patients (Rapid kit test positive 38/ 94) are reported from a PHC by the treating doctor confirms the high burden of malaria in Chhattisgarh. Although an overall decline of malaria cases are reported from the district of Bilaspur, the increase in SPR in Dhamteri during 2008 is an issue of concern.

Laboratory support is almost non existing in many PHCs leading to delayed diagnosis and treatment. In one PHC RNTCP services including laboratory support has been withdrawn. There is encouraging trend of OPD, IPD, ANC, and Delivery services in newly constructed District Hospital, Bilaspur which could be attributed to its centralized location, hygienic environment and sufficient health staff. None of the CHCs or FRUs are conducting caeserian section due to various reasons. Lacks of staff/ specialist, blood storage facilities, emergency drugs, upgraded operation theater are few identified reasons. In one of the CHCs, an orthopaedic specialist is posted but no orthopaedic surgeries are reported.

As far as family welfare services are concerned, the trends are somewhat similar in many facilities where laproscopic sterilizations are promoted. Coverage of NSVT is quite low except in Kota CHC where the coverage has been reported quite high due to personal initiatives taken by the health staff. Fixed date approach in partnership with a public sector company (NTPC) was observed in Sipat PHC where caseload for female sterilization was observed many folds than male counterpart. MTP

facilities do not exist in many CHCs in Bilaspur except Bilha CHC. In contrast to these trends in public health facilities, a significantly high patient load was observed in a NGO (JSS) run hospital (equivalent to a CHC in bed strength and population coverage) where even waiting lists for surgical cases are reported due to increase demand of services.

3.2.2 Preparedness of health facilities for patient care and utilization of services

CRM team had visited many facilities from the district hospital to SCs and a NGO run hospital. But it has been noticed that PHCs are the weakest link in the system in terms of infrastructure, availability of beds & its occupancy, drugs, manpower, 24x7 facilities, lab services etc. Bed occupancy rate has been increased in secondary level facilities. Most of the PHCs are running in buildings meant for SCs with minimal upgradation during NRHM period. Some infrastructural upgradation in newly constructed SCs were observed, however basic amenities are yet to be provided for making the institution fully functional. Provisions of residential quarters are not seen in many facilities. Most of the up-gradations are seen at district hospital. CRM team has noticed upgradation in terms of infrastructure, equipments, drug procurement, water supply, contractual service providers in the facilities which are better located. However these up-gradations are yet to reach in facilities located in remote and tribal area. Utilisation of untied fund was observed in SC whereas in few PHCs where the team has visited did not find evidence of untied fund utilization. Jeewan deep samiti formation has not been completed in one facility (PHC Bhakhara) due to non availability of doctors whereas in one block (Magarload) it has noticed that BMO is a member of JDS of many facilities. SNCU upgradation is important component for child health which is yet to be initiated in Raipur medical college due to non-releasing of funds and administrative lethargy. Acute shortages of staff nurse and doctors, pharmacist are also hampering health service delivery in many PHCs where ANM is the key service provider. Separate construction from BRGFund has been noticed in PHC compound of Amadar under Pendra block.

It has been communicated by the Director, AYUSH that AYUSH collocation had already happened in 86 facilities, but CRM team did not able to locate same in visited areas. An Ayurvadic dispensary was found in a dilapidated condition along side the PHC at Ganiari. Overall routine Drug availability for AYUSH and Allopathy was reasonably good though recent shortages of allopathic drugs were reported in some facilities due to discontinuation of purchase from district level. Utilisation of JDS funds for procurement of drugs has been reported in many facilities but the volume of drug procurement (particularly the life saving drugs) through JDS is minimal in comparison to infrastructure development.

Utilisation of ambulance service in many CHCs as marked in the log book record shows almost exclusive usage for administrative and logistic procurement matters. Utilisation of ambulance for patient referral service was only rarely reported.

Laboratory facilities are being functional in many CHCs with minimal possible facilities whereas in Abhanpur CHC it is working satisfactorily. Toilet facilities in most of the structures are below average as water supply system is faulty, though initiatives have been taken through JDS to streamline water supply in many facilities including SCs. Many facilities are yet to receive funds under NRHM for infrastructure strengthening though it has been budgeted in the PIP. When this was discussed with the state officials we have been told that due to election code of conduct the funds were not disbursed, and the process will be initiated shortly.

Large proportion of vacancies in terms of MO (64 positions vacant in Bilaspur), specialists (14/64 specialist positions in Bilaspur are vacant) are critically hampering the scope of services in most of

the institutions. Those who are trained in LSAS for anesthesia and EMOC course are not appropriately placed for making FRUs operational.

3.2.3. Quality of services

Issues of quality of services have been observed in details by the CRM team in most of the institutions using various parameters. Though many new initiatives have been undertaken, there are still rooms for improvement as far as the quality of ANC, Natal and Post natal care are concerned. CHC Pendra Road (Sanatorium hospital) shows one of the good practices in this regard. Facility up keeping of this institution needs to be replicated in other CHCs/ FRUs.

It has been observed that most of the SC are giving better services than past because of the availability of untied fund and their proper utilization, In most of the SCs visited basic materials including paediatric ambu bag, delivery trey, table with mackintosh sheet, Boiler, AD syringes, needle cutter etc. are noticed as functional. General cleanliness in SCs are good except where it is functioning from a rented building. Problems for water supply, electricity bill payment are reported from SC. Another good initiative is availability of functioning telephone connection at SCs. It has been reported by the community during group discussion that the team work between ANM, Mitanin and AWW are exceptionally encouraging in many parts of the Chhatisgarh. The untied fund utilization has helped particularly the SCs in improving the quality of services.

The service guarantees through 24x7, FRU services have to be strengthened so that state can fulfill its service targets. Blood storage facilities are not yet on track in Chhattisgarh due to some administrative problems at drug controller level. Good initiatives like mitanin help desks contributed immensely in improving the quality of referral mechanism and patient care. But there are difficulties due to the delayed payment to JSY assistance. It has been noticed that in many CHCs, male and female wards are existing in same room which hampers the privacy of the patients. One of the good practices noticed in CHCs and District hospital was the usage of bednets for the patients to protect them from mosquito bite. In spite of many new initiatives, the quality service for institutional delivery is still below optimal mainly because of lack of human resources and infrastructures. It has been observed in most of the facilities that post natal care for definite period as per the norms was not followed. Treatment facilities for STI/ RTI are not provided as per need. It has been reported from F W camp at Sipat PHC that many female patients had pelvic inflammatory diseases which was incidentally diagnosed during laproscopy. However no specific care was provided to these patients except the pre-prescribed drugs as per program guidelines. MTP facilities in CHCs do not exist except Bilha CHC in Bilaspur. None of the private sector facilities are regularized or certified for conducting MTP services. One committee has been formed recently for this certification process at district level, which is yet to start its functioning.

Infection control measures are seen at CHCs and district hospital by providing coloured bio-medical waste management containers but construction of pits are initiated only in few facilities.

3.2.4. Diagnostic facilities at facilities and their effectiveness

Many of the facilities like dist hospitals, CHCs are having functional laboratory facilities and, in most of the PHCs it is not functional due to lack of manpower. During the visit it has been noticed that Pregnancy kit and RD kits are in place in most of the institutions. In few facilities, laboratory tech/assistant has been appointed through JDS.. Some important tests like BT, CT, blood grouping, wet mount tests are not being conducted in many institutions. One of the encouraging finding was the convergence for lab services of RNTCP, General health services and Vector borne Diseases

Control Program in institutions. The standard operating procedure of laboratory services particularly in higher institutions was not noticed.

3.2.5. Drugs and Equipment Supplies

The drug procurement at district level has been stopped recently and being replaced with state level procurement system. Staffs of many intuitions have shown their concern for delayed supply in recent times. A proper mechanism for receipt, storage, indenting of drugs was found at many facilities. Many of the institutions have displayed the expiry date of the stocks in their respective stores. There are no warehouses for medicines at district level and most of the stocks are kept in the stores near CMO office.

Availability of drugs at all institutional levels are seems to be satisfactory. Occasional replenishment through JDS is also observed. Many of the emergency drugs (Mesoprostol, Methergin) are not available through the routine drug procurement system, however Anti snake venom, ARV are seen in CHCs. Local level arrangement for drug availability through Red Cross at subsidized rate (5% less and no tax) was seen in some CHCs. But they are facing difficulties due to competition with medical stores running outside the CHC. Mitanin dawa Peti scheme is getting some jolt due to irregular replenishment. Supply of chloroquine in dawa peti has not been considered. It has also been observed that stock registers in many places are occasionally verified by BMO.

Lots of equipments were also lying unutilized in many PHC and CHC without having proper support for repairing of the equipments. The recent initiative to streamline equipment management is a good innovation in Chhattisgarh.

3.2.6. Health Human Resource Planning

Table 6: Health Manpower in both districts (Rural areas) (September 2008)

Category	Bilaspur		Dhamteri	
	Sanctioned	In position	Sanctioned	In position
CHC/ FRU				
Surgeons	10	1	4	0
Obstetricians /Gynecologist	10	2	4	0
Physicians	10	2	4	0
Pediatricians	10	6	4	1
Anaesthatist		1	4	0
Eye Surgeon	1	1	0	0
General Duty Medical Officer		46	8	9
Nursing Staff PHN/ANM/SN/N Midwife	47	51	20	16
Pharmacist/Compounder	93	18	8	3
Lab Technician	61	19	4	4
Radiographer	11	8	4	0
Manpower at PHC				
Total Allopathic Doctors		54	42	10

Pharmacists		27	21	16
Lab Technician		6	13	0
Health Worker (F)/ANM		11	21	21
Nurse Midwife/Staff Nurse		2	0	0
Man Power at Sub Centres				
Health Worker (F)/ANM	440	286	165	165
Health Worker (M)	372	230	165	90

Table 7: Status of Primary health Infrastructure

(Report for IInd Qr 08)	Bilaspur	Dhamteri
SUB CENTERS		
Total No. of Sub Centers functioning	357	165
No. of Sub Centers functioning without ANMs	59	0
No. of Sub Centers functioning without HW (M)	127	75
Primary Health Centers		
Total No of PHCs functioning	75	21
No. of PHCs functioning without a Doctor	33	12
No of PHCs functioning without lab.technician	72	21
No of PHCs functioning without Pharmacist	48	6
No.of PHCs functioning without Nurse Midwife/Staff Nurse	75	Post Not Sanctioned
No.of PHCs functioning without ANMs	64	0
Additional Information on Health Facilities		
No. of PHCs having two doctors including AYUSH practitioner	0	1

Table 8: Staff position under CHC Kota, District Bilaspur

CHC Kota		PHC Ratanpur		PHC Chapora		PHC Kenda		PHC Navagaon		PHC Belgahna	
A		1		2		3		4		5	
No Of Sanctioned Post	No Of Post Vacant	No Of Sanctioned Post	No Of Post Vacant	No Of Sanctioned Post	No Of Post Vacant	No Of Sanctioned Post	No Of Post Vacant	No Of Sanctioned Post	No Of Post Vacant	No Of Sanctioned Post	No Of Post Vacant
41	12	18	11	10	5	10	8	10	8	10	7

In a state like Chhattisgarh, human resource planning is one of the important areas for implementing NRHM. During state briefing it has been admitted that HR shortage and relocation was one of the key problems that the state faced since its formation. Availability of key staffs including (doctors, nurse, and specialists) are a major concern in all facilities. Most of the SCs are facing difficulties in getting additional ANM and MPHW (M). Full-time Programme officers for Malaria at the district level, malaria inspectors and other contractual staff under malaria programme are lying vacant in the district of Bilaspur. All the ten sanctioned posts of malaria inspectors in Bilaspur are still to be

filled up. State position of consultants at SPMU level is still in the process of recruitment. Overcrowding of staff at district hospital (excess staff at Bilaspur hospital due to diversion) and their scanty presence in peripheral level institutions was noticed in both the districts where the team visited.

