Third

# Common Review Mission

State Report

# Andaman & Nicobar Islands

# Report of the 3RD Common Review Mission

# For

# The National Rural Health Mission

# THE Union Territory of Andaman & Nicobar Islands

## The Team and the Process

The members of the 3rd Common Review Mission (CRM) visited Andaman and Nicobar Island from 4th November to 10th November 2009 to review the status of implementation of the National Rural Health Mission. This was the first CRM in the UT. The objective of the CRM was to assess the progress of the Mission over the years, against the goals, objectives, outcomes, time lines and strategies in the Union Territory (UT).

**Members of the team were the following:**

**Team leader:** Dr Rajmohan Panda, Public Health Specialist (RCH), PHFI New Delhi

**Rapportteur:** Dr G P Kumar, AEA, Nirman Bhawan , New Delhi

**Team Members:**

1. Sh Dhirendra Kumar Procurement consultant ,World Bank, New Delhi
2. Dr P Sangzuala, MD (NRHM), Mizoram.
3. Sh. Talem Tapok, MD (NRHM), Arunachal Pradesh

The team members were briefed about the common review mission and the schedule of the mission at a meeting held by the Ministry of Health and Family Welfare New Delhi at Vigyan Bhavan on 3rd November 2009. The team proceeded to Port Blair the next day and reviewed the programme activities in the UT as per the following schedule:

**4th November 2008**: The team arrived in the UT headquarters Port Blair and in the evening was briefed of NRHM activities in the UT. The briefing was lead by the Mission Director Dr Sadasivan. The UT Program Manager Mr Mohammed Ismail gave an overview of the program through a presentation. Various senior programme officers were also present in the meeting. The review method included presentation by the UT team, probing by mission members and discussion with key functionaries. After discussion on various options and logistics the review mission members decided to visit the Districts of Car- Nicobar, Middle and South Andaman over the next few days to asses the health service delivery mechanisms and understand the contribution of NRHM to the overall health status of the UT. The team members split into two teams with each team going to one district each, team members also visited health facilities in the 3rd district. At the selected district headquarters, the team members were briefed on the progress made in the district, subsequently each team visited various health facilities in the districts as logistics would permit. The CRM members tried their best to cover both assessable as well as “hard to reach” health care facilities from sub centers to district hospital, however owing to poor connectivity bad weather and limited transport facilities (by sea route) the team had certain constraints. Besides review of health service delivery outlets, both teams

also interacted with village community members, ASHA (only in place in Car- Nicobar), AWWs, PRI members at various levels, Rogi Kalyan Samiti members and opinion leaders to get an idea about the incremental value that NRHM has contributed to the overall health system delivery of health care services.

The mission members reviewed the status of implementation of NRHM in the UT with an orientation towards the following mandate:

a. To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
b. To document evidence for validating the key paradigms of NRHM including decentralization process, infrastructure and HR augmentation, communitisation and others,
c. To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
d. To recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM

The specific themes focussed on were the 23 points spelt out in the TOR of the 3rd CRM for assessing change in key aspects of the health delivery system. In addition, the CRM Team also focussed on additional points like need based requirement, allocations against expenditure, Equipment procurement measures, AYUSH and Public Private Partnership (PPP).

Returning from the districts on the 9$^{th}$ of Nov, the entire team sat together and shared observations to identify the major issues emerging from the review visit. Intense discussions over one-and-a-half days led to drafting of observations and recommendations. A preliminary presentation was made for debriefing to the UT Health Secretary, Mission Director and various division heads on the afternoon of 10th November 2009. The report has been written as a consolidated one for the entire union territory with reference to specific examples in each of the 3 districts wherever required.

## Introduction of the union territory Andaman and Nicobar Islands

The Union Territory of Andaman and Nicobar Islands is known throughout the country as 'Kalapani' because of their having been a penal settlement under the British Rule. The islands lie in a long and narrow broken chain, approximately north-south sprawling like an arc. Andaman group of islands and

the Nicobar group of islands, have entirely different population and problems. The dreaded $10^{o}$ channel, which is about 145 km wide and 400 fathoms deep, separates the two groups.

This territory consists of two distinct groups of islands-Andaman and Nicobar. This territory comprises islands some of which are large such as North Andaman, Middle Andaman, South Andaman, Baratang, Little Andaman in the Andaman group and Car Nicobar. Situated in the Bay of Bengal, Andaman and Nicobar islands constitute one of the most important union territories. There are more than 3000 islands, islets and rocks in the archipelago while only about 300 of them are of appreciable size. Of these only 39 islands are inhabited. There are four Negrito tribes, viz., the Great Andamanese, Onge, Jarawa and Sentinalese in the Andaman group of islands and two Mongoloid Sentinalese are still hostile. The UT of Andaman & Nicobar Islands has an area of 8249 sq. km. and a population of 0.36 million. There are 3 districts, 7 blocks and 547 villages. The UT has population density of 43 per sq. km (as against the national average of 312). The decadal growth rate of the UT is 26.90% (against 21.54% for the country) and the population of the UT continues to grow at a much faster rate than the national rate. The inhabited islands are mainly accessible by sea or by air (limited). Such limited connectivity is a big constraint on the smooth functioning of the health delivery system.

