Report of the Seventh Common Review Mission Andhra Pradesh

SNCU, SVRRGGH, Tirupathi

The report is based on 7th CRM visit carried out in Mahbubnagar and Chittoor Districts of Andhra Pradesh from 8th to 15th November 2013.

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Executive Summary

The seventh common review mission, an annual review of the National Health Mission (earlier the National Rural Health Mission), was conducted in Andhra Pradesh from 8th to 15th November 2013 and covered two districts namely Mahbubnagar and Chittoor. The fourteen member team, focusing on the objectives laid down by the National Health Mission, visited one teaching hospital (TH), 2 district hospitals (DH), 2 Area hospitals (AH), 3 Community Health Centres (CHC), 11 Primary Health Centres (PHC), 2 Urban Health Posts (UHC), 17 Sub-centres, 6 Community Health Nutrition Clusters (CHNC), 4 AYUSH Dispensaries, 4 Village Health and Nutrition Days (VHND) and the Central Drug Stores at the State and 2 districts. The following is the summary of the key findings:

Good Practices: Before, a TOR (terms of reference) wise analysis of the health care delivery in the State is carried out, it is essential to put on record a few of the good practices initiated by the State Government:

- **Amma Kongu (Anchal)**: With several vulnerable pockets in the State recording alarmingly high incidents of maternal and infant mortality, the 'Amma Kongu' – a multi-pronged Social and Behaviour Change Communication (SBCC) – a strategy to improve quality and access to health care was launched to influence social norms in such areas, to increase demand and utilization of health care services. It aims to improve the quality of health care delivery, with focus on institutional deliveries besides antenatal and postnatal care. This was formulated by the Government of Andhra Pradesh in collaboration with UNICEF, National Rural Health Mission (NRHM) and John Hopkins University – Centre for Communication Programmes. The programme is implemented in Adilabad, Chittoor, Karimnagar, Krishna, Kurnool and Vizianagaram districts. Awareness campaigns on breast feeding, child marriages, antenatal and postnatal care, anaemia and child health including diarrhoea and immunization will be conducted at the divisional and mandal level to increase demand for public health care
- **Bangaru Talli**: This scheme enhances the social status of the Girl Child and delays her age of marriage. To incentivize institutional delivery, registration of birth, immunization, Anganwadi enrollment leading to better nutrition Government of AP has introduced this scheme. This scheme is meant to take care of the girl child in every household from her birth till she completes her graduation. If a woman gives birth to a baby girl, Rs 2,500 will be deposited into her account. Rs 1000 will be given for the first 2 years at the time of immunization. Rs 1,500 will be given every year to the family through Anganwadi's till the baby attains the age of 5 years from 3rd year onwards. At the time of admission to school, Rs 2,000 will be given every year for her studies from the first to the fifth standard and Rs 2,500 from sixth to eighth standard, Rs 3,000 for ninth and tenth standard. For the girl's study of Intermediate, she will be given Rs 3,500 each year, and Rs 3,000 a year during her graduation.

- **Video Conferences**: State conducts periodic video conferences to review the family welfare programs and & NRHM activities with all the DM&HOs & Other Programme Officers of the state.
- **Satellite based broadcast system** via Mana TV is used for departmental disseminations. The disseminations can be accessed at all government offices and social welfare residential schools.
- **Online data entry by ANMs in MCTS:** Some ANMs at PHC level are able to upload SC level data in Web Portal without any training which is incredibly encouraging.

Status of Important Health Indicators:

- IMR in Andhra Pradesh (AP) is higher than all other Southern States and just one point lower than the National Average. However, it is important to note that post NRHM, the decline in IMR has increased significantly and almost doubled from 9 points pre-NRHM (1998-2005) to 16 points post-NRHM (2005-2012).
- Similarly, U5MR in AP is higher than all other Southern States, though it is lower than the National Average. An analysis of the annual compound rate of decline reveals that while the rate of decline was higher in 2008-09 i.e 10.3%, it has now reduced to 6.3% and is the lowest among the southern States. Thus, there is urgent need to focus on the rate of decline of U5MR.
- The annual compound rate of MMR has declined significantly from 7.6% to 4. 5% post NRHM. The point of concern is the annual compound rate of decline of AP between 2005 and 2012, has lower than the other Southern States (excluding Kerala).
- As per HMIS, the State has reported 68% institutional deliveries, 5% home deliveries while 27% deliveries are unreported. The proportion of public sector deliveries (46%) is lower than that in private sector (54%).

The CRM mandated the analysis of the health care delivery in the State against ten important parameters. The following is a summary of the analysis:

Service Delivery

- The distribution of overall facilities at the level of DH, SDH, CHC, PHC, SC is adequate as per the IPHS norms.
- However, sub centers visited by the CRM teams in Chittoor were mostly running in rented buildings with no facility of electricity, toilets and water requiring upkeep and maintenance to ensure appropriate functionality for providing service to the population covered.
- It was observed that the completed buildings (maternity wards, sub-centres) are not handed over yet at some places in Chittoor. However, in Mahboobnagar, sub-centres visited were in Govt. buildings and had all facilities.
- The private sector that caters to 54% of institutional deliveries in the state is not actively involved in most of the schemes of NRHM. The State has come up with AP Clinical

Establishment Act for the private sector but should ensure strict enforcement. Regulation of the private sector in reporting the notifyable diseases such as TB and other communicable diseases and any detection of HIV positive cases should be mandated.

- Districts have a micro-plan for reaching the marginalized sections with health care services through outreach services, MMU, VHSNC and ASHA. However, in Chittoor district it was observed that the MMUs are stationed next to the Sub centres. Thus there is need to revisit the MMU visit plan to ensure that it covers outreach services. In Mahboobnagar MMU deployment was as per national guidelines.
- Complete spectrum of maternal and child health services are available, however, under Family Planning PPIUCD and NSV services have not been adequately rolled out. There has been a 38% increase in OPD services, a 14% increase in IPD services and 35 % increase in number of C-Sections conducted in public health facilities since 2008. However, a cause of concern is a 36 % decrease in the IUCD insertions in the State.
- Awareness of the 108 service is good in community in the district and is being utilized mostly for reaching the hospital. However, the drop back by 108 is not very successful due to two reasons, firstly because it is not available for drop back most of the times and secondly because some mothers do not consider it a good omen to go back home with the new born in an ambulance.
- AYUSH doctors are not being utilized to their full potential and the departments are providing isolated service without any integration, hence the objective of mainstreaming of AYUSH in NRHM has lost sight. AYUSH doctors need to be entrusted with the responsibilities and integration into the health system as per GOI directive for better utilization of their services. A proper mechanism should be evolved in this area.
- There is an urgent need to focus on Biomedical Waste Management. Waste segregation at source and bio waste management guidelines should be strictly adhered. All personnel need to be immediately re-trained in waste management as it was found that in some places at CHC level and below, placenta was being discarded in the open in Chitoor district.
- Diagnostic services are robust but user charges are being levied for radiology tests such as ultrasound & CT scan in some facilities.

Reproductive & Child Health

- Uptake of RCH services has improved**.** Full range of maternal and child health services including quality facility based new born care and NRC is available. In addition, SNCU, NBSU and NBCC were well established as per the norms and were providing good quality services. However, under Family Planning, PPIUCD and NSV services are not adequately rolled out.Though unmet need of family planning is low, state needs to focus on promotion of spacing methods especially for PPIUCD and interval IUCD. Additionally, linkages of the community with the NRC need to be improved to ensure follow-up and reduce re-admission.

- The line listing of the high risk mothers and eligible couples is done through the MCTS. The Skype based video conferencing method for follow-up of MCTS that is being implemented in Mahboobnagar should also be initiated in Chittoor district.
- Diagnostic services are robust but out of pocket expenses for the patient seen for certain services such as ultra sound and CT scan. The basic laboratory investigations for ANC like haemoglobin estimation, urine examination for protein and sugar were not being done at many facilities in Chittoor due to non-availability of kits and reagents .At some places some of these services were not being offered despite the presence of an LT due to non availably of strips etc.
- Quality Assurance Committees have not been restructured as per the revised norms.
- District level maternal deaths review sub-committees have been formed in both districts. However, in-depth analysis and usage of data is not adequate.
- Regular Infant death audits are also being conducted with adequate record maintenance. Community based verbal autopsy is being done in Chittoor.
- The implementation of JSSK in the district is good at district level hospital but needs improvement at the PHC level to ensure no out of pocket expenditure in terms of provision for ultrasound and other testing facility. At PHC level, instead of free diet pregnant women are being given Rs 56 cash for purchasing food themselves. Families of majority of pregnant women are incurring cost of transportation to health facilities as well as for drop back. Even though most of the beneficiaries know about 108 services, they are unsure about its usage by pregnant women and sick children for travel to health facility.
- The JSY implementation in the district is being implemented and money is given to the mothers after delivery. The programme does not seem to have been realized to the maximum due to reportedly excessive administrative formalities and low amount of money being in the scheme.
- Training programmes for SBA have been conducted for the past 2 years and have to be offered to all those engaged in conducting deliveries. Specific tasks that are not recommended in the SBA such as routine use of episiotomy in primy cases, have to be reiterated at the service delivery levels, by PHC MOs, CHNC/SPHO and DTT to ensure quality services as per current protocols have to be practiced.

Disease Control Programs

- The functionality of IDSP was evident by reporting the newly emerging diseases i.e., Scrub typhus and leptospirosis for the first time in district of Chittoor. Data collated by IDSP serves as an important resource and is being disseminated and utilized by different disease control programmes at the district, state and central level.
- Convergence between AIDS control program and NRHM was evident. The AIDS Control Program was well functioning and accessible. The program staff were trained and in position. Nevertheless, the capacities of the laboratory technicians need to be

enhanced in sample testing guidelines, patient referral to SRL and bio-safety, and counsellors on revised national guidelines.

- In Malaria, the point of concern is that in order to meet the target of 10% ABER, slides are being collected by the health workers from people without fever at village, sub-centre and other facilities and single dose Chloroquine(presumptive treatment) is being administered to all with or without fever.This needs to be checked immediately. Post of 20 Lab Technicians is vacant in Chittoor district and needs to be filled up. Report of cross checking of slides was not available at any of the labs. Laboratory facilities for malaria need to be operationalized at DH level and knowledge of staff needs to be improved for effective monitoring.
- The performance of Lymphatic Filariasis Elimination Programme is good and the microfilaria rate in the district is being maintained at <1%.The line list of Lymphoedema/hydrocele cases is available with the district and the very few cases of hydrocele recorded need to be operated as per GOI guidelines.
- In view of the increasing number of cases and deaths in Dengue & Chikungunya a definite micro plan for calendar of activities for prevention and control of Dengue and Chikungunya has to be laid out. In Chittoor, Chikunguinya appears to be a problem in some high risk villages and in one such village, villagers and private practitioners reported that about 30% of the population was affected by chikungunya. This was however not agreed to by the medical officer and district health authorities. Kits for chikungunya were also not available in the testing facility at Tirupati medical college and designated sentinel surveillance laboratory. IDSP and the DMO should ensure that verification of such fevers is done.
- Implementation of RNTCP in the state of Andhra Pradesh has been at desired level in all indicators and the state has been a model in rolling out PMDT services and case based web based data entry of more than 95% of all TB cases completed in the Nikshay website. Implementation of basic DOTS program in the state is a model for many other states in the country in terms of documentation, actual implementation of DOTS, provision of laboratory diagnostic services for both TB and MDRTB and payment of DOTS providers Honorarium at the desired levels. Very good collaboration between RNTCP and APSACS has been observed with good flow of data in both directions at various levels.
- RNTCP has been moving towards universal access with required increase in detection of NSN, NEP and Paediatric cases. The decentralization of DRTB ward services has to reach some more districts though the services are provided at some districts at this moment. Though initiated and in good condition at this moment, there is scope for improvement in TB-HIV collaboration, implementation of PITC and ICF activities as per national guidelines of RNTCP and NACP. Strict implementation of policies such as ban on serological diagnostic tests for TB, registering and reporting of Schedule H1 Anti TB drugs can be envisaged in near future.

- Though TB notification from private sector has seen rapid growth decently there is scope for improvement with well-established private sector in the state which can be possible by exploring all avenues/ media such as NGOs/ PP/ Pharma Industry/ Fraternities such as APNA, FOGSI and IMA etc. Finally, IEC is the area which requires major push in successful RNTCP implementation in the state.

Human Resources and Training

- Over the NRHM period, State has increased the intake of students in ANM & GNM schools. 5 medical colleges have been created under public sector 6 under private sector with an overall increase of more than 1000 medical seats during the NRHM period.
- However, the State has a vacancy of 337 medical officers, 1292 specialists, 688 paramedics, 1333 lab technicians/ paramedics, 2811 MPHWs, 3740 ANMs and 5873 ASHA facilitators. It is commendable that the State has issued fresh advertisements for recruitment of specialists and medical officers and have already filled a few positions.
- Irrational Deployment of human resources is an important cause of concern. For eg: Maternity hospital conducting more than 1000 deliveries per month and 200/300 C Sections/ month has only one or two anesthetists. In contrast, anesthetists have been posted as SPHOs in some places (eg CHNC Puttur & CHNC Tirupati). Similarly in CHC Kalwakurthi, SPHO is a gynaecologist.
- Instances of delay in salary of contractual and outsourced staff add to the issue by affecting the morale of the currently employed staff.
- In the last two years, pace of trainings has improved and several modes of training including establishment of skill labs and skill van have been attempted. However, there is no strategy for post training follow up and supervision which needs to be evolved at the earliest. Baseline assessment of knowledge and skills of doctors and ANMs also needs to be carried out.

Community Processes and Convergence

- The community processes in the State did not appear to be as remarkable and strong as they should have been and have considerable scope for improvement.
- While there is a dedicated programme officer at State who holds the charge for ASHAs, there is no officer for overall management of community processes including untied grants, VHSNCs etc. Consequently monitoring mechanisms of VHSNCs, community processes, functioning of HDS and utilization of AMG and Untied funds need to be established.
- ASHA is providing following service: Home visit; HBNC; Contraceptive distribution; VHSC meeting; Supporting in VHND; due list preparation, promotion of instiutional deliveries etc. While ASHAs are functional and trained, in Chittor district there was a gap of 700 ASHAs which needs to be filled immediately.

- Most of the ASHAs are unaware of many schemes through which they can earn income except for institutional deliveries and follow-up of pregnant and post natal women. On an average, ASHA earns around Rs. 800-1000 per month. State needs to orient ASHAs on all incentives available in health.
- ASHAs in Chittoor district have not been provided with ASHA drug kits although some medications are provided to them from the Sub centre level.
- Records of activity wise performance of ASHAs not maintained at PHC/ District level and in some cases at Sub Centres as well. 10 indicator based performance monitoring system not followed. Supportive structures for ASHAs namely ASHA Mentoring Group, ASHA Resource Centres etc not established.
- Anganwadi workers and ANMs are well versed with their duties. The VHNDs and VHSNC engagement of the panchayat members is minimal. The Anganvadi centres need substantial improvement in terms of hygiene and facilities for cooking etc., for optimal functioning.
- Community Monitoring as prescribed under NRHM has not been initiated in the State
- MAARPU programme has been initiated in the State to improve convergence at the district level.

Information and Knowledge

- The mother and child tracking system is functional. It was observed that orientation on HMIS & MCTS to the medical officers was not done. In addition, the guidelines on MCTS were not found in the facilities and checklists on MCTS were not utilized.
- Systematic and uniform record maintenance was missing. Therefore, consolidation of data for immediate use and program improvement was difficult. State has to place printed record with minimum required indicators in all departments for bringing uniformity across all hospitals and accuracy in data and improving data compilation at source.
- The mother and child cards need to be widely used across all levels of facilities.

Health Care Financing

- In the State, low utilization was observed in the year 2012-13. Overall utilization in the year under RCH and Mission Flexi pool was 39.84% and 29.94% respectively. The percentage of utilization is less than 20% of the approved budget is observed
- No TDS is being deducted at District Mahboobnagar which may attract heavy penalty and interest later.
- Books of accounts are not properly maintained at District Hospital, CHC, and PHC level and not updated on regular basis.

Medicines and technology

- There is a robust central drug procurement system and infrastructure development in place. Andhra Pradesh State Medical Infrastructure Development Corporation Ltd. (APSMIDC) is set up to provide accommodation for staff of medical institutions, particularly in rural and semi-urban areas. However, the essential medicines list was not displayed at all facilities.
- Certain essential drugs are not available even at the central drug stores and needs urgent attention.
- Stacking at the drugs stores and pharmacies needs to be improved. Restructuring the responsibilities of bio-medical engineers is quite essential to focus on high priority facilities.

National Urban Health Mission

- State has initiated mapping of urban slums
- The State PIP is not yet approved.
- Three project management units are envisaged in phase 1 of the program

Governance and Management

- Two years back, the Government of AP has taken a decision to establish a sub-district management structure, utilizing the services of staff who were drawing salaries from different heads/programmes of which many were dysfunctional. The unit at the sub district level is named as the Community Nutrition and Health Cluster (CHNC) which is headed by a special cadre of Senior Public Health Officers (SPHO) monitoring. The structure has been well conceptualized but is significantly underutilized and the role needs to be strengthened considerably.
- The State does not have SPMU and DPMUs with dedicated staff. The Department is planning to hire contractual staff but the process has been delayed. Supportive supervision is weak. Field visits by state/ district programme officers need to be improved.
- Feedback mechanisms in a systematic manner on the interventions being implemented were negligible.
- Ownership of the programme at the level of the Principal Secretary and Commissioner Health & Family Welfare was commendable, though many programme officers at and district level require to be better oriented on the programme details for effective monitoring. Co-ordination between Depts of Medical Education, APVVP and public health is poor.

Introduction to the VII CRM

Andhra Pradesh (AP) is one of the fourteen States/ UTs selected for the seventh Common Review Mission (CRM). The CRM is considered as one of the important monitoring and hand holding mechanisms under the NRHM. The state of AP has been included in the first, third, fifth and seventh CRMs. A fourteen member team comprising of representatives from the government, development partners and civil society visited the State of Andhra Pradesh for the seventh CRM between 9th November to 15th November 2013.

Proceedings

After a National briefing at New Delhi, the CRM team members were also briefed at the State level in a State level briefing at Hyderabad on 9th November 2013. The State briefing was conducted under the chairmanship of the Principal Secretary Shri. Ajay Sahni. Smt. Y.V Anuradha IAS, Commissioner Health and Family Welfare, Shri Jyoti Buddha Prakash IAS, Mission Director and the programme officers provided an overview of the Mission in the state with major activities and challenges encountered by the state. After interactions with State Programme Officers and functionaries of State Programme Management Unit (SPMU), the CRM team got divided into two groups – one group visited the Chittoor district and the second group the Mahbubnagar district. Two senior officials from the State were deputed to accompany each team for facilitation of the field visits and interaction with the district officials.