Rural Medical Assistants initiative is already rolled out in tribal districts and our interaction with the trainees revealed their motivation and zeal to work in remote areas. However reservation against their recruitment was expressed by some regular doctors. The PHCs, CHCs and SCs are running under staff. The process of contractual appointment for key professionals except for AYUSH services are yet to be started in full swing. Rational posting of in-service trained personnel (LSAS, EmOC) are also need to be streamlined so that the best possible utilization of their skill can be made. The transfer and promotion policies, rational distribution or posting of PGMOs and specialists etc. are the weak areas in the Chhattisgarh health system. It is important to mention here that the state has recruited most of the block program managers and BADAs.

3.2.7. Infrastructure

Table 9: Status of health Infrastructure till September 08

For sub centres	**Bilaspur**	**Dhamteri**
Total No. of Sub Centers functioning (As mentioned in Proforma I)	**357**	**165**
No. of Sub Centers with ANM quarters	**-**	**58**
No. of Sub Centers without regular water supply	**75**	**165**
No. of Sub Centers without electric supply.	**75**	**107**
For Primary Health Centers		
Total No of PHCs functioning (As mentioned in Proforma I)	**75**	**21**
No.of PHCs with labor room	**75**	**8**
No. of PHCs with O. T.	**-**	**0**
No. of PHCs with 4 – 6 beds	**-**	**4**
No. of PHCs without electricity	**-**	**3**
No. of PHCs without regular water supply	**-**	**10**
No. of PHCs with telephone facility	**0**	**11**
No. of PHC without all weather motorable approach road.	**0**	**0**
No. of PHCs having Doctor's quarter	**0**	**6**
No. of PHCs having a vehicle	**0**	**0**
For CHCs		
No. of CHCs with functional Laboratory, OT, Labour room, X ray	**10**	**4**
Number of CHCs with 30 beds	**5**	**3**
Number of CHCs having quarters for specialist Doctors	**10**	**0**
Number of CHCs presently operating in PHC building	**0**	**1**
First referral units		

No. of FRU's with functional O.T, labor Room, X- Ray, Lab	**4**	**4**
No. of FRU's with Blood storage/linkage facility	**0**	**1**
No. of FRU's having referral transport service	**4**	**4**
No. of FRU's with back up generator/electric supply	**0**	**4**
No. of FRU's without residential quarters for essential staff	**4**	**0**
Additional Information on Health Facilities		
No. of Mobile Medical Units operating in the State/Uts	**0**	**0**

Table 10:

Building positions in respective districts till September 08	**Bilaspur**			**Dhamteri**		
	SC	PHC	CHC	SC	PHC	CHC
Total No functioning	357	75	10	165	21	4
No functioning in Govt. Buildings	49	26	10	57	7	3
No functioning in rented Buildings	290	1	0	0	0	0
No functioning in other Buildings of Panchayatas / Vol./ social Organisations etc.	18	48	0	108	14	1*
No of Buildings Under Construction	112	21	0	92	10	1**
No of facilities in inappropriate Buildings and required to be Constructed yet.	196	28	0	16	4	1

* CHC Functioning in PHC Building.
** Building existing with16 bed (CHC Nagri), 20 bedded Building under construction.

The health infrastructure position in the state is another area of concern. The above given tables shows that many institutions have not fulfilled the basic minimum infrastructure yet. The allotted budget under NRHM is still to be disbursed to the concerned districts for infrastructure upgradation. The details with DPMU show that Bilaspur district has not received any funds for infrastructure strengthening or upgradation. Most of the constructions in Chhattisgarh that were implemented through PWD or CHIDC (a state government undertaking) led to delay in completing the work though the performance of CHIDC was reported as better compared to PWD. Separate infrastructure development wing under mission directorate is not constituted in Chhattisgarh. Recent facility survey report of Chhattisgarh (undertaken by GTZ) also has mentioned gaps in infrastructure requirement.

Sub-centres the basic unit of health service delivery is running mostly from rented building (290 out of 357) in Bilaspur, but the situation is better in Dhamteri. Many new constructions are under progress in these two districts. Most of the PHCs are functioning from incomplete structures as given in the table above. Residential quarter facilities in most of the PHCs are not available. SNCU in Medical College, Raipur has not been initiated due to lack of budgetary allocation even though the place was located long ago for upgradation up to level III.

3.2.8. Progress of decentralization and flexibility for local action

Decentralisation with community ownership is one of the core agenda of NRHM. To facilitate this NRHM has introduced many new institutional structures in the rural health institutions with

provisions for untied funds at each level. In Chhattisgarh, though the utilisation of untied funds at the level of Sub-centres was slow in the initial years, it has picked up in the 2008-09 financial year. In Sub-centres where the team visited the fund has been used for variety of purposes like purchase of furniture, repair of buildings, provision of water supply etc. The accounts are maintained and in some places detailed reports of the activities are also kept. Most ANMs reported that they felt more empowered to carry out their work with the availability of untied fund.

With reference to the composition of Jeevan Deep Samities (working as RKS in Chhattiagarh) it has been observed that seen community representatives and socially recognized figures are only occasionally included as members. In most of the visited institutions, Jeevan Deep Samities are functioning smoothly except in Bhakhara PHC. In one block most of the JDSs of its PHCs are functioning under the secretary ship of BMO in the absence of respective MOs of concerned PHCs. Process of meetings and minutising of the procedures are happening regularly (except in one PHC). Government functionaries of various departments mostly represent Jeevan Deep Samities (JDS) and their meetings. The scope for community representation is limited to few people's representatives with notable absence of local NGOs and local community leaders. A less enthusiasm of PRI leaders in JDS activities has been reported by medical officers.

Examination of the activities carried out in the previous years and the minutes of the JDS meetings gives ample evidence that samities are taking responsibilities for the upkeep of the institution. The expenditure pattern is mainly towards infrastructure maintenance and up gradation though limited money has been used for direct patient care. Many JDSs have also found to allocate funds for emergency medicines like anti-snake venom and anti rabies vaccines. Outsourcing of govt land of CHC Kota, a decision of the JDS was observed (at the rate of Rs 250 PM per shop). This money is deposited under JDS. The records Jeevan Deep Samities are also found generally well maintained.

The major source of income of JDS is user fees charges from patients which is a matter of concern as JDS will increasingly be been seen as a money making mechanisms especially in higher level facilities like district hospitals. Although the excluding mechanisms are existing, it was found to be generally inadequate to take care of all deserving patients. In the district hospital of Bilaspur, user charges for most services are found to be generally high and they are even comparable to private hospitals. All BPL cardholders are excluded from user charges. However for those poor who do not carry a BPL card, the decision for exclusion is made at the level of civil surgeon on case-by-case basis. One would wonder how many poor could access civil surgeon's office to avail such benefits.

3.2.9. ASHA (Mitanin)

Mitanin (ASHA) is a strong program in the state with 60,000 mitanins were already selected, trained and deployed in every hamlet of the state. The assessment of CRM team shows at least half of them are active in the field. They cover roughly 50 families each, compared to about 200 families at the national level. The pride and commitment of the State to take ownership of the programme is visible and wide appreciation of mitanins's role is felt in every quarters.

The key features of the programme is the comprehensive support structures including mitanin trainers (one for every 20 mitanins), block resource centers, block resource persons and district coordinators who are involved in training and mentoring of mitanins. Training is not restricted to 1-5 modules but is a continuous process. Large network of trainers and mentors are helpful in rolling out training program rapidly (10 rounds of training program). The Mitanin Help Desk was observed

in all CHCs and district hospitals is an innovative step taken to improve linkages of mitanins with the public health system. This is expected to help mitanins while referring cases to these facilities. Examination of records kept at the mitanin help desk shows significant number of referrals of patients by mitanins to higher level health facilities.

We witnessed high degree of skills and competence among mitanins in general. However the Mitaninn Dewa Peti scheme is getting into problems as irregular replenishment was noted in many places. Many mitanins also have complained that they were loosing credibility in the community due to non-availability of medicines in the deva peti on regular basis. The ASHA incentive component of JSY is not given in time to mitanin and there is backlog in many places. Many other incentives as part of disease control programmes (RNTCP) and remuneration for the work of mitanin on immunisation days are not given. Incentives however seem to have created some sense of competition with ANMs, especially for family planning incentives.

3.2.10. Systems of financial management

Financial transactions under NRHM at the state level are handled by the account operated by the state health society. Even though separate sub-accounts have been opened various disease control programmes are still transacting through the old accounts. Financial allocation from centre pool has not been disbursed due to non utilization of earlier allocation. The state budgetary contribution of Rs. 36 Cr for the year 2008-09 has no been transferred to NRHM pool, though it was informed that the process had already initiated. Another important finding from DPMU level is that though DHAP 08-09 FY has asked for specific budget for their proposed activities but budget allocation from state has not been initiated considering the demand in PIP.

District and state level audit has been done for the previous years and state report has been finalized. Budgetary disbursement has not happened for many of the planned activities in 2008-09 PIP. The non-production of utilisation certificate for previous allocation has been cited as one reason. Utilisation certificate submissions are getting delayed at all levels leading to stagnation of activities. Core banking has been initiated from dist to block, but money transfer at blocks still taking long time as reported by Kota CHC.

