PREFACE

This Report of the Comptroller and Auditor General of India for the year ended March 2008 containing the results of the Performance Audit of the implementation of the "National Rural Health Mission" has been prepared for submission to the President of India under Article 151 of the Constitution.

The Performance Audit was conducted between April 2008 and December 2008 through test check of records of the Ministry of Health and Family Welfare, State and District Health Societies and health centres covering the period 2005-06 to 2007-08.

EXECUTIVE SUMMARY

1. Background

The National Rural Health Mission (NRHM) was launched in April 2005 to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas of the entire country especially to poor and vulnerable sections of the population. The key strategy of the NRHM was to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, and provide an overarching umbrella to the existing disease control programmes run by the Ministry of Health and Family Welfare. The Union Cabinet, while approving the Framework for Implementation of the NRHM in July 2006, provided a considerable degree of delegation of financial and administrative powers to the Mission. The Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) were authorised to modify norms of approved schemes. The MSG was also empowered to approve financial norms in respect of all schemes and components that were part of NRHM. Though the Mission was launched in April 2005, the Cabinet's approval of the Framework for Implementation of the NRHM in July 2006 effectively provided the impetus for accelerating the Mission's activities.

The cutting edge of the Mission's programme and activities lies in the States and its success would, to a large measure, be closely linked to the effectiveness of the State Health Societies in implementation of the activities envisaged under the Mission. While the Ministry is ultimately responsible for providing the overall policy framework, guidance and acting on feedback, its efforts need to be complemented in equal measure by the States.

The Mission seeks to initiate key changes in the health sector, varying from the encouragement and development of planning capacity and community participation to an emphasis on convergence with other indicators of a 'good' life - safe drinking water, sanitation etc. The long-running disease control programmes have been brought under a more cohesive implementation structure and Indian Public Health Standards guiding infrastructure and facilities established.

2. Audit scope and methodology

The performance audit on implementation of the NRHM was conducted during April-December 2008 in the Ministry of Health and Family Welfare, State Health Societies (SHS) of 33 States/UTs, District Health Societies (DHS) of 129 districts and 2369 health centres at block and village levels covering the period from 2005-06 to 2007-08. The purpose of undertaking the performance audit of the implementation of activities under the Mission is to highlight the positive trends and developments, while simultaneously pointing out possible areas of weakness or shortcomings in field-level operations that could hinder progress towards achievement of the Mission's overall goals.

3. Planning and monitoring

The NRHM initiated decentralised bottom-up planning. This, however, had been hindered by non-completion of household and facility surveys and State specific perspective plans. In nine States, district level annual plans were not prepared during 2005-08 and in 24 States/UTs block and village level annual plans had not been prepared at all. The results of the outsourcing of plan preparation had been mixed, with district plans outsourced to private agencies in eight States not being prepared in time. The Mission would, in the next few years, need to emphasise strongly on generating planning capacities, as this was a basic building block for all subsequent top-down health interventions.

4. Community participation

While the Mission places considerable emphasis on decentralisation by developing a novel framework of community participation in planning and monitoring, the initial phase of establishing and orienting committees at various levels was yet to be completed. Village level health and sanitation committees were still to be constituted in nine States. The Rogi Kalyan Samitis (RKS) formed at many health centres, aiming at community ownership of healthcare delivery systems, were characterised by weak or absent grievance redressal mechanisms, outreach and awareness generation efforts. The broad guidelines on the RKS issued by the Ministry left sufficient flexibility to States to ensure the committee's effective functioning tailored to local conditions. However, no RKS in any State/UT received all the stipulated central grants. In 13 States/UTs, the Samiti failed to generate internal resources, while in the remaining States no mechanism existed to monitor the generation of a third of the RKS funds from internal resources as prescribed. Funds for local action through untied grants and annual maintenance grants to health centres remained mostly unspent and there was a need to generate greater awareness on the importance of their effective utilisation. The structure of the Mission also requires more cohesion – with the mainstreaming of health societies at the State and district levels not having fully taken place.

5. Convergence

The NRHM adopted an intersectoral convergence approach to healthcare by seeking to synergise women and child development, hygiene and sanitation, public works and panchayati raj institutions in planning and execution. However, the committee on intersectoral convergence under the chairmanship of the Mission Director did not meet frequently and the follow up action on its instructions was not monitored. This had meant that efforts at convergence required strengthening. The participation of Non-Governmental Organisations (NGOs) in the Mission's activities had not been facilitated and their contribution towards capacity building and service delivery was not effectively monitored. 71 per cent of the districts countrywide were yet to be covered under the Mother NGO scheme. The Ministry is now seeking to revise guidelines to ensure more effective NGO participation in the Mission.

6. Funds flow management

A significant development is the increase in outlays on public health in recent years, both at the Centre and in the States. During the period 2005-06 to 2007-08, the total outlay/expenditure on the NRHM was Rs. 24,151.45 crore. During the first two years the Centre was contributing 100 *per cent* of the funds. Thereafter, the States were to contribute 15 *per cent* of funds during the 11th Five Year Plan (2007-12). However, many of the States were yet to contribute their share to the Mission and this issue needs to be addressed. Many high focus States where diseases are endemic and health indicators poor, were however, receiving relatively lesser central grants, as high unspent balances of previous years remained, indicating that capacity building needs to be focussed on. Release of funds to the State Societies and consequently to district and block levels required further streamlining to ensure prompt and effective utilisation of funds. Funds advanced by the SHSs to lower level formations continue to be treated as expenditure by the SHS, regardless of whether these have actually been utilised. The practice of equating release with expenditure and short accountal of unspent balances had meant that Reproductive and Child Health (RCH) Flexi-pool funds of Rs. 862.61 crore had been released to States/UTs in excess. Various existing programmes such as the Empowered Action Group Scheme, RCH-I and National Maternity Benefit Scheme had been closed down with the initiation of the NRHM, but the unutilised balances under these programmes had not been settled and remained with States. The Ministry's efforts at e-banking suffered from some delays and most States were yet to adopt e-banking.

7. Infrastructure development and capacity building

The Mission has developed the Indian Public Health Standards (IPHS) to assist health centres improve their quality of health care and thus upgrade the capacity of the health delivery system. However, the ratio of population to health centres remained low with the targeted number of new health centres not being established. Basic facilities (proper buildings, hygienic environment, electricity and water supply etc.) were still absent in many existing health centres with many Primary Health Centres (PHCs) and Community Health Centres (CHCs) being unable to provide guaranteed services such as inpatient services, operation theatres, labour rooms, pathological tests, X-ray facilities and emergency care etc. While the Mission had renewed focus on capacity building and infrastructure development, much remains to be done. During 2005-07, Rs. 720.20 crore was released to the SHSs for upgradation of CHCs to IPHS without receiving proposals and plans of action and consequently, most funds remained unspent. The quick-response Mobile Medical Units, meant to take medical care to the patient's doorstep in far flung regions, had not been operationalised in many States even though substantial funds had been released for the purpose.

The innovative practice of engaging Accredited Social Health Activists (ASHAs) has had a positive impact on taking healthcare to and enhancing awareness of the patient. However, the shortage of service providers at different levels in different States/UTs continues to pose a challenge. While contract workers have been engaged to fill vacancies, there are still shortages of specialist doctors at CHCs, adequate staff nurses at CHCs/PHCs and Auxiliary Nursing Midwife (ANMs) / Multi-purpose Worker (MPWs) at Sub Centres.

8. Procurement and supply of medicines and equipment

While the Ministry had set up an Empowered Procurement Wing (EPW) and developed a comprehensive procurement manual centrally, in 26 States/UTs, no procurement manual had been prepared. Neither was a formulary list of drugs available nor was standard bid documents adopted in 13 States. Inadequate procurement planning also effected equipment utilisation in the States with Rs. 3.96 crore of equipment lying unutilised in six States. Cold chain equipment worth Rs. 10.43 crore and telemedicine facility equipped Mobile Medical Units on which Rs.10.72 crore had been spent, remaining non-functional due to lack of supporting infrastructure in Jharkhand. In nine States, the stock of essential drugs, contraceptives and vaccines adequate for two months consumption as required under norms were not available in any of the test checked PHCs and CHCs.

9. Information, education and communication

The Ministry had diversified its Information, Education and Communication (IEC) efforts, but the expenditure remained centralised. The importance and potential of localised efforts and simple mass-media (theatre, audio etc.) to sustain direct communication with the rural population at the block and village level had not been explored fully.

10. Achievements in healthcare

The increased patient inflow at PHCs and CHCs and improved institutional deliveries and immunisation were an indicator of the Mission's positive impact on healthcare delivery. However, it was evident that sustained efforts were still required, since a majority of registered pregnant women were still not using the health centres for institutional delivery, particularly in Empowered Action Group (EAG) States where cases of delayed payments and irregularities characterised the implementation of the Janani Suraksha Yojana (JSY). Micro birth plans and MCH cards for registered pregnant women, which were essential for the implementation and monitoring of the JSY and ensuring post-natal care, were not prepared in most states. No proper mechanism for collection and reporting of data on maternal and neo-natal deaths was seen in the audited districts of 17 States.

The SHS did not prescribe year wise targets for various terminal methods of family planning in 15 States/UTs, and there were shortfalls as high as 62 per cent in coverage in another 11 States. Vasectomy accounted for only four per cent of total sterilisation cases.

Targets for immunisation were fixed on an ad hoc basis in 15 States/UTs and despite higher rates of immunisation, the incidence of infant and child disease increased in nine States. In the audited districts of 22 States/UTs there was a shortfall in the administration of the first and second doses of vitamin A due to the drug's short supply at health centres. Despite holding two National Immunisation Days, six Special National Immunisation Days (and additional rounds in selected districts of Bihar and Uttar Pradesh), 1640 new polio cases had been detected in 17 States/UTs during 2005-08.

Quality control in programmes remained important as in spite of a complete ban on cataract surgery in camps under the National Programme for Control of Blindness

(NPCB), in 14 States/UTs 19.52 lakh cataract surgeries were performed in camps, which was 47 per cent of the total cataract surgeries in these States.

The targeted rate of 10 percent of annual blood examinations under the National Vector Borne Disease Control Programme had not been achieved in 11 States and the Annual Parasitic Incidence for Malaria was higher than the stipulated rate of less than 0.5 per thousand in all the three years in 14 States/UTs.

Despite the launch of the National Iodine Disorder Disease Control Programme (NIDDCP) in 1992 and the NRHM's focus on controlling deficiency-generated diseases, the programme suffered from an inadequacy of staff and IDD labs. Under the Integrated Disease Surveillance Project, the Centre was receiving reports from only 58 per cent of all districts and the inordinate delay in setting up of laboratories was adversely affecting the Project.

11. Conclusion

Yet, it is important to remember that health programmes played a preventive and ameliorative role and there was progress where programmes were implemented with an emphasis on proper coverage and quality. If the NRHM could bring greater cohesiveness to the implementation of various programmes, then the impact would be far reaching.

The NRHM's attempt to rejuvenate the healthcare delivery system has succeeded in raising hopes and consequently, demands from the public health system. A focused prioritisation of interventions and adaptability based on feedback from States are necessary to help the Mission deliver on its goals. In this context, key recommendations arising from the performance audit are summarized below:

- *The SHSs and DHSs should expedite the household and facility surveys and prepare State and district perspective plans, reflecting convergent functions of various government departments. The future annual State Programme Implementation Plans (PIPs) and district health plans should be based on long term requirements and results of baseline surveys.*

- *Monitoring framework may be strengthened so as to ensure periodic impact assessment of activities for timely interventions.*

- *The new health centres should be established in the under-served areas. Health infrastructure at CHCs and PHCs must be made functional with all essential infrastructure, equipment and manpower to ensure improvement in quality of healthcare in rural areas at an affordable cost.*

- *States should fill sanctioned posts of medical and support staff at health centres and revise the sanctioned strength to meet the NRHM requirements. Full induction training may be given to all ASHAs to make their services viable and effective.*

- *The RKS may be constituted and registered at all the remaining health centres with priority over other dimensions of community participation. The Samiti should be made a constructive partner in functioning of the health centres and to enable this,*

the accountability structure under the RKS may be clearly defined and management capacity may be generated.

- *Funds flow arrangement should be rationalised to ensure minimum unspent/excess amount is left outside government accounts.*
- *The Ministry should review its interface banking arrangements in consultation with the Ministry of Finance. Interface banking should be preferred with public sector banks having maximum outreach and which offered the best possible terms.*
- *There should be reasonable distribution of funds among various media of communication. IEC strategy and impact assessment should be rationalised with appropriate norms and criteria.*
- *Disaggregated State-wise targets may be set in view of overall targets set by the Ministry for the country and State-wise progress may be measured on the basis of disaggregated targets and data. The opportunity to consolidate real-time data captured by ANM and health workers may be made use of.*
- *The monitoring and reporting mechanism under Janani Suraksha Yojana should be strengthened so as to ensure availability of reliable information with the State and District Health Societies. This would help mitigate the risk of fraud and irregularities in grant of cash compensation under the JSY. The Ministry may emphasise that nodal personnel encourage data integrity under JSY at the Ministry and SHS level.*

CHAPTER 1: INTRODUCTION

1.1 Background

The National Rural Health Mission (NRHM) was launched on 12 April, 2005 throughout the country with special focus on 18 States, viz. eight Empowered Action Group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand), eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices. The aim of the Mission is to provide *accessible, affordable, accountable, effective and reliable* healthcare facilities in the rural areas of the entire country, especially to the poor and vulnerable sections of the population. The key strategy of the NRHM is to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programmes and Integrated Disease Surveillance Project. It also addresses the issue of health in the context of a sector wide approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health and advocates convergence with related social sector departments such as Women and Child Development, AYUSH, Panchayati Raj etc.

The NRHM seeks to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. The Mission envisages increasing expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2-3% of GDP over the mission period (2005-2012).

1.1.1 Objectives of the programme

The main objectives of the NRHM are:

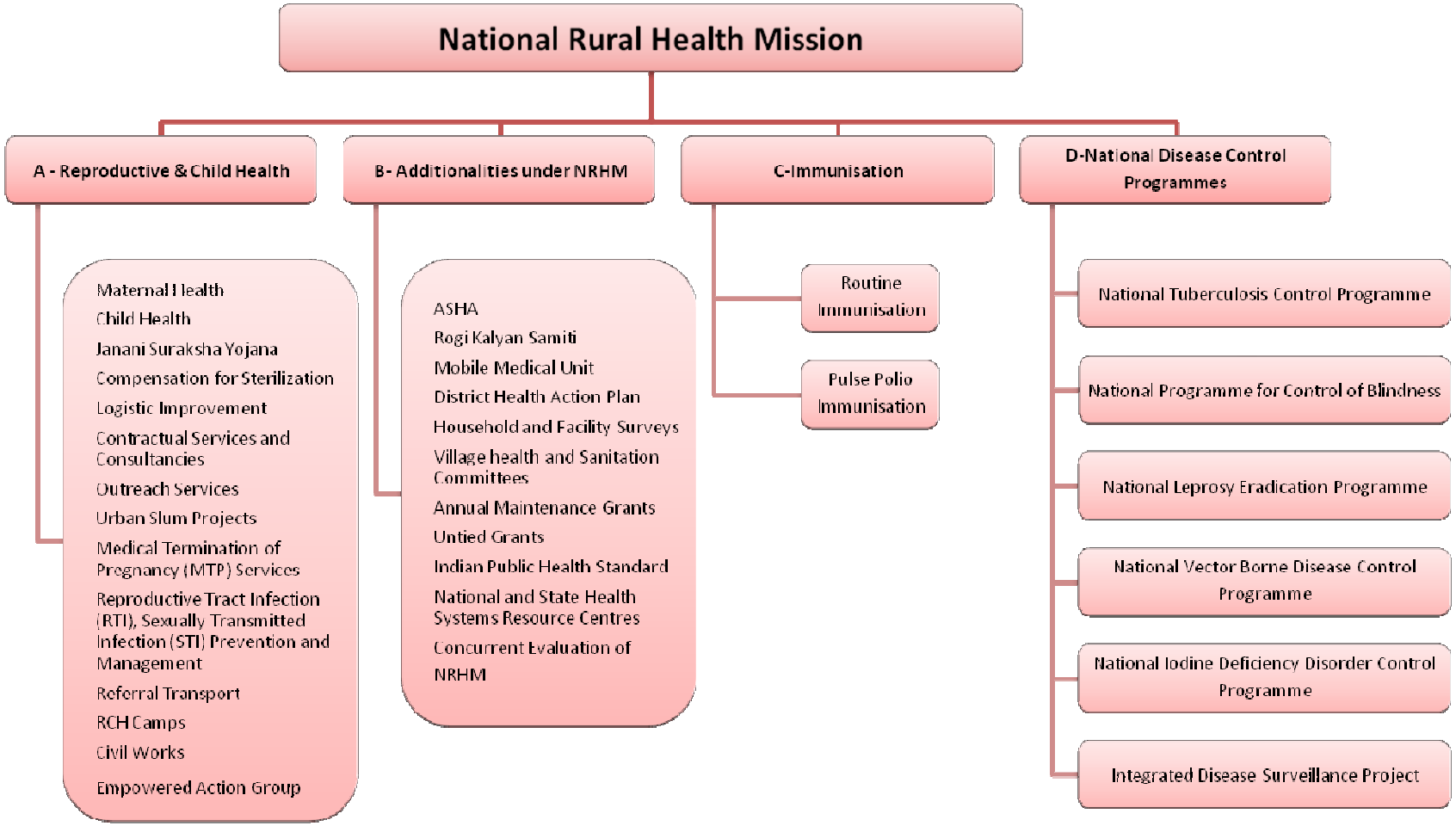
- Reduction in child and maternal mortality;
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Access to integrated comprehensive primary health care;
- Population stabilization, gender and demographic balance;
- Revitalize local health traditions & mainstream AYUSH; and
- Promotion of healthy life styles.

1.1.2 Organisational structure

1.1.2.1 Central level

At the national level, NRHM is led by a Mission Steering Group (MSG) headed by the Union Minister of Health and Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health and Family Welfare. The

Programmes covered under NRHM



MSG was empowered to approve financial norms in respect of all schemes and components which were part of NRHM. The EPC had the flexibility to change financial norms approved by the MSG within a range of (+) 25 *per cent*. The MSG and the EPC were required to periodically monitor progress of the Mission.

Besides, a Mission Directorate has been set up at the Central level for planning, implementation and monitoring of the mission activities and day-to-day administration. The Directorate is headed by a Mission Director at the level of Additional Secretary to the Govt. of India. Under the Mission Directorate, there were three Joint Secretary level officers during the period of audit.

Besides, the programmes of family welfare amalgamated into the NRHM such as the Reproductive and Child Health – II (RCH-II) and Immunisation – Routine and Pulse Polio are headed by the respective Joint Secretaries under the overall control of the Secretary, Health and Family Welfare. The various programmes for disease control such as National Vector Borne Disease Control Programme, Revised National Tuberculosis Control Programme, National Programme for Control of Blindness, National Leprosy Eradication Programme, National Iodine Deficiency Disorder Control Programme and Integrated Disease Surveillance Project are administered through respective Programme Divisions headed by Director/Deputy Director General and function under the overall control of the Director General of Health Services. The disease control programme divisions were reporting to the Mission Director through their respective Joint Secretaries.

1.1.2.2 State level

At the State level, the NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. The activities under the Mission are carried out through the State Health Society (SHS), which was formed by integrating all the societies set up for the implementation of various disease control programmes. The Governing Body of the Society, headed by Chief Secretary/Development Commissioner of the State, meets at least once in every six months. The Executive Committee of the SHS, headed by Principal Secretary/Secretary, H&FW meets at least once in every month. For administrative convenience, the States may constitute Programme Committees for various National Programmes for more focused planning and review of each activity. The State Programme Management Support Unit (SPMSU) acts as the Secretariat to the State Health Mission as well as the State Society and is headed by an Executive Director/Mission Director. The SPMSU has experts in technical areas like CAs, MBAs and MIS Specialists etc.

1.1.3 Financial inputs and fund flow arrangements

1.1.3.1 Financing pattern

Funds are released by the Central Government to the States through two separate channels, i.e. through State Finance Departments and directly to the different Societies/ State Health Society (SHS). The funds routed through the State Finance Departments are released quarterly depending on the norms prescribed for various activities under these schemes, based on infrastructure available in the States.

The funds are provided to SHSs on the basis of approval of State Programme Implementation Plans (PIPs) by the Government of India. The States/UTs are required

to reflect their requirements in a consolidated Programme Implementation Plan (PIP) having various sections for individual programmes under parts (a) RCH, (b) Additionalities under NRHM, (c) Immunisation, (d) Revised National Tuberculosis Control Programme (RNTCP), (e) National Vector Born Disease Control Programme (NVBDCP), (f) Other National Disease Control Programmes (NDCPs) and (g) Inter-sectoral issues. During 2005-06 and 2006-07, hundred percent grants were provided to States. From the Eleventh Plan Period (2007-12) States are to contribute 15 *per cent* of the funds required. At the State and District levels, Financial Management Group (FMG) under respective Programme Management Support Unit (PMSU) is responsible for centralised processing of funds releases, accounting for the expenditure reported from the subordinate units, monitoring of Utilisation Certificates and audit arrangements. They are also responsible for collecting, compiling and submitting Statements of Expenditure (SOEs), Financial Management Reports (FMRs), UCs and audit reports from District Health Societies to SHS and from SHSs to GOI. The diagrammatic presentation of funds flow is given in **Annex 1.1**.

1.1.3.2 Budget estimates and expenditure

The budgetary estimates and expenditure under NRHM during 2005-08 were as under (programme-wise details in **Annex 1.2**):

Table1.1: Budget estimates and expenditure

(Rs. in crore)

Year	Budget Estimates	Actual Expenditure
2005-06	7,189.20	6284.58
2006-07	9,000.00	7486.62
2007-08	10,890.00	10,380.25
Total	**27079.20**	**24151.45**

1.2 Audit Objectives

Performance audit was taken up with the objective of verifying whether:

I. The planning of the implementation of the Mission as well as monitoring and evaluation procedures at the level of Village, Block, District, State and Centre were oriented towards its principal objective of ensuring accessible, effective and reliable healthcare to the rural population;

II. There was adequate community participation in planning, implementation and monitoring of the Mission;

III. Convergence and regulation of the Mission activities with other departments, programmes and non-governmental stakeholders was ensured for achieving the broad objectives of the programme;

IV. The public spending on healthcare increased to the desired level as envisaged in the Mission objective/vision. Assessment and release of funds in the decentralized set up and their utilization and accounting was prompt and adequate;

V. Capacity building and strengthening of physical and human infrastructure at different levels took place as planned and targeted;

VI. The procedures and system of procurement of equipment, drugs and services, supplies and logistics management were cost effective, efficient and ensured improved availability of drugs, medicine and services;

VII. The information, education and communication (IEC) programme was implemented in an efficient, cost effective manner and led to increased awareness about preventive aspects of healthcare; and

VIII. The performance indicators and targets fixed specially in respect of reproductive and child healthcare, immunisation and disease control programmes were achieved or the outcomes point towards achieving them.

The findings of Audit with reference to each of the eight objectives of the performance audit have been presented in separate chapters, i.e. Chapter 2 to Chapter 9.

1.3 Performance Indicators/Audit Criteria

The criteria/performance indicators used for the assessment of the performance included: -

- Outcome indicators for reduction/amelioration of disease or at least an assurance of movement in that direction;
- Increase in health care facilities at sub-district levels;
- Increase in number of inpatients and outdoor patients seeking health services;
- Increase in number of institutional deliveries, immunization, family planning cases etc.;
- Decrease in morbidity and mortality due to various diseases;
- Improvement in infrastructure, equipment, supply of medicines, diagnostic services at healthcare facilities at sub-district levels as per Indian Public Health Standards (IPHS);
- Increase in number of personnel providing health care services and management of healthcare facilities;
- Improvement in awareness of health care issues;
- Community planning and participation in management; and
- Compliance with general financial and administrative rules and procedures.

1.4 Scope and Methodology

1.4.1 Scope and coverage of audit

The Performance Audit was carried out during April to December 2008 by examining the documents in the Ministry and in 26 States[1] and seven Union Territories. The period of audit coverage was from April 2005 to March 2008.

1.4.2 Audit methodology

The Performance Audit of the NRHM commenced with an entry conference with the Ministry in April 2008, in which the audit methodology, scope, objectives and criteria were explained. Simultaneously, in each state an entry conference was held by the Accountant General with the Principal Secretary/Commissioner, Health and Family Welfare. The audit methodology mainly consisted of document analysis, responses to audit queries, physical collection and testing of samples. Records relating to the

[1] All states and union territories other than Goa and Nagaland

NRHM were examined:

- by the Director General of Audit, Central Expenditure at the central level in various programme divisions of the Ministry between April 2008 and December 2008.
- by the (Principal) Accountants General (Audit) at the State level (in 26 States and seven UTs) in State Health and Family Departments, State Health Societies, District Health Societies, Community Health Centres, Primary Health Centres and Sub Centres between April 2008 and November 2008.

The Audit observations are based on analysis of information and data collected during the audit, from SHS, DHS and health centres. Audit findings were communicated separately to the State Health and Family Welfare Departments and exit conferences were conducted by the Accountants General with the auditee to discuss audit findings. The results of the performance audit were discussed with the Ministry in an exit conference on 30 September 2009.

1.4.3 Audit Sampling

The performance audit was conducted in 129 districts selected as per the following statistical sampling plan: -

- Each State was divided into various regions on the basis of geographical contiguity and in accordance with the regions outlined in the National Family Health Survey-3.
- Districts were chosen using Probability Proportional to Size with Replacement (PPSWR)[2] independently from various regions with size measure being the total amount of grants-in-aid released to respective District Health Societies during the years 2005-08 from the State.
- In each sample district, three Community Health Centres were selected using Simple Random Sampling without Replacement (SRSWOR).
- In each sample block, two Primary Health Centres were selected using SRSWOR and in each sample PHC, two Sub Centres were selected using SRSWOR.

Thus, in each selected district 3 CHCs, 6 PHCs and 12 Sub-Centres had been audited. State wise list of the selected districts are listed in **Annex 1.3.**

1.4.4 Reporting methodology

The results of audit at both the central and the State level were taken into account in arriving at audit conclusions. While framing the conclusions and recommendations, good practices and positive findings /success stories of programmes have also been reported to illustrate the fact that these can be replicated in other areas of the Mission. **The audit findings, conclusions and recommendations on each stated objective of the Performance Audit have been discussed in the following chapters**.

1.4.5 Acknowledgement

We place on record our sincere appreciation for the cooperation of the Ministry of Health and Family Welfare and State nodal departments in facilitating our audit.

[2] Probability Proportional to Size with Replacement (PPSWR) sampling is cluster sampling where larger clusters have a higher chance of selection. Thus, districts receiving larger amount of grants-in-aid had higher chances of selection.

CHAPTER 10: CONCLUSION

The NRHM is an ambitious programme that attempts to consolidate all existing disease control programmes under a common umbrella while simultaneously improving the infrastructure and capacity of the healthcare system in the country. The Mission also seeks to set in place standards for public health and enhance awareness of health issues. The Mission, while aiming at improving national health indicators, seeks to address local endemic diseases through a focus on community participation and feedback.

The targeted interventions under the Mission towards improving health infrastructure, and better grass-roots outreach through health workers such as ASHAs have shown early positive results with outpatients returning to health centres and improved manpower staffing through appointment of contractual staff. However, the Mission has yet to completely mainstream the various State Health Societies implementing disease control programmes. Monitoring of the utilisation of the substantial funds released also needs strengthening and institution of systems. New organisations such as the Rogi Kalyan Samitis are yet to realise their full potential and decentralised planning had not fully taken off. The problems that confronted facilities and services availability, convergence with other departments etc. are an offshoot of the lack of focused planning and effective monitoring – activities requiring dedicated ground work so as to help resolve health issues in accordance with local needs.

While the Ministry in its reply has stated that "Health is a State subject and the federal nature of the Centre/State relationship ought to be factored in any Central sector programme implementation", the primary responsibility for the design of the Mission and its implementation in an effective manner lies with the Government of India. In an area as critical as health care, time is of the essence. Constant and persuasive direction and guidance from the Ministry would be required so that implementation of programme activities by the States is both effective and expeditious. Given that the Ministry is directly intervening at the district level through various Societies and infusing large sums of money to build both physical and human resources capacities, it is important for the Ministry to provide effective overall leadership for the mission so that the Mission's goals are achieved and the implementation of the Mission's activities are not beset with the difficulties that have affected the implementation of Central sector programmes in the past.

However, the Mission is a major step forward and with greater State participation and effective monitoring of fund-usage, more localised mass-media efforts and community oriented health measures to tackle malnutrition and locally endemic diseases and raise awareness, has the potential to transform health delivery systems in the country.

Summary of recommendations

- ***The SHSs and DHSs should expedite the household and facility surveys and prepare State and district perspective plans, reflecting convergent functions of various government departments. The future annual State PIPs and district health plans should be based on long term requirements and results of baseline surveys.***

- ***Monitoring framework may be strengthened so as to ensure periodic impact assessment of activities for timely interventions.***

- ***The new health centres should be established in the under-served areas. Health infrastructure at CHCs and PHCs must be made functional with all essential infrastructure, equipment and manpower to ensure improvement in quality of healthcare in rural areas at an affordable cost.***

- ***States should fill sanctioned posts of medical and support staff at health centres and revise the sanctioned strength to meet the NRHM requirements. Full induction training may be given to all ASHAs to make their services viable and effective.***

- ***The RKS may be constituted and registered at all the remaining health centres with priority over other dimensions of community participation. The Samiti should be made a constructive partner in functioning of the health centres and to enable this, the accountability structure under the RKS may be clearly defined and management capacity may be generated.***

- ***Funds flow arrangement should be rationalised to ensure minimum unspent/excess amount is left outside government accounts.***

- ***The Ministry should review its interface banking arrangements in consultation with the Ministry of Finance. Interface banking should be preferred with public sector banks having maximum outreach and which offered the best possible terms.***

- ***There should be reasonable distribution of funds among various media of communication. IEC strategy and impact assessment should be rationalised with appropriate norms and criteria.***

- ***Disaggregated State-wise targets may be set in view of overall targets set by the Ministry for the country and State-wise progress may be measured on the basis of disaggregated targets and data. The opportunity to consolidate real-time data captured by ANM and health workers may be made use of.***

- ***The monitoring and reporting mechanism under Janani Suraksha Yojana should be strengthened so as to ensure availability of reliable information with the State and District Health Societies. This would help mitigate the risk of fraud and irregularities in grant of cash compensation under the JSY. The Ministry may emphasise that nodal personnel encourage data integrity under JSY at the Ministry and SHS level.***

(H. PRADEEP RAO)

New Delhi **Director General of Audit**

Dated: **Central Expenditure**

COUNTERSIGNED

New Delhi **(VINOD RAI)**

Dated: **Comptroller and Auditor General of India**

CHAPTER 2: PLANNING AND MONITORING OF THE MISSION

2. Planning and monitoring of the Mission

NRHM strives for decentralized planning. The District Health Societies (DHSs) were required to prepare perspective plans for the entire Mission period as well as annual plans consisting of all the components of the Mission. These were to be integrated into the State perspective plan and annual State Programme Implementation Plan (PIP) respectively. The NRHM focused on the village as an important unit for planning. However, realising the requirement of extensive capacity building to make villages capable of taking up a planning exercise, the Mission did not insist on village level plans for the first two years of its existence. Thus, Block Health Action Plans were to form the basis of the District Health Action Plan. Simultaneously, the Mission envisaged an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring.

2.1 District Health Society (DHS) and District Health Mission (DHM)

The NRHM aimed to ensure that need based and community owned District Health Action Plans (DHAP) become the basis for further interventions. The DHAP was to be prepared by the DHS and approved by the DHM. A DHS was to be constituted in each district by amalgamating all existing district level societies engaged in implementing national level health and family welfare programmes. The governing and executive bodies of the DHS were to meet at least twice a year and once a month respectively.

We observed that a DHM had been constituted in all districts of 18 States/UTs[3] and a DHS had been formed in districts of all States/UTs other than Jharkhand[4], Orissa and Puducherry[5] and uni-district UTs. The DHM had not been constituted in any district of Andhra Pradesh, Bihar, Delhi, Jharkhand, Madhya Pradesh, Mizoram and Uttar Pradesh. This meant that decentralised planning, as envisaged in the Mission, was yet to be achieved in these States.

The two bodies of the DHS met at the prescribed frequency only in Andhra Pradesh. The meetings of the DHS's governing and executive bodies were never held in any district of Himachal Pradesh and Puducherry. In Bihar, Manipur and Punjab the governing body had never met. In the remaining States, the meetings of these two bodies did take place intermittently and frequency was much less than prescribed. In Jammu & Kashmir, the governing and executive bodies of the DHS were not constituted separately.

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[3] A & N Islands, Arunachal Pradesh, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Meghalaya, Punjab, Rajasthan, Sikkim, Uttarakhand, Karnataka, Kerala, Manipur, Maharashtra, Tamil Nadu and Tripura.

[4] While the Department of Health and Family Welfare, Jharkhand stated that a DHS had been set up in all districts, it was not formed in any of the audited districts. Various disease control societies were functioning separately at the district level.

[5] DHS in three non-contiguous districts were set up as branches of the SHS and not as a registered society.

It is necessary to ensure the formation of DHS/DHM in all districts and conduct their meetings at regular intervals to fulfil the aim of decentralised planning for future health initiatives.

The Ministry agreed that the operationalisation of DHS and DHM had not occurred at the expected pace in some States and that it was being followed up with them. More regular meetings of the DHS were now being convened.

2.2 Baseline surveys

Under the Mission, annual DHAP were to be prepared on the basis of preparatory studies, mapping of services and household and facility surveys conducted at village, block and district level, which would act as the baseline for the Mission against which progress would be measured. The Mission targeted to complete 50 *per cent* of household and facility surveys by 2007 and 100 *per cent* by 2008.

While household surveys were conducted in all villages of eight States/UTs (Chandigarh, Chhattisgarh[6], Dadra & Nagar Haveli, Daman and Diu, Manipur, Punjab, Sikkim and Tamil Nadu), these surveys were not conducted in 20 States/UTs, viz. Andaman & Nicobar Islands, Bihar, Delhi, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Karnataka[7], Lakshadweep, Madhya Pradesh, Meghalaya[8], Mizoram, Orissa, Puducherry, Rajasthan, Tripura, Uttarakhand, Uttar Pradesh and West Bengal as of October 2008. In the remaining States (Assam, Arunachal Pradesh, Andhra Pradesh, Gujarat and Maharashtra) surveys were conducted, but the coverage was incomplete/partial.

Facility surveys at all levels of health centres were completed in eight States/UTs (Chhattisgarh, Dadra and Nagar Haveli, Daman and Diu, Himachal Pradesh, Jammu and Kashmir, Manipur, Puducherry and Sikkim). Facility surveys were completed at the CHC and the PHC levels in Assam; at the CHC level in Kerala and Orissa; at the PHC level in Jharkhand and at the Sub Centre level in Tamil Nadu.

In seven States/UTs (Andhra Pradesh, Bihar, Lakshadweep, Madhya Pradesh, Tripura West Bengal and Chandigarh) facility survey had not been conducted for any health centre. In the remaining 12 States/UTs, the facility surveys were only partially complete (Detailed in **Annex 2.1**).

Further, data on conduct of facility surveys provided by the SHS could not be verified during audit in four States as detailed in **Annex 2.1.**

2.2.1 Quality of baseline surveys

With a view to make the household and facility surveys meaningful for use in planning, these were to be conducted through local community action by engaging

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6 The data of the Community Need Assessment (CNA) Report which covered the demographic profile of the district such as population, actual availability of staff, medicine and vaccines needed, infrastructure and actual need of the concerned sub centre was used for planning.

7 Information on household surveys was not furnished by the SHFS. In six test-checked districts, household surveys were not conducted in any village.

8 DHSs of audited districts reported household surveys in 3701 villages leaving 954 villages uncovered. However, they did not furnish any record in support of conduct of household survey. Further, the SHS records also indicated that household surveys were not conducted in any village of the seven districts.

services of ASHA, Anganwadi Workers (AWW) etc. and district and block planning teams on a pre-approved format. The DHSs were required to organise training for the personnel to be engaged in conducting the baseline surveys.

However, the procedure adopted for baseline surveys did not provide enough assurance regarding quality of survey and usage of its results. In most States/UTs, household and/or facility surveys were conducted without training of the surveyors and without an approved format for the survey. In Jharkhand and Daman & Diu, the Health Society collected information in respect of facilities directly from the concerned health centres, without ensuring trained personnel's visit to the health centres. This compromised the objectivity and integrity of reporting. SHS Punjab stated that facility surveys had been completed, but during the audit it was seen that the two audited CHCs (out of 12), five PHCs (out of 24) and 12 Sub Centres (out of 48) had no information about the conduct of facility surveys.

Further, in 22 States/UTs, where the surveys had been conducted partially or fully, the data on the survey findings had not been consolidated by the SHS and the DHS. Only the SHS of Assam and Puducherry had maintained a database of survey results.

Due to absence of any comprehensive database, the gaps between demand for and availability of services could not be analysed on inter- and intra-district basis to prioritise the future course of health interventions. Moreover, the practice of sample verification of the correctness of surveyed data either by NGOs or by the DHS was not followed in any State/UT nor was the data validated by PRIs, as required under the framework of the Mission.

The Ministry stated that the household survey was an extension of the Eligible Couple Survey that already existed prior to the launch of NRHM. It had circulated the formats for surveys to the States in December, 2005 and the States were requested to follow up on the same. Further, District Level Household and Facility Surveys – III (DLHS-III) findings, published in late 2008, were being used in planning and monitoring. The Ministry also stated that the States were encouraged to undertake a facility survey of the various facilities so as to assess their status vis-à-vis the IPHS norms and prepare a plan for upgrading the facility to attain the IPHS norms.

We feel that the scope of household and facility surveys was designed to cover wider aspects than the Eligible Couple Survey. Moreover, while DLHS-III is a positive development, it can only supplement the household and facility surveys. While the DLHS was based on sample units, facility and household surveys were required to be conducted for all the units to enable preparation of need and gap based decentralized health action plans. The facility surveys conducted through DLHS-III did not take IPHS into account.

In the absence of complete household and facility surveys, the SHS could not assess pre-NRHM availability of healthcare services. Consequently, the evaluation of the requirement of future interventions based on relative need analysis and orientation would be inadequate. The discrepancies between data provided by the SHS and data verified during audit indicated weak reporting and monitoring.

2.3 Perspective and annual plans

2.3.1 Perspective Plan

Positive development

The perspective plan for the entire period was prepared for the state as well as each district in seven states/UTs, viz. Chandigarh, Chhattisgarh, Dadra and Nagar Haveli, Jammu & Kashmir, Punjab, Maharashtra and Sikkim.

The DHS and the SHS, under the NRHM guidelines, had to identify the gaps in the health care facilities, areas of intervention, probable investment, Central and State share that would be required for the entire Mission period (2005-12) as well as financial and physical targets. They were to prepare a perspective plan for each district and an overall perspective plan for the whole State for the Mission period (seven years) outlining the overall resource and activity needs.

We found that the progress regarding preparation of perspective plans was slow. In 18 States/UTs (Assam, Arunachal Pradesh, A & N Islands, Bihar, Daman and Diu, Delhi, Haryana, Himachal Pradesh, Kerala, Lakshadweep, Manipur, Meghalaya, Mizoram, Orissa, Puducherry, Rajasthan, Tamil Nadu and West Bengal), no perspective plan was prepared by the districts or by the State. In Jharkhand[9] and Uttar Pradesh[10], the perspective plan was prepared only by a few districts leading to non-preparation of the overall plan for the State.

In six States, viz. Andhra Pradesh[11], Gujarat, Karnataka, Madhya Pradesh, Maharashtra, and Tripura, the perspective plan for the State was prepared without the finalisation of perspective plans for districts.

The Ministry agreed that the process of preparation of perspective plan by the States and Districts for the Mission period was slow as it was a novel context which took time in getting internalized by the States. It also added that the NRHM framework for implementation was generic/non prescriptive which provided complete flexibility to the States to plan as per local requirements and did not prescribe fixed guidelines.

However, of the seven years of the Mission period, which was to be covered under the perspective plan, three years have already elapsed. In the absence of clear feedback on long term requirements of resources and activities, interventions under the Mission could become *ad hoc*. Significantly, out of 18 Special Focus States, perspective plans for districts and State were prepared in only three States.

2.3.2 State and district annual plans

The NRHM framework stipulated that the Project Implementation Plan (PIP) for the State be prepared annually by the SHS by aggregating the DHAPs of each district. The National Programme Coordination Committee (NPCC) of the Ministry under the chairmanship of the National Mission Director was to appraise the PIP and the

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[9] Two out of three test checked districts.
[10] 35 out of 70 districts.
[11] Rs. 2.30 crore @ Rs. 10.00 lakh per district was released during 2006-07 by the Commissioner of Family Welfare, AP, Hyderabad for preparation of perspective plan for the entire mission. However, Rs. 1.71 crore was spent for Dengue and Chikungunia and the balance of Rs. 58.75 lakh remained with District Medical and Health Officers concerned.

representatives of the State and National Health Missions were to appraise district annual plans. The guidelines issued by the Ministry prescribed a time schedule for all the activities under the planning process.

However, during 2005-08, the DHAP was prepared by all districts only in three State/UTs (Chhattisgarh, Chandigarh and Puducherry) while the annual district plan was not prepared by any district in nine States/UTs (Bihar, Daman and Diu, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Punjab, Tamil Nadu, Uttar Pradesh and Uttarakhand). In the remaining States/UTs, the district plan was not prepared by most districts in 2005-06, but the situation improved by 2007-08, detailed as below:

Table No.2.1: State wise status of preparation of DHAP during 2005-08

States where DHAP was prepared by SOME districts during 2005-08							
States/UTs	**No. of Districts**	**Districts NOT preparing DHAP**					
		2005-06		**2006-07**		**2007-08**	
		Number	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Information collected from SHSs							
Andhra Pradesh	23	22	96	22	96	22	96
A & N Islands	3	3	100	3	100	1	33
Madhya Pradesh	48	48	100	0	0	0	0
Maharashtra	33	33	100	33	100	0	0
Manipur	9	9	100	0	0	0	0
Meghalaya	7	7	100	7	100	0	0
Mizoram	9	9	100	9	100	0	0
Orissa	30	30	100	0	0	0	0
Rajasthan	32	32	100	32	100	19	59
Sikkim	4	4	100	4	100	0	0
Tripura	4	4	100	4	100	0	0
Delhi	9	9	100	0	0	0	0
Haryana	20	20	100	20	100	11	55
West Bengal	18	18	100	18	100	0	0
Information collected by Audit from sample districts							
Arunachal Pradesh	5	5	100	5	100	0	0
Assam	5	5	100	0	0	0	0
Karnataka	6	2	33	2	33	1	17
Gujarat	4	3	75	1	25	1	25
Kerala	3	Information not available				0	0

(Source: Information provided by SHSs and DHSs)

Further, in 11 States/UT (Haryana, Maharashtra, Meghalaya, Mizoram, Rajasthan, Arunachal Pradesh, Kerala, Orissa, Tripura, West Bengal and Delhi) DHAP was not prepared before the scheduled date of 31 October of the preceding year. Only in four States (Andhra Pradesh, Madhya Pradesh, Sikkim and Manipur) had the districts prepared their annual plan before the scheduled date. Moreover, the Ministry did not

participate in the appraisal of the DHAPs as required under the NRHM framework. In four States/UTs [Karnataka (Rs. 2.70 crore), Orissa (Rs. 2.58 crore), Puducherry (Rs. 39.43 lakh) and Daman and Diu (Rs. 20 lakh)] funds received for preparation of DHAPs remained unspent with SHS/DHS as of March 2008 for periods ranging from one to two years.

The State PIP was to be sent to the Ministry by the SHS for appraisal by 15th December of the preceding year and was to be approved by the NPCC by 31st January so as to ensure the finalisation of State PIP before the commencement of the financial year. The Ministry stated that during 2005-06 and 2006-07 the progress towards preparation of State PIP was not significant; in 2007-08 it received PIP from all the States/UTs. The NPCC appraisal of PIPs for the year 2007-08 did not take place before the commencement of the financial year and the PIPs of seven States were appraised in June 2007, of 24 States/UTs in July 2007 and four States/UTs in September 2007.

However, it is noted that there has been an improvement in the submission of DHAPs from 2007-08 onwards and that the appraisal of State PIPs for 2008-09 was completed before the commencement of the financial year.

The Ministry stated that the institutionalization of NRHM framework took some time, as planning required skills which were hitherto nonexistent and building capacity for the same at grassroots level takes time.

However, certain basic skills and systems for planning already existed in the form of State Planning Boards and District Planning Boards and institutional memory was already available in all the departments including the Health department. Moreover, in terms of the NRHM framework, the first year of the Mission was to be specifically devoted to institution building. There is, therefore, a need to coalesce already available knowledge in order to facilitate institution building. The initial years of the Mission period (2005-12) have elapsed without annual plans being prepared for all districts, diluting the very concept of decentralized planning.

2.3.3 Block and village level plans

Village and block level plans were to be prepared and consolidated into the DHAP forming the basis of all interventions under the Mission. Realising the requirement of extensive capacity building to make villages capable of taking up the planning exercise, the Mission did not insist on village plans for the first two years and therefore, Block Health Action Plans were to form the basis of DHAP.

However, the annual block plans during 2005-08 and village plan during 2007-08 were not prepared at all in 24 States/UTs[12]. In the remaining States/UTs, only partial preparation of block and village health plan had been done, and the progress was very slow. The absence of complete block and village plans hinders the achievement of the goal of decentralised planning. Under decentralised planning, the Mission provided untied funds and annual maintenance grants to the health centres up to the village

[12] Arunachal Pradesh, A & N Islands, Bihar, Chandigarh, Delhi, Dadra & Nagar Haveli (no block level office), Daman & Diu, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Lakshadweep, Maharashtra, Manipur, Mizoram, Orissa, Puducherry(no block level office), Punjab, Sikkim, Tamil Nadu, Tripura, Uttarakhand and Uttar Pradesh

level, allowed them to retain user charges levied for health services; gave untied grants to the Village Health and Sanitation Committees; set up Rogi Kalyan Samitis for facilitating autonomy to health centres; sought to bring health centres under community monitoring framework and aimed to ultimately bring the health centres under the community ownership. Thus, a weak planning effort meant that consequent positive spin offs were diluted and progress on related issues was delayed.

The Ministry admitted that building up of the capacity at the grass roots level to be part of the planning process took time and added that improvements in this regard had been noticed.

2.3.4 Outsourcing the task of planning

As per the NRHM guidelines, district and lower level plans were to be prepared annually by planning teams to be formed at each level under the leadership of the Panchayati Raj Institutions. However, in 11 States (Bihar, Haryana, Himachal Pradesh, Jammu and Kashmir, Meghalaya, Mizoram, Punjab, Rajasthan, Sikkim, Tripura and Uttarakhand) the SHS outsourced the task of district planning to private agencies which meant that the growth of in house capacity in decentralised planning was not fostered. Nor was work quality and output standardised.

In Mizoram, Punjab, Rajasthan and Tripura, planning was outsourced to a private agency without recording any justification for the same. In Bihar, Haryana, Himachal Pradesh, Meghalaya, Punjab, Rajasthan, Tripura and Uttarakhand the agency did not complete preparation of district plans within the stipulated time-frame. Moreover, in Haryana, Meghalaya, Punjab, Sikkim, Tripura, Uttar Pradesh and Uttarakhand the plans were not based on findings of the household and facility surveys, nor were the views of the Panchayati Raj Institutions taken into account. In Jammu & Kashmir, where the task of facility survey and district planning was outsourced to a private

Case study: Outsourcing planning

Bihar: The SHS paid Rs. 48.05 lakh to a private agency (April-June 2006) in contravention of the clause of contract signed with the agency, as the firm neither submitted any evidence of achievement of certain benchmarks along with its bills nor did it send a weekly report to the nodal officer of the SHS, as required under the agreement. The SHS terminated the contract with the agency in August 2006, after receiving reports on the poor quality of work from the Civil Surgeons of 17 districts and District Magistrates of four districts. The SHS did not redeem the bank guarantee of Rs. 25.47 lakh given by the firm (valid up to November 2006) and failed to safeguard the interest of the government.

Punjab: Payments to the agency were to be made in instalments after achievement of certain benchmarks prescribed in the contract. However, the SHS paid the entire dues of Rs. 44.94 lakh to the agency in January 2008, despite delays of 72 days in submission of the report on the benchmarks by the agency and deficiencies in the report pointed out by the Mission Director. The penalty clause for sub-standard work and clause for liquidated damages for delay in work were not included in the agreement signed with the agency. Moreover, while the agency submitted their report, the initial record/data from which these reports were complied were not available with the consultant itself and were reported to be lost. In the absence of supporting databases the report's utility was minimal. For instance, number of health centres without a good quality building or without electricity connection was given in the report, but health centre wise data on these issues were not available.

agency, the agency did not actually visit the health centres, but instead called health centre functionaries to the block level for filling up the facility survey forms.

The Ministry stated that outsourcing the task of planning adopted by some of the States has not diluted the building up of the capacity of the States. In Bihar, the outsourcing of district planning led to litigation; but, this should not be taken as derailment of planning process as considerable progress in facility access and improvement in maternal and child health indicators had occurred in Bihar. Further, in Tripura and Rajasthan, Joint Review Mission (JRM) findings indicated that PRIs had participated in the planning process.

However, in all the eight States where decentralised planning was outsourced, plans were neither prepared within the stipulated time nor in accordance with guidelines for district planning. In Bihar, the district plan was not prepared by any district even in 2008-09.

The NRHM made progress but was slow in initiating decentralised bottom-up planning primarily due to non-completion of the work of household and facility surveys and State specific perspective plans for readiness assessment. The salient feature of the scheme was localised bottom-up planning yet NRHM interventions proceeded without baseline surveys leading to, in effect top-down planning due to the skill gap at the grass root level. While the Mission succeeded in setting up health societies at the district and State levels in most of the States, it did not succeed in mainstreaming them. Since, capacity building appeared to be taking time; some states outsourced planning, resulting in lack of community participation which was one of the primary objectives of the Mission. These surveys were also not very productive as the plans were not prepared in time nor were standardised in accordance with the NRHM guidelines.

2.4 Monitoring of activities under the Mission

2.4.1. Meetings of Mission Steering Group

The NRHM framework was approved by the Cabinet in July 2006, i.e. a year after the formal launch of the Mission. The Cabinet empowered the Mission Steering Group (MSG) to approve financial norms in respect of all schemes and components which were part of NRHM and allowed the Empowered Programme Committee (EPC) the flexibility to change financial norms approved by the MSG within a range of (+) 25 *per cent*. The MSG was required to periodically monitor progress of the Mission and to meet twice a year. To review the progress, Secretaries (Health & Family Welfare) of four high focus states were to be nominated by the Ministry as members of the MSG for a period of one year each by rotation.

The MSG, however, met only four times in four years, during 2005-09, instead of eight times as envisaged. The delegation of powers to the MSG and EPC was subject to the condition that a progress report regarding NRHM, also indicating deviation from the financial norms and modifications in ongoing schemes would be placed before the Cabinet on an annual basis. However, during the past four years, the Mission had submitted a progress report to the Cabinet only once in August 2008.

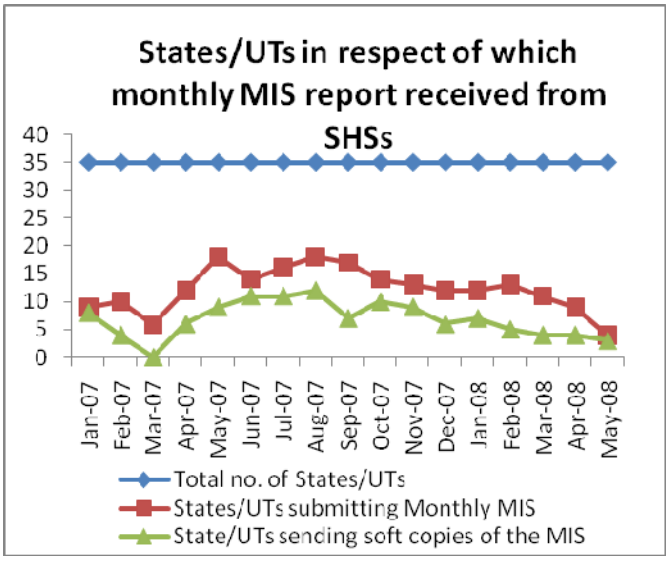
The Ministry stated that the empowerment of the MSG was received from the Cabinet in July, 2006 and since then, the MSG had held four meetings till May 2009.

However, the order of 4 May 2005 establishing the MSG had stipulated that it would meet at least twice a year. The first meeting of the MSG was held on 30 August 2005 and only three meetings (in September 2006, July 2007 and August 2008) of the Group had been held since then, against the requirement of seven meetings up to May 2009.

2.4.2 HMIS reporting system

The NRHM framework envisages intensive accountability structures based on internal monitoring through computer based monthly Health Management Information System (HMIS).

The Ministry could not adhere to the proposed date of December 2005 for implementation of the computerised MIS due to continuous revisions in the MIS format by the Ministry. The revised MIS format was sent to the States/UTs in August 2006. MIS user guidelines were subsequently being developed by the Ministry, but remained unfinalised until July 2008.



State/UT sent the quarterly and annual MIS reports to the Ministry regularly. Feedback received from the States via the revised monthly reports was also poor and the quantum of reports received showed a declining trend as indicated in the graph.

In the absence of adequate data for analysis, no formal performance report of the Mission could be prepared despite the NRHM moving into its fourth year of operation. The Ministry prepared a report on key indicators but that too was limited and based on the reports furnished by only 13 States. As the States/UTs were not providing data on a regular basis and the Ministry had also not emphasised on the same, the funds release could not be linked to performance as envisaged in the NRHM framework.

The Ministry accepted that the reporting was weak. It stated that based on the feedback from the States, a MIS format was developed and the HMIS portal was launched in October, 2008 which was followed by State and District level training and orientation. It added that a majority of the districts had uploaded data on the portal for 2008-09.

2.4.3 Computerisation and MIS in States

Under the NRHM framework, each DHS was to develop a computer based Management Information System and report monthly to the SHS. The computerisation of health centres under the NRHM up to block level and networking under the Integrated Disease Surveillance Project (a component of the NRHM) were necessary for reporting through the MIS.

Computerisation of block level health centres had not taken place in any block in Delhi and Uttar Pradesh or only in some blocks in Jharkhand and Uttarakhand. In Bihar and Karnataka even all the districts had not been computerised. The SHS Lakshadweep and A & N Islands had not started the computerisation of health facilities at all.

Success story

In 13 states/UTs (Assam, Chhattisgarh, Chandigarh, Dadra and Nagar Haveli, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Maharashtra, Orissa, Punjab and West Bengal) district as well as block level computerisation of health facilities was complete. In Andhra Pradesh all districts, except one, and all blocks, except 183, were computerised.

The targeted installation of 796 broadband connections under the Integrated Disease Surveillance Project for district level networking was only complete in 555 cases (70 *per cent*) and the remaining 241 sites (30 *per cent*) were not connected through a network. In D & N Haveli, Daman and Diu, Delhi, Lakshadweep and Sikkim, none of the districts were connected through a network, while in Arunachal Pradesh, Bihar, Jammu and Kashmir, Jharkhand, Manipur, Mizoram and West Bengal more than half of the districts were not connected through the network. In the remaining States, district level networking had been mostly completed under the IDSP.

DHSs were sending the monthly MIS reports to the SHS in time in seven States/UT (Andhra Pradesh, Assam, Karnataka, Gujarat, Himachal Pradesh, Maharashtra and Puducherry) or with delays in five States (Arunachal Pradesh, Chhattisgarh, Haryana, Orissa and Rajasthan).

Case study: Computerisation of health centres in two states

Jharkhand: An MOU was signed between Jharkhand Health Society (JHS) and a private agency to install Healthcare Information Management System (HIMS) in Ranchi district in December 2004. JHS awarded the project to the agency on selection basis without inviting tender and paid Rs. 3.15 crore from April 2005 to December 2005 as advance. However, the internet connections were either not provided or were out of order since installation of HIMS and data/information for compilation of reports at district level were being collected manually from the PHCs and consolidated by the agency. At district level, no analytical reports were generated. The agency never made the system fully functional. The training provided to the officials to run the system was inadequate and in some cases the lone trained PHC staff were subsequently transferred elsewhere. The agency was to provide maintenance of the system up to 31.10.2008 but the department cancelled the work order in March 2008 without adjusting the advances. Consequently, the HIMS project failed and resulted in infructuous expenditure of Rs. 3.15 crore.

Tripura: The SHS awarded work order to a private agency in January 2007 for implementing the first phase at a cost of Rs. 1.32 crore of the three-phase work of implementing MIS system. The work was to be completed by July 2008 and Rs. 66.22 lakh (50 *per cent* of the work order) was given as advance against the bank guarantee. The work was not completed till August 2008. One of the major component of work, i.e. supply of battery operated SIMPUTER or Monochrome PDA Units' (which was required for field level entry in 243 sub-centres) costing Rs. 32.50 lakh, was kept in abeyance by the SHS without any reason on record. The company took up only 33 health institutions (out of targeted 37) for development of HMIS and out of 33, works at 10 centres was held up due to absence of data entry operators.

