HEALTH AND FAMILY WELFARE DEPARTMENT

1.3 Implementation of National Rural Health Mission

The National Rural Health Mission (NRHM) was launched in April 2005 in the country with a view to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections of the society. The key strategy of NRHM was to support and supplement the efforts of the State for strengthening health system through the provision of financial and technical assistance.

Highlights

The State Government did not conduct household surveys to identify the local needs of health care. Village Health Action Plans were not prepared.

{Paragraph 1.3.7.1(B)}

Lack of proper assessment by the State Health Society (SHS) led to short release of ₹ 273.46 crore by Government of India (GoI). Even out of the funds provided by GoI, SHS could utilise only 51 to 69 *per cent* during 2011-16. ₹ 1.51 crore advanced to 116 officials was lying outstanding.

(Paragraphs 1.3.7.3, 1.3.7.4 & 1.3.7.6)

The number of Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) were below the prescribed level by 12, 47 and 56 *per cent* respectively in the State. In the three test checked districts, there was a shortage of SCs, PHCs and CHCs by 11, 42 and 53 *per cent* respectively. 69.57 *per cent* test checked SCs were running without water supply and electricity and 34.78 *per cent* without toilets.

(Paragraph 1.3.7.8 & 1.3.7.9)

There were no specialists in CHCs and Sub Divisional Hospitals. In 279 SCs there was no Auxiliary Nursing Midwife/Female health worker. Four test checked CHCs did not have facilities for Caesarean Section delivery and none of the 23 test checked SCs had facilities for institutional delivery.

{Paragraphs 1.3.7.15(A) & (B) & 1.3.7.18 (A)}

Although there was a high prevalence rate of Anaemia amongst pregnant women (54.4 *per cent)* in the State, 36 *per cent* of pregnant women did not receive three Ante Natal check ups, and 40 *per cent* did not receive 100 Iron & Folic Acid tablets.

{(Paragraph 1.3.7.18(B)}

State Quality Assurance Committee had not met even once till June 2016. Internal assessment and patient satisfaction survey was not done in any of the test checked facilities. Health Management Information System lacks data integrity. Hence internal control, supervision and monitoring were inadequate.

(Paragraphs 1.3.7.24, 1.3.7.25, 1.3.7.26 & 1.3.7.27)

1.3.1 Introduction

The National Rural Health Mission (NRHM) was launched on 12 April 2005 throughout the country. The NRHM seeks to provide accessible, affordable and quality health care to the rural population. The State Government signed a Memorandum of Understanding (MoU) with Government of India (GoI) in January 2006 for implementation of NRHM in Tripura.

Components of NRHM

NRHM is an umbrella programme subsuming the existing programmes of health and family welfare and comprises of the following components:

- Reproductive and child health
- Emergency and trauma care
- Control of communicable diseases
- Non-communicable disease

Framework of Implementation

The Ministry of Health and Family Welfare in its 'Framework of Implementation (2005-2012 and 2012-2017)' had laid down some anticipated outcomes to be achieved by the end of XII Five Year Plan (2012-17). The three main expected outcomes to be achieved at the end of 31 March 2016 is indicated below (details in **Appendix-1.3.1**).

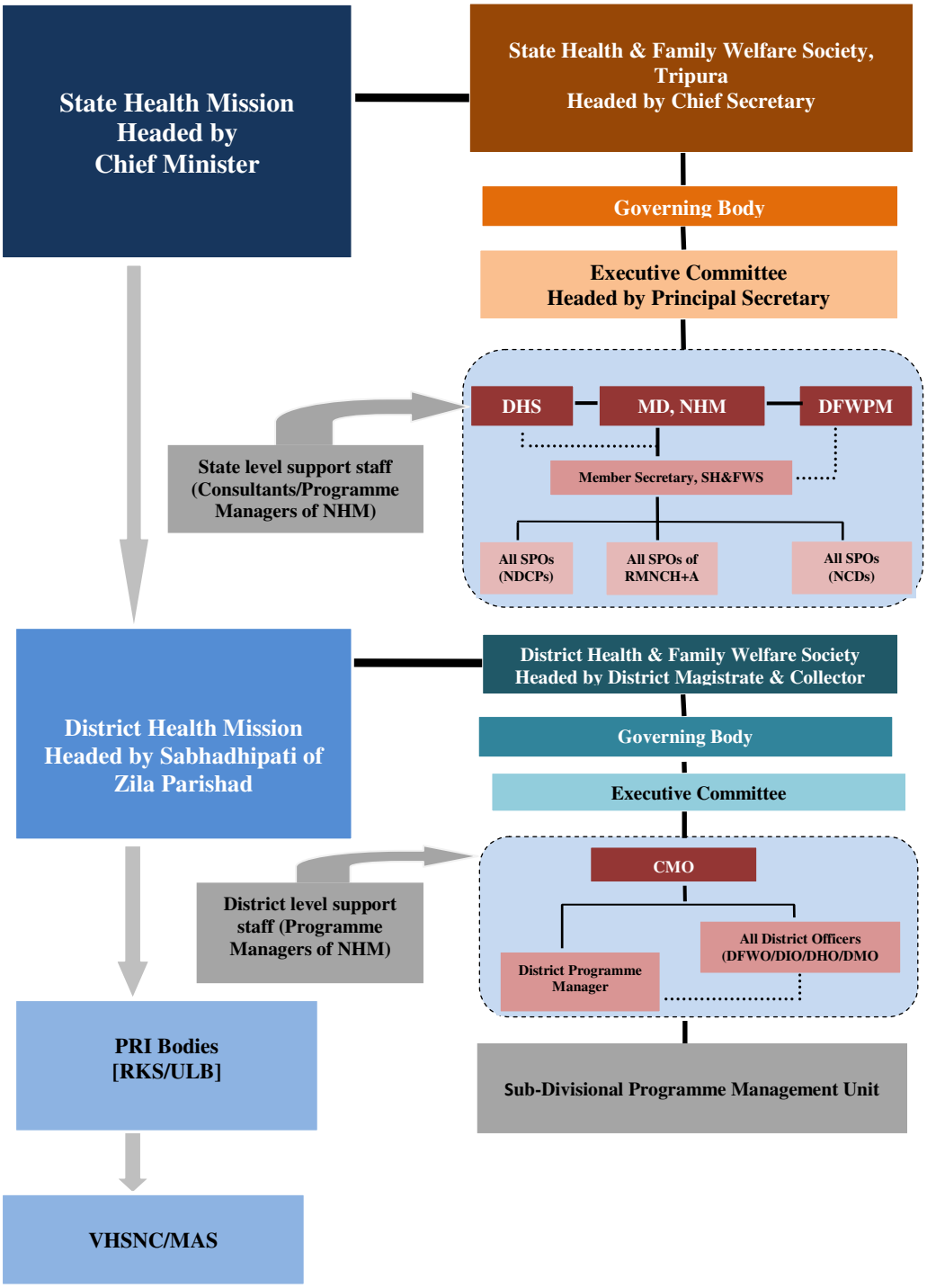
- Reduce Infant Mortality Rate (IMR) to 26/1,000 live births
- Reduce Maternal Mortality Ratio (MMR) to 100/1,00,000 live births
- Reduce Total Fertility Rate (TFR) to 2.1

1.3.2 Organisational structure

At the State level, there is a State Health Mission (SHM) headed by the Chief Minister. The activities of the SHM are carried out through the State Health Society (SHS) headed by the Chief Secretary. The Executive Committee of the Society is headed by the Principal Secretary, Health and Family Welfare Department. The State Programme Management Unit (SPMU) acts as the Secretariat to the SHM and is headed by the Mission Director.

At the District level, the District Health Mission (DHM) is headed by the *Sabhadipati* (President of Zila Parishad) and the District Health Societies (DHSs) are headed by the respective District Magistrate & Collectors. The Executive Committee is headed by the Executive Secretary (Chief Medical Officer). An organogram showing the organisational structure of NRHM in the State is shown below:

Organogram of NRHM



1.3.3 Scope of audit

A Performance Audit on implementation of NRHM in the State of Tripura was conducted during April-August 2016, covering the implementation of the programme for the period from 2011-12 to 2015-16 through test check of the records of the SHS, three[1] out of eight DHSs and District Hospitals (DHs), two blocks of each selected

[1] West Tripura, Dhalai and North Tripura District.

district, all six Sub-Divisional Hospitals (SDHs)/Community Health Centres (CHCs) under the sampled two blocks of each selected district, nine Primary Health Centres (PHCs) linked to the sampled blocks and 23 Sub Centres (SCs) linked to sampled PHCs. They were selected through statistical sampling using Simple Random Sampling Without Replacement (SRSWOR) method.

In addition, 69 Accredited Social Health Activists (ASHAs) and 230 beneficiaries[2], selected through SRSWOR method[3] under each selected SC[4] were interviewed. A list of selected units is available in **Appendix-1.3.2**.

Out of the outcome indicators specified in **Appendix-1.3.1** as per framework of implementation, we have selected Reproductive and Child Health (RCH) for analysis in this Report due to importance of these indicators in achievement of the Millenium Development Goals (2015). Further, out of the six National Disease Control Programmes, one item *i.e.* Intensified Malaria Control Project under National Vector Borne Disease Control Programme (NVBDCP) was also covered as Tripura is a Malaria prone zone.

1.3.4 Audit objectives

The Performance Audit was conducted to assess whether:

- planning was adequate, effective and in accordance with the requirements of the NRHM;
- the funds allotted were being utilised in an efficient and economic manner;
- the capacity building and strengthening of physical infrastructure and augmentation of human resources were achieved as planned and targeted;
- the performance indicators and targets fixed were achieved;
- the quality assurance, monitoring and reporting were effective.

1.3.5 Audit criteria

Audit findings were benchmarked against the following criteria:

- NRHM framework for implementation (2005-12 and 2012-17);
- NRHM operational guidelines for financial management;
- Indian Public Health Standard (IPHS) guidelines (2012) for PHCs, CHCs, SDHs and DHs;
- Operational guidelines for quality assurance in public health facilities, 2013;
- State Programme Implementation Plan (PIP) approved by National Programme Co-ordination Committee (NPCC).

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2 women who have given birth within the last 24 months.

3 SRSWOR is a method of selection of n units out of the N units one by one such that at any stage of selection, anyone of the remaining units have same chance of being selected, *i.e.* 1/ N.

4 Three ASHAs and 10 beneficiaries under each SC were selected through SRSWOR.

1.3.6 Audit methodology

The Performance Audit commenced with an entry conference on 12 April 2016 with the Principal Secretary to the Government of Tripura, Heath and Family Welfare Department, wherein the audit objectives, criteria and audit scope & methodologies were discussed. The draft Report was issued to the State Government in September 2016. The audit findings, conclusion and recommendations were discussed with the Principal Secretary in an exit conference held on 7 October 2016 and the views of the Department during exit conference have been duly incorporated in the report, where appropriate.

Audit findings

1.3.7.1 Planning

An overall perspective plan for five year period and PIP for each year were to be prepared on the basis of District Health Action Plan (DHAP). It envisaged a decentralised and participatory planning process from village level to the State level by carrying out household surveys, facility and baseline surveys.

(A) Perspective plan

According to NRHM framework, the districts would be expected to prepare Perspective Plans (PPs) for the entire Mission period outlining the year wise resource and activity needs of the district. The DHAP is the key strategy for integrated action under NRHM.

The PPs for the period under audit could not be produced to audit at the State level though called for repeatedly. The same could also not be produced in any of the test checked districts as the same were not prepared. This was confirmed by the test checked districts when asked specifically. Consequently, gaps in services, areas requiring intervention, probable investment in each area as well as requirement and availability of resources were not identified. Moreover, no baseline data had been determined against which improvements were to be benchmarked.

The absence of perspective planning had resulted in failure to effectively identify gaps in health facilities and areas of intervention.

(B) Programme Implementation Plan

Under NRHM, financing to the State is based on the State's PIPs. The annual State PIPs were to spell out key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.

According to the operational guidelines for financial management of NRHM, a 'bottom up' approach should be followed for planning and budgeting. The process should begin with the preparation of Village Health Action Plans (VHAPs) for ensuring access to health services at the village level. At the next level, Block Health Action Plans (BHAPs) were to be prepared based on village level plans. The BHAPs were to be aggregated to form an integrated DHAP which was to be sent to the State

level. The DHAPs of all districts were to be compiled and aggregated at the State level for framing the State PIP.

Test check of records revealed the following:

(i) The State PIPs were being prepared by the directorate on the basis of DHAPs. However, DHAPs were not prepared on the basis of formal plans of the lower formations. None of the villages, PHCs and CHCs in the State had prepared health plans during 2011-16 pointing towards lack of participation/involvement of the community in preparation of plans. Thus, it could not be ensured whether State PIPs were need based and these adopted a participatory approach.

(ii) As per the framework, facility and household surveys were to be conducted to identify the core/deficient indicators in order to identify areas and improve health services in the State. The NRHM household surveys were to be conducted through ASHAs and Anganwadi Workers in order to allow effective convergent action. However, scrutiny by audit revealed that in Dhalai District (one of the three test checked districts) no health facility surveys were conducted. It was further noticed that habitation/village based household surveys were not conducted in any of the three test checked districts to identify the local needs and gaps in health care facility.

Thus, the underserved areas in the districts remained unidentified. Further, due to absence of household surveys, core/deficient indicators in the locality/villages were not identified.

It was further noticed that:

(i) PIPs (2011-16) did not mention the extent of utilisation of existing and new infrastructure which was required as per the guidelines. PIPs stated physical and financial achievements of previous years, however, there was no mention about the quality of interventions and their outcomes.

(ii) In all the PIPs, physical and financial progress of the previous year (upto December) was mentioned. However, reasons for shortfall in achievements and need, if any, to change strategies/interventions were not analysed. As a result, subsequent PIPs did not contain remedial measures.

