Third

Common Review Mission

State Report

Andhra Pradesh

3rd Common Review Mission

Andhra Pradesh

AP Government's Commitment:

The Hon'ble Chief minister of Andhra Pradesh took out his time to meet the CRM team and patiently listened to our feedback on findings and recommendations. Shri Raju, Special Secretary to CM, shri Anil Punetha,CFW & MD NRHM, Dr.Srinivas, PO, NRHM were present in the meeting. The Hon'ble CM stated that the government is committed to provide quality health care and take up CRM recommendations. The chief minister has sound knowledge on the health care in the state.

In both the briefing and debriefing meetings, Sri J.Satyanarayana, Principal Secretary, Health, Sri.Anil Punetha, CFW & MD NRHM, Dr.Vijaykumar, Commissioner, Department of AYUSH, Sri B.R.Meena, Director General-Drug Control, Sri Ariz Ahmed, Additional Secretary health, Dr.Dhasharatha Rami Reddy, Director of Health and other program officers were present.

The team members of the 3rd Common Review Mission, Government of India

- ★ **Dr Himanshu Bhushan, MoHFW**
- ★ **Dr V. Rajasekhar, NHSRC, New Delhi**
- ★ **Dr Arun Agarwal, PGI, Chandigarh**
- ★ **Dr Rajiv Tandon, US AID**
- ★ **Dr K.S. Jacob, CMC, Vellore & MSG, NHRM**

We the team members of 3rd Common Review Mission, Government of India sincerely thank Hon'ble Chief Minister of AP, State Government, state and district officials, SPMU, DPMUs and all those who helped our visit.

Brief by AP state:

The visit of the team was scheduled from the 5th of November and was initiated with CFW and EO Prl Secy. to Govt. (HM&FW dept), Sri Anil Chandra Punetha briefing the team on the States NRHM activities in Hyderabad. In the meeting Shri J.Satyanarayana, Principal Secretary of Health, Shri B.R.Meena, Director General, Drug Control, Dr.Vijaykumar, Commissioner, Department of AYUSH, Shri Arizahmed, Additional secretary, Health, Dr.Dharatharami Reddy, Director of Health, Dr.Ramswaroop Reddy, Commissioner, APVVP, Additional director APSACS, program officers, a few NGOs, development partners participated. The CFW informed the team that in the state there were separate bureaucrats looking after different aspects of health care and also that there was a demand for redistricting the state from its present 23 districts to about 40 districts. The issues of low age at marriage, low female literacy, migration, gaps in human resource were also mentioned. He highlighted the special efforts like the Monthly ASHA days, Nishchay pregnancy test kits, 108, 104 services, the Second ANMs and 48-hrs stay of mothers in institutions during their PNC phase.

Andhra Pradesh is a southern state, bounded by Madhya Pradesh and Orissa in the north, the Bay of Bengal in the east, Tamil Nadu and Karnataka in the south and Maharashtra in the west. AP is the fifth largest state in India and it forms the major link between the north and the south of India. It is the biggest and most populous state in the south of India.

There are three main regions in Andhra Pradesh - (1) Coastal Andhra comprising Srikakulam, Vizianagaram, Visakhapatnam, East Godavari, West Godavari, Krishna, Guntur, Prakasam and Nellore districts; (2) Rayalaseema districts comprising Kurnool, Cuddapah, Chittoor and Anantapur districts; and (3) Telangana comprising Khammam, Nalgonda, Warangal, Karimnagar, Medak, Nizamabad, Aadilabad, Mahbubnagar, Rangareddy and Hyderabad (capital) districts. The total population is 76.21 million according to the 2001 census with 12.34% Schedule caste 5.02% belonging to Schedules Tribes (ST).

Estimated Population	866.92 lakhs
0-5 years children (lakhs)	95.67 (11.04%)
10-19 years (lakhs)	185.57 (21.41%)
60 and above (lakhs)	65.84 (7.59%)
Density of population (per sq. km)	315
Sex Ratio (Females/ 1000 males)	978
Literacy Rate	
– Total	60.47%
– Male	73.32%
– Female	50.43%

AP Health Sector at Glance

SNo	Description of Item	Number
1	Sub-centres	12,522
2	Primary Health Centres	1,570
3	Community Health Centres	169
4	Area Hospitals	58
5	District Hospitals	17
6	Specialty Hospitals (10) / Civil Dispensaries (26)	36
7	Post Partum Units	82
8	Urban Family Welfare Centres	132
9	ANM Training Schools (Govt-16 / Pvt-272)	288
12	Nursing Colleges (Govt-5 / Pvt-168)	173
13	Nursing Schools (Govt-9 / Pvt-309)	318
14	Teaching Hospitals (24) / Specialty Hospitals (14)	38
10	Medical Colleges (Govt-13 / Pvt-21)	34
11	Dental Colleges (Govt-3 / Pvt-18)	21
15	Govt. MBBS (1800) / PG medical seats (791)	2,591
16	Pvt. MBBS (2550) / PG medical seats (611)	3,161

Health Indicators

Sl.	Indicator	Present status	Target by 2012
1	TFR (children per women)	1.8##	<1.5
2	IMR (1000 live births)	52*	<30
3	MMR (1 lakh live births)	154**	<100
4	Full Immunization	67.1#	>95
5	Institutional Deliveries	71.8#	>95
6	Contraceptive Prevalence Rate (CPR)	65.8##	90
7	Malaria / 1 lakh	55	30
8	TB cases / 1 lakh	203 (84% cure rate & 74% case detection)	Maintain cure rate of 90% & 82% case detection rate
9	HIV Prevalence in 15-45 yrs population	Urban 2% Rural 1% STD clinics –n 22.8%	Urban <2% Rural <1% STD clinics –n22.8%

Source: *SRS 2009; **SRS Special Survey (2004-06); #DLHS-3 (2007-08); ##NFHS-3 (2005-06)

Institutional Deliveries – progress over years

According to DLHS reports, highest percentage of increase is observed @ 30.2%, raised from 31.3% to 61.5%. the lowest is -9.2% decreased from 52.3 to43.1 in Adilabad district. 9 districts have above 80% institutional deliveries, two districts have between 50 to 60% and others range from 60 to 80%.

RCH Progress:

- Every last Tuesday of month is observed as ASHA day for regular monitoring of ANC cases.
- Introduction of Nishchay Pregnancy Test Kits at village level.

Report	India	AP
1992-93 (NFHS-1)	33.0	34.3
1998-99 (NFHS-2)	42.4	49.8
2002-04 (DLHS-2)	40.9	59.4
2005-06 (NFHS-3)	40.7	68.6
2007-08 (DLHS-3)	47.0	71.8
2008-09 (HMIS Portal)	67.7	91.1

- With the advent of 108 Ambulances and 104 Mobile services the Maternal, Neonatal mortality and infant mortality will see a sharp decline in near future.
- 10,100 Second ANMs were appointed in addition to the existing ANMs to provide effective ANC and PNC services.
- Pregnant Women are made to stay in the hospital for 48-hrs after delivery. Every last Tuesday of month is observed as ASHA day for regular monitoring of Neonates and infants.
- With the advent of 108 Ambulances and 104 Mobile services the Maternal, Neonatal mortality and infant mortality will see a sharp decline in near future.
- 10,100 Second ANMs were appointed in addition to the existing ANMs to provide full immunization.
- Pregnant Women are made to stay in the hospital for 48-hrs after delivery.
- Through 104 Mobile, 0.95 lakh Neonates, 4.06 lakh Infants and 7.96 lakh Children are screened.
- IMNCI intervention initiated in all districts.
- 922 Medical Officers are trained in IMNCI training.
- Full Immunization: 50.10% children were fully immunized up to Sept-09 against the yearly target.

Immunization:

Its coverage is ranging from 52.4 in Srikakulam to 82.4 in Kurnool as per DLHS-3.

Sl.	Surveys (Year)	Full Immunization
1	2002-04 (DLHS-2)	62.0
2	NFHS-III (2005-06)	46.0
3	PATH (2006)	80.0
4	2006 (C.E.S. by UNICEF)	80.1
5	2006-07 (RCH-II Baseline Survey)	82.7
6	2007-08 (DLHS-3)	67.1
7	2008-09 (Dept. Statistics)	98.0

	AP	India	Highest	Lowest
Neonatal Mortality Rate*	40	39	Chattisgarh (51)	Goa (9)
Post-Neonatal Mortality*	13	18	Aruna.Pr (27)	Kerala (4)
Infant Mortality Rate#	52	53	UP (73)	Kerala (15)
Child Mortality*	10	18	Aruna.Pr (28)	Kerala (1)
Under-five Mortality*	63	74	UP (96)	Kerala (16)

Source: * NFHS-3 (2005-06); # SRS 2009

Total fertility rate:

Year	India		Andhra Pradesh	
	Total Population	TFR	Total Population	TFR
1971	54.80	5.2	4.35	4.6
1981	68.33	4.5	5.35	4.0
1991	84.39	3.6	6.65	3.0
2001	102.70	2.9*	7.62	2.3*
2005	109.87	2.7**	7.99	1.8**

Source: * NFHS-2 (1998-99); ** NFHS-3 (2005-06)

Achievements on Various FP Methods

Services	2007-08		2008-09		
	Achmt.	% of	ELA	Achmt.	% of
Sterilizations	7,22,111	90.26	7,90,000	7,00,273	88.64
IUDs	4,07,196	86.18	4,72,500	3,67,851	77.85
CC Users	9,06,085	95.88	9,45,000	8,35,758	88.44
OP Users	3,59,902	88.86	4,05,000	3,37,226	83.27

- Doctors trained in Laparoscopic … 370
- Doctors trained in Vasectomy … 514
- Doctors trained in Mini-Lap … 391
- Standard Sterilization Guidelines for Medical Officers … 1800
- Standard Sterilization Guidelines for Staff Nurses … 514
- The GoAP launched State Specific intervention under SPP, one of the first State in the country to recognize the problem of growing population.
- Standing 1st in the country in conducting FP surgeries for the last 15 years.
- 78 lakh FP surgeries conducted since 1999-2000.

Special budget allocated to implement the program

Four years of NRHM Progress:

SNo	Scheme	Progress
1	**ASHA program**	• 70,700 ASHAs are trained and positioned. o 55,400 in rural area o 5,300 in urban area o 10,000 in tribal area • 41,576 ASHAs have completed Refresher training. • For effective monitoring and prompt payment of performance based incentives, ASHA day is conducted on last Tuesday of every month
2	**24-hrs MCH centres**	• 800 PHCs strengthened as 24-hrs PHCs. • 799 Staff Nurses & 218 ANMs are recruited. • 3.32 lakh deliveries are conducted since 2005-06 and 82,982 deliveries conducted during 2008-09.
3	**JSY scheme**	• 18.66 lakh beneficiaries benefited through JSY scheme since Nov-2005 and 5.51 lakh beneficiaries

		benefited during 2008-09 • Rs.136 crores distributed.
4	**CEMONC centres**	• 156 FRUs strengthened as CEMONC centres, out of which 27 centres are functioning in Tribal areas. • 165 Specialists and 307 Staff Nurses are recruited.
5	**Blood Banks & Blood Storage centres**	• Proposed 20 BBs & 89 BSCs under NRHM • Out of which 10 BBs & 74 BSCs are functioning and remaining waiting for License.
6	**Family Planning Services**	• Standing 1st in the country in conducting FP surgeries for the last 12 years. • 78 lakh FP surgeries conducted since 1999-2000. • 7 lakh FP surgeries conducted during 2008-09.
7	**Birth Waiting Homes**	• 38 Birth waiting homes constructed at distant and interior Tribal PHCs. • Women from interior habitations can reach the PHCs before the expected date of delivery so as to prevent complications of delayed labour.
8	**108 Ambulance Services**	• 752 Ambulances positioned, out of which 58 are in ITDA areas. • Attended over 35.31 lakh emergencies since 2005 • Served 6.09 lakh Pregnancy cases. • Saved above 55,700+ lives.
9	**104 Fixed Day Health Services**	• 475 Mobiles Health Units positioned, out of which 41 MHUs are in ITDA areas. • FDHS screened about 94.21 lakhs since Sept-2008. • Antenatal cases screened – 9.35 lakhs (9.93%) • Infants and Children screened – 13.47 lakhs (14.3%) • Students screened – 13.64 lakhs (14.48%) under School Health Program
10	**2nd ANMs**	• 10,103 2nd ANM posts are filled. • 2,024 2nd ANMs deputed to FDHS (104 Mobile).
11	**Village Health & Sanitation Committees**	• 21,916 Village Health & Sanitation Committees are formed. • Rs.34.71 crores spent since 2006-07.
12	**Untied Funds**	• Untied funds are provided to 12,522 Sub-centres, 1,649 PHCs & Civil Hospital and 167 CHCs. • Rs.40.15 crores spent since 2006-07.

13	**Rogi Kalyan Samities**	• 97% (1822 / 1876) of the Hospital Development Committees registered and established. • Rs.33.37 crores spent since 2006-07.
14	**Mainstreaming of AYUSH**	• AYUSH facilities are created in 691 PHCs and 86 CHCs and proposed in 2009-10 is 696 PHCs/ CHCs. • 786 Doctors & 1572 other staff are recruited.

NRHM - Human Resources (Progress between 2005-2009)

Sl.	Designation	Number
1	Doctors / Specialists	381
2	Staff Nurses	1,424
3	2nd ANMs / MPHA(F)	10,370
4	Other paramedical staff	1,095
5	SPMU / DPMU	139
6	ASHAs	70,700
7	AYUSH (786 Doctors & 1572 other staff)	2,358
8	Staff recruited under 108 Ambulance scheme	4,771
9	Staff recruited under 104 FDHS / HIHL	5,041
	Total	**96,279**

ASHA day:

- Last Tuesday of every month being observed as ASHA day.
- In each PHC, one official (CHO) identified as Nodal Officer and he has been trained.
    - All ASHAs (70,700) converge at respective PHCs...
    - Training, capacity building, exchange of notes…
- Medical Officer will monitor and verify the records of ANM and ASHAs and ensure payment of Incentives to ASHA.
- Refilling of the ASHA Kit.

Progress of 108 Services (EMRI):

752 ambulances positioned.

Highlights

- Total Lives Saved – 55,700+
- Served 6.09 lakh Pregnancy cases
- Average Base to scene time:

- Urban : 12.9 min.
- Rural : 21.8 min.
- Tribal : 23.0 min.

– 93% of the population covered
– 92% of the Geographical area covered

Ambulance services are covering all backward and interior regions.

Sl.	Indicator	Since	During Oct-09
1	Emergencies attended	35,31,363	1,14,687
2	Total Lives saved	55,766	1,362
3	Pregnancy cases attended	6,08,982	21,167
4	Cases shifted to Govt. hospitals	62%	64%
5	Cases shifted to Private hospitals	38%	36%

104 Help line:

Details	Since	During
Calls received	3,06,16,043	16,25,047
Service provided calls	1,79,79,947	68,92,686
Medical Advice and Info.	1,73,35,149	66,51,970
Counseling calls	3,68,498	1,49,574
Information Provided calls	2,61,759	88,485
Complaint logger	4,259	2,657
Gender (Service provided)	--	15.3%
Caste (Service provided)	--	23.71%

104 mobile health services: total vehicles: 475

	Since	During
No.of PHCs covered	1,571	1,571
Total screening	94,21,375	9,44,855
Antenatal cases screening	9,35,095 (9.93)	1,17,970 (12.49)
Neonate screenings	98,576 (1.05)	2,698 (0.29)
Infants screening	4,11,838 (4.37)	43,134 (4.57)
Child screenings	8,37,065 (8.88)	80,392 (8.51)
CD cases identified	42,16,024 (44.75)	2,73,920 (28.99)

Student screening	13,64,165 (14.48)	1,48,276 (15.69)
Minor illnesses	16,54,228 (17.56)	2,78,465 (29.47)

- 38 Birth waiting homes constructed at distant and interior Tribal area PHCs.
- Each birth-waiting home will have 4 rooms of size 10'x 8.6' with a provision for a small kitchen and bathroom.
- Women from interior habitations can reach the PHCs before the expected date of delivery so as to prevent complications of delayed labour.

Trainings:

Sl.	Training Program	2008-09	2009-	Total
1	IMNCI Training to MOs	466	121	587
2	IMNCI Training to Staff Nurses / ANMs	581	238	819
3	ToT on IMNCI to MOs / Staff Nurses / DPHNOs	125	93	218
4	SBA Training to Staff Nurses / ANMs	617	125	742
5	ToT on facility based New Born Care for Staff	76		76
6	Induction training to MOs	812	255	1,067
7	Training on Standards of Sterilization Guidelines	1,919	395	2,314
8	Training on Financial Management	197		197
9	Training on ARSH	68,800		68,800
10	Other Trainings	2,589		2,589
	Total	**76,182**	**1,227**	**77,409**

Financial progress under NRHM:

Sl. No.	Intervention	Budget approval for 2009-10	Opening balance as on 1.4.2009	Releases for 2009-10	Total funds available (col.4+5)	Expr. till Sept-09	% of expr. over release
1	RCH Flexible Pool	156.55	49.44	85.34	134.78	69.21	51.35
2	NRHM Flexible Pool	376.20	61.75	113.84	175.59	129.94	74.00
3	Strengthening of Immunization	15.83	1.60	6.20	7.80	1.76	22.60
4	**National Disease Control Prog.**	**57.62**	**13.73**	**32.35**	**46.07**	**20.17**	**43.79**
a)	NVBDCP	18.18	10.43	4.79	15.22	3.59	23.58

b)	RNTCP	17.68	1.50	14.53	16.04	6.50	40.53
c)	NPCB	17.00	0.21	12.20	12.41	9.53	76.76
d)	NIDDCP	0.20	1.17	0.00	1.17	0.00	0.00
e)	NLEP	2.15	0.01	0.65	0.66	0.27	40.71
f)	IDSP	2.41	0.40	0.18	0.58	0.29	50.65
5	Pulse Polio Immunization	20.70	1.03	0.00	1.03	0.51	49.77
6	Direction & Admn. (Treasury route)	233.73	0.00	82.64	82.64	118.34	143.19
	Total	**860.63**	**127.54**	**320.37**	**447.91**	**339.93**	**75.89**

AP Health, Medical and Family Welfare allocations since 2003-04 (in Crores)

Sl. No.	Year	Allocation	% of increase
1	2003-04	1391.55	--
2	2004-05	1418.90	1.97
3	2005-06	1587.54	11.89
4	2006-07	1895.34	19.39
5	2007-08	2509.10	32.38
6	2008-09	3150.84	25.58
7	2009-10	3565.10	13.15

Nutrition Program under Indira Kranthi patham:

Society for Elimination of Rural Poverty was established in the year 2000, a 2,000 crore project financed by the state Government, World Bank. It has component like Indira kranthi patham a rural women empowerment scheme, Health & Nutrition scheme etc.

Interventions:

- Regular capacity building of health activists, health sub committees and health CRPs
- Institutionalization of Fixed Nutrition and Health Days (NHDs) towards complete immunization, ANC and PNC.
- Community managed Nutrition cum Day Care Centers (NDCCs)
- Community kitchen gardens
- Promotion of weaning foods with locally available commodities
- Regular health savings and HRF
- Community managed health insurance

- HBMNCC with technical support from SEARCH, Gadchiroli
- Mainstreaming HIV/AIDS prevention with support from Lepra Society
- Beneficiary:
    - Average of 15 pregnant & lactating mothers per center
    - Average of 15 – 20 children <5 years per center
- The cost of meal
    - Rs 25-32 per day for TWO MEALS for pregnant and lactating mothers
    - Rs 10-15 per day for TWO MEALS for Children <5 year
- Beneficiary PAY: Rs 20-25, GoAP and the Community Organization Pays: Rs 7
- Micro Credit
    - Beneficiary could finance her portion of the contribution via Micro credit offered by the Village Organization
    - Repayment period is between 24 – 36 months

Average amount borrowed was less than Rs 5000

YEAR	No. of Centers*	Beneficiaries	
		Pregnant and Lactating Mothers	Children<5 Yrs
2007 - 08	200	4060	1772
2008 - 09	600	9420	3440
2009 - 10	2500	35000	40000

Against the 2960 deliveries happened:

The outcome results of other pregnant women not mentioned.