Table 11:

State Health Society, Chhattisgarh.
Statement of Fund Position for RCH /NRHM as on 08-Dec-2008

RCH Flexi Pool (Part-A)	Amount Approved in PIP	Balance (As on 30-11-2008)
Maternal Health	**502.47**	**425.74**
Child Health	**555.51**	**464.56**
Family Planning Services	**77.10**	**46.50**
ARSH	**3.62**	**3.62**
Urban Health	**14.94**	**14.94**
Tribal Health	**0.00**	**0.00**
Vulnerable Groups / Adolescent Health	**0.00**	**-3.99**

Innovations/PPP/NGO	**25.00**	**25.00**
Infrastructure and Human Resources	**834.00**	**834.00**
Institutional Strengthening	**0.00**	**0.00**
Training	**134.82**	**119.96**
BCC/IEC	**257.90**	**223.27**
Procurement*	**190.00**	**190.00**
Programme Management	**257.40**	**68.61**

NRHM Flexi pool (Part-B)	**Amount Approved in PIP**	**Balance (As on 30-11-2008)**
Jeevan Deep Samities (RKS) {Funds for J.D.S.(RKS)}	**589.50**	**453.00**
Sub Center Strengthening (Untied Funds for S.H.C).	**837.80**	**837.80**
Monitoring & Evaluation	**105.10**	**105.10**
Alternative Human Resources Development Strategies for Clinical Manpower & Nursing /ANM Cadre	**1,930.00**	**1,930.00**
Sickle Cell Disease Control Programme	**367.64**	**367.64**
Third Party Monitories	**50.00**	**50.00**
District Envelope	**200.00**	**200.00**
Filling up Vacancies and HR Management	**30.00**	**30.00**
Community Monitories at Different Level	**67.02**	**67.02**
Professionalization of Health Management	**36.00**	**33.30**
Building and Strengthening Block PMU	**270.10**	**176.94**
Filling Gaps in Rural Medical Services	**779.68**	**779.68**
Support in Creation of Rural Medical Corps in Difficult Areas	**457.58**	**457.58**
Closing Residential and Accommodation Gap in PHCs	**500.00**	**500.00**
Strengthening Directorate	**30.00**	**30.00**
Technical assistance	**92.40**	**92.40**
Capacity Building & Mobilization of PRI	**98.20**	**98.20**

In 08-09 PIP budget analysis shows that many of the planned strategies has yet not been initiated in Chhattisgarh. For example for activities such as ARSH (3.62lacs), Urban Health (14.94 lacs), Innovations/PPP/NGO (25.00 lacs), Infrastructure and Human Resources (834.00 lacs) and Procurement (190.00 lacs) has been approved in PIP, but till 8th December 2008 report of state health society shows there is zero expenditure under these heads. Though Chhattisgarh is a tribal dominated state, but surprisingly expenditure for Tribal Health, Vulnerable Groups / Adolescent Health, Institutional Strengthening has not been planned in 08-09 FY. Under NRHM additionalities many of the strategy/ activities are not initiated due to lag of monitory disbursement from the State mission.

3.2.11. HMIS and its effectiveness

In modern day of health planning and service delivery, role of HMIS and related feedback mechanism are quite extensive. Health structure in Chhattisgarh has adapted the channel of section, sector for HMIS report generation. All the generated data from periphery are reported directly to block level bypassing PHCs. The new formats of HMIS are being used in the state level reporting. Most of the data generated through BPMU are passed to DPMUs and then to SPMU for state level compilation. Chhattisgarh has appointed State consultant (HMIS) at SPMU to streamline the process, however the state level data manager is still to be recruited. During our visit to peripheral institutions, it has been observed that the reporting under NVBDCP particularly the village level data was not made as per the norm of the program. Most of the vertical programs are still maintaining separate reporting format for their respective programs. Feed back mechanisms are yet to be initiated in state for proper usage of these collected data.

In many of the SCs visited by the team the records were found quite up-to-date whereas reports generated from PHC are not in good shape as many of the PHC are under staffed. Many PHCs/CHCs in these districts did not have formats for reporting surveillance activities. However it has been reported that reporting under IDSP has been initiated in state by activating SSU in state and DSU in many districts. The state has conducted GIS based mapping of malaria endemic areas for targeted interventions.

3.2.12. Community Processes under NRHM

As envisaged, NRHM is expected to place people at the centre of the health service delivery. The core of the idea is to make the functioning of rural health system more responsive to the needs and aspiration of community while creating multiple channels of accountability. The participation is seen as both right and duty of the community. This approach in other words looks at the communitisation process largely as an end in itself not just as a means to improve service delivery. Several new institutional and functional arrangements were envisioned under NRHM to facilitate community ownership of rural health services and their empowerment to plan and work towards health.

Table 12: ***Village Health and Sanitation Committees:***

VHSC in Chhattisgarh	Target	Achieved
Number of VHSC formed	20639	18322(92.1)%
Number of VHSC A/c. opened	20639	15326(83.7%)
Fund released in VHSC A/c.	20639	14236(71.6%)
Social mobilization campaign - Gram Sabha	20639	12630(61%)
Prerana dal activity- local social action	9820 Panchayat	7112(75%) Panchayat

Under NRHM, Village Health and Sanitation Committees need to be established to allow local community participation in planning and implementation of health activities. As reported 92.1% of VHSCs are already constituted at the village level and accounts have been opened in the name of a mitanin and panchayat secretary. However our detailed inquiry revealed that the money has not been used in most villages. Our interaction with mitanins, panchayat leaders and officials showed limited capacity/idea at the local level about the scope of utilisation or how to utilise the funds. Even though all mitanins from the village are made members of the committee, except the one who

holds the joint account with panchayat secretary, all other mitanins are unaware of the status of VHSC activities. In Koliari village we have identified a proposal to dig a wastewater pit which was taken collectively in VHSC.

Mitanins are working in tandem with ANM, AWW, SHGs etc. Monthly village health and nutrition melas are being held in Anganwadi centres. The involvement of village health and sanitation committee plays a negligible role in such events. Sishu sanrakhan mah are being observed in many areas with special rounds.

Community monitoring has been initiated in Chhattisgarh on a pilot basis but Bilaspur, Dhamtari district were not included in the pilot phase. Though the monitoring committees have been set up and the data was collected, the social auditing process is yet to begin. The state also plans to expand the process to the other districts.

3.2.13. Assessment of non-governmental partnerships for public health goals

State Health Resource Centre (SHRC), a non-governmental set up developed under earlier sector investment programme has been the backbone community based health sector reforms in Chhattisgarh. SHRC has been working as additional technical agency to department of health with a focus on NRHM planning and implementation. Their creative role has been visible in many areas and well appreciated by different quarters. However, we have observed overlap of SHRC role vis a vis other technical agencies and various wings of health department especially with the training institutions.

Large scale partnerships with non-governmental organisations has been observed in the field of mitanin programme with mentoring role is handled by block level NGOs identified by the District Health Societies. Under blindness control program lot of cataract surgeries are being carried out by NGOs. State has also involved 6 MNGOs and several Field NGOs as part of RCH programme. MNGO, FNGOs were identified in Bilaspur but detailed activities carried by them are not well within the knowledge of district authorities. The activities of Sankalp Sanskritik Samiti (Dhamtari) and Uthhan (Bilaspur), the MNGOs has not been located from the visited institutions...

During visit to JSS run horpital in block Takhatpur it was observed the need of good facilities in rural areas of Chhattisgarh. CRM team has observed huge OPD attendance in NGO run hospital as well as waiting lists for surgeries to be conducted. The hospital authorities has communicated that large number of population is suffering from diseases like tuberculosis, leprosy, malaria which was not taken care off by the routine programs run by public sector run hospitals due to lack of manpower and resources and due to the lack of flexibility of the programme.

State has longstanding partnership with leading corporate hospitals in PPP mode. This however has not been evaluated or subjected to any social audit mechanisms. Recently, a new programme called Bal Hriday Suraksha Yojana was started for the treatment of congenital cardiac ailments in partnership with leading corporate hospitals in the state. The service has been delivered to initial group of beneficiaries and a large number of eligible cases have been identified. As the demand for the program is so high and there are no sufficient financial provisions or insurance mechanisms, the backlogs have already been started increasing in state.

Outreach activities

Besides Village Health & Nutrition Days, bi-annual Child Health Months (Shishu sanrakhsan maah) has led to significant improvement in coverage of outreach services, especially immunization. It also appears to have led to equitable coverage of services. However, there is no systematic effort to strengthen the sub-centers and to place the second ANM in the sub-center. ANMs are using the old method of 'depot holders' in proving services in difficult areas which was reported from Keonchi PHC.

While ambulances are available in many CHCs and FRUs, they are not being used for referral of patients to the higher center or for brining the emergency patients to the health facility. In one of the CHC visited for example, the ambulance with two drivers had made 16 trips in the last month: only one of them for taking a patient to the district hospital: most others were related to bringing vaccine, dropping the "camp patients" etc. There is clear underutilization of ambulance services in the state.

3.2.15. Thrust on difficult areas and vulnerable social groups

Chhattisgarh is a state with high forest cover with many of its areas is conflict affected. State has about 31% of its population belong to scheduled tribe and 8.6% belong to scheduled cast community. Several initiatives that have been proposed in the 2008-09 PIP which are at different stages of implementation but vulnerable groups specific strategy has not been formulated in PIP.

A new policy for the creation of new cadre of human resources called Rural Medical Corps with special pay scales and other benefit package has been drafted and is now, waiting for the cabinet approval. The CRM team was informed about posting of Rural Medical Assistants, the three year diploma holders in modern and holistic medicine in tribal areas.

3.2.16. Convergence activities

Chhattisgarh has initiated convergence activity within the process of society formation and also in various state & district level committees of planning. However definite inputs from all other dept are yet to be practiced in the state. AYUSH dept has initiated collocation in 86 facilities apart from establishing AYUSH wing in 15 district hospitals. It has also planned to establish 42 AYUSH OPD in CHC and 357 AYUSH OPD in PHC. Ayurveda college hospital Raipur has started maternity services to support MCH component of NRHM. SHRC a technical support organization has already established a special AYUSH technical wing to support mainstreaming of AYUSH under NRHM. Technical manpower for integrated Epidemic cell in AYUSH is initiated to support NRHM process more intrinsically. AYUSH health Mela was organized to address various health issues in block Pendra successfully. Capacity building is another area where 60 AYUSH physicians are trained for essential Maternal & Child health with AYUSH component. However some resistance for co location has been reported from facilities in Pendra which is reported to be due to lack of space in the CHC.

Involvement of PWD, CHIDC has been observed in construction activities though the procedures are quite lengthy and time consuming. Mother and child health nutrition days were implemented with department of Women and Child development in the event of Sishu shanrakshn mah in the state. But during visit of CRM team convergence activities with NACP, RNTCP for integrated laboratory services have not noticed except in Abhanpur CHC. The initiatives for water supply connection process through PHED dept is not encouraging and it was observed that water supply through boring have been installed through JDS money in many facilities.

