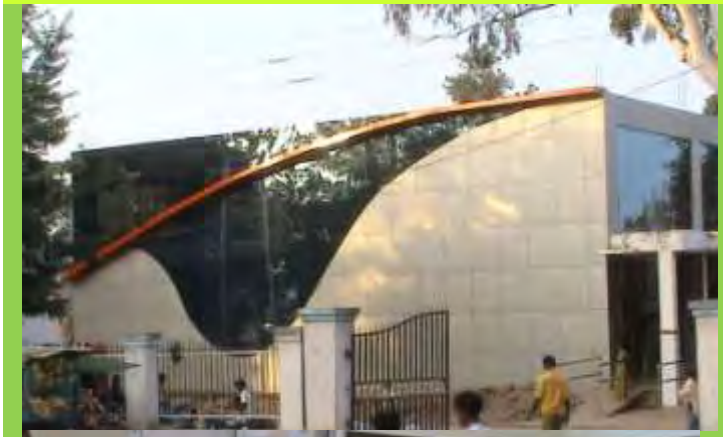
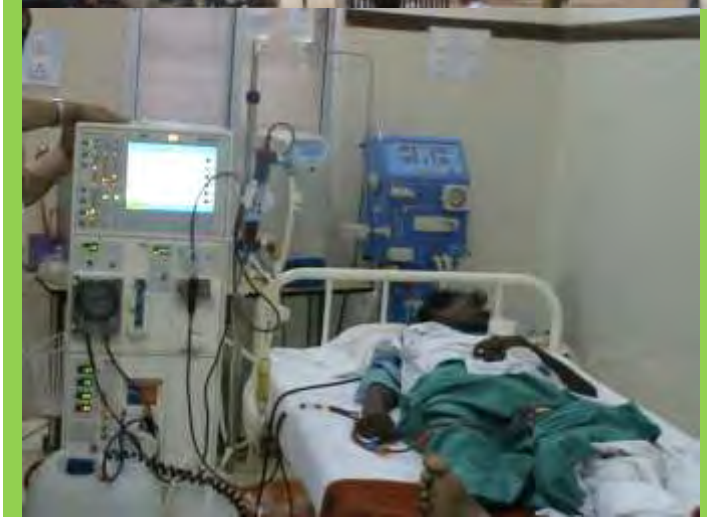
NRHM – 4th Common Review Mission Report

o – Chhattisgarh – o





Visit period: 16-23 December 2010

National Rural Health Mission
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi.

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Chhattisgarh

16-23 December 2010

The team for 4 common review mission consisted of the following members:

Raipur		Surguja	
Name	**Designation**	**Name**	**Designation**
Mr. R. N. Mishra	Chief Media; MoHFW	Dr. Sila Deb	Asst. Commissioner-Child Health, MoHFW
Mr. R. S. Sharma	JD-NVBDCP; MoHFW	Dr. Dinesh Jagtap	Consultant – Public Health Planning, NHSRC
Dr. Abhay Saraf	Sr. Public Health Specialist-Training; PHFI	Mr. Rahul Pandey	Research & Training Consultant – Family Planning Divn.; MoHFW
Dr. Anil Agarwal	UNICEF, Chhattisgarh	Mr. Anil Garg	Consultant Finance, FMG; MoHFW

List of facilities visited:

Names of Districts visited

Sno	Name	District HQ	Name of DM	Name of CMO
1	Raipur	Raipur	Dr. Yadav	Dr. G. K. Saxena
2	Surguja	Ambikapur	--	Dr. Shamsuddoha

Health Facilities visited in Raipur

Name	**Address / Location**	**Level (SC / PHC / CHC/other)**	**Name of the Person in Charge**
District Hospital, Raipur	---	Other	Dr. Kiran Malhotra, CS
Tilda CHC	Tilda, block Tilda,	CHC	Dr. S.R. Banjare, BMO
Kharora PHC	Block Tilda	PHC	Dr. S.R. Banjare, BMO
Kesla SC	Block Tilda	SC	Ms. Anita Ramteke, ANM
District Health Office	Raipur	Other	Dr. G. K. Saxena, CMO
NRHM Office	Raipur	Other	Mr. Agarwal, MD, NRHM
Champaran PHC	Champaran, Block Abhanpur	PHC	Dr. Jaiswal , MO I/c
Navagaon SC	PHC Champaran, Block Abhanpur	SC	Ms. Annapurna Verma, ANM
Hasda No 2	PHC Manik Chaouri, Block Abhanpur	SC	Ms. S. R, Devnath, ANM

Health Facilities visited in Surguja

Sno	Name	Address / Location	Level (SC / PHC / CHC/other)	Name of the Person in Charge
1.	District Hospital Ambikapur	Ambikapur	Other	Dr. Sushma Sinha
2.	Udaipur-CHC	Udaipur	CHC	Dr. A R Jayant
3.	Batauli CHC	Batauli	CHC	Dr. G R Kurrey
4.	Sitapur CHC	Sitapur	CHC	Dr. Dutta
5.	Vishrampur CHC	Surajpur Block	CHC	Dr. K.K. Tamrakar
6.	Surajpur CHC	Surajpur Block	CHC	---
7.	Bhaiyathan CHC	Bhaiyathan Block	CHC	---
8.	Salka PHC	Udaipur Block	24x7 PHC	Dr. Pandey
9.	Raghunathpur PHC	Batauli Block	PHC	Dr. Y K Kindo
10.	Batra PHC	Bhaiyathan Block	PHC	Dr. J B Singh
11.	Ajabnagar PHC	---	PHC	---
12.	Dandgaon SHC	Udaipur Block	SHC	ANM (Smt. Kanti Sharma) could not be met
13.	Kot SC	Udaipur Block	SHC	Smt. S. Chaurashia
14.	Sudamanagar SHC	Ambikapur Block	SHC	Smt. Savitri Kushwaha
15.	Keshavnagar SHC	Surajpur Block	SHC	Smt. Kunti Kashi
16.	Jaynagar SHC	---	SHC	---
17.	Kevra SHC	---	SHC	---
18.	Amgaon SHC	---	SHC	---
19.	Tendupara AWW	---	Other	---
20.	Parpatia AWW	Mainpat	Other	---
21.	Nagakhar AWW	Mainpat	Other	---
22.	DHS & DPMU	Ambikapur	Other	Dr. Samsuddoha Dr. Anil Prasad Dr. S.K. Sinha Dr. Uttam Singh Mr. Deepak Dhara Mr. Surendra Ekka Mr. Santosh Bhardwaj

4th CRM Report: Chhattisgarh

Introduction

A. About the State

Chhattisgarh is one of the youngest States of the Indian nation which is constituted on 1st November 2000. Chhattisgarh is located in the heart of India, and shares its borders with six States of the country; Uttar Pradesh to the north, Jharkhand to the north-east, Orissa to the east, Madhya Pradesh to the west and north-west, Maharashtra to the south-west and Andhra Pradesh to the south-east. The state has 18 districts and 20308 villages (RHS bulletin 2008). **Out of 18 districts, 16 are high focus districts.** The geographical area of the State covers over 135,000 square kilometres and the total population in 2001 was 20,833,803 (2.08 crores). 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 Tropic of Cancer runs through the State). The climate of Chhattisgarh is mainly tropical, humid and sub-humid. The Mahanadi is the principal river of the State. The other major rivers are - Sheonath, Hadeo, Mand, Eeb, Pairi, Jonk, Kelo Udanti, Indrawati, Arpa and Maniyari.

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. Base line of public health system in the state

a. Infrastructure:

Level of Health Facility	Number of Health Facilities falling in			
	Total	Difficult areas	Most Difficult Areas	Inaccessible Areas
Health Sub Centre	4741	-	-	-
Primary Health Centre	719	0	472	247
Community Health Centres	143	31	67	45
District Hospital	18	4	5	9

Source: state website

As per the population norms state require a total of 5049 Sub Health centres, 721 Primary Health Centres, 201 Community Health Centres, 18 District Hospitals and 6 Medical Colleges. Number of institutions available in the state is 4741 SHCs, 719 PHCs, 143 CHCs, 18 District Hospital, and 3 Medical Colleges with overall deficit of 308 Sub centres, 2 PHC, 58 CHCs and 3 Medical colleges. In terms of number of institutions and their geographical spread across the state is reasonably good. However, the 60% of Sub Health Centres, 50% of PHCs don't have their own building. Infrastructure strengthening is

being done through various budget including National Rural Health Mission, State Budget, European Union and Backward Region Grant Funds (BRGF).

b. Human Resource:

Chhattisgarh is one of the state struggling with lack of skilled human resources. Though the sanctioned posts by the department of Medical and Health is less than the population norms on the top of it the vacancy of the staff ranges from 7.4 % for Staff nurses to 65% in specialists cadre; though some of the positions are being occupied by the Post Graduate Medical Officers providing specialist's services. Irrational distribution of human resources adds to lack of availability of specialists at the desired places:

Post	Sanction	Working	Vacant	Annual Output	Vacancies (%)
Medical Officer	2147	1109	1038	200	48.35
Specialists	701	248	453	50	64.62
Staff Nurses	935	866	69	168	7.38
Lab technicians	731	357	374	100	51.16
Lady Health Visitor	1034	749	285	200	27.56
Auxiliary Nurse Midwife	5653	4984	669	500	11.83
MPW (Male)	4784	2514	2270	200	47.45
Pharmacist	974	614	360	100	36.96
Ophthalmic assistant	620	295	325	100	52.42
Dresser	936	630	306		32.69
Male Supervisor	872	722	150		

c. Trainings:

Type of Training	Cumulative number of functionaries trained							State Achievement	%
	MO	RMA	Specialists	ANM	Staff Nurse	LHV	State Target		
IUCD	**3**	**0**	**26**	**5**	**4**	**37**	**2538**	**75**	2.96
NSSK	**66**	**20**	**12**	**50**	**18**	**45**	**3236**	**211**	6.52
SBA	**18**	**0**	**59**	**10**	**7**	**88**	**902**	**182**	20.18
IMNCI	**0**	**0**	**0**	**0**	**0**	**0**	**1440**	**0**	0.00
F-IMNCI	**79**	**0**	**0**	**0**	**0**	**0**	**336**	**79**	23.51
IUCD	**1**	**0**	**26**	**5**	**4**	**37**	**-**	**73**	0.00
BeMOC	**3**	**0**	**0**	**0**	**0**	**0**	**150**	**3**	2.00
CeMOC	**15**	**0**	**0**	**0**	**0**	**0**	**32**	**15**	46.88
LSAS	**15**	**0**	**0**	**0**	**0**	**1**	**47**	**15**	31.91
MTP/MVA	**3**	**0**	**0**	**0**	**0**	**1**	**120**	**4**	3.33
NSV	**7**	**0**	**0**	**0**	**0**	**1**		**8**	

Type of Training	Cumulative number of functionaries trained							State Achievement	%
	MO	RMA	Specialists	ANM	Staff Nurse	LHV	State Target		
Minilap	2	0	0	0	0	0	50	2	4.00
(CTT)									
CCSP	1	0	0	0	0	1		2	

Indicators:

Over a period of 10 years State has shown improvement in indicators:

Indicators*	India			Chhattisgarh			
IMR Total	68	58	55	79	63	59	57
IMR Rural	74	64	61	95	65	61	59
IMR Urban	44	40	37	49	52	49	48
Birth Rate Total	25.8	23.8	23.1	26.7	27.2	26.5	26.1
Birth Rate Rural	27.6	25.6	24.7	29.2	29.0	28.0	27.6
Birth Rate Urban	20.7	19.1	18.6	22.8	20.0	19.9	19.3
Death Rate Total	8.5	7.6	7.4	9.6	8.1	8.5	8.1
Death Rate Rural	9.3	8.1	8.0	11.2	8.4	8.5	8.5
Death Rate Urban	6.3	6.0	6.0	7.1	6.9	6.5	6.4
Natural Growth rate- total	17.3	16.3	15.7	17.1	19.1	18.4	18.0
Natural growth rate- rural	18.3	17.5	16.8	18.1	20.6	19.5	19.2
Natural growth rate- urban	14.4	13.1	12.7	15.7	13.1	13.1	12.9
Maternal Mortality Ratio							335

Note: * SRS data (Report Oct – 2009), ** Census data

d. PRI framework in the state

Chhattisgarh is a unique state in terms of involvement of community and PRI. It started with involvement of *Mitanins* as a face of the community as well as making community aware regarding various services of government. This led to increase in demand for various services such as JSY. Further, state has developed village wise index on human development under Swasth Panchayat Scheme; this seems a good initiative; however, the team could not discuss this during field visit.

Findings of the 4th CRM in the State

1. Infrastructure up-gradation

Key Findings:

- Availability of infrastructure above PHC level (CHC and above facilities) is generally better than that of PHC & SHC. Among the facilities visited there were more than half of the PHCs functioning in SHC building with 2-3 beds. This was primarily due to the up gradation of SHCs to PHCs; there was no plan prepared beforehand to ensure adequate space for increased HR and services (because of shift from SHC to PHC).
- State does not have a dedicated infrastructure and finance wing in place; nevertheless, there is an attempt for systemic planning for infrastructure development. State has prepared list of all the facilities under construction/renovation from various sources of fund. State reported that formation of CSO (Central Stores Organisation) has been done in the state and it is envisaged that this organization would take care of development of infrastructure across the districts. **State does not intend to create an infrastructure and development wing within the directorate.**
- During the field visit, there was no sign of a linkage between infrastructure development and HRD and also there were cases of irrational use of newly built facilities[1]; however, state informed that in current year priority has been given to the identified MCH centres for both infrastructure and HR development.
- State has provided information on infrastructure development under various categories such as FRU renovation, new construction, and development of BSUs/BBs etc. It has been divided in 367 types of work orders starting from 2005-06 till 2010-11:

Year of Sanction	Number of infra works	Completed	Incomplete	Work yet to start	No information
2002-03	2	2	0	0	0
2004-05	4	4	0	0	0
2005-06	51	51	0	0	0
2006-07	**148**	145	1	1	1
2007-08	**6**	6	0	0	0
2008-09	**34**	14	8	5	7
2009-10	**28**	6	19	3	0
2010-11	**86**	5	33	48	0
Others*	**8**	3	2	0	3
TOTAL	**367**	**236**	**63**	**57**	**11**
% against total		**64.3**	**17.2**	**15.5**	**3.0**

** No information available on which year these works were initiated*

 # Date of initiation & completion of work is not provided

[1] In the PHC Ajabnagar it was found that newly developed facility is being used for administrative purposes while old building is for service provision.

A detailed analysis, in absence of initiation and completion date is not possible; nevertheless, available data reflects that:

- 64.3% work has been completed out of 367; however, from 2008-09 to 2010-11 completion rate varies between 5.8% and 41.2%.
- In 15.5% cases work has not even started; various reasons are cited in the information provided by state such as site not finalized, PWD has not initiated work, sanctioned awaited from state etc.
- At certain places visited (such as CHC *Udaipur* in *Surguja* district) work of the agencies are not monitored[2]. Further, overall monitoring of approved work seems to be poor by district / block level official in particular.

- Facilities, in general, were found utilizing RKS/UF/AMG funds for various local infrastructure problems such as repair of toilets, provision of curtains, painting of walls etc. However, there are certain issues, which would be discussed in detail in Part 11.
- Availability of equipments was not a major problem across the facilities; however, two issues were noted:
  - There is no annual maintenance contract of equipment; nevertheless, it was reported during the meeting with state that CSO (once completely established) would take care of this issues
  - Lack of rational distribution[3]
  - Staff not trained to use certain types of equipments in Surguja district
- Back-up power supply is generally available across facilities such as invertors, generators etc. Further, supply of electricity was good even in remote areas such as Surguja district.
- It was also found that staff quarter in general are either not available or in very bad shape. State informed that 882 staff quarters have been sanctioned in current year.
- **Other issues –** toilets, in particular in labour room and female wards, are in bad shape (such as no light, doors not available or not in proper condition etc) and even not available at some places (e.g. at certain facilities in *Surguja* district).

Recommendations:

Above findings reflects that there is a need for comprehensive planning for infrastructure development / procurement & maintenance of equipments including monitoring (quality and timeliness):

- A dedicated infrastructure wing including experts of facility mapping/planning/designing/monitoring needs to be established at state level. State may choose to attribute this task to an already available agency (such as CSO); however, TOR needs to be defined for this agency.
- A clear record needs to be maintained including date of sanction of work, date of initiation & date of completion; this would help in understanding delays (if any) and also finding out

[2] It was observed during the visit that one portion of under construction building had fallen in previous night which indicates poor quality of work.

[3] E.g. in the stores of CHC-Udaipur (Surguja district) there are loads of sterilizers are lying; while same is not available in some other CHC level facilities.

underlying reasons for the same. This would also help in minimizing the duplication of JDS/UF/AMG resources.

- Inventory of equipments / instruments including those not functioning should be maintained
- Since state is planning to use CSO for maintenance of equipments; it may be noted that a clear TOR need to be prepared for this work; this would include activities such as develop inventory of all the equipments, calibration of equipments, maintenance of equipments etc.