- 100 %of women had safe deliveries. [2559 Institutional (88.5%) /331 trained personnel (11.5%)]
- 2599 had normal deliveries (89.9%)
- 291 had cesarean section (10.1%).
- 87% women had complete ANC
- 99% women had PNC
- 46% of pregnant women gained 10-12Kgs weight; 47% gained 7-10kgs weight
- No maternal deaths reported among the women enrolled

* Source: Internal MIS

AYUSH:

The department of AYUSH is headed by Dr.Vijay Kumar, IAS, Commissioner

- Already covered in re-location (prior to NRHM):
    - Primary Health Centres: 253
    - Community Health Centres: 39
    - District Hospitals: 13 (ISM&H wings)
- No. of PHCs and CHCs where AYUSH facilities created: 777 (691 PHCs + 86 CHCs)

System	No. of units
Ayurveda	415 (370 PHCs+45 CHCs)
Homeo.	253 (224 PHCs + 29 CHCs)
Unani	60 (53 PHCs + 7 CHCs)
Naturopathy	49 (44 PHCs + 5 CHCs)

The vacancies in Unani could not be filled up for want of candidates from SC/ST/BC and P.H categories

Staff position in each Facility include (1) Medical Officer, (1) Compounder and (1) Class-IV staff. Govt. orders were issued to provide 800 Sq. ft of accommodation. Funds are available for 128 units. Medicines provided for 491 AYUSH Units – Orders placed for 311 units.

The commissioner, AYUSH has set out a few guidelines as below.

- AYUSH unit working hours to be same as that of PHC/CHC,
- No night duty for AYUSH staff except in exigencies.
- Display board to be put at PHC/CHC specifying that 'AYUSH facility availablity
- Single attendance register to be maintained.
- Separate OPD registration
- Only AYUSH practice to be done except in emergencies.
- AYUSH team to work under leadership of PHC/CHC incharge Medical Officer.
- AYUSH Medical Officer to be involved in National Health Programs.

National Disease Control Programs

National Vector Born Disease Control Program (NVBDCP):

Staff position

Name of the Posts	Sanctioned	Position	Vacant
Addl. Director of Health (M&F)	1	1	0
Deputy Director	2	2	0
Zonal Officer (Malaria)	6	6	0
Assistant Director (Entomology)	7	1	6
District Malaria Officer	22	14	8
Senior Entomologists	27	10	17
Assistant Malaria Officers	45	18	27
Sub-unit Officers	260	212	48
MPHS (Male)	2166	1656	510
MPHA (Male)	7211	5242	1969
Lab Technicians	1343	703	640

Budget: in Rs.Lakhs

- Opening Balance = Rs: 517.35
- Interest = Rs: 8.47
- Received = Rs: 470.30
- Expenditure = Rs: 340.18
- **Balance as on 31.10.09 = Rs: 630.78**

An additional support from World Bank (EAC) to the tune of Rs. 196.96 Lakhs is sanctioned for HR, trainings and mobility.

THE VECTOR BORNE DISEASES FROM 2006 TO 2009 (UP TO 03.11.09)

Year	Malaria		Dengue		Chikungunya		J.E.		Filaria	
	Cases	Death	Case	Death	Case	Death	Case	Death	Mf	Diseas
200	3408	0	197	17	248	0	2	0	930	7419
200	2780	2	587	2	11	0	22	0	716	5962
200	2642	NIL	313	2	5	0	16	NIL	659	6545
200	1738	3	806	10	113	0	24	0	470	5268

Indoor Residual Spray 1st Round 2009

Name of the Insecticide	PHCs	Sec.	Vill.	Population			HD'S			Rooms			Insecticidies Spent in Kgs
				Targetted	Covered	%	Targeted	Covered	%	Targeted	Covered	%	
Malathion 25%	111	334	2021	508959	432725	85.02	108991	88322	81.04	326442	239803	73.46	99845
Cyfluthrin 10%	159	354	3433	989023	949980	96.05	226811	217636	95.95	572096	521883	91.22	7902.4
DDT 50%	108	219	677	375221	324495	86.48	82848	74281	89.66	252832	191134	75.60	24165.5
TOTAL:	378	907	6131	1873203	1707200	91.14	418650	380239	90.83	1151370	952820	82.76	131912.9

Bednets Supplied:

SL No.	Districts	APCO	TOTAL GOI	TOTAL
1	SRIKAKULAM	26000	16500	42500
2	VIZIANAGARAM	26000	16500	42500
3	VISAKHAPATNAM	65000	27000	92000
4	EAST GODAVARI	53000	27000	80000
5	WEST GODAVARI	6000	3000	9000
6	ADILABAD	31000	57050	88050
7	WARANGAL	22000	10000	32000
8	KHAMMAM	36000	26900	62900
9	GUNTUR	6000	3000	9000
10	PRAKASHAM	14000	1000	15000
11	KURNOOL	11000	5000	16000
12	MB'NAGAR	12000	4000	16000
13	KRISHNA	4000	0	4000
14	KADAPA	18000	9000	27000
15	ANANTHAPUR	10000	3000	13000
16	KARIMNAGAR	0	3000	3000
17	CHITTOOR	0	3000	3000
18	NIZAMABAD	0	3000	3000
19	[illegible]	0	3000	3000
20	CML	0	50	50
	TOTAL:-	340000	221000	561000

The above issues and suggestion made by the program officer of the state.

RNTCP: profile

Population	83.08 million *
No. of Districts	23+1 (Badrachalam addl. DTC)
No. of TUs	177 (Govt 170; NGO 7)
No. of DMCs	918 (Govt 857 ; NGO 45; Private 15)
No of PHIs**	2111
No. of Medical Colleges	35 (Govt 13; Private 22)
No. of APVVP Hospitals/ Dispensary	228

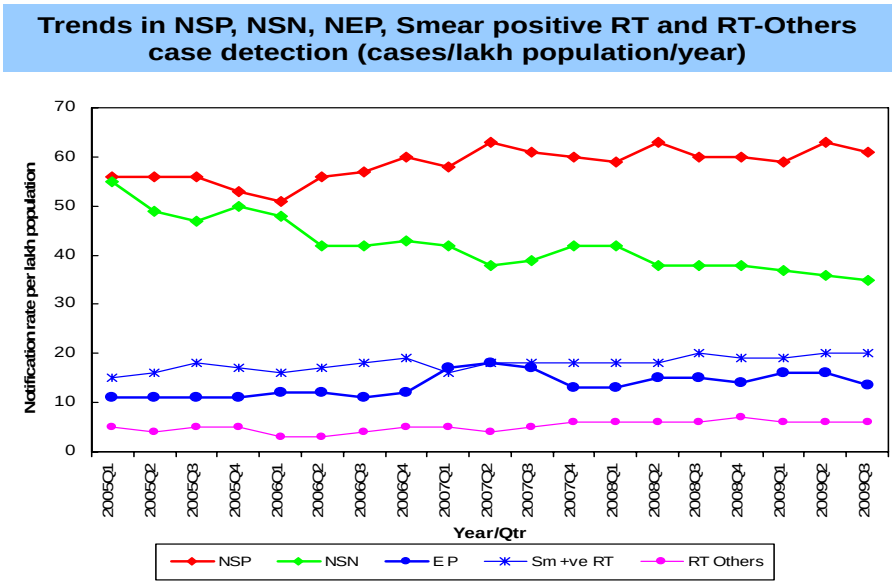
*(Projected population of 2009) based on 2001 census

Staff:

Staff	Sanctioned	In Place	Trained	Vacancy
DTCO	24	10	10	14 (FAC)
MOTC	177	163	163	14
STS	177	176	174	1
STLS	177	175	172	2
DMC LT	918	862	854	57

S. No	**Activity**	**Constraints**	**Suggestions**
1	Mobility & Budget for TA	Shortage of Vehicles & Travel Budget for Supervisory staff.	Providing Vehicles on Hiring, release enough budget
2	Vacancy Position	Vacant Post of Assistants Directors, DMOs, Sr. Entomologist and Assistant Malaria Officers	Filling of Vacant posts
3	Diagnostic facilities for Dengue disease	It is limited to only Teaching Hospitals & Head Quarters Hospitals.	The Facility may be extended to the Area Hospital and Community Health Centres.
4	Shortage of Dengue Test Kits	Lot of Demand is noticed during the transmission season from Sentinel Centres for Supply of Elisa Kits for Dengue	Provision may be made for decentralized procurement under NVBDCP
5	Trainings	In adequate budget for advance trainings for different categories of the department and other concerned departments	Sufficient Budget may be released to undertake the activities in lien period well in advance.

Examination of TB suspects is improved from 107 per lakh of population in 1st quarter 2005 to 164 in 3rd quarter 2009. Case detection rate is above 70% and cure rate for New smear positives is slightly improved over 85% in the recent past.



CRM: There is trend of decline of new smear negative cases and slightly increase new smear positive cases, both of which are normally expected to be equal proportions. The reason for this cannot be commented unless internal evaluation reports and Onsite evaluation reports are studied as regards to the quality of diagnosis.

The STDC has been accredited as intermediate reference laboratory in june 2008.
DOTS PLUS is being implemented in four districts in the first phase (102 patients on category IV) and another four districts in the second phase (25 on Cat IV). Other places are in pipeline.

TB-HIV

32 out of 35 involved Medical colleges with a DMC also have ICTC. The Standard cross-referrals established between the DMCs and ICTCs. Out of 23 ART centres, 11 Medical colleges (Govt) with DMCs have ART centres. TB-HIV cross referral are substantially increased since 2006.

Fund Flow: The fund comes directly from the Central TB division to State TB Control Society. The society is not merged with state health society. From state TB society the will be transferred to district TB societies which again have not merged with respective district health societies.

Involvement of Other sectors

All the ASHAs were trained as DOTS providers in addition to other DOTS providers like AWW, RMP.

NGOs	Schemes undertaken
Blue peter research laboratory, Hyd	Culture and DST
Lepra Society	Tuberculosis units/DMCs
World Vision	ACSM activities
Gretanaltes,Guntur	Tuberculosis unit
AMG,Guntur	Tuberculosis unit
PATH	ACSM activities
Shivananda	Tuberculosis unit
TB Alert, AVAHAN, PSI	ACSM activites

A few State level initiatives

- Involvement of Medical College Faculty in RNTCP key staff review meetings
- Posting of students/interns to DTC/Medical College DMC
- Workshops being conducted during STF meetings to strengthen the involvement of the medical colleges
- Sensitization of the Medical College Faculty in Paediatric PWBs
- Operational research on INH chemoprophylaxis conducted at Krishna district – Report not provided.
- Internal evaluation of Nizamabad district - requested by CRM to share but declined as per instructions from CTD.
- Intensive Zonal review meetings are being conducted at seven zones across the state

Issues :

- 14 posts of DTCOs are vacant in the State
- DMC – LT vacancies at District level are not being filled
- Sub-optimal involvement of DM&HO in supervision and monitoring of the programme

National Blindness control Program:

101	Total Cataract Surgeries (in Lakhs)	2006-07	510705
		2007-08	547899
		2008-09	582318
		2009-10	292713
102	(275000)Prop% Achievement on 550000 Target		107.4%
103	# Intraocular Lens(IOL) implanted		341416
104	%IOL		99.1%

105	Number of School going Children	Screened	1021070
		Detected with refractive Errors	46499
		Provided free glasses	11976
106	Eye /Cornea Donations in Total(cumulative) since 2005		17638

Particulars	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**
Allocation by GOI under items subsumed within NRHM	3,00,00,000	2,60,00,000	12,41,50,000	16,43,00,000	17,00,00,000
Amount of PIP sent by the State to GOI for items subsumed with in NRHM	-	-	26,59,77,000	30,51,88,000	28,54,00,000
Amount released by GOI under items subsumed within NRHM	1,41,96,000	4,11,30,100	12,41,50,000	22,49,80,000	12,20,00,000
Amount of Expenditure done by states under items subsumed with in NRHM	1,32,55,125	4,58,88,839	12,69,11,708	21,76,86,522	9,31,12,262
Unspent amount with the State out of funds released by GOI under items subsumed within NRHM	88,30,130	41,14,476	66,52,768	72,93,478	1,02,87,738

STATE GOVERNMENT UNDER AAROGYASREE: Ophthalmic Surgeries :

1. Cornea scleral surgery
2. Vitreo Retinal Surgery
3. Photocoagulation (Diabetic retinopathy)
4. Photocoagulation for Retinopathy of prematurity (ROP)
5. Pediatric Cataract & glaucoma
6. Squint Correction surgery
7. Retinoblastoma &Enucleation

Structures	**numbers**
Upgraded Block PHCs/CHCs equivalent (i.e.,	PHCs-350 ,FSCs-42=392
Vision Centres Govt / NGO	Govt : 392, NGO:24
District Hospitals	23
No. of District Hospital with dedicated Eye O.T.	23
Sub- District Hospitals	58
No. of Sub-districts Hospitals Where cataract surgery	47
Medical Colleges	12
CMU	04
DMU	23
Eye Banks	04
Eye Donation Centers	42
PMOA Training Schools	60
PMOA posted	402
Eye Surgeons	248
Blind Schools	07
NGO Associated with NPCB	188
No. of Medical officers trained	465
No. of PMOAs given re-Orientation	313
DCEH- trained	17

National Leprosy Eradication Program:

- No. of Urban Leprosy Clinics (ULCs) : 92
- No. of Leprosy Training Centers (LTC) : 1
- No. of Sample Survey Cum Assessment Units (SSCAUs) : 2
- Voluntary Organizations : 48
- Reconstructive Surgery (RCS) Centers : 10
- Referral Centers : 15
- Leprosy Colonies : 84
- Elimination Achieved at State level : March, 2005
- ANCDR 2008-09 : 11.37/100000 Pop
- Prevalence Rate : 0.72/10000 pop
- Treatment completion rate : 98%

Year	**08-09**	**09-10**
new Cases Detection	9546	5326

PB	5394	2851
PB RFT (cured cases)	5618	2345
MB	4152	2475
MB RFT (cured cases)	4167	2183

MB, Female, Child, GI, and GII deformity till Sept. 2009

New cases detected during the year (April to Sep.2009)	5326
Total on hand cases as on Sep - 09	6070
MB Cases %	46.1%
Female %	38.2%
Child %	11.2%
Deformity GI %	4.20%
Deformity GII%	5.50%

Activity	**08-09**	**09-10**
No. of Deformity cases (grade 1 & 2)		39780
No. patients provided with MCR foot		12828
Total No. of RCS centers in AP		10
Year	Selected for RCS	No. of RCS Conducted
2007 – 2008	1926	598
2008 - 2009	1328	582
2009 – Aug,09	956	301

Finance management:

Consolidated Statement of Receipts and expenditure (SHS + DHS) (NLEP) for the year								
	Budget Received from GOI : Rs.							
S.No	**Head of Accounts** / **State Health Society**	**April**	**May**	**June**	**July**	**Aug.**	**Sept.**	**TOTAL**
1	Capacity Building +	1303	1280	830	530	0	0	259733
2	Contract Services	5900	7175	7224	7250	6350	1950	358498
3	BCC (IEC Campaign)	0	4863	6700	6000	6000	1009	1137580
4	POL/ Vehicle	8232	8838	3860	5078	2013	5780	338029.

5	Office Expenses &	3784	2797	1376	4278	1928	3413	299633.
6	Cash Assistance	0	0	0	0	0	1544	1544181
7	Supervision	0	0	0	2500	0	0	25000
8	Materials & Supplies	0	0	0	0	0	0	0
9	Transfer to DLOs to	0	0	0	0	0	0	0
10	Advance to NGOs	0	0	0	0	0	0	0
11	DPMR	1573	0	1030	9346	0	0	261162
12	ULCP	4050	1360	2075	0	0	1350	57435
	Total	**5074**	**3660**	**3266**	**2910**	**1089**	**2665**	**4281252**

3rdCommon Review Mission					
3rd November 2009 to 13th December 2009					
Name of State				**Andhra Pradesh**	
Names of Districts visited: **1. Visakhapatnam, 2. ViziaNagaram**					
Sno	**Name**	**District HQ**	**Name of DM**		**Name of CMO**
1	Visakhapatnam	Vizag	Sh. Shyamala Rao		Dr.Sarojini
2	Vizianagaram	Vizianagaram	Sh.Ramnarayan reddy		Dr.Mahesh
Health Facilities visited					
Sno	Name	Address / Location		Level (SC / PHC / CHC/other)	Name of the Person in Charge
1	District Hospital	Ankapali		District level	
2	Area Hospital	Narsipatnam -		sub district hospital	Dr.Narsing Rao
3	CHC	Aganampudi		CHC	Dr.B.S.Nayak
4	CHC	Arku Valley			
5	Nutrition Center under SERP/ Velugu project	Jogampeta		Village	
6	PHC	Ananthagiri		24x7 facility	
7	PHC	Pendurthi		24x7 facility	
8	PHC	Kasim Kota		24x7 facility	
9	PHC	Revidi		24x7 facility	Dr Nirmala Glory
10	PHC	Anandapuram:		24x7	Dr.Kanakadurga
11	PHC	Lambasing		Tribal PHC	Dr.Sitarama raju
12	Tribal sub center	Rajupakalu		Lambasing PHC	
13	Village picked up randomly through a TB card	Pedabarada		Village under Lambasing PHC	
14	Sub-centre and AWC along with Community Interaction	SriRamPuram			
15	PHC	Lothugedda		24x7 facility – A best practice	Dr.L.Satyanarayana
16	District hospital	Vizianagaram		District level	
17	MCH/Ghosha Hospital	Vizianagaram		District level	
18	CHC	Bhogapuram			

19	CHC	S Kota		
20	CHC	Kothavalsa	24 x 7 facility	
21	PHC	PM. Palem	24X7 PHC	
22	PHC	Kottam		Dr.Mamatha rani
23	subcenter, AWC and village	Boddavaram	Under Kottam PHC	
24	AWC, Sub-centre, Out-reach Session, and Community Interaction	Rangapuram		
25	VISIT to 104 Ambulance Service Delivery Site			

Findings of the 3rd CRM in the state

1. Infrastructure Upgradation

As per census 2001, 1924 PHCs are required and 1570 PHCs are functioning of which 188 are designated as situated in difficult areas. 481 CHCs are required and 169 CHCs are are established of which 7 are in difficult areas. the state has divided areas into two categories only, Plain area and difficult area. The state has to revisit into this to demarcate most difficult and in accessible areas too for better clarity..

800 PHCs were designated as 24x7 health facility of which 630 PHCs are providing these services.144 subcenters were constructed under NRHM since 2005. 156 FRUs strengthened as CEMONC centres, out of which 27 centres are functioning in Tribal areas. These centers are FRUs but in actual terms of meeting the criteria of availability services of obstetrician, anesthetist and blood storage/bank facility only 88 are fully functional. 10 Blood Banks and 74 Blood storage centers are available in the state.

38 Birth waiting homes are proposed of which 32 are functional at distant and interior Tribal PHCs to facilitate institutional deliveries. 752 108 ambulances for emergency transport and 475 mobile Health Units are positioned in the state.

2. Human Resources

A total of 96,279 health human resources were added since 2005, inception of NRHM. 1424 Staff Nurses, 381 doctors of whom 165 are Specialists and 786 AYUSH doctors were recruited. 10,370 2nd ANMs/MPHA (F) posts are filled of whom 2,024 2nd ANMs deputed to FDHS (104 Mobile). 70,700 ASHAs are trained and positioned of whom are 55,400 in rural area, 5,300 in urban area and 10,000 in tribal area. Others are other staff under different programs, DPMU, 108, 104 services etc. Multi-Purpose Workers (Male) have huge gap with 7300 available against the need for 10,568.

The specialists available in rural areas as under:

Speciality	**Required as per existing centers**	**Sanctioned**	**Regular**	**Contractual**	**Total**
Suregeons	167 (CHCs)	111	30		30
Obstretricians	167	111	95	165	260
Physicians	167	111	20		20
Pediatricians	167	111	90		90
Anesthetists	120	120	80		80
MBBS doctors (at PHC level)	1570	2497	2214		2214 (56 are LMOs)

3. Assessment of the case load being handled by the Public System

3.32 lakh deliveries are conducted since 2005-06 and 82,982 deliveries conducted during 2008-09. 7 lakh FP surgeries conducted during 2008-09. 18.66 lakh beneficiaries benefited through JSY scheme since Nov-2005 and 5.51 lakh beneficiaries benefited during 2008-09. Rs.136 crores distributed.