Convergence within the health sector is another important area under NRHM framework. Multiple leaderships without proper cohesion and unequal distribution of work have been observed within Directorate. However coordination among SPMU, DPMU and state officials are visible during CRM visit.

3.2.17. National Disease Control Programs

National Vector borne disease control program:

Malaria is a serious problem in the state with *Pf* predominance. The disease has been showing distinct pattern and bulk of the burden is borne by tribal coastal area in north and south. The central part of the state is represented by nine districts having 66% population of the state which report low to moderate incidence of malaria (16%) and *P.falciparum* (8%). There was no death due to malaria during 2007.

Table 13: Epidemiological situation of Malaria:

Year	Population	BSE	ABER	Total Positive	*Pf*	*Pf%*	API	SPR	SFR	Deaths
2004	23646332	3584059	15.16	186056	142867	76.79	7.87	5.19	3.99	6
2005	23469487	3874911	16.51	187950	140182	74.58	8.01	4.85	3.62	3
2006	23472985	3590949	16.78	176868	137008	77.46	7.53	4.90	3.80	3
2007	24547198	3447058	14.04	145949	107321	73.53	5.95	4.23	3.11	0

- In 2008 Annual Parasite Index and malaria cases has been declined in comparison to 2007 in visited district of Bilaspur. But the SPR has increased from. 0.41 (2007) to 0.64 (2008) in Dhamtari district.
- Village wise GIS mapping for all the districts have not been completed yet though section wise mapping have been carried out. Most of the other indicators show a positive trend except in the district of central region. But the slide falciparum rate of Chhattisgarh has not been improved during 2008 min comparison to 2007.
- A total of 1, 55,250 bed nets received by state during 2007 and distributed to 6 districts namely Kanker, Dantewada, Bastar, Kawardha, Rajnandgaon and Durg.
- During 2007, 3,50,000 RD Kits received and distributed to Bilaspur (10000) and Dhamtari(4000).
- Chloroquine tablets were not available in Mitanin Dewa Peti in Bilaspur and Dhamtari. There is no shortage of chloroquine at the state level as per the feed back from state officials.
- Mitanin are trained and using RD kit and blood slides in highly endemic PHC assisted under world bank project
- Mitanin are trained as FTDs and also in the use of Rapid Diagnostic Tests in Malaria so that treatment is given immediately for Pf cases.
- The vacancy of MPHW (Male) has affected the malaria surveillance very badly resulting into delay in diagnosis, treatment, supervision of anti malarial activities and indoor Residual spraying. Appointments of 840 MPHW (Male), 33 MTS, 23 LT on contractual basis have been sanctioned for the state along with earmarked fund for cash assistance.
- Although the state is highly endemic for malaria, but the full time SPO, District malaria officers, Malaria inspectors are not available.

- IRS is based on Insecticide resistance. But there is no entomological component at state and in districts. 3 districts are covered with Synthetic pyrethriods and 13 with DDT.
- IEC activities for Mass drug administration day were observed in many villages.

National Leprosy elimination program:

- Block Leprosy Awareness Campaign which is running in Chhattisgarh has detected 62 new cases from 9 blocks of Bilaspur and 948 (12 %) of total NCD in a year from the whole state.
- Many of the District leprosy officers posts are lying vacant and temporary responsibilities has been to given to other staff
- There is no provision of District Nucleus in each district in the new set-up
- Contractual District Nucleus Medical Officers for NLEP are worried for further extension after the expiry of their contract period till 2008
- In field visit it has been noticed that many doctors are not trained to diagnose and treat the patients according to the programmatic approach. The referral mechanisms for suspected patients are poor.
- Poor monitoring of NLEP at various levels is also mentioned during state briefing.
- Smear testing facility is not being carried out at district level hospital.
- Availability of MDT particularly the paediatric doses are not available in many facilities
- increased awareness, self reporting, increase in new case detection and Improved MDT delivery are reported from various villages due to active participation of Mitanin
- Leprosy is included in the "Swasthya Panchayat Yojana" for the involvement of PRI

National Blindness control program:

- In sufficient and inequitable distribution of eye surgeons is one of the important constraint for the program
- Posts of eye surgeon are also lying vacant in many institutions. Eye mobile unit has not been created in many districts.
- Many of the eye surgeon and ophthalmic assistant are not sufficiently trained for NBCP support in various forms.
- IEC activity have not been noticed in many facilities

3.2.18. Quality and Performance of MCH

Please refer to Section **3.2.3** Quality of services

- Enhance involvement of medical colleges and private hospitals (such as one in Bhilai) to fast-track skill based training programs with appropriate dissemination
- Pre-identify the FRUs where the multi-skilled staff will be posted and enter into a contract ensuring that the staff will be retained in the facility for a specified duration
- Urgently set up a referral transport mechanisms for transporting sick persons to hospitals, especially women and children
- Follow-up on the GTZ facility survey for operationalizing 24X7 PHCs and FRUs. It is also important to ensure reflect the facility specific actions in the district action plan
- Fast track setting up of blood storage centers
- Fast-track training of Mitanin Trainers in IMNCI
- Equip all facilities (24x7 PHCs and FRUs) for essential newborn care

3.2.19. Assessment of Program Management structures

NRHM envisages new management structures at various levels to strengthen the existing system. At state level, Mission Directorate consists of Mission Director and state programme management unit which provide technical support for the role out of rural health mission. Few key positions of consultants in the state programme management units are lying vacant. The SPMU was found to be energetic and willing to work as a team and take up challenges. However there has to be more clarity on the role and responsibilities of each member of the team. The expertise of senior officials of directorate and district program officers needs to be strengthened by incorporating the managerial skills of program officers. Proper interaction between financial/ accounts mangers at various levels need to be strengthened for the better disbursement and utilization certificate generation apart from the budget utilization.

District level programme managers are in place in all districts except one. Their induction into the system has been smooth though frictions were also reported in some districts. The block level programme management teams are being constituted and their work has started in many places. Major involvement so far has been in relation to data generation. There is wide range in their level of involvement in various blocks. In some places, the work and accounts are yet to be handed over to Block Programme Management Units. Most of the block level programme management personnel have received only nominal induction training. Block medical officers too had only limited orientation on the how to make use of new personnel.

3.3 Progress against approved PIP of 2008-2009 Financial Year

During CRM Phase II process State PIP for (2008-09) was analyzed to understand the progress of various activities planned under different heads as par the framework of NRHM. The platform of state briefing and field visit were used to assess the progress.

3.3.1 Maternal Health component:

A recent survey on FRUs and CHCs carried out by GTZ, an international NGO in all the district of Chhattisgarh (reference period- 1st April 07 to 30th sept 07) gives clear indication that Bilaspur and Dhamteri districts do not have FRU upgradation and blood bank facilities in any of facilities till that period. It has been communicated by state level officials that establishment of blood storage facilities are in process at State Drug Controller level. The proposed activity of IPHS upgradation in 32 FRU have not initiated among the visited six CHCs. Though RHS report shows that 418 PHC are upgraded as 24x7 facilities, both GTZ report and CRM team did not found any of the PHCs to fulfill critical criteria for 24x7 facilities.

Although as par DLHS III report 58.6% PHCs functioning on 24 hours basis. Most of the institution has been assessed for planned services for MTP, RTI/STI Services, but it did not show any encouraging finding in this regard. Wet mounting test, specified drug supply, referral services to ICTC have not been reported during the team visit to different institution. Delivery services in most of the institutions have apparently increased particularly in SC, CHCs and Dist hospital, however the coverage in PHCs are not encouraging. The planned activities of incentivisation to the doctors for caesarean section have yet to be started. JSY helpline, Rajnandgaon Pilot Project ambulance scheme like EMRI, ANC kit, smooth availabilities of IFA tablets, and incentives to Dais are some area of concern which was located by CRM team during field visit. Availability of emergency drugs (Mag Sulfate, Mesoprostol, Oxitocin) are found to be erratic. New born care unit, are not established and PNC period stay at institutions not in practiced in many visited institution.

3.3.2 Child Health component:

As far as activities planned under PIP 08-09 regarding child health is concerned New born corner at the labour room, resuscitation kit are initiated in many of the PHC, CHC. For Severely Malnourished Sick Children, initiatives like Bal Suposhan Yojna were planned under which 5 beds are to be allotted in 48 CHCs. During CRM visit it was noted that this is yet to be initiated. Total number of 13 paediatrician has been trained under phase I & II for Accreditation of Child friendly Health Facilities through state task force. As a follow up measures for IMNCI, master trainer and dist trainer were trained apart from the strong work force of 58000 mitanin. Shishu Sanrakshan Maah- Integrated Biannual Maternal and Child Health Month was another important activity that was initiated in many visited areas. HBNC were planned to initiate in 10 pre-located blocks. It has been communicated that in 6 blocks it has been already initiated. Bal Hriday Raksha Yojana is another important innovation which was planned and started in association with few prominent private instt. in public private partnership mode. Mitanins visit to newborns for Neonatal and Child Survival Initiatives is planned in PIP as Navjaat Swagat Bheit. This activity is yet to be launched in state. Two medical colleges and district hospitals in Koria, Bastar are planned to upgrade for SNCU, for which the budget allocation was made and disbursed.

3.3.3 Adolescent health and urban health systems:

With reference to the adolescent health ARSH clinic (Sakhi/Sakha Kendras) was planned in 11 districts of Chhattisgarh, for which budget has been released. Sickle Cell test camps for screening of Sickle cell anaemia have been launched in the state in association with Red Cross society. Most of the allotted budget under urban health is still unutilized. It has been informed during state briefing that many of the PIP activities are not started because the code of conduct rules for assembly election in Chhattisgarh was in place.

3.3.4 NRHM Additionalities:

Chhattisgarh has planned many innovative activities under the additionalities of NRHM in PIP of 08-09. Posting of Hospital administrators for district hospital has been advertised in leading newspaper whereas “Rural Medical Assistant” initiatives for tribal areas are already started in many districts. The innovation like Rural Medical Corps in Difficult/conflict areas are still waiting for approval in principle. Chhattisgarh has provided telephone facilities with group calling facilities in partnership with BSNL in many SC, PHC, and CHC in the state. During team’s visit to many remote areas of the state the telephones were found in facilities. Community Monitoring process has allready been piloted in three districts of the state whereas Third Party Monitoring of JSY schemes are ongoing through SHRC in Chhattisgarh. 4.62 Cr was released as Grant for development schemes in Naxalite affected areas in Dantewada and Bijapur district. Mitanin Help Desk is initiated in most of the referral centres and during visit this activity was noticed in most of the centres. The other incentivized activities like promotional support for doctors serving in remote and rural areas are yet to be initiated in this state. Rs 5 Cr and 1.46 Cr has been released for construction of staff quarters and VHSC strengthening activities as Gram Swasthya Swachta Niyojan Abhiyaan. Chhattisgarh has already purchased 20 ambulances for Trauma Centers to be constructed near national highways.