Team Composition

Team Leader – Dr Teja Ram, Deputy Commissioner (FP), MoHFW, GOI

Mahbubnagar District		**Chittoor District**	
Name	**Organization**	**Name**	**Organization**
Dr. Teja Ram DC(FP)	MoHFW	Dr Suman Lata Wattal DD, NVBDCP	MoHFW
Dr. Sheetal Rahi Medical Officer	MoFHW	Dr S R Chinta Asst Adviser-AYUSH	MoHFW
Sh. Puneet Jain, FMG	MoHFW	Dr Salima Bhatia Consultant-Policy and Planning	NRHM-I
Dr. Venkatesh Srinivasan, Assistant Representative	UNFPA	Ms Shobhana Singh Consultant, Family Planning	MoHFW
Ms Anamika Saxena Training Division	MoHFW	Ms Aparna Addala Sr Program Manager	SAATHII
Dr. Chakrapani Chatla Consultant, RNTCP	WHO	Dr. Shazia Anjum Consultant, RNTCP	WHO
Mr. Ritesh Laddha,	Prayas	Sh Bhaswat Das FMG	NHSRC

Districts and Facilities Visited

Mahbubnagar District		Chittoor District	
Facility	**Area**	**Facility**	**Area**
District Hospital	Mahbubnagar	Government Maternity Hospital, SVRR	Tirupathi
Area Hospital	Nagarkurnool	District Hospital	Chittoor
Community Health Centre	Achampet Kalwakurthi	Area Hospital	Srikalahasthi
Primary Health Centre	Bijnepalli Balanagar Uppanuntala Kalwakurthy Bijinepalli Kothuru	Community Health Centre	Puttur
Community Health and Nutrition Cluster	Boyapalli	Primary Health Centre	Tarigonda, Gurramkonda, Chowdepalli, Mulakalacheruvu Peruru
UHC	Ramayabowla, DHQ (Matches NGO), Borabanda , Hyderabad	Community Health and Nutrition Cluster	Vayalpadu, Punganur, Puttur
Sub-Centre	Amistapur, Rudraram Veltoor Rangapur Penjerla (VHND also) Rangareddyguda (Jedcherla/Badepalli CHNC)	Sub-Centre	Peddakannali, Marripadu, Sangasamudram, Gurramkonda, Perur, Burrakailakota, Pudipatla, A-Kothakota, Patrapalle Rompicherla Piler
Central Drug Store	State, Mahbubnagar	Central Drug Store	Tirupathi
AW Centre	Veltoor	AW Centre	Piler
VHND	Penjerla	VHND	Rompicherla AW Centre

Profile of the State

Andhra Pradesh 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. The total

population of the State is 846.66 lakh as per the 2011 Census and the state profile can be seen in Table 1.

Table 1: Demographic Profile

Indicator	2005	2011
Total Population	762.10 lakhs (2001 Census)	845.81 lakhs (2011 Census)
Urban	208.09 lakhs	282.19 lakhs
Rural	554.01 lakhs	563.62 lakhs
Districts	23	23
Villages	28213	27800
Revenue Divisions	81	81
Mandals	1125	1128

Progress on Key NRHM Goals, Recommendations of Past CRMs and Conditionalities

Status of Health Indicators

The State has progressed in certain health indicators since the last CRM. Infant Mortality Rate has dropped from 59 per 1000 live births in 2005 to 41 per 1000 births in 2012. Similarly, Maternal Mortality Ratio has reduced from 154 per 100000 live births in 2004-06 to 134 per 100000 live births in 2007-09 (SRS). However, the State is yet to reach the national goals with these two indicators. (Table 2).

Table 2: Major Health Indicators of the State

Indicator	Goals (NRHM)	2005	2013
Maternal Mortality Ratio	100	154 (2004-06)	134 (2007-09)
Infant Mortality Rate	30	59 (SRS 2004)	41 (SRS 2012)
Total Fertility Rate	2.1	2.1 (SRS 2004)	1.8 (SRS 2010)

The change over the past few years as compared to India and other Southern States is shown in table 3:

Table 3: Trend in Under Five Mortality Rates

Sl.No.	Trend in Under Five Mortality Rates	Total						
		2008	2009	2010	2011	% Change		
						2009/2008	2010/2009	2011/2010
1	Kerala	14	14	15	13	0	7.1	-13.3

2	Tamil Nadu	36	33	27	25	-8.3	-18.2	-7.4
3	Maharashtra	41	36	33	28	-12.2	-8.3	-15.2
4	Karnataka	55	50	45	40	-9.1	-10	-11.1
5	Andhra Pradesh	58	52	48	45	-10.3	-7.7	-6.3
	INDIA	**69**	**64**	**59**	**55**	**-7.2**	**-7.8**	**-6.8**

- U5MR in Andhra is higher than all other Southern States, though it is lower than the National Average
- An analysis of the annual compound rate of decline (table 4) reveals that while the rate of decline was higher in 2008-09 i.e 10.3%, it has now reduced to 6.3% and is the lowest among the southern States. Thus, there is urgent need to focus on the rate of decline of U5MR.

Table 4: Annual Compound Rate of Decline in IMR

S.No.	India & Bigger States	1998	2005	2012	Decline 1998 to 2005	Decline 2005 to 2012
	India	**72**	**58**	**42**	**14**	**16**
1	Andhra Pradesh	66	57	41	9	16
2	Karnataka	58	50	32	8	18
3	Kerala	16	14	12	2	2
4	Maharashtra	49	36	25	13	11
5	Tamil Nadu	53	37	21	16	16

- IMR in Andhra is higher than all other Southern States and just one point lower than the National Average.
- However, it is important to note that post NRHM, the decline in IMR has increased significantly and almost doubled from 9 points pre NRHM (1998-2005) to 16 points post NRHM (2005-2012).

Table 5: Annual Compound Rate of Decline in MMR

MATERNAL MORTALITY RATIO (per 1,00,000 live births)						**% Annual Compound Rate of Decline**			
India/States	**1997-98**	**1999-01**	**2001-03**	**2004-06**	**2007-09**	**1999-01**	**2001-03**	**2004-06**	**2007-09**
Kerala	150	149	110	95	81	-0.3	-14.1	-4.8	-5.2
Tamil Nadu	131	167	134	111	97	10.2	-10.4	-6.1	-4.4
Maharashtra	166	169	149	130	104	0.7	-6.1	-4.4	-7.2

Andhra Pradesh	197	220	195	154	134	4.5	-5.9	-7.6	-4.5
Karnataka	245	266	228	213	178	3.3	-7.4	-2.2	-5.8
India	398	327	301	254	212	-7.6	-4.1	-5.5	-5.8

- MMR in AP is lower than the National Average and among Southern States.
- The annual compound rate of decline in MMR has declined significantly from 7.6% to 4. 5% post NRHM.
- The point of concern is the annual compound rate of decline of AP between 2005 and 2012, has been lower than the other Southern States (excluding Kerala).

As per HMIS, the State has reported 68% of institutional deliveries, 5% of home deliveries while 27% of deliveries were unreported. The proportion of public sector deliveries (46%) is lower than that in private sector (54%). (Fig 1 & 2)

Progress made against the 5th CRM

Recommendations of 5th CRM	**Observations and recommendations during the 7th CRM**
Ongoing constructions may be expedited	Though the construction was completed, the buildings were not yet handed over ex: Puttur Maternity Ward
AMG may be used for providing barrier free access for disabled and infirm/old people	In 2013-14, AMG funds were not released to most of the facilities in Chittoor and Mahbubnagar districts. In addition, during the last financial year, many sub-centres received only Rs. 2500 out of Rs. 10,000 as Untied funds in Chittoor district whereas only Rs. 8500 approx has been in some places in Mahboobnagar. Even though AMG was provided to the district hospital, they were unable to utilize due to administrative issues.
Strengthening of strategically identified CHCs for provision of round the clock CEMONC services	State has taken measures to strengthen the infrastructure as per IPHS. However, the CHCs with high client load should be either upgraded to AH or be provided with specialists.
Optimal utilization of equipment	Newly established new born stabilization units (NBSU) are yet to pick up. Maintenance or replacement of old equipment need to be done. Ex: X-ray machine and autoclaves in DH, Chittoor are very old and need to be replaced. Of the three auto claves,

	two are not in working condition and the other one requires repair to minimize damage
Human resources and trainings	Shortage of human resources for service delivery was observed. The state has made some efforts towards filling-up of the vacant posts during this PIP. Even before that, rational deployment of skilled workforce should be ensured. It was observed that some of the Senior Public Health Officers (SPHOs) were Anesthetists and Gynecologists while there was acute need of these specialists in various hospitals. Trainings: Over the years, the pace of training has shown improvement; yet, gaps exist among the health care providers. Hence, post training follow-up strategy should be developed and followed thoroughly. External assessment to measure the training outcomes should be conducted.
Development of training infrastructure and facilities	Availability of skill labs and vans in Mahbubnagar is observed
Strengthen laboratory services	SOPs are not displayed and followed in some of the laboratories visited. Lab technicians are not aware of the Post Exposure Protocol (PEP). Supply of HIV test kits, test tubes and other test kits should be uninterrupted.
Infection management and environment protection	In Chitoor district Rate contract not fixed with the AMW waste management, need to expedite the process of agreement for waste management. Refresher trainings on universal work precautions and bio-medical waste segregation at source and management are to be planned. Color coded bins to be supplied across all departments and hospitals.However in Mahbubnagar district color coded bins were available.
Safe abortions and MTP	Inadequate availability of emergency pills,
Grievance redressal mechanisms	Complaint boxes were available in some places, however, mechanisms to measure the client satisfaction not in place
Community monitoring	Strengthen community processes and supportive supervision mechanisms at all levels. Involvement of PRIs to be maximized VHNDs are not uniformly functional across all villages
Quality assurance committees	Not functional as per the GOI guidelines.

	Minutes of any such meetings not visible in the field.

TOR 1. Service Delivery

Adequacy of facilities: The Public Health System in the State

- In an endeavor to strengthen the public health care system for effective prevention and efficient management of diseases; provision of universal and comprehensive reproductive and child health services; strengthening the referral system; and improving the quality of hospital care in conformity with the Indian Public Health Standards (IPHS), the State follows the below given public health system:

Indicator	2005	2013
Health Administrative blocks (CHNCs)	--	374 (Established in Aug.2010)
Sub Centres	12522	12522
Primary Health Centres	1570	1709+135 (13th Fin Com)
24/7 PHCs	800	800
UFWCs and Urban Health Centres	199	272
Community Health Centres	167	309
Post Partum Units	82	82
Area Hospitals	58	60
District Hospitals	19	17
Teaching Hospitals	10	14
Speciality Hospitals (Secondary)	10	10
Medical Colleges (Public)	10	16
Civil Dispensaries	21	6

- The facilities are accessible to the community and are well connected with roads.
- VHNDs are held monthly once at Anganwadi center. It is observed that VHNDs and outreach services focus mainly on immunization than identification and follow-up of high risk pregnancies and nutrition related activities.
- MMU or the Fixed Day Health Service (FDHS) is functional with effective micro planning. However, in some MMUs, the medical officer was not available. Additionally, in Chittoor district, the MMUs were stationed near the sub-centres.
- Geriatric medical care is most frequently observed during the MMU camps.

MMU Camp at Peruru Village

- Expired gluco-meter strips found in FDHS at Chittoor

Infrastructure

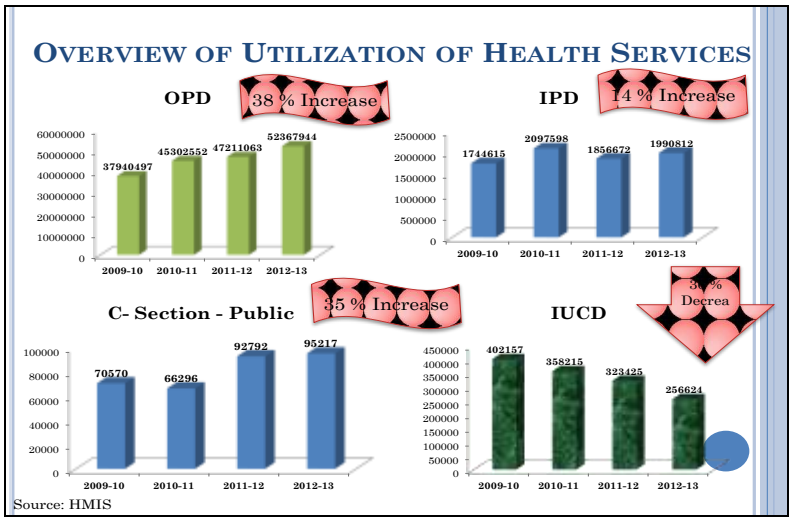
- The health facility construction is done through Andhra Pradesh Medical Services and Infrastructure Development Corporation (APMSIDC)
- Infrastructure development plan available at the State and districts
- The State has converted few district hospitals to medical colleges and hence has 17 district hospitals in place of 23 as per IPHS norms. The challenge in establishing medical colleges is that the specialists will be deployed from the FRUs and other secondary care hospitals.
- It was observed that the completed buildings (maternity wards, sub-centres) are not handed over yet at some places.
- However sub centers visited by the CRM teams in Chittoor were mostly rented with no facility of electricity, toilets and water requiring upkeep and maintenance to ensure appropriate functionality for providing service to the population covered.

AYUSH

- The AYUSH facilities at different levels in the district is adequate, however, it was observed that the constructions were mostly old and in bad condition, which require up-gradation and renovation in terms of quality of construction in-order to keep pace with the increasing patient load.
- The construction of the AYUSH- Ayurveda 10 bed hospital wing in DH- Chittoor is completed but the staff is not recruited yet and the constructed area is not sufficient to accommodate 10 beds and related facilities.

Utilization of facility based services

- Well established flow of services at all facilities
- Adequate utilization of services across all facilities including for tubectomy and diagnostic services
- Complete spectrum of maternal and child health services are available, however, under Family Planning PPIUCD and NSV services have not been adequately rolled out.
- Adolescent health services (YUVA clinics) are established, nonetheless, optimization of utility of these clinics should be ensured.
- Diagnostic services are robust but user charges are being levied for radiology tests such as ultrasound & CT scan in some facilities.



- There has been a 38% increase in OPD services, a 14% increase in IPD services and 35 % increase in number of C Sections conducted in public health facilities since 2008. However, a cause of concern is the 36 % decrease in the IUCD insertions in the State.

Quality of care

- Maternity wing of Government Maternity Hospital, Tirupathi requires refurbishment. Obstetric ICU with redeployment of specialists need to looked at urgently. With high client load, inadequate specialists such as anesthetists and gynecologists, lack of adequate labour room space and unavailability of essential drugs such as alpha-methyl dopa, nifedipine the quality of services is compromised.
- Overall support services like housekeeping, laundry, drinking water, toilets etc have been found satisfactory. However, Maternity hospital, Tirupathi with its high client load has outsourced the laundry but requires an in-house laundry facility.
- In District hospital Mehboobnagar District quality of services were found to be good.
- Privacy of patients was maintained. Proper display of signages were observed.
- No grievance redressal mechanism and no mechanism to observe the patient satisfaction was visible at most of the facilities.

Bio-medical Waste management: The State has to make considerable progress in the biomedical waste management. Tenders are invited from the third party agencies on annual basis and L1 system is followed for the selection of the agency for biomedical waste management. The waste is picked up by the outsourced agency on daily basis but had run out of contract for more than a month due to which biomedical waste disposal is not being done appropriately in the district Chitoor and needs immediate attention. In addition, adequate display of the protocols of infection control and BMW need to be practiced in laboratories and health facilities. In essence it may be said that bio-medical waste management system exits but needs to be followed uniformly. Some observations made on waste management during the visits are listed below:

- In some places in Chittoor district, at CHC level and below, placenta was being discarded in the open.
- The most alarming finding with regard to bio-medical waste disposal in HIV labs is that the samples have been directly discarded into wash basins in ICTCs in Chittoor district. Correct procedure for preparation of disinfectant was not known to lab technicians which can be a major health hazard for the lab staff as well as the community and needs urgent redressal.
- In one of the labs, needle shredder was not available and needle capping was being practiced (Tarigonda FI-ICTC)
- Standard operating procedures need to be displayed and followed.

Ambulance & Referral transport

Adequate number of 108 ambulances is available in the state with 752 vehicles providing effective and efficient transport services for all medical emergencies. The 108 ambulance services are as per the national ambulance guidelines with all vehicles having GPS and linked to a functional call centre. However, only 5-6% targeted women are being catered for health facility transfer. Other observations are:

MMU stationed at CHC, Puttur

- The ambulances are rarely used for drop back services as it is seen for providing transportation for emergency cases only.
- In most of the facilities, the ambulances need to be condemned and new ones be provided for inter facility transfer and drop back. In addition, vans for transportation of medical officers on call must be available at all hospitals.

Medical Mobile Units (MMUs)

- Though the MMU visits are conducted as per the national guidelines with effective micro planning, the basic purpose of serving the underserved population in hard to reach areas by the MMUs is defeated as currently they are stationed closer to the sub-centres. Therefore, the micro-planning for MMUs in certain areas requires revisiting.
- MMUs were adequate in terms of services, supplies and staff. However, in Chittoor district, the supplies of dip sticks, ECP etc were inadequate.
- The MMUs are reaching the geriatric population and are providing treatment for chronic diseases.

- Monitoring mechanisms need further strengthening. The monitoring visits are being conducted but supportive supervision checklists are not used.

IEC/BCC

Inadequate display of JSY entitlements and family planning in strategic location, however, IEC display for maternal health, child health and JSSK were satisfactory. State should ensure equal focus on mass-media, mid-media and Interpersonal Communication for bringing about behavior change. During 2013-14, funds received from MoHFW have not been utilised optimally at the state level and also not released to the districts.

TOR 2. Reproductive and Child Health

The availability, adequacy and accessibility of RCH services are satisfactory. Facilities are providing full range of maternal and child health services including quality facility based new born care and nutritional rehabilitation. However, the knowledge and skills imparted through trainings, do not seem to be fully practiced at many health facilities (SBA, FP & NSSK). Other observations during the visits are:

Janani Shishu Suraksha Karyakaram

- All beneficiaries get free drugs, free diagnostics and free diet at health facilities. However, it was found that at some facilities for ultrasonography (USG) pregnant women have to bear cost which should not happen and the same be provided free of cost through JSSK funds. In NBSU at Area hospital, Nagarkurnool parents were asked to buy certain consumables like diapers etc.
- Beneficiaries incur cost of transportation due to ambiguity regarding guidelines and lack of awareness regarding availability of free transport/108 service for pregnant women. Families of majority of pregnant women are incurring cost of transportation to health facilities as well as for drop back.
- At all the facilities visited pregnant women, sick neonate and children admitted in paediatric wards are getting free drugs, diagnostics and diet. However at PHC level, due to non-availability of kitchen, instead of free diet pregnant women are being given Rs 56 cash for purchasing food themselves.