Activity	Facility level	Year	Case load (in '000)
OPD	District hospital	2006-07	-
		2007-08	4883
		2008-09	4663
		Since Aril 2009	2197
	CHC	2006-07	-
		2007-08	23732
		2008-09	20907
		Since Aril 2009	9480
	PHC	2006-07	31581
		2007-08	29876
		2008-09	31565
		Since Aril 2009	14467
	Sub Centers	2006-07	7408
		2007-08	6076
		2008-09	10206
		Since Aril 2009	7549
No. of patients admitted	District hospital	2006-07	-
		2007-08	654
		2008-09	690
		Since Aril 2009	326
	CHC	2006-07	-
		2007-08	1967
		2008-09	1681
		Since Aril 2009	948
	PHC	2006-07	712
		2007-08	876
		2008-09	840
		Since Aril 2009	485
	Sub Centers	2006-07	498
		2007-08	618
		2008-09	1122
		Since Aril 2009	913

4. Preparedness of facilities for patient care services

Most of the health facilities have adequate health human resources and infrastructure, though there are under and over supply of health human resources, equipments and drugs. There are adequate supplies of medicines in most facilities. 108 EMRI services are phenomenal in providing emergency quality services including life saving support protocols and transportation. But this is not linked to preparedness of the health facility where the patient is expected to arrive. In many health facilities it was observed that there are no protocols or standard operative procedures when there is an emergency including proper triage systems. The GOI technical guidelines were not available at health facilities. The medical and paramedical staff are not trained in the latest technical protocols and needs urgent dissemination/ training. AYUSH services are also available with adequate medicines wherever centers are located and providing good services.

5. Outreach activities of Sub-centre

The state has 12522 sub centres, Sub centers visited had inadequate space and in rented buildings-only. Village Health Nutrition Days and immunization activities are planned through common micro plans of ANMs, AWW and ASHAs. There is good cross sectoral linkage with ICDS however this is weak as major point of convergent action at the nutrition day care centres.
3.70 lakh monthly Village Health and Nutrition Days were held for the year 2009-2010 across the state. The Village Health and Nutrition Days seem to be conducted regularly in the villages visited, but limited mainly to the Immunization.

In the name of convergence, 2 ANMs, 2 AWWs and ASHAs were seen at fixed health day services by 104 without doing any job since the 104 system has already 2 ANMs present onsite. However, only ASHA gets Rs 50 per day as incentive for bringing the cases. AWWs and ANMs are not getting any incentive.

On triangulation of these services with 104 and sub centre it was observed that the 2nd ANM of the SC is always busy with the 104 and the first ANM is busy with the nutrition centre. Without any work and her time is wasted. Moreover, during SC visits it was observed that at some places the routing work of BP, Hb Check etc is not being conducted since it is being said that it is done at 104 sites.

While 104 mobile units doing good job for interior and tribal areas, but also making the health sub-centre non functional. This needs attention and sub-centre should not be involved for nutritional centres and 104 activities except for referral and follow up.

IEC tools were seen in Sub-centres but in inadequate amounts, as most of the Sub-centres are in small parts of residential buildings. There is need for urgently creating appropriate

buildings for sub-centres with adequate facilities.
The BCC activities were more evident in the nutrition day care centres as compared to the VHNDs. The comprehensive integrated package of services also appears to be primarily focused in the nutrition day care centres rather than in the AWW centre where VHND are happening.

Anganwadi Centres

The state has 73944 Anganwadi centres. We visited many Anganwadis. As all sub centres were in rented buildings and were very small, the Anganwadi centres were the site of all activities related to Village Health and Nutrition Days, Antenatal care, in addition to the regular Integrated Child Development Scheme (ICDS) activities.

There seemed to have been good integration between the different programs of the ICDS and NRHM and good cooperation between the different workers i.e. ASHAs, ANMs and Anganwadi workers.

The Anganwadi workers motivate people for vasectomy. They regularly attend the weekly shandy/market and encourage men to avail of the operation and also claim Rs. 200.00 for undergoing the procedure. The male Health Assistants conduct a medical camp on shandy/market days. The beneficiary registers are being maintained at the centres.

However, introduction of NRHM platform has resulted in a general reduction in the emphasis and importance of the well established ICDS programs. In many Anganwadis, the cooperation and coordination between the Anganwadi worker, the ASHA and the ANM is good, all three categories of workers working together for VHND for nutrition counselling, noon meal scheme, immunisation. Nevertheless, there is a limited convergence of the ICDS and NRHM at the block, district and state levels. There also needs to be convergence with NREGA. Both the PIPs of ICDS and NRHM at the mandal, district and state levels should have similar PIPs, as their foci are the same

6. Utilization of untied funds:

All health facilities have received the untied funds and most facilities have utilized the fund and prepared SOEs. This fund would come to the common account of Hospital Development Society/ RKS. There is no system of collecting user charges as government policy. However in some districts fund is stopped for want of spending details and prior approval for untied fund plans which needs to be revisited. Sub centers also have opened accounts and these funds are being distributed and submitted their utilization certificates for untied fund.

7. Thrust on difficult areas and vulnerable social groups

The state of Andhra Pradesh has a total population of 76.21 million according to the 2001 census with 12.34% Schedule caste 5.02% belonging to Schedules Tribes (ST). The STs in Visakhapatnam form 14.55% and in Vizianagaram is 18.61%.

16 out of 60 PHCs in Vizianagaram and 121 out of 431 sub centres are located in the tribal areas arguing that the district is focussing on tribal health. However, the majority of the geographical area, which has significant tribal people, is hilly with forest cover making access to health care difficult.

Community Health Workers (CHW) working in tribal areas have been also trained as ASHAs. Consequently, they receive higher remuneration, which includes the salary of Rs 400 as part of being a CHW, and the ASHAs performance based incentives.

The staff across the districts were aware of the large tribal population in the region, the difficult and inaccessible terrain making health care delivery a challenge. The hilly terrain and the lack of motor able roads make the access to health care a challenge. The higher proportion of sub centres and PHCs in tribal area compared to the general population suggests that this awareness is actually put into policy and in practice. However, the remoteness of these locations and has resulted in a greater number of unfilled post in these health facilities. The 104 services less frequently visits tribal areas. There is a need to focus on the ST population, increase the infrastructure, community screening and services.

8. Quality of services provided

In most health facilities qualified doctors and other health staff services are available. However as a rule newborn or delivery protocols are not in place even where qualified specialists are available. The state is on efforts to keep delivered women in the institutions for 48 hours after delivery. Drugs are generally adequately available but they can also purchase locally in case of emergency.

9. Diagnostics

CT Scans are provided in all district hospitals which is a very welcome step from AP Government and the services are available. But the proper provision of training to the doctors is not provided. Many labs are restricted to routine investigations like Hb, urine, etc. Newer diagnostic services like HBSAg, serum creatinine and Urea are added to the diagnostic profile but without providing proper training to the Lab technicians. Cross sharing of work by LTs in the lab services is partial and variable.

10. Logistics & Supply chain management

There is an infrastructure established under AP Medial Health ‘services called APHIMIDC (AP Health & Infrastructure Management Development Corporation). The state government has

brought up the policy on rationale drug use. The team found adequate supplies available practically at all levels of facilities and outreach activities.

Equipment for

- neonatal care inadequate
- cold chain maintenance variable
- Some equipment need repairs (ILR/Freezer)
- Most Operation theatre equipped
- Eye, dental equipment available at designated facilities
- There was need to ensure appropriate inventory of equipment as many sites either had excess or inadequate equipment
- Proper maintenance of the equipments needs to be ensured.

11. Decentralized Planning

The DHAPs were prepared by Centre for Good Governance and national Institute of Health and Family welfare under Government of AP. In AP development of Program Implementation Plan started with introduction of National Rural Health Mission during the year 2005-2006, though it is not a priority state under NRHM. State PIP for 2007-08, 2008-09 and 2009-10 were prepared by SPMU. But while preparing PIP for the state, DHAPs were not taken into consideration. The review of programs also seems not based on DHAPs.

During 2006-07 22 districts out of 23 have prepared DHAP except state capital, Hyderabad. They were prepared by different organsiations as stated below. During 2007-08 only 13 districts had prepared DHAP by the district health authorities without any external support from consultancy firms which is appreciable.

They interacted with district health officials and collected districts' data before preparing DHAP. The data sets used were NFHS-3, MMR- 2006, SRS 2007 and also used some proxy estimations for the district which are otherwise not available at state level. The needs assessment is partially done in the sense that it was discussed with the district officials. Burden of disease profile is not much reflected in the DHAP strategies and activities but was taken to provide situational analysis and to comment on national health programs.
During 2008-09 again DHAP preparation was outsourced to Center for Good Governance for 19 districts and IIHFW for 3 districts but the institutes have submitted their DHAPs in 2009.
As regards to the disbursal or financial allocation to districts was made based on their preceding year's expenditure and submission of SOE but not based on DHAP.
Key points:

1. No village or block level plan are made till date
2. Preparing Districts plans since 2006, and 5 year perspective plans in place
3. Key issues are identified at district level but not for planning at higher level. But these plans are not integrated with state PIP nor monitored for implementation

4. Workshops were conducted before making plans though it was not exactly capacity building of the district officials
5. In the planning process, it was prepared by external agencies, but DPMU, officers from WCD, NGOs were participated. District plans are prepared based on some template method by each external agency.

12. Decentralised Local health action

There are a total of 26613 revenue villages in the state and 21,916 are Gram Panchayats. 21916 Village Health and Sanitation Committees (VHSC) have been constituted across the state and all of them have operational joint accounts. These committees have been installed in all villages visited. The composition includes the ASHA, Aaganwadi worker, and the village Sarpanch. They have been using the untied fund of Rs 10,000.00 for local needs. For example, they have bought tables, chairs, blood pressure apparatus, weighing scales with the money in the villages under Lambasingi PHC. However, the funds have been divided to the villages under the panchayath as per their population. We did not see much evidence of community monitoring of the process.

13. Community Processes under NRHM

Hospital Development Societies (Rogi Kalyan Samithis)

The State has registered HDS/RKS at 23 District Hospitals, 168 CHCs, 73 Other District hospitals, 1570 PHCs.

All Primary Health Centres visited have HDS/RKS comprising of medical personnel and members of the public. They had accounts opened and funds were being transferred and utilised. The public participation in these committees was good with Tahasildhars, Zilla Parishad members, Sarpanches, Rotary members, etc on these committees. The minutes of the meetings and resolutions were adequately documented. All PHCs seem to have utilised all the Rs one lakh received. The utilization certificates, signed by the Medical Officers seemed to in order. However, the number of meeting conducted were less than 3 per year. This may be because of the belief that all members of the committee should be present for all meetings. The RKS and AMC funds for 2009-10 have not yet been received.

Community monitoring

The NRHM advocates the community monitoring of public health services implying a systematic collection and audit of information and services. The Citizen's charter was displayed in most health facilities visited. The communities were mobilised to form the VHSCs. The interviews with patients, ASHAs, ANM, AWW suggest that many services were being provided. However, there was neither evidence of a social audit at the community

level nor evidence of the conduct of Jan Samvads to disseminate these findings to the community.

14. ASHA

70,700 ASHAs are trained and positioned of whom are 55,400 in rural area, 5,300 in urban area and 10,000 in tribal area. 41,576 ASHAs have completed Refresher training**.** The ASHAs has been trained in antenatal and postnatal care, immunization, nutrition, family planning, tuberculosis, leprosy, malaria, etc. They have also been given drug kits. They are selected from the village with one ASHAs per 1000 families. Their remuneration is performance based.

All ASHAs in the state have received an initial residential training of 21 days. All 5 recommended modules completed for all the recruited ASHAs. Most of them have also received one week training at the local PHCs. The 51201 ASHAs have been provided with drug kits.

The program has specific guidelines for mentoring. The many ASHAs interviewed during the CRM had a good knowledge of the health issues, the health and disease states to be recognised, nutrition, antenatal care, family planning, the immediate treatments offered and the referral. They all have drug kits, NISCHAY kits. They reported that they meet the ANMs every 2 weeks and attend the ASHA day on the last Tuesday of every month. They were involved in the VHND.

They reported an average remuneration of about Rs. 400.00 per month. They reported that they have regularly received the money. There seems to be a cap on the amount of performance incentive ASHAs get at Rs 400-600.00 defeating the purpose of the program. There seems to be a backlog of payments. Many ASHAs also expressed the view that they would prefer a regular salary as the performance based incentive was based on many factors including the number of pregnant women in the area etc.

We visited villages with tuberculosis patients, reviewed the individuals, the medicine box and the medication card and matched it with the medication cards maintained at the PHC. The ASHAs were well aware of health, nutrition and disease issues. The ASHA Day is helping in continuing education and in-service training for ASHA.

15. National Disease Control Programmes

Overall Effectiveness of NDCPs

The disease control program are running better in terms of supportive supervision and meeting the health targets. However not only the fund transfer but also the administration of the respective control programs is still vertical and not well integrated with the general health systems as normally projected. The disease control program accounts are separate

and they get the fund from respective divisions directly to their account and accordingly it will be transferred to the district program accounts. The classical example is RNTCP in which the fund from CTD comes directly to the state TB Control Society from which the fund is transferred to the respective district TB societies without the any say of state or district health societies. **These vertical programs need greater integration and convergence**.

NVBDCP:

The surveillance and diagnosis are integrated with general health care system but there are no measures for quality assurance mechanisms in implementing indicators like IRS, impregnation of bed nets etc. Supply of ACT is not there or in acute shortage, LLI are not in supply and the program staff are not using the district drug stores for storage. There is a need to strengthen the malaria control measures in high endemic areas.

RNTCP:

This is one program which is almost vertical including fund transfer and program management. However there is cross sharing of work by lab technicians in some facilities. There are 14 DTCOs, 14 MOTCs, 57 DMC LTs, 1 STS, 2 STLS including 2nd medical officers at DTCO/ STO offices are vacant.

There is trend of decline of new smear negative cases and slightly increase new smear positive cases, both of which are normally expected to be equal proportions. The reason for this cannot be commented unless internal evaluation reports and Onsite evaluation reports are studied as regards to the quality of diagnosis.

Note: The 3rd CRM team requested the State program officer (STO) to share the report on Internal evaluation done for Nizamabad district during the briefing at state level, initially agreed to provide us. But later they declined to share the report as per instruction of CTD. 3rd CRM contacted the National Program Officer, CTD, for the same, the NPO was stated that it is to be shared only with World Bank and not with Common Review Mission. This is a matter of concern as any evaluation report is to be made available to public domain or at least to the health professionals who are working for Health programs in the country particularly in the light of transparency, shared responsibility and shared Confidentiality. This paradigm likely widens the gap between general health services and disease control programs.

NBCP

This program is doing well in the state. It was informed that many NGOs are working and funding is also from the state government in addition to the support form GOI. The achievement is consistently above 100% and is appreciable. Some of the complex surgeries are covered under Arogyasri insurance for BPL families. There needs to be timely utilization

of Collected of eyeballs. School health program is doing well. Ophthalmic services need strengthening at CHC level and sub district level.

NIDDSCP

Comment on the endemicity of the Iodine deficiency related disorders in the area and the operational strength/weakness of the programme.

IDSP

The overall disease surveillance is weak under IDSP. The reporting is done upto PHC level but above PHC level there is no such system exists. Use of the epidemiological data is not practiced nor attempted for triangulation for use. The epidemiologists positions created under IDSP are vacant. DSOs are not even aware of these positions.

16. RCH II

(Maternal Health, Child Health and Family Planning Activities)

Child Health:

- Immunizations were conducted as per schedules, however at some places cold chain maintenance improper
- ORT and ARI programs needed strengthening.
- Complementary feeding needed focus.

New born Health:

- Even though some centres had Pediatricians, Infant Warmers and Phototherapy units, the team did not see new born corners, SCNUs, NICUs and protocols of ENBC, Resucitation were not being practiced. Also resuscitation equipment like bag and mask, mucus suckers were not available.

17. Preventive and promotive health aspects with special reference to inter-sectoral convergence and convergence with social determinants of health

Good convergence is seen with ICDS system and coordinated efforts are seen with involvement of professional bodies like Indian Medical Association. VHSCs need strengthening for more active participation. HIV cases are handled without much stigma or discrimination particularly positive pregnant women.

18. Nutrition

Inspite of success of Andhra Pradesh in various health indicators, there were gaps in the trends of Nutritional security in the children and women as seen in NFHS-3 and DLHS-3 State indicators. The only specific nutrition security related activity, that the team was informed was the nutrition program implemented by the Society for Elimination of Rural Poverty (SERP) under IKP through the female self help groups.

On better understanding this project the team realized that there was a focus on micro credit, community investment fund, lively hood, community participation, dairy intervention, land purchase, organic agriculture, collective marketing, employment generation, insurance, pensions, food security, etc.

It appeared that the level of effort in capacity building and monitoring and the multiplicity of activities had lead to a situation where the no.of beneficiaries of this activity with regard to nutritional security were few, for example in 2 mandals of Vizianagaram district with a population of 2 lakhs, the project was reaching only 180 mothers and children

Nutrition project - details:

The State has a special nutrition project in 600 villages under the Indira Kranthi Pathakam (IPK). The project is a multidimensional poverty elimination scheme with many divisions including capacity building, microfinance, agriculture, marketing, employment generation, gender, health and nutrition. It covers 10 million rural self help groups. This project is a joint effort of many government departments and is executed through the Society for the Elimination of Rural Poverty (SERP).

The interventions of the project includes: Nutrition and Day Care Center, Nutrition related capacity building, Fixed Nutrition and Health Days, Health Savings, Risk and Insurance funds, Water and Sanitation Program, and Employment generation. It has links with the NRHM, ICDS and JSY schemes and potential links with NREGA and Bank Linkages to SHGs. It provides two meals a day, antenatal check up and growth monitoring income generation activities, community kitchen garden and health education. The project has recruited new personnel (master trainer, community volunteers, health activists) and has become a new financial and labour intensive vertical program. The program has an intensive training and monitoring systems.

We visited the nutrition centre at Jogampeta. The nutrition standards of the Indian Council of Medical Research, New Delhi, are employed. The cooks are trained in colleges of home science. Standard measures are employed to hand out daily rations for the meals. Fixed amounts of rice, pulses, milk, oil, egg, green vegetables, tubers and curd is provided. Two meals are cooked and served along with one breakfast. There were colourful and descriptive flip charts to educate pregnant and lactating mothers about nutrition. The centre has cooking and serving vessels.

Eight pregnant and lactating mothers from below poverty line were being served by the project. 5 women were present at the centre on the day of the visit. There were 7 pregnant and lactating mothers above poverty line in the village and they were offered food at the centre at cost price. However, none of agreed to use the facility. The outcome was being measured by measuring monthly anthropometric indicators including height, weight, head, chest and mid-arm circumference for children and weight gain and height for mothers.

Vitamin A supplementation is being given every month at the Aagnawadi. However, anaemia was not being monitored.

Even though we were told that this project focuses on the poorest of the poor, while visiting one of these centres the beneficiaries did not appear to be poorest of the poor. Also on understanding some components of the costing of the project, it appeared that there was need to focus on studying the cost efficiency of this project, before taking it to scale. The team strongly recommended an appropriate scientific evaluation of this intervention.

The seed money to start such centres is given by the government. This program seems to be functioning well and seems to providing convergence between issues related to health, nutrition and livelihood issues. However, this new platform seems to duplicate and undermine the Anganwadi centre and the ICDS program. This will in the long term mean a reduced importance of the ICDS initiatives. The nutrition programs should be based in the well established Anganwadis and completely integrated with the ICDS programs.

The many new staff specifically recruited for the project makes the project cost ineffective and less likely to be scaled-up. It will need to be simplified and better integrated into existing systems. The team shared with the Project Manager, SERP a copy of the LEADERSHIP AGENDA FOR ACTION developed through the "Coalition for Sustainable Nutrition Security in India", for consideration of the AP State to operationalize the same in all its mandals. It is available at the website **www.nutritioncoalition.in.**

19. Non-governmental partnerships

There are many NGOs working in the state in the health sector. Public private partnerships are effectively functioning in running 108 and 104 services and Arogyasri, a Health Insurance Scheme for the BPL families. DFID is supporting the state directly in the health sector but the role other development partners like UNICEF is marginal.

20. Overall Programme management

There are constant efforts on part of the state to improve health care delivery through innovative strategies. Good coordination between district admin and DMHO. There appreciable inter sectoral coordination between DHMO, ICDS, DRDA, IMA,NGOs . Good understanding between DPMU and district health officials. However decentralized planning is not seen. This is outsourced to a few institutes who are making again centralized plans after taking some inputs from the districts. There needs to be plan based fund allocation and monitoring. Supportive supervision is very weak and needs urgent attention at all levels.

21. Financial management

The financial management is doing well. The fund transfer is through e bank transfer and reaches PHC level within 3 days. The state has introduced Tally system for better

accountability. Expenditures are reported on Tally Software. Auditors appointed for concurrent audit. The Utilization certificates and SOE are available in most health facilities for the fund they received. Standard guidelines for financial record maintenance particularly below district hospitals were not available hence the uniformity was not evident.

22. Data Management

This is generated regularly at facility level, compiled at district level and put on web portal at district level. But there is no validation or triangulation mechanism in place to assure quality of data. It is not integrated with IDSP. The data analysis not regularly done for monitoring and improving the service delivery. The data managers are need to be trained and also to mentored by the program officers.