Document Management System (DMS) planned in PIP as PPP mode is yet to be initiated. Mukhyamantri Dawa Peti Scheme is extremely important initiatives which are in place in Chhattisgarh but in some villages Mitanin has reported the frequent delay in replenishment of

drugs. Equip Initiative: Enhancing Quality in Primary health care are is another important steps in Chhattisgarh as during visit it has been noticed that plenty of instruments and gadgets are not utilized or not repaired in time. An equipment maintenance technical cell has been constituted under SHRC to streamline the purchase, distribution and maintenance of equipments. Recently state has already initiated the implementation process of EQUIP initiative. Swasth Panchayat Scheme based on health & human development index has been prepared in the state. Work order to Medispace pvt ltd for Mobile Medical Units is already initiated at state level. Institutional upgradations are initiated in selected areas through PWD, CHIDC. But huge delay in work progress, handing over has noticed in many facilities during visit.

Recruitment Medical officers, opening of medical college, model medical university are some of the initiatives which are actively followed up in Chhattisgarh. Dept of AYUSH has already started to collocate along with allopathic instt in 86 instt and "Ayurved Gram" concept are initiated in 22 villages. AYUSH Deep samities are already in place in 6 districts of the state. Ayurveda gram yojna, Stri-Chikitsa department of Ayurvedic College, Integrated Epidemic Cell with AYUSH practitioner are the other innovations which are implemented in Chhattisgarh. Panchayat Diary, assistance for poor patients (Sanjeevni Kosh) are some good initiatives proposed in the PIP. Social insurance support to multi-skilled staff is yet to be implemented in the state.

3.4. Progress against Time Lines

Table 14: Time line of activity

	Activity	Phasing and time line	Status on march 05	Status on march 08	Status on Dec 08
		Comment on quality and quantity of each activity			
1	Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/	50% by 2007 100% by 2008	5700	59689	59689
2	Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them.	30% by 2007 100% by 2008	0	4000	183226/20639
3	2 ANM Sub Health Centres strengthened/established to provide service guarantees as per IPHS, in 1,75000 places.	30% by 2007 60% by 2009 100% by 2010	0	0	0
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 60% by 2009 100% by 2010	0	0	0
5	6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 50% by 2009 100% by 2012	0	0	0

6	1800 Taluka/ Sub Divisional Hospitals strengthened to provide quality health services.	30% by 2007 50% by 2010 100% by 2012	8 civil hosp 13 civil disp	8	8
7	600 District Hospitals strengthened to provide quality health services.	30% by 2007 60% by 2009 100% by 2012	Put according to JDS evaluation report	15	15
8	Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.	50% by 2007 100% by 2009	0	Dh-16/16 CHC-129/129 PHC-695/707 SDH-8/8 Civil Disp-13/13	Dh-16/16 CHC-129/136 PHC-695/721 SDH-8/8 Civil Desp-13/13
9	District Health Action Plan 2005-2012 prepared by each district of the country.	50% by 2007 100% by 2008	100%	100%	100%
10	Untied grants provided to each Village Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.	50% by 2007 100% by 2008	0	0	15200/20000
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.	50% by 2007 100% by 2008	0	100%	100%
12	State and District Health Society established and fully functional with requisite management skills.	50% by 2007 100% by 2008	0	100%	100%
13	Systems of community monitoring put in place.	50% by 2007 100% by 2008.	Not statrted	On pilot basis started in 3 district by GoI	On pilot basis started in 3 district by GoI
14	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.	50% by 2007 100% by 2008.		Procurement and logistic streamlined .Availability of essential Drugs at all level	Procurement and logistic streamlined through centralized Drug procurement system

15	SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HIV/AIDS, etc.	30% by 2007 50% by 2008 70% by 2009 100% by 2012.	In DH, CHC& SDH all facility available Familily planning facility at PHC on camp basis available	Male sterilization in chc also on camp basis due to lack of surgeon-	100% district hospital/sub divisional hospital 65% CHC 35% PHC
16	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.	30% by 2007 60% by 2008 100% by 2009	-		65% SSA, PRI, Rural Dev, WCD, PHED,
17	Facility and household surveys carried out in each and every district of the country.	50% by 2007 100% by 2008	100% Completed for CHC	100% Completed for CHC for PHC & SC is in process	100% CHC PHC and Sub centre in process
18	Annual State and District specific Public Report on Health published	30% by 2008 60% by 2009 100% by 2010.	State level public report published every year	Satwik Public report	Satwik Pubication
19	Institution-wise assessment of performance against assured service guarantees carried out.	30% by 2008 60% by 2009 100% by 2010.		80%% (JDS assessment)	(95%)15/16 District hosp. 116/127,CH C
20	Mobile Medical Units provided to each district of the country.	30% by 2007 60% by 2008 100% by 2009.		64 MMU already functioning at block level(state provision)	64MMU functional and 16 more Mobile medical Unit is under process. Under NRHM

3.5 Qualitative Input against progress

Table 15:

NATIONAL RURAL HEALTH MISSION				
State: Chhattisgarh		Date :As on Oct 2008		
Sno	Action Point		Source	Qualitative aspects
Administrative structure of the state (as per RHS Bulletin- 2006 published by RHS Division)				
1	Rural Population (in lakhs)		166.48	--
2	No.of Districts		16	18
3	No. of Blocks		146	146
4	No. of Villages		20308	20308
	Rural Health Infrastructure			Present Status
5	Number of District Hospitals		16	16
6	Number of Sub Div. Hospitals		18 civil Hosp	18 civil Hosp
7	Number of CHCs		118	136
8	Number of PHCs		518	721
9	Number of SCs		4692	4728
10	Number of Aanganwadi Centres		29355	34937
11	Number of VHSC Constituted & Operational		VHSC con-18322 A/c open-16653 Fund Tran-14236	In many villages VHSC are operational, but process of operationalising A/C and maintaining Minutes of meeting are slow
12	IMR	SRS 2007	59	
		NFHS 2006	71	
13	MMR	SRS 2005	379 (SRS 03)	
14	TFR	SRS 2005		
		NFHS 2006	2.62	
15	Sex Ratio (Census-2001)		989	
16	Unmet Need (NFHS-III)		10.5	
Institutional Framework of NRHM				
17	No. of meetings of State Health Mission held till date (06-07)		1	1 in 2007-08 1 in 2008-09
18	Total No. of meetings of District Health Missions held till date (06-07)		15	20 in 2007-08 7 in 2008-09
19	Merger of Societies	State level Y/N	Yes	At state level all the societies under national programs are still having separate accounts, yet to be merged under one single account with corresponding subaccounts
		No of Districts	5	
20	No. of Rogi KalYan Samitis registered	DH	16	In many instt.(where team visited) JDS are in place except in few (Magarload
		CHCs	129	
		PHCs	695	

				block, PHC Bhakhara). Minutes of meeting are maintained, expendiyure pattern shows more attention to the infrastructure repair & upgradation
21	MoU with Government of India signed		Yes	
Appointment of ASHA/Link Workers (as certified by training division)				
22	Total No.of ASHA to be selected over the Mission period		60092	Mitanin are in place in most of the areas, interrelation with ANM, AWW are good but CM dawa peti replenishment process are weak, incentivisation from many programs are yet to be distributed. JSY money distribution has backlog
23	No. of ASHA selected during (including ASHA in tribal areas in Non-High Focus States)	05-06		
		06-07		
		Total	60092	
24	Training Calender of ASHA finalised (Y/N)		Yes	Training of mitanin are done in depth through 12 rounds by SHRC
25	Total Number of Link workers other than ASHA selected	2005-06	0	
		2006-07	0	
26	No. of ASHA s who have received training	1st module	55979	Mitanin training program was attended in chakarbhata PHC. Most of them are well motivated and know the responsibilities. Drug kit are in place, but replenishment need to be strengthened
		2nd module	55354	
		3rd module	55608	
		4th module	51168	
		5th module	58610	
27	No. of ASHAs who are in position with drug kits		59489	
28	Total No.of Monthly Health Days held till date in the state06-07	Expected	240000	58844 in 2007-08 112388 in 2008-09(oct)
		Achieved	66404	
Infrastructure & Manpower				
Sub Centres (SC's)				
29	No. of SCs in Govt. Building (as per RHS Bulletin-2007)		1458	1742 (Current Status)
30	No. of SCs which are functional with atleast one ANM (as per RHS Bulletin-2007)		3263	Many SC visited are in govt building with ANM Qr in place, but problem of water supply are reported by ANM. Telephone connectivity is available\. New SCs are constructed but
31	No. of SCs which are functional without ANM (as per RHS Bulletin-2007)		555	
32	No. of SCs where Joint Account with has been Operationalised			
33	No. of SCs with additional ANMs		24	

34	%of SCs which have submitted UC for untied funds released (05-06)			some are yet to be handed over. MPHW(M) are not in place in many place. Additional ANM are not recruited yet. Delivery services, untied fund utilization are improving prograssively, Joint A/C are operational, drug availability are reduced after new initiatives of central level procurement system as dist level supply has been stopped and central procurement has not been initiated.
Primary Health Centres (PHCs)				
35	Total No. of PHCs functioning on 24x7 basis	as on 31/3/2004	0	As per GTZ report only 5 PHC are having 24x7. but delivery in odd hours are conducted in many PHC by ANM. Staff nurse, doctors scarcity are enormous. In many PHCs doctors are coming thrice wkly or run by pharmacist/ compounders/ ANM.
		during 05-06	125	
		during 06-07	418	
36	No. of PHCs where three staff nurses are positioned		0	Acute shortage of Staff Nurse was observed in every visited PHC
37	No. of PHCs without a Doctor (as per RHS Bulletin-2007)		388	Current situation shows that PHC are the weak link in state health services with acute shortage of HR. Trained staff are less in number. New medical colleges, N colleges, ANMTC are planned. State is going to recruit 1200 MO (Allopath, AYUSH) through PSC and RMA are posted in tribal area. Many areas contractual AYUSH appointment are carried out with collocation in few instt.
Community Health Centres (CHCs)				
38	Total No. of CHCs selected for upgradation to IPHS		96	Initiatives for upgradation towards IPHS has not seen

					as HR, Infrastrucutre position are the major constraint apart from conflict in selected areas. Availability of Specialist are another problem, multiskilled professional are yet to be utilized fully. Blood storGE FACILITY, sncu, New born corner, Cs section are yet to be initiated at CHCs. Basic Drug availability are reasonably OK but emergency drugs like MEsoprostol, Mag sulf is not uniform. Citizen charters are not seen. User charges details are painted in many places. Infrastructure upgradation, utilization of JDS money for infrastructure, normal delivery in odd hours are reported in many CHCs.
39	Total No. of CHCs where facility survey has been completed			129	GTZ report on facility survey are available for almost all the instt in Chhattisgarh
40	No. of CHCs where physical upgradation work has been taken up		Identified		CHC upgradation seen in Pendra, Kurud, Senetorium hospital, Abhanpur, utilization of JDS money are also seen for water supply (Kota)
			Started	26	
			Complete	16	
41	Total Specialist post at CHCs (as per RHS Bulletin-2007)	Required	472		In many CHCs specialist dr are not in place due to shortage or overdeployment at dist level. Shortage of gynaecologist, Anaesthesists are prominent. Senetorium hospital has multiskilled Obg/ Gynae,and LSAS trained Dr but due to lack of Blood storage facilities Cs section are not initiated
		Sanctioned	700		
		In Position	49		
First Referral Units (FRUs)					
42	No. of FRUs working as on 31/3/2004		SDH	0	visited CHCs are not upgraded as FRU due to shortage of Specialist, blood
			CHC	0	
			PHC	0	

