6th Common Review Mission Report

Chattisgarh

The CRM team visited Chattisgarh from the 3rd to the 9th of November 2012. Before it reached Chattisgarh it attended a one day national briefing at New Delhi, on the 2nd. On the 3rd there was a detailed state level briefing of the team made by the Mission Director, Shri Anand Babu accompanied by all the senior programme officers and directorate officials.

The CRM team then divided into two groups and one visited the district of Mahasamund and the other, the district of Dantewada. The composition of the teams was as follows:

	Mahasamund	**Dantewada**
1	Dr. RP Meena, Director, NVBDCP	Dr. T Sundararaman, Executive Director, NHSRC
2	Dr H Sudarshan, Karuna Trust	Mr. AK Panda, Director, Planning Commission
3	Dr. RP Saini, Consultant, MoHFW	Dr. AnkurYadav, Associate Professor, NIHFW
4	Mr. KapilDev Singh	Ms. IshaRastogi, Consultant, MoHFW
5	Mr. Akshay Kumar Sahoo, Under Secretary, Maternal Health	Dr. Nitasha M. Kaur, Consultant, MoHFW
5		Dr. Anand Bang, Senior Consultant, NHSRC

The team spent four days 4th to the 7th in the districts and returned to Raipur on the 7th. On 8th they discussed their finding and recommendations with the programme officers and based on their feedback finalized the report and presented it to the Principal Health Secretary, The Mission Director and the Commissioner Health on the 9th morning.

The facilities and sites visited in the districts are given below.

Dantewada Team Visits:

S. No	**Name**	**Address / Location**	**Level (SC / PHC / CHC/other)**
1	District Hospital	Dantewada	District Hospital
2	District Hospital	Sukma	District Hospital
3	CHC	Geedam	CHC
4	CHC	Kuakonda	CHC
5	PHC	Palnar	PHC
6	PHC	Pondum	PHC
7	PHC	Metapal	PHC
8	PHC	Bhusara	PHC
9	SHC	Mokhpal	SHC
10	SHC	Matena	SHC
11	SHC	Metapal	SHC

12	SHC	Pondum	SHC
13	SHC	Balud	SHC
14	VHSC	Matse	VHSC
15	VHSC	Karli	VHSC
16	VHSC	Heeranagar	VHSC
17	VHSC	Kotwar	VHSC

Mahasamund Team Visits:

S. No	Name	Address / Location	Level (SC / PHC / CHC/other)
1	District Hospital	Mahasamund	DH
2	CHC	Pithora	CHC
3	CHC	Bagbahara	CHC
4	PHC	Tumgaon	PHC
5	PHC	Bhithidih&	PHC
6	PHC	Jhalap	PHC
7	PHC	Komakhan	PHC
8	PHC	Khallari	PHC
9	SHC	GarhSivani	SHC
10	SHC	Sarkada	SHC
11	SHC	Mudipur	SHC
12	SHC	Vrindavan, , &	SHC
13	SHC	Khopali	SHC
14	SHC	Pachera	SHC
15	SHC	SivaniKalan	SHC (State Initiative Building)
16	SHC	Nandgaon	SHC
17	SHC	Kosrangi	SHC

Chapter two:

Introduction:

Chattisgarh, spread over 135,194 sq. km. is bordered by Madhya Pradesh on north, Maharashtra on west, Andhra Pradesh on south, Orissa on south-east and by Jharkhand on the north - east. It is predominantly forested region, known for the beauty of its naturally mixed forests, Mahanadi and Indravatirivers. The state is rich in natural resources. It is also one of the most heavily affected state in India due to the left wing extremism.

The total population of Chattisgarhis 2.55 Crore with a decadal growth of 22.59%. There are 27 districts, 149 tehsils and 146 blocks in Chattisgarh. There are 20126 (2011) villages, an average of approximately1267 persons per village. The population density in Chattisgarh is 189 persons per square kilometer.

The birth rate was 23.9 per thousand and the death rate was 7.6 per thousand as compared to an all India 22.1 and 7.2 (AHS 2011). During 2002 -06 life expectancy in Chattisgarh among males & females was 66.5and 67.3 respectively which was higher as compared to All India 62.6and 64.2 during the same period. The sex ratio in Chattisgarh is 991 females per 1000 males and the sex ratio in the age group 0 – 6 years is 964. The overall literacy in Chattisgarh is 71.04%; 81.45% among males and 60.59% among females.

Though in terms of human development index, Chattisgarh is ranked 23rd, this needs to be evaluated in view of the growth achieved by the statesince it was carved out of Madhya Pradesh as a separate state, and considering the immense problems faced in terms of lack of human resource, infrastructure, difficult terrain as well as the issue of left wing extremism.

The two districts visited by the CRM team have relatively divergent profiles and this is an interesting learning experience. Despite the differences of topography and demography some health systems features are shared whereas some are widely different.

The administrative divisions, health facility infrastructure, comparative figures of major health and demographic indicators of the state are given below:

1. **State Profile:**

Rural Population (In Lakh) Census 2011	196.04
Number of Districts	27
Number of Sub Division/ Talukas	96
Number of Blocks	146
Number of Villages (RHS 2011)	20126
Number of District Hospitals	27

Number of Community Health Centres (RHS 2011)	148
Number of Primary Health Centres (RHS 2011)	741
Number of Sub Centres (RHS 2011)	5076

2. Status of Key Health Indicators

Indicator	Chhattisgarh	India
Infant Mortality Rate (SRS- 2010)	51	47
Maternal Mortality Rate (SRS 2007-09)	269	212
Total Fertility Rate (SRS- 2009)	3.0	2.6
Institutional Deliveries (In Lakh) 2011-12(Up to December) (MIS)	1.89	120.74
Full immunization (In thousands) 2011-12(Up to December) (MIS)	392	13919

3. Demographic Profile

Indicator	Chhattisgarh	India
Total population (In crore) (Census 2011)	2.55	121.01
Decadal Growth (%) (Census 2011)	22.59	17.64
Crude Birth Rate (SRS 2010)	25.3	22.1
Crude Death Rate (SRS 2010)	8.0	7.2
Natural Growth Rate (SRS 2010)	17.3	14.9
Sex Ratio (Census 2011)	991	940
Child Sex Ratio (Census 2011)	964	914
Schedule Caste population (in crore)	0.24	16.6
Schedule Tribe population (in crore)	0.66	8.43
Total Literacy Rate ((%)Census 2011)	71.04	74.04
Male Literacy Rate (%) (Census 2011)	81.45	82.14
Female Literacy Rate (%) (Census 2011)	60.59	65.46

4. Progress of NRHM

Activity	Status
24x7 PHCs	Out of 716 PHCs, 67 PHCs are functioning on 24x7 basis.
Functioning as FRUs	27 DH, 5 SDH and 53 CHC are working as FRUs.

ASHAs Selected	All 60092 ASHAs Selected and trained upto 7th Module.
ANMs at SCs	Out of 4776 SCs, 348 are functional with 2nd ANM.
Contractual appointments	325 AYUSH Doctors, 337 Staff Nurses & 337 ANMs are positioned under NRHM.
RogiKalyanSamiti	903 facilities (17 DH, 148 CHCs, 26 Other than CHCs & 695 PHCs & 17 Other Health facilities above SC) have been registered with RKS.
Village Health Sanitation & Nutrition Committees (VHSNCs)	Out of 20308 villages, 19929 villages Constituted VHSNCs.
Institutional Strengthening	• 361 SHCs have been taken up for New Construction. • 163 Primary Health Centre have been taken up for Renovation/Upgradation works under NRHM and Renovation/Upgradation of 16 PHC buildings has been completed. • 5 Community Health Centre's have been taken up for New Construction and 65 for Renovation/Upgradation works under NRHM and Renovation/Upgradation of 34 PHC buildings has been completed • 27 District Hospitals have been taken up for Renovation/Upgradation

5. Physical Progress of Institutional Deliveries and JSY (In Lakh)

Year	Institutional Deliveries	JSY beneficiaries
2005-06	1.03	0.03
2006-07	1.31	0.76
2007-08	1.49	1.76
2008-09	1.79	2.25
2009-10	2.51	2.49
2010-11	3.25	3.76
2011-12 (Upto December)	1.89	2.01

6. Health Services

Services	06-07	07-08	08-09	09-10	10-11	11-12
Male Sterilisation	6322	9922	10562	10078	7213	4520
Female sterilisation	126772	143916	136604	136761	136855	50348
Full immunisation (In thousands)		586	569	571	627	392

7. Reproductive and Child Health Programme (RCH)

a) Immunization Coverage (*Figures in percentage*)

	NFHS-2	NFHS-3	Coverage Evaluation Survey		
Year	1998-99	2005-06	2005	2006	2009
Fully Immunized	21.8	48.7	44.4	57.3	57.3
BCG	74.3	84.6	89.2	96.1	84.8
OPV 3	57.1	85.1	49.2	63.3	66.5
DPT 3	40.9	62.8	65.5	65.2	66.5
Measles	40.0	62.5	72.0	78.4	73.1

b) Information on selected MCH indicators

Indicators	DLHS -2 (2002-04)	DLHS-3 (2007-08)
Child feeding practices (%)		
Children under 3 years breastfed within one hour of birth	29.5	50.1
Children age 0-5 months exclusively breastfed	NA	78.3
Children age 6-35 months exclusively breastfed for at least 6 months	36.6	43.3
Children age 6-9 months receiving solid/semi-solid food and breast milk	NA	56.8
Awareness about Diarrhoea and ARI		
Women aware about danger signs of ARI (%)	38. 1	47.1
Treatment of childhood diseases		

Children with diarrhoea in the last 2 weeks who received ORS (%)	41.7	36.6
Children with diarrhoea in the last 2 weeks who were given treatment (%)	69.3	67.0
Children with acute respiratory infection of fever in last 2 weeks who were given advise or treatment (%)	63.3	68.1

8. Funds Released under NRHM (In Crore)

Year	Allocation	Release	Expenditure#
2005-06	119.22	94.13	107.37
2006-07	174.21	149.11	187.69
2007-08	222.60	190.85	197.77
2008-09	259.35	249.72	162.12
2009-10	292.01	261.64	240.41
2010-11	345.76	327.24	307.92
2011-12	387.64	161.31	233.23
Total	1800.79	1434.00	1436.51

*Allocation and Release figures are excluding kind grants.
*Expenditure figures for 2009-10, 2010-11 and 2011-12 (upto December) are Provisional.
Expenditure is more than Release due to previous unspent balance and include State shareTable 2: Status of Health Indicators
*SRS – Sample Registration Survey
**CES – Coverage Evaluation Survey 2009

CHAPTER THREE
FINDINGS OF THE 6th CRM IN THE STATE

TOR 1: FACILITY BAED HEALTH CARE SDRVICES:
Access, Affordability, Quality, Quantity and Equity

Positives:

- The overall status of infrastructure is improving in the state in general and the districts in particular.Staff quarters, infrastructure and equipments were adequate at most of the SHC and PHCs. Maintenance and cleanliness is satisfactory in SHC and PHCs as well as the safety issues in the labor rooms and wards.
- The districts have been sanctioned adequate facilities in terms of population and access.
- User fees are generally less or absent at the PHC and SHC level.
- In both the districts, the construction of ANMTC has been completed.
- ASHA help desk is in place at the CHCs for guidance and service guarantee to pregnant women.
- In Dantewada there was overall substantial increase in out-patient care.
- The tour plan of ANM is displayed at the SHCs.

A) Creation of facilities and access:

There are three Medical colleges (Raipur, Bilaspur and Jagadalpur), 2 Government dental colleges and 4 Private dental colleges in Chattisgarh. An AIIMS is being set up in Raipur. The ratio of beds to population at primary and secondary level is 11.2/ 1000. Of the total number of beds, the two medical colleges account for 1265.Additionally, the State has 1159 AYUSH institutions, most of which are Ayurvedic and almost every institute has one AYUSH Medical officer. This is a remarkable achievement for the new state that began with only 456 PHCs, 36 SHDs, 12 DH and 2067 SHCs just 10 years back.

Because of geographic considerations and on the principle of equity, Chattisgarh has relaxed the facility per population norms over the years.

In Mahasamund block of Mahasamund district, there is both DH as well as CHC and hence the CHC is slow to pick up. In Dantewada some of the PHCs are serving areas equivalent of sub-centers

B) Infrastructure for facilities:

a) Sources of funds for construction: The funds for construction are available from

- Integrated Action Plan
- The State Government
- The Tribal Area Sub Plan
- EU-SPP and

- NRHM

b) Agencies for construction:The state deploys 4 agencies for infrastructure / civil work. The agencies are

- PWD which does the bulk of the work.
- RES
- ZilaNirmanSamiti and
- GrihNirmanMandal.
- Additionally some work isalso commissioned through Gram Panchayat and the JivanDayiniSamiti.

c) Status and quality of construction:

Overall in the state, though there has been substantial improvement in creating infrastructure, the pace is still slow and much needs to be done to bring the infrastructure to the desired level of optimum functioning.

In Dantewada a major gap was relative shortage of residential accommodation, both at the CHC and at the PHC level. Though this shortage is currently being solved by construction of the residential facilities, the pace of improvement is slow.The building construction is generally of good quality though it is behind schedule.In Dantewada construction is complete for only 2 of the 21 Labor rooms, 5 of the 22 SHCs,8 of the 31 staff quarters and non of the 2 FRUs. In Dantewada the ZilaNirmanSamiti has completed construction in 3 SHCs but not handed over.

In Mahasamund the district is upgrading the infrastructure (new and existing) with the help of PWD and Rural Engineering Services (RES) but the pace of construction is slow. Many facilities are functional from old building with inadequate infrastructure. Most of the buildings are not as per IPHS norms, without boundary wallsand without residential facilities for the staff. This reduces the availability of staff in odd hours. Neither was there any committee formed by the health department to check the quality of the construction. Hence the District Collector herself is monitoring the infrastructure issues. The construction was completed for none of the 2 labour rooms, 7 of the 13 SHCs, none of the 7 staff quarters (to be constructed by the PWD).

