CHAPTER III : CIVIL DEPARTMENTS

SECTION-A

HEALTH AND FAMILY WELFARE DEPARTMENT

3.1 Prevention and Control of Diseases

The main objective of the programme for prevention and control of diseases remained unfulfilled for lack of effective planning. Inadequate infrastructural facilities and shortage of manpower coupled with failure to perform the prescribed duties by some of the crucial functionaries plagued the programme. Leprosy Eradication Control Programme suffered due to lack of re-constructive surgery facilities for rehabilitation of the leprosy patients.

Highlights

Against the release of grants of Rs.6.67 crore (including spillover funds of Rs.0.46 crore) by the Government of India between 1996-97 and 2000-2001, Rs.5.65 crore only was spent, as of March 2001.

(Paragraph 3.1.11(a))

As the number of sputa examined (67,124) had substantially been lower by 63 *per cent* than the target(1,81,070) for the years 1996-97 to 2000-2001, there remained the danger of a large number of sputum positive cases going undetected every year. This resulted in the chain of transmission of tuberculosis virtually remaining unbroken.

(Paragraph 3.1.15)

Against 78,525 sputa required to be examined in 20 Peripheral Health Institutions of the District Tuberculosis Centre, Agartala, during 1996-2001, a target for examination of 59,500 sputa was fixed, out of which 28,706 sputa were actually examined indicating a shortfall of sputum examination by 63 *per cent* with reference to the norm.

(Paragraph 3.1.17)

Supervision of peripheral health institutions by District Tuberculosis Centres fell much short of prescribed standards. Against the requirement of 244 visits per year in 61 PHIs, the visits actually paid were 77 and 101 during 1999-2001.

(Paragraph 3.1.20)

4,910 suspected leprosy cases identified during Modified Leprosy Elimination Campaign in 1998-99 were not brought under treatment due to lack of bacteriological testing facilities. Further, leprosy patients were released from treatment without identifying their Bacterial Index.

(Paragraphs 3.1.25 and 3.1.26)

Against the requirement of 30,000 cataract operations by 4 District Mobile Eye Units during 1996-2001, a target of 26,000 operations was fixed; of this, 13,723 operations only were carried out.

(Paragraph 3.1.34)

Against the total number of children (1-6 years) ranging from 1,91,640 (1996-97) to 2,14,500 (2000-2001), the number of children covered by vitamin A solution ranged from 76,024 to 96,784, indicating a coverage of 37 to 49 *per cent* only.

(Paragraph 3.1.36)

The performance of Family Health Awareness Campaign was very poor. Against the targeted population ranging from 5.64 lakh to 7.74 lakh in 24 Health Institutions, actual attendance in the camps ranged from 4 to 5 *per cent* and the STD patients covered by treatment ranged from 18 to 29 *per cent* of the cases identified.

(Paragraph 3.1.44)

Five Blood Banks in the State claimed by the Department to have been modernised were found not to have been actually modernised as only 11 items of equipment out of 40 major items were provided to the blood banks. Spreading of HIV infection from the infected persons was allowed to continue unchecked as persons afflicted with HIV/AIDS were neither informed of the disease, nor treated and provided with counselling, as envisaged in the programme.

(Paragraphs 3.1.45 and 3.1.47)

Introduction

3.1.1 With a view to containing the magnitude of the diseases causing major health problems, the Government of India (GOI) started various Centrally sponsored schemes grouped under a common heading of "Prevention and Control of Diseases".

3.1.2 National Tuberculosis (TB) Control Programme (NTCP) launched in 1962 was reviewed in 1992 by a committee of experts and, based on the findings of the committee, a Revised Strategy for National Tuberculosis Control Programme (RNTCP) was evolved in 1993-94. It was decided by the GOI to extend the programme throughout the country in a phased manner with the aim to detect 75 *per cent* of the TB cases and cure at least 85 *per cent* of the cases so detected.

3.1.3 National Leprosy Control Programme launched in 1954-55 was redesignated as National Leprosy Eradication Programme (NLEP) in 1983. The objective of the programme was to achieve elimination of leprosy by 2000 AD by reducing the leprosy cases to less than 1 per 10,000 population.