43	No. of centres upgraded as FRUs (05-06)		SDH	0	storage, non availability of facilities like Cs section etc.
			CHC	32	
			PHC	0	
44	No. of centres to be upgraded as FRUs (06-07)	SDH	Expected	0	
			Achieved	0	
		CHC	Expected	64	
			Achieved	64	
		PHC	Expected	0	
			Achieved	0	
District Hospitals					
45	Number of District Hospitals			16	
46	No. of DH which are of FRU level			16	Blood bank or storage facilities are not been established at Bilaspur as it is operating recently from a newly constructed building
47	No. of DH where physical infrastructure is being upgraded			3	Upgradtion seen in Bilaspur and Dhamteri DH
Availability of Consumables					
48	%of centres with at least 2 month supply of essentialdrugs	CHCs			Many instt has maintained designated stores for drugs, equipments. Expiry date against lists of drugs are pasted in walls. Inventory record are maintained in CHC level. Stock registers are signed by MO I/C. Centralised drug procurement are initiated. Centralised Equipment management system are planned to reduce irrational purchase of gadgets at instt. Many unutilized instruments & gadgets are seen at instt. Level.
		PHCs			
		SCs			
49	%of centres with at least 2 month supply of vaccines	CHCs		100%	Supply of Measles vaccine, Vit A interrupted for some time. Overall vaccine stock at CHCs are reasonably O K. Anti snake venom, ARV are purchased through JDS if
		PHCs		100%	
		SCs		100%	

					there is shortage from regular supply. Cold chain system are in reasonably good shape with alternative power back up.
50	%of centres with at least 2 month supply of contraceptives	CHCs		100%	Shortage of EC pills are reported from many centres. There is also lack of IEC and awareness about EC pills observed.
		PHCs		100%	
		SCs		100%	
Manpower					
51	No. of contractual manpower positioned (06-07)	Specialist	Expected	435	Contractual staff were not located in any of the visited instt., but during interaction with Director (AYUSH) it has been communicated that contractual appointment of doctors are in place along with RMA in tribal areas. Contractual appointment of Additional ANM, SN, specialists are yet to be initiated
			Achieved	0	
		Doctors	Expected	1374	
			Achieved	369	
		SN	Expected	104	
			Achieved	0	
		ANM	Expected	963	
			Achieved	0	
		Others	Expected		
			Achieved		
52	PMU setup at State level(Y/N)			Yes	SPMU, DPMU are in place with specified staffs but all consultants proposed in SPMU are not filled up (5 posts of specialists are vacant). BPM, BADA are in place & few are already trained under NRHM
53	No. of Districts where PMU set up			16	
54	No. of Districts where the PMU has persons	Accounts		9	
		Managerial		15	
		MIS		9	
55	No. of Blocks where PMU set up			106	
Institutional Delivery					
56	No.of Institutional Deliveries as per NFHS-III			15.7	
57	No. of Institutional Deliveries (in lakhs)		05-06	1.03	Instt deliveries are yet to be gain momentum in this state. Strong community process through Mitanin at ground level creates lot of demand but poor inputs like instt upgradation particularly PHCs, lack of HR support, delayed JSY money disbursement nullify the demand.
			06-07	1.31	
58	No.of beneficiaries of JSY (in lakhs)		05-06	0.02	
			06-07	0.75	
59	No.of pvt institutions accredited under JSY		Exp.	32	
			Ach.	9	
Decentralised Planning					
60	PIP Received (Y/N)	2006-07		Yes	PIP planning are done with the help of SHRC, CARE,
		2007-08		Yes	

61	Perspective Plan of the State Mission Period received (Y/N)			Yes	UNICEF and state officials.
62	Date by when Perspective State Action Plan under NRHM shall be finalised for Mission Period			Finalized	In visited districts PIP are in place for 08-09 but activities planned are not executed as financial disbursement from state are not as par the activity plan.
63	No. of Districts where Annual Integrated District Action Plan under NRHM prepared for 06-07			16	
Immunisation					
64	Number of Polio Cases during 06-07			0	
65	% of fully immunised children		NFHS-I	NA	
			NFHS-II	21.80	
			NFHS-III	48.70	
66	No. of Children vaccinated (in '000s)	BCG	since Apr 08	331565	Sishu Sanrakshan Maah - Special initiative done by the state to promote immunization which is carried out with enthusiasm
			During last month	46319	
		DPT	since Apr 08	292768	
			During last month	41244	
		Measles	since Apr 08	325181	
			During last month	42639	
		Full immunization	since Apr 08	324859	
			During last month	42618	
67	No of Districts where AD (.1ml, .5ml & 5ml) syringes are NOTavailable			0	Stock out of Measles, Vit A was reported in past. RI strengthening process adopted. But monitory disbursement of incentives to Mitanin needs to be strengthened further. Cold chain maintenances are reasonably OK in visited instt. along with power back up. Ice packs, cold boxes, are in good number. BBM checking register, cold chain monitoring register are maintained in many instt.
Others					
68	No. of Districts where mobile medical units are working			0	It has been procured for all 16 districts, but MMU are not yet operational
69	No.of Health Mela held)		05-06	NA	144 in 2007-08 91 in 2008-09 (up Sept)
			06-07	74	
70	No. of beneficiaries of Male Sterlisation 06-07		Exp.	14267	NSV coverage in most of the instt are low in comparison
			Ach.	6322	

71	No.of beneficiaries of Female Sterlisation 06-07	Exp.	128403	to the minilap. F S camp was attended by CRM team in Sipat PHC & has came across the delayed payments to the Mitanin/ benificiaries, lack of sterilization practices of Laproscope, privacy issues in OT, Biomedical waste management practices etc.
		Ach.	126772	
72	No. of cases in prosecute of PNDT launches		0	
73	No. of cases in which action has been taken under PNDT		5	
74	No of districts implementing IMNCI		3	57730 Mitanin of 16 districts are trained
75	No of People trained on IMNCI till date		57806	
76	Funds released for selection of MNGOs 06-07 (Rs. in Lakhs)			MNGO activity are not noticed in visited areas
77	Total No. of MNGOs in the state	as on 31-3-2004	2	
		Selected during 2005-06	6	
		Selected during (06-07)	1	
		Total	9	
Ayurveda Yoga Unani Siddha Homeopathy (AYUSH)				
78	No. of PHCs where AYUSH practitioners have been co located (05-06)	Exp.	Nil	Update number, whether AYUSh utilised, medicines available. Status of procurement of AYUSH drugs
		Ach.	Nil	
79	No. of PHCs where AYUSH practitioners are being co located (06-07)	Exp.		
		Ach.	85	
80	Whether AYUSH officer included in (Y/N)	Health Society	Yes	AYUSH collocation is in place, but some resistance from Allopathic Health instt. are reported. Further recruitment under ayush are in progress through PSC. Paramedic's recruitments are in stage of planning under NRHM. Ayush drug availabilities are planned for instt.where newly contractual doctors are posted, Ayurveda Gram concepts are initiated. Many AYUSH personnel are trained under NDCP.
		State Mission	Yes	
		Rogi Kalyan Samities	Yes	
		ASHA Training	Yes	
81	No. of AYUSH Doctors Posted on contractual appointment	CHCs	225	
		PHCs		
82	No. of AYUSH Paramedics posted on contractual appointment	CHCs	Nil	
		PHCs	Nil	
83	No. where AYUSH facilities is co-located	DH	15	
		PHCs	353	
		CHCs	92	
84	AYUSH components included in NRHM PIP		Yes	
85	Funds sanctioned for AYUSH schemes during (In Lakhs) (as reported by	2006-07	352.25 lakhs	

	DO AYUSH)					
Financial Matters						
FINANCIAL MANAGEMENT UNDER NRHM						
86	Allocation in State budget for health & Family Welfare	2005-06	Amount in Rs		289	State contribution for 08-09 (35Cr) yet not been released as par the latest document dated 6.12.08. In 07-08 Rs 12 cr was released as state contribution. E banking is operational from state to dist bur core banking is still a problem for dist to block level. U C submission is delayed at various level, JSY money disbursement is still slow in many areas led to existence of backlog in payments to beneficiaries. State/ dist concurrent audit has been carried out in 07-08 FY.
			% of total State Budget			
		2006-07	Amount in Rs		412.15	
			% of total State Budget			
		2007-08	Amount in Rs		487.1	
			% of total State Budget			
87	Allocation by GoI under items subsumed within NRHM as per the respective division	RCH	Immunisation	2005-06	4.23	Monitory disbursement from centre to state is also delayed due to various reasons. Around Rs 77 Cr has been released till date. However old accounts of vertical programmes are still being used.
				2006-07	4.2	
				2007-08	3.86	
			JSY	2005-06	2.27	
				2006-07	4	
				2007-08	27.12	
			RCH Flexipool	2005-06	27.46	
				2006-07	43.96	
				2007-08	39.66	
		NRHM		2005-06	35.77	
				2006-07	61.5	
				2007-08	64.23	
		NVBDCP		2005-06	7.57	
				2006-07	6.4	
				2007-08	12.14	
		NLEP		2005-06	1.22	
				2006-07	1.29	
				2007-08	1.33	
		RNTCP		2005-06	2.73	
				2006-07	4.4	
				2007-08	3.9	
		NIDDCP		2005-06		
				2006-07		
				2007-08	0.12	
		NBCP		2005-06	2.1	