23. Status of the progress of state against Specific objectives, expected outcomes and expected Outcomes at Community level under NRHM.

*The Principal Secretary, Sri J. Satyanarayana then, highlighted additional innovations that the state was initiating like**.***

- Focusing on Key Performance Indicators as self appraisal tool for all PHCs and higher facilities.
- An Intensive Comprehensive HMIS with special focus on Health Governance, Financial Inventory, Personal Management, HR Issues, Patient Care and Drug regulatory issues to be launched next month.
- An Innovative Drug Procurement policy with management tools to be launched in January 2010.
- A Cell under Commissioner, Family Welfare to act as the Think Tank and monitoring unit for NRHM to be setup. This will ensure appropriate utilization of SIHFW, SHSRC, APHSDP, SPIU all of whom will support capacity building.
- A massive recruitment drive to fill MOs vacancies at PHC level.
- HR rationalization between primary, secondary and tertiary units with the special reservation for in-service candidates towards Super Specialty areas.
- Special focus on Water Sanitation and Hygiene.
- Partnership with International Finance Corporation, World Bank for contracting out of PHCs by NGOs.
- Future PIPs to be based on DHAP with multi sectoral inputs

Recommendations from CRM

Human resources and Infrastructure:

1. *Rational deployment of specialist staff & filling up of vacant posts at all levels. Filling up of program officers vacant positions (not full additional charges) in all the programs including disease control programs particularly at district level needs focus.*
2. *Supervisory and program implementation to be carried out by public health specialists*
3. *Classify the difficult, most difficult and in accessible areas and to provide Incentives accordingly for working in these areas*
4. *Relocation of poorly functioning (because of poor location) of PHCs*
5. *ASHA incentive should not be capped*
6. *Retraining for use of new equipment and new diagnostic and treatment procedures*
7. *Effective and rational policies for career progression at all levels like GDM0s, specialists, nursing, and other cadre*
8. *All district and state program officers to be oriented to public health programs and finance management*
9. *DPMU and SPMU to be trained and involved in program supervision including disease control programs using respective program modules. Provide them check lists of respective programs for field visits.*

RCH Program:

10. *District nodal officer for maternal, child and family planning services be designated*
11. *Alternate plan for JSY to those who are migrant workers and not have any identity card – DM&HOs may be empowered accordingly*
12. *Special focus on technical protocols of labor rooms, ENBC and resuscitation and District specific action plans for operationalizing FRUs and PHCs with time line*
13. *Tracking of missed out and left out cases for ANC and immunization be ensured*
14. *Targets for family planning being achieved at health facilities but other spacing methods like condoms, IUCD mare missing, needs these to be strengthened.*
15. *Vaccines available at all levels but generator, POL, cold chain equipment need attention at facility level.*

16. *Weekly outreach sessions at AWC and other outreach activities need rationalization*
17. *Comprehensive VHND be organized and monitored*

Disease Control Programs:

18. *Cross sharing of reports/results across all programs including disease control programs not only with respective program officers but also with DPMUs and SPMU*
19. *Overall RNTCP working well except for few districts which need strengthening. Efforts to be made on: 1.smear negative cases – under or over diagnosis, 2.strategies for improving tracking mechanism for defaulters including initial defaulters and 3.improving cure rates for retreatment cases.*
20. *Adequate supply and re-impregnation of bed nets in malaria endemic district with Quality assurance mechanisms for residual spray, re-impregnation*
21. *Adequate supply of ACT and LLIs in malaria endemic areas*
22. *Malaria workers should be used for all vector borne disease*
23. *Reorientation of health care providers and community screening for leprosy cases, efforts to make early identification of leprosy cases need atttention*
24. *Strengthening of disease surveillance mechanism above PHC levels*
25. *Eye care facilities at CHCs need focus*
26. *HIV/STI Counselors for to be used for other conditions especially nutrition of pregnant women.*
27. *Cross sharing of work of laboratory technicians recruited from different programs*

Trainings:

28. *In-service training, particularly skill based training like LSAS, EMOC, SBA, IMNCI, NSSK needs immediate implementation with quality protocols*
29. *SIHFW, CMOs and professional bodies to be involved in ensuring training quality*
30. *All district hospitals be designated and strengthening for conducting training*

Monitoring:

31. *State and district level quality assurance committees to be constituted and made functional*

32. *Regional directorate to be strengthened with adequate staff for effective supervision and monitoring*
33. *PHC/CHC medical officers, District program officers should monitor programs implementation with defined checklists*
34. *Adequate funds/vehicles/POLs to be ensured for monitoring visits*
35. *Transparency in public health through social audit, citizen's charter, Display of JSY beneficiaries list*

State Specific Issues: CRM recommendations

1. *Different division of health such as Directorate of health services, APVVP, DME, CFW needs unification and better coordination*
2. *"104" and other outreach activities should be streamlined and not affect routine sub center function*
3. *Nutritional supplement for provision of diet under SERP is a complex program and a duplication of ICDS, needs synchronization before scaling up*
4. *The Media was aggressive, threatening on medical fraternity irrespective of the services provided and focused on sensationalization. The authorities need to be sensitive in over reacting to media reports against the medical professionals.*
5. *The Directorate drug control needs strengthening for better quality assurance mechanisms.*

District Vishakhapatnam

Population at a Glance

2001 Census Population	… 38,32,336
Estimated Population as on 01.10.09	… 42,52,667
a) Male population	… 21,43,344
b) Female population	… 21,09,323

Area wise Population

a) Rural Population	… 20,07,939
b) Urban Population	… 15,93,935
c) Tribal Population	… 6,38,346
0-5 years children	…4,45,250
Sex Ratio per 1000 Males	… 985
Revenue divisions	… 03
Number of Mandals	… 43
Greater Visakha	… 01
No. of Municipalities	… 02
No.of Revenue Villages	… 3294
No.of In habited villages	… 3108
No.of Un habited villages	… 186
No.of Grama Panchayats	… 944
Density of population	...342 per sq.km
Area	… 11,161 Sq. K.Ms

Literacy Rate (Census 2001)

Male … 75.85%, Female … 54.16%

Public Health Institutions in the district

	Institution wise	Total	Under DH	APVPP	DME
1	Sub Centre	584	Plain: 378 Tribal : 195	0	0
2	Primary Health Centre	76	Plain :43 Tribal :33	0	0
3	Rural Health Centre	1	0	0	1
4	Urban Family Welfare Centres	11	10	0	1
5	Post Partum Units	1	0	0	1
6	Urban Health Centre	15	15	0	0
7	First Referral Unit	2	2	0	0
8	Govt. Dispensary	4	4	0	0
9	Community Health Centre	11	5	6	0
10	CEMONC	8	2	6	0
11	Area Hospital	1	0	1	0
12	District Hospital	1	0	1	0
13	Teaching Hospital	7	0	0	7
14	Medical College	1	0	0	1
15	Mobile Medical Units	8	Govt. :6, NRHM :2		

Human Resources in the District

Sl. No	Category of Staff	Sanctioned	Positioned	Vacancy
1	Civil Surgeon (General)	7	6	1
2	Civil Surgeon (Specialists)	6	-	6
3	Deputy Civil Surgeon	10	6	4
4	Medical Officer	168	159	9
5	Community Health Officer	16	12	4
6	P.H.Ns	27	16	11
7	Staff Nurse	110	58	52
8	MPHEO	100	84	16
9	MPHS(M)	166	138	28
10	MPHS(F)	106	103	03
11	Radiographer	9	4	5
12	MPHA (F)	642	557	85
13	MPHA (M)	477	387	90
14	Pharmacist Gr.II	112	91	21
15	Lab. Technician	134	130	4

Human Resources of various Levels Under NRHM

1	Dist. Programme Officer	1
2	Accounts Officer	1
3	M I S Officer	1
4	Computer Asst.	2
5	ASHA	5734
6	Medical Officers(MMU+CEMONC)	13
7	Staff Nurses	65
8	2nd ANMs	520
9	MPHA(F)	20

There are 660 private nursing homes and clinics in the district.

District CHMO Office

Major Interventions under NRHM

1) Accredited Social Health Activists (ASHAs)
2) 24-hours PHCs
3) CEMONC centres
4) Janani Suraksha Yoajana
5) 2nd ANM
6) Village Health and Sanitation Committees
7) Untied funds for Sub-centres, PHCs & CHCs
8) Annual Maintenance Grant for PHCs
9) RKS funds for PHCs, CHCs, Area Hospitals & District Hospitals
10) 108 Ambulance scheme
11) 104 Mobile Health Units (Fixed Day Health Services)
12) 104 Health Information Help Line
13) Birth Waiting Homes

NRHM Progress

As per state HMIS, 101% mothers in 2008-09 and 97.7% in 2009-10 (till date) had received atleast 3 antenatal visits for their last birth, institutional deliveries were 96.1% in 2008-09 and 95.9% in 2009-10 (till date), TT immunization was 99.1% in 2008-09, and 95.1% in 2009-10 (till Oct 2009).

NRHM Progress:

SNo	Scheme	Progress		
1	ASHA program	Trained and positioned 5734		
2	24-hrs MCH centres	35 MCH centres functioning (Plain Area: 24 Agency Area: 11)		
3	JSY scheme	Year	No. of Beneficiaries	Spent (in Crores)
		2008-09	28475	2.43
		2009-10 (up to Oct'09)	10656	0.74
4	CEMONC centres	CEMONC CENTRES - 08 Under APVVP - 06 Under Director of Health - 02		
5	Blood Banks & Blood Storage centres	Blood Bank – 01 Storage Centres – 04		
6	Family Planning Services	32253 (80.6%) in the year 2008-09 12772 (59.2%) in the year 2009-10 (up to Oct'09)		
7	Birth Waiting Homes	Constructed 4 Homes in Agency area Under DH – 2 :: 1. Chintapalli 2. Hukumpeta Under APVVP – 2 :: 1. Aruku 2. Paderu,		
8	108 Ambulance Services	No. of Vehicles - 36 Rural – 17 Urban – 09 Tribal - 10		
9	104 Fixed Day Health Services	No. of Vehicles – 20, Plain – 14, Tribal - 06		
10	Village Health & Sanitation Committees	Funds Released Rs. 1.22 Crores & Utilized Rs. 1.01 crores in 2008-09 (82.79%) Funds Released Rs. 0.99 Crores & Utilized Rs. 19 Lakhs in 2009-10 (Up to Oct'09) (19.19%)		
11	Sub centre Untied Funds	Funds Released Rs. NIL & Utilized Rs. 0.49 crores in 2008-09 Funds Released Rs. 1.27 Crores & Utilized Rs. 15 Lakhs in 2009-10 (Up to Oct'09) (11.81%)		
12	Rogi Kalyan Samities (HDS)	Funds Released Rs. 4 Lakhs & Utilized Rs. 0.84 crores in 2008-09 Funds Released Rs. 0.55 Crores & Utilized Rs. 24 Lakhs in 2009-10 (Up to Oct'09) (43.64%).		

13	Mainstreaming of AYUSH	74 Medical Officers
14	Nutrition Day Care Centres (Interior and Tribal areas)	Devarapalli – 32, Golugonda – 30
15	ICDS	No. of Anganwadi Centres 3394 Plain - 2272 Tribal - 1122

DPMU

Well functioning unit with district program manager and district data manager. Accounts work is being seen by the district accounts officer. Other staff: two computer operators- one for RI and one for NRHM. Funds are received online and transmitted to the different units online. FMR received fortnightly through meetings and consolidated at district. Funds are released under the joint signatories of DMO and DC. Tally implemented. Files are cleared by DC without any delay. Auditors for concurrent audit appointed.

AMG and untied funds for PHCs not received from the state. RKS funds received and disseminated to the facilities. Subcentre untied fund is in the process of release to the facilities. Funds utilization 77.4% in 2008-09 and 59.5% in 2009-10 till now.

Progress of 108 Ambulance Service

No of Ambulances : 36

Highlights

Total Lives Saved : 3150

Average Base to scene time:

Urban : 11.06 min.
Rural : 20.51 min.
Tribal : 29:23 min.

Population covered : 100 %

Geographical area covered : 76.69 %

Ambulance services are covering all backward and interior regions

Sl. No	Indicator	Since Aug-05	During Oct-09
1	Emergencies attended	180125	5916
2	Total Lives saved	3150	148
3	Pregnancy cases attended	27135	1074

Mobile Medical Units: 6 units- with 2 units functional run by an **NGO** in **public private mode** with doctors in tribal areas. they are functioning since last 2 years. The cost is 77000 + for one month that includes cost of vehicle (Rs 25000), cost of two medical officers @ Rs 18000

per month per person, and Rs 5000 per month for one staff nurse. Vehicles are stationed at Mandal Head quarters.

104 Fixed Day Mobile Service: 43 vans with 8 parking places. There are 7 staff members in each vehicle; data entry operator, LT, pharmacist, 3 ANMS and a driver. They provide following services: 1) antenatal/ postnatal/ infant care 2) detection of chronic cases 3) school health service.

Service timings are 8 AM to 12 AM, 1 PM to 5 PM. They cover 3000 population, 1500 in morning and 1500 in afternoon. This is a fixed day service. Even if fixed date falls on any holiday, service is provided. Each unit has 28 fixed points. They screen cases and refer it to PHC. About 60% referrals reach PHC. In tribal areas it is around 30%. In these areas, services are provided on shandy days.

104 Mobile Health Units (FDHS) in Vizag district

Health Services through Mobile Health Units

Target groups: Pregnant women, infants, children and people with chronic diseases.

No.of Vans in service 20

Population covered 1636880

All high risk pregnancies are identified and referred to nearby FRU 24x7 PHCs.

	Since February-08
No.of PHCs covered	71
Antenatal cases screening	18526
Neonate screenings	746
Infants screening	9452
Child screenings	20934
Student screening	40916
CD cases identified	38607
Minor illnesses	59701

RNTCP

There are 11 TB units. Each unit has 1 MOTC, 1 STS, and 1STLS. There are 5049 DOTS centers (2550 in Plains and 2499 in Tribal areas). No shortage of manpower, District has achieved more than 80% case detection and more than 85% cure rate of NSPs for last 4 years. Quarterly analysis is being done by the district officers.

Total population	4155178
Total number of TUs	11
Total number of DMCs	55
Total number of PHIs	108
Total number of medical colleges participating in RNTCP	1
Total number of ART centres in the district	2
Total no. of PPs involved in RNTCP	49
Total number of care and support centres	3
Total number of ICTCs	23

The Central Internal evaluation of RNTCP was done in the district in July 2009 and the report is not available to triangulate.

NVBDCP

The staff vacancy is as follows: Health supervisors (M) – 16, Health supervisors (F) – 23, MPHA (M)- 90, MPHA (F)- 89 and LTs – 25 posts. However, most of the vacancies are in non-endemic areas.

Human Resources

S. No	Health facility	Sanctioned	In Place	Vacant
1	District Malaria Officer	1	1	0
2	Senior Entomologist	1	1	0
3	AMO	5	5	0
4	Health Supervisors (M)	166	150	16
5	Health Supervisors (F)	106	83	23
6	MPHA (M)	477	387	90
7	MPHA (F)	672	583	89
8	Lab Technician	134	109	25

Tribal area is endemic for PF and plain area endemic for PV. No deaths reported after 2005. API- 1.2 and SPR-0.7 for the year 2009. DFID support Vulnerability Community Plan. Rapid Diagnostic Kits/ New Drugs are being supplied by NRHM and training by DFID. Bednet coverage 30-40 % in tribal areas. LLIN are not in supply. There is no quality assurance mechanism in IRS.

DISTRICT MALARIA STATUS 05-09

Year	B.S.C	Tot. +'ves	Pf. Cases	Deaths	API	S.P.R
2005	1014787	11053	8572	7	2.9	1.09
2006	768442	5984	3921	0	1.6	0.8
2007	711664	5251	3051	0	1.4	0.7
2008	706313	4949	2509	0	1.3	0.7
2009 (Upto Sep)	628855	4642	2464	0	1.2	0.7

Bed-nets distribution in Visakhapatnam 2005-09

Indent given for bednets to the states but not yet supplied. Bednets are being impregnated every 6 months. There is no quality assurance for re impregnation of the bednets signature from the beneficiaries are taken. This needs involvement of communities, SHGs and ASHAs for quality assurance mechanisms.

Sl. No	Name of the Mandal	2004-05	2007-08	2008-09
1	Ananthagiri	1500	8421	0
2	Arakuvally	1075	10154	0
3	Dumbriguda	1125	5173	0
4	Hukumpeta	0	0	0
5	Paderu	1450	0	0
6	Pedabailu	466	6260	0
7	Munchingput	905	13151	0
8	G.Madugula	1184	16751	0
9	Chinthapalli	8599	0	14700
10	G.K.Veedhi	10986	0	10300
11	Koyyuru	17291	0	3100
12	Hostels	0	0	3900
Total		44581	59910	32000

IDSP

One post of epidemiologist and entomologist not sanctioned and is vacant. The contractual recruitments made under IDSP recently were also not given appointment orders in the state. Other staff available but not trained. 40 LTs available and 60% of them are in tribal areas. Every week P & L forms from are submitted to the DSO, IDSP. 96% funds since 2005 have been utilized.

NLEP

Assistant paramedical officer available 61 out of 89 and Deputy Paramedical officer 11 out of 16 sanctioned.

Part of general health services. ASHAs are being involved in a big way in a service model. ASHAs help in identification of cases. Rs 500 are given per ASHA for identification and completion of treatment for MB cases and Rs 300 for PB cases

Prevalence rate – 0.55 per 10000 population. NCDR – 9.5%, declining trend of cases. However, decline is not uniform in all the Mandals. Treatment completion rate 98.3%; with rates almost equal in rural and urban areas and for both PB and MB cases. Deformity grade I - 488 and grade II -1518.

Epidemiological Situation of Leprosy in the district

Year	Total No. of new cases detected	No. of cases cured MB	No. of cases cured PB	cases cured Total	No. Of child cases	Disability %
2000	1697	301	1582	1883	551	1.8 %
2001	2645	489	2003	2492	959	1.9 %
2002	2156	330	1684	2014	794	0.8 %
2003	1619	192	1328	1520	505	1.3 %
2004	1264	251	959	1210	289	0.7 %
2005	862	203	356	559	158	0.4 %
2006	271	110	119	239	17	0.7 %
2007	305	122	218	340	41	2.9 %
2008	332	95	154	249	39	5.7 %
2009	384	163	220	383	26	5.2 %

HIV/AIDS

TB-HIV Co-ordination meeting is held every month and DCC every quarter. Red ribbon clubs are formed in many colleges for awareness generation amongst students. There is noticeable decline in HIV positivity since 2002-03. It has declined from 16.9% to 6.45% in VCTCCs, from 1.56% to 0.6% in PPTCTs, and from 0.85% to 0.32% in blood banks from 2002-03 to 2009-10 (till date)

Established – DAPCC and DAPCU from April-2009

- ICTC's- in the DISTRICT(Stand Alone) – 22(Medical College, DH, CHCs, upgraded PHCs)
- FI-I.C.T.C's IN THE DISTRICT - 3
- FI-ICTC ' s – PPP IN THE DISTRICT - 6
- ART Centers - 2

- Link-ART center – 1
- District STI/RTI Clinics (DSRC) -3
- Community Care Centes (CCC) -3
- Target Interventions (TI) NGOs – 8
  - FSW - 2
  - FSW & MSM - 2
  - IDU - 1
  - Truckers - 1
  - Migrant - 2

Network for PLHAs (SVNP+) - 1

Blindness Control

Till now 120% achievement in the year 2009-10. A total of 23186 cataract surgeries have been conducted this year till now. 16 OAs conduct School Health for refractory errors and distribute the glasses both in plain and tribal areas. A total of 50331 children have been examined against target of 38600. A total of 1403 refractory errors were identified and 162 glasses have been distributed. In tribal areas 272 refractory errors were identified but none has been given glasses so far. Teleophthalmic unit functional at a tertiary centre. Fund utilization – 50% in the current financial year.

