3.1.14 Recommendations

- The Planning and Co-ordination Department should be more proactive in scrutinising the project proposals submitted by the departments for grants under NLCPR;
- Adequate funds should be provided for and released on a timely basis to ensure compliance with the stipulated time-lines for completion of the projects;
- The Nodal Department should ensure post completion checks especially with reference to the utility and impact assessment of all the projects, so as to obviate abandonment/non-utilisation of infrastructure created;
- Stringent inspection of all on-going projects should be carried out regularly to avoid extra expenditure and to ensure timely utilisation of funds and derivation of benefits;
- Monitoring and internal control mechanism should be more effective to ensure that intended benefits are derived by the Society/targeted population.

The matter was reported to the Departments/Government (August 2008); replies have not been received (November 2008).

HEALTH AND FAMILY WELFARE DEPARTMENT

3.2 National Rural Health Mission

The National Rural Health Mission was launched all over the country from April 2005 for a seven year period 2005-12. In Nagaland, the programme was launched only in February 2006. A mid term review of the Mission revealed that the basic inputs were not in place. State had not prepared Perspective Plan (2005-12) and household and facility survey covering all villages and health centres was yet to be completed. The upgradation of District Hospitals, Community Health Centres, Primary Health Centres and Sub-Centres to the level of Indian Public Health Standards has not been achieved. The State Health Society has not framed any time bound programme to train ASHAs up to the fifth module.

Highlights

Household survey was conducted only in seven out of 11 districts in the year 2007-08.

(Paragraph 3.2.8.1)

There was a shortfall in creation of CHCs, PHCs, and SCs and there were lack of medical officers, medicines and equipment in the test-checked units.

(Paragraph 3.2.10.1)

Mobile medical units were not operationalised despite incurring an expenditure of Rs. 5.01 crore, thereby defeating the objective to take health care to the door steps of the people in the under-served areas.

(Paragraph 3.2.10.4)

Monitoring mechanism was non-existent in the Department.

(Paragraph 3.2.18)

3.2.1 Introduction

The National Rural Health Mission (NRHM) was launched in April 2005 by the GOI for the period 2005-12 with special focus on 18 States, including Nagaland, with the objective of providing accessible, affordable and effective public health care in rural areas. The Mission was made effective in Nagaland in February 2006. The Mission envisaged convergence of various existing standalone national disease control programmes with the exception of the National AIDS and Cancer Control Programmes. The components of the NRHM include bridging gaps in healthcare facilities, facilitating decentralized planning in health sector and addressing the issue of health in the context of a sector-wise approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health and advocates convergence with related social sector departments like Women and Child Development, AYUSH, Panchayati Raj etc.

3.2.2 Objectives of the Mission

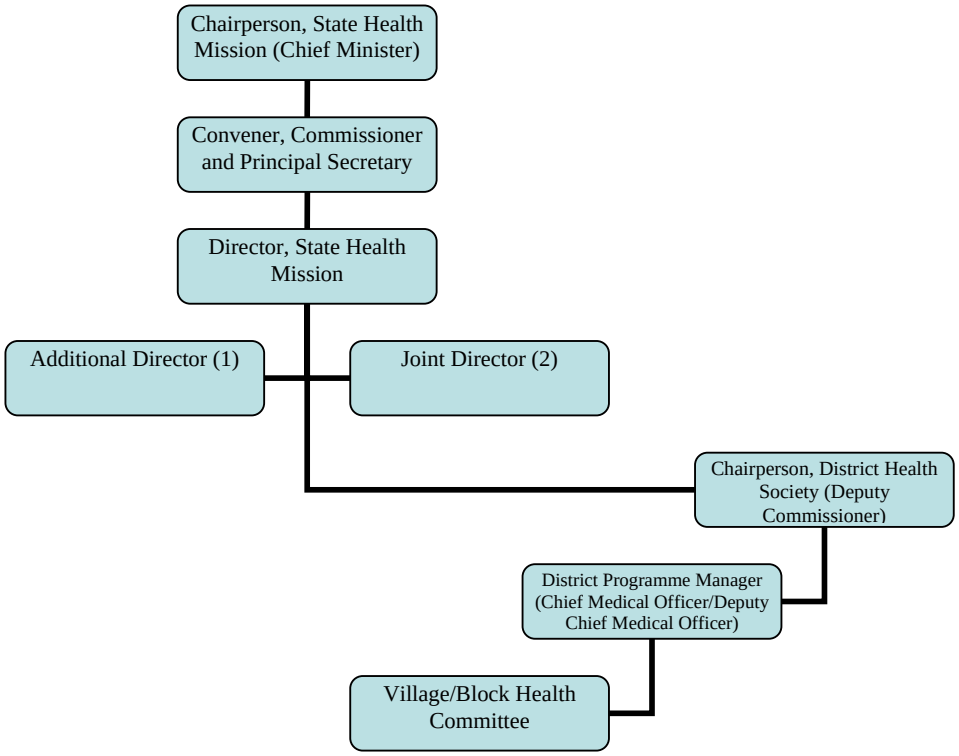
The main objectives of NRHM are to:

- provide accessible, affordable, accountable, effective and reliable health care facilities in the rural areas, especially to the poor and vulnerable sections of the population;
- involve community in planning and monitoring;
- reduce infant mortality rate, maternal mortality rate and total fertility rate for population stabilisation; and
- prevent and control communicable and non-communicable diseases, including endemic diseases.

3.2.3 Organisational set-up

The organisational structure for implementation of NRHM in the State is given below:

Chart 3.2.1



3.2.4 Scope of Audit

A mid-term performance review of the scheme was carried out between May and August 2008 covering the progress of various activities of NRHM during 2005-08. Four[8] out of 11 districts were selected for detailed review based on random sampling method and records of the State Health Society (SHS), four District Health Societies (DHSs), four Community Health Centers (CHCs) out of 10 in the selected districts, eight Primary Health Centres (PHCs) out of 37 in the selected districts and 16 Sub Centres (SCs) out of 176 in the selected districts were examined in detail. Out of a total expenditure of Rs.53.26 crore incurred on the activities of the Mission during the review period, Rs.43.33 crore (81 *per cent*) was covered in audit.

3.2.5 Audit objectives

The audit objectives were to see whether:

- Planning for implementation of various components of the programme was based on realistic and reliable data from the village, block and district level;

[8] Kohima, Tuensang, Mokokchung and Dimapur

- Health service delivery infrastructure was created and equipped with trained manpower and requisite medicines;
- Performance indicators and targets fixed for various components were achieved;
- Adequate funds were released on time and utilised for the intended purpose; and
- Monitoring mechanism was effective.

3.2.6 Audit criteria

Audit findings were benchmarked against the following criteria:

- Mission guidelines issued by Union Ministry of Health and Family Welfare;
- Financial guidelines and framework for delegation of administrative and financial powers under NRHM;
- State Programme Implementation Plan;
- Prescribed Monitoring Mechanism.

3.2.7 Audit methodology

The performance review commenced with an entry conference (May 2008) with the Director, Rural Health Mission besides other implementing officers wherein, the audit objectives, criteria, scope and methodology were discussed. Audit conclusions were drawn after a scrutiny of records relating to the implementation of the various components of the Mission for the years 2005-08. The report was finalised after taking into account the views put forth by the Department during an exit conference (November 2008).

Audit findings

Audit findings are detailed in the succeeding paragraphs:

3.2.8 Planning

3.2.8.1 Household survey and preparation of plan

NRHM envisaged a decentralised and participatory planning process with a bottom up approach from village level to the State level. A perspective plan for the Mission period (2005-12) and action plan for each year were to be prepared by the State by consolidating all the district level plans to enable interventions in the health sector.

For preparation of a comprehensive district action plan, a facility and household survey at the CHC, PHC and SC level was required to be conducted.

Scrutiny of the records of SHS revealed that no household survey was conducted during the years 2005-07. The survey was conducted only in seven[9] out of 11 districts (64 *per cent*) in the State during 2007-08. The SHS had, however, not compiled the household survey data submitted by these seven districts (August 2008). Further, facility survey of CHCs/PHCs/SCs was not fully conducted by the respective districts. The details in this regard are shown in the table below:

Table 3.2.1

CHC			PHC			SC		
Total CHCs in the State	Facility survey conducted	Facility survey not conducted	Total PHCs in the State	Facility survey conducted	Facility survey not conducted	Total SCs in the State	Facility survey conducted	Facility survey not conducted
21	18	3	86	74	12	397	342	55

(Source: survey report of the SHS)

As can be seen from the above, though the State Government has done quite well by conducting facility survey in respect of 434 out of 504 units (86 *per cent*), the survey in respect of 70 units is yet to be done (August 2008).

