Chapter-II
Performance Audit

This Chapter presents the Performance Audits of 'National Rural Health Mission' and 'Implementation of Right of Children to Free and Compulsory Education Act, 2009'.

Department of Medical, Health and Family Welfare

2.1 National Rural Health Mission

Executive summary

The National Rural Health Mission (NRHM) was launched by the Government of India (GoI) on 12 April 2005 throughout the country with special focus on 18 states including Rajasthan. The Mission aimed at reducing child and maternal mortality rate, providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to poor and the vulnerable section of the population.

The Department did not follow the "Bottom up approach" for planning in accordance with the NRHM framework. Baseline Survey comprising Household Survey and Annual Facility Survey was not conducted during 2011-16. Annual State Programme Implementation Plans were submitted with delays and consequently approvals of GoI were also delayed, resulting in cascading delays in the implementation of the programme at various levels.

State Government could not provide all the basic infrastructural facilities in 75.77 *per cent* of Rural Health Centres. Health Centres were constructed at inaccessible and uninhabited locations and contracts for construction of buildings were awarded to contractors without ensuring the availability of land. Emphasis on providing all essential equipment in Rural Health Centres was not given as they had more shortages of essential equipment as compared to District Hospitals. Furthermore, equipment were lying unutilised in the Health Centres due to non-availability of trained staff to operate them. There were shortages in the availability of essential drugs particularly at CHCs and PHCs.

There was 62.93 *per cent* shortage of manpower in Health Centres located in rural areas while District Hospitals catering mostly the urban population had to excess manpower of 35.46 *per cent*. The gap in availability of manpower was not even filled up with engagement of medical and para medical manpower on contractual basis.

The percentage of women registered in first trimester of the pregnancy, increased from 46.59 *per cent* to 60 *per cent* during 2011-16, yet 26.93 *per cent* to 31.02 *per cent* pregnant women did not get all three mandatory checkups. Only 67.77 *per cent* pregnant women were given IFA tablets inspite

of widely prevalent anaemia in the State. Further, 26.23 to 34.15 *per cent* newborns delivered at home were not visited by the doctors/ANMs/Nurses within 24 hours of delivery.

There was low coverage in administering vaccines viz. Measles, OPV booster, DPT booster and TT 10/16 to infants (0 to 1 year) and children (1 to 16 years). The achievement against the target of sterilisation was only 54.48 *per cent* and the involvement of men in the family planning process continued to be abysmally low.

Though the State Government projected the requirement of ₹ 8,645.98 crore during 2011-16, ₹ 6,762.38 crore (78.21 *per cent*) were released to State Health Society, who utilised only ₹ 6,494.75 crore (75.11 *per cent*) of the funds. Huge unadjusted advances were outstanding against Rajasthan Medical Services Corporation Limited, State Institute of Health and Family Welfare, Blocks, CHCs and PHCs.

State Health Mission did not hold any meeting during 2011-16 and only two meetings (against stipulated seven) of Governing Body were held, which pointed to weaknesses in the apex monitoring process. Further at the district level, only 14 *per cent* of the prescribed meetings of District Health Mission could be held.

The State continues to lag behind the All India Averages and stood at 23rd position (out of 28) in Infant Mortality Ratio, 25th position (out of 28) in Maternal Mortality Ratio and 17th (out of 20) in Total Fertility Rate.

2.1.1 Introduction

The National Rural Health Mission (NRHM) was launched by the Government of India (GoI) on 12 April 2005 throughout the country with special focus on 18 states including Rajasthan. The Mission aimed at reducing child and maternal mortality rate, providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to the poor and the vulnerable section of the population. Period for first phase of the NRHM programme was 2005-06 to 2011-12 and the programme was extended for second phase from 2012-13 to 2016-17.

2.1.2 Organisational set up

The NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The Governing Body (GB) of the State Health Society (SHS) is headed by the Chief Secretary of the State. Its Executive Committee (EC) is headed by the Principal Secretary, Medical and Health Department. A State Programme Management Support Unit (SPMSU) headed by the Mission Director, acts as the secretariat to SHS.

At the district level, every district has a District Health Society (DHS) headed by District Collector and its Executive Committee is headed by the Chief Medical and Health Officer (CMHO). District Hospitals (DHs) at the district level, Community Health Centres (CHCs) at block level, Primary Health

Centres (PHCs) and Sub Centres (SCs) at village level deliver healthcare services to the community.

During 2011-16, the GoI approved State Programme Implementation Plans (PIPs) for ₹ 8,645.98 crore under NRHM, against which ₹ 6,762.38 crore[1] was released and ₹ 6,494.75 crore was utilised in the State.

2.1.3 Objectives of the Programme

The main objectives of the Mission were as under:

- Reduction in child and maternal mortality;
- Universal access to public healthcare services with emphasis on services addressing women's and children's health and universal immunisation;
- Prevention and control of communicable and non-communicable diseases including local endemic diseases;
- Access to integrated comprehensive primary healthcare;
- Population stabilisation, gender and demographic balances;
- Revitalize local health tradition and mainstream AYUSH; and
- Promotion of healthy lifestyles.

2.1.4 Audit Objective

The objectives of Performance Audit were to assess the:

(i) Efficacy of planning in achievement of the objectives of NRHM;

(ii) Availability of adequate physical infrastructure and equipment to meet the requirements of beneficiaries;

(iii) Availability of healthcare professionals as per requirement of the norms;

(iv) Extent and quality of healthcare services provided and impact of NRHM on reducing Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate;

(v) Existence of prudent financial management; and

(vi) Adequacy of the monitoring mechanism.

2.1.5 Audit criteria

The criteria used for the assessment of performance included:

- NRHM Framework for Implementation 2005-12 and 2012-17;
- Operational Guidelines for Financial Management;

1 GoI share: ₹ 4,948.61 crore and State Government share: ₹ 1,813.77 crore.

- Indian Public Health Standards 2012 for Sub Centres, Primary Health Centres, Community Health Centres, Sub-Division Hospitals and District Hospitals;
- Operational Guidelines for Quality Assurance in Public Health Facilities 2013; and
- Audited Annual Financial Statements of SHS.

2.1.6 Scope and methodology

The Performance Audit was carried out during April-July 2016, covering the period 2011-16. The selection of healthcare centres was made at District, Block and Village levels by *'Simple Random Sampling without Replacement'* method.

Seven District Health Societies (DHS) were selected from 28 rural districts[2] along with seven District Hospitals[3] (DHs) and two blocks in each district[4]. Further, 15 CHCs and one Sub Division Hospital (SDH) were selected in these blocks. Two PHCs (making a total of 30 PHCs) under each CHC and three SCs (making a total of 88 SCs[5]) under each PHC were also selected.

Test check of records of the Mission Directorate was also carried out. Apart from examination of documents, joint physical inspections, interview of the beneficiaries and cross verifications of records at various levels were also undertaken.

An Entry Conference was held with Principal Secretary, Medical and Health Department along with Mission Director on 11 April 2016. Audit Findings and the Audit Recommendations were also discussed with Principal Secretary in the Exit Conference held on 15 November 2016.

2.1.7 Audit Findings

Efficacy of planning

Audit Objective 1: To assess the efficacy of planning in achievement of the objectives of NRHM

2.1.7.1 Planning

NRHM adopts a *"bottom up approach"* for planning. As per paragraphs 78 to 80 of the NRHM framework, the process begins at the village level with the preparation of a "Village Health Action Plan" (VHAP). Village Health Sanitation and Nutrition Committee, which includes an Accredited Social Health Activist (ASHA) and an *Anganwari* Worker plays the critical role of recording people's needs and is also responsible for preparation of VHAP

2 The districts having at least 70 *per cent* rural population were classified as rural.
3 Dausa, Jalore, Jhalawar, Nagaur, Pratapgarh, Rajsamand and Sirohi.
4 Except Nagaur, where three blocks were selected.
5 There is only one SC under PHC Diver (District-Rajsamand).

through consultation. Thereafter a "Block Health Action Plan" (BHAP) is prepared at the Block level based on inputs from the VHAP and after discussions with the implementing units. BHAPs are then aggregated to form an integrated "District Health Action Plan" (DHAP). DHAPs of all districts are compiled and aggregated at the State level for framing the State "Program Implementation Plan" (PIP). Funds under NRHM are allocated activity wise by GoI to the State as per approved State PIP.

2.1.7.2 Baseline Survey

As per paragraph 81 of the NRHM framework, a Baseline Survey consisting of a Household Survey[6] and a facility survey[7] was required to be undertaken by DHS to enable comprehensive district planning. This survey when repeated after a gap would provide the details of improvement which came about due to the investment made under the Mission.

It was observed that household survey and annual facility survey were not conducted in the State during 2011-16 as per NRHM framework. The State Government stated (November 2016) that Household Surveys were conducted in the form of Annual Eligible Couple Surveys by the Auxiliary Nurse Midwives (ANM) and data was compiled in the Reproductive and Child Health Register. Regarding facility survey it was stated that district PIPs were prepared after gap analysis of infrastructure, human resources and equipment within the district.

The reply was not convincing as Annual Eligible Couple survey could not substitute the Household Survey as it was deficient in vital information like complete details of the family members in the household, their economic status, health status and lifestyle.

Further, it was noticed that no document/survey report regarding gap analysis in the facilities, was made available to substantiate the reply by any of the test checked units. Furthermore, the practice adopted by the Department for the survey was also not in consonance with the NRHM framework. In the absence of this, the detailed impact of NRHM on improvements in healthcare in households and health facilities could not be assessed.

2.1.7.3 Village and Block level Health Action Plan

Scrutiny of records of test checked districts revealed that Village Health Action Plans (VHAPs) and Block Health Action Plans (BHAPs) were not prepared by the competent authorities during 2011-16. In the absence of inputs[8] from VHAPs, a village level health mapping exercise could not be done. BHAPs could also not be consolidated on the basis of these VHAPs.

6 Household Survey consists of details of the family members, details of economic status, details of health status and lifestyle etc., of households.

7 Facility Survey consists of details of nearby health centres, hospitals, investigation facilities and medical professionals etc.

8 Inputs like number of households, access to drinking water sources, status of household and village sanitation, nearest health facility for primary healthcare, emergency obstetric care and morbidity pattern.

Finally the DHAPs were made without collecting information flowing from VHAPs and BHAPs. This resulted in district level planning being done without involvement of the beneficiaries at the village and block levels. Further, the very purpose of a *"bottom up approach"* of planning was defeated.

State Government stated (November 2016) that annual PIPs were prepared after incorporating requirements of equipment, civil works and human resources through orientations/discussions with the district and block teams. Further on the basis of gap analysis exercise at block and village level, the state PIP was compiled and finalised at the State level after analysis and discussed several times.

The reply needs to be viewed in the light of the fact that the practice adopted by the department was not in accordance with NRHM framework. Further, no document was made available to verify that all requirements which emanated from the village/block level had been incorporated in the overall plans.

2.1.7.4 Programme Implementation Plan/Perspective Plan

As per paragraph 2.4.4 of the Operational Guideline for Financial Management of NRHM, the DHAPs were to be reviewed in detail at the State level and finalised through extensive meetings and discussions with the district authorities. The requirements for all the districts are combined with the State level budgetary requirements to form a State Programme Implementation Plan (PIP). This annual State PIP helps the State in identifying and quantifying the targets required for programme implementation for the proposed year.

The State PIP is required to be submitted to Ministry of Health and Family Welfare, GoI for approval.

It was observed that all the PIPs submitted by the State during 2011-16 to GoI were delayed ranging from 14 to 143 days, which in turn delayed the approval of GoI to the annual PIPs. This resulted in cascading delays of 56 to 193 days in the implementation of the programme and underutilisation of available funds at various levels.

State Government stated (November 2016) that the delay in submission of PIPs occurred due to changes in the guidelines and schedule of submission of State PIP to GoI every year and it was further assured to follow the '*bottom up approach*' in future.

The reply was not convincing as planning is a regular and time bound process to incorporate requirements and make budgetary projections for the coming year. Therefore, the process needed to be started well in advance so that all procedural requirements could be accommodated before finalisation of PIPs.

It was observed that an amount of ₹ 206.97 crore was allotted to the SHS as per approved PIPs of the State during 2012-16 for organising 157 healthcare activities under NRHM. SHS however, did not carry out any of the projected activities during 2012-16. This indicates that the provisions were made in the PIPs without ascertaining the necessities.

It was further observed that perspective plan to outline the year-wise resource and activity needs of the district as required under the NRHM framework was not prepared at both District and State level in phase-I and phase-II.

State Government, while accepting the facts, stated (November 2016) that perspective plans were not prepared on the assumption that district level health action plans and perspective plans were the same.

The reply was not convincing as the perspective plan was required to be prepared for the Mission period as per the NRHM framework, which was not done.

Planning

Household Survey and annual facility survey were not conducted in the State during 2011-16. The Department did not follow the "Bottom up approach" for preparing District Level Health Plans in accordance with the requirements of the NRHM framework. Annual State Programme Implementation Plans were submitted with delays and consequently approvals of GoI were also delayed. This resulted in the cascading delays in the implementation of the programme at various levels. Perspective plans were not prepared at both District and State level for the period 2005-12 and 2012-17.

Recommendations:

1. *Baseline survey including Household Survey and Annual Facility Survey should be conducted by the State Health Mission for assessment of improvement in the available healthcare facilities.*

2. *Perspective plan should be prepared to outline the year wise resource and activity needs of the district. State Government should follow the "Bottom up approach" while preparing District Level Health Plans as outlined in the NRHM framework to ascertain the actual requirements of the rural population.*

2.1.8 Infrastructure and equipment

Audit Objective 2: To assess the availability of adequate physical infrastructure and equipment to meet the requirement of beneficiaries.

2.1.8.1 Physical Infrastructure

NRHM aimed to bridge the gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revitalisation of the existing physical infrastructure such as health centres and new constructions or renovation wherever required.