In both the districts, facilities were generally clean but with scope of improvement especially in case of toilets. The waiting area was satisfactory in most of the facilities. Boundary wall need to be constructed in most of the facilities (PHCs, SCs). Neverthless, in both the districts, most of the PHCs are still operating out of HSC buildings, the staff quarters, infrastructure and equipments were inadequate at CHC and DH. Development of infrastructure including staff quarters was underway at several of the health facilities visited.

*d) Causes of delays and slow pace of construction:*One important cause of the delay is the adverse conditions in the left wing extremism affected districts of the state. Similarly in both the districts, importantly there are neither MOUs nor any penalties, instead the agencies ask for more funds to compensate delay in completing the construction.

C) Service provision: OPD, IPD, Range of services, AYUSH services

In both the districts, though some facilities have increased flow of in-patient admissions with admissions of primarily of Institutional deliveries and cases of fever. Nevertheless the

limitations of infrastructure are limiting the bed occupancy. Similarly and especially in Dantewada the lack of specialists is the reason of referral of complicated cases to higher centers in public health care system in other district (Jagadalpur) or NMDC and Apollo hospital. There are also few admissions of patients with non communicable diseases.

Importantly, in district Dantewada, the shortage of MBBS doctors were filled by RMAs and AYUSH doctors. Most of the PHCs had AYUSH MOs posted in them. They were doing OPD and prescribing drugs for all the major and minor complaints of the patients. A good integration of AYUSH and allopathic services were seen in the district. Drugs were found optimum in the district.

In Mahasamund five AYUSH practitioners are in place under NRHM and performing well. All five are placed at PHCs. AYUSH drugs are sufficiently supplied but few additional medicines need to be added. Main types of cases encountered in AYUSH OPDs are as follows:

1. Cold and Cough
2. Joint pain
3. Constipation
4. Itching

D) Drugs and Diagnostics:

In both the districts, the supply of medicines was inadequate with most of the facilities not receiving the required medicines and the majority purchasing the medicines from JDS/RKS funds. Due to shortage of drugs, the out of pocket expenditure is substantial.

In Mahasamund, the availability of drugs is satisfactory including that of antibiotics but in Dantewada, the availability is inadequate especially for higher range of care, for basic emergency obstetrics care as well as management of complicated malaria.In Mahasamund there is a central medical store. The new building of drug store in under construction as the current space is not adequate. Rate contract was used at the district level for procuring drugs to fill gaps reducing the gaps to some extent. No diagnostic services were outsourced. But all the facilities (DH/CHCs/PHCs) have started charging user charges). OPD and IPD facilities are free for BPL beneficiaries whereas for X-ray and laboratory services the user charges are placed for both APL and for BPL. All the patients get an OPD slip from the registration counter/table and then proceed in sequence for the services (except the emergencies) to systematize smooth flow of beneficiaries. In Dantewada also no diagnostic services have been outsourced.

In Mahasamund there is only one blood bank at the district hospital. The district has planned three blood bank at proposed FRUs but not functional. PHCs and SCs are maintaining good records but there is scope of improvement for district hospital and CHCs.In Dantewada also there is only one blood bank in the district hospital; nevertheless renewal of registration of the same can be a problem.

In Mahasamund multiple laboratory technicians were placed on many centers from different programme (HIV/AIDS, RNTCP, NVBDCP, NRHM) whereas no laboratory technicians were present in some facilities. Bio medical waste management was poor and most of the staff untrained in bio medical waste management and infection management control measures. There were very poor safety measures (installation of fire safety equipment etc.) for beneficiary and service providers. The situation was similar in Dantewada as well.

E) Maintenance / Hygiene / Sanitation / Water / Electricity:

In both the districts, the maintenance was poor in CHCs but satisfactory in SHCs and PHCs.Cleanliness and hygiene was also good in SHCs and PHCs but needs improvement in CHCs and DH. The safety issues in the labor rooms and wards are satisfactory.

F) Infection Control:

In both the districts procedures for sterilization of equipment needs improvement. Non-functional autoclaves were found at the facilities during the field visit and gas stoves were being used for sterilization. Infection control measures are inadequate in many of the facilities. No colored bins are available at most of the facilities. Needle cutters are used at most of the facilities. BMW has not been outsources to any agency. In Mahasamund the community members take the placenta back with them after the delivery from the SHCs and pits were observed at the CHCs and PHCs as no boundary wall was present at many of the facilities.

G) Support services:

In Mahasamundthe district hospital has no separate laundry arrangements for separate departments. There is only one dhobi/sweeper responsible for at the CHCs/PHCs. The district hospital has outsourced the laundry serviceand the collection is weekly. There was separate arrangement of washing for wards and OTs linen. District Hospital has also outsourced the dietary services and made diet available free to the patients. Contents of meals are displayed in the wards. In Mahasamund the dietary services were outsourced in District Hospital, CHCs and PHC (under JSSK). The CHCs/PHCs are providing food at the facilities arranged through different sources based on the local conditions. The situation was similar in Dantewada.

H) Gender:

In both the districts privacy for women was lacking in CHC and District Hospital and separate male and female wards are needed especially when there are beds and facilities available for the same. Similarly in most of the PHC also there is lack of separate wards as the PHCs are functioning in sub center building. In both the districts DH/CHCs and PHCs have separate toilets for male and female. Some of the facilities (CHCs/PHCs) are though not having attached toilets in the labor room. ASHA help desk is in place at the CHCs for guidance and service guarantee to pregnant women.

I) Cost of care:

In both the districts, the out of pocket expenditure was substantial at the district hospitals with approximately Rs 400 on drugs and / or diagnostics. Diet and transport are generally a significant problem in most of the facilities. In district hospital and CHC Geedam, 5 patients were interviewed. One patient who was admitted with fever, paid Rs 40 for injection Taxim and Rs 300 for getting Malaria and typhoid tests done from outside. Another patient who was not RSBY card holder paid Rs 300 on medicines. There was one RSBY card holder patient who was on Anti tuberculosis therapy admitted with fever and weakness bought 4 health tonics for Rs 484. In CHC Geedam, Out of Pocket Expenditure varied from Rs 30 to Rs 60 on drugs particularly Injection PCM and aciloc, inspite of huge unspent balance in JDS/RKS accounts.

In both the districts, in case of RSBY patients, many have expenditure due to purchasing unessential drugs on the card in addition to the out of pocket expenditure on drugs and diagnostics. In Dantewada, only 3 RSBYs card holders were found with nil external

expenditure. Non RSBY card holder patients were prescribed drugs from outside such as IV paracetamol and ranitidine.

J) Other:

In Mahasamund, there is no public announcement system at the facilities. In both the districts there was relative lack of display of citizen charter is displayed at the facilities for awareness among beneficiaries.

TOR II: OUTREACH AND PATIENT TRANSPORT SERVICES

Positives findings:

- In both the districts, the cold chain is maintained well with proper micro planning and ILRs with ice packs are available at most of the PHCs.

- In Dantewada, there are 74 SHCs with adequate infrastructure confirming to the norms in tribal areas of each SHC serving approximately 2000-3000 population. The SHCs are doing OPD, VHND and 25% of Institutional deliveries. This is remarkable considering the LWE affected status of Dantewada.

- In both the districts, the ANMs are conducting VHNDs as per schedule spending approximately six hours per VHND. The line list is regularly prepared by the ANM for immunization. The ANM adds the name of the dropout in the next list to cover the same. They have adequate knowledge and supply of IFA and Zinc.

- In both the districts, the Mitanin (ASHAs) are performing well as well as distributing sanitary napkins in the community.

- In Mahasamund, the district officials conduct the health camp jointly with NACO for migratory population once in a year before Diwali.

- The state has started conducting biannual round for Vitamin A supplementation programme for under five children. The first round took place in August, 2012 and the second is planned in January, 2013.

A) Services provided:

In both the districts, the ANM carries vaccine from the PHCs for immunization. The alternative vaccine delivery amount is paid to the ANM. No SHC is with second ANM as the ANMs appointed initially as second ANM have been absorbed by the state in the state budget. In case the post of ANM is vacant, the ANM of nearby SHCs is given additional charge to the adjacent SHC.

The ANMs are conducting VHNDs as per schedule. Average time for VHND is around six hours. Line list is being prepared by the ANM for immunization. ANM add the name of the dropout in the next list to cover the drop out. A VHND session was visited in village Matse in district Dantewada where the ANM from SHC Matsewas conducting outreach session. The ANM was SBA trained and conducts approximately 3-4 deliveries in a year. There are 17 Anganwadi Centers under the SHC. 2-3 Angangwadiare clubbed and 6 VHND sessions are conducted in a month, which covers all the Anganwadi centers. ANM was doing blood sugar level tests with the help of glucometer and was providing combination medicine for malaria (P. Falciparum). The ANMs have adequate knowledge of IFA and Zine.

The state has started conducting biannual round for Vitamin A supplementation programme for under five children. The first round took place in August, 2012 and the second is planned in January, 2013.

In both the districts, no gap identification exercise was done to identify the gap for SHCs. Hence, for example, in Dantewada, the outreach services were not population based but facility based and hence hamlets were getting left out.

There is no specific manpower for urban areas of Mahasamund district. All the outreach services in the urban areas are being provided by the ANMs. No urban setup in the district.

B) Emergency and Patient Transport Services:

State has started EMRI-108 services in the year January, 2011. In Dantewada there are 4 EMRI 108 at block level and district level with - the performance ranges from 2/day to 5 /day. About 30 to 40% of pregnancies- and of the pregnancies about 4% delivered on the van and another 4% delivered at home before pick-up. Low areas of use are associated with low mobile connectivity. Currently district Mahasamund is having eight EMRI-108 ambulances with similar experience.

The EMRT centre was visited in the district Dantewada. In block Geedam, 1536 cases were picked up by EMRI out of which 500 (32 %) were delivery cases. Out of these 500 deliveries, 48 deliveries took place at home before EMRI could reach to the beneficiaries and 34 deliveries happened on the way, which were conducted by the EMTs. Low areas of use are associated with low mobile connectivity. The EMTs underwent training for 2 months where they were trained for conducting deliveries for 10 days.

State will be starting 102 ambulatory services for inter facility transport and drop back facility, under which state will be outsourcing the management services where the ambulances will be provided by the state.

C) Ambulances:

Dantewaada has 32 ambulances stationed at the health facilities for the population of 2, 50,000. Out of these 32 ambulances, 25 ambulances are functional with about 2 drivers for 3 vehicles. According to the criterion of ambulance per population, there is no shortage of ambulances in the district. Additionally, every block would be getting 2 more ambulances in next month. However, the ambulances were seen defunct at most of the health facilities due to the shortage of drivers. Hence the district needs to utilize the stationed ambulances by hiring drivers through JDS/RKS. In case of ambulance services, there is lack of emphasis on use in drop back and lack of promotion of this as a patient transport vehicle. The experience is similar in Mahasamund.

D) MMUs:

There are currently no MMUs in either of the districts.

E) Social Marketing:

District Dantewaada has yet not been covered under Social Marketing of contraceptives and Menstrual Hygiene for Adolescent girls schemes of Government of India. However, District is provided contraceptives under tribal supply which is distributed by Mitanins (ASHA). In Mahasamund, Freeday sanitary napkins are supplied and ASHAs are distributing to the community. Quality issues have been raised by the beneficiaries with the absorbent capacity of the napkins.In both the districts, no fixed day in the week for iron and folic acid administration to adolescent observed.

F) IEC/BCC:

In dantewaada, IEC was found displayed in almost all the health facilities. However, the IEC material was not language and local culture specific, as most of the IEC material was in English and had displayed images of non-tribal community. IEC on JSSK was misleading as it was displayed that Rs 100 is given for diet for every pregnant woman, which could be displayed in a manner that free diet is available in all the health facilities for every pregnant woman.

The status of human resource for outreach activities:

Cadre of male and female health care workers	Mahasamund		Dantewada	
	Sanctioned	Filled	Sanctioned	Filled
Female Health Workers	256	233	90	97
Male Health Workers	226	210	78	48
Female Health Supervisors	44	19	18	12
Male Health Supervisors	40	13	15	10

TOR III: HUMAN RESOURCE FOR HEALTH:
Planning, Training and Performance

Positive findings:

- In case of MPWs, both regular and link worker 210 of 226 were recruited in Mahasamund and all were recruited in Dantewada.

- To a large extent the gap in MBBS doctors is filled by AYUSH doctors and the RMA. In fact, they continue to work as the backbone of the health care system. The skill set of the RMA has been expanded further by 10 days training in CMC Vellore. In such, Chattisgarh has devised a system of compensating to a degree the lack of availability absence of retention of allopathic doctors in remote areas as well as retention.

A) Availability of Human Resources, Gap analysis&vacancy by category

Chattisgarh has a major human resources problem in the public health sector in form of substantial vacancies in general and of specialists in particular. The state finds it difficult to fill up posts in rural, tribal and left wing extremism affected areas. There is also lack of skills and inadequate performance. Hence admittedly the central problem of health care in Chattisgarh is the availability, skills and performance of its human resources.

In DHMahasamund6 of the 12 specialists posts were filled in and 3 of the 30 specialists posts in CHCs were filled. In Dantewada there were no specialists in the public health care system except a radiologist at the district hospital and the CMHO who is an orthopedician. Of the posts of the Medical officers, in Mahasamund6 of the 15 posts were filled in the DH and 24 of the 29 posts of medical officers in PHCs were filled. In Dantewada 19 of 40 posts of Medical Officers were filled out of which 3 were contractual.Dantewada has 23 RMAs posted against sanctioned post of 12, 2 were posted at CHCs, 12 were posted at PHCs and 9 were at SHC level. There are 37 RMAs at Mahasamund of which 7 are in sub-centers and rest in PHCs.