In the absence of a complete household and facility survey, the Department could not have a complete database for a meaningful assessment of health care services and identify the gaps for future course of interventions on need analysis for formulation of the State Project Implementation Plan (SPIP) covering all the villages, blocks and districts of the State.

The District Health Action Plan (DHAP) prepared by the DHS incorporating the block plans of all NRHM activities are to be submitted to the SHS for incorporation in the State Plan and onward transmission to the National Programme Co-ordination Committee (NPCC) for their appraisal.

Scrutiny revealed that during 2005-06 and 2006-07 none of the districts prepared the DHAP and the State plan for 2006-07 was prepared without incorporating the DHAP and other NRHM activities i.e., National Disease Control Programmes. Seven[10] out of 11 DHS prepared DHAPs only in 2007-08. Hence, bottom up approach as envisaged in the guidelines was not adopted in the preparation of plans for NRHM activities.

GOI in fact, released Rs.1.10 crore during March to September 2007 for the preparation of DHAP in respect of all 11 districts on the basis of the NPCC's approval (November 2006). Scrutiny revealed that against the approval of Rs.1.10 crore, Rs.1.65 crore was incurred for preparation of DHAP during 2006-07 and 2007-08. Of these, only Rs.38 lakh was released to the 11 districts while the remaining Rs.1.27 crore was spent by the SHS. Besides, there was an excess expenditure of Rs.55 lakh in violation of NPCC approval.

While admitting (November 2008) the facts, the Department stated that the excess expenditure would be adjusted in the following financial year (2008-09).

[9] Kohima, Mokokchung, Dimapur, Longleng, Kiphire, Phek and Peren.

[10] Kohima, Mokokchung, Dimapur, Longleng, Kiphire, Phek and Peren.

3.2.9 Financial management

3.2.9.1 Funding pattern

GOI provided 100 *per cent* funds for implementation of the scheme to the Director, SHM through bank drafts during 2005-06 to 2006-07. From 2007-08 onwards, the contribution was to be in the ratio of 85:15 between the Centre and the State.

3.2.9.2 Financial performance

The details of the funds released by the GOI and the State Government and expenditure thereagainst during 2005-08 were as under:

Table 3.2.2

(Rupees in crore)

Year	Opening Balance	Funds released		Total	Expenditure	Closing Balance
		GOI	State share			
2005-06	0.42	11.66	-	12.08	3.77	8.31
2006-07	8.31	24.08	-	32.39	22.67	9.72
2007-08	9.72	35.53	-	45.25	26.82	18.43
Total		**71.27**	**-**		**53.26**	

(*Source*: *Annual accounts of State Health Society excluding grants of other disease control programmes)*

3.2.9.3 Non release of State matching share

As per NRHM guidelines, the contribution was to be in the ratio of 85:15 between the GOI and the State Governments from 2007-08 onwards. While the GOI released Rs.35.53 crore during 2007-08, the State Government failed to release its corresponding share.

The Department, in reply (November 2008) stated that the State share of Rs.6 crore was released and distributed to DHS. The reply is not acceptable as the fund was released by the Department through its regular budget for being spent in the State on health sector and was not related to NRHM activities which is evident by the fact that the amount was not reflected in the annual accounts of the SHS as well as DHS.

3.2.9.4 Non release of funds through State Health Society

GOI issued a directive (July 2005) to merge all the State Level Vertical Societies under National Disease Control Programmes (NDCP) into an integrated society. The State Government, therefore, constituted the Nagaland State Health Society (February 2006) under NRHM and all the NDCPs were included in the State Programme Implementation Plan (SPIP) of SHS for 2007-08. However, the GOI continued to release funds directly to the respective Programme Officers of NDCPs and Rs.6.52 crore released by GOI during 2007-08 could not therefore be accounted for in the annual accounts of the SHS.

3.2.9.5 Untied and Maintenance Grant

Every year untied funds at the rate of Rs.50000, Rs.25000 and Rs.10000 are to be provided to each CHC, PHC and SC respectively for undertaking public health orientation activities like nutritional support, education and sanitation, environmental protection etc. The untied fund can also be used for any local health activities in case there is a demand. Similarly, maintenance grant of Rs.1,00,000, Rs.50,000 and Rs.10,000 was to be paid to each CHC, PHC and SC respectively which would be used only for major repairs, providing water, toilets etc., to ensure quality services through functional physical infrastructure.