GoI prescribed (January-February 2007) a set of uniform Indian Public Health (IPH) Standards for planning and upgradation of public healthcare infrastructure (like SCs, PHCs, CHCs, Sub-Divisonal Hospitals and District

Hospitals) in the country. The NRHM framework for implementation, further provided that upgradation of public healthcare infrastructure to the IPH Standards would be one of the core objectives of NRHM.

The Civil construction wing was set up by the State Government for constructions and renovation of health infrastructure facilities under NRHM and it functions under the Mission Director. There was overall projection of ₹ 1417.06 crore during 2011-16 as per approved PIPs for construction and renovation of health infrastructure facilities. During 2011-16, against allocation of ₹ 1107.22 crore, ₹ 892.85 crore was released out of which expenditure of ₹ 888.88 crore (99.55 *per cent*) was incurred.

Instances of creation of lesser number of facilities in tribal areas than the norms, delayed/non-completion of construction works, construction of facilities in remote and unpopulated areas and non-utilisation of infrastructure were noticed during test check, which are discussed in succeeding paragraphs:

2.1.8.2 Availability of Health Centres against IPH Standards

The position of requirement of health infrastructure facilities, as per IPH Standards for rural population and their availability as on 31 March 2016, is given in **Table 2.1**.

Table 2.1

(Position as on 31 March 2016)

Health Infrastructure Facilities	Number of Health Infrastructure Facilities								
	CHCs			PHCs			SCs		
	Non- Tribal Areas	Tribal Areas	Total	Non- Tribal Areas	Tribal Areas	Total	Non- Tribal Areas	Tribal Areas	Total
Requirement as per IPH Standards[9]	384	67	451	1,536	269	1,805	9,220	1,795	11,015
Availability	512	59	571	1,899	181	2,080	12,971	1,437	14,408
Excess(+)/ Shortage(-) (*Per cent*)	(+)128 (33.33)	(-)8 (11.94)	(+)120 (26.60)	(+)363 (23.63)	(-)88 (32.71)	(+)275 (15.24)	(+)3,751 (40.68)	(-)358 (19.94)	(+)3,393 (30.80)

Source: Census 2011.

From the above table, it is seen that as per IPH Standards, the non-tribal areas had excess health facilities, whereas there were deficiencies of eight CHCs (11.94 *per cent*), 88 PHCs (32.71 *per cent*) and 358 SCs (19.94 *per cent*) in tribal areas. Further, two test checked districts (Pratapgarh and Sirohi) had deficiency of one CHC, 14 PHCs and 53 SCs in tribal areas[10]. This indicated that emphasis was not given on establishment of health facilities in the tribal areas.

State Government stated (November 2016) that the IPH Standards are general and not practical to follow in the State of large geographical area and diversity like Rajasthan.

9 The total rural population of Rajasthan was 5,15,00,352 (Non-Tribal Area: 4,61,07,191 (89.53 *per cent*) and Tribal Area: 53,93,161 (10.47 *per cent*). The requirement is based on district-wise rural population as per Census 2011.

10 Pratapgarh has four tribal blocks (Arnod, Dhariawad, Pipalkhunt and Pratapgarh) and Sirohi has one tribal block (Abu Road).

The reply was not convincing as there were inequities in the availability of health infrastructure facilities in tribal areas as compared to non tribal areas. Further, as regards applicability of IPH Standards, SHS confirmed (September 2016) that the IPH Standards were adopted for implementation of the programme.

2.1.8.3 Location of Health Centre

IPH Standards provided that health centres should be centrally located and easily accessible to people and connected with all weather motorable approach road. Further, GoI while approving PIP for the State, also endorsed (June 2011) the construction of new health facility at a place, accessible to people to avail healthcare services in time and discouraged construction in remote and unpopulated areas. It was, however, observed that many health centres were either constructed in remote or unpopulated areas as discussed below:

- IPH Standards provided that a person should have access to a SC within 30 minutes (three kilometres) walking distance. It was, however, observed that 48 SCs (54.54 *per cent*) out of 88 test checked SCs were located beyond 30 minutes walking distance from the remotest village. Further, 56 SCs (63.63 *per cent*) were not accessible by public transport.

- IPH Standards also provided that a PHC should be centrally located in an easily accessible area and have facility of all weather road communication. It was, however, observed that out of 30 test checked PHCs, three PHCs[11] were located at a distance of more than 30 kilometres (kms) from the remotest village and five PHCs[12] were not accessible by all weather roads whereas, other five PHCs[13] were not accessible by public transport.

- IPH Standards further provided that a CHC should be located at a distance of less than two hours travel time from the farthest village. It was, however, observed that out of 15 test checked CHCs, four CHCs[14] were located at a distance of more than 30 kms from the farthest village.

2.1.8.4 Deficiencies in infrastructure in Health Centres

As per IPH Standards, health centres should have their own building with boundary wall, gate, electricity and water supply. They should also be far away from garbage dumps, cattle shed, water logging area etc., and should have adequate manpower, medical departments, wards, beds, laboratories and equipment.

Scrutiny of information provided by the Mission Director, NRHM revealed that 11,268 (78.20 *per cent* of total 14,408) SCs, 1,320 (63.46 *per cent* of total

11 PHC Deldar(Sirohi): 50 kms; PHC Durgapura (Jhalawar):45 kms and PHC Tantwas (Nagaur): 35 kms.

12 PHC Khinyala and Makodi (Nagaur), PHC Chupana and Salamgarh (Pratapgarh) and PHC Sakroda (Rajsamand).

13 PHC Baant (Sirohi), PHC Durgapura (Jhalawar), PHC Makodi (Nagaur), PHC Mohi (Rajsamand) and PHC Punasa (Jalore).

14 CHC Bandikui (Dausa): 35 kms; CHC Bhim (Rajsamand): 60 kms; CHC Bhinmal (Jalore): 64 kms and CHC Nawacity (Nagaur): 40 kms.

2,080) PHCs and 338 (59.19 *per cent* of total 571) CHCs did not have infrastructural facilities[15] as prescribed in IPH standards, as of 31 March 2016.

Similar deficiencies were also noticed in health centres falling under test checked districts which are discussed in succeeding paragraph 2.1.8.7 (equipment deficiencies), paragraph 2.1.9.1 (shortage of manpower) and paragraph 2.1.10.4 (essential drugs deficiencies). Despite emphasis of GoI on providing adequate infrastructural facilities in all rural health centres (CHCs, PHCs and SCs) since launch of NRHM in 2005-06, the State Government could not provide all infrastructural facilities in 75.77 *per cent* of rural health centres.

2.1.8.5 Delays in construction and taking over of Health Facilities

The physical status as of 31 March 2016 of 3,494 construction works sanctioned during 2011-16, is given in **Table 2.2**.

Table 2.2

(As on 31 March 2016)

Year	Number of works sanctioned	Number of works completed and handed over	Number of works completed but not handed over	Number of works in Progress	Number of works not started due to non availability of land	Number of works not started due to other reasons	Number of works de-sanctioned during October 2015
2011-12*	-	-	-	-	-	-	-
2012-13	1923	1289	51	24	01	05	553
2013-14	88	35	16	26	05	05	01
2014-15	699	251	173	118	114	42	01
2015-16	784	18	51	289	06	408	12
Total	**3,494**	**1,593**	**291**	**457**	**126**	**460**	**567**

*No work was sanctioned during 2011-12.

Source: Monthly Progress Report (MPR) provided by Chief Engineer, NRHM.

It is seen from the table that total 3,494 construction works were sanctioned during 2012-16, of which 457 works (13.08 *per cent*) were not completed as of March 2016. Further, 586 works (16.77 *per cent*) could not be taken up for construction (non availability of land: 126 and other reasons: 460) and 567 works were de-sanctioned in October 2015.

Test check of 113 construction works costing ₹ 80.67 crore, taken up in 141 test checked units, revealed the following irregularities:

(i) Non-utilisation of Health Infrastructure

Scrutiny of records and joint physical inspection (May-June 2016) in seven test checked districts revealed that 17 buildings[16] were constructed under

15 Own building, residential quarters for staff, equipment, laboratory, manpower and drugs etc.

16 Buildings of staff quarters at one CHC (Pipalkhunt) and two PHCs (Ghantali and Roll), renovation work of two PHCs (Chanar and Delder), staff quarters at DH Nagaur, one ANM training institute at Pratapgarh, one Swasthya Bhawan at Pratapgarh, three JSY wards at CHC Bhim, Reodar and Maternal Child Health and Nutrition Centre (MCHN), Jhalawar, three MCHNs at Dausa, Jalore and Pratapgarh, one waiting hall at DH Sirohi, *Janani Suraksha Yojana* ward at PHC Reodar and office building of Block Chief Medical Officer at Kuchaman City.

NRHM (between June 2010 and January 2016) by incurring an expenditure of ₹ 43.22 crore, but these buildings were not put to use even after lapse of two to 70 months after their completion.

The concerned Executive Engineers stated (May-June 2016) that responsibility of utilisation of the completed building rests with the Medical Officer In Charge (MOIC) of the health centre. The MOIC attributed the non-utilisation of these buildings to non-availability of staff, construction of buildings at faraway places, non-availability of water and electricity connection, etc.

20 bedded JSY ward at CHC Reodar (District Sirohi) was unutilised due to shortage of manpower.

50 bedded JSY ward at Medical College Hospital Jhalawar was unutilised due to shortage of manpower.

State Government did not intimate reasons for non-utilisation of 17 buildings constructed under NRHM.

(ii) Delay in completion of MCHN/JSY Wards at District Hospitals

Scrutiny of records and joint physical inspection (May-June 2016) in seven test checked districts revealed that five Maternal Child Health and Nutrition (MCHN) centres[17] and one *Janani Suraksha Yojana* (JSY) ward at Jhalawar were completed by incurring an expenditure of ₹ 40.14 crore, with delays ranging between four to 12 months which resulted in delayed establishment of health infrastructure for vital maternal and child healthcare facilities.

(iii) Award of works without ensuring availability of land

Rule 351 of Public Works Financial and Accounts Rules (PWF&AR) provided that the availability of land should be ensured before awarding the construction work.

It was observed that in seven test checked districts, 20 works (Dausa: three, Nagaur: six, Jalore: eight, Rajsamand: two and Sirohi: one) were sanctioned during 2012-15 (2012-13: 17 and 2014-15: three) and the work orders (total amounting to ₹ 2.47 crore) were issued to the contractors for construction. The contractors, however, could not commence the works because the land for construction was not available. This resulted in the works not starting and subsequently being de-sanctioned (October 2015)**.** Details of the cases have been given in ***Appendix 2.1***.

17 100 bedded MCHN at DH Pratapgarh and Nagaur and 50 bedded MCHN at DH Jalore, Rajsamand and Sirohi.

Further, cost overrun of ₹ 0.30 crore was noticed in two cases[18] of delayed completion of buildings due to non-availability of land at the sites selected for construction of these buildings.

Thus, the works were awarded to the contractors for construction without ensuring the availability of land before awarding them, which subsequently led to the works being de-sanctioned.

State Government stated (November 2016) that in most of the cases the land disputes occurred at time of start of work at site, whereas the MOICs reported availability of dispute free land in the proposal for sanction of the works. This was indicative of the fact that MOICs did not coordinate with land revenue authorities before reporting the status of availability of land.

(iv) Infrastructures created at inaccessible and uninhabited locations

- Construction of Hostel Building at Rajsamand for Auxiliary Nurse Midwife (ANM) trainees was sanctioned during 2010-11 for ₹ 0.52 crore. The work was later withdrawn due to non-availability of land and the work was subsequently allotted (December 2012) to another contractor for construction at another place. The building was completed at an expenditure of ₹ 0.82 crore and handed over in March 2015. It was noticed that the hostel building was not utilised and another building was taken on rent to operate the hostel and an amount of ₹ 0.03 crore was paid on account of rent during April 2015 to July 2016.

The Medical Officer In-Charge stated (May 2016) that the building was constructed close to the National Highway and was unsafe, further it was also insufficient to accommodate all the trainees. The fact of non-utilisation of hostel building was confirmed during joint physical inspection with the departmental representatives on 11 May 2016.

Thus, the hostel building was constructed at an unsuitable location and was not utilised. Besides, additional expenditure of ₹ 0.03 crore was also incurred for operation of the hostel in the rental building, which would increase with the passage of time.

ANM hostel building at Rajsamand was constructed and was not utilised.

18 ANM trainees hostel building at Rajsamand (₹ 0.21 crore) and staff quarters at CHC Pipalkhunt (₹ 0.09 crore).

- Staff quarters at CHC Bhim were constructed at an expenditure of ₹ 0.63 crore[19] and handed over in January 2012. It was observed that the staff quarters were lying vacant and not utilised. The MOIC, CHC, Bhim informed (May 2016) that staff quarters were constructed in an uninhabitable area and 2.5 kms away from the CHC building. The fact of non-utilisation of staff quarters was also confirmed during joint physical inspection with the departmental representatives on 12 May 2016.

Unutilised Staff quarters at CHC Bhim, which were constructed 2.5 kms away from CHC building in an uninhabitable area.

State Government (November 2016) did not offer specific comments on these cases of construction of facilities at unsuitable locations.

2.1.8.6 Non-utilisation of staff quarters

In Rajasthan, out of 17,059 rural health centres (CHCs-571, PHCs-2,080 and SCs-14,408) only 8,430 (49.42 *per cent*) health centres (CHCs-392, PHCs-1,244 and SCs-6,794) had residential quarters for doctors and staff, of which quarters at 421 (4.99 *per cent*) health centres were lying vacant as of March 2016.

Test check of 133 selected health centres (CHCs-15, PHCs-30 and SCs-88) revealed that out of 182 quarters available at these health centres, 26 *(*14.28 *per cent)* residential quarters were lying vacant due to the reasons like buildings requiring repair/ maintenance (16), non-availability of water/ electricity connections (six) and shortage of staff (four).