**Table II: Health Infrastructure of Andaman & Nicobar Islands**

| **Particulars** | **Required** | **In Position** | **Shortfall** |
|---|---|---|---|
| Sub-centre | 51 | 114 | - |
| Primary Health Centre | 8 | 19 | - |
| Community Health Centre | 2 | 4 | - |
| Multipurpose worker (Female)/ANM at Sub Centres & PHCs | 133 | 272 | - |
| Health Worker (Male) MPW(M) at Sub Centres | 114 | 22 | 92 |
| Health Assistant (Female)/LHV at PHCs | 19 | 19 | 0 |
| Health Assistant (Male) at PHCs | 19 | 0 | 19 |
| Doctor at PHCs | 19 | 73 | - |
| Obstetricians & Gynaecologists at CHCs | 4 | 4 | 0 |
| Physicians at CHCs | 4 | 4 | 0 |
| Paediatricians at CHCs | 4 | 0 | 4 |
| Total specialists at CHCs | 16 | 10 | 6 |
| Radiographers | 4 | 4 | 0 |

| | | | |
|---|---|---|---|
| Pharmacist | 23 | 31 | - |
| Laboratory Technicians | 23 | 27 | - |
| Nurse/Midwife | 47 | 118 | - |

(Source: RHS Bulletin, March 2008, M/O Health & F.W., GOI)

## Health Institution in the UT is detailed as below:

| **Health Institution** | **Number** |
|---|---|
| Medical College | The UT has engaged the services of HSCC India limited to prepare a detailed implementation plan to set up a medical college with 100 seats at Port Blair in PPP mode |
| District Hospitals | 3 |
| Referral Hospitals | 1 ( G.B. Pant hospital , Port Blair |
| Urban Dispensaries | 6 |
| Ayurvedic Hospitals | 1 Port Bair ( 30 bedded) |
| Ayurvedic Dispensaries | 5 |
| Unani Hospitals | 1 |
| Homeopathic Hospitals | 1 |
| Homeopathic Dispensary | 15 |

Before the launch of NRHM in 2005 the UT already had existing health delivery mechanism in place. The launch of NRHM has strengthened the management systems and helped in significant improvements in both infrastructure up gradation as well as related health service delivery. NRHM funds have been used for filling up various vacancies in the health system since the last two years and this has contributed in good quality of health care delivery.

**Major Health Indicators of the UT**

1. **Birth Rate (SRS 2008) - 16.9 (Per 1000 population)**
2. **Death Rate (SRS 2008) - 4.8 (Per 1000 population)**
3. **IMR (SRS 2008) - 31(per 1000 births)**
4. **MMR –(as per state calculations,2008) - 130 (per 1 lakh live births)**

The UT health department is reporting IMR (15.03) and MMR (130.74) based on calculations which have taken in account both facilities based births and deaths as well as community reporting by ASHAs and ANM. This data however has not been validated or published in any Govt of India reports. Malaria and Tuberculosis continues to be a major public health problem in the UT.

The UT has a well established PRI system who is participating in the NRHM activities. The head of the village the captain is a joint signatory in the VHSC committee as well as the funds allotted under the sub centres

| Names of Districts visited: | | | | |
|---|---|---|---|---|
| Sl.no | Name | District HQ | Name of Deputy Commissioner | Name of MS |
| 1 | Nicobar | Car- Nicobar | T. Sreekant | Dr Halder |
| 2 | Middle and North Andaman | Mayabunder | Ashish More | Dr.S.K Paul |
| 3 | South Andaman | Port Blair | S.N Jha | Dr. M.K Saha |
| Health Facilities visited: | | | | |
| S. No. | Name | Address / Location | Level (SC / PHC / CHC/other) | Name of the Person in Charge |
| District Nicobar: | | | | |
| 1 | BJR District Hospital | Car Nicobar | DH | Dr Halder |
| 2 | Malacca | Village Malacca | SC | Ms Prema Lakra |
| 3 | Kakana | Village Kakana | SC | Ms Shiela |
| 4 | Nancowry | Village Nancowry | SC | Ms Prabhapravati |
| District Middle Andaman | | | | |
| 1 | Dr. R.P Hospital | Mayabunder | DH | Dr. S.K Paul |
| 3 | CHC Rangat | Rangat | CHC | Dr. Prasad |
| 4 | PHC Kadamtala | Kadamtala | PHC | Dr. A.K Das |
| 7 | PHC Baratang | Baratang | PHC | Dr. Arun Pal Singh |
| 8 | SC Oralkatcha | Village Oralkatcha | SC | Mrs Karuna Danga |
| 9 | SC Nimbutala | Village Nimbutala | SC | Mrs Durga Mani |

| | | | | |
|---|---|---|---|---|
| | | | | Mandal |
| 10 | SC Webi | Village Webi | SC | Mrs Snehalata |
| District South Andaman: | | | | |
| 1 | G.B.Pant Hospital | Port Blair | DH (Referral hospital) | Dr.M.K Saha |
| 2 | Ayush Hospital | Port Blair | DH ( Ayush ) | Dr.Sabita Biswas |
| 3 | PHC Garacharma | Garacharma | PHC | Dr Mahato |
| 4 | PHC Havelock | Havelock | PHC | Dr.Ashok |
| 5 | SC Carbyne's | Carbyne's | SC | Mrs Mungeshwari |
| 6 | SC Krishnanagar | Village Krishnanagar | SC | Mrs Jagatara Joydhar |
| 7 | Aanganwadi Center | Bathubasti | AWC | |

