Third

Common Review Mission

State Report

Chhattisgarh

Chhattisgarh

Third CRM Report

Bastar, Narayanpur and Raigarh Districts

November 5-10, 2009

CHAPTER 1

TEAM:

The Third CRM Team visited the state of Chhattisgarh from November 5 to 10, 2009. The team consisted of the following members:

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They were accompanied to the districts by officials of the state government whose names are given in Annexure 1. The names of the persons contacted at the facilities visited in the districts are given in Chapter 3 below. In addition, meetings were held with state officials in the state capital before and after the district visits, and the names of those attending are also listed in Annexure 1.

CHAPTER 2

INTRODUCTION TO THE STATE

A. General Information

Chhattisgarh was carved out of the state of Madhya Pradesh in the year 2000. It has a population of 2.083 crores, distributed among 18 districts (96 sub-divisions, 146 blocks, 20,308 villages). Population density is low – at 154 per sq. km, about half the national average. The terrain is hilly and thickly forested. The population is 32% Scheduled Tribe, 12% Scheduled Caste, and 46% are Below the Poverty Line. The sex ratio is 989 females per 1000 males. Female literacy is 51.9%. The growth rate of population in the 1991-2001 decade was lower than the national average.

The area of Chhattisgarh was originally in that of the eight EAG states, and the state is among the 18 high focus states under NRHM. According to the DLHS-3 (2007-08), about 84 % of rural households in Chhattisgarh live in kachcha houses, , about 4% have piped drinking water (urban 65%), and fewer than 10% have access to a toilet facility (urban – 57%). About 83% have a low 'standard of living' (SOL) and 4% a high SOL; in urban areas the figures are 27% low and 46% high, which shows the great disparities in the state.

B. Baseline of the State's Public Health System

The state has the following number of health facilities (RHS 2008), human resources, and health indicators.

(i) Infrastructure: Pls refer to Tables 2 and 3

(ii) Human Resources: Pls refer to Table 4

(iii) Indicators: Pls refer to Table 6

(iv) Status of PRI Framework

The total number of VHSCs in the state is 18,570 (in 20,308 villages). Other data are provided in Table 6.

(v) Special Constraints

While the network of roads travelled by the CRM team was good, a large number of habitations in the state are remote and inaccessible as the area is hilly and thickly forested. In addition, at least 10 of the 18 districts are affected by left-wing extremism, which poses difficulties in terms of establishment of facilities and access to them.

CHAPTER 3

THIRD CRM DATA

Districts Visited

	District	District HQ	Name of DM	Name of the CMO
1.	Bastar	Jagdalpur	M.S. Paraste	Dr. Abdul Rasheed
2.	Raigarh	Raigarh	I.P. Tyagi	Dr. Havell Oraon

Facilities Visited

Raigarh District

Date	Name of Institution	Name of Block	Name of Person Contacted	Designation
5/11/2009	District Hospital	Raigarh	Dr.R.P.Pandey	Civil Surgeon
	PHC Loing	Raigarh	Dr.G.S.Paikra	BMO
			Shri Vaibhav Deodia	BPM
	CHC Pussore	Pussore	Dr.M.K.Patel	BMO
			Smt. Sunita Upadhyay	BADA
	PHC Badebhandar	Pussore	Dr.A.K.Bhagat	MO
	SC Kotmara	Pussore	Ku.Shushma Sidar	ANM
6/11/2009	PHC Saraipali (VHND)	Tamnar	Ku. Laxmi Sahu	ANM
	Punjipatra(VHND)	Tamnar	Smt. Yogeshwari Sahu	ANM
			Shri Anil Kumar Lakra	MPW
	CHC Tamnar	Tamnar	Dr. D.S.Paikra	BMO
			Shri Ashok Singh	BPM
	CHC Gharghoda	Gharghoda	Shri S.N.Keshri	BMO
			Shri Rupadas Mahant	BADA
	SC Amlidihi	Gharghoda	Smt. R.P.Mahant	ANM
			Shri R.S.Swarnkar	MPW
7/11/2009	CHC Lailunga	Lailunga	Dr.S.N.Upadhyay	BMO
			Shri N.L.Nayak	BEE
	PHC Rajpur	Lailunga	Ku.Manjusha Bhagat	ANM
			Shri Jitendra Patnayak	Pharmasist
	PHC Sisringa	Dharamjaigarh	Dr.Gayendra Diwan	MO
	Civil Hospital D.Garh	Dharamjaigarh	Dr.B.L.Bhagat	BMO
			Dr. Soni	MO
8/11/2009	CMHO, Raigarh	Raigarh	Dr. H.S.Uraon	CMHO
			Shri Girish Kurre	DPM

Bastar District

			Dr. Abdul Rashid	CMHO
			Dr. C. Maitri	DIO
			Sh. Akhilesh Sharma	DPM
4/11/2009	FRU RNT Kondagaon	Kanker	Dr. O.P. Parikh	M.S. Ophthalmology
			Dr. Devendra Nag	Eye Surgeon
5/11/2009	CHC Bakawand	Bakawand	Dr. R.K. Chaturvedi	MBBS
	SHC Kinjoli	Kachnar		
	PHC Kachnar	Kachnar	Dr. Saroj Ahuja	AYUSH
6/112009	CHC Darabha	Daarbha	Dr. P.L. Mandavi	MBBS
	PHC Pakhnar	Darabha	Dr. C.K. Gedam	AYUSH
	Village Kutapara	Darabha		
	SHC Tirathgarh	Darabha		
	PHC Chindbal	Darabha		
	SHC Sohanpal	Darabha		
	SHC Keslur	Darabha		
	Village Sohanpal	Darabha		
7/112009	Civil Hospital	Bhanpuri	Dr. R.S. Paikra	MBBS
	DH Narayanpur	Narayanpur	Dr. G.R. Dhaneliya	DHO, MBBS
			Dr. M.K. Suryavanshi	MBBS
	PHC Chhotedongarh	Narayanpur		
	Ramakrishna Mission Hospital	Narayanpur		
	SHC Garhbengal	Orcha		
8/112009	CHC Lohandiguda	Lohandiguda	Dr. V.K. Thakur	MBBS
	PHC Chaperbhanpuri	Lohandiguda	Dr. K.S. Patel	AYUSH
	SHC Chitrakoot	Chitrakoot		
	Village Chitrakoot	Chitrakoot		

CHAPTER 4

PROGRESS OF NRHM IN THE STATE – DESK REVIEW

Table 1. Progress against Targets and Time line: Data provided by the State Govt.

	Activity	Phasing and time line	Status on march 05	Status on march 09	Status on Oct 09
		Comment on quality and quantity of status as of			
1	Fully trained Accredited Social Health Activist (ASHA) for every 300 population	30% by 2007 100% by 2009	57000 (95%)	59489 (99.1%)	59489 (99.1%)
2	Village Health &Sanitation Committees constituted in over 6 lakh villages and untied grants provided to them	30% by 2007 100% by 2010	0	18587 (90.9%)	18587 (90.9%)
3	2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75,000 places	30% by 2010 60% by 2011 100% by 2012	0	0	0
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS	30% by 2010 60% by 2011 100% by 2012	0	0	0
5	6500 CHCs strengthened/ established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS	30% by 2010 50% by 2011 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 civil hosp 17 civil disp	8 civil hosp 17 civil disp
7	600 District Hospitals strengthened to provide quality health services	30% by 2007 60% by 2009 100% by 2012	15/16	15/18	16/18
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 CHC129/136 PHC695/721 Civil Hosp-13/17	DH-16/18 CHC129/136 PHC695/721 Civil Hosp-13/17
9	District Health Action Plan 2005-2012 prepared by each district	50% by 2007 100% by 2008	100%	100%	100%
10	Untied grants provided to each VHSC, Sub Centre, PHC, CHC to promote local health action	50% by 2008 100% by 2009	0	100%	100%
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals	50% by 2008 100% by 2011	0	100% for CHC and PHC in govt. building	100% for all CHC, PHC and SCs in govt.building
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 2011	Not started	On pilot basis in 3 distt by GoI	Re-proposed in same 3 districts.

	Activity	Phasing and time line	Status on march 05	Status on march 09	Status on Oct 09
14	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs	50% by 2007 100% by 2010.			TMNC model for Procurement and logistics-streamlining in process
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 FP facility at PHC on camp basis available	100% district hospital	100% district hospital 30% CHC 50% PHC
16	District Health Plan reflects convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.		YES	YES	YES
17	Facility and household surveys carried out in each and every district of the country	50% by 2007 100% by 2010	100% Completed for CHC	100% household under CNAA	Facility surveys of DH, CHC and PHC 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	State level public report published every year	State level public report published every year
19	Institution-wise assessment of performance against assured service guarantees carried out	30% by 2008 60% by 2009 100% by 2010			Nodal officer appointed at each level to monitor the performance institution-wise
20	Mobile Medical Units provided to each district of the country	30% by 2007 60% by 2008 100% by 2010		20 Mobile Medical Units under process under NRHM	20 Mobile Medical Units under process under NRHM

CHAPTER 5

FINDINGS OF THIRD CRM

INFRASTRUCTURE UPGRADATION

Table 2. Status of Primary health Infrastructure (June or Sept 2008)

Sub-centres	Raigarh	Bastar	Remarks
Total No. of Sub Centers functioning (as mentioned in Proforma I)	**311**	**372**	**Sub-centers were found functioning with Mitanins and ANMs providing services, and well maintained infrastructure in most places in Bastar.**
No. of Sub Centers functioning without ANMs	37	15	**Not found in Bastar.**
No. of Sub Centers functioning without HW (M)	80	150	
No. of Sub Centers with ANM quarters	**213**	**192**	**The team observed ANMs staying in their quarters which led to better services.**
No. of Sub Centers without regular water supply	**109**	**316**	**No SC has regular water supply in Bastar – it has to be manually arranged.**
No. of Sub Centers without electric supply	**102**	**124**	**Nil**
Primary Health Centers			
Total No of PHCs functioning (As mentioned in Proforma I)	**51**	73	
No. of PHCs functioning without a Doctor	26	1	
No. of PHCs functioning without lab.technician	12	3	
No. of PHCs functioning without Pharmacist	Nil	9	
No. of PHCs functioning without Nurse Midwife/ Staff Nurse	39	41	
No.of PHCs functioning without ANMs	13	10	
No. of PHCs having two doctors including AYUSH practitioner	Nil	-	**PHCs in Bastar have AYUSH doctors as well as Rural Medical Assistants. There are very few MBBS doctors. RMAs are poorly paid,**
No.of PHCs with labor room	**32**	**45**	
No. of PHCs with O. T.	**32**	**2**	
No. of PHCs with 4 – 6 beds	**32**	**2**	
No. of PHCs without electricity	**19**	**-**	
No. of PHCs without regular water supply	**19**	**56**	
No. of PHCs with telephone facility		**11**	
No. of PHC without all weather motorable approach road.	**0**	**1**	**Most PHCs are approachable by good all- weather roads in Bastar.**
No. of PHCs having Doctor's quarter	**7**	**27**	**State must plan & identify PHCs for providing full complement of services where residential quarters for the doctors may be built on priority.**
No. of PHCs having a vehicle	**0**	**4**	
CHCs			
No. of CHCs with functional Laboratory, OT, Labour room, X ray	**8**	**10 + X-ray**	**In Bastar, CHCs found to be functioning with lab, OT, labour room and X-ray**

		in 6	**facility.**
Number of CHCs with 30 beds	**8**	**3**	
Number of CHCs having quarters for specialist Doctors	**0**	**0**	
Number of CHCs presently operating in PHC building	**0**	**0**	
First referral units			
No. of FRU's with functional O.T, labor Room, X-Ray, Lab	**6**	**3**	**No FRU found to be functioning in Bastar district. Only teaching hospital OT, labour room functioning unsatisfactorily.**
No. of FRU's with Blood storage/linkage facility	**0**	**1**	**Not found**
No. of FRU's having referral transport service	**6**	**3**	**Though ambulances were found at the CHCs, they did not seem to be used for referrals.**
No. of FRU's with back-up generator/electric supply	**6**	**3**	
No. of FRU's without residential quarters for essential staff	**6**	**3**	**Residential quarters were found by the Raigarh team at 2 DH/FRU & CHC/FRU at Lailunga.**
Additional Information on Health Facilities			
No. of Mobile Medical Units operating in the State/UTs	**-**	**-**	**Not found.**