Cataracts indicators, district Vishakhapatnam

Year	Target	Achievement	Percentage	Rank in the state
2005-2006	30556	31485	103.04%	5th Rank
2006-2007	28000	31024	111%	2nd Rank
2007-2008	30000	32686	108.9%	11th Rank
2008-2009	33000	37097	112.4%	4th Rank
2009-2010	33000 **Proportionate**	23186	120.4%	---

School Health Eye Screening Programme and Eye Balls collection

Year	**School children Target**	**No. of Schools Covered**	**No of Children Examined**	**No. of Refractive Errors**	**No. of Glasses distributed**	**No of Eye Balls collected**
2005-2006	100500	680	72757	3465	1292	105
2006-2007	124437	695	88494	1906	1181	181
2007-2008	38000	512	40136	1762	909	171

2008-2009	24100	783	77177	4522	1415	240
2009-2010 (04/09 to 10/09)	77200 Proportionate Target upto 10/09 38600	242	50331	1403	162	111

Trainings

1. ASHAs Regular Training : 5734
2. ASHAs Refresher Training (3 days) : Trained 2041 in 21 batches in 2007-08
3. ASHA Nodal Officers Training (2 days) : 80 trained
4. Skilled Birth Attendant Training :
    a. Staff Nurses: 2007-08: 83 trained in 21 batches
        i. 2008-09 : 19 trained in 05 batches
    b. MPHA (F) : 2007-08 : 24 trained in 6 batches
        i. 2008-09: 23 trained in 6 batches
5. SBA workshop : 23 Medical Officers & 21 staff Nurses participated
6. SBA TOT : 2 Days :
    a. Visakhapatnam Dist: Gynecologist : 6, Pediatricians : 3 & Staff Nurses : 3
    b. Srikakulam Dist: Gynecologist : 2, Pediatricians : 2 & Staff Nurses : 7 & DPHNO: 1
7. IMNCI : 2008-09 : 47 MOs trained & 2009-10 : 13 MOs trained
8. ARSH training : No.of Participants : MOs -14, Staff Nurses - 09 , MPHA(F) -3
9. UHC Training : Total Participants : 59
10. Workshop on Standard Sterilization Training : 2 Batches : 65 & 32 MOs
    a. attended
11. NISHCHAY training to AHSA nodal Officers: 74 Nodal Officers participated, gave importance to Nischay training
12. IYCF training to ASHA nodal Officers : 80 members trained
13. Minilap Trainings
    a. 2008-09: 13 Batches; MOs(13), Staff Nurses(13), FNO/MNO/Attendents-11
    b. 2009-10: 6 Batches; MOs(06), Staff Nurses(04), FNO/MNO/Attendants(03)

No information on Navjot Shishu Suraksha Training and No IMNCI training for ANMS/AWWs

Convergence:

Interdepartmental Convergence with ICDS, IMA, NGO, DRDA, PD SACS, and Care India was seen.

Health and Nutrition programme being carried out through DRDA involving ANM, AWW, and project staff of rural development.

Tribal Health Organisation: This is an NGO working in Tribal health since 2007. It runs 2 mobile medical units with 2 vehicles. It works in 2 mandals in Tribal Areas in Vishakapatnam district. It provides transport, a doctor and a nurse to visit relatively inaccessible villages not well served by the government system. It visits these villages every two weeks and seems to provide some continuity of care. It charges work out to about Rs 77,000.00 and Rs 10,000.00 for medicines per month.

Care India: An NGO works in both Vishakapanam and Vizianagaram districts. Its main focus is to systematically help coordinate ICDS and NRHM protocols and platforms. Prior to its intervention, the Anganwadi worker and the ANM provided the VHND service on separate days. This has increased the compliance rates and has reduced drop outs. It has highlighted the poor compliance to nutrition and immunization in tribal areas. It has highlighted the need to increase the focus on anaemic pregnant women and children. It has focused on the poor understanding of the issues among village and panchayath leaders and has carried out capacity building events at panchayath and zilla levels. Its analysis of IKP program also suggests duplication. It is strengthening VNSD for NRHM and ICDS; provided technical inputs and advice to both platforms and has assisted in convergence.

Indian Medical Association: It has about 2000 members. It regularly conducts monthly meetings where government programs are presented Continuing Medical Education programs (e.g. HIV/AIDS, RNTCP). It empowers doctors technically by teaching newer issues (e.g. Swine flu). It has organised blood donation and the IMA at Vizag has adopted a village. The IMA members now refer patients with tuberculosis to government hospitals. Its members are part of District Health Society. It has been encouraging its members to register their hospital with the government. JSY payments to patients delivering in private nursing home (to be registered) are planned. IMA is also a member of district health society

ICDS

1/3rd AWCs are in tribal areas. They attend district health society meeting. AWWs are not involved in nutrition centres. ICDS giving take home ration to pregnant women and involved in nutritional councelling and immunization.

JSY

Rs 700 given to BPL and Rs 200 to ASHA incentives for bringing the woman to institutional delivery. Payment done by cheque in non tribal areas and through cash in tribal areas. Backlog of the payment is about one month.

ASHA

The government has recruited a total of 70,700 ASHAs across the state. Visakhapatnam district has recruited 5734. Community Health Workers (CHW) working in tribal areas have been also trained as ASHAs.

The ASHAs has been trained in antenatal and postnatal care, immunization, nutrition, family planning, tuberculosis, leprosy, malaria, etc. They have also been given drug kits. They are selected from the village with one ASHAs per 1000 families. Their remuneration is performance based.

All ASHAs in the state have received an initial residential training of 21 days. All 5 recommended modules completed for all the recruited ASHAs. Most of them have also received one week training at the local PHCs. The 51201 ASHAs have been provided with drug kits. The program has specific guidelines for mentoring. The mentoring for ASHAs in Vishakapatnam included 80 ASHA nodal officers with 2 days training. These nodal officers also received IYCF training. 74 nodal officers received NISHCHAY training.

The many ASHAs interviewed during the CRM had a good knowledge of the health issues, the health and disease states to be recognised, nutrition, antenatal care, family planning, the immediate treatments offered and the referral. They all have drug kits, NISCHAY kits. They reported that they meet the ANMs every 2 weeks and attend the ASHA day on the last Tuesday of every month. They were involved in the VHND.

They reported an average remuneration of about Rs. 400.00 per month. They reported that they have regularly received the money. There seems to be a cap on the amount of performance incentive ASHAs get at Rs 400-600.00 defeating the purpose of the program. There seems to be a backlog of payments. Many ASHAs also expressed the view that they would prefer a regular salary as the performance based incentive was based on many factors including the number of pregnant women in the area etc.

We visited villages with tuberculosis patients, reviewed the individuals, the medicine box and the medication card and matched it with the medication cards maintained at the PHC. The ASHAs were well aware of health, nutrition and disease issues. The ASHA Day is helping in continuing education and in-service training for ASHA.

Field Visits

SNO	**Institution Visited**
1	District Hospital Ankapali
2	Narsipatnam - Area Hospital/ sub district hospital
3.	Aganampudi CHC
4.	CHC Arku Valley
5.	Jogampeta Village – Nutrition Center under SERP/ Velugu project
6.	PHC Ananthagiri 24x7 facility
7.	PHC Pendurthi 24x7 facility
8.	PHC Kasim Kota 24x7 facility

9	PHC Revidi 24x7 facility
10	Anandapuram: 24x7 PHC
11	Lambasing PHC
12	Rampuram Sub-centre and SriRamPuram AWC along with Community Interaction
13	Rajupakalu sub center
14	Pedabarada – Village picked up randomly through a TB card under Lambasing PHC
15	Lothugedda 24x7 facility, A best practice

Debriefing meeting:

We met the district collector along with all district health officials in vizag on 9th night. The CRM has appreciated the proactive support from DM to the health care delivery and officials. We provided him the feedback on the district findings and he responded positively.

District Hospital- Ankapalli

This hospital started as L.F. Dispensary, later converted to 10 bedded govt. hospital, subsequently to 22 bedded hospital. In 1986m it became 32 bedded Taluque hospital. Subsequently 20 bed leprosy ward was constructed. In 1987, it was brought under the control of APVVP and was redesigned as 32 bedded CHC. Later it was upgraded to 100 bedded area hospital in 2001. Hospital is located in an area of 5.37 acres.

OP and IP services are organized in all the important specialities. Hospital has four fully equipped A/c operation theatres and all other modern equipments required for patient diagnostics and care, including CT scan facility.

Sanitation contract is outsourced to a private agency

CEMONC Centre: One MO, two SNs and one ANM has been appointed for the CEMONC centre.

Human Resource

Sl.No	Staff	Numbers
1	Obstetricians	1 –MS, 3 - DGO
2	Paediatrician	1 (diploma)
3	General Surgeon	1 (MS)
4	Anaesthesia	2 (diploma)
5	ENT	2(diploma),
6	Opthalmology	1 – MS (degree), 2 - diploma
7	dental surgeon	2
8	Psychiatry	1
9	Orthopeadics	1
10	Dermatologists	2, 2 (ART center)

11	Medical Officers	1 MO, 1LMO
12	Staff Nurses	24
13	ANMs	5
14	LTs	9 (ART- 1, TB-1, PPTCT- 1, ICTC- 1, BB- 2, General -3)
15	ART Center	One Senior MO, One MO, 1 counsellor, 1 data manager, 1 LT, 1 SN, 1 care coordinator, 1 pharmacist, 2 counsellors

ART Centre:. Recently opened. It is well functioning with 7 networks of NGOs. Coordinating with two active NGOs and 30 ICTC centres,
RTI/ STI centre: Well maintained centre with separate counselor,
RNTCP has a proper network under the district RNTCP officer.

Infrastructure

Labour Room

Two labour tables, all drugs available but no suction, no warmer, no oxygen, broken ambu bag. OT well maintained. There is no elbow operated doctor/s wash.

Blood Bank

Very good and well maintained infrastructure with license for blood banking. Dermatologist trained in the blood banking is the in charge with one SN and one LT. All testing kits are available. No separate generator and POL funds for regular generator is sometimes not available. Not getting any grant from PD SACS except Rs 10000 for blood donation. Only 13 blood bags were available of which only five blood units were tested for blood groups.
All blood groups not available. One LT and SN on duty during day time. LT on call duty at night. If there is some requirement of blood that is not available, then either the case is referred to VIZAG or blood sample is sent over there. There are strong possibilities of delays. There are no staff quarters.

Services

100 bedded with 80% occupancy
OPD 600 per day. Deliveries 187 per month, LSCS 34 per month, IUDs 4 per month, Forceps 2 per month. About 4 HIV positive deliveries are conducted every month. Hospital treats around 239 diarrhoea cases per month and about one case of malaria per month.
Lab does only limited investigations, that is, routine urine, haemogram, VDRL, RBS, serum creatinine, HBs AG, HIV, Malaria and Sputum examination.
ART center seeing only 15-25 cases per day.
RTI/ STI centre: counseling 30 cases per day. Treat about 150 cases per month.
Total 39 CT scans were done in July 2009 of which 35 were CT scan Brain and 2 cases were CT PNS and 2 were CT Neck.

Quality of Care

In labor room 3 cases waiting for delivery and one was undergoing caesarean.

Case files of term ANC cases were reviewed.

Case 1: Waiting delivery. Antenatal record showed HB 4 gm at first trimester. Doctor said that she was given blood transfusion 4-5 times, but there was no evidence from the records. Now at admission her HB was 7.6 gms. She was prescrisbed some B protein preparation that was to be taken from the market. When asked, what is the possible cause of this anaemia, she said malnutrition, inability to take food. There was no other evident medical cause. When asked that woman who could not afford to take food, how can she buy such food products, there was no answer.

Case2: Registered in first trimester, all investigations were done. HB was 8.2 gms. No haematinic was prescribed as she said that it can not be prescribed in the first trimester. This woman visited hospital another five times for antenatal care. But in none of the visit, emphasis was given to prescribe haematinics, and monitor HB. At admission her HB was written as 8.2 gms.

Same story with the third patient.

Technical Protocols of maternal and child care completely missing. Injection Oxytocin being administered almost routinely.

Sanitation and Housekeeping

District hospital sanitation was very poor although it was on contract. Wards: Generally stinky. Sanitation and housekeeping are poor. Toilets are without water, not in proper condition.

104 Service Evaluation was done from the field registers:

On 6/11/2009 following work was done

	Time	Village	Total cases	ANC	Total NCDs	BP	Sugar
1.	AM	UMMALADA 50	10	18	8	3	
2.	AM	Nagulapathi	65	22	20	12	2
3.	PM	JP Agraharam	33	12	12	7	4
4.	PM	Vempoli	22	9	8	7	-

They have very good MIS software with provision to issue ID cards to each beneficiary, with their photograph and fingerprint. They can track and generate list of beneficiary that need services on their next visit. They also have module to record the referral notes.

Area Hospital- Narsipatnam

It is serving the area of about 15 lakh population with 100 beds.

Medical Superintendent: Dr.Nageshwar Rao on leave

Resident Medical Officer and I/c Med.Supdt. Dr.Narsing Rao

No citizen's charter is available. The facility was clean and tidy.
In Civil surgeon category 2 out 3 specialists' positions are vacant
The facility had 3 pediatricians and 1 gynecologist. All other positions are full.
Conducting 300 deliveries a month of which 40-50 were LSCS. The incidents of low birth weight babies were about 1%.Infant warmer, photo therapy unit and pulse oximeter were available and functional. Additional delivery kits, an additional fetal monitor, a blood bank, NICU unit, appropriate training of nurses for newborn care, better financial incentives, better SBA and IMNCI training The facility required additional gynecologists and anaesthetists.

A case study: the team witnessed a 4th grade staff providing the entire Neonatal care from thermal protection to weight monitoring and resuscitation. Even though, this unit had more than 1 Pediatrician, Nurses, ANMs in the labour room at the time of the Baby's birth.

It has a blood storage centre where as it needs to have a Blood bank. 8-10 patients were referred mainly for severe anaemia. There was shortage of kerosene for the generator and fuel for the ambulance.
Enough drugs are available including emergency medicines and Anti snake venom and funds are available for purchase of emergency medicines provided by APVVP.
Lab facilities: CBP, MP, widal, sr. creatinine, urea etc are done.

RNTCP: It is a TU. Lab is available. Diagnostic and treatment facilities are remotely located in the hospital and it is difficult access the services when a patient from general OP is referred to these services. It is prudent to shift the TU nearer to General OP. Total of 433 cases are on DOTS. Peadiatric boxes are not available. Cure rate is above 85% and conversion rate is above 90%.

NLEP: only clinical diagnosis is made, for lab confirmation, the cases are sent to district Leprosy office. Number of deformity cases are seemingly on rise diagnosed as new cases which needs strengthening.
The drug stored at health facility level are for one month, available at PHC level and 2 month stock at sub district and district level hospitals.
Blood storage unit is available but maintenance of temperature is variable due to power interruptions and shortages in kerosene supply.

RKS/HDS
The Area Hospital had 2 meetings of RKS 29.1.09 and 31.10.09. The committee included the MLA, members of the Zilla Parishad and Rotary and other public participants. The money was used for improvement of the sanitation in hospital, and the maintenance of the generator. They bought tables, chairs and a UPS for their computer. HDS meetings are not regular.

Biomedical waste management:

Hospitals with above 30 beds were out sourced for biomedical waste management to an agency called Meridi. The hospital staff were well aware of biomedical waste management as regards to segregation, appropriate storage and disposal.

CHC -Aganampudi

It is a 50 bedded hospital and another 20 beds and two OBG specialists were added under CeMONC facility.

Medical Superintendent: Dr.B.S.Nayak, DCHS – Dr.B.K.Nayak

Staff	Number
Civil surgeon specialists	2 (1-OBG, 1-General medicine)
Dentists	1
Aneasthetist	1
Medical Officers	5 (4 women – 3 are OBG , 1- MBBS, specialists, 1 male)
Opthalmologist	1
Pediatrician	1 – vacant

Ophthalmologists is available but restricted to OP services

One paediatrician position is vacant since one month. Blood transfusion is not practised at the center. Staff nurse positions are full.

Monthly 140-160 deliveries are conducted and 20-30 CS are conducted. No partograph, no foetal monitoring is practiced. There was no newborn care centre. Lacked fetal monitors.

JSY beneficiairies are due for the last 2 months, last HDS meeting was held in February 2009.

The DCHS has requested the CRM to allow purchase of emergency fund from RKS. Needed additional support for fuel for the ambulance

There is one warmer cum photo therapy unit available for the facility. But the staff or doctors are not much aware of the operating the warmer. Training of the staff would help in using such equipment to the maximum.

The facility was not clean including the toilets.

Interacted with the delivered woman and has expressed her satisfaction over availability of services.

Interaction with staff revealed that they lacked time bound promotions and appropriate compensation packages.

This CHC is on national highway but there is no orthopeadician at the center, they refer accident cases to the teaching hospital or district hospital.

CHC Arku Valley

Human Resources

Sl.No.	Staff	Number
1	Medical Officers	5-MBBS
2	Staff Nurses	10
3	ANMs	4
4	LTs	2

There is no lady medical Officer.

Infrastructure

50 bedded CHC with 50% occupancy. Citizen charter is displayed.

Excellent infrastructure, classically clean and well maintained CHS including clean toilets. Doctors rooms are good with examination facilities, hand washing facilities. They have adjoing toilets that are quite clean.

Labour room: Conducted 15 deliveries (normal) per month, The staff nurse did not have any SBA training. There was no infant warmer.

Operation theater was not used at all due to lack of surgeon.

Dental services like extraction, scaling, fill up anterior RCT and OP services are available. No accidents are dealt. Surprisingly the dentist is not aware of ASHA.

It is TU of RNTCP, has one STS, one STLS and 1 LT, gets referral from 8 PHCs

Malaria was a major problem (PF) with high mortality. There is no clarity on Leprosy case identification or procedure of referral of a case for treatment.

Surveillance /IDSP mechanism is almost nonexistent.

Labour room has no ambu bag, neonatal care facility. Ultrasound machine is present.

Pharmacy seems to have supplies and looked good.

Dr PK Kezia of Homeo clinc said that there is shortage of medicines esp. dilutions. There is no supply. She said that she has to take it from another dispensary which is state dispensary. That dispensary has supplies, however, this is NRHM clinic, they don't have supplies.

One radiographer available and one XRay unit 100 mm. He said that another unit in the ward, but could not be seen in the ward. SN was also not aware of this second unit. There is no problem of any supplies for X Rays. Drinking water, signage, trolleys etc available. ICTC has TV and computers. But TV not used as DVD player non functional.

Casuality: Pulse oxymeter, ECG machine, 2 beds, suction machine, Oxygen present.

104 office available with 2 vehicles.

Blood Bank

A beautiful infrastructure with all equipments and 2 LTs for the blood bank is available but no blood bags and non functional. No medical officer for more than 6 months. Because of no work in BB, LTs are helping in general lab.

Services

As per OPD register, OPD 125 per day. Not many admissions and emergency patients.

Homeopathic clinic – 25-30 cases per day.

Delivery room abstract register October 2009 : Deliveries 21, 10 male and 12 female (one twins) were born. Hb not written in the registger. Not sure whether it was omitted or not done at all.

There is no case load in casuality

Category	Numbers
ST	20
OC	1
Primi	6
2nd gravid/pregnancy	9
3rd gravid/pregnancy	6

Lab conducting 70 tests per day which include, haemogram, routine urine, serum bilirubin, serum creatinine, sputum examinations and malaria slides. No separate LT for RNTCP is available. General LT is carrying the RNTCP work which is appreciable. Many new diagnostic tests like HBSAg, RDK for malaria, etc are added but the LT is not given any refresher training.

Laboratory tests done in Oct 2009: BS 905, TB 36, general 398, ICTC 301

This CHC does not do immunization since SC is near by and vaccinations are done there.

Quality of Care

Treatment charts in the ward admissions are incomplete. Medications given are not recorded. Cases not investigated fully, considering the level of investigations available in the hospital.

For example, for a case of fever with expectoration only BS and sputum for AFB are doing.

Fund Utilization

RKS funds (1,67,963) available unutilized. Funds for 2009-10 and AMG not received.

This is the only facility seen in 2 districts where cash books and ledger are accurately maintained. Interest amount is shown in the cash books and records kept updated. This is because of the personal initiative and interest of the MO incharge. The record keeping of this facility can be replicated to other facilities.

The CHC at Araku valley met on 18.9.09 and spent 1.5 lakhs for buying mattresses, water cooler and for dental scaling equipment. The documentation was well maintained.

PHC Revidi - 24x 7 PHC

Human Resources

Nmae of MO: Dr Nirmala Glory, 9440604470. She is MD (Gynae and Obs) stay at distance of 2-3 kilometres.

Sl.No.	Staff	Number
1	Medical Officers	2 – LMO (1- MD-OBG and 1- MBBS)
2	AYUSH doctor	1
3	Staff nurses	2
4	ANMs	2
5	LTs	2 (1- malaria, 1-TB)

Infrastructure

Infrastructure of the facility is well maintained and clean except the toilet.

Oxygen and suction machine not available.

Hub cutters functional. Waste disposal pit is there for needles only.

ILR and cold chain maintained. No shortage of vaccines.

One Ayush doctor is posted and medicines also available. One contractual night watchman is also available.

2 staff nurses and SC ANMs jointly do duty. SNs work in day time from 9-12 AM and 4-6 PM. And then do night duty twice a week. ANMs do night duty once a week. They get Rs 40/- for night duty. Ambulance is stationed and 108 service is there for referral. Doctor is available on call.