However, in Meghalaya, Mizoram and Punjab despite internet connectivity in all the districts, monthly MIS reports to the SHS were not being sent. In Tamil Nadu, the MIS had not been developed as the network under IDSP was still under testing process by National Informatics Centre at State and District levels. In Bihar, the MIS reports were prepared on the basis of telephonic conversations with the lower level functionaries without validation of data, thus making these unreliable. In Jammu and Kashmir, reports were being collected by health centres and submitted to DHS and SHS without any analysis of data collected. In Orissa, data furnished in three MIS reports of a district did not match with the data furnished by the CHCs, PHCs and Sub Centres. Thus it was clear that the networking and generation of reports through the MIS was not achieved according to a phased timeline and data flow, availability and integrity was intermittent and doubtful.

2.4.4 Public report on health

As envisaged under the NRHM, each district was required to publish a public report on health annually. During 2005-08, in most districts DHSs did not publish an annual report on public health[13].

The Ministry stated that that annual public report on health depended on the level of community participation and hence had a long gestation period. As the health MIS and local capacities improved; more districts would be able to publish the annual public report on health.

However, while the presence of a long gestation period can be appreciated, district-wise annual reports on health can be made a part of overall reporting framework. The annual report need not necessarily be a comprehensive document and in the initial years it may contain only output and outcome indicators, survey results etc., but these would provide signposts for further progress and a record of development would be in place.

The monitoring of the activities under the Mission needed strengthening. Delay in the issue of the final guidelines on reporting by the Ministry resulted in deficient reporting through monthly MIS report from the DHS to the SHS and from the SHS to the Ministry. In the absence of a strong monitoring mechanism, the planning process did not receive regular inputs and feedback on the nature and direction of required future interventions. It is expected that the newly launched HMIS web-portal will add adequate strength to the monitoring framework, but the veracity of data uploaded by districts will remain a challenge for the Mission.

Recommendations

- ***The SHSs may be asked to undertake household and facility surveys as per programme guidelines without delay so as to frame district and lower***

[13] Only one district of Andhra Pradesh had published the public report annually. Four districts of Assam in 2007-08 and one audited district of Rajasthan in 2006-07 had also published the report. In Puducherry, the SHS published the public report annually district wise. In Chandigarh, an annual public report (AAKAR) on health was published in August 2007 and June 2008, but the data published in the report in June 2008 under the Family Welfare Programme did not match with data reported to the Ministry.

level plans compatible with current service availability and future need/demand interventions.

- ***A comprehensive central database may be prepared for all districts and the State as a whole, in electronic form and may be uploaded on the SHS's website for easy access by district planning teams.***
- ***SHSs may be asked to adhere to the framework of decentralised planning to ensure that the State PIP reflects the requirements based on actual demand.***
- ***Outsourcing of the task of decentralised planning should be reduced and phased out gradually and community capacities fostered instead.***
- ***Skill gap in planning at the grass root level may be bridged through capacity building and training, if necessary.***
- ***Monitoring framework may be strengthened so as to ensure periodic impact assessment of activities for timely interventions. A mechanism for sample verification of data by competent authorities may be put in place.***
- ***A monthly and annual report on issues pointed out by lower level monitoring committees and action taken thereon may be prescribed for DHSs and SHSs so as to make monitoring more effective.***

CHAPTER 3: COMMUNITY PARTICIPATION

3. Community involvement under the Mission

NRHM envisaged involving Panchayati Raj Institutions and the community in the management of primary health programmes and infrastructure, empowering the community to take leadership in health matters, put in place a pool of community workers and establishes institutional arrangement for community involvement in planning, management and monitoring of the Mission through setting up community based Planning and Monitoring Committees at State, district, block, PHC and village levels, Rogi Kalyan Samiti at District Hospitals, CHCs and PHCs and Village Health and Sanitation Committee in every village.

3.1 Community representation in planning and monitoring

As per the NRHM framework, every SHS was to constitute health planning and monitoring committees at village, PHC, block/CHC, district and State levels with representation from elected bodies of appropriate level, self-help groups/NGOs, user groups and government departments. 50 *per cent* of the community planning and monitoring set up was to be in place by the end of March 2007.

The Ministry constituted an Advisory Group for Community Action (AGCA) in August 2005 to develop the process of community planning and monitoring and build the capacity required. A detailed system of community planning and monitoring was started on a pilot basis in nine States viz. Tamil Nadu, Orissa, Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra and Rajasthan with the assistance of AGCA in a phase-wise manner[14].

The progress on community planning and monitoring so far made under the pilot project indicated that against the target of 1620 VHSCs, 324 PHC level committees, 108 block level committees and 36 district level committees envisaged to be operationalised in nine pilot States, only 1441 VHSCs (89 *per cent*), 173 PHCs (53 *per cent*), 34 blocks (31 *per cent*) and 12 district (33 *per cent*) level committees respectively had been set up. No committee was operational in Chhattisgarh. District and block level community monitoring committees had not been constituted in any of the selected districts and blocks in Assam, Jharkhand, Karnataka, Madhya Pradesh and Maharashtra (five States). In the absence of block level committee, other activities such as block providers' level workshop, media workshop and publishing of village report cards were also pending. Besides, Jan Sunwai at block and PHC level had not been conducted in any State, other than Maharashtra where Jan Sunwai was conducted in 13 out of 45 PHCs targeted under the pilots.

The progress on activities under community planning and monitoring made so far under the pilot project was not commensurate with targets. The target of setting up 50 *per cent* of various committees and activities by the end of March 2007 had not been achieved in any of the nine pilot States till July 2008. Review and revision of the

[14] National preparatory phase (March 2007 to May 2007), State preparatory phase (April 2007 to June 2007), Pilot implementation in the district (July 2007 to December 2007) and process documentation and review (July 2007 to January 2008)

State pilot projects was also not undertaken. Non-formation of community planning and monitoring committees at various levels adversely affected the monitoring of the programme by various stakeholders.

The Ministry stated that the process of community based monitoring and planning was by nature, a slow activity, which was acutely dependent upon capacity of the community to undertake organised and concerted action. The type of community empowerment, envisaged under NRHM, had never been attempted in any other department or programme. However, efforts were being made to accelerate the initiative so as to improve efficiency of the Mission.

However, the Ministry's correlation of delays in setting up community based planning and monitoring committees with the community's apparent inability to undertake organised and concerted action is not entirely correct. The AGCA delayed publishing manuals for (a) workshop, orientation and training of planning and monitoring committees, (b) monitoring framework and (c) management/ organisational responsibilities in respect of community monitoring until between December 2008 and March 2009. Thus the initial delays in outlining the manner of streamlining and encouraging community participation meant that no concerted effort towards this goal was made.

3.1.1 Complex design of community partnership

The framework of NRHM prescribes a multiplicity of committees at various levels details of which are as under:

Level	Name of the Committee	Membership structure
District	(i) District Health Mission	Chairman of Zilla Parishad, local MPs, MLAs, government officials and PRI and NGO representatives
	(ii) District Health Society	Governing body - District Collector, government officers and NGO representatives Executive committee - Civil Surgeon/CMO, government officials and NGO representatives
	(iii) District Health Planning and Monitoring Committee	PRIs, NGOs and government officials
	(iv) Rogi Kalyan Samiti (RKS) of District Hospital	PRIs, NGOs, CBOs and government officials Monitoring Committee under RKS - Composition not yet prescribed
Block	(i) Block Health Mission	Composition not yet prescribed
	(ii) Block Health Society	Composition not yet prescribed
	(iii) Block Health Planning and Monitoring Committee	PRIs, NGOs, CBOs and government officials
	(iv) Rogi Kalyan Samiti of the CHC	PRIs, NGOs, CBOs and government officials Monitoring Committee under RKS - Composition not yet prescribed
Village	(i) PHC Health Planning and Monitoring Committee	PRIs, NGOs, CBOs and government officials
	(ii) Rogi Kalyan Samiti of the PHC	PRIs, NGOs, CBOs and government officials Monitoring Committee under RKS - Composition not yet prescribed
	(iii) Village Health and Sanitation Committee (in each village with 1500 population)	PRIs, ANM and ASHA

Each of the committees was designed to draw their membership from nearly similar sources and was to perform two sets of functions, viz. (i) planning and monitoring, and (ii) implementation, thus creating an overlap[15].

The Ministry stated that the institutional framework of NRHM as contained in framework for implementation was prepared after due consultations with experts and all stakeholders and had been approved by the competent authority.

It is not clear as to whether this complex structure would ultimately succeed in delivering the envisaged results, since it was noticed that the multiplicity of institutions and committees at district and sub-district levels resulted in delay in their constitution at different levels. Wherever formed, these functioned with varying degrees of effectiveness (discussed in succeeding paragraphs). This could affect expeditiously achieving the goal of effective community participation.

3.2 Village Health and Sanitation Committee

A Village Health and Sanitation Committee (VHSC) was to be formed in each village within the overall framework of the Gram Sabha. The VHSC was to be responsible for village level planning and monitoring. The Ministry had set the goal of constituting VHSC in 30 *per cent* of six lakh villages by 2007 and 100 *per cent* by 2008. Every village with a population of up to 1500 was to receive an annual untied grant of up to Rs. 10,000, after constitution and orientation of the VHSC. The untied grant was to be used for household surveys, health camps, sanitation drives, revolving fund etc. The Mission envisaged setting up of a revolving fund at village level by the VHSC for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization.

Success story

Against the target of formation of VHSCs in 30 per cent villages by 2007, VHSCs were formed in all villages of Andhra Pradesh, Sikkim, Manipur, Tamil Nadu and Puducherry.

The progress towards formation of the VHSC showed the scope of improvement in the Special Focus States. In nine States/UTs, the VHSC had not been formed in any village. In Rajasthan and Uttar Pradesh the Committee was formed in less than 30 per cent of the villages. In 14 States/UTs, VHSCs were formed in 30 to 96 per cent of the villages. The State wise status is at **Annex 3.1**.

During 2006-07, untied grants of Rs. 123.62 crore was approved/released to 19 States whereas VHSCs were formed only in two States resulting in non-utilisation of Rs. 119.28 crore released to the SHSs for the VHSCs. Similarly, during 2007-08, Rs. 282.52 crore was approved/released as untied grants to the health societies of 28 States/UTs. However, no VHSCs were formed in eight States/UTs.

[15] For instance, at the block level plans were to be prepared by the Block Health Society and approved by the Block Health Mission, the task of monitoring was entrusted to the Rogi Kalyan Samiti; while Block Planning and Monitoring Committee was also required to be set up for planning and monitoring purposes.

The revolving fund was not created with VHSCs in any State, (except Sikkim and Manipur) due to delayed setting up of VHSCs and consequent delays in release of grants to them.

The Ministry stated that they had issued detailed guidelines for VHSCs approximately two years back. However, the percolation of information and its implementation had taken time.

The delay in percolation of information to the grass roots, indicated that the goal of improving the healthcare delivery by setting up health societies at the State and district levels and orienting them to work in Mission mode met with limited success.

3.3 Monitoring/validation of data by the community

In terms of the NRHM framework, a desirable outcome of the Mission was to enable the community and community based organisations to become equal partners in the planning process. The community monitoring framework could be used for validating the data collected by the ANM, Anganwadi Worker (AWW) and other functionary of the public health system. The practice of validation of data collected by the ANM, AWW etc. or monitoring of data collection process by the local community/representatives of PRIs had not been initiated in any State/ UT except A & N Islands and only partially in Rajasthan (the data was validated by PRI in 13 out of 72 tested Sub Centres).

The Ministry stated that the data collected by ANM, AWW etc. is proposed to be triangulated (compared with each other) against the other sources of information including survey reports, community reports, findings of public hearings etc. and should not be viewed as a system of community validation of data.

The concept of triangulation of data is a commendable innovation. However, the Ministry needs to encourage the development of a system for sample verification of data as an internal control to improve data integrity.

3.4 Rogi Kalyan Samities (RKS)

3.4.1 Setting up of RKS

As per the NRHM guidelines, the RKS were to be constituted and registered under the Societies Registration Act, 1860 for efficient community management of healthcare centres up to the PHC level under the Panchayati Raj framework by 2007-08. A grant of Rs. 1 lakh per PHC/CHC and Rs. 5 lakh per District Hospital was to be given to the States for PHCs/CHCs/District Hospitals, wherein RKS had actually been constituted. RKS had been authorized to retain the user fee at the institutional level for its everyday needs.

Case study: RKS in Punjab

The health centres were under the control of the Punjab Health Systems Corporation (PHSC) since October 1996. The SHS transferred Rs. 2.44 crore to PHSC (April, 2007) for further release to the RKS. However, no RKS was constituted by the PHSC on the ground that hospitals were under their control and management which was already an autonomous body constituted through a special Act. The PHSC issued instructions that amount released as corpus grant at the rate of Rs. one lakh to each CHC may be utilised by the Medical Officers in consultation with the Civil Surgeon by involving the representatives of local MLAs and Deputy Commissioners. The reply of PHSC that NRHM guidelines were merely guidelines not instructions was incorrect. Further the SHS released Rs. 3.63 crore to 484 PHCs @ Rs.75000/- each PHC with the instructions to constitute an alternate committee at PHC level i.e. PHC Management Committee headed by Senior Medical Officer/Medical Officer in-charge PHC till the RKS was constituted. The release of Rs. 2.44 crore for RKS at District Hospitals, Sub Divisional Hospitals/CHC level and Rs. 3.63 crore to 484 PHC level RKS without constitution/registration of RKS was incorrect.

The RKS was formed at every health centre in Chandigarh, Gujarat, Jammu & Kashmir, Kerala, Manipur, Mizoram, Rajasthan, Sikkim, Tamil Nadu and West Bengal. However, in Delhi and Punjab, no RKS was formed. In the remaining 21 States/UTs, the RKS was formed at 420 District Hospitals and was not formed at 29 District Hospitals of seven States/UTs. At CHC level, the Samiti was formed at 2069 CHCs and was not formed at 166 CHCs involving 10 States/UTs. The shortfall was more striking at the PHC level. While the Samiti was formed at 8514 PHCs, it was not formed at 6023 PHCs of 20 States/UTs. The State wise status of shortfall in formation of the RKS is highlighted in **Annex 3.2.**

During 2006-07, the Ministry released Rs. 92.76 crore to 15 States as grants for the RKS. However, in 11 States, Rs. 41 crore was released in excess of the requirements, which were calculated on the basis of details about the number of RKS formed and registered by the end of the financial year (details in **Annex 3.2**). This resulted in an unspent balance of Rs. 41 crore with 11 States as of August 2007.

3.4.2 Proceedings of the RKS bodies

The Governing Body and the Executive Body of the RKS were required to hold meetings on a quarterly basis and monthly basis respectively for reviewing the functioning of healthcare facilities. The RKS was to submit a monthly report to the DHS and give recommendations for improvement of the healthcare system.

Positive development

In Andhra Pradesh 6 District Hospitals, 10 CHCs and 21 PHCs made recommendations to the District Health Society (DHS). The DHS took immediate action on sanitation matters. The feedback on action taken by the DHS was communicated to the RKS in all test-checked cases.

The meetings of the RKS bodies did not take place at the prescribed/regular intervals in any State. In Assam, Puducherry (9 PHCs), Rajasthan (6 CHCs and 13 PHCs) and Karnataka (two District Hospitals), records of meetings of the RKS were not maintained. No meeting of the RKS was held in Haryana, Karnataka (one District Hospital), Lakshadweep and Manipur[16] (3

[16] At one CHC meeting was held regularly

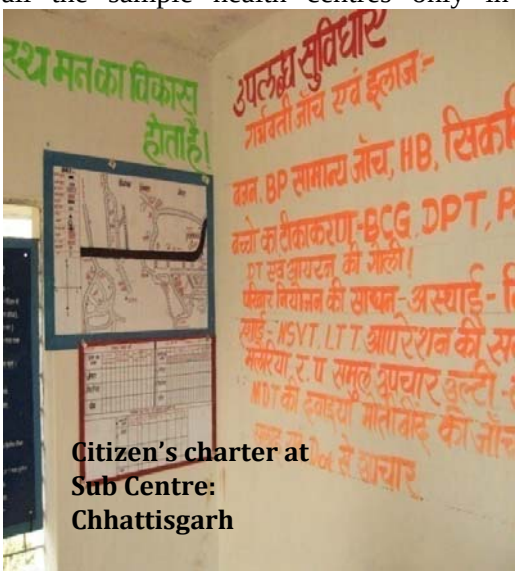
District Hospitals, 5 CHCs, 14 PHCs). In Jammu & Kashmir, Jharkhand, Kerala (RKS not registered) and Tamil Nadu, the governing body and executive body were not formed separately under the RKS.

Further, monthly reports, and hence recommendations for improvement of the healthcare system, were not sent by the RKS in most States (except Andhra Pradesh, Chhattisgarh and Rajasthan).

3.4.3 Efficacy of monitoring by RKS

The RKS was to develop and display a charter of citizens' health rights at each level of health facilities so as to make healthcare users aware of their health rights and facilities available. Compliance with the citizens' charter was to be ensured through operationalisation of a grievance redressal mechanism. A monitoring committee was to be constituted by the RKS to visit hospital wards and collect patient feedback for remedial action.

The citizens' charter was displayed at all the sample health centres only in Puducherry, Punjab, Delhi and Manipur. In Andaman & Nicobar Islands, Haryana, Himachal Pradesh, Bihar, Jharkhand, Lakshadweep, Orissa, Mizoram, Tamil Nadu, and West Bengal, the charter was not displayed in any of the audited health centres and other than in Andaman & Nicobar Islands and Tamil Nadu, the SHS had also not issued any instructions/ guidelines for the display of citizens' charter at health centres. In the remaining States/UTs, the citizens' charter was displayed at some health centres and not displayed at others. At 66 District Hospitals of 13 States/UTs, the charter was displayed but was not displayed at five District Hospitals of three States. At the CHCs, the charter was displayed at 123 centres of 15 States, while at 77 CHCs of 15 States/UTs it was missing. At the PHCs, the shortfall was quite considerable, while the charter was displayed at 178 centres of 14 States/UTs; it was not displayed at 221 PHCs of 16 States/UTs.



Citizen's charter at Sub Centre: Chhattisgarh

In Arunachal Pradesh, Sikkim and Manipur, the citizens' charter was not displayed in the local language. In Andhra Pradesh, Assam, Gujarat, Kerala, Karnataka, Jammu & Kashmir, Maharashtra, Punjab, Rajasthan, Uttar Pradesh and Uttarakhand, the citizens' charter was displayed in the local language.

Barring a few exceptions, a mechanism for redressal of the grievances of individuals and the community regarding demand/need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, denial of care and negligence was not institutionalised, nor was the reference to a grievance redressal mechanism found in the citizens' charter displayed at sample health centres in any State.

The monitoring committee was not constituted in most of the test checked Health centres where the RKS had been set up. The monitoring committee under the RKS, where formed, had neither collected feedback from the patients on presence and conduct of health care personnel nor sent any report to any authority and hence was mostly dysfunctional.

3.4.4 Levying of user charges by the RKS

The RKS was to prescribe user charges for non-BPL patients for various types of services rendered by the healthcare centres. The only condition for release of central grants to the States for the RKS was that the Samiti would levy the charges and retain the money received on account of those charges for using them as per local needs.

In Andaman & Nicobar Islands, Andhra Pradesh, Jammu & Kashmir, Puducherry, Punjab, Sikkim, Arunachal Pradesh, Tamil Nadu and Jharkhand, no user charges were collected from non-BPL patients. In Gujarat and Karnataka, the RKS of PHCs did not levy any user charges. At 6 CHCs and 19 PHCs in Rajasthan, 14 CHCs and 30 PHCs in West Bengal and 2 CHCs and 17 PHCs in Tripura, user charges were not levied.

The Samitis were authorised to retain only 50 *per cent* of the amount of user charges in Uttar Pradesh. In West Bengal, the RKS could retain 40 *per cent* of the collection of user charges in 2005-06 and 80 *per cent* of all additions to the 2005-06 level subsequently. In Lakshadweep, user charges were deposited into government account. In Bihar, all the CHCs were levying users charges at the rate of Rs one per patient instead of Rs 2 per patient as prescribed by the government.

The Ministry stated that money was provided to RKS to operationalise a transparent management structure with public participation.

However, release of the funds to States not levying user charges was not in accordance with the Framework for Implementation of the NRHM.

3.4.5 Flow of funds to the RKS

RKS at a district hospital was to receive a corpus grant of Rs. 5 lakh per year. At CHCs and PHCs, the Samiti was to receive annual corpus grant of Rs. 1 lakh each, annual untied grant of Rs. 50,000 and Rs. 25,000 respectively and annual maintenance grant of Rs. 1 lakh and Rs. 50,000 respectively as Central grants. Besides, the RKS were to receive grants from State Governments and were supposed to generate their own resources through levying user charges, receiving philanthropic donations etc. From 2007-08 onwards, the funds at RKS from three sources, viz. internal, State and Centre, were to maintain a ratio of 1:1:3.

The RKS did not receive all the three central grants every year after their constitution in any State. Further, the State/UT Governments of A & N Islands, Andhra Pradesh, Arunachal Pradesh, Haryana, Jammu & Kashmir, Maharashtra, Mizoram, Punjab, Jharkhand, Orissa, Tamil Nadu, Lakshadweep and Sikkim had neither made their contribution nor had the RKS been able to generate resources to maintain the prescribed ratio of sources of RKS funds.

In the remaining States, while the RKS had generated internal resources, chiefly through collection of user charges[17], the State government had not made any contribution to the RKSs in any State/UT other than Gujarat and Bihar. Further, there was no mechanism at the SHS to verify that the prescribed ratio of funds at RKS was adhered to.

In Bihar, the State Government released an amount of Rs 10.12 crore in December 2007 for annual grant of RKS for 84 Referral Hospitals (RH equivalent to CHC) and 470 PHCs[18] disregarding the fact that the RKS had been formed only at 44 RHs and 311 PHCs in the State as of March 2008. Further, the RKSs concerned could not receive this grant as the funds remained in the bank account of the civil surgeon and subsequently lapsed. In addition, the central fund of the RKS at the rate of Rs 1.5 lakh per PHC and Rs 2 lakh per RH (CHC) was provided to Medical Officer in-charge of three PHCs and one RH in Bihar having no RKS.

In Uttar Pradesh, Rs. 36.60 crore was released for all PHCs (3660) as corpus grants as against the eligible PHCs (only 560) in which RKS had been formed. Thus, Rs. 31 crore released to 3100 PHCs was in contravention of both the norms of financial discipline and the framework of the NRHM.

3.4.6 Utilisation of funds by the RKS

Considerable funds were with the Rogi Kalyan Samitis for their use as per local requirements. The utilisation of funds available with the RKS was, however, very low. In 16 States/UTs, 31 to 98 per cent of the funds available with the RKS remained unspent. The details are as follows:

Table 3.1: Funds utilisation by RKS in sample districts during 2005-08

(Rs. in crore)

State/UT	No. of RKS	Funds with RKS	Expenditure incurred	Unspent amount	Unspent amount as per cent of total funds
Bihar	52	1.57	0.03	1.54	**98.25**
A & N Islands	19	0.21	0.01	0.20	**97.56**
Manipur	38	0.66	0.12	0.54	**81.95**
Jharkhand	78	0.85	0.15	0.69	**81.78**
Meghalaya	98	1.98	0.55	1.43	**72.08**
D & N Haveli	1	0.20	0.09	0.11	**53.36**
Uttar Pradesh	78	2.88	1.22	1.67	**57.79**
Orissa	269	1.87	0.80	1.06	**57.05**
Jammu & Kashmir	136	1.53	0.67	0.85	**55.80**
Chhattisgarh	22	0.68	0.34	0.34	**50.17**
West Bengal	305	5.58	2.85	2.73	**48.98**
Gujarat	30	15.13	7.91	7.22	**47.73**
Maharashtra	525	6.69	4.15	2.54	**38.02**
Assam	230	6.12	3.80	2.32	**37.94**
Himachal Pradesh	14	1.96	1.29	0.67	**34.28**
Karnataka	59	9.41	6.50	2.91	**30.91**
Total	**1954**	**57.31**	**30.48**	**26.83**	**46.82**

(Source: Information provided by SHSs/DHSs/health centres)

[17] Only one RKS of Lakhimpur District in Assam has generated resources through philanthropic donations from ONGC for Rs.2.00 lakh.

[18] Only 70 RH and 398 PHCs existed in the State

Further, in Assam, Chhattisgarh, Jammu & Kashmir, Madhya Pradesh[19], Uttar Pradesh, Uttarakhand and Jharkhand the books of accounts and subsidiary records like cash book, vouchers, ledgers etc., were either not maintained or not maintained as per government accounting rules of the States. Discrepancies in expenditure by the RKS were also noticed in 13 States/UT as detailed in **Annex 3.3**.

The Rogi Kalyan Samiti, which was designed as a pro-active intervention under the Mission to ensure the goal of reliable and accountable health delivery through community ownership of the health centres was not functioning as prescribed under the NRHM framework. There were delays in setting up of the Samities and in most of the States, particularly in Special Focus States, the RKS was yet to be constituted at each health centre. Wherever established, the failure to hold prescribed number of meetings of the governing and the executive bodies affected the regular management and monitoring of the activities of the health centres by the RKS. The general performance of the health centres was not reviewed by the Samities, as the Samities did not send the reports and suggestions to higher levels for improvement of facilities and services available at health centres. The accountability structure under the RKS framework was further weakened by the non-institutionalisation of grievance redressal mechanism, non-display of citizen charters at the majority of tested health centres and non-formation of monitoring committees under the RKS.

The Ministry released RKS funds to the State Health Societies for all health centres without confirming the constitution of RKS at the health centre and authenticating the fulfilment of the condition of levy and retention of user charges by the RKS.

The Rogi Kalyan Samitis were not receiving the prescribed grants from all the sources, specially from the State Government nor were they able to generate their internal resources, other than the user charges which had been prescribed mostly by the State Government. Thus the nature of funding affected the viability of the long term goal of community ownership of the health centres through the RKS. Funds available with the RKS, mostly remained unutilised due to lack of generation of capacity within the Samiti to incur expenditure.

In response to the observations on the functioning of RKS, the Ministry stated that it had issued detailed guidelines for RKS approximately two years back. The percolation of information and its implementation had taken time. The functioning of the RKS was under the overall supervision of the State Government through the Mission Director, NRHM. It added that the Ministry conducted regular surveys to review progress and take appropriate remedial actions.

However, the Ministry's contention that the inadequacies in the functioning of the RKS was due to the inability of the State Governments to implement the Mission, needs to be seen in perspective. RKS is an innovation to encourage quality health services through community participation. The RKS was functioning within the ambit of autonomous health societies in the States and districts, receiving funds and directions from the Ministry directly, and so the Ministry had a guiding role to play.

[19] at three PHCs

3.5 Interaction with the community

Community action was to be catalysed through conducting public hearings (Jan Sunwai) or Public dialogues (Jan Samvad) which were required to be conducted at PHC, block and district levels once or twice in a year. Health camps were also to be organized to bring a range of health services to the community and make them aware of their entitlements.

Jan Sunvai/Jan Samvad was not conducted at PHC, block and district levels in most States. Only in Chhattisgarh, Gujarat, Rajasthan and Tripura were these conducted and that too not on a regular basis at each centre at every level.

Further, no health camps were organised at any level in Bihar, D & N Haveli, Daman Diu, Haryana, Himachal Pradesh, Jharkhand and Jammu & Kashmir. In Assam, Chhattisgarh, Maharashtra, Madhya Pradesh, Puducherry, Punjab, Rajasthan, Sikkim, Uttarakhand, Kerala, Lakshadweep, Manipur, Tamil Nadu, Tripura and West Bengal health camps under various disease control programmes, especially Reproductive and Child Health were organised. However, in A & N Islands, Chhattisgarh, Madhya Pradesh, Punjab, Rajasthan, Tamil Nadu and Tripura health camps were not organised regularly at the prescribed frequency at all the health centres. In Orissa and Uttar Pradesh, records relating to data on total number of camps were not maintained.

The Ministry stated that the community monitoring process had been internalised by various States and that community interactions were increasing at various levels.

However, the achievements regarding the indicators of community participation did not match the targets prescribed for these under the NRHM Framework.

Recommendations

- ***The process of community monitoring needs to be accelerated to help develop community based planning and monitoring system of health delivery/services.***
- ***The VHSC may be formed in every village as prescribed in the guidelines and funds to support the VHSCs may be released to the SHS only after receiving information on setting up of the committees.***
- ***The prescribed revolving fund may be set up with the VHSCs from the untied grants of the Sub Centre and expenditure from the same may be monitored by the ANM on a regular basis.***
- ***The RKS may be constituted with broad-based representation and registered at all the remaining health centres, so as to constructively participate in the functioning of the health centres as envisaged under the NRHM framework.***
- ***Management capacity under the RKS may be generated to ensure timely utilisation of funds available. The Ministry noted this recommendation for consideration.***

CHAPTER 4: CONVERGENCE

4 Convergence with other departments

Health is as much a function of availability of safe drinking water, female literacy, nutrition, early childhood development, sanitation, and women's empowerment as of hospitals and a reliable medical system. NRHM viewed health through the prism of a sector-wide approach, encompassing sanitation and hygiene, nutrition and convergence with related social sector departments such as Woman & Child Development, AYUSH, Panchayati Raj etc. and sought to adopt a co-ordinated approach for intervention under the umbrella of the district plan.

4.1 Planning and monitoring of convergent activities at central level

A committee for intersectoral convergence had been constituted under the chairmanship of the Mission Director for planning and monitoring of the NRHM strategy on convergence with related departments in policy and operations at both GOI and State levels. The committee was initially to meet at least once in every quarter. However, in the first meeting it was decided that the committee would meet once in every two months.

However, the committee met only four times i.e. twice during 2005 and twice during 2008. The recommendations of the committee were placed only twice before the Empowered Programme Committee (EPC) in July 2005 and August 2006.

The Ministry Stated in September 2008 that approximately 18 meetings i.e. 16 during 2005-07 and 2 during 2007-09 on convergence have been held on smaller scale with individual Ministries such as Panchayati Raj, Women and Child Development etc. Meetings of the committee could not be convened due to the post of Mission Director remaining vacant for a few months.

The Ministry had not prepared any detailed action plan outlining the specific targets and timelines for activities to be undertaken for intersectoral convergence by the different departments i.e. Panchayati Raj, Women and Child Development, Safe drinking water, Sanitation, AYUSH etc. acting together. The Ministry, in its meeting with the Ministry of PRI held in March 2006 decided to prepare a module on intersectoral convergence within a month and impart training to PRIs on convergence and financial management, preparation of health plans and monitoring of the health delivery system. However, the detailed strategy of training for orientation of PRIs was yet to be devised as of December 2008. Similarly, actions on decisions taken in the various convergence meetings such as joint training, Information, Education and Communication (IEC) activities and framing of operational strategies and the guidelines for integration of various committees and schemes under different departments with the VHSC and NRHM were still pending. The Ministry had issued instructions to States/UTs Mission to set up and promote the convergence mechanism between different departments at various levels. However, no follow up action to monitor the progress against the instructions issued had been taken.

The Ministry stated that the 2nd Common Review Mission, held in November-December 2008, had found increasing inter-sectoral convergence at grass-root levels and that convergence meetings, at a smaller level, with related departments has generated progress.

The reply of the Ministry did not address the specific issue of the absence of a super structure to plan strategy on convergence and monitor progress thereon. The reply has to be viewed against the background of the Ministry's own decision to constitute a committee under the Mission Director for inter-sectoral convergence on policy and operations at GoI and State levels.

4.1.1 Convergent approach in State PIPs and DHAPs

The District Health Action Plans (DHAPs) and State PIPs were expected to reflect integrated action in all areas that determine good health viz. drinking water, sanitation, women's empowerment, adolescent health, education, female literacy, early child development, nutrition, gender, social equality.

Most of the States/UTs did not include a detailed plan and strategy for encouraging convergence with the different associated departments, in their PIPs. Only 19 States/UTs[20] included the component of AYUSH in their PIPs and 21 States/UTs had come up with a plan on the School Health Programme. It was noted that State Health Mission in Delhi earmarked an amount of Rs. 1.40 crore, for School Health Scheme, but did not incur any expenditure for this activity during the year 2007-08.

DHAPs did not show any attempts at convergent action in the audited districts in Assam, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Lakshadweep, Manipur, Mizoram, Orissa, Puducherry, Punjab, West Bengal and Uttar Pradesh and in 14 out of 23 sample districts audited in Andhra Pradesh, Gujarat, Haryana, Karnataka and Sikkim. DHAPs had not even been prepared in Jammu & Kashmir, Himachal Pradesh, Jharkhand, Rajasthan, Tripura, Tamil Nadu Bihar and Daman & Diu. However, that this could be done with effort and commitment was evident in Arunachal Pradesh, Maharashtra, Madhya Pradesh, Kerala and Meghalaya, where DHAPs reflected convergent activities and participatory functioning. Non-convergent approaches in district and State health planning had resulted in disconnected efforts being made by the various departments and NGOs working towards the same goal of better health facilities.

The Ministry stated that almost all States have included chapters on inter-sectoral convergence in State PIP for 2009-10. With regard to non utilization of Rs. 1.40 crore by State Health Mission Delhi for School Health Scheme, the Ministry reiterated that the States prioritize the activities as per existing requirements for the current year.

4.2 Involvement and regulation of NGOs in the Mission

The participation of non-governmental organisations at all levels of the health delivery system was identified as critical for the success of the NRHM. NGOs' services were being utilized under various programmes subsumed in the Mission.

4.2.1 Mother NGO scheme

The scheme of Mother NGO (MNGO) was introduced in the Ninth Five Year Plan to strengthen NGOs participation in the RCH programme. Under the scheme, the

[20] Jharkhand, Rajasthan, Uttarakhand, Jammu and Kashmir, Orissa, Chandigarh, Delhi, Puducherry, Maharashtra, Haryana, Gujarat, Andhra Pradesh, Kerala, Assam, Nagaland, Manipur, Sikkim, Mizoram and Tripura

Ministry sanctioned grants to selected NGOs called Mother NGOs in allocated districts through the SHS. These MNGOs, in turn issued grants to the smaller NGOs, called Field NGOs (FNGOs). However, the scheme was not effectively implemented in the States/UTs as discussed below:

(a) Institutional mechanisms

The MNGO scheme includes multiple institutions and partners at the national, State and district levels. At the central level, the Apex Resource Centre (ARC) was set up to coordinate the activities of the Regional Resource Centres (RRCs), manage budgets and facilitate RRC coordination and interaction with State governments. At present, there are only 11 RRCs throughout the country providing technical support to the State Societies. The ARC was non-functional since September 2007. NGOs committees at the State and District levels were either not formed or non functional in most of the States which resulted in lack of institutional support to the MNGO scheme.

Further, local government bodies/PRIs were not involved in the institutional frame work of MNGO scheme. In the absence of defined role/networking of PRIs in MNGO scheme, the actual delivery and problem areas remained unevaluated by the representatives of the beneficiaries.

The Ministry stated that the ARC was earlier being funded by United Nations Population Fund (UNFPA) which has since withdrawn the support. Therefore, ARC had stopped functioning.

However, the Ministry did not make alternate funding arrangements for ARC and may need to devise an alternative mechanism to coordinate the activities of the RRCs.

(b) Coverage

Out of 609 districts, only 178 districts were covered by 125 functional Mother NGOs across the country as on 31 March 2008. Thus, 71 *per cent* of districts remained out of the coverage of the MNGO scheme. The number of Field NGOs functional under the MNGOs was not available with the Ministry.

The Ministry in July 2003, revised the MNGO scheme and introduced the Service NGO (SNGO) scheme. SNGOs differed from MNGOs in term of their scope and coverage of work. SNGOs were expected to provide a range of clinical and non-clinical services (such as adolescent education, gender sensitisation etc.) under the integrated RCH package directly to the community, while the MNGOs provided only clinical services through the FNGOs, in particular service delivery areas. However, no funds had yet been released by the State RCH Societies to the small number of selected SNGOs. Thus due to non implementation of the scheme, the aim of increasing access and coverage of health services in partnership with NGOs, was not served.

c) Pattern of funds release under the scheme

Rs. 44.76 crore, Rs. 11 lakh and Rs. 15.74 crore was released to 24, 2 and 8 State Health Societies for further release to MNGOs during 2005-06, 2006-07 and 2007-08 respectively. The pattern of funds release showed that the scheme was not functional in other States. Further, out of the funds of Rs. 44.87 crore released by the Ministry during the period 2005-07, utilisation certificates of Rs. 27.48 crore (61 *per cent*) were awaited from 16 State Societies as on March 2008.

Besides, grants-in-aid of Rs. 3.46 crore and Rs. 5.40 crore were released to the State RCH Societies, Uttar Pradesh and Madhya Pradesh during 2004-07 and 2005-06 respectively, out of which Rs. 2.40 crore and Rs. 3.06 crore was refunded to the Ministry in January 2008 and December 2006 respectively. Funds of Rs. 7.41 crore released to the SHS of Bihar, Tamil Nadu and Meghalaya lay unutilised with these societies.

The pattern of funds release in the year 2006-07 was also erratic, as the total funds released to the States were a mere Rs. 11 lakh, whereas the funds released to the RRCs, which provide technical support to the States was Rs. 1.55 crore (93 *per cent* of the total release for the year).

The Ministry stated that they constantly advised the States to take timely measures to select SNGOs and release funds to them. It added that States had been advised to send SOEs and UCs for the period in question. Some States were not taking active interest in the implementation of the scheme. The Ministry also stated that since the States had sufficient unspent balances, no grants were released to them, under the scheme, during that period. However, RRCs were released funds because they had to maintain a regular administrative infrastructure.

(d) Integration of the MNGO scheme with other interventions under NRHM

With NRHM, all existing disease control programmes and RCH programme were merged under NRHM. The Ministry continued to fund MNGO scheme under the RCH and NGOs under NDCPs separately resulting in disintegrated functioning and weak monitoring of the NGOs. Had all activities linked to the participation of the NGOs under NRHM been integrated, the technical support of the RRCs could have been utilised for all rather than limiting their expertise to RCH activities. Moreover, the possibility also exists of multiple projects being awarded to the same NGO without coordination and common information sharing as to its capabilities.

The MNGO scheme did not have the desired impact as the involvement of NGOs in building capacity towards health delivery systems was in the primary stage and due to delay/non selection of SNGOs in the targeted districts, the Mission's objectives of building capacity at all levels of the health delivery system and delivering health care services under RCH to the underserved/unserved areas remained unfulfilled.

The Ministry stated that guidelines on the MNGO scheme were being revised.

4.2.2 Release and utilisation of funds to NGOs

NGOs were to be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas. To ensure their full participation, grant-in-aid systems for NGOs was envisaged to be established at District, State and National level. Five *per cent* of total NRHM funds were to be released as grants-in-aid to NGOs at District, State and National levels.

The system of grants-in-aid was not in place as the grants-in-aid committee had not been established in Andhra Pradesh, Bihar, Jammu & Kashmir, Haryana, Himachal Pradesh, Madhya Pradesh, Manipur, Puducherry, Punjab, Sikkim, Uttarakhand and West Bengal (12 States/UT).

The consolidated position of funds released to NGOs under the NRHM as a whole was not made available by the Ministry. However, at State level, five percent of the

total NRHM funds, though prescribed, were not released as grants-in-aid to NGOs in Assam, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Haryana, Jharkhand, Jammu & Kashmir, Kerala, Lakshadweep, Maharashtra, Orissa, Puducherry, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal (18 States/UTs).

Further, out of the total grants-in aid of Rs. 81.50 crore released to the NGOs by the SHS in 24 States during the period 2005-08, Rs. 31.22 crore were utilised and expenditure against remaining Rs. 50.29 crore (61 *per cent)* could not be verified due to non submission of UCs as of March 2008 (**Annex 4.1**).

Only 20, out of the 97 NGOs, to whom grants were released during the period 2005-08, had submitted audited accounts. No audited accounts had been submitted by 77 NGOs in Assam, Jammu & Kashmir, Kerala, Manipur, Orissa, Rajasthan, Sikkim and Uttar Pradesh (8 States).

Further, grant of Rs. 45 lakh and Rs. 47 lakh against the maximum admissible amount of Rs. 30 lakh per MNGO had been released to two MNGOs in Assam in 2008. In Chandigarh and Kerala, the State Health Mission was not monitoring the activities of NGOs.

The Ministry stated that in Assam higher amount was released to MNGOs as they catered to two districts.

However, as per NGO guidelines as well as sanction orders issued by the Ministry ceiling for grant-in-aid to MNGO was Rs. 15 lakh per district.

Besides in seven States/UTs, viz. A & N Islands, Bihar, Dadra & Nagar Haveli, Daman & Diu, Meghalaya, Lakshadweep and Tamil Nadu, no grants-in-aid had been released to NGOs indicating non-involvement of NGOs in the implementation of the Mission.

The Ministry stated that the MNGOs/FNGOs submit their Statements of Expenditure (SOE) and Utilisation Certificates (UC) to respective State governments and a consolidated SOE and UC were to be sent by each State government to the centre. Despite repeated reminders and personal visits by the Desk Officers, some States had not furnished SOEs and UCs. The Ministry added, in the proposed revised guidelines; monitoring and evaluation has been specified in more clear terms.

System of grants-in-aid to NGOs was not established at various levels and State Health Societies released the funds to NGOs without signing MOUs and formulating detailed guidelines for the participatory role of the NGOs towards their functioning, cooperation, monitoring and supervision under the framework of the NRHM. In the absence of any defined accountability structure and monitoring mechanism, activities of NGOs remained unchecked, their funds utilisation not fully verified and their contribution towards capacity building and delivery of health services to marginalized sections in underserved and un-served areas could not be realised in full.

Recommendations

- ***The SHSs should ensure that the State and District Health plans clearly reflect convergent functions of various government departments. A mechanism for effective pooling and utilisation of resources also needs to be established at various levels.***

- ***Health services outreach can be more wide ranging if involvement of NGOs is encouraged. However, their participatory role in the health sector needs to be defined, facilitated and monitored.***
- ***Given the high risks involved in non submission of accounts and UCs by NGOs, there is a need for strong financial controls and a system of accountability to monitor the activities of NGOs. Standards to evaluate NGOs' performance should also be developed so as to ensure effective utilisation of Government grants.***

CHAPTER 5: FUND FLOW MANAGEMENT

5. Public spending on health care

The Mission aimed to annually increase allocation by the central government for the health sector by 30 per cent up to 2007-08 and by 40 percent from 2009-10. State governments were also required to increase their allocation on health by 10 per cent annually during the Mission period. Details of increase in expenditure/allocation on healthcare by the Ministry and the States was as under:

Table: 5.1 Government expenditure on healthcare including NRHM

(Rs. in crore)

Year	Union Government*		State Governments#		Total Union and State Governments	
	Expenditure	Percent increase over previous year	Expenditure	Percent increase over previous year	Expenditure	Percent increase over previous year
2004-05	8086.46		18771.00		26857.46	
2005-06	9650.24	19.34	22031.00	17.37	31681.24	17.96
2006-07	10948.24	13.45	25375.00	15.18	36323.24	14.65
2007-08	14410.37	31.62	31567.00 (RE)	24.40	45977.37	26.58
2008-09	18476.00 (RE)	28.21	36961.00 (BE)	17.09	55437.00	20.57

*** Source: Government of India Budget Documents**

 # Source: State Finances: A Study of Budgets of 2008-09 (Reserve Bank of India)

The NRHM also aimed at strengthening the financial management structure and accounting systems so as to conform to best practices and meet accounting and auditing standards, at all levels.

5.1 Parameters for release of grants

While implementing the NRHM, grants were to be allocated to States according to the norms developed on the basis of composite index incorporating population, disease burden, health indicators, state of public health infrastructure etc.

However, no such composite index for allocation of grants among the States was developed under the Mission. The Ministry continued to allocate grants among various States mainly on the population based state factor[21]. Even the existing formula was not applied equitably across the board during 2005-06 to 2007-08, with wide variations between the formulaic total grant to be released and that actually released. Moreover, the States relatively weaker on health and family welfare indicators received lesser grants and stronger States received larger grants during the first three years of the Mission is shown in Table No.5.2.

[21] Population of each state multiplied by 1.3 for eight Empowered Action Group (EAG) states, viz. Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand, by 1 for other than EAG states and by 3.2 for all eight North Eastern states.

Table 5.2: Excess/short release on the basis of formula

Special focus States	Less grants released by[22]		Other States	Excess grants released by	
	Rs. in crore	Percentage		Rs. in crore	Percentage
Bihar	-548.61	-29.30	Andhra Pradesh	153.68	11.67
Jharkhand	-87.93	-14.46	Gujarat	236.64	26.90
Uttar Pradesh	-30.77	-0.82	Kerala	60.59	10.94
Assam	-332.23	-22.42	Tamil Nadu	156.65	14.51
Manipur	-12.41	-9.37	*(Source: Information provided by the Ministry)*		
Meghalaya	-25.19	-19.65			
Tripura	-26.53	-14.90			

The core goal of the Mission is self evident in that it seeks to transform rural healthcare for the better. However, the respective state weightages in accordance with which funds were allocated were based on 'total population' and not on rural population.

The Ministry stated that the reason for releasing lesser grants to some high focus States was due to presence of substantial unspent balances with them. On the other hand, after assessing utilization of funds in States like Andhra Pradesh, Gujarat, Kerala and Tamil Nadu larger grants were released to them.

This indicated that high focus States are trapped in a vicious cycle wherein institutional deficiencies result in low absorptive capacity for utilization of funds leading to lesser release of grants to them. Release of funds also needs to be linked with utilisation, as the resources of the Government of India are limited.

5.2 Integration of health programmes under the NRHM

The NRHM framework had emphasised the need for horizontal integration amongst the various family welfare and disease control programmes for better coordination and convergent action. The Ministry consequently sought to amalgamate financial and fund flow and banking arrangements with effect from 1 April 2007. These guidelines also stipulated that the Finance Management Group (FMG) of the Mission was to transfer funds to SHSs for all programmes under the NRHM, receive Statements of Expenditure/ Financial Management Reports, audited accounts and UCs for them, thereby ensuring centralised financial management and data processing for all programmes under the Mission.

However, the Ministry was yet to effectively coalesce its functions and until December 2008 it was seen that the FMG was processing reports, releasing funds and monitoring the status only for three components of the Mission viz. the Mission Flexible Pool, the RCH Flexible Pool and the Immunisation Strengthening Programme under Routine Immunisation separately. The remaining programmes continued to be run by individual programme divisions without any coordination by the FMG.

The Ministry stated that NVBDCP was now releasing funds through FMG. The matter was being taken up with the remaining NDCPs to transfer their funds to the

[22] The less/excess release of grants is calculated by subtracting actual release of grants to the States under all components of the NRHM from funds required to be released derived by multiplying State weightage to total release of grants to all States.

SHSs for their respective programmes through the centralized arrangement of FMG-NRHM.

5.3 Banking arrangement under NRHM

In August 2004, the Ministry had proposed to undertake an e-banking initiative which envisaged transmission of funds down to the lowest level possible, with a Management Information System (MIS) which would provide all information regarding funds utilisation and report it online up to central level. The key feature of the e-banking initiative was that all transactions would take place electronically. The Ministry constituted a committee and seven banks were asked to provide solutions to meet proposed e-banking requirements. The committee analysed the proposals of these seven banks including the Bank of Baroda which is the accredited bank of the Ministry. The Ministry selected ICICI bank on the basis of the strength of their e-enabled branch transactions, technical prowess and the solutions suggested. The accredited bank, viz. Bank of Baroda was not found adequate for this task.

5.3.1 Subsequently, in June 2005, the Controller General of Accounts, Ministry of Finance instructed the Ministry to install a system which would enable quick electronic funds transfer, i.e. within 24-48 hours of amounts more than Rs. 10 crore to State, District level Autonomous Bodies/agencies etc. The system should also provide for getting reports back from banks on the credit of such amounts to the beneficiaries. The Ministry was to consult with the existing bankers on the mode of transmission of funds and, where required, an additional bank with higher technological capability may be used as an interface for faster transmission of funds. The Ministry, thereafter, intimated the Controller General of Accounts that ICICI bank had been appointed as the interface bank.

5.3.2 Review of the e-banking arrangements of the Ministry with the ICICI bank revealed that the overall objectives of the e-banking initiative had not been achieved and that there were certain shortcomings as briefly detailed below:-

- E-banking was to be started on a pilot basis in six States, viz. Gujarat, Goa, Jharkhand, Uttarakhand, Kerala and Rajasthan. The pilot was to be implemented in a phased manner initially in one State by end of January 2005 and subsequently to cover all the six States over a period of three months. Evaluation of pilot results was to be the basis for rolling out the e-banking project countrywide. Three of these States, i.e. Goa, Rajasthan and Jharkhand had not agreed for the pilot project either due to a thin network of ICICI branches or unwillingness to change their bankers. While the pilot project was started in Gujarat and Kerala, it was badly delayed. It took the bank more than three years to complete the project in Kerala and it was yet to be completed in Gujarat and Uttarakhand.

- Presently only 13 States/UTs were receiving funds through the ICICI bank. In the majority of these 13 States, ICICI bank only had a branch at the State level. The remaining 22 States/UTs were using the services of different banks to transfer funds electronically. Uttar Pradesh and Madhya Pradesh had started an e-banking initiative of their own with State Bank of India (SBI). Out of a total 612 districts countrywide, 441 districts had accounts with Public Sector banks.

- The Ministry had not carried out adequate consultations with the States while deciding to go ahead with the selection of ICICI bank. The sparse presence of ICICI bank in many States/Districts was a factor which led to the State Health Society to opt for other banks.
- Though the Ministry had assigned the e-banking and electronic funds transfer functions to ICICI bank, it was yet to enter into a formal agreement with the bank.
- Considerable funds remained with ICICI bank, both at State and District levels, till such time they were actually utilised. For example, in Kerala, the monthly balance in the ICICI bank account of the SHS ranged between Rs. 17.52 crore to Rs. 86.12 crore during 2007-08. Average monthly balance worked out to Rs. 49.52 crore.
- Again in Sikkim, ICICI bank offered free remittances up to Rs. 1 lakh provided that the balance in the account of the SHS was kept at a minimum of Rs. 50 lakh at any given time. In contrast, SBI allowed free remittances irrespective of the quantum of funds remitted. The Ministry had not negotiated favourable terms with ICICI bank though it transacted a substantial portion of the Ministry's business.
- The Ministry of Finance, in January 2008, had instructed that 60 *per cent* of funds under the control of Ministries/Departments (including funds distributed by them to the agencies) may be placed with Public Sector banks. Ministry/Departments were requested to issue instructions on these lines to State Government agencies and entities to which they distributed funds.

The Ministry stated that only 13 SHSs were using ICICI bank to keep their funds and that the remaining funds of the Ministry were kept in PSU banks. Therefore, the criterion of keeping 60 *per cent* of funds in PSU bank was fulfilled. It further stated that e-banking initiative is branch independent as the system is web-enabled and can function even at those locations where the partner bank does not have its branch as long as internet is available. Local branch is needed only in case of cash requirement for office expenses.

However, the Ministry of Finance's instructions apply equally to subordinate offices, attached offices and autonomous organisations mainly funded by government. The transaction of government business through a bank's web portal would require redefinition of control structures in respect of drawal and disbursement. Further, district societies and lower level entities would need to open a different bank account for cash requirements, which might result in multiplicity of bank accounts and diffusion of internal controls. Further one of the criteria for selection of banks for e-banking was branch coverage.

While e-banking was a necessary initiative taken by the Ministry, its implementation through the ICICI bank was not effective. The Ministry agreed in October 2008 that the implementation of the larger e-banking solution as envisaged, in the entire country, was not possible with only ICICI as the sole bank. The Ministry further stated in June 2009 that it would set up an expert committee with representatives from Ministry of Finance (Controller General of Accounts) and the Reserve Bank of India that would look into all aspects of the problem and reach a pragmatic and workable

solution for transfer of funds and e-banking solutions for improving reporting of expenditure.

5.4 States' contribution to NRHM from their own resources/budget

As per NRHM framework, during the 11th Five Year Plan (2007-12), States were to contribute 15 *per cent* of the funds requirement of the Mission. During 2007-08 only 4 States/UT (Andhra Pradesh, Bihar, Gujarat and West Bengal) made the desired contribution of 15 per cent of State PIP from their own budget. Six States/UTs (Assam, Chhattisgarh, Haryana, Rajasthan, Sikkim and Chandigarh) also contributed to the NRHM from the State/UT budget, but their contribution remained between 0.54 to 13.59 *per cent*.

The remaining 18 States/UTs (Arunachal Pradesh, Jharkhand, Himachal Pradesh, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Punjab, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand, A&N Islands, D&N Haveli, Lakshadweep and Puducherry) did not contribute at all to the NRHM from their own budget during 2007-08. The Ministry too did not insist on the States/UTs contribution during 2007-08.

The Ministry stated that the States were directed to show their contribution in the State PIPs. Since 2008-09, the States were directed to transfer the 15 *per cent* State share to the State Health Societies from the State funds.

The reply of the Ministry should be viewed in the context that the direction for States to contribute their share for funds for the Mission was already a part of the NRHM Framework for implementation. Even in 2008-09, State/UT Governments of Manipur and Lakshadweep did not make any contribution while the contribution made by Arunachal Pradesh, Assam, Bihar, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Delhi, Goa, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Maharashtra, Meghalaya, Orissa, Puducherry, Punjab, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand and West Bengal (24 States/UTs) was less than 15 per cent.

5.5 Release of funds

5.5.1 Excess release of Mission Flexi-pool funds to SHSs

During 2007-08 the Ministry incorrectly released Rs. 174.84 crore under the Mission Flexible Pool to four States due to deficient assessment of PIPs or non-observance of NPCC's records of proceedings[23] by the NRHM Finance Management Group. The details were as under:

(Rs. in crore)

Tamil Nadu	Funds released for supply of equipment to PHCs and Sub Centres. NPCC's condition that funds could be released only after charting out of requirements of equipment at health centres and convey of exact budgetary requirement by SHS was not observed.	5.00

[23] National Programme Coordination Committee (NPCC) was an apex committee that appraised the State PIPs and laid down conditions in its records of proceedings that were to be fulfilled before release of grants-in-aid to the SHSs.

	Funds released for supply of medicines to health facilities without fulfilment of NPCC's condition of receipt of the details of system of procurement from the SHS.	11.19
	Training component in capacity building of Rs. 5.55 lakh was wrongly calculated as Rs. 55.45 lakh.	0.50
	Despite catering to needs of quite unequal numbers of health centres, Rs.76.24 lakh each for Health Manpower Development Institute (HMDI) Villupuram and Salem were proposed for release.	
Uttar Pradesh	Rs. 26.78 crore for training of ASHA in the PIP was wrongly indicated as Rs. 28.78 crore in the budget summary.	2.00
	Under incentive for exceptional services (Sub Centre and PHC level Swasthya Puraskar Yojana) the proposed budget was wrongly calculated as Rs. 28 lakh instead of Rs. 21 lakh.	0.07
	The Ministry approved PIP for Rs. 337.33 crore in June 2007 against demand of Rs.425.81 crore. SHS submitted revised PIP for Rs. 269.60 crore on 21 August 2007. The Ministry, however, had neither taken any action on the revised PIP nor forwarded it to NPCC for their consideration and released first instalment of Rs. 268.38 crore in September 2007 i.e. after 27 days of receipt of revised PIP and the second instalment of Rs. 68.94 crore in December 2007. Thus funds were released in excess of the requirement demanded by the SHS through the revised PIP.	67.73
	Funds were released in March 2008 to the SHS as the second instalment of grant-in-aid for 2007-08. The Ministry did not take into account the unspent balance of Rs. 200.46 crore lying with the State Health Society as a relaxation had been obtained from the Ministry of Finance for non-adjustment of unspent balance of previous year's grant under the Mission Flexible Pool. However, as per the Ministry of Finance's orders, the dispensation for release of funds without considering unspent balance of the previous year was to be granted for releases made up to 31 December 2007, while Rs. 79.89 crore was released to the State in March 2008.	79.89
Andhra Pradesh	During 2006-07, the Ministry released the entire amount of budget proposal of Rs. 102.90 crore to the SHS, while the NPCC had approved the State PIP for Rs. 94.94 crore only and Rs. 1.40 crore was already lying as unspent balance (of 2005-06) with the SHS.	7.96
Tripura	Funds were approved by the Ministry for hiring one Multi Purpose Worker (Male) @ Rs.7,000 per sub-centre per month for 60 sub-centres for 12 months, while as per the NRHM framework, salary for MPW was to be provided exclusively by the State government.	0.50

The Ministry in March 2009 accepted the observations relating to excess release of Rs. 49.90 lakh to SHS Tamil Nadu and stated that these were due to a calculation error. Release of the same amount to the HMDI Salem and Villupuram despite different numbers of units attached to these HMDIs, was also accepted. However, the Ministry stated in December 2008 that release of Rs. 7.96 crore to SHS Andhra Pradesh was within the Mission Flexi-pool budget of the SHS. The reply is not tenable as the release of funds was over and above the PIP approved by the NPCC.

Regarding Uttar Pradesh, the Ministry stated that the State had sent a supplementary PIP and not the revised PIP; hence the releases made to the State were not irregular.