**Total no of Institutions Visited: ANDAMAN & NICOBAR ISLANDS**

| Institutions | Number |
|---|---|
| DH | 3 +1 ( Ayush ) |
| CHC | 1 |
| PHC | 5 |
| SC | 8 |
| Village | 3 |
| AWC | 1 |

# Observations of the 3rd CRM Team

# Part 1

# Change in Key Aspects of the Health Delivery System

## 1. Infrastructure Up-gradation

NRHM funds have been appropriately used for the up gradation/new construction and mantainence of health facilities at different levels in the UT. In some cases charitable organizations such as Bharatiya Jain Sanghatan and other international NGOS have made significant contributions to infrastructure construction as well as up gradation. This has helped in achieving progress towards the NRHM goals of good infrastructure in health facilities. Some of the funds earmarked (released during the current year) for infrastructure maintenance however has still not been utilized fully. The new constructions are conveniently located, of good quality and are user friendly. Sub centres are able to cater to the population (Sub centres are catering to around 1000-1500 population in some cases).The up gradation initiative has been based on the facility survey undertaken prior to taking up the work. Further extensions of new indoor wards in some of the PHCs are being done with NRHM funds. PWD is the agency entrusted with the development of the infrastructure. One new building for AYUSH hospital has been constructed (from UT funds), which has facilities for Yoga (Panchkarma), OPD, free medicine supply and 30 indoor beds. There are 10 AYUSH dispensaries in the UT which are catering to the health needs of the local population. There is shortage of water in most of the health facilities. Water is supplied for about one to two hours on alternate days even in Port Blair (UT Headquarter). The shortfall is made up by getting Water Tankers from Municipal Corporation and storing water in tanks in the hospital. The UT has a good referral transport services available for patients, attendants and providers. Emergency cases are also provided free transport by air and sea routes. Residential accommodations for providers are available and in some district hospitals both temporary accommodations as well as permanent accommodation for attendants (dormitories) are being constructed. NRHM funds have contributed to purchase and use of equipments available in the facilities and overall good quality of maintenance of infrastructure. The team found reasonably good mantainence of infrastructure and equipments in most health facilities visited. However there remains considerable scope for improvement in the mantainence of specialized equipment (Many of the new born warmers and other specialised new born care equipment even in referral hospital G.B Pant were non functional)through AMCs or even long term in-house arrangements through the establishment of biomedical unit in the health department. Uninterrupted supply of electricity and that of clean drinking water is a major constraint through out the islands. Health department is trying to do rain water harvesting wherever possible.

## 2. Human Resources Planning

- **Availability of Human Resources & Gap analysis**

NRHM funds have been effectively used for hiring various categories of human resources and filling vacancies at various levels. eg Doctors, Specialists, Nurses, ANMs, paramedics, etc. NRHM funds have also been utilized for hiring of support staff like ambulance drivers, ward staff, cleaning staff etc. There is an urgent need for the health department to hire NRHM consultants at both headquarters as well as the districts to strengthen the smooth management and functioning of the health system. The provision for incentivization of doctors and Para- medical staff recruited under NRHM and working in difficult areas is a thoughtful gesture and has helped in retaining the staff.

- **Pre-service Training capacity**

The UT has engaged the services of HSCC India limited to prepare a detailed implementation plan to set up a medical college with 100 seats at Port Blair in PPP mode, land has already been allotted for the medical college and survey is in progress. The UT has an ANM training school and a MPW (Male) training school at Port Blair each having a capacity of 30 candidates per year each, these candidates are readily absorbed in the health department. The capacity of both schools needs to be expanded. There is no separate institute in the health department on the lines of State Institute of Health and Family welfare for providing in-service training as well as for technical inputs for public health programs. There is also no dedicated pool of master trainers as well as a strategic training plan in place. The UT has neither a BCC consultant nor a BCC strategy in place.

- **Recruitment and cadre management**

The gap between "needed" and "available" has been reduced in most places. Health facilities are well staffed, however the UT is hiving difficulty in the recruitment of specialist to serve in "hard to reach areas". Multi skilling of Para-medical staff such as SBA have been initiated but not updated.

- **Plan for Augmentation of Health Human Resources**

The health department short-term measures of hiring doctors, specialist and paramedical has enhanced the health care delivery mechanism. The department however needs to put a strategy and a long-term plan for sustaining this effort through the establishment of a HR cell. HR cell should take care of recruitment and career progression. At present this is being managed by the Directorate of health services.

- **Skill quality of Health Human Resources**

Regular technical supervision and monitoring are being undertaken by senior staff; however these are not well documented well and analysed to take corrective measures if required. Refresher trainings in

disease specific areas are being undertaken. There are no measures in place for the multi-skilling of doctors in Emergency obstetric care (EmoC) and Life saving anaesthetic skills (LSAS). IMNCI training have been conducted in some places.