2. Human Resources Planning

Key findings:

- Availability of Human Resources & Gap analysis
  - Huge shortage of human resources at various levels particularly in Medical and Specialist cadre. Total vacancy ranges from 7.5% for staff nurses to 65% in specialists cadre. The another challenge which in the state is that total number of posts of nursing staff sanctioned for the CHCs and PHCs including 24X7 PHCs and FRUs is much below the Standards. In the current scenario total of 3 staff nurses are posted at most of the FRUs and either none or one staff nurse is posted at PHCs including 24X7 PHCs. Doctor Nursing staff is skewed even in FRUs visited. In Tilda CHC Doctors Nurses ratio is 2.66: 1 which hampers delivering quality of care and is much below any standard for curative care.
  - Out of 312 positions of the Class I and II Medical, Health officers 145 positions out of 312 (47%) are vacant. Out of 390 positions of Class IV support staff, 28 percent (108) positions are vacant. Overall vacancy in all the cadres essential for the effective and efficient service delivery is 37 percent (1052 positions vacant out of 2819 sanctioned positions). As per state website situation of key specialist cadres is provided below:

Category of specialists	Sanctioned Post	In Place	Gap	Gap %
Paediatrician	168	41	127	75.6
Gynaecologist	168	32	136	81.0
PGMO Anaesthetist	147	18	129	87.8
Anaesthetist	17	11	6	35.3

Source: state website

  - Weak Human Resource Planning:
    - Not currently addressed the gap in sanctioned and essential posts as per IPHS norms
    - Lack of support staff which hampers maintenance of cleanliness the facilities
  - There are less number of staff at PHC
  - PHC doctors are not available 7 days (deputed to CHC for 3 days)
  - Support staff is another challenge and most of the institutions in the state have less number of the support staff. Total support staff in the state distributed over more than

18 district hospitals, 136 CHCs and 721 PHCs of the state. Some of the institutions have outsourced services of the support staff.

- Keeping in view the vacancy of 316 MPWs, the inadequacy in terms of the MPW training school is evident.

- Pre-service Training capacity
  - There are total 13 ANM Training schools in the public sector and the 12 in private sectors and the total 4 GNM schools in the public sector and 10 in private sector. Total 3 MPW training schools in Public sectors and 22 MPW training schools in the private sectors. Every year estimated 960 ANMs, 416 GNMs and 1026 MPWs are produced both by Govt. and Private institutions which is sufficient to meet the existing demand for ANMs and MPWs as well as future demands of looking to the attrition rate of 10% per year. However there is a huge capacity gap in the state to meet the demand of specialist cadre including MBBS Doctors.
  - Training is a key issue in HR. It was observed by the team that systems were by and large in place but it was highly underutilized. During the current year, training was given only to Nurses, Lab Technicians and MOs.
  - To address the issue of lack of availability of skilled specialists and MBBS Doctors, State Government has initiated a Rural Medical Assistant curriculum. Which is a 3 year course initiated by the state Govt. The course have been found successful by various assessments and also during the field visit by the team members this has been found that the skills and knowledge of RMA were satisfactory and are able to perform as part of primary health care.
  - Training capacity for the General Nursing Midwife (GNM) is much less than requirement even if we include Govt and Private sectors
  - State Government also initiated 3 Months course to meet the deficit of Obstetrician in the year 2005-06 however as it started before the 16 weeks training course by FOGSI and Govt of India total 45 trained are not being utilized by the state. If these are also certified in EmOC than state will have a pool of additional 25-30 Doctors for providing EmOC services.

- Recruitment and Cadre Management
  - State has identified difficult and most difficult areas and has planned incentives for service providers for these areas.
  - At one of the place technical resource like Staff Nurse is being used for account maintenance purposes[4].

  - Availability of key specialists/ doctors positions is affected by irrational distribution of HR[5].

[4] Vishrampur CHC-Surguja district

- Recruitment is being done through State Public Service Commission however for hiring of specialists Govt has delegated powers to the Districts. In one district Bijapur which is one of the tribal districts some specialists and MBBS have been hired at the district level on contractual basis. State has to review and scale it up.
- The state Government in under the process of broadening the base and for improving work force management like incentives to the Doctors and nursing staff who have perform to certain benchmarks of service provision like number of Delivery, Number of Caesarean Section, Number of cataract operation, number of family planning operation etc.

- Plan for Augmentation of Health Human Resources
  - State does not have a comprehensive short and long terms plan for HR; nevertheless, there are various steps taken to ensure availability of HR at every facility:
    - State has relaxed norms for hiring staff nurses who are from Arts background.
    - Mobilization of Medical Officers to operationalize prioritized institutions and PHCs to be manned by Rural Medical Assistants.
  - For long terms plan state is looking for increasing the number of seats in various specialties as well opening of new Medical Colleges in more districts; however, state informed during the discussion that there would not be much focus on opening government medical colleges rather PPP would be considered with various institutions who wants to open medical college in the state.
  - State Under National Rural Health Mission have appointed one staff nurse at the selected PHCs. State is also planning to amend the cadre of leprosy workers to Multipurpose workers so that the gap of MPW can be filled and additional ANM can be deployed at the Sub centres particularly for the difficult and remote areas.
  - Rural Medical Assistants are put in place since last one year at every PHC and CHC. Plans are on way to pool all the available MBBS doctors at CHC level for manning CHC effectively and efficiently. These doctors will visit the PHCs on designated days for OPD/IPD.
  - State has formed Chhattisgarh Medical Rural Core Scheme under which various incentives to the service providers are being given right from the specialists to the staff nurses and RMA working in the difficult and most difficult areas. The staff working in difficult and most difficult area is given incentives under "Chhattisgarh Rural Medical Core Scheme". Similarly preference by way of additional marks for the PG admission is given to the doctors working in the difficult areas. Preference is given to *Mitanins* for ANM trainings:

[5] On the one hand one Medical Officer is doing all the functions right from Block CMO to that of service providers in one **block** (*Mainpat* in *Surguja* district), on the contrary there are 22 Doctors in a 20 Bedded District Hospital (Raipur) that hasan average OPD of 50-60 per day.

Details of Incentives given under CMRC					
Sn.	Category	Monthly incentive in first and second years		Monthly incentive in third and fourth years	
		Most difficult area	Difficult area	Most difficult area	Difficult area
1	Specialists	Rs. 15,000	Rs. 12,000	Rs. 18,000	Rs. 15,000
2	PGMO	Rs. 12,000	Rs. 10,000	Rs. 15,000	Rs. 12,000
3	EMOC or LSAS	Rs. 10,000	Rs. 9,000	Rs. 12,000	Rs. 11,000
4	MO	Rs. 8,000	Rs. 5,000	Rs. 10,000	Rs. 7,000
5	RMA	Rs. 3,000	Rs. 2,000	Rs. 4,000	Rs. 3,000
6	Nursing Sister	Rs. 2,000	Rs. 1,500	Rs. 3,000	Rs. 2,500
7	Staff Nurse	Rs. 2,000	Rs. 1,500	Rs. 3,000	Rs. 2,500

- Skill quality of Health Human Resources
  - Various trainings have been planned under the PIP of the state. However there was no comprehensive calendar provided for the trainings either by the State Institute of Health and Family Welfare or by the department.

Training proposed by state in 2010-11 PIP

Training	Training Load
SBA	142 batches of ANMs/SNs 30 batches of MOs (BEmOC)
EmOC	45 MOs
LSAS	3 batches of MOs
MTP	120 MOs and 51 OB/ Gyn
RTI/STI	10 batches of MOs 32 batches of SNs and ANMs
IMEP	36 state and district level programme
IMNCI	1440 health workers
NSSK	17 batches of MOs 64 batches of RMAs, SNs, LHVs, and ANMs
Laparoscopic sterilisation	8 batches / teams
Mini-lap	10 batches of MOs
NSV	8 batches of MOs
SPMU	20 batches
DPMU	54 batches
Management training to BPMU	206 batches

Source: RoP for 2010-11

- Though state informed there is a training calendar in place, trainings are not conducted as per the calendar. The trainings for SBA, IMNCI, EmOc are not started at all in current year. NSSK training coverage is around 50%. Total trainings planned versus held ranges from 3% to 33 % in most of the trainings.
- Further, it was observed during the visit to Surguja district that ANM/SN trained in SBA is not available at SHC/PHC/CHC; some of them received training after launch of RCH-II programme in management aspects. While there were few ANMs found to be trained in IUD insertions.
- In service training capacity is unutilized both for skill Based Trainings and Modular trainings both at the state and district level. State Institute has organized only 5 trainings of two days each for basic Emergency Obstetric Care and one training on facility based IMNCI. The SIHFW has 3 Dy Directors, One Director and one registrar.
- Placement of trained staff at right place is a challenge to the state[6].