The reply of the Ministry is not acceptable. As per facts on record, the SHS Uttar Pradesh had sent a revised PIP of Rs. 269.60 crore in August 2007. The Ministry's reply had mentioned another supplementary PIP of Rs. 225.12 crore in January 2008 about which there is no audit comment. Further, release of Rs. 79.89 crore to the State in March 2008 was also irregular as there was an unspent balance of Rs. 200.46 crore available under the Mission Flexible Pool with the State and relaxation of Ministry of Finance for not considering unspent balance for releases under the

Mission Flexible Pool was only up to December 2007. Thus, there was an excess release due to lack of proper monitoring by the Ministry in accordance with Rule 209 of GFRs.

5.5.2 Excess release of annual maintenance grant for PHCs

Under the NRHM implementation framework, an annual maintenance grant (AMG) of Rs. 50,000/- per PHC was to be released to the SHSs. During 2006-07, the Ministry released Rs. 116.18 crore for 23236 PHCs but only 22669 PHCs were actually functioning as per Rural Health Statistics Bulletin 2006 (updated up to March 2006). Further, as per the RHS Bulletin, 3437 PHCs in 14 States did not possess their own building and were functioning in rented buildings. Since a primary objective of the Mission was to construct new infrastructure for healthcare centres, the release of maintenance grants for PHCs running in rented buildings and release for number of PHCs over and above the number mentioned in the RHS Bulletin resulted in an excess release of Rs. 20.02 crore (for 4004 PHCs).

Further, during 2006-07, the Ministry released Rs. 3.05 crore for 491 PHCs to SHS Assam as annual maintenance grant before receipt of the State PIP and finalisation of NPCC proceedings, instead of requirement of Rs. 2.46 crore as per the prescribed rate of grants. The Ministry further released Rs. 1.49 crore for remaining 149 PHCs at the rate of Rs. 1 lakh per PHC under RCH Flexi-pool in contravention to the norms. This resulted in excess release of Rs. 1.34 crore under AMG for PHCs.

The Ministry stated that the basic intention behind AMG and untied funds for PHCs was to maintain basic infrastructure facilities at PHCs for smooth day to day functioning of the centre. Further, the AMG was not only for the building but could be used for furniture, equipment, electrical fittings etc., AMG and untied funds were released for funding urgent yet discrete activities that need relatively small sums of money and for which it was thought that the community should decide whether the expenditure was to be undertaken or not, without going through the channels of approvals.

However, under the NRHM guidelines and implementation framework AMG were specifically meant for maintenance of physical infrastructure, while annual untied grant of Rs. 25,000 had been separately provided for minor repair works, electricity fittings etc. required at the PHCs located in rented buildings. It would be appropriate to have clear cut guidelines in respect of different funds[24] clearly indicating the purpose of the fund and its utilisation.

5.5.3 Excess release of RCH Flexi-Pool funds

As per the General Financial Rules 2005, when recurring grants-in-aid are sanctioned to the same organization for the same purpose, the unspent balance of the previous grant should be taken into account in sanctioning the subsequent grant.

While releasing funds to SHSs under the RCH Flexi-pool for 2007-08, advances paid by the societies were treated as expenditure and were deducted from the unspent

[24] In respect of AMG, no separate guidelines were issued by the Ministry regarding purposes for which these can be used.

balance of the previous year resulting in excess release of Rs.525.57 crore (**Annex 5.1-A**).

Moreover, in March 2008, Rs.194.75 crore was released after taking into account Rs.93.93 crore as unspent balances up to 2006-07 pertaining to 23 States/UTs as on 1.1.2008. However as per the Ministry's information of February 2009 the unspent balance as per audited accounts of 2006-07 was Rs.438.34 crore. Thus Rs.337.04 crore was short accounted as unspent balance and an excess release of the same amount under the RCH Flexi-pool had been made in 2007-08 (**Annex 5.1-B**).

The Ministry stated that the excess release to States was due to considering unspent balances on the basis of Financial Management Reports (FMRs) which depicted inflated utilisation of funds by the States and not the audited reports, as the States did not send audited reports in time.

However, this was in violation of Rule 212 of the GFR, 2005 which stipulated that release of grants-in-aid in excess of seventy five per cent of the total amount sanctioned for the subsequent financial year shall be done only after the annual audited statement relating to grants-in-aid released in the preceding year are submitted to the satisfaction of the Ministry/Department concerned.

5.5.4 Rush of expenditure and unspent balance with the States

The NRHM implementation framework stipulates release of first instalment of grants-in-aid to the SHS by April/May and second instalment by September/October.

Eighteen *per cent* of the total releases under the Routine Immunization during 2005-06 and 20 to 61 *per cent* of funds released under Mission Flexi-pool during 2005-08 were made in the month of March as shown in the following table:

Table: 5.3 Releases in the month of March

(Rs. in crore)

Name of the Programme	Year	Total release of grant-in-aid	Release of grant-in-aid during March	Releases in March as a percentage of total release
Routine Immunisation	2005-06	150.78	26.81	17.78
Mission Flexible Pool	2005-06	962.13	591.66	61.49
Mission Flexible Pool	2006-07	2069.36	577.65	27.91
Mission Flexible Pool	2007-08	3149.97	614.18	19.50

(Source: Information provided by the Ministry)

Further, Rs. 20.31 crore under the National Programme for Control of Blindness during 2005-08 and Rs. 224.94 crore under the Mission Flexible-Pool during 2006-07 were sanctioned at the close of the financial year, whereas the amount was remitted in the next financial year.

The release of funds to the SHSs at the close of the financial year resulted in poor utilisation of funds by the SHSs as shown below:

Table 5.4: Utilization under the Mission

(Rs. in crore)

Programme	2005-06			2006-07			2007-08		
	Release	Expenditure	Expenditure as percentage of release	Release+ Unspent balance	Expenditure	Expenditure as percent of release +unspent balance	Release+ Unspent balance	Expenditure	Expenditure as percent of release +unspent balance
Mission Flexible Pool	962.13	40.76	4.24	2990.73	417.43	13.96	5723.27	1490.67	26.05
RCH Flexible Pool	898.84	253.69	28.22	1996.85	883.69	44.25	2829.10	1883.09	66.56
Routine Immunisation	150.68	37.80	25.09	188.21	87.54	46.51	227.45	120.03	52.77
Total	**2011.65**	**332.25**	**16.52**	**5175.79**	**1388.66**	**26.83**	**8779.82**	**3493.79**	**39.79**

(Source: Information provided by the Ministry)

The substantial unspent balances retained by the SHSs were attributable to delayed release of grants-in-aid to them by the Ministry, resulting in a cycle of unspent balances year after year.

Unspent funds in Bihar

During 2005-08, the Ministry released grants-in-aid for 21 specific activities, in eight activities (Rs. 33.57 crore), no expenditure was incurred and in seven activities, out of Rs. 125.02 crore released by the Ministry only Rs. 22.30 crore were spent. These activities were related with preparation of Village Health Plan, District Action Plan, up-gradation of different level health care units, mass awareness about programmes of NRHM, procurement of medical kits, training of doctors, routine immunization etc.

The Ministry stated that during 2005-06, under Mission Flexible Pool, the bulk of the releases i.e. 61.5 *per cent* funds were during the last quarter because NRHM was launched on 12 April 2005 and the Cabinet approval was obtained in July 2006. In the year 2006-07, audit reports from the States were received very late which were to be scrutinised before the release of funds.

The reasons explained by the Ministry were only partially correct, as the expenditure as a percentage of funds available with the SHS remained low for all the three components of the programme mentioned in table 5.3 prepage in all years from 2006 to (March) 2008.

5.6 Non refund /adjustment of unspent balance under the old programmes

The launch of NRHM, RCH-II and Janani Suraksha Yojana (JSY) in 2005-06 resulted in the termination/merger of earlier operational programmes such as Empowered Action Group (EAG) Scheme, RCH – I Programme and National Maternity Benefit Scheme (NMBS) respectively.

The Ministry stated that an aggregate amount of Rs. 87.37 crore was lying as unspent balance with the EAG States under the EAG Scheme; Rs. 2.79 crore of the earlier RCH-I programme was lying unspent with 9 States/UTs[25] and Rs. 42.74 crore of

[25] A & N Islands, Arunachal Pradesh, Assam, Chhattisgarh, Orissa, Manipur, Meghalaya, Sikkim and Tripura.

NMBS scheme was lying unspent with 31 States (all States/UTs other than Sikkim, D & N Haveli, Chandigarh and Puducherry).

However as per information provided by the SHSs of 11 States/UTs (Assam, Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Orissa, Punjab, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand and Puducherry) an unspent balance of Rs.133.28 crore pertaining to RCH-I were available with them. In districts of Assam and Himachal Pradesh alone, an unspent balance of Rs. 1.48 crore and Rs. 51 lakh pertaining to RCH-I respectively were found. Similarly, as per records in the Ministry, unspent balance with Uttarakhand under EAG scheme was Rs. 1.26 crore, while as per SHS records this amount was Rs.5.33 crore.

These wide differences in data regarding unspent balances under RCH-I available with the Ministry and as obtained from SHSs showed lack of monitoring and deficient financial control. The Ministry also did not attempt to obtain correct figures of unspent balances from the SHSs, so as to adjust these amounts from further releases under the NRHM.

The Ministry stated that they were insisting upon the States to refund the unspent balances of RCH Phase-I and NMBS.

The Ministry should reconcile and adjust the unspent balances under the lapsed programmes expeditiously.

5.7 Outstanding utilisation certificates

Programme wise status of outstanding UCs against funds released during 2005-08 indicated that UCs of Rs.3227.95 crore for Mission-Flexi-Pool were pending from 33 States/UTs[26]and UCs of Rs.841.82 crore were pending from 24 States/UTs[27] under RCH Flexi-pool as of October 2009.

UCs of Rs. 140.00 crore were pending from 26 States/UTs under Pulse Polio Immunisation Programme and UCs of Rs. 101.75 crore were pending under Routine Immunization from 28 States/UTs, as of 31 March 2009. Similarly, UC of Rs.29.08 lakh was pending from Kerala under the NLEP and UCs for Rs. 79.48 lakh was pending from Delhi, Goa and Kerala under the NVBDCP. Details of pending UCs are given in **Annex 5.2**. Further, there were cases of submission of incorrect UCs by SHSs of three States (**Annex 5.3)**.

It would thus appear that funds were released by the Ministry without considering the absorptive capacity of the SHSs and ensuring utilization of funds released earlier. The incorrect UCs issued to the Ministry by the SHSs before utilizing the funds presented an incorrect picture to the Ministry.

5.8 Management expenditure

To attain the desired outcomes and build up management capacity at each level, the NRHM provided funds for management costs up to 6 *per cent* of the total annual plan

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[26] UCs were not pending from Assam and Nagaland.

[27] Andhra Pradesh, A & N Islands, Bihar, Chandigarh, D & N Haveli, Daman & Diu, Delhi, Goa, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Lakshadweep, Maharashtra, Manipur, Meghalaya, Orissa, Tamil Nadu, Tripura, Uttar Pradesh, and West Bengal

approved for a State/district. The management expenditure included both the expenses related to the medical/para-medical staff and also other services such as financial management, improved community processes, logistics, collection and maintenance of data, use of information technology and improved monitoring and evaluation etc.

An analysis of expenditure on the management of the NRHM during 2005-08, showed that nine States/UTs had spent more than the prescribed funds on management expenditure. The details are in the following table:

Table 5.5: Management expenditure as per cent of total expenditure under the NRHM

States/UTs	Year	Management Expenditure as per cent of total expenditure	States/UTs	Year	Management Expenditure as per cent of total expenditure
Assam	2006-07	13.80	**Gujarat**	2005-06	18.07
Haryana	2007-08	12.00	**Madhya Pradesh**	2005-06	10.29
Manipur	2005-06	73.44		2006-07	7.75
	2006-07	34.78	**Punjab**	2005-06	6.36
	2007-08	20.63		2006-07	8.21
Rajasthan	2005-06	9.94		2007-08	12.75
	2007-08	7.83	**D & N Haveli**	2005-06	10.63
Lakshadweep	2005-06	19.35		2006-07	23.84
	2006-07	20.40		2007-08	18.02
	2007-08	9.00			

(Source: Information provided by SHSs)

All the components forming management expenditure had not been booked in the accounts of State Health Mission in Kerala and the SHS of Bihar and Karnataka failed to furnish component-wise expenditure so that these could not be analysed effectively in audit.

The Ministry stated that efforts are being made to impress upon the States to keep the management expenditure within the prescribed limit of six per cent.

5.9 Allocation of funds to the districts

The Ministry released substantial funds to the SHSs for implementation of the Mission in States. The Ministry stated that the rationale of opting for the society route, instead of prevalent treasury route under the centrally sponsored schemes, for transfer of funds was to minimise the time lag in funds transfer. However, in 11 States delay of nine days to 34 months was noticed in transferring the funds from the SHS to DHSs and from the DHS to health centres, as detailed in **Annex 5.4-A**. The delay in release of funds down the line and consequent delay in implementation of the Mission was inspite of creating a set of societies at the State and district level and incurring expenditure on their management as well as transferring funds from the Ministry to SHSs electronically.

Further, it was noticed that in 13 States/UTs (Andhra Pradesh, Assam, Bihar, Haryana, Himachal Pradesh, Jammu & Kashmir, Madhya Pradesh, Maharashtra, Punjab, Uttar Pradesh, Uttarakhand, Sikkim and Andaman & Nicobar Islands) funds were released by the SHSs to districts as a routine allocation of resources without assessing the likely utilization of resources**.** This resulted in considerable unspent balances at district/CHC/PHC/SC levels, details of which are given in **Annex 5.4-B.**

In Gujarat, Orissa and Uttar Pradesh, database in respect of category-wise (CHC, PHC and Sub Centre-wise) and year-wise position of funds allocated to CHC, PHC and Sub Centres was not maintained due to which the adequacy of allocation and spending efficiency of these institutions could not be examined in audit. Only in Tamil Nadu, funds allocations were based on the inputs received from the districts.

The Ministry stated that it was the responsibility of the States to allocate funds to districts based upon specific demands and inputs received from the districts.

The reply of the Ministry should be viewed in the light of the fact that it had set up autonomous health societies in the States and districts, incurred expenditure for their professional management and gave funds and instructions to them directly. Hence, the Ministry's role in encouraging the States to respond to district level needs and its own guidance by example through the societies needs to be strengthened.

5.10 Diversion of funds

As per rules, funds were required to be spent for the purpose for which they were intended. Any diversion of funds required approval of the competent authority.

However, during the year 2007-08 SHSs Bihar, Chhattisgarh and Madhya Pradesh incurred expenditure of Rs. 58.64 crore, Rs. 17.47 crore and Rs. 52.07 crore respectively, in excess of the funds available under their respective RCH Flexi-pool by diverting funds from the Mission Flexi-Pool without the approval of the Ministry. The Ministry stated that sometimes, diversion of funds takes place owing to delay in receipt of funds by the States from the Ministry for want of fulfilling the criteria for release of funds such as receipt of UCs/Audit Reports for the previous year etc. The Ministry stated that a probable reason for diverting funds from the Mission Flexible Pool in States is to tide over the immediate crisis i.e. payments under JSY and Compensation for Sterilization beneficiaries.

Moreover, in six States diversion of Rs.94.84 crore in 12 test checked cases at the SHS and the DHS level, on purposes other than the purposes for which the funds were originally sanctioned, was observed during 2006-08 (details in **Annex 5.5**).

The instances of diversion of funds, without obtaining the approval of the Ministry, indicated insufficient internal controls resulting in non-achievement of programme objectives.

5.11 Untied grants

5.11.1 Untied grants to health centres

As per NRHM framework, untied grants of Rs. 10,000, Rs. 25000 and Rs. 50000 were to be provided to every SC, PHC and CHC respectively. These resources were to be used for any local health activity in accordance with the guidelines issued by the Ministry.

As on 31 March 2008, Rs. 132.33 crore in untied grants was lying unspent at various CHCs, PHCs and Sub Centres in 29 States/UTs (State wise details in **Annex 5.6**). Substantial unutilized untied grants indicated that funds were released without having assessed the absorptive capacity of the health centres (State specific cases are given in **Annex 5.7-A**).

Incorrect use of untied grants, only furniture and equipment purchased: CHC Darshal, Jammu and Kashmir

Further, in eight States there were several instances of misuse of untied funds for the purposes that were barred under the guidelines on utilisation of untied funds, such as purchase of furniture, equipment, television, stationery, fuel etc. (details in **Annex 5.7-B**).

The Ministry stated that SHSs were expected to prepare their PIPs keeping in view their absorptive capacity. The concept of untied grants was introduced to evolve community participation and their absorptive capacity would not improve immediately. As regards misuse of untied grants, the Ministry stated that discrepancies were being brought to the notice of States.

5.11.2 Untied grants to Village Health and Sanitation Committee (VHSC)

As per the NRHM framework, every village with a population up to 1500 was to get an annual grant of up to Rs.10000 after constitution and orientation of Village Health and Sanitation Committees. The untied grant was to be used for household surveys, health camps, sanitation drives, revolving fund etc.

However, out of 32678 villages of sample districts in 10 States[28], untied grants were not released to 20839 villages during 2005-08. In Himachal Pradesh, Tripura, Uttarakhand, A&N Islands, D& N Haveli, Delhi and Lakshadweep no untied grant was released to the villages. In Orissa, Rs. 9.50 crore were released to all the 30 Zilla Swasthya Samities (ZSS) during December 2007 and March 2008 as untied grant for VHSCs despite non-formation of VHSCs and, therefore the funds remained unutilised with ZSS/CHCs. In West Bengal, VHSCs had not been formed and the Gram Unnayan Samitis (GUS) already existing were performing the functions of VHSCs. Out of Rs. 45.54 crore released to the P&RD Department during 2006-08 for payment of untied grants to 16770 GUS in 2006-07 and 28770 GUS in 2007-08, Rs. 32.31 crore were not released to 32310 GUS as of March 2008. In Kerala, untied grants were provided to wards instead of villages. During 2006-07, untied grants were provided to 18868 wards including 2729 urban wards. Therefore, there was excess release of untied grants of Rs.2.73 crore to DHSs on account of 2729 urban wards.

However, on the positive side the untied grants were released to all the 1193 sample villages in Manipur. In Sikkim, no untied grant was released to 452 VHSCs during 2005-07; however Rs. 45.90 lakh were released during 2007-08 to VHSCs.

In four States [West Bengal (81 out of 323), Gujarat (16 out of 48), Madhya Pradesh (971 out of 2765) and Chhattisgarh (4238)], separate bank account was not opened for

[28] Gujarat, Haryana, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Maharashtra, Meghalaya, Orissa, Punjab, Rajasthan

VHSC funds. In Assam, Rs. 1.66 crore received from the Ministry for VHSC was diverted by the SHS for other purposes (Health Day).

The Ministry stated that untied grants @ Rs.10,000/- per VHSC was released to all State/ UT Governments. From 2007-08, the State/ UT Governments started reflecting their requirements for formation of VHSC in the annual PIPs and the funds were released accordingly. However, from the current financial year, it has been decided that the untied funds for all VHSC will be released for at least one VHSC per revenue village.

However, the Ministry's reply did not provide reasons for not releasing untied grants to villages where VHSCs had been formed. Nor did the Ministry clarify as to why grants-in-aid were released to the SHSs and/or DHSs without ensuring constitution and orientation of VHSCs in many cases.

5.12 Maintenance of accounts

5.12.1 Non-reconciliation of funds

There was a wide difference between funds released by the Ministry and the funds received by the SHSs in most of the States/UTs during 2005-08. During 2005-06, funds received by 21 SHSs were lesser by Rs. 883.05 crore than the figures of funds released shown by the Ministry, while figures of funds received by the SHS was higher by Rs. 13.12 crore in one State. Similarly during 2006-07 and 2007-08 funds received by 14 and 10 SHSs were less by Rs. 618.12 crore and Rs. 311.72 crore whereas figures of funds received by 7 and 10 SHSs was in excess by Rs. 55.24 crore and Rs. 322.96 crore respectively as compared to Ministry figures (details in **Annex 5.8-A**).

Further, in nine States there was considerable difference between the funds released by the SHS and received by the DHSs. During 2005-06, 2006-07 and 2007-08 figures of funds received by DHSs in five, five and four States were less by Rs. 5.22 crore, Rs. 10.31 crore and Rs. 13.13 crore respectively from the figures of the funds released by SHSs, whereas figures of funds received by DHSs in one, three and three States were in excess by Rs. 2.92 crore, Rs. 4.67 crore and Rs. 5.10 crore respectively **(Annex 5.8-B)**. There was no system of reconciliation of the fund flow from SHS to DHS in these States.

The Ministry stated that the reason for the difference was due to the fact that the funds released by the Ministry in March was accounted for in the next financial year by the SHSs whereas the Ministry accounted for it according to the date of sanction order issued. To overcome this problem, the concept of concurrent audit was introduced from 2007-08.

However, the release of grants-in-aid to the SHSs in March was a poor financial practice. The NRHM framework too stipulated that the second instalment of grants-in-aid should be released by September-October but this was not adhered to. Further, out of 26 States and 98 sample districts, the mechanism of concurrent audit by a chartered accountant was implemented only in 11 SHSs and 30 DHSs during 2007-08.

5.12.2 Discrepancy in accounts

The guidelines under the Mission prescribed double-entry bookkeeping system of accounting for the SHSs and DHSs, which were to be audited by chartered accountants.

However, in seven States/UT accounts audited by the chartered accountants were not maintained properly by the SHS and/or the DHS. Cases of discrepancy between opening balance of SHSs and DHSs, difference between cash balance depicted in accounts and bank pass book, inconsistency between opening balance of the current year and closing balance of the previous year etc. were observed by Audit. The State wise details are given in **Annex 5.9**, while findings of two States are given in the box.

Case study: Discrepancy in accounts

Karnataka

- There was a difference between the bank balance as reflected in the Annual accounts (Rs. (-) 314.66 lakh and the actual closing balances, as reflected in the pass books of the banks (Rs. 49.53 lakh) for the year 2005-06. Thus cash balance in banks had been understated in Receipts and Payment Account and the Balance sheet (assets side), to that extent.
- Though funds had been received from the Ministry and there were sufficient unspent grants, Rs.272.39 lakh was continued to be shown on the liability side of the Balance Sheet under the head 'Drawn from the Government of Karnataka State Treasury towards expenditure for the year 2005-06' pending receipt from the Ministry through RCH flexi-pool. The amount has not been refunded to the Government of Karnataka even after 2 years, and continued to be shown as liability.
- Due to not taking closing balance for 2005-06 as opening balance for 2006-07 under the heads 'RI strengthening' and 'Untied funds for sub-centres', the liabilities side of the Balance Sheet for the year 2006-07, had been understated to the extent of Rs.10.28 crore.
- Against interest earned Rs.747.72 lakh, only Rs. 622.71 lakh were shown received in the audited accounts for 2006-07. This had resulted in understatement of receipts by Rs. 125.01lakh in Receipt and Payment accounts and also the income in Income and Expenditure account.
- Loans and Advances of Rs. 10 lakh in the accounts of 2006-07 had been understated.

Bihar

- Four different opening balances as on 1 April 2005 were noticed in four different sets of documents of SHS detailed below:

Opening balance	Amount (Rs. in crore) as on 01-04-2005
As per SOE	47.66
As per annual account of 2005-06	45.12
As per financial statement	52.67
As per Bank account	43.78

- Discrepancies in the closing balance and succeeding opening balance of the three quarters SoEs resulted in keeping the net amount of Rs 46.48 crore out of the account of SHS.
- Advance of Rs.306.87 crore given to DHSs was not reduced from the total available fund. In the Financial Monitoring Report (FMR) pertaining to October 2007 to March 2008 submitted to the Ministry in May 2008, no closing and opening balance of the specific activity were mentioned.

The Ministry stated that the States/UTs were taking steps to ensure the maintenance of books of accounts in accordance with the procedure laid down by the Government and a mechanism of concurrent audit by chartered accountants had been laid down.

However, it was noticed that out of 26 States and 98 sample districts, mechanism of concurrent audit by a chartered accountant was implemented only in 11 SHSs and 30 DHSs during 2007-08.

The Ministry may consider strengthening the monitoring of maintenance of accounts by State units so that a system of proper checks and balances is institutionalised thereby reflecting a correct view of fund utilisation.

5.12.3 Loss of interest

As per the NRHM framework, funds were to be kept in interest bearing bank accounts. The SHS were required to provide details of interest accrued on unspent balances.

However, in two States, unspent funds were not kept in interest bearing accounts. In Assam, DHS Lakhimpur kept Rs.1.20 crore in current account. Similarly, in Bihar, SHS deposited Rs. 106.76 crore in March 2007 in non-interest bearing account and DHS, Bhojpur kept the NRHM funds in a current account and sustained an interest loss of Rs 37.42 lakh as of June 2008.

Further, the guidelines under the Mission had not mentioned the treatment of interest earnings on unspent balances. The Ministry neither monitored the amount of interest earned by the SHSs and DHSs during 2005-08, nor had a control over expenditure incurred therefrom. This led to unauthorised expenditure from the interest earned in States. In Rajasthan, interest earned on NRHM funds were used in November 2007 for payment of pending liabilities of Rs 3.09 crore of 2006-07 pertaining to micro nutrients for school health programme for Tribal Area under Mid Day Meal scheme which had no relationship with the NRHM activities till 2007-08.

This indicated ineffective controls at the SHSs and the DHSs. The Ministry also failed to prescribe clear guidelines on treatment of interest earnings despite the fact that substantial sums remained unspent at the State and the district level.

The Ministry stated that there is no guideline about treatment of interest in the GFRs.

The reply of the Ministry needs to be viewed in the light of the fact that the NRHM framework stipulated that the SHSs would provide details of interest accrued on unspent balances.

5.12.4 Improper maintenance of control registers

Every organisation is required to maintain proper control registers and subsidiary books of accounts for exercising check over expenditure and enforcing other administrative controls. However, it was observed that some of control registers and subsidiary books of accounts such as cash book, ledger, stock register, bank reconciliation statements, fixed deposit register etc. were not maintained at all or were not maintained in the prescribed form at the SHSs, the DHSs and health centres. Details of these cases are listed in **Annex 5.10**.

For such a major scheme, involving substantial funds; accounting procedures need to be streamlined and adopted comprehensively by all States.

The Ministry stated that the States/UTs have been informed of the discrepancies noticed by Audit and that they were taking steps to ensure that books of accounts are maintained properly.

Recommendations

- ***The Ministry may in consultation with the Planning Commission and the Finance Commission develop a criteria/weightage formula for funds release based on composite parameters of rural population, area, and existing status of health care infrastructure, demographic indicators, socio-economic indicators and disease burden and use of funds. The Ministry noted the recommendation.***
- ***The Ministry should review its interface banking arrangements in consultation with the Ministry of Finance. Interface banking should be preferred with Public Sector banks having maximum outreach and which offered the best possible terms, given the quantum of funds involved.***
- ***The SHSs should ensure that the UCs are obtained for actual expenditure and forwarded to the Ministry to facilitate smooth flow of funds.***
- ***Funds flow arrangement should be rationalised to ensure minimum unspent/excess amount is left outside government accounts.***
- ***The SHSs should assess the requirement of funds by the district/CHCs/PHCs/Sub Centres based on their specific demands and should ensure the distribution of funds under NRHM at the district and lower levels is need -driven.***
- ***SHSs should ensure that the untied funds are released and utilised as per the guidelines there is no diversion/misuse of these funds.***
- ***The Ministry may monitor interest earned on the unspent balances by the SHS and expenditure incurred therefrom through their audited accounts.***
- ***The SHSs should ensure proper maintenance of accounts and prescribe records to facilitate verification of expenditure and detection of cases of fraud, misappropriation or misuse of Mission funds.***

CHAPTER 6: INFRASTRUCTURE DEVELOPMENT AND CAPACITY BUILDING

6 Capacity building of physical and human infrastructure

The NRHM aimed to bridge gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revitalization of the existing physical infrastructure, such as health centre buildings and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning and infrastructure strengthening. The Mission had developed comprehensive Indian Public Health Standards (IPHS) defining infrastructural, personnel, equipment and management standards for different levels of health centres. Besides, the Mission also aimed to generate management capacity at every level of implementation of the Mission by creating a large pool of community health workers to act as an interface between the health centre and the rural population.

6.1 Release of funds for upgradation of CHCs to IPHS

The NRHM implementation framework stipulated upgradation of health centres to Indian Public Health Standards (IPHS). As per guidelines issued to States for preparation of PIP for 2005-06, the average cost of upgradation of a CHC to IPHS was fixed as Rs. 40 lakh. During 2005-06 and 2006-07, Rs. 720.20 crore was released as first instalment of grants to States for upgradation of CHCs. The Cabinet approved the IPHS for different levels of health centres in 2007-08.

The sanction orders releasing funds required the States to furnish a report on facility surveys for all CHCs and details of CHCs selected for upgradation. However, the States did not furnish the required information to the Ministry. Moreover, during 2005-07, Rs. 55.80 crore was released to six States @ Rs. 20 lakh per CHC, while as per RHS Bulletin 2007 these States had 169 CHCs and hence, were eligible for Rs. 33.80 crore. This resulted in excess release of Rs. 22.00 crore to these States (details in table 6.1).

Table 6.1: Excess release for upgradation of CHCs

(Rs. in crore)

Name of State/UT	No. of CHCs (RHS Bulletin 2007)	Funds released	Maximum funds to be released	Excess funds released
		@ Rs 20 lakh per CHC		
Bihar	70	30.80	14.00	16.80
Uttarakhand	49	10.40	9.80	0.60
Manipur	16	4.60	3.20	1.40
Mizoram	9	3.40	1.80	1.60
Nagaland	21	5.00	4.20	0.80
Sikkim	4	1.60	0.80	0.80
Total	**169**	**55.80**	**33.80**	**22.00**

Consequent to the Ministry's release of Rs. 20 lakh per CHC as the first instalment, a second instalment was to be released on the basis of actual cost identified per CHC. However, the same had not been released to most of the States even 12 to 31 months after the release of initial instalment as the States did not send the actual cost requirement for each CHC identified for upgradation and the Ministry failed to follow this up.

The State wise details on upgradation of CHCs to IPHS and expenditure incurred thereon were not made available by the Ministry. Out of Rs. 393.80 crore released during 2005-06 and Rs. 326.40 crore released during 2006-07 the Ministry had received utilisation certificates of only Rs. 109.95 crore (28 *per cent*) and Rs. 35.14 crore (11 *per cent*) from the SHSs for the respective years until July 2008.

The release of grant for upgrading CHCs to IPHS without receiving a requirement from the States and without analysis of the demand based on a facility survey and mapping of requirements, resulted in non-utilisation or at least absence of information on the use of Rs. 575.11 crore even after 24 to 36 months had passed from the time of release of funds.

The Ministry stated that the first instalment of funds was released to start the upgradation of CHCs without receiving a formal proposal from State/UT. Funds for this activity since 2007-08 had been released only as per annual PIP.

However, the reply of the Ministry did not indicate reasons for SHSs' failure to provide facility survey reports, details on CHCs upgraded, utilisation certificates etc. even after the initial period of fund release.

6.2 Inadequate planning for creation/strengthening of infrastructure

The NRHM aimed at creation of new infrastructure/buildings and strengthening of the existing infrastructure for health centres so as to improve accessibility and quality of healthcare delivery and targeted completion of 30 *per cent* of the works by 2007.

Complete data on the status of the existing infrastructure of health centres was not available with the SHSs and the DHSs due to non-completion/non-conducting of facility surveys in six States/UTs and only partial completion of the survey in 24 States/UTs. The assessment of work/patient load on the existing health centres and requirement for creation/upgradation of health centres to cater to the potential increase in the number of patients after improvement of services was not factored in before taking up the task of infrastructure creation/ strengthening. In 23 States/UTs, Rs. 827.81 crore was released to the DHSs and other executing agencies such as DRDA, PWD, State/Central PSUs etc. for creation and strengthening of infrastructure during 2005-08 without developing a proper plan based on demand, need and prioritization.

The audited DHS of 18 States/UTs had completed works for only Rs. 13.37 crore (9 *per cent*) out of Rs. 146.25 crore received for the creation and upgradation of the infrastructure at the health centres. In 16 States/UTs, works of Rs. 85.80 crore (60 *per cent*) were in progress for which advances had been given to the executing agencies and Rs. 30.07 crore (21 *per cent*) remained unspent with the DHS as of March 2008.

Uttarakhand: PHC Manthat, Dehradun under construction since 2005 (Rs. 56.10 lakh released till March 2008)

Moreover, cases of delay in completion of civil works were observed in 11 States (details in **Annex 6.1)** and cases of irregularities in execution of civil works were noticed in 11 States involving Rs. 232.46 crore (details in **Annex 6.2)**.

The considerable infusion of funds under NRHM aimed to create and upgrade infrastructure to the IPHS levels. It is, therefore, essential that adequate preparatory planning and prioritisation be done to achieve these objectives. It is necessary that the SHSs and DHSs take expeditious measures to survey requirements, plan and execute the task of creating/upgrading the health infrastructure.

6.3 Contribution of the States in creation and upgradation of infrastructure

State governments were to contribute 25 *per cent* of the cost of creation and upgradation of the infrastructure for Sub-centres. During 2005-08, 10 State governments (Arunachal Pradesh, Assam, Madhya Pradesh, Manipur, Meghalaya, Punjab, Rajasthan, Tripura, Uttar Pradesh and West Bengal) did not contribute the matching amount of Rs. 16.81 crore towards creation and upgradation of infrastructure at Sub-centres.

The Ministry stated that this issue had been discussed with State/UT Governments during the NPCC deliberations, while appraising their annual PIPs and need for appropriate contribution for health infrastructure had been impressed upon them. The recommendation of Audit for getting such information through Financial Management Reports (FMRs) had been noted for taking appropriate action and monitoring thereof.

6.4 Shortfall in establishment of new health centres

The NRHM framework had set the target of providing one Sub Centre for 5000 population (3000 in tribal areas), one PHC for 30000 population (20000 in tribal/desert areas) and one CHC for 100000 population (80000 in tribal/desert areas).

While the required number of health centres at each level was available in Mizoram, A and N Islands and Puducherry, in the remaining States/UTs[29] the health centres required/prescribed as per population norms did not exist. There was a shortfall of 43,987 Sub Centres (27 *per cent*) in 22 States/UTs, 8613 PHCs (31 *per cent*) in 21 States/UTs and 4200 CHCs (55 *per cent*) in 23 States/UTs, which are required to be created during the NRHM period (2005-12).

The shortfall of health centres was noteworthy in the eight EAG States, which had 74 *per cent* of the total shortfall in Sub Centres, 60 *per cent* of PHCs and 70 *per cent* of CHCs countrywide. These States, where the health and family welfare indicators were already poor, received fewer grants from the Ministry, as the grants were linked to the total number of health centres functioning in the State.

As the Mission targeted creation of 30 *per cent* of the proposed new infrastructure by 2007, 13196 Sub Centres, 2585 PHCs and 1261 CHCs were required to be constructed. However, during 2005-08, 14 States/UTs[30] had not taken up the work of

[29] Except six states, viz. Goa, Nagaland, Arunachal Pradesh, Sikkim, Delhi and Chandigarh

30 Haryana, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Manipur, Punjab, Tamil Nadu, Uttar Pradesh, West Bengal, D & N Haveli, Daman & Diu and Lakshadweep

setting up of infrastructure for new health centres to bridge the gap. Only 19 per cent Sub Centres in seven States, 26 *per cent* PHCs in four States and 11 *per cent* CHCs in seven States were created, while the work was in progress for 7 *per cent* Sub Centres in six States, 7 *per cent* PHCs in five States and 5 *per cent* CHCs in four States. Only one State, Chhattisgarh, had created the targeted number of health centres. The State wise details on shortfall and consequent setting up of new centres are at **Annex 6.3**.

The Ministry stated that the State Government had now started indicating their requirements for establishment of new health centres in their annual NRHM PIPs.

6.5 Physical infrastructure at health centres

6.5.1 Building

A health centre requires a building in good condition. Three years after the launch of the Mission, several health centres, particularly sub-centres were operating without buildings.

Among audited units, 216 Sub Centres (16 *per cent*) of 10 States and 19 PHCs (3 *per cent*) of four States were operating without buildings. Further, 435 Sub Centres (32 *per cent*) of 28 States/UTs and 102 PHCs (15 *per cent*) of 17 States and seven CHCs of four States were operating in a rented building/ panchayat bhawan/others for want of a designated government building. Further, 217 Sub-centres (16 *per cent*) of 16 States/UT, 86 PHCs (13 *per cent*) of 16 States/UTs and 23 CHCs (7 *per cent*) of five States/UT were functioning in dilapidated buildings. The State wise details on the condition of buildings are given in **Annex 6.4**. In four States, there were instances of misuse or improper use of health infrastructure, as detailed below:

Bihar	In a PHC, the operation theatre was used as a medical store, while in 3 PHCs minor operations were carried out in wards.
Jharkhand	In Hazaribagh district, a portion of the building of a Sub Centre was used for distribution of foodgrains by the public distribution system dealer. In Barharwa PHC of Sahebganj district, labour room was used as medical store and deliveries were carried out in the General Ward.
Uttar Pradesh	In Banda and Etawah districts, the premises of Sub Centres at Baragaon and Akbarpur respectively were used as a cattle shed for villagers. In Bahraich district, three out of four wards of CHC Risia were used as a meeting hall and store for vaccines and one OT was used as a delivery room. In Barabanki district, at PHC Suratganj, Leprosy clinic was running while the PHC, Jaswantnagar in Etawah district was under the occupation of the Tehsil.
West Bengal	In four districts, the staff quarters of 24 PHCs were in a dilapidated condition and were being used by villagers for storing straw, cow dung cakes, etc.

The deficit in primary infrastructure for health centres, coupled with the non-availability of health centres in rural areas, poses a serious challenge to the future course of the Mission and the progress made under it.

CHC Shirur, Distt. Pune, Maharashtra functioning in PHC building

Newly constructed Khanajan Sub Centre in Assam

Sub Centre Dhanidhar, Jammu and Kashmir in rented building

6.5.2 Hygiene and sanitation at health centres

A large number of health centres were functioning in unhygienic conditions due to various infrastructural deficiencies.

Audit teams carried out test-checks in CHCs, PHCs and Sub Centres in different States/UTs. In many cases, centres were functioning in an unhygienic environment since they were located in the close vicinity of garbage dumps, cattle sheds, stagnant water bodies or polluting industries. Audit checks also revealed that many health centres lacked essential infrastructure viz., water supply and storage tanks; sewage disposal facilities; disposal facilities for biomedical waste and separate utilities for men and women. The details are as under:

Table 6.2: Status of hygiene and sanitation at sample health centres

Infrastructural attributes	Sub Centres			PHCs			CHCs		
	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved
Substandard environment	159	12	21	69	10	16	24	7	10
Poor cleanliness	322	24	22	91	13	15	25	8	10
Lack of separate utilities for men and women	1108	81	28	431	63	26	102	32	22
No arrangement for water supply	529	39	27	120	17	18	14	4	6
No infrastructure for water storage	1008	74	28	287	42	24	60	19	15
No sewage disposal facility	668	49	18	241	35	23	58	18	13
No facility for disposal of bio-medical waste	1000	73	28	332	48	21	142	42	20

(Source: Information collected from health centres)

The State-wise position of hygiene and sanitation at different health centres, as revealed in the sample examined, is in **Annex 6.5**.

There was a wide inter-State as well as inter-level variation in hygiene awareness and facilities. While, health centres at Sikkim, Daman and Diu, Uttarakhand, Tamil Nadu, Puducherry, Manipur, Lakshadweep, D & N Haveli, Andhra Pradesh and A &

N Islands maintained a relatively acceptable level of hygiene with deficiency in only a few determinants of sanitation; hygiene at many of the health centres of Bihar, Karnataka, Madhya Pradesh and Orissa was poor. Further, while CHCs in almost every State had maintained a certain minimum level of sanitation, the condition at Sub Centres was not up to a minimum standard.

Unhygienic water storage facility at Sub Centre Madavoor, Kerala

Lack of waste management at Nowboicha CHC, Assam

6.5.3 Support infrastructure at health centres

The Indian Public Health Standards (IPHS) stipulated a number of infrastructural parameters for the health centres, among which minimum necessities such as provision of electricity, telephone, vehicles and computers were test checked.

Audit checks revealed that many Sub Centres and some PHCs were functioning without provision of electricity. A standby source of power (generator) was yet to be made available in many sample CHCs and PHCs which was necessary for maintaining indoor patient services, operation theatre, labour room, emergency services and cold chain equipment for storing vaccines, all of which require uninterrupted power supply. Telephone connectivity[31], computers and vehicles, including ambulance, were yet to be made available in many health centres. The details are as under:

Table 6.3: Lack of support infrastructure at health centres

Infrastructural attributes	Sub Centres			PHCs			CHCs		
	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved
Electricity connection	657	48	22	93	14	18	2	0.3	2
Standby power source/ generator	NOT APPLICABLE			446	65	27	87	27	24
Telephone connection	1107	81	28	375	55	25	54	17	12

[31] Tamil Nadu's example of providing mobile phones to ANMs of Sub Centres was a positive initiative, worthy of emulation.

Required number of vehicle/ambulance	NOT APPLICABLE	441	64	26	74	23	16
Computer	NOT APPLICABLE	446	65	25	100	31	17

(Source: Information collected from health centres)

The State-wise status of gaps in various kinds of support infrastructure is given in **Annex 6.6**.

The inadequate infrastructural support to health centres adversely affected the quality of healthcare available to the rural population, particularly the emergency and indoor services. This also weakened the control structure which required connectivity between the DHS and health centres for real time monitoring and quality MIS reporting.

6.5.4 Subsidiary infrastructure

The subsidiary infrastructure, which was required to optimise the functioning of health centres, was yet to be set up at many health centres as detailed in the following table:

Table 6.4: Lack of subsidiary infrastructure at health centres

Infrastructural attributes	CHCs			PHCs			Sub Centres		
	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved
Accommodation facilities for staff NOT present/ occupied	50	16	17	305	44	25	803	59	28
Accommodation facilities for staff PARTIALLY present/occupied	227	71	24	215	31	24	226	17	12
Adequate furniture NOT present	95	30	13	321	47	20	815	60	21
Suggestion/complaint box NOT present	190	59	29	514	75	30	1130	83	30
Medical store NOT present	38	12	10	170	25	19	NOT APPLICABLE		
Waiting room for patients NOT present	131	41	22	346	50	27	NOT APPLICABLE		
Facility for stay of attendants NOT present	261	81	27	NOT APPLICABLE					

(Source: Information collected from health centres)

It is evident that more focussed efforts are required to be made by SHS/DHS in the States to provide critical infrastructure and overall hygiene and sanitation in the health centres. Support infrastructure including electricity, telephones, ambulances etc. need to be provided so as to improve health care services in rural areas.

The Ministry stated that implementation of IPHS while upgrading rural health centres would take some time. It would also consider demands of State governments of establishment of rural health centres at specific places to meet local needs.

6.6 Services and facilities

6.6.1 Essential services at health centres

NRHM aimed to guarantee essential healthcare services at CHCs and PHCs such as outpatient service; inpatient service with 30 beds at CHCs and six beds at PHCs with separate wards for male and female; labour room; diagnostic facilities with stipulated laboratory tests and AYUSH services. Operation theatre, blood storage facility and x-ray facilities were essential at CHCs and emergency services with 24x7 delivery

services were required at PHCs. Further, the programmes to control leprosy and tuberculosis aimed at ensuring availability of diagnostic facilities at CHCs and PHCs. The status of availability of services guaranteed under the NRHM was as under:

Table 6.5: Availability of essential services at CHCs and PHCs

Services/Facilities	Total test checked units		No. of units where facilities were available	No. of units where facilities were not available	Per centage of units where facilities were not available
Out-patient services	1003	CHCs and PHCs	947	56	5.58
Inpatient services	971		770	201	20.70
Separate wards for male and female	770		330	440	57.14
Labour room	1007		772	235	23.34
Diagnostic services	976		628	348	35.66
AYUSH services	858		154	704	82.05
Operation theatre	321	CHCs	261	60	18.69
X-ray facilities	317		232	85	26.81
Blood storage facilities	317		29	288	90.85
Minor operation theatre	686	PHCs	242	444	64.72
Emergency services	648		273	375	57.87
24x7 delivery facilities[32]	21377		4868	16509	77.23

The following points were also observed regarding delivery of guaranteed services:

- OPD at 161 health centres was functioning without a separate room/cubicle.
- 137 CHCs had less than 30 beds and 161 PHCs had less than six beds, as prescribed under the Mission.

[32] As per information provided by SHSs.

A. Separate AYUSH clinics in two states (Achievement)

In Delhi there were three specialised AYUSH hospital and 263 dispensaries and in Kerala 1422 separate AYUSH health centres were functioning independent of the allopathic system to cater to the requirements of alternative system of medicines.

B. Outsourcing diagnostic and x-ray services in Bihar

SHS, Bihar signed an agreement with two private agencies in the last quarter of 2005-06 for outsourcing of pathological services on public private partnership basis. Both firms (in 19 districts each) were to establish diagnostic laboratories in District Hospital and run collection centres at Sub-divisional Hospitals, Referral Hospitals and PHCs and make them operational by June 2006. Similarly x-ray facilities, along with x-ray technicians in all PHCs, Referral Hospitals, Sub-Divisional Hospitals and Districts Hospitals were outsourced to a private agency in April 2006 with a stipulation to complete the work by December 2006.

As per information furnished by the SHS in August 2008, out of total 516 different level of hospitals, only in 133 hospitals (DH: 11, RH: 20 and PHC: 102) a pathological test-facility/collection centre was set up and in 151 hospitals x-ray centres were opened, out of which 88 (PHC-53; CHC-09 and others-26) x-ray facilities were put into operation. Due to suitable space not being provided by hospitals, pathological centres could not be opened. The SHS did not intervene to provide space and other facilities as per the agreement.

- At 37 per cent CHCs and 54 per cent PHCs more than half of the beds remained unoccupied. At 25 per cent of the test checked PHCs and CHCs, the patient-bed ratio was more than 1.5 indicating substantial over-load on the system resulting in use of one hospital bed by more than one patient at a time. The under-utilisation of indoor facilities was attributable to absence of doctors, non-functional operation theatre, poor condition of wards and presence of a nearby civil hospital/CHC with better inpatient services etc. The overload on indoor services at some health centres was attributable to a spurt in indoor patients after the launch of Janani Suraksha Yojana and non-availability of adequate beds/indoor facilities for the patients.
- 92 health centres had no functional labour room and in 33 health centres deliveries were carried out in wards, vacant staff quarters etc.
- 476 health centres were not able to provide all the stipulated laboratory tests. At 313 PHCs and 91 CHCs the full range of equipment was yet to be made available in the lab.
- Leprosy diagnostic facilities were not available in CHCs and PHCs of Bihar, Haryana, Kerala, Manipur, Punjab and Tamil Nadu and PHCs in West Bengal and in 19 CHCs and 104 PHCs of Jammu & Kashmir, Jharkhand, Gujarat, Rajasthan and Uttar Pradesh. TB diagnosis facilities were not available in 2 CHCs and 98 PHCs of Andhra Pradesh, Madhya Pradesh, Mizoram, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal (SHS of these States had reported full coverage of diagnosis of TB). In Bihar, against a target of 188 TB units and 940 microscopy centres, only 168 TB units and 743 microscopy centres had been set up.
- In Bihar and Uttar Pradesh, AYUSH doctors were prescribing allopathic medicines due to non-availability of AYUSH medicines, in a departure from norms.

- Operation theatre of 50 CHCs was non-functional and in 88 CHCs operations were not conducted despite the presence of an operation theatre for want of surgeon/anaesthetist or electricity/generator etc. Most of the CHCs did not have stipulated equipment for OTs.
- 41 CHCs had non-functional X-ray facilities. Utilisation of X-ray facilities at 26 CHCs was sub-optimal where average daily cases remained below four.
- At 35 PHCs, minor OTs were non-functional.
- A strength of three staff nurses, which was essential for running emergency services, was not posted at 533 PHCs.

The facilities provided at the CHCs and PHCs were not always in consonance with the services guaranteed under the framework of implementation of the NRHM. Basic services like in-patient services, diagnostic facilities, X-ray services etc. were not fully functional at all the CHCs and PHCs. The CHCs were to be rechristened as the first referral unit, but had no fully functional operation theatre, blood storage facility, labour room etc. Similarly, the PHC, which is the first interface of the patient with a doctor, often had insufficient in-patient services, labour room and emergency facilities. The inadequate infrastructure, especially equipment, and absence of doctors and para-medical staff were common reasons for inadequate healthcare facilities.

The Ministry stated that the funds were now being released to all State/UTs as per their requirements reflected in the annual PIPs. Regarding 24x7 emergency services it stated that States need to link operationalisation of 24x7 PHC with rational deployment of human resources like doctors, nurses and ANMs and their training and skill development. As regard mainstreaming of AYUSH, it stated that the States had been advised to co-locate AYUSH facilities at PHCs/CHCs and DHs. Department of AYUSH, through Centrally Sponsored Scheme of Hospital & dispensaries, would provide financial assistance for infrastructure, equipment and medicines for creating AYUSH units at these public health care facilities. Under NRHM Mission flexipool, the Ministry stated that the States were being supported for the contractual hiring of AYUSH doctors and supporting staff and also for their training.

Indoor Ward at Referral Hospital (CHC) Sandesh, Bihar

Good condition of ward at Referral Hospital (CHC) Nimgaon Distt. Pune, Maharashtra

Labour room of Referral Hospital (CHC) Sahpur, Bihar

Well equipped labour room at a NGO run health centre in Gujarat

Operation Theatre at PHC-Kendur, Distt. Pune, Maharashtra

Unequipped Operation Theatre of PHC Piro, Bihar

6.6.2 Essential obstetric care

In a positive development all test checked health centres in Andhra Pradesh and Chandigarh had adequate supplies of Kits A and B as well as equipment for normal delivery. However, none of the sample health centres had adequate supplies of Kit A and Kit B as well as equipment for normal delivery in 11 States and less than 50 per cent health centres in seven States/UTs. Equipment for neonatal care and neonatal resuscitation were yet to be made available in any of the audited health centres in five States. While in other five States only 23 per cent health centres had equipment for neonatal care and neonatal resuscitation.

Only 1007 CHCs (45 *per cent*) out of the total 2239 CHCs had been upgraded as first referral units (FRUs) in 13 States/UTs. None of the CHC had been upgraded as FRUs in 12 States/UTs. Emergency obstetric care including the facilities of caesarean section was yet to be set up in any CHC in 8 States/UTs. In another 17 States/UTs, only 39 *per cent* of CHCs had emergency obstetric care including the facility of caesarean section available. (State-wise details in **Annex 6.7**)

The reasons of non-availability of emergency obstetric care at the CHCs were varied with absence of specialists in obstetrics and gynaecology, anaesthetist, non-functional operation theatre, lack of adequate infrastructure, support staff, blood storage facility being among them. Inadequate supply of Kit A and B as well as equipment for normal delivery, neonatal care, non up-gradation of the CHCs as FRU and non availability of emergency obstetric care in the CHCs adversely affected essential obstetric care services in the health centres.

6.6.3 RTI and STI management

With the large-scale prevalence of Reproductive Tract Infection and Sexually Transmitted Infection, especially among women, the RCH II programme envisaged establishment of RTI and STI clinics at each district hospital and CHC.

However, RTI/STI clinics had not been established in district hospitals and CHCs in Bihar, Uttarakhand, Sikkim and Lakshadweep. Further, in Uttar Pradesh, Orissa, Tripura, Punjab, West Bengal, Himachal Pradesh Madhya Pradesh and Dadra & Nagar Haveli clinics had been established at CHCs. As per the SHS, RTI/STI clinics had been established in all the CHCs in Gujarat and Mizoram. However, test checks showed that these clinics had not been established in 11 out of sampled 12 CHCs and one out of three sampled CHCs in Gujarat and Mizoram respectively. In Jharkhand, though RTI/STI clinics were established in 22 district hospitals, they were non-operational due to absence of gynaecologist and diagnostic facilities.

The Ministry stated that STI and RTI facilities are covered under National AIDS Control Programme and there was no provision for separate STI clinics at sub-district level facilities under the RCH programme.

However, the Framework for Implementation of the NRHM clearly mandated management of RTI/STI as a guaranteed service at CHCs.

6.6.4 Medical termination of pregnancy (MTP) services

Enhancing the quality and number of facilities for MTP is an important component of the RCH II. The programme envisaged need based training to medical officers and nurses, provision of equipment and operation theatre and MTP kits at district hospitals, CHCs and PHCs.

However, none of the audited CHC and PHC had MTP facilities in Andhra Pradesh, Bihar, Lakshadweep, Manipur, A & N Islands and Puducherry. Further, only 62 *per cent* CHCs and 25 *per cent* PHCs had facilities for MTP in 18 States/UTs[33]. The non-availability of service was mainly due to absence of MTP kits, doctors/ nurses and equipment.

The Ministry stated that States needed to link the operationalisation of FRUs and 24x7 PHCs with training of doctors on Safe Abortion Services and provision of equipment. The Ministry further added that the same was reiterated to the States many times.

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[33] Assam, Jharkhand, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh, Chhattisgarh, Jammu & Kashmir, Meghalaya, Himachal Pradesh, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu and West Bengal

6.6.5 Cold chain management

To support the immunisation programme, cold chain maintenance was visualised in all CHCs and PHCs. Out of 220 audited CHCs, the essential equipment to maintain cold chain i.e. ice lined freezers, refrigerators and deep freezers were available in 205 CHCs (93 *per cent*), 156 CHCs (71 *per cent*) and 209 CHCs (95 *per cent*) respectively in 21 States/UTs (details in **Annex 6.8-A**). In none of the 12 sample test checked CHCs in Bihar, was cold chain equipment available.

While out of 217 PHCs test checked, ice lined freezers, refrigerators, and deep freezers were available in 110 PHCs (51 *per cent*), 90 PHCs (41 *per cent*) and 104 PHCs (48 *per cent*) respectively (details in **Annex 6.8-B**). However, none of the cold chain equipment was available in any of the 124 test checked PHCs in Haryana, Meghalaya, Madhya Pradesh, Puducherry and West Bengal (5 States/UTs).

Further, the equipment available was not put to efficient use for want of continuous power supply and due to non-functioning/non-availability of standby power sources. Besides, in Bihar, Lakshadweep and Uttar Pradesh, 31 to 68 *per cent* of cold chain equipment was non functional.

The Ministry stated that GOI provided budgetary support for maintenance of cold chain equipment to the States/UTs under Strengthening of Routine Immunization as well as supplied spare parts. Further, in case of disruption of power supply, the GOI also provided for POL for generator for PHC/CHC for alternate power supply which can be used for maintenance of cold chain.

However, it appears that SHSs were not utilizing the resources provided by the Ministry effectively. The absence of cold chain management could adversely impact on the effectiveness of the Universal Immunization Programme, a high priority area under the Mission.

6.7 Staff availability and deployment

6.7.1 Sub Centres

Each Sub Centre under the NRHM was to be run by two Auxiliary Nursing Midwives (ANM, female) and a Multipurpose Worker (MPW, male). The Mission aimed to ensure two ANMs at 30 *per cent* Sub Centres by 2007 and 60 *per cent* by 2008 with the second ANM being appointed on a contract basis. While the ANMs were to be paid out of central grants, the MPWs were to be paid by the State Government.

Among sample units, 116 Sub Centres (9 *per cent*) of 20 States/UTs were functioning without an ANM. At 992 Sub Centres (77 *per cent*) of 29 States/UTs two ANMs were not posted and in Himachal Pradesh, Karnataka, Madhya Pradesh, Manipur, Meghalaya, Sikkim, Tamil Nadu, Uttar Pradesh, West Bengal and Lakshadweep none of Sub Centres had two ANMs. The deployment of MPWs was inadequate and 775 Sub Centres (60 *per cent*) of 27 States/UTs had no MPW. In Bihar, Uttar Pradesh, Lakshadweep, Chandigarh and Puducherry none of the test checked Sub Centres had an MPW. In contrast, in Meghalaya, Mizoram, Sikkim and Daman & Diu all the tested Sub Centres had an MPW. The State-wise status of non-availability of required staff at Sub Centres is detailed in **Annex 6.9**.

6.7.2 Primary Health Centres (PHCs)

The PHC was the first point of interaction of the rural population with a doctor and was to be manned by a medical officer. Besides, the Mission aimed to provide an AYUSH doctor at each PHC on contract basis. Since the NRHM aimed to run the PHCs on 24x7 basis, three staff nurses were to be appointed at each PHC (at 30 *per cent* PHCs by 2007 and 60 *per cent* by 2008). Support para medical staff such as Nursing Mid-wife, Pharmacist, Lab Technician and Lady Health Visitor were also to be appointed at the PHCs.

71 PHCs (11 *per cent*) of 15 States were functioning without an allopathic doctor. In 518 PHCs (86 *per cent*) of 28 States/UTs an AYUSH doctor had never been appointed. 69 test-checked PHCs were functioning without an allopathic doctor or an AYUSH doctor. This meant that population residing in their sphere of coverage had no doctor available at all in the public domain. In Andhra Pradesh, Haryana, Himachal Pradesh, Kerala, Madhya Pradesh, Mizoram, Punjab, Sikkim, Tripura and Lakshadweep none of the test checked centres had an AYUSH doctor.