(iii) In PIP 2015-16, proposals involving convergence with other departments to control Malaria and other vector borne diseases were made. However, it was noticed that the concerned PIP did not elaborate on data sharing, planning for physical and human resources, mechanism for joint monitoring, coordination, etc.

Thus, the state planning process was not comprehensive and it failed to put in place the horizontal and vertical linkages required for effective implementation of the scheme in the State.

The Department stated (October 2016) that VHSNCs were present in each Gram Panchayat (GP)/Autonomous District Council (ADC) village where Panchayati Raj Institutions (PRIs) representative was a member along with health staff. Any required activities were sent to PHC before incorporation in the district plan.

But the fact remained that the VHAPs were not prepared.

1.3.7.2 Utilisation of funds

The National Health Policy 2002 recommended that State Governments should allocate 8 *per cent* of the budget to the Health Sector by 2010. According to NRHM framework, the State Government should maintain a minimum of 10 *per cent* annual increase in budgetary outlay on Health Sector. The year wise details of total public spending during 2011-16 are as under:

Table No.1.3.1: Details of funding in Health Sector in the State

(₹ in crore)

Year	Expected population *(in lakh)*	Total spending including NRHM on Health Sector	GSDP[5]	Spending to GSDP on Health Sector	State spending on health care through budget (excluding CASP[6])	Total budget of the State	*Percentage* of spending on Health Sector on total budget	Yearly increase in State spending *(per cent)*	Per capita spending on Health Sector *(in ₹)*
2011-12	36.71	339.12	18795.53	1.80	296.54	7054.72	4.20	31.56	924
2012-13	37.25	311.62	21289.38	1.46	288.28	8282.37	3.48	-2.79	837
2013-14	37.80	408.83	25039.40	1.63	381.40	9642.30	3.96	32.30	1082
2014-15	38.36	646.43	29113.19	2.22	462.37	12399.45	3.73	21.23	1685
2015-16	38.92	610.33	33189.03	1.84	410.74	12993.10	3.16	-11.16	1568

(**Source:** Quarterly Review Report of the Finance Minister for the 3rd Quarter of 2015-16, Annual Financial Statement of 2012-13 to 2016-17, Budget at a Glance of 2011-12 to 2016-17 and Finance Accounts 2015-16)

It was observed that:

- During 2011-16, spending on health sector was in the range of 3.48 to 4.20 *per cent* of the State budget which was below the recommended 8 *per cent*.
- State spending on Health Sector showed a mixed trend. It decreased in 2012-13 by 2.79 *per cent*, showed an increasing trend in 2013-14 & 2014-15 and again decreased in 2015-16 by 11.16 *per cent*.

According to the Health and Family Welfare Statistics in India (2015)[7], every fifth resident of Tripura (20 *per cent*) does not use Government health facilities and prefers private medical sector. Among the various reasons mentioned in the publication brought out by the Ministry, nearly half (47.10 *per cent*) gave 'poor quality of care' as a major reason. Distance of the public sector facility (29.40 *per cent*), long waiting time (23.80 *per cent*) and inconvenient hours of operation (20.40 *per cent*) were other significant reasons cited. This shows that despite Government efforts, health facilities have not gained the confidence of a significant percentage of the population.

5 Gross State Domestic Product.
6 CASP-Central Assisted State Plan.
7 Published by Ministry of Health & Family Welfare, Government of India.

1.3.7.3 Availability of funds and expenditure

The details of availability of funds *vis-à-vis* expenditure and the contribution of Central and State share thereof under NRHM from 2011-12 to 2015-16 are shown in **Table No. 1.3.2.**

Table No. 1.3.2: Availability of funds and expenditure figure of State Health Mission

(₹ in crore)

Year	Opening balance	Funds received		Bank interest received	Total availability of funds	Expenditure incurred (*per cent* in bracket)		Refund to GoI	Closing balance
		GoI share transferred to SHM	State share						
2011-12	125.53	62.32	28.75	1.38	217.98	115.56	(53)	0	102.42
2012-13	102.42	75.38	0.33	1.33	179.46	123.78	(69)	0	55.68
2013-14	55.68	134.92	21.41	1.59	213.60	107.94	(51)	10.37	95.29
2014-15	95.29	109.77	14.17	2.05	221.28	133.58	(60)	0	87.70
2015-16	87.70	107.64	12.35	1.11	208.80	118.89	(57)	0	89.91
Total		**490.03**	**77.01**	**7.46**		**599.75**		**10.37**	

(**Source**: Information furnished by the State Health Society, NRHM)

During 2011-16, against total availability of ₹ 700.03 crore, actual utilisation was ₹ 599.75 crore with percentage of utilisation ranging from 51 to 69 *per cent*. Poor utilisation of funds was mainly noticed due to delay in procurement of medicine, equipment, construction and huge vacancies in human resources, which are discussed in ensuing paragraphs.

The Mission Director, NRHM accepted (August 2016) the audit findings.

1.3.7.4 Sanction and release of Central and State share

NRHM funds were to be provided by the Central and State Government in the ratio of 85:15 upto 2011-12 and thereafter in the ratio of 90:10. The outlays approved as per annual approved plans from 2011-12 to 2015-16 and proportionate share of Central and State Government are shown in **Chart Nos. 1.3.1 & 1.3.2** below:

Chart No. 1.3.1

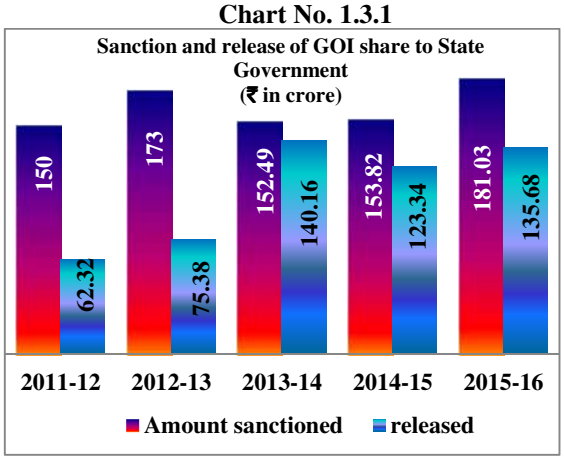
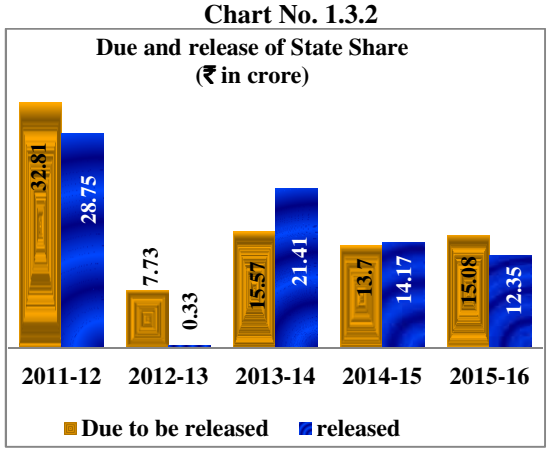


Chart No. 1.3.2



(**Note**: 1. State share due for the year 2011-12 is calculated taking due of ₹ 21.74 crore upto March 2011.
2. GoI share released to State Government during 2013-14, 2014-15 and 2015-16 is not matching with corresponding figures of data provided by SHM (**Table No. 1.3.2**) because of delay or non-release of some funds by State Government to SHM).
(**Source**: Information furnished by the State Health Society, NRHM)

Audit observed that during 2011-16, out of the total sanctioned amount of ₹ 895.23 crore, only ₹ 613.89 crore *i.e.* 68.57 *per cent* was released. Of the total sanctioned amount, the share of GoI was ₹ 810.34 crore out of which only ₹ 536.88 crore (66.25 *per cent*) was released resulting in short release of ₹ 273.46 crore (33.74 *per cent*). The reason was attributed entirely to non-utilisation of funds in the previous years. There was a short release of State share by ₹ 7.88 crore, the reason for which was not found on record.

Thus, it appears that during preparation of PIPs the capacity of the SHS to utilise the funds was not considered. As a result, despite availability of funds SHS could not utilise it due to shortage of resources. This is indicative of lack of proper assessment prior to implementation of the scheme and poor execution.

The Department stated (October 2016) that pending State share of ₹ 7.85 crore had been released by the Finance Department.

(A) Short release of funds (GoI share) by the State Finance Department to the Mission

Audit observed that in 2015-16, GoI released ₹ 135.68 crore[8] but against this amount Finance Department released only ₹ 130.43 crore resulting in short release of ₹ 5.25 crore to the SHS till July 2016. Reason for delay in release of the balance Central share was neither found on record nor stated to audit.

(B) Loss of interest due to delayed release of funds by the State Government.

It was noticed that there was delay in release of funds by the State Finance Department. During 2014-16, it took 50 to 100 days for release in 31 cases, 100 to 199 days in 98 cases, and 226 to 437 days in 18 cases. Reasons for delay in release of funds were not found on record.

[8] Cash - ₹ 125.58 crore and kind - ₹ 10.10 crore.

Further, it was noticed that due to delay in release of funds by the Finance Department, SHS suffered a loss of interest[9] of ₹ 2.55 crore during 2014-16.

1.3.7.5 Programme funds remained unutilised

(A) State level

During scrutiny of records, it was noticed that out of ₹ 89.91 crore remaining unspent as of March 2016, ₹ 67.15 crore was lying with the SHS and rest ₹ 22.76 crore was lying unspent with DHSs. The details of unutilised funds against major programmes at the close of last five years up to March 2016 are shown below:

Table No. 1.3.3: Unutilised funds against major programmes at the close of last five years up to March 2016

(₹in crore)

Sl. No.	Name of the programme	2011-12	2012-13	2013-14	2014-15	2015-16
1	RCH-II/RCH-Flexi Pool	33.72	24.06	33.63	42.46	46.19
2	Additionalities under NRHM	62.21	24.14	49.87	28.56	29.89
3	Immunisation					
	Routine Immunisation	0.62	0.16	0.06	(-) 1.60	(-) 0.8
	Pulse Polio Immunisation	0.72	0.26	0	(-) 1.08	(-) 0.37
4	NIDDCP					0.34
5	**National Disease Control Programme**					
	Integrated Disease Surveillance Project (IDSP)	0.19	0.02	(-) 0.09	(-) 0.24	(-) 0.13
	National Leprosy Eradication Programme (NLEP)	0.01	0.15	0.11	0.08	(-) 0.07
	National Vector Born Disease Control Programme (NVBDCP)	2.04	1.43	6.28	11.05	11.80
	Revised National Tuberculosis Programme (RNTCP)	0.06	0.19	0.28	(-) 0.39	(-) 0.34
6	**Non Communicable Disease Control Programme**					
	National Programme for Control of Blindness (NPCB)	0.95	4.06	0.33	1.38	(-) 0.07
	National Mental Health Programme(NMHP)	0.13	0.11	0.07	0.85	1.64
	National Programme for prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)	-	-	2.01	2.00	3.28
	National Programme for Prevention and Control of Deafness (NPPCD)					0.22
	National Tobacco Control Programme(NTCP)	-	-	0.58	0.50	0.90
7	**Infrastructure Maintenance**	0.00	(-)1.47	0.60	(-) 0.87	(-)11.63
Total		**100.65**	**53.11**	**93.73**	**82.70**	**80.85**

(**Source**: Information furnished by the State Health Society, NRHM)

The above table shows that most of the unspent balances were lying against RCH-Flexi Pool, Additionalities under NRHM and NVBDCP which reflects that there was a shortfall in implementation of these components.

(B) District level

During test check of three districts, it was noticed that at the end of each financial year huge balances were lying with the DHSs, as detailed below:

[9] Interest was calculated taking interest on savings account at 4 *per cent* per annum.

Table No. 1.3.4: Details of balances lying with three test checked districts

(₹in crore)

Name of the district	2011-12	2012-13	2013-14	2014-15	2015-16
West Tripura	5.69	3.68	4.41	3.99	2.03
Dhalai	3.83	1.79	1.00	1.27	0.21
North Tripura	NA	0.81	1.28	1.57	2.22

(**Source**: Annual accounts of DHAPs and information furnished by the District Health Society, NRHM)

Moreover, unspent balances showed an increasing trend in North Tripura District over the period. Reasons for keeping huge unspent balances were lack of recruitment of human resources, shortfall in organising training for ASHAs, Auxiliary Nursing Midwives (ANMs), Lady Health Visitors (LHVs), Skilled Birth Attendant (SBA) services and shortfall in organising health camps.

The Mission Director, NRHM accepted (August 2016) the audit findings.

1.3.7.6 Outstanding advances

In Unakoti District, ₹ 1.62 crore was lying outstanding against 10 officials. Further, ₹ 1.18 crore was advanced by seven Chief Medical Officers during 2006-14 to the health facilities under its jurisdiction for implementation of various national health programmes approved under NRHM but no records were maintained as against whom the advances had been made. Details are in **Appendix-1.3.3 (A)** & **1.3.3 (B).** The Mission Director, NRHM lodged an FIR against these 17 officials with Kailashahar Police Station in April 2015. Present status of the case was not on record.

Similarly, it was noticed that ₹ 1.51 crore (**Appendix- 1.3.4**) was advanced to 116 officials for different purposes during June 2009 to November 2015 by the SHS and was lying outstanding till May 2016. It was neither on record nor stated to audit whether programmes for which advances given were actually implemented by the persons concerned.

Advances outstanding for such long periods is fraught with the risk of not utilising of funds for the purpose for which it was given and may lead to misappropriation of Government money.

The Department stated (October 2016) that out of advances of ₹ 1.51 crore, ₹ 1.03 crore had since been adjusted through submission of vouchers.

1.3.7.7 Outstanding loan

During test check of records, it was noticed that ₹ 7.25 crore transferred by the SHS to seven departments/societies as loan during September 2013 to June 2015 for running different project work/programmes were lying outstanding till August 2016. Authority under which loan was given and initiatives taken to adjust the outstanding loan was not found on record.