Interview with postnatal mothers in wards

- During pregnancy, whether in private or government facilities, women got registered in 3rd month of pregnancy
- They have undergone regular ANC including blood examination, urine test, weight and height measurement, 2 doses of TT injection, Ultrasonography, given IFA and calcium tablets. All these were done and provided free of cost.
- They came to hospital in their own vehicle or by hiring private vehicle and were not sure whether 108 could be used by them.
- Women were getting free diet during pre-partum and postpartum period.
- They were unaware about their JSY entitlements.
- Newborns had received zero dose of BCG, OPV and Hepatitis B
- Breast feeding was initiated within one hour of birth

- There is lack of understanding among programme managers and hospital administration regarding JSSK programme. Funds under JSSK have been released to districts under specific budget heads of drugs, diagnostics, diet and POL. Hence, there is lack of flexibility at district level for re-appropriation of funds among these heads at the time of need. Districts are also using JSSK units used by Ministry/state for release of funds as the ceiling for providing reimbursement to beneficiaries, especially in case of use of private vehicle for travel.

Janani Suraksha Yojana

- In Mahboobnagar district there was lack of awareness about JSY entitlements both at community level and among pregnant women admitted in facilities.
- Mechanism for ensuring payment of JSY incentive at the time of discharge was weak and most of the beneficiaries have to re-visit the facility for this.

Care of Mother and Child:

- **Quality of Care –** Quality of client care is satisfactory. Clients are provided with basic care facilities like beds, bed-sheets, food etc. but there is still a scope for improvement. Providing pillows in wards, mattresses and Kelley's pads on the labour table, and sheets over the mackintosh will add to the comfort to clients.
- The basic laboratory investigations for ANC like haemoglobin estimation, urine examination for protein and sugar were not being done at many facilities in Chittoor due to non-availability of kits and reagents. At few hospitals visited, some of these services were not being offered despite the presence of an LT due to non- availabilityy of strips, reagents and kits.

Labour rooms

- In Mahboobnagar DH, there is a separate room for high risk pregnancy including HIV with beds and labour table.
- Labour rooms had tiled floors and were adequately ventilated.
- Trays that were available in labour room were delivery tray, baby tray, medicine tray with injection oxytocin, tab misoprostol, inj betamethason, inj Magsulf
- Labour room had 24x7 water supplies with back electricity and separate toilets for female.
- Privacy was ensured with demarcation of labour room area and separating it from general services by means of doors and ante-rooms

New born care

- New born care corners have been established in all labour rooms visited, with radiant warmer, bag and mask, Et tubes, mucus extractor, feeding tubes, however, were under-utilized.
- There was a separate in-born and out-born SNCU with good case load and NBSU with good infrastructure and adequate number of beds and phototherapy units with proper spacing. In

SNCU, neonates were admitted with low birth weight, neonatal sepsis, prematurity, phototherapy, transient tachypnea of newborn etc.

- Staff are well trained in Infant and young child feeding counselling (IYCF) and the SNCUs are fully equipped
- Kangaroo mother care (KMC) has been provided to SNCU admissions that are stable enough. There is a separate dedicated room for KMC within SNCU.
- Temperature management protocols need to be strengthened along with focus on training on use of radiant warmer.

Nutrition Rehabilitation Centre (NRC)

- The 20 bedded NRC is well established as per the norms and has adequate facilities to cater the SAM children with medical complication.
- NRC was functional in Mahboobnagar DH, but there were poor community and ICDS linkages. Linkages of the community with the NRC need to be improved to ensure follow-up and reduce re-admission.
- Children admitted were provided toys to play with but there was no structured plan for providing early stimulation for improving developmental achievements.
- SNCUs, NBSUs and NBCCs are well established as per the norms and are providing good quality services.

Infection control

- Infection control requires strengthening and protocols to be followed.
- Use of 0.5% Chlorine Solution is very limited, which needs to be widely used for prevention of infections like HIV, HBV and other nosocomial infections.
- The bio-medical waste management is an area of concern, as in Chittoor there exists a problem with the rate contract with the AMW waste management collectors. Waste segregation protocol is not strictly followed.

Basic Amenities

- Toilets, drinking water, electricity back-up, house-keeping etc. were found to be satisfactory.

Family Planning

- Though unmet need of family planning is low, state needs to focus on promotion of spacing methods especially for PPIUCD and interval IUCD.
- Sterilization services are being provided on fixed days (once a week) in a camp mode.
- Number of personnel trained on PPIUCD is very less, trainings need to be expedited. Only four trained doctors on PPIUCD are present in Chittoor district but the cascade trainings have to be rolled out.
- Quality Assurance Committees were formed but have to be restructured as per the revised norms.

- ASHAs were well aware about the scheme of delivery of contraceptives during their home visits and were distributing contraceptives door to door as per the requirement of the clients. 'Nishchay' kits were available with ASHAs and they had knowledge on using those kits.
- Family Planning Indemnity sub-committee needs to be established as per revised guidelines.
- IUCD 375 & EC Pills were not available in Chittoor district. Supply of other contraceptives is regular. In Mehboobngar district supply of contraceptives was found to be adequate.
- RMNCH counsellors have not being appointed in both districts.
- Male sterilization is negligible
- IEC BCC related to family planning services is scanty. Even IEC related to increasing age at marriage and delaying birth of the first child needs to be emphasized.

ARSH and School Health:

- **Adolescent friendly health clinics** branded as YUVA clinics are functional at DH and CHC facility level and have dedicated counsellors. The client load across all YUVA clinics is low and requires extensive awareness creation activities. Display of information material in YUVA clinic was good but there was no standardization of commodities and information material provided at these clinics. Referral linkages for in-facility and out-of-facility management of health problems were poor and not clearly defined. A Centre for Excellence(COE) in ARSH has been established at the Niloufer Hospital, under the leadership of a Professor, Paediatrics. This centre has a large contingent of doctors and well qualified counselors. However they seem to be performing as one other YUVA clinic. Their strengths have to be harnesses to act as the COE to roll out ARSH services in the State, to have a monitoring role(beyond the current training role) on quality of services provided in the State and also undertake certain innovations, such as establishing a 1800 facility for adolescents to seek guidance backed with an appropriate counseling facility. If the State visualizes, as it was mentioned, to establish good quality ARSH services, the COE will have to establish linkages with medical colleges. These institutions in different regions of the State have to be mandated to provide critical inputs for implementation, have an oversight and monitor the quality of ARSH provided in the State. Therefore COE is a good initiative but will have to be more strategic in its efforts and also increase its reach by partnering with other institutions in the State.
- **WIFS** has been rolled out across the district with good coverage in schools. However, out of school component at the Anganwadi centres needs uniform implementation. in the tribal block visited there were no supplies of IFA blue in AWCs.
- **Menstrual Hygiene**- There is wide acceptability of sanitary napkins by the target group. ASHAs are selling sanitary napkins to adolescent as well as to other women. Better counselling will improve the uptake and use further.
- **RBSK** – Field level of RBSK implementation is yet to be started.

Community Level Care Arrangements

- Considerable decrease in home deliveries observed when compared to the previous year. However, the State needs to ensure that even these small numbers of home deliveries are conducted by SBA trained personnel.

TOR 3- Disease Control Programmes

The CRM visit showed that the districts have been able to implement all Disease Control Programmes and many good practices are being adopted for surveillance, prevention and control of the communicable as well as non-communicable diseases. However, strengthening of the surveillance system, effective monitoring and evaluation through designated and well qualified staff at all levels should be in place for all the programs. Towards this, vacant positions to be filled and trainings and intermittent re-orientations to be provided and fixing the responsibilities at all levels will go a long way in effective surveillance, monitoring and evaluation.
The major observations are given below:

Integrated Disease Surveillance Program (IDSP)

- IDSP is actively involved in collection, collation, compilation and dissemination of the data in the districts as per the S, P, L forms. State Surveillance Unit and District Surveillance Units have been made operational.
- In Chittoor total reporting units are 111,107 & 644 (P,L,S forms) with reporting ranging from 75-98% against the > 80% target set by the Central Surveillance Unit (SSU). Performance of the reporting units was poor or low during the third quarter due to the Samikiya Andhra Strike from August to October 2013.
- The completeness of 'P' forms reporting from health facilities ranges from around 29-100%, S form from 9-98% and L form from 6-100%, the low reporting being mainly during the third quarter between August and October due to the Samikiya Andhra Strike .The generated data is used for mapping of vulnerable districts/blocks for ADD, Measles, Dengue, leptospirosis, Scrub typhus and other outbreaks and taking preventive and containment measures. Review meetings are being conducted at all levels with all the stakeholders for sensitization & sharing of information.
- Reporting of all communicable diseases prevalent in the district by PHCs to DSU and SSU is done.
- 28 outbreaks of swine flu, Dengue, Chikungunya, food poisoning and acute diarrhoeal disease and typhoid have been reported from district Chittoor & Mahboobnagar in 2013 so far.
- Media alerts received from the local media and central surveillance units are being immediately verified by the IDSP district unit
- The functionality of IDSP was evident by its reporting of the newly emerging diseases i.e., Scrub typhus and leptospirosis for the first time in district of Chittoor.
- IT infrastructure is available and being utilized for IDSP
- Data collated by IDSP in the two districts serves as an important resource and is being disseminated and utilized by different disease control programmes at the district, state and central level.

National Vector Borne Disease Control Programme

Out of the 6 VBDs, Malaria and Filariasis are prevalent in both districts while Chikungunya and Dengue have emerged recently and reported since 2006. Additionally, JE is reported in Mahboobnagar.

Malaria

- Malaria is not a major public health problem in Chittoor and the disease is well under control, though a marginal increase in cases is being recorded during past years whereas in Mahboobnagar during the recent period, decreasing trend is seen in Malarial cases. (Table 6)

Table 6: Trends in Malaria Case Detection

Chittoor		Mahboobnagar	
Year	**Cases**	**Year**	**Cases**
2005	190		
2006	205		
2007	221		
2008	251		
2009	208		
2010	251		
2011	322	**2011**	222
2012	277	**2012**	175
2013 till date	103	**2013 till date**	114

- The Incidence is low and there are no deaths due to malaria in Chittoor. Rapid Diagnostic tests (RDT) and Rapid Diagnostic Kits and new drug for treatment of falciparum malaria i.e. Artemisinin Combination Therapy (ACT) has been introduced in the district upto the village level in certain areas of the districts.
- Post of 20 LTs is vacant in Chittoor district and needs to be filled up
- No record of training on VBDs could be provided by the district
- Both active and passive surveillance are in place through sub centres, PHCs, Health Assistants ANMs and MPWs for whom a target for slide collection has been set to reach the ABR of 10%. However, the point of concern is that in order to meet the target of 10% ABER, slides are being collected by the health workers from people without fever at village, sub-centre and other facilities and single dose Chloroquine(presumptive treatment) is being administered to all with or without fever. Irrational use of Chloroquine needs to be discontinued immediately.
- ASHAs are playing only the role of activists and are not trained/involved in the preparation of slides/ testing by RDTs /administration of drug.
- Report of cross checking of slides was not available at any of the labs. The M1-M4 forms were not available in any of the labs. Surveillance should be done as per the NVBDCP guidelines. Chittoor district is still using the old malaria proformas which need to be changed to the M1-4 forms as per programme guidelines.
- Laboratory in the District Hospital Chittoor does not have facilities for testing of Malaria through microscopy and technician in District Hospital Chittoor does not examine Malaria slides. The hospital is dependent on DMO office staff for collection as well as examination of slides. Rapid diagnostic tests for Malaria for immediate confirmation of complicated malarial cases are also not available at the district hospital. Hospital needs to have independent facility for both RDTs as well as malaria microscopy in place for timely confirmation of complicated malarial cases admitted in the district hospital.

Dengue

- In Chittoor, 135 high priority areas for Dengue and Chikungunya have been identified.
- No definite plan was found for calendar activities for prevention and control of Dengue and Chikungunya.
- Schedule for IRS is the only anti vector activity planned
- Supervision of all vector borne diseases in the district is poor due to lack of entomological set-up.
- Vector Surveillance and Source Reduction awareness in community is minimal.
- Water storage practices (in cemented tanks – Sumps, open vessels) are perpetual source of vector breeding all over the area.

Cemented tank for water storage in Palamner

- Confirmation of Dengue cases in designated lab. and SVR Medical college is operational for which the NS1 & IgM ELISA based test kits are being supplied by the state . The state Govt. has declared dengue cases diagnosis and treatment at sentinel site hospitals is free However, test kits were neither available at both Medical colleges nor have not been supplied by the state during 2013 for Chikungunya.
- There were no Dengue deaths reported from Mahboobnagar in last three years (though one case of dengue death was reported by people/ media during field visits which needs to be further confirmed)
- Recently Chittoor district is contributing to majority of the deaths due to Dengue in the state

Table 7: Deaths due to Dengue in State and Chittoor District

Year	# Dengue Deaths in Chittoor	# Dengue Deaths in State
2006	1	17
2007	0	2
2008	0	2
2009	1	11
2010	2	3
2011	2	6
2012	1	2

- No IEC material and community awareness on source reduction for control of Dengue was found in the areas visited

Chikungunya

- Community and private practitioners reported to the CRM team in Chittoor that large number of cases in certain areas were affected by Chikungunya (about 30% of population) which were not verified by the district authorities. In contrast, in Mahboobnagar, 60-70% of the cases in villages visited by the CRM members were verified and treated.
- Test kits for Chikungunya are not available in the designated SS lab in Chittoor district.
- No requisition for the kits has been placed by the Chittoor district/lab authorities
- No IEC material and community awareness on source reduction for control of Chikungunya was found in the areas visited

Lymphatic Filariasis

- In Chitoor, Lymphatic Filariasis Elimination Program is well performing and less than 1% MF rate is being reported consistently for more than three years and the district is ready for Transmission Assessment Survey (TAS).
- The coverage and reported compliance of MDA has been above 80%. During 2013 the MDA has been deferred due to problem in procurement of DEC, followed by PHILINE and is to be rescheduled.
- Line listing of hydrocele cases requiring surgery has been done but surgeries not conducted.

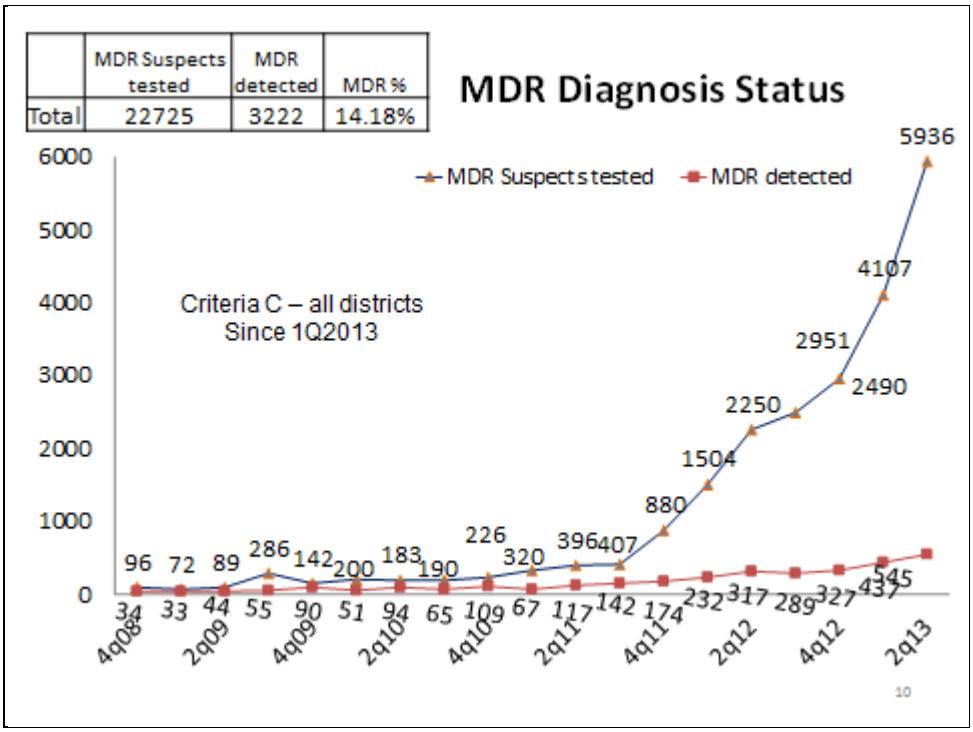
Revised National Tuberculosis Control Programme

- RNTCP treatment cards are well maintained and DOTS is happening as per guidelines
- Laboratory diagnosis services are sufficiently placed in the state and districts visited
- Disbursal of DOT provider honorarium is smoothly implemented though some delay is found
- For the TB cases detected at CHCs treatment was provided in nearby PHCs and sub-centres and no facility based DOTS was provided at CHCs across the district in Mahboobnagar
- Though the districts/ state have achieved the NSP case notification and cure rate targets (70% & 85%respectively) it is yet to achieve the universal access in terms of Total TB Case notification (recent targets of 90% & 90%)
- Major gap was found in detection of NSN and NEP cases

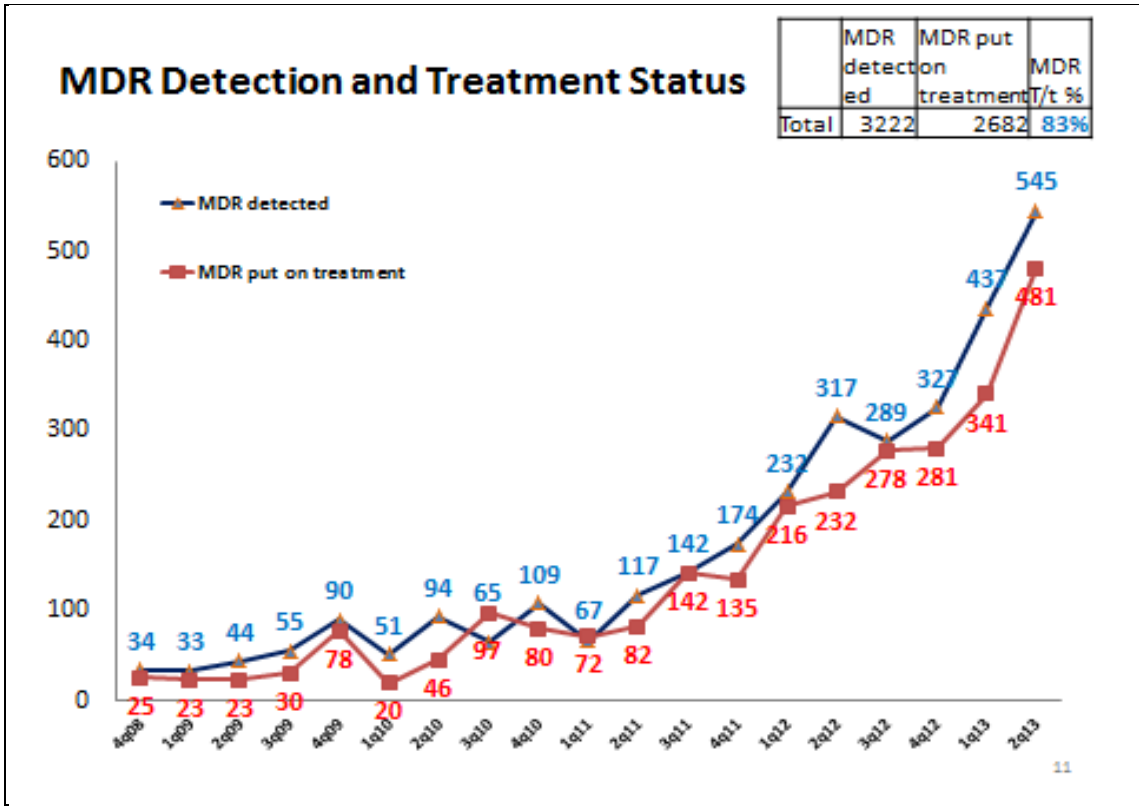
In Chittoor, Chikunguinya appears to be a problem in some high risk villages and in one such village, villagers and private practitioners reported that about 30% of the population was affected by chikungunya. This was however not validated by the medical officer and district health authorities. Kits for chikungunya were also not available in the testing facility at Tirupati medical college and designated sentinel surveillance laboratory. IDSP and the DMO should ensure that verification of such fevers is done.