The availability of support/para-medical staff was also far from satisfactory as depicted in table 6.6:

Table 6.6: Status of support staff at PHCs

Post/ Designation	Number (per cent) of PHCs where required support staff was not posted	Number of States/UTs involved	States where all the tested PHCs had required staff (Positive indicator)
One Staff Nurse[34]	285 (44)	24	
Three Staff Nurse[35]	535 (82)	29	A & N Islands
Nursing Mid-wife[36]	179 (46)	15	Tamil Nadu, Sikkim, A & N Islands, D&N Haveli, Puducherry
Lab Technician	336 (52)	25	Tripura, A&N Islands, D&N Haveli, Daman & Diu, Lakshadweep
Pharmacist	191 (29)	21	Jammu & Kashmir, Maharashtra, Mizoram, Punjab, Tamil Nadu, A&N Islands, D&N Haveli, Daman & Diu, Lakshadweep
Lady Health Visitor[37]	312 (53)	19	Maharashtra, Punjab Tamil Nadu, A&N Islands, D&N Haveli, Daman & Diu, Puducherry

The State-wise status of non-availability of manpower at the PHCs is at **Annex 6.10**.

6.7.3 Community Health Centres (CHCs)

The NRHM aimed to develop the Community Health Centres as the First Referral Unit for the rural population by providing seven specialist doctors and nine staff nurses under the IPHS (30

Positive development

In A & N Islands, Chandigarh, D & N Haveli, Daman & Diu and Puducherry the full strength of nurses was available at all the test-checked CHCs.

[34] In Bihar and Sikkim, none of 42 test-checked PHCs had even one staff nurse.
[35] None of the sample PHCs of Bihar, Gujarat, Himachal Pradesh, Madhya Pradesh, Meghalaya, Orissa, Rajasthan, Sikkim, Uttar Pradesh, D & N Haveli and Lakshadweep had three staff nurses.
[36] None of the sample PHCs of Himachal Pradesh, Sikkim, Uttar Pradesh, Lakshadweep had Nursing Mid-wife.
[37] In Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Manipur, Mizoram, Orissa, Uttar Pradesh none of the sample PHCs had Lady Health Visitor.

per cent by 2007 and 50 *per cent* by 2009). Support staff such as pharmacist and lab technicians was also to be provided at the CHCs.

Availability of specialist doctors at the CHCs was very low at the test-checked CHCs as depicted in table 6.7. The State wise status of availability of specialist doctors is in **Annex 6.11**.

Table 6.7: Number of CHCs where specialist doctors were not available

Specialist doctor	Number of CHCs	Per cent of the sample	Number of States/UTs involved
General Physician	219	72	23
General Surgeon	224	74	28
Obstetrician & Gynaecologist	226	74	28
Paediatrician	236	78	28
Anaesthetist	272	89	29

Note: Data not received from Arunachal Pradesh and Delhi

As regards availability of nine staff nurses (two of whom might be ANMs), 245 CHCs (81 *per cent*) of 25 States/UTs did not have the full strength of nurses, out of which 145 CHCs (48 *per cent*) of 23 States/UTs did not have even five staff nurses. Further, 14 CHCs (5 *per cent*) of 11 States were functioning without a nurse. All the test checked CHCs of Bihar and Lakshadweep had less than five nurses and all the test checked CHCs of Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Mizoram, Orissa, Tamil Nadu, Tripura and Uttar Pradesh had less than nine staff nurses. The status of support staff at test-checked CHCs is depicted in the following table:

Table 6.8: Status of support staff at CHCs

Post/ Designation	Number (per cent) of CHCs where required support staff was not posted	Number of States/ UTs involved	States where all the tested CHCs had required staff (Positive indicator)
Radiologist[38]	209 (69)	25	D & N Haveli, Daman & Diu, Lakshadweep, Puducherry
Pharmacist	55 (18)	16	Jammu & Kashmir, Meghalaya, Mizoram, Punjab, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal, A & N Islands, Chandigarh, D & N Haveli, Daman & Diu, Lakshadweep, Puducherry
Lab Technician	60 (20)	19	Himachal Pradesh, Mizoram, Punjab, Tripura, Sikkim, A & N Islands, Chandigarh, D & N Haveli, Daman & Diu, Lakshadweep, Puducherry

The State-wise details of shortfall of medical and paramedical staff at test checked CHCs is given in **Annex 6.12**.

The deployment of medical care providers such as specialist doctors, nurses, ANMs and support staff like pharmacist, lab technician, lady health visitors, multi purpose workers requires to be accelerated, in order to provide health care to the rural population.

The Ministry stated that all the State/UT Governments had taken a range of steps to improve the availability of manpower in health centres. Under NRHM, funds were also released for contractual appointment of medical and para-medical staff to improve the situation of manpower availability.

[38] In Andhra Pradesh, Himachal Pradesh, Meghalaya, Orissa, Punjab, West Bengal and A & N Islands none of the sample CHCs had a radiologist.

However, it appears that steps taken by the States Governments were not adequate to effectively address the shortfall in medical care providers in rural areas.

6.8 Appointment of contractual staff

To fill the gaps and provide additional manpower for the delivery of healthcare services, NRHM provides for engagement of medical and support manpower on contractual basis. However, shortfall was noticed in the appointment of the contractual staff vis-à-vis targets set under the PIPs as depicted in 19 States/UTs[39].

The shortfall was high in engagement of contractual manpower at medical levels of doctors and nurses and support staff at block level. The shortfall was relatively less with regard to engaging support staff at district level. The reasons for this divergent trend may be lack of qualified people to serve in the rural areas and delayed/non-initiation of the process of recruitment of contractual staff by the SHS and the DHS.

Further, in five States/UTs (Chhattisgarh, D & N Haveli, Gujarat, Madhya Pradesh and Puducherry) 29 to 57 *per cent* of contractual staff left before completion of their contract period. As the delivery of public health services requires continuous presence of service personnel, high turnover of the contractual manpower especially of medical officers would make quality service delivery difficult.

In four States, test check revealed following irregularities in appointment of contractual staff:

Kerala	The SHS appointed in-service doctors on contract basis to perform evening shift duty in contravention of the rule that the Government employees, while in service, were not allowed to enter into any type of contractual appointments. After being pointed out by Audit, the State Mission terminated their evening shift services.
Bihar	During 2007-08, contractual ANMs were selected on the basis of marks obtained in their matriculation examination. The mark-sheets of 14 candidates were found doubtful, when compared with the records of Bihar School Examination Board (BSEB), as candidates were selected on identical mark-sheets or their actual marks were different or no such roll codes were available in the records of the BSEB. DHS, Nalanda, did not reply to the audit query issued in August 2008.
Jammu & Kashmir	In 92 out of 384 cases, the criterion of local residence was not adhered to while appointing contractual staff.
Orissa	20 Block Programme Organisers were appointed by diluting the required qualifications after publishing an advertisement and by reducing the prescribed minimum pass marks after conducting a test.

6.9 Programme Management Support Units

The guidelines on the NRHM provide for establishment of Programme Management Support Units (PMSUs) at State, district and block levels to function as secretariats for health societies and facilitate management of healthcare services by professionals. The State Programme Management Support Unit (SPMSU) was required to be manned by experts in the areas of human resources, behavioural change

[39] Assam, Gujarat, Himachal Pradesh, Jammu & Kashmir, Kerala, Madhya Pradesh, Manipur, Punjab, Tripura, Uttar Pradesh, Uttarakhand, West Bengal, D&N Haveli, Lakshadweep, Bihar, Chhattisgarh, Haryana, Rajasthan and Puducherry

communication, monitoring and evaluation, MBAs, Chartered Accountants, MIS Specialists, and consultants for RCH and other National Disease Control Programmes. District and block PMSUs were also to be manned by personnel with specialisation in management, accounting and computer application.

All States, except Jharkhand, Uttar Pradesh, West Bengal and Chandigarh had set up State PMSUs. In Andhra Pradesh, Punjab and Tamil Nadu while a PMSU was set up at the State level, it was not set up at district and block levels. Further, in Chhattisgarh, Haryana and Karnataka it was not set up at block level and in Bihar, Maharashtra, Orissa, Rajasthan and Uttarakhand block level units were only sporadically established.

Further, in 12 States/UTs[40] sanctioned strength of staff at the State PMSU ranged between three to six, generally comprising a programme manager, an accounts manager and a data manager. Given the wide range of responsibilities attributed to the SHS and funds at their disposal, the SPMSUs were not functioning with a sustainable level of staff in these States/UTs. This also indicated that merger of societies implementing various disease control programmes with the SHS had not taken place effectively; as the guidelines on the institutional set up at State level under the NRHM stipulated that the SPMSU was to consist of consultants for RCH and other National Disease Control Programmes. Besides, in four States/UT, (Bihar, Kerala, Tamil Nadu, Lakshadweep) where the SPMSU had adequate sanctioned staff strength, some important posts remained vacant.

At district level, three essential management personnel, viz. Programme Manager, Accounts Manager and Data Manager were yet to be engaged at the DPMSU of 12 States/UTs[41]. At block level also, the PMSUs were set up only partially, i.e. without support of the norm of three management staff, in 12 States[42].

The partial setting up/non-formation of PMSUs in health societies at three levels of the Mission's implementation and the shortage of managerial staff indicated that the purpose of managing varying jobs by experts in their relevant field was only beginning. The quality of management functions such as accounting, MIS reporting, manpower management etc. necessitated that the task be approached more holistically.

The Ministry stated that it was correct that a wide range of responsibilities were being discharged by the PMUs with limited staff. However, the situation was fast changing and in most States these units had been made fully functional.

6.10 Accredited Social Health Activists (ASHA)

Under the NRHM a trained female community health worker called Accredited Social Health Activist (ASHA) was to be placed in each village in the ratio of one per 1000 population (or less for large isolated habitations) in the 18 high focus States using the

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[40] Chhattisgarh, Haryana, Himachal Pradesh, Maharashtra, Meghalaya, Punjab, Orissa, Rajasthan, Sikkim, Uttarakhand, Dadra and Nagar Haveli and Daman and Diu

[41] Bihar, Chhattisgarh, Himachal Pradesh, Karnataka, Madhya Pradesh, Meghalaya, Rajasthan, Tripura, Uttarakhand, A & N Islands, Delhi and Puducherry

[42] Assam, Bihar, Gujarat, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Maharashtra, Meghalaya, Orissa, Rajasthan, Uttarakhand and West Bengal

Mission Flexible Pool funds. States were given the freedom to relax the population norms prescribed for ASHA so as to suit their local conditions. The ASHA was expected to act as an interface between the community and the public health system.[43] About 6.16 lakh ASHAs have been engaged under the Mission in the States/UTs.

The ASHA had been engaged in all high-focus States, except Himachal Pradesh. In six high focus States shortfall in the selection of ASHA ranged between 4 to 24 *per cent*[44], when compared with the requirements as per population norms. In five high focus States a larger number of ASHAs were engaged when compared with the requirements as per population norms, but as long as this had been in response to a felt need this was a proactive development[45]. Further, among non-high focus States, Andhra Pradesh had engaged 28 *per cent* more ASHAs than required as per population norm. Maharashtra had engaged ASHAs only for the tribal areas. Few State specific findings on selection of ASHAs are given in **Annex 6.13-A.**

6.10.1 Training of ASHAs

The NRHM guidelines provided for training of ASHAs to equip them with necessary knowledge and skills. The guidelines provided for five modules of induction training, as well as periodic trainings for skill enhancement. ASHAs were to be provided with drug kits containing medicines for minor ailments, ORS, contraceptives etc.

In none of the States/UTs had all the five modules of induction training been given to all the selected ASHAs as shown in the following table:

Table 6.9: Training of ASHAs

Training up to	States (figures in bracket indicate the per cent of ASHAs receiving the training
5th modules	Andhra Pradesh (86%), Chhattisgarh (99%) and West Bengal (68%)
4th modules	Assam (100%), Mizoram (100%), Orissa (100%), Sikkim (100%), Gujarat (31%) and Uttarakhand (96%), Arunachal Pradesh (19%) and Madhya Pradesh (24%)
3rd modules	Jharkhand (13%)
2nd modules	Haryana (6%), Jammu & Kashmir (73%), Kerala (38%), Rajasthan (75%), Tripura (13%), Uttar Pradesh (66%), Delhi (12%)
1st modules	Bihar (86%), Maharashtra (36%), Punjab (100%), D & N Haveli (81%), Lakshadweep (100%), Manipur (100%)
No training	Meghalaya, A & N Islands

Incomplete training was a major problem in mainstreaming the workers. Moreover, inconsistencies in district-wise data provided by the SHS regarding training and selection of ASHAs and data provided by the DHSs of the audited districts were observed in some States/UTs as detailed in **Annex 6.13 B and 6.13 C** respectively.

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[43] The ASHA was to be supported in the non-high focus states in very remote, backward/ tribal regions. Further, the non-high focus states/UTs were also free to opt for the ASHA from the grants released under RCH-II Flexible Pool.

[44] Arunachal Pradesh-18%, Bihar-9%, Madhya Pradesh-9%, Rajasthan-24%, Tripura-14% and Uttar Pradesh-4%

[45] In Assam and Uttarakhand 13 and 10 per cent more ASHAs were selected respectively, while in Jharkhand, Meghalaya and Chhattisgarh 95, 217 and 222 per cent more ASHAs were selected respectively. Chhattisgarh had decided to engage one ASHA for the population of 250, in Meghalaya the population norm was relaxed in view of the large number of smaller villages in the state.

Further, ASHAs were not provided with a drug kit in Bihar, Gujarat, Haryana, Jharkhand, Kerala, Meghalaya, Mizoram, Sikkim, Tripura, Uttar Pradesh, West Bengal, A & N Islands and D & N Haveli. Non-completion of induction training of the ASHA was the main reason behind this, making their full utilisation difficult.

The Ministry stated that all high focus States except Bihar had since distributed drug kits. The Ministry also stated that there were delays in commencing training in many States because different States had to adopt the ASHA scheme after an internal process of discussions and consultations. While noting the discrepancies between DHS and SHS figures; the Ministry stated that the difference was less than five *per cent*, as a rule. This may occur since these health workers were volunteers and, at any time, there were changes with some ASHAs ceasing to function, new recruitments taking place. Discrepancies may also merely reflect the time period to which the data relates.

6.11 Mobile Medical Units (MMUs)

Achievement

The MMUs were rendering the full prescribed range of services in outreach areas of Assam, Mizoram and tribal districts of Madhya Pradesh.

Under NRHM, one Mobile Medical Unit (MMU) was to be provided in each district to serve outreach areas with the aim of taking the health care to the doorstep of needy people. The ceiling of the capital cost was Rs. 49 lakh for the North Eastern States and hill States of Jammu and Kashmir and Himachal Pradesh and Rs. 25.25 lakh for other States for one MMU. The Ministry released Rs. 199.84 crore in 2006-07 and Rs. 116.78 crore in 2007-08 to SHSs for operationalisation of MMUs in 27 States/UTs and 21 States/UTs respectively.

However, the release of funds for MMUs did not follow a defined pattern. During 2006-07, Rs. 19.95 crore and Rs. 5.13 crore were released to Uttar Pradesh (for 70 districts) and to Punjab (for 18 districts) respectively as capital cost of the MMUs, which included excess release of Rs. 2.28 crore (Uttar Pradesh) and Rs. 58.50 lakh (Punjab). Further, Rs. 22.33 crore was released to Rajasthan for 52 MMUs (at the rate of two MMUs per district for 20 tribal districts and one MMU per district for remaining 12 districts) and Rs. 9.66 crore was released to Andhra Pradesh for 23 districts (at the rate of 2 MMUs per districts). This resulted in excess release of Rs. 8.59 crore (Rajasthan) and Rs. 4.83 crore (Andhra Pradesh). Further, during 2007-08 Rs. 12.56 crore was released by the Ministry to five SHSs (Karnataka, Rajasthan, Uttar Pradesh, Manipur and Tripura) as recurring cost of MMUs, without ascertaining that the MMUs were not made operational in these States at all.

The MMUs were not operational in any district of 13 States (Bihar, Himachal Pradesh, Jammu and Kashmir, Karnataka, Maharashtra, Meghalaya, Orissa, Punjab, Rajasthan, Sikkim, Tamil Nadu[46], Uttar Pradesh and West Bengal) and all UTs. In the remaining 12 States, out of 223 districts the MMUs were available only in 123 districts, of which again 22 districts of five States had non-functional MMUs. Funds

[46] In Tamil Nadu against the requirement of one MMU per district 100 MMUs (ambulances) were present, which were not equipped as per norms for MMUs.

released for procurement of MMUs were lying unspent in most of the States. Few State specific findings on MMUs are given in **Annex 6.14**.

The non-operationalisation/inadequate functioning of the MMUs affected the goal of improving accessibility to health care services in outreach areas, leaving the remote and difficult areas without any reliable and quality medical care. These funds were lying unspent in States. The Ministry did not follow guidelines, while approving the State PIPs for release of funds to SHS for operationalisation of MMUs.

The Ministry stated that if the requirement on the basis of specific need of a particular district was more than one MMU, then the same was allowed e.g. more than one MMU was allowed in tribal area in some States. However, only EPC/MSG was empowered to relax the provisions of the Framework of Implementation and not the NPCC.

6.12 Health System Resource Centre

As per the NRHM framework, a National Health System Resource Centre at the centre and a State Health System Resource Centre in each State were to be established to provide technical support to the Mission by providing and operationalising new ideas to improve effectiveness of service delivery and efficiency of resources.

The NHSRC provided technical support and capacity building for strengthening public health systems and functioned as a focal point in the identification, documentation and dissemination of knowledge and experiences in health systems and health programmes. The Ministry released the annual corpus of Rs. 15 crore for NHSRC in March 2007. During 2007-08, the NHSRC spent Rs. 1.68 crore, out of which Rs. 1.1 crore was released to the Regional Resource Centre, Guwahati. Instead of investing the corpus fund to earn returns, the balance was kept in the current account.

As per the information provided by the Ministry SHSRCs were established in Chhattisgarh, Maharashtra, Uttarakhand, Bihar, Orissa, Rajasthan, Jharkhand, Haryana, Punjab and one RRC at Guwahati catering to the needs of eight North East States. The SHSRCs were not set up in remaining States and UTs. The Ministry had released funds to three States [Jammu and Kashmir (Rs. 1crore), Madhya Pradesh (Rs. 1.68 crore) and Tamil Nadu (Rs. 1.47 crore)] for setting up a resource centre, but the funds remained unspent at the SHSs. In West Bengal although the SHSRC was established, the annual corpus of Rs 1 crore was not created. In Gujarat construction work was under process.

The Ministry stated that the Cabinet approval for setting up of the NHSRC had not mandated for investing the corpus and run NHSRC from interest accrued.

The reply of the Ministry is not correct. By definition, corpus funds are required to be invested for keeping the corpus intact and using the interest accrued to the principal for expenditure, as is also indicated in Rule 208 (iv) of the GFRs.

Recommendations

- ***The Ministry may ask the States to report on their contribution of the matching amount under the Mission and link up State funds with their contribution.***
- ***The Ministry may ask the SHSs to map available services and supporting infrastructure at the health centres as well as the existing load on the***

available infrastructure. On this basis, relative need for setting up of new infrastructure and strengthening the existing ones as per IPHS may be assessed.

- ***The essential services such as OPD and in-patient services at the CHCs and PHCs need to be ensured on a priority basis across all health centres countrywide.***
- ***Adequate diagnostic and radiological services should be provided at all health centres.***
- ***Operation theatre at CHCs and labour room at CHCs and PHCs must be made functional with all essential equipment and manpower.***
- ***States should be instructed to fill sanctioned posts of medical and support staff at health centres and revise the sanctioned strength to meet the NRHM requirements. Release of further grants under the Mission Flexible Pool may be linked with achievements/progress on this count.***
- ***SHSs may segregate medical services and the management functions and ensure that the latter be strictly performed by management professionals. The Ministry has noted this for consideration.***
- ***Steps may be taken to fill up the management posts at the earliest as this would positively impact on the functioning of the Mission.***
- ***Complete induction training may be given to all ASHAs to make their services effective and viable.***
- ***The issue of inconsistency between data given by the SHSs and data obtained from DHSs may be taken up with the concerned States to ensure data integrity.***
- ***The Ministry may ask the SHSs to purchase and operationalise MMUs at the earliest.***
- ***SHSRC should be established in all States, especially in the EAG States where the requirement for technical support to the Mission was greatest.***

CHAPTER -7: PROCUREMENT AND SUPPLY OF MEDICINE AND EQUIPMENT

7. Procurement and supply

Timely supply of drugs of good quality, which involves procurement as well as logistics management, is of critical importance in any health system. To decentralise the procurement activities and build capacity for this purpose, NRHM emphasised setting up State Procurement Systems and Distribution Networks for improved supplies and distribution.

7.1 Procurement manual/policy

All organizations should prepare codified purchase manuals, containing detailed purchase procedures, guidelines and also proper delegation of powers, so as to ensure systematic and uniform approach in decision-making relating to procurements. However, in 26 States/UTs,[47] SHSs had no documented written procedures and practices on procurement.

Positive development

The Ministry had developed a comprehensive manual codifying best practice of procurement. A positive development in three states viz. Orissa, Gujarat and Uttarakhand was that the purchase procedure had been codified. Orissa had documented 'Drug Management Policy 2003' and the remaining two states had adopted a procurement manual.

In the absence of a uniform and well documented procurement policy, the system of procurement was quite often ad-hoc and there was no uniformity in the procedures followed by the various procurement wings under SHS/DHS.

7.2 Empowered Procurement Wing

The Ministry had set up an Empowered Procurement Wing (EPW) in October 2005 to consolidate, streamline, strengthen and professionalize the procurement of health sector goods under the NRHM, which were made by the various programme divisions in a fragmented and disjointed manner. There were to be three functional units of EPW, viz. Health, Family Welfare and Universal Immunisation Programme, under three Directors headed by a Joint Secretary. Seven Deputy Directors oversee

Work done by EPW

- Preparation of procurement manual and standard bidding document.
- Compendium of technical specifications of 800 generic equipment under preparation.
- Preparation of specification and quality assurance requirements for kit A and kit B under RCH.
- Preparation of Logistics Improvement Strategy Plan.
- Creation of a list of "approved" testing laboratories.
- Procurement and logistics training at central and state level (six states).
- Development of Procurement Management Information System (ProMIS) under process.

[47] Andaman and Nicobar, Andhra Pradesh, Arunachal Pradesh, Assam, Bihar, Chandigarh, Dadra and Nagar Haveli, Delhi, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Lakshadweep, Madhya Pradesh, Manipur, Meghalaya, Mizoram, West Bengal, Uttar Pradesh, Tripura, Sikkim, Rajasthan, Punjab and Chhattisgarh.

procurement activities under the disease control programmes (DCPs) and IDSP.

However, the desired structure did not physically exist under one wing. The EPW had been only directly handling the procurement of vaccines and contraceptives and supervising the procurement undertaken by RNTCP. The EPW was not overseeing the procurements made by various programme divisions by monitoring their procurement plan. Thus, the intended purpose of having a centralised procurement unit so as to generate cohesiveness and efficiency remained unfulfilled.

Further, an integrated procurement plan and fixed time schedule for completion of procurement activities had not been prepared by the EPW as envisaged. The EPW was also required to maintain computerized databases on requirement of goods and services; firms holding the Good Manufacturing Practices (GMP) certificate; market surveys/market intelligence; complaints received and services etc. However, the Wing did not maintain any such databases. No market survey of goods and services etc. had been carried out so far.

Another objective of the EPW was to build capacities of State and dependent agencies and monitor them for improving procurement of health sector goods and services etc. However, no progress in this regard had been made. In the absence of computerized database and integrated procurement plan, the EPW failed to monitor the procurement activities in the various divisions under the Ministry and in the States.

The Ministry stated that in January 2009 a section has been set up for the EPW and it is in the process of setting up a Centralized Procurement Agency (CPA).

However, establishment and operationalisation of the CPA needs to be expedited, since the Mission has entered its fifth year of operation.

7.2.1 Involvement of UNOPS as procurement agent

The Ministry had appointed United Nations Offices for Project Services (UNOPS) to carry out complete task of procurement for World Bank financed projects. As per the agreement with the UNOPS, bid evaluation according to international standards, pre and post shipment inspection and other procedures were the responsibilities of the agent, while the Ministry had been appointed as an observer.

The responsibilities of the Ministry as observer in examination and evaluation of the bid and post shipment inspection were not well defined and there was a lack of technical expertise and shortage of staff in the programme divisions as well as in EPW to carry out the tasks of observer. Further, programme divisions were not reporting to EPW regarding total indents placed and payment made to UNOPS. In the absence of reporting by the programme divisions, EPW could not monitor and reconcile the payment of advances and cost of services and management fee to UNOPS. Thus the purposes to consolidate, streamline, and strengthen and to professionalize the procurement activities for which the EPW established were not served.

7.3 Procurement process management

7.3.1 Formulary list of drugs

A health care system can ill-afford to purchase drugs mentioned under different proprietary brands at widely varying prices. A limited list of essential drugs, also

referred to as a drug formulary, defines which drugs would be regularly purchased for stock.

A review of the procedures followed revealed that a common formulary or essential drugs list was available only in 14 States/UTs,[48] but had not been developed in 13 States/UTs[49] and there were wide variations between the number and type of drugs included in the essential drugs list adopted by the districts/SHSs.

7.3.2 Bid document

Standard bidding documents were adopted only in four States[50], while in 13 States[51], separate non-standard bid documents were adopted by the SHSs and the DHSs. In Chandigarh, Arunachal Pradesh, Meghalaya[52] and Chhattisgarh important provisions relating to 'liquidated damages', 'pre-qualification norms', 'force majeure', 'packaging', 'performance security', 'warranty period', 'imposition of penalty for delay in supply and installation of equipment', 'remaining life' and 'bid security' etc. had been left out.

7.4 Bidding process management

7.4.1 Delay in processing and award of contract

To reduce delay, appropriate time-frames for each stage of procurement should be prescribed. To minimise the time needed for decision making and placement of contracts, appropriate purchasing powers may be delegated to lower functionaries with the approval of the competent authority.

However, in three States procurement process had not been completed according to the fixed schedule, mainly because of delays ranging from two months to two years in obtaining administrative approval and financial sanction from the competent authority. For instance, in Uttarakhand procurement of Mobile Medical Unit worth Rs.5.08 crore was not completed despite a lapse of two years. In Jammu and Kashmir, delay of 12-13 months was noticed in obtaining administrative approval and financial sanction for finalization of rates of drug kits. Similarly, though Ministry released funds to Daman and Diu in 2006, procurement of the drug kits was made after a delay of two years.

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[48] Bihar, Chandigarh, Dadra and Nagar Haveli, Himachal Pradesh, Madhya Pradesh, Maharashtra, Orissa, West Bengal, Uttarakhand, Uttar Pradesh, Sikkim, Rajasthan, Gujarat and Chhattisgarh.

[49] Assam, Delhi, Haryana, Jammu & Kashmir, Jharkhand, Lakshadweep, Manipur, Meghalaya, Mizoram, Punjab, Puducherry, Tripura and Arunachal Pradesh.

[50] Himachal Pradesh, Rajasthan, Uttarakhand and Uttar Pradesh.

[51] Assam, Chandigarh, Dadra and Nagar Haveli, Delhi, Haryana, Jharkhand, Kerala, Lakshadweep, Madhya Pradesh, Meghalaya, Punjab, Arunachal Pradesh and Chhattisgarh.

[52] In Meghalaya the absence of penalty clause in bidding document for delay in supply and installation of equipment resulted in undue financial aid to supplier of Mobile Medical Units for Rs.2.58 crore.

Thus, undue delay in obtaining the administrative approval and financial sanction resulted in delay in processing and award of contract. Such delays may have an adverse impact on the stock position of the health centres.

7.4.2 Irregularities in selection of supplier

In four States, irregularities such as absence of standard tender process, ignoring lowest rates, procurement from black listed supplier etc. involving Rs.36.07 crore were noticed as detailed below:

(Rs. in crore)

State	Nature of irregularity	Amount
Uttar Pradesh	Standard bidding process such as invitation of open tenders was not followed to avail the benefit of competitive rates in purchase of medicines.	25.66
Jharkhand	i) Drugs were purchased by SHS from a company blacklisted by Gujarat, Rajasthan and Maharashtra due to supply of sub-standard drugs. Quality test was also not conducted before payment.	6.20
	ii) State RCH Society purchased medicine/syringe without floating tender.	2.66
Chhattisgarh	Accepted tender of a firm after due date and placed supply order.	1.20
Manipur	16 generator sets were procured without inviting tenders.	0.35
TOTAL		36.07

7.4.3 Procurement of drugs/equipment at higher rates

As per Rule 160 of GFR 2005, contract for procurement should ordinarily be awarded to the lowest responsive bidder. The Ministry had placed supply orders of Rs. 22.37 crore for 1440 lakh doses of DPT vaccines on three agencies) @ Rs. 13.40 per vial for 340 lakh doses from L1, @ 14.37 per vial for 300 lakh doses from L2 and @ 16.88 per vial for 800 lakh doses from L3 bidder by adopting the process of limited tender inquiry in July 2008.

Achievement: Procurement of drugs in Gujarat

The SHS did not purchase medicines from the Central Public Sector Enterprises (CPSE) as the net rates (offered by them after discounts) were higher than the Rate Contract (RC) of the Central Medical Stores Organisation (CMSO). By purchasing five medicines at RC rate fixed by the CMSO the SHS saved Rs.40.08 lakh in respect of purchase orders placed between January and March 2007.

The limited tender inquiry involving bids from four agencies was in contravention to the GFR, which required open tendering for procurement of goods above Rs. 25 lakh. Moreover, the L1 firm was willing to supply DPT vaccines @ 12 per vial with a condition that supply order should be of 680 lakh doses and otherwise @ of Rs. 13.40 per vial. However, the Ministry placed supply order of only 340 lakh doses The decision of the Ministry not to place the order for maximum quantity i.e. 680 lakh doses to the L1 firm and procure the vaccines at higher rates was injudicious resulting in avoidable liability to incur expenditure of Rs. 2.14 crore on purchase of 340 lakh doses of vaccine at a higher rate of Rs. 16.88 per vial.

The Ministry stated that the L1 firm got the manufacturing license in January 2007 and therefore did not have the two years manufacturing and marketing experience. As per the condition of bid document, a firm which did not have two years manufacturing and marketing experience would qualify only for the trial order. Since this firm was also falling in this category, it was considered for only 20 *per cent* trial order.

However, the bid document for the purchase of vaccines stipulated that the

manufacturer who did not have two years of manufacturing and marketing experience in the specific vaccine (DPT) may not be given full orders without testing their ability through placement of trial order. Prior to the supply order in question, the firm had successfully supplied a trial order of 63 lakh doses at the rate of Rs. 12.00 per vial during 2007-08.

Further, in three States the medicines/equipment were procured at higher rates than those approved by other govt agencies resulting in extra expenditure of Rs. 3.29 crore as detailed below:

(Rs. in crore)

State	Nature Of Irregularity	Amount
Chhattisgarh	i) State Malaria Society procured Lab Materials at higher rates than the rate contract finalised by DHS involving extra expenditure.	1.62
	ii) Equipment was purchased at rates higher than lowest rate obtained in tendering resulting in excess payment.	0.03
	iii) Incorrect determination of L1 rates by not considering the tax component (inclusive/exclusive) in the comparative statement resulted in excess payment.	0.27
Bihar	Medicines were procured by 3 DHS at rates higher than approved by the SHS resulting in extra expenditure	1.27
Andhra Pradesh	Medicines were procured at rates higher than approved by AP Health Medical Housing and Infrastructure Development Corporation (APHMHIDC) resulting in extra expenditure	0.10
TOTAL		**3.29**

Moreover, in eight States avoidable expenditure of Rs. 8.09 crore incurred by various agencies on purchase of drugs which were not required, payment of avoidable taxes, non-deduction of tax at source, irregular payment without delivery receipt of medicines, etc. as detailed in **Annex 7.1**.

7.5 Procurement by hiring consultants

7.5.1 Avoidable payment and advances lying outstanding

Under the Pulse Polio Immunisation Programme, the Ministry had released US$ 24,48,50,047 to UNICEF during 2005-08. Supply-order/agreement-wise details of receipt of consignment by the State governments/Medical Store Depots were not on record for the supply of vaccines made between March 2006 to January 2008 at the Ministry and the adjustment of advances (by transferring the amount from non-plan to plan heads) was made without ascertaining the actual supply of the OPV.

The final adjustment of advances with UNICEF had not been done so far despite timely receipt of adjustment bill resulting in US$ 10,22,232.07 (Rs. 5.10 crore[53]) lying outstanding. Although, UNICEF clearly indicated the unspent amount of advances, the Ministry never tried to secure refund of the same. At the instance of Audit, the Ministry took up the matter with the UNICEF and UNICEF advised to utilise the unspent balances in future procurement. The Ministry also decided to work out an annual system of reconciliation with UNICEF.

In July 2007, the Minister, Health & Family Welfare had directed a review of the 4.5 *per cent* commission paid to the UNICEF as handling charges in view of the fact that

[53] 1 US$=Rs. 49.90 on 14-04-09

most of the procurement of OPV was done by local suppliers and most of the funding of the PPI programme was through the domestic budget. Between July 2007 and March 2008 the Ministry had purchased OPV through the UNICEF on four occasions. However, only on the fourth occasion, the Ministry negotiated the commission of the UNICEF, which was subsequently reduced to 2.25 percent of the total value of supplies. Had the Ministry finalised the negotiation with the UNICEF promptly after the Minister's observation, it would had saved US$ 10,72,655 (Rs. 4.26 crore) paid as handling commission.

7.5.2 Delay in supply of equipment and medicine

Under the NRHM, programme divisions of Integrated Disease Surveillance Project (IDSP) and Universal Immunisation Project under RCH-II had engaged HSCC in 2005 as consultant for procurement to inculcate professionalism in the activities related to procurement. For this, the HSCC was to inspect the equipment/examine the goods before their despatch to the consignee.

The HSCC failed to carry out the pre-despatch inspection of 10 test-checked consignments in time due to which, the delivery schedule of the consignment was to be deferred by the number of days equal to the delay (18 to 109 days) in inspection of goods. The Ministry failed to secure the interest of the government by not including the penalty clause for the delay on the part of the consultant in the agreement signed with the HSCC.

Further in Assam, delay of more than one year was noticed in supply of medicines by Tamil Nadu Medical Services Corporation (TNMSC) and delay of three months in supply of medicines occurred due to shifting of policy of procurement through consultants to Director of Health Services, Assam. The delay in supply of medicines in State had an adverse impact on the stock position of the receiving health centres.

7.5.3 Non-levy of liquidated damages

As per Rule 204 of the GFR 2005, all contracts shall contain a provision for recovery of liquidated damages for defaults on the part of the contractor. In three States, loss of Rs. 1.44 crore was incurred due to non-deduction of liquidated damages as detailed below:

(Rs. in lakh)

State	Nature of irregularity	Amount
Maharashtra	Payment made by the State Family Welfare Board (SFWB), Pune to supplier without deducting liquidated damages for delay ranging from 15 to 81 days in supply of drugs.	48.35
Gujarat	Non-recovery of penal charges by Central Medical Store Organisation (CMSO) for non-supply /undelivered quantity of goods.	5.75
Jharkhand	Delay in supply of medicines to State RCH society ranged from 5 to 80 days. Penalty as per contract was not imposed.	89.54
TOTAL		**143.64**

7.6 Utilisation of funds released for procurement

The Ministry released funds to the SHSs for procurement of medicines and equipment based on their annual PIPs. However, during 2005-08, 50 to 100 *per cent* of funds

released for procurement remained unspent in 17 States/UT[54] as of 31 March 2008, as detailed in **Annex 7.2**.

Further, in five States diversion of funds and medicine of Rs.22.84 crore was noticed resulting in non-achieving of objectives of the scheme and denying the intended benefits to earmarked areas as detailed below: ***(Rs. in lakh)***

State	Nature of irregularity	Amount
Maharashtra	Expenditure incurred on purchase of Ferrous Fumarate Syrup, not included in the list of GOI for preferential purchase of 102 medicines under RCH PIP, was booked under RCH.	1399.46
Uttar Pradesh	Funds, pertaining to Sectoral Investment Programme (SIP), for procurement of laparoscope were diverted in 2006-07 for purchase of Diesel Generator sets without approval of the government.	627.00
Karnataka	Payment made out of NRHM funds for the purchase and supply of 35,000 drug kits under the State sector scheme Stri Shakti (Self-Help Group) whereas guidelines of NRHM allow for supply of drug kits to the PHCs and the CHCs only.	205.00
Assam	Medicines purchased in November 2007 out of NRHM funds sanctioned categorically for Sub Centres, PHCs, CHCs, SDHs and District Hospitals only, were diverted to three Government Medical College Hospitals and one State level Mahendra Mohan Choudhury Hospital.	43.32
Chhattisgarh	CMHO, Kanker utilised 40 percent funds for purchase of medicine instead of prescribed 75 percent and 60 percent funds for Information Education and Communication (IEC) instead of prescribed 25 percent, resulting in diversion of funds towards non-sanctioned purposes.	9.40
TOTAL		**2284.18**

7.7 Equipment lying unutilised

In seven States medical equipment worth Rs. 24.69 crore were lying unutilised, resulting in non-achievement of scheme objective and blocking of funds as shown in the following table:

(Rupees in lakh)

State	Audit Observation	Amount
Orissa	In four test checked district hospitals, one Sub-divisional hospital (Jeypore) and one CHC (Ghasian), Diagnostic, OT and other equipment were lying idle without installation / commissioning for over one to five years due to want of required infrastructure and trained manpower.	112.88
Maharashtra	26 laparoscopes were lying unutilised from January 2008 (8) and October 2008 (18) with State Family Welfare Bureau.	92.12
Karnataka	i) 40 anaesthesia machines were lying idle in CHCs since January 2007 in the absence of any sanctioned posts of anaesthetics.	72.14
	ii) Glass syringes were purchased without requirement/indent.	20.33
Assam	i) Basic equipment (27 items) procured in 2007-08 without assessment of availability of required infrastructure to perform 24 X 7 PHC sent to 54 PHCs were lying idle.	47.74
	ii) 4265 beds transferred to districts from National Games Village, Guwahati without assessment of requirement, out of these 177 beds could not be installed due to non-availability of space.	12.75
	In one CHC equipment like ultrasound, X-ray, ECG machines procured during 2004-06 were lying unutilised/un-installed in absence of electrical	-NA-

[54] Andaman & Nicobar Islands, Chandigarh, Delhi, Haryana, Jharkhand, Lakshadweep, Maharashtra, Manipur, Orissa, Punjab, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand and West Bengal.

State	Audit Observation	Amount
	connection.	
Bihar	In East Champaran district, Medical equipment viz. OT light, hydraulic operation table etc. procured in excess of requirement were lying idle since March 2006 in district stores.	25.68
Jammu & Kashmir	Equipment viz. Semi-Auto Analyser, Life Pack etc. lay in stores un-utilised for more than one year.	12.56
TOTAL		**396.20**

Case study: Unutilised equipment in Jharkhand

- 130 Vaccine Deep Freezers (VDFs) and 268 Portable Vaccine Carriers (PVCs) of Rs. 10.43 crore were procured and 202 rooms at installation sites were developed in June 2006 to maintain the Cold Chain, necessary for safe carriage of potent vaccines. The equipment however remained un-utilised as (a) Deep Freezers did not work on solar power back up (b) required temperatures could not be maintained (c) equipment damaged due to high voltage fluctuations (d) 72 sites remained unutilised due to non-installation of VDFs. This resulted in unfruitful expenditure.

- 24 MMUs with telemedicine facilities were purchased at the rate of Rs. 66.67 lakh per unit although telemedicine facilities in the MMUs were not provided as per NRHM framework and infrastructure to provide telemedicine facilities was not available in Jharkhand. MMUs without telemedicine facilities were, however, available at the rate of 22.00 lakh per unit. The telemedicine function of MMUs remained unutilised resulting in un-fruitful expenditure of Rs. 10.72 crore.

Unutilised beds at Dekhoumukh PHC: Assam

Radiant warmers remaining unutilized at Panigaon Sub Centre: Assam

7.8 Non availability of essential drugs in health centre

Availability of drugs, which involves procurement, as well as logistics management, is of critical importance in any health system. Under NRHM, it was provided that two months stock for

Success story

A positive impact of the Mission was that two months' buffer stock of medicines was available in nine states/UT (Madhya Pradesh, Maharashtra, Uttar Pradesh, Punjab, Chhattisgarh, Chandigarh, Delhi, Himachal Pradesh and Lakshadweep).

essential medicines/drugs was to be maintained in the health centres.

The stock of essential drugs, contraceptives and vaccines adequate for two months consumption were not available in any of the test checked PHCs and CHCs in nine States/UT (Assam, Bihar, D & N Haveli, Jharkhand, Manipur, Mizoram, Orissa, West Bengal and Sikkim). In six States, two months' stock was available partially at sample health centres as given in table 7.1

Table 7.1: Percent of health centres with two months' stock of drugs, contraceptives and vaccines

State	CHC	PHC
Jammu & Kashmir	75	59
Karnataka	89	89
Meghalaya	38	9
Uttarakhand	100	92
Rajasthan	67	72
Gujarat	83	87

7.9 Quality assurance of drugs

The pre and post-shipment quality tests are required, especially in the case of purchase of medicines. However, in three States cases of procurement of sub-standard drugs or procurement of drugs without assuring quality was noticed as detailed below:

(Rupees in lakh)

State	Nature of irregularity	Amount
Orissa	Though Drug Management Policy of the State provided for sample testing of each batch of medicines purchased before allowing full payment, quality testing of samples of 303 batches of ASHA kits was not conducted and these were distributed to ASHAs.	141.00
	Drug Management Policy of the State prescribed for not procuring any drug with less than 5/6th shelf life, however in 11 cases drugs were purchased with less than prescribed life of 5/6th shelf life.	19.51
Jharkhand	Sub-standard DEC tablets (Broken/bad) were supplied to State Malaria Control Society under NVBDC Programme for Mass Drug Administration (MDA) towards elimination of Lymphatic filariasis.	55.00
West Bengal	In five districts drugs purchased by procurement wing of Chief Medical Officer of Health (CMOH) was found to be substandard.	16.44
TOTAL		**231.95**

In Orissa, sub-standard drugs were administered to patients in Koraput district due to belated receipt of test reports from lab and late communication from the State Drug Management Unit (SDMU). Similarly, in Sundergarh and Bolangir districts, in 14 cases, time expired medicines of Rs.3.02 lakh were administered to patients due to late receipt of communication from SDMU declaring the drugs as 'not of standard quality'.

In Bihar, quality test mechanism of drugs was non-existent and medicines were used without ensuring quality. In Assam 58.13 lakh condoms of 10 different batch numbers were supplied, of which sample from five batches were sent to laboratory for testing. The entire sample was tested as sub-standard and subsequently was replaced by the supplier. However, 43 lakh condoms of remaining five batches were supplied to districts without conducting laboratory tests.

7.10 Management of supplies

In August 2007, the Ministry issued an order to Government Medical Store Depot (GMSD), Guwahati for release of 79.61 lakh pieces of condoms with expiry date of June 2008, to State Family Welfare Bureau (SFWB), Kolkata. However, SFWB, Kolkata refused to accept the supply of condoms due to short expiry period.

Consequently, in January 2008, the Ministry asked GMSD, Guwahati to dispatch the above quantity to Gujarat, Madhya Pradesh, Rajasthan and Uttar Pradesh. However, Bhopal State office also did not accept the stock due to short expiry period and it was decided to divert the supply to Pune, Maharashtra. The stock was not accepted by Maharashtra, for the same reason. However, the State later accepted the stock when the same was delivered by the transporting agency in the campus of Directorate of Health Services, Pune in March 2008. The Directorate of Health Services distributed 20 lakh condoms expiring in June 2008 (worth Rs. 25.13 lakh) to 30 districts between 25 March 2008 and 03 May 2008. From district headquarters, these condoms were required to be sent to health centres for further distribution to patients. The above facts indicated deficient management of supplies by the Ministry, as the health centres received condoms for distribution with a shelf-life of one month to three months, while the Ministry generally procures condoms with a shelf life of three years.

Similarly, in West Bengal also there was a loss of Rs. 47.54 lakh due to expiry of medicines lying in store.

PHC Morwahi, Gondia, Maharashtra

PHC Kendur, Pune, Maharashtra

Contrasting Patterns of Store Management

Recommendations

- ***The Ministry may ask SHSs to adopt and follow the procurement manual developed by the Ministry for all subsequent procurement activities so as to ensure uniformity and standardization countrywide.***
- ***EPW's functioning in terms of technical and professional expertise may be strengthened so as to infuse professionalism in the management of high value centralised procurement of medicines and equipment under the NRHM.***
- ***Department should strengthen internal controls to check delay in procurement process, avoid excess procurements and stockouts and ensure purchases of good quality medicines and equipment at the most competitive rates by adhering to General Financial Rules.***
- ***The procurement procedures and bidding documents should be reviewed and standard bid documents and contract agreements should be adopted for procurement as part of a model manual.***
- ***The Ministry and States should share data regarding blacklisted firms on their websites.***

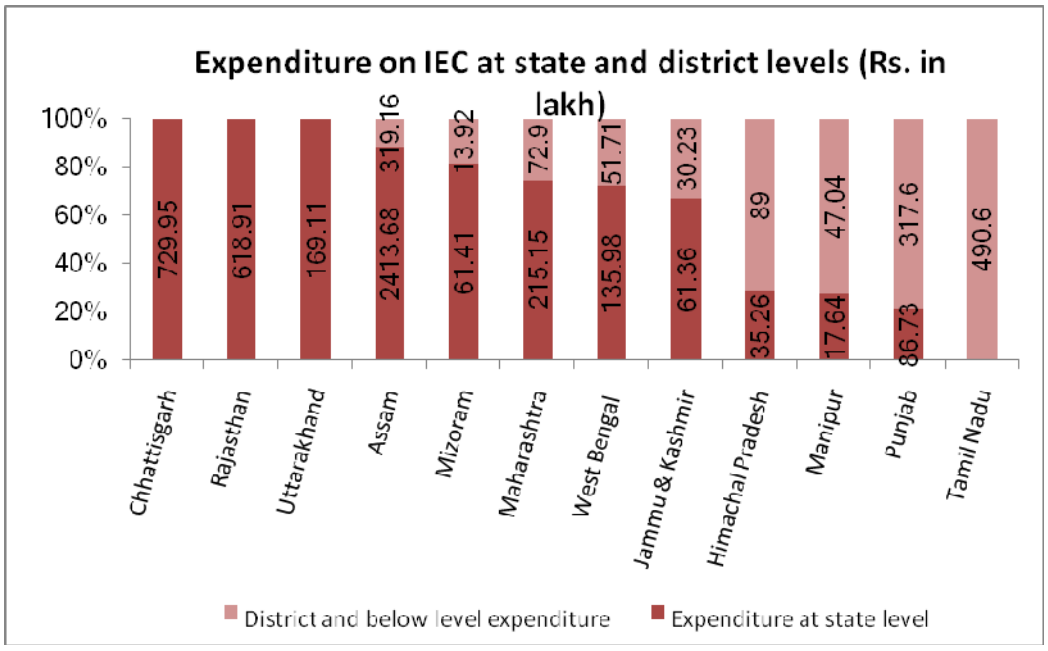
CHAPTER 8: INFORMATION EDUCATION AND COMMUNICATION (IEC)

8. IEC strategy

The Information, Education and Communication (IEC) strategy under the NRHM, aimed to spread awareness on the preventive aspect of healthcare and disseminate information regarding availability of and access to quality healthcare for the poor, women and children in rural areas. The Ministry had been implementing a comprehensive IEC package for publicity through extensive use of television, radio and other media with the help of the Song and Drama Division, Directorate of Advertising and Visual Publicity and Directorate of Field Publicity of the Ministry of Information and Broadcasting. In addition, hoardings in rural areas, advertisements in print media, and printed material in regional languages by the States were also being utilised for IEC activities.

8.1 IEC expenditure in States

The NRHM framework stipulated that the allocations made to support IEC activities were to be spent equally (one third each) at three levels viz. national, state and district level. Utilisation of IEC funds by States was varied both in the proportion of usage and its level/area. While in eight States, most of the funds received for IEC activities were utilized at State level and only a meagre amount was released to districts for utilization down the order, in another four States, most of the funds were spent at district level and below indicating that there was no settled route for IEC fund dissemination. The modalities to monitor the allocation of resources under IEC for different levels of implementation of the Mission were yet to develop.



(Source: Information provided by SHSs)

As can be seen from the graph above that expenditure at district level and below, where it was most needed was not sufficient.

The level of utilization of IEC funds was poor in some States. In Rajasthan, Rs 6.19 crore (27.4 *per cent*) out of Rs 22.57 crore released by the Ministry during 2005-08 was used and the entire fund released during 2005-06 and 2006-07 remained unutilised. In Jharkhand, only Rs. 5.38 crore (53 *per cent*) had been utilised out of funds of Rs.10.18 crore released by the Ministry for IEC activities. In Orissa, Rs. 9.21 crore (61 *per cent*) out of Rs. 15.06 crore and in Chandigarh, Rs. 37.21 lakh (40.2 *per cent*) out of Rs. 92.52 lakh had been spent. In Kerala (2006-07) and Gujarat (2007-08) 88 and 53 *per cent* respectively of fund released remained unutilised. SHS of Bihar, Madhya Pradesh and Karnataka did not furnish information on expenditure on IEC activities. Moreover, interest accrued on unspent balances had not been accounted for.

Irregularities were also observed in expenditure of Rs. 30.38 crore in six States for IEC activities as detailed in **Annex 8.1**. The irregularities resulted in overpayment of Rs. 1.68 crore in Chhattisgarh, as highlighted in the box below.

Case study: Irregularities and overpayments under IEC in Chhattisgarh

- During 2005-06, in six cases, IEC works such as wall paintings, poster and display of hoardings were awarded by the State RCH Society and State Malaria Society to the private agencies on rates higher than those charged by the State Government's agency dealing with the publicity work (SAMVAD) resulting in overpayment of Rs. 1.01 crore. These societies did not obtain the rates of SAMVAD before awarding the work in contravention to the instructions issued by the State Government.
- Directorate of Health Services procured IEC materials, viz. posters and banners, in September 2005 at rates much higher than those procured in February 2005. The failure of the Directorate to place repeat orders, the option of which was available and valid under Government rules, resulted in avoidable payment of Rs. 48.04 lakh.
- The work order for printing of 10 lakh pamphlets was given to a private firm @ Rs. 80 per 100 pamphlets, while the prevailing approved rate contract of the department was Rs. 65 per 100 pamphlets resulting in over-payment of Rs. 1.5 lakh.
- The work of geru painting was executed through a private agency @ Rs.5.00 per sq. ft. in September 2005, whereas the same work was executed through another firm @ Rs.0.89 per sq. ft. in December 2004. The large variance in rate over such a short period resulted in overpayment of Rs. 8.22 lakh.
- Under the Kalajatha programme overpayment of Rs. 9.37 lakh was made to two agencies due to payment for higher number of shows than actually awarded in one case and higher payment in another case.

The IEC expenditure showed a preference towards television, radio and print media. Local media such as street shows, drama, direct interaction etc., which were simpler means for reaching the target group of rural population, remained neglected. Specific IEC strategies should be worked out at the local sub-district levels and funds separately allocated for the purpose.

The Ministry stated that inter-personal communication had rightly been emphasized by audit and that was the direction in which NRHM was attempting to move. Since the Mission had 700,000 ASHAs or Community Health Workers, it was important to use them for behaviour change on a large scale.

8.2 IEC through prescription slips

As a pilot activity, the Ministry provided Rs. 6.46 crore to 18 special focus States (2004-05) for printing prescription slips with health messages for use at the PHCs, CHCs and District Hospitals. However, no formal detailed proposals were received from the States.

The funds were only released in April 2005, and Rs. 1.29 crore (20 *per cent* of total release) still remained unspent with the States (August 2008). Moreover, the Ministry did not conduct any evaluation of the scheme.

Case Study: IEC activities through prescription slips in Orissa

In November 2006, SHS released Rs. 73.31 lakh, received from the Ministry, to State Institute of Health and Family Welfare (SIHFW) for printing of 2.44 crore prescription slips containing the NRHM message and symbol at the rate of 30 paise per slip through departmentally managed offset printing press. However, only 1.43 crore such slips were printed and supplied to different CDMOs of the State as of October 2008 and the balance amount of Rs 30.54 lakh was lying unspent. Further, among audited districts, while 7.72 lakh prescription slips were shown by the SIHFW as issued to CDMO, Kalahandi during January to December 2007 in different challans, verification of Stock Register of the concerned CDMO revealed receipt of only 4.62 lakh such slips up to 31 March 2008 as certified by the Store-keeper. Despite this being pointed out by audit, the SHS did not inquire into the issue of short accountal/doubtful issue of 3.10 lakh prescription slips costing Rs. 0.93 lakh.

The Ministry stated that the programme of advocacy through prescription slips was started as a pilot in 18 States which constituted the priority areas under NRHM. Evaluation was not done as it was considered a one time activity. Vigorous efforts were being made to settle accounts of States/UTs and UCs and SOEs were being received.

However, post-scheme evaluation of this easily disseminable IEC media would be beneficial to decide on its continuation on a regular basis.

8.3 Health melas

Source: Ministry's website

The NRHM framework stated that health melas were to be conducted annually in all parliamentary constituencies so as to make people aware of the number of options in terms of different systems of medicine (allopathy, homeopathy, ayurveda and unani etc.), to help them comprehend the linkages between preventive, promotive, curative and rehabilitative health care as well between the primary, secondary and tertiary health sectors and to sensitize them to the roles played by the Central Government, State Government, elected local bodies, NGOs and professional organizations. A grant of Rs. 8 lakh per mela was given by the Ministry to meet the cost of logistic arrangements, publicity and necessary drugs, medicines etc.

The Ministry released Rs. 3.68 crore to 15 States/UTs (2005-06) and Rs. 43.44 crore (2006-07) to all the States/UTs. However, Rs. 2.50 crore (68 *per cent* of the release in 2005-06) remained unspent with 10 States/UTs. In seven States (Manipur, Nagaland, Sikkim, Assam, Tamil Nadu, Haryana and Gujarat), no expenditure was incurred at all from the funds received for health melas.

For funds released (2006-07), the Ministry received utilisation details of only Rs. 3.39 crore (8 *per cent* of the release) from seven States/ UTs. While Rs. 6.05 crore was lying unspent with five States/UT (Uttar Pradesh, Himachal Pradesh, Haryana, Kerala and Daman and Diu), 27 States/UTs[55] did not report on funds utilisation as of August 2008.

The Ministry was unable to provide State wise details regarding the number of health melas organised and activities undertaken therein, in the absence of which correlation between financial progress and actual achievements could not be made.

The lack of utilisation of funds for health melas indicated that the goal of using IEC to encourage wider participation of all the stakeholders and target populations needed to be emphasised more.

The Ministry stated that in view of the unspent funds with States and pending utilisation certificates, no funds for health mela were released during 2007-08.

8.4 Village Health and Nutrition days and school health check-up

NRHM guidelines stated that the ANM with the help of Anganwadi Workers and ASHA was to organise village health and nutrition days (VHND) in every village. Similarly, the PHCs were to organise school health check-ups on a quarterly basis so as to disseminate knowledge on health and family welfare issues through direct interaction.

Positive development

In Himachal Pradesh and Jammu and Kashmir VHND and health check-ups were organised despite not fixing any targets. In Kerala, the SHS stated that school health check-ups were organised in every school once a year.

In nine States[56] no targets were fixed for conducting VHND during 2005-06. Even in 2006-07 and 2007-08 targets were not fixed in six[57] and five[58] States/UTs respectively. Nor were targets for quarterly school health check-ups fixed in eight States/UTs[59] during the audit period.

In seven States (Andhra Pradesh, Assam, Maharashtra, Uttar Pradesh, Rajasthan, Sikkim and Uttarakhand) there was shortfall against targets in organising VHNDs and/or school health check-ups. VHNDs were not being organised in Assam,

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[55] Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttarakhand, Manipur, Meghalaya, Nagaland, Sikkim, Tripura, Assam, Jammu & Kashmir, West Bengal, Tamil Nadu, Gujarat, Goa, Andhra Pradesh, Karnataka, Maharashtra, Punjab, A & N Islands, D & N Haveli, Delhi, Lakshadweep and Puducherry.

[56] Manipur, Mizoram, Tripura, Sikkim, Uttar Pradesh, Arunachal Pradesh, Chandigarh, Meghalaya and Assam.

[57] Mizoram, Tripura, Sikkim, Arunachal Pradesh, Chandigarh and Manipur.

[58] Chandigarh, Arunachal Pradesh, Tripura, Mizoram and Manipur.

[59] Assam, Jammu and Kashmir, Himachal Pradesh, Mizoram, Puducherry, Uttar Pradesh, Uttarakhand and Chandigarh

Mizoram and Tripura (2005-06), Sikkim and Puducherry (2005-07) and Jharkhand (2005-08). Similarly, school health check-ups were not conducted in Assam, Jharkhand and Manipur (2005-08), Arunachal Pradesh (2007-08). The SHS of Gujarat, Madhya Pradesh, Punjab, Orissa and Puducherry did not furnish information on VHNDs and/or school health check-ups.