State Government, while accepting the facts, stated (November 2016) that these quarters were constructed on land, which was generally available at places located far away from populated area, schools and markets.

2.1.8.7 Non-availability of equipment in health centres

The IPH Standards have prescribed two categories of equipment as essential (minimum assured services) and desirable (the ideal level of services) for health centres (DHs, SDHs, CHCs, PHCs and SCs).

Availability of essential equipment in 141 test checked health centres (DHs: seven, SDH: One; CHCs: 15, PHCs: 30 and SCs: 88) and their shortfall are enumerated in the **Table 2.3**.

19 Including boundary wall constructed later during 2015-16 at an expenditure of ₹ 0.12 crore.

Table 2.3

S. No.	Equipment	Status of availability
District Hospitals: Seven		
1.	2 D Eco Machine	Not available in all seven selected district hospitals.
2.	Ultrasound facility	Available in all seven selected districts but non- functional in Sirohi DH.
Community Health Centres: 15		
1.	Operation Theatre Table	Not available in three CHCs (Basni, Bhandarej and Pipalkhunt) and non functional in CHC Arnod.
2.	Bedside screen	Not available in two CHCs (Ahore and Bhandarej).
3.	ECG facilities	Not available in three CHCs (Bhandarej, Kankroli and Roll) and non-functional in three CHCs (Bakani, Bhim and Jhalrapatan).
4.	X-ray facility	Not available in three CHCs (Bhandarej, Kankroli and Roll) non-functional in one CHC (Reodar).
5.	Sterlisation Instruments	Not available in one CHC (Bhandarej).
Primary Health Centres: 30		
1.	Delivery table	Not available in one PHC (Ghana) and non-functional in one PHC (Chupana).
2.	Operation Theatre Table	Available and functional in six PHCs[20] and in one PHC (Sarda) it was available but not functional.
3.	Bed side screen	Not available in six PHCs[21].
4.	Sterilisation instruments	Not available in 14 PHC[22]s and non-functional in one PHC (Salamgarh).
5.	IUD Insertion Kit	Not available in one PHC (Ghana).
6.	Normal delivery kit	Not available in one PHC (Ghana) and non functional in two PHCs (Aloonda and Bhagwanpura).
7.	Vaccine carrier	Not available in three PHCs (Aloonda, Bali-Jassakheda and Chupana).
Sub Centre: 88		
1.	Examination table	Not available in 14 SCs[23], and non-functional in seven SCs (Bhanskheri, Bori, Girwar, Kachotya, Lodham, Manpura and Nandi- Kheda).
2.	Labour table	Labour Table was not available in 38 SCs[24] and non-usable in 12 SCs[25].
3.	Weighing machine	Not available in 14 selected SCs[26] and non-functional in four SCs (Bijapura, Kaloda, Nogava and Thaneta).
4.	Disposable delivery kit	Available and functional in only 13 selected SCs[27] and in four SCs (Jaitpura, Kalota, Maharajpura and Mahikheda) kits were available but not functional.

Source: Information provided by the Healthcare Facilities.

20 Arniya, Badikhatu, Chanar, Chupana, Durgapura and Minda.
21 Aloonda, Bali-Jassakheda, Ghana, Makodi, Minda and Panchola.
22 Aloonda, Baant, Bali-Jassakheda, Chupana, Diver, Donda, Ghana, Khinyala, Makodi, Nosra, Panchola, Punasa, Sanwara and Tantwas.
23 Bakli, Bas-Bewai, Dahikhera, Daytra, Devaldi, Dhani-Nimbodi, Ghanliyawas, Ghatiyad, Kaliswar, Khinyawas, Liliya, Moikala, Padaliya and Thikarya.
24 Asawa, Badayala, Bakli, Bas-Bewai, Bhanskheri, Bhanwarsa, Bheboli, Bori, Dahikhera, Devaldi, Dhani-Nimbodi, Dhanoda, Digariya-Tappa, Gangliyawas, Ghatiyad, Govindpura, Gudha-Ashiqpura, Hajya-ka-Vas, Jaitpura, Jetawara, Kaliswar, Khinyawas, Ladli-Ka-Bas, Liliya, Kalota, Mahuakhoh, Moheda, Moikala, Mundghosoi, Padaliya, Rajod, Raipur-Jangal, Salotiya, Sirsi, Thikariya, Thikariya-Khurd, Udwaria and Viyo-Ka-Gholiya.
25 Bijapura, Lodhan, Mahikheda, Malgaon, Manpura, Matasen, Nandikheda, Nogava, Panchola, Pilanwasi, Thenchala and Tongi.
26 Bhanskheri, Dahikhera, Dhani-Nimbodi, Devaldi, Ghatiyad, Giriwar, Kaliswar, Khinyawas, Liliya, Lodhan, Manpura, Moheda, Moikala and Padaliya.
27 Balwa, Batoli, Dantiwas, Datina, Doyeba, Gagron, Gudha-Ashiqpura, Khedli-khurd, Nakli, Pindya, Rajawas, Raipur-jungle and Ruchiyar.

It is seen from the table that health centres catering to rural population (CHCs, PHCs and SCs) were having shortage of more equipment as compared to DHs. This indicated that emphasis on providing all essential equipment in rural health centres was not given.

Thus, in absence of essential equipment, the minimum assured services could not be provided to the targeted rural population as envisaged under NRHM.

State Government accepted the facts and stated (November 2016) that due to non-availability of staff to operate the equipment and proper space/building to install them, the equipment were non-functional. Further, remedial steps are being initiated to provide the equipment at health centres.

2.1.8.8 Utilisation of equipment

Scrutiny of 141 test checked health centres revealed that apart from the essential equipment, in following instances equipment for blood bank, ophthalmic, cardiac and life saving Intensive Care Unit (ICU) could not be utilised because of shortage/non-availability of staff to operate them indicating that equipment were supplied without any proper plan as discussed below:

- Five ventilators (costing ₹ 0.61 crore) received in October 2013-April 2015 in DH, Nagaur were not installed and lying unutilised due to delay in completion and taking over of the hospital building.

- One ventilator (costing ₹ 0.07 crore) received in December 2009 in DH, Jalore was not installed and lying unutilised.

- Various equipment like ventilator, Multi Para-monitor, Cardic Monitor, ICU Bed, Operation Theatre (OT) Table, Suction Table etc., costing ₹ 0.35 crore for ICU ward in DH, Dausa were not utilised due to shortage of staff.

- A blood bank refrigerator (60 bags capacity) with printer and real time clock (purchased during November 2006) was lying unutilised in CHC Bakani, since its receipt due to non-deployment of a trained operator. It was also noticed that license to establish blood bank was also not obtained by MOIC. Further, cardiac equipment (Biphasic Defibrillator 400-200 Jules) was also lying unutilised since its purchase in February 2010, due to non appointment of Junior Specialist.

- Ophthalmic equipment (purchased during May 2006) and Tread Mill Test (TMT) machine (purchased during July 2010) costing ₹ 0.03 crore were lying unutilised since their purchase in CHC, Bhinmal due to non-availability of specialists.

- Cardiac equipment (Cardiac Monitor: February 2006, Pulse Monitor: April 2007 and Biphasic Defibrillator 400-200 Jules: February 2010) costing ₹ 0.03 crore were lying unutilised since their purchase in CHC, Ahore.

To address the problem of non-functioning of equipment in the health centres, the State Government stated (November 2016) that a new Equipment Management and Maintenance System (e-Upkaran) had been launched.

2.1.8.9 Payment to supplier without installation of equipment

Rajasthan Medical Services Corporation Limited (RMSCL) issued (November 2014) supply orders to M/s Schiller Healthcare India Private Limited, for procurement and installation of life saving equipment (viz. Ventilator, Multi Para-Monitor, Cardiac Monitor and Fetal monitor) in 22 Maternal Child Health and Nutrition (MCHN) Centres at the cost ₹ 7.52 crore. As per condition of supply order, 70 *per cent* payment was to be made on receipt of equipment and remaining 30 *per cent* after their installation subject to the condition that supplier would be responsible for installation of the equipment on intimation of readiness of site by the health centre.

It was, however, observed that full and final payment of ₹ 2.39 crore was made (March 2015 to January 2016) to the supplier for supply and installation of equipment in nine[28] MCHN centres even though the sites were not ready for installation. Further in case of 10 ventilators (cost: ₹ 1.26 crore), installation certificates were issued by five DHs[29] though the site was not ready.

Thus, the supplier was paid ₹ 0.72 crore (30 *per cent* of ₹ 2.39 crore) without installation of equipment, which was irregular.

State Government accepted the facts and stated (November 2016) that the payment was released on the request of the supplier.

The reply was not acceptable as contrary to the condition of the supply orders, the payment of ₹ 0.72 crore (30 *per cent* amount) was made without installation of the equipment.

Infrastructure and equipment

NRHM aimed to bridge the gaps in the existing capacity of the rural health infrastructure and GoI has prescribed Indian Public Health Standards for availability of public healthcare infrastructure. As per these Standards, lesser number of health centres was provided in the tribal areas as compared to non-tribal areas.

State Government could not provide all the basic infrastructural facilities in 75.77 per cent of rural health centres. Health centres were constructed at inaccessible and uninhabited locations and contracts for construction of buildings were awarded to the contractors without ensuring availability of the land.

There was 50.58 per cent shortage in staff quarters. Further, even the constructed staff quarters and Health Centres were not utilised due to shortage of staff.

Emphasis on providing all essential equipment in rural health centres (CHCs, PHCs and SCs) was not given as they were having more shortages of essential equipment as compared to District Hospitals. Further, equipment were lying unutilized in health centres due to non-availability of trained staff to operate them.

28 Sites were not ready for installation as construction of three MCHN centres (Bhilwara, Dungarpur and Sikar) was under progress and possession of other six MCHN centres (Banswara, Baran, Beawar, Karauli, Nagaur and Udaipur) were not taken over by the hospital authorities as of August 2016.

29 Banswara, Bhilwara, Dungarpur, Nagaur and Udaipur.

Recommendations:

3. *State Government should follow the IPH Standards to provide adequate number of accessible health centres and infrastructure in the rural areas.*
4. *Availability of adequate number of functional equipment and operating manpower in Rural Health Centres should be ensured by the State Health Mission so that the rural people do not migrate to urban areas for medical services.*

2.1.9 Manpower Management

Audit objective-3: To assess the availability of healthcare professionals as per requirement of the norms.

2.1.9.1 The mission aimed at increasing the availability of manpower as per IPH Standards. GoI also extended assistance to the State Government for filling up the existing vacancies on contractual appointments.

The position of deployment of manpower required *vis a vis* IPH Standards in health centres (DHs, SDHs, CHCs, PHCs and SCs) and sanctioned by the State Government is given in **Table 2.4**.

Table 2.4

Health Facilities	Number of Health Centres	Manpower required as per IPH Standards for each centre	Total Man power required as per IPH Standards	Number of Sanctioned Posts by the State Government	Men in position	Shortage(-) /Excess(+) as per IPH Standard *(per cent)*	Shortage(-) /Excess(+) *vis a vis* sanctioned post *(per cent)*
DHs	34	123	4,182	6,963	5,665	(+) 1,483 *(35.46)*	(-)1,298 (*18.64*)
SDHs	19	86	1,634	2,754	1,637	(+) 3 *(0.18)*	(-)1,117 (*40.56*)
CHCs	571	46	26,266	13,542	8,493	(-) 17,773 *(67.67)*	(-)5,049 (*37.28*)
PHCs	2,080	13	27,040	16,398	11,856	(-) 15,184 (*56.15*)	(-)4,542 (*27.70*)
SCs	14,408	3	43,224	21,554	15,430	(-) 27,794 (*64.30*)	(-)6,124 (*28.41*)
Total	**17,112**		**1,02,346**	**61,211**	**43,081**	**(-) 59265 (*57.91*)**	(-)**18,130 (*29.62*)**

Source: Data provided by the Department.

The above table shows an overall shortage of 62.93 *per cent* of manpower in rural areas (CHCs; 67.67 *per cent*, PHCs; 56.15 *per cent* and SCs; 64.30 *per cent*). DHs, catering mostly urban population however, had excess of 1,483 manpower (35.46 *per cent*) as compared to IPH Standards.

Further, when compared to sanctioned posts, it was noticed that there was shortage of manpower at all levels i.e. at DHs (18.64 *per cent*), SDHs (40.56 *per cent*), CHCs (37.28 *per cent*), PHCs (27.70 *per cent*) and SCs (28.41 *per cent*).

The comparison of posts sanctioned by the State Government with IPH Standards also indicates that less posts were sanctioned for rural health centres (CHCs, PHCs and SCs) than for urban health centres at DHs.

Deployment of manpower was also checked in 141 selected health centres in seven rural districts and deficiencies noticed are discussed below:

(i) District Hospitals

The requirement of medical professionals[30] and para medical manpower as per IPH Standards, post sanctioned by the State Government and men in position in seven test checked DHs as on 31 March 2016 is given in **Table 2.5**.

Table 2.5

Name of DH	Manpower required as per IPH Standards		Posts sanctioned by the State Government		Men in position		Variation over parameters (+) excess; (-) shortage			
	Medical profe-ssional	Nurses and para medical staff	Medical profe-ssional	Nurses and para medical staff	Medical profe-ssional	Nurses and para medical staff	Medical professional		Nurses and para medical staff	
							As per IPH Stan-dards	As per sancti-oned posts	As per IPH Stan-dards	As per sancti-oned posts
Dausa	29	76	48	113	43	93	(+)14	(-)5	(+)17	(-)20
Jhalawar	29	76	53	138	23	122	(-)6	(-)30	(+)46	(-)16
Jalore	29	76	39	87	14	65	(-)15	(-)25	(-)11	(-)22
Nagaur	29	76	60	91	41	85	(+)12	(-)19	(+)9	(-)6
Pratapgarh	29	76	46	130	12	83	(-)17	(-)34	(+)7	(-)47
Rajsamand	29	76	42	113	15	73	(-)14	(-)27	(-)3	(-)40
Sirohi	29	76	41	112	16	48	(-)13	(-)25	(-)28	(-)64
	203	**532**	**329**	**784**	**164**	**569**	**(-)39**	**(-)165**	**(+)37**	**(-)215**

Source: Data provided by the respective Health Centres.