All PHCs and CHCs had AYUSH MOs as well in Dantewada (16) but not in Mahasamund. It is interesting to note that to a large extent the gap in MBBS doctors is filled by AYUSH doctors and the RMA. In fact, they continue to work as the backbone of the health care system.

In Mahasamund of the required 35 SN at CHC, only 8 posts were filled. At the district hospital 10 of the 36 posts and at the PHC 10 of the 28 vacancies were filled. ANMs along with MPWs are posted one in every SHC in both the districts.

In both the districts, there is a shortage of permanent support staff like ward boys, “ayahs”, administrative staff, and cleaning staff. The districts have hired such manpower under JDS/RKS to fill the gap.

The staff position at DH, CHCs and PHCs in Mahasamund and Dantewada:
District Hospital:

Name of Post		Mahasamund			Dantewada		
		Sanctioned	In Position	Vacant	Sanctioned	In Position	Vacant
Specialist		12	06	06	23	1	22
Medical Officers		15	6	9	40	19	21
Staff Nurse	Regular	36	10	26	82	18	64
	Contractual	-	0	-	0	0	0
ANMs		0	2	0	90	97	-7
Pharmacists		02	02	0	22	19	3
Lab Technicians		04	05	0	22	10	12
X-Ray Technician		02	02	0	5	4	1
Dresser		03	02	01	19	15	4

CHCs:

Name of Post	Mahasamund			Dantewada		
	Sanctioned	Working	Vacant	Sanctioned	Working	Vacant
Specialist - Medicine	5	1	4	3	0	3
Specialist - Surgery	5	1	4	3	0	3
Gynecologist	5	0	5	3	0	3
Pediatrician	5	1	4	3	0	3
Anesthetist	5	0	5	3	0	3
BMO	5	0	5	3	0	3
Medical Officer	10	10	0	6	4	2
Nursing Sister	5	0	5	3	0	3
BEE	5	1	4	4	2	2
Staff Nurse	35	08	27	21	3	18
Lab Technician	5	4	1	3	3	0
Pharmacist	10	4	6	6	3	3
Radiographer	5	1	4	3	3	0
Male Supervisors	5	1	4	3	3	0
Female Supervisors	10	5	5	6	3	3
MPW (Male)	5	3	2	3	3	0
MPW (Female)	5	3	2	3	3	0

PHCs:

Name of Post	Mahasamund			Dantewada		
	Sanctioned	Working	Vacant	Sanctioned	Working	Vacant
Medical Officer	29	24	05	12	4	8
Pharmacist Grade II	29	22	07	12	9	3
Lab Technician	29	07	22	12	9	3
Ophthalmic Asst.	29	09	20	12	8	4
MPW (F)	29	29	00	12	12	0
Dresser	29	21	07	12	11	1

B) Workforce Management:

The appointment of Contractual staff is made under Chhattisgarh government Civil service, 2004 (Contractual rule). The staff is contracted in for 5 years, after which he is either absorbed or terminated. The age limit for the entry is 35 years- no increment for contractual staff. The contractual staff has not received any increment apparently due to some central guideline. No on paper appraisal system below the PMU for staff. Hence it was challenging to manage such alarge contractual staff. Formats are developed to assess the NRHM workforce performance of PMU staff. No mechanism for training has been developed.

No increments were paid for the contractual staff from the last year in Mahasamund neither was there rationalization of salary paid to contractual staff under different programme of NRHM which leads to frequent change and high attrition.The state is not having any specific plan for regularization of the NRHM staff.

C) Training

In both the districts there is urgent need for capacity building of the health service providers. Areas of training for immediate attention are SBA, bio medical waste management(as per IMEP Guidelines), LSAS, BEMOC andCeMOC. In both the districts, there is lack of facilities in the districts with reasonable case load to serve as adequate training site. In both the districts, for capacity building there is strong need to establish DTC

The performance of training

- **In Mahasamund:**

S.No.	Training of	Target Group	Target	Achievement	% of Achievement
1	SBA	ANM/LHV	20	4	20.00%
2	MTP	MO	2	2	100%
3	RTI/STI	RMA	8	8	100%

		SN	8	7	87.50%
		LT	8	7	87.50%
4	BEMoC	RMA	5	0	0%
		MO	5	5	100%
5	ANC	ANM	210	0	0
6	NSSK	ANM	150	108	72%
7	VHND	Other Staff	180	0	0
8	IUCD	MO+SN+LHV+ ANM	28	0	0
9	PPIUCD	MO+SN+O&G	20	0	0

- **In Dantewada:**

S.No.	Training of	Target Group	Target	Achievement	% of Achievement
1	SBA	ANM/LHV	8	8	100%
2	MTP	MO	1	0	0%
3	RTI/STI	RMA	4	4	100%
		SN	4	3	75%
		LT	4	4	100%
4	BEMoC	RMA	3	3	100%
		MO	3	3	100%
5	ANC	ANM	90	0	0%
6	NSSK	ANM	90	19	21%
7	VHND	Other Staff	90	90	100%
8	IUCD	MO+SN+LHV+ANM	28	0	0%
9	PPIUCD	MO+SN+O&G	10	0	0%

Conclusion:

At the time of creation of the state only 40% or less of required facilities were existing and in the same up to 40% vacancies were present. Has the state advanced? Today every SHC in Dantewada has one male and one female worker (as against 2 female and 1 male worker planned for), every PHC has one RMA, one AYUSH doctor and 2 or 3 nurse equivalent as against 2 MBBS and 5 nurses. Every CHC and DH has MBBS medical officers.

One would celebrate that the HRH gap has been successfully filled or one would conclude that the state has failed since there are still vacancies at each level. The CRM team would call for building on the task shifting where non allopathic practitioners have been successfully equipped with allopathic skills.

TOR IV: REPRODUCTIVE AND CHILD HEALTH PROGRAMME:

Positives:

- Both the districts have functional blood bank facilities and no patient is charged for providing blood.In both the districts, 24*7 delivery services are available in most of the facilities visited. The Labour rooms were following proper waste disposal practices. All the necessary drugs were available in the facilities visited and oxytocin was absent in only 1 SHC. In both the districts, specific standard operating procedures after second stage of labour were followed though not displayed in the labour rooms. In both the districts, breast feeding initiation happening in post labor wards and counseling is given by present delivery handlers like SN/ANM/MO.
- In both the districts, the cold chain is maintained properly and stocks were adequate.
- In both the districts, JSY payments backlog was minimal with regular payments by cheque.
- In both the districts, overall the 108 services and drop back home as well as free care have had positive impact. In both the districts, generally the pick- up from referral from homes as well as inter facility transfer is satisfactory.
- In both the districts, the VHSCs also maintain a register of all the deaths in the village including the probable cause of death. This provides a fairly accurate picture of the local epidemiology and insight into the possible interventions as well as the gaps in health care delivery.
- In both the districts, community level management of sicknessis mostly done by the Mitanin who identify cases of diarrhea and ARI. The Mitanin initiate the treatment for diarrhea using ORS and refer in cases of childhood ARI. ANM provide postpartum visits in case of home deliveries.
- In both the districts, TT doses and IFA distribution is done by ANMs. MCP card and ANC card in the facilities are issued at the time of registration and maintained throughout the antenatal period. ANMs and MPWs are providing services for ARI, Diarrheal disease through the SCs and Mitanin as well as AWWs also supporting at their AWW Centers. A referral mechanism under JSSK for neonates is available.

Key observations:

A) Planning of the facilities, Health services and Human resource:

In Mahasamund there are 118 (46%) delivery points out of 255 health facilities, in which 92 are SHCs. Major proportion(37.5%) of institutional deliveries are taking place at SHCs. In Dantewada though volume is low and deliveries are at sub-threshold level at several delivery points, they should still qualify for delivery points on the basis of equity. Overall there was no significant difference between 24*7 and PHC.

B) Maternal health: FRU, 24*7, SNC, skills

a) Antenatal care:

In both the districts, most of the facilities except DH were not doing lab tests other than Hb, UPT and MP ROT in both the districts. Hence the detection of high risk pregnancies as well as early referral is limited by the absence of blood and urine testing facilities at SHC and PHC level. 67.70% of the women registered received 3 ANC checkups

b) Emergency obstetric care:

In Dantewada, there is no fully functional FRU in the district nor are C-Sections conducted in the public health facilities, due to the absence of Obstetrician and Anesthetist. Emergency obstetric care is provided in Jagdalpur for patients from katekalyan block and from Chindgarh. The NMDC hospital provides care to Kirandul, Kuakonda and Dantewada block. The Apollo hospital provides care to Bacheli, Kuakonda as well as Dantewada. Malkangiri district from Odisha is the place providing emergency obstetric care for Sukma block and Bhadrachalam district from Andhra Pradesh provides for Konda block. Overall the district hospitals are weak. Though there is a plan of starting up FRU in DH Dantewada, it has not yet started and no clear plan of action.With NMDC hospital and Apollo hospital there are no formal linkages of the public health facilities. These facilities only accept the patients for delivery if they have Domicile card.

c) Blood bank:

Though blood bank is functional at Dantewada DH, the license renewal could be a problem due to lack of technician. In Mahasamund, the Blood Bank at DH is functioning and 53 bloods bags were available during the visit of the DH.

d) Quality of care in Institutional deliveries:

In Dantewada, the provision of emergency obstetric care and safe abortion is limited due to absence of trained human resource in the district. In case the SBA training was conducted, the SN / ANM were aware of partographs but it was not used. Dietary services were available for mothers but the utilization was limited due to a menu which was culturally inappropriate. Overall, the improvement in maternal health is gradual but steady with the proportion of institutional deliveries gradually reaching 40 to 50%.
In Mahasamund 44.9 %(CES 2009) deliveries are conducted at health facilities. Stay for 48 hrs, and diet provision were available at District Hospital, CHC and PHC level. Facilities for normal deliveries were largely satisfactory with the RMAs filling the critical gaps of MOs. Partographs being used at Sub Centres where ANM is SBA trained. Ambu bag and mask was available in most of the facilities. Majority of the deliveries conducted at SHCs are those SHCs where ANMs are residing in Sub Centre building itself. C-sections facilities are formally not available in any of the Govt. health facility in the District.
In both the districts, in the Labour rooms the aseptic precautions and infection control practices can be improved upon. Approximately 15% of the delivery cases were referred to higher facilities, and most of these received assured government or EMRI vehicle. None of the delivery points were equipped with functional newborn care units. In Mahasamund there are four (I DH and 3 CHCs) designated FRU in the District-Mahasamund but unfortunately not a single one is fully functional FRU as per norms because of vacancies of Surgeons, Obstetrician & Gynecologist and Anesthetics.Similarly there was an overall lack

of supportive supervision activities. There was also lack of intra facility monitoring & supervision which was affecting the quality of care. Hence there is an urgent need to strengthen these.

e) SBA training:

In Dantewada the majority of ANMs/SNs are not trained in SBA trained. In Mahasamund, during the current financial year only 4 ANMs/LHVs out of targeted 20 are given SBA Training

f) MDR:

In Dantewada facility level MDR committees are functional. In Mahasamund Process of Maternal and Infant Death Review is not institutionalized in the District. District level MDR and IDR committees are framed but no Maternal Death and Infant death review done by the committee. Till September 2012, 13 Maternal Deaths has been reported but no death was audited. 13 maternal deaths reported but no MDR done during the Year.

C) JSSK and JSY:

In Mahasamund JSSK was well implemented. JSSK entitlements have been well displayed in the walls of most the health facilities in the District. Grievance redressal mechanism has been set up. Referral transport mechanism is good. 37 Vehicles including 15 vehicles under PPP mode are made available for referral of delivery cases from home to institution, inter facility and drop back to home. During the month of September 2012, 250 cases were picked up from home to health facilities, 13 cases transported to higher facilities and 116 cases were drop back without any charges by 108 Sanjeevani vehicles or any other Govt. Ambulance. Health care providers including Mitanins and AWWs are well aware of this programme. All the patients are getting free diagnostics, diet, drugs and OPD and IPD services.

In Dantewada, JSSK is being implemented in 1 DH, 3 CHCs, 2 PHCs. Diet was provided at CHC and DH level. The diet chart issued by the state was not culturally accepted locally and hence need modifications. Generally exemption of charges on tests, drugs were observed. The referral transport in the district had mixed reviews. At few health facilities, they were picking up the pregnant women and not dropping back and other health facilities, it was vice versa. District had enough vehicles for ensuring referral transport under JSSK; however shortage of drivers was a barrier in ensured referral transport.

In Dantewada, total 1395 cases were eligible for JSY incentive payment in 6 months upto September. Of which 1180 (84.58%) were paid the incentive and of the 982 Mitanin to be paid the JSY incentive, 970 were paid. The completion of the payments was similar in Mahasamund.

D**) Child health:**

a) Facility based:

In Dantewada there was no SNCU, in fact SNCU was not even sanctioned. Though there were NBSU and NBCC in the district, there was no suitably trained person to manage and hence utilization was not optimal. Total 22 infant deaths were reported in the period April to August 2012. Radiant warmers are present in some facilities, nevertheless in several

facilities 200W bulb was used for thermoregulation. According to the CHMO where the staff nurses were trained previously in using Radiant Warmers, nurses complaint that due to delay in actually practicing the same they have forgotten the skill.
InMahasamund also there is no SNCU and NBSU functional in the District. Newborn Care Corners (NBCCs) are also not fully functional as per guidelines. Overall the main constrain in making SNCU/NBSU/NBCC functional is shortage of trained manpower (MO trained in F-IMNCI) and procurement of essential equipments.Radiant warmers are not available in the health facilities and 200 watt bulbs are being used in NBCC. No such HR as per FBNC guidelines made available in the designated health facilities for newborn care.
Referral facility for sick children is available but as such NBSU/SNCU at DH needs to be strengthened.

b) Community based:

In both the districts, the Mitanins are the main linkage between beneficiary (community) and health facility for new borne care. Nevertheless, and especially in Mahasamund, the linkages with the community to identify sick newborn in the community and initiate treatment of institute referral are limited.

c) Immunization:

Immunization at birth had still varied practices-some being immunized at facility where as some being immunized at the Sub-Centre concerned. No specific supervision for immunization sessions is planned. Vaccinations services for babies delivered in institution are partially available at CHC and DH level.In Mahasamund 38% and in Dantewada, 42.17% of the expected children were fully immunized.