The following was observed in this regard:

(i) Untied funds of Rs.32.50 lakh for 325 SCs released by GOI during 2005-06 was diverted by SHS to State Communitisation Committee for purchase of medicines instead of orientation of village and public health activities through SCs.

(ii) None of the SCs furnished statement of expenditure (SOE) to the respective District Health Societies for Rs.50.40 lakh released to SCs in the selected districts during 2006-07 and 2007-08 (August 2008). Inspite of not receiving the SOEs for the previous year, an amount of Rs.35 lakh was released as untied and maintenance grant during 2007-08 by the SHS which was irregular. While accepting the observation, the Department stated that SOEs are now being received on fairly regular basis.

(iii) During the year 2007-08, the GOI released Rs.39.90 lakh as annual maintenance grant for all the SCs functioning in the State. It was seen that out of 397 SCs functioning in the State, 137 SCs were located in rented buildings and maintenance of rented buildings was not permissible. Thus, the release of Rs.13.70 lakh as maintenance grants to SCs functioning in rented buildings was irregular. While accepting the fact, the Department stated that since the SCs were functioning from rented buildings the funds were being utilised for payment of rent.

3.2.10 Programme implementation

3.2.10.1 Infrastructure

As per NRHM norms one CHC, PHC and SC is to be set up for a population of 80000, 20000 and 3000 respectively in tribal and hilly areas. The total population of Nagaland as per census 2001 is 19.88 lakh. The requirement as compared to the population and creation of CHC, PHC and SC in the State is detailed below:

Table 3.2.3

Details	Requirement as per norms	Actually created	Shortfall (-)/ excess (+)
CHCs	25	21	(-) 4 (16)
PHCs	99	86	(-) 13 (13)
SCs	663	397	(-) 266 (40)

(Source: SHS, NRHM) *(figures in brackets represent percentage of shortfall)*

The above table reveals that there was a shortfall in creation of CHCs (16 *per cent*), PHCs (13 *per cent*) and SCs (40 *per cent*) in the State. Nagaland being a hilly State, non-creation of the required number of CHCs/PHCs/SCs has resulted in denying the benefits of basic health care facilities to the rural population as envisaged in the Mission and the people were forced to travel long distances to avail of medical facilities.

The requirement of CHC/PHC/SC in the districts selected for detailed check vis-à-vis actual availability is detailed in the table below:

Table 3.2.4

Name of the district	Population of the district	Requirement			Created			Excess(+)/Shortfall(-)		
		CHC	PHC	SC	CHC	PHC	SC	CHC	PHC	SC
Kohima	238619	3	12	80	3	12	40	-	-	(-) 40
Mokokchung	227230	3	11	76	3	11	51	-	-	(-) 25
Dimapur	308382	4	15	103	2	6	46	(-) 2	(-) 9	(-) 57
Tuensang	164361	2	8	55	2	8	39	-	-	(-) 16
Total	**938592**	**12**	**46**	**314**	**10**	**37**	**176**	**(-) 2**	**(-) 9**	**(-) 138**

Source: Census 2001 and departmental records.

There was shortfall of 2 CHCs, 9 PHCs and 57 SCs in Dimapur district while there was a shortfall of 40, 25 and 16 SCs in Kohima, Mokokchung and Tuensang districts respectively. Considering that the SC is the first point of interaction between the rural populace and the health authorities, shortfall in setting up SCs would affect the implementation of various components of the Mission adversely. Apart from shortfall in creation of CHC/PHC/SC, there was shortage of manpower and lack of equipment in the CHC/PHC/SCs as detailed below:

There was a shortage of medical officers while there was excess para-medical staff in the CHCs. The PHCs had a shortage of both medical officers and para-medical staff, whereas the SCs had shortage of para-medical staff at the selected health centres as detailed in the table below:

Table 3.2.5

Category of centres	Manpower required (as per IPHS norm)		Men-in-position		(-) Short/(+) Excess	
	Medical Officers/ Specialists	Paramedical staff	Medical Officers/ Specialists	Paramedical staff	Medical Officers/ Specialists	Paramedical staff
CHC	28 (7 each x 4 CHCs)	52 (13 each x 4 CHCs)	14	101	(-) 14	(+) 49
PHC	16 (2 each x 8 PHCs)	72 (9 each x 8 PHCs)	8	49	(-) 8	(-) 23
SC	Nil	32 (2 each x 16 SCs)	Nil	47	Nil	(+) 15

