HEALTH, MEDICAL AND FAMILY WELFARE DEPARTMENT

3.2 Primary Healthcare in rural areas

Highlights

Primary Healthcare to the rural people is provided through the network of Sub-centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs). Primary healthcare in rural areas was not adequate in the State. Only 22 per cent of the doctors were in place to serve 73 per cent of the population in rural areas. There was huge shortage of medical officers, paramedical staff and health workers. Specialist services were not provided in the Round the clock PHCs. Performance of the Mobile Medical Units was very poor. National Filaria Control Prgramme was altogether neglected in rural areas. The incidence of malaria in tribal areas continued to be very high. Infant mortality rate was very high.

- **There were savings of Rs 60.41 crore (12 per cent) under 'Family Welfare' during 1999-2004.**

[Paragraph 3.2.5]

- **There were only 48 CHCs (nine per cent) against 554 required in the State. Shortfall in number of PHCs was 26 per cent. Position was worst in Anantapur, Karimnagar and Khammam Districts.**

[Paragraph 3.2.6]

- **PHCs were located in dilapidated buildings, without sufficient accommodation and basic amenities.**

[Paragraph 3.2.8]

- **There were no Mobile Medical Units (MMUs) in four districts. MMUs in Anantapur, Khammam and Prakasam districts were not functioning for want of vehicles.**

[Paragraph 3.2.10]

- **Only 22 per cent of the doctors were in place in rural areas with 73 per cent of the total population, leading to wide disparity between urban and rural areas. There was a large number of vacancies in the posts of medical officers and paramedical staff.**

[Paragraphs 3.2.12 and 3.2.13]

- **Against 25000 health workers required, only 32 per cent (8050 workers) were provided in the Sub-centres at village level. All the 1954 additional Sub-centres created in March 2003 were functioning without Male Health workers.**

[Paragraph 3.2.16]

- **Mother and child care services were not provided in the Round the clock PHCs as the specialists were unwilling to serve in PHCs.**

[Paragraph 3.2.18]

- **National Filaria Control Programme was altogether neglected in rural areas. The incidence of malaria also continued to be very high in tribal areas.**

[Paragraphs 3.2.19 and 3.2.20]

- **Infant Mortality Rate (IMR) was alarmingly high at 71 per thousand live births as against the target of 45 in rural areas.**

[Paragraph 3.2.21]

- **Inspection of CHCs and PHCs was not at all conducted by the District Medical and Health Officers. Monitoring was poor both at DMHO level and Director level.**

[Paragraphs 3.2.23 and 3.2.24]

3.2.1 Introduction

Objective

The objective of 'Primary Healthcare' is to provide the basic health services to the doorsteps of rural people through the network of Sub-centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs).

The major components of primary healthcare are (i) Health Education to the community, (ii) Maternal and Child Health and Family planning, (iii) Curative services, (iv) Maintenance of demographic statistics, (v) Prevention and control of local epidemics, and (vi) Implementation of National Health programmes. Several National Health programmes sponsored by GOI and World Bank under AP Economic Restructuring Project (APERP) are under implementation in the State.

3.2.2 Organisational set up

The Director of Health (DOH) is the Head of Department and is assisted by five Additional Directors. The Commissioner of Family Welfare (CFW) is responsible for implementation of all family welfare programmes in the State. There is a District Medical and Health Officer (DMHO) in each district, Additional DMHO in each division and Medical Officers (MOs) at PHC level. There are programme officers at district level for implementation of national health programmes. There were 48 CHCs, 1386 PHCs, 12522 Sub-centres, 45 Mobile Medical Units (MMUs) in the State to cater to the medical care of the rural population. The AP Health, Medical Housing and Infrastructure Development Corporation (APHMHIDC) is the nodal agency for purchase and supply of medicines and equipment as well as for construction and maintenance of buildings.