Scrutiny also revealed that loan amounting to ₹ 50.00 lakh was given to Revised National Tuberculosis Control Programme (RNTCP) in April 2014 which was

outstanding as of March 2016. However, as per information furnished by the Mission, only ₹ 33.96 lakh was shown as loan against RNTCP. Reason for such discrepancy was not found on record.

On being pointed out in audit, Mission Director, NRHM stated (August 2016) that as per approval of the authority loan was given to take up the activities on emergency basis and ₹ 1.81 crore had since been refunded.

The fact remained that the records of refund of ₹ 1.81 crore were not produced to audit and the reply does not mention about the remaining outstanding amount of ₹ 5.44 crore. The discrepancy of ₹ 16.04 lakh in RNTCP was also not explained by the Department.

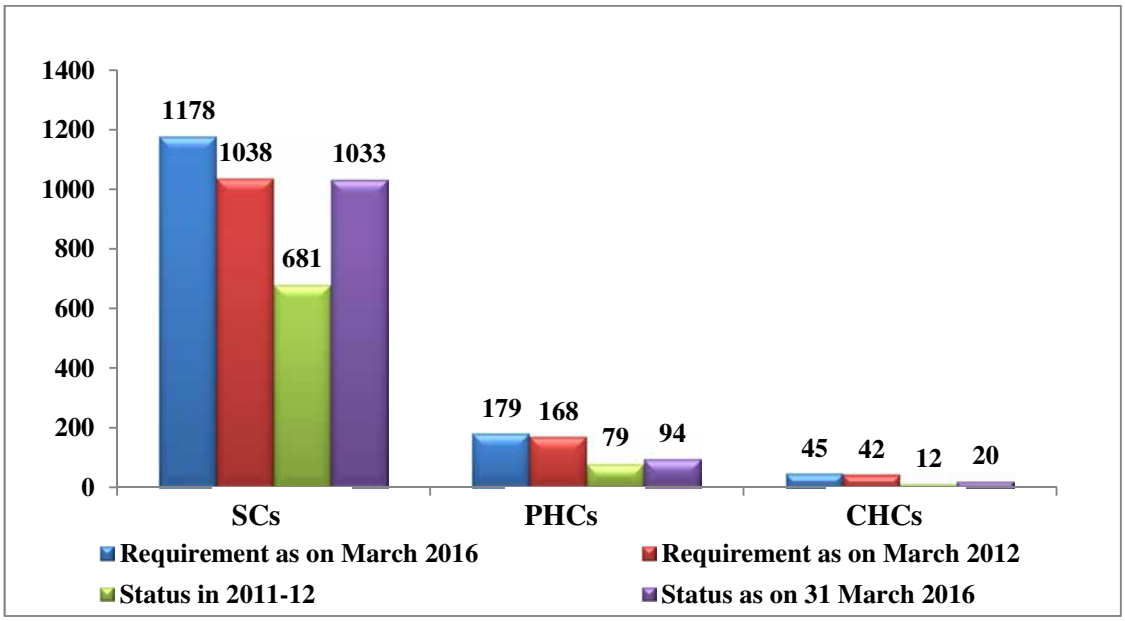
Capacity building and physical infrastructure

1.3.7.8 Failure to achieve targets

The health care infrastructure in rural areas has been developed as a three tier system *viz*., SC, PHC and CHC. As per decision of the State Government, every GP/ADC village should be covered by a SC. PHCs and CHCs were constructed following IPHS norms: one PHC per 30,000 population in general areas and one PHC per 20,000 population in difficult/tribal and hilly areas; one CHC per 1,20,000 population in general areas and one CHC per 80,000 population in difficult/tribal and hilly areas.

Status of health facilities as on 31 March 2016 are shown in **Chart No. 1.3.3**. It is seen that the number of SC, PHC and CHC in the State had increased from 681, 79 and 12 in 2011-12 to 1,033, 94 and 20 respectively in 2015-16. Yet, the existing number of SCs, PHCs and CHCs were short of their targets by 145, 85 and 25 (12, 47 and 56 *per cent)* respectively. Thus, despite improvement in the last few years, there existed a big gap between the requirement and the available health care infrastructure, particularly at the PHC and CHC level.

Chart No. 1.3.3: Status of SCs, PHCs and CHCs as of 2011-12 and 2015-16 against requirement



Source: Census 2011, Economic Review of Tripura and Departmental records.

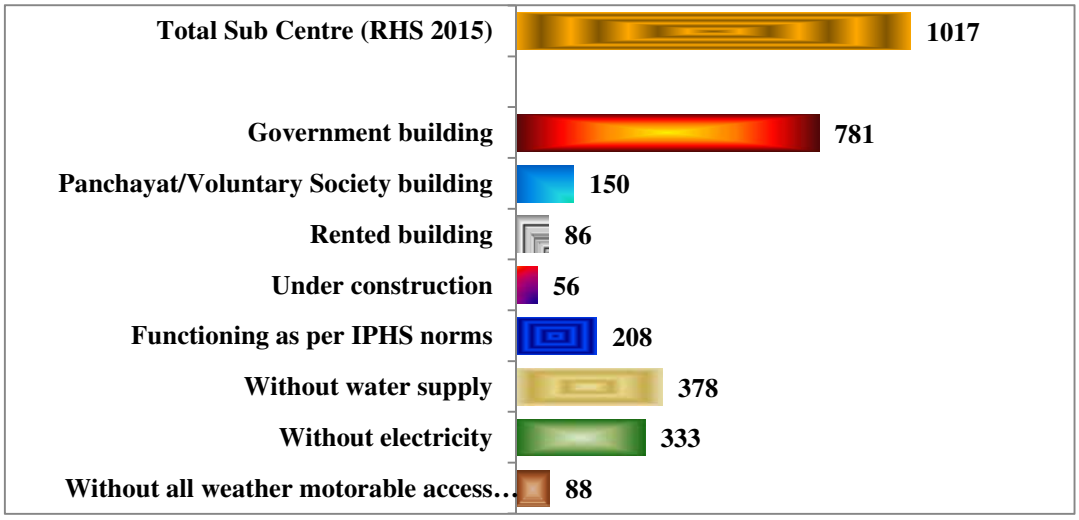
Test check of three districts revealed that there was a shortage of SCs, PHCs and CHCs by 11, 42 and 53 *per cent* respectively. North Tripura District was having 27 *per cent* shortages of SCs and Dhalai District 61 *per cent* shortages of CHCs.

The Department stated (October 2016) that phase wise implementation was going on to fill up the gap in infrastructure.

1.3.7.9 Quality of infrastructure

According to Rural Health Statistics (RHS) 2015, State-wise status of infrastructure in SCs is shown in **Chart No. 1.3.4.**

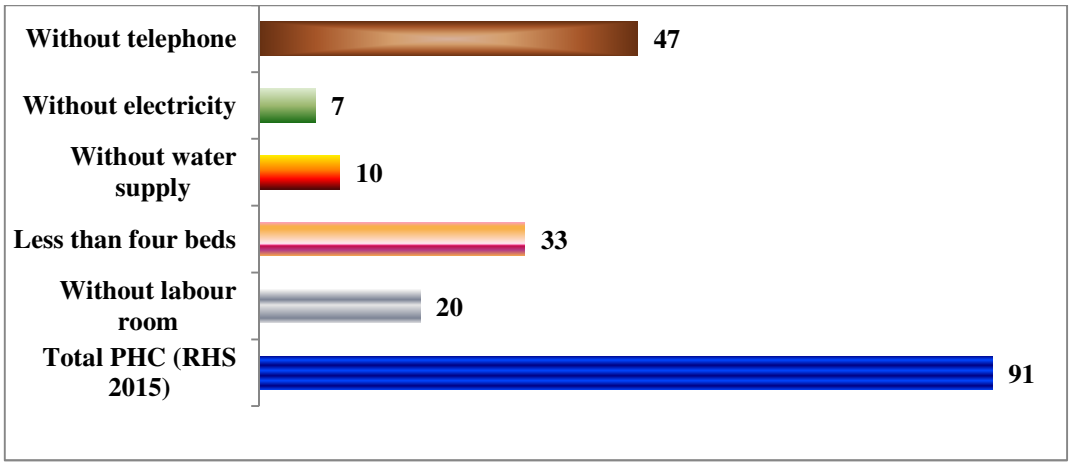
Chart No. 1.3.4: State statistics of SCs



(**Source**: Rural Health Statistics, 2015)

During physical verification of 23 SCs, it was noticed that 16 SCs (69.57 *per cent*) were running without water supply, 16 (69.57 *per cent*) without electricity , eight (34.78 *per cent*) without toilet, 22 (95.65 *per cent*) without telephone, and 19 (82.61 *per cent*) without ANM quarters. It was further noticed that though there were quarters for ANM in four SCs, they were unoccupied due to non-availability of water supply and dilapidated condition of the quarters. Details are shown in **Appendix-1.3.5**.

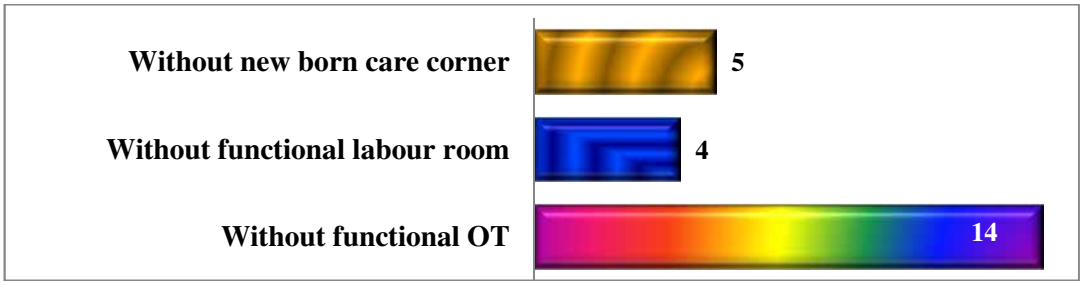
Chart No. 1.3.5: State statistics of PHCs



(**Source**: Rural Health Statistics, 2015)

Similarly, during physical verification of nine PHCs, it was noticed that two PHCs were functioning without electricity and eight PHCs without telephone. It was also noticed that labour room in three PHCs were not made operational due to non-availability of staff and lack of equipment *viz*., Radiant Warmer, Suction Machine, Steriliser, Normal Delivery Kit, etc. Details are shown in **Appendix-1.3.6**.

Chart No. 1.3.6: State statistics of CHCs



(**Source**: Rural Health Statistics, 2015)

Further, during physical verification of six SDHs/CHCs it was noticed that five CHCs/SDHs did not have Telephone, five CHCs/SDHs were not having Operation Theatre (OT), three CHCs/SDHs were without New Born Care Stabilisation Unit and four CHCs were without Blood storage facility. Though one SDH had Blood storage facility, it was not operational due to lack of manpower. Details are shown in **Appendix- 1.3.7**.

Thus, the existing infrastructure is devoid of even the basic amenities, and there had been under-utilisation of the resources.

It is evident that promotion of institutional deliveries was lacking as 22 *per cent* PHCs were running without labour room, 20 *per cent* CHCs without functional labour room and 70 *per cent* CHCs without functional OT in the State.

1.3.7.10 Development of infrastructure

NRHM aimed to bridge gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revamp of existing physical infrastructure and fresh construction or renovation wherever required. In Tripura, NRHM framework allowed expenditure upto 33 *per cent* of the total outlay on construction to remove deficiencies in public health infrastructure.

During 2011-16, out of the total available amount of ₹ 700.03 crore, ₹ 232.06 crore was spent on civil works. However, during the entire Mission period, Mission Director executed 430 new works (406 SCs, 24 PHCs) by investing ₹ 141.52 crore. It upgraded 97 facilities (50 SCs, 19 PHCs, 18 CHCs, eight SDHs/First Referral Units & two DHs) to IPHS benchmarks by investing ₹ 72.78 crore, 76 renovation works at a cost of ₹ 6.49 crore and other 21 works at a cost of ₹ 11.27 crore were taken up through four executing agencies.[10]

During the course of audit the following was noticed:

(A) Delay in completion of works

₹ 35.79 lakh was placed with the Rural Development Department (RDD) during 2007-08 to 2011-12 for construction of three SCs[11] but the works had not been completed due to reasons such as site dispute and delay in taking up construction works.

(B) Blockage of funds amounting to ₹ 2.93 crore

During 2009-10 to 2013-14, SHS placed ₹ 2.93 crore[12] with the RDD for construction of 13 SCs, one Neonatal Intensive Care Unit (NICU) in Belonia SDH and renovation of Madhupur PHC. It was observed that the construction work of none of the SCs had commenced as of July 2016 due to not handing over of site to the implementing agency. Though the funds were placed with the RDD for renovation of Madhupur PHC, Mission could not take decision whether the work was to be carried out through RDD or Public Works Department. It was noticed that provision of NICU had already been made in the newly constructed building for SDH, Belonia. So separate building was not required for NICU. Neither NRHM asked RDD to refund the fund already placed for construction of NICU in Belonia SDH nor RDD refunded the said amount.

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[10] Rural Development Department, Public Works Department, Tripura Housing and Construction Board and Engineering Cell of the NHM.

[11] New Health Sub Centre in Fultali GP, Noorpur GP and Monacherra GP.

[12] 2009-10: ₹ 10.35 lakh; 2010-11: ₹ 4.00 lakh; 2011-12: ₹ 13.39 lakh; 2012-13: ₹ 100 lakh; 2013-14: ₹ 165 lakh.

Consequently, an amount of ₹ 2.93 crore had been blocked over the years due to poor coordination, absence of proper assessment and lack of holistic planning at the level of the SHS.

(C) Inadequate utilisation of constructed buildings

SHS did not maintain status of utilisation of existing and newly created health facilities. During course of audit it was noticed that construction of one CHC, one PHC along with staff quarters and one SC were completed at a total cost of ₹ 6.64 crore and taken over by the concerned medical officers but were not utilised.