Thus, IEC through local health activists and village level personnel had not attained full momentum due to non-conducting of VHNDs in some of the States, non-fixation of targets for conducting VHNDs in some States and shortfall against targets in others.

Recommendations

- ***Funds need to be distributed among varied media of communication across Centre, State and districts so that the message of the programme is delivered in the most simple and effective manner.***
- ***Internal controls may be strengthened at SHSs to prevent financial irregularities.***

CHAPTER-9: ACHIEVEMENTS IN HEALTHCARE

9.1 Performance indicators

The NRHM prescribed national targets for reducing infant mortality rate (IMR), maternal mortality rate (MMR), total fertility rate (TFR) and morbidity and mortality rates and increasing the cure rate of different endemic diseases covered under various NDCPs. The State specific targets were not prescribed under the Mission. States had to fix their own targets keeping in view the overall national targets.

However, SHSs in Assam, Arunachal Pradesh, Andaman & Nicobar, Bihar, Chhattisgarh, Daman & Diu, Delhi Jharkhand, Karnataka[60], Manipur, Meghalaya, Mizoram, Punjab, Sikkim, Tripura, Uttar Pradesh and West Bengal (17 States/UTs) did not prescribe long term goals and targets in respect of these performance indicators. In nine States,[61] outcome goals for performance indicators as well as long term goals under NRHM were prescribed. However, pre NRHM data on various impact and performance indicators was not compiled/available in Chandigarh, Jammu & Kashmir, Kerala and Uttarakhand. In the absence of pre NRHM data on IMR, MMR, TFR etc. and various performance indicators, the reasonableness of targets set and progress post NRHM could not be measured.

The district is the basic unit for all interventions under the NRHM. However, the district-wise long term targets for impact indicators and annual targets for performance indicators were also not prescribed in Assam, Arunachal Pradesh, Andaman & Nicobar, Bihar, Chhattisgarh, Daman & Diu, Delhi, Jharkhand, Rajasthan, Manipur, Meghalaya, Mizoram, Madhya Pradesh, Orissa, Punjab, Sikkim, Tripura, Uttar Pradesh and West Bengal (19 States/UTs).

The Ministry stated that State and district targets and corresponding performance indicators were available for examining the impact of NRHM. Each Integrated District Health Action Plan (IDHAP) contains the base line of respective district and goals (including intermediate goals) which the district concerned wants to attain. Similarly, the annual PIP of the States draws support and direction from the perspective goals laid down by the respective State. The Ministry stated that State and district targets had not been laid out centrally under NRHM. In a large and diverse country like India, with wide interstate and intrastate variations, the Ministry felt that it would be inappropriate to centrally prescribe local targets of the health sector reform agenda. Each State would need to be conscious of its base line and its capacities before adopting realistic, targets. The same applies to the districts also.

The Ministry further stated that NRHM did prescribe output targets and overall outcome targets for various interventions. The various programme constituents of NRHM had their own targets which are honoured as part of the overall NRHM agenda. Vigorous efforts for operationalising the web base health MIS have shown

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[60] SHS did not provide information regarding target set for impact and performance indicators.

[61] Andhra Pradesh, Chandigarh, Dadra & Nagar Haveli, Himachal Pradesh, Jammu & Kashmir, Kerala, Maharashtra, Uttarakhand and Tamil Nadu

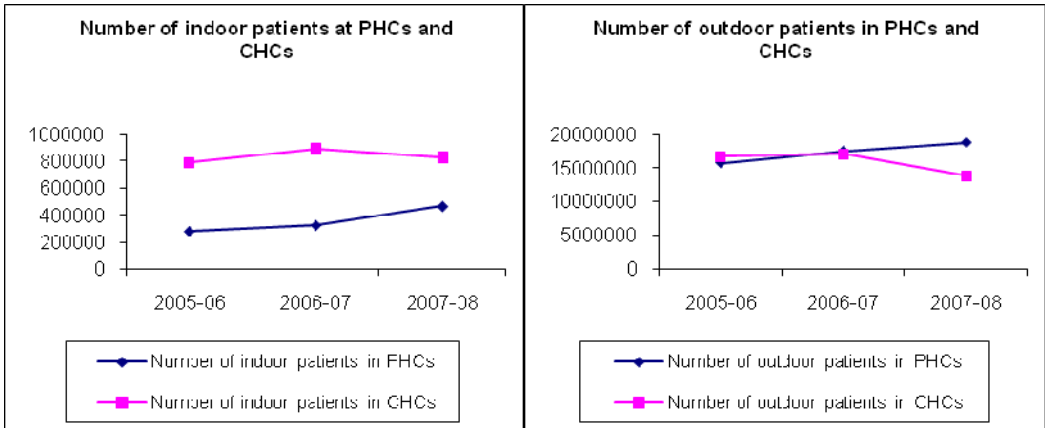
positive results and more robust, regular MIS was becoming available for matching the achievement of various programmes against the targets.

While the Ministry's emphasis on the IDHAP was appreciated, the fact remains that half of the States/UTs and most of the districts had not prepared their perspective plans indicating long-term goals. At the Ministry level also, no roadmap had been developed in consultation with States to set the disaggregated State wise long term targets, goals and outputs to achieve the overall national outcomes prescribed under the NRHM. The national targets did not reflect the inter-state and intra-state variations pre-NRHM, for various indicators. The targets should be based on clear and achievable goals built up from grassroots data set by the States. The need for the Ministry to guide and ensure that State goals are achievable and are in line with overall national indicators, is again emphasised. Overall targets should be set for the country by the Ministry. The States can set their own annual targets to reach the national goal.

9.2 Increase/ decrease in in-patient and out-patient cases

Increase/decrease in the number of in-patient and out-patient cases is an important indicator to help assess the effectiveness of various interventions under the NRHM.

The number of out patients cases reaching the PHCs had increased substantially but the number of inpatient and outpatient cases at CHCs was not increasing apace as seen in the sample audited districts of Assam, Andaman & Nicobar, Bihar, Chhattisgarh, Jammu & Kashmir, Himachal Pradesh, Haryana, Meghalaya, Punjab, Puducherry, Uttar Pradesh and Tamil Nadu (12 States/UTs). However, the overall number of OPD and IPD patients had decreased in five States (Himachal Pradesh, Orissa, Lakshadweep, Madhya Pradesh and Gujarat). The trend of OPD IPD patients at the CHCs and PHCs of audited districts in 26 States/UTs was as under:



In eight States (Andhra Pradesh, Arunachal Pradesh, Assam, Jharkhand, Mizoram, Kerala, Sikkim and Chhattisgarh), SHSs did not maintain overall data on number of patients during 2005-08. In Maharashtra (up to 2006-07), Uttarakhand and Punjab data for CHC only was maintained.

The varying response by patients to the interventions made under NRHM indicated asymmetrical implementation of various components of the Mission countrywide. For instance, increase in outpatient cases at PHCs but stagnancy in in-patient and out-

patient cases at CHCs indicated facility of doctors, medicines, etc. but lack of adequate facilities for nursing, emergency services etc.

Patients waiting at a health facility in Bihar

The Ministry stated that no two States in the country are identical. The health seeking behaviour of communities also varies from district to district and state to state. As the health system is rejuvenated, absolute number of citizens utilizing the services is bound to improve. However, spread of this increase was not expected to be uniform. Some States had allocated sequential attention to rejuvenation of various levels of health facilities. Others had undertaken jurisdiction wise upgradation of services. Still others had adopted thematic focus. Hence the improvement of OPD at various levels in many States was not uniform. The OPD attendance at various levels was also a function of the health seeking preferences of the community. The overall transactional capacity of the State in terms of availability of transport, road condition, communication services etc. also determines the preferred locus of interaction of citizens with the health system. The relatively slower improvement in the inpatient statistics can be attributed to several reasons including lack of residences / transport for service providers (because of which they are inclined to restrict the services to OPD only). Efforts were being made under NRHM to improve the availability of physical infrastructure, augmenting the nursing HR etc. to improve the utilization of inpatient beds in public facilities.

9.3 Reproductive and Child Health (RCH)

9.3.1 Maternal health

Under maternal health, the RCH II aimed to reduce maternal and infant mortality rates to 100 per one lakh and 30 per thousand respectively by 2010. The important services for ensuring maternal health and care included antenatal care, institutional delivery care, post natal care and referral services.

(a) Antenatal care

One of the major aims of the safe motherhood programme was to register all pregnant women within 12 weeks of pregnancy, provide them four antenatal check-ups, Iron Folic Acid tablets for 100 days, two doses of tetanus toxoid (TT) and advice on the correct diet and vitamin supplements and in case of complications refer them to more specialised gynaecological care.

(i) Registration and checkups

Systematic records for all the four ante-natal checkups were not maintained in sample districts in 19 States/UTs (Assam, Andhra Pradesh, Arunachal Pradesh, Chhattisgarh,

Dadra & Nagar Haveli, Daman & Diu, Himachal Pradesh, Haryana, Jammu & Kashmir, Jharkhand, Kerala, Mizoram, Orissa, Rajasthan, Sikkim, Tripura, Uttar Pradesh, Uttarakhand and West Bengal). The details of registration of pregnant women were not recorded in Andaman & Nicobar, Arunachal Pradesh, Bihar, Jharkhand[62], Orissa, Sikkim, Tripura and Uttarakhand. Mother and Child Health (MCH) registers were also not maintained properly in most cases.

Moreover, less than 50 *per cent of* pregnant women were registered within 12 weeks of pregnancy in five States/UT (Dadra & Nagar Haveli, Jharkhand, Madhya Pradesh, Mizoram and Rajasthan). State-wise details are in Annex **9.1**. Data in this regard was not made available in nine States/UTs (Andaman & Nicobar Islands, Arunachal Pradesh, Orissa, Chhattisgarh, Meghalaya, Punjab, West Bengal, Uttarakhand and Tripura) .

Only 21 to 57 *per cent* of pregnant women received four antenatal checkups in Assam, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Meghalaya and Uttar Pradesh. 38 to 58 *per cent* of pregnant women had not received any checkups in Gujarat, Jharkhand and Meghalaya. In contrast, all pregnant women had been registered within 12 weeks of pregnancy in eight States/UTs[63]. However, the data provided by the SHS needs to be checked given the absence of systematic records of registration, checkups and sound reporting system from CHCs, PHCs and Sub Centres to the DHS and further above. Specific cases of variation in data provided by the SHS and data verified during audit are given in Table 9.1:

Table: 9.1 Variation in number of pregnant women registered

Name of the State	Year	No. of pregnant women registered as reported by	
		DHS	SHS
Uttar Pradesh	2005-06	396000	494000
	2006-07	409000	503000
	2007-08	422000	500000
Mizoram	2005-08	20307	20246

The Ministry stated that while the report of District Level Household and Facility Survey- 3 (DLHS-3, 2007-08) conforms to the audit findings on most of the parameters, in some States data of audit and DLHS vary on some parameters.

However, the variation between DLHS-3 data and the audit finding is inevitable. While DLHS-3 was based on surveys of sample households, the audit findings are based on information for three years (2005-06 to 2007-08) provided by the SHSs. Wherever, the variation is considerable the matter needs to be examined by the Ministry.

(ii) Iron Folic Acid Administration

In nine States/UTs (Gujarat, H.P, Kerala, Punjab, Uttarakhand, Delhi, Arunachal Pradesh, Orissa, Uttar Pradesh) 20 to 50 per cent pregnant women could not receive the full dose of IFA tablets while in seven States/UTs (Jammu & Kashmir, Jharkhand, Sikkim, Assam, Chandigarh, Puducherry and Maharashtra) the shortfall was more

[62] In Jharkhand, the SHS provided data on registration of pregnant women, while no such data was maintained in any of the audited districts, which raises doubts on data provided by the SHS.

[63] Assam, Chandigarh, Haryana, Himachal Pradesh, Jammu & Kashmir, Kerala Puducherry and Uttar Pradesh.

than 50 per cent. The SHS did not maintain data on administration of IFA tablets to pregnant women in Andaman & Nicobar, Bihar, Daman & Diu, Karnataka, Manipur, Mizoram, and Tripura (7 States/UTs).

As per data provided by the SHSs, the number of pregnant women administered IFA gradually decreased from 2005 to 2008 in 17 States/UT as detailed in **Annex 9.2**. In 4 sample districts of Assam, Punjab[64] and Andhra Pradesh, IFA tablets were not given to any of the 520661 registered pregnant women during the year 2005-08. In most States, the shortfall in administration of IFA tablets was mainly due to non-supply or short supply[65] of IFA tablets. State specific cases of discrepancies in administration of IFA tablets are given below**:**

Uttar Pradesh	Government of India released Rs. 38.49 crore in March 2006 for procurement of Kit A containing IFA tablets and Kit B. However, due to non-finalisation of the procurement agency, the procurement of Kits was delayed and the kits were distributed to ANMs in April 2008. All 68 Sub Centres, 25 PHCs and 18 CHCs of the audited districts had reported (2005-08) the distribution of IFA tablets to the pregnant women to the SHS in their progress reports, although IFA tablets were not available with them during this period.
Bihar	In audited districts, proper records were not maintained by the health units to show the status of pregnant women actually receiving IFA administration. In Kishanganj district both the prophylaxis and therapeutic tablets were shown as administered to expectant mothers but each beneficiary received only 10 to 30 tablets during 2005-08.

In 90 CHCs, 208 PHCs and 707 Sub Centres of Bihar, Haryana, Punjab, Rajasthan, Manipur, Uttar Pradesh and Tamil Nadu (7 States) the stock of IFA tablets was nil during the most of the period from 2005-08 and in 18 CHCs, 55 PHCs and 108 Sub Centres of Jharkhand, Mizoram, Sikkim, Uttarakhand and Chhattisgarh (5 States) the stock of IFA tablets was below the minimum recommended level during 2005-08.

The Ministry stated that there had been shortfalls in IFA tablets availability at peripheral health centres of some States of the country in the past. This was now being supplied by procurement through UNOPS.

(iii) Tetanus Toxoid Immunisation

Data for immunisation against the tetanus toxoid was not maintained by SHS and DHS in Bihar and Arunachal Pradesh.

Further, the targets fixed by other States had no relationship with the demographic profile, nor were they based on any baseline survey. While Madhya Pradesh and Uttar Pradesh fixed a target of 62.88 lakh and 193.06 lakh respectively, the target for Tamil Nadu and Andhra Pradesh was only 37.71 lakh and 54.56 lakh respectively. Figures of achievement also showed wide variations. While Chandigarh and Lakshadweep exceeded their targets, Jammu & Kashmir, Jharkhand, Uttar Pradesh and Tripura fell short and reached less than 75 *per cent* of the target. Besides, the data

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[64] In Bathinda, IFA was administered to 1534 women only out of the total 88265 registered pregnant women. In Hoshiarpur IFA tablet was not administered to any pregnant woman during 2005-07.

[65] An exception was Jammu & Kashmir where shortfall was due to poor response from pregnant women as sufficient stocks of IFA tablet were available at the health centres.

was not very reliable as no systematic records on pregnant women were available in most districts and States.

The Ministry stated that in the absence of well defined systems in the State, target for TT immunization was fixed centrally based on projections of Census 2001. Ideally, States should decide targets based on annual household surveys at the field level and bottom-up approach should be taken in fixing targets from sub-centre level upwards. Further, the reporting system in some of the States was weak as reflected in wide gap between the evaluated and reported data.

Poor condition of maternity ward at District Hospital, Rajouri, Jammu and Kashmir

(b) Institutional delivery care & Janani Suraksha Yojna

The Janani Suraksha Yojna (JSY) scheme was introduced in April 2005 replacing the earlier National Maternal Benefit Scheme (NMBS). JSY had the twin objectives of reducing maternal and infant mortality by providing cash incentive to pregnant women of BPL/SC/ST families in all States and all pregnant women in ten low performing States (eight EAG States, Assam and Jammu and Kashmir).

(i) Targets and achievement

A primary objective of the scheme was to increase institutional deliveries and achieve the target of 100 *per cent* institutional deliveries by the end of 2010. However, in 12 States/UTs viz. Andaman & Nicobar, Arunachal Pradesh, Bihar, Chandigarh, Dadra & Nagar Haveli, Himachal Pradesh, Karnataka, Kerala, Manipur, Mizoram, West Bengal and Orissa, the SHS did not prescribe year-wise targets for institutional deliveries. Shortfall in target achievement was noticed in 11 States which ranged between 25 to 81 *per cent* in six States and maximum in Jharkhand (60 *per cent*), Uttarakhand (78 *per cent*) and Punjab (81 *per cent*) (**Annex 9.3**). Further, even in 47 audited districts of low performing States, a shortfall was noticed in 19 districts (40 *per cent*) and shortfall was not measured in 16 districts due to non-fixation of targets.

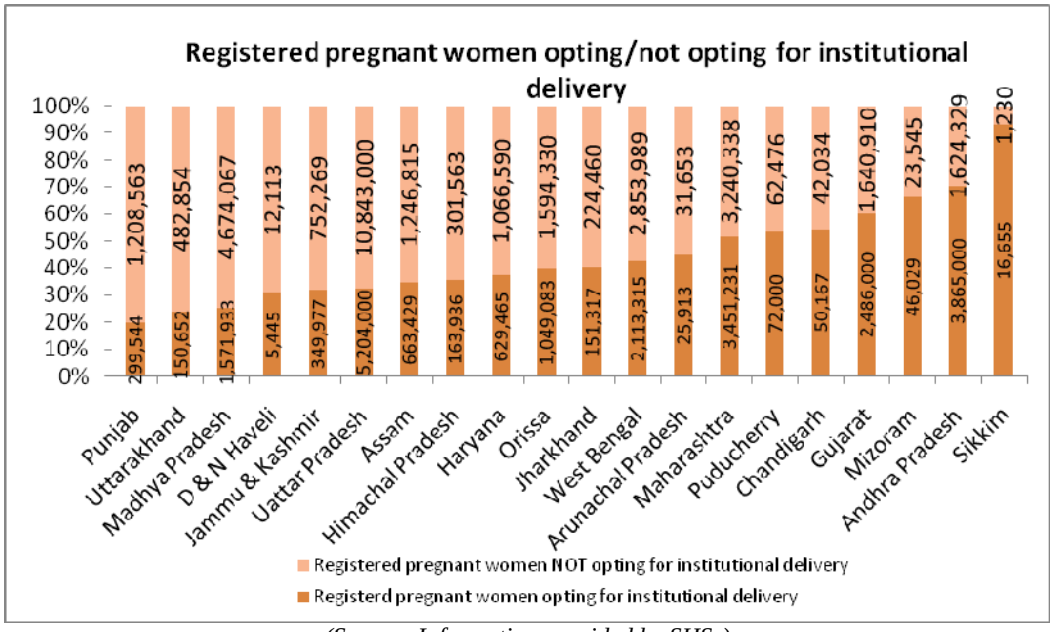
The Ministry stated that for the year 2007-08 more than 540 districts had made their health action plans fixing physical and financial targets. Substantial progress had been made in this regard. Overall figures of JSY beneficiaries had risen 11 times (approx.) between 2005-06 (7.39 lakh) and 2008-09 (84.5 lakh). However, the States were being advised to fix their targets keeping in mind the available resources both in terms of infrastructure and manpower.

(ii) Implementation of the scheme

The scheme envisaged that all registered pregnant women would be provided with JSY and Mother and Child Health (MCH) cards and ASHAs would keep track of them for ante-natal care (ANC), delivery and post delivery care. The ANM would prepare Micro Birth Plan for effective monitoring of the antenatal and post delivery care. However, the Micro Birth Plan had not been prepared in the audited districts at

the PHC and Sub Centre levels in Arunachal Pradesh, Andhra Pradesh, Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Madhya Pradesh, Orissa, Rajasthan, Sikkim, Tripura, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal (17 States). In the absence of any Micro Birth Plan, JSY and MCH cards, all the registered pregnant women could not be tracked for checkups, institutional delivery and post natal care.

Further, a majority of pregnant women were registered but did not use the health centres for institutional delivery particularly in EAG States as shown in the chart below.



(Source: Information provided by SHSs)

In 13 out of 20 States, less than 50 percent of total registered pregnant women preferred institutional delivery at health centres. Further, in 19 out of 23 sample districts of Chhattisgarh, Himachal Pradesh, Jharkhand, Orissa, Uttar Pradesh and Uttarakhand (6 States) domiciliary deliveries were more than institutional deliveries.

Besides, women were discharged after delivery and without the minimum recommended stay, and consequently the proper delivery and post natal care required to be provided under the scheme was not availed of. Lack of infrastructure, supporting staff and doctors at health centres, further affected the extent and quality of institutional delivery care.

The Ministry stated that the issue pointed out by Audit was well taken. It has been a constant endeavour of the Ministry to ensure that after registration of the pregnant women in the first trimester, a Micro Birth Plan was made. The Micro Birth Plan captures all essential data required. States were constantly striving towards preparations of the Micro Birth Plan for each pregnant woman. The Ministry stated that while audit had pointed out domiciliary deliveries were more than institutional deliveries, however, institutional deliveries as percentage of total deliveries rose from 42 *per cent* (2005-06) to 84 *per cent* (2006-07) among the below poverty line JSY beneficiaries. The Ministry had been advising States to ensure that the women staying at the facility for two days after delivery for proper post-natal care (PNC).

The Ministry felt that recent trends were encouraging. The States were being advised to ensure quality of care for the pregnant women both in terms of PNC and ANC.

While the progress shown by the Ministry was a positive development, as per DLHS-III (2007-08), the percentage of institutional deliveries was 47 per cent of the total deliveries. During DLHS-II (2002-04) this percentage for institutional deliveries was 40.9 per cent, while during DLHS-I (1998-99) this was 37 per cent. The three DLHSs indicate a steady but slow increase in the percentage of institutional deliveries.

(iii) Payment of incentive under JSY

Under the JSY, disbursement of cash incentive was to be made to the beneficiaries immediately after the delivery. As per the scheme, any payment after 7 days of delivery would be illegitimate. In 249 test checked units of 13 States viz. Andhra Pradesh, Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Manipur, Mizoram, Madhya Pradesh, Orissa, Punjab, Rajasthan, Tamil Nadu and Uttarakhand payment of cash incentive to eligible beneficiaries was delayed for periods ranging from 8 to 730 days. Delays were due to lack of funds, non-provision of imprest with the ANM and lack of awareness among the beneficiaries about the scheme. In Arunachal Pradesh, Jammu & Kashmir, Karnataka, Rajasthan and Uttar Pradesh, only 6 to 38 *per cent* beneficiaries were paid the cash incentive.

Further, proper records and vouchers in support of payment of incentive were not always maintained. Cases of fraudulent and excess payment, non-payment and inordinate delay are given in **Annex 9.4** and text box below**.**

The Ministry stated that for timely payment to the ASHA & beneficiaries, the scheme envisages creation of an Imprest Money Fund with the ANM. The Ministry had also mandated that payment to the beneficiaries and ASHA be made through cheques. The Ministry stated that it monitored these aspects during the course of Review Missions and the Financial Management Division under NRHM also conducted regular review. Complaints about financial irregularities as and when received in the Ministry were brought to the notice of the States with a request to conduct thorough investigation in the matter. As regards the timelines, the Ministry stated that the States were being advised to adhere to the timelines laid down in the JSY guidelines.

However, the fact remained that non payment, inordinate delay and irregularities in payment of incentives defeated the very purpose of mother and child care through the provision of cash incentives and resulted in denial of benefits to the intended beneficiaries.

(iv) Monitoring of the scheme

The Ministry was monitoring the scheme through the quarterly physical and financial reports furnished by the States/UTs, but these were not regularly sent by the States/UTs. In 2007-08 only ten States/UTs viz. Andhra Pradesh, Lakshadweep, Mizoram, Tripura, Delhi, Jharkhand, Uttar Pradesh, West Bengal, Orissa and Arunachal Pradesh had submitted quarterly reports on physical achievement for all the four quarters.

Case study: Implementation of JSY in Bihar and Orissa

Bihar:

- During 2006-08, Rs 16.15 lakh was paid to the expectant mothers in the 37 PHCs against registration in the health centres. But no record regarding further tracking of beneficiaries were available with PHCs.
- Janani and Bal Suraksha Yojana beneficiaries were released from the health units just after 2 to 4 hours (average) of delivery against the IPHS norm of stay of 3 days after delivery under normal condition.
- Same 298 beneficiaries (detected on the basis of their photographs and registration number/date mentioned on the JSY payment register) had been paid two to five times within the period of one day to two months resulting in fraudulent payment of Rs. 6.67 lakh in the 14 PHCs of audited districts. On this being pointed out in August 2008 DHS, Nalanda had recovered the amount of Rs. 4.84 lakh and other DHS had stated that appropriate action would be taken after proper investigation.
- In 2 PHCs viz. Sadar and Barhara of Bhojpur district, during 2006-08, cash incentive of Rs 8.03 lakh was paid to 429 beneficiaries for delivery in non-accredited private clinics. PHC, Sadar had neither indoor nor outdoor patient facility.
- Neither JSY card nor MCH card was maintained in any of the test checked PHCs. Micro Birth Plan was not prepared by any ANM though these basic records were to be mandatory maintained/ prepared by ANM after identification of expectant mother by ASHA. Prescribed monthly meeting with ASHA and ANM for the effective implementation of the JSY was also not organized in any of the PHC regularly.

Orissa:

- Institutional deliveries declined from 6.5 per cent in 2005-06 to 1.9 per cent in 2007-08 in Sub-centres due to non availability of trained man-power and equipment. In audited districts, institutional delivery was conducted in only 19 PHCs out of total 244 PHC (N). No institutional delivery was conducted in 963 PHCs (N) of the State during 2005-07. Delivery by untrained dais constituted about 10 per cent of total deliveries during the period 2005-08.
- Maternal deaths during pregnancy increased from 296 in 2004-05 to 430 in 2006-07, during delivery increased from 331 (2004-05) to 525 (2006-07) and with in six weeks of delivery increased from 288 (2004-05) to 411 (2006-07).

In an oversight, the quarterly report's format did not contain any column for enumerating the number of BPL women registered as beneficiaries under the scheme, while one of the determinants of the success of the scheme was the increase in institutional deliveries among poor families.

The Ministry had been monitoring the expenditure under JSY through quarterly and annual progress reports and the Financial Management Report sent by the field nodal officers of JSY and SHS respectively. However, there were variations in the expenditure reported through these two reports. Further, the Ministry's data on institutional deliveries and number of beneficiaries who had been paid an incentive was inconsistent with the data verified during audits. The reporting system from CHCs, PHCs and Sub Centres to the DHS and finally SHS was not very reliable, making SHS and Ministry's figures doubtful. Details of data inconsistencies are in **Annex 9.5**.

The Ministry had no mechanism to check the authenticity of the data and figures of expenditure and beneficiaries reported by the States regarding payments under the JSY and the quality of data and expenditure reported needed improvement.

The Ministry stated that the data available with the Ministry at times changes on account of revision of data submitted by the States. To have a sound, fool-proof and quick reporting system, the Ministry had launched a web based data reporting system namely the HMIS. The quality, speed and accuracy of the data reported by the States would improve drastically under the new reporting system. States were being told to ensure that the data on the HMIS web portal was accurately loaded. Quarterly physical and financial reports were one of the mechanisms for monitoring the scheme. Variations in the financial reports as per data available in the Ministry and SHS may be on account of further reconciliation of data by SHSs. The Ministry opined that reporting systems both physical and financial had progressed considerably over time. This was on account of availability of infrastructure like computers and data entry operators at the PHCs and CHCs. Training to health functionaries on financial and physical reporting had also helped in maintaining quality, accuracy of the data submitted. The HMIS would go a long way in ensuring that data is captured quickly, reliably and is submitted in time.

(v) Impact assessment

While approving the outlay of the scheme, Expenditure Finance Committee in April 2004 provided Rs. 12 crore for the assessment study/survey at district level to assess the impact of the scheme. However no such survey had so far been conducted to assess the impact of the scheme.

The Ministry stated that the impact of the scheme was evaluated through various mechanisms. Apart from the regular data reports from States, the biannual Joint Review Missions and the Common Review Missions also evaluate the impact of JSY. Recently, the Ministry had commissioned an evaluation of the scheme through UNFPA in five States of Uttar Pradesh, Madhya Pradesh, Bihar, Orissa and Rajasthan in 2007. The Ministry intends to commission an assessment survey shortly.

The role of ASHA/ANM under the JSY scheme was limited to payment of cash incentives and the consistent tracking of expectant mothers for antenatal and post partum check-ups and deliveries and preparation of mandatory records such as Micro Birth Plan needed more attention. Meetings to monitor the implementation of the JSY were not organized in PHCs regularly and the lack of facilities and shortage of supporting staff and doctors' at the health centres had also further hampered the quality health care required during delivery.

(c) Postnatal care

The percentage of women receiving post natal care (PNC) increased in eight States during 2005-08 and declined in seven States. Details are given in **Annex 9.6**. In Jammu & Kashmir, Uttar Pradesh and Sikkim the number of women availing of post natal care was below 10 *per cent* of the figure for all registered women. Besides, the post natal care facilities were yet to be made available in four CHCs and 16 PHCs test checked in Orissa. Records relating to postnatal care were not maintained in all the test checked districts of Assam, Bihar, Tripura and Uttarakhand and in two districts of Jammu & Kashmir and Karnataka.

The Ministry stated that there were variations between DLHS-3 data on PNC and the audit finding.

While some variations are bound to occur as DLHS-3 was based on surveying sample households, the audit findings are based on information for three years (2005-08) provided by the State Health Societies. But wherever, the variation is considerable, the matter needs to be examined by the Ministry.

(d) Referral services

The RCH II scheme outlined lump sum assistance to panchayats to transport pregnant women from indigent families to health centres. During 2005-08 no funds were distributed to panchayats/VHSCs for referral services in the 21 States/UTs (Haryana, West Bengal, Assam, Bihar, Chhattisgarh, Punjab, Rajasthan, Jammu & Kashmir, Uttar Pradesh, West Bengal, Lakshadweep, Dadra & Nagar Haveli, Puducherry, Andaman & Nicobar, Orissa, Tripura, Gujarat, Kerala, Karnataka and Uttarakhand). In 34 sample audited districts in Tripura, Gujarat, Madhya Pradesh, Assam , Himachal Pradesh, Jammu & Kashmir, Jharkhand, Manipur and West Bengal[66] (9 States/UTs), Rs. 4.48 crore (57 *per cent*) out of Rs. 7.87 crore released for referral services to DHS remained unutilised. In Sikkim and Manipur the utilisation of funds of Rs. 45.90 lakh and Rs. 2 crore respectively distributed to VHSCs could not be monitored due to poor reporting and non maintenance of records.

Further, the referring centre was to get feedback from the referral centres regarding progress of treatment given by the specialist, records of referred women were to be maintained at all levels and ANMs were to visit referred women every week during their antenatal, natal and postnatal periods for follow-up. However, in most of the audited health centres, registers for referral cases were not maintained and feedback from the referred centres was not received. The ANM rarely visited the patient during her referral.

The scheme of referral services was not implemented through the Panchayat/VHSCs as envisaged under the Mission. The funds utilisation under the scheme was very low and utilisation of funds was not accounted for properly.

The Ministry stated that under NRHM rather than distributing funds to panchayats,

Case study: Referral service in Andhra Pradesh

In a positive innovation in Andhra Pradesh, the Government sought to encourage health seeking behaviour and proper institutional care by providing free travel passes @ Rs. 19.36 to BPL pregnant women for three round trips to the nearest health centre during the validity of a year for check up/referral services. However, almost 40 per cent of the passes were not utilised and out of 16 lakh passes, only 13.03 lakh passes had been distributed and remaining 2.97 lakh passes valuing Rs. 57.46 lakh could not be distributed and expired. The Government may like to explore the linkage of distribution of passes through health centres with the validity period being stated by the ANM concerned so that the awareness about the measure and its greater adoption is ensured. Since, the target population will always be an approximation, being expectant mothers, the state government may like to consider improving the scheme by making it a continuing one and exploring the option to revalidating unused passes for use in subsequent years.

[66] Rs 1.56 crore paid to Block Societies and Hospitals but utilisation thereof was not accounted for properly

innovative models of public private partnerships for providing referral transport were being encouraged. In addition, resources were available at the facilities through untied funds. The Ministry accepted that the States need to focus on proper maintenance of records for monitoring the referral transport system including utilization of untied funds.

(e) Maternal deaths

SHS and DHS in Chandigarh, Bihar, Rajasthan, Sikkim and Uttar Pradesh did not maintain data on maternal and neonatal deaths. In 59 out of the 67 audited districts in 17 States/UTs of Haryana, Andaman & Nicobar, Andhra Pradesh, Bihar, Jammu & Kashmir, Jharkhand, Lakshadweep, Manipur, Mizoram, Madhya Pradesh, Puducherry, Punjab, Sikkim, Tripura, Uttarakhand, Rajasthan and Uttar Pradesh there was no proper mechanism to get regular information about maternal and neonatal deaths from post partum centres. In Uttarakhand, the data on maternal deaths provided by the DHS and those maintained at SHS was inconsistent.

Thus, in the absence of a proper system of collection and reporting of data on maternal and neonatal deaths, the data available with the SHS was less reliable and the actual number of deaths could not be ascertained.

The Ministry stated that States were being advised to institute a regular system of maternal death audit.

The maternal health care under the RCH II required better monitoring in the States. All the registered expectant mothers were not tracked for ANC, TT immunisation and for delivery and post delivery care. The weak reporting of registration of pregnant women, antenatal checkups, IFA and TT administration, institutional deliveries, postpartum care and maternal and neonatal deaths were a cause of concern because this reduced the effectiveness of the consequent monitoring and future interventions.

9.3.2 Family planning

The RCH II had launched a number of initiatives under family planning while continuing existing methods to achieve the goal of population stability and reduction of total fertility rate to the replacement level viz. 2.1 by 2012. The family planning programme includes terminal and spacing methods to increase the contraceptive prevalence rates and ultimately reduce the total fertility rate.

(a) Terminal method

The terminal method of family planning includes vasectomy for males and tubectomy for females. The SHS did not prescribe year wise targets in various terminal methods in Assam, Arunachal Pradesh, Chhattisgarh, Jammu & Kashmir, Kerala, Karnataka[67], Puducherry, Himachal Pradesh, Lakshadweep, Mizoram, Delhi, Manipur, Andaman & Nicobar, Rajasthan, and Chandigarh (15 States/UTs). Due to non-fixing of targets the shortfall in achievement could not be measured in these States. However, out of 13 States in which targets had been prescribed, the shortfall of 11 to 62 *per cent* was noticed in 11 States (**Annex 9.7-A**).

[67] SHS did not provide information on the status of target and achievement in various terminal methods for the state as a whole.

The proportion of vasectomy to total sterilisation was only 4 *per cent* and this is a manifestation of the gender imbalance that plagues the programme. State wise performance (Details in **Annex 9.7-B**) showed that percentage of vasectomy to total sterilization was less than one in 10 States/UTs while it ranged between one to nine in 16 States/UTs. In Lakshadweep no vasectomy had been done and in Mizoram only two vasectomies had been conducted out of the total 6740 sterilisation operations.

The performance of laparoscopic tubectomy during 2005-08 was low ranging in 10 States/UTs (detail in **Annex 9.7-C**) between 11 to 27 *per cent*. In Bihar and Lakshadweep it was nil and abysmally low in Jharkhand (1.58 *per cent*) and Puducherry (1.36 *per cent*). The reason of low performance was attributed to lack of trained doctor and equipment in the PHCs and CHCs in most of the States.

Further, 3074 cases of unsuccessful sterilisation in the 13 States during 2005-08 were noticed (**Annex 9.7-D**). Cases of sterilisation failure were significantly higher in Tamil Nadu, Rajasthan, Puducherry, Himachal Pradesh, Uttar Pradesh and Delhi as compared to Maharashtra. In five States viz. Andaman & Nicobar, Bihar, Sikkim, Madhya Pradesh and Kerala SHS had not maintained data on unsuccessful cases of sterilisation. In 17 test checked districts, the DHS had not received reports of failure of sterilisation in Haryana, Chhattisgarh, Chandigarh, Uttar Pradesh, Jammu & Kashmir, and Mizoram.

(b) Spacing methods

Oral pills, condoms and inter uterine device insertions are three prevailing spacing methods of family planning to regulate fertility and promote couple protection ratio. SHS had not prescribed year wise targets for various spacing methods in Manipur, Tripura, Himachal Pradesh, Arunachal Pradesh, Andaman & Nicobar, Bihar, Chandigarh, Delhi, Kerala, Lakshadweep and Puducherry (9 States/UTs).

In all PHCs and CHCs of the audited districts of Bihar and Orissa and 730 Sub Centres and 92 PHCs of the selected districts of Gujarat, the ANMs, nurses and doctors were not trained in IUD insertion.

There was a shortfall in achievement vis-à-vis targets for IUD insertion and oral pill distribution in 18 and 15 States respectively. The shortfall was maximum in Jharkhand, i.e. 68 and 81 percent. Among the total spacing methods, usage of condoms was maximum in 22 States ranging from 51 to 98 *per cent* alone, while the usage of IUDs was greater in four States only. Oral pill usage was below 38 *per cent* in 25 States/UTs other than Sikkim and West Bengal (Details in **Annex 9.7-E**).

In the family planning schemes, female sterilisation constitutes 96 *per cent* of total sterilisation. Low usage of feminine spacing methods i.e. oral pill and IUD meant that the decision-making role of women in family planning was limited.

9.3.3 Immunisation and child health

(a) Routine Immunisation

The immunisation of children against six preventable diseases, namely tuberculosis, diphtheria, pertussis, tetanus, polio and measles had been the cornerstone of routine immunisation under the universal immunisation programme.

The SHSs had not fixed targets for secondary immunisation of children in the age group of 5 to 6 years in Bihar, Tamil Nadu, Uttarakhand and Lakshadweep. The percentage achievement against the targets of fully immunised children was quite low in Manipur (37), Arunachal Pradesh (45) and Jharkhand (65), while in remaining States this ranged between 77 to 100 *per cent.* Target of fully immunised children were, however, not made available in Bihar. Besides, the targets for immunisation had been fixed on an ad hoc basis in test checked districts in Bihar, Jharkhand, Himachal Pradesh, Madhya Pradesh, Uttar Pradesh, Uttarakhand, Assam, Manipur, Sikkim, Tripura, Kerala, Punjab, Puducherry, Tamil Nadu and West Bengal (15 States/UTs).

Despite the higher rate of coverage, the incidence of infant and child diseases also increased during the period 2005-08 in 9 States. Moreover, 957, 544, 462, 1980 and 29321 cases of neonatal tetanus, diphtheria, tetanus, whooping cough and measles respectively were reported in 104 test checked districts in 23 States/UTs (Detail in **Annex 9.8**). In Andaman & Nicobar, Chandigarh and Manipur data on incidence of infant and child diseases was not maintained by the SHS.

The Ministry stated that increase in number of cases did not necessarily reflect an increase in incidence rate of these diseases. The increase in cases could also be due to an improvement in detection, diagnosis, reporting and health service reach and does not necessarily reflect upon less effectiveness of immunization.

Case study: Use of glass syringe in Mizoram

Against the total requirement of 3,72,009 AD syringes for immunisation, based on number of children immunised during the years 2006-08, the Mission actually used 1,40,491 syringes raising doubts on the veracity of the achievement of the immunisation coverage claimed by the State Mission. However, the Department stated in November 2008 that due to short supply of AD syringes by the Central Government, re-usable glass syringes had been used. However, adequate funds were available with the State Mission for procurement of the syringes.

The use of re-useable glass syringe contradicted the Government strategy of single syringe usage per child, and also exposed the rural population to the risk of transmission of diseases like HIV.

The Ministry stated that ideally as per GoI norm AD Syringes should be used however during initial stage of introduction of Auto-disable Syringe (ADS) in 2006, the States were asked to use glass syringes with all precautions in case of shortage of AD Syringe so that the immunization programme doesn't suffer.

(b) Pulse polio immunisation (PPI)

The pulse polio immunisation was launched under the RCH II to eradicate polio and ensure zero transmission by the end of 2008. The continuing reported cases of polio showed that the Mission had not been successful in its quest for polio free country.

Despite 2 National Immunisation Days, 6 Special National Immunisation Days (and additional rounds in selected districts of Bihar and Uttar Pradesh), 1640 new polio cases had been detected in 17 States/UTs. The maximum new cases were reported in Bihar (594) and Uttar Pradesh (948) (Details in **Annex 9.9**).

OPV being administered

The shortfall in achievement of targets under PPI was the greatest in Sikkim (16 per cent) and Meghalaya (9 per cent). In 11 States/UTs, the shortfall was less than five per cent whereas targets were exceeded in seven States/UTs. State specific deficiencies in pulse polio immunisation in Bihar and Mizoram are in **Annex 9.10**.

Case study: Deficiencies in pulse polio immunisation in Bihar

During joint physical verification in 20 Routine Immunization Centres in audited districts, under pulse polio immunisation audit noticed serious lapses in administration and handling of vaccines as detailed below :

- In East Champaran district, vaccine carrier of all the ten pulse polio teams inspected were containing water instead of ice and OPV vials were kept in the vaccine carrier containing water at normal temperature.
- In Bhojpur district, no thermometer was available to measure temperature and in 19 out of 23 health units, temperature of the cold box/ILR containing vaccine vials ranged between12 ^{0} to 19^{0} C.
- In two PHCs, temperature ranged between -10^{0} to - 22^{0} C against the required temperature of 2^{0} to 8^{0} C, hence vaccine vials were found in frozen condition.
- Instead of ice, normal water was kept in ice pack and immunization was being conducted by keeping the vaccine vial on the table at atmospheric temperature.

(c) Vitamin A solution

The RCH II programme advocated a Vitamin A solution for all children less than three years of age. In the audited districts of the 22 States/UTs (details in **Annex 9.11**) there was a shortfall in administration of the first and second dose of vitamin A. Shortfall in first, second and subsequent doses was maximum in Punjab (86.29 *per cent*), Jammu & Kashmir (91.37 *per cent*) and Meghalaya (80.58 *per cent*). However, targets were exceeded in administration of third to fifth dose of vitamin A in 10 States.

The SHSs did not fix targets and maintain records on administration of vitamin A doses in Arunachal Pradesh, Andaman & Nicobar and Lakshadweep. Besides, in 12 out of 24 test checked districts of Assam, Andhra Pradesh, Bihar, Mizoram and Sikkim, no targets were found to be fixed.

The main reason of shortfall in achievements was short supply of Vitamin A at health centres in most of the States. In Delhi[68] and Uttarakhand, the stock of Vitamin A was not available over the period 2006-08 and Chandigarh had suffered short supply up to January 2007. In 30 CHCs, 72 PHCs and 144 Sub Centres stock of Vitamin A was nil

[68] Supply started in March 2008.

for 8 to 12, 24 to 36 and up to 36 months in Bihar, Haryana and Punjab respectively during 2005-08. While in 15 CHCs, 28 PHCs and 63 Sub Centres of Jammu & Kashmir and Mizoram the stock was not adequate. In Rajasthan and Uttar Pradesh shortfall in administrating Vitamin A was caused by a lack of awareness.

9.4 National Leprosy Elimination Programme (NLEP)

The NLEP aimed to eliminate leprosy by the end of 11th Five Year Plan and ensure a leprosy prevalence rate of less than one per ten thousand. In Bihar, Chandigarh, Delhi and Jharkhand the leprosy prevalence rate was more than one per ten thousand. The prevalence rate was more than one per ten thousand in 16 out of 30 districts and 94 out of 314 blocks of Orissa.

Positive development

The prevalence rate of leprosy was less than one in Arunachal Pradesh, Assam, Andhra Pradesh, Andaman & Nicobar, Dadra & Nagar Haveli, Himachal Pradesh, Madhya Pradesh, Orissa, Puducherry, Tamil Nadu, Uttar Pradesh and Uttarakhand.

However, the total cases and also new cases of leprosy detected during 2005 to 2008 remained high. New cases increased in Bihar, Chhattisgarh, Dadra & Nagar Haveli, Himachal Pradesh, Karnataka, Maharashtra, Mizoram, Orissa, Tripura, Tamil Nadu and Madhya Pradesh in 2007-08. Medicines for treatment of leprosy were also not available in 29 CHCs and 82 PHCs test-checked in Bihar, Haryana and Punjab.

The Ministry stated that the goal set by National Health Policy, 2002 was elimination of leprosy as a public health problem (reducing the prevalence of leprosy to less than one case per 10,000 population) at national level by the year 2005. As set, the goal of elimination which was at national level had already been achieved by India in December 2005. For better monitoring of the programme, the government was monitoring the achievement of leprosy elimination at State level. As on 31st March 2009, out of 35 States/ UTs, only 3 States had prevalence rate of more than one per ten thousand namely Bihar, Chhattisgarh and D & N Haveli. Out of 630 districts, 510 districts had already achieved the elimination status. The aim of NLEP during the 11th plan is to further reduce the leprosy burden in the country by providing quality leprosy services. Govt. of India had provided adequate quantity of MDT (Multi drug therapy) drugs to all States including Bihar, Haryana, Punjab and Manipur with necessary guidelines for supply and management of MDT. The States are repeatedly advised to keep 2 months buffer stock at all districts and PHCs. Under NLEP, more emphasis was given on two component viz. detection of new cases and completion of their treatment. Increase in number of new leprosy cases detected in the States suggest that the States were making efforts to detect new cases at early stage so that they may not suffer from any consequences.

9.5 National Programme for Control of Blindness (NPCB)

The NPCB aimed to reduce the cases of blindness to 0.8% by 2007 through increased cataract surgery (46 lakh by 2012), eye screening in schools and free distribution of spectacles, collection of donated eyes and creation of donation centres and eye-banks and strengthening of infrastructure by way of supply of equipment and training of eye surgeons and nurses.

9.5.1 Cataract operation performance

The distribution of workload between private and public sectors for cataract operation was expected to be in the ratio of 1:1.

Sector wise details of cataract surgery performed in the 19 States indicated that while the NGOs and private sector exceeded the 50 *per cent* mark, the Government sector lagged behind, logging barely 5 to 27 *per cent* in 10 States and 31 to 48 *per cent* in 5 States as evident from the table in **Annex 9.12**. The SHSs in D & N Haveli, Delhi, Manipur, Meghalaya, Punjab and Tripura did not maintain data on cataract surgeries performed in the private sector /and by NGOs.

Further, as per Ministry's guidelines, surgeries in Eye Camps are banned under the NPCB. Screening Eye Camps are organized and the patients are referred to fixed facilities for operation. However, in 14 States/UTs 19.52 lakh cataract surgeries were performed in camps which was 47 per cent of the total cataract surgeries in these States (**Annex 9.13-A)**.

The cataract surgery rate (CSR) was lower than the desired level of 600 cataract operations per lakh population per year and ranged between 100 to 276 in six States, 285 to 394 in five States and 455 to 560 in two States as shown in **Annex 9.13-B**. State specific cases are in **Annex 9.13-C**.

Case study: Failure of cataract operation in Orissa

Orissa: In three separate incidents in September 2006 (Deogarh), January 2007 (Bhabanipatna) and March 2007 (Cuttack), 25 out of 36 persons who were operated in eye camp at Government / charitable hospitals and discharged on next day of the operation lost their vision. Subsequent investigation of sterility of medication and materials used in eye OT confirmed infection in infusion sets, single use needle, the ringer lactate procured locally and intra-ocular lenses etc. due to presence of harmful bacteria. Besides, possibility of infection due to unhygienic conditions at home could not be ruled out as the patients were discharged on the same day of surgery. As a result, operated eyes of 18 patients were to be removed. In spite of successive failures, the department failed to initiate remedial measures to avoid recurrence. Even precautionary instructions were not issued as of June 2008.

The DHS stated that instructions would be issued for taking proper postoperative measures in respect of cataract operations by insisting on mandatory stay in hospitals after the operation for at least three days. However, action in this regard was awaited as of September 2008.

The non-achievement of desired cataract surgery rate and high cataract operations in eye camps and non-Government Institutions in disregard of Government orders indicates a lack of adequate infrastructure / eye surgeons for the rural population. For instance, in the 14 audited districts in Kerala, Orissa and Uttar Pradesh, only 48 eye surgeons were posted in CHCs and district and other hospitals against the requirement of 189 eye surgeons.

The Ministry stated that as per report received from States up to 2008-09, around 60 lakh cataract surgeries are being performed in the country per year. It further stated that participation of Voluntary Organizations had been very significant in controlling blindness in the country. However, major portion of cataract surgeries in private/NGO

run eye hospitals was a result of various schemes run under the National Programme for Control of Blindness to support private/NGO eye hospitals. Effective measures like construction of dedicated Eye Wards & Eye OTs in District Hospitals, appointment of Ophthalmic manpower, development of Mobile Ophthalmic Units particularly in NE States, Hilly States & difficult Terrains for diagnosis and medical management of eye diseases and involvement of private practitioners in sub district, blocks and village level were being taken to improve cataract surgery rate during the 11th Five Year Plan. However, surgeries in Eye Camps are banned under the NPCB and necessary instructions/guidelines in this regard were being sent to States from time to time.

9.5.2 Refractive error and free distribution of spectacles

The programme envisaged training of teachers in government and government aided schools, for screening refractive errors among students and free distribution of spectacles to the students having refractive errors.

As against total number of 5.61 lakh schools in the 16 States/UTs only 2.85 lakh teachers were trained. In Orissa and Dadra & Nagar Haveli, no teachers had been trained for eye screening and in Jammu & Kashmir only five teachers had been trained for the entire State. In Lakshadweep no such programme for screening and free distribution of spectacles had been evolved so far, while in four audited districts of Rajasthan no eye screening was done.

The number of free spectacles issued did not correspond to the students having refractive errors. During the period 2005-08, only 10.67 lakh (51 *per cent*) spectacles were issued against the total detection of 21.07 lakh cases of refractive errors in 24 States/UTs. In Sikkim, D & N Haveli and Uttar Pradesh nil, six and 39 per cent of the total students detected with refractive error were distributed with spectacles, mainly due to paucity of funds. In Orissa 16557 spectacles had been distributed free whereas only 14680 students were detected with refractive errors. Data on eye screening and distribution of spectacles was not maintained in Manipur and audited districts of Jammu and Kashmir.

The Ministry stated that against the provision of 98,697 free spectacles during 2002-03, more than 4,62,688 free spectacles were provided to poor school age group children in States during 2008-09 under NPCB. The State Governments were being instructed suitably to provide free spectacles to needy poor school age group children under the programme. 20 per cent can be provided free. As per reports received from States, during the year 2002-03, 35,267 teachers were trained for eye screening under NPCB. The number of teachers trained had gone up to 77,157 during 2008-09. It was being ensured that more number of teachers were trained under the School Eye Screening Programme by providing adequate funds to States for organizing training of teachers for eye screening.

9.5.3 Eye banks

Development of eye banks is an important activity to help address corneal blindness. No eye bank was operational in Andaman & Nicobar, Arunachal Pradesh, Daman & Diu, Dadra & Nagar Haveli, Himachal Pradesh, Jammu & Kashmir, Lakshadweep,

Manipur, Meghalaya and Uttarakhand (10 States/UTs). As of March 2008 only 346 eye banks were operational in the 17 States/UT[69] out of which 97 were in the government sector and 249 were in the voluntary sector. Further, out of 375 district hospitals in the 13 States/UT[70] only 44 had facilities for eye donation.

The detail of performance of eye banks in Government and voluntary sectors is given in the **Annex 9.14-A**. The SHS did not maintain data for the voluntary sector in 5 States/UTs. No data was maintained for both the sectors in Punjab and Sikkim and separately for each sector in Maharashtra and Rajasthan regarding the performance of eye bank. Comparative analysis of performance in nine States/UTs where data on both the sectors was available separately showed that the voluntary sector collected 76 *per cent* of the eyes donated. The low presence and performance of the Government sector was due to lack of eye donation facilities in the Government hospitals. State specific audit findings are in **Annex 9.14-B**. Besides, almost 52 *per cent* of the eyes collected in the Government sector had been either rendered unfit or were used for research purposes as compared to 34 *per cent* in the voluntary sector. Moreover, the percentage of eyes actually utilised for keratoplasty was low overall.

The Ministry stated that in order to increase number of Eye Banks in the country and to cover all the States to encourage eye donation, it had been proposed to strengthen 50 Eye Banks during 11th Five Year Plan with enhanced assistance from Rs.10 lakh to Rs.15 lakh as non-recurring grant to Eye Banks in Govt./voluntary Sector. In addition, recurring assistance of Rs.1500 per pair of eyes was also being provided to Eye Banks towards honorarium to Eye Bank staff, consumables including preservation material and media, transportation/POL and contingencies. It had also been proposed to appoint 150 Eye Donation Counselors in Eye Banks in Govt. and NGO Sector. Donated eyes were utilized for corneal transplantation of needy population. Donated eyes which were not fit for transplantation were utilized for study and research purpose. State Health authorities were being advised separately to ensure proper utilization of donated eyes for corneal transplantation to the maximum possible extent. Ministry further stated that in order to ensure adequate supply of free spectacles to poor school age group children, a provision for supply of 4,73,472 free spectacles had been made in the Annual Plan 2009-10 under NPCB. Necessary funds to meet the provision were being released to States on the basis of utilization position furnished by them for the earlier years.

The shortfall in supply of free spectacles to children with refractive errors and non-utilisation of eyes collected through donations during 2005-08 are hurdles to overcome in the quest to reduce the prevalence of blindness in the States. The poor performance of government sector in eye bank activities was due to absence of eye donation facilities and inadequate number of eye banks in government hospitals.

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[69] Assam, Chandigarh, Chhattisgarh, Gujarat, Haryana Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Punjab, Rajasthan, Sikkim, Tripura, Tamil Nadu, Uttar Pradesh and West Bengal

[70] Assam, Chandigarh, Chhattisgarh, Gujarat, Haryana Jharkhand, Madhya Pradesh, Orissa, Punjab, Sikkim, Tamil Nadu, Uttar Pradesh and West Bengal

9.6 Revised National Tuberculosis Control Programme

The main objective of the Revised National Tuberculosis Control Programme (RNTCP) was to detect and maintain at least 70 *per cent* of the estimated New Smear Positive cases and to achieve and maintain at least 85 *per cent* treatment success rate among these cases through Directly Observed Treatment Short course (DOTS).

However, the cure rate was below 85 *per cent* in Assam, Andaman & Nicobar, Bihar, Chhattisgarh, Dadra & Nagar Haveli, Jammu & Kashmir, Haryana, Kerala, Madhya Pradesh, Manipur, Meghalaya, Puducherry and Tamil Nadu (13 States/UTs) and complete data on outcome of treatment from 2005 to 2008 was not made available in A & N Islands, Jharkhand, Kerala, Orissa, Rajasthan, Manipur, Uttar Pradesh and Karnataka.

The Ministry stated that the RNTCP had consistently maintained treatment success rate above 85 per cent. Although the national goal had been achieved by the programme, average cure rate for 2005-08 was less than 85 per cent in the above mentioned States/UTs. These States/UTs would require focus under the programme to ensure consistent achievement of cure rate targets.

9.7 National Vector Borne Disease Control Programme (NVBDCP)

The NVBDCP aims to control vector borne diseases by reducing mortality and morbidity due to malaria, filaria, kala azar, dengue, chikungunia and japanese encephalitis in endemic areas.

9.7.1 Annual Blood Examination Rate (ABER) and Annual Parasitic Incidence (API) for malaria

The programme stipulated achievement of an ABER of 10 percent and API of less than 0.5 per thousand for the country[71]. Year wise details of ABER and API (**Annex 9.15**) indicated that targeted rate of 10 percent of annual blood examinations had not been achieved in 11 States/UT and in the audited districts of these States the ABER was even less than the State average. ABER showed a decreasing trend during the period 2005 to 2008 in seven States.

The API was higher than the stipulated rate in all the three years in 14 States/UTs and maximum in Arunachal Pradesh, ranging from 29 to 37. In Chandigarh, Jammu & Kashmir, Himachal Pradesh, Kerala, Sikkim, Uttar Pradesh and Uttarakhand the API was less than the stipulated rate. However lower API was not due to less incidence of malaria in the States but due to lesser blood examinations leading to cases of malaria remaining undetected.

Trend analysis of the API and ABER revealed that API increased/decreased in direct proportion to ABER in most of the States/UTs, therefore to detect all/maximum cases of malaria in the population under surveillance, not only does the targeted rate of ABER need to be achieved but it should be also revised upward.

The Ministry stated that the poor surveillance resulting in under achievement of ABER is mainly due to vacancies at the level of male multipurpose worker (MPW). The programme

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[71] ABER-Cumulative sum of monthly rate per 100 population under surveillance of blood examination during the year.
API-Positive malaria cases per thousand population.

was emphasizing passive surveillance by involving the community volunteers like ASHA through imparting training on malaria diagnosis and treatment in the high endemic districts. Further 5057 contractual MPWs had been allotted to the 14 States including Assam, Tripura, Jharkhand and West Bengal. For rationalization of screening of fever cases for malaria a definition of suspected malaria case had been incorporated in the operational manual for implementation of malaria programme 2009. The overall target of country for API to be achieved by the end of 11th Five year plan (2012) is 1.3.