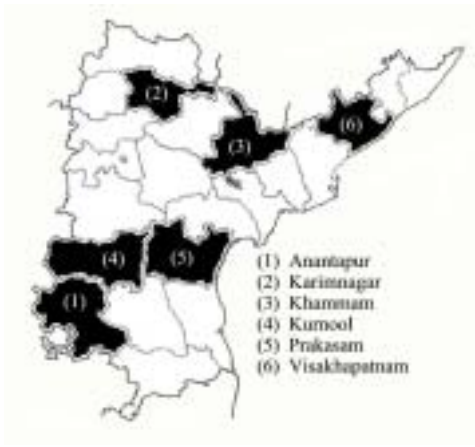
3.2.3 Audit objectives

Audit objectives were to assess the effectiveness of the primary healthcare being provided to the rural people by examining

- Adequacy of medical institutions
- Infrastructural facilities such as buildings, equipment and manpower
- Implementation of National and State Health schemes
- System of supply of medicines to the health centres

3.2.4 Audit coverage

Provision of primary healthcare in rural areas was reviewed (February-May 2004) by test-check of records for the period 1999-2004 in the offices of the DOH, CFW, six (out of 22[17]) selected DMHOs including 50 PHCs and other records relating to the implementation of various national programmes. The review covered 27 per cent of the rural population (5.54 crore) in the State. The results of the review are mentioned in the succeeding paragraphs. The views of Government could not be taken into account as no response was received from Government on the draft review forwarded in August 2004.



3.2.5 Budget and expenditure

Huge savings under 'Family Welfare'

Budget vis-a-vis expenditure towards provision of primary healthcare services during 1999-2004 were as follows:

(Rupees in crore)

Year	Budget	Expenditure	Excess (+)/ Saving (-)
1999-2000	217.11	216.43	(-)0.68
2000-01	254.07	247.91	(-)6.16
2001-02	247.48	242.90	(-)4.58
2002-03	278.49	286.08	(+)7.59
2003-04	379.48	350.30	(-)29.18
Total	**1376.63***	**1343.62$**	**(-)33.01**

* Medical and Health : Rs 867.72 crore; Family Welfare : Rs 508.91 crore (includes CSS : Rs 434.49 crore, APERP (Health component) : Rs 201.51 crore)

$ Medical and Health : Rs 895.12 crore; Family Welfare : Rs 448.50 crore (includes CSS : Rs 374.07 crore, APERP : Rs 177.03 crore)

There was saving of Rs 60.41 crore (12 per cent) under 'Family welfare'. The CFW stated (November 2004) that the savings were due to non-receipt of proposals from DMHOs and non-filling up of

[17] i.e., excluding Hyderabad

vacant posts of Health Workers in the Sub-centres. Reasons for the excess expenditure in 2002-03 were, however, not stated.

Adequacy of medical institutions (CHCs, PHCs, SCs)

Community Health Centre is a 30-bedded hospital which functions round the clock. The Primary Health Centre provides basic health services in rural areas. It is the initial point of contact for patients with a doctor. It also provides curative services and managerial support for the family welfare programme. Sub-centres are located at the village level.

3.2.6 Huge shortages in number of CHCs and PHCs

Huge shortage in the number of CHCs (91 per cent) and PHCs (26 per cent)

The number of medical institutions required as per norms fixed by GOI and the number actually functioning in the State as of March 2004 are given below:

Institution	Norms (Population to be served by one)		Number	
	In general area	In difficult terrain	Required	Existed
CHCs	100000	100000	554	48
PHCs	30000	20000	1876	1386
SCs	5000	3000	11316	12522

During 1999-2004, only one CHC and 86 PHCs were set up in the State. There was a huge shortage in the number of CHCs (91 per cent) and PHCs (26 per cent) in the State. The position in the six sample districts was as follows:

District	Population (in lakh)	CHCs		PHCs		SCs	
		Required	Existed	Required	Existed	Required	Existed
Anantapur	27.21	27	1	91	68	544	609
Karimnagar	28.13	28	2	94	63	563	580
Khammam	20.68	21	2	79	53	493	591
Kurnool	27.12	27	4	90	71	542	576
Prakasam	25.92	26	3	86	72	518	555
Visakhapatnam	23.01	23	4	85	61	526	573

Of the six sample districts, the position was alarming in Anantapur, with only one CHC (four per cent) functioning against the 27 required. There were only two CHCs each in Karimnagar (seven per cent) and Khammam (10 per cent) as against the requirement of 28 and 21 respectively. The shortages of PHCs was very high in Karimnagar (33 per cent), Khammam (33 per cent), and Visakhapatnam (28 per cent). Shortages in CHCs and PHCs adversely affected the primary healthcare service to the rural people.