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

The OPD case load in PHCs is generally about 2500 patients per month and in CHCs it is about 5000 per month. The District Hospital at Mayabunder has a case load of about 3000 patients per month. The rate of institutional deliveries in the PHCs visited was reported to be 4 to 6 per month. This rate in CHC Rangat was reported to be about 20 per month. The number of cases being handled at various health facilities is relatively less as per population norms. However considering the difficult terrain and inaccessibility of many places in the UT such increased numbers of health facilities services are warranted. Institutional deliveries are very high in the UT (The UT is reporting around 86 % of institutional deliveries). Sub centres are providing good quality of Ante- and post- natal care, Vitamin A prophylaxis, immunization, Iron and Folic Acid (IFA) and counselling on maternal nutrition and a host of family planning services including IUD insertions. Safe abortion services, RTI/STI, spacing methods, male and female sterilization, new born care, and IMNCI are some of the RCH services provided at the PHCs. Some of the district hospitals are undergoing renovations and new operation theatres (OTs) have been constructed and this has contributed to increase in the number of surgeries being conducted.

### 4. Preparedness of facilities for patient care services

The UT is making provisions for increasing the number of beds at various levels as well as the availability of appropriate human resources. Facilities are well stocked with medicines, drug and investigations kits. Infrastructure is rapidly coming up in several places although delays have taken place. The UT has only one functional First Referral Units (FRUs) and 17 24x7 Primary Health centres out of a total of 19 PHCs. Although the UT has made good use of untied fund, maintenance grants and RKS grants and user fees to improve preparedness and functionality of health facilities in some places, there remains considerable scope for full utilization of these resources for improving the quality of service delivery. NRHM funds have been used for installing water filters and general improvement of waiting areas, OPDs, wards, toilets. Funds have also been used to create temporary shelters for attendants to stay and cook etc. Referral systems are in place and free transportation is provided to the patient. It is important to note that in such difficult terrain this is a great relief for most patients. Seven ambulances have been procured from NRHM funds and are being deputed to facilities across the UT. Ambulances drivers have also been hired from NRHM funds

## 5. Outreach activities of Sub-centre

**CRM Team Members reviewing records in a Sub Centre in Nicobar District**

Sub-centres are being effectively utilized for outreach activities especially MCH and Family planning. ANMs are working in close coordination with AWWs and ASHAs (at present only in Car Nicobar). Village Health and Nutrition Days are effectively planned for immunization coverage. Limited IEC/BCC activities are in evidence in the sub centers as well as in the VHNDs (in the form of IPC). The larger issue of community mobilization for IEC/BCC remains an area of concern. The availability of second ANM in many areas has contributed to the improvement in IEC activities as well as overall good record keeping. Mobile Medical Units are of limited use in the inaccessible areas so the DHS has prioritized the procurement and use of fully equipped Ambulances in the UT. Seven Ambulances have been procured from NRHM funds and are currently being deployed to health facilities. New born care Ambulances supplied by UNICEF are being used effectively for the transfer of sick new born's to referral units

## 6. Utilisation of untied fund

There have been efforts to improve amenities in all the facilities visited such as lighting, wiring, water supply, flooring, providing curtains patient waiting halls, toilets etc with untied funds. Since most of the sub-centres in Nicobar region have been constructed after the 2004 Tsunami and are relatively new, the need for utilisation of untied fund for major construction activities has been limited. Also annual maintenance grant of Rs. 10,000 sanctioned to sub-centres in Nicobar District has been unutilized as maintenance needs are few in the newly constructed facilities. The PIP for 2009-10 has a lot of provisions for use of these untied funds for further strengthening and utilization of untied fund.

## 7. Thrust on difficult areas and vulnerable social groups

Special provisions have been made for rendering health services for Tribal, vulnerable and underserved groups and improving access for these groups. One such example is the reservation of beds especially for minority (aboriginal groups) and free health care delivery for these populations. Keeping in mind the difficult terrain the UT has successfully been able to recruit specialist as well as doctors from the mainland by offering them a good pay package as well as other incentives such as free housing and schooling for their children. Health Mela called Swasthya Jagruti Maah are being organized in various districts to provide services in all disease control programmes and RCH.

## 8. Quality of services provided

Although there is evidence of good Sanitation and Hygiene and most facilities are clean, fencing of hospital premises and bio medical waste management still remains areas of neglect. There is evidence to suggest that quality of care for institutional delivery and other RCH services are in place. The health system is trying to ensure 48 hours stay after delivery, however local customs limit such efforts. The health system has not undertaken any accreditation and quality improvement processes. Maternal death audits are being conducted and recorded but there is still considerable scope for improvement in the process. There are clean toilets with running water available in the women friendly labor rooms. Most facilities have no display of information or entitlements for either ASHAs or even JSY benefeciaries.

## 9. Diagnostics

The health facilities are adequately stocked with diagnostic kits right down to the sub centre where the ANM is doing haemogram and blood smears for malaria. All sort of tests starting from routine blood and urine microscopy to Xray and ecg are being done in the PHCs. All diagnostics tests are provided free of cost to all segments of the population.