Table 3. Position of Buildings in the Districts visited (September 09)

Building position in respective districts up to September 09	**Raigarh**			**Bastar**		
	SC	PHC	CHC	SC	PHC	CHC
Total No functioning	311	51	8	372	73	11
No. functioning in Govt. Buildings	212	29	5	248	31	10
No. functioning in rented Buildings						
No. functioning in Buildings of Panchayats/ Voluntary/Social Organizations, etc.	6	10	1	0	1	0
No. of Buildings Under Construction	73	5	2	35	18	1
No. of facilities in inappropriate Buildings and required to be Constructed	0	1	5	67	8	0

Overall, physical infrastructure in the districts visited was adequate in terms of the space needed for the provision of services. The exceptions were: some PHCs which were housed in 'converted' Subcentre buildings, with the SHC still co-located; and some Block PHCs and CHCs in poor condition in Bastar. Sub-centre buildings and residential facilities were good, with adequate space to conduct clinics and deliveries and usually with and adjacent residence for the ANM.

In Bastar, three FRUs identified for the district were not functioning. The only FRU was at the Teaching Hospital of the Medical College but this was of poor quality. Pregnant women were found being transported in an open truck with Rs. 500 being charged by the truck-driver from the attendants. This indicates that referral services are not supported by proper ambulance services to the Teaching

Hospital. Proper biomedical waste management was not in place and all hospital waste, including plastics, sharps, broken ampoules, cotton swabs, etc. were discarded in a single container. No awareness of BMW was found. The wards were ill-ventilated and poorly lit. Cleanliness was not satisfactory, and foul smells prevailed. Women who had had Cesarean sections (LSCS) purchased medicines and materials worth Rs. 3000 from outside as the hospital did not supply them. Out-of-pocket expenditure was very high, defeating the very purpose of JSY. The quality of linen was not good and patients were using their own clothes. Pregnant women are not provided free bed nets to be used in the wards. No SOPs are found for common processes used in intra-natal care and emergency obstetric care. The overall picture of quality of Comprehensive Emergency Obstetrics care was not satisfactory. The situation was similar at the Raigarh District Hospital. In Raigarh, although two CHCs visited were labeled as FRUs, they still lacked Anesthetists and Blood Storage facilities (the refrigerators had been received but not installed, and no blood was available. In one case the Blood Bank was 70 kms away). The only functioning FRU was the district hospital.

All facilities other than the District Hospitals (DH) and one CHC (at Lailunga, Raigarh) were found to be underutilized. An example: Loing PHC (9 kms from the Raigarh district headquarters) had 22 rooms, most of which were under lock and key, and an additional eight rooms were under construction, but the OPD load was less than ten patients per day and there were no in-patients. The low use of peripheral facilities puts additional pressure on the DH.

At most facilities attention was required to: signage, patient flow, location of emergency rooms, suitability for the physically-challenged (including patients in wheel chairs due to accidents which are very common in the area). Toilets were in dreadful condition – blocked or uncleaned, and lacking in water supply. In many cases, including SHCs, there were no women's toilets. There was also no drinking water at the facilities for the most part.

Maintenance of physical infrastructure was inadequate in all cases, and worst in the District Hospitals. Facilities for proper Biomedical Waste disposal, which is now mandatory, were not in evidence anywhere. The buildings required major cleaning, repairs, management of solid waste disposal, provision of water supply, and so on. The team was informed that the PWD is unresponsive, and the process of obtaining maintenance and repairs is lengthy. As resource allocations are not separate for the Health Department, it is not possible for the Civil Surgeon or CMHO to access funds or (if allocated) to track utilization. The Jeevan Deep Samitis (JDS, as the RKS is known in the state) at several facilities were collecting funds but not spending them on required maintenance or repairs.

Condemned or unusable equipment/furniture etc. (sometimes rusty and hazardous) was also found ubiquitously, stored in wards, clinical rooms, drug storerooms, corridors, toilets, staircases, etc. There were also many expired/old cartons of medicines and supplies. Many condemned/ unusable vehicles including ambulances were also found parked at a number of facilities. Much equipment was found in need of either repair or replacement. AMCs were not in place at all. On the other hand, the team also observed many unused **new** equipment in storage which were meant for the facility itself (e.g., at Loing PHC, Gharghoda FRU in Raigarh district, and in many facilities in Bastar as well) or for the related peripheral facilities (e.g., SHCs).

Staff Quarters were available and occupied at about half of the facilities in Raigarh, and this supported service availability. New quarters were also seen to be under construction. A significant exception was the District Hospital in Raigarh where quarters were in woefully poor condition and inadequate in number. Doctors are staying in the damaged (and possibly hazardous) quarters in the district hospital campus. In Bastar, more facilities were in need of quarters.

Recommendations

The districts should carry out a careful facility survey to rationalize physical infrastructure and human resources, equipment, cold chain facilities, and supplies. This may also look into the logistics (e.g., of blood supply, drugs and equipment), referral and supervision. It should include the state of equipment – whether repairs are possible or replacement/supply is needed. The use of facilities should also be included, so that rationalization can be done on the basis of local demand. Reasons for the underutilization of peripheral facilities could be explored through Focus Group Discussions in the surrounding communities (and plans made to address the issues raised). The Facility Survey should be done by a team with all the needed expertise that moves from facility to facility, covering the DHs, CHCs/FRUs, PHCs and a sample of Sub-centres in the first phase. It should use 'management-friendly' formats to facilitate follow-up action.

Protocols need to be put in place to ensure cleanliness of wards, toilets, public spaces, corridors, patient-attendant waiting areas with water and toilets, and Citizens Charter framed to guarantee this. Equipment requiring minor repairs should be repaired. Unusable/condemned articles need to be disposed off in a campaign mode through auction. Similarly, the chemical contents of supplies should be appropriately disposed and the containers sold. The funds could be added to the JDS account and spent in turn on the necessary improvements. New equipment that is stored needs to be put into use or distributed as required.

It is suggested that a separate construction wing controlled by the Health Department be set up, with separate budget allocations for maintenance and repairs/ renovations where required. Financial powers may be delegated to the Civil Surgeon/CMHO to condemn and dispose off unusable items and carry out minor repair works, and s/he could then be held accountable for functionality and maintenance of the facilities.

Full-scale improvement of the District Hospitals is highly necessary as noted above. The newly-appointed Hospital Administrators could be given the task of facility management to improve patient amenities. S/he could carry out joint rounds with the key managers of the facilities to record problems and solutions, and the follow-up actions taken.

All CHCs need to be strengthened to provide the full expected range of services. Facilities marked for up-gradation should have the full complement of services including labour rooms and newborn corners at PHCs, and provisions for referrals. HR planning and implementation need to done alongside the physical up-gradation to ensure that the facilities are made fully functional.

In the case of co-located PHCs and Sub-centres, it would be better to relocate one of these facilities elsewhere to expand coverage (which greatly needs to be done). However, adequacy of staff to do this needs to be assesses simultaneously.

As the JDS's have ample funds (from user charges and untied grants) but are not spending it on the much-needed improvements noted above, they need to be facilitated to do so. The state could consider calling for fixed-day meetings for decisions to be taken. It could provide 'auto-approved' lists of items on which expenditure can be made – such as ensuring water supply, electricity and lighting, cleanliness, signage, etc., including contracting out of non-clinical services. Cleaning services are at the top of the list to be outsourced.

Further provision of staff quarters for MOs and other should be based on need assessed by the facilities survey.

HUMAN RESOURCE PLANNING

Table 4. Health Manpower in the districts visited (Rural areas) (October 2009)

Category	Raigarh				Bastar			
	Sanctioned	In position		Total	Sanctioned	In position		Total
		Regular	Contractual			Regular	Contractual	
CHC/ FRU								
Surgeons	5	1	0	1	20	20	0	20
Obstetricians /Gynecologist	5	1	0	1	10	0	0	0
Physicians	5	2	0	2	10	0	0	0
Pediatricians	5	1	0	1	0	0	0	0
Anaesthetist	5	0	0	0	10	0	0	0
Eye Surgeon	-	-	-	-	0	0	0	0
General Duty Medical Off.	-	-	-	-	0	0	0	0
Nursing Staff PHN/ANM/SN/N Midwife	12	13	0	13	70	21	3	24
Pharmacist/Compounder	8	6	0	6	19	13	6	19
Lab Technician	4	7	0	7	10	9	1	10
Radiographer	4	2	0	2	12	5	5	10
PHC								
Total Allopathic Doctors	54	16	1	17	112	22	87	109
Pharmacists	18	16	0	16	56	19	28	47
Lab Technician	23	1	0	1	48	12	33	45
Health Worker (F)/ANM	26	15	0	15	56	46	0	46
Nurse Midwife/Staff Nurse	12	13	0	13	0	0	15	15
Sub-centres								
Health Worker (F)/ANM	178	152	0	152	316	269	5	274
Health Worker (M)	182	99	0	99	316	176	0	176

The state has a shortage of personnel in virtually all cadres, and this was clearly evident in the districts visited, especially in Bastar (where MOs, Specialists and POs were especially in short supply). There is no separate Public Health cadre at the State or District level. While in Bastar, PHCs are managed by AYUSH and RMAs (where they are practicing allopathy as no AYUSH drugs are available), no AYUSH doctors were met in Raigarh. No second ANMs have been posted. This may be due to the shortage of ANMs and also to NHRM's mandate that GOI would not finance these posts until MPWMs have been posted at all Sub-Centres, financed by the states. While many MPWMs are in position and working, many Sub-centres are still lacking in these staff.

While Human Resources (HR) are inadequate with respect to the sanctioned posts, those available are not being used effectively. There is irrational deployment of doctors, and great need to improve the fit between Specialists posted and patient load, including Staff Nurses. For example, at Gharghoda CHC/FRU and Loing PHC in Raigarh, several specialist doctors were not performing the procedures in which they are trained. At Loing PHC, a DGO was posted but the delivery load was 11 per month, and though there were also a SN and an ANM, no safe abortion or tubectomy services were being offered and no special clinics were held. Gharghoda CHC had an MD (Obstet) and MS (Genl) and Tamnar PHC had an orthopedic surgeon who had not performed an orthopedic surgery for the past 18 months. In Basthar there were two Ophthalmic Surgeons and one of them was doing surgeries regularly where as the other one was a non-operating surgeon!