Infrastructural facilities

3.2.7 Non-establishment of new PHCs

102 (out of 188) PHCs sanctioned during 2001-04 not established

There was no time frame fixed to set up a PHC after approval by the Government. Although Government accorded sanction for establishment of 188 new PHCs during 1999-2004, Audit observed that only 86 PHCs were set up as of March 2004. The remaining 102 PHCs were not established as Government's sanction for staff, equipment and other infrastructure facilities was awaited as of October 2004. Thus there was lack of follow-up action after Government approval to set up new PHCs.

Buildings

3.2.8 PHCs working in dilapidated buildings

PHCs functioning in dilapidated buildings, and without basic facilities

Scrutiny of records of 50 PHCs in the sample districts revealed that 11 PHCs[18] were functioning in dilapidated buildings; repair works were in progress in respect of six PHCs. Nine[19] PHCs were functioning in buildings without adequate accommodation and without basic facilities like labour room, laboratory and store room.

Scrutiny also revealed that six new buildings for PHCs in three sample districts remained un-occupied, abandoned or underutilised as follows:

Place and District	Expenditure incurred (Rupees in lakh)	Intended utility of the building	Present status of the building/Remarks
Pamudurthi (Anantapur)	8.00	As new PHC building	The construction of the building remained incomplete even after 10 years (taken up in January 1994). Electrical wiring, sanitary fittings and water supply were yet to be provided.
Tangutur (Kurnool)	20.51	As new PHC building	Though the building was completed/handed over in December 1999/October 2000 it was not put to use (March 2004). Reasons for non-occupation were not stated by the DMHO.
Revanoor (Kurnool)	12.58	As new PHC building	Civil works were completed in September 1999 but the building was not taken over for want of amenities for which funds were not made available. In the meantime, as the building developed cracks and the flooring sank, the building was abandoned.
Alur (Kurnool)	10.00	As pediatric ward in CHC, Alur	Not put to use though taken over in 2001, for want of required furniture and staff.
Parchur, (Prakasam)	70.15	As upgraded PHC	Not functioning in upgraded status though taken over in December 2002, for want of equipment and staff (March 2004)
S. N. Padu, (Prakasam)	49.23	As upgraded PHC	The building was taken over in July 2003. However, it was not functioning in upgraded status for want of equipment and staff (March 2004).
Total	**170.47**		

[18] PHC Pamudurthi (Anantapur); Gundi, Kataram, Kothapally, Mutharam, Raikbal, Thotapally (Karimnagar); Revanur (Kurnool); Santamaguluru, Ethamukkala (Prakasam); K.J. Puram (Visakhapatnam)

[19] PHC Bathalapally (Anantapur); Chigurumamidi, Odela, Raghavapuram, Vemulawada (Karimnagar), Wyra (Khammam); Tangutur (Kurnool); Cheemakurthy (Prakasam); R. Thallavalasa (Visakhapatnam)

The construction of the building for the PHC, Ada (Adilabad District) was stopped at basement level and was abandoned after incurring an expenditure of Rs 5 lakh as it was getting submerged due to Ada Irrigation Project.

PHC at Tangutur (Kurnool District)

Rs 1.75 crore incurred on seven PHC buildings remained unfruitful

Thus, the improved buildings as envisaged were denied to the rural population. Besides, the entire expenditure of Rs 1.75 crore incurred on construction of the above seven PHC buildings remained unfruitful, for about four years.