PMDT (Program Management of Drug Resistant TB)

- Identification of MDR-TB suspects is sub optimal
- Collection and transportation of C&DST samples is being undertaken at TU level in Chittoor and Mahboobnagar
- There are identified labs for diagnosis and follow –up testing of MDR-TB cases;



- The diagnostic services for the MDR TB have increased substantially in recent period. Andhra Pradesh is one of the leading states in implementing PMDT successfully and is one of the training centre for National Level training on PMDT.



- Overall treatment services for DRTB patients is at satisfactory level in the state with 8 full fledged DRTB wards and 2 Satellite wards functioning catering to the patients from all the districts in the state.
- DRTB centre in Mahboobnagar is yet to start and the sudden closure of DRTB centre in AP Chest Hospital is affecting the treatment initiation of DRTB cases in the district
- The DRTB centre at the DH in Chittoor lacks adequate beds and needs partition between beds for male and female patients

Ban on Serological Tests:

- Notification on Ban of Serological tests for diagnosing TB was circulated across the state as a follow-up to WHO guidelines and circular from Central TB Division.
- Upon field level survey, 3 out of 5 private labs explored were selling the banned serological tests.

Drugs

- Anti TB drugs are now categorized as Schedule – H1 drugs. It means the chemist should retain a copy of the prescription and maintain a separate register for these drugs where the name of the patient and details of the doctor who prescribed the drugs will be noted. This register will have to be kept for 3 years before being destroyed.
- Awareness of the chemists regarding schedule – H1 drugs is poor in both the districts.
- Anti TB Drugs availability is adequate at all levels with sufficient buffer stocks available in RNTCP units.

TB Notification from Private Sector

- TB is a notifyable disease. A GO from the centre and state have been circulated among the key private sector hospitals and diagnostic centres seeking notification.
- State has received notification from around 500 such private institutions so far notifying more than 1500 cases.
- TB Notification from private sector is incomplete though the efforts have taken off by the district administration in both Chittoor and Mahboobnagar.

Nikshay

- Data entry in Nikshay is being done by STS which is up to date.
- Many medical officers are unaware of NIKSHAY

Paediatric TB

- Chemoprophylaxis of 10 mg/kg body wt. is being given to contacts of smear positive cases and sufficient INH 100 mg tablets are available throughout

Trainings

- Medical Officers' training is not up to the mark on RNTCP in Chittoor district

HR

- Non availability of full time DTO is a problem in smooth implementation of the program
- Delay in filling the vacancies leading to impaired implementation of the program

- Number of contractual LTs is insufficient in Chittoor district as per eligibility criteria per district (13 of 49 – 26.5% against 30%). In Mahboobnagar 10 of 38 – 26.3% against 30%). Though the overall number of contractual LTs in the state is 30% there is gross mismatch in the district level contractual LTs

IEC/ ACSM

- IEC material was displayed in the government health facilities. However; field level IEC and ACSM activities is rarely seen

AP State AIDS Control Program

Access

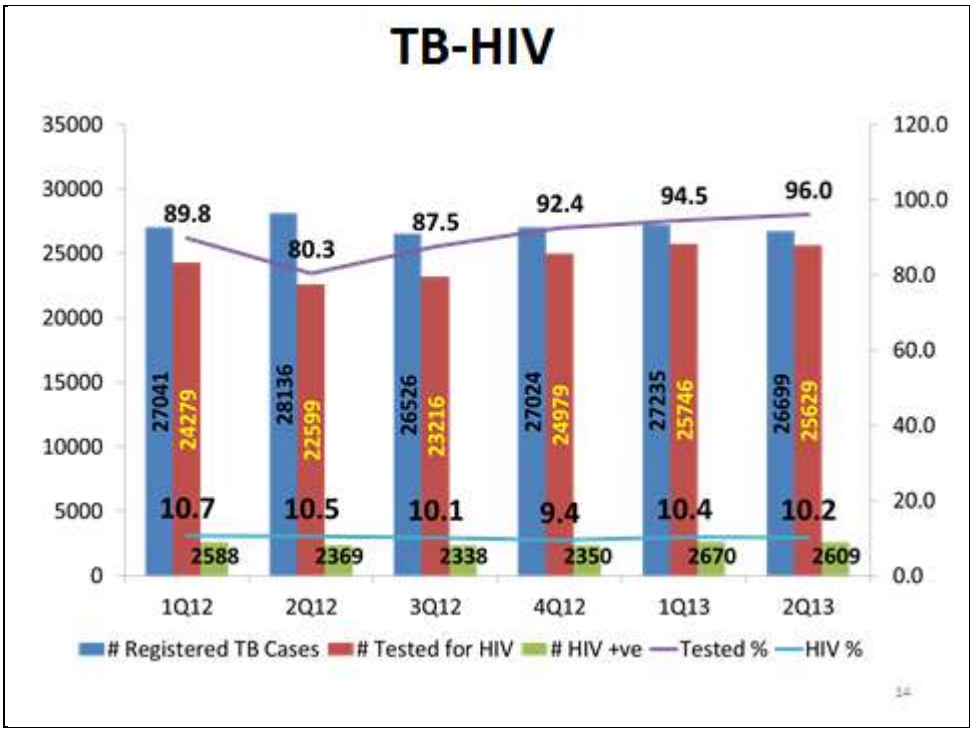
- All ICTCs, ART, Link ARTs are functioning well and in accessible areas.
- Private sector involvement and reporting through public private partnership (PPP) model is encouraging in the AIDS control program.

Test kits

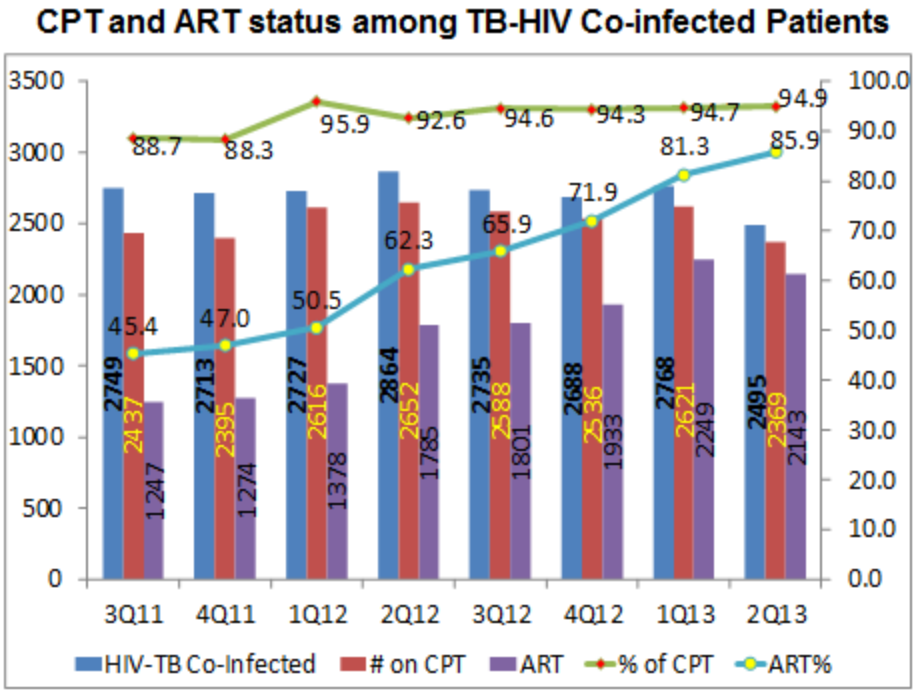
- Test kits were available in requisite numbers.

TB – HIV Collaboration

- A good TB-HIV collaboration is established. With more than 96% HIV testing conducted among the registered TB patients.
- Collocation of DMCs and ICTCs/ FI-ICTCs exist with good collaboration between the programs



- Provider initiated testing and counselling (PITC) of all TB suspects for HIV is initiated but yet to be uniformly rolled out.



- Provision of CPT (Co-trimoxazole Prophylactic Therapy) and ART (Anti-Retroviral Therapy) to the TB-HIV co-infected patients is showing satisfactory progress though the minimal gap can be filled up with little more efforts.

SOPs

- While SOPs were not displaced in the labs in Chittoor, they were well displayed in Mahboobnagar

Bio-safety

- Bio-safety guidelines not displayed in the labs in Chittoor but were well displayed in Mahboobnagar.
- Bio-safety and laboratory waste disposal mechanisms were not available in Chittoor districts which could become a major health hazard for the lab staff as well as community.
- Personal protection guidelines (including PEP) neither displayed nor followed in both the districts
- The most alarming finding with regard to bio-medical waste disposal in HIV labs – samples have been directly discarded into wash basins in ICTCs in Chittoor districts. Correct procedure for preparation of disinfectant was not known to lab technicians which can be a major health hazard for the lab staff as well as the community and needs urgent redressal.
- In one of the labs, needle shredder was not available and needle capping was being practiced (Tarigonda FI-ICTC)
- Recording and reporting was maintained and updated

HR

- All the staff are trained and in position. Though the lab technicians were trained and re-oriented periodically, upon personal interview with the lab technicians' (at all 4 ICTCs in

district and sub-district level in Chittoor) knowledge was very poor on sample testing guidelines, patient referral to SRL and bio safety

- The salaries of senior counselors with 8-10 years of experience and those who were recruited recently are same. This can result in staff turnover and differences among staff recruited in the same program.

Training

- Refresher trainings for the lab technicians in universal work precautions, bio-medical waste management should be expedited.
- Counsellors including the link ART centres require an update on the national revised parent to child transmission of HIV (PPTCT) guidelines

National Leprosy Elimination Program (NLEP)

- Reconstructive Surgery (RCS) is conducted in Govt. hospitals and Medical colleges.
- Multi Drug Therapy (MDT) & other logistics are being supplied to the district & block level on regular basis for providing quality service.
- Deformity Prevention and Medical Rehabilitation (DPMR) services are provided by the district.
- MOs, Paramedical staffs are providing DPMR services like ulcer care, self care practice, supply of MCR Foot wear, management of Leprosy reaction etc.
- Skin smear examination facility is available at Dist Head Quarter level for confirmation of difficult to diagnose cases.

Non- Communicable Disease Control Programmes:

National Programme for Control of Blindness (NPCB)

NPCB is being implemented in the districts and the achievement in operating Cataract is shown below:

2011-12				2012-13				2013-14*			
Govt.	NGO	Private	Total	Govt.	NGO	Private	Total	Govt.	NGO	Private	Total
90529	275638	281665	647832	83555	244575	198718	526848	19001	54302	45341	118644

In the above table it would be seen that the contribution of NGO and private sector is more than the public sector. So the State Govt. need to take necessary steps for improving facilities in the public sector.

Under NPCB screening for refractive errors for correction is being carried out. The target and achievements since 2011-12 to Q-2 of 2-13-14 is given below

Year	No. of school children screened	Free spectacles provided to students
2013-14(upto Qtr.2)	4,80,000	1865

National Programme for prevention and control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

To control and prevent the enormous burden of NCD's Government of India has launched NPCDCS and NPHCE Programmes during 2010-11 and implemented in a Phased manner.

The NPCDCS was started in 2 districts during 2010 – 11 in Vizianagaram and Nellore Districts. In this intervention, a dedicated State Nodal Officer in the rank of Additional Director and a State Programme Officer in the cadre of Joint Director were placed to manage and execute various activities of NPCDCS. Subsequently the program was extended to six more Districts during 2011 – 12 in Srikakulam, Krishna, Prakasam, Kurnool, Kadapa and Chittoor. In the districts of expansion also Nodal officers are given responsibility of implementation of both the programmes.

As per the instructions issued in Govt Memo No. 17308/M2/2011-3 dated 13-6-2012 of Finance and Planning (SMPC) Department Govt of Andhra Pradesh recruitment for all the posts for State NCD Cell and District NCD Cell and NCD Clinics is done by taking the services of the existing personnel on deputation / redeployment. But practically deputation or redeployment of existing personnel was not possible due to scarcity of staff.

Trainings:

Ninety Four SPHOs from all eight districts were trained at Indian Institution of Health and Family Welfare, A.P Hyderabad in three batches during Jan-Feb 2012. Training of Medical Officers and ANMs were done as shown in the table.

Sl. No.	Name of the District	No. of Medical Officers Trained	No. of ANMs Trained
1	Srikakulam	67	809
2	Vizianagaram	80	425
3	Krishna	72	765
4	Prakasam	188	712
5	Nellore	60	575
6	Kurnool	90	564
7	Kadapa	56	463
8	Chittoor	87	942
Total		**700**	**5255**

Progress so far…

Massive Screening programme was launched to screen people above 30 years and pregnant women for Diabetes and Hypertension in Eight identified Districts and nearly 84 Lakh persons were screened so far at sub centers, villages and CHC's and 7.12% are Diabetic and 7.32% are Hypertensive among the screened.

District	No. of Glucometers Distributed	No. of Gluco Strips Distributed	No. of Lancets Distributed
Srikakulam	545	1176000	1326400
Vizianagaram	445	825000	981000
Krishna	666	1418000	1606700
Prakasam	612	1310000	1480500
Nellore	262	515000	296000
Chittoor	710	1441000	1705900
Cuddapah	519	1124000	1266600
Kurnool	576	1352000	1528800
Total	**4335**	**9161000**	**10191900**

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETIC, CARDIOVASCULAR DISEASES AND STROKE

CUMMULATIVE REPORT UPTO 30-11-2013

District	Cummulative			Percentage	
	Total No. of Persons screened	Positive Diabetic Cases (>140)	Positive Hypertension Cases (>90)	% of Diabetic Cases	% of Hypertension Cases
Srikakulam	1090800	76440	84672	7.01	7.76
Vizianagaram	743095	39380	42425	5.30	5.71
Krishna	1411500	133309	123829	9.44	8.77
Prakasam	1310000	106864	112552	8.16	8.59
Nellore	413602	44179	44958	10.68	10.87
Chittoor	1536525	70190	67050	4.57	4.36
Cuddapah	835917	60971	78866	7.29	9.43
Kurnool	1041622	51612	50994	4.95	4.90
Total	**8383061**	**582945**	**605346**	**6.95**	**7.22**

Further, the Department of Public Health and Family Welfare have entered into MoU with Novo Nordisk Education Foundation in screening Diabetes, Hypertension, Body Mass Index, HbA1C etc., in a phased manner. During the first year of the project viz., Changing Diabetes Barometer, Hyderabad and Warangal Municipal Corporations will be covered and in the 2nd phase, the Municipal Corporations of Vijayawada, Visakhapatnam and Tirupathi will be covered. Novo Nordisk Education Foundation will take care of IEC, Screening, Training to the Medical and Para Medical Persons etc.,

- DH has established a NCD Clinic which is functional and screening of all NCDs is being done. However, at the PHC and sub-centre level screening is done more for diabetes and hypertension.
- 424000 suspected cases of diabetes and 70059 cases of suspected Hypertension have been reported in 94 PHCs and 644 sub-centres from March 2012- Sept., 2013.
- MMUs(104) were also found screening the villagers for these two diseases only. Mechanisms for confirmation, follow up and treatment of the suspected cases needs to be strengthened.
- Concentration on Cancer, Tobacco and Stroke etc. need to be increased.
- A more targeted approach for screening of the vulnerable population needs to be adopted at the village and PHC level.
- The Diabetes awareness program is being implemented in 8 of 23 districts in the state in Phase I. All the 8 districts are from coastal region only. The geographic distribution of the pilot districts was uneven. Hyderabad, known as diabetes capital of India is not part of the study. None of the Telangana districts are made part of the implementation. Selection of implementation areas must be made based on scientific data and with valid justifications.

National Tobacco Control Program (NTCP)

State Tobacco control cell (STCC) has been implementing National Tobacco Control Program (NTCP) under the department of Directorate of Public Health and Family Welfare's office. NTCP is responsible for the overall planning, implementation and monitoring of different activities, and achievements of physical and financial targets planned under the program in state with the main components such as training of stakeholders, state level public awareness campaigns/IEC, monitoring tobacco control laws and reporting. The **STCC is headed by a State Nodal Officer** who is also taking care of all the NCD programmes. Other team members of this cell includes state consultant **(MOHFW and WHO initiative)** appointed on contract basis.

NTCP in Andhra Pradesh is being implemented as a pilot project in 2 Districts i.e. Guntur and Hyderabad. District Tobacco Control Cell (DTCC) has been established in both districts, which is responsible for the overall planning, implementation and monitoring of different activities and achievement of physical and financial targets under the programme at the district level. DTCC is been headed by District Nodal Officer preferably DMHO, with additional staff including a psychologist / counselor, social worker and data entry operator appointed on contract basis.