Doctors were absent from many facilities. In most instances, supervisors were unable to do anything about 'absconders.' Often, Specialists who had little to do were on formal leave. Thus, there is the problem of 'overburden' and 'multiple work' on the one hand, and doctors not working on the other. The irrational deployment of specialist doctors also contributes to underutilization of facilities.

Nurses and ANMs are also in short supply, but were found to be doing good work for the most part. Staff Nurses need a career growth path (e.g., they could qualify in Midwifery). ANMs also need development avenues. They could be promoted to LHVs based on seniority as in Tamil Nadu, or have the option of going into nursing, or doing the condensed course for GNMs/ LHV training course.

Male workers (MPWMs) were encountered in several SHCs. While the 'older' cadre appeared to be working well, formal training needs to be provided to new recruits (who were also referred to as "Link Workers") – they are currently collecting malaria slides, etc. without having been trained in disease surveillance.

The team met several RMAs and found them to be young, energetic and useful. They could fill in the HR gaps in difficult areas. However, their skills need to be constantly developed, and the state must ensure that these RMAs stay at the facilities where they are posted.

An ANMTC and a GNMTC were visited in Bastar. The training was good but their infrastructure needs great improvement.

Training under NRHM

The NRHM training has been scanty.

SBA training. The state has trained 1838 persons for Skilled Birth Attendance (15-day module) so far, and carried out 36 Training of Trainers (TOT). One TOT was conducted by the District Hospital in Raigarh, but the trainers at the District Hospital are themselves not practicing several SBA protocols in which they are training such as infection control, active management of the third stage of labour, use of partographs, etc. Hence the quality of this training is likely to be inadequate.

LSAS training. The state has trained 48 MBBS doctors in Life-Saving Anesthesia Skills, but they have yet to receive their certification. The team met some of these in Raigarh and found that the lack of certification has prevented them from practicing the skills they acquired, in some cases for over two years.

EmOC and IMNCI Training. The state has prepared master trainers for EmOC and IMNCI, but training in these areas has been slow. It is reported that the confidence of the LSAS and EmOC (multi-skilled) doctors is low, and that Caeserean sections are not being performed by them because most of the FRUs are not functioning. Only 8 of the 16 District Hospitals are doing Cx and 4 of the 146 CHCs. It is expected that 8 and 12 more of these facilities, respectively, would become functional FRUs on completion of the rationalization being undertaken currently by the state government.

Recommendations

Overall, to address the lack of HR planning in the state, the team recommends that a detailed 'mapping' of HR be done and a Personnel Management Information System (PMIS) be set-up. This would facilitate a clear and transparent Transfer and Promotion policy which is needed. Personnel should be carefully mentored and monitored, and the transfer policy should also be sensitive to the needs of families (life-cycle needs of the staff).

The state's effort to rationalize postings by counseling is a good initiative and should be taken forward. The state needs to ensure the posting of doctors to places where appropriate equipment and demand is available so that s/he can perform and provide services that are in demand. The skills of MBBS doctors and RMAs working at PHCs and BPHCs should be built up (e.g., through computer-based or distance learning for RMA), and an enabling environment created for staff at the lower level facilities to function. This will also reduce the load at the higher level facilities, where more specialized doctors can be posted and utilized appropriately. The motto for the system at each level could be "Resolve more, refer less" (the referral system also requires improvement, however). Community confidence will also be built in this way.

Given the shortage of Specialists, they should be deployed to provide clinical services and not for program work which can be looked after by MBBS doctors or non-medical persons.

A separate Public Health cadre with Health and Hospital Administration sub-cadres should be established in the state so that the health and medical services are provided in a more professionalized

way. This would be in accordance with the recommendations of the 11th Planning Commission to the Ministry of Health and Family Welfare, Government of India. The Medical Superintendents of Teaching and District hospitals need to be trained in hospital management/administration for 4 to 6 weeks before they are appointed, or at least before they take up their posts. Alternatively, a separate Hospital Administration cadre should be developed with qualifications in Hospital Management.

Rational deployment of doctors would help to cut down on absenteeism, and so would proper monitoring. The authorization of leave needs to be looked into.

A performance monitoring system should be put in place to ensure accountability. Performance-based incentives need to be provided for doctors and others working in difficult areas. These could be monetary and/or in terms of postings, retaining accommodation for families, etc. The incentives for doctors could include Post-Graduate seats.

The team advocates that career development be considered for Mitanins – they could rise to be ANMs or GNMs (rather than to B.Sc. Nursing which is currently proving to be difficult because of their lack of English language skills). ANMs could be promoted to LHVs or join the B.Sc. Nursing course. In all cases, the educational requirements, etc. should be retained.

All NRHM training (LSAS, EmOC, SBA, Multi-skilling, etc.) needs to be increased, and the other issues mentioned above also addressed.

ASSESSMENT OF CASE LOAD BEING HANDLED BY PUBLIC SYSTEM

Except for the Teaching Hospital in Bastar, District Hospital in Raigarh and one CHC (Lailunga, Raigarh), all facilities were underutilized – the per doctor load was less than 15 OPD per day, and Institutional deliveries were less than one per day at PHCs and above. The women's ward at one CHC/FRU (Ghargodha, Raigarh) was completely empty. At the other extreme, there was an overload at the CHC in Lailunga (although this was not functioning as an FRU because there was no Anesthetist and no functioning blood storage unit). Here, the doctor was committed and had organized his team to ensure that common emergencies were being handled – bed occupancy was over 200%, with beds spilling into the corridors. The team observed that where doctors had such commitment, services were being provided as supplies were also available. Although equipment was in short supply or not in working order in some cases (as noted elsewhere), the doctors were making do with their basic skills and supplies.

The delivered mothers mostly stay for 48 hours in the facilities, but most facilities do not provide free food for in-patients.

No overload was observed in the facilities due to JSY – usually there were far more beds than patients. This is commensurate with the low rate of institutional deliveries in the state and districts visited.

Recommendations

The FRUs need to be fully operationalized, and the CHCs need to be strengthened to handle most of the common emergencies found in the area, such as fractures, accidents, snakebite, and RCH activities. This includes ensuring a wide range of facilities - from working Xray machines to refrigeration for anti-snake venom to emergency transport.

EmOC training centers also need to be made fully functional, effective and efficient to prepare M.B.B.S. doctors to perform LSCS and to give life-saving anesthesia skills, to reduce dependence on Obgyn specialists who are in short supply. Where required, more Master trainers need to be prepared.

Doctors from the CHCs who have the aptitude to learn Family Medicine may be selected for the two-year distance education course organized by the CMC Vellore which is due to commence in January 2010. This course has been approved by the Government of India. It would strengthen the confidence of CHC doctors to handle medical and surgical emergencies.

Free food may be provided to all in-patients. This would cut down the out of pocket expenditure by the poor.

In addition, several of the infrastructure-related and HR actions recommended in earlier sections would help to even out the caseload on other facilities in general, especially rationalization of doctor postings and staff nurse availability, monitoring of attendance and performance, and proper management of facilities.

PREPAREDNESS OF FACILITIES FOR PATIENT CARE SERVICES

Several relevant points have already been made in the Infrastructure section above.

Boards displaying the names of staff, availability of medicines, JSY benefits and numbers of beneficiaries were found everywhere. Contact numbers for emergency transport and a wide range of health message (e.g., on AIDS, ORS, TB, FP and legal age of marriage) were also found widely. The lack of proper signage to guide patients was, however, a lacuna. Although Mitanin Help Desks were indicated, they were not functioning during the teams' visits.

The daily on-line reporting system from CHCs and 50% of PHCs to the state headquarters is a welcome step.

Recommendations

CHCs in particular should be provided the basic diagnostic equipment (e.g., Ultrasound, semi-auto analyzers, ECG, X-ray, lab equipment and consumables) to create an enabling environment for doctors to provide services using their skills.

Drug requirements need to be calculated in a decentralized manner and indenting improved, rather than centralized purchasing and dumping of drugs/equipment, etc. at CHCs, PHCs and SCs.

Management of stores needs to be improved and use of expired stock stopped. As also noted above, stocks intended for lower-level facilities need to be distributed to them in a timely manner; and defunct equipment needs to be either repaired or removed from the premises.

Standardization of facility-based registers is needed.

OUTREACH ACTIVITIES OF SUB-CENTRE

The team witnessed two VHNDs which were well attended by mothers with 6 month – 3 year-olds who required immunization. Pre-school children were also present, but other under-threes were largely absent. The VHNDs were held at Anganwadi Centers which had good facilities, including space to cook food, water and toilets. The AWWs stated that they were carrying out all the key health activities of the AWC together with the ANMs and Mitanins (see below), i.e., immunization, treatment of minor ailments, ANC, counseling of mothers, growth monitoring, supplementary feeding, vitamin A supplementation, testing of salt for iodine, etc. However, the team did not find much evidence of ANC being provided to mothers at the VHNDs attended – the focus appeared to be on immunization of children. All the necessary drugs were available with the ANMs and Mitanins, though these were supplied loose rather than in the form of Kits.

Eighty percent of ANMs reportedly stay in their Sub-centres. ANMs reported that they attended deliveries in homes as, despite their repeated urging, women did not go to a health facility on account of distances or the lack of transport, or because they were not convinced of the need to do so. However, the ANMs did not carry any kit, equipment and supplies for the most part, and they too faced difficulties getting to their villages (as well as to the monthly meeting at the sector level).

FP outreach appears to be at a standstill, but the team met a few AWWs at the District Hospital in Raigarh who had brought in women seeking sterilization.

ANMs and MPWMs also are making blood slides to be tested for malaria (active case detection). See Diagnostics section below for suggestions.

UTILIZATION OF UNTIED FUND

Untied fund and JDS monies are hardly being used although many improvements are needed in the facilities as noted above and below. One reason given was that the committees meet very rarely. The other reasons were lack of awareness about untied funds and how to spend them, and unavailability of laid-down rules and procedures.

Even at the Sub-centre level funds are unspent. In one village, however, an active VHSC was spending the funds as well as obtaining additional funds/donations in kind for village sanitation, FP camps, etc.

Recommendation

The JDS's need to be encouraged and facilitated to utilize the funds at their disposal rather than accumulating it without a prospective plan. In addition to maintenance and repairs which could be outsourced, they could improve patient amenities and contract in clinical staff (e.g., nurses). Since meetings are not being held, a limited set of 'auto-approved' items could be suggested on which the institutional head could spend to maintain specified standards. The state/districts could also (or alternatively) mandate a 'fixed-day meeting' so that decisions can be taken locally. Simple guidelines for spending of untied funds should be developed at state or district level, and supplied to all Sub-centers. Providing standard purchase and repair rates (allowing 10% variation) could also be helpful.

ANMs reported that a good number of deliveries are attended by them at home. They also informed the team about a higher number of still-births among home deliveries. Hence, it is important to develop protocols for them and conduct training for them to properly supervise deliveries at home.

THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

The team found that access to health facilities is still a significant problem in the remote areas of Raigarh and Bastar. This explains to a great extent why the ANC coverage is less than 50% and institutional deliveries only 37% according to the state.[1] Most of the women who are not tracked by the health system live in underserved areas, and it is likely that most maternal and infant deaths are taking place amongst them. ANMs conduct deliveries at home without any clear protocol/instructions or kit, and an emergency management system is not in place.