Recommendations:

State has taken various steps and in process of redefining cadre system; however, focus should be goven to comprehensive assessment and planning for HR gaps including strengthening in-service training capacities:

- State needs to have long term HR plan by:
  - Assessment of current / projected HR need
  - Assessment of capacity and plan for increase
- State is taking steps to ensure trained personnel are posted at facilities which are identified for up gradation (such as counseling of MOs before engaging them for EmOC/LSAS training); however, distribution of these trained personnel (& specialists) to difficult areas (such as Surguja) need to be in place).
- Capacity building of RMAs needs to be in place in areas of skilled care at birth. CME for RMAs to be designed with help of Medical colleges
- Training management overall needs attention:
  - Training coordinator at district level to be part of preparation of training component of PIP
  - Data base of all the trained personnel so that they can be tracked
  - Assessment of training capacity to be part of overall training PIP
- District/ state officials to monitor clinical services performed by trained personnel
- The State had trained 45 Doctors in 3 months course on EmOC. They are not being used as MOHFW has not approved it. The committee recommends the MOHFW may grant recognition after testing EmOC Skills.
- Counseling of health staff should be done before placing them into difficult, most difficult and LWE areas

[6] At CHC Tilda where master trainer for BEmOC trainings is working in Raipur districts

- Proposed incentive mechanism need to be reviewed since its not yielding expected results; state may form a group of expert who carry out consultations from various stakeholders and define new set of incentives
- Financial training should be imparted to BMOs, DMOs and CMO so that they could discharge their increasingly complex administrative duties more efficiently. It will be better if they are made aware of the vigilance issues. We recommend that SIHFW which has infrastructure should broad base its courses

3. Health Care Service Delivery – Facility Based - Quantity and Quality

Key findings:

- Overall findings of the facilities visited it was found that facilities are grossly underutilized. For all the facilities visited there is gross under utilization of OPD and IPD services including institutional deliveries. For example in 30 bedded Tilda CHC, with 9 Doctors in position, the average bed occupancy is less than 40 percent and average OPD /day is between 90 to 120 per day. Mostly planned LSCS are being conducted amounting to 16 in the current FY till date with CS rate of 3 percent.
- Total available beds in the state are 6820 for the secondary level care. Average Bed occupancy rate is around 37%. More than 40% of which is contributed by the institutional deliveries. Bed occupancy rates of the FRU and 24X7 PHC is much below state average. Out of all CHCs and 24x7 PHCs were visited by the CRM team in Raipur and Sarguja district, average bed occupancy rate at FRUs is less than 20 to 30 percent and of 24X7 PHCs is less than 10%.
- District Surguja has many PHCs with just 2-3 beds, even these beds are not being utilised at certain facilities.

An analysis of facilities visited in *Surguja* district is provided below:

- **Average OPD per month:**
  - CHC: 800
  - PHC: 200
- **Average Deliveries per month:**
  - CHC: 60
  - PHC: 15
  - SHC: 2-3 (except Sudamanagar)
- **Average bed per facility:**
  - CHC: range from 12-40
  - PHC: 2-3
  - SHC: nil

- Of all the facilities visited (in both the districts), it was found that laboratory services are underutilized; primarily because of not enough case load. Further, at certain places lack of reagents & supplies was also observed. Total investigation to against total admissions in the

district is less than 70%. Which indicate under utilization of available laboratory services in the state. No dosimeters provided for the Radiographer. Adequate asepsis observed in the laboratory.

- Both Drugs and equipments were not used rationally. Available equipment which were available in the hospital were found in the stores for the reasons of fear of getting destroyed, stealing or lack of space. Particularly equipments like BP instruments, Radiant baby warmers, Ambu bags etc. At some of the SHCs it was noticed that equipments have been supplied; however, ANM is not aware/not confident of using the equipment7. Drugs like Iron Folic Acid was found in access stock at every level which were about to expire in the month of Jan 2011. Similarly other drugs like oral penicillin, Amoxyxcillin were found at PHCs and CHC in the quantities which looking to their OPD case load and uptake rate of those medicines will not be able to utilize before there expiry dates. For example PHC Champaran having a case load of 8-10 patients per day has more than 1500 Methyl penicillin about to expire in the month of January 2011. Which they will not be able to utilize even they give it to all the patients.
- **Out of pocket expenditure** is very high across the facilities including district hospital[8]. This was also highlighted in previous CRM and state was requested to take steep measures to curb this issue. It was informed by the state that RSBY is in place and strict monitoring would be carried out to deal with the issue.
- Laundry Services in the District Hospital and CHCs were found to be satisfactory. Some of the FRU like Tilda have procured washing machine which helps in washing of clothes on the same day at a much cheaper rates; however, situation was not that good in Surguja district.
- Sanitation facilities at FRU and PHCs were poor due to lack of support staff as well as lack of interest on part of facility in charge.
- There are no diet services in the District Hospital or CHC visited. It was also observed that there is ample opportunity to engage JDS for this purpose.
- **Referral transport** facilities were available at all most of the centres visited however there are variations across the districts and in-charge of the CHC/ PHC have the authority to use funds for the same:
    - Mahatari express is a good step forward to ensure referral services; however, coverage is not uniform
    - These vehicles on an average ferrying around 20-30 cases in a month; however, this is lower than the institutional delivery figures9; rest of the deliveries are covered through private mechanism. During the discussion with various community members it was observed that private vehicles charge around Rs. 400-500 for one round trip to facility for institutional delivery.

[7] SHS *Kot* & *Keshavnagar*

[8] The LSCS patients were being asked to purchase disposables and catgut from the market in CHC Tilda and DH Raipur. Similar findings were observed in *Surguja* district, where patients were asked to buy IV bottles, antibiotics etc from open market.

[9] In *Surguja* district: CHC conducting around 40-60 deliveries per month

- There is no arrangement for second referral and become more crucial since vehicle available at CHC is mostly used for trauma cases by Police department10.
- Safety during transportation is a concern which state Govt has also identified and is willing to address this through capacity building and appointing one technician trained in Emergency and response.
- State is in process of starting 108 emergency transport system and it is expected that this would help in improving the situation.

- The privacy and safety issues are adequately addressed in the visited institutions. The service guarantee and citizen charter were visible, however there was no standard pattern of display. State has provided a standard format for display of information for JSY across facilities; however, regular updation of this information is an issue. Grievance redressal system is not displayed universally.
- **Waste Management:** Infection control and hygiene, sterilisation of equipment and biomedical waste segregation and disposal is a weak areas at all the centres visited right from PHC through CHC to the District Hospitals. IMEP protocols and guidelines are not in place and patient perspective in planning and implementation is lacking.

Recommendations:

State is monitoring clinical output of various facilities and it is a welcome step; however, focus should be given on supervision to ensure off take of services, maintenance of quality, assured referral and client satisfaction:

- Well planned IEC system should be instituted at three tier level -State, District and Block so that state could inform community about the services offered to them through the Health Care Delivery (HCD) system.
- Counselling of health staff should be done before placing them into difficult, most difficult and LWE areas.
- To develop a mechanism for supportive supervision of clinical services provided by trained personnel as per the operational guidelines on MNH.
- Adequate beds need to be made available to PHCs for catering increased demand
- **Facilities identified for MCH delivery centers need to be revised** considering current status of output and service availability.
- Bio-medical waste management needs to be strengthened including training of personnel and necessary equipment
- Ambulances available at the facilities (at least CHCs) may be used for second referral as well as sending beneficiaries back home after 48 hours stay.
- Analysis of impact of Mahatari express may be carried out to understand its effectiveness as well as its role after implementation of 108 services.
- Monitoring of logistics and supply chain management needs to be done:
  - Inclusion of store verification in the monitoring system
  - Cross verification of sample prescription during these visits

[10] As mentioned by CHC Udaipur and Sitapur in Surguja district

- Developing coordination between state and district level store.

- Training of personnel in waste management does not seem to be providing expected results; state may conduct an assessment for underlying reasons and strategies may be adopted subsequently. In the mean time training of personnel may be continued to keep the focus on.

4. Outreach services

Key Findings:

- VHND is an important outreach activity under NRHM; however, this could not be observed during the visit period (because of holidays and schedule of VHNDs) and hence all the findings are on the basis of records made available at SHCs and PHCs
  - In almost all the villages/facilities visited, it was noted that VHNDs are organised on regular basis and accessible to villagers. However, comprehensive range of services is an issue; it was reported by various ANMs/Aws that only ANC and immunisation service are provided during VHNDs and there is no focus on counselling for FP, creating awareness on ARSH etc. Nevertheless, it was good to note that state has gone beyond immunisation during VHNDs.
  - Though there was a mention of VHND micro plans, they could not be seen in the field.
- Availability of ANMs was good even in remote areas of *Surguja* district; community interaction revealed that availability of ANMs has improved image of public healthcare delivery system.
- State has initiated Fixed Day Services for maternal care at PHC level where a lady medical officer (either form the same facility or from a different facility) would provide services on predefined day & time. This is a good initiative considering socio-cultural barriers at village level; however, average number of beneficiaries is ranging between 10 & 15 and record keeping of services provided is poor.
- State does not have an IEC bureau[11] at state and district levels; and absence of comprehensive planning for BCC/IEC was visible across the districts. Primarily centrally printed materials were found at facilities and villages, while other methods of creating awareness such as engaging local theatre groups, IPC etc were missing. *Mitanins* were found a good source of generating awareness regarding various health services among the community.