E) Family Planning services:

TFR is 2.8 in the State. In Dantewada, family planning services are provided through camp based approach in the district and the district is dependent on camps by specialists from outside the district for sterilization. In 6 months, 630 Sterilizations operations were conducted and 692 IUD were inserted. Fixed day IUCD services at PHC and SHC are provided. IUCD, Condoms, OCPs, ECPs and PTKs are supplied up to the peripheral facilities. No facility in the district is providing MTP services. ANM inserts IUCD in the district and in 6 months have inserted 692 IUCD. The state level training of IUCD – Cu IUCD 375 is over. There are no private providers in the districts apart from NMDC and Apollo who can be roped in to increase coverage.
In Mahasamund, MTPs are taking place at District Hospital and CHC Pithora. District wise Annual Calendar for Camps at identified centers is in place. Fixed day IUD services at DH, 4 CHCs, and 28 PHCs is made available. Social marketing of contraceptives by Mitanni's has been started.During 2011-12, 59 (RMA+SN+LHV+ANM) have been trained for IUCD insertion. No training for IUCD conducted this year and No MO was trained last year also.PPIUCD training programme is not yet started. Achievement of oral pills cycles and condom users is more than 70% but permanent methods is quite low (Sterilization 20% and IUD 33%) up to September 2012.
In Mahasamund, District Level Committees (DLCs) for certification and regulation of private sector providers for Safe Abortion services are not constituted and functioning in the District.

F) Other (ARSH program, Quality assurance, etc)

In both the districts there is need to strengthen Adolescent Health Programme. No AFHC was functional in either of the districts. Awareness creation is required among school girls about the programme. In Mahasamund distribution of sanitary napkins, weekly IFA and de-warming tablets are given by the Mitanins to adolescent girls. In both the districts, the Quality Assurance committees have been formed but not functional.

G) Referral and transport:

In both the districts, the drop back home is unsatisfactory with absence of optimum utilization of the ambulances provided. There are inter-district and interstate restrictions on the use of EMRI services, whereas for the many parts of the districts, the nearest FRU is either in the adjoining district or the border state. Hence such limitations need to be relaxed.A substantial proportion of the deliveries are happening in the EMRI. Lack of mobile connectivity is limiting the use of ambulances. At places people from villages are travelling using a motor cycle to reach a place where there is mobile connectivity. Overall 108, drop back home and free care have had positive impact

Achievement of districts under family planning programme:
Dantewada:

Method	2009-10	2010-11	2011-12	2012-13	
				Q1	Q2
IUDInsertions	3184	2461	2770	219	389
Sterilization:	**2403**	**1503**	**1923**	**24**	**606**
FemaleSterilisation	584	546	1115	23	223
Male Sterilisation(NSV)	1819	957	808	1	383
CondomUsers	13647	7492	9745	2512	1245
Oral PillUsers	19723	10244	13955	1978	1370

Mahasamund:

Method	2009-10	2010-11	2011-12	2012-13	
				Q1	Q2
IUDInsertions	5180	4097	3840	778	1241
Sterilization:	7280	7544	7582	60	1504
FemaleSterilisation	7029	7259	7340	59	1461
Male Sterilisation(NSV)	251	284	242	01	43
CondomUsers	7969	7354	2935	3739	2489
Oral PillUsers	7400	6774	3968	4007	1042

Human resource development under family planning program:
Dantewada:

1	HumanResources tomeetELA(total)		Ason 31st March2012	During 2012-13(1st April2012-tilldate)
	1.1	IUCD		
	1.1.1	*MOs providingIUCDServices*	6	6
	1.1.2	*ANMs/SNs providing IUCD Services*	80	43
	1.2	PPIUCD		
	1.2.1	*MOs providing PPIUCD Services*	0	0
	1.2.2	*ANMs/SNsprovidingPPIUCD Services*	0	0
	1.3	Tubectomy		
	1.3.1	*Minilapsurgeons*	0	0
	1.3.2	*Laparoscopicsurgeons*	0	0

	1.4	NSVsurgeons	1						1							
			DH (no.)			**SDH/CHC/ FRU (no.)**			**PHC (no.)**			**SHC (no.)**				
2	Human Resources to meet ELA (delivery pointwise)		R	A	G	R	A	G	R	A	G	R	A	G		
	2.1	IUCD														
	2.1.1	*MOs providingIUCDServices*	2	2	0	4	4	0	0	0	0	0				
	2.1.2	*ANMs/SNs providing IUCD Services*	0	0	0	0	0	0	7	12	5	32	74	42		
	2.2	PPIUCD	0	00	0	0	0	0	0	0	0	0				
	2.2.1	*MOs providingIUCDServices*	0	0	0	0	0	0	0							
	2.2.2	*ANMs/SNs providing IUCD Services*	0	0	0	0	0	0	0							
	2.3	Tubectomy:														
	2.3.1	*Minilapsurgeons*	0	0	0	0	0	0	0	0	0	0				
	2.3.2	*Laparoscopicsurgeons*	0	0	0	0	0	0	0	0	0	0				
	2.4	NSVsurgeons	5	1	4	0	0	0	0	0	0	0				
3	HumanResourceDevelopmentand DeploymentPlan															
	3.1	Human resource development plan for the state in place as per above identified gaps (Yes/No)	No													

Mahasamund:

1	HumanResources tomeetELA(total)		Ason 31st March2012	During 2012-13(1st April2012-tilldate)
	1.1	IUCD		
	1.1.1	*MOs providingIUCDServices*	---	---
	1.1.2	*ANMs/SNs providing IUCD Services*	82	125
	1.2	PPIUCD	0	0
	1.2.1	*MOs providing PPIUCD Services*	0	0
	1.2.2	*ANMs/SNsprovidingPPIUCD Services*	---	---
	1.3	Tubectomy		
	1.3.1	*Minilapsurgeons*	06	06
	1.3.2	*Laparoscopicsurgeons*	----	----

	1.4	NSVsurgeons	1						1								
			DH (no.)			**SDH/CHC/ FRU (no.)**			**PHC (no.)**			**SHC (no.)**				
2	Human Resources to meet ELA (delivery pointwise)		R	A	G	R	A	G	R	A	G	R	A	G		
	2.1	IUCD															
	2.1.1	*MOs providingIUCDServices*	2	2	0				28	28	0	*NA*					
	2.1.2	*ANMs/SNs providing IUCD Services*	221	221	-	--	--	--	--	---	--	---	--	--			
	2.2	PPIUCD															
	2.2.1	*MOs providingIUCDServices*	3	3	0				*NA*								
	2.2.2	*ANMs/SNs providing IUCD Services*	3	3	0				*NA*								
	2.3	Tubectomy:										NA					
	2.3.1	*Minilapsurgeons*	3	3	0	5	3	2	-	-	-						
	2.3.2	*Laparoscopicsurgeons*	0	0	0	0	0	0	0	0	0	*NA*					
	2.4	NSVsurgeons	-	-	-	3	1	2	-	-	-	NA					
3	HumanResourceDevelopmentand DeploymentPlan																
	3.1	Human resource development plan for the state in place as per above identified gaps (Yes/No)	No														

Legends:R:Required;A:Available;G:Gaptobeaddressed(equivalenttoTrainingload);NA:NotApplicable

Planning and prioritizing of facilities for assured RCH services:

Dantewada

Facility	Total No. existing	Total No. Declared As delivery points	Maternal Health				Child Health			
			Inst. deliv	C - section	MTP	RTI/ STI	NBCC	NBSU	SNCU	NRC
Sub-Centres	74	15	412	0	0	0	0	0	0	0
24x7 PHCs	4	0	89	0	0	151	0	0	0	0
Other PHCs	8	0	56	0	0	144	0	0	0	0
CHCs (Non-FRU)	1	1	75	0	0	0	0	0	0	1
CHCs (FRU)	2	1	232	0	0	16	0	0	0	2
Other FRUs (excl. CHC-FRUs)	0	0	0	0	0	0	0	0	0	0
DH & DWH	1	1	418	0	3	5	0	0	0	1
Medical colleges	0	0	0	0	0	0	0	0	0	0
Total Public	90	18	1282	0	3	316	0	0	0	0
Total Accredited PHF	2	2	260	0	0	0	0	0	0	0

Mahasamund:

Facility	Total No. existing	Total No. Declared As delivery points	Maternal Health				Child Health			
			Inst. deliv	C - section	MTP	RTI /STI	NBCC	NBSU	SNCU	NRC
Sub-Centres	221	92	1580	0	0	0	0	0	0	0
24x7 PHCs	05	5	686	0	8	0	2	0	0	0
Other PHCs	24	16	662	0	0	0	0	0	0	0
CHCs (Non-FRU)	04	04	1747	0	0	1255	4	O	0	1
CHCs (FRU)	0	0	0	0	0	0	0	0	0	0
Other FRUs	0	0	0	0	0	0	0	0	0	0

(excl. CHC-FRUs)										
DH & DWH	1	1	723	22	17	349	1	0	0	1
Medical colleges	0	0	0	0	0	0	0	0	0	0
Total Public	255	118	5398	22	25	1604	7	0	0	2
Total Accredited PHF										

*Family Planning: all the delivery points are expected to provide all spacing methods (OCPs, condoms, IUCD). In case facilities are not providing spacing services please note separately.

Performance during 2011-12 and the current year 2012 (April to September):

Dantewada:

	Total (2011-12)	**Total (2012-13) up to sep. 12**
1. No. of deliveries in the facility		
– normal	-4029	-1686
– assisted (Forceps delivery/Vacuum)	-0	- 0
– complications handled	-51	-15
– caesarean section	-0	-0
2. No. of live Births	10181	2974
– No. of neonates weighed at birth	-9206	-2829
– No. of low birth weight babies	-1244	-384
3. No. Of		
– Neonatal deaths in the facility	-14	-2
– Infant deaths in the facility	-67	-10
4. No. of maternal deaths reported and reviewed in the facility in last 6 months	9	2
5. No. of maternal cases given blood transfusion	0	0
6. No. of MTPs	0	0
– MVA		
– EVA		
– MMA		
7. No. of sterilizations		
– Male (conventional/NSV)	-808	-384
– Female (Laparoscopic)	-1010	-220
– Female (Minilap)	-105	-26
– Female (Post partum)	-0	-0

	Total (2011-12)	Total (2012-13) up to sep. 12
8. No. of FP Spacing Methods		
– IUD insertions;	-2770	-608
– OP cycles distributed	-13955	-3348
– Condoms distributed	-97450	-37570
– ECPs distributed	-32	-113
9. No. of cases of RTIs/STIs treated		
– Male	-236	-144
– Female	-474	-172
10. No. of high risk pregnancies identified during ANC	843	223

Mahasamund:

	Total (2011-12)	Total (2012-13) up to sep. 12
1. No. of deliveries in the facility		
– normal	1058	701
– assisted (Forceps delivery/Vacuum)		
– complications handled	17	0
– caesarean section	48	22
2. No. of live Births		
– No. of neonates weighed at birth	1074	601
– No. of low birth weight babies	128	92
3. No. Of		
– Neonatal deaths in the facility	8	7
– Infant deaths in the facility	4	1
4. No. of maternal deaths reported and reviewed in the facility in last 6 months	1	1
5. No. of maternal cases given blood transfusion	0	0
6. No. of MTPs	17	33
– MVA		
– EVA		
– MMA		
7. No. of sterilizations		
– Male (conventional/NSV)	122	30
– Female (Laparoscopic)	0	0
– Female (Minilap)	1469	481

	Total (2011-12)	**Total (2012-13) up to sep. 12**
– Female (Post partum)	7	4
8. No. of FP Spacing Methods – IUD insertions; – OP cycles distributed – Condoms distributed – ECPs distributed	 13 0 22680 0	 17 0 6860 0
9. No. of cases of RTIs/STIs treated – Male – Female	 63 105	 166 183
10. No. of high risk pregnancies identified during ANC	25	15

TOR V:
Disease Control Programs-Communicable and Non Communicable

Positives:

- The data entry on IDSP portal from block level is happening. In Mahasamund, Reporting of IDSP from District level is adequate and prompt. Collection of IDSP Data from major hospitals is functional.
- In case of NMCP, tanks of Gambosia fishes were present in most of the facilities.
- In case of RNTCP, the treatment rate was fair in case of diagnosed TB. In RNTCP, the financial management guidelines of NRHM have been shared with programme officers and RNTCP officers are called for review meetings regularly. Funds are getting released for RNTCP programme from SHS in time.
- In case of NLEP, the case detection in the state has increased with the total new cases detected in 2011 – 12 being 6999 versus 4603 in the 6 months of the year 2012 – 13. Especially in Mahasamund district, there was full involvement of the district administration with RCS camps were regularly organized by the districts administration, master treatment registers are maintained with updated individual patient cards as well as adequate stock of MDT and DT at all facilities. The ANM's are actively searching for grade I and new disability cases.

A. IDSP :

Reporting is regular, but there is no analysis of data at district level. Some analysis of data happens at the state level. Data is not being shared with the district administration. It is also not generally used in the health review meetings except in case of outbreaks. There is no connectivity with the laboratories. There is one week turnaround time of reporting of key diseases which are part of the IDSP reporting framework.