In addition to Untied Funds, the JDS's are collecting funds through user fees levied at their facilities. User charges are well advertised at facilities and user fee records in Raigarh showed that up to 90-95% of patients may be charged for diagnostic tests, medicines, supplies (e.g., saline and glucose drips), deliveries, etc. They were also charging for patients' food (although cooking facilities at the centres are inadequate) and, in some cases, have started levying high charges. Those charged most likely include BPL patients as 46% of the state's population is below the poverty line. Indeed, the team observed that most of the patients at the facilities were poor.

With regard to gender aspects, it was noted above that women's toilets leave much to be desired. While screens were available to provide privacy in examination rooms, and labour rooms were generally secluded, window screens were less in evidence and the crowding of waiting areas and women's wards in some facilities (including large numbers of patients' attendants) denied women privacy in other circumstances.

Recommendations

Fully-equipped mobile RCH teams could provide fixed-day services at remote locations to manage ANC, PNC and newborn care in addition to IEC and vector control activities. The team should provide

[1]. According to DLHS-3 institutional delivery in the state was 18% in 2007-08.

the entire range of services in addition to treatment of minor ailments. VHSCs should be actively involved in the selection of fixed sites for the mobile RCH clinics. An Emergency Medical System (EMS) could be developed, for which PPP models may be explored as there is a possibility of tying up with industrial houses and other private agencies at least in Raigarh.

As the NRHM and state mandate that BPL patients should be treated completely free, instructions need to be issued to eliminate the practice of charging them. This should be strictly implemented and monitored.

QUALITY OF SERVICES

Clinical protocols for active management of third stage labour, infection control, labour room management and partographs are not being used even in the District Hospital in Raigarh. The hospital is a training centre for ANMs and Nurses and the DH staff have also trained one batch of Trainers under the NRHM SBA training. Similar observations were made at the Medical College Teaching Hospital in Bastar.

In Basthar the team witnessed Laparoscopic sterilizations in a CHC. More than 70 surgeries were being carried out. The laparoscopes were not properly sterilized with Antiseptic solutions after every case. Instead they were washing the scope in hot water. The Standard operating procedures (SOPs) were not seen in any of the hospitals

An anomalous finding of the team was that expensive equipment was being bought but not used in Bastar (such as phototherapy units, lead protection equipment, electrophoresis machines, etc).

Biomedical waste management which is a statutory requirement was not observed at any level (CHCs, PHCs and SCs).

Several other aspects of quality have been discussed above.

Recomendations

To ensure quality improvement of services and develop 'women and child friendly' facilities, the facility teams could be trained to do a gap analysis and set the deficiencies right. If this self-improvement process is put in place, JDS money could be well utilized and pride in and ownership of quality services would increase. Some of the aspects on which quality improvements need to focus are given below.

- Clinical protocols (SOPs) (e.g., for labour rooms, LTT) should be put in place and displayed, and the hospital staff should practice them unfailingly.
- Cleanliness of facilities requires major emphasis, including toilets and running water (e.g., in labour rooms).

- Adequacy of facilities for basic diagnostics (e.g., Hb measurement, malaria, VDRL, routine urine exam).
- Biomedical waste management training programs and logistics need to be made available as BMWM is a statutory requirement.
- Basic patient care inputs (e.g., bed-nets to prevent cross-infection given the high Pf rates in the forest areas).
- Multi-skilling of doctors in the CHCs to handle common emergencies and RCH.
- Behaviour of staff. In particular, the facilities should be gender-sensitive, and women should be provided with facilities that enable them to deliver with dignity.
- Provision of free food for all in-patients.

DIAGNOSTICS

The team met some Lab Technicians and found them to be interested in their work and carrying out a variety of tests (malaria slides, Hb measurement, blood cell counting and sputum testing were observed most commonly). However, the supply situation is poor. The overall system for diagnostic tests needs to be streamlined, particularly through the provision of reagents, supplies, kits, etc.

In several cases, blood slides collected by ANMs/MPWMs were collected at the PHC labs, and were not being processed. In other cases, the LT was carrying out the test and recording results – but the MOs did not review the results, and report-back and follow-up systems were missing.

While VDRL tests are expected to be available at District Hospitals and CHCs, it appeared that VDRL and HIV testing were not being done even at the district hospitals visited. While ICTCs are 'advertised' they do not seem to be actively providing counseling.

In some places LTs were not in position or not working. In Bastar, although contracts for Lab and Xray technicians had been made, these had not been renewed. Therefore, many PHCs were not performing lab investigations, as the LTs had left them.

Recommendations

Review of diagnostic facilities and processes should form a part of the recommended facilities survey, with a focus on the availability of Technicians, equipment and supplies, and communication of the results to the appropriate persons.

Contracting and renewals for personnel such as Lab Technicians could be decentralized at least to the district level.

Establishing/improving functioning of existing ICTC/VCTC centres for HIV counseling and testing.

LOGISTICS AND SUPPLY CHAIN MANAGEMENT

In Bastar some life-saving drugs and others were not available or were being poorly managed (e.g., Insulin, ASV - not refrigerated – there was circular that ILR refrigerators should be used only for

vaccines and not be used for other life saving drugs!). Many of the drugs did not have the Govt of Chattisgarh seal on them and the officers were not sure how and from where they were supplied. Many non-essential drugs – which were not in the Essential drug list of the state were found.

Most facilities had a good stock of medicines and supplies, but inventory and store management were poor, including adherence to 'FIFO.' It was observed that even the Sub-centres have BP monitors and weighing scales that are not working, while similar new equipment is piled up at the PHCs/CHCs. The excess of some medicines/supplies and equipment in some facilities suggests that there may be duplication of procurement at state, district and local levels.

The team found that even when supplies appeared to be available under NRHM, large prescriptions were being written for outside purchase of drugs (e.g., for malaria and deliveries)

In some places, unnecessary 'high end' equipment such as digital BP monitors and anesthetic agents such as halothane were found where no surgeries/anesthesia done.

For the most part, ambulances were found to be used sparingly or were not functioning at all.

Recommendations

Key aspects to which attention needs to be given are:

- Elimination of 'outside prescription' except when absolutely unavoidable
- A list of essential and life-saving/emergency drugs should to be made available at each CHC, PHC and SC
- Proper storage of life-saving drugs
- Training of store managers particularly to ensure FIFO and timely use of medicines/supplies
- Need-based planning of equipment purchases and assessment of equipment purchased
- Distribution of stocks to peripheral facilities
- Establishing an Emergency Medical System (ambulance transport).

DECENTRALIZED PLANNING

District ROPs have not been shared with the district health societies nor approvals with the DPMUs or CMHOs. The result is that the district health managers are not aware of their allocations and they are finding it difficult to get approval.

The process of preparing the District Plans for 2009-10 was not based on need (data) nor on visits to facilities. Orientation was done by different support agencies, and time was short. All districts did not prepare full-fledged plans; some were just budget heads. More time will be available to prepare the 2010-11 District Plans, and the DPMU in Raigarh proposes to engage appropriate human resources, orient staff, make separate block-level plans and aggregate these into the District Plan. It will need vehicles, support and interest from the CMHO.

Recommendations

The ROP should be shared so that one-time approval of the DHS can be obtained for expenditure. Other generic approvals for the functioning of the DPMUs are also needed so the individual written orders are not sought by supervisors.

DECENTRALIZED LOCAL HEALTH ACTION

As described above, JDS's have been collecting funds and are also receiving the untied grants under NRHM. These funds are hardly utilized, and there are no plans for utilization, in part because the committees are not meeting regularly. While the funds are accumulating, facilities are suffering from a lack of improvement.

VHSCs have been formed widely throughout the state, and in some instances were found to be working toward 'clean villages' and assisting with family planning camps and VHNDs (particularly supplementary feeding).

Recommendations. The JDS committee and PRIs need to be oriented to NRHM, their roles and responsibilities, and program procedures. JDS's need to ensure that the facilities for which charges are being levied are in working order, in accordance with the suggestions made above. The team has recommended that the Samitis be asked to meet regularly on fixed days, and suggests that these meetings be attended by knowledgeable resource persons from the district or state to facilitate good plans and decisions. A system of 'auto-approved' items of expenditure may also be put in place to ensure adherence to certain standards, for example, for adequate water supply, lighting, safety, solid waste disposal, cleanliness of facilities, repair of equipment, etc. Other possible measures to make the JDS's more functional include changing the Chairpersons, including civil society members and other officials. Still other ways of improving the functioning of the JDS's and VHSCs may be developed and implemented as this is an important aspect of the NRHM that needs to be well operationalized. The pilot projects on community Monitoring done by NGOs needs to be scaled up to cover all the villages.

COMMUNITY PROCESSES UNDER NRHM

VHSCs (and JDSs) have been set up but villagers don't know about them. They also need capacity building to enhance decisions to spend untied funds and participation in village activities.

BCC activities need to be strengthened for awareness.

Community monitoring was not seen as there are only three pilot districts in the state. Monitoring to find out how many Mitanins are working, facilitating safe deliveries, etc. would also be useful.

Other activities are covered below in the section on Mitanins, etc.

MITANINS – CHHATTISGARH'S ASHAS

The team found Mitanins to be present, enthusiastic, knowledgeable, committed and working well with their communities. They serve a population of 300 (50-60 households) only, which enables them to know their clients well, and record all significant information. This information could be used to track mothers and children and build services for them in a systematic manner, as there is currently a gap between the high level of community activity by the Mitanins and the use of essential services by their clients.

The interpersonal communication by Mitanins appears to be successful as mothers whom the team met at the VHND gatherings were aware of pregnancy care, immunization, growth monitoring and so on. The Mitanins also had drug kits and were using them.

Their small populations and limited incentive payments mean that Mitanins currently earn very little. Further, in Bastar, Supervisers did not know how much Mitanins are earning. Some 'non-functioning' Mitanins were found in Naxal areas and in some other areas where there was a lack of supervision and monitoring.

Mitanins have a different training and supervision system from those of ASHAs and AWWs. Many have been in position for seven years, during which time they have received several modules of training as well as regular refresher training. However, Mitanins (and AWWs) do not have a career growth path.

Recommendations

To sustain their interest in the program, opportunities to pay more incentives to Mitanins could be explored. For example, they could be asked to roll out other services – such as Adolescent Health care - for which they could be paid. They may also be given incentives to use the household information they have to ensure coverage of mothers and children with 'life-cycle' services. They could list all mothers and children in the households they supervise and track each pregnancy until the child born is five years of age. A suitable incentive scheme for achievement of important milestones could be worked out.

To ensure that Mitanins are paid and develop a database of performance, a passbook system could be introduced wherein a record is kept of tasks done and payments completed.

Further, interest may also be sustained by developing career advancement avenues. The team recommends that Mitanins and AWWs be considered for ANM and GNM training (after selection according to Nursing Council norms).

The model for Mitanin training and supervision may be looked into by other states and GOI to develop ASHAs and AWWs elsewhere.

First and second referral to government facilities needs to be clarified and strengthened.