Status of District Tobacco Control Cells/ District level Coordination Committee

Chairmen: Joint Collector		Member Convener: DM&HO	
District	**Nodal Officer**	**Social Worker**	**Psychologist**
Guntur	Yes	Yes	Yes
Hyderabad	Yes	Yes	Yes

Progress in program implementation:

- **State level Coordination Committee (SLCC):** 43 Review meetings were conducted at DPH&FW level since 2008-2010, 3 High power committee meetings held till date at Chief Secretary level since 2011.
- **District level Coordination Committee (DLCC):** 7 district level review committee has been conducted at joint collector level in NTCP District
- **IEC/ Mass Awareness Campaigns:** There were various public campaigns and IEC material prepared,
    - 1150 boards of section 4 were prepared for all districts @ 50 each district.
    - Section 4 and section 6b posters stickers prepared.
    - Manuals prepared, health worker manual, doctors manual, teacher manual, law and enforcement manual, tobacco cessation manuals.
    - Conducted 45 days outdoor campaign with big van carries various types of videos posters a dummy pan shop, dummy cigarette and leaflets.
    - Voice of victims video was prepared for advocacy purpose
    - 80 feet inflated cigarette butt was prepared with health messages and warning
    - 20ft cigarette butt was placed on various traffic islands on occasion of world no tobacco day
    - 60 hoarding boards were prepared

- **School Advocacy Program:** 185 school advocacy program has been covered under school component of the NTCP and many community awareness programs

- **Enforcement of COTPA act 2003:** Head of account for challan collected from violator under the name DIRECTORATE OF HEALTH AND FAMILY WELFARE was establish in 2008
    - 22462 challan book has been prepared and has been distributed in all the district to police, food safety and health department. Total no of person challaned was **71,705** and the amount collected was approximately **Rs. 52,83,948**
    - COTPA act violation has been incorporated in the monthly crime review meeting and monthly reporting format has been formed
    - Police dept., food and drug, health dept. has been furnishing regular monthly report on the COTP Act violation
    - Sensitized police by conducting one hour session in the crime review meetings in their respective districts. mainly in Guntur, Nizamabad, Nalgonda, Vishakapatnam and Rangareddy

- **Stake holder advocacy workshop**: National level consultation was conducted, involving 14 NTCP States, training program for the state and district staff. Advocacy program conducted with film certification department to involve scrolling which specify tobacco kills, during smoking scenes in movie. Total 1545 Medical officers, 850 Health supervisory staff, 7000 ANMs were trained under NTCP.

- **Tobacco Cessation Center:** Total 18 tobacco cessation center has been established throughout state to provide facilities for treatment for tobacco dependence.

TOR 4: Human Resources & Training

State has taken steps to fill in the vacancies at various facilities.

- Over the NRHM period, State has increased the intake of students through 5 medical colleges that have been created under public sector and 6 under the private sector with an overall increase of more than 1000 medical seats in addition to the ANM & GNM schools.
- However, the State has a vacancy of 337 medical officers, 1292 specialists, 688 paramedics, 1333 lab technicians/ paramedics, 2811 MPHWs, 3740 ANMs and 5873 ASHA facilitators. The dearth of human resources and trained personnel is visible across all the facilities visited. Moreover, in the clusters that were visited, the SPHOs were specialists (gynecologist and anesthetist). State needs to think of rational deployment of such specialists.
- Irrational deployment of human resources is an important cause of concern. For eg: Maternity hospital conducting more than 1000 deliveries per month and 200/300 C Sections/ month has only one or two anesthetists. In contrast, anesthetists have been posted as SPHOs in some places (eg CHNC Puttur & CHNC Tirupati). Similarly in CHC Kalwakurthi, SPHO is a gynaecologist. Doctors have been trained in LSAS, however district authorities in Chittoor are not aware of where they are posted.
- Decentralization has been done at district level for recruitment of contractual HR

- Plan for baseline assessment of competencies of SNs, ANMs and Lab Technicians was not evident.
- The laboratory technicians employed through outsourcing agency were provided salaries for 10 months only and later stopped. State needs to take action on the same.
- Tribal areas face additional burden of poor human resources, especially specialists, however in the last two years the pace of trainings has improved.
- Several modes of training including establishment of skill labs and skill van have been attempted, however, there was no strategy for post training follow-up
- Inadequacy in knowledge and skills among doctors and ANMs found on specific service delivery related aspects. These gaps compromise the guidelines for delivery of quality services (eg. Awareness of critical SBA, FP and NSSK guidelines need improvement. Plan for baseline assessment of competencies of SNs, ANMs and Lab Technicians was not evident
- The laboratory technicians employed through outsourcing agency were provided salaries for 10 months only and later stopped. Similarly under NRHM, salaries of staff in SNCU delayed by more than 3 months.
    - In AIDS control program, the salaries of senior counselors with 8-10 years of experience and those who were recruited recently are same. This can result in staff turnover and differences among staff recruited in the same program. The current status of the vacancies is provided below:

Table 8: Current HR Status in the State:

HR status	Gap/vacancy
Doctors (Allopathic)	337
Specialists	1292
Paramedics	688
Lab tech./Pharmacists	1333
MPHA (Male)	2811
ANM	3740
ASHA Facilitators	5873

- Shortage of ANMs as per norms is another area which needs immediate attention.

AYUSH:

- The 1525 PHC's in AP entail the appointment of an equal number of AYUSH medical officers, however, still 634 AYUSH medical officers are yet to be appointed.
- The contractual AYUSH Medical Officers report to the Regional Deputy Director of the respective zone under the commissioner of AYUSH of the State.
- Lack of co-ordination between the AYUSH and Health directorates.
- Facilities for AYUSH Medical Officers are not satisfactory.

- AYUSH doctors are rendering only OPD services and are not participating/ involved in the National Health Programs.

Status of Trainings under NRHM

- State does not have State Health Resource Centre.
- State Institute of Health & Family Welfare (SIHFW) is renamed as Indian Institute of Health & Family Welfare (IIHFW), Hyderabad, is an apex training institute with autonomus status functioning under aegis of Department of Health & Family Welfare, Govt. of Andhra Pradesh. The institute was established in August 1992. The Institute has six departments covering the areas of Public Health, Epidemiology, Reproductive Health, Demography, Management & Health Communication supported by experienced social health scientists specialized in various disciplines. Given the capabilities and strengths of the IIHFW, quality of trainings can be improved if the faculty members are utilized in accordance with the objectives of the IIHFW.

  The objectives of IIHFW that were envisaged at the time of establishment of the institute are:

  - To develop trained health manpower resources for better delivery of health care services.
  - To conduct policy relevant and field based research studies in the areas relating to population, health and family welfare.
  - To provide technical guidance to Regional Training Centers and District Training Teams.
  - To render advisory and consultancy services to Government and other health related organizations for developing programmes and policies on population and health.
- Prior to 2010, the IIHFW actively involved in evaluation and rapid assessment of various NRHM initiatives. The IIHFW conducted many evaluation studies in the areas of training needs assessment, evaluation of ASHA (2009), public health facility survey (2009) and Post training of NSSK etc. In the last three years, looking at the PIP documents, no funds were released for evaluation studies thinking that HMIS and MCTS can provide such data. But they are serving the purpose.
- Centre for Advanced Midwifery Training Centre (CAMT) has been recently brought under the administrative control of the IIHFW. The Centre conducts Pre-service & In-service trainings for ANM / GNM.
- Under NRHM, the GoAP is undertaking Induction Training, In-service Training and Refresher Training for various categories of health functionaries. Private providers are also being trained.
- The State has created 8 Regional Training Centres (RTC (M) & RTC (F) in Hyderabad, Guntur, Kurnool and Visakhapattanam and District Training Centres under the purview of IIHFW to provide training at regional level.

- At the District level, District Medical & Health Officer and Programme Officer-District Training Team (PODTT) are responsible for all trainings conducted at district level. The PODTT prepares training calendar, conduct and coordinate training programmes and ensure coordination with RTCs, other training institutes and IIHFW.
- In 2012-13 RoP, refresher training of 500 staff nurse on SBA was approved. However, the IIHFW annual report, 2012-13 did not reflect it.

Figure 3: Organogram of Trainings Infrastructure

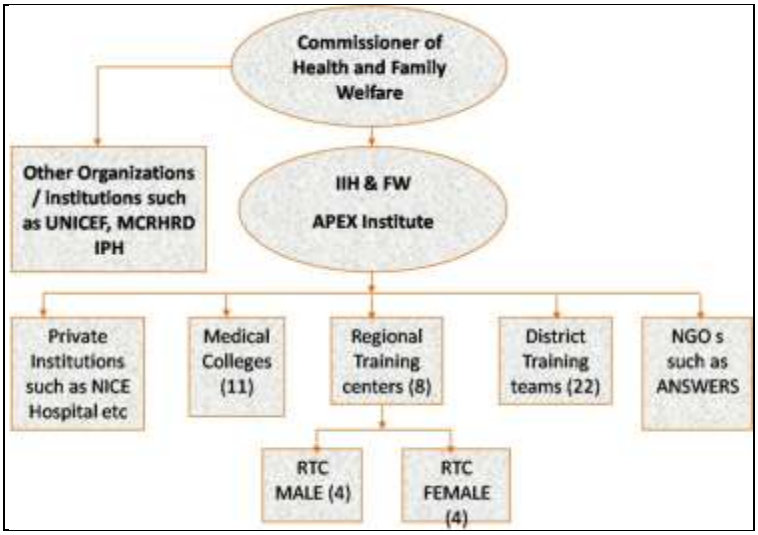


Table 8: Trainings conducted in Andhra Pradesh from April to October 2013

Type of Training		Total Training Load	Total Trained	Performance (%)
Maternal Health	SBA	1576	466	29.6
	EmOC	14	24	171.4
	BeMOC	267	76	28.5
	LSAS	23	12	52.2
	STI/RTI Mos	414	153	37
	STI/RTI SNs	414	109	26.3
	STI/RTI LTs	414	30	7.2
	STI/RTI Overall	1242	292	23.5
Child Health	B-IMNCI	2689	1996	74.2
	F- IMNCI Mos	343	91	26.5
	F- IMNCI SNs	343	115	33.5
	F- IMNCI Total	686	206	30
	NSSK (MO)	437	262	60

Type of Training		Total Training Load	Total Trained	Performance (%)
	NSSK (SN)	851	1561	183.4
	NSSK (ANM)	1288	147	11.4
	NSSK (Total)	2576	1970	76.5
	IIYCF	1114	214	19.2
	HBNC(ASHA R1)	6603	1859	28.2
Family Planning	Minilap	276	36	13
	IUCD	221	0	0
	PPIUCD	432	77	17.8
	ARSH MO	712	28	3.9
	ARSH ANM	2033	540	26.6
	ARSH Total	2745	568	20.7
ASHA	ASHA Round 2	19536	10828	55.4

The CRM team of the NRHM, GoI met the faculty of IIHFW on 13th November 2013 and discussed various issues pertaining to trainings under NRHM.

- The total staff strength of IIHFW is 41 members. It has 10 Faculty Members, 2 Research Associates, 5 Administrative Staff and about 24 contractual staff.
- The Institute has one Auditorium, three training Hall and Computer Lab (Approx 30 computers) with internet connectivity. Generally training load per batch is around 50.
- Research Studies conducted by IIHFW : During 2011-12 & 12-13 are as follows:
    - A Meta Analysis of IEC intervention studies undertaken by IIHFW for promotion of Public Health
    - Evidence to Guide the development of Social & Behaviour Change Communication (SBCC) strategy for Maternal & Child Health and Nutrition in Andhra Pradesh
    - An Evaluation of Roles & Responsibilities of 2nd ANMs in Andhra Pradesh
    - Multi Indicator Cluster Evaluation Survey (MICES) in Medak, Warangal and Kurnool districts of AP
    - Evaluation of Urban Health Centres under APUSHCP / NRHM
    - Application of NSSK training skills (Basic Resuscitation) at workplace by Health Personal in AP

TOR 5: Community Processes and Convergence

- The community processes in the State did not appear to be as remarkable and strong as they should have been and have considerable scope for improvement.

- While there is a dedicated programme officer at State who holds the charge for ASHAs, there is no officer for overall management of community processes including untied grants, VHSNCs etc. Consequently monitoring mechanisms of VHSNCs, community processes, functioning of HDS and utilization of AMG and Untied funds need to be established. The functioning of various community processes are explained below:

Panchayat Raj Institutions (PRI)

At VHSNC level:

- PRI members are part of VHSNC and they chair this committee meeting.
- Meetings of VHSNCs are taking place every month and minutes of same are maintained properly.
- Although the signatory of VHSNC bank account are ANM and Village Revenue Officer. PRI member is not a signatory of VHSC bank account.

At HDS level:

- At most of facilities visited, HDS meeting is not taking place on regular basis.
- PRIs role in HDS is very negligible.

Village Health Sanitation and Nutrition Committees (VHSNC)

- VHSNCs have been formed at Gram Panchayat level instead of village level as prescribed.
- VHSNCs composites of PRI members; ANM, ASHA, AWW, and other officials at Gram Panchayat level. However, participation of NGOs, Self Help Groups and other community members is not visible.
- Bank account of VHSNCs has been opened and signatory of the same is the Village Revenue Officer and ANM, instead of ASHA.
- Meetings of VHSNCs take place every month and minutes of the same is properly maintained in Mahboobnagar. However, regularity of meetings was not observed in Chittoor.
- VHSNC funds are utilized for Cleaning Drainages/ Water tanks; Spraying and fogging and Chlorination/ purchase of bleaching powder

Village Health Nutrition Days (VHND)

- In the state, VHND is conducted in following manner:
    - Each Monday: ANC and PNC services at Sub Centre level.
    - Each Wednesday: Immunization services at Sub Centre level.
    - Each Saturday: Immunization services at Village level.
    - Each Day: Nutrition services through **"Amrit Hastam"** programme, in which they are providing Milk, Rice, Pulses,

VHND at Rompicherla Anganwadi Centre

Vegetables etc. to each pregnant and lactating women (up to 6th months after delivery)

- However, outreach services are focused only on immunization. Lack of activities related to nutrition at VHNDs and ANC and PNC services at village level were weak.
- Convergence between WCD and Health department is working well at field level.

ASHA Training and Performance

ASHAs are a good interface between the community and the health centres**.** While ASHAs are functional and trained, in Chittoor district there was a gap of 700 ASHAs which needs to be filled immediately. Most ASHAs trained up to module 6 & 7.

- ASHA conduct home visits, provide home based newborn care (HBNC), distribute contraceptives, coordinate VHSC meetings, support VHND; prepare due lists and promote institutional deliveries and immunization through accompanied referral.
- ASHA kit is available in Mahboobnagar and it's been regularly replenished by SC. (Zinc tablets are not supplied). In Chittoor, ASHAs have not received drug kits (although some medications are provided to them from the Sub centre level). Moreover, ASHAs of many clusters have not received their complete HBNC kits although HBNC kits are being provided to ASHAs after their training. System for replenishment of kits also needs to be systematized. Distribution of HBNC kits has been initiated.

ASHA Worker in the field at Rompicherla

- Most of the officials and ASHA nodal officers accept that ASHAs are working well in their area.

ASHA Incentives and Support Systems

- Most of the ASHAs are unaware of many schemes through which they can earn income except for institutional deliveries and follow-up of pregnant and post natal women. On an average, ASHA earns around Rs. 800-1000 per month. State needs to orient ASHAs on all incentives available in health.
- ASHAs are getting incentives on regular basis. Incentives of ASHA are directly been transferred to their respective bank accounts in Mahboobnagar. In Chittoor, the incentives are being given through cheques currently and the process of online transfer will be operationalized soon.
- Records of activity wise performance of ASHAs not maintained at PHC/ District level. In some cases not at Sub Centres as well

- 10 indicators based performance monitoring system not followed
- ASHA ghars, special facilities for ASHAs not established
- Supportive structures for ASHAs namely ASHA Mentoring Group, ASHA Resource Centres etc not established.

Untied Funds/ AMG/ RKS

- Last year many SCs in Chittoor received only Rs. 2500 out of Rs. 10,000 as Untied funds wheras only Rs. 8500 approx has been released as untied funds in some places in Mahboobnagar too.
- In 2013-14, AMG funds not released, in some places in Mahboobnagar. In Chittoor, funds not released to most facilities
- Utilization of RKS funds at facilities was good.
- Differential financing not yet initiated.
- Monitoring mechanisms of these funds are weak.

Community Monitoring

- Participation of community members in VHSNC and other bodies is negligible; hence they are not playing any key role in planning and monitoring.
- Community Monitoring as prescribed under NRHM has not been initiated in the State

Convergence

- Good Convergence with ICDS at village level.
- Social marketing of sanitary napkins is found to be satisfactory. However, the information and accessibility should extend to the post-natal women also.
- Mid-day meals scheme is not uniformly implemented across the places visited. In some centres, cooked food is provided and in other ration.
- MAARPU programme has been initiated to improve convergence at the district level.

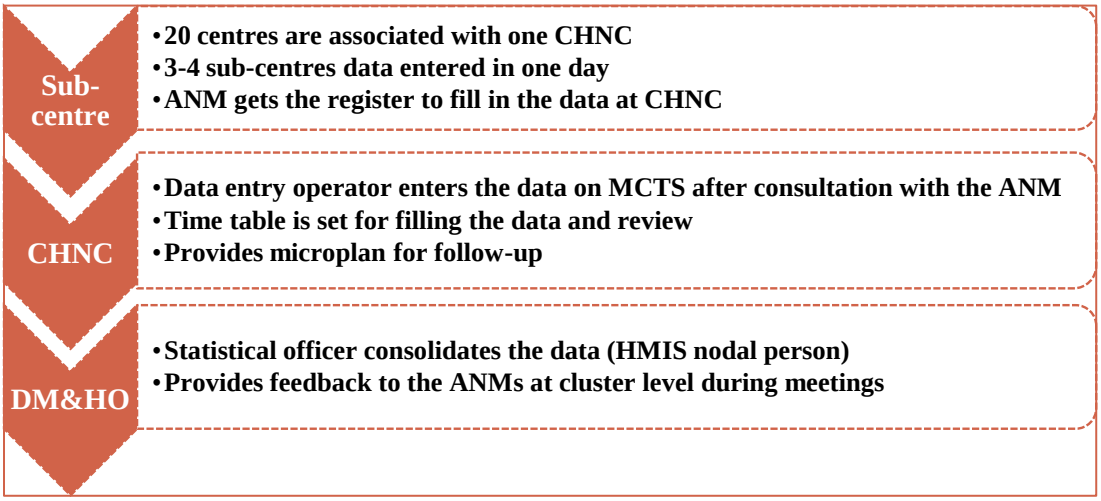
TOR 6: Information and Knowledge

Health Management Information System

- Deputy Director (Demo) & Chief Information Officer is working as Nodal Officer for HMIS & MCTS. There is no contractual State Data Manager or HMIS Consultant. Each district has constituted District Health & Family Welfare Statistics Cell which is looking HMIS at district Level. Statistical Officer (FW)/ Statistical Officer (UIP) and District Programme Officer & MIS Asst. (NRHM) are the member of District H&FW statistics cell. Two DEOs are placed in each District Head Quarter.
- Facility based data uploading in HMIS Web Portal is in place. But out of 23 districts only 17 Districts has started facility level data uploading in the portal. Six districts; namely East Godavari, Hyderabad, Khammam, Krishna, Mahboobnagar and Medak are uploading District Consolidated Report only.