Source: Figures furnished by CHCs, PHCs, SCs

Further, the selected health centres had not been provided with the required basic physical infrastructure, necessary equipment to deliver the essential/specialist services etc., as mentioned below:

- Though there was an Operation Theatre (OT) in all the four selected CHCs, none of the centres was provided with Anaesthetists.
- Against the sanctioned strength of four Surgeons, only one Surgeon was posted in Changtongya CHC.
- Light was available in OT only in one CHC i.e., Viswema CHC.
- No CHCs were provided with Gynecologists and male and female specialists.
- None of the CHCs was provided with the essential equipment[11].
- Services pertaining to cataract surgery, facilities for tubectomy and vasectomy, extension of AYUSH service, indoor bed for paediatric patients were not available in PHCs test-checked.
- None of the SCs was stocked with two months essential medicines, as required under Indian Public Health Standards (IPHS) norms.
- Out of 16 test-checked SCs, Intranatal Care facilities were not available in 9 SCs.
- 24 hour service for referral of complicated cases was not available in 12 out of 16 SCs reviewed.

[11] Boyles apparatus, EMO machine, cardiac machine for OT, defibrillator for OT, ventilator for OT, OT care/fumigation apparatus, oxygen cylinder.

Thus, the CHCs/PHCs/SCs were functioning without adequate medical officers/specialists, para-medical staff, equipment and medicines and therefore it is evident that they are not able to deliver health care facilities to the rural populace as envisaged in the Mission.

3.2.10.2 Up-gradation of CHC

During 2005-06 and 2006-07, GOI released Rs.5 crore (Rs.3.40 crore + Rs.1.60 crore) towards up-gradation of 25 CHCs in the State at the rate of Rs.20 lakh to each CHC. The GOI while releasing the funds stipulated that at least two CHCs in a district should be upgraded to the level of IPHS.

The following was observed in this regard:

(i) As per the norms only 33 *per cent* would be spent for civil works and remaining for medicine and equipment. The SHS spent Rs.67.44 lakh (including purchase of a ready built building) towards civil works for upgradation of two CHCs against the permissible amount of Rs. 13.20 lakh. Therefore, an amount of Rs.54.24[12] lakh was spent on civil works in excess of the prescribed norms.

(ii) The Department also diverted an amount of Rs.40 lakh for execution of works under PMGY.

Besides the above shortcomings, it was also noticed that out of 25 CHCs taken up for upgradation by the Department, only two CHCs in one district had been upgraded to the level of IPHS after incurring an expenditure of Rs. 5 crore meant for upgradation of 25 CHCs in the State.

The Department during exit conference accepted the observations and stated that it is not practical to follow the GOI norms in Nagaland. The fact, however, remains that the State Government has spent the total grants received by it and it has also not taken up the matter with the GOI for exemption in case of non-feasibility of implementing any component/activity under NRHM.

3.2.10.3 Accredited Social Health Activist (ASHA)

The main aim of NRHM is to provide accessible, affordable, effective and reliable primary health care facilities to the poor and vulnerable sections of the population. For this purpose, operationalisation of the cadre of ASHA was considered most important.

As per NRHM guidelines, one married/widowed/divorced woman in the age group of 25 to 45 years possessing formal education up to Class VIII was to be selected by the village committee as ASHA from the village wherein she would render her services with close liaison with the village councils. ASHA are not paid any formal salary but are

[12] Rs 20 lakh per CHC x 2= Rs 40 lakh; Admissible as per norms of 33 *per cent* for civil works computes to Rs 13.20 lakh. Excess over norms= Rs.67.44 lakh – Rs.13.20 lakh=Rs.54.24 lakh.

compensated with incentives at the prescribed rates. They act as a link between the Government health system and the community for all health related services.

One ASHA was to be provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norm could be relaxed for one ASHA per habitation depending on the workload. As per this norm, the State required a total of 1278 ASHAs. Against this requirement, the number of ASHAs appointed along with training imparted (against the requirement of 23 days training in five modules) is detailed in the table below:

Table 3.2.6

Year	No. of ASHAs appointed	No. of ASHAs imparted induction training (module-wise)					Shortfall in induction training				
		1st	2nd	3rd	4th	5th	1st	2nd	3rd	4th	5th
2006-07	1180	1101	309	0	0	0	79	871	1180	1180	1180
2007-08	79	44	0	0	0	0	35	79	79	79	79
Total	**1259**	**1145**	**309**	**0**	**0**	**0**	**114**	**950**	**1259**	**1259**	**1259**

Source: Information furnished by SHS.