9.7.2 Incidence of vector borne diseases

During 2005-08, morbidity and mortality due to various vector borne diseases were as under:

Table: 9.15 Status on number of deaths due to vector borne diseases[72]

Year	Kala Azar		Malaria		Filaria		Japanese Encephalitis		Dengue	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
2005-06	32152	153	1708665	926	178006	0	5902	1660	10449	131
2006-07	39151	183	1690061	1503	150875	0	2594	599	8560	116
2007-08	44496	43	1423975	1190	202852	0	3159	712	4876	67

(Source: Figures from SHSs)

Cases of kala azar and filaria had been increased while cases of malaria and dengue had decreased. However, in 11 States/UTs (Andhra Pradesh, Chandigarh, Gujarat, Haryana, Maharashtra, Madhya Pradesh, Puducherry, Rajasthan, Uttar Pradesh, Uttarakhand and Orissa number of dengue cases increased from 2005-06 to 2007-08. Cases of kala azar decreased in Jharkhand and West Bengal but increased in the main affected State, Bihar and a few cases were also reported from Assam, Kerala and Sikkim. State-wise incidence of vector borne diseases are given in **Annex 9.16**.

The Ministry stated that the Directorate of NVBDCP did not capture all the morbidity and mortality due to malaria. It intends to monitor the trend. Since the country average ABER had been around 10 during the years so the reported cases and deaths due to malaria would indicate an actual trend of this disease in the country.

It further stated that increase in number of cases of kala azar was due to saturation of anti-kala azar drugs at the periphery level i.e. PHC, case search programme conducted twice a year and incentive given to patients on account of free diet to attendant and compensation for wage loss. The number of cases in West Bengal and Jharkhand had declined because of the reason that all the patients confirmed for kala azar were treated in the Government Health facilities to ensure complete treatment.

The Ministry also stated that in India, filarial elimination programme was launched since 2004. However, the coverage of eligible population in filaria endemic districts during Mass Drug Administration had increased from 72.4 *per cent* in 2004 to 82.82 *per cent* in 2007 and the microfilaria rate in the community has declined from 1.36 *per cent* in 2004 to 0.72 *per cent* in 2007.

Regarding Japanese Encephalitis, the Ministry stated that during 2005, a massive outbreak due to JE was reported mainly from seven districts in Gorakhpur and Basti

[72] Based on data in respect of 29 states

Divisions resulting in more that 6000 cases and 1500 deaths. As a result of this outbreak, Government of India decided to vaccinate children (1-15 years of age) with single dose of JE vaccine imported from China. The vaccination had been launched in campaign mode since 2006 and till 2009, 89 districts would be covered. During 2008, there was a marginal decrease in the number of cases (7%), however, significant reduction was reported in the number of deaths (31%).

The Ministry further added that for prevention and control of dengue, a long term action plan had been developed and sent to States for implementation.

9.7.3 Population protected with insecticides

Under the NVBDCP, all the areas having API of 2 and above were required to be covered under compulsory indoor residual spray of DDT and anti larva solution. There was shortfall in residual spray of DDT and anti larva solution vis-à-vis the target in most States. The shortfall was above 65 *percent* in Bihar, Gujarat and West Bengal and ranged up to 100 *percent* in Haryana, Punjab and Orissa. In Andaman & Nicobar data on spraying was not made available by the SHS.

In the audited districts of Assam, Chhattisgarh, Jammu & Kashmir, Jharkhand, Rajasthan, Sikkim and Uttar Pradesh, 35 to 100 *per cent* of areas had not been covered with indoor residual spray. The low percentage of coverage was mainly due to non-availability of DDT and targeting of only endemic areas in Uttar Pradesh. Few State specific cases are given in **Annex 9.17**.

The Ministry stated that the DDT insecticide was being provided by the Centre to the States where vector was susceptible to this insecticide, while the operational cost for spray and insecticide other than DDT was to be managed by the State. Haryana, Punjab, Jammu & Kashmir, Sikkim and Uttar Pradesh were low endemic and needed small focus for the spray. In high malaria endemic States apart from Indoor Residual Spray, insecticide treated bednets are provided by the programme and the community owned bednets were also treated with insecticides. Around 70-80 million population in the country was annually targeted for IRS with DDT, Malathion and Synthetic Pyrethroid in the rural areas.

Achievement of target for ABER and API for malaria needed further efforts as cases of malaria remained undetected. Adequate and timely spraying of DDT is an important component of the vector borne disease control programme. However, a regular supply and spraying of DDT and anti larva solution needs to be done according to the prescribed frequency so as to ensure greater effectiveness of the programme.

9.8 National Iodine Deficiency Disorder Control Programme (NIDDCP)

The NIDDCP was launched in 1992 to control iodine deficiency disorder below 10 *per cent* in the entire country by 2012. The important objectives and components of NIDDCP are - surveys to assess the magnitude of the Iodine Deficiency Disorders, supply of iodised salt in place of common salt, resurvey after every 5 years to asses the extent of Iodine Deficiency Disorders and the impact of iodated salt, laboratory monitoring of iodised salt and urinary iodine excretion, health education and publicity.

The programme was not implemented till March 2008 in Himachal Pradesh, Jharkhand and West Bengal, while there were delays in launching the programme in Chhattisgarh (in 2006-07), Jammu & Kashmir, Madhya Pradesh and Punjab (in 2005-06). Surveys/resurveys to assess the magnitude of iodine deficiency disorders were not conducted in Delhi, Jammu & Kashmir, Rajasthan and Uttar Pradesh during 2005-08. The coverage of surveys were 14 out of 23 districts in Andhra Pradesh, 6 out of 25 districts in Gujarat, 7 out of 20 districts in Punjab and 4 out of 7 districts in Meghalaya. IDD monitoring labs were yet to be established in Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Madhya Pradesh, Punjab, Uttar Pradesh, Uttarakhand and Rajasthan.

Case study: Implementation of NIDDCP in Chandigarh (an IDD endemic area)

A survey concluded in 2006 revealed an increase of 2.4 percent in the prevalence of goitre against an earlier survey of 1999. As against the target of analysis of 600 salt samples every year, 557 and 134 samples were analysed in 2005-06 and 2006-07 respectively. Further, the number of urinary excretions analysed during 2005-08 was 262, 51 and 160 respectively as against the target of 300 samples per year. However, the year-wise number of patients reported with iodine deficiency disorder in the UT could not be assessed due to absence of symptom-wise reporting mechanism.

The Ministry stated that due to non filling up of vacant sanctioned posts and non establishment of IDD Lab the target for analysis of salt and urine samples was not achieved The matter was being pursued with States/UTs to establish IDD labs and also fill up sanctioned vacant post.

9.9 Integrated Diseases Surveillance programme

The IDSP was launched to establish a decentralised state based system of surveillance for communicable and non-communicable diseases by establishing and operating a central level disease surveillance unit, integrating and strengthening disease surveillance at the State and districts levels, improving laboratory support and training for disease surveillance and action. The project was launched in a phased manner covering 9 States[73], 13 States[74] and 13 States [75] under phase I, II and III during 2004-05, 2005-06 and 2006-07 respectively.

The Central Surveillance Unit was receiving weekly disease surveillance reports from only about 58 *per cent* districts (349/606) despite the fact that even nil reporting was mandated for DSU.

Further, no formal training was imparted to NGOs and other volunteers or personnel of other related departments. The project had also failed to train private practitioners and staff of private hospitals. The orientation workshop on IDSP and its reporting pattern was conducted in only 13 States with the members of Indian Medical Association (IMA). Further, no MOU had been signed at the central or the State level with IMA and Indian Association of Paediatrics so as to ensure participation of

[73] Andhra Pradesh, Himachal Pradesh, Karnataka, Uttarakhand, Madhya Pradesh, Maharashtra, Tamil Nadu, Kerala and Mizoram,
[74] Chhattisgarh, Goa, Gujarat, Haryana, Rajasthan, Orissa, West Bengal, Chandigarh, Puducherry, Delhi, Manipur, Meghalaya, and Tripura,
[75] Uttar Pradesh, Jammu & Kashmir, Punjab, Andaman & Nicobar, Dadra & Nagar Haveli, Daman & Diu, Lakshadweep, Bihar, Arunachal Pradesh, Assam, Jharkhand, Nagaland and Sikkim.

private practitioners in IDSP which was required to be done as per PIP. Besides, no training was imparted to Medical officers, Health workers, district lab technicians and peripheral lab technicians in the 13 States/UTs where the project was launched in the Phase III. The Video Conferencing (VC) technique was set up to organise training sessions with States and districts and was to be held on regular basis, but the log book of VCs revealed that only 105 VCs had been held till November 2008 and the VC technique was used only 12 times to impart training.

It was decided to develop 50 labs in phase II and III States at the first instance. Though the 50 district laboratories had been identified, the procurement process was yet to commence as of December 2008 and the inordinate delay was adversely affecting the project.

The Ministry stated that the priority labs had been identified and communications for procurement of equipment along with technical specification had been sent to States in February 2009. The Ministry further stated that –

- The implementation of IDSP had been done in a phased manner in different States (9 in phase-I, 14 in phase-II & 12 in phase-III) of the country. Implementation had been slow in phase III States.
- Presently the State Surveillance Units had been established in all the States.
- The district surveillance units had also been established in most of the States.
- Training of Surveillance Officers and Rapid Response Team members had been completed in most of the phase-III states.
- In addition, the system of reporting of outbreaks immediately to DSU/SSU/CSU had been established through Telephone, fax, E-Mail & IDSP Portal. Supplemental source of information is Media Scanning and IDSP 24X7 Call Centre toll free number 1075.
- State governments had been advised to encourage reporting through voluntary organizations.
- At present, 332 Satellite Interactive Terminals had been established across the country and in the remaining, installation is in process.

IDSP was not fully operational as the project was yet to be fully operationalised in five States including Uttar Pradesh, Bihar and Jharkhand covering one third of the population of the country and prone to outbreak of diseases. Strengthening of laboratories was yet to be completed at all the levels. In the absence of networking among/between the DSUs and SSUs, surveillance activities could not be integrated and, therefore, the establishment of a decentralized state-based system of surveillance for diseases for initiating timely and effective public health action was still in process.

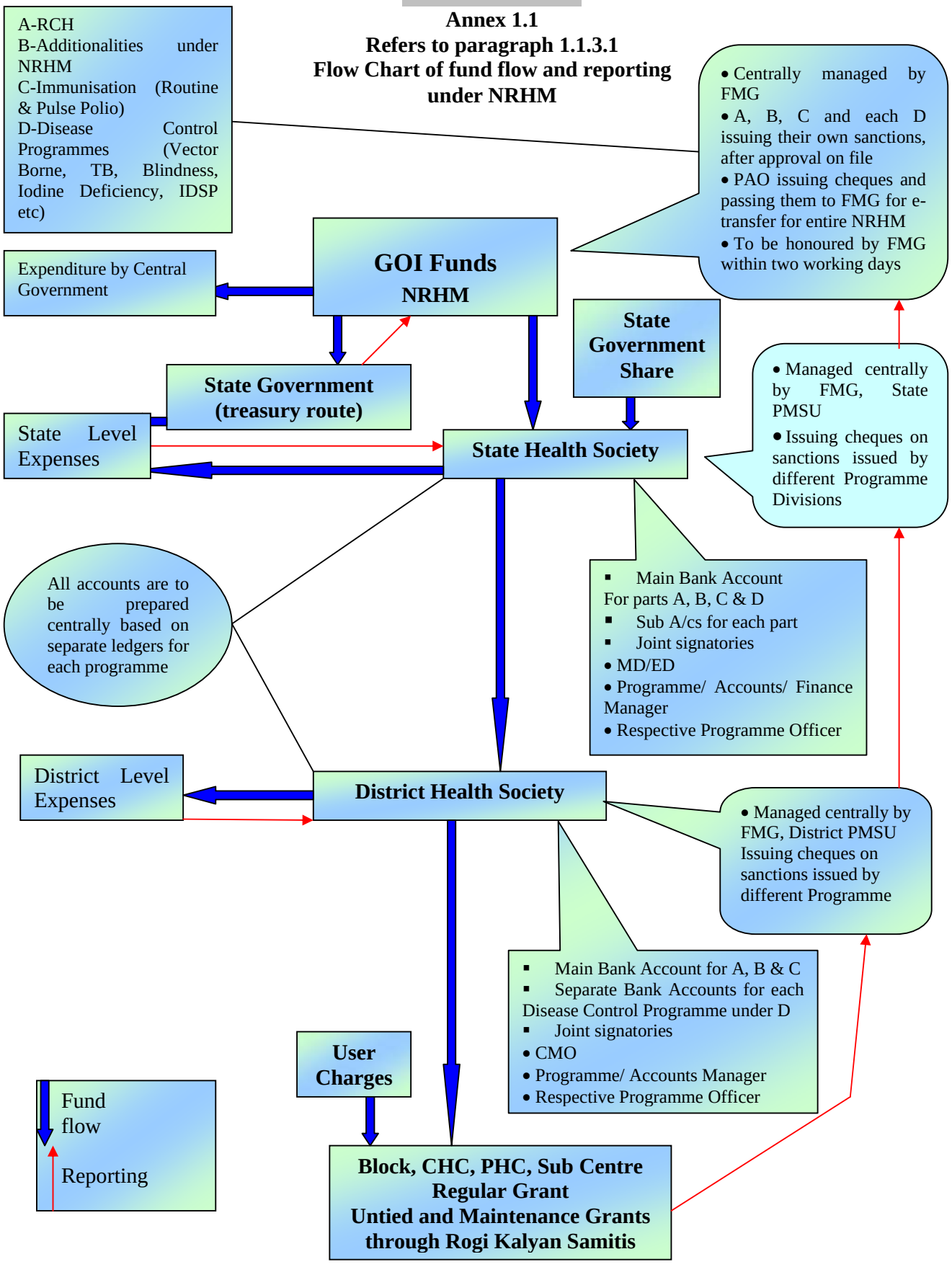
Recommendations

- ***Disaggregated State-wise targets may be set in view of overall target set by the Ministry for the country and State-wise progress may be measured***

on the basis of disaggregated targets and data. The opportunity to consolidate real-time data captured by ANM and health workers may be made use of.

- ***The monitoring and reporting mechanism under Janani Suraksha Yojana should be strengthened so as to ensure availability of reliable information with the State and District Health Societies. This would help mitigate the risk of fraud and irregularities in grant of cash compensation under the JSY. The Ministry may emphasise that nodal personnel encourage data integrity under JSY at the Ministry and SHS level.***
- ***The new technologies such as laparoscopy in tubectomy, new spacing methods etc. should be made available at prescribed levels of health centres. Usage of oral pill and IUD may be encouraged among women. Training in IUD insertions needs to be provided to doctors, nurses and ANMs posted in PHCs and CHCs.***
- ***The targets fixed for immunisation may be re-examined in the light of household surveys conducted in the States. The targets should be designed and monitoring and reporting structure should be strengthened to achieve universal immunisation and ensure negligible morbidity due to vaccine preventable diseases in areas covered by full immunisation efforts.***
- ***Supply of free spectacles to children identified with refractive errors should be improved and the utilisation of eyes collected through donations should be to the maximum possible extent.***
- ***IDD monitoring labs may be established and made functional to monitor the IDD cases. Fresh surveys may be conducted to locate new iodine deficiency areas and monitor prevalence of the disease.***
- ***The complete operationalisation of IDSP should be expedited to meet the health challenges effectively. The integration of activities through networking of surveillance unit and procurement of equipment for strengthening of laboratories at district level should be expedited for sustaining surveillance activities.***

Annex 1.1
Refers to paragraph 1.1.3.1
Flow Chart of fund flow and reporting under NRHM



Annex 1.2
(Refers to paragraph 1.1.3.2)
Programme wise details of Budget Estimates and Actual expenditure under different components of the NRHM

(Rs. in crore)

SN	Name of the scheme	2005-06		2006-07		2007-08	
		BE	AE	BE	AE	BE	AE[1]
Centrally sponsored programmes: Funded through State Budget (Treasury Route)							
1.	Direction & Administration	275.80	226.60	245.00	147.47	255.28	215.80
2.	Rural Family Welfare Services	1964.40	1231.06	1556.68	977.12	1939.00	2029.13
3.	Urban Family Welfare Services	135.33	122.73	125.00	73.59	122.84	130.99
4.	Grants to State Training Institutions and Strengthening of Basic Training Schools	106.87	83.51	91.15	52.07	92.07	92.18
5.	Free distribution of contraceptives and Free condoms for NACO	172.52	163.61	300.00	358.73	335.00	311.94
6.	Procurement of supplies and materials	250.00	0.00	250.00	0.00	200.00	0.00
7.	Sterilisation beds	2.02	1.88	2.02	1.16	0	0
	Sub total (1 to 7)	2,906.94	1,829.39	2,569.85	1,610.14	2,944.19	2,780.04
Centrally sponsored programmes: Funded through State Health Society (Society Route)[2]							
8.	Area Projects	536.26	360.12	215.27	120.96	50.01	46.23
9.	Routine Immunisation	507.00	162.58	345.00	228.83	317.00	236.49
10.	Pulse Polio Immunisation	877.00	918.07	1049.00	1064.61	1341.48	1084.00
11.	Information, Education, Communication	129.10	122.87	130.10	134.60	160.00	155.83
12.	RCH Flexible Pool	955.74	2011.76	1705.72	1427.03	1725.00	1842.88
13.	Mission Flexible Pool	0	0	1943.18	2069.36	3155.32	3151.65
14	National Vector Borne Disease Control Programme	348.45	259.92	371.58	318.13	399.50	383.65
15.	National TB Control Programme	186.00	188.12	202.17	220.62	267.00	261.96
16.	National Leprosy Eradication Programme	41.75	23.12	42.25	34.15	40.00	25.00
17.	National Programme for Control of Blindness	89.00	92.97	90.00	110.34	140.00	163.50
18.	Iodine Deficiency Disorder Disease Control Programme	12.00	9.01	15.00	11.79	25.00	19.46
19.	National Drugs De-addiction Control Programme	Nil	Nil	Nil	Nil	10.50	9.63
	Sub total (8 to 19)	3,682.30	4,148.54	6,109.27	5,740.42	7,630.81	7,380.28
Central Sector Schemes							
20	Integrated Disease Surveillance Project	88.00	39.26	102.00	12.93	80.00	41.07
21	Social marketing of contraceptives	241.04	107.65	49.50	20.31	50.00	26.71
22.	NGOs (Public Private Partnership)	102.70	49.45	32.91	3.68	20.50	18.01
23.	Other schemes including grant to research and training institutes	168.22	110.29	136.47	99.14	164.50	134.14
	Sub total (20 to 23)	599.96	306.65	320.88	136.06	315.00	219.93
	GRAND TOTAL	7,189.20	6284.58	9,000.00	7486.62	10,890.00	10,380.25

(Source: Information provided by the Ministry)

[1] BE – Budget Estimates; AE – Actual Expenditure as reported by the Ministry

[2] Under the Routine Immunisation, Pulse Polio Immunisation and various disease control programmes, while operating cost is released to the State Health Societies, the medicines and vaccines are sent in-kind grants to the State Health Department, i.e. through the State Budget.

Introduction

Annex 1.3
(Refers to paragraph 1.4.3)
List of sample districts

Name of the State	Name of the district	No. of sample units		
		CHCs	PHCs	Sub Centres
Andhra Pradesh	1.Adilabad, 2. Khammam, 3. Krishna, 4. Kurnool, 5. Nellore, 6. Vizianagaram	18	36	72
Arunachal Pradesh	7. Changlang, 8. East Kameng, 9. East Siang, 10. Lohit, 11. Upper Subansiri	8	20	40
Assam	12. Nagaon, 13. Nalbari, 14. Sibsagar, 15. Lakhimpur, 16. Karbi Anglong	14	29	58
Bihar	17. Kishanganj, 18. Bhojpur, 19. Sheikhpura, 20. Samastipur, 21. East Champaran, 22. Nalanda	12	36	72
Chhattisgarh	23. Raipur, 24. Kanker, 25. Raigarh	9	18	36
Gujarat	26. Jamnagar, 27. Gandhinagar, 28. Kachcha, 29. Valsad	12	24	48
Haryana	30. Faridabad, 31. Ambala, 32. Bhiwani, 33. Fatehabad	12	24	48
Himachal Pradesh	34. Kinnaur, 35. Hamirpur, 36. Bilaspur	9	18	36
Jammu & Kashmir	37. Leh, 38. Anantnag, 39. Rajouri, 40. Doda	12	22	45
Jharkhand	41. Sahebganj, 42. Hazaribagh, 43. Ranchi	0	24	36
Karnataka	44. Bidar, 45. Dharwar, 46. Dakshina Kannada, 47. Chickmagalur, 48. Tumkur, 49. Chamaraja Nagar	18	36	72
Kerala	50. Thiruvananthapuram, 51. Alappuzha, 52. Kozhikode	9	18	36
Madhya Pradesh	53. Shahdol, 54. Vidisha, 55. Ujjain, 56. Seoni, 57. Betul, 58. Morena	18	35	70
Maharashtra	59. Thane, 60. Nasik, 61. Pune, 62. Osmanabad, 63. Yeotmal, 64. Gondia	18	36	72
Manipur	65. Senapati, 66. Churachandpur, 67. Bishenpur	5	14	27
Meghalaya	68. West Garo Hills, 69. South Garo Hills, 70. West Khasi Hills, 71. East Khasi Hills, 72. Jaintia Hills	13	22	30
Mizoram	73. Kolasib, 74. Lunglei, 75. Lawngtali	3	6	18
Orissa	76. Sundargarh, 77. Koraput, 78. Bolangir, 79. Jajpur, 80. Cuttack	15	30	60
Punjab	81. Amritsar, 82. Bathinda, 83. Hoshiarpur, 84. Ludhiana	12	24	48
Rajasthan	85. Jaipur, 86. Bundi, 87. Udaipur, 88. Ajmer, 89. Ganganagar, 90. Pali	18	36	72
Sikkim	91. East District, 92. South District, 93. West District	3	6	12
Tamil Nadu	94. Erode, 95. Vellore, 96. Kanyakumari, 97. Villupuram, 98. Pudukottai	15	30	60
Tripura	99. Dhalai, 100. South Tripura, 101. West Tripura	3	18	36
Uttarakhand	102. Dehradun, 103. Pauri Garhwal, 104. Almora	9	13	30
Uttar Pradesh	105. Saharanpur, 106. Mirzapur, 107. Banda, 108. Etawah, 109. Bahraich, 110. Barabanki	18	36	72
West Bengal	111. Jalpaiguri, 112. Uttar Dinajpur, 113. Howrah, 114. Birbhum, 115. Purulia	15	30	60
A & N Islands	116. South Andaman, 117. North & Middle Andaman, 118. Nicobar	4	8	16
Chandigarh	119. Chandigarh	2	0	4
D & N Haveli	120. Silvassa	1	2	7
Daman & Diu	121. Daman, 122. Diu	1	3	6
Delhi	123. North West District, 124. South West District,	9	18	36

Name of the State	Name of the district	No. of sample units		
		CHCs	PHCs	Sub Centres
	125. West District			
Lakshadweep	126. Lakshadweep	2	2	4
Puducherry	127. Puducherry, 128. Mahe, 129. Karaikal	4	13	22
Total	129	321	687	1361

Planning and Monitoring

Annex 2.1
(Refers to paragraph 2.2)

A. Status of facility survey

Name of the State	Total centres			Facility survey conducted			Test checked centres			No of centres where facility survey was conducted		
	CHC	PHC	SC	CHC	PHC	SC	CHC	PHC	SC	CHC	PHC	SC
Arunachal Pradesh	31	85	378	29	41	299						
A & N Islands	4	19	114	4	18	Nil	4	8	16	4	8	Nil
Gujarat#	273	1073	7274	273	1073	Nil	12	24	48	8	17	20
Haryana	87	420	2465	31	Nil	Nil	12	24	48	Nil	Nil	Nil
Karnataka	NF	NF	NF	NF	NF	NF	18	36	72	12	24	48
Maharashtra	448	1818	10535	276	397	Nil	18	36	72	4	5	Nil
Meghalaya	28	101	401	15	54	257	13	22	30	3	12	19
Mizoram#	9	57	366	9	57	366	3	6	18	2	2	8
Punjab#	128	484	2858	128	484	2858	12	24	48	10	19	36
Rajasthan	116	1503	10742	NA	NA	NA	18	36	72	7	5	8
Uttarakhand	49	232	1765	26	Nil	Nil	9	13	30	4	Nil	Nil
Uttar Pradesh	393	3660	20521	323	2962	19678	18	36	72	Nil	Nil	Nil

(Source: Information collected from SHSs/DHSs)

The information on facility survey furnished by the SHS differed from the same furnished by the lower level formations.

B. Inconsistency in data provided by the SHS and data verified during audit

States	Information provided by the SHS	Discrepancy in data observed during audit of sample units
Punjab	Facility surveys were complete for all the units	Facility surveys were not conducted at 2 CHCs, 5 PHCs and 12 Sub Centres
Mizoram	Facility surveys were complete for all the units	Facility surveys were not conducted at 1 CHC, 4 PHCs and 10 Sub Centres
Gujarat	Facility surveys were complete for CHCs and PHCs and not started for Sub Centres	Facility surveys were not conducted at 4 CHCs and 7 PHCs. The surveys had been conducted at 20 Sub Centres.
Uttar Pradesh	Facility surveys were complete for 82% CHCs, 81% PHCs and 96% Sub Centres	Facility surveys were not conducted at any of the audited CHCs, PHCs and Sub Centres

Community Participation

Annex 3.1
(Refers to paragraph 3.2)
State wise status of constitution of VHSCs

VHSCs formed in all villages	
State	**No. of villages**
Andhra Pradesh	21,916
Sikkim	452
Manipur	2391
Tamil Nadu	12618
Puducherry	92

VHSCs not formed at all	
Himachal Pradesh	17495
Bihar	45356
Chandigarh	22
D & N Haveli[4]	72
Assam	26247
Orissa	47529
Tripura	1040
Uttarakhand	16826
Daman & Diu[5]	23

(Source: Information provided by SHSs)

VHSCs formed in some villages			
State	**Total no. of villages**	**Villages with VHSCs**	
		Number	**Percentage**
Jharkhand[3]	32615	29822	91.44
Lakshadweep	10	3	30.00
Madhya Pradesh	52009	16349	31.43
Jammu & Kashmir	7537	6745	89.49
Meghalaya	6180	4952	80.13
Mizoram	817	786	96.21
Rajasthan	39859	9188	23.05
Gujarat	18123	16730	92.31
A & N Islands	302	238	78.81
Uttar Pradesh	107452	29136	27.12
Maharashtra	43876	25786	58.77
Punjab	12278	11319	92.19
Chhattisgarh	20639	7301	35.37
Haryana	6955	6223	89.48
Arunachal Pradesh	3862	2178	56.40
Delhi	Formed only in South West District		

- In West Bengal, it was decided to constitute Functional Committees on Health and Sanitation under already existing Gram Unnayan Samitis (GUS). However, in five audited districts no such committee had been formed and the GUS was performing the functions of the VHSC.
- In Karnataka and Kerala, the State Health Society did not make information on setting up of VHSCs available. However, in all test checked (144) villages in Karnataka and 36 rural wards in Kerala, the Committee had been formed.

[3] VHSCs were formed but non-functional.
[4] The orders for formation of VHSCs had been issued by the UT Panchayat department.
[5] The proposal for VHSC formation had been sent to Sarpanchs in September 2007. The Director of Health stated in July 2008 that the VHSCs were being constituted and would commence functioning from August 2008.

Community Participation

Annex 3.2

(Refers to paragraph 3.4.1)

A - Status of formation of the Rogi Kalyan Samitis at health centres in States where the Samiti had not been formed at all centres at a particular level

State/UT	DH		CHC		PHC	
	Formed	Not Formed	Formed	Not Formed	Formed	Not Formed
Assam	21	Nil	99	9	844	68
Andhra Pradesh	19	Nil	166	1	1516	54
Bihar	20	5	44	26	311	1330
D & N Haveli	1	Nil	Nil	1	Nil	6
Daman & Diu	1	1	Nil	1	Nil	6
Himachal Pradesh	12	0	48	25	44	405
Jharkhand	18	4	181	13	318	12
Maharashtra	23	0	346	17	1786	30
Orissa	32	0	231	0	870	409
Puducherry	0	4	4	0	39	0
Tripura	2	0	11[6]	0	73	3
Uttar Pradesh	131	9	325	68	560	3100
A & N Islands	2	0	4	0	18	1
Karnataka	6	0	17	1	32	4
Haryana	20	0	87	0	366	54
Meghalaya	3	0	28	0	99	2
Lakshadweep	1	1	1	2	2	2
Chhattisgarh	16	0	129	0	695	12
Madhya Pradesh	48	0	270	0	870	279
Uttarakhand	30	5	49	0	0	232
Arunachal Pradesh	14	0	29	2	71	14
Total	420	29	2069	166	8514	6023

(Source: Information provided by SHSs)

Note: 1. Data of Karnataka is based on sample test. Data for the entire State was not made available to audit.

B- Excess funds released for the RKS

(Rs. in lakh)

Sl. No.	State	Funds released for RKS	State's requirement	Excess release
1.	**Andhra Pradesh**	953.0	89.0	864.0
2.	**Haryana**	590.0	0	590.0
3.	**Himachal Pradesh**	102.0	94.0	8.0
4.	**Jammu & Kashmir**	517.0	475.0	42.0
5.	**Karnataka**	429.0	343.0	86.0
6.	**Maharashtra**	535.0	425.0	110.0
7.	**Chhattisgarh**	714.0	654.0	60.0
8.	**Jharkhand**	300.0	0	300.0
9.	**Madhya Pradesh**	1636.0	484.0	1152.0
10.	**Uttar Pradesh**	87.5	0	87.5
11	**Bihar**	800.0	0	800.0
Total		**6663.5**	**2564.0**	**4099.5**

(Source: Information compiled from Ministry's records)

[6] Including Sub Divisional Hospital

Community Participation

Annex 3.3
(Refers to paragraph 3.4.6)
Discrepancies/irregularities in expenditure by the RKS : State specific audit findings

(Rs. in lakh)

State	Audit Findings	Amount
Andhra Pradesh	PHC Cherla (Khammam) - Repairs to forest guest house. 18 PHCs – Procurement without following procedures.	0.32 11.10
	PHC Agiripalli (Krishna)- Purchase of flower bouquet for MLA.	0.09
Assam	Diphu District Hospital – Unauthorized financial aid to the contractors. Issue of self cheques for cash and drawl for reimbursement.	6.00 57.22
	Lakhimpur District Hospital – Advances paid by RKS to contractors for works done but not measured, remained unadjusted for 10 months. Eight construction works were awarded by RKS without inviting tenders and without execution of agreement.	10.50 50.31 (estimates)
	All test checked RKS (109) - Assets created out of RKS funds and user charges were neither booked in Government account and nor was any separate Asset Register maintained.	
Chhattisgarh	Kanker – Purchase of video camera without approval of the RKS.	0.11
D & N Haveli	Assets created out of RKS funds were not handed over to the government and hence were not booked in government accounts.	1.19
Himachal Pradesh	In four cases expenditure was incurred for non-health delivery purposes.	12.63
Jammu & Kashmir	In 15 cases expenditure was incurred for non-health delivery purposes.	2.88
Maharashtra	In 17 PHCs the expenditure was incurred for non-health delivery purposes, i.e. for the purchase of computers, furniture, music system etc.	7.63
	PHC Vasantnagar (Yavatmal) - Medical Officer had incurred the expenditure without approval of RKS.	1.75
	CHC Manor (Thane) - Cleanliness services were outsourced despite the services of two regular sweepers on rolls.	0.70
Madhya Pradesh	Assets created out of RKS funds were not handed over to the government and hence were not booked in government accounts.	84.54
Uttar Pradesh	District Hospital Barabanki - Clearance of outstanding liabilities and repair of equipment.	5.00
Kerala	CHC Nedumangad - Fund was diverted to meet the expenditure on electricity and water charges.	3.00
Manipur	District Hospital Churachandpur - Expenditure for non-health delivery purposes.	2.93
Orissa	Koraput – In two cases, money was paid to the Medical Officers in charge for Post Partum Centre without indicating any purpose and vouchers were not submitted. In five cases, advance was given to one pharmacist, CDMO and two others without assigning any reason and vouchers were not submitted. [Health Department stated that the matter was brought to the notice of the District Collector and further action was awaited.]	2.00 1.05
Tamil Nadu	Erode & Villupuram - Payment of salaries (July 2006 to November 2007) to outsourced employees such as Lab Assistant, Drivers and House Keeping Staff.	2.09 & 2.78

Convergence

Annex 4.1
(Refers to Paragraph 4.2.2)
Status of funds released by State Health Societies to NGOs and their utilisation

(Rs. in Lakh)

Sl. No.	Name of the State/UT	Grants-in-aid released to NGOs			Amount of UCs furnished by NGOs		
		2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
1	Andhra Pradesh	225.47	1110.03	733.41	Nil	Nil	113.81
2	Assam	45	3	105	12	Nil	Nil
3	Chandigarh	Nil	4.97	Nil	Nil	Nil	4.93
4	Himachal Pradesh	90	50	166	Nil	84.55	95.55
5	Jammu & Kashmir	Nil	47	30		Nil	Nil
6	Jharkhand	90.12	92.15	267.97	90.12	92.15	100
7	Kerala	5	90	139	5	90	Nil
8	Arunachal Pradesh	80	391.21	439.12	75	331.41	455.22
9	Maharashtra	21	167.5	144.85	Nil	Nil	300.85
10	Manipur	Nil	60	30	Nil	Nil	45
11	Orissa	237	319.88	153.24	173.84	247.65	125.1
12	Puducherry	1	Nil	5.03	0.29	0.71	0.03
13	Rajasthan	8	1	97	Nil	Nil	Nil
14	Sikkim	Nil	Nil	43	Nil	Nil	32.45
15	Tripura	Nil	Nil	1	Nil	Nil	1
16	Uttar Pradesh		63.07	Nil	Nil	58.14	Nil
17	West Bengal	Nil	144.15	256.61	Nil	128.07	134.71
18	Uttarakhand	6	174.25	20.41	Nil	Nil	109
19	Gujarat	151.5	507.23	209.96	62.5	55.21	10.88
20	Delhi	2	4	88	2	4	41.02
21	Chhattisgarh	Nil	Nil	224.92	Nil	Nil	Nil
22	Haryana	Nil	36.22	Nil	Nil	Nil	Nil
23	Madhya Pradesh	Nil	145	505	Nil	Nil	Nil
24	Punjab	Nil	Nil	118.25	Nil	Nil	39.45
	Total	**962.09**	**3410.66**	**3777.77**	**420.75**	**1091.89**	**1609.00**

(Source: Information provided by SHSs)

Fund Flow Management

Annex 5.1
(Refers to paragraph 5.5.3)
A- Advances by the SHSs excluded from unspent balances for 2007-08

(*Rs. in crore*)

Sl. No.	State/UT	Funds eligibility to the State/UT[7]	Unspent balance with SHS	Advances excluded from unspent balance
1.	Chhattisgarh	35.76	20.70	23.10
2.	Gujarat	61.10	29.55	51.51
3.	Jammu & Kashmir	9.16	8.10	2.69
4.	Jharkhand	39.33	39.29	9.95
5.	Karnataka	64.25	56.11	22.33
6.	Kerala	37.17	42.04	14.94
7.	Madhya Pradesh	214.25	32.52	25.86
8.	Maharashtra	105.92	135.86	62.83
9.	Mizoram	5.66	0.99	0.42
10.	Orissa	106.25	44.28	41.76
11.	Rajasthan	78.05	51.67	90.06
12.	Sikkim	2.33	0.60	0.98
13.	Tamil Nadu	78.46	66.89	66.89
14.	Uttar Pradesh	230.80	170.90	69.85
15.	Uttarakhand	12.10	10.34	6.24
16.	West Bengal	97.88	96.54	35.80
17.	A&N Islands	0.35	0.17	0.22
18.	Puducherry	1.26	0.77	0.14
	Total	**1180.38**	**807.32**	**525.57**

B- Short accountal of unspent balances for 2007-08

(*Rs. in crore*)

Sl. No.	State/UT	Unspent balance as on 1.1.2008	Unspent balance as Audited Report	Short accountal of unspent balance
1.	Andhra Pradesh	0	52.19	52.19
2.	Assam	0	52.09	52.09
3.	Arunachal Pradesh	0	2.35	2.35
4.	Goa	0.75	0.92	0.17
5.	Haryana	2.07	12.51	10.44
6.	Himachal Pradesh	3.54	7.84	4.30
7.	Jammu & Kashmir	0.05	10.13	10.08
8.	Karnataka	21.63	47.04	25.41
9.	Kerala	15.20	36.72	21.52
10.	Manipur	0.40	5.84	5.44
11.	Meghalaya	3.66	6.46	2.80
12.	Mizoram	0	1.18	1.18
13.	Nagaland	0.59	3.62	3.03
14.	Punjab	15.49	24.95	9.46
15.	Rajasthan	0	43.67	43.67
16.	Sikkim	0	0.86	0.86
17.	Tripura	4.39	9.20	4.81
18.	Uttarakhand	1.13	9.86	8.73
19.	West Bengal	16.45	94.80	71.10
20.	Chandigarh	0.51	0.94	0.43
21.	D&N Haveli	0.18	0.46	0.16
22.	Delhi	7.89	13.84	5.95
23.	Puducherry	0	0.87	0.87
	Total	**93.93**	**438.34**	**337.04**

[7] 75 *per cent* of BE or 100 *per cent* of BE where Audit Report and UC received

Fund Flow Management

Annex 5.2
(Refers to paragraph 5.7)
State wise status of outstanding Utilization Certificates under various programmes as of October 2009

(Rs. in lakh)

State/UT	Mission Flexi-pool			RCH Flexi-pool			Routine Immunisation	Pulse Polio Immunisation
	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	Up to 2007-08	Up to 2007-08
Andhra Pradesh	369.41	3596.96	14650.21	0	0	6171.49	0	498.80
A &N Islands	142.17	61.92	324.12	0	0	25.63	11	14.76
Arunachal Pradesh	119.24	344.17	55.88	0	0	0	28	0
Assam	0	0	0	0	0	0	0	0
Bihar	6219.67	12536.69	13763.00	806.51	0	0	1896	1183.05
Chandigarh	31.30	37.32	177.00	0	38.02	42.00	6	0
Chhattisgarh	0	1023.30	6413.00	0	0	0	0	28.36
D&N Haveli	10.99	8.09	0	0	0	1.50	2	0
Daman & Diu	34.57	55.77	0	0	31.63	0	2	0.87
Delhi	105.54	399.21	2323.00	0	0	619.00	33	483.31
Goa	186.20	111.57	94.00	98.49	45.51	32.25	0	0.38
Gujarat	1853.90	7651.13	6772.55	0	0	6700.90	0	855.53
Haryana	1955.67	2628.87	4651.00	0	0	1461.66	119	149.82
Himachal Pradesh	356.73	3029.21	536.00	188.82	0	664.00	89	1.23
J&K	284.00	994.78	11933.54	0	0	820.89	63	53.34
Jharkhand	713.97	4618.63	6647.00	0	1315.73	2215.51	600	459.16
Karnataka	3237.17	5902.41	8425.36	0	0	1716.83	32	126.47
Kerala	316.48	1899.36	14311.00	0	0	3396.45	347	0
Lakshadweep	75.52	14.30	0	0	0	0	4	0.68
Madhya Pradesh	5831.75	2415.18	14076.00	0	0	0	773	50.94
Manipur	670.37	738.53	1372.00	0	341.60	1261.26	12	0
Meghalaya	106.40	1213.48	2322.00	0	291.15	995.92	39	49.04
Mizoram	0	587.03	895.00	0	0	0	0	0
Maharashtra	2865.86	9654.59	17788.00	0	4194.82	18620.70	424	1121.22
Nagaland	0	0	0	0	0	0	4	0
Orissa	2118.42	5414.54	9885.10	0	0	6507.17	515	154.66
Punjab	0	0	105.23	0	0	0	21	273.48
Puducherry	0	0	212.84	0	0	0	0	13.31
Rajasthan	0	0	3096.04	0	0	0	306	124.96
Sikkim	0	0	594.68	0	0	0	16	15.15
Tamil Nadu	0	3333.92	20607.09	0	0	9019.20	815	0
Tripura	92.71	426.58	3806.00	0	293.23	1434.40	21	19.50
Uttar Pradesh	0	0	35602.55	0	0	5944.30	2813	7225.37
Uttarakhand	0	0	1588.95	0	0	0	150	190.66
West Bengal	0	0	23371.00	0	1776.58	7109.92	1034	906.36
Total	**27698.04**	**68697.53**	**226399.16**	**1093.82**	**8328.27**	**74760.99**	**10175**	**14000.41**

(Source: Information provided by the Ministry)

Fund Flow Management

Annex 5.3
(Refers to Paragraph 5.7)
Submission of incorrect Utilisation Certificates

State/UT	Remarks
Orissa	(i) The SHS sent UCs in March, 2006 to the Ministry in respect of Rs. 590 lakh received in March, 2005 for the construction of operation theatre (OT) and labour rooms in 180 PHCs and CHCs although Rs 560 lakh were actually advanced in July 2006 to Orissa Industrial Infrastructure Development Corporation Limited for the above construction. No construction was done and the funds were refunded to the Ministry in February 2008. (ii) Out of Rs. 1343 lakh advanced to three executing agencies during 2006-08 under 'up-gradation of CHC/PHC to IPHS', Rs. 846 lakh was booked during 2007-08 as expenditure and UC submitted to the Ministry in November 2008, however only Rs. 164 lakh was actually spent by these agencies by 31 March 2008. Thus, advance of Rs 682 lakh was irregularly shown as expenditure in UC. (iii) UCs in respect of the entire funds of Rs 73.34 lakh received in April 2005 for IEC activities were sent to the Ministry in February 2007 by the SHS. However, it was noticed that only Rs 46.87 lakh was spent.
Karnataka	(i) Under National Programme for Control of Blindness, Rs. 490 lakh was shown as received during 2005-06 in the audited accounts of SHS. Out of this, Rs. 43 lakh was not included in the amount of UCs furnished to the Ministry for the year 2005-06. This amount was included and shown as utilised in the UC for 2004-05 leading to misrepresentation of facts. (ii) DHS Chamrajnagar, had received Rs. 154.25 lakh from the SHS during 2007-08 for Untied Funds to Sub Centre and PHC and Annual Maintenace Grants to the PHCs. Out of this, the health centres had incurred an expenditure of only Rs. 40.24 lakh as of 31 March 2008. Instead of submitting utilisation certificates to the SHS for Rs. 40.24 lakh, the DHS had submitted utilisation certificates for Rs. 142.49 lakh. (iii) In a UC furnished by the SHS to the Ministry in respect of Rs. 21.80 crore received for the procurement of drugs kits under ASHA, Kit A and Kit B, PHC kits, RTI/STI kits under RCH/NRHM programme, an amount of Rs.165 lakh had been shown as utilised. However, it had not been reflected in the audited accounts.
Assam	Director of Health Services submitted UCs of Rs. 87.68 lakh in March 2008 in respect of procurement of drugs and medicines prior to actual expenditure and even before the placement of supply orders.

Fund Flow Management

Annex-5.4
(Refers to paragraph 5.9)
A- Delay in release of funds

State/UT	Delay period	Details of funds transfer
Assam	12 days to 3.5month	Funds transfer from SHS to DHSs during 2005-06 and 2006-07
Gujarat	9 days to 34 months.	Transfer of Rs.139.21 crore from State Finance Department during 2005-08
	8 months	Transfer of Rs. 69.70 lakh from DHS Jamnagar to VHSCs during 2007-08
Jammu & Kashmir	2 to 9 months	Release of Rs. 12.19 crore from the administrative department to SHS
Jharkhand	4 to 14 months	Transfer of untied funds and annual maintenance grants of Rs. 2.90 crore from SHS to PHCs
Karnataka	1months 19 days to 13 months	Transfer of untied funds and JSY funds of Rs. 1.57 crore from DHS to health centres
Maharashtra	1 month to 9.5 months	Transfer from Rs. 266.37 crore received from the Ministry by the SHS to DHS
	1.5 months to 7.5 months	Transfer from Rs. 2.97 crore received from the SHS by DHS to health centres
Orissa	82 days	Transfer of Rs. 4.75 crore to DHS from SHS meant for immunisation
	15 days to 13 months	Transfer of funds to health centres from DHS meant for immunisation
Punjab	1month to 11 month	Transfer of Rs. 27.96 crore for upgradation of CHCs, grants for health centres, health mela etc. from SHS to DHS and other administrative units
Rajasthan	3 months to 30 months	Transfer of Rs. 16.87 crore from three DHS to health centres during 2005-08
Sikkim	23 days to 6.5 months.	Transfer of funds from SHS to executing authorities
Uttar Pradesh	5 months	Transfer of Rs. 18.57 crore for untied funds from SHS to DHS
	6 months	Transfer of untied funds from DHS to Sub Centres

B - Details of unspent balances at District/CHC/PHC/Sub Centre levels

Sl. No.	State/UT	As on 31st March,2008 (Rs. in lakh)			
		District level	CHC level	PHC level	SC level
1.	**Assam**	8693.11	NA	NA	NA
3.	**Bihar**	26363.00	NA	NA	NA
4.	**Haryana**	NA	NA	168.09	262.26
5.	**Himachal Pradesh**	NA	1972.90		
6.	**Jammu &Kashmir**	NA	7249.62		
7.	**Karnataka(S)**	NA	29.70	24.20	3.44
8.	**Kerala**	6808.05	NA	NA	NA
9.	**Madhya Pradesh**	6257.31	NA	NA	NA
10.	**Maharashtra**	NA	2792.02	1994.07	323.39
11.	**Manipur**	NA	477.77	407.65	321.81
12.	**Meghalaya**	NA	132.61	128.38	183.28
13.	**Punjab**	NA	2123.30	315.37	202.64
14.	**Sikkim**	NA	291.78	NA	NA
15.	**Tamil Nadu(S)**	953.22			NA
16.	**Tripura**	NA	1555.94		
17.	**A&N Islands**	NA	4.00	9.00	18.76
18.	**D&N Haveli**	NA	14.14	4.50	3.80
19.	**Delhi**	1494.87	NA	NA	NA
20.	**Lakshadweep**	NA	4.80	Nil	1.40

(Source: Information provided by SHSs)

Annex 5.5
(Refers to paragraph 5.10)
State specific audit findings on diversion of funds

(Rs. in crore)

State	SHS/ DHS	Year	Purpose for which funds were released	Purpose for which funds were spent	Amount
Assam	SHS	2006-07	Orientation of VHSCs	Village Health and Nutrition Days	0.40
	DHSs	2007-08	Unspent fund of EC-SIP	JSY scheme	5.74
	SHS	2007-08	Unspent fund of the RCH-I	Receipt under RCH-II	0.36
Jammu & Kashmir	DHS Rajouri	2006-07	Activities to be undertaken by RKS at PHC level	O.E., POL at district level	0.06
Maharashtra	SHS	2007-08	Up-gradation of 3 SDHs to IPHS	Purchase of medicines	0.22
Tamil Nadu	SHS	2006-07	RCH funds	15 Government Medical College Hospitals	7.00
	SHS	2006-08	NRHM funds	State schemes	2.78
Uttar Pradesh	SHS	2007-08	Mission Flexible Pool	Settling old claims under the Blindness Control Programme	24.57
	SHS	2006-07	Mission Flexible Pool	Advance to DGMH	50.00
Karnataka	SHS	2007-08	Up-gradation of CHCs to IPHS	Repairs of quarters of doctors, ANMs, nurses, Group D	2.40
	SHS	2006-07	RCH flexi-pool	Control of Chikungunia disease	0.95
	SHS	2008-09	NRHM funds	Purchase of four wheelers (Kysanur Forest Disease Control Programme), control of Handigodu disease, 'Mysore Dasara Exhibition'	0.36
TOTAL					**94.84**

Fund Flow Management

Annex-5.6
(Refers to paragraph 5.11.1)
Details of Unspent balance in respect of untied funds released to Health Centres during 2005-08

Sl. No	State/UT	Unspent balance (Rs. In lakh)									
		SC level			PHC level			CHC level			
		2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	Unspent as on 31.03.2008
1.	Andhra Pradesh	NA	NA	459.09	NA	NA	-NA	NA	NA	NA	459.09
2.	Arunachal Pradesh	9.90	0.20	23.44	NA	9.51	22.92	NA	NA	25.03	71.39
3.	Assam	467.22	NA	NA	NA	NA	NA	NA	NA	NA	121.11
4.	Bihar(Sample)	Nil	52.91	4.40	Nil	Nil	11.50	Nil	Nil	Nil	68.81
5.	Chhattisgarh	3.28	2.83	5.70	Nil			Nil	Nil	Nil	3.78
6.	Gujarat	Nil	235.59	131.28	Nil	Nil	105.02			46.86	518.75
7.	Haryana	196.95	95.45	262.26	Nil	289.03	168.09	Nil	Nil	Nil	430.35
8	Himachal Pradesh	170.44	38.12	132.35	Nil	109.75	105.75	Nil	Nil	Nil	238.10
9.	Jammu & Kashmir	Nil	38.16	102.29		83.50	-32.58	-	-	33.14	224.51
10	Jharkhand	Nil	370.45	525.86	Nil	48.25	12.38	-	-	-	956.94
11.	Karnataka (Sample)	0.93	0.83	2.35	Nil	1.82	4.43				10.36
12.	Madhya Pradesh	839.50	748.55	69.61	Nil	235.14	-6.03	Nil	129.51	31.22	1985.06
13.	Maharashtra	769.81	246.78	150.37	Nil	445.00	111.14	Nil	Nil	45.89	307.40
14.	Manipur	42.0	25.1	21.81	Nil	18	4.8	Nil	16	-0.60	85.11
15.	Meghalaya	40.10	21.58	9.28	-	25.25	15.10		--	9.59	33.97
16.	Mizoram						0.47			0.43	0.90
17.	Orissa(Sample)	110.00	101.78	90.15	Nil	55	Nil	Nil	Nil	38	394.93
18.	Rajasthan (Sample)	1.38	3.17	0.025	0.15	3.03	3.70	3.12	4.16	7.36	26.10
19.	Sikkim	14.70	NA	2.80	NA	6	-2.27	NA	NA	0.27	21.50
20.	Tamil Nadu	-	286.87	-27.75	-	74.00	162.52				170.80
21.	Tripura	53.90	3.47	7.12	Nil	13.11	14.12	Nil	Nil	5	39.35
22.	Uttar Pradesh	1857	167	1332	NR	NR	3306	NR	NR	270	6932.00
23.	Uttarakhand	Nil	Nil	46.14	Nil	Nil	12.05	Nil	Nil	4.65	62.84
24.	West Bengal (Sample)	3.42	2.78	4.22	Nil	2.98	6	Nil	Nil	7.13	17.35
25.	A&N Islands	10.70	5.54	13.89	NR	5	4.79	NR	NR	NR	18.68
26.	Delhi	Nil	Nil	1.25	Nil	Nil	0.75	Nil	Nil	4	6.00
27.	Chandigarh	0.80	0.30	0.66							0.66
28.	Lakshadweep	1.40	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	1.40
29.	Puducherry	6.05	0.40	8	-	9.75	13.73	-	-	3.87	25.60
										TOTAL	13232.84

(Source: Information provided by SHSs)

NA-Not Available
NR-Not Reported

Fund Flow Management

Annex 5.7
(Refers to paragraph 5.11.1)
A. State specific cases: Untied grants

State/UT	Audit findings
Bihar	Only 573 Sub Centres out of 1482 Sub Centres in sample districts had received untied grants of Rs. 57.31 lakh during 2005-08, which also remained unutilized. Untied grants of Rs. 89.12 lakh for Sub Centres remained idle in the accounts of 70 PHCs.
Chhattisgarh	Against entitlement of untied funds of Rs.381.80 lakh (Rs. 10000 per sub centres for 3818 sub centres), Rs. 883.50 lakh was released by the Ministry during 2004-05. Thus Rs. 501.70 lakh was released in excess, out of which Rs. 381.80 lakh was adjusted during 2005-06 and Rs. 119.90 lakh remained unadjusted.
Gujarat	Untied grants to Sub Centres during 2005-06 and to PHCs and CHCs during 2005-07 were not released and out of untied funds of Rs. 183.30 lakh released to health centres in sample districts, Rs. 77.90 lakh (42.48 *per cent)* remained unspent.
Himachal Pradesh	Untied funds ranging from 21 to 82 *percent* at Sub Centre level and ranging from 96 to 100 *per cent* at PHC level remained unspent during 2005-08.
Jharkhand	Untied funds ranging from 69 to 98 *per cent* in Sub Centres and from 26 to 100 *per cent* in PHCs released during 2006-08 remained unspent.
Kerala	Information given by the State Health Mission regarding untied grants released to CHCs, PHCs and Sub Centres was incorrect as the number of institutions, amount released etc. were at variance with other relevant records.
Orissa	Untied grants were not released to 243 PHCs during 2005-06 and 2007-08 and 76 CHCs in sample districts during 2005-06 and 2006-07.
Sikkim	Untied grants were not released to CHCs during 2005-07.
Uttar Pradesh	Out of Rs. 37.14 crore released to the Sub Centres during 2005-07, Rs.20.24 crore were not utilised due to delay in opening of joint bank accounts.

B. State specific audit findings on misuse of untied funds

(Rs. in lakh)

State/UT	Audit findings	Amount
Arunachal Pradesh	During 2005-06, in two sample districts, untied funds of the Sub Centres were spent on construction and procurement of furniture and hospital accessories etc.	5.00
Chhattisgarh	Out of the untied funds, which were for release to Sub Centres during 2005-08, DHSs in sample districts utilized these for procurement of equipment/furniture.	59.68
Jammu & Kashmir	Untied funds during 2005-08 were used for Office Expenditure and purchase of stationery, furniture etc at Sub Centre and PHC levels.	8.79
Karnataka	i) Rs.814.30 lakh received during 2005-06 from the Ministry for untied funds was not released to Sub Centres and of this, Rs. 800 lakh was kept in fixed deposits for six months. ii) Untied funds and Annual Maintenance Grants were diverted by the Sub Centres, PHCs and the CHCs for transportation charges and purchase of television, furniture, stationery, drugs and fuel etc.	3.58
Madhya Pradesh	During 2006-08, untied funds were used for purchase of furniture and stationery etc. at Sub Centres/CHC/PHC levels.	6.11
Punjab	Untied funds (Rs. 7.72 lakh at Sub Centre and Rs. 1.12 lakh at PHC level) during the period 2005-08 were used for purchase of stationery, equipment, drugs and furniture etc.	8.84
Tamil Nadu	Untied funds during 2006-08 were used for recurring expenditure (electricity charges), purchase of furniture and equipment at Sub Centre and PHC levels.	8.75
West Bengal	Untied funds during 2005-08 at 56 Sub Centres and at 27 PHCs during 2006-08 were used for purchase of stationery, equipment, drugs and furniture etc.	11.15
	Total	111.90

Annex-5.8
(Refers to paragraph 5.12.1)
Non-reconciliation of funds flow
A - From the Ministry to SHS

(Rs. in crore)

Sl. No.	State/UT	Difference between Ministry's figure and SHS's figure (_-short /+ excess) of receipt of funds		
		2005-06	2006-07	2007-08
1.	Andhra Pradesh	(-)128.05	(+)0.69	(-)40.88
2.	Assam	(-)14.66	(-)130.13	(+)122.66
3.	Chhattisgarh	(-)8.42	(-)17.15.	(-)32.11
4.	Gujarat	(-)112.94	(-)67.07.	(-)48.87
5.	Haryana	(+) 13.12	(+) 26.20.	(+) 19.56
6.	Himachal Pradesh	(-)9.77	(+)1.16	(-)8.35
7.	Jharkhand	(-)52.79	(-)3.55	(-)35.89
8.	Kerala	(-)21.14	(-)4.70	(+)6.32
9.	Madhya Pradesh	(-)126.85	(-)90.72	(+)31.15
10.	Maharashtra	(-)148.37	(-)31.82	(-)25.58
11.	Meghalaya	(-)4.58	(-)0.61	(+)1.73
12.	Mizoram	(-)7.76	(-)20.36	(+)16.08
13.	Orissa	(-)60.00	(+)15.77	(-)39.11
14.	Punjab	(-)16.14	(+)4.82	(+)3.05
15.	Rajasthan	(-)95.63	(+) 6.17	(-)56.54
16.	Tripura	(-)21.53	(-)16.15	(-)23.94
17.	Uttar Pradesh	(-)19.54	(-212.83	(+)114.74
18.	Uttarakhand	(-)10.58	(-)4.62	(+)7.62
19.	West Bengal	(-)22.54	(-)18.05	-
20.	A&N Islands	(-)0.58	Nil	Nil
21.	D&N Haveli	(-)0.57	(-)0.36	(-)0.45
22.	Lakshadweep	(-)0.61	(+)0.43	(+)0.05
TOTAL		21 States (-)883.05 1 State (+)13.12	14 States (-)618.12 7 States (+)55.24	10 States (-)311.72 10 States(+)322.96

B- From the SHS to DHS

(Rs. in crore)

Sl. No.	State/UT	Difference between SHS figures and DHS figures (-short receipt/+ excess receipt of funds)		
		2005-06	2006-07	2007-08
1.	Andhra Pradesh(S)	(-)2.83	(-)4.25	(+)1.48
2.	Assam	(-)0.11	Nil	(-)3.09
3.	Gujarat(S)	(+)2.92	(+)1.72	(+)3.61
4.	Kerala	Nil	(-)1.85	NA
5.	Maharashtra	(-)1.44	(+) 2.39	(-)5.67
6.	Meghalaya	(-)0.01	(-)0.49	(-)0.66
7.	Orissa	Nil	(-)1.41	Nil
8.	Rajasthan(S)	(-)0.83	(+) 0.56	(+)0.01
9.	Tripura	NA	(-)2.31	(-)3.71
TOTAL		5States (-)5.22 1 State (+) 2.92	5States (-)10.31 3States (+)4.67	4States (-)13.13 3States (+)5.10

Annex 5.9
(Refers to paragraph 5.12.2)
State specific audit findings on discrepancies in accounts

State	Audit findings
Assam	Discrepancy of Rs. 41.92 lakh in the opening balances of the SHS and DHS accounts under RCH-I was adjusted with the closing balance of IEC for Rs. 42.50 lakh as on 31-03-2008 in the schedule of expenditure under RCH-I resulting in understatement of closing balance under RCH-I as on 31.03.2008.
	Difference of Rs. 85.89 lakh and Rs. 358.97 lakh, between the opening balance of SHS and DHS under RCH-II and NRHM-Additionalities programmes respectively, were adjusted with district level total expenditures and this resulted in reduction of expenditure shown in SOEs submitted by DHSs with corresponding overstatement of closing balances in relevant districts and State as a whole in the State accounts.
Bihar	There was a difference of Rs. 31.56 crore between the figures computed by audit (on the basis of bank pass books/statements pertaining to the SHS and release orders of grants-in-aid by the Ministry/Govt. of Bihar) and the financial statement of grants-in-aid submitted by the SHS in respect of the expenditure/amount released by the SHS during 2005-08.
Madhya Pradesh	There was short accountal of Rs. 33.53 lakh in the opening balances of the accounts of the 6 DHSs and excess accountal of Rs. 2.14 lakh in the opening balances of the accounts of the 3 DHSs.
Maharashtra	In General Hospital Nasik, there was a difference of Rs. 9.96 lakh between the cash book and actual cash balance as on 31-3-2008. Expenditure of Rs. 1.01 lakh incurred on Immunisation, Family Planning etc. was also not accounted for in the cash book. No action had been taken till November 2008 against the person held responsible for the embezzlement.
Sikkim	In the accounts of the DHS of East district, closing balance pertaining to 2005-06 was undercasted by Rs. 2.57 lakh.
Chandigarh	There was excess reporting of expenditure of Rs. 89.14 lakh in the Financial Management Reports for the year 2005-06 and 2006-07 vis-à-vis expenditure as per the cash book.
	There was a difference of Rs. 30.93 lakh between expenditure figures as per cash book and those certified by Chartered Accountant under programme RCH-II for 2005-07.