- The first level entry point in HMIS web portal by DEO is at Community Health Nutrition Centres which are Administrative Blocks in the District.
- Most of the PHCs have 6 to 10 years old computers which need to be replaced in a phased manner. Approximately 75 to 80 % PHCs can access internet. Net Connectivity proposed to all PHCs through APSWAN by this year.
- Data of total number of private facilities providing MCH services is not available. Only 153 Pvt Facility data of Andhra Pradesh can be uploaded in HMIS portal (based on AP HMIS master) whereas 209 Pvt Facilities are functional in Chittoor district itself.
- Notional SCs in HMIS master have not been created in Andhra Pradesh, due to that home delivery data of SC area is missing.
- SAS VDD software is installed at State HQ which is being used for HMIS data analysis.
- Any other software has not been used by the State.

Information Flow from Sub-centre to MCTS Portal

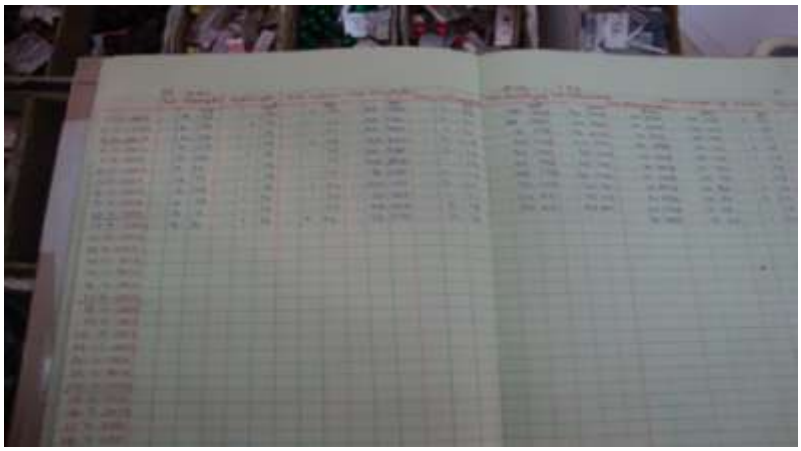


NRHM HMIS Portal:

- Data uploading at the HMIS portal is not consistent at all levels & most of the private facilities are not reporting. The performance data of each district is not complete. The data uploading status of District Hospital is very dismal. (Annexure 1). It needs to be noted that six districts have not yet started facility level data uploading.

Record Keeping

- Record keeping is not uniform. Different MCTS registers for pregnant women is being used at District Hospital and other facilities.
- In addition to the printed MCTS register which are being used for RCH activities. Hand written, non-uniform ANC, Delivery and Immunization service delivery registers are also maintained at the facility level by ANM. In the service delivery register of ANC and Immunization where details of the Pregnant Mother and Child is also maintained by the ANM which increases the redundant workload of the ANM. This workload can be reduced either by maintaining serial number (or UIC of MCTS) of the beneficiaries from MCTS register, name of the beneficiary and service provided on the day or by using Tally Sheet. One serial number for the beneficiary (or UIC of MCTS) which is generated at the time of registration in the system need to be used in other related registers also. e.g. The serial number (UIC) provided to a pregnant woman at the time of ANC registration should be reflected in the Delivery Register and in JSY payment Register & PNC Register as well. It will help to update the MCTS register smoothly.



- At the District Hospital Chittoor Immunization record is maintained at Maternal Health Register.

- OPD, IPD, PNC, Family Planning, Labour Room, Drug Stock, JSY payment Registers are maintained at the facility level. It is also verified that at the SC level, ANM is maintaining Untied Fund & Annual Maintenance Grant expenditure register.
- MCTS registers is not updated on time & this is reflected in the MCTS portal also. The registration number at the MCTS portal for PW & children is quite good but the follow up is missing. Difference between HMIS & MCTS data regarding place of delivery and coverage of measles vaccine is indicative of the difference.
- Office copy of HMIS monthly Reporting Format has not been found at SC during field visit.

Training

- Orientation training of HMIS & MCTS to the Medical Officers is not done as reported by MO i/c during field visit. Therefore, few MO i/c of PHCs/ CHCs are not aware about HMIS format. Knowledge on HMIS & MCTS format is essential for MO i/c to monitor the different programmes. Display of performance indicator is missing in PHCs as well as SCs.
- Refresher Training on HMIS web portal in last one year has not done at Cluster/ PHC level which is of immediate need.

Tracking of mother and child

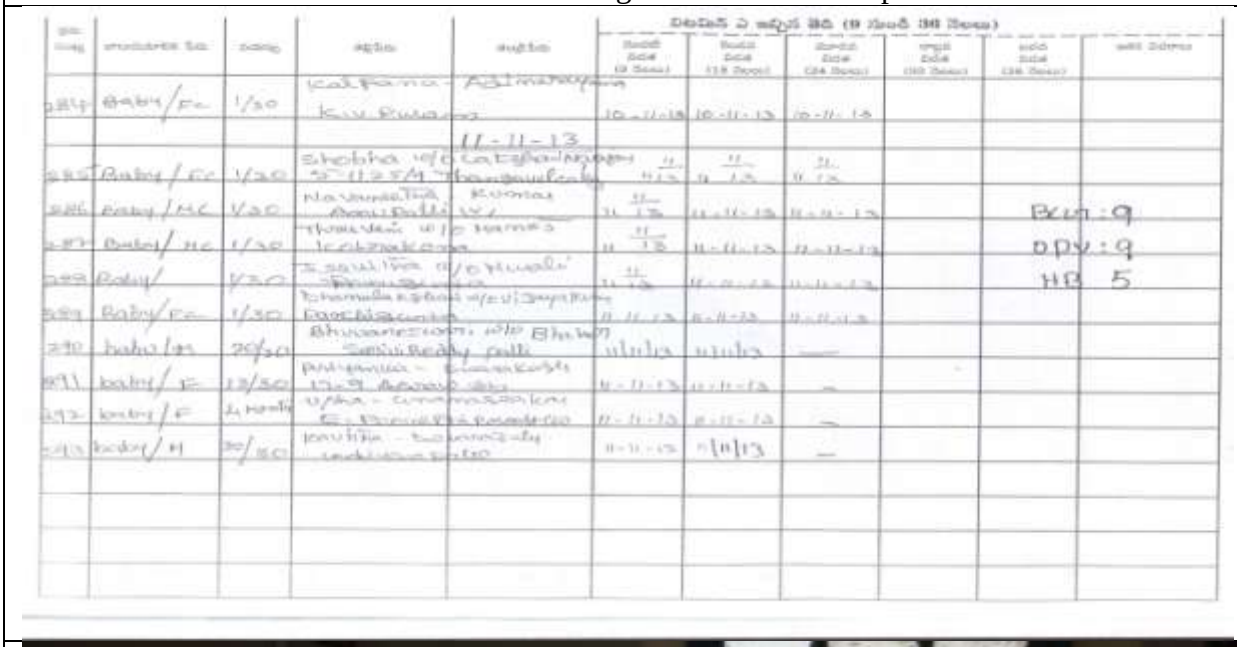
- The line listing of the high risk mothers and eligible couples is done through the MCTS. The skype based video conferencing method for follow-up of MCTS that is being implemented in Mahboobnagar should also be initiated in Chittoor district.
- Data uploading at MCTS portal is in place. The first level entry point in MCTS web portal by DEO is Community Health Nutrition Centre.
- Work plan for due services of pregnant mother & Children are generated at PHC level and the same is used by ANM at SC level.
- Services are provided to the beneficiaries but not updated in the MCTS portal.

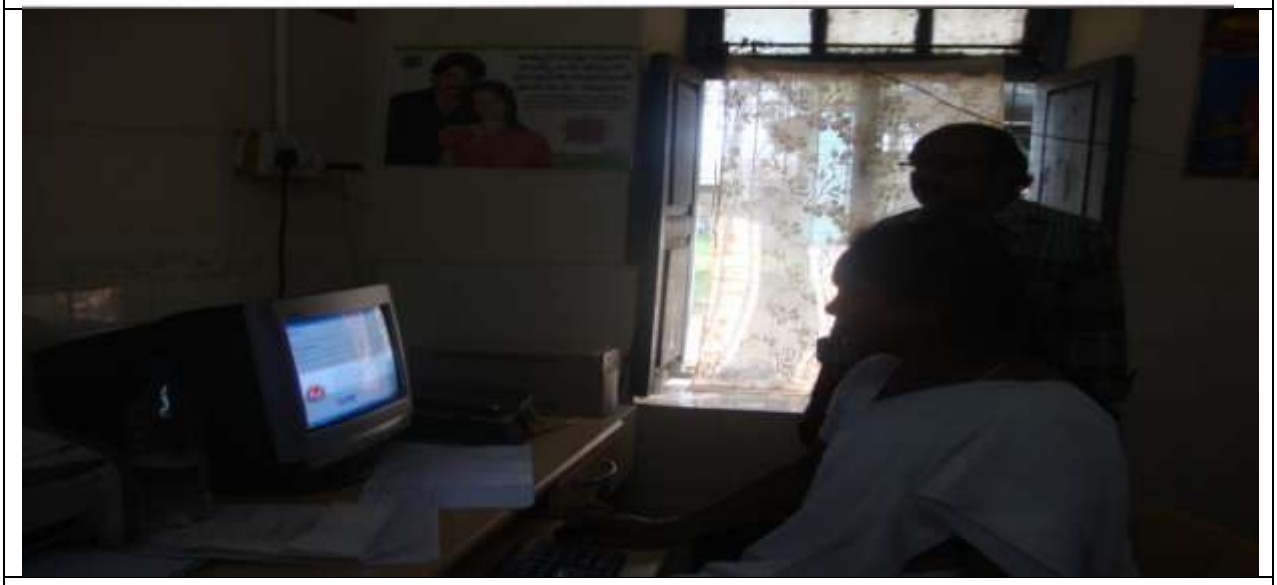
Table 14: Details of training conducted in last one year

S.No	Name of the training	Cadre of the trainees	Training Schedule	No.of Participants
1	"Review cum Training in HMIS"	SO(FW) & SO(UIP)	29th to 30th January 2013	About 50
2	"Review cum Training in HMIS"	SO(FW) & SO(UIP)	27th to 28th February 2013	About 50
3	"Training in HMIS & MCTS"	SO(FW),SO(UIP), DPO & MIS Asst	29th to 31st May 2013	About 50
4	Training on MCTS & HMIS	SPHOs & DMHOs	30th October to 12th November 2013	360-SPHOs & 23 DMHOs on different days

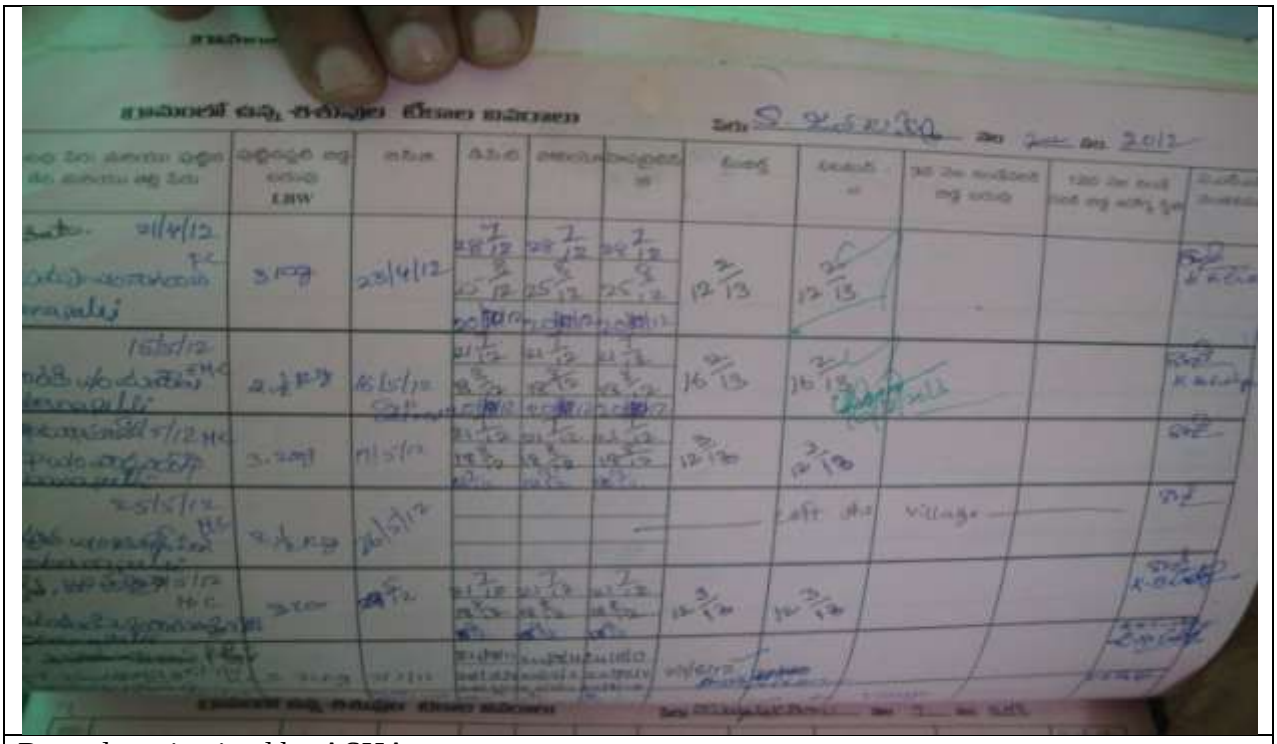
5	"Synchronization of Facility Masters in HMIS & MCTS"	SO(FW),SO(UIP), DPO & MIS Asst	Proposed training on 20th to 22nd November 2013	About 50

Immunization of children is recorded in PW register at District Hospital Chittoor





ANM entering Data at MCTS portal at PHC Chowdepalli



Records maintained by ASHA

Data Analysis

- HMIS data are used for State as well as District planning. It is observed that the most of the beneficiaries & patients access private facilities which are unreported; therefore it needs to be considered during PIP as well as District Action Plan preparation. e.g. More than 50% deliveries are conducted at Pvt facilities in Chittoor District and these mothers are not eligible for JSY benefit, needs to be considered for budgeting.
- Supportive Supervision regarding HMIS at facility level is missing.
- Analysis of HMIS data for programmatic monitoring at District Level / Cluster level is missing. Graphical presentation of any analysis is not observed at all levels especially in Chittoor District.
- In District Chitoor, Cluster level Programme Management Unit is not in place. Only DEO is in place at cluster level and is capable of Data uploading at HMIS portal but not to analyze the Cluster /PHC level data. However, in Mehboobnagar district it was available as envisaged.

Registration Status of Beneficiaries

- Total 35,52,199 pregnant women and 30,27,542 children have been registered in MCTS since inception.
- Total 14,82,079 pregnant women have been registered in MCTS for the year 2012-13.The rate of registration for the year 2012-13 is 88.47%.

- Total 7,33,613 pregnant women have been registered in MCTS for the year 2013-14.The rate of registration is 74.45% only on pro-rata basis. Total 1,266,656 children have been registered in MCTS for the year 2012-13. The rate of registration for the year 2012-13 is 83.18%.
- Total 535,049 children have been registered in MCTS for the year 2013-14. The rate of registration is 59.72% only on pro-rata basis.

Service Delivery Status

1. Pregnant Women

Total 1,26,044 pregnant women were registered in MCTS with LMP in **November,** 2012. Service delivery status of these pregnant women is as follows:

S. No.	Services	No. of Pregnant women received services	% of Pregnant women received services
1	ANC1	126,044	100.0%
2	ANC2	74,751	59.31%
3	ANC3	57,861	45.91%
4	ANC4	41,710	33.09%
5	All ANC's	37,898	30.07%
6	Deliveries Reported	45,082	35.77**%**

Pregnant women registered with LMP in **November,** 2012 should have received all ANC services by now. Also approximately 90% delivery should have been reported by now. 10% need to be considered for pregnancy wastage.

Although, the HMIS & MCTS data sets as well as portals are different, a comparison of the same indicator should be equal approximately. Difference between MCTS data and HMIS data has been observed. e.g. 3 ANC visits coverage is approximately 46% in MCTS data where as nearly 78% in HMIS data was noticed. Similarly reported delivery is approximately 80% as per HMIS whereas MCTS reflects approx 36% in 2012-13.

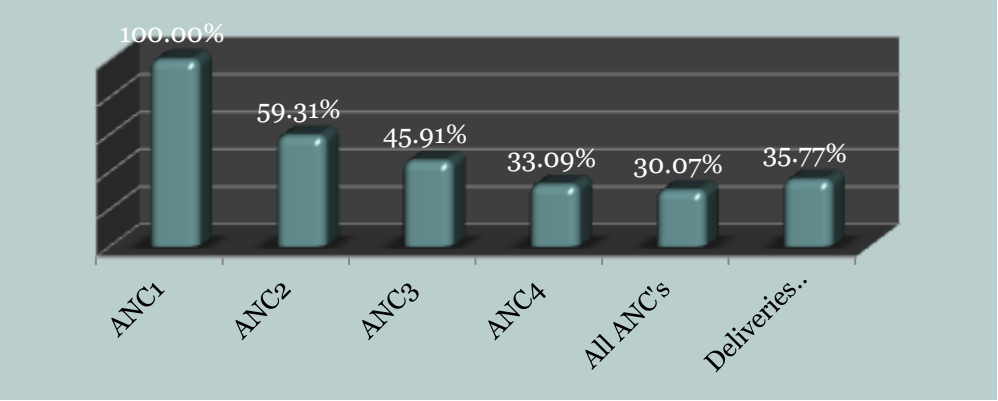


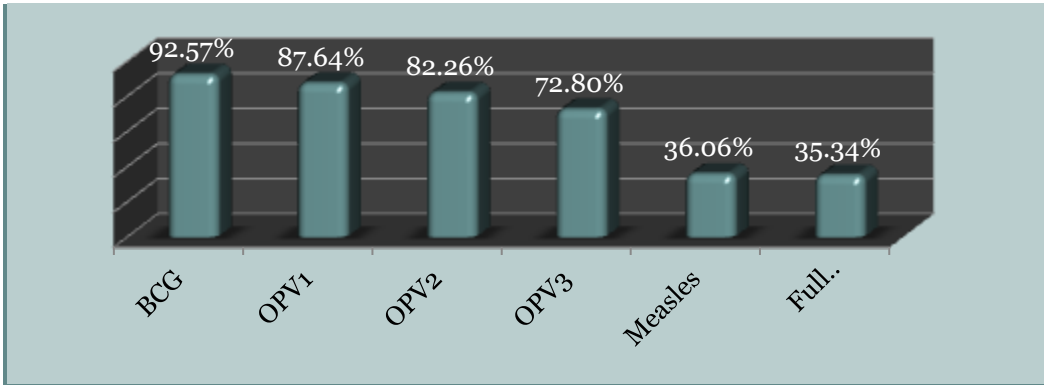
Fig : Services provided to the Pregnant Women with LMP in the month of **Nov.** 2012

2. Children

Total 110,326 live births were reported in **September,** 2012. Service delivery status of these children is as follows:

S. No.	Services	No. of Children received services	% of Children received services
1	BCG	102,129	92.57%
2	OPV0	88,165	79.91%
3	OPV1	96,692	87.64%
4	DPT1	97,343	88.23%
5	OPV2	90,751	82.26%
6	DPT2	91,249	82.71%
7	OPV3	80,320	72.8%
8	DPT3	80,732	73.18%
9	Measles	39,784	36.06%
10	Full Immunization	38,988	35.34%

Fig: Services provided to the Children with DoB in the month of **Nov.** 2012



Only approx 3% drop out from BCG to Measles has been observed in HMIS 2012-13 data.