3.2.9 Staff quarters kept vacant

Occupancy rate was very low at 40 to 77 per cent

The Minimum Needs Programme envisages construction of buildings for PHCs, CHCs and staff quarters. The medical/ paramedical staff of the PHCs are to be provided with staff quarters near the PHCs, so that their services would be available to the patients round the clock. The status of availability of staff quarters and their occupancy in the sample districts is given in *Appendix 3.2 (A)*. It was seen that a large number of PHCs (including Round the Clock PHCs and CHCs) were not provided with staff quarters. Even where staff quarters were available, the occupation rate was low at 40 to 77 per cent. Non-occupation of the quarters was attributed by the DMHOs (March – May 2004) to unfit condition, absence of amenities like water and sanitation, and repairs.

Equipment

3.2.10 Mobile Medical Units (MMUs)

MMUs not existed in Mahboobnagar, Nalgonda, Nizamabad and RangaReddy Districts

The MMUs were required to cover all the villages/hamlets at least once in a month and attend to medical needs of the inhabitations. There were 45 MMUs under the control of DMHOs, each with a staff strength of six[20], in 18 districts. There were no MMUs in four[21] districts. DOH had, however, no information about the functioning of MMUs in the State.

In Anantapur, Khammam and Prakasam Districts, the MMUs did not function because no vehicle was provided, as detailed in *Appendix 3.2 (B)*.

[20] Medical officer, Male Nursing Orderly, Female Nursing orderly, Pharmacist, Auxiliary Nurse Mid wife and Driver

[21] Mahboobnagar, Nalgonda, Nizamabad and RangaReddy

3.2.11 Non-functioning of X-ray equipment

In the CHCs at Alur and Pattikonda in Kurnool District and Darsi in Prakasam District the X-ray equipment was not in working condition. The details are as follows:

Name of the CHC	Date of acquisition of X-ray equipment	Cost (Rs. in lakh)	Date from which not functioning
Alur (Kurnool)	26 March 1998	2.40	26 March 1998
Pattikonda (Kurnool)	2 April 1994	2.40	30 October 2002
Darsi (Prakasam)	19 April 1994	2.40	19 April 1994

DMHOs did not take action as of August 2004 either to get them repaired or replaced in CHCs, Alur and Pattikonda. At Darsi, there was no Radiographer and Darkroom Assistant though the X-ray equipment has since been brought to working condition in June 2004.

Manpower

3.2.12 Vacancies in posts of key functionaries

CHC functions under the administrative control of DMHO and is headed by a Deputy Civil Surgeon. It provides Specialist services of Civil Surgeon and Dental Surgeon. The MO incharge of the PHC is responsible for implementing all health activities under Health and Family Welfare delivery system in the PHC area. Each Sub-centre is provided with one HW(M) and one HW(F).

Huge vacancies in posts of medical and para medical staff

As against 29489 posts sanctioned as of March 2004, 3284 posts (in all cadres) remained vacant. Percentage of vacancies was high in the cadre of Civil Surgeons (47 per cent), Civil Assistant Surgeons (13 per cent), Assistant Paramedical Officers (16 per cent), Community Health Officers (25 per cent), Multipurpose Health Extension Officers (10 per cent), Staff Nurses (11 per cent).

There was no recruitment of Civil Assistant Surgeons for rural health services after the year 2000. Non-filling up of vacancies especially of the posts of medical officers adversely affected the primary healthcare for the rural population.

3.2.13 Disparity between urban and rural/tribal healthcare

Only 22 per cent of doctors posted to serve 73 per cent of total population living in rural areas

There was wide disparity in the posting of doctors in urban and rural areas. Only 22 per cent (1580) of the doctors (primary healthcare) were posted in rural areas to serve 73 per cent (5.54 crore) of the population. While there was one doctor for a population of 10907 in the State as on 31 March 2004, the doctor-population ratio was far below average in the four predominantly tribal districts (1:42511 in

Adilabad, 1:34087 in East Godavari, 1:22480 in Khammam and 1:41844 in Visakhapatnam), indicative of deficient healthcare in tribal areas.