Recommendations:

Availability of outreach services in form of VHND, fixed day etc. is satisfactory; however, state needs to develop system for closed supervision and monitoring:

- State has developed online system for provision feedback on field monitoring; additional focus needs to be given on monitoring of VHNDS including provision of comprehensive services. Already developed micro-plan for VHND needs to be followed for conduct of VHNDs.
- In regular sector meeting ANMs & *Mitanins* need to be oriented (with structured checklists, if possible) on comprehensive service provision during VHNDs.

[11] State was suggested to develop team of BCC/IEC experts at state and district level in CRM-2.

- To generate demand for healthcare services (beyond JSY), BCC/IEC system needs to be strengthened including placement of experts at state district and block level[12]. Further, *Mitanins'* role needs to be defined to ensure they have enough time for IPC.
- State is spending significant amount on Fixed Day services at PHC level (Rs. 300 per visit plus POL charges), focus now should be given to generate demand for these services and also proper record keeping to be ensured.

5. ASHA- Mitanin Programme

Status as on September 2010

No. of Mitanins selected	60092 / 60092
No. of Mitanins selected in %	100%
Total no. of training Days completed (mention round of training)	36 days .....13th round (3+ 2+3+ 2+ 4+ 2+ 2+ 2+ 2+ 8+ 2 +2+2)
No of trained as % on selection	60092 ASHAs (100%) trained on 13 modules. TOT for 14 Module ongoing (Disease Control)
Drug Kit distribution to Mitanin	Drug kit distributed to 60092 ASHAs (100%)
Availability of united schedule of Mitanin's payment :	Integrated ASHA Compensation Package available (Mitanin Passbook designed for streamlining ASHA incentive payments)
JSY	Rs.350 Payment is made to ASHAs by cheque in the health facility.
Immunization	Rs.150/- per immunization session
Constitution of State Mitanin Resource Centre	SHRC is working as ASHA Resource Centre
Constitution of State Mitanins Mentoring Group	State AMG constituted
Monitoring & Support System	30 state field coordinators, 427 district resource persons in 18 districts & 2920 block resource persons in 146 blocks form the monitoring and support system for the ASHA Program
Meeting schedule of Mitanins	- Regular participation in VHND. - Regular monthly meeting of VHSCs
Indicator defined (What are the jobs exactly Mitanins are doing)	- Birth preparedness - Visit at Child birth - ensuring care as per HBNC and IMNCI, - Identification /referral of malnourished children -Depot holder - Leading the hamlet level initiatives under Panchayat Health Planning -Participation in VHND & VHSC meetings

[12] State has recently placed a dedicated official for IEC; however, support structure is still lacking.

Key Findings:

- ASHAs locally known as Mitanins are trained and well oiled effective foot soldiers of the system. They are effective catalyst of the entire service delivery system. The Mitanin programme in Chattisgarh has been operational even before NRHM. In fact, most of the strategies in current ASHA programme under NRHM were formed on the basis of Chhattisgarh experience. Training of Mitanin is well ahead of the national schedule here as compare to other states. Presently module 13 is near completion and this will collectively accomplish 36 days of training covering various thematic areas. Mitanin programme has a well supported district and block level structure which provides training and field support to Mitanin. SHRC has planned 14 and 15 module which will be for 5 more days.
- Presently, in the state there is no formal ASHA mentoring group in place but equivalent support to the programme has been provided by the SHRC. SHRC is acting as an ASHA resource centre for the Mitanin and there are around eight persons in place to provide support with the help of district and block level coordinators.
- State has started community monitoring in three pilot districts in the year 2008-09 only and in this model NGOs were involved. But it was found to be non-feasible in terms of NGO's capacity and cost effectiveness. Therefore, alternate to this it was proposed that state will carry out the community monitoring with the help of field and district coordinators which will cost less. This alternate model appears to be weak in terms of achieving objectives of community monitoring where involvement of community itself is minimal or absent.

- Incentives to Mitanin are not streamlined but a JSY incentive seems to be satisfactory. It was observed during the interaction with mitanin that incentives for institutional delivery under JSY was paid with some conditions where mitanin have to remain with the pregnant women after delivery till 48 hours to get JSY entitlement. In other programmes, incentives are not paid, lesser amount paid as proposed and approved in PIP or payments are delayed. So far mitanin are not getting any incentive for the preparation of malaria slides and for cataract surgery mitanin are getting only Rs. 100/- but in PIP Rs. 175/- approved. Drugs are available with the Mitanin under a scheme called *Mitanin Dawa Peti* but the replenishment of the drugs is a major issue. Probably system for the refilling may be strengthened because it is now become a chronic problem. It was observed that there is no drug supply from April to December 2010. Drugs are procured and supplied from the State where every four monthly irrespective of consumption pattern or a stock out in between these four months, no surplus or buffer stock at district level is available.

- Mitanins are mainly mobilizing the community to seek healthcare and also facilitating them to get appropriate care at appropriate facility where they have a Mitanin help desk across the facility to guide and ensure the facility based services. Apart from community mobilization Mitanin are serving people with the available drugs and in addition making malaria slides,

helping mothers in early and exclusive breast feeding, also ensures adherence on DOTS etc. In terms of their contribution in improving the health status of community, it was observed that breast feeding practices, facility and home-based neonatal care, institutional deliveries have been improved. Since Mitanins are undergone various rounds of training they have got adequate skills to provide services at community level but there are certain areas to be strengthened like identifying sick neonates, timely referral, and stabilizing and administering initial doses of medication before referral to the appropriate facility.

- Support at field level by the coordinators is improving their skills to provide basic services at village level. State has informed CRM team regarding the career path of Mitanin; that some of the Mitanin have been provided the admission to pursue B.Sc. Nursing and GNM.

Recommendations:

- Although the recognition among the community is a major motivating factor for mitanins but an award or certification at each level may be useful to further enhance their contribution to the system.
- State has to create a formal AMG or Mitanin Mentoring Group with involving experts from various competent organizations or civil societies.
- An assessment should be done for delay in paying incentives across the programmes. There is also uniformity should be maintained to pay incentives as proposed and approved in the PIP. There is a need to create an incentive mechanism or guidelines which should have adequate fund at district level to avoid delay in payments.
- Regular community monitoring system should be roped in where adequate involvement of civil societies required making system more accountable.
- Mitanin drug replenishment mechanisms should be revised to ensure required amount of drugs to be available with each of the volunteer and adequate buffer stock with the district / block. Consumption pattern of drug may be studied and accordingly an advance stock to be stored at district or block level to ensure uninterrupted supply.
- There may be a clear GO should be made available across the facilities where mitanins need not to stay with mother till 48 hours.
- Career enhancement of Mitanin is one of the good initiatives to be continued and strengthened further.

6. RCH II (Maternal Health, Child Health and Family Planning Activities)

- Quality of Antenatal, Natal and Postnatal care is an area which needs tremendous improvement on priority basis, if the momentum gained through Janani Suraksha Yojna is to be translated in to results. The state data reveals average still birth rate of 36/1000 live births in the district hospitals which ranges from 15/1000 live births to 86/1000 live births.

- Till October 2010, 53.58% of pregnancies have been registered, 27.31% have been registered early, i.e. within first trimester, and 80.02% have completed 3 antenatal check up (as per the data provided by state). According to DLHS III data, 51.2% of pregnant women are getting 3 ANC check up. However, the recent Coverage Evaluation Survey (2009) of UNICEF shows that the coverage of full ANC (at least 3 ANC check up, 1 TT injection and >/= 100 IFA tablets consumed) is only 19.9% in the state.
- Some good maternal health initiatives have been reported to be adopted by the state, like Iron – Sucrose supplement for severely anaemic patients in DHs, at least 1 ANC being arranged at PHC by Doctor/RMA, incentivizing ANM for identification of high risk pregnant mothers and their delivery in FRUs, Doctor / RMA to be present at the VHND once in 6 months so that at least 1 ANC can be done by Doctor/RMA in outreach areas.
- Vitamin A and IFA are being provided without any shortage and being distributed. However instead of double the dose for the anaemic mothers, single dose is being given.
- Health Messages are written in the PHCs, CHCs and District Hospital in unplanned way. But the visibilities of the health program messages are rare elsewhere through mid-media like buses, hoardings etc.
- During the team visit it was observed that delivery points are increasing and more and more staffs are conducting deliveries but facility preparedness is very poor in terms of providing basic quality of care. It was revealed through the available records that deliveries after 6 PM are relatively very low except in district hospitals. Still lot more to be done for to handle maternal and neonatal complications.
- ANC Registers were available at the PHCs only, where fixed day ANC clinics are conducted, but clinical findings/observations of the antenatal check up are not being recorded/ partially recorded in the register. There is no ANC register/record of the Antenatal check up being done at CHCs and SHCs visited by CRM team.
- There is no record of identified high risk pregnancy cases and their referral from SHCs and PHCs to higher facility for investigations and further management.
- At some facilities, hemoglobinometer, measuring tape, functional BP instrument etc. are not available with the concerned staff but there is sufficient stocks are available in the store of the same facility. No mechanism of repair
- Hb estimation
- Some ANMs found to be ignorant about using Haemoglobinometer and Reagents for urine analysis that are supplied to them.
- Name-based tracking of pregnant women and children is yet to be started and in the facilities new registers are available but not started any entry. It is being done offline and planned for online system shortly.
- The CRM team observed a highly unsatisfactory conditions of most of the Labour rooms of visited facilities upto CHC level in the following aspects –
- Availability of sterile gloves and drapes, towels, cleaning materials, soap and antiseptic solution, baby receiving trays, sterilizing instruments, functional equipments like suction machines, oxygen cylinder.