In terms of human resources, IDSP programme is facing problems. Manpower is deficient at the district level. All posts of Epidemiologists in the districts are lying vacant. District data entry operators are in place. Recruitment of contractual manpower and their training is not regular.

Action is taken on major outbreaks based on the outcome of reporting. Weekly data reaches state level surveillance unit. But there is no analysis of data at the district level. Some analysis is carried out at the state level. Response to the out breaks is planned based on the data. district level headquarters surveillance units (DSUs) are generating outbreak alerts regularly.

In both the districts, IDSP data is an important resource by which cross checking of various vertical disease control programs can be done; however reconciliation with data reported under disease control programs is not being carried out. All district level headquarters surveillance units (DSUs) are not fully operational.

One important area of concerns is the poor reporting of outbreaks and deaths. Even malarial deaths are not being picked up. Based on VHSC visits we find almost 3**likely** malarial deaths per VHSC per year mostly, but these are not reported at block or district level.

NVBDCP: Dantewada is highly endemic are for malaria with the API above 40 in Kuakonda Block. The LLIN distribution and IRS program is on track with VHSNCs doing monitoring and implementing IRS. Bed nets distribution is organized by CEO of panchayats and the distribution is done with adequate IEC. Bednets are distributed through the PDS. Total bed nets supplied were 181321 at 2 per household of which 181300 distributed so far. Of the 220 villages to be covered under IRS, 123 covered so far. At the state level due to lack of supply from the Center of Synthetic Pyrethroid, the state purchased 100 Mt against the total requirement of 113 Mt. Of the total 49221 slides taken or RDK test conducted, 12798 were positive meaning 26% SPR. The SPR was highest in District Hospital Dantewada (69%) and Katekalyan block (23%). Overall, RDK and ACT were available but underutilized. There were approximately 3-5 fever related deaths in each VHSC area. The death register maintained by the Mitanin and the VHSC should be used better for identifying malaria deaths. Supply of drugs and RDK to Mitanin poor and interrupted. The male worker appointed for malaria in place in all Sub Center but under trained and underutilized. There was substantial load of doing PS for MP, which according to laboratory technicians was limiting the availability of time for doing other tests. There is a need to review strategy in Dantewada. It appears that the programme has been rolled out well- and most outputs are achieved. Though the API has decreased from 74 to the 40s, it is still far too high. There is a need for carefully planned mass drug survey and treatment- to cut transmission in the high malaria pockets. Some village surveys have been attempted- but it needs to go on scale. The other big gap is the availability of anti-malarials and RDKs at the community level. Though Mitanins are supplied, given the vey high fever incidence, they run out of antimalarials soon, and refills take too long.

In Mahasamund availability of RDT kits, ACT and anti malarial drugs were found adequate. MPWs are in position; however, some of the MPWs could not be found using rapid diagnostic test. ACT was received by the district recently. More than 70% of the reported cases were of falciparum type. Most of the ANMs and MPWs were found to be averse in reporting the cases in lengthy M4 forms. There was probably under reporting of mortality due to malaria as mortality due to fever is found to be high.Regular Health staffs are involved in malaria prevention activities. ASHA/ Mitanin do involve themselves in malaria prevention they are not trained in using RDT kits.. In District Mahasamund IRS and LLINs were not distributed. Spray was found in adequate. Microscopic facilities were available

In Mahasamundkala-azar, JE and dengue are not a problem, but district is endemic for filariasis. However, coverage of Mass drug administration is only about 70%.. Exact numbers of Lymphodema and Hydococele case have not been measured.

Diagnostic centers for Jap Encephalitis, Chikungunya and dengue are functional at State level.

1. The state has undertaken an initiative for prevention of Malaria through Homoeopathy in 20 blocks. They assure us that none of the scheme measures are adversely affected by the introduction of this pilot. They also submit that there has been a pilot on the same. Still there is concern about such an intiative- and its careful coordination with NVBDCP to see that the mainstream efforts are not distracted from is essential.

B. RNTCP: In Dantewada, microscopy centers are functional at CHC level but not in most PHCs. The case detection of TB is low though the follow up for detected cases is goodCurrently there is no system for providing incentive to the DOT providers and the MDR diagnosis and treatment site not yet established. Poor case detection is largely due to low identification of chest symptomatics for sputum testing. Since much of the outpatient activity occurs at sub-center and PHC level, it is important to either introduce microscopy centers here or at least make sputum collection more active.

In Mahasamund all contractual posts like Senior Treatment Supervisors; Senior TB Lab Supervisors under the programme are filled. Lab Technicians and diagnostic facilities are available at DMC Bagbahara, PHC Komakhaan and PHC Jhalap in addition to the district hospital. RNTCP account was being sub-accounted under NRHM account.

C. NPCB: In Dantewada, there is no Ophthalmologist in district but 105 cataract operations were performed by visiting surgeons. The per capita payment for cataract insufficient to get ophthalmologist on regular basis. The distribution of Spectacles for school children is weak. And under NPCB, no spectacles have been distributed. Though for the state overall 6785 children have been identified with refractory error and 2223 given spectacles. In Mahasamund NPCB is linked with school health programe in the district. 457 IOL were implanted during eye operation camps in the district. Iodized salt universally used in the district. Test kits are not in use. There is no awareness about the national program.

D. NLEP: In Dantewada, 14 new leprosy cases were detected and 26 are on treatment. Overall for the state, the case detection has increased with the total new cases detected in 2011 – 12 being 6999 versus 4603 in the 6 months of the year 2012 – 13. This is a welcome achievement. The number of reconstructive surgeries done in 2012 – 13 is only 24 compared to 253 in the previous year. Important to find out whether this is due to lack of surgical options and surgeons or lack of deformities in the newly identified cases?

In Mahasamund, NLEP is working well. There is full involvement of the district administration. Last year in MahaAbhyan in the district more than 9 lakh suspected cases were screened in a single day in which more than 300 cases were found to be positive. No full time DLOs in some districts. Entire health staff of the district is involved in anti leprosy activities. All health workers involved. DPMR guidelines implemented. RCS camps were regularly organized by the districts administration. Master treatment registers are maintained individual patient cards found updated. Adequate stock of MDT and DT is made available at all facilities. ANM's actively search for grade I and new disability cases. Entire district administration was found involved in such anti leprosy activities.

E. **Non communicable diseases:** There is no specific data available on the prevalence of NCD. Laboratory testing facilities for blood sugar and urine albumin are limited. The accident related deaths and suicide deaths were high in some of the villages visited. Insulin and other drugs for NCD not yet part of most facility services. Even at CHC level, insulin is available but very few patients are on regular care. In Mahasamund NCDs are screened under School health program. Separate program on sickle cell anaemia is being implemented in the state. There is no special programme for disability screening and treatment, though under school health programs, screening for such disability is done.

F. **Involvement of AYUSH doctors in NCD:** AYUSH services with adequate drugs are available at almost all facilities inDantewada but not in Mahasamund. AYUSH Doctors underutilized in disease control programs and 18 Lakh Rs fund unspent for training of Doctors. AYUSH Doctors are not involved in Non Communicable Disease control programs.

TOR VI- Community Processes including ASHA, PRI, VHSNC, Community Based Monitoring and NGO involvement:

Positives:

- IEC material covering major health programs could be seen at the SHCs.

- Mitanins support structure is in place with training provided under 16th& 17th round including the training of life saving skills.Helpdesks are functioning at DH and CHC level with 2 full time workers placed by rotation basis. Mitanins are actively involved in VHS&NCs as both communities monitoring and village planning. MT acts as knowledge source and technical support.

- Overall the VHSNCs are quite active. The VHSNCs are meeting regularly and maintaining the records as birth register, death register and village planning register. Panch of the village and women panch playing vital role with adequate public participation.

- Gram panchayat represents in RogiKayanSamitis and ZilaParishad in DHS. Discussion on various health issues regularly takes place in Gram Sabha/GP meetings.

- SHSRC is actively involved in the mentoring at state level with District and Block Mitanin Coordinators providing mentoring at that level.

Key observations:

- Overall the VHSCs are quite active. There are 1135 VHNC functioning in Mahasamunddistrict. Guidelines are made available to all the VHSNCs. VHSNC meetings were not minuted. Funds provide are mainly spent for purchasing assets like Chair, Table and Curtails. Percentage of Expenditure on Sanitation and nutrition activities is less. There is no structured training plan for VHSNC members. However individual Mitanins and ANMs and MPWs were trained separately.

- The strength of the VHSNCs are :a) systematic recording of deaths- which gives us a good understanding of health priorities in the village b) a monitoring of 24 points related to health and health related public services- which helps close gaps in access and acts as a vehicle for improved convergence and c) a recording of births. The village register also records action taken on gaps detected during monitoring

- . 16th module of Mitanin's training has been completed in the district. Training modules and training aids were available.15th round of training of the Mitanin has ensured parity with 6th and 7th modules.

- In Dantewada, there are around 1300 Mitanins. Payment to Mitanins delayed and insufficient. Drug kits refilling weak. Mitanins didn't have Chloroquinine in their dug kits even in areas with API more than 40..

- Mitanins are mainly involved in Family planning activities (accompanying delivery cases, distribution of contraceptives, ANC checkups, follow up) immunization, detection of new cases of TB, malaria and leprosy, collection of blood slides of fever cases and provision of DOT for TB.

- District and block level Mitanin coordinators keep data pertaining to Mitanin's performance, however, block and district level medical officers do not monitor performance of Mitanins District Mitanin coordinators are in place , however, their activities are limited in mobilizing only the Mitanin workers. The state reports having a functional performance system in place, and also contends it is superior to the national recommendation of the same- but the team did not have occasion to see and assess this.

- Almost every center Mitanin has asked for 50 percentage hike in their remunerations. There was a system in place for replenishment of the drug kits though the supply of HBNC kits was not available.. In district MahasamundMitanin were not provided remunerations meant for collection of blood slides. Remunerations meant for other programs were paid in time.

- Especially in Mahasamund the implementation of community based monitoring has started with Panchayat level Nodal person mobilizing the community and ensuring the availability of health services. The scheme has been implemented in all the villages since last two years.

- Village level planning exists in the district with 5 prominent person of a village (Mitanin, School teacher, Secretary of VHSNC, Panchayat member and ANM constituting a group to find out new cases of leprosy. These are named as "PanchPrayas". Village level planning is also reflected in functioning of village sanitation and nutrition committee. Social audit is planned by the district administration. NGO involvement in the District is not exists.

In Mahasamund, PRI are involved in VHNSC, RKS and DHS, but meetings of DHS are not taking place regularly.No meeting of District Health Society has been taken place after August 2012.

A number of welfare initiatives for Mitanins are another major feature of the Chhattisgarh programme.

TOR VII

Promotive Health Care, Action on Social Determinants and Equity concerns:

Positive:

- In both the districts, there is good convergence at village level through medium of VHSCs. Mitanins active in drinking water issues and overall the Mitanins (ASHAs) are playing an important role in reaching the community in both the districts.
- In Mahasamund the district is having coordination with ICDS, education, water and sanitation and rural development department. The district collector has made responsible district level officers from different departments for each Panchayat and these nodal officers review the implementation and progress of various public health programs by different department including health. The District collector conducts the monthly meeting of all department officers to review the progress and intersectoral issues. The officers of different department are members in JDS/RKSs at block and PHC level. No issues were identified related to coordination and overlapping of job among AWW, ASHA and ANM in any of the sub center during the field visit.
- In Mahasamund the district conducts one health camp very year before Diwali for migratory population jointly under NRHM and NACO. All specialized services (pediatric, orthopedic etc.) are made available during the health camps. An intensive drive of BCC and IEC is conducted for community awareness regarding preventive healthcare in these health camps.
- Sex ratio is 1022.

Key observations:

- In Mahasamund ,Water and sanitation programme is running but Mitanins (ASHAs) and VHSNCs are not much involved in it.

- **Nutrition Rehabilitation Centers:**

The state has given considerable emphasis to this component. On the ground, we find these still at the initial stages.

In Dantewada, there was 1 functional NRC in the district, at the District Hospital and it was starting up in all the CHCs. The NRC at the DH had a separate kitchen, dish washing basin, hand washing facility and toilets / bathrooms. A separate play area with toys was not yet in place. From April to September it has treated 48 children. There is referral mechanism present according to the district officials nevertheless the bed occupancy rate is low. The district has not been mapped for malnourished children.

In Mahasamund There is a five bedded NRC functional at District Hospital with average 60% Bed Occupancy Rate. Admissions are routine as per need. Only one Staff Nurse and Kitchen attendant were posted in the NRC. Most of the cases of malnutrition are referred by AWWs with the help of Mitanins, ANMs and Doctors who are attending labour in their institutions. Incentive also paid to Mitanins as per number of follow up visits. No death was recorded among the admissions. Two Nutrition Rehabilitation centers (NRCs) are functional in Mahasamund district, one at district hospital and other at Saraipali CHC with

five beds at each facility. The district hospital is having one pediatrician and planning to for expansion of the beds upto 10 in NRC. Average bed occupancy rate is around 60% in the current year 2012-13. AWW take the follow up of the children discharged from the NRC and bring them back the children in case of any problem.

- **School Health Programme:**
  Because of the large number of residential " ashram " schools, housing hundreds of students in each district, this programme has a very complexion from the usual school health model in the tribal districts. The main focus is of having a Doctor/RMA assigned to every residential ashram school. Under "Swastha Tan Man Yojana" Rs 500 is given to RMA/AYUSH MO per visit per doctor for 250 bedded ashram school and Rs 800 is given for visit to 500 bedded ashram school. Visit by doctors is fortnightly. The more

  In both districts there is also a school health programme in which the health department is screening all school children twice in a year for health related issues. There is a provision for financial assistance from chief minister funds for major surgeries of the children screened during school health programme. The specific school health teams are not formed yet in the districts- and this aspect remains weak. Despite this, in Mahasamund 73.5% schools were covered, 65.8% children screened, with 27% children having some detected health problems ….but only 0.26% children referred for tertiary care.