NATIONAL DISEASE CONTROL PROGRAMMES

Malaria

Table 5. Epidemiological situation of Malaria

Year	Pop. in 000's	BSE	ABER	Total Positive	*Pf*	*Pf%*	API	SPR	SFR	Deaths	Remark
2004	23469	3598383	15.33	194256	148695	76.59	8.28	5.40	4.13	4	No. of deaths reported is very low (particularly in pregnant women) considering that the state is malaria hyperendemic in Bastar and Raigarh.
2005	23469	3874911	16.51	187950	140182	74.58	8.01	4.85	3.62	3	
2006	24123	3770468	15.63	190590	147766	77.53	7.90	5.05	3.92	3	
2007	24632	3509666	14.25	147615	103016	69.79	5.99	4.21	2.94	0	
2008	24777	3041667	12.28	123495	94803	76.77	4.98	4.06	3.12	0	
<Sep 2009		2120657	8.76	79453	63096	79.41	-	3.75	2.98	4	

Raigarh is a 'High Pf' district - 90% of malaria cases as caused by Plasmodium falciparum. However, only in one facility were RDKs found, and these had expired. Link workers under the (earlier) Malaria Control program had been given no training, but had started collecting blood smears. Although smear collection was being done by ANMs and MPWMs, these were accumulating at the labs and in some cases were not being examined. MOs were not reviewing the lab records, and no feedback was being provided to the source of the positive blood slide except in the facility in which the lab was located.

Despite the high incidence of Pf in the state, only 4 deaths were recorded in the first six months of 2009-10 (which includes the high transmission season). This shows the decline of malaria surveillance in the state.

Management of malaria at the facilities is poor. There is a lack of bednets even in wards in the crowded health facilities. In addition, as noted above, patients in Bastar had high out-of-pocket expenditure on account of medicines being prescribed for outside purchase .

There is no active environmental control of the vector.

Recommendations. The availability of diagnostics (RDKs, lab supplies, Technicians, etc.) needs to be strengthened. A system to follow-up positive cases also needs to be put in place. This applies to TB (below) as well.

Bednets should be provided to in-patients to avoid cross infection.

A biological and/or IRS based environmental vector control system (with timely procurement and use of pesticide) needs to be developed and actively implemented.

A dialysis unit is needed at the DH to handle cases of renal failure due to malaria or snakebite.

Tuberculosis. DOTS providers are in place and treatment is being given. However, only cases that are coming to facilities where there is a lab are being detected as there is no detection through outreach.

Recommendation. There may be a need in some areas to carry out screening through outreach. The proposed Mobile RCH team could also detect cases and start treatment through DOTs providers or Mitanins.

Leprosy. In Basthar though there was a full time Leprosy program officer the case detection was poor. The integration Leprosy vertical program in to the Primary health care system has not been effectively implemented.

Cataract Blindness. Active screening for cataract and surgeries are being performed largely through camps, for which modern ophthalmological equipment is available. Unfortunately, the team did not witness any camps. However, it learned that the availability of ophthalmologists is low and, at the state level, 50% are not operating (i.e., they have become 'deskilled'). As a result, there has been a steady decline in the number of cataract surgeries performed in the state. Against a constant target, the achievements were 103% in 2007-08, 87% in 2008-09, and 22% in the first six months of 2009-10. There is a backlog in payments to NGOs in Bastar which needs to be rectified.

Recommendation: Screening could be done by the mobile RCH teams and patients referred to a 'fixed day camp.' Rationalizing the deployment of doctors may help to carry out more camps in pre-decided areas and days.

Iodine Deficiency Disorders: Salt testing kits were available at the VHND, and were being used to test samples. The state has not surveyed any districts in the current year and the number of samples tested for iodine was nil in 2008-09 and 2009-10 (thus far).

Integrated Disease Surveillance Programme: No Surveillance cell was found. In Bastharthe Disease surveillance unit at DHO office was locked when the team visited the office. The IDSP is very weak.

REPRODUCTIVE AND CHILD HEALTH

Janani Suraksha Yojana (JSY):. At all facilities visited, the team found that JSY posters, and boards giving information about amounts being paid under JSY as well as numbers of cases in the month and in the year were displayed prominently. Patient records and verbal reports from clients and staff in Raigarh revealed that mothers who came to the facilities to deliver were staying at least 48 hours, and were receiving their JSY payments. The payments are made by bearer cheques, usually within 7 days though not necessarily at time of discharge. However, the team found the names of JSY beneficiaries displayed only at one facility in each district (Lailunga CHC in Raigarh). The situation was quite different in Bastar – the duration of stay was low, records were poor, there was a backlog of payments and no advances. But improvements are underway.

JSY coverage overall is low (under 40%). Only 22% of deliveries in the state take place in public health institutions. Hence the vast majority are still home-based. Less than half of these may be supervised (the state has no information on safe home deliveries). ANMs do not have a kit or instructions to manage these deliveries. Payments are also being made for home-based deliveries, although these may be somewhat delayed. Hence, there is great scope for improvement. A large number of stillbirths were reported by ANMs and Mitanins to the CRM team – these may in fact be neonatal deaths, and should be investigated.

Demand creation for Institutional Delivery: Mitanins, AWWs and ANMs report that they try to encourage mothers to deliver in a health facility, but access is still an issue and hence the response of mothers is weak. The state is piloting a 'Matari express' (similar to the Janani express) in one district (Bilaspur). Available ambulances are not used for obstetric or other emergencies. The state has only 13 blood banks in the districts – i.e., three of the original 16 districts do not have blood banks at all. Currently only 12 FRUs are reported to be functioning in the state.

Maternal Death Audits: Although state and district MDA committees, and a system originating with ANMs for death reporting have reportedly been set up, no information on audits conducted was available in the districts. See below for the team's recommendations.

Neonatal Care: Equipment for neonatal management such as resuscitators and warmers were mostly out of order or not in use. Newborn corners were not in evidence in any of the facilities except the DH in Raigarh. Here, the JDS had received Rs. 40 lakhs for home-based neonatal care, but there was no plan yet for its use.

Immunization: As VHNDs are taking place and focusing largely on immunization, coverage of mothers and children is good. AWWs are keeping immunization cards, and appear to be following up in time. However, mothers may not be coming to VHNDs during the fifth and ninth months of their child's life (when no vaccinations are due), a period that is critical for weaning and supplementation of infants.

Family Planning: The state's FP coverage is low (below national average). It is still focusing on laparoscopic tubectomy through the camp approach at CHCs. At a 'mega camp' in Bastar, lapascopes were being washed in warm water between patients. Male sterilization accounted for 25% of cases in Bastar. Spacing methods are hardly being promoted.

Safe abortion services were not being provided in any of the facilities visited, although the state reported that services were available in the district hospitals and in private accredited hospitals. The state has no data on safe abortions provided. Nischay kits were available and the early detection of pregnancy that they allow could help to provide timely and safe abortion when requested.

RTIs/STIs and HIV/AIDS: The state reports that RTI/STI services are provided at all District Hospitals and CHCs, and in one-third of PHCs. There was no VDRL or HIV and testing in any facility. No mention was made of RTI/STI management at any facility. ICTCs were seen to be advertised in a couple of facilities, but were not functioning during the times of the team's visits.

ARSH: There are virtually no adolescent health activities in the state. The team was informed that the Department of Women and Child had been running Adolescent Girls' centres earlier and providing some iron supplementation, but these were no longer functional. School health programs (which could also be used for weekly iron supplementation) are also not running. The high maternal anemia in the state warrants an active thrust on iron supplementation of adolescent girls as well as instruction in nutrition and other reproductive and sexual health topics.

Recommendations

The team recommends that, as long as institutional deliveries in the state are low, ANMS be provided protocols and a kit to provide proper attention to all the home-based deliveries if their clients refuse to or are unable to go to an institution. They may also be provided performance-based incentives for supervised deliveries at home. In areas where these are potentially useful they may be given mopeds/moped loans along with training to drive them.

Another useful strategy in the situation of Chhattisgarh where many villages still remain remote from health centres is to provide maternity waiting-rooms (with free food for the mother and an attendant) at PHCs and CHCs. This may encourage women to come to the facilities for deliveries.

Mobile RCH teams could be created to conduct fixed day camps in remote locations after advertising the dates.

Where facility-based services are being utilized (e.g., Lailunga CHC), the facilities need to be strengthened with additional staff (and wards), which would in turn reduce the load on the DH.

An Emergency Medical System must be put in place(for all medical emergencies), especially for the difficult tribal areas. This could be along the lines of the EMRI ("108") services in Andhra Pradesh.

As several districts in the state are endemic for malaria, which is a significant cause of maternal death, priority should be given to pregnant women in the distribution of bednets. All facilities need to use bednets in the wards to prevent cross-infection.

Maternal death reporting. As Mitanins have data on their families it could be used to track pregnant women and identify maternal and infant deaths. The deaths of all women in the 15-49 year age-group should be followed up with an audit. Stillbirths and neonatal deaths may also be investigated.

Newborn care needs full-fledged improvement.

Urban primary health care programs covering slum areas are needed.

PREVENTIVE AND PROMOTIVE HEALTH ASPECTS

There was widespread evidence of wall-written health messages and information charts and posters at the facilities, but this is not as evident in the villages. However, Mitanins and AWWs appear to be providing good inter-personal communications.

Recommendation: However, several references have been made above to the need to improve preventive and promotive measures, for example, in malaria, maternal and child care, and ARSH. A concerted BCC strategy and implementation may be useful.

INTER-SECTORAL CONVERGENCE

Local Government: The role of PRIs is limited except in the VHSCs and some membership of the JDS's. The CMHOs are expected to attend ZP meetings.

Formal coordination at the District and Block levels is weak. For example, the Revenue department in Bastar does not cooperate well, resulting in approvals being delayed. In Raigarh, a case in point is the slow response of the PWD mentioned above to the needs of the Raigarh District Hospital. This could have been facilitated by the District Collectors' office.

ICDS: Convergence with ICDS at the village level appeared strong. The Mitanins, AWWs and ANMs were found to be working together at the two VHNDs, which were held at the AWCs and were providing good services. Mitanins are also helping ANMs to collect vaccine (and getting payment). There were reports of convergence with women's SHGs.

Water and Sanitation: There is a need for convergence with the PHED for water supply, storage and testing. The situation vis a vis water supply was mixed - some facilities had ample water flowing, but no systems to provide water to labour rooms, etc.

Recommendation: The lack of toilets could be addressed by the Total Sanitation Campaign; and NREGA could be used to improve the grounds of facilities, environmental sanitation, and to put in gardens and sheds for use by patients/attendants.

NUTRITION

While malnutrition is likely to be highly prevalent in the villages, the team could not assess this. AWWs are and carrying out growth monitoring and keeping growth charts on their children, and providing nutritious food. Mitanins are giving counseling on the feeding of mothers and infants, including early initiation and exclusive breastfeeding. They are also referring malnourished children to health facilities but there does not appear to be any facility-based care as severely malnourished children were not seen at the facilities.

Anemia is not being adequately addressed among pregnant women or adolescents, and very low Hb levels were frequently reported among pregnant women. The Mitanins' drug kits include IFA.

Vitamin A is being administered and wall-written messages were seen widely.

Recommendation: Interventions against anemia need to be improved, including early detection, de-worming, provision of IFA or par-enteral iron, and food-based supplementation. As noted above, weekly IFA supplementation of adolescents could be implemented through Mitanins. A strategy for children is also needed.

NGO PARTNERSHIPS

The team did not find any involvement of NGOs in Raigarh except for those who are training Mitanins. These seem to be doing well as the Mitanins are doing good work. The District Hospital at Raigarh had an OPD wing established by a well-known company as part of their Corporate Social Responsibility. In Bastar, a highly respected NGO is involved in eye camps and other activities on behalf of the state, but payment to it has not been prompt. Besides these, there was no mention of innovations or PPPs.

Recommendation: The state needs to explore PPPs to boost its infrastructure, management and service provision including, for example, to set up the recommended mobile RCH teams and PHC management by NGOs. These may be possible because of the existence of a large number of industries in Raigarh district and the likelihood that there will be more who will set up factories, etc. and with NGOs in other parts of the states.