## 10. Logistics & Supply chain management

The UT of A&N has a fairly good system of supply chain management for drugs and medicines. The main procurement agencies for drugs and medicines for the UT of A&N are the Government Medical Supply Depots (GMSD) at Kolkata and Chennai. They procure and supply the bulk requirement of drugs and medicines on the basis of annual indents placed on them by the UT. The medicines received from GMSDs are stored in the Central Medical Store in G. B. Pant Hospital and supplied to PHCs and CHCs quarterly on the basis of their requirement. In addition, a Rate Contract valid for one year is also finalized on the basis of open tender issued by DHS. The requirement of shortage items is procured through this rate contract as and when required. The quality control is ensured by stipulating the condition of GMP Certificate and Manufacturer's Test Certificate. The requirements of urgently required items not available against the rate contract as well as urgent requirements of simple medical

equipment are procured through limited tenders issued to local medical dealers. The availability of medicines and record keeping was found to be quite good in all the facilities visited. However, it was noticed during the field visits that most of the facilities need more space for storage of medicines, as the medicine boxes were found to have been kept in packed condition in non-storage areas (e.g. office area and verandhas etc.). CRM team noticed that the supply of medicines from GMSD Kolkata have been unduly delayed this year as no supplies have been received till November 09 although the same are usually received by July/August. This is due to outstanding payments and the Assistant Director General (MS) of GMSD Kolkata has advised that the indents for 2009-10 can only be entertained if outstanding dues are cleared. The Government of A&N is trying to sort out this problem as delay in supply from GMSD may result in shortages. Although, the above system has been working quite satisfactorily for several years, it may be worthwhile to investigate the possibility of establishing own GMSD of A&N.

**Stacking and improper storage of medicines in a health facility in Middle Andaman district**

### 11. Decentralized Planning

Integrated District Health Action Plans are planned with inputs from sub centres onwards, however community mobilization and involvement in the form of village health action plans are missing. The planning is more of Top down approach rather than decentralization. District Health Mission and RKS meetings are taking place with participation of key functionaries, such as panchayat functionaries and some civil society groups.

### 12. Decentralised Local health action

Village health & sanitation committee have been constituted, however it is not clear as to extent of their involvement in health and sanitation Rogi Kalyan Samiti and other untied funds are being

utilized at various levels of the system in a variety of ways for the benefits of the patient such as ensuring sanitation and Hygiene in the health facilities, provision of water filters, benches for the waiting area etcetera. The involvement of Panchayati Raj Institutions in the functioning of health system is very limited.

## 13. Community Processes under NRHM

There is no community monitoring initiative in place. Some degree of community involvement is being done by engaging Village captains (heads) in NRHM activities, however community level planning and the process of community ownership has not been strengthened. Overall community mobilization and village level health plans need a lot of strengthening. Citizen charter is present in some health facilities, however social audits of services and entitlements needs strengthening.

## 14. ASHA

ASHAs are only in place in one district (Car Nicobar). Selection processes through community based facilitatation by NGO/Civil Society representatives has been completed in the other districts and are awaiting placements. The ASHAs in place have been trained in all modules from I to V which was imparted through cascading ToT model and there is adequate provisions of drug kits to ASHAs There is no ASHA mentoring group established, informal mentoring is taking place by ANM and AWW. ASHAs are helping ANM and AWW in all outreach activities including RCH. They have good knowledge on maternal and child health issues and are using it effectively in Inter personal communication (IPCs) at the community level. There is a backlog of payments to ASHA in Nicobar district in Car Nicobar district.

## 15. National Disease Control Programmes

### 15.1 Overall Effectiveness of NDCPs

The programme is integrated within the overall NRHM framework and the UT and District level set up for the programme has been integrated into the UT & District Health Society. Training, IEC, M& E for the programme as a constituent of NRHM have been limited and are currently being strengthened. There are various posts under NDCPs that have not been filled yet at the district level and this is affecting the performance of various programs for example because of paucity of ophthalmologist/ophthalmic assistants only 200 out of a target of 1200 cataract operations could be performed in the year 2008-2009.

### 15.2 NVBDCP

Vector control measures are in place, Fogging and spraying activities are being routinely carried out. Impregnated bed nets are used in health facilities. Biological control through Gambusia fish are in place in certain areas.

### 15.3 RNTCP

There are vacancies of contractual staff like Senior Treatment Supervisors, Senior TB Lab Supervisors since last year. Lab technicians at PHC are conducting quality diagnostic sputum some of the smear microscopy activities at the Designated Microscopy Centres have been hampered because some of the microscopes have not been repaired

### 15.4 NLEP

The UT has achieved the level of elimination: i.e.: PR<1/ 10000 well before target date. The level of elimination has been sustained and as on Dec 2008 is around 0.46. The elimination efforts particularly good IEC services are important for sustaining elimination as there is a lot of migrant population coming from West Bengal, Orissa Bihar and Jharkhand.

### 15.5 NBCP

There is no independent fully functional Eye Operation Theatres in the UT. Paucity of eye surgeons in the rural areas is hampering cataract and other eye operations. Cataract and other Eye operations are rendered free of cost.

### 15.5 NIDDSCP

The NIDDCP is running in the state with financial constraints, although the NIDDCP project under SPIP has been approved through ROP the funds have not been released to the State Health Society in 2009-2010. Last year the funds were released through treasury route in spite of repeated request to release the same through the State Health Society.