The above table reveals that none of the 1259 ASHAs appointed during the review period were imparted training even upto the 3rd module (August 2008).

The GOI provided upto Rs.10,000 per ASHA for training, monthly orientation, drugs, kit, support material, travel expenses etc. The Department received a total grant of Rs.2.44 crore for this purpose till March 2008, out of which, Rs.2.18 crore was expended. Against the maximum permissible amount of Rs. 1.26 crore for 1259 ASHAs in the State, the Department spent Rs.2.18 crore resulting in an expenditure of Rs. 0.92 crore in excess of the norms. Scrutiny revealed that this excess expenditure was due to the procurement of ASHA kits in excess of requirement as detailed below:

Against the requirement of 1259 kits, the SHS procured 8963 kits valued at Rs.1.57 crore (8963 x Rs.1756) during 2006-07. Out of these, 3423 kits were distributed to the districts and the remaining 5540 kits were retained in the Directorate's stock (August 2008). Out of the 3423 kits distributed to the districts, 1259 were distributed to ASHAs and the balance 2164 kits remained in stock in the districts. Thus, there was an avoidable extra expenditure of Rs. 1.35 crore on procurement of kits beyond requirement.

The Department accepted the observations during the exit conference and stated that the matter was under investigation.

3.2.10.4 Procurement and distribution of Mobile Medical Unit (MMU)

Considering the difficult hilly terrain, the GOI sanctioned Rs.5.61 crore during 2006-07 (capital cost:Rs.3.63 crore and recurring cost: Rs 1.98 crore) for providing health care at the door step of the residents through Mobile Medical Units (MMU) (one per district) equipped with specialised facilities.

Scrutiny revealed that an expenditure of Rs.3.58 crore was incurred on the purchase of 11 Boleros (8 seater) and 11 mobile vans and Rs 1.43 crore was spent on drugs and

manpower. The Boleros and the mobile vans were issued to the districts. While the Boleros were used by the Chief Medical Officers (CMOs), the mobile vans remained idle.

Thus, the objective of taking health care to the door steps of the people in the under-served areas was not accomplished despite incurring an expenditure of Rs. 5.01 crore.

The Department accepted the observations during the exit conference and stated that the matter was under investigation.

3.2.11 Immunisation

3.2.11.1 Intensified Pulse Polio Immunisation (IPPI) Programme

Intensified Pulse Polio Immunisation (IPPI) programme was organised on National Immunisation days/Sub-National Immunisation Days with the aim of eradicating polio and to ensure zero transmission by the end of 2008 by providing oral polio vaccine and its related operating cost in various polio rounds.

Children in the age group of 0-5 years were immunized through different rounds in the State. The details of children vaccinated through immunization during 2005-08 are detailed below:

Table 3.2.7

Year	Immunisation days		Total number of children in the State	No. of children vaccinated	Percentage of achievement
	IPPI round	Date			
2005	1st	10 April	315407	258548	82
	2nd	15 May	315407	256778	81
2006	1st	9 April	331485	245530	74
	2nd	21 May	331485	247567	75
2007	1st	7 January	331485	270537	82
	2nd	11 February	331485	264743	80
2008 (upto March)	1st	January	348384	228940	66
	2nd	February	348384	250570	72

(Source: SHS data)

It is evident from the above that the State could administer polio vaccine to only 76 *per cent* of the children on an average thereby failing to fulfill the aim of eradicating polio and to ensure zero transmission by the end of 2008.

The Department accepted the observation during the exit conference.

3.2.12 Disease Control Programme

The following six National Disease Control Programmes were taken up for implementation in the State under NRHM.

(i) National Vector Borne Disease Control Programme (NVBDCP)
(ii) National Programme for Control of Blindness (NPCB)
(iii) Revised National Tuberculosis Control Programme (RNTCP)
(iv) National Leprosy Eradication Programme (NLEP)
(v) National Iodine Deficiency Disorder Control Programme (NIDDCP)

(vi) National Integrated Disease Surveilance Project (NIDSP)

Out of the above six programmes, one item i.e. National Vector Borne Disease Control Programme was test-checked and the following were observed.