OVERALL PROGRAM MANAGEMENT

The state PMU is in place. SPMU staff report that 80% of their time is spent on activities such as CRMs/JRMs, Vidhan Soudha, departmental meetings, etc. They felt that many of the points made by the CRM team were recorded in the minutes of various meetings, but that there is no follow-up by those in charge of implementation.

A DPMU was in place in Raigarh but not in Bastar. Block level staff are being recruited now by the SHRCs (two out of nine BPMUs are in place in Raigarh). The working relationship between the DPMU and the CMHO needs to be streamlined as problems are being encountered currently. For example, while the DPM has been verbally authorized to hire a vehicle, the CMHO is asking for written orders. State-level instructions are often not routed through or copied to DPMU, so that they do not know what is to be done.

Supportive supervision is not in place although facility visits are being done as a formality (e.g., to SHCs). Sector meetings are to be held weekly, but they do not have any 'outputs', and a monthly frequency would be adequate.

The DPMU team is in a better position this year to develop District and Block Health Plans as discussed above.

Recommendations. SPMU staff should also be released from other unnecessary/non-NRHM tasks so that they can concentrate on travelling to and assisting the districts.

DPMUs could put in place TORs for key staff to do their specific jobs (including the Hospital Administrator at the DH).

Program management information/instruction flow can be improved using e-mail with copies to all concerned.

The data from the on-line system (see below) could also be used for the district, block and facility planning that is to be done.

There is need for better integration of the NRHM with existing health efforts – which could be facilitated by full orientation of the key staff at state and district levels. The state could appoint a nodal officer for each district who facilitates the district to actively implement the program and obtain health department support when needed, and reviews the district's performance regularly. This would help to improve ownership of NRHM by the state and districts.

Monitoring needs to be strengthened through regular and meaningful visits from district to block level and to the facilities below. This could be supported by checklists for supervisors to review outputs. Both sector Supervisors and Doctors should visit their facilities monthly and carry out supportive supervision.

FINANCIAL MANAGEMENT

Chartered Accountant firms (selected through an open tender system) have just been hired to conduct concurrent audits monthly. They are visiting the districts. The audit report for FY 2008-09 has been prepared and sent to the District Headquarters. The DPUs were not adequately staffed. The accountants were not appointed and hence the financial management was weak. The utilization of budget s was poor

DATA MANAGEMENT

The state has developed a daily on-line data reporting system which the team observed was functioning at the district level and CHC level, and is being spread at the PHC level. Fifty percent of PHCs (those which have electricity connections) have been provided computers. At those which do not have electricity, data will be collected manually from the facilities and uploaded at the district level. The format for primary data capture has been developed, as well as the basic registers. Only a small proportion of data is being collected and quality is also an issue currently.

Recommendation. The system needs to be fully operationalized and data quality monitored and improved constantly.

Progress of Implementation

Table 6. Overall position of NRHM, Year-wise Progress and Financial Data, October 2009

	Administrative structure of the state (as per RHS Bulletin- 2006 published by RHS Division)		
1	Rural Population	**1,88,49,651**	
2	No. of Districts	18	
3	No. of Blocks	146	
4	No. of Villages	20,344	

	Rural Health Infrastructure		Present Status	
5	Number of District Hospitals		16	
6	Number of Sub Div. Hospitals (incl. Civil Hospitals)		17	
7	Number of CHCs		143	
8	Number of PHCs		716	
9	Number of SCs		4,776	
10	Number of Anganwadi Centres		29,355	
11	Number of VHSC Constituted & Operational			
12	IMR	SRS 2008	59	
		NFHS 2006		
13	MMR	SRS 2008	335	
14	TFR	SRS 2008		
		NFHS 2006	2.62	
15	Sex Ratio	Census 2001	989	
16	Unmet Need	NFHS 2006	10.5	

Institutional Framework of NRHM				
17	No. of meetings of State Health Mission held till date (09-10)		3	
18	Total No. of meetings of District Health Missions held till date (09-10)		19	
19	Merger of Societies	State Y/N	Yes	Only 7 districts out of 18 have merged their accounts.
		No of Districts	7	
20	No. of Rogi Kalyan Samitis registered	DH	16	The JDSs meet infrequently resulting in poor use of user charges collected. Also, the user charges are excessive & collected from almost all in-patients.
		CHCs	129	
		PHCs	695	
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			The Mitanins were found to be enthusiastic and aware of health-related issues. Efforts may be made to have line-listing of pregnant mothers and children under-five for better tracking.
23	No. of ASHA selected during (including ASHA in tribal areas in Non-High Focus States)	05-06		
		06-07		
		Total	59489	
24	Training Calender of ASHA finalised (Y/N)		Yes	(13th round of training going on)
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**	Mitanins have been given drug kits. They also dispense antibiotics. This may be looked into by the state as prescription drugs are not to be dispensed by non-qualified persons.
		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 state08-09	Expected		
		Achieved	**63518**	
Infrastructure and Human Resources				
Sub Centres (SCs)				
29	No. of SCs in Govt. Building (RHS Bulletin-2007)		**1458**	
30	No. of SCs functioning with at least one ANM (RHS Bulletin 2007)		**3263**	Running water was found to be a problem in most of the sub-centres visited. 2nd ANMs have not been recruited by the state.
31	No. of SCs which are functional without ANM (RHS Bulletin 2007)		**255**	
32	No. of SCs where Joint Account with has been Operationalised		**4776**	
33	No. of SCs with additional ANMs		0	
34	Percent of SCs submitted UC for untied funds released 2005-06			
Primary Health Centres (PHCs)				
35	Total No. of PHCs functioning on 24x7 basis	on 31/3/2005	125	
		during 08-09	418	

		during 09-10		319	
36	No. of PHCs where three staff nurses are positioned			0	The team found an acute shortage of staff nurses in every PHC visited.
37	No. of PHCs without a Doctor (as per RHS Bulletin 2007)			216	PHCs were found to be grossly underutilized. There was a mismatch between the skill sets of the staff resulting in poor off-take of services. The tendency of the PHCs for immediate referral without management also encourages people to skirt the primary health centres. This leads to both poor service delivery on the one hand and crowding of the DH on the other. RMAs have been posted recently. Their performance needs to be closely monitored.
Community Health Centres (CHCs)					
38	Total No. of CHCs selected for upgradation to IPHS			40	The state has initiated a process of posting personnel after counseling. This is a welcome step. Facility upgradation should be undertaken in those facilities having proper HR and infrastructure.
39	Total No. of CHCs where facility survey has been completed			129	
40	No. of CHCs where physical upgradation work has been taken up	Identified		96	CHC upgradation work was seen at Lailunga.
		Started		70	
		Complete		17	
41	Total Specialist post at CHCs (as per RHS Bulletin-2007)	Required		472	There is a severe shortage of Gynecologists and Anesthetists. Doctors who have undergone LSAS training have not been certified. Refresher course required for their certification must be conducted urgently.
		Sanctioned		700	
		In Position		49	
First Referral Units (FRUs)					
42	No. of FRUs working as on Year 2009-10	SDH		0	Blood bank is available only at the district headquarters. Blood storage units have been supplied but not yet installed. The FRUs have an acute shortage of specialists.
		CHC		40	
43	No. of centres upgraded as FRUs (05-06)	SDH		0	
		CHC		0	
		PHC		0	
44	No. of centres to be upgraded as FRUs(06-07)	SDH	Expected		
			Achieved		
		CHC	Expected		
			Achieved		
		PHC	Expected		
			Achieved		
District Hospitals					

45	Number of District Hospitals			16	
46	No. of DH which are of FRU level			16	The District Hospital at Jagdalpur was not functioning as an FRU.
47	No. of DH where physical infrastructure is being upgraded			-	
Availability of Consumables					
48	% of centres with at least 2 month supply of essential drugs	CHCs			Drugs were available at the health centers but their inventory management needs to be improved.
		PHCs			
		SCs			
49	% of centres with at least 2 month supply of vaccines	CHCs		100%	Overall vaccine supply was adequate; however, refrigeration at DH, Raigarh was not maintained as per protocol. Power backup was available at some facilities.
		PHCs		100%	
		SCs		100%	
50	% of centres with at least 2 month supply of contraceptives	CHCs		100%	
		PHCs		100%	
		SCs		100%	
Human Resources					
51	No. of contractual manpower positioned (06-07)	Specialists	Expected		State needs to fill up the posts of contracted specialists immediately as none of them have yet been appointed. Similar position exists with reference to ANMs. RMAs have been recruited and posted at the PHCs. Their performance including their stay at facilities needs to be closely monitored.
			Achieved		
		Doctors	Expected		
			Achieved	429	
		Staff Nurses	Expected	716	
			Achieved	330	
		ANMs	Expected		
			Achieved		
		RMAs	Expected	1000	
			Achieved	858	
52	PMU setup at State level (Y/N)			Yes	Consultants' positions at the block level had not been filled up, leading to poor monitoring of the programme. Working of the DPMU needs better synchronization with the office of the CMO.
53	No. of Districts where PMU set up			16/18	
54	No. of Districts where the PMU has persons	Accounts		16	
		Managerial		16	
		MIS		14	
55	No. of Blocks where PMU set up			54	
Institutional Delivery					
56	No. of Institutional Deliveries as per NFHS-III			15.70	The stay of JSY beneficiaries at Raigarh was found to be 48 hrs. or more. However, this was not found at Bastar. Payments are being made through bearer cheques. Though no backlog of payment was seen at Raigarh, the disbursement

					was not found to be smooth in Bastar.
57	No. of Institutional Deliveries (in lakhs)		08-09	1.79	
			09-10	1.03	
58	No.of beneficiaries of JSY (in lakhs)		08-09	0.94	
			09-10	1.90	
59	No.of private institutions accredited under JSY		Expected		
			Achieved	117	
Decentralised Planning					
60	PIP Received (Y/N)		2006-07	Yes	The District Health Societies had not yet received the RoP of their districts, leading to problems in getting approvals from DHS. The district planning process is weak.
			2007-08	Yes	
61	Perspective Plan of the State Mission Period received (Y/N)			Yes	
62	Date by when Perspective State Action Plan under NRHM shall be finalised for Mission Period			Yes	Since the districts have not yet received their RoPs, execution of the programmes is not as per the proposals contained in the District plan.
63	No. of Districts where Annual Integrated District Action Plan under NRHM prepared for 06-07				
Immunisation					
64	Number of Polio Cases during 08-09			**0**	The State has not reported a polio case for the last 4 years.
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 09	279764	Shishu Suraksha Maah was being observed in the state during the time of the CRM visit.
			During last month	49425	
		DPT	since Apr 09	274867	
			During last month	48508	
		Measles	since Apr 09	271634	
			During last month	48907	
		Fully immunized	since Apr 09	275165	
			During last month	48853	
67	No of Districts where AD (.1ml, .5ml & 5ml) syringes are NOT available			**0**	AD syringes were available. However, the facilities did not have a proper disposal system.
Others					
68	No. of Districts where mobile medical units are working			0	MMUs were not found operational. The ambulances also do not seem to be used for referrals. Considering the low institutional delivery percentage, high MMR and the inaccessible and difficult terrain of the state, a fully functional MMU for carrying out RCH and disease control activities through outreach is recommended.