Supply chain management was assessed. It was observed that pharmacist indents materials every month from district, however, if some materials are not received, then he does not track it and do efforts for procurement. Facemasks were indented 5 months back and were not available. Since then his stock register shows nil stock and these were not procured. However, OT stock was able to manage without any new supply for last 5 months. Now only 10-15 masks were left whereas there requirement is about 40-50 masks on every tubectomy day. Drugs including Kit A and B available.

Services

OPD load 100 per day, 6 bedded indoor with occupancy 2-3 per week, delivery load 16 per month, sterilizations 40 per month.

Service utilization has improved. In 2008-09 there were 65 referrals (5+ per month), in 2009-10, there were 15 referrals (2+ per month). Major causes of referring delivery cases are: prolonged labour, elderly primi, APH/ PD, PIH, twins, severe anaemia and malpresentation.

Institutional deliveries have improved after introduction of JSY scheme and after making this PHC 24x7 PHC.

ANMs/ ASHAs accompany the patients. On Saturdays village sanitation committee motivate antenatal cases to come to PHCs.

PHC has good display of EDD of all antenatal mothers of their area. On monthly meeting day, ANMS bring the list with them and update the list. They encircle the EDD due in the month and do the follow up. Monthly meeting is done on 22nd of the month.
Lab tests are done for malaria, 15 slides per day and sputum examination 4-5 slides per day. Sputum positive cases are followed up for DOTs and anti malaria treatment is given for PF and PV positive cases. No other routine tests are conducted. Contact samples are taken. If 3-4 persons are found positive then surveillance is conducted.
Ophthalmic Assistant comes twice in a week and referred cases from SCs are being seen.
IDSP charts uptill October is completed. Reports on fever, ARI, and loose motion are filled in and there was no reporting on jaundice and flaccid paralysis etc.

Quality of Care

Protocols for delivery room, ENBC and resuscitation were not available.
Inj Oxytocin used during labour pains by both LMOs. IMEP protocols missing both in labour room in minor OT.

Fund Utilisation

Two sterilization cases were done and interaction with beneficiaries confirmed receiving of Rs 800 by the beneficiary and RS 200 for the motivator.
JSY payments done upto 19th September. Vouchers available but standard protocol for records not maintained. Till December 2008 payments were made even to those deliveries being conducted in any private institute. Now it is stopped.
RKS president comes every week. Meetings are held regularly for last 3 years when she joined this PHC 3 years ago. Funds are being utilized but records could not be utilized as record were taken for verification by the audit party. Some concrete roads were laid with the help of the community. Well displayed IEC materials including that of the snake bite and dog bite.
Comments: This PHC had received best PHC award. However, posting of Obsterictian was misfit for PHC.

PHC Kasim Kota- 24x 7 PHC

MO1, LMO 1, SN 1, ANM 1.
Doctors stay at district HQ. One night watchman looks after the PHC.
12-15 deliveries are conducted every month and ANMs come for morning duty from the sub-centre. **Should not be designated as 24x7 PHC**

PHC Pendurthi-(24x7) -Upgraded PHC

Human Resources

S.no.	Staff	Number
1	Medical Officer	1 -MS General Surgery

2	Lady Medical Officer	1 -DGO
3	Medical Officer	1-MBBS
4	Dental Surgeon	1
5	AYUSH	1
6	Stafff Nurses	6
7	ANMs	1
8	Public Health Nurse	1
9	LT	1, one vacancy under malaria
10	Driver	1
11	Data entry operator	1- doing entry for sterilizations only

Infrastructure

10 bedded PHC, upgraded to 30 beds (UPHC almost equivalent of CHC), constructed at the at the outskirts of main city of Vizag. Maintain good displays of various activities like Name of Subcentre, Population, Immunization day in which week 1 2 3 4 5, and reporting dates etc.

Overall maintenance of the PHC was very poor. Toilets, waiting area corridors were poor. Flooring and tiling good everywhere inside the rooms.

Labor room: clean with two labor tables. No ambu bag, suction equipment available but no electric point. Well maintained minor OT. OT had no oxygen cylinder. It was under repair. Injection magnesium sulfate is not available.

Immunization: ILR, DF functioning with temperature maintained and all vaccines available.

Computer available but it seems that not used for months together as was evident by the dust on it. Printer was out of order for more than a year.

One pit could be seen for disposal of needles.

Services

OPD 350 per day. As such no case load and remains unutilized. At the time of visit there was only one delivery. No admission

Ayush doctor and two staff are seeing 40 patients per day and most of the medicines are available.

Sterilization: Tubectomy 50 per month, NSV 10 per month.

Needle cutter is being used in injection room. Plastic parts are disinfected and put into plastic bags and disposed off through municipal vans

Lab tests: limited to HB, routine urine, malaria and sputum testing, blood group.

Quality of Care

Protocols of labor room including ENBC and resuscitation missing. Injection oxytocin being used during labor pains.

Funds Utilisation

RKS and JSY funds are available, however, AMG, untied funds not received for current year. A formal complaint was received by MR GS Naidu, Mandal Parisad member and PHC development committee member about fudging of the accounts. The team checked the details and the complaint was unfounded. This was explained to Mr Naidu who expressed his satisfaction over the team's initiative and checking up of the accounts. He also expressed satisfaction about the working of ASHA, ANM and AWW.

PHC Ananthagiri (24x 7)

Human Resource

S.No.	Staff	Number
	Medical Officer	1
	Staff nurses	2
	PHN	1
	ANMs	2
	LT	2 (1-TB, 1-General/malaria)
	Opthalmic assistant	1
	ASHA	106

Infrastructure

6 bedded PHC, 3 functional beds and no occupancy.

Services

OPD 40 per day, about 1000 per month. Deliveries 4 per month. Sterilization camps are done during winter season. Around 50 cataract surgeries are done per year. Of total 178 deliveries during the year, 76 (42%) were institutional deliveries. JSY was paid to 54 eligible women.

40 routine tests are done per day which includes HB, TLC, DLC, RBS, Sputum examination and about 100 new malaria slides per day from the periphery.

Ophthalmic assistant examines 40-50 patients per month and goes in field for 15-20 days covering 23 schools in 2 Mandals.

Fund Utilisation

Although records verification did not indicate any fudging, however, record up-keeping including that of cash ledgers verified from facility to facility. The staff needs orientation o accounting procedure.

Rampuram Sub-centre and SriRamPuram AWC along with Community Interaction

AWC has 2 well built newly constructed rooms, good coordination between ANM, AWW and ASHA. ANM has brought the beneficiary list of the children to be vaccinated on the day.

Cold-Chain temperature maintained. Vaccines brought at 8 AM by the male worker. ASHA well acquainted of her knowledge about care for mother and child.
Sub-centre is in rental building. Rent paid till March 2009. They received Rs 30000 as untied fund for last 3 years. Utilized the funds and expenditure reported back to the HQ.
Sub-center is having 1 male and 1 female worker. Male worker is involved in sanitation, carrying vaccines, preparing malaria slides etc.
Cough cases of 3-4 days are referred for investigation at PHC and confirmed cases are given DOTS treatment.
Community interaction appreciated the existence of NRHM. VHSC funds are being utilized for sanitation. People in the area expressed their satisfaction for the job done by the health worker.

Anandapuram: – 24x7 facility

M.O. Dr.Kanakadurga
MPHA(Male) – 4 vacant and one CHO
6 2nd ANM on deputation to 104 services, 86 2nd ANMs are given to 104 of 370
JSY is paid to only PHC area – Eligible couples, but there are no guidelines for immigrant and migrant pregnant women One health facility to another health facility is through 108 even if distance is more

Infrastructure:

It has 3 beds, mainly admitted patients for sterilization and was used as a store room
The PHC did have electricity but lacked an ambulance and was not appropriately located

- Labor Room
    - did not have a suction machine, infant warmer, appropriate mucus sucker, partograph and AMTSL guidelines.
    - Ambu bag was present though not well maintained
    - The staff had a mobile phone and could call 108 whenever required.
- Operation Theatre
    - was used only on tubectomies done on Mondays and Thursday only
    - it had a suction machine and appropriate functional spotlight.

AYUSH medical officer is available and medicines are available. Providing AYUSH OP services, but not oriented towards national health programs

Quality of care:

There is Lacking training of AMTSL(Active management of third stage of labor). Did not have Misoprostol injection Methargine.
ASHA:

- The pin-point program between Asha and ANM meeting twice in a month was going on well.
- VHNDs were being conducted.

- AWW and Ashas survey for routine immunization was happening.
- Home visits for newborn care(NBC kits, KMC and EBF) provided appropriately.
- The medicine kits of Asha's were available.
- Asha's day was held on last Tuesday of every month.
- Terminal methods of family planning IUCD and Condoms were provided.
- Messages on menstrual hygiene and personal hygiene were provided
- ORT and ARI for child health were gaps.

Diagnostic Services:
Availability of pregnancy test kits, iron folic acid tablets, TT injections and HIV testing kits for pregnant women.
This center is a DMC for RNTCP, HIV referrals are made to nearby CHC, Bhimili
There are 39 patients put on DOTS and one is on paediatric treatment
Lab: TB, HB, urine exam and malaria are done here
Leprosy cases identification is weak, Periodical reorientation of Health workers is not practised
The PHC at Anandapuram bought surgical equipment, bed sheets, emergency lamp and letter pads. They have also used the money to build a gate, for septic tank repair, electrical work and sanitary work. SOE for untied fund, HDS was prepared. Last HDS meeting held in March 2008.

108 Ambulance:
Just outside the PHC the team also visited a 108. which was manned by a pilot(male driver) and an emergency management technician (female) who worked for 12 hours at stretch, had adequate equipment, emergency drugs, resuscitation, oxygen, splints etc.
The personal security of the female staff could be an issue of concern.

Jogampeta Village: Nutrition project

The State has a special nutrition project in 600 villages under the Indira Kranthi Pathakam (IPK). The project is a multidimensional poverty elimination scheme with many divisions including capacity building, microfinance, agriculture, marketing, employment generation, gender, health and nutrition. It covers 10 million rural self help groups. This project is a joint effort of many government departments and is executed through the Society for the Elimination of Rural Poverty (SERP).

The interventions of the project includes: Nutrition and Day Care Center, Nutrition related capacity building, Fixed Nutrition and Health Days, Health Savings, Risk and Insurance funds, Water and Sanitation Program, and Employment generation. It has links with the NRHM, ICDS and JSY schemes and potential links with NREGA and Bank Linkages to SHGs. It

provides two meals a day, antenatal check up and growth monitoring income generation activities, community kitchen garden and health education. The project has recruited new personnel (master trainer, community volunteers, health activists) and has become a new financial and labour intensive vertical program. The program has an intensive training and monitoring systems.

We visited the nutrition centre at Jogampatti. The nutrition standards of the Indian Council of Medical Research, New Delhi, are employed. The cooks are trained in colleges of home science. Standard measures are employed to hand out daily rations for the meals. Fixed amounts of rice, pulses, milk, oil, egg, green vegetables, tubers and curd is provided. Three meals are cooked and served. There were colourful and descriptive flip charts to educate pregnant and lactating mothers about nutrition. The centre has cooking and serving vessels.

Eight pregnant and lactating mothers from below poverty line were being served by the project. 5 women were present at the centre on the day of the visit. There were 7 pregnant and lactating mothers above poverty line in the village and they were offered food at the centre at cost price. However, none of agreed to use the facility. The outcome was being measured by measuring monthly anthropometric indicators including height, weight, head, chest and mid-arm circumference for children and weight gain and height for mothers. Vitamin A supplementation is being given every month at the Aagnawadi. However, anaemia was not being monitored.

The seed money to start such centres is given by the government. Each woman who attends these nutrition centre get about Rs 200-400.00 per month for doing an income generation activity. Making sweets and plates using leafs, which are locally marketable, are the preferred income generating activities. Each women pays back Rs 200.00 for the cost of food. These women also get rations from the Aaganwadi, which she takes home and shares with the family.

This program seems to be functioning well and seems to providing convergence between issues related to health, nutrition and livelihood issues. However, this new platform seems to duplicate and undermine the Anganwadi centre and the ICDS program. This will in the long term mean a reduced importance of the ICDS initiatives. The nutrition programs should be based in the well established Anganwadis and completely integrated with the ICDS programs.

The many new staff specifically recruited for the project makes the project cost ineffective and less likely to be scaled-up. It will need to be simplified and better integrated into existing systems.

Village Organisation of Women's Self Help Groups

The state has millions of Self Help Groups organised into Village Organization. This program has many components including nutrition, microcredit, micro thrift and livelihood issues.

We attended a meeting of the Village Organisation, which is the federation of Women's Self Help Groups, at Jogampatti – 463 families in the village. The meeting started with a prayer followed by a welcome by the President of the Federation. Each of 37 representatives from this village introduced themselves. 90-95% of village women are covered by these self help groups. 426 families out of a total of 463 families are covered by these schemes. Some families who have migrated and some who are well off have not joined the self help groups. The selection of the president and members of board of this group was unanimous and the women selected were said to have better education, had good communication and interpersonal skills. They are elected for a period of 2 years. They get loans for income generation activities like buying cattle, starting petty shops and for other, activities to generate incomes for livelihood.

The federation meets every month. The agenda for today meeting was a review of the decision of the last meeting, plans for the village preschool and loans for the self help group. The main aim of such microfinance was for health, education and nutrition. The village has started a preschool to add an education component as they felt that the current Anganwadi Workers did not provide such education. Self help groups from below poverty line get more loans compared to those from above the poverty line.

The women were aware of HIV/AIDS and tuberculosis. They were aware of alcohol problems among men and domestic violence among women. They claimed that the panchayat sarpanch was supportive. They were all members of gram shabha. They were, aware of the Village Health and Sanitation Committee and the Rs 10,000.00 untied fund. Most were NREGA card holders. Some of them also availed pensions.

This nutrition program is vertical and intensive, duplicates the NRHM's VHND and ICDS's Anganwadi services and undermines them. The project also uses ASHAs and ANMs.
The anganwadi centre at Jogampatti was bright with a lot of IEC material. There seemed to have been good integration between the different programs of the ICDS and NRHM and good cooperation between the different workers i.e. ASHAs, ANMs and Anganwadi workers. 20 children and 5 pregnant women attend the centre. The food is cooked at the centre. De-worming is done regularly and IFA syrup distributed.

The Anganwadi workers motivate people for vasectomy. They regularly attend the weekly shandy/market and encourage men to avail of the operation and also claim Rs. 200.00 for

undergoing the procedure. The male Health Assistants conduct a medial camp on shandy/market days. The beneficiary registers are being maintained at the centres.

Lambasing PHC

MO: Dr.Sitarama raju
Deliveries: claimed 4 per month but could not show the records. 3 ANM positions are vacant. The staff lacked training for SBA and AMTCL.
IDSP: P forms and S forms are reported regularly.
NVBDCP: malaria cases are surveillance and treatment.
ILR and Deep freezer both are at temperature 10C. Cold chain needs focus and strengthening.
RNTCP: there are 7 cases put on DOTS and one is paediatric case smear negative. This TB card was chosen to visit the village and also to observe DOTS.
RKS
The PHC at Lambasingi had the mandal president, sarpanch, tahasildar among other on the RKS. They conducted 2 meetings last year but none this year. The one lakh was spent on painting, outpatient stationary, fencing, crockery and plumbing for the hospital. The maintenance fund of Rs 50,000 was spent on buying cleaning liquids, detergents, bleaching powder, lime, for hiring contingency workers and for labour charges

Pedabarada village under Rajupakalu subcenter

This patient Gouthami resides in a village called Pedabarada under Rajupakalu sub center area. By the time we reached the village it was 5.00 pm and asked for ASHA worker. The ASHA worker, Vanam devi resides in the village and administering DOTS to the child. Villagers also recognize the services rendered by the ASHA. Interacted with the villages on the services they take, they told that they use 108 services and go the PHC called Lothugadda, a 24x7 facility.

Rajupakalu subcenter:

It is serving the area of 4032 population and 4 panchayaths. The sub center is located in a rented house and ANM is residing at the center. The sub centre room was very small and unsuitable for use. There was IEC material. The sub centres were used to store records, weighing machines, blood pressure apparatus, drug kits, family planning medication, etc. Free condoms are placed in the community centres of the village and are regularly replenished. Since the sub centre was very small most activities VHND, Antenatal Checkups and immunisations were being done at Aanganwadi centres. There is a need to build specific purpose built sub centres in the districts

LothuGadda 24x7 PHC: A Success story

MO: Dr.L.Satyanarayana

It is a tribal PHC in the almost middle of the forest with 20, 249 population with 7 subcenters. 3 subcenters' 1st ANM positions are vacant and in one center there is no ANM. There are 6 2nd ANMs available for the subcenters. The total staff strength is 32 now including subcenters staff.

We heard about this facility through other medical doctors and also from the villagers. We couldnot visit the facilty, hence we requested the district authorities to invite the staff and its medical officer for interaction. The Medical officer could not turn up as it was a shandy day but sent him team and he remained at the center which is certainly worth mentioning.

When interacted with staff, they told that the doctor has joined the facility 7years back when this PHC was also like any other routine PHC with 30-40 OP per day. But this medical officer started staying at the facility and encouraged other staff also stay at the facility. Since accommodation for many was not available, he persuaded with the Project director, ITDA (Integrated tribal development agency) and got single rooms with attached toilets were constructed. The Medical officer does not have private practice. Now the OP load is increased to 350-500 per day and still this single MO manages to provide services. He does NSV, conduct deliveries about 25 per month also conduct deliveries to HIV positive women.

Ambulance services are available with PHC ambulance in working condition and they refer complicated cases to chintapalli CHC or Narsipatnam sub district hospital.

This PHC also got the best PHC award .

3rd Common Review Mission Observations

Best practices:

1. ASHAs are present in the villages and they know the health issues and protocols
2. Good infrastructure and availability of Health HR
3. Active district level administration and good coordination of the district health authorities with district magistrate and others
4. Good convergence activity is seen with other departments like ICDS, IMA, NGOs etc
5. Untied funds are utilized in many facilities and SOE are prepared
6. 108 EMRI services excellent, transportation is also done for pregnant women from facility to higher facility.
7. 104 fixed health day and help line are providing services to difficult areas
8. Nutrition program under SERP/Velugu/IKP is good and comprehensive with involvement of SHGs
9. Disease control programs RNTCP, HIV and Family planning program are doing well
10. AYSUH doctors are providing services in AYUSH collated centers

Major Observations:

1. There is no nodal person for monitoring RCH program other than DM&HO
2. In many places birth protocols are followed
3. Cold chain maintenance is variable but temperatures are not maintained
4. ASHAs are provided remuneration with a cap of Rs.400 – to Rs600/-
5. A sizable number of 2nd ANMs of the subcenters are deputed to 104 services which is affecting subcenter functioning.
6. Weak monitoring/supervision, poor allocation of finances for field visits
7. IDSP is weak above PHC level
8. RKS/HDS meetings are not regular in many facilities

Recommendations:

1. *A nodal officer to be designated for RCH and delivery/new born protocols to be followed in every facility and medical staff to be trained/ oriented accordingly.*
2. *The cap on ASHA incentives to be removed*

3. *Rationale Redeployment of specialists*
4. *Relocation of remotely placed / dysfunctional/poorly functional PHCs to main areas*
5. *Some LTs are sharing works but needs strengthening across all facilities and programs*
6. *Subcenters needs strengthening including retaining of 2nd ANMs at the center*
7. *Strengthening the monitoring system with focus on RCH and immunization including cold chain maintenance.*
8. *strategies to improve tracking mechanisms for initial defaulters and defaulters and needs to improve cure rates in retreatment cases*
9. *Sensitization (for a day on key aspects of the program and check list for supervisory visits or alternatively can go for modular training or RNTCP (can use STS / MO manual) for DPMU and other district key officials who make field visits. They are expected to share the important findings with DTO for corrective actions.*
10. *Nutrition program under SERP/Velugu/IKP is a complex program which includes microfinance and is difficult to scale up. However some of the best practices are to be taken from this to expand the horizons of ICDS.*

District: Vizianagram

District at a Glance

1) District	: Vizianagaram
2) Population as per cencus 2001	: 22, 49,254
a) Urban	: 4, 12,395
b) Rural	: 18, 36,859
3) Estimated Population as on 1-10-09	: 24, 86,739
4) Growth Rate	: 6.55
5) Tribal Population	: 4,18,670
6) Revenue Divisions	: 2
7) Municipalités	: 4
8) Mandals	: 34
9) No.of Panchayats	: 931
10) Total No. villages	: 2927
11) Villages inhabitated	: 1482
12) Hamlets	: 1445

Public Sector Institutions

HEALTH INSTITUTIONS UNDER D.M&H.O., CONTROL

1) P.H.Centres	: 60 (16 Tribal PHCs, 44 Plain PHCs)
2) Sub-Centers	: 431 (121 Tribal Area)
3) Govt. Dispensaries	: 4
4) M.M. Units	: 4 (Tribal)
5) P.P. Units	: 3
6) C.H.Centres	: 3
7) No. of Round the clock PHCs	: 33
8) No of CEMONC Centers	: 7
9) No of NIC Units	: 5
10) 30 Beded Hospital	: 1

HEALTH INSTITUTIONS UNDER A.P.V.V.P., D.C.H.S. CONTROL

1) Dist.Hospital, Vizianagaram	: 1
2) C.H.Centres	: 4
3) Gosha (MCH) Hospital, VZM	: 1
4) Area Hospital, Parvathipuram	: 1

Private Sector Institutions

PRIVATE SECTOR

1) Private Medical College	: 1 (MIMS, Nellimarla)
2) Private Nursing Homes	: 192
a) Vizianagaram	: 116
b) S.Kota	: 10
c) Parvathipuram	: 21
d) Nellimarla	: 02
e) Garividi	: 04
f) Bobbili	: 15
g) Chipurupalli	: 07
h) Gajapathinagaram	: 10
i) Jami	: 01
j) Kothavalasa	: 04
k) Bhogapuram	: 01

District CMHO Office

3 CEMonC Centers conducting C- sections

5 NIC Units; 4 Birth waiting Homes under construction

Maternal and Child Health district review could not be done since no nodal officer. Presentation was prepared by data operator and information given on MMR and IMR were wrong.