- Most of the Labour rooms visited were poorly illuminated and lack of general cleanliness, lack of privacy, lack of attached toilet (toilets are not available/ non-functional/ not adjacent to LR and at some places not having running water supply) were issues of concern in quality of care.
- There is no use of partograph across the facilities but use of oxytocin before childbirth is in practice.
- Availability of emergengy drugs (Misopristol, Magnesium Sulphate, Inj. Sodium Bicarbonate) are found to be erratic. While interacting with the labour room staff it was revealed that they have very poor knowledge of emergency management at CHC and below facilities.
- Even at DH, no record of standard clinical procedures during intra-natal period was seen e.g. Vital Signs, FHS, Partograph, I/O charting. Considering the observation by CRM team it is a questionable issue whether the staffs are equipped and skilled to identify and manage emergencies.
- As per UNICEF Coverage Evaluation Survey (2009), 45% of total deliveries in the state are institutional deliveries, and 55% are home deliveries, and 56.4% of total deliveries are conducted by SBA. In Surguja , except in DH and one CHC, assisted deliveries were not found to be conducted in other CHCs or 24x7PHCs visited. UNICEF Coverage Evaluation Survey (2009) data shows 0.8% as assisted deliveries and only 6.3% as LSCS of the total deliveries conducted.
- Infection prevention measures are not being followed in almost all facilities.
- In providing safe delivery services, role of *Dais* are to be clarified. At some facilities, *Dais* are engaged in labour room to assist the ANM or SN. It seems that they are being involved in core clinical procedures in intranatal period as observed by the team in one PHC during the visit.
- There is no shadow-less lamp was available in some of the operation theatres. There was inadequacy in maintenance of aseptic measures required for an Operation theatre in some of the CHCs visited where OTs are mainly being used for Sterilization camps(Udypur CHC and Batauli CHC).
- Post-natal stay of minimum 6 hours at (L-1) / 48 at hours (L-2) is not being followed across the facility. Even staffs are not keen to convince the mother to remain in the ward till 48 hours. Facilities, amenities and security are not available to make hospital family friendly for 48 hours stay. Beneficiaries are not being counseled about the importance of post-natal stay. Due to shorter duration of stay at the facilities counseling on breast-feeding, nutrition, family planning, immunization are not being done adequately. Early initiation of breast feeding was not being encouraged (Cow milk and Honey found to be given to the newborns at the institutions even at DH).
- There is no record of post-natal visits in any of the facility visited, probably it is not happening.
- As per information obtained from state regarding functional New born care units, there is 1 SNCU at Durg District Hospital, 12 NBSUs in other DHs and 28 NBCCS at different CHCs. But the CRM team could not observe any New Born Care Corner (NBCC) [the basic newborn care unit that should be present wherever institutional deliveries are taking place], across the facilities except in DH of Ambikapur.

- Labour room Staff engaged in deliveries found to have very poor orientation in essential newborn care, including use of life saving devices like ambu bag, mucus extractor etc though some of them have received NSSK training.
- At most of the facilities, radiant warmers are out of order and no other arrangement to prevent hypothermia in neonates was observed.
- Many of the staff engaged in conducting deliveries did not have the knowledge of operating the radiant baby warmer.
- Availability and administration of Inj. Vit. K was found to be erratic.
- Immunization: Community interactions undertaken during the visit suggests that at VHNDs, Immunization and Antenatal check up are the two activities that are primarily being taken care of. In 2009-10, 5.71 lakh children were fully immunized, and in 2010-11, 2.97 lakh children were fully immunized in first quarter.
- As per Coverage Evaluation Survey (2009) of UNICEF, 57.3% of children (12-23 months) are fully immunized and 79% of immunization activity in the state has been taken place throughout outreach activity – 73% at AWC, 4% in some places in villages, and only 2% in sub-centers. Government/Municipal Hospitals, PHCs and CHCs account for only 15% of the immunization done. The routine immunization coverage is lower than national average (66.5% for DPT and OPV, and 73.1% for measles), and booster immunization among 18-23 months old children is as low as 37.4% for DPT and 34.8% for OPV.
- 32% of state population are ST population and immunization coverage among S.T. population is lowest (46.6%) as compared to other categories of backward classes.
- The state is still lagging behind in Family planning. Due to paucity of trained service providers in sterilization at the CHCs and PHCs, Laparoscopic tubectomy at CHCs through camp mode is the main approach for family planning. Male sterilization accounts for only 7.4% of total cases of sterilization. In 2009-10, 10,078 male sterilizations have been performed compared to the 1,36,761 female sterilizations done during the same period. Spacing methods are not being practiced sufficiently. Staffs trained in IUD insertion are found to be in-confident and hence, patients are being referred to CHCs and DH for the same. The CRM team could not find any record of Family Planning in the PHCs and SHCs, and even in CHCs (other than for Laparoscopic Tubectomy records).
- Safe abortion services are not being provided in most of the facilities visited and there is no record of the same. Nischay kits are available, but in CHCs the kits are kept with the Lab. Technician.
- RTIs/STIs and HIV/AIDS: The services are said to be provided at DHs and CHCs, but the team could not find VDRL or HIV testing at most of the CHC level facilities visited. RTI/STI management seems to be inadequate as no records could be made available regarding service delivery as well as lack of display of IEC materials observed in most of the facilities visited.

Recommendations:

- 55% of deliveries in the state are home deliveries. To create the facilities attractive for institutional deliveries, a lot is to be done to improve the service delivery at the facilities.

- The DPMs should have training for district PIP and reviewing of ongoing programmes. Implementation of the mechanism of regular monitoring of programme activities and supervision by District CMOs was a felt need of the CRM team. A dedicated effort is needed from the district programme management level to regularly supervise the functioning of the facilities, the quality aspects in clinical care, observance of clinical protocols, proper utilization of the available resources including drugs, equipments, disinfectants, linens, dressing materials, ferniture, registers, charts.

- There is need for ensuring good housekeeping practices by nursing staff. A system of incentives and disincentives for all cadres need to be developed for encouraging a good working culture and inculcating motivation.

JSY:

- Almost 100% of the community aware of JSY and its benefits
- There are issues in JSY payment to the beneficiaries – e.g. community interaction revealed that there no institutional deliveries at HSC (Keshavnagar – Surajpur CHC) and there is no evidence of the same but register was showing payment given to the beneficiaries for institutional deliveries.
- Payment of JSY within 7-8 days of delivery
- JDS money used for constructions rather than the procurement of heaters for the newborns.

7. Nutrition

- The state has higher rural population (79.9%) than national average(72.2%). The extent of malnutrition among children is also on the higher side of national average. 52.6% of children under 3 years of age are stunted, 24.1% are wasted, 47.8% are underweight, and 80.9% are anaemic, as per NFHS 3 (2005-06).
- 63.1 % of pregnant women are anaemic (NFHS 3). Despite improvements over time, the high levels of all three indicators of nutritional status indicate that acute and chronic under-nutrition are still major problems in Chhattisgarh.
- 20 NRCs have been established in the state and 18 of them are functioning. Children of Grade IV SAM are being admitted and treated at the NRCs. There is problem of retention of the patients for 12 days mandatory for treatment, as wage loss of parents prompts them to take early discharge of children from NRCs. There is also

problem of irrational referrals from AWCs as the Awws are not sensitized to the SAM classification standards and refer the children according to their perceptions.

- AWCs visited by the CRM team were not found to be well equipped to provide necessary services and timings were not followed in some remote areas. It appeared that Growth Monitoring is not being done, the team could not find any weighing machine of Height measuring scale in the AWWs visited and no record was available at AWCs in this regard. State Health Department needs to focus on convergence with Women & Child Department and also to reinforce the Mitanins involvement to improve the status.