- Chhattisgarh has no ultrasound clinics in private sector- at least in most of the districts. In Mahasamund, the district is having PCPNDT committee under the chairmanship of District Collector but the frequency of meeting is an area for improvement. So far eight machines are registered under PCPNDT. The sex ratio at birth is 1018 as per Census 2011 same as it was in Census 2001. The Child sex ratio (0-6 years) is 960 as per census 2011.

- The districts do not have any separate BCC and IEC plan. The BCC and IEC activities are conducted as per the directions under different health programme. The efforts on IEC for leprosy, malaria and JSY were visible during the field visit but there is scope for BCC on different health problems.

- In Mahasamund, the district needs to monitor the records of private facilities regularly. The district does not have any separate gender sensitization training at any level. In Dantewada there is hardly any private facility- but the few mines hospitals require to be linked more officially as referral sites.

- The health department is not involved in civil -birth and death registration. There is scope for better coordination between health and Panchayat department for complete reporting of birth and death and analysis of the reported data.

TOR VIII

Program Management: Monitoring, Logistics and Issues of integration and institutional capacity.

Positive:

- Both the districts conduct the monthly meeting of block level officer to provide feedback on the block performance based on the programme information.
- The DPMU and BPMUs are formed and functional in both the districts. The DPMU has been given dedicated space for DPMU.
- State level CRM which visits all districts is innovative improvement in internal monitoring.
- SHSRC active in providing support to community processes.

Key observations:

- The directorate remains relatively weak- both in capacity and in its own internal management. All posts from the joint director down to chief medical officers- are held by officers-in charge in an ad hoc arrangement. Regular promotions have not occurred. This is turn has led to considerable loss of morale. While personally the IAS officer who is now DHS is held in esteem, a return to technical leadership is also desired.
- The state programme management unit has very little staff strength- with only four key posts occupied. There are many programme components – like infrastructure development, or HR management , or logistics or child health components which needs a team in place for expediting
- In Dantewada, DPMU at district level has one DPM; District Account Manager, District Data Officers, District Training Officer and Data Entry Operators, every block have Block Programme Manager, Block Account Cum Data Assistant. There is good coordination among DPMU and Mitanins and NRHM Officers and RCH Officers. Nevertheless, there is a high attrition rate of Data Entry Operators.
- There is lack of medicines in CHC and PHC level. The supply of drugs is very poor from the state and not responsive to the utilization pattern. One of the biggest management issues in CG is the poor situation in procurement. The districts has done a rate contract based on competitive prices centrally to purchase the essential drugs due to short supply from the state. The ANMs are using untied funds whereas PHCs are using JDS/RKS funds to purchase essential drugs. ANMs and PHCs are utilizing untied and RKS fund for purchasing the drugs during any emergency. The district is having a drug store but the space is not sufficient so new store is proposed for construction. Overall the purchase of drug and equipment is a major issue in the state. Even though the CG Medical services corporation has been established, no officer has been posted and therefore no staff has been recruited and it

remains non functional. The directorate officers are reluctant to get caught up in procurement. If procurement is removed from the directorate and goes to the CGMSC, then it would pave the way for revitalization of the directorate.

- One problem in both districts is the lack of delegation of sufficient powers to the district leadership. The entire administrative power (Appointment, promotion, increment etc.) for DPMU staff is lying with Mission Director (NRHM). The coordination among PMU staff and regular staff at all level needs improvement. Programme officers at the district level should be seen as part of the DPMU – in addition to the contractual staff.

- As can be seen from the table, the DPMU is in full strength- but it is essentially a management support- and without the programme officers it would not be able to function.

Name of Post	Mahasamund			Dantewada		
	Sanctioned	Posted	Vacant	Sanctioned	Posted	Vacant
District Program Manager	01	01	0	01	01	0
District Accounts Manager	01	01	0	01	01	0
District Data Officer	01	01	0	01	01	0
District Training Co-ordinator	01	01	0	01	01	0
District Accounts Assistant	01	01	0	01	01	0
District Data Assistant	01	0	01	01	0	01
Computer Assistant (in Immunization)	01	01	0	01	01	0

- The capacity building of PMU is also an area of improvement. There is no assessment for training needs and also no planned trainings are planned for PMU staff. There is no policy for the career progression of NRHM staff. District Accounts Officer is responsible for releasing the salary of the contractual staff. There is no appraisal system in-place below the district level for NRHM staff (RMA, Staff Nurse, Data operators) and no annual increment.

  There is no cell for grievance redressal at the district level for NRHM staff.

- In Mahasamund, the district has accredited the private institutions for support under JSY scheme. 8 private institutions are accredited so far under the scheme. 3646 deliveries were conducted by these eight institutions in the year 2011-12 whereas 991 deliveries have been

conducted so far in the year 2012-13. In Dantewada, there are two facilities which are accredited such facilities.

TOR IX

Knowledge Management: Technical assistance, SIHFWs, SHSRC, ANMTCs, DTCs and use of Information Technology:

Positives:

- SHSRC is functional in the state and playing important role in implementation of Mitaninprogramme and VHSNC as well as providing support to Mitanin (ASHA) programme. SHSRC has field coordinator appointed at the district level with two district resource persons (DRPs) placed at the block. Under each DRP there are 20 Mitanin trainers per block.

- One UNICEF Coordinator is also placed at the district level in District Collector office. The coordinator is providing support in monitoring and supervision for leprosy and malnutrition initiatives and having good connectivity with CMHO office. In Mahasamund CINI is providing support in training and programme management under ShishuSurakshaMaah (SSM) and Nutrition Rehabilitation Centers (NRCs).

- In both the districts, facility wise HMIS reporting was being done and MCTS registers were filled by ANMs at SHC level.

- The state and district level training coordinators have been appointed recently with the district level training coordinator placed at CMHO office.

Key observations:

- All the infrastructure of SIFHW is satisfactory but the institute is not functioning as per the requirements and there is no leadership by SIHFW at the district level. This remains a persistent problem since the inception of this institution.No evaluation study and training needs assessment are conducted in the district by SIHFW and other agencies. No post training assessment done at the district lev

- Coordination between SHSRC and the CMHO office is inadequate .The withdrawal of SHSRC from its prime role in providing support to district level planning- has led to a weaker supportive functioning of the SHSRC. The SHSRC in effect becomes a community processes resource center. There are however two other roles the SHSRC is playing. One is to provide support to the roll out of the urban health programme- financed by the state-. The second is in drawing up RFPs and contract drafts for building public private partnerships. The SHSRC's contribution to sector-wide strategic planning and policy through evidence and advocacy is also more limited than before.

- The MCTS is fully operational in the state. However, feedback on MCTS by district officials and use of information was lacking. The districts are unable toanalyze and utilize the MCTS data. The data entry is also not complete at most of the facilities- as the data load is high in relation to availability of both staff and connectivitly. Vacant positions at the PHC level are

one contributory problem and data entry has to happen at block level. The utility of MCTS system is also not clear to the staff below the district. The district data officer is the nodal person for MCTS. The analysis and use of the HMIS data at district level for corrective action or midterm correction in the strategies is not in place. The PHC Account and data assistants (PADA) are deployed at the PHCs for entering the data in the HMIS but due to logistics issues (Internet etc.) some of the data personnel are working at block level. Seven PHCs are not having PADAs.

- The facility level data is uploaded- but not available or possible to use for information purposes.

- In Dantewada ANMTC in district has been provided with infrastructure, but it is not operationalised due to lack of faculty. In Mahasamund also the district is not having the district training center (DTT) whereas the ANM training center is functional in the District Hospital building. The total intake for the ANM training center is 60 per year. The dedicated building for ANM center is under construction within the district hospital campus.

- Training is required for all medical and para medical staff.ANMs(SBA), RMA (SBA, BeMoNC, IMNCI), MBBS(BEmOC, EMoC, LSAS, SNCU,IMNCI and New Born Care), AYUSH MO (IMNCI, BEmOC and National Programmes), MPW to be trained adequately.

- Standard treatment guidelines need to be re-issued. Those that were made once have been forgotten.

TOR-X
Financial Management-Fund flows, accounting and absorption

Good Practices:

1. The State has conducted the audit for all the Rogi kalian Samitis and the reports were also prepared.
2. The State implemented the Tally upto the Block level and the reports were also being generated.
3. The State is collecting the compliance report on the observations of the Statutory and Concurrent Auditor from the Districts.
4. The State is transferring the funds through e-transfer upto the block level.

Observations:

List of Facilities in Dantewada District visited and officials in charge of finance met

S.No.	Facilities visited	Officials
1.	District Health Society, Dantewada	James Beck (District Accounts Manager) ChatradhawajSahu (Accounts Assistant)
2.	District Hospital, Dantewada	DevendraChapdi (in charge Accountant)
3.	Sub Centre, Balud	ANM
4.	Sub Centre, Matenar	DeepikaNath (ANM)
5.	PHC, Pondum	ANM
6.	PHC, Metapal	ANM
7.	Block Kuakonda	GovindAnant (BADA)
8.	PHC, Palnar	Sunita Nag, (PADA)
9.	Sub Centre, Mokhpal	ANM
10.	PHC, Bhusaras	PADA not in position
11.	District Health Society, Sukma	Reena (District Accounts Manager)

List of Facilities in Mahasamund District visited and officials met

S.No.	Facilities visited	Officials
1.	District Hospital, Mahasamund	Neeraj Mukherjee (DPM) Dr. S.B. Magrulkar (CMO)
2.	CHC-Pithora	Mitanin, BADA, Radiographer and LT
3.	CHC-Bagbahara	Dr. V.P. Singh (DMO)

		N.K. Bhoi (Attendant)
4.	PHC-Tumgaon	RMA
5.	PHC-Bhithidih&Jhalap	Dr. Hemo Ram PADA
6.	PHC-Komakhan&Khallari	RMA
7.	SC-GarhSivani	ANM
8.	SC-Sarkada&Mudipur	ANM
9.	SC-Vrindavan, SivaniKalan(State Initiative Building), Khopali&Pachera	ANM
10.	SC- Nandgaon, Kosrangi	ANM

Key observations:

1**HR Status under Financial Management**

- There was large vacancy in HR under financial management. The vacancy position is given under:

S.No.	Position	Sanctioned	In Position	Vacancy	%
1.	Director Finance	1	1	0	-
2.	State Finance Manager	1	1	0	-
3.	State Accounts Manager	1	0	1	100%
4.	District Accounts Manager	27	27*	0	-
5.	District Accounts Assistants	27	12	15	55%
6.	Block Accountants (BADA)	146	116	30	21%
7.	PADA (PHC Accounts and Data Accountants	741	500	241	33%

- At present the State recruits the staff under financial management upto the block level and below the block level, the responsibility of appointment of staff lies with the District level. The delay in appointment of staff causes delay in reporting of expenditure and problems in maintenance of books of accounts.
- The Director Finance is in position and had additional charge of Additional Director Finance (Health).
- In Dantewada District out of four BADA two were in position and two are vacant for more than 3 months. In case of PADA, out of 12 sanctioned positions, 9 were filled up and 3 were vacant for more than six months. Further, in Sukma District there was no BADA in position against sanctioned positions.
- In Mahasamund District all the BADA were in position. Out of 28 sanctioned positions of PADA 22 are in position.

2. Trending of the State/District on the absorption of funds. Activity Heads with low and high Expenditure.

Reasons for low expenditure

The State is having very low expenditure against their approved budget The State has incurred 78% in 2011-12, 63% in 2010-11 and 59% in 2009-10 under RCH Flexipool and 68% in 2011-12, 34% in 2010-11 and 31% in 2009-10 under Mission Flexipool. The trend of expenditure under RCH and Mission Flexible Pool is given in **Annexure-A**. The low expenditure has been observed in ARSH, Child Health, Training, Infrastructure, Untied Funds and RKS. However, the expenditure trend under Untied Funds and RKS has been improved in 2011-12.

In Dantewada District too there was overall poor absorptions of funds. There were unspent amount is 9.22 crore of which 2.64 crore were advances in infrastructure and Rs. 2.62 crore were advances in untied funds, Rs. 1.89 crore were total RCH advances and Rs. 0.23 RCH was bank balance. NRHM bank balance was Rs. 2.76 crore. Under RCH Rs. 60 lakhs were advances in maternal health (31 + 17 JSSK+7 VHNDs,+ 4.76 transport), Rs.34 lakhs in child health, Rs. 45 lakhs in HR, Rs. 19 lakhs in Family Planning, Rs. 6.00 lakhs in Training, Bank interest is Rs. 22 lakhs. There was Rs. 1 crore unspent under VHSNCs.

Money for 2011-12 did not reach timely and for earlier periods some of it was spent and not accounted.

3. Factors responsible for low utilization of funds under approved activities:

- Poor utilization of infrastructure funds
- Poor utilization of untied funds.
- Problems in accounting and consequent delays in UC.

  The poor utilization of infrastructure funds is due to delays in completion of works by the agencies hired to do the same. These are all government and paragovt agencies- and

their management capacity has been limited, the lack of a dedicated infrastructure team at the state level also cripples the forward progress.

The poor utilization of untied funds relates to lack of guidelines, lack of local capacity and confidence and inadequate supportive supervision of this aspect. The problems related to accounting are given below.

4. The following accounting problems were observed during the visit. :

a) Delay in financial reporting from the sub district level units.

a) Full strength of financial staff not in position.
b) Delay in submission of SoE from the outside agencies such as PWD, RES etc.
c) 15 DAMs are posted in September after orientation from the State level.
d) Disbursement of funds to the facilities having high unspent balances.
e) Accounting of funds received from other sources such as IAP, NMDC, RajivGnadhiShiksha Mission etc. under NRHM which inflates the unspent balance under any activity. (PHC-Bacheli, District Dantewada)
f) Schemes which had been discontinued or closed such as JSY second referral scheme was having unspent balance at the block level pending for settlement.
g) Funds were being released to the unregistered entities such as District Health Society Sukma and for RKS not constituted at the District.
h) Advances given to Staff for implementation of any activity were not settled.