- Director of Family Welfare and Preventive Medicine, Government of Tripura, decided in October 2005 for upgradation of Mohanpur CHC under NRHM and placed ₹ 0.98 crore with Block Development Officer, Mohanpur in six installments during December 2005 to September 2011. The work was completed and handed over to the Medical Officer (in charge), CHC, Mohanpur in November 2014.
- The building had not been made operational till July 2016 due to a number of problems such as construction defects, absence of water supply and power connection, lack of provision for dressing room, nurse changing room, rest room with toilets for Doctors and Nurse, etc. despite the fact that the building was meant to be a health centre. As a result, there had been an idle expenditure of ₹ 0.98 crore. While admitting the facts, Director of Family Welfare and Preventive Medicine stated (July 2016) that an estimate was being prepared for rectifying the defects and other requirements.
- The work "Construction of Bhandarima PHC along with Staff Quarters" in North Tripura District was completed by the Public Works Department (Roads & Building), Kanchanpur Division at a cost of ₹ 5.40 crore and handed over to the Sub Divisional Medical Officer, Kanchanpur in March 2015. It was noticed (June 2016) that one Out Patient Department (OPD) Clinic was being run in one room of the PHC building and another room was used by Bhandarima (West) SC for Maternal and Child Health Clinic. Other 15 rooms of the building and 10 staff quarters were lying vacant and were not utilised.
- It was noticed that the building constructed for Bhandarima (West) SC in North Tripura District at a total cost of ₹ 0.13 crore were illegally used by "anti-social elements." A complaint was lodged in December 2015 with Anandabazar Police Station by the Medical Officer, however, further action in this regard is pending.
- One building constructed in July 2011 at a total cost of ₹ 0.13 crore for Kachimcharra SC in Dhalai District was not operational. On being pointed out in audit, Director of Family Welfare and Preventive Medicine stated (July 2016) that the new SC building could not be operationailised due to dispute with the private land owner.

Thus, lack of planning and monitoring led to delays and non-utilisation of facilities despite incurring expenditure of ₹ 6.64 crore.

1.3.7.11 Mobile Medical Units

With a view to provide health care at the door step of residents of inaccessible areas, GoI sanctioned (July 2008) four Mobile Medical Units (MMUs) equipped with specialised facilities. Audit noticed that three of the MMUs were not functioning for want of major repairs and maintenance. In 2015-16, GoI suggested (May 2015) that non-functional MMUs be condemned and proposal for new MMUs be submitted. However, these MMUs were neither declared as condemned nor were any fresh proposal submitted to GoI till July 2016.

Thus, due to non-availability of MMU services, rural people were deprived of getting specialised services at their door step.

1.3.7.12 Emergency Response Service

To provide 24x7 health emergency services throughout the State and pre-hospitalisation care to patients enroute to hospitals, SHS proposed ₹ 6.69 crore for procurement of Global Positioning System (GPS) enabled ambulances, establishment of Call Centre, etc. in 2012-13. Based on the proposal, GoI sanctioned ₹ 6.69 crore for procurement of 62 Basic Life Support (BLS) Ambulances, three Advance Life Support (ALS) Ambulances and their operational cost, etc. under Emergency Response Service (ERS).

Accordingly, the SHS invited tender in May 2013 *inter-alia* for procurement of above ambulances. These could not be procured by SHS because of poor response to the tender of May 2013. In 2013-14, GoI revalidated ₹ 3.58 crore for 37 BLS and three ALS but SHS did not procure the ambulances and no proposal was initiated by the SHS for revalidation.

In December 2015, the State Government decided that since ambulance facilities had already been extended to almost all CHCs and PHCs, present proposal for procuring BLS and ALS was not required.

During physical verification of test checked CHCs and PHCs it was noticed in audit that ambulances provided in the CHCs and PHCs were not equipped with the life saving equipment.

The fact remained that the GoI sanctioned fund for ERS to the State in 2012-13. This could not be availed by the State and these facilities were still not available.

1.3.7.13 Delay in procurement of Baby Care Pack

To incentivise 48 hours stay at health institutions after delivery, SHS proposed, in PIP 2011-12, for providing gift pack[13] to every mother for staying 48 hours in health institutions (PHCs, CHCs and SDHs) after delivery. Accordingly GoI sanctioned ₹ 1.40 crore for procurement of 20,000 Baby Care Packs in May 2011.

[13] Two nos towel, two meter funnel cloth, one duck-back sheet, baby bed net, baby blanket.

Supply orders for supply of 12,000 Baby Care Packs could be issued only in November 2015 and accordingly Baby Care Packs could be distributed to all the eight districts only in March 2016 after a delay of more than four years from the date of sanctioning of funds by GoI.

It was also noticed that during 2011-16, 2.23 lakh institutional deliveries were recorded against which 1.12 lakh mothers were discharged within 48 hours of delivery compromising the objective of providing safe delivery and safe natal care.

1.3.7.14 Medicines

State Government had drawn up a comprehensive drug list for different levels of health facilities. Medicines[14] were to be supplied to SCs, PHCs, CHCs, SDHs and DHs as per the essential drug list.

In course of audit it was noticed that only 17 to 63 *per cent* medicines in PHCs, 22 to 59 *per cent* medicines in SDHs and 8 to 18 *per cent* medicines in DHs were available against the norms. This indicated that all types of medicines were not available in the facilities.

On the other hand, it was noticed that out of the total amount of ₹ 40.91 crore sanctioned by the GoI for drugs and medicines, only ₹ 21.76 crore was spent for the same.

On being pointed out in audit Mission Director, NRHM stated (August 2016) that procurement of medicines was a time consuming process. Most of the funds were kept as committed expenditure for next year and hence year wise expenditure was not uniform. Funds for procurement of medicines had been placed with Director of Health Services and Director of Family Welfare and Preventive Medicine but Utilisation Certificate had not been received.

However, during physical verification it was noticed that test checked facilities were running with shortage of medicines and patients were directed to purchase medicines from the market.

1.3.7.15 Human resource

Efficiency and quality of health services largely depends on adequate number of qualified Doctors, Nurses and other Para-Medical Staff. There were no separate norms of State Government for posting of Medical Officers, Nurses and other Para-Medical Staff in the SCs, PHCs and CHCs. The availability of key health personnel *vis-a-vis* the overall sanctioned strength was as follows:

[14] SC-36; PHC-139; CHC/SDH- 249; DH-310.

Table No. 1.3.5: Availability of key health personnel *vis-a-vis* the sanctioned strength for the State as a whole

(***in number***)

Category	Sanctioned strength			Staff in position			Vacancies (percentage)
	State	NRHM	Total	State	NRHM	Total	
Medical Officer (Allo)	1480	7	1487	953	0	953	534(36)
Medical Officer (Ayur)	58	229	376	49	156	254	122(32)
Medical Officer (Homeo)	89			49			
Medical Officer (Dental)	105	71	176	35	48	83	93(53)
Specialist	NA	NA	NA	130	0	130	NA
Auxiliary Nursing Midwife	691	210	901	673	6	679	222(24)
Multi-Purpose Worker (Male)	704	86	790	689	0	689	15(02)
Staff Nurse	2092	3	2095	1891	3	1894	201(10)

(**Source**: Departmental records)

It would be seen from the above table that vacancies ranged between 2 and 53 *per cent* as compared to sanctioned strength in eight categories of health personnel. Sanctioned strength of specialists was not furnished though called for.

(A) Specialists

In course of audit, the following were noticed:

- In two test checked DHs[15], Radiologists, Pathologists and Dietician were not available. There was one Medicine specialist and one Obstetrician & Gynecologist against norms of two in each category.
- In four CHCs and two SDHs[16] specialists like Physician/Medicine specialist, General Surgeon/Surgery specialist, Obstetrician & Gynaecologist, Paediatrician and Anesthetist were not posted during 2011-16.

Shortage of specialists in DHs and non-availability of specialists in CHCs & SDHs in the test checked districts are symptomatic of a wider trend, where access to healthcare in rural areas remains limited to primary healthcare due to non-availability of specialists.

(B) Auxiliary Nursing Midwife

There were 1,033 SCs in the State as of March 2016. As per IPHS norms, 2,066 ANMs were required to be posted in 1,033 SCs. However, only 901 posts were sanctioned of which only 679 ANMs were in position and 222 posts (25 *per cent*) remained vacant as of July 2016. In 279 SCs (27 *per cent*) no ANM/Female Health Worker was posted.

Scrutiny of records in the three test checked districts[17] revealed that in 167 SCs (42 *per cent*) there was no ANM/Female Health Worker. Vacancy in North Tripura

[15] Kulai DH, Dhalai and Dharmanagar DHs.
[16] Mohanpur, Jirania, Anandabazar, Panisagar CHCs and Gandacharra, Kanchanpur SDHs.
[17] West Tripura, Dhalai and North Tripura District.

and Dhalai Districts were to the extent of 61 and 60 *per cent* respectively while in West Tripura District it was 18 *per cent*. Thus, there was disparity in posting of ANM/Female Health Workers amongst the districts.

During physical verification of 23 SCs it was further noticed that there was no ANM in 14 SCs and only one ANM each in eight SCs against requirement of two in each SC.

Acute shortage of ANMs in SC level showed that even though health centres had been established in most parts of the State, the quality of service provided remained questionable due to shortage of human resources (Medical Personnel).

(C) Other medical staff

Scrutiny of records revealed that out of three test checked districts, six PHCs in Dhalai District were running without Laboratory Technician and one PHC without Pharmacist.

It was further noticed that during 2011-16, GoI sanctioned ₹ 93.82 crore for the purpose of salary of human resources against which only ₹ 55.46 crore (59 *per cent*) was spent by the SHS. Scrutiny of PIP, Record of Proceedings (RoPs), Annual Accounts and Financial Management Report for the period 2011-16 revealed that the SHS did not recruit Anaesthetist, Obstetrician & Gynaecologist specialist, Dietician, RMNCH/FP Counsellors, Nutritionist, Health Economist, Technical Officer, Statistical Assistant, Epidemiologist, Microbiologists at District Laboratory, etc. although sanctions were obtained from the GoI.

Reason for non-recruitment against the vacant posts even after the sanction was granted by the GoI was neither found on record nor stated to audit.

(D) Accredited Social Health Activist

NRHM framework envisages providing one ASHA in every village with a population of 1,000. Audit observed that there were 7,332 ASHAs against the requirement of 3,892 as per the NRHM framework. While there were seven ASHAs per SC on an average, yet audit observed various problems relating to capacity building and infrastructure as stated below:

During 2011-16, SHS did not provide any drug kits to ASHAs. The ASHAs were made to work without even being provided with the most basic requirement *i.e.* the drug kits.

Further, when 69 ASHAs were interviewed by audit, the following were the responses:

- Pregnancy kit was not available with 35 ASHAs (51 *per cent*).
- Disposable delivery kit was not available with 62 ASHAs (90 *per cent*) and three ASHAs (4 *per cent*) had disposable delivery kit but they were not aware of its use.

- Blood pressure monitor was not available with 63 ASHAs (91 *per cent*) and six ASHAs (9 *per cent*) had blood pressure monitor but they were not aware of its use.

Thus, it could be concluded that Tripura faced a unique contradiction. On the one hand, the number of ASHAs was more than requirement as per NRHM norms. On the other hand, the ASHAs had neither been equipped with the required kits nor quality training given. Therefore, capacity building remained a major issue with consequences on the efficiency and effectiveness of the Mission.

The Department stated (October 2016) that due to shortage of specialists and other technical staff, sufficient human resource support could not be provided to all health facilities. Phase wise recruitment was going on to fill up the gap.

1.3.7.16 Training

NRHM framework stipulates that the implementation teams, particularly at the district level and State level, should develop specific skills. Analysis of the training schedule revealed that;

During 2011-16, out of a total of 3,492 trainings planned, only 1,165 were conducted leading to a shortfall of 2,327 trainings and the percentage of shortfall ranged between 34 and 100 *per cent* in various categories of training. The position of training in respect of some of the categories is detailed below:

- During 2011-16, training for medical officers on Laparoscopic Ligation (LL), Aneasthesia/Life Saving Anaesthesia Skills (LSAS), No Scalpel Vasectomy (NSV), Post Partum Intra Uterine Contraceptive Device (PPIUCD) and Rashtriya Bal Swasthyo Karyakram (RBSK) were not conducted although planned for.
- SHS planned to provide training to 84 health personnel on facility based Integrated Management of Neonatal and Childhood Illness during 2011-12 to 2014-15 against which only nine persons were trained in 2011-12. No training was planned in 2015-16.
- Training on Emergency Obstetric Care was planned to train 10 Medical Officers but only three persons were trained. Basic Emergency Obstetric Care training was provided to 168 Medical Officers only against target of 315.
- Immunisation training was provided to 102 Medical Officers against target of 192.
- Training on Reproductive Tract Infection/Sexually Transmitted Infection was provided to 170 Medical Officers against target of 500. No training was provided in 2015-16.
- 621 ASHAs had not been trained on each module against the prescribed seven modules for them.

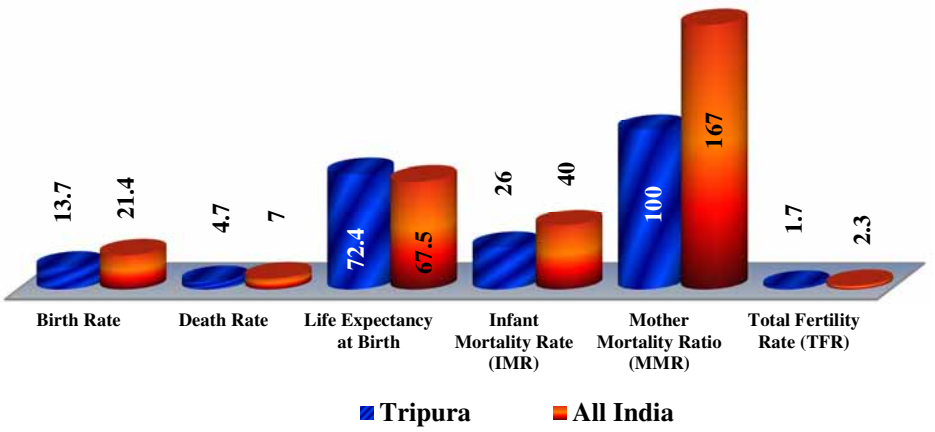
While no training programme was conducted in respect of LL, LSAS, NSV, PPIUCD and RBSK, the number of training programmes conducted in other modules as mentioned above fell short ranging from 34 to 89 *per cent*. Reasons for non-achievement of targets were neither found on record nor stated to audit. Thus, the State faces the twin problems of inadequate manpower and capacity building of the existing human resources.