8. National Disease Control Programmes (NDCP)

a. NVBDCP:

- Malaria is a major Public health problem in the state.
- Annual parasite indemic (API) was more than 5 districts viz Dantewada, Baster, Kanker, Korea, Sarguja, Korba and Jaspur.
- Dengue is also emerging public health Problem in the state due to urbanization and industrialization.
- Malaria, Deaths are the major issue and 32 Death in low endemic areas. It clearly shows block out of surveillance and treatment in these areas.
- 18 post of District malaria Officer 15, 386 lab tech, 389 health supervisors 16 Malaria Technical Supervisor 2387 MPW (Regular) and 120 MPW (on contract) 11 Finance assistant and 6 Data entry operators may be filled up on priority
- Indoor Residue spray Action Plan may be based on Insecticide resistance and epidemiological impact of malaria
- Village health Sanitation committee may be involved in source reduction to reduce mosquito genic Condition as well as during spray operations.
- Prior information to ASHA Workers and village health Community for better Coverage of indoor Residual Spray (IRS)
- Rapid diagnostic kits with with each Mitanins in hard core areas as well as Treatment facilities to control e malarial deaths in 2011.
- Distribution plan for long lasting insecticide net in high risk inaccessible areas where IRS is not possible.
- Audit of every malaria death at district level by district malaria officer
- Raipur District :-
- 122 Village above 5 API should be covered with IRS with effective Supervision. All Mitanins and S/C under these areas should have diagnostics facilities (RD Kits)
- Office infrastructure like Store, Office building, Computers, vehicle for dumping of insecticide and drugs is to arrange by the state.
- Timely Release of funds for training IEC, Anti Malaria month, and spray wages

b. IDSP:

- All the facilities are involved in generating the data and sending upwards without analysing for their local action
- Regular reporting system is not providing information on outbreak
- Programme officer for IDSP are also has many other programme responsibilities
- Emergency or epidemic management preparedness is not available

c. NLEP:

- Drugs are available in the facilities visited
- Vacancy of 17 NMS in Raipur district. Against the 37 sanctioned posts of NMA, 74 are in position in Raipur district.
- Treatment Completion Rate- State/District level _ Raipur-92 %, State – 95 %
- RCS (Re-Constructive Surgery) conducted during the year- Raipur 27, State 182
- MCR (Micro cellular Rubber) footwear procurement status- 881 provided in the current year.
- Fund utilization at state level is very low. As against 165 Lakhs approval, only 33.49 Lakhs are utilized till November 2010 (20 %).
- Considering the high prevalence rate of more than 3 per 10000 in Janjgir, Mahasamaund, Raigarh and Raipur districts,separate IEC strategy be planned and implemented. Supervision in high prevalence districts need to be strengthened by filling all the vacancies. Considering the state is having 2 Institutes, one each at Raipur and Bilaspur, RCSs can be scaled up.
- School Health Program: It is functional in all the districts. Considering the good work being done by state in terms of heart surgeries/ eye checkups for school and out of school children, it is suggested that the state may undertake comprehensive planning for timelines, team composition, drug supplies and referral and include it in the State PIP for next FY.

9. Institutional mechanisms and Programme Management

Key Findings:

- In almost all the facilities visited, registered *Rogi Kalyan Samiti* (called as *Jeevan Deep Samiti* in Chhattisgarh) has been established and meetings have been conducted; however, these meetings are not regular and there is no time line followed. Moreover, similar trend was found regarding District & State Health Mission's meeting.

Type of Institution	Sanction	Registered	Unregistered	Meeting of JDS	2010-11 ROP Sanctioned
District Hospital	**17**	**17**	**0**	**23**	**Rs. 3452 Lakhs ¼Sanctiones not received for the year**
Community Health Centre	**144**	**144**	**0**	**112**	
Civil Hospital	**11**	**11**	**0**	**7**	

Type of Institution	Sanction	Registered	Unregistered	Meeting of JDS	2010-11 ROP Sanctioned
Civil Dispensary	**17**	**17**	**0**	**0**	**2010-11**
Primary Health Centre	**716**	**662**	**54**	**248**	
Total	**905**	**851**	**54**	**390**	

- There are instances when JDS fund has been utilized for certain patient specific needs; however, JDS meetings minutes and other documents reveals that most of the money has been spent on painting, printing and purchasing. In few cases minor construction/repair has been taken under JDS. In spite of this utilization of JDS fund is very low.
- As per the mandate, PRIs are members are part of JDSs; however, it was found during the visit that meetings are most often organized on the basis of needs of the Block CMO and institutions in-charges.
- SPMU and DPMUs are generally in place; however, BPMUs are not yet established as envisaged under NRHM. Around fifty percent of SPMU position, one fourth of DPMU positions and two third of block programme unit positions are lying vacant. Infrastructure for SPMU and DPMU are reasonably good.
- Procurement of medicines is done as per Essential Drug List; however, it needs updation since various newer drugs are not part of it. Further, none of the stores in Surguja district were having a copy of essential drug list[13] and awareness regarding the same could not be witnessed. It was also noticed that there are huge out of pocket expenditure primarily for drugs/medicines[14].

- Management of store is an serious concern:
  - No information on expiry drugs (*336 Pack of Potassium Phosphate – Analytical 500 mg Mfrd. In April, 07 by Smithklan Ind. Received from DHS on 26/3/2008 with expiry within 3 yrs. i.e. April, 2010 was lying unused*).
  - Imbalanced distribution of available resources in store (such as CHC *Udaipur*).
  - Expiry medicines mixed with medicines being distributed to patients (PHC *Batra*)
  - Forced supply from top level (*Tab. ACT Combipack 775 Strip supplied from DHS on 23 June 10 with expiry on July 10*)
- State has developed system for supervision and monitoring activities such as check list for field visit, preparation of visit report, feedback system etc; however, frequency and intensity of visit varies across districts e.g. it was found in Raipur district but not in Surguja district. The online system developed by state is in infancy stage and hence not delivering enough results.
- In bigger districts such as *Surguja* DPMU is not able to conduct various monitoring visits:

[13] Except district hospital store; however, store keeper was not using the EDL for monitoring the stock of essential drugs.

[14] At certain places in spite of medicines available in the store room patients were given prescription to buy from outside; further, there were instances that, in spite of prescribed medicines available another medicine is being given to patient.

- Though state has rationalized various registers and guidelines been prepared, there are still loopholes in overall recording and reporting system at district and below:
  - At various places registers were found blank.
  - Critical registers such as delivery register does not include all the key information
  - Case history of patients (particularly delivery cases) was not found uniformly across the facilities, which is very much required in case of emergency referral.
  - Use of HMIS data could not be seen at district and below levels.

Recommendations:

State has come a long way in terms of establishing basic systems (at least at state level) for programme management, procurement, monitoring and supervision; however, focus now should be given to make these systems functional up to the lowest level:

- Hand holding support need to be given to JDSs to empower them for proper utilization of fund in patient welfare activities. There might not be a need for developing a separate training programme; however, structured checklists / tools may be provided to them which would be useful for their day-to-day decision making. Training on account keeping under NRHM may be organized.
- BPMUs need to be established urgently to help administrative and financial support to block and below level; state may think of delegating power of recruitment of BPMU staff to district health society.
- Drugs procurement, logistics and monitoring of stores need complete overhauling:
  - Checking of stores need to be part of regular monitoring visits to ensure no expiry drug is being stored / distributed. Also during these visits focus should be given to understand out of pocket expenditure and ways to reduce it.
  - A special training (refresher) programme may be developed for Stores Staff focusing issues such as storage of drugs, monitoring expiry stocks, managing store record etc.
  - Software installed at *Surguja* District for Stores Management was found very good may be introduced at other places
- Large districts such as Surguja may be provided with additional managerial / admin support
- Analysis and use of HMIS data need to be promoted at district and below level; one easy way may be review of district's performance on the basis of HMIS data so that to make them to utilize the data.
- Filed visit reports should be used for analyzing underlying reasons for low performance of a particular district and taking corrective actions for the same.

10. **Financial management**

Key findings:

The State of Chhattisgarh is managing its financial management at State level with the help of State Finance & Accounts Manager and two assistants. Funds are being e-transferred to all the districts and

other implementing agencies. As per the review of State and District financial management systems following major findings were noted:

1. Post of Director (Finance & Accounts) from the State Finance / Accounts wing is vacant
2. Books of Accounts (Cash Book) are being maintained but not up-to-date.
3. Reporting is very weak from the Sub-District Levels
4. Major Cash Handling for transferring funds from Block to VHSC and for minor/ major procurements.
5. Advances in the shape of Untied Funds with PHC/ Sub-Centre and VHSC lying unspent for 2 to 3 years at few places
6. Low utilization of budget due to lack of understanding and also due to activity-wise transfer of funds.
7. Concept of double entry system is missing; trained staff not available at Block.
8. Untied Funds are blocked at Sub-Centre and VHSCs even for 3 years.
9. Delegation of Financial & Administrative Powers at District level is not properly implemented.