According to the recruitment conditions the Civil Assistant Surgeons should work in rural/tribal areas for a minimum period of three/five years (excluding leave and time spent for pursuing higher studies). Audit, however, observed that compliance of this condition was not watched/monitored by the Director of Health. As a result healthcare of rural and tribal population suffered.

3.2.14 No uniformity in sanction of MOs posts in the PHCs

142 out of 274 PHCs in four sample districts had only single MO

Though the functions of all PHCs are the same, there was no uniformity in the sanction of MOs posts as evident from the following table:

Sample District	Total number of PHCs	Number of PHCs manned by			
		Single MO	Two MOs	Three or more MOs	without full time doctors
Anantapur	68	31	29	8	11
Karimnagar	63	30	29	4	9
Kurnool	71	31	38	2	17
Prakasam	72	50	19	3	17
Total	**274**	**142**	**115**	**17**	**54**

Data in respect of Khammam and Visakhapatnam Districts was not available

54 PHCs had no full time doctors

Of the 142 PHCs manned by single MO, 54 PHCs were running without full time doctors.

The MO was required to visit each Sub-centre at least once in a fortnight on a fixed day to provide curative services and to check the work of the staff. The PHCs running with single MO would be without a MO when the MO was away from the PHC Headquarters either for attending the meetings at district headquarters or for visiting the Sub-centres. In the absence of MO, the pharmacists and staff nurses were attending to out-patient cases. Thus the services of the MOs in these PHCs were not fully available to the patients all the time.

3.2.15 Additional MO posts not filled under APERP

Apart from the regular sanctioned strength of doctors, the AP Economic Restructuring Project provided for placement of one additional MO in each of the 500 selected PHCs running with single MO. As against this, Government sanctioned only 280 posts of MO in December 1998.

Additional MO posts not filled up though sanctioned

The details of number of additional MOs sanctioned and operated in the State under the project was not furnished by the Director of Health. In four sample districts, it was noticed that 27 MOs posts[22] were vacant out of 58 sanctioned as of September 2004.

Thus, adequate number of MOs were not sanctioned in spite of the availability of World Bank assistance.

3.2.16 Shortage of Health workers

Each Sub-centre was to have one Health worker (Male) and Health worker (Female). The HW (M) was to visit each family once a fortnight to undertake multifarious activities to motivate defaulters to take regular treatment besides providing treatment for minor ailments. The HW (F), besides assisting the HW(M) in identifying suspected cases under different health programmes was also to carryout the functions relating to Maternal and Child health, Family planning, Medical termination of pregnancy and Dais training.

Huge shortage (68 per cent) of Health workers in Sub-centres

There were 12522 Sub-centres in the State. As against 25044 health workers needed, only 8668 (35 per cent) were sanctioned and 8050 posts were operated as of March 2004; shortage being 68 per cent. None of the 1954 Sub-centres created in March 2003, had any Male Health Worker.

In the 3484 Sub-centres in six sample districts, 362 posts of Health workers (Male : 318, Female : 44) were vacant against the 5856 posts sanctioned as of March 2004.

Due to huge shortage of health workers the rural people were deprived of the basic healthcare facilities.

3.2.17 Shortage of Ophthalmic Assistants

1104 PHCs out of 1386 (80 per cent) had no Ophthalmic Assistants

Ophthalmic Assistants (OAs) are to assist the MO of PHC in conducting refraction, other eye care tests, give advice for cataract operations and to conduct screening for school children for correcting refractive errors and treat minor eye ailments. Government sanctioned (1993) one post of OA each in 350 PHCs. As against this, only 282 OAs were in position as of March 2004. Thus 1104 PHCs were left without the services of OAs thereby denying the eye care facilities to the targeted rural population.