4. **Audit Procedures:**

a) **Statutory Audit:**The State has conducted the Statutory Audit in 2010-11 and under process for 2011-12. The State is required to take immediate steps for early submission of the Statutory Audit Report for 2011-12 as it had already been delayed by more than three months. The Statutory Audit Reports was also made available to the Districts but does not include all programmes under NRHM. The quality of the reports was not satisfactory and does not include the details of bank balances and facility wise advances.

b) **Concurrent Audit:** The State has implemented the Concurrent Audit System in 2011-12 which is a good practice implemented by the State. The report for the same was also made available. However, the report was not sent by the State to the Ministry.

c) **RKS Audit:** The State has also got conducted the RKS audit for all the registered RKS and the report submitted which is a good practice implemented by the State.

The action taken by the Districts on the reports of Statutory and Concurrent Auditor was also made available by the District Health Society.

5. **Delegation of Financial Powers:** The delegation of financial powers had been done at all levels.

6. **E-Transfer of Funds:** The State is transferring the funds through e-transfer to all the District Health Societies and Block level via SBI. The State has opened the group bank accounts upto the Block level. However, at the PHC and Sub Centre level only two bank accounts are maintained, one for JSY and the other was for RKS.

7. **Implementation of Tally ERP 9:**Customised Tally ERP 9 had been implemented by the State upto the block level and reports were being generated through Tally which is a good practice.

8. **Pendency of Utilization Certificates:** As per FMG's records, the UCs are pending as below:

Programme	2008-09	2009-10	2010-11	Upto 2010-11	2011-12	Total
RCH			58.82	58.82	121.58	180.40
Mission Flexipool	0.34	82.42	80.00	162.76	118.90	281.66

9. **Expenditure against Untied Grants, AMG and RKS Grant**

The State had reported low expenditure against Untied Grants (17.21%), AMG (13%) and Corpus Grants (28%) upto September, 2012. The position of the trend of expenditure of the districts visited is given below:

Dantewada District:

	Allocation	Expenditure	% of Utilization
Untied Grant	33.59	3.88	11.55%
AMG	23.00	3.67	16%
RKS	35.00	15.50	44%

Mahasamund District:

	Allocation	Expenditure	% of Utilization
Untied Grant	141.00	25.43	18%
AMG	23.00	2.04	8.87%

RKS	35.00	12.86	36.74%

10. **Training Measures and Monitoring Activities Undertaken:** The State had initiated training measures for the financial staff as below:

a) Training in Financial Management had been organized by the State in June, 2012 upto the PHC level at Raipur.
b) Tally training had also been organized by State upto the Block level.
c) The State had also organised an induction programme for the new recruited staff in the month of August, 2012.

However, there is lack of training sessions planned below the District level.Therefore, the District Health Societies should organize the training programmes at the CHC/PHC level on quarterly/half yearly basis.

11**. State Share Contribution:** There is shortfall in the State share contribution of Rs. 74.77 crore which is 21% of the total releases of Rs. 310.59 crore made to the State. However, the state has informed that some releases under the NVBDCP have yet not been transferred by the Ministry even though the sanction order issued. Hence, there is difference in state share shortfall as per Ministry's record and the State's record. The details are given below:

Year	Amounts required on basis of releases (Rs. in Crore)	Amount Credited in SHS Bank A/C (Rs. in Crore)	Short/ (Excess) (Rs. In Crore)
2007-08	33.68	12.00	21.68
2008-09	44.07	35.00	9.07
2009-10	46.17	31.11	15.06
2010-11	57.75	47.00	10.75
2011-12	74.39	94.00	-19.61
Total (2007-08 to 2011-12)	**256.06**	**219.11**	**36.95**
2012-13	103.53	65.71	37.82
Total	**359.59**	**284.82**	**74.77**

12. **Accounting Gaps in Detail:** The following accounting gaps were noted during the review. They ar e indicative of the need for training and supportive supervision of accounts management.

1. The books of accounts were maintained in Tally and a manual cash books was also maintained at the District level. However, in Sukma District, books of accounts were maintained only on Tally. There was no verification of the entries made by CMO or any other supervisor.
2. The State was following the practice of transferring money of JSSK through the JSY account and then to the RKS bank account at the PHC and lower level which leads to double booking of expenditure of JSSK.
3. The advances or cash withdrawals were booked as expenditure as found in PHC-Metapal, Sub Centre-Balud, District Dantewada.
4. The funds received from other schemes such as IAP are also accounted for in the NRHM books and kept at NRHM bank accounts below the block level as found in PHC-Bacheli, District Dantewada.
5. No bank reconciliation statement has been prepared at the District and Sub District level.

14. Infrastructure: The major portions of funds were blocked in civil works. However, no status of completion (physical progress) was made available in Dantewada District. The details are given below:

Construction Agency	Facility	no.	unit cost	old bal as on 01.04.12	fund released in current year	Expenditure	Unspent funds
JDS	Labour Room Construction	4	2.54	10,16,000.00	-	2,54,000	7,62,000.00
Gram Panchayat	Labour Room Construction	11	2.54	27,94,000.00	-	6,02,141.00	21,91,859.00
RES	Labour Room Construction	5	1.9	-	9,50,000.00	-	9,50,000.00
	Sub Centre	9	-	45,84,000.00	57,30,000.00	-	1,03,14,000.00

	Sub Total			**45,84,000.00**	**66,80,000.00**	0.00	**1,12,64,000.00**
JilaNirmanSamiti	Sub Centre	3	-	0.00	6876000	6844500	31,500.00
	Others	2	-	0.00	3493000	0.00	3493000
	CHMO building	-	-	**-**	4,50000.00	450000.00	0.00
	Sub total				**1,08,19,000.00**	**72,94,500.00**	**35,24,500.00**
PWD	Quarters	5	-	2931000	4244000	1747000	54,28,000.00
GrihNirman Mandal	Quarters & CHC	12	-	0.00	6146000	0.00	6146000

As given in the table, the funds given to JDS, Gram Panchayat and Rural Engineering Services shows the slow progress made by these agencies under the civil works. This has aroused the following financial implications:

a) The delay in completion of the work pushes up the construction cost of these agencies which exceeds the approved amount in the ROP in any respective year. For eg, an amount of Rs. 2.54 lakhs was given to Gram Panchayat Pondum for construction of Labour room in 2011-12 against which the whole expenditure was booked in July, 2012 even though the work has not been completed and an additional demand was also put up by the Gram PanchyatPondum for Rs. 1,15,800/- for completion of the construction works.
b) Loss of interest in case of funds lying with the construction agency beyond a definite timeline and non imposition of penalty in case of delays by DHS.
c) Total expenditure booked against the approved amount does not indicate the completion of the work as the actual construction cost exceeds the sanctioned amount.
d) Even the facilities completed and expenditure booked against has not been handed over by the construction agencies and any funds left with the agencies after completion of the work was also not being refunded back. For eg. A utilization certificate has been received from JilaNirmanSamiti for construction of Sub Centres of Gumiyapal, Tetam and Aranpur dated 06.06.2012 for Rs. 68.44 lakhs against the sanctioned amount of Rs. 68.76 lakhs. The balance amount of Rs. 0.32 lakhs was not refunded back by the agency and the facility was also not handed over even after completion of four months.

Recommendations:

1. It is suggested that the state may rationalize their recruitment policy and may allow the District Health Society to appoint the financial staff for the block level and may also relax the qualification or experience criteria depending upon the HR available in that area. The state should also follow the rotation policy within the available finance resources to ensure that the books of accounts and the SoEis updated periodically. The state can consider allowing the District Health Society to appoint the financial staff for the block level.

2. The District Health Societies should organize the training programmes at the CHC/PHC level on quarterly/half yearly basis.

3. The pay scales of the finance staff should be fixed in terms of the position, work load and the performance appraisal during a year.

4. The funds of other progarmmes should not be mixed with the NRHM funds.

5. The State should get it registered all its District Health Societies and the RKS constituted.

6. Bank reconciliations should be prepared for all bank accounts at State/Districts/Block level and entries for the interest and bank charges and reversal of stale cheques as well as adjustments, if any should be carried out on monthly basis.

7. Director Finance and State Finance Manager must visit at least two Districts in a month for monitoring and improving the financial management system.

8. District Accounts Manager/Accountant may also plan to visit at least two blocks in a month for supervising the working of the Accountant and submit his report to the CMHO and a copy to the concerned BMO.

9. The State needs to ensure that the actual expenditure incurred at any level/facility should be reported by such units on a monthly basis.

10. The expenditure of JSSK should not be double counted. The State may looked into the guidelines issued by them to the lower levels for the implementation of JSSK funds.

11. Cash withdrawal by the facilities should not be booked as expenditure until SoE is furnished and expenditure incurred by such facility.

Important innovations observed in Chhattisgarh:

2. The State has ensured critical role for RMAs in providing health services and ensured that their skill set is satisfactory by a 10 day CMC, Vellore training

3. The VHSNC and Mitanin in Chhattisgarh are remarkably empowered. The VHSNCs are maintaining a meticulous death register documenting the probable cause of death. The VHSNCs are also evaluating the performance of health services and documenting the problems using a structured 24 point check list.

4. The state has adapted the IPHS designs to suits is requirements and improvised the design of SHC as a unique double storied building with health facilities on the ground floor and residential facilities on the 1st floor. The cost of this design is 22.8 lakh INR.

5. The state has ensured the installation of solar power panels for back up at all points along the cold chain including the PHCs and CHCs.

6. The State has started EMRI-108 services in the January, 2011 with satisfactory performance. EMRI Technicians in the 108 services are performing more deliveries per person due to significant number of on route delivery in the vehicle. Hence their training in especially asphyxia management would be useful.

7. The State will be starting 102 ambulatory services for inter facility transport and drop back facility, under which state will provide the ambulances but outsource the management.

8. The State is utilizing AYUSH doctors extensively for providing outpatient services.

9. The Chhattisgarh Rural Medical Corps is an important innovation which has helped close gaps in rural and remote areas. Its actual performance needs to be measured before recommendations on strengthening and replication.The state has been able to provide health care in intense conflict situations.

10. The state has been innovating with AYUSH in the public health area- use of homeopathy in malaria prevention, distributed Decoction for prevention and treatment of Seasonal Diseases, preventing disability in Leprosy Cured Person through AYUSH in 2 Districts in JanjgirChampa and Korba.

11. The state has undertaken steps to provide pure drinking water in fluorosis affected viillages.

12. The state has started a scheme BalHridaySurakshaYojna including providing INR 35 for establishing a Technical Support Unit for 500 Surgery Cases of heart disease.

13. The state has started a Chief Minister BalShravanYojana for providing cochlear implants in cases of hearing disability.

14. The state has undertaken steps of managing Sickle Cell in patients suffering from the same.

15. The state has started a Tele medicine service and online 104 call centre for giving advice to patients.

Recommendations:

TOR 1:

1. The state should ensure that RSBY drugs are prescribed only from within the list of the generic essential drugs. Help-desks at the facilities should cover RSBY and let the users specifically know about:

   a) The entitlements and

   b) The sum deducted and sum left on card.

2. To reduce out of pocket expenditure, following measures can be undertaken by the state:

   a) As an immediate measure RKS funds should be utilized to procure medicines.

   b) As a long term solution functional CGMSC and a good procurement and logistics system should be put in place.

   c) Similarly timely procurement and supply of medicine needs to be ensured at SHC level.

3. The state should expedite infrastructure construction. The CHCs need to be brought up to the desirable level in maintenance. The state needs to provide semi-furnished residential facilities at all facilities including PHCs conducting deliveries as well as SHCs in remote areas, and in the districts such as Dantewada to attract and retain human resources.

4. The state should ensure privacy for women in CHC and District Hospital and separate male and female wards should be a priority especially when beds and facilities are available for the same.

5. The state can increase the number of in-patient admissions, improve in patient care and increase the range of services by ensuring adequate and timely drug supply.

6. The state should consider the optimal location of all PHCs considering the local factors, need and the availability of other health care services.

7. AYUSH medical officers who already are providing outpatient care can be involved more in national programs as well as in overall public health roles. AYUSH doctors should be provided the necessary training to play these roles.

TOR 2:

1. The stationed ambulances and drivers need to be fully optimized with mandatory transport back home for pregnant women. If required, additional drivers can be hired through RKS/JDS. Similarly to complement and increase the coverage, a link up with 108 services should be instituted in a coordinated fashion.

2. There are currently no MMU and establishing the same should be a priority.

3. IEC should be area, language and culture specific with proper monitoring by senior officials from the state.

4. The population covered per worker is less. Similarly there is less case load at the hospital as well as less number of under 5 children in the community. Hence more time is available for health services beyond routine immunization and antenatal care and this time should be optimally utilized.

TOR 3:

1. However except in case of availability of specialists to fill up positions in interior districts, some other problems are administrative or design problems and amenable to management initiatives. The first priority should be to fill up all sanctioned posts which are lying vacant. Of these vacancies, the most critical are of nurses, ANMs and of RMA. The posting of three nurses in those PHCs chosen for 24*7 services should be also prioritized.

2. State needs to urgently frame HR policy in concurrence with existing rule i.e. *Samvida recruitment Rule.* The contractual staff should be regularized to retain them, reduce attrition as well as maintain their motivation.

3. State needs to reconsider the criterion of classification of difficult, most difficult and inaccessible areas. State should have higher scale of difficult allowance for regions like Dantewaada for medical and para-medical staff as well as should maintain the differential in salary between left wing extremism affected areas like Dantewada which are additionally distant from the state capital, in general inaccessible as well as lacking in other facilities.