- Book-keeping, Accounting and Reporting:
    - Books of Accounts at CHCs are being maintained separately for JSY, NRHM, Jeevan Deep Samiti by Block Accounts and Data Assistant (BADA), BETO and Non-Medical Supervisor (NMS). Bank Account is in joint operation of MOIC and BADA normally with BPM.

- Internal Controls:
    - No system of making payments through account payee cheque. It was noticed that most of the payments are made by withdrawing cash from bank in the name of MOIC or any other assistant of PHC/CHC/ Accountant. (As noted at CHC-Tilda Distt. Raipur)

- Bank Reconciliation:
    - In most of the facilities visited no system of preparing Bank Reconciliation Statement (BRS) existed.

- RKS (Jeevan Deep Samiti) Funds:
    - Minute Book of Jeewan Deep Samittee (RKS) was found to have been maintained. But meetings are not conducted regularly.
    - There was a gap of one month in making cash withdrawal from bank and booking of expenditure in the cash book.
    - *(Out of Cash withdrawn of Rs. 44,000/- and Rs.5744/- on 10.8.2009 Rs. 26,627/- remained unutilized as on 31.8.2010 and remaining amount was booked in the next month with a closing cash balance of Rs.12,948/-on 30.9.2010.)*

- Sub Centers Untied Fund utilization:

- At CHC-Tilda, there are 35 Sub-Centre out of which 18 are in own buildings. It was noticed that the bank account is managed by ANM jointly with PHC In charge (instead of Village Pradhan) to avoid inconvenience.
- There is lying large unutilized amount with SCs Rs. 8,91,635/- as on 30/11/2010 ranging average Rs.25,000/- with each SC as against the annual grant of Rs. 10,000/- p.a.. However, there are some Sub-Center those are having just Rs.625/- (Kaisla) and Rs.45,101/- (Kanki) also. At Kaisla S.C. ANM has not able to get his expenditures incurred after August, 2010.

- VHSC Funds Utilizations:
  - Under CHC Tilda ther are 132 VHSCs and for which Rs.13,20,000/- was received and distributed to each VHSC and during 2010-11 Rs.8,51,359/- has been reported as spent. Rs.13,20,000/- has been received on 21.4.2010 and further distributed.
  - For transfer of funds from CHC to VHSC, huge cash is withdrawn from bank and given to VHSC who in turn deposit the same into their bank account and provide bank receipt. This is due to not having similar bank account.

Programme-wise comments on funds utilization are as under:

RCH:

Total approval Rs.144.47 crore out of which for Maternal Health Rs.2.01 crore and reported expenditure is just Rs. 0.28 crore and for JSY against approval of Rs.74.67 crore reported expenditure Rs.20.11 crore. It shows either lack or improper reporting.

Mission:

Total approval Rs.236.68 crore out of which for 60,000 Mitanin Rs.25.83 crore is approved but the reported expenditure is just Rs. 4.65 crore and for untied funds against approval of Rs.26.56 crore reported expenditure Rs.6.75 crore. It shows either lack or improper reporting.

Immunisation:

Total approval Rs.7.14 crore expenditure on Review Meeting, mobility support, outreach services is Rs. 1.36 crore and for PPIP Operating Cost against approval of Rs.4.59 crore reported expenditure Rs.0.20 crore. It shows reporting system is weak.

IDSP:

For surveillance preparedness, Training and Staff Salary budget of Rs.1.35 crore approved for which expenditure of Rs.0.25 crore has been reported. Funds released by GOI Rs.0.30 crore.

RNTCP:

For various components like Civil Work, Lab. Material, Honorarium and Contractual Staff etc. a budget of Rs.8.25 crore (released by GOI Rs.3.31 crore) has been approved out which total Rs.1.88 crore has been reported as expenditure. Programme Officer should see that a detailed expenditure report is also provided to NRHM – SPMU / DPMU is also provided.

NVBDCP:

Under this programme towards Salary of Contractual Staff and ASHA incentive a provision of Rs.11.24 crore approved and for Filaria Rs.0.90 cr. , Decentralised Drugs Rs. 1.15 cr. and for commodity Support Rs.20.13 cr. approved whereas the reported expense is Rs.3.19 cr. Only. Release by GOI is Rs.5.13 cr.

NLEP:

Total approval Rs.1.65 crore include towards Contractual Services , Services through Mitanin, BCCD and DPMR etc. expenditure on which has been reported Rs.0.08 crore. The concerned programme officer are not looking at the reporting of expenditure.

NBCP:

For Strengthening of Medical College, Rs.0.40 cr. And School Eye Screening Programme Rs.4.48 crore a total budget of Rs.5.00 crore approved for which expenditure of Rs.0.68 crore has been reported.

Stores Management:

There is a need a regular detailed checking of stores record and to provide training for Stores Staff. A regular Review of expired drugs/ obsolete items is very necessary. Software installed at Surguja Distt for Stores Management was found very good may be introduced at other places also.

Recommendations:

- For the purpose of having proper control, accountability & responsibility, the Ministry has issued instructions in 2007 to appoint a person to hold the charge of Director (Finance & Accounts) at State level from State Finance Dept. and this post has not been filled. It is therefore recommended that the said post be filled on priority.
- State has recruited Block Accounts & Data Assistant but these posts have been filled only in 50% blocks, therefore priority be given to fill up these posts so as to get proper accounting. And these assistants need more F&A Training.
- It was noticed that physical achievement is higher as compared to the reported financial expenditures from the lower levels. It shows lack of reporting. It is therefore recommended that the system of reporting the expenditures from lower levels needs to be strengthened. For this purpose State should devise a Format of Reporting Expenditure (Monthly) for each level right from the level of VHSC and Sub-Centre, PHC, CHC to DHS containing all the program heads/ Jeeval Deep Samiti (JDS) - (according to the need of the reporting facility) so that proper expenditure is reported and advances gets reduced.
- Payment for small/ major procurements were noticed being made through cash by withdrawing money from the bank through bearer cheques which is not justified in comparison to making payment of JSY to a beneficiary residing in a rural area and not having bank account. It is therefore necessary that detailed instructions be issued from the State level for making such payments through account payee cheques/ draft/ on-line transfer only.
- The State has implemented the instructions issued by the Ministry for Delegation of Financial & Administrative Powers at district level but it is seen that files are still being sent to the Dy. Collector

for approval for transferring the funds from District to Blocks and for payment of Contractual Staff Salary etc. Since, as per the said guidelines once the District PIP has been duly approved by the Dy. Collector, the District CMO is vested with full powers to spend as per the District PIP. Therefore, the said aspect may be reviewed to save the time and energy for smoother functioning.

- Maintenance of timely and proper books of accounts is necessary at each level and is back bone of a good financial management system. In order to get proper reporting and authentication of the same and to sensitize the Finance & Account Staff, State may plan to hold a meeting/ conference at least once in a year either at State level or zone-wise to realize them their responsibility and to clear their various queries etc.

11. Decentralized Local Health Action

Key Findings:

- District Action plans are available for all the district and a mechanism to share record of proceedings have been initiated from this year; however, most of the time the district plans are not used and still vertical mechanism for each component exists. Decentralized Planning process is still not being followed; state informed that due to lack of capacity and rigidity in guidelines (such as fixed a yearly sum of Rs. 10000 for VHSC) it is not possible to develop bottom up planning. Nevertheless, state would focus on planning up to block level.
- During the discussion at district level it was understood that all the programme officers are not made part of planning process and they are communicated approved fund for their programme at the end of planning process (such as Training Officer in Surguja district).
- The District Plans are prepared by compiling formats from various facilities which primarily include HR and infrastructure status and fund for various UF/AMG/RKS:
  - PHC/CHC filling up formats on demand from district;
  - At district level individual programs just submit demands and DPMU compiles
  - No monitoring of progress against agreed targets in the PIP
- More than 97% of VHSCs have been formed having accounts and funds have been transferred. However most of the VHSC have not yet utilized funds and the state is facing a challenge to strengthen VHSC planning process. Funds have not yet been released as most of the VHSC could not utilize funds released earlier. VHSC members aware of health programmes; however, very little involvement found during interaction
- Community monitoring system is yet to germinate in the state.
- Involvement of Panchayati Raj Institutions in Jeevan Deep Samities and VHSCs is very weak. Community representative are not aware of their roles.

Recommendations:

- Programme officers at district level should be made part of the entire planning process and it should not be limited to DPMU

- Block level upward planning process need to be strengthened till the time village level capacities are geared up
- For each activity approved under PIP, a person responsible need to be identified and made accountable
- Monitoring of progress against PIP need to be focused; tools such as variance analysis may be used
- Training /orientation of VHSC members may be organized

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