TOR 7: Health Care Financing

Finance & Administration:

HR Position (Finance & Accounts Staff) – In the State of Andhra Pradesh one Chief Finance Officer (CFO) at State Health Society who is from State Finance Services. In addition, four Accounts Officers (two officers joined only in September, 2013 and prior to this only two Accounts Officers were posted since Feb, 2011) are also posted which are assisted by four contractual finance personnel from outsourced agency (HLFPPT). The posts of State Finance Manager (SFM) and State Accounts Manager (SAM) have not been created in the State. Whereas at the District level one District Accounts Manager and one Junior Accounts Assistant (both are contractual) and one Senior and Two Junior Assistant (both are regular) are posted.

With regards to the post of Accounts Assistant at PHC/ BPMU, out of total posts of 375 only 26 are filled and remaining 349 are lying vacant.

Thus, the financial management is at setback due to inadequate manpower at State and district level.

Utilization of Funds: In the State, low utilization was observed in the year 2012-13. Overall utilization in the year under RCH and Mission Flexi pool was 39.84% and 29.94% respectively. The percentage of utilization is less than 20% of the approved budget is observed (Annexure 2-Table 9-13) is as follows:

- The above table shows the underutilization of funds under the activities for current year. The state needs to take care.
- It was observed during visit that in both the district Untied and AMG funds for CHC, PHC and Sub-center have not been released till date of our visit due to heavy unspent balance.

Delegation of Financial & Administrative Powers

In December, 2006 a detailed guidelines for Financial & Administrative Powers were issued by Government of India and the same has been implemented**.**

Funds Flow

Release of Funds: In the state of Andhra Pradesh release of NRHM funds is made to different agencies for various activities mentioned below:

Purpose	**Agency**
Civil and Procurements	A.P. State Medical Services & Infrastructure Development Corporation Ltd. (APSMIDC)
JSSK & HDS (RKS)	Commissioner, A.P. Vaidya Vidhan Parishad (APVVP) in turn releases funds to CHC and District Hospitals only
Other activities of RCH & Mission (mainly Salary, JSY and ASHA component, as well as for JSSK & HDS/ RKS	District Health Societies (DHS) in turn release funds to PHCs

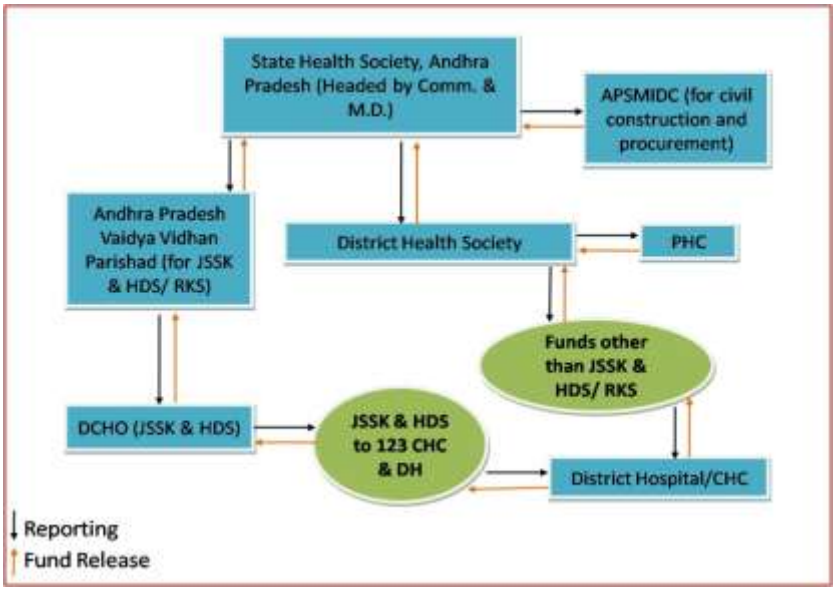
In the State of Andhra Pradesh, District Hospital and 123 CHC out of 282 CHC is monitored by Andhra Pradesh Vaidya Vidhan Parishad. Funds pertaining JSSK and HDS/ RKS for these units are transferred to APVVP who consequently transfer funds to DCHO and DCHO transfers funds to DH and CHC. Expenditure reports are also routed in same manner resulting in delayed reporting. Almost 40% of NRHM funds are given to APSMIDC and APVVP at the State Level.

As per the system followed in the State, for the release of funds to APSMIDC, note for release is made by the State Administrative Officer/ State Concerned Programme Officer and approval is obtained from the Commissioner (HFW). No concurrence is obtained of CFO and only the

Sanction Proceedings are given to CFO for the release of funds. Thus there is no control of CFO over the release of funds to APSMIDC. Similarly for release of funds to Commissioner, APVVP is done without the concurrence of CFO. CFO is entrusted with the release of funds for limited activities of RCH and Mission Flexible Pool. Thus, in the State, it is observed that there is multi-layer system for release of funds.

Similarly the reporting of expenditure is done i.e. for the funds released through Comm., APVVP CHCs and DH do not furnish the expenditure reports to DHS for compilation as the funds are not received through DHS, which makes delay and improper reporting of expenditure. In short one institution is receiving of funds from two different agencies i.e. from DHS and other from DCHO (who maintains funds received from Comm., APVVP). This scenario is displayed as under:

Funds Release & Reporting Mechanism



- **Reporting Mechanism of Expenditure:** District Health Society (DHS) is consolidating expenditure of CHC/PHC other than HDS and JSSK. For HDS and JSSK expenditure, CHC and District Hospital are reporting the expenditure to DCHO and they further report to APVVP. APPVP consolidates the expenditure for JSSK and HDS and report to State Health Society. Due to multilayer system, timely reporting of expenditure is not done.
- **Advances at State & District Level:** A substantial amount of advances were lying at State Level & District Level.

Accountability

- **Registration of State & District Health Society**: State & District Health Society is are not registered under section 12 A and also not filling Annual reports with the office of

Registrar of Societies since inception. Only one meeting of executive body of District Health Society has been held in Chittoor in the past one and a half year.

- **Deduction of Tax at Source (TDS)**: It was noticed that no TDS is being deducted at District Mahboobnagar. This may attract heavy penalty and interest.
- **Interest earned against NRHM funds**: At State level the bank interest has not been utilized but in District level the bank interest has been utilized under "MARPHU" programme which was not approved in PIP.
- **Auditing Procedures**: Statutory Audit for FY 2012-13 is in progress and the status of Concurrent Audit FY 2013-14, appointment of Auditors completed in all the Districts.

Finance Management

- **Group Bank Account**: The state has not implemented the guidelines issued by this Ministry vide letter G-27017/21/2010 -NRHM (F) dated 23.01.2012 regarding opening of Group Bank Account. According to the guidelines, the state needs to open a Group Bank Account in which there should be a main bank account and different sub accounts. The funds from Government of India (GOI) are to be transferred into this main account. The sub accounts for all other programmes should be linked with main bank account. Once the fund is received by the state in the main bank account, the same will be transferred to Subsidiary Sub Bank Accounts of the respective programmes. State of Andhra Pradesh has one bank account for receiving funds for programmes like RCH Flexible Pool, Mission Flexible Pool, Routine Immunization and PPI and separate bank account each for other National Disease Control Programmes. The state health society has bank account in ICICI Bank despite the instructions of GOI that it should be preferably in a Nationalised Bank.

Books of Accounts

Cash Book/ Bank Pass Book: It was observed that books of accounts are not properly maintained at District Hospital, CHC, and PHC level and not updated on regular basis. Bank pass book at PHC Bijnapally was updated up to March 2013 only.

Ledger: It is observed that such accounting ledger is not being prepared. In the absence of such ledger the correct state of affairs cannot be ascertained. SOE/FMR received from the Sub-district level is consolidated in Excel sheet and same is reported to SHS. Thus, there is no system of maintaining the books of accounts on Double Entry System.

Register for Advance & Fixed Assets: Advance Register is not being maintained at any level. Due to the non-maintenance of proper advance register the position of advances with various agencies/ units cannot be ascertained at any point of time. No register maintaining the record of fixed assets was found.

Bank Reconciliation Statement: Bank Reconciliation Statement is prepared at State level only and from District level on not monthly basis but at sub district level Bank Reconciliation statement is not being prepared as no account personnel are posted.

Supporting Bills & Vouchers: Supporting bills and vouchers are not available at the Finance & Accounts department. The bills are not properly verified by the competent authority. Vouchers kept in loose bundles.

Usage of Tally: Tally ERP 9 customized version has been implemented upto DHS level. But during the visit the license of Tally has been expired. Some mismatches of master heads also noticed from DHS.

Electronic Fund Transfer System: Electronic Fund Transfer System being implemented upto CHC level.

Unspent balance of EC SIP Programme: Unspent balance of Rs. 5.18 crore of EC SIP programme is lying with SHS. This amount needs to be refunded.

Cash Payments: Under JSSK programme, there is a provision to provide diet to the beneficiary. In PHC Balanagar, Rs. 56/- has been given to the beneficiary instead of providing the diet. In many other transactions payment is being made by cash. Cash is withdrawn and not disbursed immediately.

Meeting of HDS/ RKS: All RKS/ HDS registered in the State but the meetings are not organized regularly.

Physical Progress: Physical progress is not given by the State in the FMRs. The administrative approvals are issued to districts six months after the start of the financial year.

ANDHRA PRADESH VAIDHYA VIDHAN PARISHAD (APVVP): The following issues were observed during the visit:

- All advances given to units are treated as expenditures.
- It appears that salary of contractual consultant (Finance) is being paid without seeking approval since (approx) three years.
- It appears that approx Rs. 92,000 released to DH Karimnagar under the head of CEmOC centre which was not approved.
- Tracking of advances needs immediate attention as advances for more than one year are still outstanding.

TOR 8: Medicine & Technology

There is a robust central drug procurement system and infrastructure development in place. Andhra Pradesh State Medical Infrastructure Corporation Ltd. (APSMIDC) is set up to provide accommodation for staff of medical institutions, particularly in rural and semi-urban areas. Some observations during the visits are:

- The essential medicines list was not displayed at all facilities. Certain essential drugs are not available even at the central drug stores and needs urgent attention.
- Stacking at the drugs stores and pharmacies needs to be improved
- Restructuring the responsibilities of bio-medical engineers is quite essential to focus on high priority facilities.

- The District Drug Store showed availability of essential drugs list and good availability of drugs, inventory and stock management. The computerized monitoring of the drugs in stock, availability and expiry is being maintained at the district drug store for re-appropriation of drugs within facilities and district to minimize wastage. The drug warehouse in the district is well maintained but still has scope of improvement.
- Overall drug availability is good.
- Drug inventories are not computerised at facility level.
- E-Aushadi (for better and online management) is under proposal.
- Facilities are also getting 10% of their drugs budget for purchasing of medicines from outside in case of any shortage. Remaining budget lies with the APMIDC.

TOR 9: National Urban Health Mission

For addressing health needs of urban poor, UHCs have been established by the State Govt. The UHCs visited by the team were located within the slum to ensure easy access to the target population. The facility is catering on an average 15-20 thousand population and it is run by a Medical Officer with the help of Community Organiser, 2 ANMs and 3 Support Staff. The focus of work is on reproductive and child health. These facilities are well utilized by target population and are being monitored on monthly basis. Monthly performance of one of the

facility is as under:

ANDHRA PRADESH URBAN SLUMS HEALTH CARE PROJECT
Performance under Family Welfare Indicators in the UHC Jurisdiction

Name of the UHC : Urban Health Centre-I Population of UHC: 19,607
Name of Urban Area : Gandhinagar, Wanaparthy.
Name of the District : Mahaboobnagar
Month & Year of Report: October - 2013

Sl. No	Indicator	Monthly		Proportionate		% Achievement	Grade	Marks
		Target	Achievement	Target	Achievement			
1	No. of ANCs given TT1 (No. of ANCs Registered)	35	32	227	238	100%	A	10
2	No. of ANCs given TT2	35	32	227	238	100%	A	10
3	No. of ANCs given IFA Tablets	35	32	227	238	100%	A	10
4	No. of pregnant woman undergone HB test	35	32	227	238	100%	A	10
5	No. of pregnant woman undergone Urine test	35	32	227	238	100%	A	10
6	No. of ANCs given 4 check-ups	35	32	227	238	100%	A	10
7	No. of ANCs visited PHC/Hospital at least once	35	32	227	238	100%	A	10
8	No. of Institutional deliveries *	30	27	201	196	100%	A	20
9	Recording of maternal deaths	0.08	-	0.41	-	100%	A	10
10	Recording of live births	32	32	206	212	100%	A	10
11	No. of infants given full immunization *	30	21	190	202	100%	A	20
12	No. of infants given 1st dose of Vitamin - A	30	21	190	202	100%	A	10
13	Recording of infant deaths (below 1 year)	1.6	-	6.416	-	100%	A	10
14	No. of sterilizations *	12	07	93	51	100%	A	20
15	No. of IUD insertions	06	06	51	58	100%	A	10
16	No. of OP Users	76	76	258	262	100%	A	10
17	No. of Nirodh Users	142	142	492	506	100%	A	10

** Marked indicators to be given max 20 marks each;*
All other indicators to be given max 10 marks each; The report should reach by 5th of every month

TOTAL MARKS : 200
TOTAL MARKS OBTAINED : 200
100 % of MARKS :
GRADE : A

Community Organizer
URBAN HEALTH CENTRE
Gandhinagar, WANAPARTHY

Medical Officer:
MEDICAL OFFICER
Urban Health Centre-I
Gandhinagar, Wanaparthy

Regional Coordinating Officer
(o/o CFW Hyd.):

Note: HBs, Specialist officers should read carefully and ensure proper filling of columns. Any irregularity will be viewed seriously and Medical Officer alone is accountable for lapses.

The State PIP covering 116 ULBs with an outlay of Rs. 261.19 crores is awaiting approval and therefore, program is not yet rolled-out. The State will focus on 33 urban areas. The State proposed 3 program management units for 3 major cities. The proposition is 471 UPHCs; 2394 ANMs; 4929 ASHA's; 19733 Mahila Arogya Samithi's (MAS)

TOR 10: Governance and Management

Programme Management and Monitoring

Andhra Pradesh, unlike many states, did not have a Block/CHC level management structure, comprising of an M/O IC who was deemed to be responsible for the management of all health programmes in the PHCs and Sub Centres falling under the purview of the Block. However, two years back, the State, has taken a decision to establish a sub-district management structure, utilizing the services of staff who were drawing salaries from different heads/programmes that were dysfunctional. Through a process of identification of such surplus staff, about 400 members were identified. Thus, cadre of the Senior Pubic Health Officer (SPHO) who is in-charge of this sub-district management unit came into being at the Community Nutrition and Health Cluster (CHNC) with clearly laid down TOR. The other members of the team are Community Health Officer, Health Education Officer, Health Educator and Deputy Para Medical Officer (leprosy) responsible for monitoring at the sub-district level.

Interactions with the CHNC staff revealed that the unit is being under-utilized. The SPHO's undertake some programme monitoring, though not structured using checklists. Their role with regards to financial functions/oversight is abysmal. Most of the SPHO's who were met during the visits were oblivious of the funds received by the PHCs or the U/Cs to be submitted (which is a major issue in the State with large amounts of funds still outstanding to be cleared). Similarly, the three staff members responsible for IEC, are not provided funds for IEC activities nor are they engaged in the design and implementation of IEC activities at the PHCs (as no funds have been released for two financial years to PHCs). The IEC Officers were left to distribute IEC materials received from the state level. A valuable resource pool of officials is therefore under-utilized though well conceptualized.

SPMU and DPMUs and linkages with Programme Managers

The State does not have SPMU and DPMUs with dedicated staff. The Department is planning to hire contractual staff but the process has been delayed. The Chief Finance Officer and the Chief Administrative Officer, are very effective, but they don't seem to have the required HR support to undertake detailed analysis of FMRs or interact with the programme managers. The interface between the program and finance team could be improved to ensure that the funds received are optimally utilized with clarity on each line item.

Accountability

The state has not done much work on, either on seeking feedback internally or from external sources, feedback on the interventions that they have pursued over the years, in a systematic manner.

Coordination:

Co-ordination between departments of Medical Education, APVVP, and public health is poor. This is particularly visible at the district level for eg. department of public health is not aware of where the LSAS trained staff has been posted by the APVVP officials or how much staff posted in the hospitals is trained and many require further trainings. Coordination at the time of preparation of PIPs is also weak, significantly affecting the planning process.

Recommendations

Service Delivery

- Strict enforcement of the AP Clinical Establishment Act for the private sector with regulation in reporting the notifyable diseases such as TB, other communicable diseases and detection of HIV positive cases.
- Adequate display of the protocols of infection control and BMW need to be practiced in laboratories and health facilities.
- State should ensure equal focus on mass-media, mid-media and Interpersonal Communication for bringing about behaviour change.
- A set of appropriate IPC activities should be defined that are to be conducted at all levels and funds utilized optimally.
- State should adopt the scheme of 'Ensuring spacing at Birth', where ASHAs should be provided incentive of Rs. 500/- for counselling a couple and delaying the birth of their first child by 2 years and Rs. 500/- for maintaining spacing of 3 years between 1st and the 2nd child. Counselling by AHSAs will motivate eligible couples to adopt spacing methods and will help in improving the health of mother and child.

Reproductive and Child Health

- Client's comfort could be improved by inputs such as mattress on labour table, use of Kelley's pads, and pillows in the delivery wards.
- The client load across all YUVA clinics is low and requires extensive awareness creation activities
- Though unmet need of family planning is low, state needs to focus on promotion of spacing methods especially for PPIUCD and interval IUCD.
- Restructuring of Quality Assurance Committees as per the revised norms is recommended.