### 15.6 IDSP

IDSP is not functioning well in the UT because of various reasons, one of them being the un-availability of trained manpower at different levels of health facilities. Data collection on P, S and L forms has not been put in place. Lab facilities are not in place for validating and confirming L forms. Some training in IDSP of medical officers has been imparted and the health department has recently hired an IDSP Manager at Port Blair.

Health units have been mobilized as part of routine disaster management exercise. There should be efforts to strengthen and use surveillance information collected through IDSP for effective management of disease control during disasters.

## 16. RCH II

## (Maternal Health, Child Health and Family Planning Activities)

Good quality RCH services are being provided by SC, PHCs, CHCs and District Hospitals. ASHAs (in Car Nicobar) are creating demand for services in the community as well as making timely referral

to the facility for MH, CH and FP services This has promoted institutional delivery. Community is aware of range of RCH services offered by the health department and is making good use of it. Labor rooms and residential quarters are being constructed in sub centers with NRHM funds. JSY payments have been timely in most places and this has also increased institutional delivery. Sick New born Care Unit (SNCU) is functioning well in the G.B. Pant referral hospital, however there is the issue of repairing several new born care equipment which currently are lying unutilized in the hospital. The issue of non functioning specialized equipment especially new born care equipment was also found in facilities in other districts visited. There is one functional First Referral Unit (FRU) in the UT in referral hospital in Port Blair and the health department has not been able to reach it target of operationalization of 4 FRUs through- out the UT as planned in the PIP. The major road block is the recruitment of specialist especially for serving in the isolated and inaccessible islands. The State department has also not rolled out the multi skilling of medical officers in Emergency Obstetric Care (EmoC) to fill in the manpower and skill gap required. The issues of operationalization of FRUs in the other districts should be given high priority as the population living in these districts do not have easy access at all times to the single functional FRU in Port Blair. Nutritional services and counseling with micro-nutrient supplementation (Vitamin A & IFA) are being provided at Sub centers and Anganwadi centers.

**Sick new born care unit (SNCU), G.B. Pant Referral Hospital, Port Blair**

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

There is some degree of the involvement of Panchayats/ civil society with the health planning but community mobilization and monitoring through Village Health and Sanitation Committees have not

been fully explored. There is very little emphasis on engaging the community in preventive and promotion health care services. There has been negligible emphasis on the use of IEC/ BCC messages in the form of wall paintings/ folk theatre/ hoardings etcetera in the community. There is good convergence of health dept with Women and Child welfare (WCD) department in the efforts at reducing malnutrition. Greater inter sectoral convergence has to be taken up with other departments like PWD, electricity and water and sanitation.

### 18. Nutrition

IPC through Aanganwadi worker as well as ASHAs on early & exclusive breast feeding, proper weaning practises and the introduction of early age food items are taking place in the community. IEC material on nutrition and BCC strategies need review. The roll out of comprehensive BCC strategies in nutrition and greater coordination of the health department with WCD for the treatment of severely acute malnourished children needs attention.

### 19. Non-governmental partnerships

The health department is exploring partnerships with various non –governmental organizations. At present they have entered into a partnership with the NGO Prayas for school health program as well as for orienting VHSC. The health department has appointed consultancy firm HSSC for setting up a medical college in PPP mode. The UT is keen on exploring further collaborations with various established NGOs in the health care sector for various areas like training, service delivery, security etcetera and has started the process of dialogue with them

### 20. Overall Programme management

There is a programme management system in place at UT and district level. Decentralized planning for operationalization facilities and up-gradation of facilities for improving service delivery is in place at the district level. Program Management Unit NRHM is burdened with work and this leaves them less time for critical analysis and reflection for program planning and quality improvement. Programme management teams below district level suffer from lack of appropriate mentoring primarily because of the heavy workload on senior staff

### 21. Financial management

The UT Health Mission is transferring the funds to all the districts by e-transfer. The release of funds to the sub-district levels up to the level of Sub-centres and VHSC is also through E-transfer, wherever the services of nationalised banking services are available. In all other cases, where co-operative banking services are available, the transfer of funds is through telegraphic transfer (TT). In the Nicobar District, fund transfer is through TT in respect of 3- PHCs (Katchal, Campbell Bay,

Teressa) and 14 –Sub Centres, 32 –VHSC. All the health centres and hospitals visited by the team, have received the RKS grants / annual maintenance grants / Untied Funds as per their eligibility. In all the Health facilities visited, the financial records were well maintained. There is good integration of FM processes with disease control programmes

All the contractual staff are receiving their payments on due dates. The JSY payments to the beneficiaries' pregnant women are made through cash. However, some delay is noticed in payment to JSY beneficiaries' in Nicobar District. Surprisingly, in one of the Sub-centres (Krishna Nagar- South Andaman District.) no BPL family has been reported and hence, no JSY beneficiary.

Due to in-accessibility of areas, procedural delays are taking place and delays in finalization of accounts were noticed. The post of Manager (Finance) at UT headquarters is vacant for which recruitment is in progress. The accounts for the year 2007-08 were audited by the auditors appointed by the UT Health Mission and the audit remarks were communicated to the districts. The districts are to yet to furnish the replies for the auditor's remarks. Accounts for 2008-09 are still to be audited.

### 22. Data Management

HMIS data is being collected effectively from sub center onwards. Data is entered at the District level directly. The entry at block level is not possible this is because of the constraints of difficult terrain and communication as well as the unavailability of trained personnel. Data validation is thus a major issue. There have no major initiatives at the UT for the convergence of HMIS with IDSP.