Fund Flow Management

Annex 5.10
(Refers to paragraph 5.12.4)
State specific audit findings on improper maintenance of control registers

State/UT	Audit findings
Andhra Pradesh	Stock registers were not maintained for items purchased from untied funds in Krishna district (Rs. 6.53 lakh).
Assam	i) Cash book with day to day attestation of transactions and monthly closing certificates by the DDO was not maintained at SHS as well as in 3 out of 5 audited districts. Basic records such as expenditure register, fund register; other registers relating to grants, release of funds, SoEs etc. were also not maintained at State level. Day to day transactions were uploaded on computer periodically from cheque issue register without data scrutiny in the absence of approved software leaving scope for alteration of data. The authenticity of the entries in cash book without any authentication/certification was not ensured. ii) In Nalbari district 24 cash books were maintained instead of a single main cash book.
Bihar	i)None of the DHSs had maintained cash book in double entry system and bank reconciliation had never been done in four test-checked districts ii) Financial records and accounts of the SHS were not maintained separately for each activity. Transactions involving cash, stores etc. were not brought to account under proper head of accounting.
Gujarat	i) Accounts were maintained by the SHS and in the selected DHSs in Tally without formal orders of the administrative authority. ii) Though the erstwhile health societies had been integrated, the accounts continued to be prepared separately.
Jharkhand	i) Periodical reconciliation of cash balance and bank balance was not done. ii) Unspent balance of Rs. 847 lakh of erstwhile programme e.g. RCH-I, RNTCP-I etc. was not brought into the accounts of NRHM. iii) Instead of five bank accounts, 17 banks accounts were in operation in SHS.
Karnataka	i) Bank reconciliation had not been done in the SHS and in the audited units during 2005-08. ii) The SHS had not maintained the cash book for the year 2007-08. For 2005-06 and 2006-07, the cash books had not been maintained properly; field units also had either not maintained the cash book or maintained it improperly. iii) Register of fixed deposits had not been maintained in SHS for the years 2005-08 and the grant register had not been maintained properly in the SHS. The entries were not attested by the officials concerned. iv) In CHC Bhalki of Bidar district, cash book, receipt books, daily receipt register and expenditure register had not been maintained for accounting user charges received by the RKS (Arogya Raksha Samiti). Reconciliation had been not done between the pass book and the user charges actually received and accounted for in the CHC.
Kerala	In four PHCs bank cash book, general ledger and advance register were not maintained. Bank reconciliation with cash book had not been done in one DHS, two CHCs and two PHCs.
Madhya Pradesh	i) In some CHCs and PHCs of four districts, cash books and ledgers for the year 2006-07 were not maintained. ii) Original vouchers worth Rs.125.15 lakh (out of Rs.340.41 lakh) for the year 2006-07 by the DHS Bhopal and vouchers for Rs. 59.70 lakh and Rs. 439.27 lakh for the year 2005-06 and 2006-07 respectively by the DHS Morena were not produced to the chartered accountants for audit.
Rajasthan	In 106 cases, UCs were received for Rs 44.21 lakh instead of Rs 30.50 lakh from sub centres against untied fund in DPMU Udaipur.
Sikkim	i) In SHS and test checked DHSs, cash books were not maintained properly. ii) The SHS opened four bank accounts instead of single bank account for crediting the funds received under RCH, Additionalities under NRHM and Immunisation programmes.

Tamil Nadu	i) System of monitoring the advances (Advances Registers) made to the procurement agencies did not exist at SHS. ii) Specific format had not been developed for recording the cash and other related transactions in SHS, DHS, BPHC and PHC levels, which resulted in poor maintenance of accounts. iii) System to monitor the accrual of interest at various levels and their utilisation had not been prescribed. iv) Double entry system of accounts was not followed in SHS/DHSs for 2005-06 and 2006-07 and UCs were not received from all 29 DHSs by SHS for the period from 2005-06 to 2007-08. v) Reconciliation of accounts with bank was not done in three sample DHSs. In all sample Block PHCs and PHCs reconciliation had not been done.
Uttar Pradesh	i) In the audited districts, the books of accounts and subsidiary records like cash book, ledger, etc. were not maintained in the prescribed format at CHC and PHC level. Vouchers duly marked as paid and cancelled were also not maintained. Details of expenditure at the Sub Centre level were neither maintained nor was monthly progress of expenditure in respect of untied funds reported to the DHSs. ii) At the DHS and SHS level, despite the constitution of the integrated societies, details of expenditure under various programmes were not centrally maintained. Instead, these were maintained by the concerned programme officers.
Uttarakhand	i) Subsidiary books of account like ledger, journal, and register for temporary advances to staff, contractors, suppliers, register for advance to voluntary agencies etc., were not maintained by the SCOVA or DHSs. ii) Some sample CHCs did not maintain the cash book. In some other facilities, combined cash book was being maintained, in which NRHM transactions were also being recorded. iii) The annual accounts of the SHS were to be submitted to the Ministry by 31st July of the succeeding financial year, but were not submitted in time for any of the years. Accounts of 2005-06 and 2006-07 were submitted on 12th October 2006 and 3rd January 2008 respectively. The accounts for the year 2007-08 had not been submitted till October 2008.
West Bengal	The audited accounts of SHS for the years 2005-06 and 2006-07 and accounts of DHSs and RKSs were not submitted to the Principal Accountant General (Audit).
Chandigarh	i) The value of drugs/equipment received directly from central store of the Ministry was not recorded in the stock registers. ii) The account of expenditure for IEC under RNTCP-II/NLEP programmes for the period 2005-08 was not in consonance with the records of trainees/participants. iii) IEC material worth Rs. 0.41 lakh under NPCB was not taken into the stock register. Further, items shown as issued in the stock register were issued without obtaining indents.

Infrastructure Development and Capacity Building

Annex 6.1
(Refers to paragraph 6.2)
Delay in completion of works as of March 2008: State specific audit findings

(Rs. in crore)

State/UT	Audit findings	Amount involved
Andhra Pradesh	▪ Work on upgradation of only 77 out of 151 Comprehensive Emergency Obstetric and Neonatal Care (CEMONC) Centres attached to CHCs, taken up by Andhra Pradesh Health Medical Housing and Infrastructure Development Corporation (APHMHIDC) in 2006-07, had been completed.	31.62
	▪ Construction of 14 out of 38 birth waiting homes in tribal areas started in 2007-08 remained incomplete.	1.76
Assam	▪ Out of 404 works of construction of Sub Centres taken up in 2006-07, none had been completed.	9.99
	▪ SHS released Rs. 143.15 crore to executing agencies such as State PWD, Assam State Housing Board and the District Collector (DC) for civil works. Out of 918 sanctioned works, only 82 were complete involving Rs. 8.74 crore. The utilisation position of the remaining amount was not available with the SHS.	NA
Jammu & Kashmir	▪ Upgradation of 69 CHCs to IPHS - Work on 13 CHCs with estimated cost of Rs. 191.16 lakh started in first quarter of 2006 was completed but only 4 works at a cost of Rs. 48.72 lakh had been handed over as of March 2008. Construction on 4 works with estimated cost of Rs. 72.25 lakh was held up due to change of site/design and land dispute etc.	8.68
	▪ Funds for upgradation of sub district hospitals received during 2007-08 were lying unspent with the Director, Health Services.	20.00
Madhya Pradesh	▪ Only four works of Rs.46.71 lakh had been completed and handed over out of the 94 works for which advances were given to government agencies.	9.42
Rajasthan	▪ Construction work of 269 buildings could not be started as of June 2008 due to land disputes.	17.92
Jharkhand	▪ Funds drawn by Additional Chief Medical Officer (ACMO), Ranchi for construction of labour rooms remained unutilised (RCH II).	0.91
	▪ Funds allotted for strengthening of Sub Centres, APHCs and PHCs remained unutilised with ACMO, Ranchi, DHS, Hazaribagh, DC, Ramgarh and State Building Construction Department.	12.61
	▪ Entire amount of Rs. 33.72 crore received from the Ministry for upgradation of CHCs and PHCs remained unspent at the SHS (Rs. 27.32 crore) and two district boards (Rs. 6 crore).	33.72
Kerala	▪ Out of upgradation of 54 CHCs, the work for which a Central PSU had received advance remained incomplete. In respect of 30 CHCs, work had not even started as of March 2008.	4.12
Tripura	▪ Work on six out of nine CHCs for upgradation to IPHS, renovation of six out of seven Sub Divisional Health Centres and 13 out of 19 PHCs taken up during 2006-07 remained incomplete, resulting in unspent balance with executing officers.	1.31
Tamil Nadu	▪ Rs. 9.82 crore was received by the audited DHS for infrastructure development, out of which 14 civil works were sanctioned. Out of these 14 sanctioned works, seven were in progress, while seven had been stopped due to insufficient funds.	9.82
Uttarakhand	▪ Funds were released to the construction agencies for 64 works without ensuring availability of land resulting in blocking of funds for periods up to 4 years.	12.41
Puducherry	▪ SHS received Rs. 2.06 crore for creation and upgradation of infrastructure of health centres, out of which Rs. 1.86 crore remained unspent.	1.86

Infrastructure Development and Capacity Building

Annex 6.2

(Refers to paragraph 6.2)

Irregularities in civil works: State specific audit findings

(Rs. in crore)

State	Nature of irregularities	Amount involved
Orissa	SHS released Rs. 45.80 crore for upgrading CHCs to IPHS, to Zilla Swasthya Samitees (ZSSs) during 2005-07 with an instruction to entrust the work to respective DRDAs. However, DRDAs refused to take up these works. In March 2007, the SHS instructed the ZSSs to refund the amount. However, Rs. 6.69 crore was outstanding till October 2008 with various ZSSs, and interest accrued on principal amount while these sums were in ZSS accounts were not accounted for.	6.69
	141 works with estimated cost of Rs 70.44 crore were entrusted to two State owned companies on negotiation basis with 12 per cent supervision charges, creating a liability of Rs 7.55 crore on this account. The SHS did not consider offers of Prasar Bharati (7 per cent) and NBCC (10 per cent) despite these organisations' past experience. The deviation from the lowest offer resulted in avoidable liability of Rs. 2.94 crore.	2.94
	The SHS did not follow codal provisions to safeguard the public funds as two executing agencies were allowed contingencies and charges for quality control at varied rates of two to five per cent of estimated cost of works. No such charges were claimed by the third PSU (OPHC).	0.59
	In 17 cases of construction of 59 quarters for health staff with estimated cost of Rs 7 crore, 15 to 20 per cent supervision charges were allowed to the State Rural Works Divisions. Such charges were not payable for Government works.	0.97
	The advance of Rs.17.68 crore was given to the State PSUs, on the basis of rough cost estimates based on plinth area, seven months to one year prior to preparation and administrative approval of the estimates which was in contravention to the State Finance Department's directives.	-NA-
	The execution of 41 works was entrusted to a State PSU. The company did not have the minimum technical manpower (civil degree engineers) required in the agreement and hence, could not prepare any estimate as of October 2008. The works were to be completed within '8 to 12 months' of according administrative approval or handing over of site whichever was earlier. However, no penal provision was made in the contract for the delays.	2.05
	Interest accrued on advances up to March 2008 had not been refunded by two executing agencies. One agency (OSIC) retained Rs 1 crore in the current account and lost the opportunity to earn interest on the same.	0.14
Assam	In DHS, Lakhimpur eight civil works were awarded to contractors and advances were paid without inviting tenders.	0.13
	Funds were sanctioned for strengthening the infrastructure of the existing health centres on a single design approved for all works without taking into account the status of the existing infrastructure at the centres.	48.14
Andhra Pradesh	Funds released in October 2006 to Municipal Corporation, Nellore for establishment of an Urban Health Centre and First Referral Unit in Nellore town were deposited in bank as FDR. However, the Municipal Corporation, Nellore furnished the Utilisation Certificate for the entire amount in June 2008.	0.74
Bihar	Funds sanctioned for renovation of PHCs and construction of diagnostic centres were diverted for repairing staff quarters.	1.63
	Funds were released for construction of diagnostic centres in seven non-functional PHCs where neither indoor nor outdoor facilities were available. Out of these seven units, at two units construction was completed at a cost of Rs 46 lakh, but the facility remained non-functional.	1.48
	Funds were spent on strengthening the infrastructure of the existing health centres on a single design approved for all works without taking into account the status of the existing infrastructure at the centres.	4.68

State	Nature of irregularities	Amount involved
Haryana	Funds were spent on strengthening the infrastructure of the existing health centres on a single design approved for all works without taking into account the status of the existing infrastructure at the centres.	0.31
Jammu & Kashmir	Work was awarded to Government department (PWD) and State corporations without a contract. The Director Health Services, Jammu advanced the funds to the executing agencies without involving District Health Societies.	20.00
	Equipment of Rs 1.13 crore were purchased from funds received for infrastructure improvement at district/sub district hospitals. Rs. 1.67 crore continued to be unspent with the Director Health Services.	2.80
Maharashtra	DHSs of Pune, Yavatmal and Gondia received funds for strengthening of nursing schools. Rs. 1.12 crore remained unutilised as there was no nursing school in these districts, while Rs. 2.95 lakh was used for purchase of linen and furniture and payment of stipend.	1.15
Madhya Pradesh	In 90 works, advances were not adjusted/recovered from the Government agencies, viz. PWD and RES.	8.95
Punjab	Funds received for upgradation of CHCs to IPHS were spent on upgradation of three Sub District Hospitals and one PHC.	0.66
	Funds received for providing 24 hours delivery service at PHCs were utilised for strengthening of CHCs.	0.42
Tripura	Funds were sanctioned for strengthening of the infrastructure of the existing health centres on a single design approved for all works without taking into account the status of the existing infrastructure at the centres.	8.87
Uttar Pradesh	SHS awarded the work of upgradation of 50 CHCs in 37 districts to three state owned construction agencies and released advances without inviting tenders.	53.53
	During 2005-06, SHS Uttar Pradesh spent Rs. 65.59 crore for upgradation of 50 First Referral Units, but had no information on their operationalisation. In three audited districts the FRUs were not operational for want of necessary medical and paramedical staff and establishment of blood storage facility etc.	65.59

Infrastructure Development and Capacity Building

Annex 6.3
(Refers to paragraph 6.4)
Status of shortfall in health centres, infrastructure targetted and infrastructure created and works in progress

States	Shortfall in health centres			Infrastructure required to be created by 2007			Infrastructure created and handed over			Works in progress		
	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC
Andhra Pradesh	303	527	450	91	158	135	Information not reported					
Assam	1428	338	180	428	101	54	248	307	14	404	0	0
Bihar	7742	1126	760	2323	338	228	Information not provided by the SHS.					
Chhattisgarh	5750	766	191	1725	230	57	1742	345	56	106	59	20
Gujarat	0	94	45	0	28	14	0	1	1	31	12	0
Haryana	573	93	43	172	28	13	0	0	0	4	42	4
Himachal Pradesh	0	0	3	0	0	1	0	0	7	0	0	0
Jammu & Kashmir	1474	114	36	442	34	11	0	0	0	0	0	0
Jharkhand	2761	1005	380	828	302	114	0	0	0	0	0	0
Karnataka	0	0	48	0	0	14	0	0	0	0	0	0
Kerala	0	0	82	0	0	25	0	0	0	0	0	0
Madhya Pradesh	1309	487	66	393	146	20	0	0	0	0	0	0
Maharashtra	2627	394	95	788	118	29	18	0	0	0	0	0
Manipur	118	13	6	35	4	2	0	0	0	0	0	0
Meghalaya	144	0	0	43	0	0	2	0	0	0	0	0
Orissa	2520	83	158	756	25	47	5	0	0	0	0	0
Punjab	361	53	6	108	16	2	0	0	0	0	0	0
Rajasthan	4626	843	336	1388	253	101	355	0	50	0	0	0
Tamil Nadu	516	501	0	155	150	0	0	0	0	0	0	0
Tripura	384	19	6	115	6	2	0	0	1	60	4	3
Uttarakhand	1260	200	66	378	60	20	192	32	9	330	61	40
Uttar Pradesh	6669	676	968	2001	203	290	0	0	0	0	0	0
West Bengal	3388	1277	273	1016	383	82	0	0	0	0	0	0
D & N Haveli	13	2	1	4	1	0	0	0	0	0	0	0
Daman & Diu	15	2	1	5	1	0	0	0	0	0	0	0
Lakshadweep	6	0	0	2	0	0	0	0	0	0		0
Total	43987	8613	4200	13196	2585	1261	2562	685	138	935	178	67

(Source: Information provided by SHSs)

Infrastructure Development and Capacity Building

Annex 6.4
(Refers to paragraph 6.5.1)
Shortfall in availability of buildings for health centres

Health centres without a building	Sub Centres	Bihar (39), Gujarat (10), Karnataka (42), Maharashtra (12), Manipur (11), Madhya Pradesh (46), Orissa (34), Punjab (4), Tripura (16) and West Bengal (2)
	PHCs	Bihar (14), Jharkhand (1), Orissa (3) and Uttarakhand (1)
Health centres not running in a government building	Sub Centres	Andhra Pradesh (62), Arunachal Pradesh (9), Assam (3), Bihar (6), Chhattisgarh (17), Chandigarh (1), Daman Diu (1), Delhi (7), Gujarat (7), Haryana (13), Himachal Pradesh (8), Jammu & Kashmir (27), Jharkhand (13), Karnataka (18), Kerala (12), Lakshadweep (3), Maharashtra (21), Manipur (11), Madhya Pradesh (24), Orissa (29), Punjab (13), Rajasthan (10), Sikkim (2), Tamil Nadu (28), Tripura (14), Uttar Pradesh (42), Uttarakhand (13), West Bengal (21)
	PHCs	Andhra Pradesh (4), Bihar (6), Chhattisgarh (5), Gujarat (2), Haryana (3), Himachal Pradesh (5), Jammu & Kashmir (7), Jharkhand (4), Karnataka (2), Kerala (3), Maharashtra (5), Madhya Pradesh (8), Orissa (3), Punjab (2), Rajasthan (10), Uttar Pradesh (10), Tamil Nadu (3)
	CHCs	Gujarat (1), Jammu & Kashmir (1), Maharashtra (3), Rajasthan (2)
Health centres running in a dilapidated building	Sub Centres	Assam (11), Bihar (12), Delhi (2), Haryana (13), Himachal Pradesh (23), Jammu & Kashmir (17), Jharkhand (13), Maharashtra (41), Madhya Pradesh (36), Meghalaya (2), Orissa (5), Punjab (9), Rajasthan (12), Uttar Pradesh (12), West Bengal (4), Tamil Nadu (5)
	PHCs	A & N Islands (1), Andhra Pradesh (1), Bihar (4), Chhattisgarh (1), Delhi (2), Haryana (2), Himachal Pradesh (11), Jammu & Kashmir (7), Jharkhand (7), Maharashtra (13), Madhya Pradesh (10), Punjab (3), Rajasthan (5), Uttar Pradesh (11), West Bengal (7), Tamil Nadu (1)
	CHCs	Bihar (5), Haryana (1), Himachal Pradesh (9), Jammu & Kashmir (5), Uttar Pradesh (3)

(Source: Information collected from health centres)

Infrastructure Development and Capacity Building

Annex 6.5

(Refers to paragraph no. 6.5.2)

State wise data on hygiene and sanitation at sample health centres

States	Bad milieu/ surroundings			Poor cleanliness			No separate utilities for men and women			Absence of water supply			Absence of water storage			Absence of sewerage			Absence of medical waste disposal		
	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC	SC	PHC	CHC
A & N Islands	Nil	Nil	Nil	Nil	Nil	Nil	16	Nil	Nil	1	Nil	Nil	Nil	Nil	Nil	16	8	4	16	Nil	Nil
Andhra Pradesh	Nil	Nil	Nil	Nil	Nil	Nil	63	12	4	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Arunachal Pradesh	Nil	Nil	Nil	10	6	4	40	20	2	Nil	Nil	Nil	20	Nil	Nil	Nil	Nil	Nil	40	13	Nil
Assam	Nil	Nil	Nil	10	5	Nil	46	21	7	58	Nil	Nil	58	9	1	58	10	Nil	58	29	11
Bihar	41	24	7	72	30	5	72	36	10	70	31	Nil	72	32	11	72	34	10	72	36	12
Chandigarh	Nil	Nil	Nil	Nil	Nil	Nil	1	Nil	Nil	1	Nil	Nil	1	Nil	Nil	1	Nil	Nil	1	Nil	Nil
Chhattisgarh	6	5	2	10	2	Nil	32	14	2	23	6	Nil	30	12	3	Nil	5	Nil	13	4	Nil
DNH	Nil	Nil	Nil	Nil	Nil	Nil	7	Nil	Nil	3	Nil	Nil	6	1	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Delhi	4	8	3	1	Nil	Nil	Nil	Nil	Nil	5	Nil	Nil	5	1	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Gujarat	5	3	2	7	Nil	Nil	Nil	10	2	7	3	Nil	29	5	Nil	Nil	1	Nil	24	1	3
Haryana	7	1	Nil	28	10	5	48	23	11	31	`1	Nil	35	1	Nil	48	21	9	48	24	12
Himachal Pradesh	2	Nil	1	5	3	2	36	13	3	6	1	Nil	36	18	9	Nil	18	9	36	18	9
Jammu & Kashmir	3	Nil	Nil	13	6	Nil	43	15	5	35	9	1	45	15	7	45	12	5	45	22	12
Jharkhand	1	1	Nil	16	3	Nil	34	19	Nil	27	13	Nil	34	16	Nil	34	15	Nil	33	17	Nil
Karnataka	12	4	2	34	4	Nil	62	23	2	28	1	Nil	63	16	Nil	Nil	3	Nil	40	36	14
Kerala	3	1	1	8	Nil	Nil	35	9	2	14	Nil	Nil	34	1	1	Nil	1	Nil	27	Nil	5
Lakshadweep	Nil	Nil	Nil	Nil	Nil	Nil	4	1	1	Nil	Nil	Nil	3	Nil	Nil	4	Nil	Nil	4	Nil	Nil
Maharashtra	4	1	Nil	8	3	Nil	44	16	7	25	Nil	Nil	69	18	5	Nil	6	Nil	42	Nil	Nil
Manipur	Nil	Nil	Nil	Nil	Nil	Nil	16	14	Nil	27	14	5	27	14	3	27	14	5	27	14	5
Meghalaya	2	1	3	5	Nil	Nil	Nil	12	7	12	6	1	27	15	5	Nil	3	2	22	Nil	1
Madhya Pradesh	30	5	1	10	6	4	70	25	6	Nil	Nil	Nil	Nil	Nil	Nil	35	12	Nil	60	Nil	Nil
Mizoram	3	Nil	Nil	1	Nil	Nil	18	Nil	Nil	14	3	Nil	8	2	Nil	10	4	Nil	18	6	3
Orissa	1	Nil	Nil	38	05	01	60	29	Nil	26	11	04	60	27	04	60	29	06	60	30	15
Puducherry	Nil	Nil	Nil	Nil	Nil	Nil	11	3	1	2	Nil	Nil	12	Nil	Nil	Nil	Nil	Nil	5	2	1
Punjab	9	6	2	4	1	Nil	36	11	Nil	22	1	Nil	32	8	1	32	2	Nil	35	12	3
Rajasthan	5	6	Nil	Nil	2	1	62	22	6	12	4	Nil	61	21	6	Nil	6	3	51	6	4
Tamil Nadu	6	1	Nil	10	Nil	Nil	58	8	6	4	Nil	Nil	55	1	1	60	Nil	2	32	2	1
Tripura	Nil	Nil	Nil	8	Nil	Nil	35	07	03	22	01	Nil	36	06	Nil	36	06	01	36	02	03

Uttar Pradesh	8	1	Nil	14	Nil	1	72	32	7	9	7	2	72	21	1	42	8	1	72	24	16
Uttarakhand	1	Nil	Nil	Nil	Nil	1	29	8	5	16	3	1	24	10	2	30	2	1	23	4	1
West Bengal	6	1	Nil	10	5	1	58	28	3	29	6	Nil	54	17	Nil	58	21	Nil	60	30	11
Total	159	69	24	322	91	25	1108	431	102	529	120	14	1008	287	60	688	241	58	1000	332	142

(Source: Information collected from health centres)

Infrastructure Development and Capacity Building

Annex 6.6

(Refers to paragraph No. 6.5.3)

State wise data on lack of basic infrastructural support at sample health centres

States	No telephone			No electricity			No generator		No vehicle		No computer	
	SC	PHC	CHC	SC	PHC	CHC	PHC	CHC	PHC	CHC	PHC	CHC
Andhra Pradesh	65	20	5	0	0	0	13	6	29	5	0	15
Arunachal Pradesh	40	13	0	37	5	0	13	0	14	8	20	8
Assam	58	16	9	58	1	0	15	2	19	0	17	6
Bihar	72	29	2	72	31	0	30	3	35	9	35	10
Chhattisgarh	36	16	2	0	1	0	18	4	15	0	18	2
Gujarat	37	2	0	0	1	0	8	4	7	1	0	3
Haryana	48	2	0	23	0	0	15	5	15	3	8	0
Himachal Pradesh	36	17	0	3	1	0	18	8	15	0	18	0
Jammu & Kashmir	45	22	5	38	1	0	15	0	10	7	21	2
Jharkhand	34	15	NA	34	15	NA	8	NA	17	NA	20	NA
Karnataka	72	7	0	53	1	0	27	2	24	1	36	6
Kerala	36	13	0	14	0	0	18	5	18	0	7	0
Madhya Pradesh	70	28	1	22	0	0	26	1	28	4	35	0
Maharashtra	68	21	4	45	1	0	7	3	3	0	19	5
Manipur	27	14	3	0	0	0	14	0	11	0	0	0
Meghalaya	DNA	20	7	22	1	0	19	6	14	5	DNA	13
Mizoram	18	2	0	8	2	0	6	2	4	0	6	3
Orissa	60	29	0	24	8	0	30	7	29	8	29	1
Punjab	48	16	0	13	0	0	17	0	20	0	23	0
Rajasthan	0	3	0	50	3	1	33	8	35	8	34	9
Sikkim	0	0	0	0	0	0	6	3	0	0	0	0
Tamil Nadu	0	0	0	4	0	0	0	1	14	1	1	0
Tripura	36	5	1	29	1	0	17	3	1	0	13	3
Uttarakhand	30	8	2	5	1	1	10	2	10	1	12	0
Uttar Pradesh	72	23	13	59	10	0	19	1	23	2	24	12
West Bengal	60	30	0	42	9	0	29	7	30	0	30	0
A & N Islands	16	0	0	0	0	0	0	0	1	0	0	0
Chandigarh	3	0	0	0	0	0	0	2	0	2	0	0
D & N Haveli	7	0	0	0	0	0	0	1	0	0	2	0
Delhi	6	4	0	0	0	0	8	0	0	9	7	0
Lakshadweep	3	0	0	0	0	0	0	1	0	0	1	1
Puducherry	4	0	0	2	0	0	7	0	0	0	10	1
Total	1107	375	54	657	93	2	446	87	441	74	446	100

(Source: Information collected from health centres)

DNA- Data not available

Infrastructure Development and Capacity Building

Annex 6.7

(Refers to paragraph 6.6.2)

Status of essential obstetric care facilities

States where none of the health centres had adequate supply of Kit A and Kit B	Haryana, Bihar, Himachal Pradesh Jammu & Kashmir, Madhya Pradesh, Punjab Sikkim, Uttar Pradesh, Manipur, Mizoram and Uttarakhand
States where some of the health centres had adequate supply of kit A and kit B	Gujarat-6, Jharkhand-7, Rajasthan-14, Puducherry-30, Andaman & Nicobar-12, West Bengal-60, Lakshadweep-4
States where none of the health centres had equipment for neonatal resusciation	Uttar Pradesh, Bihar, Sikkim, West Bengal and Uttarakhand
States where some of the health centres had equipment for neonatal resusciation	Assam-20, Jammu & Kashmir-2, Orissa-8, Punjab-4 , Jharkhand-7
States where none of the CHCs had been upgraded to FRU	Andaman & Nicobar, Bihar, Dadra & Nagar Haveli, Kerala, Madhya Pradesh, Mizoram, Orissa, Puducherry, Tamil Nadu, Tripura, West Bengal and Sikkim
States where some of the CHCs had been upgraded to FRU	Haryana-45, Andhra Pradesh-151, Assam-30, Chhattisgarh-94, Gujarat-101, Himachal Pradesh-36, Jammu & Kashmir-24, Manipur-13, Maharashtra-123, Punjab-75, Rajasthan-237, Uttar Pradesh-52, Uttarakhand -26
States where none of the CHCs had facilities for caesarian section	Andaman & Nicobar, Bihar, Dadra & Nagar Haveli, Himachal Pradesh, Meghalaya, Mizoram, Tamil Nadu, Tripura and Uttar Pradesh
States where some of the CHCs had facilities for caesarian section	Haryana-4, Andhra Pradesh-6, Madhya Pradesh-6, Puducherry-3, Assam-10, Chhattisgarh-4, Gujarat-6, Jammu & Kashmir-2, Maharashtra-6, Punjab-5, Rajasthan-8, Manipur-2, Kerala-3, Sikkim-2, Orissa-8, West Bengal-1, Uttarakhand-1

(Source: Information collected from health centres and information provided by SHSs)

Infrastructure Development and Capacity Building

Annex 6.8
Refers to Paragraph 6.6.5

A - Status of cold chain equipment in CHCs

Name of the State/UT	No. of audited CHCs	No. of CHCs with cold chain equipment		
		Ice lined freezers	Refrigerators	Deep freezers
Madhya Pradesh	18	15	13	18
Rajasthan	18	16	16	18
Uttarakhand	9	8	7	9
Chhattisgarh	9	8	6	8
Jammu & Kashmir	12	10	8	11
Manipur	5	2	5	3
Meghalaya*	13	13	3	13
Mizoram	3	3	3	3
Himachal Pradesh	9	9	8	9
Sikkim	3	3	1	3
Andaman & Nicobar*	4	4	4	4
Chandigarh	2	1	1	2
Gujarat	12	11	9	9
Haryana	12	11	9	12
Karnataka	18	18	14	18
Kerala	9	9	9	7
Puducherry	4	4	4	4
Punjab	12	12	11	11
Tamil Nadu	15	15	15	15
West Bengal	15	15	10	14
Uttar Pradesh	18	18	0	18
Total	220	205	156	209

***CHCs in audited districts**

B - Status of cold chain equipment in PHCs

Name of the State/UT	No. audited PHCs	No. of PHCs with cold chain equipment		
		Ice lined freezers	Refrigerators	Deep freezers
Uttarakhand	13	12	12	2
Chhattisgarh	18	7	2	8
Jammu & Kashmir	22	10	0	3
Manipur	15	0	14	8
Himachal Pradesh	18	8	4	11
Sikkim	6	6	6	6
Andaman & Nicobar	8	8	8	8
Kerala	18	1	5	2
Punjab	24	15	9	17
Tamil Nadu	30	30	30	30
Jharkhand	9	9	0	9
Uttar Pradesh	36	4	0	4
Total	217	110	90	104

(Source: Information collected from health centres)

Infrastructure Development and Capacity Building

Annex 6.9
(Refers to paragraph 6.7.1)
Staff status at Sub centres

States	No. of Sub Centres without prescribed staff					
	Two ANMs	Per cent	One ANM	Per cent	MPW	Per cent
Andhra Pradesh	12	17	0	0	35	49
Assam	30	52	0	0	52	90
Bihar	50	69	9	13	72	100
Chhattisgarh	35	97	1	3	16	44
Gujarat	44	92	4	8	16	33
Haryana	24	50	0	0	24	50
Himachal Pradesh	36	100	11	31	2	6
Jammu & Kashmir	38	84	1	2	13	19
Jharkhand	16	44	2	6	25	69
Karnataka	72	100	10	14	49	89
Kerala	30	83	8	22	22	61
Madhya Pradesh	70	100	11	16	46	66
Maharashtra	55	82	4	6	19	26
Manipur	27	100	7	26	19	70
Meghalaya	30	100	0	0	0	0
Mizoram	0	0	0	0	0	0
Orissa	52	87	6	10	43	72
Punjab	42	88	4	8	17	35
Rajasthan	61	85	14	19	68	94
Sikkim	12	100	0	0	0	0
Tamil Nadu	60	100	0	0	44	74
Tripura	8	22	5	14	19	53
Uttarakhand	27	90	3	10	22	73
Uttar Pradesh	72	100	8	11	72	100
West Bengal	60	100	2	3	27	45
A & N Islands	11	70	4	25	15	93
Chandigarh	6	75	0	0	8	100
D & N Haveli	3	43	2	29	4	57
Daman & Diu	5	83	0	0	0	0
Lakshadweep	4	100	0	0	4	100
Puducherry	0	0	0	0	22	100
Total	992	77	116	9	775	60

(Source: Information collected from health centres)

Infrastructure Development and Capacity Building

Annex 6.10

(Refers to paragraph 6.7.2)

Staff status at PHCs- Number of PHCs without prescribed staff

States	Medical Officer	Per cent	AYUSH Doctor	Per cent	3 Staff Nurses	Per cent	1 Staff Nurse	Per cent	Nurse Midwife	Per cent	Lab Technician	Per cent	Pharmacist	Per cent	LHV	Per cent
Andhra Pradesh	0	0	36	100	34	94	7	19	9	25	12	33	4	11	15	42
Assam	0	0	18	62	17	59	1	3	DNA	DNA	3	10	3	10	20	69
Bihar	13	36	33	92	36	100	36	100	DNA	DNA	33	92	31	86	34	94
Chhattisgarh	3	17	17	94	16	89	15	83	7	39	12	67	10	56	18	100
Gujarat	1	4	20	84	24	100	12	50	DNA	DNA	8	33	7	29	DNA	DNA
Haryana	7	29	24	100	16	67	12	50	DNA	DNA	10	42	5	21	12	50
Himachal Pradesh	7	39	18	100	18	100	12	67	18	100	12	67	7	39	18	100
Jammu & Kashmir	6	27	12	55	20	91	3	14	17	77	6	27	0	0	22	100
Jharkhand	4	17	23	96	19	79	18	75	5	21	15	63	18	75	11	46
Karnataka	3	8	24	67	29	64	6	17	DNA	DNA	8	22	6	17	9	25
Kerala	0	0	18	100	16	89	7	39	16	89	17	94	2	11	15	83
Madhya Pradesh	10	29	35	100	35	100	24	69	DNA	DNA	23	66	16	46	9	26
Maharashtra	0	0	DNA	DNA	32	89	23	64	DNA	DNA	17	47	0	0	0	0
Manipur	2	14	2	14	13	93	5	36	4	29	3	21	2	14	14	100
Meghalaya	2	9	18	82	22	100	2	9	DNA	DNA	3	14	2	9	DNA	DNA
Mizoram	1	16	6	100	2	33	0	0	DNA	DNA	4	66	0	0	6	100
Orissa	6	20	29	97	30	100	27	90	18	60	28	93	19	63	30	100
Punjab	3	13	24	100	20	83	12	50	4	17	14	58	0	0	0	0
Rajasthan	0	0	30	83	36	100	8	22	11	31	20	56	35	97	12	33
Sikkim	0	0	6	100	6	100	6	100	0	0	3	50	5	83	1	17
Tamil Nadu	0	0	26	87	12	40	12	40	0	0	20	67	0	0	0	0
Tripura	0	0	18	100	3	17	0	0	6	33	0	0	1	6	DNA	DNA
Uttarakhand	3	23	12	92	11	85	9	69	DNA	DNA	10	77	4	31	4	31
Uttar Pradesh	0	0	35	97	36	100	21	58	36	100	18	50	4	11	36	100
West Bengal	0	0	23	77	22	73	6	20	24	80	29	97	8	27	24	80
A & N Islands	0	0	6	75	0	0	0	0	0	0	0	0	0	0	0	0
D & N Haveli	0	0	1	50	2	100	0	0	0	0	0	0	0	0	0	0

States	Medical Officer	Per cent	AYUSH Doctor	Per cent	3 Staff Nurses	Per cent	1 Staff Nurse	Per cent	Nurse Midwife	Per cent	Lab Technician	Per cent	Pharmacist	Per cent	LHV	Per cent
Daman & Diu	0	0	2	67	1	33	1	33	2	66	0	0	0	0	0	0
Lakshadweep	0	0	2	100	2	100	0	0	2	100	0	0	0	0	2	100
Puducherry	0	0	DNA	DNA	5	30	0	0	0	0	8	62	2	15	0	0
Total	71	11	518	86	535	82	285	44	179	46	336	52	191	29	312	53

(Source: Information collected from health centres)

DNA: Data not available

Annex 6.11
(Refers to paragraph 6.7.3)
Status of specialist doctors at CHCs

States	No. of CHCs without prescribed specialist doctors									
	General Physician	Per cent	General Surgeon	Per cent	Obstetrician Gynaecologist	Per cent	Paediatrician	Per cent	Anaesthetist	Per cent
Andhra Pradesh	14	78	14	78	12	67	14	78	17	95
Assam	6	43	12	86	10	71	13	93	12	86
Bihar	11	92	9	75	11	92	12	100	12	100
Chhattisgarh	8	89	3	33	8	89	7	78	9	100
Gujarat	11	92	10	83	11	92	11	92	12	100
Haryana	11	92	11	92	11	92	10	83	10	83
Himachal Pradesh	9	100	9	100	9	100	9	100	9	100
Jammu & Kashmir	6	50	9	75	10	83	7	58	9	75
Karnataka	12	67	8	44	7	39	8	44	11	61
Kerala	7	78	2	22	6	67	8	89	8	89
Madhya Pradesh	16	89	16	89	15	83	16	89	18	100
Maharashtra	17	94	12	67	12	67	14	78	14	78
Manipur	0	0	5	100	5	100	5	100	5	100
Meghalaya	11	85	13	100	13	100	13	100	13	100
Mizoram	0	0	3	100	3	100	3	100	3	100
Orissa	14	93	9	60	4	27	10	67	15	100
Punjab	8	67	4	33	6	50	5	42	10	83
Rajasthan	4	22	7	39	12	67	16	89	18	100
Sikkim	0	0	2	67	2	67	2	67	2	67
Tamil Nadu	15	100	15	100	15	100	15	100	15	100
Tripura	0	0	3	100	3	100	3	100	3	100
Uttarakhand	8	89	8	89	8	89	4	44	8	89
Uttar Pradesh	11	61	14	78	13	72	11	61	14	78
West Bengal	15	100	15	100	11	73	12	80	13	87
A & N Islands	0	0	4	100	4	100	4	100	4	100
Chandigarh	0	0	0	0	0	0	0	0	1	50
D & N Haveli	1	100	1	100	1	100	1	100	1	100
Lakshadweep	2	100	2	100	2	100	2	100	2	100
Puducherry	2	50	4	100	2	50	1	25	4	100
Total	219	72	224	74	226	74	236	78	272	89

(Source: Information collected from health centres)

Infrastructure Development and Capacity Building

Annex 6.12
(Refers to paragraph 6.7.3)
Staff status at CHCs

States/UTs	CHCs without prescribed staff											
	9 Staff Nurses	Per cent	5 Staff Nurses	Per cent	1 Staff Nurse	Per cent	Radio logist	Per cent	Pharm acist	Per cent	Lab technician	Per cent
Andhra Pradesh	14	78	6	33	1	6	18	100	1	6	3	17
Assam	9	64	1	7	1	7	6	43	1	7	3	21
Bihar	12	100	12	100			7	58	7	58	9	75
Chhattisgarh	9	100	8	89	1	11	4	44	3	33	1	11
Gujarat	11	92	1	8	0	0	5	42	4	33	2	17
Haryana	5	41	4	34	3	25	6	50	4	33	5	42
Himachal Pradesh	9	100	5	56	0	0	9	100	2	22	0	0
Jammu & Kashmir	10	83	4	33	1	5	11	92	0	0	2	17
Karnataka	11	61	5	28	0	0	10	56	3	17	8	36
Kerala	3	33	1	11	0	0	8	89	1	11	1	11
Madhya Pradesh	18	100	16	89	1	6	6	33	5	28	1	6
Maharashtra	16	89	4	22	1	6	15	83	1	6	3	17
Manipur	2	40	2	40	2	40	3	60	1	20	1	20
Meghalaya	11	85	7	54	0	0	13	100	0	0	1	8
Mizoram	3	100	1	33	0	0	1	33	0	0	0	0
Orissa	15	100	11	73	1	7	15	100	2	15	4	27
Punjab	11	92	5	42	0		12	100	0	0	0	0
Rajasthan	16	89	11	61	0	0	14	78	17	94	3	17
Sikkim	2	66	0	0	0	0	2	67	2	67	0	0
Tamil Nadu	15	100	12	80	0	0	7	48	0	0	3	20
Tripura	3	100	0	0	0	0	1	33	0	0	0	0
Uttarakhand	8	89	8	89	1	11	6	67	1	11	5	56
Uttar Pradesh	18	100	14	78	1	6	10	56	0	0	4	22
West Bengal	12	80	5	33	0	0	15	100	0	0	1	7
A & N Islands	0	0	0	0	0	0	4	100	0	0	0	0
Chandigarh	0	0	0	0	0	0	1	50	0	0	0	0
Lakshadweep	2	100	2	100	0	0	0	0	0	0	0	0
Puducherry	0	0	0	0	0	0	0	0	0	0	0	0
Total	245	81	145	48	14	5	209	69	55	18	60	20

(Source: Information collected from health centres)

Infrastructure Development and Capacity Building

Annex 6.13
(Refers to paragraph 6.10 & 6.10.1)

A. Engagement of ASHAs: State specific cases

Himachal Pradesh	Against the requirement of 7750 ASHAs, 2393 had been selected but none of them were appointed. The SHS and DHSs incurred expenditure of Rs. 31.77 lakh on selection of ASHAs, procurement of drug kits (lying idle), printing of booklet and IEC, which remained unfruitful. Rs. 3.28 crore received from the Ministry for ASHA remained unutilised at SHS and DHSs.
Karnataka	During 2006-07, the SHS received Rs. 2.93 crore from the Ministry for selection, training and mobilisation of ASHA, out of which Rs. 45 lakh was released to DHSs and Rs. 2.48 crore was lying in the bank account of the SHS. The ASHAs were not selected in the State. Further, Rs. 33.62 lakh was spent on printing reading materials/booklets for the ASHA which remained unused in the stores.
Tamil Nadu	No ASHA was engaged in the State against the target of engagement of 12,619 ASHAs in 2007-08. The Ministry had approved Rs. 8.34 lakh for engagement of ASHA in the State PIP of 2007-08.

B. Engagement of ASHAs: Inconsistency in data provided by the SHS and the DHS

State/UT	Number of ASHAs engaged in the audited districts		Difference between the SHS and DHS data
	Data provided by the SHS	Data provided by the DHSs	
Andhra Pradesh	14702	12965	1737
Assam	5324	6009	-685
Bihar	11034	11231	-197
Gujarat	2040	1228	812
Haryana	2404	2355	49
Kerala	1940	1720	220
Madhya Pradesh	5774	6034	-260
Mizoram	401	420	-19
Punjab	3330	3396	-66
Rajasthan	8452	8023	429
Uttar Pradesh	11151	11473	-322
Delhi	1190	1208	-18

C. Training of ASHAs: Inconsistency in data provided by the SHS and the DHS

State/UT	Module	Number of ASHAs trained in the audited districts		Difference between the SHS and the DHS data
		Data provided by SHS	Data provided by DHSs	
Assam	1 & 2	5324	4881	443
	3	5324	4340	984
	4	5234	955	4279
Bihar	1	10024	9907	117
Kerala	1	1940	1264	676
	2	1300	657	643
Madhya Pradesh	1	4990	5687	-697
	2	2672	3889	-1217
	3	2673	3750	-1077
	4	921	2222	-1301
Maharashtra	1	1547	2251	-704
Mizoram	1 to 4	401	391	10
Rajasthan	1	6596	6325	271
	2	6384	0	6384

State/UT	Module	Number of ASHAs trained in the audited districts		Difference between the SHS and the DHS data
		Data provided by SHS	Data provided by DHSs	
Uttar Pradesh	1	11037	10845	192
	2	7687	3479	4208
Delhi	1	785	779	6

Infrastructure Development and Capacity Building

Annex 6.14
(Refers to Paragraph 6.11)
Mobile Medical Units: State specific cases

Karnataka	SHS Karnataka received Rs. 11.37 crore from the Ministry in September 2006 for the purchase of 26 MMUs, each carrying a medically equipped vehicle and a passenger vehicle to carry medical staff, in accordance with approved PIP for 2006-07. The SHS kept the entire fund in the fixed deposit. The SHS purchased passenger vehicles of Rs. 1.47 crore for the MMUs in December 2007 and Rs. 9.87 crore remained in the FD. The SHS stated that the Mission Director has now decided to outsource the MMU services. This indicated poor planning by the SHS resulting in wasteful expenditure of Rs. 1.47 crore.
Tamil Nadu	Instead of fully equipped MMUs for 30 districts as envisaged in the PIP, 100 ambulances at the cost of 6 crore were purchased during 2007-08 without having essential drugs/equipment prescribed for MMUs.
Bihar	The MMU service was outsourced in September 2006 to a private agency which initially started mobile clinics in four districts. The MMU remained operational in those districts during June 2006 to December 2006. The SHS terminated the contract in March 2007 due to unsatisfactory delivery of services.
Manipur	The MMUs were procured but remained unutilised as of October 2008 for want of technical know how and specialist doctors.
Tripura	The MMUs were procured but remained unutilised. Expression of interest was floated in May 2008 inviting interested NGO/charitable organization to operationalise the MMUs.
Andhra Pradesh	The MMUs were not equipped as per the guidelines and BP apparatus, ECG machine, lab equipment etc. were not present in MMUs. These were consequently not providing full prescribed range of services.

Procurement and Supply of Medicine and Equipment

Annex 7.1

(Refers to paragraph 7.4.3)

Cases of excessive and infructuous purchases: State specific audit findings

(Rupees in lakh)

State	Audit findings	Amount
Maharashtra	i) As per the terms and conditions of the contract, 100 *per cent* payment was to be made only on submission of Receipt and Acceptance Certificate in the prescribed proforma from all the consignees. However payment was made to the suppliers without receipt of certificate of delivery of medicines from consignees.	188.08
	ii) Medicines were procured and distributed by State Family Welfare Bureau (SFWB) Maharashtra, Pune without requirement.	63.72
	iii) Irregular payment of Rs.14.49 lakh to the supplier without receipt of final installation certificate from the consignee.	14.49
Bihar	i) 1452133 indelible ink marker pens were purchased under pulse polio immunization programme having capacity of 300 impressions only, against the GOI norm of 600 impressions per pen. However only 473921 pens (includes 10 per cent extra) were required for the number of children immunised (1: 600 ratio of pen and children). This resulted in excess expenditure on purchase of 978212 pens.	128.00
	ii) In East Champaran district 800 plastic chairs were purchased in March 2006 without observing the purchase procedure and ensuring good quality.	2.15
Assam	i) Medicines were procured during 2006-07 though the same were not required as components of any kit.	19.94
	ii) Drugs and medicines were procured in excess of the quantity required for kit preparation resulting in excess expenditure.	8.34
	iii) Avoidable payment of central sales tax, as medicines were not purchased directly from the manufacturer.	36.16
	iii) Procurement of condom in excess of requirement resulting in extra expenditure.	19.06
	iv) 5000 beds were procured and assembled at National Games Village, Guwahati out of which 4265 beds were finally distributed to various health centres in the district level. The whereabouts of remaining 735 beds were not known.	52.94
Uttarakhand	i) AYUSH Kits supplied on the basis of sanction strength of doctors instead of actual number of doctors posted resulted in excess procurement.	101.00
	ii) 33 computers were purchased (instead of the sanctioned 40) at a higher cost with TFT monitor. As a result 7 PHCs/CHCs were deprived of computerised facilities.	2.50
Daman and Diu	Drugs procured in excess of requirement resulted in extra expenditure.	7.41
Karnataka	Against the supply order of 12 lakh immunisation cards, the firm supplied only 11.45 lakh cards while the department paid for entire 12 lakh cards. Thus, short supply of indented item resulted in extra payment.	3.56
Madhya Pradesh	ASHA kits procured in excess of requirement resulted in extra expenditure.	73.49
Chhattisgarh	i) Double the sanctioned quantity procured in October 2005 against a single sanction order resulted in extra procurement.	15.62
	ii) Payment to firms by the State Malaria Control Society without deducting commercial tax on purchase of Lab equipment/ consumables resulted in excess payment.	52.13
	iii) Neo natal care equipment procured for the hospital was diverted to other CHCs, as the items were not required at the hospital which had no Neo natal care unit.	20.51
	TOTAL	809.10

Procurement and Supply of Medicine and Equipment

Annex 7.2
(Refers to paragraph 7.6)
Utilisation of funds released for procurement at SHSs

(Rupees in lakh)

State	Year	Funds released by Central Government for procurement	Actual Expenditure	Unspent amount (% of release)
A & N Islands	2006-07	38.00	Nil	38.00 (100)
Andhra Pradesh	2007-08	1538.27	1346.88	191.39 (12.44)
Assam	2005-08	10189.52	9568.37[8]	621.15 (6.10)
Arunachal Pradesh	2005-08	1450.52	1149.90	300.62 (20.72)
Chandigarh	2005-08	61.19	24.57	36.62 (59.85)
D & N Haveli	2006-07	13.00	7.34	5.66 (43.54)
Delhi	2006-08	375.61	30.81	344.80 (91.80)
Gujarat	2005-08	2751.90	2160.99	590.91 (21.47)
Haryana	2005-08	757.66	201.26	556.40 (73.44)
Himachal Pradesh	2006-08	1122.84	969.38	153.46 (13.67)
Jharkhand	2005-08	2015.91	729.63	1286.28 (63.81)
Jammu & Kashmir	2005-07	941.45	480.65	460.80 (48.96)
Lakshadweep	2005-06	23.00	5.93	17.07 (74.22)
Madhya Pradesh	2005-08	6972.15	5721.46	1250.69 (17.94)
Maharashtra	2005-08	15847.70	3558.10	12289.60 (77.55)
Manipur	2005-08	785.65	267.11	518.54 (66.00)
Meghalaya	2006-08	666.05	457.38	208.67 (31.33)
Mizoram	2005-08	1073.98	754.57	319.41 (29.74)
Orissa	2005-08	5316.04	2068.72	3247.32 (61.09)
Puducherry	2006-08	94.17	91.04	3.13 (3.29)
Punjab	2005-08	1170.76	208.76	962.00 (82.17)
Rajasthan	2005-08	8190.15	3757.88	4432.27 (54.12)
Sikkim	2005-08	2493.00	94.00	2399.00 (96.23)
Tamil Nadu	2005-08	12123.16	4961.44	7161.72[9] (59.07)
Tripura	2006-08	186.29	80.39	105.90[10] (56.85)
Uttar Pradesh	2005-08	20989.00	3541.00	17448.00 (83.13)
Uttarakhand	2005-08	1141.71	421.35	720.36 (63.09)
West Bengal	2005-07	2606.00	1292.00	1314.00 (50.42)

(Source: Information compiled from SHS records)

[8] A substantial part of Rs.10.80 crore released for procurement of drugs in 2005-06 had been utilized for supplies made in 2007-08.
[9] Rs 5330.44 lakh was lying with procurement agencies.
[10] Rs.24.79 lakh was lying unadjusted with M/s Tamil Nadu Medical Services Corporation Limited (TNMSC)

Information, Education and Communication

Annex 8.1
(Refers to paragraph 8.1.1)
Financial irregularities in expenditure on IEC: State specific audit findings

(Rs. in crore)

State	Audit findings	Amount
Assam	IEC activities were outsourced at a cost of Rs. 1512.04 lakh to18 private agencies through 68 supply orders during 2007-08 without inviting any tender/bid to ensure competitive price in contravention to rules.	15.12
	The SHS entered into an understanding with Assam State Transport Corporation (ASTC) without execution of any formal agreement for displaying the JSY message on 200 buses for one year. The SHS released Rs. 24 lakh during 2006-07 to ASTC in two instalments at the rate Rs. 12,000 per bus. However, the ASTC did not carry out the publicity and the message was removed from buses long before the expiry of the one year period. Consequent upon the failure to re-display the message and despite requests made by the MD, NRHM to refund half of the advance, viz. Rs. 12 lakh, ASTC did not return any amount as of August 2008. The SHS failed to secure its financial interests by releasing full amount as advance in contravention to the rules.	0.24
Chhattis garh	Directorate of Health Services placed in March 2006 the work order to a private agency for 3,456 programmes of folk play and dance drama @ Rs.1940/- per programme unilaterally which was irregular and a favour to the agency, as neither the agency had quoted any rates for programmes, nor the department obtained rates from SAMVAD (an agency of the State Government dealing with publicity work) that was required under rules.	0.67
	During 2005-06 Directorate of Health Services issued work order to three Kalajatha Samitis to conduct folk dance programmes under IEC. These Samitis were required to submit the certificates from Sarpanchs of the villages or social workers, and photographs of the programmes actually held to the Directorate. The District Chief Medical & Health Officers were made responsible to execute the Kalajatha programmes in the villages under their districts and provide a certificate of proof of execution of programme. No certificate regarding conduct of programmes or photographs supporting the claim of conduct of the show was produced either by the Directorate or CMHOs in the test-checked districts. Further, while CMHOs of two test-checked districts stated that the records relating to execution of programmes were kept at State level, CMHO of one district (Kanker) stated in November 2008 that no such programmes had taken place although the work orders included 850 programmes for Kanker district involving a payment of Rs. 16.49 lakh.	4.16
	State Health Society advertised various health programmes at a cost of 4.03 lakh in various little known magazines like "Janjgir Manch", "Satwan Falak", "Rashmi Pravah", "Souvenir" and “Fight Open" and had no record regarding their circulation. The SHS stated in June 2008 that order for publicity was given in these magazines on the basis of request made by their editors and the range of circulation of the magazines was not known.	0.04
Karnataka	Expenditure was incurred for conducting health check-up camp for legislators in Bangalore in July 2007 out of the funds released for IEC activities which was irregular.	0.11
	Expenditure was incurred on 1000 umbrellas and on printing and supply of hand bills on World Population Day out of IEC funds, which did not serve any IEC objective.	0.02
	In two districts vouchers of expenditure incurred on IEC activities were not produced to audit.	0.05
	The advertisements of the NRHM were placed in magazines/souvenirs/special editions which had urban circulation. The department stated that the expenditure had been incurred as per the orders of the higher authorities.	0.02
Uttar Pradesh	Broadcasting of NRHM messages through Doordarshan and All India Radio was done through a private agency which was selected as a single source without following rules ensuring competitive selection.	8.02
Uttara khand	The NRHM message was published at a cost of Rs. 1.20 lakh in monthly magazine Vichar Mimansa, published from Bhopal, the data on circulation of which in rural areas of the State was not available.	0.01
Madhya Pradesh	During 2006-07, SHS released Rs. 889.00 lakh to the IEC Bureau. The IEC Bureau, however, had shown the receipt of Rs. 697.08 lakh and the remaining amount could not be reconciled.	1.92