4. ANMTC across the State and especially in Dantewada should be given urgent priority to start up. To do this, the state can use PPPs for faculty and faculty development. The state can focus on area based selection of tribal girls to fill ST quota as per the state training and recruitment rules. Similarly ANM training for ASHAs should be promoted.

5. ANMs can and should be used to replace all SN positions

6. The RMA form the backbone of the public health care delivery system especially in PHCs and SHCs. Hence the training of RMAs (as well as AYUSH) based on Vellore course

should be expedited using more partnerships. Similarly the RMAs should be brought back to fill the vacancies. The RMA in carefully selected sub-centers seems to have worked well. Should not reverse it hastily.

7. There should be timely monitoring especially of district like Dantewada both from state and center level. The newly formed districts (such as Bijapur and Sukma) should be accorded special attention.

8. CRMC tweak for a Dantewada add on of Rs 20,000; plus Positive environment building.

9. Semi-furnished accommodation for residences of staff posted in difficult and hard to reach facilities is needed. The other package of measures to attract and retain doctors in rural areas- the graded monetary incentive, the graded increased eligibility for post graduation, the preference given to locality for postings- are all to be maintained and expanded.

10. The doctors, RMA and staff nurses are being provided incentives of 35000, 15000 and 5000 per month. Providing some incentives to the other paramedical and program management staff can also be considered especially in left wing extremism affected districts such as Dantewada.

11. In all cadre, powers for contractual appointments against approved/sanctioned posts- whether under state government of under NRHM funds should be immediately devolved to district health societies. Since these societies are chaired by DMs and convened by the CHMOs, accountability, transparency can be ensured. Such a measure would lead to closure of vacancies in all class IV posts, and technical posts like pharmacists, X-ray technicians, and Laboratory technicians and even in nurse and ANM posts. When a district is unable to find recruits for its posts, this could be referred to the state for further recruitment effort. Today concentrating these powers in the states has led to considerable delays and a vulnerability to pressures of appointment in favourable locations leading to under-serviced areas being further deprived.

12. Regular appointments by state service commission should also be streamlined and expedited with specific deadlines. Where recruitment boards are unable to do this, one could consider hastening the process by a measures such as have been taken in Haryana –where the PSC has more a regulatory function, with department undertaking the actual recruitment

13. There is a need for a greater public health orientation in all the service providers working at the periphery. Most of them see their task as providing good clinical care to those who present themselves at the outpatient. But have limited understanding of the health of the population, of who is getting left out and why, and much less of the disease burden in their communities. Most important – through a public health orientation-they must see their task as maintain the health of the community, and hold themselves accountable for the same- even those who do not present to them.

14. At the secondary level- of block hospitals and CHCs- to close the specialist gaps at the CHC, multi -skilling medical officers posted in the CHC through specific short term courses- or through a generic family medicine course would lead to "resolving more and referring less" at these facilities. But this should go along with being able to ensure that those trained to serve in these facilities are in fact posted here.

15. The state should also develop/revise Standard Treatment Protocols (STGs) for common conditions and emergencies and ensure implementation of the same. There is a need for state wide capacity building of health professionals for use of STGs to rationalize prescriptions and improve outcomes.

TOR 4:

1. State should consider the implementation of JSSK to all the facilities. Additionally the State should set up a JSSK grievances Redressal system.

2. Culturally specific and nutritious Diet chart should be prepared and followed with reasonable space to allow local flexibility.

3. Referral transport, especially in case of obsterrical and child as well as newborn health emergencies needs to be uniformly implemented. The restriction on inter district and inter state referral should be relaxed and formal MoU may be signed with the nearest FRU to increase the coverage. Similarly formal linkages with the other obstetric care facilities in the Dantewada district such as NMDC and Apollo hospital should be created. The intervening limitations and formalities should be addressed.

4. SNCU, NBCC and NBSU need to be urgently operationalised.

5. Transport back home for pregnant women needs to be made mandatory and should optimally use the vehicles available with the drivers. The stationed ambulances need to be fully optimized nd if required, additional drivers may be hired through RKS/JDS.

6. There are currently no MMU in the district and that should be urgently considered.

7. IEC needs to be area, language and culture specific with proper monitoring by senior officials.

8. NSV training of MBBS doctors can be done to increase camps.

9. Local facilities such as Livelihood College and Education hub can be utilized for imparting training as well as developing local human resource. The district officials are supportive regarding this.

10. Need specific job charter for workers especially MPW.

11. To increase the number of MBBS doctors, state can consider strict implementation of the post MBBS bond as well as increase the amount to be paid in case of default of the bond. Same can be done in the case of postgraduate doctors.

12. In case of getting more postgraduate doctors to practice in the State, a system similar to the CPS in Maharashtra can be considered and / or a tie up with the Maharashtra CPS can be considered.

TOR 5:

1. Timely supply of Chloroquinine and anti snake venom needs to be ensured on a priority basis.

2. To avoid transmission of Malaria, urgent consideration should be given to the opetion of FRT (Fever Radical Treatment) which is to be given to every patient of fever on a fixed day. In some situation, in consultation with MoHFW, FRT can be given to everyone including mass survey and administration.

3. Stock card to be maintained by Mitanins and MPW of the drug supply.

4. Refresher Training of MPWs is urgently required to optimally utilize their services.

5. A mechanism for timely reporting of positive cases of malaria needs to be developed.

6. Use of VHSC Death register for IDSP as well as planning interventions and identifying gaps in the delivery of health care services.

7. The IDSP programme needs urgent strengthening. The information from S forms and P forms should be analysed at the block level- or if sent directly to the district should get a feedback to the block level. This has to be used for action at the block and district level. The entire mindset of IDSP should be to make an immediate and appropriate public health response to disease outbreaks and use the information for local planning. The current mindset is of data collectors- sending the reports upwards as a routine without any application of mind to what is being sent up and why- needs to change urgently.

8. Considering the higher malaria mortality figures in Dantewada, a special task force to audit the malaria mortality figures and to suggest remedial measures may be set up.

TOR 6:

1. The reports generated by VHS&NCs should be utilised adequately for the purpose of planning health care and priorities.

2. Master trainers should be trained to train the VHS&NC members on epidemiological issues.

3. Timely payment of incentives to Mitanins should be done on a priority.

4. Drug kits of Mitanins should be refilled on regular basis.

5. Community based monitoring through VHSNC is done efficiently and should be replicated across the state as well as other places.

TOR 7, 8 and 9:

1. The involvement of SHSRC in other programs needs to be extended at the district level. Including conducting assessment, evaluation and other studies.

2. The state should ensure that the NRC should be made functional at DH and CHC level.

3. The state should consider Spectacles distribution to school going children.

4. The state should consider specific planning for constructing toilets.

5. Data entry operators at block level may be hired through JDS.

6. The state should ensure the use of MCTS and HMIS information for planning purposes.

7. The state should endure the training of all staff in knowledge management and the purpose of the data analysis and its use.
8. The coordination among the different development partners present at the district level should be ensured.

TOR 10:

12. The state may consider rationalizing the recruitment policy and may allow the District Health Society to appoint financial staff at block level and relax the qualification or experience criteria depending upon the availability of HR available in a particular area.
13. The state can consider following the rotation policy within the available finance resources to ensure that the books of accounts and the SoE is updated periodically.

14. The state can consider rationalizing their recruitment policy and may allow the District Health Society to appoint the financial staff for the block level.

15. The state should urgently fill the accountant positions.

16. The state should ensure that the expenditure rate is improved.

17. As there is lack of training sessions below the District level, the state should ensure that the District Health Societies are instructed to organize the training programs at the CHC/PHC level on quarterly/half yearly basis.

Key recommendations from the visit:

1. The single biggest management failure is in strengthening the drug procurement and logistic systems. Though the CGMSC has been created, appointment of an officer, recruitment of staff, and putting all processes in place should be expedited. One could consider a management consultancy to support this

2. For improved absorption of funds, attention should be focused on creating an infrastructure management cell at the state level as well as more robust and innovative contracting mechanisms. For improving use of untied funds- better guidelines, better accounting, and giving more funds to facilities whose requirement is more is the key.

3. Training coordination requires a set up at state level created within the SPMU or directorate- given the inability to re-vitalise the SIHFW. It would also need partnerships which are facilitated by the national center- especially for revitalizing their ANM, and other training center.

4. Given the high number of unreported deliveries against expected deliveries, careful mapping of inaccessible areas vulnerable population and improving accessibility of health facilities is needed. This also needs strengthening the SHSRC and making it accountable for good quality district plans, analytics of health data and feedbacks to the districts in addition to the two areas where they are already contributing (community processes and urban health care planning).HMIS reporting affected due to high turnover and large gaps in data entry operators. In addition there is poor use of data and no established feedbackprocesses.

5. CRMC incentives to Doctors and Para medics are proving helpful but the gradient needs to be increased for more difficult districts like Dantewada. The scheme should be evaluated for improving its performance and assessing the adequacy of incentives and the mode and terms of payment. .

6. An empowered state level management team directly reporting to director health services or mission director should be set up to expedite the quality and access to facility based child care and nutrition rehabilitation centers. This is needed to put all the equipment and infrastructure and human resources needed in place. In addition the state would have to contract training capacity from a national canvas to begin the facility based training state should urgently undertake steps to establish the proposed SNCU at facility level.

7. The state should urgently undertake steps to reduce the persisting out of pocket expenses incurred by pregnant women. The main contributors to out of pockets expenses are drugs, ultra sonogram, transport and diet charges. Informal charges are rare. This withdrawal of user fees should merge into gradual withdrawal of user fees in other areas as well.

8. The state should strengthen the Drop back facility and referral transport for pregnant women. Though much improved, there are still gaps that would need area-specific innovative solutions- largely by merging 108 services with local tie-ups and 102 services and better mobile connectivity.

9. Infection prevention practices are below optimal level in facilities visited in both the districts. Infection prevention practices needs improvement in all facilities. The state needs to build upon its early efforts in quality assurance by establishing state and district quality committees and putting in place a road map towards quality assurance in all its facilities. The JeevandeepSamitis had started up with scoring for quality and awards to best scoring facilities. This had been strengthened by the quality certification programme- but currently these initiatives require to be followed up.

10. Malaria control in high endemic areas require more than the usual bednets and spray approach. There is a need to launch mass surveys and fever treatments in select areas jointly identified with the national center. A visit from a technical agency like MRC or the VCRC could also be called for. The other requirement could be as much as a ten times increase in availability of anti-malarial drugs and RDKs in the hands of the MPWs, ASHAs and ANMs. There is considerable under-estimation of the need in this regard. Much urgency is needed due to the possibility of a large number of deaths attributable to malaria.

11. The performance monitoring and assessment system of the Mitaninprogramme should be reviewed. If adequately designed it could be strengthened, if not it should be realigned with national guidelines. The VHSNC needs to be evaluated as a best practice for other states to learn from and replicate, and for the state itself to further strengthen VHSNC capacity.

12. The RSBY roll out requires far better monitoring. In the public facility ASHA help desks should help beneficiaries understand what is sum assured, and what is the billed amount. There should be an effort to limit unwanted and irrational care. For monitoring private sector, the RSBY should present the data on number of cases treated/reimbursed in each facility and this could be used for both planning and for monitoring and for identifying patterns of health care consumption that are clearly irrational.

13. A clearer strategy for addressing health care needs in conflict areas needs to be put in place. The main components of this would be a) building on partnerships with agencies like MSF and ICRC which are able to secure and pay for skilled human resources to work in such areas and b) improving incentives for govt staff working in this area,c) ensuring

more frequent supportive visits and encouragement to staff posted in these areas d) resuming the helicopter based rotational 15 day rotational posting in two or three most affected and remote areas, and e) higher skill levels and support to ASHAs working in this area, with specially motivated trainers and linkages with literacy and equivalency programmes f) much more inputs to girls in Ashram schools with the best of these being seamlessly drawn into CHW and ANM certification. Only a separate task force would be able to take on such an organizational challenge.

Annexure:

Annexure 1: Total functional delivery points in Public Health Facilities of the districts

S.No	Indicator	
1	**Total No. of SCs**	**3719**
	No. of SCs conducting >3 deliveries/month	**606**
2	**Total No. of 24X7 PHCs**	**217**
	No. of 24X7 PHCs conducting > 10 deliveries /month	**128**
3	**Total No. of any other PHCs**	**330**
	No. of any other PHCs conducting > 10 deliveries/ month	**45**
4	**Total No. of CHCs (Non- FRU)**	**79**
	No. of CHCs (Non- FRU) conducting > 10 deliveries /month	**71**
5	**Total No. of CHCs (FRU)**	**38**
	No. of CHCs (FRU) conducting > 20 deliveries /month	**40**
	No. of CHCs (FRU) conducting C-sections	**10**
6	**Total No. of any other FRUs (excluding CHC-FRUs)**	**5**
	No. of any other FRUs (excluding CHC-FRUs) conducting > 20 deliveries /month	**6**
	No. of any other FRUs (excluding CHC-FRUs) conducting C-sections	**4**
7	**Total No. of DH**	**18**
	No. of DH conducting > 50 deliveries /month	**15**
	No. of DH conducting C-section	**14**
	No. of DH conducting C-section at least 5/month	**10**
8	**Total No. of District Women And Children hospital (if separate from DH)**	**0**
	No. of District Women And Children hospital (if separate from DH) conducting > 50 deliveries / month	**0**
	No. of District Women And Children hospital (if separate from DH) conducting C-section	**0**
9	**Total No. of Medical colleges**	**3**
	No. of Medical colleges conducting > 50 deliveries per month	**2**
	No. of Medical colleges conducting C-section	**2**
10	**Total No. of Accredited PHF in the district**	**186**
	No. of Accredited PHF conducting > 10 deliveries per month	**120**
	No. of Accredited PHF conducting C-sections	**133**