- Robust mop-up immunization plan needs to be in place to improve coverage and minimize seasonal drop outs
- Linkages of the community with the NRC need to be improved to ensure follow-up and reduce re-admission.
- Activate the grievance redressal system at all levels

Disease Control Program

- IDSP should generate alerts on other diseases along with diarrhoeal diseases.
- Outbreak monitoring systems can be strengthened further
- IDSP has to work on newly emerging and increasing diseases like scrub typhus, leptospirosis, Dengue and Chikungunya and generate timely alerts to prevent further outbreaks
- State and district surveillance officers/ epidemiologists need to be trained for better performance

Malaria

- Functional microscopes are to be placed in 20 labs in Chittoor
- Irrational use of Chloroquine needs to be discontinued else this will lead to drug resistance and side-effects
- Both active and passive surveillance should be done as per the NVBDCP guidelines
- Effective supervision for Indoor residual spray (IRS) is required
- Quality assurance of Malaria microscopy to be improved
- As per the treatment guidelines of Falciparum Malaria, state should use ACT as the first line of treatment
- Fever alert surveillance and collaboration with IDSP for Malaria is required.
- Knowledge of DMO needs to be augmented for effective monitoring.

Dengue and Chikungunya

- In view of the increasing number of cases and deaths in Dengue & Chikungunya a definite micro plan for calendar of activities for prevention and control of Dengue and Chikungunya has to be laid out.
- For control of Dengue important steps like regular Muliti-sectoral meetings both at state and district level involving all related deptts. and sectors (H&FW, PRI, RD, S&ME, Industries, SC&ST, Agriculture, Envt. & Forest), Corporate houses, Municipalities/Corporations &Urban local Bodies in all affected districts, Making Sub Collectors and BDOs nodal officer at Sub-divisional and block level respectively for intersectoral activities , training of Master trainers from each of the dengue-vulnerable districts, involvement of Dengue volunteers for conducting community level.
- Supervision by ANMs need to be strengthened
- IEC for source reduction is the most important for prevention of Dengue and Chikungunya and thus should be planned and implemented effectively

- Vector surveillance activities by zonal entomologist needs to be strengthened and proper plan for the entire district/ state need to be made and implemented to control the raising VBDs in Chittoor district
- Supervision of all vector borne diseases in the district is poor due to lack of a complete entomological set-up. The Zonal Entomological team catering to district Chittor needs to draw up a specific plan of action for effective vector surveillance and control.
- District Malaria officer (DMO) should be redesignated as District Vector Borne Diseases Control officer (DVBDCO). Knowledge of DMO needs to be augmented for effective monitoring.
- The vacant posts of 1 DD Entomology & 2 posts of AD Entomologists (at state level), 2 AMOs, 133 MPHWs,33 LT(NVBDCP) and 3 field workers and 6 posts of insect collectors in district Chittoor may be filled up for better functioning
- Reorientation training of ASHA and Health workers for vector surveillance and source reduction may be useful. Supply of diagnostic, drugs and Nets should be sustained.
- Simple source reduction for elimination of breeding sources of vectors can also be done within the activities of VHSC (GKS) also.
- Public reports/ media reports need to be thoroughly investigated and lab confirmed
- IEC for source reduction is the most important for prevention of Chikungunya and thus should be planned and implemented effectively

Lymphatic Filariasis

- Districts needs to organize the surgery of all hydrocele cases before elimination (2015)
- The district also needs to desirably introduce morbidity management for home based care of lymphodema cases as per programme guidelines.

Tuberculosis

- Involvement of Private/ NGO sectors can be explored for achieving universal access
- Smear Negative case detection can be improved with the utilization of available X-ray facilities at all levels
- A DMC level DRTB suspect line list to be placed and linking courier services at DMC level can be planned
- Sample collection for C&DST to be in place at DMC level
- Increase the number of beds in Chittoor DRTB centre
- DRTB Centre in Mahaboobnagar needs to be made functional at the earliest
- PITC implementation to be strengthened and monitored regularly in district level coordination meetings under the chairman ship of district collector
- Strict implementation and routine monitoring of ban of serological tests in the private sector has to be ensured through the district collector
- All anti TB drugs (among a total of 46 drugs) are now declared as Schedule – H1 drugs which are not to be dispensed without valid prescription and a separate register has to be maintained with regard to the patient and the doctor

- Frequent physical verification can be undertaken to avoid drug stock-outs
- A cafeteria of options like e-mails, SMS, toll free number, mis-call, call, IVRS, direct entry, post card, data collection in person can be explored to strengthen notification
- Ideally data entry in Nikshay is to be done in real time by the CHNC DEO/ health system staff who manages the HMIS or MCTS
- Identification of Paediatric TB needs to be strengthened from the private sector and utilizing the specialist services in public sector
- Periodic on site sensitizations of all medical officers on RNTCP to be undertaken by the SPHOs
- District collectors should ensure having full time DTO and filling all the vacancies and timely fund flow for smooth implementation of the program
- A transfer counselling of LTs at DMCs can be undertaken at the state level based on the eligibility of criteria per district for uniform provision of contractual LTs across the state so that all the districts will have required proportion of contractual LTs in their districts for effective utilization of LTs in critical/ strategic locations.
- IEC is an important area which needs to be strengthened for universal access and control of the disease

AIDS Control Program

- Convergence between AIDS Control Program and NRHM needs to be strengthened
- Updating knowledge on bio-safety mechanisms and PEP is to be ensured to all staff at all levels
- Regular state, district and sub-district level coordination meetings between TB & HIV program staff need to be ensured at regular intervals as per the guidelines.
- Refresher trainings on lab practices and revised national PPTCT guidelines to all staff are needed at regular intervals
- Uninterrupted supply of test kits to be ensured for PITC and at all FI-ICTCs in the state
- Intensive Case Finding (ICF) of TB among people attending ART centres needs to be strengthened.

NLEP

- In order to achieve elimination of Leprosy in the state, all health care providers & ASHAs should be trained on early detection of Leprosy cases.
- The suspect referral mechanism & case validation needs to be strengthened for early case detection and treatment.
- ASHA/AWW/MPHWs should be involved more extensively for the Intensive for Case Detection Drive (ICDD) at more frequent intervals.

NPCDCS

- Concentration on Cancer, Tobacco and Stroke etc. need to be increased
- Reassessment of high focus areas for Diabetes awareness has to be made

- Integration of TB Control Program and Tobacco Control Activities to be planned at all levels possible.

Governance and Management

- Optimal utilization of the SPHOs, SPMUs and DPMUs for strengthening the service delivery is essential.
- Structured monitoring visits using the supervisory checklists is essential.
- Ensure regular feedback to the units supervised for improvement.

Human Resources and Training

- Training component in the state PIPs should be developed in consultation with IIFHW
- Allocation of adequate budget for materials and conduct of each batch and timely release
- Timely supply & replacement of materials & equipments
- Strengthening of administrative hands, particularly accounts department and ease of procedures.
- Conduct performance needs assessment (PNA) to identify the performance gap
- Establish a monitoring and evaluation strategy
- Provide follow up support for learners and supervisors after training
- IIHFW may be strengthened with medical and management consultants as supported by NIHFW.
- Conduct evaluation of each training program - on-going & completed. Towards this, up to 5% of budget in every training program for evaluation, in addition to monitoring should be allotted.
- Besides, evaluation of training programs, evaluation of various health interventions under NRHM can also be entrusted to IIHFW faculty to assess the levels of process and outcome indicators of health.
- Monitoring and evaluation of trainings should go hand in hand by adopting continuous modifications in the managing the successful completion of trainings. A.P state has not initiated any such research studies in general to assess the impact of NRHM since last 2 years.
- The institute developed a comprehensive training assessment questionnaire along with the JD (Trg) covering five training programs (SBA, NSSK, IMNCI, IUCD/PPIUCD and ASHA (HBNC) conducted in the state. The training evaluation study requires funding from the NRHM in developing questionnaire, adopting proven methodology, field work, analysis and report preparation following a good statistical sampling design.
- It is required to sanction Rs. 20 lakhs annually to IIHFW for initiating the research studies. The Commissioner, NRHM Mission Director, Director, IIHFW may scrutinize the proposals and allocate the required budget accordingly.
- The IIHFW administration is currently following state administrative and financial procedures to spend budget for undertaking research projects. The IIHFW may also see the

procedures by the Administrative Staff College of India (ASCI) and Centre for Economic and Social Studies (CESS) as a reference and encourage the faculty to take up research studies/consultations to accomplish the tasks.

Community Processes and Convergence

- Use the State and District meetings to reiterate the role of CHNC and TORs of each functionary in the Cluster.
- Re-emphasize the role of CHNC vis-a-vis PHCs, so that any issues related to reporting/oversight could be addressed
- Through e-learning (internet or communication centres operated through the state), orient the SPHOs as well as the other staff of the CHNC, especially on financial management.
- Visualize the role for the IEC staff of the CHNC by making them responsible for finalizing the IEC plans that could be implemented in the PHCs and Sub centres. Observations have been made, in other sections of the report, for the critical need for IEC activities, at the community level to improve awareness on the services and benefits available through NRHM. Therefore a good IEC plan developed at the cluster level and implemented well at the PHCs/Sub Centres would go a long way in making IEC functional at the sub district levels.
- A well defined supervisory visit plan has to be defined, given the availability of one vehicle to the team.
- Conduct review meetings of CHNC units, in a detailed manner. This is feasible as there are only 6/7 Clusters in a district where as there would be about 40 odd PHCs in a district.
- A structured meeting schedule for the CHNC meetings has to be evolved, to place good emphasis on programme and financial management aspects.
- Putting in place a mechanism of seeking feedback from communities as has been followed in community monitoring processes evolved elsewhere.
- Strengthening the VHSNC mechanism so that regular meetings are held with panchanyat members at all levels upto the district. We understand that the panchayat has been established recently, after the elections.
- Though the FP Committees at the district level are functional the need is to have District Monitoring committees with active participation of the civil society.
- On the training front, though the pace picked up in the last year and half, there is the need to use institutions such as PSM department of medical colleges and IIHFW (which currently is the organizer and coordinator of trainings, only) should be engaged, with requisite budgets to undertake post training assessments. The CHNC mechanism should also be actively engaged to find out the clinical practices at the service delivery level. The trainings are necessary input for improved practices in service delivery which will lead to improved quality. E-mode of orientation of CHNC staff can also be attempted rather than expecting them to be trained in the class room to improve the quality of trainings.

Information and Knowledge

- Ensure uniformity in registers maintenance across all the facilities for simplifying the consolidation process. Towards this, registers printed centrally may be supplied
- Consistency between the HMIS and MCTS data to be ensured
- Use of Weekly performance Tally Sheet can reduce the burden of maintaining additional ANC & Immunization register.
- Data analysis and data use for program improvement at all levels is recommended.

Health Care Financing

- A meeting under the Principal Secretary / Chairpersonship of the MD NRHM be held, once approval is received of the ROPs and release of budgets form NRHM, New Delhi. Such a meeting should also be conducted once the consequent tranche of funds are received.
- The engagement of the Programme Managers on analysis of expenditures/outstandings is low, which should be rectified by holding monthly meeting between finance/administrative and Programme Managers.
- State should follow the guidelines as issued by GOI on having a Bank Account with a Nationalized Bank
- System for release of funds on a timely basis and ensure on-time reporting for accurate monitoring of funds is necessary.
- System of maintaining the Books of Accounts on Double Entry System and issue instructions for the maintenance of proper supporting bills & vouchers, registers for BRS, Fixed Assets and Advances should be available
- Appointment of regular staff at each level for efficient record keeping on funds
- Financial orientation of MOs, ANMs and finance personnel to be initiated immediately.
- Adherence to Income Tax rules and avoid Cash payments.
- Advance tracking system must be followed.
- SOEs/ FMRs to be checked at each level.
- Bills and Vouchers must be verified and signed by competent authority.
- Supporting bills and documents (e.g. quotations) are always to be retained with the Finance & Accounts Department.
- Cash/ Bank book, Bank Reconciliation Statements must be maintained regularly.
- Advances should not be treated as expenditures.

Medicine and Technology

- Display of essential drug list across all facilities
- Replacement of expired drugs and kits after following appropriate procedures of bio-medical waste
- Uninterrupted supply of essential drugs in the central drug stores and pharmacies of all facilities to be ensured to reduce out of pocket expenditure or last minute replenishment.

National Urban Health Mission

- Expedite the approval of state PIP for NUHM activities

Governance and Management

- State to expedite hiring of SPMU and DPMU staff and augment the currently existing units as per the needs.
- Use the State and District meetings to reiterate the role of SPHOs and TORs of each functionary in the cluster.
- Executive body meetings of District Health Society should be conducted regularly

Annexure 1: Data Uploading Status of District Level Hospital from April to September 2013-14

District	Sub District	Health Facility	Apr	May	Jun	Jul	Aug	Sep	Total
Adilabad	RIMS Adb	RIMS Adilabad (Medical College)	No	No	No	No	No	No	0
Anantapur	Anantapur	Anantapur	Yes	Yes	Yes	Yes	No	No	4
	Hindupur	Hindupur	Yes	Yes	Yes	Yes	No	No	4
Chittoor	Chittoor	Chittor	No	No	No	No	No	No	0
	Tirupathi	S.V.Medical College	No	No	No	No	No	No	0
Cuddapah	Proddatur	DH Proddutur	No	No	No	No	Yes	Yes	3
East Godavari	Kadiyam	DH Rajahmundry	Dist. Consolidated report is uploading						0
Guntur	Kollipara	Tenali	Yes	Yes	Yes	Yes	Yes	No	5
Hyderabad	Kingkoti	Kingkoti	Dist. Consolidated report is uploading						0
		Sultan Bazar							0
	Nampally	Niloufer							0
	Seethapalmandi	Gandhi							0
	Suraj Bhan	Nayapool							0
		Osmania Hospital							0
Karim Nagar	Karim Nagar	Karimnagar	No	No	No	No	No	No	0
Khammam	Khammam	DH Khammam	Dist. Consolidated report is uploading						0
Krishna	District HQ	Private Facility							0
	Guduru	DH Machilipatnam							0
Kurnool	NANDYAL	DH Nandyal	Yes	Yes	Yes	Yes	Yes	Yes	7
Mahbubnagar	Mahabubnagar	DH	Dist. Consolidated report is						0

		Mahabubnagar	uploading						
Medak	SADASHIVPET	DH Sangareddy							0
Nalgonda	Nalgonda	Nalgonda	Yes	Yes	Yes	Yes	Yes	Yes	7
Nellore	Venkatachalam	Nellore	No	No	No	No	No	No	0
Nizamabad	Dichpally	DH Nizamabad	No	No	No	No	Yes	Yes	2
Prakasam			No District level hospital						
Ranga Reddy	Tandur	Tandur	Yes	Yes	Yes	Yes	No	No	4
Srikakulam			No District level hospital						
Vishakapatnam	District Hospital Anakapalli	District Hospital Anakapalli	No	No	No	No	Yes	Yes	3
Vizianagaram	Nellimarla	Nellimarla	Yes	Yes	Yes	Yes	Yes	Yes	7
Warangal			No District level hospital						
West Godavari	Denduluru	DH Eluru	No	Yes	Yes	No	No	No	2
Total	**26**	**28**	**7**	**8**	**8**	**7**	**7**	**6**	**48**

Data Uploading Status Other facilities from April to September 2013-14:

Type of Facilities	As per State (Govt facilities only)	Total Facilities in the HMIS portal including Pvt.	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Total**	**% of data uploading / month**
SC	12522	12152	7452	7438	7357	7307	8224	7922	45700	62.7
PHC	1624	1871	1005	999	997	964	990	935	5890	52.5
CHC	309	332	130	129	124	113	128	119	743	37.3
Area Hospital	60	93	44	45	45	44	45	45	268	48.0

Annexure 2

Table 9: UTILIZATION STATUS UNDER RCH FLEXIBLE POOL 2012-13

Amount in Lakh

S.No	Activity	SPIP Approved	Utilization	% age Utilization of PIP
A.2	Child Health	6386.98	866.21	13.56%
A.3	Family Planning Services (other than sterilisation)	3626.76	39.89	1.10%
A.6	Tribal RCH	257.20	0.00	0.00%
A.11.	Vulnerable Groups	27.00	0.00	0.00%

Table 10: UTILIZATION STATUS UNDER MISSION FLEXIBLE POOL 2012-13

Amount in Lakh

S. No.	Activity	SPIP	Utilization	% Utilization
B5	New Constructions/ Renovation and Setting up	25315.31	4434.81	17.52%
B8	Panchayati Raj Initiative	36.00	0.00	0.00%
B10	IEC-BCC NRHM	1913.44	372.00	19.44%
B12	Referral Transport	1990.00	0.00	0.00%
B14	Innovations(if any)	168.80	0.00	0.00%
B15	Planning, Implementation and Monitoring	732.89	36.43	4.97%
B16	PROCUREMENT	9858.74	1943.90	19.72%
B18	New Initiatives/ Strategic Interventions (As per State health policy)	333.50	25.50	7.65%
B22	Support Services	331.11	0.00	0.00%
B23	Other Expenditures (Power Backup, Convergence etc.)	175.75	2.40	1.37%

Utilization Status (2013-14):

Overall utilization in current year 2013-14 till 30th September, 2013 under RCH and Mission Flexi pool is just1 23% and 7% respectively. A detail of some of the activities where percentage of utilization is less than 10% of the approved budget is as follows:

Table 11: Utilization Status under RCH Flexible Pool (2013-14):

Amount in Lakh

FMR Code	Activities	SPIP*	Utilization (Sept-2013)	% Utilization
A.2	Child Health (Other than JSSK)	4,657.21	463.33	9.95%
A.3	Family Planning Services	318.78	26.05	8.17%

A.6	Tribal RCH	172.20	16.16	9.38%
A.9	Training	3,983.43	0.00	0.00%
A.11.	Vulnerable Groups	175.68	0.00	0.00%
A 1.7 & A 2.10	Janani Shishu Suraksha Karyakram	10,235.20	66.66	0.65%

Table 12: Utilization Status under Mission Flexible Pool (2013-14):

Amount in Lakh

FMR Code	Activities	SPIP*	Utilization (Sept -2013)	% Utilization
B3	Annual Maintenance Grants	1,343.99	132.63	9.87%
B4	Hospital Strengthening	29,367.62	-	0.00%
B5	New Constructions/ Renovation and Setting up	10,458.61	163.50	1.56%
B8	Panchayati Raj Initiative	72	-	0.00%
B14	Innovations(if any)	438.8		0.00%
B15	Planning, Implementation and Monitoring	2,249.42	9.21	0.41%
B16	PROCUREMENT	14,955.60	0.65	0.00%
B18	New Initiatives/ Strategic Interventions (As per State health policy)	11.4		0.00%
B19	Health Insurance Scheme	36.9		0.00%
B22	Support Services	715.03	-	0.00%
B23	Other Expenditures (Power Backup, Convergence etc.)	235.85		0.00%

Table 13: Utilization of Annual Maintenance Grant and Untied Funds:

Amount in Lakh

Activity	2012-13			2013-14 (upto 2nd quarter)		
	SPIP	Expenditure	% of Utilization	SPIP	Expenditure	% of Utilization
Untied Funds	7719.71	3339.56	43.26%	4045.61	686.43	16.97%
Annual Maintenance Grant	1779.97	808.35	45.41%	1343.99	132.63	9.87%