Reproductive and Child Health Care, Immunisation and disease control programmes

1.3.7.17 Health indicators

Health indicators measure different aspects of health. When indicators are tracked over time, they allow us to see how the health of population is changing. A broad overview on Morbidity & Associated Mortality, Health Risks, Reproductive and Child Health in the State are shown in the chart below:

Chart No. 1.3.7: Status of health parameters of Tripura



(**Source**: Sample Registration System in India 2014; National Health Policy 2015; National Health and Family Welfare Statistics 2015; Programme Implementation Plan 2015-16)

From the above chart, it is seen that the Birth Rate in Tripura was 13.7 which was below the national average of 21.4. Similarly, the State performed better across various indicators such as Death Rate, IMR, MMR and TFR. Life Expectancy at Birth in Tripura was 72.4 while the national average was 67.5. Thus, health status indicators in Tripura under various parameters were better as compared to all India averages. However, a number of areas requiring improvements were noticed during audit.

1.3.7.18 Reproductive and Child Health programme

The RCH approach comprises critical components like informed choice of quality contraception, treatment of infertility, prenatal, natal and post-natal care for mother, etc. Some of the components of RCH and achievements there against are discussed below:

(A) Institutional deliveries

Maternal mortality and foetal losses could be reduced considerably if women undergo delivery under hygienic conditions under the supervision of trained health professionals.

Table No. 1.3.6: Details of home and institutional deliveries achieved during 2011-16

(in number)

Component	2011-12	2012-13	2013-14	2014-15	2015-16
No. of registered pregnant women	76,202	73,915	77,985	77,290	76,138
Total number of deliveries	51,277	52,191	52,424	51,514	50,847
Balance (untraced)	24,925 (33 %)	21,724 (29%)	25,561 (33%)	25,776 (33%)	25,291 (33%)
Institutional delivery	43,751	45,028	44,595	44,735	45,057
Home delivery	7,526	7,163	7,829	6,779	5,790
Percentage of institutional delivery	85	86	85	87	89
Percentage of home delivery	15	14	15	13	11

(Source: Departmental records)

Audit analysis revealed that:

- Institutional delivery showed an increasing trend, from 85 to 89 *per cent* during 2011-16 while home delivery decreased from 15 *per cent* in 2011-12 to 11 *per cent* in 2015-16.
- The Department could not track the fate of the balance registered pregnant women constituting about 29 to 33 *per cent* during the last five years for which no recorded reason was found. However, during test check of records at Anandanagar PHC three cases of duplication in registration of pregnant women was noticed.
- During 2013-16 only 2 *per cent* home deliveries were attended by Skilled Birth Attendants (SBAs). Thus, safe home deliveries were not ensured as number of home deliveries attended by SBAs was nominal. Reason stated for not attending home deliveries by the SBAs was shortage of trained SBAs since there were only 565 trained SBAs as of March 2016.
- During 2011-16, in the test checked districts institutional delivery ranged between 95 and 98 *per cent* in West Tripura District, between 84 and 87 *per cent* in Dhalai District while North Tripura District recorded the lowest institutional delivery ranging between 63 and 68 *per cent*.

In course of audit it was further noticed that-

- According to NRHM guidelines, Type-A SC may conduct normal delivery in case of need. But all 23 test checked SCs did not have the facility for institutional delivery.
- As per the guidelines, CHC should provide facilities for Obstetric Care and Emergency Obstetric Care including Surgical Interventions like Caesarean Sections. However, all four test checked CHCs did not have the facility of Caesarean Section delivery.

- The three selected districts showed a wide disparity in terms of percentage of institutional deliveries. At one extreme, North Tripura District registered low institutional deliveries ranging from 63 to 68 *per cent* due to less awareness among the beneficiaries, non-availability of transport facilities, etc. On the other extreme, in West Tripura District, institutional deliveries were in the range of 95 to 98 *per cent*.
- Out of 230 beneficiaries interviewed during Performance Audit, 194 were provided the facilities of institutional deliveries and 36 beneficiaries intimated that they preferred home delivery due to high institutional cost, non-availability of transportation, opinion of family members, etc. This indicated that the beneficiaries were not made aware of Janani Sishu Suraksha Karyakram (JSSK) under which pregnant women get free and cashless delivery and free transport.

Thus, while rate of institutional deliveries was high and increasing, yet the quality of the service provided was questionable due to lack of essential facilities and specialised medical persons. Further, there were pockets of the State where institutional deliveries were low thereby raising the question whether the programme had been effective across the State.

The Department stated (October 2016) that women prefer to be delivered by Medical Officer at PHC than delivery by ANM at SC. Due to lack of specialists, CHCs and SDHs were not strengthened.

(B) Ante Natal Care

As per norms, expecting mothers should receive two doses of Tetanus Toxoid (TT) vaccine, adequate amount of Iron and Folic Acid (IFA) tablets or syrup to prevent Anaemia. Pregnant women are expected to visit a health facility to have at least three Ante Natal check up for Blood and Urine Test and other procedures to detect pregnancy related complications.

Status of Ante Natal Care (ANC) coverage during 2011-16 was as under:

Table No. 1.3.7: Status of Ante Natal Care coverage during 2011-16

(in number)

Year	No. of pregnant women registered	No. of pregnant women who received three ANC check up	No. of pregnant women given 1st and 2nd TT immunisation	No. of pregnant women given100 IFA tablets
2011-12	76,202	42,646	50,730	60,245
2012-13	73,915	45,241	49,935	43,586
2013-14	77,985	48,026	50,716	29,850
2014-15	77,290	55,291	51,788	46,465
2015-16	76,138	51,776	50,899	49,069

(**Source**: Departmental records)

Scrutiny of the records revealed that:

- 36 *per cent* pregnant women did not receive three ANC check up during 2011-12 to 2015-16.

- 33 *per cent* pregnant women did not receive two doses of TT during 2011-12 to 2015-16.
- 40 *per cent* pregnant women did not receive 100 IFA tablets during 2011-12 to 2015-16. In course of audit it was noticed that there was a short supply of IFA tablets in the SCs which could be one of the reasons for short supply of IFA tablets to the pregnant women.

  The extent of ineffectiveness can be gauged from the fact that 54.4 *per cent* of pregnant women in Tripura suffer from Anaemia. Yet, 40 *per cent* of pregnant women did not receive the required 100 IFA tablets as per the norms.

In the test checked districts during 2011-16, shortfall in ANC check up was highest (44 *per cent*) in North Tripura District while shortfall in giving TT (60 *per cent*) and IFA tablets (56 *per cent*) was highest in West Tripura District.

From the findings mentioned above, it is evident that Information Education and Communications (IEC) activities *i.e.* awareness programmes were ineffective to a large extent. For instance, ASHAs could not motivate 36 *per cent* pregnant women to visit the facilities for taking preventive measures against risk of complications at the time of delivery.

The Department stated (October 2016) that micro plan for 100 *per cent* coverage had been taken up for remote villages and tea gardens. There was no short supply of IFA tablets but consumption by the mother was less due to its side effect *i.e.,* Gastric Irritation and Black Stool. However, extensive IEC was taken up.

The fact remains that inspite of extensive awareness programme, 36 *per cent* pregnant women did not receive three ANC check ups and 40 *per cent* pregnant women did not receive 100 IFA tablets during 2011-12 to 2015-16.

(C) Post Natal Care

The well-being of a mother and the newborn child depends not only on the care she receives during pregnancy and delivery, but also on the type of care the infant and the mother receives during the crucial first few weeks after delivery.

Scrutiny of records revealed that during 2011-16, against 2.23 lakh institutional deliveries 1.12 lakh women were discharged within 48 hours of delivery. It was observed that out of three tests checked districts, North Tripura District registered the highest percentage (72 *per cent*) of discharge within 48 hours of delivery during 2011-16, although reason for discharge was neither found on record nor stated to audit. However, test checked facilities reported that in case of normal deliveries women took discharge from the facilities at their own request.

The year wise status of post natal care coverage during 2011-16 is shown in **Chart No. 1.3.8.**

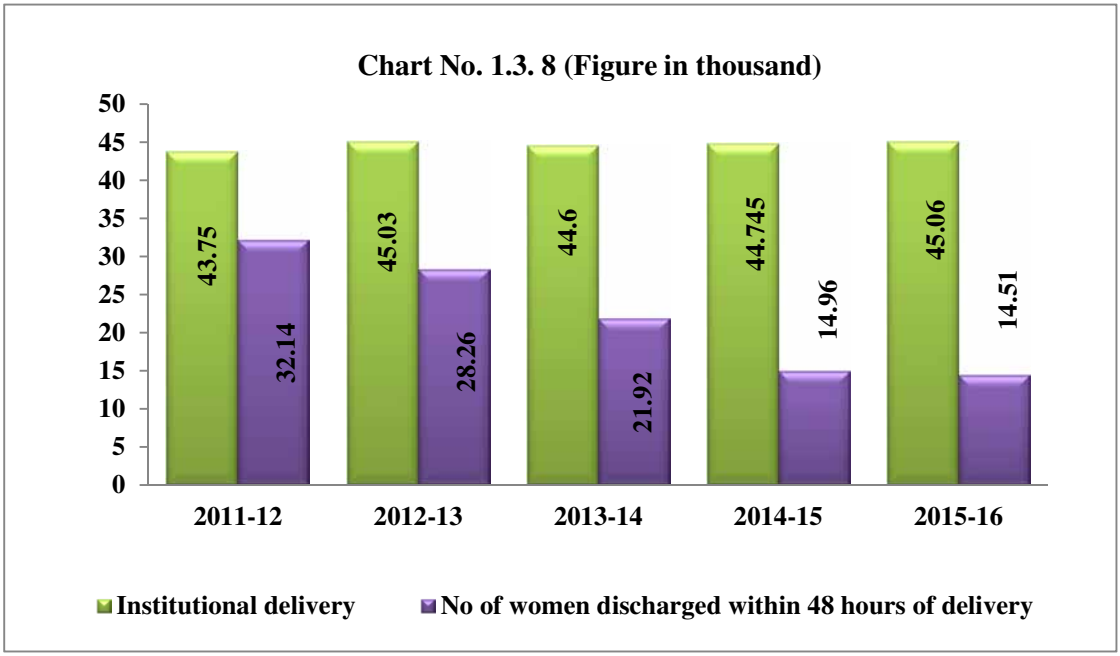


Table No. 1.3.8: Status of post natal care coverage during 2011-16

(in number)

Component	2011-12	2012-13	2013-14	2014-15	2015-16
Total number of deliveries	51,277	52,191	52,424	51,514	50,847
Women received post partum check up within 48 hours after delivery	NA	NA	43,672 (83%)	45,778 (89%)	44,110 (87%)

(**Source**: Departmental records)

During 2013-14 to 2015-16, 11 to 17 *per cent* women did not receive Post-Partum Check up within 48 hours of delivery. Thus, while all the programmes were being implemented across the State as per the guidelines, the coverage, the quality and effectiveness of the interventions cannot be assured.

1.3.7.19 Janani SurakshaYojana

The Janani Suraksha Yojana (JSY) was introduced in 2005-06 as a key intervention to enable and encourage women to access Institutional Delivery services and thereby effect reductions in MMR and IMR to 100/1,00,000 and 26/1,000 live births respectively by 2016. Status of MMR and IMR in Tripura was 100/1,00,000 and 26/1,000 live births and the target in the State of Tripura was achieved.

As an incentive to boost the goals stated, a financial package was provided through the JSY to all pregnant women. Below Poverty Line (BPL), Scheduled Castes and Scheduled Tribes pregnant women in rural areas of high focus States, who deliver in a health centres, were eligible for a cash incentive of ₹ 700 to meet both direct and indirect expenses incurred on delivery. The scheme also provides ₹ 500 to BPL women who prefer to deliver at home.

Targets and achievement during 2011-16 are shown below:

Table No.1.3.9: Target and achievement against JSY scheme during 2011-16

(in number)

Year	No. of pregnant women registered for ANC	No. of pregnant women registered under JSY	Target for payment	No. of beneficiaries received cash payment	Expendi-ture (₹ in crore)	No. of institutional deliveries	No. of home deliveries
2011-12	76,202	40,125	NA	39,088	3.51	43,751 (57%)	7,526
2012-13	73,915	40,785	NA	28,077	2.42	45,028 (61%)	7,163
2013-14	77,985	43,959	50,490	37,157	2.30	44,595 (57%)	7,829
2014-15	77,290	44,687	45,088	42,549	2.68	44,735 (58%)	6,779
2015-16	76,138	44,498	66,299	47,752	3.19	45,057(59%)	5,790

(**Source**: Target- RoP; Expenditure: Annual Accounts/Financial Management Rreport/Progress Report Registration: Health Management Information System data provided by Mission Director)

Scrutiny of records revealed that ₹ 14.10 crore was paid to the 1.95 lakh beneficiaries during 2011-16.

Under JSY, disbursement of cash incentive was to be made to the beneficiary immediately after delivery or at the time of discharge. However, during survey of beneficiaries, it was noticed that 46 *per cent* did not receive incentives and 44 *per cent* beneficiaries' intimated receipt of JSY incentives with a delay ranging from 8 days to 365 days.