It is seen from the above table that:

Medical professionals: As per IPH Standards, 203 medical professionals were required in seven test checked DHs and the State Government sanctioned 329 posts. But only 164 medical professionals were deployed there. Thus there was a shortage of 165 medical professionals (50.15 *per cent*) in these seven test checked DHs.

Further, disproportionate deployment of medical professionals was also observed in DH, Dausa and Nagaur, where 26 medical professionals were deployed in excess of IPH Standards whereas, in the other five test checked DHs, there was shortage of 65 medical professionals.

Para medical manpower: As per IPH Standards, 532 para medical staff was required in seven test checked DHs and the State Government sanctioned 784 posts. But only 569 para medical staff were deployed there. Thus there was a shortage of 215 para medical staff (27.42 *per cent*) in these seven test checked DHs.

30 Medical professional includes Doctors such as Anaesthesiologists, Dentists, General practitioners, Gynaecologists, Obstetricians, Ophthalmologists, Orthopaedists, Paediatricians, Surgeons etc.

Further, disproportionate deployment of para medical staff was also observed in DH, Dausa and Jhalawar, where 63 para medical staff was deployed in excess of IPH Standards whereas, in DH, Sirohi there was shortage of 28 para medical staff.

Furthermore, against the requirement of one ECG Technician in each DH, no ECG Technician was posted in any of test checked DHs.

State Government stated (November 2016) that the posts of ECG technician at DHs were not yet created and now it has been proposed. Further, the advertisement has been published by Rajasthan Subordinates and Ministerial Service Board for the post of Lab Technician, Assistant Radiographer, Ophthalmic Assistant and Dental Technician.

(ii) Community Health Centres

Medical professionals: Test check of 15 CHCs in seven districts revealed that against the requirement of 165 medical professionals only 68 medical professionals (41.21 *per cent*) were posted there, as of March 2016. Thus, there was a shortage of 97 medical professionals[31] in these 15 CHCs. Further, Medical Officer-AYUSH were not posted in any of the test checked CHCs, as out of 1013 sanctioned posts, 907 posts (89.54 *per cent*) were vacant in the State as of March 2016.

Para medical manpower: Against the total requirement of 375 para-medical staff as per IPH Standards, only 215 para medical staff (57.33 *per cent)* were deployed.

(iii) Primary Health Centres

Medical professionals: One doctor (Medical Officer) was required in each PHC, as per IPH Standards**.** It was, however, observed that in three test checked PHCs (Ghana, Baant and Sanwara) Medical Officers were not posted whereas two Medical Officers were posted in five other test checked PHCs (Khatukalan, Bhagwanpura, Salamgarh, Chanar and Deldar). This indicated disproportionate deployment of medical professionals in PHCs.

Para medical manpower: IPH Standards provided deployment of 12 para-medical staff in each PHC. The State Government sanctioned 213 posts of para-medical staff against the requirement of 360 in 30 test checked PHCs, and against this, only 139 (38.61 *per cent)* were posted. Further out of 30 test checked PHCs, 29 were functioning without Pharmacists.

State Government stated (November 2016) that the Department has since appointed 589 Pharmacists during 2016-17.

(iv) Sub Centres

IPH Standards provided for appointment of one ANM (Female), one Health Worker (Male) and one *Safai Karamchari* in each SC. It was, however,

31 Anesthetist (13), Dental Surgeon (eight), General Medical Officer (7), General Surgeon (10), Obstetrician & Gynecologist (11), Pediatrician (12), Physician (eight), Public Health Nurse (13) and Public Health Specialist (15).

observed that ANMs were not posted in the 12 out of 88 test checked SCs. Further, Health Workers (Male) and *Safai Karamchari* were not posted in any of the 88 test checked SCs.

State Government stated (November 2016) that instructions have been issued to fill the vacant post of Women Health Worker by relocating the Women Health Workers from other health facilities where more than one were working.

The fact however remains that any mismatch between availability of medical professionals, para medical staff, skilled technicians and availability of buildings/equipment will not serve the purpose of providing healthcare facilities to rural people.

2.1.9.2 Accredited Social Health Activist

NRHM Framework for Implementation provided for appointment of Accredited Social Health Activist (ASHA) to forge the linkage of hamlet to hospital for curative services, empowerment of women and universalisation of child development services for every 1000 population/large isolated habitations. Payments to the ASHAs are made on the basis of services rendered by them. Further, the State Government prescribed (October 2009) that a woman in the age group of 21-45 years and possessing formal education[32] could be appointed as ASHA.

It was observed that against the sanction of 54,915 ASHAs, only 47,927 ASHAs (87.27 *per cent*) were working as of March 2016. In seven test checked districts, 9,681 ASHAs were sanctioned and against which 8,154 (84.22 *per cent*) were working as of March 2016.

State Government, while accepting the facts, stated (November 2016) that selection of ASHAs could not be completed due to non-availability of women of prescribed qualification. Further, to fulfil the backlog of ASHAs, the matter had been taken up with the Rural Development and Panchayati Raj Department.

In addition, drug kits containing, Oral Rehydration Solution, contraceptives and a set of ten basic drugs were required to be provided to ASHAs for immediate and easy access to the rural population. Analysis of feedback obtained from 180 ASHAs in 88 test checked SCs revealed that drug kits of 90 ASHAs (50 *per cent*) were replenished within 10 days while drug kits of other ASHAs were replenished after 10 days {i.e. 18 ASHAs (10 *per cent*) between 10 days and three weeks and 72 ASHAs (40 *per cent*) after three weeks time}.

State Government stated (November 2016) that the drugs had been replenished as per demand of the ASHAs.

The reply needs to be viewed in the light of the fact that ASHAs were required to provide immediate and easy access to the rural population to essential health supplies and any delays in replenishment of the kits would adversely affect these response provided.

32 Minimum of VIII standard.

Good Practice

ASHA Soft is an online system launched in 2014 which facilitates the department to capture beneficiary wise details of services given by ASHA to the community, online payment to ASHA into their bank account and generate various reports to monitor the progress of the programme. Rajasthan is the first State in the country to start online payments to ASHAs in all the districts.

2.1.9.3 Training to ASHAs

GoI prescribed two levels of training for ASHAs, *viz*. Induction training (in module I to V, of 23 days over 12 months) and capacity building (in module VI to VII, in four rounds of five days each).

It was observed that during 2011-16, against the target of providing induction training (module I to V) to 27,800 ASHAs, only 11,926 ASHAs (42.90 *per cent*) were imparted induction training.

Further, out of 47,927 working ASHAs, only 5,143 ASHAs (10.73 *per cent*) could complete all four rounds of the capacity building training. Thus the capacity building training was not provided to the remaining 42,784 working ASHAs as of March 2016.

Analysis of feedback obtained from 180 ASHAs revealed that 157 ASHAs in 88 test checked SCs were not trained and did not have necessary equipment to perform a normal delivery.

State Government accepted the facts and stated (November 2016) that the achievement of target of induction training was not possible due to non selection of eligible ASHAs. It was further stated that capacity building training was not provided to ASHAs, as the trainers were not selected.

2.1.9.4 Appointment of Contractual Staff

NRHM provides for engagement of medical and para medical manpower on contractual basis to fill the gaps in availability of manpower and provide additional manpower for the delivery of healthcare services. NRHM Framework for Implementation further provided that GoI would provide financial support to fill up all new contractual posts.

Accordingly, the provision for appointment of 21,245 persons during 2014-15 and 22,773 persons during 2015-16, on contractual basis was approved by GoI in the State PIP. It was, however, observed that only 13,752 (64.73 *per cent*) persons during 2014-15 and 13,311 (58.45 *per cent*) persons during 2015-16 were appointed on contractual basis.

State Government stated (November 2016) that Finance Department stopped (June 2011) the recruitment on contractual post therefore most of the contractual post could not be filled. Subsequently Finance Department permitted (June 2014) for recruitment and 575 persons were recruited on

contractual posts of different cadres at State/District and Block level during 2015-16.

The fact remains that despite priority on filling the gaps in availability of manpower by GoI and approval of the proposal of the State Government in the State PIP, persons were not appointed on contractual basis for the delivery of healthcare services.

Manpower management

The mission aimed at increasing the availability of manpower as per IPH Standards. There was a 62.93 per cent shortage of manpower in health centres located in rural areas while District Hospitals catering mostly the urban population had excess manpower of 35.46 per cent as compared to IPH Standards.

Though ASHAs had a pivotal role in providing healthcare support services at the village level, empowerment of women and universalisation of child development services, there was shortage of 12.73 per cent ASHAs in the State. Further, only 42.90 per cent of ASHAs could be imparted induction training.

Though GoI emphasised on filling up the gaps in availability of manpower by engagement of medical and para medical manpower on contractual basis, yet only 64.73 and 58.45 per cent persons were appointed on contractual basis during 2014-15 and 2015-16 respectively against the provision approved in annual PIP.

Recommendation:

5. State Government should endeavor to provide the sufficient manpower as per standards at the rural health centres and also rationalise the posting of existing staff from surplus centres to deficit centres.

2.1.10 Quality of Healthcare services

Audit Objective 4: To assess the extent and quality of healthcare services provided and impact of NRHM on reducing Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate.

2.1.10.1 Maternal healthcare services

(i) Ante Natal Care

Ante Natal care (ANC) is the healthcare received by a woman during her pregnancy and starts with recording the history of the patient followed by examination of the woman[33], guidance for nutritional diet, regular antenatal

33 As per the ANM guidelines, this includes recording of weight and height, blood test for anaemia, blood pressure measurement and regular abdominal examination etc.

checkups and counseling for family planning. She is also immunised with Tetanus Toxoid (TT) and provided Iron Folic Acid (IFA) tablets. Every pregnant woman should be registered during the first trimester (first 12 weeks) of her pregnancy and undergo three checkups during the pregnancy, at prescribed intervals for proper ANC.

Table 2.6 below depicts the status of total number of pregnant women registered for ANC and their follow up during 2011-16.

Table 2.6

Year	Total Number of pregnant women registered	Number of pregnant women registered under ANC in first trimester (*per cent*)	Three checkups (*per cent*)	Number of pregnant women provided TT (*per cent*)	Number of pregnant women given IFA tablets (*per cent*)
2011-12	18,51,453	8,62,679 (*46.59*)	13,41,543 (*72.46*)	15,15,772 (*81.87*)	11,75,154 (*63.47*)
2012-13	19,14,624	9,49,018 (*49.57*)	13,82,822 (*72.22*)	15,92,126 (*83.16*)	14,46,784 (*75.56*)
2013-14	19,38,528	10,57,498 (*54.55*)	14,16,481 (*73.07*)	16,39,231 (*84.56*)	13,28,552 (*68.53*)
2014-15	19,21,561	11,24,015 (*58.49*)	13,97,211 (*72.71*)	16,04,367 (*83.49*)	13,09,710 (*68.16*)
2015-16	19,04,886	11,43,116 (*60.00*)	13,14,084 (*68.98*)	15,49,442 (*81.34*)	11,98,592 (*62.92*)
Total	**95,31,052**	**51,36,326 (*53.89*)**	**68,52,141 (*71.89*)**	**79,00,938 (*82.90*)**	**64,58,792 (*67.77*)**

Source: Information provided by SHS and extracted from the Demographic Report for the respective year.

It is seen from the above table that:

- Though the percentage of women registered in first trimester increased from 46.59 *per cent* to 60 *per cent* during 2011-16, yet 26.93 *per cent* to 31.02 *per cent* pregnant women did not get all three checkups.

- 15.44 to 18.66 *per cent* women were not immunised during their pregnancy, with both doses (TT-1 and TT-2) of TT vaccine.

- Anaemia in pregnancy is associated with high maternal morbidity and mortality[34] in the State for last three decades and persistence of anaemia during the second trimester is associated with preterm (premature) birth. To prevent/cure anaemia, IFA tablets (100 mg iron with 0.5 mg folic acid) are given once daily for 100 days after the first trimester of pregnancy.

In this regard, it was observed that only 64.59 lakh (67.77 *per cent)* out of 95.31 lakh pregnant women registered in the State, were given IFA tablets. Thus, despite the fact that a large percentage of pregnant women of the State were suffering from anaemia for three decades, the problem was not adequately addressed under NRHM.

34 Mortality is a measure of deaths within a population or geographic area whereas morbidity is a measure of sickness or disease within a geographic area. Further, mortality is being susceptible to death while morbidity is having diseases to cause death later on.

Scrutiny of ANC provided to 14.14 lakh pregnant women registered for ANC in seven test checked districts revealed the followings deficiencies:

- Only 10.50 lakh (74.25 *per cent*) pregnant women were given three mandatory checkups during their pregnancy. Further, only Jalore and Pratapgarh districts maintained records of first and second checkups and rest of test checked districts did not maintain the records of first and second checkups of pregnant women.

- Distribution of IFA tablets to the pregnant women ranged between 60.27 to 77.76 *per cent* during 2011-16.

- Further, 39.05 to 44.97 *per cent* women were not immunized with TT during their pregnancy.

State Government accepted the fact and stated (November 2016) that efforts were being made to improve three ANC checkups, distribution of IFA tablets and providing TT to pregnant women against total ANC registration.