3.2.12.1 National Vector Borne Disease Control Programme (NVBDCP)

The NVBDCP was launched (1977) in the State to reduce morbidity and mortality and to increase Annual Blood Examination Rate (ABER) to cover the targeted population by indoor residual spray of DDT, and to provide diagnosis and treatment facilities in all villages, blocks, PHCs and SCs.

The incidence of malaria positive cases indicated an upward trend from 2989 (2005-06) to 4976 (2007-08) and the number of deaths due to malaria also increased from Nil in 2005-06 to 75 in 2006-07. The details of Blood Slide Examination (BSE), ABER positive cases, P. Falcirum (PF) and death cases during 2005-08 are shown in the table below.

Table 3.2.8

Year	Targeted population	Malaria						
		BSE	ABER (*per cent*)	Positive	PF	PF percentage	API	Deaths
2005-06	1805632	64482	3.57	2989	90	3.01	1.65	Nil
2006-07	1805632	91953	5.09	3361	506	15.05	1.86	75
2007-08	1805632	105856	5.86	4976	806	16.19	2.75	26

(Source: SHS data)

The NVBDCP guidelines stipulated increase of ABER to 10 *per cent* of the target population under surveillance and Annual Parasite Incidence of less than 0.50 per thousand for the country. However, the programme has fallen short on these counts. Due to non-achievement of the requisite increase in ABER, the performance relating to positive and PF cases detection has also been portrayed on the lower side.

3.2.13 Village Health and Sanitation Committee

A Village Health and Sanitation Committees (VHSC) were to be formed in each village/hamlet to create public awareness on health, nutritional activities, maintenance of village health registers, health information board, preparation of village health plan etc.

As per NRHM norms every village with a population of upto 1500 is entitled to get an annual untied grant of Rs.10,000. Out of the total 1278 villages in the State, 995 villages have a population of upto 1500. The details of VHSC constituted in the State, grants received from GOI and released to VHSCs are shown in the table below:

Table 3.2.9

Year	Total No. of villages in the State	No. of VHSCs constituted	No. of VHCs entitled for grants as per norm	No. of VHSCs to whom grants were released	Annual funds required as per norm	Funds released by GOI	Fund released to VHSCs	Unspent balance
					(Rupees in lakh)			
2006-07	1278	1278	995	334	33	40	33	7
2007-08	1278	1278	995	634	63	128	63	65
Total					**96**	**168**	**96**	

(Source: Annual accounts and other records)

It would be seen from the above that there are 995 VHSCs with a population of upto 1500 against which, only 634 VHSCs were made functional leaving 361 non functional as of March 2008. Against the receipt of Rs. 168 lakh from the GOI, the Department spent Rs.96 lakh leaving an unspent balance of Rs. 72 lakh. Thus, 361 villages were deprived of intended services of VHSCs.

3.2.14 Formation of Rogi Kalyan Samiti (RKS)

The Rogi Kalyan Samitis (RKS) were to be formed in each health centre to upgrade the SCs, CHCs and PHCs to Indian Public Health Standards to provide sustainable quality health care with people's participation and to make the community accountable and responsible in running these rural health centres. NRHM guidelines provided that constitution of 50 *per cent* of RKS would be completed by 2007 and *cent per cent* by 2009. Financial assistance of rupees five lakh to each rural hospital and rupees one lakh to each CHC and PHC are to be released annually by GOI, only when the State Government authorises the RKSs to retain the user charges.

Scrutiny of records of the Mission Director revealed that against the target of 160 RKS, only 32 RKS (11 DHs and 21 CHCs) could be constituted as of March 2008. Year-wise financial position of RKS is shown in the table below:

Table 3.2.10

(Rupees in lakh)

Year	Total number of RKS targeted	No. of RKS established		Total	Release of funds by GOI		Release of fund by SHS
		District Hospital	CHC		Require-ment	Funds released	
2006-07	160	11	-	11	55	55	55
2007-08	160	-	21	21	76	204	55
Total		**11**	**21**	**32**	**131**	**259**	**110**

(Source: Approved annual accounts of the society)

It would be seen from the above table that the SHS did not release funds of Rs.21 lakh (Rs.1 lakh x 21) to the RKS created at CHC level during 2007-08.