Further, in two test checked facilities,[18] 1,722 beneficiaries did not receive incentives. Reason given for not disbursing the incentives was that the beneficiaries did not turn up to receive the incentives after discharging from the facilities or papers were not submitted by the beneficiaries.

While accepting audit observation, the Department stated (October 2016) that low coverage and delay in payment was due to Aadhaar based direct benefit transfer payment system.

1.3.7.20 Complete Immunisation not achieved

Immunisation of children against six preventable diseases, namely Diphtheria, Measles, Polio, Tetanus, Pertussis and Tuberculosis has been the cornerstone of routine immunisation under the universal immunisation programme.

The immunisation coverage during 2011-16 was as under:

Table No. 1.3.10: Target and coverage of children under routine immunisation during 2011-16

(in number)

Year	Target	Coverage of children up to one year (full immunisation)	Vitamin-A (1st dose) provided to the children
2011-12	55,686	44,119 (79)	22,906
2012-13	53,316	45,965 (86)	52,486
2013-14	52,586	47,315 (90)	44,174
2014-15	53,370	48,784 (91)	44,573
2015-16	53,379	47,013 (88)	39,162

Source: Departmental figures. (Figures in bracket indicate percentage)

[18] Kulai District Hospital, Dhalai; Ganganagar PHC.

The above table shows that during 2011-16, 79 to 91 *per cent* children upto one year were fully immunised. However, the 1st dose of Vitamin-A was also not provided to many of the children. It was further observed from records that birth dose of Oral Polio Vaccine (OPV) was administered only in 52 *per cent* cases, with Dhalai District recording the lowest (25 *per cent*).

Thus, complete immunisation was lacking and drop outs were substantial during the course of full vaccination period which was supposed to be completed by around nine months of child's age.

On being pointed out in audit Mission Director, NRHM stated (August 2016) that to prevent wastage of vaccine zero dose OPV was not administered in the facilities where number of deliveries per day varied from 0 to 10.

Thus, by not administering zero dose OPV, immunisation of the new born babies was compromised.

1.3.7.21 Janani Sishu Suraksha Karyakram

Janani Sishu Suraksha Karyakram (JSSK), introduced in 2011, is an initiative to eliminate out of pocket expenses for both pregnant women and sick neonates. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including in the case of a caesarean section.

According to National Family Health Survey (NFHS) number 4, average out of pocket expenditure per delivery in public health facility was ₹ 4,248 in rural areas in Tripura. Audit noticed that at the time of delivery, doctors directed pregnant women to purchase prescribed medicine and other consumables of their own from private medicine shop in violation of the JSSK scheme.

Thus, the objective of the scheme to provide free and cashless services to all pregnant women had not materialised.

While accepting audit observation, the Department stated (October 2016) that all the medicines may not be available at the facilities. In that cases patients had to buy from local shop which was reimbursed later on. Now all the required medicines are procured from State and supplied to facilities.

1.3.7.22 Family planning

The SHS procured 15 Laparoscopes at a cost of ₹ 1.04 crore in 2011 and distributed to different facilities.

Five Laparoscopes Machines (Kanchanpur SDH, Sabroom SDH, Dharmanagar DH and Kailasahar DH) valued ₹ 34.66 lakh were lying idle due to non-availability of trained Medical Officers and discontinuation of annual maintenance contract.

While accepting the audit observation, the Department stated (October 2016) that training of Medical Officers and continuation of annual maintenance contract would be taken up.

1.3.7.23 National Disease Control Programme

National Vector Borne Disease Control Programme (NVBDCP) for Malaria was one of the programmes under National Disease Control Programme (NDCP) which was test checked during the Performance Audit and the followings were observed.

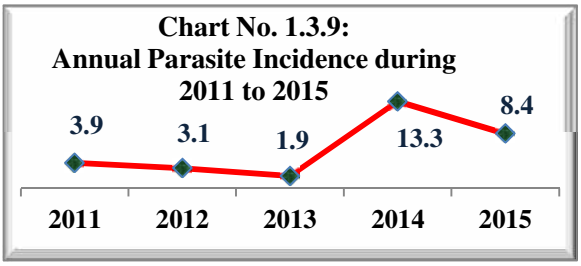
National Vector Borne Disease Control Programme

NVBDCP endeavours to control vector borne diseases by reducing Mortality and Morbidity due to Malaria, Filaria, Kala-azar, Dengue, Chikengunya and Acute Encephalitis Syndrome/Japanese Encephalitis in endemic areas.

Malaria

NVBDCP targeted achieving Annual Parasite Incidence (API) of less than one per thousand of population nationwide by 2017. It was noticed that during 2011-16 in the State, API ranged from 1.9 to 13.3, as shown in **Chart No. 1.3.9**, with Dhalai District having the highest API (52.4) in 2014.

Chart No. 1.3.9:
Annual Parasite Incidence during 2011 to 2015



During 2011-16, 1.17 lakh Malaria positive cases were recorded in the State of which Plasmodium falciparum[19] cases were 1.11 lakh and 143 death cases were registered.

Scrutiny of records of Dhalai District with respect to sudden spurt of Malaria after 2013 revealed that:

- To prevent malaria, the Department was to conduct 1st round of DDT spray during February to April and 2nd round between May to July each year and distribute Long Lasting Insecticidal Treated Mosquito Nets (LLINs).

  In 2014, 1st round DDT spray took place in Dhalai during 30 May 2014 to 19 July 2014 and 2nd round between 1 August 2014 and 8 September 2014 instead of the scheduled time *i.e.* 1st round- February to April and 2nd round-May to July. Reasons for delay in DDT spray was neither found on record nor intimated to audit. Further, during the years 2012-13 and 2013-14, no LLINs were supplied.

- The Multi Purpose Worker (MPW)/ANMs were not visiting the interior areas of Dhalai District. ASHAs of the remote villages were staying in the town areas and they did not visit field regularly. Malaria screening done by ASHAs was also inadequate. It was further noticed that 18 ASHAs and six MPWs were absent from their duties for a long time. They neither stayed in the respective villages nor provided any information about the occurrence of Malaria/Fever cases within the time which ultimately led to nine deaths at Girendrachandra

[19] Plasmodium falciparum is a protozoan parasite, causing the most dangerous form of Malaria in human.

Para and Joychandra Para under Gandacherra Sub Division in May-June 2014.

- No review meeting had been held during the period of audit *i.e*. 2011-16. Reason for not conducting review meetings was neither found on record nor stated to audit.
- During 2013-14 as per NVBDCP guidelines, Artemisinin- based Combination Therapy[20] (Artesunate + Sulfadoxine-Pyrimethamine) {ACT (SP)} was replaced by Artemisinin- based Combination Therapy- Artemether- Lumefantrine (ACT-AL). In that period Rapid Diagnostic kit (bivalent) and ACT-AL were not supplied to the district resulting in acute shortage of diagnostic kits and Anti-Malarial drugs in the district. Thus, due to shortage of ACT-AL, patients suffering from Malaria could not be treated.

Mortality rates from Malaria continue to be high in the State. The Mission had been ineffective in addressing this due to systemic failure where the entire machinery from ASHAs to SHS seems to have been ineffectual due to reasons cited above.

Quality assurance

1.3.7.24 Setting up of organisational framework for quality assurance

State Quality Assurance Committee (SQAC) at the State had been constituted (August 2014) which was headed by the Principal Secretary, Health and Family Welfare Department. District Quality Assurance Committees (DQACs) at the district level had been constituted (August 2014) headed by the District Magistrate and Collector of the respective districts. The broad responsibility of the SQAC was to oversee the quality assurance of activities across the State and also ensure regular and accurate reporting of the various key indicators. However, the SQAC had not met till June 2016.

In 2015-16, State Quality Assurance Unit (SQAU[21]) visited 21 field units but tour records were not made available to audit. As a result, gaps identified by the SQAU and action taken report, if any, could not be analysed.

Scrutiny of records further revealed the following:

- Operational guidelines on quality assurance requires that the DQAC meet at least once in a quarter. But in three test checked districts, DQAC did not organise any meeting to oversee the quality assurance activities in the districts.
- According to the operational guidelines on quality assurance, in-charge of health facility should form an Internal Quality Assurance Team (IQAT), which should have representation from all departments, Nursing Staff, Laboratory and Support Staff. The team should meet periodically (more frequently initially) to

[20] Artemisinin-based combination therapy (ACT) is recommended for the treatment of Plasmodium falciparum malaria. Fast acting artemisinin-based compounds are combined with a drug from a different class.

[21] Operational and implementation arm of SQAC.

discuss the status of quality initiative in their area of work. But in none of the test checked facilities IQAT were constituted.

Thus, assessment and reporting of quality of health care in health centres had not been given adequate importance over the years.

1.3.7.25 Quality in health care

(A) Internal assessment

In three test checked districts, internal assessment was not done in any of the test checked facilities. Thus, due to absence of internal assessment at the facility level, gaps in the services provided by the facility could not be identified.

(B) Patient satisfaction survey

According to the operational guidelines on quality assurance, a quarterly feedback {OPD – 30 patients, and for In Patient Department (IPD) – 30 patients in a month, separately} should be taken on a structured format by the hospital manager. This feedback would be analysed to see which are the lowest performing attributes and further action would be planned accordingly.

In the test checked facilities, patient satisfaction survey was not conducted during 2011-16. As a result, quality of service provided to those facilities could not be ascertained. During physical verification it was noticed that cleanliness of premises, OPD, Wards and Toilets in most of the facilities were not up to the mark. The position of some of the facilities is shown in the following photographs:

Poor cleanliness-SDH, Gandacherra

Poor cleanliness -SDH, Gandacherra

Poor waste management-DH, Dharmanagar

Poor waste management-SDH, Kanchanpur

Dumping of waste inside the hospital premises, beside the kitchen- SDH, Gandacherra

Medicines were kept in floor flooded with water-Brajendranagar PHC

1.3.7.26 Health Management Information System

An updated and reliable health database is the foundation of decision making across all health system building blocks.

During scrutiny of Health Management Information System (HMIS) data uploaded in the website along with records maintained in the test checked facilities few parameters were cross checked wherein it was noticed that data fed in the HMIS differed by 18 to 109 *per cent* in SCs, 2 to 48 *per cent* in PHCs, 45 to 97 *per cent* in CHCs, 7 to 210 *per cent* in SDHs and 4 to 75 *per cent* in DHs. Details are shown in **Appendix- 1.3.8**.

Thus, audit observed that HMIS lacks data integrity and its data cannot be relied upon for making decisions.

1.3.7.27 Reporting and monitoring

- According to notification (July 2005) issued by the Health and Family Welfare Department, GoI, the State Rural Health Mission should meet at least once in every six months to review progress in implementation of NRHM and to assess inter-sectoral co-ordination, etc. However, no such meetings took place during 2011-16.

- According to the rules and regulations of the SHS, meeting of the Governing Body shall be held at least once in every six months. At the annual meeting, Income and Expenditure Account and the Balance Sheet for the past year, Annual Report of the Society, Budget for next year, Annual Action Plan and research work for the next year, etc. shall be brought before the members and discussed. However, it was noticed that Annual Accounts of the Society and related aspects were never discussed and approved in the Governing Body meetings during 2011-16.

While accepting audit observation, the Department stated (October 2016) that it would be strengthened as Information Technology based systems were initiated.

1.3.8 Conclusion

A 'bottom-up' approach to planning, as was envisaged by the Mission, was not followed. Absence of perspective planning, non-conduct of household surveys and inadequate community involvement had resulted in failure to identify gaps in health facilities and areas of intervention.

Budget estimates were not realistic. Financial management and coordination was poor as percentage of utilisation of available funds was in the range of 51 to 69 *per cent*. There was short release of ₹ 273.46 crore by GoI due to non-utilisation of funds in the previous years and non-fulfilment of prescribed conditions for release of funds.

The desired level of capacity building and strengthening of physical infrastructure had not been achieved. Existing number of SCs, PHCs and CHCs were short of the targets by 12, 47 and 56 *per cent* respectively. Many of the existing SCs lacked basic amenities and construction activities were delayed on account of various reasons. Shortages of specialists in DHs and non-availability of specialists in CHCs and PHCs in the test checked districts were symptomatic of a wider trend, where access to health care in rural areas remained limited to primary health care due to non-availability of specialists. Adequate training was not being provided to the existing medical staff.

The effectiveness of the programmes under the Mission could not be fully vouched for as gaps had been found in their implementation. For instance, a third of pregnant women did not receive TT and 40 *per cent* did not receive the required IFA tablets. In the last five years the Department could not track the fate of about 29 to 33 *per cent* of registered pregnant women for which no reasons were found on record.

Assessment and reporting of quality of health care in health centres were not done in the three test checked districts. Monitoring at the State level had been inadequate.

1.3.9 Recommendations

- Horizontal and vertical linkages should be identified and included in plans for effective implementation of the Mission. The mechanism for coordination between district, block and village levels should be strengthened.

- The financial management should be improved and steps should be taken to avoid accumulation of unspent balances by timely spending on various aspects of the programme and increasing the pace of implementation of the programme.
- Steps should be taken for speedy completion and utilisation of all the construction works undertaken and facilities available.
- Appropriate steps should be taken by the SHS for increasing the proportion of institutional deliveries, especially in tribal and remote areas of the state.
- Availability of human resource at various levels may be ensured through regular and/or contractual recruitment. Training courses, as per training need analysis, should be undertaken to harness the full potential of available human resources.
- Discrepancy between the HMIS data and field data should be assessed and minimised.