(ii) Institutional Delivery

NRHM encouraged institutional deliveries for improving maternal healthcare through creating awareness among people. *Janani Suraksha Yojana* (JSY) was launched (April 2005) by modifying the National Maternity Benefit Scheme (NMBS) to promote institutional deliveries and reduce Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). Status of the institutional deliveries conducted in the State and in seven test checked districts during 2011-16 is given in **Table 2.7**.

Table 2.7

Year	State level				Seven test checked district			
	Registered for Ante Natal Care	Targets for institutional delivery	Total Institutional deliveries *(per cent)*	Home Delivery	Registered for Ante Natal Care	Targets for institutional delivery	Total Institutional deliveries *(per cent)*	Home Delivery
2011-12	18,51,453	16,54,148	12,79,264 (*77.34*)	1,31,732	2,99,149	2,59,744	2,13,093 (*82.04*)	19,027
2012-13	19,14,624	17,22,136	13,46,810 (*78.20*)	1,21,065	2,85,932	2,57,544	2,29,902 (*89.27*)	17,441
2013-14	19,38,528	17,64,959	13,73,512 (*77.82*)	1,03,072	2,74,656	2,86,673	2,35,135 (*82.02*)	14,394
2014-15	19,21,561	17,86,892	13,50,242 (*75.56*)	86,639	2,76,473	2,90,378	2,26,181 (*77.89*)	10,833
2015-16	19,04,886	17,90,050	13,53,622 (*75.62*)	65,515	2,77,397	2,90,591	2,26,402 (*77.91*)	6,168
Total	**95,31,052**	**87,18,185**	**67,03,450 (*76.89*)**	**5,08,023**	**14,13,607**	**13,84,930**	**11,30,713 (*81.64*)**	**67,863**

Source: information provided by the Department.

Analysis of data relating to pregnant women registered for ANC revealed that:

- Against the targets of 87.18 lakh institutional deliveries in the State, the achievement was only 67.03 lakh (76.89 *per cent*) during 2011-16, leading to shortfalls during 2011-12 (22.66 *per cent*), 2012-13 (21.80 *per cent*),

2013-14 (22.18 *per cent*), 2014-15 (24.44 *per cent*) and 2015-16 (24.38 *per cent*) in achieving targets of institutional deliveries.

State Government stated (November 2016) that institutional deliveries were gradually rising in the State.

The reply was not convincing as the year-wise data of institutional deliveries was stagnant between 75 to 78 *per cent* during 2011-16.

- The total number of pregnant women registered in the State during 2011-16 was 95.31 lakh. As per data furnished by the Department, there were 67.03 lakh institutional deliveries and 5.08 lakh home deliveries leaving a balance of 23.20 lakh pregnant women, for which no information was available.

State Government, while accepting (November 2016) the facts, attributed the reasons for gap in total ANC registration and institutional deliveries to possible loss of pregnancy due to abortion, miscarriage & medical termination of pregnancy and non reporting of deliveries in urban areas due to lack of manpower.

The fact however remains that no authentic information was available about the type of delivery for 24.34 *per cent* of the pregnant women. There is an urgent need to keep a track of these pregnant women considering the high MMR and IMR in the State.

- Out of total home deliveries during 2011-15, deliveries ranging between 40.84 to 60.95 *per cent* were carried out by *dais*[35]/relatives/others and 34.15 to 26.23 *per cent* newborns were not visited by a Doctor/ANM/Nurse within 24 hours of delivery as required under the norms. Thus, the directions of guidelines to reduce IMR by providing healthcare to newborns within 24 hours of birth were not adhered to.

State Government accepted the fact and stated (November 2016) that still there are areas in the State where people prefer the traditional method of delivery conducted by *dais*.

There is, however, a need to increase awareness about the advantages of institutional deliveries so that the MMR and IMR in the State is reduced.

- In seven test checked districts, institutional deliveries decreased from 89.27 *per cent* in 2012-13 to 77.91 *per cent* in 2015-16.

Further, test check of 88 SCs revealed that out of 2,104 deliveries conducted at home during 2011-16, 70.48 *per cent* home deliveries (1,483) were not attended by Doctor/skilled birth attendant Nurse/ANM and 45.01 *per cent* newborns (947) were not visited by health worker within 24 hours of home delivery.

35 Untrained midwives.

Thus, the objectives of NRHM to encourage institutional deliveries for improving maternal health could not be achieved as the number of institutional deliveries did not increase during 2011-16.

(iii) Non-availability of maternal healthcare services in rural health centres

Assessment of availability of maternal healthcare services in rural health centres (15 CHCs) revealed the following:

- Post partum sterilisation service was available in only eight CHCs[36],
- Caesarean section service was available in only two CHCs[37],
- Ultra Sonography service was available in only three CHCs[38],
- Comprehensive obstetric service was available in only seven CHCs[39] and
- Round the clock blood storage service was available in only two CHCs[40].

This indicates that a large number of CHCs were not able to provide essential maternal healthcare services and facility of institutional delivery to cater the demand of rural community.

State Government, while accepting the facts, stated (November 2016) that only District Hospitals were initially covered and instructions have been issued to CMHOs for improvement in facilities at CHC and PHC level.

(iv) Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) was launched to promote institutional deliveries and reduce MMR and IMR. JSY awards cash assistance[41] for post-delivery care at the time of discharge. ASHA has significant role in encouraging the pregnant women to institutional deliveries. Both the pregnant woman and ASHA receive the cash benefits under JSY.

Non-payment of incentive to beneficiaries

- In the State, out of total 55.50 lakh institutional deliveries[42] under JSY, cash incentive was paid to 52.73 lakh women, depriving benefit to 2.77 lakh women (4.99 *per cent*) during 2011-16. Further, only 25.35 *per cent* JSY beneficiaries were assisted by ASHAs.
- In seven test checked districts, out of 10.48 lakh institutional deliveries under JSY, 1.09 lakh (10.40 *per cent*) women were deprived of cash

36 Abu Road, Bakani, Bandikui, Basni, Bhandarej, Kankroli, Pipalkhunt and Reodar.
37 Abu Road and Bhim.
38 Abu Road, Ahore and Bakani.
39 Abu Road, Arnod, Bakani, Bandikui, Basni, Bhandarej and Jhalrapatan.
40 Abu Road and Bakani.
41 ₹ 1,400 in rural area and ₹ 1,000 in urban area were provided to the beneficiaries at the time of discharge.
42 This exclude 11.53 lakh deliveries performed in private hospitals.

incentive during 2011-16 and only 13.64 *per cent* JSY beneficiaries were assisted by an ASHA.

State Government accepted the facts and stated (November 2016) that due to non-submission of required documents in health centres, discharge before 48 hours and non-providing of KYC of the beneficiary's bank account, the cash benefits could not be disbursed to the beneficiaries. It was, further, stated that efforts were being made to record the bank account number of the beneficiary in the early time of ANC.

Good Practice

State Government has started (August 2015) an Online JSY and Shubhlaxmi payment system (OJAS) wherein cash incentives for institutional deliveries are directly deposited into the bank accounts of the beneficiaries. Currently cash incentives for 75 per cent of the institutional deliveries in the State are being transferred through OJAS.

Post Natal Care

According to JSY, as part of Post Natal Care (PNC), a pregnant woman has to stay for minimum 48 hours after her delivery. Scrutiny of records of SHS revealed that during 2011-16, out of 67.03 lakh Institutional deliveries conducted in the State, 9.19 lakh (13.71 *per cent*) women were discharged within 48 hours of delivery. This resulted in the eligible beneficiaries being deprived of JSY incentives and facing PNC complications.

In seven test check districts it was observed that:

- During 2011-16, out of 11.31 lakh institutional deliveries conducted, 2.44 lakh (21.57 *per cent*) women were discharged within 48 hours of delivery.

- Out of total 8.11 lakh women who availed PNC facility, 3.62 *per cent* to 7.18 *per cent* women had PNC complications during 2011-16. In Jalore district, the situation of PNC complications was highest and it ranged between 8.37 to 24.11 *per cent* during 2011-16.

State Government stated (November 2016) that pregnant women were discharged before 48 hours due to non availability of proper arrangement of stay in outreach areas/over crowding and non/under availability of healthcare staff. It was further assured that efforts are being made to increase the stay of women up to 48 hours after delivery.

(v) Beneficiary Survey

To assess the impact of quality of services provided by the State Government, a survey was conducted (during April-June 2016) with a random sample of 880 beneficiaries in 88 SCs by Audit, in which response of beneficiaries was obtained on a predefined set of questions. The survey revealed that:

- 330 beneficiaries (37.50 *per cent*) out of 880 did not register themselves within three months of their pregnancy.

- 483 beneficiaries (54.89 *per cent*) did not visit the health centres for follow ups against prescribed four medical check up during their pregnancy.

Thus, the survey further substantiated the fact that the main objective of NRHM to provide ANC to all pregnant women was not achieved.

State Government stated (November 2016) that nearly 91.07 *per cent* beneficiaries were getting ANC services before six months of pregnancy and 96.02 *per cent* beneficiaries visited hospitals/health centres during pregnancy once or more than once.

The position stated by the Department was contrary to the NRHM framework which required at least four checkups during the pregnancy period.

2.1.10.2 Immunisation

Routine immunisation is an important strategy for child survival, focusing on preventive care to reduce morbidity against six preventable diseases. Accordingly, vaccinations for tuberculosis, diphtheria, pertussis, tetanus, polio and measles are to be given in seven stages to the age group of 0-1 years. Vaccines like Bacille Calmette Guerians (BCG), Oral Polio Vaccine (OPV), Tetanus Toxoid (TT), Diphtheria Pertussis and Tetanus (DPT), Diphtheria and Tetanus (DT) and Measles were provided under universal immunisation programme. Pulse Polio immunisation campaigns were also taken up for eradication of polio.

Achievement of Target for immunisation

(i) In the State, achievements against the targets of full immunisation for 0-1 year infants, DPT Booster I, OPV Booster and Measles for 01-02 years children, during 2011-16 are given in the **Table 2.8**.

Table 2.8

Year	Target for full immunisation of infants (0-1 year)	Achievement *(per cent)*	Target for immunisation (1-2 year)	Achievements		
				DPT Booster I *(per cent)*	OPV Booster *(per cent)*	Measles *(per cent)*
2011-12	15,70,602	13,36,402 (*85.09*)	14,86,153	7,76,950 (*52.28*)	7,64,057 (*51.41*)	3,42,826 (*23.07*)
2012-13	16,35,882	13,36,841 (*81.72*)	15,32,811	8,56,361 (*55.87*)	8,45,138 (*55.14*)	1,46,544 (*9.56*)
2013-14	16,64,485	13,80,291 (*82.93*)	15,23,444	9,96,275 (*65.40*)	9,92,761 (*65.17*)	5,76,767 (*37.86*)
2014-15	16,80,133	13,62,148 (*81.07*)	16,50,587	10,67,818 (*64.69*)	10,63,030 (*64.40*)	9,52,315 (*57.70*)
2015-16	16,91,597	13,62,794 (*80.56*)	16,62,177	11,42,992 (*68.76*)	11,43,106 (*68.77*)	11,30,880 (*68.03*)

Source: Information provided by the Department.

It is seen from the table that:

- During 2011-16, the achievement in number of immunisations of infants (0 to 1 year) was decreasing from 85.09 to 80.56 *per cent*.

- Further, target for 1-2 year children for DPT Booster-I, OPV Booster and Measles were not fully achieved during 2011-16 though there were improvements in coverage of the number of children. In seven test checked

districts, it was also noticed that 16.12 to 19.14 *per cent* infants were not fully immunised during 2011-16.

State Government stated (November 2016) that the targets were set for quantities to be indented to GoI and not based on head count, further lack of awareness among parents/guardians (illiteracy) and fear of adverse events following immunisation were the reasons for short achievement of targets.

The reply was not acceptable as quantity targets should have been set on the basis of eligible infants and children. This also highlights the need for a more effective "*Bottom up approach*" for planning.

(ii) Similarly, in the State, achievements against the targets of DPT Booster II upto 5 year children, TT 10 for 10 years children and TT 16 for 16 years children during 2011-16 are given in the **Table 2.9**.

Table 2.9

Year	Target for DPT Booster II	Achievements *(per cent)*	Target for TT 10	Achievements *(per cent)*	Target for TT 16	Achievements *(per cent)*
2011-12	14,44,485	3,69,617 (*25.59*)	15,34,765	4,63,136 (*30.18*)	15,69,489	4,29,631 (*27.37*)
2012-13	14,90,967	4,15,944 (*27.90*)	15,86,897	4,85,899 (*30.62*)	16,18,530	4,58,460 (*28.33*)
2013-14	14,81,460	6,17,131 (*41.66*)	15,77,424	9,72,389 (*61.64*)	16,08,415	8,63,933 (*53.71*)
2014-15	15,03,000	7,35,404 (*48.93*)	16,00,000	9,16,123 (*57.26*)	16,32,000	8,18,059 (*50.13*)
2015-16	15,24,000	8,35,269 (*54.80*)	16,22,000	8,36,494 (*51.57*)	16,55,000	7,32,608 (*44.27*)

Source: Information provided by the Department.

It is seen from the table that against the targets, achievement of immunisation through DPT Booster-II (45.20 to 74.41 *per cent*), TT 10 (38.36 to 69.82 *per cent*) and TT 16 (46.29 to 72.63 *per cent*) were not fully achieved for children of 5-16 years during 2011-16. This indicates the dismal performance in immunisation in the State, particularly for children above five years of age.

State Government, while accepting the facts, stated (November 2016) that many schools, including private schools did not cooperate for vaccinations. This indicated lack of coordination and awareness of community.

Providing Vitamin 'A' supplements to children

As envisaged in the guidelines, all children of the age of nine months to five years were required to be administered Vitamin 'A' dose. Against the targets of 82.43 lakh for administration of five doses of vitamin 'A', first dose was administrated to 59.78 lakh (72.52 *per cent*), second dose was administrated to 33.51 lakh (40.66 *per cent*) and third, fourth and fifth doses were administrated to 26.30 lakh (31.91 *per cent*) children only.