District authorities did not have any specific district action plan for operationalization of health facilities.

Major Interventions under NRHM

1) Accredited Social Health Activists (ASHAs)
2) 24-hours PHCs
3) CEMONC centres
4) Janani Suraksha Yoajana
5) 2nd ANM
6) Village Health and Sanitation Committees
7) Untied funds for Sub-centres, PHCs & CHCs
8) Annual Maintenance Grant for PHCs
9) RKS funds for PHCs, CHCs, Area Hospitals & District Hospitals
10) 108 Ambulance scheme
11) Mobile Medical Units
12) 104 Mobile Health Units (Fixed Day Health Services)
13) 104 Health Information Help Line

Four Years of NRHM in Vizianagaram

SNo	Scheme	Progress
1	ASHA program	2596 ASHAs are appointed in the District for a population of 1000/500 to look after the health activities (inclusive 454 community health workers who are working in tribal areas were converted as ASHAs.) in the above population such as ANC Registration, Hospital Deliveries, Emergency Transportation, Immunization, etc… Remuneration will be given to the ASHAs to the event wise as per NRHM guidelines. An amount 3.82 crores of rupees are incurred towards the ASHAs Performance base incentive, ASHA day monthly meeting, Training Program TA/DA incurred upto date from the date of the inception NRHM-RCH II Team
2	24-hrs MCH centres	33 PHCs are converted in to 24X7 Hours Centers to provide Pre and postnatal care to the pregnant women and also provide child health care to the newly born baby. An amount 1.34 crores are incurred towards the 24 Hrs MCH Center staff salaries and genaral assistance from the date of the inception NRHM-RCH II.
3	JSY scheme	Janani Surakshana Yojana Scheme was introduced to promote hospital deliveries. An amount of Rs 1000/- (700 Central + 300 State) will be given to the BPL families for first and second deliveries occurred in the hospitals. By promoting hospital deliveries Infant Mortality Rate and Maternal Mortality Rate to be reduced as per expected goals of NRHM. An amount 6.34 crores was incurred towards the JSY scheme and 67344 BPL families are benefited with this scheme.
4	CEMONC centres	Seven CEMONC Centers are established in the District at Chepurupalli, Bobbili, Parvathipuram, Kurupam, Vizianagaram, S.Kota and Saluru with Gynecologist and Pediatrician facilities to look after the mother and child health care. An amount 69.7 lakhs was utilized towards the salaries of the CEMONC from the date of the inception NRHM-RCH II.
5	Family Planning Services	To promote Family Planning permanent methods are being provided from 70 Govt Institutions and 44 Accredited Nursing Homes (Private) are identified to undergo Family Planning operations. An amount of Rs.1300 for all families for

		Vasectomies and Rs.1350/- for Tubectomy for BPL, SC and ST Families to undergo Sterilization. An amount of Rs.200/150 will be given to the ASHA worker for promoting the case. 87418 sterilization operations conducted from the date of inception of NRHM_RCH II. An amount of 5.99 crores was incurred towards the Family Planning from the date of the inception NRHM-RCH II Team.
6	Birth Waiting Homes	Four Birth Waiting homes are constructed at PHC Vepada, Kurupam, Saluru and Parvatipuram to stay the accompanied member of the delivery case.
7	108 Ambulance Services	Twenty six numbers of 108 Ambulances (EMRI) are providing health care to the pregnant women and providing emergency cases to nearest PHC/CHCs and first referral units. So far 126614 number of Medical cases transported to PHC/CHCs and First referral units.
8	104 Fixed Day Health Services	Seventeen numbers of 104 Ambulances (HMRI) are working in the District to provide a fixed date health care to people above three kilometer area of the PHC. Tests are conducting to the patients and referred to hospital in case of emergency. 2302 number of villages are covered in the district during the month.
9	Nutrition Day Care Centres (Interior and Tribal areas)	Thirty four Nutrition Day care centers are existing in the District and run by Indira Kranthi Padam (IKP). 11 Nutrition Day Care Centres are existing in S.Kota and Mentada mandal. 23 Nutrition Day Care Centres are existing in Tribal Area at Kurupam and G.L.Puram. The Nutrition Day Care centres are run by NRHM-RCH-II funds, established in the year 2008-2009. As on 31.10.2009 180 pregnant women, 242 lacting mothers and 151 lacting children are enrolled in the centres of S.Kota and Mentada. 147 Deliveries were conducted as an institution deliveries. Neo-Natal, Maternal and Infant Deaths are not reported so far.
10	Village Health & Sanitation Committees	The funds released according to the population of the Panchayats were sanctioned for each sub-center to maintain the village level sanitation with the village health sanitation funds for control of water born and vector born diseases with the approval of village health sanitation committee for maintaining the village sanitation. An amount of 2.57 crores was released towards the Village & Health Sanitation

		Committees from the date of the inception NRHM-RCH II Team
11	Untied Funds Sub-Center	An amount of RS.10000/- is releasing for each sub-center for maintaining the sub-center clean and neat such as purchasing of door curtains, bulbs, weighing machines and Examine tables etc.. to the sub-center. The funds will be utilized by the approval of the village health sanitation committee (ANM and surpanch) of the sub-center. An amount of 1.72 crores was released towards the Untied Fund for Sub-Centers from the date of the inception NRHM-RCH II Team
12	Rogi Kalyan Samities	An amount of Rupees 1.0 lakhs for PHCs and CHCs Rs.2.50 Lakhs fro area hospitals Rs.5.00 Lakhs for development activities of the institution, to purchase Life Saving drugs, cleanliness of hospitals and other activities as per the guidelines with the approval of the Health Society Committee Members. The funds was released towards the PHC/CHC Untied Fund and Annual Maintenance Grants under NRHM-RCH II programme.
13	Mainstreaming of AYUSH	AYUSH programme is covering in the District as 1st phase in 22 institutions and in the 2nd phase 22 institutions are covered. Totally 44 institutions are giving AYUSH services in the District.

Progress of 108 Services (EMRI):

26 ambulances positioned.

Highlights

Total Lives Saved 130291

Served 31395 Pregnancy cases

Average Base to scene time:

Urban : 12.9 min.

Rural : 21.8 min.

Tribal : 23.0 min.

2392546 of the population covered

100 % of the Geographical area covered

Ambulance services are covering all backward and interior regions**.**

Sl. No	Indicator	Since Aug-05	During Oct-09
1	Emergencies attended	126614	3677
2	Total Lives saved	126614	3677
3	Pregnancy cases attended	31395	1125

104 Mobile Health Units (FDHS) in Vizianagaram Dist

Health Services through Mobile Health Units

Target groups: Pregnant women, infants, children and people with chronic diseases.

No.of Vans in service 17

Population covered 1452416 cr.

All high risk pregnancies are identified and referred to nearby FRU / 24x7 PHCs.

	Upto Sep-09
No.of PHCs covered	60
Total screening	333045
Antenatal cases screening	34938
Neonate screenings	2335
Infants screening	18842
Child screenings	31510
Student screening	53958
CD cases identified	128104
Minor illnesses	61090

RNTCP

Total population	2461541
Total number of TUs	6
Total number of DMCs	31
Total number of PHIs	77
Total number of medical colleges participating in RNTCP	1
Total number of ART centres in the district	1
Total no. of PPs involved in RNTCP	33
Total number of care and support centres	3
Total number of ICTCs	22
No of DOT Providers	4959

District RNTCP Officer gave a good presentation. All posts are full, all LTs doing their job and directions have gone for LTs to do the RCH tests also.
Detection rate of TB is 75% and cure rate is 87%. 80% TB cases are tested for HIV and 8-9% of them are co-infected with HIV. 100% of them are getting the treatment.
Quarterly analysis of data is being done by the district officers.

Malaria

a) 8 Mandals in TSP area out of 34 recording 85% to 90% district incidence.
b) PF is predominant, accounts to 85 – 90
c) Incidence is perennial
d) July is the peak incidence month, then August.
e) One PHC Mondemkhallu in TSP area established resistance to chloroquine.

District malaria officer gave an impressive presentation. It was explained that although there are only 17% tribal area but they are reporting 90% of the malaria cases. Out of these malaria cases, 90% of them are PF.

District Population : 2001 Census - 2245103
2009 Estimation: 2362921
b) Population under active surveillance : 2090739
c) No of muncipalities : 4 Population : 315898
d) No of Mandals : 34 In TSP Area : 8
e) No of PHCs : 59 + 1
f) No of Sub centres MPHA (F) : 431
g) No of Sections MPHA (M) : 229
h) No.of CHCs : 7 + 1 Area Hospital
i) No of ASHAS : 2130
J) No of MM Units : 4

Malaria Indices

Year	ABER	API	SPR	SFR	P.f %
1998	15.12	1.02	0.62	0.59	94.8
1999	16.83	3.74	2.01	1.77	88.2
2000	15.83	2.1	1.26	0.91	72.5
2001	14.42	1.94	1.29	0.86	66.6
2002	13.92	1.56	1.08	0.77	70.6
2003	18.67	1.29	0.67	0.54	80.2
2004	20.12	0.9	0.43	0.35	81.1

2005	19.6	1.06	0.52	0.4	76.8
2006	16.79	1.04	0.6	0.51	85.4
2007	16.48	0.92	0.55	0.49	88.6
2008	16.98	0.91	0.54	0.48	89.4

Since 2005, only 2 deaths in the year 2005 and 2 deaths in the year 2009 has taken place.
1 PHC in the area is chloroquine resistant and there are issues with trans-border migration from Orissa
There was no case detection in urban areas. Active and passive surveillance along with mass contact and follow up which used family members is in place. Asha's role was only for drug distribution.
Malaria indices of more than 10% ABER are being checked. A special vulnerable community plan has been developed.

Human Resources
44 MPHA and 24LTs posts are vacant and it was suggested that the vacancies of MPHA needs to be filled in along-with their defined responsibility towards disease control programs.
Bed net requirement is 1.8 lacs; however the supply is only 42500. The bed-nets are impregnated with insecticides by ASHA workers at the doorstep of beneficiary.

FILARIA CONTROL PROGRAMME
Data being collected only at district hospital and was not captured from the rest of the area

Year	Blood Smears Tested	Microfilaria Cases	Disease Cases	MFRate	Disease Rate
1999	24,450	343	421	1.4	1.71
2000	18,378	184	386	1	2.02
2001	15,743	127	351	0.8	2.2
2002	22,717	399	517	1.75	2.27
2003	31,152	177	409	0.56	1.31
2004	29,401	76	248	0.25	0.84
2005	30,331	57	237	0.18	0.78
2006	30,844	56	263	0.18	0.85
2007	28,869	40	158	0.13	0.54
2008	28,089	19	158	0.06	0.56
2009	21004	6	80		

Dengue

10 cases detected in the year 2009. There was a rapid increase in the number of cases after the recent monsoons

It was further suggested that zonal Entomologists posts should be filled in since we are not getting any feed-back for our guidance

Blindness Control

More than 100% of the targets for Cataract Surgery are being met by the districts. All School health check-ups are conducted by Ophthalmic Assistants and identified cases of refractory error are getting the spectacles. Lack of specialists are there in the district.

DISTRICT BLINDNESS CONTROL SOCIETY; VIZIANAGARAM

PERFORMANCE OF SCHOOL CHILDREN EYE SCREENING PROGRAMME
FROM 2005-06 to 2009-10(upto October,09)IN VIZIANAGARAM

YEAR	NO.OF TEACHERS TRAINED	NO.OF CHILDREN SCREENED	NO.OF REFRACTIVE ERRORS	NO.OF FREE SPECTACLES DISTRIBUTED TO THE SCHOOL CHILDREN
2005-06	796	1,09,296	750	962
2006-07	785	95,726	1093	476
2007-08	695	1,04,699	1296	817
2008-09	408	75,575	753	651
2009-10	184	52,010	535	475

DISTRICT BLINDNESS CONTROL SOCIETY, VIZIANAGARAM

PERFORMANCE OF CATARACT OPERATIONS FROM 2005-06 to 2009-10(upto October,09) IN VIZIANAGARAM DISTRICT

YEAR	TARGET	ACHIEVEMENT	NO.OF ECCE OPERATIONS	NO.OF IOL OPERATIONS	TOTAL	% OF ACHIEVEMENT	No.of Camps Conducted
2005-06	16,000	18,235	1237	16998	18235	113.96	
2006-07	16,000	18,215	1292	16923	18215	113.84	581
2007-08	17,000	18,302	1036	17266	18302	107.65	637
2008-09	18,000	21103	997	20106	21103	117.23	856
2009-10	18000	13162	631	12531	13162	125.35	464

Iodine Deficiency program

Not running in the district

Convergence:

Interdepartmental Convergence with ICDS, IMA, NGO, DRDA, PD SACS, and Care India was seen.

Care India: An NGO working in the district. Prior to its intervention, the Anganwadi worker and the ANM provided the VHND service on separate days and clubbing of these has increased the compliance rates and has reduced drop outs. It has highlighted the poor compliance to nutrition and immunization in tribal areas. It has highlighted the need to increase the focus on anaemic pregnant women and children. It has focussed on the poor understanding of the issues among village and panchayat leaders and has carried out capacity building events at panchayat and zilla levels.

Indian Medical Associations: It regularly conducts monthly meetings where government programs are presented Continuing Medical Education programs (E.g. HIV/AIDS, RNTCP). It empowers doctors technically by teaching newer issues (E.g.Swine flu). The IMA members now refer patients with tuberculosis to government hospitals. Its members are part of District Health Society. It has been encouraging its members to register their hospital with the government. JSY payments to patients delivering in private nursing home (to be registered) are planned.

Maternal and Neonatal death Investigation

System to record and investigate maternal and infant deaths exist. However, investigators are not able to identify the delays and gaps in the health care delivery as is evident from the following two case studies:

Maternal death investigation: 21 years old, labour class, GI, received 4 ANCs, fully immunized, received 100 IFA tablets, had severe anaemia, but normal weight gain during pregnancy, had received supplementary nutrition. She was identified as high risk during pregnancy- having PIH and severe anaemia. She was admitted to PHC for delivery. Labor pain started on 22.4.2009 at 5 AM. She developed maternal distress during delivery. She was referred from PHC to CHC using 108 ambulance service, after 6 hours of onset of labour pain. Mother died on the way. Audit report did not identify any gaps in the health care delivery. No avoidable factor could be identified.

In March 2009 (25.3.2009 onwards), patient was referred to MCH centre vizianagaram. Patient did not comply. On 29.3.2009 again referred and received 2units of BT. On 4.4.209 patient personally taken to KGH. Patient absconded.

Infant Death Investigation: Death at 3 days, normal delivery, primi, Birth weight < 2.5 Kg, colostrums not given, baby was kept in ICU, delivered at KGH, Vizag.

Preceding death, jaundice and anaemia for 3 days. Mother was registered early, full 4 ANCs, IMMUNISATION complete, 100 IFA tablets received and consumed, had severe anaemia, weight gain was recorded as abnormal, had received ICDS food. Deceased had jaundice and anaemia. At delivery she had gross anaemia. Live birth baby delivered at 1130 PM on 25.6.2009. Baby was LBW and had jaundice. Was not referred anywhere. There was no lack of health care reported and no avoidable factors in the hospital.

Field Visits

Institutions Visited

1. **District Hospital, Vizianagaram**
2. **MCH/ Ghosa Hospital**
3. **CHC Bhogapuram**
4. **CHC - S Kota**
5. **PHC Kothavalsa (24 x 7)**
6. **PHC PM. Palem- 24X7 PHC**
7. **PHC – Kottam**
8. **Boddavaram – subcenter, AWC and village**
9. **Rangapuram AWC, Sub-centre, Out-reach Session, and Community Interaction**
10. **VISIT to 104 Ambulance Service Delivery Site**

Debriefing meeting:

Because of time constraints, we met the District Collector Shir.Ramnarayan Reddy along with district officials on 8th evening before we completed the total filed visits of the district. He responded positively on our feedback.

District Hospital

It is a 200 bedded hospital and another 20 beds were added under NPCB program.

Human Resources:

The medical superintendent is a male obstetrician.

It has all the posts filled with doctors. It has Orthopaedecian -1, ENT surgeon -1 , Opthomolomigists -3, OBG -1, pediatrician -1, anesthetist -1, Physician -1and 4 MBBS doctors on contractual services. AYUSH position is vacant.

All other staff positions are full.

The district coordinator for hospital services is one of the ophthalmologist working here.

Infrastructure:

Had 2 ambulances.

Had huge infrastructure much beyond the needs it was catering to. Had a CT scan, ultrasound, and endoscope.

The Blood bank is available with a blood component separation unit which yet to be installed. It has lot lab equipment and some are duplicated. Some equipments like Auto analyser were lining unused. Many equipments were in bad position of maintenance.
There were also issues found in operation theatre, they are lacking proper lighting and authorities not keen in improving the services.
There are other equipments like CD4 machine provided by NACO/APSACS for HIV patients.
ART center is well equipped with infrastructure and manpower. It has one medical officer, one counselor , two LTs and one data management person. The place is neat and tidy and looking a corporate center. ICTC has one counselor and STI clinic has one more counselor.

Labour room was not functional and no deliveries are conducted.

The hospital has very good infrastructure with conference rooms, biostatistician room etc none of them were put to use. It is not put to use for training or capacity building of any staff.
But hospital maintenance was poor.

Services:

It has an OPD of about 800 to a 1000 and 60 to 80 admissions daily.
185 Conducted major and 1629 minor surgeries, 66-IOLs for cataract surgeries were conducted in the last month. Under arogryasri 60 major out of 104 surgeries carried out. They conduct major and minor surgeries
ICTC, TB and diagnostic and treatment services are available. 80-90 CT scans were done per month.
There was very weak maternal and child health provided. . There are no services available for pregnant women and they refer these cases to maternity hospital. There is no even OP for pregnant women. Gynecology services both Op and IP are regularly available.
There was no routine immunisation and new born care unit. There was no NICU. They want to have a NICU though there are no services for children.

Quality of care:

Many wards appeared vacant. Interviewed on female patient who was seen with POP on her leg, she told that she met with an accident and soon after she came to the hospital, the last night the doctors attended to her.

RKS:
More than Rs. 8 Lakh remained unspent form HDS. There are initiatives by the hospital authorities or district coordinator of hospital services to improve quality of care to the patients.

Biomedical waste management was outsourced.

MCH Hospital (Gosha Hospital)

Human Resource

Sl.No.	Staff	Number
1	OBG specialists	7 (3-MD, 4-diploma)
2	Anesthesia	2 (1 MD; I diploma)
3	Pediatrician	2(1-degree, 1-dploma)
4	LMO	2
5	Dental MO	1
6	Staff nurses	14
7	ANMs	3
8	PPTCT/ICTC counselors	2
9	LTs	3 (1-ICTC/PPTCT, 2- Gen)

Infrastructure

100 bedded hospital with bed occupancy of 130 per day.

OT-1; All equipments are available but dirty and not maintained properly.

Labour Rooms-2 with 2 Labor beds in each room, again not properly maintained and all the protocols of birth and ENBC including Resuscitation were missing. No Oxygen, No suction, No warmer, 1 NICU unit kept in pediatric Unit. No SNCUs and neither plan for this.