69	No. of Health Melas held		08-09	220	220 health melas were held in 2008-09. Data for the current year is not available.
			09-10	-	
70	No. of beneficiaries of Male Sterilisation 09-10		Expected	19469	Male participation in sterilization services in Raigarh was negligible; however, the percentage was encouraging in Bastar. Laproscopic services provided at Bastar were of poor quality (equipment not sterilized).
			Achieved	2322	
71	No. of beneficiaries of Female Sterilisation 09-10		Expected	175226	
			Achieved	19852	
72	No. of cases in prosecution under PNDT Act			0	
73	No. of cases in which action has been taken under PNDT			5	
74	No of districts implementing IMNCI			3	Though more than 50,000 persons have been trained in IMNCI, services were not found in the field.
75	No of People trained on IMNCI till date			57806	
76	Funds released for selection of MNGOs 06-07 (Rs. in Lakhs)			-	MNGO activity was not noticed in the areas visited.
77	Total No. of MNGOs in the state		as on 31-3-2004		
			Selected during 2005-06	7	
			Selected during (06-07)	2	
			Total	9	
AYUSH					
78	No. of PHCs where AYUSH practitioners have been co- located (05-06)		Expected		AYUSH activities were found non-existent in Raigarh. These practitioners were found dispensing allopathic medicines in Bastar.
			Achieved		
79	No. of PHCs where AYUSH practitioners are being co located (06-07)		Expected		
			Achieved	353	
80	Whether AYUSH officer included in (Y/N)	Health Society		Yes	
		State Mission		Yes	
		Rogi Kalyan Samitis		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			
		PHCs			
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 DO AYUSH)	2006-07			

FINANCIAL MATTERS						
FINANCIAL MANAGEMENT UNDER NRHM						
86	Allocation in State budget for Health & Family Welfare Department	2005-06	Amount in Rs		**32.61**	
			% of total State Budget			
		2006-07	Amount in Rs		**43.59**	
			% of total State Budget			
		2007-08	Amount in Rs		**48.66**	
			% of total State Budget			
		2008-09	Amount in Rs		**60.49**	
			% of total State Budget			
		2009-10	Amount in Rs		**62.71**	
			% of total State Budget			
FINANCIAL MANAGEMENT UNDER NRHM(Rs. Crore)						
87	Allocation by GoI under items subsumed within NRHM	RCH	Immunisation	2005-06		
				2006-07		
				2007-08		
				2008-09	**6.10**	
				2009-10	**9.26**	
				Total	**15.36**	
			JSY	2005-06		
				2006-07		
				2007-08		
				2008-09	**34.87**	
				2009-10	**57.40**	
				Total	**92.27**	
			RCH Flexipool (Including JSY)	2005-06		
				2006-07		
				2007-08		
				2008-09	**113.79**	
				2009-10	**107.89**	
				Total	**221.68**	
		IPPI (Pulse Polio)		2005-06		
				2006-07		
				2007-08		
				2008-09	**4.38**	
				2009-10	**6.72**	
				Total	**11.10**	
		NRHM Flexipool		2005-06		
				2006-07		
				2007-08		
				2008-09	**92.27**	
				2009-10	**144.30**	
				Total	**236.57**	
		Infrastructure Maintenance		2005-06		
				2006-07		
				2007-08		
				2008-09	**88.72**	
				2009-10	**88.60**	
				Total	**177.32**	

	Allocation by GoI under items subsumed within NRHM	NVBDCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**24.05**	
				2009-10	**26.82**	
				Total	**50.87**	
		NLEP		2005-06		
				2006-07		
				2007-08		
				2008-09	**1.68**	
				2009-10	**1.60**	
				Total	**3.28**	
		RNTCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**5.07**	
				2009-10	**6.32**	
				Total	**11.39**	
		NIDDCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**0.18**	
				2009-10	**0.18**	
				Total	**0.36**	
		NPCB		2005-06		
				2006-07		
				2007-08		
				2008-09	**3.62**	
				2009-10	**7.00**	
				Total	**10.62**	
		IDSP		2005-06		
				2006-07		
				2007-08		
				2008-09	**3.88**	
				2009-10	**1.55**	
				Total	**5.44**	
	Allocation by GoI under items subsumed within NRHM	Total statewise Allocation under NRHM		2005-06		
				2006-07		
				2007-08		
				2008-09	**378.61**	
				2009-10	**457.66**	
				Total	**836.27**	
88	Amount of PIP sent by the state to GoI for items subsumed within NRHM	RCH	Immunisation	2005-06		
				2006-07		
				2007-08		
				2008-09	**7.55**	
				2009-10	**9.67**	
				Total	**17.22**	
			RCH Flexipool (including JSY)	2005-06		
				2006-07		

				2007-08		
				2008-09	**124.87**	
				2009-10	**114.12**	
				Total	**238.99**	
		NRHM Flexipool		2005-06		
				2006-07		
				2007-08		
				2008-09	**92.27**	
				2009-10	**146.36**	
				Total	**238.64**	
		NVBDCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**27.05**	
				2009-10	**7.75**	
				Total	**34.80**	
		NLEP		2005-06		
				2006-07		
				2007-08		
				2008-09	**6.89**	
				2009-10	**1.92**	
				Total	**8.81**	
		RNTCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**6.76**	
				2009-10	**8.29**	
				Total	**15.05**	
		NIDDCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**0.12**	
				2009-10	**0.20**	
				Total	**0.32**	
		NPCB		2005-06		
				2006-07		
				2007-08		
				2008-09	**8.31**	
				2009-10	**8.59**	
				Total	**16.90**	
		IDSP		2005-06		
				2006-07		
				2007-08		
				2008-09	**2.70**	
				2009-10	**5.01**	
				Total	**7.71**	
89	Amount released by GoI under items subsumed within NRHM	RCH	Immunisation	2005-06		
				2006-07		
				2007-08		
				2008-09	**0.00**	

				2009-10	**0.00**	
				Total	**0.00**	
			RCH Flexipool (including JSY)	2005-06		
				2006-07		
				2007-08		
				2008-09	**63.01**	
				2009-10	**57.84**	
				Total	**120.85**	
		IPPI (Pulse Polio)		2005-06		
				2006-07		
				2007-08		
				2008-09	**6.72**	
				2009-10	**0.00**	
				Total	**6.72**	
		NRHM Flexipool		2005-06		
				2006-07		
				2007-08		
				2008-09	**54.18**	
				2009-10	**13.94**	
				Total	**68.12**	
		Infrastructure Maintenance		2005-06		
				2006-07		
				2007-08		
				2008-09	**88.72**	
				2009-10	**88.60**	
	Amount released by GoI under items subsumed within NRHM			**Total**	**177.32**	
		IEC		2006-07		
				2007-08		
				2008-09		
				2009-10		
				Total	**0.00**	
		Training		2005-06		
				2006-07		
				2007-08		
				2008-09		
				2009-10		
				Total		
		SIP		2005-06		
				2006-07		
				2007-08		
				2008-09	**0.00**	
				2009-10	**0.00**	
				Total	**0.00**	
	Amount released by GoI under items subsumed within NRHM	NVBDCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**6.26**	
				2009-10	**1.39**	
				Total	**7.65**	
		NLEP		2005-06		

				2006-07		
				2007-08		
				2008-09	**1.24**	
				2009-10	**1.24**	
				Total	**2.48**	
				2005-06		
				2006-07		
			RNTCP	2007-08		
				2008-09	**4.47**	
				2009-10	**1.50**	
				Total	**5.97**	
				2005-06		
				2006-07		
			NIDDCP	2007-08		
				2008-09	**0.00**	
				2009-10	**0.00**	
				Total	**0.00**	
				2005-06		
				2006-07		
			NPCB	2007-08		
				2008-09	**9.27**	
				2009-10	**0.00**	
				Total	**9.27**	
				2005-06		
				2006-07		
			IDSP	2007-08		
				2008-09	**0.00**	
				2009-10	**0.00**	
				Total	**0.00**	
				2005-06		
				2006-07		
			Total statewise NRHM Fund	2007-08		
				2008-09	**233.87**	
				2009-10	**164.51**	
				Total	**398.38**	
90	Amounts of expenditure done by States under items subsumed within NRHM	RCH	Immunisation	2005-06		
				2006-07		
				2007-08		
				2008-09	**1.77**	
				2009-10	**0.23**	
				Total	**2.00**	
			RCH Flexipool (including JSY)	2005-06		
				2006-07		
				2007-08		
				2008-09	**42.66**	
				2009-10	**4.70**	
				Total	**47.36**	
			PPI	2005-06		
				2006-07		
				2007-08		

	Amounts of expenditure done by States under items subsumed within NRHM		2008-09	**6.39**	
			2009-10	**0.04**	
			Total	**6.43**	
		NRHM Flexipool	2005-06		
			2006-07		
			2007-08		
			2008-09	**15.44**	
			2009-10	**1.63**	
			Total	**17.06**	
		Infrastructure Maintenance	2005-06		
			2006-07		
			2007-08		
			2008-09	**65.59**	
			2009-10	**17.35**	
			Total	**82.95**	
		NVBDCP	2005-06		
			2006-07		
			2007-08		
			2008-09		
			2009-10		
			Total	**0.00**	
		NLEP	2005-06		
			2006-07		
			2007-08		
			2008-09	**1.50**	
			2009-10	**0.14**	
			Total	**1.64**	
		RNTCP	2005-06		
			2006-07		
			2007-08		
			2008-09	**4.89**	
			2009-10	**0.21**	
			Total	**5.10**	
		NIDDCP	2005-06		
			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**0.00**	
			Total	**0.00**	
		NPCB	2005-06		
			2006-07		
			2007-08		
			2008-09	**3.77**	
			2009-10	**0.62**	
			Total	**4.39**	
		IDSP	2005-06		
			2006-07		
			2007-08		
			2008-09	**0.74**	
			2009-10	**0.10**	

				Total	**0.83**	
		Total statewise NRHM Expenditure		2005-06		
				2006-07		
				2007-08		
				2008-09	**142.75**	
				2009-10	**25.02**	
				Total	**167.76**	
91	Unspent amount available with state out of funds released by GoI under items subsumed within NRHM	RCH	Immunisation	2005-06		
				2006-07		
				2007-08		
				2008-09	**0.59**	
				2009-10	**0.36**	
				Total	**0.95**	
			RCH Flexipool (including JSY)	2005-06		
				2006-07		
				2007-08		
				2008-09	**24.19**	
				2009-10	**35.29**	
				Total	**59.47**	
		IPPI (Pulse Polio)		2005-06		
				2006-07		
				2007-08		
				2008-09	**0.61**	
				2009-10	**0.57**	
				Total	**1.18**	
		NRHM Flexipool		2005-06		
				2006-07		
				2007-08		
				2008-09	**127.28**	
				2009-10	**139.59**	
				Total	**266.87**	
	Unspent amount available with state out of funds released by GoI under items subsumed within NRHM	NVBDCP		2005-06		
				2006-07		
				2007-08		
				2008-09		
				2009-10		
				Total	**0.00**	
		NLEP		2005-06		
				2006-07		
				2007-08		
				2008-09	**0.18**	
				2009-10	**0.79**	
				Total	**0.97**	
		RNTCP		2005-06		
				2006-07		
				2007-08		
				2008-09	**0.51**	
				2009-10	**0.31**	
				Total	**0.82**	
		NIDDCP		2005-06		