In seven test checked districts it was observed that 5.76 to 10.96 *per cent*, 38.67 to 51.58 *per cent* and 60.40 to 67.14 *per cent* children were not given Vitamin 'A' first dose, second dose and third to fifth doses respectively

during 2011-16, which reflected dismal performance of administering vitamin 'A' doses.

State Government accepted (November 2016) that vitamin A dose was not administered to children as per plan.

2.1.10.3 Family Planning

Objective of the family planning programme was to reduce the Total Fertility Rate (TFR) and improve the health status of people particularly, women by encouraging adoption of appropriate family planning methods. Male involvement in family planning including male sterilisation would also be promoted. Vasectomy for male and tubectomy for female are family limiting methods and oral pills, condoms and Intra Uterine Device (IUD) insertion are the methods for family spacing, to reduce TFR.

Achievements *vis. a vis.* targets of sterilisation for the State during 2011-16 are discussed in **Table 2.10**.

Table 2.10

Year	Target for sterilisation	Achievement			Shortfall *(per cent)*
		Tubectomy cases *(per cent)*	Vasectomy cases *(per cent)*	Total cases	
2011-12	**6,86,210**	3,09,426 (*98.25*)	5,528 (*1.75*)	3,14,954	3,71,256 (*54.10*)
2012-13	**6,98,604**	3,11,539 (*98.44*)	4,949 (*1.56*)	3,16,488	3,82,116 (*54.69*)
2013-14	**5,01,170**	2,98,898 (*98.75*)	3,769 (*1.25*)	3,02,667	1,98,503 (*39.60*)
2014-15	**4,62,304**	2,99,302 (*98.58*)	4,304 (*1.42*)	3,03,606	1,58,698 (*34.33*)
2015-16 (Provisional)	**4,50,000**	2,81,927 (*98.34*)	4,748 (*1.66*)	2,86,675	1,63,325 (*36.29*)
	27,98,288	**15,01,092 (*98.47*)**	**23,298 (*1.53*)**	**15,24,390 (*54.48*)**	**12,73,898 (*45.52*)**

Source: Information provided by the Department.

It is seen from the above table that:

- Against the target of 27.98 lakh sterilisation for the State, only 15.24 lakh (54.48 *per cent*) sterilisation were done during 2011-16, leading a shortfall ranged between 34.33 to 54.69 *per cent.*

- Further, the percentage of vasectomy operations in the State was only 1.53 *per cent* of the total sterilisation operations.

- In seven test checked districts, shortfall in sterilisation ranged between 53.91 and 65.26 *per cent*. Further the percentage of vasectomy operations to total sterilisation operations was abysmally low (2.05 *per cent)*.

Thus, despite instructions in the NRHM framework for promoting male involvement in family planning, male sterilisations continued to be low.

State Government stated (November 2016) that the eligible couples are counselled to adopt family planning practices and they select the method of their choice. Further, trainings were imparted to service providers and male sterilisation camps were planned in each district.

However, the fact remains that the participation of male in the sterilisation process was very low and needed concerted efforts to improve the same.

2.1.10.4 Other healthcare services

(i) Non-availability of essential drugs

State Government following the IPH Standards, issued Essential Drugs List (EDL) of 522 drugs for DH, 445 drugs for CHC, 236 drugs for PHC and 32 drugs for SC. RMSCL, is responsible for distribution and management of essential drugs in all the health centres. Audit scrutiny revealed that the position of distribution of drugs in DHs, CHCs, PHCs and SCs in the entire State was not maintained.

Audit scrutiny of seven test checked districts revealed that:

There were shortages in the availability of essential drugs, as only 320 to 409 drugs were available in six DHs (except Jhalawar), 125 to 324 essential drugs in all CHCs, four to 100 drugs in 12 PHCs[43] and eight to 20 drugs in 21 SCs[44].

It was also noticed that essential obstetric care drug kit was not available in four CHCs (Abu Road, Ahore, Bandikui and Reodar) and further Reproductive Transmitted Infection/Sexual Transmitted Infection drugs were not found available in four CHCs (Abu Road, Ahore, Bhinmal and Kankroli).

State Government did not provide the reasons for non-availability of essential drugs in test checked districts. This also highlights the need for a more effective "*Bottom up approach*" for planning which would have thrown up such shortages in essential medicines.

(ii) Mobile Medical Units

The objective of having Mobile Medical Units (MMU) was to take healthcare to the doorsteps of the public in the rural areas, especially in underserved areas and in urban slums. As per IPH Standards, 20 camps per month per MMU were required to be organised.

There were 52 MMUs deployed in 31 districts in the State, which organized only 33,879 camps (54.29 *per cent*), against stipulated 62,400 camps during 2011-16.

In seven test checked districts, eight MMUs were deployed, which organised camps ranging from 1,128 (67.14 *per cent*) to 1,136 (67.62 *per cent*) during

43 Arniya, Bali-Jassakhera, Bhagwanpura, Donda, Ghana, Ghantali, Khinyala, Nausara, Panchola, Sarda, Suhagpura and Tantwas.

44 Balwa, Bijapura, Dantina, Dantiwas, Dhani-Nimbodi, Digariya-Tappa, Guda-Ahiqpura, Hajya-Ka-Vas, Jaitpura, Kalota, Karwa, Khedala-Khurd, Khinyawas, Kotra, Ladli-Ka-Bas, Panchola, Rajod, Sindhipura, Sirsi, Sugli-Jodha and Thikriya.

2013-15, against the target of 1,680 camps per annum. Further, no MMU camp was organised in Rajsamand district during 2011-15.

State Government, while accepting the facts, stated (November 2016) that IPH standard could not be achieved due to poor and damaged conditions of MMUs and expiry of contract period with service provider.

2.1.10.5 Quality Assurance Programme

GoI has prescribed 70 Quality Assurance Standards for public health which have been categorised into eight broad areas of Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management and Outcome.

The State level Quality Assurance Committee (SQAC), State Quality Assurance Unit (SQAU) along with District level Quality Assurance Committee (DQAC) and District level Quality Assurance unit (DQAU) in all 33 districts was constituted (February 2015) to oversee the quality assurance activities across the State and also to ensure regular and accurate reporting of the various key indicators. Further, every DQAU was required to submit monthly report on the performance indicators to SQAU.

It was observed that against prescribed four meetings during 2015-16, SQAU convened only one meeting (March 2016). Further, during 2015-16 though SQAC visited all 34 DHs to assess the qualities of services provided by the DHs, but it did not visit any rural health facilities (SDH/CHC/PHC).

It was further observed in test checked units (30 PHCs, 15 CHCs and seven DHs) that:

- None of the DQAUs submitted the monthly report on the performance indicators to SQAU.

- Key outcome indicators pertaining to Reproductive Maternal Newborn Child Health (RMNCH) were not measured and monitored in 27 PHCs[45], 13 CHCs[46] and three DHs (Nagaur, Pratapgarh and Sirohi).

State Government, while accepting the facts, stated (November 2016) that instructions had been issued to all districts for patient satisfaction survey/patient feedback, conducting regular meeting and sending returns on scheduled dates.

The fact remains that the implementation of Quality Assurance Programme, which was intended to enhance the satisfaction level among the users of the Government health facilities, was in a nascent stage in the State and needed improvement.

45 Aluda, Arniya, Baant, Bali-Jassakheda, Bhagwanpura, Bivai, Chupana, Daspa, Deldar, Diver, Durgapura, Ghana, Ghantali, Khinyala, Kundal, Makodi, Minda, Mohi, Nosara, Panchola, Punasa, Salmgarh, Sankroda, Sanwara, Sarda, Suhagpura and Tantwas

46 Aburoad, Ahore, Arnod, Bandikui, Basni, Bhandarej, Bhim, Bhinmal, Kankroli, Nawacity, Pipalkhunt, Reodar and Roll.

2.1.10.6 Impact of NRHM on IMR, MMR and TFR

Maternal Mortality Ratio (MMR) measures the number of women of reproductive age (15–49 years) dying due to maternal causes per 1,00,000 live births and is a sensitive indicator of the quality of the healthcare system for women. Infant Mortality Ratio (IMR), a measurement of death of children before the age of one year per 1,000 live births, is a sensitive indicator of the health and nutritional status of population of children. Further, Total Fertility Rate (TFR) is a measure of number of children born to a woman during her entire reproductive age. Due to early marriage, close spacing of births, high unmet need and lack of skilled contraceptive services, high fertility remains a problem.

(i) Trend of achievements at State level

A comparison of the State[47] with other states and All India average for IMR, MMR and TFR revealed that:

- During 2009, IMR in the State was 59, which reduced to 47 during 2013 for per 1000 live births, but during the same period All India average of IMR declined from 50 to 40. The State stood at 23rd position among 28 states of the country during 2013.

  Further during 2013, IMR in seven test checked districts[48] was higher than the IMR of the State and ranged between 52 (Nagaur) to 72 (Jalore).

- During 2009, MMR in the State was 318, which reduced to 244 during 2013 for per 1,00,000 live births. However, during the same period All India average of MMR declined from 212 to 167. The State stood at the 25th position among 28 states of the country during 2013.

- During 2009, TFR in the State was 3.3, which reduced to 2.8 during 2013. However, during the same period All India average of TFR was reduced from 2.6 to 2.3. The State stood at 17th position among 20 states in the country during 2013 for which details were available.

  Further, during 2013 TFR in seven test checked districts, was not significantly different in comparison of State average and ranged between 2.7 (Nagaur) to 3.6 (Jalore).

Thus, specific initiatives were needed to focus on districts by providing better infrastructural/services for maternal and child healthcare, where IMR/MMR/ TFR has not been reduced substantially.

47 As per Sample Registration System Statistical Report 2013 published by the Registrar General of India, Ministry of Home Affairs, New Delhi.

48 As per Annual Health Survey 2012-13 published by the Registrar General and Census Commissioner, India, Ministry of Home Affairs, New Delhi.

Quality of Healthcare services

The percentage of women registered in first trimester of the pregnancy increased from 46.59 per cent to 60.00 per cent during 2011-16, yet 26.93 per cent to 31.02 per cent pregnant women did not get all three mandatory checkups. Further only 67.77 per cent pregnant women were given IFA tablets inspite of anaemia being widely prevalent in the State.

There was no significant variation in institutional deliveries in the State during 2011-16. Further 26.23 to 34.15 per cent newborns were not visited by a Doctor/ANM/Nurse within 24 hours of delivery in case of deliveries at home.

The position of immunisation was poor for infants (0 to 1 year) and children (1 to 16 years) as there was low coverage in administering vaccines i.e. Measles, OPV booster, DPT booster and TT 10/16.

The achievement against the target of sterilisation was only 54.48 per cent and the involvement of men in the family planning process continued to be abysmally low. There were also shortages in the availability of essential drugs particularly at CHCs and PHCs.

Thus, inspite of Rajasthan being a special focus State under NRHM, the State continues to lag behind the All India Averages and stood at 23rd position (out of 28) in Infant Mortality Ratio, 25th position (out of 28) in Maternal Mortality Ratio and 17th position (out of 20) in Total Fertility Rate.

Recommendations:

6. *To reduce the risk and complications involved during pregnancy, the State Health Mission should ensure that all the pregnant women are mandatorily registered in the first trimester and get three checkups during pregnancy to improve the Maternal Mortality Ratio in the State.*

7. *The State Health Mission should ensure full immunisation of infants and children to improve the Infant Mortality Ratio in the State by introducing awareness programmes and better coordination with schools.*

8. *The State Health Mission should improve the position of sterilisation in the State and make special efforts to increase the involvement of men in the sterilisation process so that the Total Fertility Rate in the State is reduced.*

2.1.11 Adequacy of Financial Management

Audit Objective -5: To assess the existence of prudent financial management.

2.1.11.1 Funding pattern

The Centre and State Governments provided funds for NRHM in the ratio 85:15 during 2011-12. The funding pattern was revised to 75:25 during

2012-15 and further 60:40 during 2015-16. GoI directly released the funds to the bank account of the State Health Society (SHS) upto 2013-14. From 2014-15 onwards all funds were released through treasury route of the State Government.

The details of funds released by the GoI and the State Government and expenditure incurred there against during 2011-16 [49] are shown in the **Table 2.11**.

Table 2.11

(₹ in crore)

Year	Funds approved in State PIP	Opening Balance	Funds released by			Total fund available for the year	Expenditure[50] (*per cent*)	Closing Balance
			GoI	State Govt	Total			
2011-12	1,015.70	213.12[51]	1,029.64	173.21	1,202.85	1,415.97	979.98 (*69.21*)	435.99
2012-13	1,545.60	435.99	800.59	256.71	1,057.30	1,493.29	1,065.33 (*71.34*)	427.96
2013-14	1,796.62	427.96	867.47	278.05	1,145.52	1,573.48	1,315.55 (*83.61*)	257.93
2014-15	1,896.24	285.51[52]	1,031.02	351.08	1,382.10	1,667.61	1,436.22 (*86.12*)	231.39
2015-16 (Provisional)	2,391.82	231.39	1,219.89	754.72	1,974.61	2,206.00	1,697.67 (*76.96*)	508.33
Total	**8,645.98**		**4,948.61**	**1813.77**	**6,762.38**		**6,494.75**	

Source: Data provided by the SHS

It is seen from the above table that during 2011-16, against aggregate approval of ₹ 8,645.98 crore in the State PIPs, funds amounting to ₹ 6,762.38 crore (78.21 *per cent*) were released to SHS and funds of ₹ 6,494.75 crore (75.11 *per cent*) were actually utilised. The utilisation of the available funds by the SHS ranged between 69.21 and 86.12 *per cent* during 2011-16. The State Government was to contribute ₹ 1,832.12 crore as per prescribed ratios, however matching share was short released by ₹ 18.35 crore.