				2006-07	1.96
				2007-08	2.17
				2005-06	7.01
				2006-07	0.45
		IDSP		2007-08	0.45
	Amount of PIP sent by the state to GoI for items subsumed within NRHM	RCH	Immunisation	2005-06	4.23
				2006-07	7.55
				2007-08	7.7
			JSY	2005-06	2.27
				2006-07	4
				2007-08	27.12
			RCH Flexipool	2005-06	32.67
				2006-07	38.83
				2007-08	43
		NRHM		2005-06	
				2006-07	55.69
				2007-08	74
		NVBDCP		2005-06	8.89
				2006-07	21.81
				2007-08	29.91
		NLEP		2005-06	
				2006-07	2.09
				2007-08	6.00
		RNTCP		2005-06	5.36
				2006-07	0.51
				2007-08	6.7
		NIDDCP		2005-06	0.06
				2006-07	0.06
				2007-08	0.12
		NBCP		2005-06	3.2
				2006-07	5.08
				2007-08	6.57
		IDSP		2005-06	2.46
				2006-07	1.41
88				2007-08	3.95
	Amount released by GoI under items subsumed within NRHM	RCH	Immunisation	2005-06	5.23
				2006-07	4.2
				2007-08	0.25
			JSY	2005-06	2.27
				2006-07	4
				2007-08	27.12
			RCH Flexipool	2005-06	25.19
				2006-07	39.96
				2007-08	8.64
89		NRHM		2005-06	35.77

				2006-07	61.5	
				2007-08	64.22	
				2005-06	8.25	
				2006-07	5.72	
		NVBDCP		2007-08	3.3	
				2005-06	0.48	
				2006-07	1.29	
		NLEP		2007-08	0.47	
				2005-06	2.73	
				2006-07	4.4	
		RNTCP		2007-08	3.9	
				2005-06		
				2006-07		
		NIDDCP		2007-08		
				2005-06	2.15	
				2006-07	1.95	
		NBCP		2007-08	3.64	
				2005-06	2.46	
				2006-07	0	
		IDSP		2007-08	1.7	
	Unspend amount with the state out of funds released by GoI released by GoI under items subsumed within NRHM as per last FMR	RCH	Immunisation	2005-06	0.09	
				2006-07	0.09	
				2007-08	0.36	
				Total	0.54	
			JSY	2005-06		
				2006-07		
				2007-08		
				Total	0	
			RCH Flexipool	2005-06	4.52	
				2006-07	2.52	
				2007-08	0.02	
				Total	7.06	
		NRHM		2005-06	30.02	
				2006-07	34.09	
				2007-08	34.01	
				Total	98.12	
		NVBDCP		2005-06	2.18	
				2006-07	2.7	
				2007-08	0.01	
				Total	4.89	
		NLEP		2005-06	0.18	
				2006-07	0.3	
				2007-08	0.07	
				Total	0.55	
90		RNTCP		2005-06	0.63	

			2006-07	0.79	
			2007-08	0.83	
			Total	2.25	
			2005-06		
			2006-07		
			2007-08		
		NIDDCP	Total	0	
			2005-06	0.66	
			2006-07	0.39	
			2007-08	0.54	
		NBCP	Total	1.59	
			2005-06	2.46	
			2006-07	0.99	
			2007-08	1.82	
		IDSP	Total	5.27	
91	Total Unspent amount with the state out of funds released by GoI under items subsumed within NRHM over past years			120.27	
DETAILED FINANCIAL DATA REGARDING NRHM ADDITIONALITIES					
			2005-06	4.1	
	Funds released for selection/training		2006-07	6.92	
92	of asha		2007-08	13.44	
			2005-06	8.82	
			2006-07	2.35	
		SC	2007-08	4.69	
			2005-06		
			2006-07		
		CHC	2007-08		
			2005-06		
			2006-07	1.29	
93	Untied grant	PHC	2007-08		
			2005-06	12.8	
			2006-07	10.4	
94	Upgradation fo CHCs		2007-08		
			2005-06	0.8	
			2006-07		
95	IDHAP		2007-08	0.8	
			2005-06	12.39	
			2006-07	12.39	
96	Drug procurement		2007-08		
			2005-06	0.88	
			2006-07	0.88	
97	Health Mela		2007-08		
			2005-06		
98	Annual Maintainence Grant	CHC	2006-07		

			2007-08		
			2005-06		
			2006-07	2.58	
		PHC	2007-08		
			2005-06		
			2006-07	6.34	
99	RKS corpus funds		2007-08	2.26	
	Village Health &Sanitation Commitee		2005-06		
	untied grant		2006-07		
100			2007-08	20.34	
STATUS OF FINANCIAL REPORTING					
		III quarter 2006-07 due on December 06		yes	
		IV quarter 2006-07 due on March 07		yes	
101	Financial Management Reports sent (Y/N)	I quarter 2007-08 due on June 07		yes	
		NRHM		yes	
		RCH		yes	
		NVBDCP		yes	
		NLEP		yes	
		RNTCP		yes	
	Provisional UCs for 2005-06 submitted (Y/N) due	NIDDCP		yes	
		NBCP		yes	
102	dated 30/4/2006	IDSP		yes	
		NRHM		yes	
		RCH		yes	
		NVBDCP		yes	
		NLEP		yes	
		RNTCP		yes	
	Provisional UCs for 2006-07 submitted (Y/N) due	NIDDCP		yes	
		NBCP		yes	
103	dated 30/4/2007	IDSP		yes	
		NRHM		yes	
		RCH		yes	
		NVBDCP		yes	
		NLEP		yes	
		RNTCP		yes	
	Audited statement of accounts for 2005-06 sent	NIDDCP		yes	
		NBCP		yes	
104	(Y/N) due dated 31/7/2006	IDSP		yes	
National Leprosy Eradication Programme					

105	Prevalence Rate/ 10,000		2.43	
106	Annual New Case Detection Rate /100,000		18.39	
107	Among newly detected cases	Multi Bacillary%	51.48	
		Female%	35.25	
		Child%	7.81	
		Visible deformity%	3.84	
National Programme for Control of Blindness				
110	Total Cataract Surgeries in 06-07 (in lakhs)		88330	
111	% Achievement		105%	
112	#Intra Ocular Lens (IOL) implanted		23201	
113	% IOL		93%	
114	No. of School going children	Screened(in lakhs)	2.12	
		Detected with Refractive Errors	4605	
		Provided free glasses	1755	
115	Eye Donations in 2005-06		167	
116	Eye Donations in 2006-07		108	
National Vector Borne Diseases Control Programme				
117	Annual Blood Examination Rate for malaria (per 100 population)		10.58	
118	Annual Parasitic Incidence of malaria (per 1000 population)		3.4	
119	Deaths due to Malaria		0	
120	Cases of Kala azar		0	
121	Deaths due to Kala azar		0	
122	Suspected cases of Japenese Encephalitis		0	
123	Deaths due to Japenese Encephalitis		0	
124	Dengue Cases		0	
125	Deaths due to dengue		0	
126	No of confirmes cases of Chikungunya		0	
National Iodine Deficiency Disorder Control Programme				
127	No. of Districts Surveyed		0	
128	No. of Endemic Districts		0	
129	Total No. of samples of iodised salt collected in 05-06		0	165284 in 2006-07, 88890 in 2007-08
130	No. of Samples of iodised salt found confirmed to the standards		0	141556 in 2006-07, 84915 in 2007-08
National Tuberculosis Control Programme (data for 3rd Quarter 1st July to 30th Sept. 2006)				
131	% of TB suspects examined out of total new adult out-patient (target 2%-3%)		2.54%	2.35% (Oct 08)
132	Annualized total case detection rate(per 1 Lakh Population)		123	118 (Oct 08)

133	Annualized new smear positive case detection rate(%)	47%	52% (Oct 08)
134	Success rate of new smear positive patients (in %)	83%	88% (Oct 08)
Integrated Disease Surveillance Programme (IDSP)			
135	Setting up of State surveillance Unit	Yes	
136	Setting up of State surveillance Unit	Yes	
137	Establishment of EDUSAT Centre	Yes	
138	Training of trainers	Yes	

Chapter 4 Recommendations

Recommendations

4.1 Planning process:

- Strengthening process of VHSC and sensitization of PRI leaders should be given priority through participation of Mitanins and relevant health functionaries. Village level planning process need to be considered at this stage in Chhattisgarh as community participation is sufficiently active through the ground level initiatives by Mitanin.

- Strengthening of health facilities through infrastructure development and provision of human resources are crucial to address demands created by the initiatives at the community level. It is advisable at this stage to conduct a Sub Centre and PHC level facility survey by BPMU staff to project a realistic picture of the lower level institutions and their issues that's that further rectification can be planned by block planning team.

- Although the DHAPs were prepared in all districts and state PIP has been formalized after considering all DHAPs in 08-09 financial year, the financial allocation and disbursement to districts are in mismatch with the original district plans. The budget allocation has been made considering the amount received from centre for a particular strategy rather than looking the need specified in DHAP. It is therefore recommended that state should consider DHAPs seriously during financial disbursement from state to districts.

- Many activities specified in the PIP 08-09 have not either been considered or initiated in many districts. It is therefore recommended that state health society should give prime importance to the implementation of the planned activities.

- It has been noticed that many of the recommendation of previous CRM, JRM report have yet to be considered seriously therefore the process of further improvement getting slower. Therefore 2nd CRM team also suggests to consider better reflection of previous committees recommendation along with the current one.

4.2 Human Resources

- Although non-availability of health human resources are one among the major problems of Chhattisgarh health system, there are gross anomalies in the distribution, transfer & posting policy, promotional avenues, incentivisation etc. This has to be addressed on a priority basis and immediate measures should be taken to improve the situation. Appropriate posting and relocation of multi-skilled personnel like EmOC and LSAS trained doctors is a crucial initial step. Rational deployment of Post-Graduate Medical Officers to cater need of the state will improve the service delivery in many institutions.

- The issue of non-availability of specialists, staff nurses, ANMs other staffs has to be addressed comprehensively. The Directorates of medical education and nursing education need to be sensitized to the public health and government health service needs. Reservation

of post graduate courses for the service doctors need to be more attractive so that more and more people join the state services.

- Innovations will be key to tackle the issue of non-availability of human resources in Chhattisgarh. The performance of Rural Medical Assistants who are presently posted in tribal/difficult areas should be evaluated and their training may be restarted if found satisfactory.

- It has been noticed that contractual appointment process was slow and insufficient. Therefore scope for contract appointments under NRHM needs to be tapped fully through the Mission directorate, District health societies and JDS. Frequent efforts along with provision of additional benefits need to be planned for filling of regular vacant posts and to bridge the gaps effectively. Many of the planned consultants supposed to be recruited under SPMU are to be filled at the earliest.