### 23. Status of the progress of UT against Specific objectives and expected Outcomes at Community level under NRHM

There have been significant improvements under NRHM public health services, with greater decentralization and responsiveness as well as strengthening basic management structures, infrastructure and human resources is concerned. The progress of the ASHA initiative is impressive and effective although limited at present to only one district. X no of ASHAs have already been selected, trained and expected to be deployed in the other districts very soon. There is good convergence of the health system with ICDS and VHNDs are being conducted regularly. Sub-centers in the districts visited have 2$^{nd}$ ANM in place and are well equipped to render quality health services at the grass roots level. The provision of second ANM has considerably improved out reach facilities. There have been delays in the up- gradation of existing physical infrastructure primarily because of logistical problems in some inaccessible areas in the UT. The cost of construction is high in these inaccessible areas. Patients are able access good health services in the existing health facilities free of cost. Referral services are in place and are provided free of cost for all patients. RCH and disease control programs have been strengthened with NRHM funds and management. Community level

engagement and PRI involvement in health planning needs further strengthening. Systematic planning and execution of BCC activities and public health training are not getting the required priority. The health department should give priority attention to these areas and get technical assistance to build in-house capacities. IMR has decreased from 34 to 31 as per SRS 2006-2008; the UT is reporting IMR of 15 (based on its facility and community based data). Immunization services have got good coverage and cold chain facilities are maintained in all facilities visited.

The JSY benefits in the UT have increased the number of institutional deliveries. Integrated RCH outreach camps are organized in inaccessible areas. There is a good demand for modern contraceptives including emergency contraception and IUD insertions are being routinely done in Sub centres. The operationalization of FRUs continues to be an area of concern and the health department should take urgent measures to operationalize other district hospitals as FRUs. AYUSH hospital at Port Blair and 10 AYUSH dispensaries have been mainstreamed under NRHM to provide holistic health care to the community. Comprehensive eye care facilities are not available in most places because of the non availability of ophthalmic surgeons and equipment. The DOTS program of RNTCP is functioning well; there is good case detection as well as around 90%cure rate. Elimination of leprosy has been achieved and is being sustained. The UT has made attempts to improve outreach services to medically under-served remote areas through the setting up of tele medicine centres (which are expected to be functional very soon). Focus on preventive health services including nutrition should be given high priority. The UT has the potential of building a strong and robust health system with NRHM support and serve as a good role model for the rest of the country.

## Key Recommendations:

- There is a need for strategic and visionary HR cell to be established in the Health system and need for formulating policy with a focus on identifying and filling human resource gaps in a timely manner. Provisions for establishing centres for public health training should be given high priority. Mechanisms for strengthening in service training should be a part of the HR policy. NRHM should help in creating and nurturing a public health cadre for professional management of public health sector

- Policy level actions for exploring multi-skilling of contractual doctors and paramedics ( eg: Consider the multi skilling of existing contractual general duty medical officers)

- Communitization needs to be strengthened, greater involvement of community for local health planning facilitated by VHSC involvement

- IEC/ BCC activities should be strengthened at all levels especially at the grass roots level

- Enhanced monitoring and support to districts by UT NRHM staff to improve their performance & proper budget utilization
- Validation, analysis and utilization of HMIS data for effective planning and implementation, community monitoring process to be initiated and strengthened to understand and address local needs
- Provision of separate Infectious disease ward/ beds in all health facilities
- Trained ASHAs to be in place in all districts. Prioritize the setting up of ASHA mentoring group, back logs of payments to be disbursed immediately.
- PMU/ DPMU needs strengthening, filling up existing vacancies, skill building of staff by exposure visits and short term trainings in other states
- Create Health Systems Management support network similar to NHSRC/SHRC of other states.
- Prioritize the setting up of a biomedical waste management system in the UT.
- FRU operationalization in district hospitals and CHCs to be taken up on a urgent basis
- Operationalization of Tele medicine facilities should be expedited.
- Accreditation and certification process of health facilities for ensuring quality of services to be started.

# Part 2

## Progress against the approved PIP 2008-09

The PIP 2009-10 of Union Territory (UT) of Andaman Nicobar Islands was focused mainly on two dimensions, the first one is strengthening the Human Resource situation of the public health system through improving availability of doctors, nurses, paramedics etc. and the second on overall Infra structure development.