State Government stated (November 2016) that non utilisation of available funds during 2015-16 was due to change in sharing ratio during 2015-16 (December 2015) from 75:25 to 60:40 and delayed release (March 2016) of additional state share to SHS. The reasons for less utilisation of available funds during 2011-15 and for short release of states share to the SHS were not intimated.

The fact however remained that utilisation of funds was consistently low during 2011-16. Further, delay approval of PIPs by GoI was also due to delay in submission of PIPs by the SHS.

2.1.11.2 Delay in release of funds

Paragraph 3.3.1 and 3.3.2 of the Operational Guidelines for Financial Management of NRHM provides that the State Government would release the proportionate share to the SHS within seven days of the release of fund by

49 Final accounts for the period 2015-16 are under finalisation.

50 Amount received through treasury route and fund received/expenditure whichever is less, has been taken as expenditure under NIDDCP and Infrastructure Maintenance.

51 It includes ₹ 119.30 crore, released in 2011-12 but pertains to previous years.

52 Due to inclusion of NPHCE, NTCP and Cancer programmes under umbrella of NRHM the opening balance of ₹ 27.58 crore of these programmes was included.

GoI, who in turn would release the funds to DHSs within 15 days of receipt of the funds.

It was, however, observed that during 2011-16, the State Government released the matching share of ₹ 1,175.69 crore with delays ranging from 31 days to 362 days (average delay of 135 days).

State Government accepted the facts and stated (November 2016) that the amount was transferred /deposited in the bank account of SHS with delay of 40 to 45 days as it entails a long process[53].

Similarly, SHS also delayed the release of ₹ 1,460.94 crore to the DHSs ranging from 31 days to 275 days (average delay of 118 days).

State Government stated (November 2016) that the transfer of funds by SHS to DHS was delayed to control unnecessary accumulation of advances lying at district and lower level. Further, funds were released after analysis of the requirement of district demands and this took time.

2.1.11.3 Diversion of funds

As paragraph 3.3.5 of the Operational Guidelines for Financial Management of NRHM, the funds provided for various programmes should only be used for the intended purpose and not be mixed with other funds. Paragraph 10.3 *ibid* further prohibited the diversion of NRHM funds for another programme, without approval of GoI. In following instances, funds of NRHM were however, diverted:

- An amount of ₹ 257.62 crore (₹ 103.09 crore during 2013-14 and ₹ 154.53 crore during 2014-15) was diverted from *Janani Suraksha Yojana* of NRHM to another State Government Scheme i.e. *Mukhyamantri Subh Lakshmi Yojana*. However, funds of ₹ 247.36 crore (₹ 88 crore during 2013-14 and ₹ 159.36 crore during 2014-15) was later recouped. The remaining amount ₹ 10.26 crore has not been recovered from the State Scheme as of March 2016.

- During 2015-16, an amount of ₹ 3.66 crore was diverted from NRHM to *Mukhyamantri BPL Jeevan Raksha Kosh*, which is a State Government Scheme.

State Government, while accepting the facts, stated (November 2016) that such irregularity would not be repeated in future.

2.1.11.4 Unadjusted advances to various agencies

(a) As per paragraph 6.9.1 of Operational Guidelines for Financial Management, all advances should be duly approved by the Competent Authority and should preferably be settled within a maximum period of 90 days. Consolidated Balance Sheet of SHS exhibited unadjusted advances of

53 Delay attributed to time taken in receiving copy of GoI sanction order, non-uploading of sanction on site, time taken in reconciliation, approval and release of fund, release in administrative sanction etc.

₹ 199.42 crore as of March 2012 at SHS level, which increased to ₹ 605.57 crore by the end of March 2015. In following cases, non-adjustment of advances reflected lack of monitoring:

- All DHSs of the State exhibited (March 2016) total outstanding advances of ₹ 111.09 crore against Blocks, CHCs, PHCs and others. Out of which, a sum of ₹ 11.55 crore was outstanding for more than five years.

- Unadjusted/unspent advances to ₹ 181.87 crore was outstanding against RMSCL as of March 2016, out of which advance of ₹ 24.27 crore was outstanding for more than two years.

- Due to continuous release of advances to State Institute of Health and Family Welfare (SIHFW) without adjustment of previous advances, unadjusted sum of ₹ 16.86 crore had accumulated as of March 2016. Further, an amount of ₹ 2.33 crore was released to SIHFW for providing trainings for 12 activities. SIHFW did not organise the training programmes and refunded back the amount with delays ranging between eight to 23 months.

State Government stated (November 2016) that letters were being issued and meetings were being conducted with the officers of RMSCL/SIHFW on regular basis for settlement of advances.

Thus, huge amount of advances pending for refund/adjustment reflects lack of monitoring.

(b) Against an advance of ₹ 106.25 crore, given to Director, Information, Education and Communication (IEC) during 2011-16, Utilisation Certificates (UCs) for ₹ 46.24 crore were only submitted and an advances of ₹ 60.01 crore were lying unadjusted as of March 2016. Records relating to utilisation of ₹ 46.24 crore though called for by Audit, were not made available and it was intimated (June-September 2016) that all the records relating to this utilised amount were seized by Anti Corruption Bureau. Thus, the entire amount of ₹ 106.25 crore given to Director, IEC could not be vouchsafed by Audit.

Financial Management

Though the State Government projected the requirement of ₹ 8645.98 crore during 2011-16 in the State PIP but only 78.21 per cent funds were released and 75.11 per cent was utilised by SHS. Instances of delay in release of proportionate share by State Government to the SHS were noticed. Funds received for NRHM were diverted for other schemes of the State Government. Huge unadjusted advances were outstanding against Rajasthan Medical Services Corporation Limited, State Institute of Health and Family Welfare, Blocks, CHCs, PHCs and others.

Recommendation:

9. State Government should ensure better financial management by preparing realistic PIPs, better utilisation of available funds and ensure timely adjustment of outstanding advances.

2.1.12 Monitoring Mechanism

Audit Objective 6: To assess the adequacy of the monitoring mechanism.

The NRHM framework envisages intensive accountability structures based on internal monitoring through computer based Health Management Information System (HMIS). Further, Pregnancy, Child Tracking and Health Services Management System (PCTS) was implemented in Rajasthan during September 2009, for online tracking of pregnant women and infant and children, monitoring of immunisation and institutional deliveries etc. Each DHS was to develop a computer based Management Information System under NRHM framework and submit monthly reports to SHS.

2.1.12.1 Discrepancies in data

Scrutiny of data collected from PCTS, HMIS and basic records maintained in health centres related to 27 Reproductive and Child Health activities implemented during 2011-16, revealed the data of the activity was different in all three information systems, which are given in detail in ***Appendix 2.2***. Instances of substantial differences are elaborated below:

(i) Comparison of PCTS data with HMIS data

- Difference in the number of pregnant women to whom IFA tablets were given ranged from 15,217 (7.95 *per cent*) in 2011-12 to 52,431 (26.02 *per cent*) in 2015-16.
- Difference in number of women discharged within 48 hours of deliveries ranged from 13,817 (35.87 *per cent*) in 2014-15 to 56,215 (78.08 *per cent*) in 2012-13.

(ii) Comparison of PCTS data with basic records

- Difference in tubectomy sterilisations ranged from 9,948 (25.19 *per cent*) in 2014-15 to 12,702 (31.42 *per cent*) in 2012-13.
- Difference in 'oral pill cycles' ranged from 22,732 (3.04 *per cent*) in 2013-14 to 1,26,997 (14.11 *per cent*) in 2011-12.

(iii) Comparison of HMIS data with basic record

- Difference in tubectomy sterilisations ranged from 9,772 (24.75 *per cent*) in 2014-15 to 13,179 (40.14 *per cent*) in 2015-16.
- Difference in 'oral pill cycles' ranged from 23,250 (3.11 *per cent*) in 2013-14 to 1,27,383 (14.15 *per cent*) in 2011-12.
- Difference in women discharged within 48 hours of delivery ranged from 20,273 (45.07 *per cent*) in 2014-15 to 54,541 (74.04 *per cent*) in 2012-13.

The presence of such huge difference across the activities raises serious concern over utility of data for the purpose of planning and evaluation.

State Government, while accepting the facts, stated (November 2016) that validation error occurred while uploading in few cases. Further, data was not compiled during 2015-16, on the web portal due to technical reasons.

2.1.12.2 Monitoring by State and District Health Missions

NRHM envisaged an intensive accountability framework through a three pronged mechanism of internal monitoring, community based monitoring and external evaluations. The deficiencies noticed in monitoring are discussed below:

(i) As per NRHM guidelines, SHM at State level and DHM in each district were to conduct at least one meeting in every six month interval to discuss issues related to inter-sectoral coordination to promote NRHM. In this regard it was observed that:

- SHM did not hold any meeting during 2011-16, against the requirement of 10 meetings.
- Only two meetings of the Governing Body[54] were convened during 2011-16 against prescribed seven meetings. Similarly, only 22 meetings of the Executive Committee[55] were held during 2011-16 against prescribed 33 meetings.
- All DHMs in the State held only 45 meetings[56] against prescribed 334 meetings.
- In seven test checked districts, only 11 meetings[57] of DHMs were held against prescribed 70 meetings. Further, in Rajsamand district no meeting of DHM was held during 2011-16.
- 33 DHSs of the State held 301 meetings (during 2011-12), 291 meetings (during 2012-13), 236 meetings (during 2013-14), 269 meetings (during 2014-15) and 313 meetings (during 2015-16) against prescribed 396 meetings[58] per year.

State Government, while accepting the facts, stated (November 2016) that though the meeting of SHM was not conducted due to State Legislative Election in 2013, several review meetings were organised under the chairmanship of the Chief Minister.

The reply was not acceptable as the meeting of SHM, GB and EB of SHS, DHM were to be organised at the prescribed intervals for monitoring of the programme.

2.1.12.3 Community based monitoring

(i) Village Health Sanitation and Nutrition Committee (VHSNC), at village level was responsible for preparation of the Village Health Plans, organising public awareness programmes, analysing key issues and problems related to village level health activities etc. It was, however, observed that out

54 Governing Body: Six monthly meeting upto April 2013 and annual meeting from May 2013.

55 Executive Committee: Monthly meetings upto April 2013 and thrice in a year from May 2013.

56 17 meetings in 2011-12, eight meetings in 2012-13, seven meetings in 2013-14, two meeting in 2014-15 and 11 meeting in 2015-16.

57 Dausa-one, Jalore-two, Jhalawar-four, Nagaur-one, Pratapgarh-two, Rajsamand-nil and Sirohi-one.

58 12 monthly meetings for each DHS.

of 45,123 revenue villages in the State, VHSNCs were formed in 43,440 villages as of March 2016.

VHSNCs were not formed in 34 revenue villages of test checked district Jalore as of March 2016.

(ii) *Rogi Kalyan Samiti* (RKS) was to be constituted for day-to-day management of the affairs of the healthcare facilities at the DH, CHC and PHC levels. In State, RKSs was established with the nomenclature of Rajasthan Medicare Relief Society in all DHs. However, RKSs were not formed in 87 (out of 2080) PHCs and 13 (out of 571) CHCs of the State as of March 2016. In seven test checked districts, it was observed that RKS were not formed in nine PHCs of Jalore district as of March 2016.

State Government stated (November 2016) that 43,440 VHSNCs were formed in the State and the revenue villages having population less than 100 persons would be merged with nearby VHSNCs.

The reply was not acceptable as VHSNCs in 1683 villages were not formed and the village level planning was not done in all villages. Reasons for non constitution of RKSs in PHCs and CHCs were not intimated by the Government.

2.1.12.4 External evaluation

NRHM framework provided for external evaluation to track the effectiveness of the various activities for providing quality health services. It was observed that external evaluation of implementation of NRHM by an independent agency was not conducted in the State during 2011-2016.

Monitoring Mechanism

There were differences in data maintained in various databases i.e. Health Management Information System, Pregnancy Child Tracking & Health Services Management System and the original records available at the health centres, leading to huge discrepancies which were not reconciled.

State Health Mission did not hold any meeting during 2011-16 and the only two meetings (against seven) of Governing Body were conducted, which pointed to weaknesses in the apex monitoring process. Further at the district level only 14 per cent of the prescribed meetings of District Health Mission could be held.

Recommendations:

10. State Health Mission should ensure reconciliation and correctness of data so that the planning and decision making process could be based on more realistic inputs.

11. State Government should ensure that the prescribed monitoring system is followed at all levels so that the implementation of NRHM becomes more effective in the State.

2.1.13 Conclusion

The National Rural Health Mission aimed at reducing child and maternal mortality rate, providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to poor and the vulnerable section of the population.

The State Health Mission did not follow the "Bottom up approach" for planning at the village and block level and this resulted in gaps in availability of infrastructure, equipment and manpower in most of the rural areas. Further instances of non-utilisation of staff quarters in health centres, non availability of all essential equipment in rural health centres and equipment lying unutilised, were also noticed. There were also shortages of medical and para medical staff in rural areas as compared to urban areas.

To reduce the risk and complications during pregnancy, all the pregnant women in the State could not be registered in the first trimester of their pregnancy and were also not provided all three mandatory checkups, IFA tablets and prescribed immunisations. Proper Post Natal Care could not be extended in case of home deliveries. The achievement against the target of sterilisation was just above fifty *per cent* and the involvement of men in the family planning process continued to be abysmally low.

The monitoring mechanism was weak as the State Health Mission, Governing Body and District Health Missions did not even hold twenty *per cent* of the required meetings.

The State continues to lag behind the All India Average and stood at 23rd position (out of 28) in Infant Mortality Ratio, 25th position (out of 28) in Maternal Mortality Ratio and 17th (out of 20) in Total Fertility Rate.