- Chhattisgarh govt has allowed its MO, PGMO and specialists to do private practice outside of their duty hours with a justification to make them financially comfortable. It is advisable to re-look by analyzing the impact of this relaxation on public health service delivery mechanism.

- Many of the Multi-skilled personnel like EmOC, LSAS trained doctors are not able to perform due to various inherent systemic reasons. The CRM team suggests addressing these issues and strengthening the training program as per government norms so that many of them can be utilized fully at various levels.

- All the concerned training centres for ANM, Staff Nurse and paramedics are to be regulated to give preferences to the state government sponsored candidates so that massive vacant positions can be filled at the earliest. Encouraging the private sectors to setup relevant institutions is an option which however regulated to cater to the human resource requirement of public health system.

- The vacancy of MPW (Male) has effected the malaria surveillance very badly resulting into delay in diagnosis, treatment etc. Although the state is highly endemic for malaria, but the full time SPO, District malaria officers, Malaria inspectors are not available. It is therefore strongly recommended that these regular as well as contractual posts are to be filled up at the earliest so that programs do not suffer any more.

4.3 Financial Management

- In many blocks delay in the disbursement of money particularly JSY benefits has been reported due to non implementation of core banking. This need to be addressed. The backlog of incentive disbursement to the beneficiaries as well as providers of JSY scheme needs to be corrected.

- Another issue is the quick retrieval mechanism of utilisation certificates (UC) from many fronts. It is therefore recommended to evolve mechanism/guidelines at state level for UC submission so that further delay at all levels can be avoided.

- The CRM team strongly recommends the state to initiate the process of ROP after the DHAPs are prepared at the district. Every district should know their planned activities along with budgetary proposal. This decentralized and transparent activity will help the state to monitor the financial outflow for particular activity to the respective district.

- Most of the national programs are maintaining separate bank accounts which are to be merged immediately under the account of State Health Society as sub-accounts so that financial convergence takes place.

- Delay in percolation of state contribution to the NRHM pool amounting Rs. 36 Cr need to be taken care off on first track basis. It should be ensured that the state contribution have been transferred from state treasury to NRHM pool immediately.

- Expenditure against financial allocation from centre under NRHM need to be expedited as non utilization of existing funds have been reported from SPMU as well as state machineries.

4.4 Infrastructure

- Fund allocation for infrastructural improvement of health facilities are allocated from State treasury, NRHM Flexipool, BRG funds and projects like EUSPP which is in partnership with a development partner. In this regard CRM team specifically suggests the state mission to map the location of those institutions that need to be planned for upgradation so that duplication or exclusion of needy institution can be ruled out.

- Many of the PHCs are running from a building which are supposed to be a building meant for SCs. There are no residential quarters in those premises apart from the other structural needs. Therefore it is recommended that the pathetic conditions of the PHCs are to be considered immediately and seriously so that proposed service guarantees can be rendered.

- Many of the visited institutions are though constructed recently but the handing over process has been delayed due to non completion of some minor activities. It is therefore recommended that a particular standard procedures need to be followed for streamlining the handing over process of these constructed institutions.

- Electricity connection, water supply restoration in many institutions has been taken care by JDSs. CRM team feels that these activities could be dealt through additionalities or NRHM flexipool so that JDS money can be utilised for other purposes.

- CRM term is proposing immediate attention for most of the infrastructural criteria for 24x7, FRU, blood storage, residential quarters so that motivation to work in peripheral institutions can be generated among the work force.

- As it was reported by state officials that process of construction/ maintenance through PWD department are always getting delayed. Therefore CRM team recommends that over dependence on PWD for construction requirements needs to be re-looked and possibilities of using organization like CHIDC, NGOs or private sector can be explored. CRM team also feels that there is an urgent need of infrastructure development wing under State health societies or (state health mission) to expedite the process.

- There are no proper civic amenities for ANM/ Mitanins and other health functionaries at health institutions. So it has been suggested that civic amenities need to be provided in bigger facilities like CHC, District hospital where they can spend time in odd hours.

- Infrastructural strengthening for ANMTC and RFWTC and DTCs are also need of the hour as these structures are important for capacity building and resource generation.

4.5 Training and Capacity building

- Training and capacity development are important area to be dealt seriously under NRHM. The newly constructed SIHFW and existing RFWTC & DTC are in almost non functional because of lack of human resources and dilapidated condition of infrastructures. The strengthening process of these institutes should be done on priority basis in following area like infrastructure, HR, reorientation for skill building and coordination. The annual comprehensive training calendars for these institutions should be developed in consultation with the NRHM mission Directorate. There is a serious need to develop a congenial atmosphere among State health mission, SHRC and these training institutions.

- This effort from state mission and Directorate should encompass in identification of trainees to be trained, needs, methodology of training, selection of partner institutions and devising non- institutional arrangements, skill development and evaluation mechanism.

- There is a tremendous need of induction and orientation course for the newly recruited Human resources along with comprehensive training schedule.

- There is a constant need of proper training of newly recruited BPMU staff for optimum utilisation of their services and participation for block level planning.

4.6 Drug / procurement/ laboratory services

- CRM team feels that drug, equipment procurement and logistics management should be dealt promptly as many of the institutions have poor management and maintenance mechanism in this area. There should be a proper procurement policy as well as condemnation procedure at institutional level.

- Centralized health equipment management system as proposed need to be considered seriously after analyzing cost effectiveness. Common Inventory control mechanism needs to be strengthened. State should ensure that the status of existing equipments in various institutions should be made functional so that these can be reutilized for patient care.

- Centralized Drug procurement system as proposed by state government needs to be formalized at the earliest so that drug availability at periphery should not be further affected.

- All the mechanic or logistics support manpower who are posted in various places under health dept should be further trained for handling minor repair jobs of the equipments.

- Laboratory services in most of the facilities are not functioning due to the lack of trained staff, range of investigation etc. Laboratory services need to be initiated on exigency basis in

institutions where it is not functioning with integrated support mechanism and resources from RNTCP, NVBDCP and NACP etc.

4.7 HMIS

- HMIS is another area which is functioning through reporting mechanism initiated from BPMU. All the reports generated from Sector, section to the Block level BMO office bypassing role of PHCs need to be relooked. CRM team has reserved their opinion that report should be generated from SC for further discussion at PHC level along with their respective Sector supervisors to make PHC in charge responsible and accountable so that feed mechanism from the ground level can be generated.

- CRM team suggests that a sustainable mechanism should be developed to support the ground level workers through a good feedback mechanism after analysing them at superior level. It is recommended that all the immediate superior staffs should ensure their responsibilities to give feed back to the below staff before sending the report upwards.

4.8 Convergence

- Chhattisgarh has taken exemplary steps in convergence by recommending representatives from other allied departments in various societies and samities. However no major initiatives in health in collaboration with these departments are observed. Therefore CRM team feels that state should take necessary steps to incorporate concerned activities in relation to greater goal of comprehensive health care.

- Under mainstreaming of AYUSH collocation has been initiated in 86 facilities. Considering the acute shortage of human resources in health and to strengthen existing health facilities in Chhattisgarh, collocation should be considered in other facilities too. The resistance which is reported in field from block level officials should be solved immediately for the greater goal of health service delivery.

- Convergence has to be implemented along with National AIDS control Program, RNTCP through integrated laboratory services, cross referral, social marketing and disease surveillance more proactively.

- Strengthening and capacity building of PRI leaders is another area which has to be initiated so that their participation in planning, social auditing, community monitoring can be established.

- It has been noticed during CRM that directorate has multiple posts of directors with less coordination among them particularly for the planning and implementation of health service delivery in the state. Disproportionate distribution of work among all the directors also has been noticed. It is therefore recommended that all disintegrated activities of health system need to be uniformly coordinated and converged under comprehensive leadership.

- Convergence activities between WCD department (ICDS), Education and Health Department need to be actively coordinated for Health care, malnutrition, immunization, health promotion and adolescent health after breaking the barriers of hierarchy.

4.9 Governance and Programme management

- The members of the newly constituted state programme management team should be provided with more clarity on their roles and responsibilities. There is a need to take full advantage this new set up by delegating clear responsibilities to State Programme Manager and other members of the team.

- Many senior officials at state, district and peripheral level require NRHM specific reorientation. Their status needs to be elevated from supervisory jobs which were one among the characteristic of earlier centralized way of functioning. Their ability to function as stewards of their jurisdiction is crucial for further implementation of the program.

- Frequent reshuffling of administrative and technical officials need to be relooked seriously so that pace of program should not slow down.

- Decentralization of financial power to the peripheral institutions needs to be paced up quickly so that the expenditure pattern under NRHM may gain momentum.

- Administrative and directorate level coordination is to be strengthened for the greater goal of successful implementation of NRHM.

Chapter 5 Conclusion

Conclusion:

The first generation health sector reforms, especially its community oriented activities initiated by the State of Chhattisgarh in the beginning of this decade is vindicated by the fruits it bears today after few years its implementation. The state has remarkable success in creating a vibrant comminitisation of health systems. The initiation of NRHM affected this communitisation process in two ways; i) it added credibility to the reforms and ii) helped in getting the reforms institutionalised.

Nevertheless, as the reform process advances, new forms of challenges are coming up. The biggest challenge in its broad sense is the weakness of the other levels of the health system to reciprocate the demand generated by the communitisation process. In other words, a vital aspect will be the capacity of the rural healthcare institutions get vitalised and functional. This is especially true as far as the functioning of Primary Health Centres is concerned. In this regard, addressing the issue of human resources and infrastructures will be an acid test for Chhattisgarh in the coming years..

The path before the state is to design and advance its second generation reforms to substantiate its first generation reforms. This requires the state to immediately address issues at the level of health governance. The different directorates which divide public health functions into compartments should be able to work in close collaboration with the mission directorate with an objective of achieving greater public health goals. Many of the problems faced by the state are complex and require extra ordinary solutions. This is possible only when there is greater synergy at the leadership level and a willingness to express an oversight of the health system development process.

The new programme management units at three levels of health system provide a great support in terms of improving its 1st level of governance that include day-to-day problem solving and opportunity creation. The need of the hour is to take care of higher level governance especially at the district and block level. This requires a paradigm shift from earlier centralized system where leaders at these levels were expected to be supervisors of programmes rather than stewards of public health functions.

The observations made by the team are based on our short visit to Chhattisgah state. We tried to present both the strengths and weaknesses of the reform process as realistically as possible. We appreciate the fact that the State authorities have already taken note of many of these factors as evident in our final debriefing with the state authorities.