Annex 9.1
Refers to Paragraph 9.3.1 a (i)
Status of registration and ante natal check-ups of pregnant women

Sl. No.	Name of the state/UT	Year	No. of total pregnancies	No. of pregnant women registered at any health centre	No. of pregnant women registered during 12 weeks of pregnancy	Percentage of women registered within 12 weeks of pregnancy	No. of registered pregnant women receiving four antenatal checkups (ANC)	Percentage of women received four ANC	No. of pregnant women not receiving any antenatal checkups	Percentage of women not received any ANC
1.	Jharkhand	2006-08	375777	375777	173901	46	77804	21	201876	53.72
2.	Madhya Pradesh	2005-08	6246000	6246000	2790000	45	2790000	45	1356000	21.71
3.	Orissa	2005-08	2643413	2643413	NA	NA	2352796	89	NA	NA
4.	Rajasthan	2005-08	6150001	5907243	2711253	46	3616654	61	NA	NA
5.	Uttar Pradesh	2005-08	19356000	16047000	16047000	100	8743000	54	500000	3.12
6.	Uttarakhand	2005-08	633506	633506	NA		NA	NA	NA	NA
7.	Chhattisgarh	2005-08	1991851	1991851	NA		1634079	82	NA	NA
8.	Assam	2005-08	2234710	1910244	1910244	100	1080270	57	324466	16.99
9.	Jammu & Kashmir	2005-08	1128696	1102246	1102246	100	420070	38	NA	NA
10.	Manipur[11]	2005-08	8609	2361	554	23	554	23	0	NA
11.	Meghalaya	2005-08	NA	237263	NA		100310	42	136953	57.72
12.	Mizoram	2006-08	NA	14583	5028	34	NA	NA	NA	NA
13.	Himachal Pradesh	2005-08	NA	465499	465499	100	351342	75		NA
14	Sikkim	2005-08	30828	17885	11598	65	11598	65	Not available	NA
15.	Arunachal Pradesh	2005-08	NA	57566	NA	NA	NA	NA	NA	NA
16	Tripura	2005-08		196502	NA	NA	NA	NA	NA	NA
17	Andaman & Nicobar	2005-08	NA	NA	NA	NA	NA	NA	NA	NA

[11] For one district only

Sl. No.	Name of the state/UT	Year	No. of total pregnancies	No. of pregnant women registered at any health centre	No. of pregnant women registered during 12 weeks of pregnancy	Percentage of women registered within 12 weeks of pregnancy	No. of registered pregnant women receiving four antenatal checkups (ANC)	Percentage of women received four ANC	No. of pregnant women not receiving any antenatal checkups	Percentage of women not received any ANC
18.	Andhra Pradesh	2005-08	NA	5489329	4394767	80	5077078	92	412250	7.51
19.	Chandigarh	2005-08	95806	92201	92201	100	65007	71		NA
20.	Dadra & Nagar Haveli	2005-08	NA	17558	5185	30	12150	69	NA	
21.	Gujarat	2005-08	4092566	4126910	2186737	53	NA	NA	1564077	37.90
22.	Haryana	2005-08	1696055	1696055	1696055	100	NA	NA	NA	NA
23.	Kerala	2005-08	1887878	1852581	1852581	100	1383435	75	35297	1.91
24.	Lakshadweep	2005-08	1102	1102	1051	95	1102	100	Nil	NA
25.	Maharashtra	2005-08	6691569	6691569	6021548	90	6691569	100	NA	NA
26.	Puducherry	2005-08	134476	134476	134476	100	134476	100	0	NA
27.	Punjab	2005-08	1508107	1508107	NA	NA	1296985	86	Nil	NA
28.	West Bengal	2005-08	4967304	4967304	NA	NA	3123726	63	Nil	NA

(Source: Figures from State Audit Reports)

Annex 9.2
(Refers to Paragraph 9.3.1 a (ii))
Administration of IFA tablets

Name of the State/UT	Year	No. of pregnant women receiving 100 days of IFA tablets	Percentage of registered pregnant received IFA tablets	Name of the State/UT	Year	No. of pregnant women receiving 100 days of IFA tablets	Percentage of registered pregnant received IFA tablets
Andhra Pradesh	**2005-06**	1,838,140	99.51	**Rajasthan**	**2005-06**	2,172,998	111.44
	2006-07	1,561,118	84.60		**2006-07**	1,952,280	100.63
	2007-08	1,439,431	80.11		**2007-08**	1,787,436	88.61
Gujarat	**2005-06**	982,548	70.64	**Sikkim**	**2005-06**	3,596	56.96
	2006-07	980,797	71.83		**2006-07**	2,642	47.73
	2007-08	902,973	65.88		**2007-08**	2,404	39.82
Himachal Pradesh	**2005-06**	147,593	93.13	**Uttar Pradesh**	**2005-06**	5,249,000	98.52
	2006-07	97,711	63		**2006-07**	2,014,000	37.60
	2007-08	112,619	74.13		**2007-08**	1,480,000	27.60
Jammu & Kashmir	**2005-06**	192,701	63.16	**Uttarakhand**	**2005-06**	191,456	85.69
	2006-07	177,323	44.83		**2006-07**	87,489	38.68
	2007-08	163,373	40.69		**2007-08**	57,262	31.14
Jharkhand	**2005-06**	N.A	NA	**West Bengal**	**2005-06**	1,481,520	97.98
	2006-07	45,793	36.96		**2006-07**	1,120,597	71.26
	2007-08	80,066	31.79		**2007-08**	1,384,850	73.56
Kerala	**2005-06**	562,603	84.37	**Haryana**	**2005-06**	737,184	134.65
	2006-07	340,988	55.94		**2006-07**	517,517	86.55
	2007-08	451,487	78.35		**2007-08**	607,568	110.34
Maharashtra	**2005-06**	1,322,687	59.16	**Madhya Pradesh**	**2005-06**	2,052,000	98.89
	2006-07	705,680	31.65		**2006-07**	1,693,000	82.38
	2007-08	1,007,441	45.25		**2007-08**	1,977,000	93.43
Puducherry	**2005-06**	18,165	44.19	**Chhattisgarh**	**2005-06**	674,427	100.24
	2006-07	15,271	33.83		**2006-07**	444,045	65.71
	2007-08	16,833	34.90		**2007-08**	557,894	85.67
Punjab	**2005-06**	597,534	112.12				
	2006-07	223,675	43.88				
	2007-08	25,041	5.38				

(Source: Data provided by SHSs)

Achievements in Healthcare

Annex 9.3
Refers to Paragraph 9.3.1 b (i)
Target and achievement for institutional deliveries under JSY

Sl. No.	Name of the State/UT	Year	Target	Achievement	Percentage shortfall/ excess (achievement)
1.	Andhra Pradesh	2005-08	4,516,000	3,865,000	14
2.	Assam	2005-08	670,414	663,429	1
3.	Chandigarh	2005-08	NA	50,207	-
4.	Dadra & Nagar Haveli	2005-08	NA	5,445	-
5.	Gujarat	2005-08	3,575,000	2,486,000	30
6.	Himachal Pradesh	2005-08	NA	163,936	-
7.	Jammu & Kashmir	2005-08	429188	349,977	18
8.	Jharkhand	2006-08	375,777	151,317	60
9.	Maharashtra	2005-08	4,911,563	3,451,231	30
10.	Mizoram	2005-08	NA	46,029	-
11.	Puducherry	2005-08	NA	72,000	-
12.	Punjab	2005-08	1,554,950	299,544	81
13.	Rajasthan	2005-07	3,690,556	3,690,556	0
14.	Sikkim	2005-08	NA	16,655	-
15.	Uttar Pradesh	2005-08	5,794,000	5,204,000	10
16.	Uttarakhand	2005-08	698,425	150,652	78
17.	West Bengal	2005-08	NA	2,113,315	-
18.	Haryana	2005-08	848,027	629,465	26
19.	Madhya Pradesh	2005-08	1,365,516	1,571,933	(15.12)
20.	Arunachal Pradesh	2005-08	NA	25,913	
21.	Tripura	2005-08	119,782	95,704	20

(Source: Information compiled from SHS records)

Annex 9.4
Refers to Paragraph 9.3.1 (b-iii)
Irregularities in payment of incentive under the JSY: State specific audit findings

Bihar	▪ Out of the cash incentive of Rs 13.75 crore paid to 1,00,192 beneficiaries during 2005-08, payment of Rs 8.72 crore was made to 62685 beneficiaries after delays ranging between 10 and 357 days. ▪ In the audited districts, during 2005-08, payments were not made to 32,575 beneficiaries during their stay at health units due to non-availability of funds. These beneficiaries did not turn up to receive the payment later. ▪ Vouchers in support of payment of transportation cost were not available in the health units. ▪ In PHC, Barhara, records like cash book, JSY payment register, vouchers etc. in support of payment made to the beneficiaries/ASHA during 2006-08 were not maintained.
Uttar Pradesh	Despite the availability of funds, cash incentive was not paid to any of the 1,48,241 beneficiaries during 2005-06 and only 8,626 (6.27 per cent) out of 1,37,494 beneficiaries were paid cash incentive in 2006-07 in the audited district.
Punjab	In 190 cases, payment of Rs. 0.95 lakh was made in advance of delivery for periods ranging from 30 to 210 days in 2006-07 and 2007-08.
Chhattisgarh	Incentive of Rs.1.13 lakh was paid at the rate of Rs.1000 instead of Rs.1400 to 284 beneficiaries of rural areas in District Hospital at Raigarh and Civil Hospital at Dharamjaigarh.
Assam	In Guwahati Medical College and Hospital, in 4,164 cases, payment of cash incentive was made (during the period 2007-08) at the higher rate of Rs.1,500 by the DHS, Kamrup (Metro), against the admissible rate of Rs.1,200 in urban areas.
Madhya Pradesh	Payment of Rs 33.34 lakh in 2840 cases was made to beneficiaries after 7 days of delivery.
Andhra Pradesh	▪ There was a delay of 5 months in paying Rs. 13.80 lakh to 1,474 beneficiaries. ▪ Irregular payment of Rs. 2.66 crore of cash incentive to 38,065 urban women at the rate of Rs. 700 per delivery was paid prior to the date of extending the facility in urban areas. ▪ Incentives were paid to 2,56,010 urban beneficiaries at a higher rate of Rs. 700 instead of Rs. 600 fixed for urban areas resulting in excess payment of Rs. 2.56 crore during 2006-08.
Arunachal Pradesh	Actual pay receipt (APRs) for payments of Rs. 4.47 lakh made to the beneficiaries in the two test-checked districts were not produced to audit.
Chandigarh	Benefit under JSY was allowed without obtaining the requisite documents viz. BPL certificate/ proof of residence etc.
Madhya Pradesh	▪ Payments of Rs.0.58 lakh in Lakhanadaon CHC of Seoni district made in 35 cases under the JSY were doubtful as the names of the patients were different in the payment register and IPD register against the same IPD nos. ▪ The expenditure on cash incentive under JSY increased from Rs. 49.60 crore in 2006-07 to Rs. 194.31 crore in 2007-08 and beneficiaries increased from 3.97 lakh to 11.06 lakh for institutional deliveries while as per IPD figures provided by the SHS, number of in-patients were 2.60 lakh in 37 out of 48 districts in 2007-08.
Maharashtra	In DHS Nasik, irregular expenditure of Rs. 3.82 lakh was incurred in November 2007 for the insurance of JSY beneficiaries.

Achievements in Healthcare

Annex 9.5
(Refers to paragraph 9.3.1 (b-iv)

A - Variation in expenditure under JSY reported to the Ministry

(Rs. In crore)

Name of the State	Expenditure reported in the FMR	Expenditure reported in the progress report	Name of the State	Expenditure reported in the FMR	Expenditure reported in the progress report
Bihar	0.00	126.03	Mizoram	0.91	0.85
Chhattisgarh	10.20	16.50	Gujarat	9.55	9.82
Uttar Pradesh	118.56	113.06	Karnataka	18.28	21.70
Arunachal Pradesh	0.45	0.49	West Bengal	27.15	33.74

B- Inconsistency in data

Ministry

- As per the data available with the Ministry, number of domiciliary deliveries were 'Nil' in Andhra Pradesh, Bihar and Chandigarh whereas in the audited districts as per the records of DHS 1,81,748, 10,193 and 11,079 domiciliary deliveries had been noticed respectively during the year 2005-08.
- The Ministry provided two different sets of data on the number of beneficiaries under JSY to Audit. According to the quarterly report up to December 2007, the number of beneficiaries of domiciliary deliveries was 15.95 lakh, which came down to 11.30 lakh at the end of the year as per data provided to audit for the whole year. Thus, either the quarterly or annual data reported to Ministry was not correct.

Jharkhand

As per data provided by the SHS, during 2006-07 and 2007-08, the targeted institutional deliveries in the State were 1,23,910 and 2,51,867 out of which total institutional deliveries were 68,900 and 82,417 respectively, but cash incentive was paid to 1,23,910 and 2,51,867 women during the two years. However in audited districts, against the 1,26,565 domiciliary deliveries and 50,900 institutional deliveries noted, cash payment of incentive was made to 7,800 beneficiaries only.

Bihar

Inconsistency in the total number of institutional deliveries and payments made to beneficiaries noticed in audited districts were as under:

Year	No. of institutional deliveries		No. of beneficiary paid incentive	
	As per DHS	As per records of Health units	As per DHS	As per records of Health units
2005-06	856	2344	Nil	Nil
2006-07	24079	17079	13590	7558
2007-08	157277	113344	137891	92634
Total	**182212**	**132767**	**151481**	**100192**

Annex 9.6
(Refers to paragraph 9.3.1 (c))
Percentage of women reaching the health centre for post natal care

Year	Name of the State	Percentage of women reaching the centre for post natal care	Name of the State	Percentage of women reaching the centre for post natal care	Name of the State	Percentage of women reaching the centre for post natal care
2005-06	**Haryana**	67	**Maharashtra**	78.16	**Jharkhand**	44
2006-07		76		79.92		45
2007-08		77		68.90		41
2005-06	**Dadra & Nagar Haveli**	65	**Orissa**	57	**West Bengal**	57.59
2006-07		59		57		64.79
2007-08		79		45		59.40
2005-06	**Rajasthan**	40	**Mizoram**	87	**Karnataka**	27
2006-07		28		91		25
2007-08		29		89		18
2005-06	**Gujarat**	70	**Puducherry**	39	**Kerala**	76.22
2006-07		58		71		59.23
2007-08		66		91		N.A
2005-06	**Himachal Pradesh**	37	**Sikkim**	N.A	**Jammu & Kashmir**	3.20
2006-07		38		0.2		6.82
2007-08		43		4.9		9.24

(Source: Information compiled from SHS records)

Annex 9.7
Refers to Paragraph 9.3.2
A - Status of target and achievement under sterilisation during 2005-08

Name of the State	Targets	Achievement	% shortfall
Bihar	906347	581539	36
Gujarat	1022794	857947	16
Andhra Pradesh	800000	711748	11
West Bengal	1027532	622700	39
Madhya Pradesh	1749000	1192503	32
Uttar Pradesh	2910000	1352200	54
Haryana	311800	259409	17
Sikkim	5580	4864	13
Jharkhand	465699	311430	33
Orissa	528218	382918	27
Tripura	51563	19595	62

B- Performance in vasectomy during 2005-08

Name of the State/UT	Percentage of vasectomy	Name of the State/UT	Percentage of vasectomy
States in which percentage of vasectomy was below 1			
Arunachal Pradesh	0.53	**Mizoram**	0.03
Bihar	Less than 1	**Puducherry**	0.18
Dadra & Nagar Haveli	0.18	**Tamil Nadu**	0.2 – 0.4
Karnataka	0.14	**Tripura**	0.19
Lakshadweep	0	**Uttar Pradesh**	0.68
States in which percentage of vasectomy ranged between 1 – 9			
Andaman & Nicobar	1	**Jharkhand**	9
Assam	9.16	**Kerala**	1
Andhra Pradesh	3.53 – 3.83	**Maharashtra**	3.23
Chhattisgarh	6	**Madhya Pradesh**	6.12
Chandigarh	1.20-1.71	**Orissa**	1.25
Delhi	9	**Rajasthan**	4
Gujarat	2.70	**Uttarakhand**	5
Jammu & Kashmir	4.2	**West Bengal**	3.75

C - Performance in Laparoscopy

Name of the State/UT	Percentage of laparoscopy	Name of the State/UT	Percentage of laparoscopy
A & N Islands	26	**Kerala**	12
Andhra Pradesh	11.75	**Maharashtra**	23.67
Assam	96	**Manipur**	85.07
Bihar	0	**Madhya Pradesh**	84
Chandigarh	64.28	**Orissa**	22.03
Chhattisgarh,	18	**Puducherry**	1.36
D & N Haveli	72	**Punjab**	47.42
Gujarat	52	**Rajasthan**	82
Jammu & Kashmir	63	**Tamil Nadu**	11-12
Jharkhand	1.58	**Tripura**	39
Haryana	27	**Uttarakhand**	66
Himachal Pradesh	87	**Uttar Pradesh**	87
Karnataka	20	**West Bengal**	18

D - Cases of unsuccessful sterilisation

Name of the State/UT	Total no. of sterilisations	Cases of failure	Name of the State/UT	Total no. of sterilisations	Cases of failure
Uttar Pradesh	1,828,000	373	**Uttarakhand**	166,844	15
Chhattisgarh	411,429	41	**Himachal Pradesh**	85,308	65
Tamil Nadu	1,089,820	1,113	**Puducherry**	30,999	113
Punjab	305,257	69	**Delhi**	92,288	52
Rajasthan	940,425	1,012	**Maharashtra**	2,346,742	33
Mizoram	6,741	21	**Gujarat**	857,947	13
Haryana	221,768	154			

E - Usage in spacing methods

Name of the State/UT	Percentage of usage of various spacing methods		
	Oral pill	IUD	Condom
Jharkhand	9	1	90
Madhya Pradesh	23	18	59
Orissa	27	23	50
Rajasthan	37	20	43
Uttar Pradesh	37	45	18
Uttarakhand	16	45	39
Chhattisgarh	30	34	36
Assam (2007-08)	38	35	27
Jammu & Kashmir	7	1	92
Manipur	9	2.8	88.2
Mizoram	33.17	3.48	63.35
Himachal Pradesh	19	19	62
Sikkim	63	17	20
Arunachal Pradesh	29	04	67
Tripura	24	0	76
Andaman & Nicobar	29	17	54
Andhra Pradesh	22	25	53
Chandigarh	0.90	0.53	98.57
Dadra & Nagar Haveli	25	02	73
Gujarat	14	26	60
Haryana	14	25	61
Kerala	3.4	0.60	96
Lakshadweep	3.25	0.09	96.66
Puducherry	14	26	60
Punjab	4.51	0.98	94.51
Tamil Nadu	20	55	25
West Bengal	43	6	51

(Source: Information compiled from SHS records)

Achievements in Healthcare

Annex 9.8
(Refers to Paragraph 9.3.3 (a))
Incidence of infant diseases

Sl.No.	Name of State/UT	Year	Number of cases of infant diseases				
			Neonatal tetanus	Diphtheria	Tetanus	Whooping cough	Measles
1	Assam	2005-06	3	7	3	9	2137
		2006-07	0	0	0	0	1924
		2007-08	10	28	10	6	2650
2	Gujarat	2005-06	3	1	1	0	19
		2006-07	9	51	12	0	36
		2007-08	3	4	1	1	336
3	Haryana	2005-06	0	0	0	0	11
		2006-07	0	0	1	0	38
		2007-08	0	0	0	0	16
4	Jharkhand	2005-06		5	0	0	6
		2006-07	0	6	0	0	13
		2007-08	1	0	0	0	11
5	Rajasthan	2005-06	8	26	23	2	262
		2006-07	5	0	15	0	116
		2007-08	9	40	9	3	284
6	Jammu & Kashmir	2005-06	0	0	0	0	0
		2006-07	0	0	0	5	74
		2007-08	0	0	0	572	433
7	Karnataka	2005-06	3	12	5	0	374
		2006-07	0	7	8	2	477
		2007-08	0	18	3	2	384
8	Madhya Pradesh	2005-06	15	34	36	250	240
		2006-07	12	16	46	3	309
		2007-08	69	171	103	7	718
9	Punjab	2005-06	111	0	2	0	0
		2006-07	99	0	0	0	13
		2007-08	297	0	1	0	0
10.	Uttar Pradesh	2005-06	6	0	0	0	89
		2006-07	1	0	6	0	112
		2007-08	1	1	3	0	48
11.	Meghalaya	2005-06	0	0	0	39	1407
		2006-07	0	0	0	13	981
		2007-08	0	0	0	6	453
12.	Sikkim	2005-06	NA	NA	NA	NA	46
		2006-07	NA	NA	NA	NA	247
		2007-08	NA	NA	NA	NA	4
13.	Arunachal Pradesh	2005-06	0	0	0	0	169
		2006-07	0	0	0	0	183
		2007-08	0	0	0	0	91
14.	Tripura	2005-06	19	0	15	326	404
		2006-07	1	0	9	148	320
		2007-08	1	0	5	125	176
15.	Dadra & Nagar Haveli	2005-06	0	0	0	0	101
		2006-07	0	0	0	0	68
		2007-08	0	0	0	0	26
16.	Kerala	2005-06	0	0	0	102	592
		2006-07	0	0	0	34	186
		2007-08	0	2	1	29	437

Sl.No.	Name of State/UT	Year	Number of cases of infant diseases				
			Neonatal tetanus	Diphtheria	Tetanus	Whooping cough	Measles
17.	Puducherry	2005-06	0	2	37	0	231
		2006-07	0	2	9	1	313
		2007-08	0	0	2	0	137
18.	Tamil Nadu	2005-06		0	0	0	1619
		2006-07		2	0	0	1204
		2007-08		1	0	0	1013
19.	West Bengal	2005-06	13	6	38	40	3291
		2006-07	11	3	37	44	3847
		2007-08	6	10	21	3	2909
20.	Bihar	2005-06	0	0	0	24	154
		2006-07	0	2	0	48	0
		2007-08	4	0	0	3	46
21.	Orissa	2005-06	0	0	0	24	7
		2006-07	2	0	0	72	81
		2007-08	90	90	0	37	4
22.	Uttarakhand	2005-06	--	--	--	--	--
		2006-07	--	--	--	--	72
		2007-08	--	--	--	--	--
23.	Andhra Pradesh	2005-06	17				
		2006-07	126				
		2007-08	3				
		Total	957	544	462	1980	29321

(Source: Information compiled from SHS records)

Achievements in Healthcare

Annex 9.9
Refers to Paragraph 9.3.3 (b)
New polio cases detected during 2005-08

Sl.No.	Name of the State/UT	No. of new Polio cases	No. of children given Polio drops		
			Targets	Achievement	Percentage shortfall / higher (achievement)
1	**Bihar**	594	N.A	59361078	NA
2	**Jharkhand**	2	62684524	62684524	0.00
3	**Madhya Pradesh**	3	28494000	33520000	(17.64)
4	**Orissa**	2	14214696	13644860	4.01
5	**Rajasthan**	4	124436401	121966358	1.98
6	**Uttar Pradesh**	948	116780000	116780000	0.00
7	**Uttarakhand**	20	27874582	27541132	1.20
8	**Chhattisgarh**	0	7011390	7029580	(0.26)
9	**Assam**	2	14083345	13626420	3.24
10	**Manipur**	NA	1061569	1015754	4.32
11	**Meghalaya**	0	186135	169927	8.71
12	**Himachal Pradesh**	1	2213417	2144454	3.12
13	**Sikkim**	NA	35865	30260	15.63
14	**Arunachal Pradesh**	0	183823	333702	(81.53)
15	**Tripura**	0	1253260	1250762	0.20
16	**Andaman & Nicobar**	0	NA	NA	NA
17	**Andhra Pradesh**	0	57409372	59546851	(3.72)
18	**Chandigarh**	1	NA	1538784	NA
19	**Delhi**	12	NA	64162000	
20	**Dadra & Nagar Haveli**	0	110372	112434	(1.87)
21	**Jammu & Kashmir**	1	7299259	7295762	0.05
22	**Haryana**	26	62718442	62884762	(0.27)
23	**Kerala**	**0**	8813282	8610411	2.30
24	**Lakshadweep**	0	17920	17953	(0.18)
25	**Maharashtra**	7	142491191	140473088	1.42
26	**Puducherry**	0	278296	292913	(5.25)
27	**Punjab**	10	50158816	49826519	0.66
28	**Tamil Nadu**	0	54908456	57562785	(4.83)
29	**West Bengal**	1	NA	NA	NA
30	**Gujarat**	6	919,9100	925,45,000	(0.01)

(Source: Information compiled from SHS records)

Annex 9.10
(Refers to paragraph 9.3.3 (b))
Deficiencies in Pulse Polio Immunisation

Bihar

- As per the SHS new polio cases detected during 2006-07 were only 61 for the entire State, whereas in six test-checked districts alone, the new polio cases reported were 64.
- In Bhojpur district, functional Sub Centres were 303 during 2005-08 whereas the number of Sub Centres shown by the district while incurring expenditure on courier services was 308 to 355 (During July 2007 to March 2008 funds were provided for 924 immunisation centres). Hence, against requirement of funds of Rs 46.15 lakh for courier services, Rs 62.92 lakh was made available to and spent by PHCs during 2005-08 on an inflated figure of functional Sub Centres. No supporting vouchers were available in the DHS. Hence, suspected misappropriation of Rs 16.77 lakh could not be ruled out.
- In Bhojpur district, only one outsourced generator was available and functional since July 2006 in each PHC for which payment of Rs 42.80 lakh had been made in advance by the Civil Surgeon-cum-CMO during 2006-2008. Thus, no separate fund was required to be spent for maintaining cold chain system in the PHC, as on an average each PHC had only one Ice Lined Refrigerator and deep freezer. In Bhojpur Rs. 27.36 lakh made available to PHCs for Petrol, Oil and Lubricant had never been refunded and was booked as spent. Thus, possibility of misappropriation of the entire amount of Rs 27.36 lakh could not be ruled out.
- Despite acute shortage of cold chain equipment, supplies against the requisitioned quantity ranged between 16 and 44 per cent only. 7000 vaccine carriers supplied by the Ministry at a cost of Rs. 25.13 lakh during 2005-06 were found to be substandard. Moreover, there was acute shortage of thermometers.

Mizoram

The Mission had not conducted any survey to identify the number of children (0-5). In the absence of this baseline survey, the basis for fixation of targets remained adhoc. However, based on population of the State, the number of children of different age groups during 2005-06 to 2007-08 was higher than the target fixed and the achievement claimed by the Department was not correct.

Year	Target to be fixed	Target actually fixed	Shortfall
2005-06	122683	117318	5365
2006-07	132272	115397	16875
2007-08	132775	123809	8966

The Department stated in November 2008 that shortfall would be covered in the subsequent rounds.

Annex 9.11
Refers to Paragraph 9.3.3 (c)
Target and achievement for administration of Vitamin A

Name of the State/UT	Targets	Ist dose	Percentage shortfall	2nd dose	Percentage shortfall	3rd - 5th dose	Percentage shortfall/ higher (achievement)
Bihar	1406193	730374	48.06	552570	60.70	855862	39.14
Jharkhand	630586	604607	4.12	562300	10.83	1300025	(106.16)
Mizoram	41945	10771	74.32	11240	73.20	24363	41.92
Orissa	620678	543656	12.41	229819	62.97	1412610	(127.59)
Rajasthan	1524152	968976	36.43	592044	61.16	699948	54.08
Uttar Pradesh	1250000	1055000	15.60	687000	45.04	703000	43.76
Uttarakhand	188528	120695	35.98	84423	55.22	121487	35.56
Chhattisgarh	365399	362533	0.78	348911	4.51	839824	(129.84)
Himachal Pradesh	50821	48378	4.81	46027	9.43	111740	(119.87)
Jammu & Kashmir	398773	113759	71.47	34395	91.37	81720	79.51
Meghalaya	400122	84828	78.80	62842	84.29	77717	80.58
Sikkim	35238	20109	42.93	20305	42.38	32180	8.68
Chandigarh	159685	32403	79.71	27473	82.80	36340	77.24
Maharashtra	1646129	981150	40.40	976187	40.70	2126637	(29.19)
Gujarat	544747	351829	35.41	515117	5.44	824670	(51.39)
Haryana	890095	271503	69.50	238998	73.15	363248	59.19
Karnataka	718380	460818	35.85	410997	42.79	784822	(9.25)
Kerala	474529	253856	46.50	213620	54.98	624944	(31.70)
Puducherry	54014	42968	20.45	42211	21.85	74650	(38.20)
Punjab	1162366	159305	86.29	243773	79.03	270342	76.74
West Bengal	1120485	887770	20.77	857495	23.47	1521063	(35.75)
Tamil Nadu (sample)	3243971	2485098	23.39	2109901	34.96	741449	77.14

(Source: Information compiled from SHS records)

Annex 9.12

Refers to Paragraph 9.5.1
Sector wise status of cataract operations performed

Name of State	Performance of cataract operations in Government sector		Performance of cataract operations by NGOs		Performance of cataract operations by private practitioners and others		Total cataract operations
	Number	Percentage	Number	Percentage	Number	Percentage	
Jharkhand	8857	4.92	106401	59.15	64632	35.93	179890
Madhya Pradesh	194945	21.65	405752	45.07	299647	33.28	900000
Orissa[12]	21111	22.06	63629	66.50	10950	11.44	95690
Uttar Pradesh	450000	24.17	697000	37.43	715000	38.40	1856000
Uttarakhand	43960	31.31	60642	43.19	35795	25.50	140397
Chhattisgarh	68744	26.51	91821	35.41	98752	38.08	259317
Assam	40572	36.39	42617	38.23	28295	25.38	111484
Jammu & Kashmir	24197	47.70	3242	6.39	23289	45.91	57899
Himachal Pradesh	27514	42.71	29484	45.77	7426	11.52	64424
Sikkim	1007	89.99	55	4.92	57	5.09	1119
Andhra Pradesh	274668	17.47	663618	42.21	633826	40.32	1572112
Chandigarh	10995	52.74	1002	4.81	8850	42.45	20847
Dadra & Nagar Haveli	533		1206		NA		
Gujarat	175226	9.71	639714	35.47	988639	54.82	1803579
Haryana	168243	47.62	84573	23.94	100458	28.44	353274
Maharashtra	438249	21.35	441446	21.51	1172709	57.14	2052404
Puducherry	18265	52.86	0	0.00	16289	47.14	34554
Tamil Nadu	201349	13.34	1070171	70.90	237791	15.76	1509311
West Bengal	166820	21.29	364520	46.52	252185	32.19	783525
Arunachal Pradesh	2600	76.45	801	23.55	0		
A & N Islands	1946	100	0	0	0		1946

(Source: Information compiled from SHS records)

[12] 2007-08

Achievements in Healthcare

Annex 9.13
Refers to Paragraph 9.5.1
A - Cataract operations in camps

Name of the State/UT	No. of cataract operations performed		Camps as percentage of total
	Total	In camps	
Madhya Pradesh	900000	406000	45.11
Puducherry	18265	1593	8.72
Lakshadweep	110	1	0.91
Karnataka	60038	1046	1.74
Haryana	353274	100458	28.44
Dadra & Nagar Haveli	1739	111	6.38
Andhra Pradesh	547899	203621	37.16
Tripura	16906	970	5.74
Himachal Pradesh	64424	14008	21.74
Manipur	1642	45	2.74
Jammu & Kashmir	57899	7171	12.39
Assam	111484	42617	38.22
Uttarakhand	140397	60642	43.19
Uttar Pradesh	18.56 lakh	11.52 lakh	62.07

B - Cataract surgery rate

State/UT	Cataract Surgery Rate			State/UT	Cataract Surgery Rate		
	2005-06	2006-07	2007-08		2005-06	2006-07	2007-08
Jharkhand	158	204	232	**Madhya Pradesh**	455	482	534
Assam	107	148	163	**Rajasthan**	480	471	560
Orissa	276	242	260	**Manipur**	210	747	685
Jammu & Kashmir	160	211	200	**D & N Haveli**	153	61	481
Andaman & Nicobar	172	164	170	**Haryana**	511	535	629
Bihar	200	200	100	**Uttarakhand**	501	501	650
Kerala	287	304	298	**Maharashtra**	678	707	736
Uttar Pradesh	300	307	314	**Punjab**	669	640	621
Himachal Pradesh	335	354	370	**Tamil Nadu**	760	780	760
Chhattisgarh	376	394	387	**Puducherry**	993	1110	1185
West Bengal	335	285	356				

(Source: Information compiled from SHS records)

C. State Specific Cases: Cataract operation

Orissa	Against the requirement of 314 Ophthalmic assistants for 314 block level health institutions (CHC/Block PHCs), only 197 posts were sanctioned and 194 were in position as of March 2008. In the remaining 117 block PHCs/ CHCs, facility for ophthalmic care was not available. In 4 out of 15 test-checked CHCs ophthalmic care was not available. No post of eye surgeon was available in any of the 231 CHCs of the State.
Manipur	No eye surgeon was posted in the health centres and the eye surgeons from the State Hospital and Medical College performed cataract surgeries in eye camps.
Chandigarh	Rs. 6.90 lakh was reimbursed to NGOs for cataract operation whereas surgeries were performed by the Government doctors using Government infrastructure and NGOs performed only IEC activities.

Annex 9.14
Refers to Paragraph 9.5.3
A- Performance of eye banks

State	Year	No. of eyes						
		Opening balance	Donated	Utilised	Transferred	Rendered unfit	Used for research	Closing balance
Government sector								
Jharkhand	**2005-08**	0	0	0	0	0	0	0
Orissa	**2005-08**	0	28	28	0	0	0	0
Uttar Pradesh	**2005-08**		186	174	0	0	10	2
Assam	**2005-08**	-	39	34	-	-	-	-
Delhi	**2005-08**		3552	1944	103	804	517	
Gujarat	**2005-08**		4452	1431			3021	
Haryana	**2005-08**	0	175	145	0	0	30	0
Tamil Nadu	**2005-08**	--	3752	--	--	--	1660	0
West Bengal	**2005-08**	0	1802	570	0	1	1231	0
	Total	**0**	**13986**	**4326**		**814**	**6469**	
Voluntary sector								
Jharkhand	**2005-08**	0	10	10	0	0	0	0
Orissa	**2005-08**	0	64	34	0	0	0	0
Uttar Pradesh	**2005-08**	10	654	531	83	15	94	10
Assam	**2005-08**	-	322	145	-	-	-	-
Delhi	**2005-08**		5268	2515	375	1427	1039	
Gujarat	**2005-08**		14917	4910	9095		912	
Haryana	**2005-08**	0	704	177	345	169	13	0
Tamil Nadu	**2005-08**	--	20284	--	--	--	10317	Nil
West Bengal	**2005-08**	0	2741	1040	0	100	1331	Nil
	Total	**10**	**44964**	**9362**		**1711**	**13706**	
Government sector (States provided data for Government sector only)								
Madhya Pradesh	**2005-08**	NA	834	506	0	0	0	NA
Chhattisgarh	**2005-08**	184	380	285	NA	NA	NA	279
Tripura	**2005-08**	0	6	6	0	0	2	0
Chandigarh	**2005-08**		870	624		94	152	
Puducherry	**200508**	0	796	407	0	0	389	0
	Total	**184**	**2886**	**1828**	**0**	**94**	**606**	
Aggregated data on Government and voluntary sector								
Rajasthan	2005-08	0	3335	1753	400	526	445	0
Maharashtra	2005-08	N.A.	13125	4741	2404	498	4786	N.A.
	Total		**16460**	**6494**		**1024**	**5231**	

(Source: Information compiled from SHS records)

B- State specific cases

Bihar	Against the target of establishing 50 vision centres, 2 eye banks, 3 eye donation centres and 2 paediatric ophthalmic units and collection of 1500 eyes through donation, there was Nil achievement during the period 2005-08.
Orissa	Eye donation facility was made available in Government sector from 2007-08 only. As against the target of collection of 500 donated eyes, achievement was only 92 (28 in Govt. and 64 voluntary sector) during 2007-08 of which only 62 were utilised.
Andhra Pradesh	Against the annual target of collection of 5000 eyes per annum 9231 (62 *per cent*) eyes were collected during 2005-08. The details of performance of the voluntary sector were not maintained.

Annex 9.15
(Refers to Paragraph 9.7.1)
Status of ABER and API during the period 2005-08

Name of the State/UT	ABER			API		
	2005	2006	2007	2005	2006	2007
Jharkhand	10.08	7.12	6.65	6.84	6.59	6.15
Madhya Pradesh	13.44	14.16	13.22	1.55	1.40	1.31
Orissa	12.40	12.48	12.24	10.14	9.57	9.20
Uttar Pradesh	2.53	2.33	2.02	0.63	0.54	0.47
Rajasthan	12.42	15.32	12.52	0.92	1.76	0.97
Uttarakhand	3.5	3.22	2.51	0.13	0.12	0.10
Chhattisgarh	16.51	15.38	14.03	8.01	7.53	5.95
Assam	7.92	9.75	8.09	2.34	4.30	3.19
Jammu & Kashmir	8.37	8.30	7.68	0.05	0.032	0.04
Meghalaya	9.4	12.5	13.6	7.2	12.9	14.7
Himachal Pradesh	9.7	9.4	9.1	0.03	0.02	0.02
Sikkim	6	5	4	0.46	0.61	0.29
Arunachal Pradesh	24.51	26.18	23.16	29.54	37.13	30.36
Tripura	8.6	9.1	8.3	5.5	6.8	5.3
Andaman & Nicobar	25.62	30.99	33.92	5.26	7.76	9.28
Andhra Pradesh	14.2	13.2	12.	0.55	0.47	0.38
Chandigarh	9.6	7.7	8.8	0.4	0.04	0.3
Dadra & Nagar Haveli	17.90	22.39	20.71	4.32	14.41	13.45
Gujarat	19.9	19.6	16.4	3.2	1.6	1.2
Haryana	11.32	11.87	11	1.48	2.10	1.36
Kerala	6.4	5.62	5.58	0.077	0.062	0.57
Karnataka	18.9	16.8	NA	1.2	0.9	NA
Maharashtra	16.6	21.9	13.6	0.5	0.7	0.6
Punjab	10.5	9.78	10.22	0.072	0.072	0.07
Tamil Nadu	11.85,	9.67	8.72	0.61	0.43	0.34
Puducherry	21.22	18.71	11.73	0.04	0.05	0.06
West Bengal	5.5	6.15	5.63	2.32	1.86	1.06

(Source: Information compiled from SHS records)

Annex 9.16
(Refers to Paragraph 9.7.2)
Status of morbidity and mortality due to vector borne diseases during 2005-08

States/UTs	Year	Kala Azar		Malaria		Filaria		Japanese Encephalitis		Dengue	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Bihar	2005-06	23383	125	2744	6	6676	Nil	Nil	Nil	Nil	Nil
	2006-07	29711	162	2411	3	8923	Nil	39	6	Nil	Nil
	2007-08	37738	13	1451	Nil	9094	Nil	1	Nil	Nil	Nil
Jharkhand	2005-06	5990	11	193144	55	56590	Nil	Nil	Nil	Nil	Nil
	2006-07	7509	11	193888	22	39100	Nil	Nil	Nil	13	Nil
	2007-08	4803	20	184878	47	12407	Nil	Nil	Nil	Nil	Nil
Madhya Pradesh	2005	Nil	Nil	104317	44	2552	Nil	Nil	Nil	Nil	Nil
	2006	Nil	Nil	96130	56	2688	Nil	Nil	Nil	16	Nil
	2007	Nil	Nil	90829	41	3214	Nil	Nil	Nil	51	Nil
Orissa	2005-06	Nil	Nil	396573	255	3099	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	380216	257	3405	Nil	Nil	Nil	1	Nil
	2007-08	Nil	Nil	365592	218	2862	Nil	Nil	Nil	21	Nil
Rajasthan	2005-06	Nil	Nil	52286	22	Nil	Nil	Nil	Nil	370	5
	2006-07	Nil	Nil	99529	58	Nil	Nil	Nil	Nil	1805	26
	2007-08	Nil	Nil	55043	46	Nil	Nil	Nil	Nil	540	10
Uttar Pradesh	2005-06	68	2	105302	Nil	7613	Nil	5581	1593	121	4
	2006-07	83	Nil	91566	Nil	5738	Nil	2073	476	617	14
	2007-08	69	1	81580	Nil	5791	Nil	2675	577	130	2
Uttarakhand	2005	Nil	Nil	1242	Nil	Nil	Nil	Nil	Nil	Nil	Nil
	2006	Nil	Nil	1108	Nil	Nil	Nil	58	Nil	6	1
	2007	2	Nil	953	Nil	Nil	Nil	2	Nil	46	Nil
Chhattisgarh	2005-06	--	--	187950	3	416	0	--	--	--	--
	2006-07	--	--	176868	3	416	0	--	--	--	--
	2007-08	--	--	145949	--	452	0	--	--	--	--
Assam	2005-06	0	0	67885	113	80	0	140	50	0	0
	2006-07	0	0	126178	304	24	0	363	112	0	0
	2007-08	65	0	94853	152	490	0	360	116	0	0
Jammu & Kashmir	2005-06	Nil	Nil	277	Nil	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	159	Nil	Nil	Nil	Nil	Nil	23	1
	2007-08	Nil	Nil	251	1	Nil		Nil		Nil	Nil
Manipur	2005-06	Nil	Nil	2071	3	-	-	-	-	-	-
	2006-07	Nil	Nil	2709	8	-	-	-	-	-	-
	2007-08	Nil	Nil	1194	4	-	-	-	-	-	-
Meghalaya	2005-06	Nil	Nil	16876	41	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	29924	167	Nil	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	33979	237	Nil	Nil	Nil	Nil	Nil	Nil
Himachal Pradesh	2005-06	Nil	Nil	129	Nil	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	114	Nil	Nil	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	104	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Sikkim	2005-06	Nil	Nil	69	3	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	5	Nil	93	Nil	Nil	Nil	Nil	Nil	Nil	Nil
	2007-08	2	Nil	48	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tripura	2005-06	Nil	Nil	18637	21	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	22369	41	Nil	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	18669	52	Nil	Nil	Nil	Nil	Nil	Nil
A & N Islands	2005-06	Nil	Nil	388	Nil	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	298	1	Nil	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	554	Nil	184	Nil	Nil	Nil	Nil	Nil

States/UTs	Year	Kala Azar		Malaria		Filaria		Japanese Encephalitis		Dengue	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Andhra Pradesh	2005-06	Nil	Nil	39099	10	11303	Nil	34	Nil	99	2
	2006-07	Nil	Nil	34081	Nil	7419	Nil	2	Nil	197	17
	2007-08	Nil	Nil	27803	2	6448	Nil	22	Nil	587	2
Chandigarh	2005-06	Nil	Nil	440	Nil	Nil	Nil	Nil	Nil	2	Nil
	2006-07	Nil	Nil	440	Nil	Nil	Nil	Nil	Nil	182	Nil
	2007-08	Nil	Nil	342	Nil	Nil	Nil	Nil	Nil	99	Nil
Dadra & Nagar Haveli	2005-06	Nil	Nil	1144	Nil	81	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	3813	Nil	123	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	3780	Nil	163	Nil	Nil	Nil	Nil	Nil
Haryana	2005-06	Nil	Nil	33204	Nil	Nil	Nil	4	2	183	1
	2006-07	Nil	Nil	47077	Nil	Nil	Nil	3	1	838	4
	2007-08	Nil	Nil	30895	Nil	Nil	Nil	32	18	365	11
Kerala	2005-06	1	Nil	2554	6	908	Nil	14	1	1028	8
	2006-07	Nil	Nil	2131	6	895	Nil	Nil	Nil	959	5
	2007-08	Nil	Nil	1927	6	532	Nil	Nil	Nil	677	12
Lakshadweep	2005-06	Nil	Nil	Nil	Nil	17	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	Nil	Nil	6	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	Nil	Nil	8	Nil	Nil	Nil	Nil	Nil
Maharashtra	2005-06	Nil	Nil	45614	103	87926	Nil	9	Nil	396	56
	2006-07	Nil	Nil	56852	133	80736	Nil	14	Nil	609	27
	2007-08	Nil	Nil	67844	176	93912	Nil	Nil	Nil	619	25
Puducherry	2005	Nil	Nil	44	Nil	45	Nil	Nil	Nil	18	Nil
	2006	Nil	Nil	50	Nil	54	Nil	Nil	Nil	42	Nil
	2007	Nil	Nil	68	Nil	57	Nil	Nil	Nil	216	Nil
Punjab	2005-06	Nil	Nil	1883	Nil	Nil	Nil	Nil	Nil	253	2
	2006-07	Nil	Nil	1888	Nil	Nil	Nil	Nil	Nil	1166	6
	2007-08	Nil	Nil	2054	Nil	Nil	Nil	Nil	Nil	28	Nil
Tamil Nadu	2005-06	Nil	Nil	39678	1	234	Nil	48	7	1150	8
	2006-07	Nil	Nil	28219	Nil	139	Nil	18	1	477	2
	2007-08	Nil	Nil	22389	1	123	Nil	42	Nil	707	2
Gujarat	2005	Nil	Nil	177936	54	336	Nil	Nil	Nil	454	11
	2006	Nil	Nil	93071	45	142	Nil	Nil	Nil	545	5
	2007	Nil	Nil	71121	75	112	Nil	Nil	Nil	640	2
West Bengal	2005-06	2710	15	185964	175	130	Nil	72	7	6375	34
	2006-07	1843	10	159646	203	1483	Nil	24	3	1064	8
	2007-08	1817	9	87754	96	67003	Nil	25	1	150	1
Arunachal Pradesh	2005-06	Nil	Nil	31215	11	Nil	Nil	Nil	Nil	Nil	Nil
	2006-07	Nil	Nil	39233	196	Nil	Nil	Nil	Nil	Nil	Nil
	2007-08	Nil	Nil	32071	36	Nil	Nil	Nil	Nil	Nil	Nil

Annex 9.17
(Refers to paragraph 9. 7.3)
State specific cases: Population protected by using insecticides

Orissa	In Koraput district, shelf life of 53 MT of DDT costing Rs 13.47 lakh expired in September 2007 without being used and remained in the stock as of May 2008.
Mizoram	Against 2412 bags (120.60 MT) of DDT issued during 2005-08 to the three CMOs (Lunglei, Lawngtlai and Kolasib) only 1069 bags (53.45 MT) were reported as received by the CMOs. Despite the short receipt of DDT powder, the Department claimed that it had fully covered the 186, 161 and 53 villages respectively for 2005-08. The Department could not furnish information on the targeted population for 2007-08. However, even with the available information for two years i.e. 2005-2007, the claim of the Department of having covered the entire targeted population appears to be incorrect. The Department stated in November 2008 that the balance DDT powder (1343 bags) issued to the districts was supplied enroute to the CHCs and PHCs to avoid further transportation from district headquarters. The reply was not substantiated with any records indicating separate centre-wise receipt accompanied with their utilization. The shortfall in receipt of DDT by the CMOs against the required quantity as per prescribed norms for 2005-07, was 33.75 MT which would have adversely affected the achievement of insecticide spray programme for control of malaria in this high risk State.
Bihar	SHS had paid Rs. 2.31 crore in February/March 2007 from RCH Flexipool Fund towards outstanding wages payment for spraying of DDT pertaining to the period 1999-2003. As per guideline of NVBDCP, establishment cost and expenditure on transportation, storage and spraying of DDT was to be borne by the State Government fund. Thus, entire payment of Rs 2.31 crore was irregular.
Sikkim	Due to non supply of DDT by the Ministry, spraying was not done.

LIST OF ABBREVIATIONS

A & N Islands	Andaman and Nicobar Islands
ABER	Annual Blood Examination Rate
ACMO	Additional Chief Medical Officer
AD	Automatic Disposable
AE	Actual Expenditure
AGCA	Advisory Group for Community Action
AMG	Annual Maintenance Grant
ANC	Ante Natal Checkup
ANM	Auxiliary Nursing Midwife
APHC	Additional Primary Health Centre
APHMHIDC	Andhra Pradesh Health Medical Housing and Infrastructure Development Corporation
API	Annual Parasitic Incidence
ARC	Apex Resource Centre
ASHA	Accredited Social health Activist
ASTC	Assam State Transport Corporation
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga-Naturopathy Unani Sidha and Homoeopathy
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guerin
BDA	Block Data Assistant
BDO	Block Development Officer
BE	Budget Estimates
BER	Bid Evaluation Report
BFA	Block Finance Assistant
BoB	Bank of Baroda
BPL	Below Poverty Line
BPM	Block Programme Manager
BSEB	Bihar School Examination Board
CA	Chartered Accountant
CAC	Chief Advisor Cost
CAN	Community Need Assessment
CBO	Community Based Organisation
CCA	Chief Controller of Accounts
CDMO	Chief District Medical Officer
CEMONC	Comprehensive Emergency Obstetric and Neonatal Care
CEO	Chief Executive Officer
CHC	Community Health Centre
CMHO	Chief Medical Officer of Health
CMO	Chief Medical Officer
CMSO	Central Medical Store Organisation
CPSE	Central Public Sector Enterprise

CSR	Cataract Surgery Rate
CVC	Central Vigilance Commission
D & N Haveli	Dadra and Nagar Haveli
DC	District Collector
DDM	District Data Manager
DDT	Dichloro Dimethyl Trichloro Ethane
DFM	District Finance Manager
DG	Diesel Generator
DGHS	Directorate General Health Services
DH	District Hospital
DHAP	District Health Action Plan
DHM	District Health Mission
DHS	District Health Society
DPM	District Programme Manager
DPT	Diphtheria Pertusis Tetanus
DRDA	District Rural Development Authority
DSU	District Surveillance Unit
EAG	Empowered Action Group
E-banking	Electronic Banking
EC-SIP	European Commission - Sectoral Investment Programme
EPC	Empowered Programme Committee
EPW	Empowered Procurement Wing
E-transfer	Electronic Transfer
FI	Full Immunisation
FMG	Financial Management Group
FMR	Financial Management Report
FNGO	Field Non-Governmental Organisation
FRU	First Referral Unit
GDP	Gross Domestic Project
GFR	General Financial Rules
GIA	Grant-in-Aid
GMP	Good Manufacturing Practices
GMSD	Government Medical Store Depot
GOI	Government of India
GSDP	Gross State Domestic Project
GUS	Gram Unnayan Samiti
HDFC	Housing Development Finance Corporation
HMDI	Health Manpower Development Institute
HPS	High Performing States
HSCC	Hospital Services Consultancy Corporation
ICICI	Industrial Credit and Investment Corporation of India
IDSP	Integrated Disease Surveillance Project
IEC	Information Education and Communication
IFA	Iron Folic Acid

IMR	Infant Mortality Rate
IPC	Integrated Purchase Committee
IPD	Inpatient Department
IPHS	Indian Public Health Standards
ISRO	Indian Space Research Organisation
IT	Information Technology
IUD	Intra Uterine Device
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LPS	Low Performing States
MBA	Master of Business Administration
MCH	Mother and Child Health
MDA	Mass Drugs Administration
MIS	Management Information System
MLA	Member of Legislative Assembly
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MNGO	Mother Non-Governmental Organisation
MOU	Memorandum of Understanding
MP	Member of Parliament
MPW	Multipurpose Worker
MSG	Mission Steering Group
MTP	Medical Termination of Pregnancy
NBCC	National Building Construction Corporation
NDCP	National Disease Control Programmes
NE	North Eastern
NGO	Non-Governmental Organisation
NHSRC	National Health System Resource Centre
NIC	National Informatics Centre
NIDDCP	National Iodine Deficiency Disorder Control Programme
NIHFW	National Institute of Health and Family Welfare
NLEP	National Leprosy Elimination Programme
NMBS	National Maternal Benefit Scheme
NOC	No Objection Certificate
NPCB	National Programme for Control of Blindness
NPCC	National Programme Coordination Committee
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Outpatient Department
OPHC	Orissa State Police Housing and Welfare Corporation
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
OSIC	Orissa Small Scale Industries Corporation
OT	Operation Theatre

PA	Performance Audit
PB ratio	Patient Bed Ratio
PHC	Primary Health Centre
PHSC	Punjab Health Systems Corporation
PIP	Programme Implementation Plan
PMG	Programme Management Group
PMSU	Programme Management Support Unit
PPI	Pulse Polio Immunisation
PPSWR	Probability Proportion to Size With Replacement
PRI	Panchayati Raj Institutions
PS	Panchayat Samiti
PSU	Public Sector Undertaking
PWD	Public Works Department
RBI	Reserve Bank of India
RC	Rate Contract
RCH	Reproductive and Child Health
RH	Referral Hospital
RHS	Rural Health Survey
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RRC	Regional Resource Centre
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
SBI	State Bank of India
SC	Scheduled Castes
SCOVA	Standing Committee on Voluntary Action
SDMU	State Drug Management Unit
SFU	State Facilitation Unit
SFWB	State Family Welfare Bureau
SHM	State Health Mission
SHS	State Health Society
SHSRC	State Health System Resource Centre
SIHFW	State Institute of Health and Family Welfare
SIT	Satellite Interactive Terminal
SNGO	Service Non-Governmental Organisation
SOE	Statement of Expenditure
SPMSU	State Programme Management Support Unit
SRSWOR	Simple Random Sampling without Replacement
SSU	State Surveillance Unit
ST	Scheduled Tribes
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TNMSC	Tamil Nadu Medical Services Corporation
TOR	Terms of Reference

TT	Tetanus Toxoid
TTD	Thirumala Tirupati Devasthanam
UBI	Union Bank of India
UC	Utilisation Certificate
UHC	Urban Health Centre
UNICEF	United Nations' Children Fund
UNOPS	United Nations Operations
USAID	United States Assistance for International Development
UT	Union Territory
UTI	Unit Trust of India
VC	Video Conferencing
VDF	Vaccine Deep Freezer
VEN	Vital, essential and non-essential
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WCD	Women and Child Development
ZSS	Zilla Swasthya Samiti

LIST OF ABBREVIATIONS

A & N Islands	Andaman and Nicobar Islands
ABER	Annual Blood Examination Rate
ACMO	Additional Chief Medical Officer
AD	Automatic Disposable
AE	Actual Expenditure
AGCA	Advisory Group for Community Action
AMG	Annual Maintenance Grant
ANC	Ante Natal Checkup
ANM	Auxiliary Nursing Midwife
APHC	Additional Primary Health Centre
APHMHIDC	Andhra Pradesh Health Medical Housing and Infrastructure Development Corporation
API	Annual Parasitic Incidence
ARC	Apex Resource Centre
ASHA	Accredited Social health Activist
ASTC	Assam State Transport Corporation
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga-Naturopathy Unani Sidha and Homoeopathy
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guerin
BDA	Block Data Assistant
BDO	Block Development Officer
BE	Budget Estimates
BER	Bid Evaluation Report
BFA	Block Finance Assistant
BoB	Bank of Baroda
BPL	Below Poverty Line
BPM	Block Programme Manager
BSEB	Bihar School Examination Board
CA	Chartered Accountant
CAC	Chief Advisor Cost
CAN	Community Need Assessment
CBO	Community Based Organisation
CCA	Chief Controller of Accounts
CDMO	Chief District Medical Officer
CEMONC	Comprehensive Emergency Obstetric and Neonatal Care
CEO	Chief Executive Officer
CHC	Community Health Centre
CMHO	Chief Medical Officer of Health
CMO	Chief Medical Officer
CMSO	Central Medical Store Organisation
CPSE	Central Public Sector Enterprise

CSR	Cataract Surgery Rate
CVC	Central Vigilance Commission
D & N Haveli	Dadra and Nagar Haveli
DC	District Collector
DDM	District Data Manager
DDT	Dichloro Dimethyl Trichloro Ethane
DFM	District Finance Manager
DG	Diesel Generator
DGHS	Directorate General Health Services
DH	District Hospital
DHAP	District Health Action Plan
DHM	District Health Mission
DHS	District Health Society
DPM	District Programme Manager
DPT	Diphtheria Pertusis Tetanus
DRDA	District Rural Development Authority
DSU	District Surveillance Unit
EAG	Empowered Action Group
E-banking	Electronic Banking
EC-SIP	European Commission - Sectoral Investment Programme
EPC	Empowered Programme Committee
EPW	Empowered Procurement Wing
E-transfer	Electronic Transfer
FI	Full Immunisation
FMG	Financial Management Group
FMR	Financial Management Report
FNGO	Field Non-Governmental Organisation
FRU	First Referral Unit
GDP	Gross Domestic Project
GFR	General Financial Rules
GIA	Grant-in-Aid
GMP	Good Manufacturing Practices
GMSD	Government Medical Store Depot
GOI	Government of India
GSDP	Gross State Domestic Project
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