1 Radiant warmer, 2 Phototherapy Units purchased from RKS was kept in the Pediatric OPD for emergency care of neonates which is not available after the OPD hours.

Blood Bank is not available. Infrastructure is available but despite request from the in-charge no initiative taken.

Services

OPD- Obstetric-150 cases; Gynae-100 cases; Pediatric-150 cases; Dental-25 cases per day

Avg. 500 deliveries per month; CS section- 100-150 per month,

ICTC/PPTCT center**:** conducting counseling for 8 new and 50 old cases and lab tests for about 50 cases daily. From April to October, 2009, 20 positive cases were seen after 5625 ANC and 15 positive women's were delivered out of 3513 deliveries conducted in the institute

14 spouses were found to be positive. Treatment is given at ART center.

Lab Tests: Routine Hemogram, Blood group, HbsAg, MPRBS and routine Urine tests are being done

Quality of Care

Interview of a mother waiting for delivery:

Mother belongs to village Panchpenta but had gone to her mother's village Datti after 5th month of gestation. No one accompanied her to MCH centre for delivery. Till 5 months, 2 ANCs were done with the ANM. After 5 months one ANC was done by PHC ANM. She visited

CHC Gajjapathinagram 3 times. She did receive monthly medicines. She was a case of threatened abortion and was referred from CHC Gajjapathinagram to this MCH centre as doctor said that scan facility is not available in the CHC.
Referral register was checked: case of eclampsia was referred from Gajjapathinagram. For ambulance service, non tribal patients have to pay Rs 500. But for tribal people it is free. Ambulance driver was not available and did not respond to the telephonic calls. Cases are referred from here to Vizag.

RKS

Rs 175,000 were available since 08-09. The in-charge is keeping it for establishing blood Bank which is not being supported by the district.
RKS funds for 09-10 not received.
1 Ambulance but driver could not be traced despite calls to him for transporting cases.

CHC- Bhogapuram

Human Resources

S.No.	Staff	Number
1	OBG specialists	2(1 Degree and 1 Diploma);
2	Pediatrician	1
3	Anesthesia	nil
4	ENT	1
5	Medical officers	2
6	Dentist	1
7	Staff nurses	6
8	Counselors	1(ICTC)
9	LTs	2 (1-ICTC, 1-general)

No staff resides here and comes from the District HQ/Vizag city.

Infrastructure

A beautiful and clean 30 bedded hospital, well maintained infrastructure with all the equipments in place.
Delivery Room- 2 NCUs, Suction could not be operated despite calling electrician since the area surrounding the plug and the floors were full of ants.
Oxygen Cylinder could not be opened even after bringing the instruments
OT : All latest equipments available. Non- functional because of Anesthetists and Blood Storage facilities
Supply chain management was assessed. X-ray developer was indented on 22.6.209 and was not issued from the district. However, stock was purchased through local purchase.

Services

OPD-250-300 per day, Deliveries-25 per month. 22 lab tests for HB and other tests, 13 Hb for females done. 1 sputum examination done. on the day of visit at 5.30pm.

Quality of Care

Injection Oxytocin is being given routinely to all patients in labor pain.

Comments: Location of CHC is wrongly selected, about 2KMs from main village. Hence no case-load and non-utilization of specialists.

CHC – S. Kota

Human Resources

Sl.No	Staff	Number
1	General surgery	MS-1
2	OBG	1 (MD)
3	Pediatrician	1 (DCH)
4	Medical Officers	4
5	Dental Surgeon	1
6	Staff Nurses	17
7	ANM	1
8	Counselor –HIV	1(ICTC)
9	LT	4 (one each from malaria, TB, HIV and blood storage.)
10	AYUSH doctor`	1
11	Pharmacist	1
12	Nursing assistant	1

Infrastructure

Well maintained CHC with clean toilets.

90 bedded hospital with 1/3rd occupancy rate.

Labour room: Labour room having protective kits for HIV delivery. Very clean with two labour tables. Only one adult sized ambu bag (not clean) could be seen with a very dirty mask of oxygen cylinder.

One unit of warmer and phototherapy placed elsewhere in the facility.

Blood Storage Unit: Very good infrastructure and well maintained.

Services

OPD 250 per day. Delivery 80 per month. CS 5-10 per month (by hiring anaesthetist)

AYUSH: seeing 40 OPD cases per day.

Sterilisations 40 per month, NSV 5 per month.

Laboratory is conducting around 50-60 tests per day which include haemogram, ESR, RBS, Serun bilirubin, Widal, routine urine, MP and sputum.
ICTC: doing 10 counsellings per day. Records till October 2009 indicate 1 positive ANC, 2 +ve deliveries and 14 +ve new cases.
Programs of TB, Malaria and HIV being carried out as per the protocol however, CHC not involved in disease surveillance.
Blood Storage: Every month around 20 units are consumed but only 5 units of O + blood available at the time of visit. No user charge for admitted patients. Rs 850 per bag being charged for outsiders.
Blood bank/ Blood storage unit had scarcity of blood. Blood was indented on 22/10/09 as follows: A-2, B-4, AB-2, O-6. Blood group A was issued on 29/10/2009, and B was issued from 31/10 to 3/11. Despite exhausting all blood units, he did not indent blood. He says that there is scarcity of blood at blood bank and is about 40KMs away which is not very far for frequent visit by the LT for collection of blood, but it is far in case of emergency, delays in blood transfusion are inevitable even if the patient is referred immediately, or someone take the blood sample and bring the blood from the blood bank.. It was evident there are some operational and supervisory issues in maintaining the blood storage to its full of capacity.

Quality of Care
No protocols of care during birth and ENBC and resuscitation. Despite paediatrican available in house, no ENBC protocols are followed.

Fund Utilisation:
Cash book is maintained but interest not indicated the ledger..

PHC Kothavalsa (24 x 7)

Human Resource

S.No	Staff	Number
1	Medical Officer	1 (trained in minilap)
2	Staff nurses	3
3	ANMs	
4	LHV	1
5	AYUSH doctor	1 with 2 staff
6	LT	1

Infrastructure
PHC has good and new infrastructure with labor room, OT, pharmacy, AYUSH Clinic, Laboratory, doctor/s room and training hall
Medical doctors rooms have good examination facility

Delivery room was clean

2 properly maintained OT with 2 labor tables for sterilization. In OT there was no oxygen cylinder.

ILR/ DF maintained and no shortage of vaccines. ILR temperature was +10 degree. Pharmacist told that today in the morning at 8 Am vaccines was issued to the subcentre. For last 3 hours ILR was closed, but still its temperature was high. It seems that adequate attention was not given while issuing vaccines and ILR remained open for substantial time.

In pharmacy, there was stock out of some drugs like fruscemide, glibenclamide etc. Pharmacist said, that doctors donot prescribe these medicines, hence these were not procured.

Services

OPD 120 per day. 6 bedded PHC with 50% occupancy. Delivery load 12 per month. Tubectomies done are 27 per month.

AYUSH: doctor seeing 30-40 patients per day. AYUSH clinic was functioning well. It was homeopathic clinic. One patient was interviewed who was very much satisfied.

Quality of Care:

No protocols of labor room in place. Injection oxytocin misused due to lack of knowledge.

Fund Utilization

Cash books and records for JSY, RKS, AMG, untied funds not maintained properly. District accounts officer not giving any guidance on record maintenance.

No monitoring visits by the DPMs since state have told that they will remain at the HQ only. (To be verified from the state).

Note : Adjacent to it, a dispensary is working vertically with 1 MO, 1 pharmacist and 1 female nursing assistant. Without any caseload. Building is pathetic and two dirty beds without any mattress were lying in the corridor. One patient had a big wound and his dressing was being done on that bed. Pharmacist was out of stock for some medicine. She could not indent medicines, because medical officer who is signing authority was on leave.

This dispensary needs to be closed and merged with 24x 7 PHC.

PHC L.Kota (24 x 7) facility

Human Resources

Sl.No.	Staff	Number
1	Medical Officers	2 (1-DA, 1-DGO)
2	Staff nurses	2
3	ANM	1
4	LHV	2
	LTs	(1-malarai, 1-TB)

Infrastructure

9 bedded PHC with 50% bed occupancy.

Infrastructure was good. There was waiting space, toilets, labor room, OT, pharmacy. IEC display was very good.

ILR, DF maintained and vaccines available.

Labor room: clean with one delivery table.

In OT there was no boyles apparatus, no oxygen cylinder.

Services

OPD 70 per month. Delivery 28 per month. Sterilization 40 per month, Vasectomy 5-6 per month. Doctor attended to the deliveries at night as well. He lives nearby and is on call. Although male, but his acceptability to the women is very good. There is no gender barrier.

Lab conducted 5-6 routine tests, limited to HB and routine urine, sputum examination 3 per day and malaria slides 15-20 per day. However, In laboratory, no HB test was done for last more than 2 weeks, as it was not prescribed. On an average, 40-50 ANC cases come every week, however, only 15 HB examinations were done in last one month.

Quality of Care:

No protocols for labor and ENBC could be seen. Even the Gynecologist not clear about the dosage of oxytocin for AMTSL. The injection is being given routinely during the labor pains. No suction and Oxygen.

Fund Utilization

JSY record maintenance is not proper and statements are spread over the different registers. Some of them are in sub-centres. Triangulation is not possible. Ledger indicated only Rs 12000/-balance.

Records for other funds like RKS are similar. 09-10 RKS funds and AMG not received.

Budgetary problem was reported by the medical officer, Dr Dillep Kumar, who is also DGO. (phone number 9440878926) He said that ASHA budget is @ Rs 400 per month, however, their incentives reach upto Rs 1000 or so. They are not able to pay as per the guidelines. His request was to increase the incentive rates. He was very enthusiastic about ASHA system. He said that ASHA system and 24 x 7 system is working well. Now more that 80% deliveries are institutional and most of these are in public sector. Previously, around 50% deliveries used to be home deliveries and among the rest, it was mostly in private sector. Now all MCH services have improved with the involvement of ASHAs.

PHC PM. Palem- 24X7 PHC

Human Resources

Medical Officer-1; SNs/ANMs- ---; LTs- 1

Infrastructure

A non- functional PHC with 6 bedded. A new building is being constructed and shall be shifted after electric connection.

Currently PHC operated from old building that is in very pathetic situation. The building is in shambles and so is its upkeep. Delivery room/ OT room is common, and an air conditioner has been installed. But PP room/ Post operative rooms donot have even fan. Premises are very untidy. Toilets are in worst conditions

There is no laboratory but there is one LT

One vehicle has been condemned many years back and the driver has been transferred to the district HQ.

Services

10 deliveries in a month. All discharged within 12 hours. HB recorded but there is no facility for HB estimation. There is no delivery and discharge after 6 PM. There is no referral record. They use 108 to refer cases to vizianagaram

Average OPD attendance is 25-30 cases as seen by MO, and another 30-40 by SN. Two opd registers are maintained- separate for MO and SN.

Untied Funds:

Full disbursement of Rs 10,000/- per sub-center was not given to the PHC from DMHO since the 5 sub-centers under the jurisdiction of PHC had a balance of Rs 33500/- from the year 2007-08. So the DMHO disbursed Rs 10,000/- only for giving Rs 2000/- each to all 5 sub-centers in the PHC area for 2008-09. Funds for 2009-10 have not been received.

VHSC:

VHSC fund allotment is differential varying from Rs 2300/- to Rs 12,000/- for 16 VHSCs in the PHC area. Rs 1,13,853/- were received. For the year 2008-09. Here again, norms of giving Rs 10,000/- for each sub-center was not followed. No funds have been received in the present year.

RKS:

It was observed that some of the drugs which can be a part of the normal drug supply were purchased out of RKS fund.

Besides this, funds were used for expenses incurred on transportation of regular supply. The supplies of the drugs are kept at DMHO Office and every quarter the PHC MO send some transport for obtaining the drugs. Such visits can be longer and of frequent in nature because many a times some of the drugs are not available in district store.

AMG

Received only for 2007-08;

Maintenance of Cash Registers and other accounting procedures were very poor. No training/orientation on accounting and up-keeping of the records were ever given to the medical officer.

Monitoring Visits

No POL, No vehicle, MOs are asked to avail public transport (Bus etc) for monitoring visits and claim normal TA/DA for such visits. These are also pending since December, 07.

Rangapuram AWC, Sub-centre, Out-reach Session, and Community Interaction

AWC has good and clean infrastructure.

Very good coordination between ANM, AWW and ASHA. ANM has brought the beneficiary list of the children to be vaccinated on the day. Cold Chain temperature maintained. Vaccines brought by the male worker. 12 children immunized. ASHA well acquainted of her knowledge about care for mother and child. UIP watch register being maintained. 20 children fed with Halwa. Take away ration given to registered pregnancies for 25 days in a month. Pregnant woman coming to parents place for delivery are not given take ration.

All records and registers well maintained.

Community interaction appreciated the existence of NRHM. VHSC funds are being utilized for sanitation. DD Naidu Sarpanch received Rs 10000 for 2008-09 and expenditure reported. Funds for 2009-10 not yet received. People in the area expressed their satisfaction for the job done by the health worker.

Sub-center Thatipudi

Working in small rental facility. This is very small passage to the main house of the ANM. Even this passage is used to keep their house belongings like motorcycle and shoe racks etc. Subcentre is limited to an examination table and materials are kept on a shelf.

JSY

Triangulation of records for JSY payment could not be done since system followed is beneficiary delivering in any health facility comes back to sub-center to payment. Here the records are verified and then these records like discharge ticket, BPL Card are sent to the PHC. Cheques are then issued from the PHC and sent to sub-center for the payment to beneficiary.

Sometimes, whenever the funds are available at PHC, signed and blank cheques are given to sub-center ANMs for issuing the cheque. The requisite records of the delivery are then sent to MO- PHC for their record keeping.

Untied Funds

Expenses on untied funds could not be verified since some of the records are kept at PHC.

Nischay Pregnancy Tests available and positive patients are registered for ANC. ANC is limited to injection, TT and IFA

Eligible Couple Register, ANC and Immunization register were maintained, however the ANC findings were missing in some cases like BP etc and on enquiry from the ANM she said that they are being checked at 104 camps.

No HB apparatus, BP apparatus given to MO during a camp, weighing scale not OK,, No OPD record available.

PHC-Kottam

MO of the PHC – Dr.Mamatha rani, a paediatrician (Diploma) by qualification.

PHC has a population of 88,000 with 14 subcenters. The PHC is located in a very remote area far from main locality. Infact the PHC area has only about 400 population around for accessing the services.

The PHC at Kotam maintained the documentation of the members list and bought metal benches for patient waiting area, glucometer and nebulizer. They have also spent money to build a gate for the PHC.

At PHC, JSY backlog of 4-5 months. OPD of PHC is 40/day on average which is very less. They are maintaining the list of pregnant women and EDD list at the PHC. Citizen charter is not available.

Immunization: ILR and deep freezer are not maintained properly and thermometers are not available for monitoring and temperatures are not seemingly maintained as per norms. This needs focus and regular monitoring.

The labor room was used as a store room and do not conduct any deliveries or FP operations at the facility. FP operations are conducted at nearby CHC, S.Kota. Had no equipment.

Staff lacked training.No AYUSH services are available.

This PHC needs relocation.

Boddavaram – subcenter, AWC and village

It is a tribal subcenter with 4551 population and is in a very small, rented house and unsuitable for use. Activities are carried at anganwadi center. Nischay test kits are available. 2nd ANM is on deputation to 104 services. Conduct 1 delivery per month on average.

There was IEC material. The sub centres were used to store records, weighing machines, blood pressure apparatus, drug kits, family planning medication, etc. Free condoms are placed in the community centres of the village and are regularly replenished. Since the sub centre was very small most activities VHND, Antenatal Checkups and immunisations were being done at Aanganwadi centres. There is a need to build specific purpose built sub centres in the districts. ASHA is a DOTS provider for three patients. Interacted with AWW , ASHA and a few villagers and they are fairly doing their job.

Nutritional Supplement Programm under IKP

At level District : Project Director
1 DPM (H&N) Covers 3-4 mandals (Covering 1 lakh popln.) and every mandal has 30-40 VOs
One time one days trg. For ANMs, AWWs, ASHAs and VHSC members. Every month 4 days orientation will continue for next 2 yrs to make them competent for the programme.
In 2008-09 NRHM has given 15 lakhs as grant for capacity building.
In 2009-10 6 lakhs for capacity building and 7 lakhs for Nutritional activities have been given.
180 pregnant women are registered for food under the district. Food is given at Rs. 25 per meal and women are supposed to come morning and evening for taking food
No evaluation has yet been taken.

VISIT to 104 Ambulance Service Delivery Site:

Well maintained van with video for IEC, ANC able and other requisite equipments could be seen. The Van carries fixed day services for 28 days, in two shifts- morning and evening at different village sites, covering about 3000 population per session. Per day 50 new and 50 old cases are seen.
Organisation of five tables was good, Van facility including possibility of IEC through TV was good. Written protocols for screeing were available with the ANMs.
At the service delivery site, 5 tables are set up, manned by 3 ANMs, 1clerk and 1 technician.
The first table does the registration, the next table measures height, weight, refraction through snellens chart and 3rd table does antenatal check, 4th table does lab tests limited to Hb, blood sugar, 5th table does the surveillance for chronic diseases and refers the cases of Hypertension, Diabetes and other chronic problems to the area PHCs. The routine checks of BP, blood sugar and also the drug distribution are done once the medical officer has seen the case.
In the name of convergence, 2 ANMs, 2 AWWs and ASHAs were seen without doing any job since the 104 system has already 2 ANMs present onsite. However, only ASHA gets Rs 50 per day as incentive for bringing the cases. AWWs and ANMs are not getting any incentive.
On triangulation of these services with 104 and sub centre it was observed that the 2nd ANM of the SC is always busy with the 104 and the first ANM is busy with the nutrition centre. Without any work and her time is wasted. Moreover, during SC visits it was observed that at some places the routing work of BP, Hb Check etc is not being conducted since it is being said that it is done at 104 sites.
The 104 ambulance while doing good job for interior and tribal area also making the health sub-centre non functional. This needs attention and sub-centre should not be involved for nutritional centres and 104.

3rd Common Review Mission Observations

Best practices:

1. ASHAs are present in the villages and they know the health issues and protocols
2. Good infrastructure and availability of Health HR
3. Good convergence activity is seen with other departments like ICDS, IMA, NGOs etc
4. Untied funds are utilized in many facilities and SOE are prepared
5. 108 EMRI services excellent, transportation is also done for pregnant women from facility to higher facility.
6. 104 fixed health day and help line are providing services to difficult areas
7. Nutrition program under SERP/Velugu/IKP is good and comprehensive with involvement of SHGs
8. Disease control programs RNTCP, malaria, HIV are doing better
9. AYSUH doctors are providing services in AYUSH collated centers
10. Family planning program is running well

Major Observations:

1. There is no nodal person for monitoring RCH program other than DM&HO
2. There are no obstetric or immunization services in the district hospital
3. In many places delivery/new born protocols are not followed
4. Cold chain maintenance is variable but temperatures are not maintained
5. ASHAs are provided remuneration with a cap of Rs.400 – to Rs600/-
6. A sizable number of 2nd ANMs of the subcenters are deputed to 104 services which is affecting subcenter functioning.
7. Weak monitoring/supervision, poor allocation of finances for field visits
8. IDSP is weak above PHC level
9. RKS/HDS meetings are not regular in many facilities

Recommendations:

1. *A nodal officer to be designated for RCH and delivery/new born protocols to be followed in every facility and medical staff to be trained/ oriented accordingly.*
2. *The district hospital should provide regular OP and IP services for pregnant women and newborns including immunization services*
3. *The cap on ASHA incentives to be removed*
4. *Rationale Redeployment of specialists*
5. *Relocation of remotely placed / dysfunctional/poorly functional PHCs to main*
6. *Some LTs are sharing works but needs strengthening across all facilities and programs*
7. *Subcenters needs strengthening including retaining of 2nd ANMs at the center*
8. *Strengthening the monitoring system with focus on RCH and immunization including cold chain maintenance.*
9. *strategies to improve tracking mechanisms for initial defaulters and defaulters and needs to improve cure rates in retreatment cases*
10. *Sensitization (for a day on key aspects of the program and check list for supervisory visits or alternatively can go for modular training or RNTCP (can use STS / MO manual) for DPMU and other district key officials who make field visits. They are expected to share the important findings with DTO for corrective actions.*
11. *Nutrition program under SERP/Velugu/IKP is a complex program which includes microfinance and is difficult to scale up. However some of the best practices are to be taken from this to expand the horizons of ICDS.*