[22] Anantapur 6/17, Karimnagar 9/15, Kurnool 8/12, Prakasam 4/14

3.2.18 Inadequate provision of specialist services in Round the clock PHCs

Mother and Child health services not provided in the Round the clock PHCs

With a view to improving the availability of quality services in mother's care and childcare especially in interior areas, 349 interior PHCs were converted as RPHCs since 1999-2000. The facilities in RPHCs include round the clock essential and emergency services, shifting of emergency cases to hospitals and providing specialist services of Gynecologist and Pediatrician once a week.

In the nine sample PHCs of Anantapur (one), Karimnagar (three), Khammam (four) and Prakasam (one) Districts, the specialist services were discontinued for over four years (May 1999 to August 2003). The MOs attributed (May 2004) this to unwillingness of specialists to work in the PHCs.

There was huge shortfall (55 per cent) in visits by the Gynecologists and pediatricians in the RPHCs in Visakhapatnam District.

Audit also observed that specialist services were not at all provided in the RPHCs, Lothugedda, RJ Palem, Gannela, Munchingput since inception, in Rolugunta and Nathavaram from 2002-03 onwards and in Godicherla during 2001-02.

Implementation of National and State Health schemes

Government had been implementing various State programmes and National Programmes to provide healthcare delivery services to the rural population. Scrutiny revealed that implementation of the three schemes studied was not effective in rural areas.

3.2.19 National Filaria Control Programme (NFCP)

The National Filaria Control Programme is a Centrally Sponsored Scheme with the cost of material and equipment being shared on 50:50 basis. The objective of the NFCP is to break the transmission of the disease through mass drug administration and anti-larval measures, to carry out surveys to determine the prevalence and incidence, to undertake pilot projects, evaluate the known methods of Filaria control in selected areas, and to train professionals and health functionaries for the programme.

Filaria Control Units existed only in 13 districts

As of March 2004, there were 29 Filaria Control Units, and four Filaria Clinics, in 13 districts[23] in the State and all of these are located in the urban areas. Further, there were only two survey units in the State to conduct night blood survey in the villages to detect

[23] not implemented in the other 10 districts (Adilabad, Anantapur, Chittoor, Hyderabad, Kadapa, Khammam, Kurnool, Prakasam, RangaReddy and Warangal)

There were only two survey units (Chittoor and Guntur) to cover the entire State

Micro Filaria carriers. Except in Chittoor and Guntur, no data was collected by the survey units of other districts. The performance of the survey units in Chittoor and Guntur Districts during the period 1999-2003 was as follows:

Year	Chittoor				Guntur			
	Number of villages covered	Number of blood smears collected and examined	Disease cases (percentage)	Endemicity* rate	Number of villages covered	Number of blood smears collected and examined	Disease cases (percentage)	Endemicity* rate
1999	44	1280	1072 (84)	84	10	10296	143(1)	6
2000	79	1576	1111(70)	71	13	10195	88(1)	3
2001	72	4231	980(23)	24	23	13140	81(1)	2
2002	83	10772	1025(10)	11	20	13585	96(1)	1
2003	211	10539	799(8)	8	22	9854	146(2)	3

Source : Survey reports of the units – Number of villages (Chittoor : 1481; Guntur : 692)

* Endemicity rate is the percentage of total number of microfilaria positive cases plus number of persons with disease manifestations

Percentage of disease cases/Endemicity rate of Filaria was alarming in Chittoor

Though the cases of disease Endemicity rate was alarmingly high in Chittoor during 2000 and 2001 the position improved in 2002 and 2003. Though the disease was prevalent in rural areas, efforts were not made to conduct surveys in other rural areas. Even in these two districts the annual coverage of villages was low. This indicated lack of serious concern to improve the primary health care in rural areas.

3.2.20 High incidence of Malaria in tribal areas

In Khammam and Visakhapatnam Districts, out of the total population of 25.79 lakh[24] and 38.32 lakh, a population of 5.97 lakh and 5.58 lakh respectively reside in tribal areas. Areas with the annual parasite incidence (API) of more than two are treated as high risk areas for malaria and those would be selected for intensified indoor residual spray operations for control of malaria. It was seen that API was very high (ranging from 5.5 to 37.2) in all tribal PHC areas of these districts.