3.1.4 AIDS (Acquired Immuno-Deficiency Syndrome) is a fatal disease, caused by HIV and is non-curable. National AIDS Control Programme was launched in 1987 with the objective to bring down the spread of HIV.

3.1.5 National Programme for Control of Blindness (NPCB) was launched in 1976 with the aim to reduce blindness from 1.4 *per cent* of the population to 0.3 *per cent* by 2000 AD by providing District Hospitals and Mobile Eye Units with better eye care facilities and various ophthalmic services.

Organisational set up

3.1.6 The State TB Officer, responsible for implementation of the programme, is assisted by 3 District Tuberculosis Officers (DTOs) of 3 District Tuberculosis Centres (DTCs)[#] through 61 Peripheral Health Institutions (PHIs).

3.1.7 The State Leprosy Officer is responsible for supervision of National Leprosy Eradication Programme. The Programme is implemented by Zonal Leprosy Officer, Agartala and he is assisted by 3 District Leprosy Officers posted at Agartala, Santirbazar and Manu and 3 Leprosy Control Societies located at these stations.

3.1.8 National AIDS control Programme is implemented by the Programme Officer of State AIDS Cell upto 1998-99 and thereafter by the Project Director, Tripura State AIDS Control Society and is integrated with 2 State Hospitals (GB Hospital and IGM Hospital), 3 District Hospitals (Udaipur, Kailashahar and Kamalpur), 10 Sub-Divisional Hospitals, 9 Rural Hospitals and 50 Primary Health Centres (PHCs).

3.1.9 The Programme Officer of State Ophthalmic Cell is responsible for implementation of National Programme for Control of Blindness. The programme is implemented through 4 District Blindness Control Societies (DBCSs)[•], 4 District Hospitals[*], 4 District Mobile Units (DMUs)[Ψ], 2 Sub-Divisional Hospitals (Dharmanagar and Melaghar) and 36 PHCs.

Audit coverage

3.1.10 Implementation of the above four programmes during the period from 1996-97 to 2000-2001 was reviewed in audit between December 2000 and May 2001 based on test check of records of 4 District Hospitals, 2 State Hospitals, 4 Sub-divisional Hospitals (Bishalgarh, Melaghar, Dharmanagar and Belonia), 2 Community Health Centres (Jirania and Teliamura), 11 PHCs[Θ], 3 DTCs, 3 Leprosy Control Units, and 4 DMUs, covering an expenditure of Rs. 1.90 crore (19.42 *per cent* of the total expenditure). The results of audit are discussed in succeeding paragraphs.

Outlay and expenditure

3.1.11 For National AIDS Control Programme, 100 *per cent* cost is borne by the GOI. For National TB Control Programme, only the cost of anti-TB drugs is borne by the GOI, while the operational expenditure including salary of staff is met by the State Government. For both the National Leprosy Eradication Programme and National Programme for Control of Blindness, the GOI provides the entire cost, except salary of staff which is borne by the State

[#] West District, Agartala; South District, Udaipur ; and North District, Kailashahar.

[•] West, South, North and Dhalai.

[*] BR Ambedkar Hospital (Agartala), Tripura Sundari (TS) Hospital (Udaipur), Rajib Gandhi Memorial (RGM) Hospital (Kailashahar) and Bimal Sinha Memorial (BSM) Hospital (Kamalpur).

[Ψ] West, South, North and Dhalai.

[Θ] Narsingarh, Bamutia, Mohanpur, Bisramganj, Madhupur, Kakraban, Manu, Panisagar, Santirbazar, Fatikroy, and Kadamtala.

Government. The grants released by the GOI and the expenditure thereagainst including the expenditure under State Plan during the period from 1996-97 to 2000-2001 are detailed in **Appendix-XIII.**

(a) Against the release of grants of Rs.6.67 crore by the GOI (including spillover funds of Rs. 0.46 crore) between 1996-97 and 2000-2001, Rs. 5.65 crore was spent by the State Government, leaving an unspent balance of Rs. 1.02 crore as of March 2001. Savings under NLEP were attributed by the State Government mainly to release of grants by the GOI to the State and to the Societies for the purposes which were identical. Savings under NPCB were due to not taking up of the works of constructions of an eye operation theatre and 10 - bedded eye ward (both at Ambassa) during 2000-2001 in absence of administrative approval from GOI.