Appendix 2.1

(Refer paragraph 2.1.8.5; page 21)

Statement showing the details of civil works in which work orders issued without availability of Land

(₹ in lakh)

Sl. No.	Name of work	Name of district	Year of Sanction	Work order Amount	Work status
1	ANM quarters at Kuncholi	Rajsamand	2012-13	8.93	De-sanctioned due to Land Not Available
2	PHC quarters at Diver	Rajsamand	2012-13	12.79	De-sanctioned due to Land Not Available
3	20 bedded JSY ward at CHC, Bhinmal	Jalore	2012-13	47.70	De-sanctioned due to Land Not Available
4	ANM quarters at SC Bibalsar	Jalore	2012-13	50.61	De-sanctioned due to Land Not Available
5	ANM quarters at SC Meda	Jalore	2012-13	Not Available	De-sanctioned due to Land Not Available
6	ANM quarters at SC Munthalakaba	Jalore	2012-13	Not Available	De-sanctioned due to Land Not Available
7	ANM quarters at SC Thobau	Jalore	2012-13	Not Available	De-sanctioned due to Land Not Available
8	PHC quarters, at L1 PHC, Jhab	Jalore	2012-13	12.42	De-sanctioned due to Land Not Available
9	Labour Room at SC, Thobau	Jalore	2012-13	Not Available	De-sanctioned due to Land Not Available
10	Toilet at SC, Thobau	Jalore	2012-13	Not Available	De-sanctioned due to Land Not Available
11	ANM quarters at SC Padar	Sirohi	2014-15	12.22	De-sanctioned due to Land Not Available
12	ANM quarters at SC Ahemedpura	Nagaur	2012-13	7.30	De-sanctioned due to Land Not Available
13	PHC quarters at L1 PHC, Chanwadia	Nagaur	2012-13	12.91	De-sanctioned due to Land Not Available
14	LR at SC, Makodi	Nagaur	2012-13	4.94	De-sanctioned due to Land Not Available
15	Toilet at SC, Makodi	Nagaur	2012-13	1.53	De-sanctioned due to Land Not Available
16	PHC quarters at L1 PHC, Merta Road	Nagaur	2012-13	23.24	De-sanctioned due to Land Not Available
17	Toilet at SC, Bhadana	Nagaur	2012-13	1.54	De-sanctioned due to Land Not Available
18	PHC quarters at L1 PHC, Khedlabujurg	Dausa	2012-13	13.87	De-sanctioned due to Land Not Available
19	Construction. of SC, Agauli	Dausa	2014-15	18.28	De-sanctioned due to Land Not Available
20	Construction. of SC, Bhojpura,	Dausa	2014-15	18.36	De-sanctioned due to Land Not Available
Total				**246.64**	

Appendix 2.2

(Refer paragraph 2.1.12.1; page 48)

Statement showing the differences among records maintained at health facilities, PCTS and HMIS

Part-I (2011-12 to 2013-14)

Activities	2011-12						2012-13						2013-14					
	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS
Total No. of pregnant women registered for ANC	2,97,166	2,99,149	-1,983	2,99,315	-2,149	-166	2,86,144	2,85,932	212	2,86,000	144	-68	2,75,961	2,74,656	1,305	2,74,820	1,141	-164
of which No. registered within first trimester (within 12 weeks)	1,43,690	1,42,794	896	1,42,857	833	-63	1,51,299	1,50,603	696	1,50,628	671	-25	1,49,909	1,49,075	834	1,49,158	751	-83
Total No. of pregnant women registered under JSY	2,93,297	2,95,273	-1,976	2,95,339	-2,042	-66	2,85,751	2,85,545	206	2,85,561	190	-16	2,75,369	2,74,109	1,260	2,74,274	1,095	-165
Total No. of pregnant women received 3 ANC checkups during pregnancy	2,19,087	2,20,870	-1,783	2,20,987	-1,900	-117	2,21,750	2,21,245	505	2,21,288	462	-43	2,10,574	2,09,663	911	2,09,771	803	-108
Total No. of pregnant women given 100 IFA tablets	1,84,154	1,91,357	-7,203	2,06,574	-22,420	-15,217	2,35,133	2,33,737	1,396	2,72,358	-37,225	-38,621	2,07,954	2,06,085	1,869	2,49,598	-41,644	-43,513
Totanl No. of Home Deliveries	19,027	19,027	0	19,072	-45	-45	16,841	17,441	-600	16,213	628	1,228	14,394	14,394	0	12,572	1,822	1,822
Total No. of Institutional Deliveries	2,09,706	2,10,187	-481	2,12,666	-2,960	-2,479	2,16,131	2,26,531	-10,400	2,27,111	-10,980	-580	2,25,529	2,31,893	-6,364	2,33,542	-8,013	-1,649
Deliveries conducted at public institutions (including C-section)	1,58,754	1,57,250	1,504	1,57,274	1,480	-24	1,41,664	1,61,391	-19,727	1,61,390	-19,726	1	1,71,738	1,70,501	1,237	1,70,332	1,406	169
Deliveries conducted at private institutions (including C-section)	50,952	54,206	-3,254	54,514	-3,562	-308	53,066	65,140	-12,074	67,012	-13,946	-1,872	53,791	63,331	-9,540	63,210	-9,419	121

Activities	2011-12						2012-13						2013-14					
	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS
No. of mothers paid JSY incentive for deliveries conducted at Public Institutions	1,64,599	1,55,167	9,432	1,55,171	9,428	-4	1,62,570	1,54,349	8,221	1,54,611	7,959	-262	1,76,849	1,75,477	1,372	1,75,684	1,165	-207
Total MTP cases	1,612	1,590	22	1,535	77	55	1,117	1,113	4	1,101	16	12	879	879	0	879	0	0
Total No. of sterilisation cases	51,935	51,963	-28	51,784	151	179	52,961	53,602	-641	53,396	-435	206	49,803	50,556	-753	50,342	-539	214
Vasectomy Achievement	161	442	-281	446	-285	-4	166	424	-258	450	-284	-26	107	235	-128	260	-153	-25
Tubectomy Achievement	38,855	51,431	-12,576	50,853	-11,998	578	40,418	53,120	-12,702	52,664	-12,246	456	37,718	50,301	-12,583	50,082	-12,364	219
No of Beneficiaries assisted by ASHA	24,332	27,997	-3,665	27,822	-3,490	175	21,228	24,175	-2,947	24,130	-2,902	45	29,286	37,027	-7,741	37,052	-7,766	-25
Women Discharged Within 48 hours of Deliveries	85,863	84,359	1,504	1,15,466	-29,603	-31,107	73,663	71,989	1,674	1,28,204	-54,541	-56,215	44,273	42,645	1,628	95,783	-51,510	-53,138
No. of cases of Maternal Death	115	110	5	103	12	7	144	139	5	112	32	27	149	148	1	157	-8	-9
Total No of Still Death	4,896	4,899	-3	5,299	-403	-400	5,067	4,872	195	4,852	215	20	4,715	4,694	21	4,701	14	-7
No. of women who attended for facilities for availing post natal care	1,64,310	1,62,804	1,506	1,62,886	1,424	-82	1,89,072	2,27,183	-38,111	2,28,505	-39,433	-1,322	1,93,604	1,91,997	1,607	1,92,005	1,599	-8
Achievement of Oral Pills Cycle	8,99,945	10,26,942	-1,26,997	10,27,328	-1,27,383	-386	7,76,260	8,13,147	-36,887	8,13,229	-36,969	-82	7,46,521	7,69,253	-22,732	7,69,771	-23,250	-518
No. of IUD insertions	68,377	68,161	216	67,723	654	438	68,554	68,582	-28	68,327	227	255	60,931	60,803	128	60,389	542	414
No. of Pregnant women who have been detected with severe Anaemia	4,936	4,595	341	4,595	341	0	3,130	3,077	53	2,977	153	100	3,553	3,491	62	3,480	73	11
BCG	2,34,055	2,32,474	1,581	2,32,579	1,476	-105	2,31,000	2,38,575	-7,575	2,38,240	-7,240	335	2,42,464	2,44,579	-2,115	2,44,653	-2,189	-74
DPT-1	2,36,455	2,35,488	967	2,35,594	861	-106	2,45,168	2,73,996	-28,828	2,44,041	1,127	29,955	2,50,659	2,49,594	1,065	2,49,700	959	-106
DPT-2	2,30,239	2,29,333	906	2,29,436	803	-103	2,40,793	2,37,716	3,077	2,36,759	4,034	957	2,42,033	2,41,013	1,020	2,41,113	920	-100
DPT_3	2,34,343	2,33,377	966	2,43,470	-9,127	-10,093	2,38,832	2,37,302	1,530	2,37,345	1,487	-43	2,42,469	2,41,518	951	2,41,608	861	-90
No. of Newborn having weight less than 2.5 kg	45,486	44,746	740	39,107	6,379	5,639	57,014	56,953	61	56,999	15	-46	62,632	74,367	-11,735	74,402	-11,770	-35

Part-II (2014-15 to 2015-16)												
Activities	**2014-15**						**2015-16**					
	As per Records	**As per PCTS**	**Diff. Between Records & PCTS**	**As per HMIS**	**Diff. Between records & HMIS**	**Diff. Between PCTS & HMIS**	**As per Records**	**As per PCTS**	**Diff. Between Records & PCTS**	**As per HMIS**	**Diff. Between records & HMIS**	**Diff. Between PCTS & HMIS**
Total No. of pregnant women registered for ANC	2,77,576	2,76,473	1,103	2,76,485	1,091	-12	2,76,286	2,77,642	-1,356	2,62,371	13,915	15,271
of which No. registered within first trimester (within 12 weeks)	1,60,480	1,59,845	635	1,59,850	630	-5	1,65,995	1,65,154	841	1,60,199	5,796	4,955
Total No. of pregnant women registered under JSY	2,77,209	2,76,106	1,103	2,76,118	1,091	-12	2,76,338	2,74,657	1,681	2,66,641	9,697	8,016
Total No. of pregnant women received 3 ANC checkups during pregnancy	2,09,308	2,07,891	1,417	2,07,892	1,416	-1	1,91,096	1,90,321	775	1,84,101	6,995	6,220
Total No. of pregnant women given 100 IFA tablets	2,13,651	2,11,913	1,738	2,63,390	-49,739	-51,477	2,03,474	2,01,524	1,950	2,53,955	-50,481	-52,431
Totanl No. of Home Deliveries	10,833	10,833	0	9,013	1,820	1,820	6,207	6,168	39	4,696	1,511	1,472
Total No. of Institutional Deliveries	2,19,768	2,22,549	-2,781	2,23,337	-3,569	-788	2,23,532	2,23,703	-171	2,17,853	5,679	5,850
Deliveries conducted at public institutions (including C-section)	1,64,248	1,63,427	821	1,62,750	1,498	677	1,66,988	1,66,379	609	1,59,924	7,064	6,455
Deliveries conducted at private institutions (including C-section)	55,520	61,407	-5,887	60,587	-5,067	820	56,544	60,802	-4,258	57,929	-1,385	2,873
No. of mothers paid JSY incentive for deliveries conducted at Public Institutions	1,69,976	1,60,845	9,131	1,60,845	9,131	0	1,66,685	1,56,033	10,652	1,51,225	15,460	4,808
Total MTP cases	733	738	-5	738	-5	0	507	503	4	743	-236	-240
Total No. of sterilisation cases	44,486	49,828	-5,342	50,156	-5,670	-328	44,100	45,117	-1,017	46,426	-2,326	-1,309

Activities	2014-15						2015-16					
	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS	As per Records	As per PCTS	Diff. Between Records & PCTS	As per HMIS	Diff. Between records & HMIS	Diff. Between PCTS & HMIS
Vasectomy Achievement	188	205	-17	303	-115	-98	109	125	-16	254	-145	-129
Tubectomy Achievement	39,481	49,429	-9,948	49,253	-9,772	176	32,827	44,746	-11,919	46,006	-13,179	-1,260
No of Beneficiaries assisted by ASHA	26,378	29,777	-3,399	29,777	-3,399	0	14,236	13,666	570	15,055	-819	-1,389
Women Discharged Within 48 hours of Deliveries	44,981	38,525	6,456	24,708	20,273	13,817	65,923	44,200	21,723	27,721	38,202	16,479
No. of cases of Maternal Death	185	178	7	212	-27	-34	194	193	1	188	6	5
Total No of Still Death	4,494	4,467	27	4,467	27	0	4,337	4,347	-10	4,235	102	112
No. of women who attended for facilities for availing post natal care	1,75,837	1,74,331	1,506	1,74,340	1,497	-9	1,70,190	1,68,579	1,611	1,64,410	5,780	4,169
Achievement of Oral Pills Cycle	6,98,969	7,43,097	-44,128	7,43,245	-44,276	-148	5,89,632	6,82,259	-92,627	6,62,866	-73,234	19,393
No. of IUD insertions	54,473	60,357	-5,884	60,116	-5,643	241	71,830	70,844	986	68,207	3,623	2,637
No. of Pregnant women who have been detected with severe Anaemia	3,784	3,695	89	3,695	89	0	5,447	5,698	-251	4,407	1,040	1,291
BCG	1,97,565	2,42,976	-45,411	2,42,984	-45,419	-8	2,53,282	2,53,725	-443	2,46,708	6,574	7,017
DPT-1	1,02,209	1,39,458	-37,249	1,39,458	-37,249	0	394	388	6	388	6	0
DPT-2	1,17,411	1,59,433	-42,022	1,59,443	-42,032	-10	504	479	25	479	25	0
DPT_3	1,32,678	1,79,956	-47,278	1,79,966	-47,288	-10	937	907	30	907	30	0
No. of Newborn having weight less than 2.5 kg	58,737	58,390	347	58,491	246	-101	33,271	30,797	2,474	59,137	-25,866	-28,340