The malaria positive cases comprise Plasmodium Vivax (PV) and Plasmodium falciparum (PF). Of the total malaria positive cases recorded in the tribal areas, the PF cases, which are more harmful, ranged between 60 per cent and 75 per cent during the period from 1999-2003. The District Malaria Officers, Bhadrachalam (Khammam) and Paderu (Visakhapatnam) replied (June 2004) that the schedule of spraying operations was adversely affected due to non-receipt of required quantity of insecticides in time. Thus, it was evident that inadequate spraying operations contributed to the alarming situation.

[24] as per 2001 census

3.2.21 State Population Policy

New 'State Population Policy' initiatives were developed (1997) to address core areas and to achieve the demographic goals set for couple protection rate, maternal mortality rate, and infant mortality rate. However, district level action plans were not prepared so far. District Population Stabilisation Societies were established for implementation of specific interventions[25].

Goals and Achievements

The details of demographic goals set by the Government and achievements made as of March 2004 are given below:

	Goals			Position as of 31.03.2004 (State average)	Position in rural areas
	2000	2010	2020		
A. Natural Growth Rate percentage	1.15	0.80	0.70	1.26	1.22
B. Crude Birth Rate* (CBR)	19.00	15.00	13	20.6	21.00
C. Crude Death Rate* (CDR)	7.5	7.00	6	8	8.8
D. Infant Mortality Rate** (IMR)	45	30	15	62	71
E. Maternal Mortality Rate* (MMR)	2.0	1.2	0.5	1.54	NA
F. Couple Protection rate percentage	60.0	70.00	75	62.5	NA
G. Total fertility Rate (TFR)	2.1	1.5	1.5	2.25	NA

* per thousand population ** per thousand live births NA : Not available

Infant Mortality Rate was alarmingly high

The goals set for the year 2000 had not been achieved even as of 2004 in respect of the Natural Growth rate, CBR, CDR, IMR and TFR. In particular, the Infant Mortality Rate was very high at 71 per thousand live births in rural areas. This indicated that health services in rural areas was poor.

System of supply of medicines

3.2.22 Funds not provided to DMHOs and PHCs for procurement of drugs

APHMHIDC withheld the funds of PHCs/ DMHOs intended for emergency purchase of drugs/medicine

The State Government accorded sanctions every year for procurement and supply of drugs, through Central Drug Stores, to the medical institutions (PHCs) in the districts. The AP Health, Medical Housing and Infrastructure Development Corporation (APHMHIDC) is the Nodal Agency for undertaking centralised drug procurement. Based on the Government sanctions the DOH drew and transferred the amounts to the APHMHIDC. According to Government Orders of April 1999, 10 per cent of allocation should be placed at the disposal of the individual institutions and another 10 per cent at the disposal of the DMHOs to meet any contingencies arising out of an epidemic in the area.

[25] Round the clock PHCs, training to doctors in laparoscopy techniques

There was a short release of Rs 8.32 crore by the APHMHIDC to the PHCs (Rs 2.80 crore) and DMHOs (Rs 5.52 crore) during 1999-2002. During 2002-04 the entire amount of Rs 10.04 crore due to be released to the PHCs (Rs 5.04 crore) and DMHOs (Rs 5 crore) was not released by APHMHIDC. As a result, the PHCs were not in a position to purchase emergency drugs in case of non-availability in the Central Drugs Stores, as also confirmed by the DMHOs, Anantapur and Kurnool. The DMHOs did not however, report this position to DOH.

Thus the DOH failed to release the due share of PHCs and DMHOs, but released the entire budget to the APHMHIDC. As a result the Director had lost control over procurement and distribution of drugs and medicines to the medical institutions.

3.2.23 Departmental inspections not conducted

DMHOs altogether ignored departmental inspections of CHCs and PHCs

As per the guidelines indicated in the Functionary Manual, all DMHOs are required to inspect CHCs, PHCs and offices of the programme officers by a team headed by DMHOs at least once in a year. The DMHOs in the sample districts did not conduct the annual inspections during 1999-2004 statedly for want of staff. As a result, monitoring of the PHCs was diluted. This adversely affected the primary healthcare to rural people.