APPENDICES

Appendix -1.3.1

Targets fixed under NHM and Millenium Development Goals and expected outcomes by the end of 31 March 2016

(Reference: Paragraph No. 1.3.1)

Framework of Implementation (2005-2012)		Framework of Implementation (2012-17)		Expected outcomes by the end of 31 March 2016	Millenium Development Goals (2015)
1)	Infant Mortality Ratio (IMR) reduced to 30/1000 per 1000 live births by 2012	1)	Reduce IMR to 25/1000 live births	Reduce IMR to 26/1000 live births	Reduce IMR to 27/1000 live births
2)	Maternal Mortality Ratio (MMR) reduced to 100 per 1,00,000 live births by 2012	2)	Reduce MMR to 100/100,000 live births	Reduce MMR to 100/100,000 live births	Reduce MMR to 109/100,000 live births
3)	Total Fertility Rate (TFR) to 2.1 by 2012	3)	Reduce TFR to 2.1	Reduce TFR to 2.1	
4)	Kala Azar Mortality Reduction Rate – 100 per cent by 2010 and sustaining elimination until 2012.	4)	Kala Azar elimination by 2015, <1 case per 10000 population in all block		
5)	Malaria Mortality Reduction Rate – 50 per cent upto 2010, additional 10 per cent by 2012.	5)	Annual malaria incidence to be <1/1000		
6)	Filaria/Microfilaria Reduction Rate – 70 per cent by 2010, 80 per cent by 2012 and elimination by 2015. Dengue Mortality Reduction Rate – 50 per cent by 2010 and sustaining at that level until 2012	6)	Less than 1 per cent microfilaria prevalence in all districts		
7)	Cataract operations – increasing to 46 lakh until 2012.	7)	Prevention reduction of anaemia in women aged 15-49 years		
8)	Leprosy Prevalence Rate reduced from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter.	8)	Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts		
9)	Tuberculosis DOTS series – maintain 85 per cent cure rate through entire Mission Period and also sustain planned case detection rate.	9)	Reduce annual incidence and mortality from Tuberculosis by half		
10)	Upgrading all Community Health Centres to Indian Public Health Standards.	10)	Prevent and reduce mortality and morbidity from communicable, non-communicable, injuries and emerging diseases		
11)	Increase utilisation of First Referral units from bed occupancy by referred cases of less than 20 *per cent* to over 75 *per cent*.	11)	Reduce household out-of-pocket expenditure on total health care expenditure		
12)	Engaging 4,00,000 female Accredited Social Health Activists (ASHAs).				

Appendix-1.3.2

List of units selected through SRSWOR for PA on NRHM

(Reference: Paragraph No. 1.3.3)

1. State : Tripura

i) Mission Director, NRHM
ii) State Health and Family Welfare Society
iii) GBP Hospital.

2. District: West Tripura

DHS	CHC	PHC	SC
i) District Health and Family Welfare Society, West Tripura	i)Community Health Centre,Jirania ii)Community Health Centre, Mohanpur	i)Primary Health Centre, Anandanagar ii)Primary Health Centre, Bamutia	i)Anandanagar Sub Centre ii)Dukli Sub Centre iii)East Jarulbachai Sub Centre iv)Fatikcharra Sub Centre v)Laxmilunga Sub Centre vi)Taltala Sub Centre

3. District: Dhalai

DHS	DH	SDH	PHC	SC
i) District Health and Family Welfare Society, Dhalai	i)District Hospital, Ambassa, Dhalai	i)Sub Divisional Hospital, Gandacherra	i)Primary Health Centre, Ambassa ii)Primary Health Centre, Ganganagar iii)Primary Health Centre, Jagabandhu Para iv)Primary Health Centre, Dalapati	i)Durbajoy Chowdhury Para Sub Centre ii)Ruhidapara Sub Centre iii)Kalabari Sub Centre iv)Karnamanipara Sub Centre v)Krishnajoy Para Sub Centre vi)Harinchara Sub Centre vii)Jaharnagar Sub Centre viii)Kachimcherra Sub Centre

4. District: North Tripura

DHS	DH	SDH	CHC	PHC	SC
i) District Health and Family Welfare Society, North Tripura	i)District Hospital, Dharmanagar, North Tripura	i)Sub Divisional Hospital, Kanchanpur	i)Community Health Centre, Panisagar ii) Community Health Centre, Anandabajar	i)Primary Health Centre, Brajendranagar ii)Primary Health Centre, Bungnung iii)Primary Health Centre, Bhandarima	i)Bokboki Sub Centre ii_Ranibari Sub Centre iii) Satsangam Sub Centre iv)Balidhum Sub Centre v)Baruakandi Para Sub Centre vi)Haflong Sub Centre vii)Gochirampara Sub Centre viii)Kalapani Sub Centre ix) S K Sermun Sub Centre

Appendix- 1.3.3 (A)

Statement showing list of officials against which FIR was lodged for outstanding advances

(Reference: Paragraph No. 1.3.7.6)

(₹ in lakh)

Sl. No.	Name of the In-Charge	Name of the Health Facility	Amount pending adjustment	Total
1	Dr. Subrata Roy	Kanchanpur SDH	34.70	39.67
		Pecharthal PHC	4.97	
2	Dr. Debashish Tarafdar	R.G.M. Hospital	21.73	21.73
3	Dr. Indrajit Mahishya Das	Khedacherra PHC	13.77	15.91
		Upthakali PHC	2.14	
4	Dr. Chaittanya Reang	Anandabazar PHC	14.25	14.75
		Kanchanpur SDH	0.50	
5	Dr. Harendra Reang	Damcherra PHC	14.05	14.05
6	Dr. Dipak Halder	Fatikroy PHC	12.87	12.87
7	Dr. Hirak Chowdhury	Upthakali PHC	11.38	11.38
8	Dr. Pulak Barua	Kadamtala PHC	11.18	11.18
9	Dr. Anindita Chakma	Pecharthal PHC	10.49	10.49
10	Dr. Sirsendu Chakma	Jampui PHC	10.33	10.33
Total			**162.36**	**162.36**

Appendix- 1.3.3 (B)

Statement showing list of CMOs who were given advances

(Reference: Paragraph No. 1.3.7.6)

(₹ in lakh)

Sl. No.	Name of the In-Charge	Name of Office	Amount pending adjustment
1	Dr. S. Choudhuri	O/o The CMO, Kailashahar	15.14
2	Dr. R. K. Das		4.14
3	Dr. Subrata Das		26.59
4	Dr. Bibekananda Das		0.68
5	Dr. M. K. malakar		41.68
6	Dr. D. K. Das		23.94
7	Dr. Alak Dewan		5.97
Total			**118.14**

Appendix- 1.3.4

Statement showing outstanding advances as on 31 March 2016

(Reference: Paragraph No. 1.3.7.6)

(in ₹)

Sl No.	Name of Implementing Agency	Name of component	Cheque No.	Date	Amount	Adjustment received during 2015-16	Refunded	Balance as on 31 March 2016
1	K. Sanamatam	Meeting	431390	27-Sep-10	4500			4500
2	Surajit Paul, FM, AYUSH	Statutory Audit	4613	22-Sep-12	10000			10000
3	Officials	Office Expenses (RCH)	Cash	18-Oct-12	37500			37500
4	Officials	Office Expenses (RCH)	Cash	25-Oct-12	4500			4500
5	Sanjay Malakar	Office Expenses (RCH)	5860	18-Dec-12	5200			5200
6	Officials	Office Expenses (RCH)	Cash	27-Dec-12	28000			28000
7	Officials	Office Expenses (RCH)	10607	18-Feb-13	4500			4500
8	Officials	Office Expenses (RCH)	Cash	18-Feb-13	29000	5661		23339
9	Officials	Office Expenses (RCH)	Cash	14-Mar-13	20000			20000
10	Officials	Office Expenses (RCH)	Cash	28-Mar-13	45100		21219	23881
11	Sanjay Malakar	Office Expenses (RCH)	13340	09-Apr-13	3500			3500
12	Dr. Madhusudhan Chowdhury	TA & DA Advance	19547	19-Sep-13	25000			25000
13	Dr.Sandeep R.Rathod,MD	TA & DA Advance	19624	23-Oct-13	35000			35000
14	Dr.Sandeep R.Rathod,MD	TA & DA Advance	26246	13-Jan-14	25000			25000
15	Ramanuj Dasgupta	TA & DA		21-02-2011	10000			10000
16	Dr. Sanjib kumar Debbarma		36842	20-12-2014	30000			30000
17	Amit Dey	Office Expenses (RCH)	Cash	31-Mar-15	7300			7300
18	Ashis Dey	Office Expenses (RCH)	Cash	31-Mar-15	700			700
19	Bidhan Saha	Office Expenses (RCH)	Cash	31-Mar-15	5554			5554
20	Ganash Ch. Das	Office Expenses (RCH)	Cash	31-Mar-15	1800			1800
21	Officials	Office Expenses (RCH)	Cash	31-Mar-15	470			470
22	Nandan Das	Office Expenses (RCH)	Cash	31-Mar-15	500			500
23	Jayadrata Roy	Office Expenses (RCH)	Cash	31-Mar-15	3900	500		3400
24	Khokan Shill	Office Expenses (RCH)	Cash	31-Mar-15	1200			1200
25	Ramanuj Dasgupta	Office Expenses (RCH)	Cash	31-Mar-15	4400			4400

Appendix- 1.3.4 (contd…)

Statement showing outstanding advances as on 31 March 2016

(Reference: Paragraph No. 1.3.7.6)

(in ₹)

Sl No.	Name of Implementing Agency	Name of component	Cheque No.	Date	Amount	Adjustment received during 2015-16	Refunded	Balance as on 31 March 2016
26	Sajal Debbarma	Office Expenses (RCH)	Cash	31-Mar-15	31000			31000
27	Shiba Prasad Bardan	Office Expenses (RCH)	Cash	31-Mar-15	4000	2000		2000
28	Sudip Deb	Office Expenses (RCH)	Cash	31-Mar-15	3500			3500
29	Tapan Saha	Office Expenses (RCH)	Cash	31-Mar-15	9573			9573
30	Mridul Debroy	Office Expenses (RCH)	Cash	31-Mar-15	17310	6014	3200	8096
31	Karnajit Debnath	Office Expenses (RCH)	Cash	31-Mar-15	100			100
32	K Sanamatum	Office Expenses (RCH)	Cash	31-Mar-15	100			100
33	Surekha Roy	Office Expenses (RCH)	Cash	31-Mar-15	500			500
34	Asso. Of surgeon of india	NSV camp at TSDH	79850	03-Jun-10	15000			15000
35	Arindam Saha	Screening cum Evaluation camp on Healt diseases under RBSK	40461	05-01-2015	68800			68800
36	Mridul Debroy	Camp under RBSK	38789	20-Feb-15	158000			158000
37	Joydeep Datta	Holding of State Level Workshop	11874	12-Jul-13	11307			11307
38	Dr. Pranadish Das	TA/DA	36785	11-02-2015	12000			12000
39	Kanak Kanti Mandal	LSAS Training at Silchar M.C.	429529	19-Nov-10	18000			18000
40	Arindam Saha,SF, RRC	Training of Mobile Health Team under RBSK	27261	05-Mar-14	275625			275625
41	Arindam Saha,SF, RRC	Training on RBSK	27283	15-Mar-14	152000			152000
42	Santanu Saha	Training on supply chain Management system	36784	11-Feb-15	12000			12000
43	Santanu Saha	Assurance internal process Training	25746	12-Mar-15	95220			95220
44	Santanu Saha	RKSK Training	25772	18-Mar-15	130000			130000
45	Rajib Ghosh, SAPM	ASHA Training	12306	31-Mar-13	13000			13000
46	Rajib Ghosh, SAPM	ASHA Meeting	12311	31-Mar-13	3800			3800
47	Rajib Ghosh, SAPM	State ASHA group Meeting	29882	15-May-14	18992			18992

Appendix- 1.3.4 (contd…)

Statement showing outstanding advances as on 31 March 2016

(Reference: Paragraph No. 1.3.7.6)

(in ₹)

Sl No.	Name of Implementing Agency	Name of component	Cheque No.	Date	Amount	Adjustment received during 2015-16	Refunded	Balance as on 31 March 2016
48	Rajib Ghosh, SAPM	ASHA Support System	6037	08-Nov-12	3000			3000
49	Tapash Saha	TA & DA	29815	20-05-2014	20000			20000
50	Ashish Dey	TA & DA	29816	20-05-2014	20000			20000
51	Tapas Saha	Training of HMIS	79811	17-May-10	3750			3750
52	Sudip Deb, SPM	DAP Advance	543126	01-06-2011	7500			7500
53	Programme Officer AYUSH	AYUSH	530075	10-Jun-09	673634			673634
54	B.O.-AUSH	Advance for AYUSH	914726	12-Feb-15	6511000	1231892		5279108
55	Programme Officer AYUSH	AYUSH	712957	16-12-2009	1013200			1013200
56	Programme Officer AYUSH	AYUSH	711792	26-11-2009	765601			765601
57	B.O.-AUSH	Contingency Purpose for AYUSH Cell	9737	22-Feb-13	21066			21066
58	B.O.-AUSH	Promotion of Yoga(Therapeutic Yoga)	47779	20-Nov-15	1802000			1802000
59	B.O.-AUSH	Training of MO, Pharmacists, ANMs, Massur	19453	29-Nov-13	348483	264287		84196
60	B.O.-AUSH	AYUSH (Training on Mos, Pharmacist, ANM)	93937	21-Dec-11	1054320			1054320
61	B.O.-AUSH	PMU Cost -AYUSH	543198	28-Jan-11	1309708			1309708
62	B.O.-AUSH	Audit purpose	9738	22-Feb-13	175280			175280
63	Rajib Ghosh	Immunization Meeting		02-10-2011	17000			17000
64	Nishikanta Roy	P.Oil for Vehicle	10086	01-Oct-13	5000			5000
65	Amit Kr. Dey	Training	10053	24-Apr-13	4800			4800
66	Santanu Saha	Purchasing of Training Materials for NCCMIS Training	23609	03-Mar-14	10000			10000
67	Kores India Ltd.	PPI	544252	17-02-2011	137816			137816
68	Sudip Deb, SPM	NRHM Meeting	431311	23-Aug-10	8750			8750
69	Dr.S. Debbarma	NRHM Meeting	431322	30-Aug-10	9675			9675