### Strengthening Human Resources and Facilities

There has been a pro-active effort to strengthen human resources and facilities as had been planned in the PIP. Contractual recruitment at all levels such as Specialist, ANMs, Public Health Nurses, Paramedics, Accountants, and Data Entry Operators etc have already been done. Trainings for specialized skills are underway. However, the recruitment of Gynaecologist, Ophthalmologists from the mainland is proving difficult due to shortage of specialists. Training pre-service and in-service as well as capacity building activities in public health has not picked up in the UT. Vacancies in NRHM staff at the UT headquarters as well as the districts are hindering the smooth functioning of supportive activities of the mission. These vacancies needs to be prioritized and filled up as early as possible for the smooth functioning of the mission as well as to expedite necessary support to the various public health programs currently underway in the UT. The existing staff also needs to be updated and trained in certain specific areas of public health management like data analysis, program management etcetera. Multi skilling of doctors in EmoC, LSAS and paramedics in SBA has not taken place as planned in the work plan and needs careful thought and execution. This has to be prioritized as specialists are not available even though significant efforts to recruit has been tried them have taken place by DHS. This is all the more important as the UT has been able to operationalize only one First Referral Unit (FRU) thus meeting 25% of target for 2009-2010. Multiskilling will go a long way in the provision of skilled manpower in the UT. The UT has begun the process of engaging private hospitals for special services at the headquarters, however in order to reach out to inaccessible areas the health department needs to explore PPP model. Some PPP models have been explored for school health programs and for orientation of village health sanitation committees. This needs to be expanded into service delivery areas. As of now, 49 ASHAs are in position in Nicobar District only; they have been trained in all five modules and are engaged in the community for public health program. Selection process has also been completed in the other two districts and a total of 191 ASHAs will be inducted soon.

**Infrastructure Development**

Up gradation of infrastructure of facilities such as Sub-centers, PHC/CHC/DH maintenance works is being undertaken. Construction work is behind schedule because of logistics and transport constraints. RKS committees at several places are involved in the planning of these up-gradations. Tele medicine centers have been installed in many PHC/ CHCs in inaccessible areas and are expected to be functional soon. The UT's programme of making the Sub-centers 24X7 functional as planned in the PIP is possible only when the 2nd ANM is in position in all sub centers ( Second ANM is in place in several sub centers and these are functional 24x7). In many places this has been made possible with NRHM funds. Many PHCs are not 24X7 functional due to manpower constraints, also because up gradation works is slow due to problems in construction. Public health nurses deployed under NRHM fund are helping out in many of the public health activities including MCH as well as disease control programs. Skill development of the staff of PHCs needs a lot of strengthening in particular relation to public health programs. In the absence of availability of doctors at PHCs as per the IPHS norms, 24X7 functional PHCs as planned in the PIP appears to be an ambitious goal.

The District Hospital at Nicobar has got all facilities except the availability specialists to declare it as a functional FRU. There is an urgent need to post specialists especially Gynecologist and make it a functional FRU as the patients have to be air lifted to Port Blair in case of emergency. The SNCU at G.B. Pant referral hospital is functioning well, some additional construction and the provision of a dormitory for patient family has been done. The SNCU is understaffed and many of the new born care equipment are not functioning properly.

Given the constraints and the difficulty in accessibility of some parts of the islands, referral transport seems to be functioning well and is provided free of cost. Recently, the UT Govt. purchased 7 Ambulances with facilities for deployment at various PHCs. The plan to engage NGOs in running some of these Ambulances is not yet in place but efforts have been started.

Sub- centers are well equipped and labor rooms and residential facilities have been built through out the UTs. They have good supply on medicines/basic diagnostic kits and are using it effectively. Many of Sub-centers in Nicobar District as well as the district referral hospital at Port Blair in have facilities conforming to IPHS standards; the UT administration should take steps to start the process of certification and accreditation by respective bodies.

Drug and diagnostic kits are in place at all level of health facilities, diagnosis and medicines are provided free of cost to all patients.

**Progress in RCH and Disease Control Programmes**

Normal deliveries are not conducted at sub-centers but NRHM activities have contributed to significant increase in Institutional deliveries in PHC, CHC and DH in the UT. Female sterilization and temporary spacing methods are well accepted in the community. Immunization of children is well documented in the Sub centers. Adolescent Reproductive Sexual Health (ARSH) activity is not in place. School health programmes with the collaboration of NGOs have been initiated in the UT.

The UT is implementing all national disease control programs and a designated program officer is positioned in Directorate of Health services. Based on the current burden of disease, three of these programs remain high priority for the UT and these include TB, Malaria and Blindness Control. Though latest statistics are not available, available data suggest that the cure rate TB is 84% and planned to achieve 90% during 2009-10. This is verified by our field visits. ASHAs are identifying TB pateinets and helping with the DOTS program. Elimination of leprosy had been achieved in the UT. The level of elimination has been sustained and as on Dec 2008 is around 0.46

Due to shortage of ophthalmic surgeons, only 20% of the, the targets fixed for cataract operations have been achieved in 2009-10. There is also no independent ophthalmic OT in the UT. Outbreak of malaria has not been reported in the UT during the recent past. Various preventive measures are being carried out including the use of biological control (Gambusia Fish). As per the available statistics one death occurred in 2006 due to malaria.

IDSP needs to be strengthened and convergence needs to be done with HMIS as well as disaster control activities in the state.

Communitization needs considerable attention, VHSC has been formulated across the UT. However they need to be engaged sufficiently in order to reap dividends of community level ownership. VHND are in place because is good convergence of ANM and AWWs. Untied funds for VHSC remain unutilized in many places. BCC/ IEC activities have not been planned systematically (there is no BCC consultant in place) and there needs a greater engagement of communities so that they can take part in the ownership and help in the formulation of village health plan.

**Mainstreaming of AYUSH under NRHM**

AYUSH personnel have been hired and deployed to the PHCs. AYUSH drug kits are available at all facilities. The 30 bedded AYUSH district hospital is providing a range of outdoor as well as indoor facilities for patients.