3.2.24 Conclusions

The objective of taking primary healthcare delivery system to the doorsteps of rural people could not be achieved, mainly due to huge shortage of CHCs and PHCs, as well as medical and paramedical staff. Only 22 per cent of the doctors were in place in rural areas to serve 73 per cent of the total population. More than half of the PHCs in the six sample districts were manned by a single medical officer. Mother and Child health services were not provided in Round the clock PHCs. Majority of the Sub-centres were functioning without Health workers. Performance of the Mobile Medical Units was very poor. The Director of Health failed to provide funds to DMHOs and PHCs for procuring emergency drugs. National Filaria Control Programme was altogether neglected in rural areas. The incidence of malaria continued to be very high in tribal areas. The infant mortality rate was also alarmingly high at 71 per thousand live births. Monitoring of primary healthcare services by the DMHOs was poor. The Director also did not effectively monitor the services in rural areas.

3.2.25 Recommendations

- Adequate number of Community Health Centres and Primary Health Centres should be opened as per the norms to cover the entire rural population.

- Manpower, particularly medical and paramedical staff, needs to be augmented. Mother and Child health services in Round the clock PHCs should be ensured.
- Mobile Medical Units should be made fully functional by providing adequate number of vehicles.
- Infrastructure provided, including new buildings for PHCs, need to be fully utilised.
- Procurement of drugs, medicines and equipment needs to be delinked from the AP Health, Medical Housing and Infrastructure Development Corporation; which has mostly engineers on its rolls.

The above points were referred to Government in August 2004; reply had not been received (October 2004).

Appendix 3.2
(Reference to paragraphs 3.2.9 and 3.2.10 page 53)

A. Status of staff quarters and their occupancy in the sample districts (Primary healthcare)

Name of the District	Total No. of PHCs	No. of PHCs having staff quarters	Type of quarters		Position of occupation		Vacant	
			MO	PMS	MO	PMS	MO	PMS
Anantapur	68	39		288*		174*		114*
Karimnagar	63	22	40	48	13	14	27	34
Khammam	53	31	41	77	9	18	32	59
Kurnool	71	NA	NA	NA	NA	NA	NA	NA
Prakasam	72	27	47	75	35	38	12	37
Visakhapatnam	61	13	13	26	4	6	9	20

NA : Information not available; MO : Medical Officer; PMS : Para Medical Staff
* includes all types of quarters

B. Functioning of Mobile Medical Units in the sample districts

District	MMUs sanctioned	MMUs not functioning	Audit findings
Anantapur	One	One	The MMU, Kalyandurg was not functioning since a decade due to non-replacement of the condemned vehicle thereby denying the medical facilities to the rural population of 67 villages.
Khammam	Four	Four	Four units (Chintur, Jeediguppa, Patwarigudem, and Wazeedu) were not functioning since no vehicles were provided for conducting health camps. The services of the staff of the units were being utilised in outpatient units of PHCs and other purposes.
Prakasam	Two	One	Out of two MMUs, the MMU at Chirala was not functioning since 1990. The vehicle was condemned in 1990 and the MMU was utilising the vehicle of PP unit for two days in a week since April 1995. During 1999-2004 as against the targeted number of 64 villages the unit covered only 16 villages per month thereby denying the services to the fishermen in the remaining 48 coastal villages.
Visakhapatnam	Six	Nil	None of the six (Aruku, Jerrila, Kilagada, Rudakota, RV Nagar, Sunkarametta) MMUs in the tribal area had produced records to audit. However, scrutiny of the data received from the Additional DMHO, Paderu, revealed that there was a huge shortfall in the coverage of villages in tribal areas by 80960 visits (only 7460 visits made as against 88320) during 1999-2004. Reasons for shortfall were however, not forthcoming.

Note: Records were not produced in respect of Karimnagar and Kurnool Districts