Test check of the records of selected four District Hospitals revealed that during 2006-07 and 2007-08 user charges collected for Rs.86.25 lakh in three DHS were not generated through RKS accounts. Thus, release of funds to RKS without insisting on retention of funds, was in contravention of NRHM guidelines.

The Department, in reply (November 2008) stated that the entire fund could not be released to the RKS constituted at CHC level during 2007-08 due to non opening of bank accounts by the RKS.

3.2.15 Information, Education and Communication (IEC) activities

IEC forms a vital part of the health programme, to create awareness and dissemination of information regarding availability of quality health care. In addition, it seeks to correct the behaviour patterns that have an adverse impact on health, particularly among the weaker sections of the society. Activities of IEC Bureau are aimed at reducing birth rate, infant mortality rate, increasing coverage of maternal care and immunization of pregnant women and children through media, wall writings etc.

The State Medical Department had established an IEC Bureau in 1989. Annual Action Plans (AAP) for IEC activities were being drawn since inception of the Mission indicating the proposed activities and the estimated cost for 2005-08. Rupees 98.75 lakh were received from the GOI during 2005-08 for the IEC activities and have been spent on the intended activities of the IEC quite satisfactorily.

3.2.16 Quality Control

It is the primary responsibility of the Health Department to procure medicines from enlisted dealers and ensure quality of the medicines by proper checks before supplying them to the hospitals for their use. Though the Health & Family Welfare Department has a Drug Controller in charge, there is no system of lab testing of medicines in the State. This is all the more important in view of the fact that there were cases of death of two female patients in August 2005 at PHC Thonoknyu under Tuensang district and again of two children in Sanglao village under Tuensang district in September 2006. The samples of the drugs administered to the above patients have been sent for testing at Guwahati and Kolkata. Final reports in this regard are awaited.

3.2.17 Non production of records on purchase of medicines under NRHM flexible pool

An amount of Rs.50 lakh was released in February 2007 to the Principal Director, H&FW for procurement of medicines, nursing sundries etc., under NRHM flexible pool, which was in turn released to two firms[13] (Rs.20 lakh and Rs.30 lakh) for supply of these items.

Tender quotation, supply orders, vouchers and stock registers in support of the purchase of goods could not be produced to audit in spite of repeated requisitions in June 2008. In the absence of the relevant records, audit could not ascertain if these items were actually procured. The entire expenditure of Rs.50 lakh therefore seems to be doubtful.

3.2.18 Monitoring and evaluation

As per programme guidelines, there was a five tier system of monitoring and supervision viz., State level, District level, Block level, PHC level and Village level. At the State

[13] M/s. Brahmaputra Pioneers and Indian Trade Centre

level, the SHS was to evolve a monitoring format indicating the process and quality indicators in order to track the quality of programme implementation through various activities. At the District level, the DHS is to contribute for development of District Health Plan based on an assessment of the situation and priorities of the District. Similarly at Block, PHC and Village level, all the committees were to move towards a community based monitoring that allowed continuous assessment of planning and implementation of the programme. The main purpose of the monitoring framework at different levels was to provide accessible, affordable and quality health care to the rural people.

The Department however, during the years 2005-08, has not formulated any monitoring mechanism for complying with the above guidelines. Besides, no evidence whatsoever was available in records to show that the Department had taken any steps to evolve a monitoring mechanism.

The Department while admitting the facts stated (November 2008) that monitoring and evaluation activities have been increased for proper and effective implementation of the NRHM activities from 2008-09.

3.2.19 Conclusion

The implementation of the Mission activities as noticed in the mid-term review for the period 2005-08 was not encouraging due to non-completion of household and facility survey within the targeted date and non-identification of the gaps in rural healthcare. There was a shortfall in the creation of infrastructure and inadequate number of medical officers, medicines and equipment. This was further compounded by non-release of State share of funds and non-existence of monitoring mechanism in the Department which points to the possibility that the State may not achieve the objectives of the Mission by the target date.

3.2.20 Recommendations

- A comprehensive plan should be prepared breaking down the targets into actionable items, indicating need-based, locality specific requirements of infrastructure;

- Household and facility surveys at village, block and district levels need to be conducted at regular intervals and gaps in health care services should be identified and appropriate corrective action taken;

- Projects taken up during the year should be widely publicized to ensure accountability at various levels;

- Monitoring and supervision of the Mission activities should be strengthened by establishing monitoring and planning committees at all levels as envisaged in the Mission Guidelines.