			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**0.00**	
			Total	**0.00**	
		NPCB	2005-06		
			2006-07		
			2007-08		
			2008-09	**6.09**	
			2009-10	**5.48**	
			Total	**11.57**	
		IDSP	2005-06		
			2006-07		
			2007-08		
			2008-09	**1.18**	
			2009-10	**1.08**	
			Total	**2.26**	
		Total NRHM Fund	2005-06		
			2006-07		
			2007-08		
			2008-09	**160.63**	
			2009-10	**183.46**	
			Total	**344.10**	
DETAILED DATA ON NRHM ADDITIONALITIES (Rs.Crore)(State PIP approved amount for 2007-08,08-09)					
92	Funds released for selection/ training of ASHA		2005-06		
			2006-07		
			2007-08		
			2008-09	**15.00**	
			2009-10	**15.00**	
			Total	**30.00**	
93	Untied grant	SC	2005-06		
			2006-07		
			2007-08		
			2008-09	**4.70**	
			2009-10	**4.74**	
			Total	**9.44**	
		CHC	2005-06		
			2006-07		
			2007-08		
			2008-09	**0**	
			2009-10	**0.68**	
			Total	**0.68**	
		PHC	2005-06		
			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**1.80**	
			Total	**1.80**	
94	Upgradation of CHCs		2005-06		
			2006-07		

			2007-08		
			2008-09	**0.00**	
			2009-10	**0.00**	
			Total	**0.00**	
95	IDHAP		2005-06		
			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**0.00**	
			Total	**0.00**	
96	Drug procurement		2005-06		
			2006-07		
			2007-08		
			2008-09	**1.90**	
			2009-10	**10.00**	
			Total	**11.90**	
97	Health Mela		2005-06		
			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**0.00**	
			Total	**0.00**	
98	Annual Maintenance Grant	CHC	2005-06		
			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**1.29**	
			Total	**1.29**	
		PHC	2005-06		
			2006-07		
			2007-08		
			2008-09	**0.00**	
			2009-10	**1.77**	
			Total	**1.77**	
99	RKS Corpus Funds		2005-06		
			2006-07		
			2007-08		
			2008-09	**5.90**	
			2009-10	**10.66**	
			Total	**16.56**	
100	Village Health & Sanitation Committee untied grant		2008-09	**1.46**	
			2009-10	**20.33**	
			Total	**21.79**	
STATUS OF FINANCIAL REPORTING					
101	Financial Management Reports (FMR) sent (Y/N)	I quarter 08-09 due on 30 June 09			
		II quarter 08-09 due on 30 Sep 09			
		III quarter 08-09 due on 31 Dec 09			
		IV quarter 08-09 due on 31Mar 10		**y**	

102	Audited Utilisation Certificates(UCs) for 2005-06 submitted (Y/N) due dated 31/3/2007	NRHM		
		RCH		
		NVBDCP		
		NLEP		
		RNTCP		
		NIDDCP		
		NBCP		
		IDSP		
	Audited Utilisation Certificates(UCs) for 2006-07 submitted (Y/N) due dated 31/3/2008	NRHM	**y**	
		RCH	**y**	
		NVBDCP		
		NLEP	**y**	
		RNTCP	**y**	
		NIDDCP		
		NBCP	**y**	
		IDSP	**y**	
	Provisional UCs for 2007-08 submitted (Y/N) due dated 31/3/2009	NRHM	**y**	
		RCH	**y**	
		NVBDCP		
		NLEP	**y**	
		RNTCP	**y**	
		NIDDCP		
		NBCP	**y**	
		IDSP	**y**	
National Leprosy Eradication Programme (NLEP)				
103	Prevalence Rate/ 10,000		**2.64**	
104	Annual New Case Detection Rate /100,000		**16.45**	
105	Among newly detected cases	Multi Bacillary %	**53.82**	
		Female %	**36.69**	
		Child %	**7.95**	
		Visible deformity %	**4.15**	
National Programme for Control of Blindness(NPCB)				
106	Total Cataract Surgeries (in Lakhs)	2006-07		
		2007-08		
		2008-09	**0.87**	
		2009-10	**0.16**	
107	% Achievement	2006-07		
		2007-08		
		2008-09	**87.04**	
		2009-10	**15.78**	
108	#Intra Ocular Lens (IOL) implanted		**14667**	
109	% IOL		**92.97**	
110	Number of School-going children	Screened (in lakhs)	**1.74**	
		Detected with Refractive Errors	**2957**	

		Provided free glasses	**1277**	
111	Eye / Cornea Donations in	2006-07		
		2007-08		
		2008-09	**117**	
		2009-10	**62**	
		Total	**179**	
National Vector Borne Diseases Control Programme (NVBDCP)				
112	Annual Blood Examination Rate for malaria (per 1000)			
113	Annual Parasitic Incidence of malaria (per 1000)			
114	Deaths due to Malaria	2006-07		
		2007-08		
		2008-09		
		2009-10		
115	Cases of Kala azar	2006-07		
		2007-08		
		2008-09		
		2009-10		
116	Deaths due to Kala azar	2006-07		
		2007-08		
		2008-09		
		2009-10		
117	Suspected cases of Japanese Encephalitis	2006-07		
		2007-08		
		2008-09		
		2009-10		
118	Deaths due to suspected Japanese Encephalitis	2006-07		
		2007-08		
		2008-09		
		2009-10		
119	Suspected cases of Dengue	2006-07		
		2007-08		
		2008-09		
		2009-10		
121	Deaths due to dengue	2006-07		
		2007-08		
		2008-09		
		2009-10		
122	No. of confirmed cases of Chikungunya	2006-07		
		2007-08		
		2008-09		
		2009-10		
National Iodine Deficiency Disorder Control Programme(NIDDCP)				
123	Number of Districts Surveyed			
124	Number of Endemic Districts			

125	Total No. of samples of iodised salt collected	2006-07 2007-08		
		2008-09		
		2009-10		
126	No. of Samples of iodised salt found confoirmed to the standards			
National Tuberculosis Control Programme(RNTCP)				
127	Annualized new smear positive case detection rate (%)		**55**	
128	Success rate of new smear positive patients (in %)		**87**	
Integrated Disease Surveillance Programme (IDSP)				
129	IDSP unit functional at	State	**y**	
		Number of District	**16**	
130	Number of persons trained		**6547**	

CHAPTER 6

KEY RECOMMENDATIONS

1. Facility survey by districts to rationalize physical infrastructure and human resources, equipment, cold chain facilities, supplies, logistics, use of facilities, referral and supervision. See p. 9-10 for details.

2. A detailed 'mapping' of HR by the state and a Personnel Management Information System, along with a clear and transparent Transfer and Promotion policy. Rationalizing of postings on the basis of need/demand. See p. 13.

3. Establishment of a separate Public Health cadre with Hospital and Health Administration sub-cadres, and posting of Public Health specialists as Program Managers of various national health programs. See p. 13-14.

4. To ensure quality of services, gap analysis by facility teams and self- improvement process, covering

- Clinical protocols displayed and practiced, especially for deliveries.
- Cleanliness of facilities, including wards, toilets, public spaces, corridors, patient-attendant waiting areas and water supply
- Adequacy of facilities for diagnostics
- Basic patient care inputs
- Appropriate deployment of doctors
- Behaviour of staff.
- Biomedical waste management and other statutory requirements to be implemented by BWM training and awareness creation.

See pp. 17-18.

5. Facilitation of the JDS's to spend their funds on improvements, including fixed-day meetings, 'auto-approved' lists of items. See page 20.

6. Mobile RCH teams providing fixed-day services at remote locations to manage ANC, PNC and newborn care. PPP for management of PHCs

7. An Emergency Medical System (108)for which PPP models may be explored.

8. Protocols and a kit for ANMs to provide supervise all home-based deliveries and performance-based incentives for these.

9. Free treatment of all BPL patients implemented and monitored.

10. Good Governance: Transparency and accountability in procurement of drugs & equipment

Annexure 1

A. Lists of Names of State Officers accompanying the CRM teams to Bastar and Raigarh

STATE CRM TEAM, RAIGARH		
1	Dr. Khemraj Sonwani	Deputy Director
2	Mr. Anand Kumar Sahu	State M&E Officer
3	Mr. Arun Dubey	State IEC Incharge
STATE CRM TEAM, BASTAR		
1	Dr. Sahani	Joint Director
2	Mr. Urya Nag	SPM
3	Mr. C.C. Santosh	State HMIS Officer
4	Dr. Kamlesh Jain	Senior Consultant SHRC (C.G.)

B. State Officers attending the Briefing Meeting on November 4, 2009

1	Mr. Vikash Sheel	MD, NRHM & Secretary Health
2	Dr. Sarva	Director, DFW
3	Dr. Pramod Singh	Director, Health Services
4	Dr. Badesha	Director, Ayush
5	Dr. J. Dave	Joint Director
6	Dr. Sahni	Joint Director
7	Dr. Khemraj Sonwani	Deputy Director, NRHM
8	Dr. R.R. Varma	Deputy Director, Blindness & Leprosy
9	Dr. Subhash Pandey	Deputy Director, FW & Child Health
10	Dr. Alka Gupta	Deputy Director, Matornal & Training
11	Dr. T. K. Agrwal	Deputy Director, Malaria
12	Dr. Murty	Deputy Director, IDSP
13	Dr. P.N. Devangan	Deputy Director, TB
14	Dr. B.R. Soni	Deputy Director, Stablishment
15	Dr. Kamlesh Jain	Senior Consultant, SHRC
16	Mr. Urya Nag	State Programme Manager, NRHM
17	Mr. Anand Sahu	State M&E Officer, NRHM
18	Mr. C.C. Satosh	State HMIS Officer, NRHM
19	Smt. Shrutisen Gupta	State Training Officer, NRHM
20	Mr. Shailvin Mikka	State Finance Manager, NRHM
21	Mr. Prakash Saheta	Sate Account Manager, NRHM

C. State and District Officers attending the Debriefing Meeting on November 9, 2009

1	Mr. Vikash Sheel	MD, NRHM & Secretary Health
2	Dr. R.K. Rajmani	Director, Training
3	Dr. Pramod Singh	Director, Health Services
4	Dr. Badesha	Director, Ayush
5	Dr. J. Dave	Joint Director

6	Dr. Sahni	Joint Director
7	Dr. Khemraj Sonwani	Deputy Director, NRHM
8	Dr. R.R. Varma	Deputy Director, Blindness & Leprosy
9	Dr. Subhash Pandey	Deputy Director, FW & Child Health
10	Dr. Alka Gupta	Deputy Director, Matornal & Training
11	Dr. T. K. Agrwal	Deputy Director, Malaria
13	Dr. P.N. Devangan	Deputy Director, TB
14	Dr. B.R. Soni	Deputy Director, Stablishment
15	Dr. Kamlesh Jain	Senior Consultant, SHRC
16	Mr. Urya Nag	State Programme Manager, NRHM
17	Mr. Anand Sahu	State M&E Officer, NRHM
18	Mr. C.C. Satosh	State HMIS Officer, NRHM
19	Smt. Shrutisen Gupta	State Training Officer, NRHM
20	Mr. Shailvin Mikka	State Finance Manager, NRHM
21	Mr. Prakash Saheta	State Account Manager, NRHM
22	Dr. Uraon	CMO, Raigarh
23	Mr. Girish Kurre	DPM Raigarh
24	Mr. Akhilesh Sharma	DPM, Bastar
25	Dr. Maitri	Programme Officer, Bastar