Appendix- 1.3.4 (contd…)

Statement showing outstanding advances as on 31 March 2016

(Reference: Paragraph No. 1.3.7.6)

(in ₹)

Sl No.	Name of Implementing Agency	Name of component	Cheque No.	Date	Amount	Adjustment received during 2015-16	Refunded	Balance as on 31 March 2016
70	Dinesh Debnath	EMoC Training	93155	02-Nov-11	10000			10000
71	Sajal D/barma	Cold Chain maintenance	93719	21-Nov-11	6000			6000
72	Saikat Dey, IEC Officer	Printing of IEC	93736	21-Nov-11	8268			8268
73	Sajal D/barma	Cold Chain maintenance	1910	06-Jun-12	10000			10000
74	Dr. S.N.Choudhury	TA & DA	6100	12-Oct-12	24000			24000
75	Dr.S.N.Chowdhury	PPI	10063	28-May-13	16000			16000
76	Rajib Ghosh	Capacity Dev. Training	15474	21-Aug-13	11100			11100
77	Rajib Ghosh	State Level Quaterly Meeting	15476	30-Aug-13	4320			4320
78	Dr.S.N.Chowdhury	PPI	10087	01-Oct-13	1850			1850
79	Sudip Deb, SPM	Office Expenses (RCH)	19605	10-Oct-13	9500			9500
80	Mridul Debroy	School Health	22153	16-Nov-13	2600			2600
81	Asish Dey	HMIS Training	3769	28-Nov-13	61550			61550
82	Tapas Saha	HMIS/MCTS Training	19476	20-Dec-13	27700			27700
83	Buddhi Ch. D/barma	PPI	3773	07-Jan-14	2500			2500
84	Buddhi Ch. D/barma	PPI	23605	12-Feb-14	1000			1000
85	Dr. Madhusudhan Chowdhury	TA & DA Advance	23726	25-Feb-14	5000			5000
86	Asish Dey	National Workshop on MCTS	27270	12-Mar-14	20000			20000
87	Tapas Saha	National Workshop on MCTS	27271	12-Mar-14	20000			20000
88	Sudip Deb (SPM)		29804	19-05-2014	3200			3200
89	Prasenjit Saha	State Level Monthly Meeting	29817	21-05-2014	7100			7100
90	Prasenjit Saha	State Level Monthly Meeting	30716	21-06-2014	7800			7800
91	Rakhi Debbarma	TA & DA	30819	14-08-2014	32000			32000
92	Dr.M.S.Choudhury	Immunization Review Meeting	23645	19-Aug-14	61			61
93	Dr.B.K.Sen	RBSK(Review Meeting Delhi)	29145	25-08-2014	21000			21000

Appendix- 1.3.4 (contd…)

Statement showing outstanding advances as on 31 March 2016

(Reference: Paragraph No. 1.3.7.6)

(in ₹)

Sl No.	Name of Implementing Agency	Name of component	Cheque No.	Date	Amount	Adjustment received during 2015-16	Refunded	Balance as on 31 March 2016
94	Dr.Kalipada Chaudhuri	TA & DA	32859	22-09-2014	20000			20000
95	Dr.Sanjib Kumar Debbarma	Travelling cost to attend for TOT under RKSK	36337	18-10-2014	100000			100000
96	Dr.Basudeb Roy	TA/DA (Work shop on NDD in Children)	36365	29-11-2014	25000			25000
97	Rajib Ghosh, SAPM	WorkShop Asha Nodal Officer Capacity Development Trainning & ASHA TOT	36935-9	11-Dec-14	221670			221670
98	Sribash Debnath	State Level Workshop	38351	17-Jan-15	40000			40000
99	Dr. Debasish Saha	TA/DA	40498	17-01-2015	30000			30000
100	Rajib Ghosh	TA/DA	38875	09-Feb-15	8000			8000
101	Narayan Goswami	TA/DA	36786	12-02-2015	12000			12000
102	Dr.Kamal Reang	TA/DA to attend CRM discussion in New Delhi	36791-2	13-02-2015	90000			90000
103	Asish Dey	State level review meeting on Imm. 3rd Qtr. 2014-15	22035	26-Feb-15	25000			25000
104	Rajib Ghosh	TA/DA	25783	05-Mar-15	40000			40000
105	Tapash Saha	TA/DA	25753	13-03-2015	20000			20000
106	Nabanita Dey	TA/DA (NPCC Meeting Purpose)	25773	18-03-2015	20000			20000
107	Mridul Debroy	TA/DA (ARSH TOT)	44156	21-03-2015	140000			140000
108	Dr. Pranadish Das	TA/DA	44179	27-03-2015	24000			24000
109	Dr. Joydeep Chakraborty	TA/DA	44180	27-03-2015	30000			30000
110	Dr.Kamal Reang	TA/DA (NPCC Meeting Purpose)	44151	20-08-2015	100000			100000
111	Dr. Sandeep N. Mahatme	TA/DA (NPCC Meeting Purpose)	44152	20-08-2015	35000			35000

Appendix- 1.3.4 (concld.)

Statement showing outstanding advances as on 31 March 2016

(Reference: Paragraph No. 1.3.7.6)

(in ₹)

Sl No.	Name of Implementing Agency	Name of component	Cheque No.	Date	Amount	Adjustment received during 2015-16	Refunded	Balance as on 31 March 2016
112	Dr. Madhusudhan Choudhury	TA/DA (NPCC Meeting Purpose)	44153	20-08-2015	25000			25000
113	Officials	Cash Advance	Cash	2013-14	83935	73100		10835
114	Dr. A.K.Ghosh	AYUSH			3814			3814
115	S. Paul Majumder	AYUSH			5000			5000
116	A. Chakraborty	AYUSH			5000			5000
Total								**15122129**

Appendix- 1.3.5

Statement showing availability of facilities at test checked Sub Centres

(Reference: Paragraph No. 1.3.7.9)

Sl. No.	Name of the SC	Name of PHC	Name of district	Type of SC	Availability of facility					
					Water Supply	Electricity (hours per day)	Functional Toilets	Telephone available and functional	Is ANM quarter attached to the SCs?	Is the ANM residing in the quarter?
1	Harincherra	Ambassa	Dhalai	Type-A	Unavailable	3 hours	Separate Male & Female Toilets	Unavailable	no ANM quarter	Not applicable
2	Ambassa	Ambassa	Dhalai	Type-A	Well	4 hours	Available but not separate toilets	Unavailable	Quarter available	ANM not residing
3	Kachimcherra	Ambassa	Dhalai	Type-A	Unavailable	no current supply	no toilets available	Unavailable	no ANM quarter	Not applicable
4	Karnamoani Para	Ganganagar	Dhalai	Type-A	Well	24 hours	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
5	Krishnajoy Para	Ganganagar	Dhalai	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
6	Kalabari	Ganganagar	Dhalai	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
7	Ruhida Para	Jagabandhu Para	Dhalai	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
8	Durba Joy Choudhury Para	Jagabandhu Para	Dhalai	Type-A	Bore well	1 hours	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
9	Haflong	Bungnung	North Tripura	Type-A	Unavailable	3 hours	no toilets available	Unavailable	no ANM quarter	Not applicable
10	Barua Kandi	Bungnung	North Tripura	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
11	Kalapani	Anandabajar	North Tripura	Type-A	Unavailable	no current supply	no toilets available	Unavailable	no ANM quarter	Not applicable
12	Gachiram para	Anandabajar	North Tripura	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
13	S K Rerhmun	Anandabajar	North Tripura	Type-A	Unavailable	no current supply	no toilets available	Unavailable	no ANM quarter	Not applicable

Appendix- 1.3.5

Statement showing availability of facilities at test checked SCs

(Reference: Paragraph No. 1.3.7.9)

Sl. No.	Name of the SC	Name of PHC	Name of district	Type of SC	Availability of facility					
					Water Supply	Electricity (hours per day)	Functional Toilets	Telephone available and functional	Is ANM quarter attached to the SCs?	Is the ANM residing in the quarter?
14	Ranibari	Brajendra nagar	North Tripura	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	Quarter available	ANM not residing
15	Balidhum	Bungnung	North Tripura	Type-A	Unavailable	no current supply	no toilets available	Unavailable	no ANM quarter	Not applicable
16	Satsangam	Brajendra nagar	North Tripura	Type-A	Well	7 hours	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
17	Bakabaki	Brajendra nagar	North Tripura	Type-A	Unavailable	no current supply	no toilets available	Available	Quarter available	ANM not residing
18	Fatikcharra	Bamutia	West Tripura	Type-A	Unavailable	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
19	Laxmilunga	Bamutia	West Tripura	Type-A	Piped	3 hours	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
20	Taltala	Bamutia	West Tripura	Type-A	Unavailable	no current supply	no toilets available	Unavailable	no ANM quarter	Not applicable
21	East Dukli	Ananda nagar	West Tripura	Type-A	Bore well	no current supply	Available but not separate toilets	Unavailable	Quarter available	ANM not residing
22	East Jarulbachaai	Ananda nagar	West Tripura	Type-A	Piped	no current supply	Available but not separate toilets	Unavailable	no ANM quarter	Not applicable
23	Anandanagar	Ananda nagar	West Tripura	Type-A	Unavailable	no current supply	no toilets available	Unavailable	no ANM quarter	Not applicable

Appendix- 1.3.6

Statement showing availability of facilities at test checked PHCs

(Reference: Paragraph No. 1.3.7.9)

Sl. No.	Name of PHC	Name of district	Availability of facility			
			Type of PHC	Electricity (hours per day)	Telephone available and functional	Labour room available
1	Ambassa	Dhalai	Type-A	7 hours	Not available	Available but not in use
2	Ganganagar	Dhalai	Type-B	20 hours	Not available	Available and in use
3	Jagabandhu Para	Dhalai	Type-A	5 hours	Not available	Available but not in use
4	Dalapati	Dhalai	Type-A	No current supply	Not available	Not available
5	Brajendranagar	Tripura North	Type-B	6 hours	Not available	Available and in use
6	Bungnung	Tripura North	Type-B	16 hours	Not available	Available and in use
7	Bhandarima	Tripura North	Type-A	No current supply	Not available	Available but not in use
8	Bamutia	West Tripura	Type-B	24 hours	Not available	Available and in use
9	Anandanagar	West Tripura	Type-B	24 hours	Available	Available and in use

Appendix- 1.3.7

Statement showing availability of facilities at test checked CHCs/SDHs

(Reference: Paragraph No. 1.3.7.9)

Sl. No.	Name of facility	Name of district	Availability of facility			
			Telephone available and functional	Operation Theatre available	New Born Care Stabilization Unit?	Blood storage facility
1	CHC, Anand Bazar	Tripura North	Not available	Not available	Available	Not available
2	CHC, Panisagar	Tripura North	Not available	Not available	Available	Not available
3	Mohanpur CHC	West	Available	Not available	Not Available	Not available
4	Jirania CHC	West	Not available	Available but not in use	Available	Not available
5	Gandacherra SDH	Dhalai	Not available	Not available	Not Available	Available but not functional
6	Kanchanpur SDH	Tripura North	Not available	Not available	Not Available	Available & Functional

Appendix- 1.3.8

Statement showing differences in data uploaded on website and physical records

(Reference: Paragraph No. 1.3.7.26)

Sl No.	Parameters	SC				PHC				CHC			
		2011-16				2011-16				2011-16			
		Data fed in HMIS	Data provided by SC	Difference	Percentage	Data fed in HMIS	Data provided by PHC	Difference	Percentage	Data fed in HMIS	Data provided by CHC	Difference	Percentage
1	Total number of pregnant women Registered for ANC	8194	6951	1243	18	4597	5562	965	17	1601	21491	19890	93
2	New women registered underJanani Suraksha Yogna					2764	3185	421	13	173	5980	5807	97
3	Number of pregnant women received 3 ANC check ups	4919	2355	2564	109	2284	3766	1482	39	270	8272	8002	97
4	Total number of pregnant women given 100 IFA tablets	4355	3270	1085	33	2982	4199	1217	29	1106	8061	6955	86
5	Deliveries conducted at facility (Including C-Sections)					1649	1657	8	0	5529	5509	20	0
6	Out of 8, Number discharged under 48 hours of delivery					983	714	269	38	2798	1926	872	45
7	Number of new IUCD Insertions at facility					855	835	20	2				
8	Number of Oral Pills cycles distributed	8702	4876	3826	78	3760	2539	1221	48	320	5509	5189	94
9	Number of Condom pieces distributed	30591	18025	12566	70	16437	18822	2385	13	2463	31220	28757	92

Appendix- 1.3.8 (concld.)

Statement showing difference in data uploaded in website and physical records

(Reference: Paragraph No. 1.3.7.27)

Sl. No.	Parameters	SDH				DH			
		2011-16				2011-16			
		Data fed in HMIS	Data provided by SDH	Difference	Percentage	Data fed in HMIS	Data provided by DH	Difference	Percentage
1	Total number of pregnant women Registered for ANC	4106	3827	279	7	2998	2998	0	0
2	New women registered underJanani Suraksha Yogna	2573	3544	971	27	806	2017	1211	60
3	Number of pregnant women received 3 ANC check ups	2845	1467	1378	94	1226	1226	0	0
4	Total number of pregnant women given 100 IFA tablets	3167	3167	0	0	503	503	0	0
5	Deliveries conducted at facility (Including C-Sections)	6061	6033	28	0	6987	7269	282	4
6	Out of 8, Number discharged under 48 hours of delivery	3993	3995	2	0	3732	3732	0	0
7	Number of new IUCD Insertions at facility	87	87	0	0	150	132	18	14
8	Number of Oral Pills cycles distributed	2672	2672	0	0	3411	13577	10166	75
9	Number of Condom pieces distributed	17082	5519	11563	210	10200	31966	21766	68