VISIT Report of NVBDCP World bank District Kondagaon, Chhattisgarh

-Dr Sunil Gitte, Deputy Director and team

About District: Kondagaon is a district separated from bastar district on 24 January 2012 and formed as 27th district of Chhattisgarh state a municipality in the Indianstate. This is a tribal district. Thus the culture and the customs are different here from the other parts of the state. The population of the district is 5,64,645.

Surveyed Health Facility:

CHC	PHC	HSC	District Hospital
Makdi	Dahikonga, Anantpur	Badekanera,Tortanga	Sentinal site
Pharsasgaon	Badedonger	Alor	Record Room
Kaskal	Bhaigaon	Nayanar	wards

District Epidemiological Profile of malaria of Year 2012and Visited Blocks:

API =5.8

ABER 12.75

SPR-4

There is reduction in API and ABER as compare to year 2011. LLIN were distributed in the selected blocks of the district. MTS has not done the LQAS and assessment survey after the distribution.

A) District headquarter:

Human Resource: Recently a medical officer ha given charge of DMO. MTS is looking technical aspects of the programme. The post of VBD consultant was vacant and only two MTS are in place. There is shortage of manpower, of doctors and MPWs 11/44) in the district. The Lab technicians are also posted at PHC and start the microscopic blood slide examination at **Dahikonga, Anantpur, Badedonger and Bhaigaon. The untrained new technician needs training in malaria. The MTS and MI should focus on the recording and reporting.**

District Hospital malaria mortality:

The team has visited the district Hospital and scrutinized indoor mortality and morbidity records of male, female and paediatrics wards.Staffs of sentinel site of the district hospital wereinteracted on day of visit.

The indoor records showing mortality due to malaria was noted by team which was neither investigated nor noted in the sentinel site reporting or district malaria mortality report. All deaths were microscopic or Rd kits positive.Most of the cases were referred from the peripheral health facility. The Slides was prepared of these cases send for microscopic

examination. The RD kits were not issued at IPD in case of emergency. They are waiting for microscopy results. The record keeping of the lab is poorly maintained.

Table showing the year wise total death, admission, malaria deaths mention on IPD sheet.

Month	No of Admission	No of Deaths	Deaths who are Malaria Positive on IPD paper
Jan-12	502	15	1
Feb-12	513	17	1
Mar-12	544	24	
Apr-12	539	9	
May-12	601	15	
Jun-12	510	16	
Jul-12	447	6	1
Aug-12	480	10	2
Sep-12	552	10	1
Oct-12	458	11	2
Nov-12	376	13	1
Dec-12	411	8	
Jan-13	417	4	1
Feb-13	373	11	
Mar-13	437	12	
Apr-13	442	6	
16th May 2013	273	17	
Total	7875	204	10

@ Source Daily reporting on state web (cg health.nic.in)
 # Data collected and verified from IPD record of the district Hospital by RD Team (Details attached as part-2 and Annexure I and II)

B) Visited Blocks

Diagnosis and Treatment:

The team has visitedMakadi, Pharasgaon and Kaskal block. One PHC and health Sub-Center was selected based on the approachability and feasibility. The Rd kits are utilized at CHC laboratory. A passive case after diagnosis and treatment is given at CHC OPD cases with Chloroquine and Primaquine. There is scarcity of ACT in the district in last and current year. NO ACT given to malaria affected person. The record was keeping and management of antimalarial is very poorly maintained in all surveyed sectors.

Logistics:

1) **RDK:** In year 2012-13 83625 kits were received to district and all were distributed in the field but there is variation in the report regarding to consumption. MTS looking the logistic monitoring of all blocks. Last year the logestics related to malaria received from parent district (Jagdalpur, Bastar). The Record keeping is very poor at level regarding RD kit. Variation in the distribution and utilized stock of RD kits.

At Pharasgaon CHC, 31500 rupees from JDS funds purchase bivalent RD kits from market in spite of the free supply of Pf kit from govt. For bivalent test they charges 40 rupees from malaria patients as per JDS. The BMO should follow the GOI, RD kit guidelines for diagnosis. MI posted for monitoring and supervision of block. He is not aware of the guidelines and LLIN distribution in high endemic areas of block. No epidemiology indicators are calculated or none were aware of it.

2) **ACT:** The ACT blister packs were not found in all surveyed health facility they used only Chloroquine and primaquine. The presumptive treatment is practiced in all surveyed health facilities. The recording regarding the ACT is not available with MTS who looking technical aspects of the programme. There RMA were interacted about the ACT usage , none of them able to reply about the combination and dosage etc. there is urgent need of training on the malaria to RMA. They are the backbone of primary health care in terms of curative services. Nearly about 90% of patient comes to OPD they are diagnosing and treating. **Step should be taken for uninterrupted ACT supply to all peripheral health institutes.** Steps should take for channelized this distributed peripheralstock for proper and timely utilization**.**

3) Chloroquine and Primaquine:

There was scarcity of Chloroquine and Primaquine in the District in year 2012 -13 . The tablets were purchase from JDS in all surveyed health facilities.The above consumption of these tablets indicating staff is still giving focus on presumptive treatment.Presently the stock of the block was exhausted.

IRS coverage: In year 2012 IRS coverage ranging from 86 to 92% in four blocks.

Reporting:M formats are filledat CHC level and end to district Malaria office

INDOOR RECORD: Indoor record was not properly maintained at Makdi CHC while neat and properly record is maintained at Keskal and Pharasgaon CHC block.

D) Visited Primary Healthcenters

The team visited 3 PHCs namely in selected blocks.The facility of Blood smear examination by trained technician are available in all visited PHCs so from all suspected cases blood slides were prepared and examined.

PHCs having no ACT stock ,theChloroquineandPrimaquine arelimited available since last I year. Presumptive treatment is practiced based on the availability of antimalarial drugs at primary health center. On interviewed at one RMA (Rural Medical Assistant) at primary health Center told that they gives Presumptive treatment to clinically suspected fever cases . No ACT supply to surveyed PHC. RD kits were supplied irregular so there is no effective utilization during and after transmission season

No any record related to malaria available and kept at Primary health centre for evaluation reference purpose.

E) Visited Health Subcenters

The team has visited 4HSCs in the surveyed blocks interacted with Subcenter staff(only ANM) and village ASHA (Mitainins) workers.

The subcenter staffs prepared the slides and send the slide for microscopic centres but results were not received 24 hrs. More than weeks are required for getting microscopic slide result.

Presently stock of RD kits available at surveyed subcenters.

HSC	RD kits	ACT	Chloroquine	Primaquine
Badekanera,	125	NIL	yes	NIL
Alor	46	NIL	yes	NIL
Nayanar	72	NIL	yes	NIL
Tortanga	25	NIL	NIL	NIL

F) Involvement of ASHA

The team has interacted with 5 ASHAs at surveyed Subcenter village. None of them were supply RDKits and ACTs.Presently, chloroquine and primaquine tablets were not available in their drugs kit.

All interacted ASHA having logistics like slides, pricking needles and spiritnot available with them. Last year in the report of District none of mitanin prepared the slides.