(b) Grants of Rs. 50 lakh under AIDS Control Programme for the year 1998-99, though sanctioned, were not released by the GOI due to poor utilisation of funds by the State during earlier years and also due to not forming State AIDS Control Society during the year.

(c) Salaries of the staff deployed under National TB Control Programme and financial assistance to TB patients were booked under non-plan and amalgamated with other non-plan items. As such, actual expenditure incurred by the State Government under the programme could not be ascertained.

National TB Control Programme

Infrastructure

3.1.12 The target fixed for creation of infrastructure for the period ending 1996-97 and achievement thereagainst, as of 2000-2001, are shown below:

Particulars	Target	Achievement
District Tuberculosis Centres (DTCs)	3	3
50 - bedded TB ward (at GB Hospital)	1	1
20 - bedded TB wards (at TS Hospital, Udaipur, and RGM Hospital, Kailashahar)	2	NIL

Records indicated that two 20 - bedded TB wards were constructed in 1986 at a total cost of Rs. 15 lakh at Udaipur and Kailashahar. But the buildings were utilised by the Health Department for education and training and not handed over to the State TB Officer for utilisation under the programme.

Staffing pattern

3.1.13 For smooth functioning of DTCs, various key posts were to be created as per Manual of District Tuberculosis Programme brought out by the National TB Institute, Bangalore. It was noticed that the 3 DTCs suffered from shortage of key personnel (Second Medical Officers: 2; Treatment Organisers: 4; Laboratory Technicians: 3; Statistical Assistants: 3), which adversely affected the implementation of the programme. The State TB Officer informed (April 2001) that posts fell vacant due to retirement or death of the personnel. But the reasons for not filling up the posts during the last 3 to 4 years were not stated.

Identification of TB cases

3.1.14 Sputum positive cases are responsible for transmission of Tuberculosis in the community. Maximum number of sputum positive cases should be detected to break the chain of transmission. On an average, which is also the national average, 2.5 to 3 *per cent* of patients who are attending hospitals have chest symptoms, which is taken as a norm by the department and 2.5 to 3 *per cent* chest symptomatic patients are subjected to sputum examination. Of this, 10 *per cent* are estimated to be sputum positive. The target fixed for sputum examination and detection of sputum positive cases during 1996-2001 and actual achievement thereagainst with other relevant details are detailed in **Appendix–XIV**.

3.1.15 It would be seen that the number of sputa examined (67,124) during the years was far less than the target (1,81,070). The norm for estimation of sputum positive cases based on the number of sputa examined suggests that the number of sputum positive cases would have increased had the number of sputa examined been larger. As the number of sputa examined had substantially been lower by 63 *per cent* than the target for these years, there remained the danger of a large number of sputum positive cases going undetected every year. This ultimately made the chain of transmission of tuberculosis virtually remaining unbroken.

Sputum examination in Peripheral Health Institutions (PHIs)

3.1.16 As per revised strategy of NTCP, PHIs[±] are required to examine 500 chest symptomatic cases per one lakh population per year, and 3 samples of sputum are to be examined for each chest symptomatic patients.

3.1.17 **Appendix-XV** indicates that against 78,525 sputa required to be examined during 1996-2001 in 20 PHIs of West District, a target of 59,500 sputa to be examined was fixed and, out of this, 28,706 were actually examined, indicating a shortfall in performance by 63 *per cent* with reference to the norm.

3.1.18 Regarding shortfall of sputum examination, the State TB Officer stated (April 2001) that the State Government had accepted the target fixed by the GOI for the benefit of the common people. But to achieve the goal of Revised National Tuberculosis Control Programme (RNTCP), more manpower was required particularly in laboratory section and supervision of different sections of a District Tuberculosis Centre. The State TB officer stated (December 2001) that the action plan for the RNTCP was being processed to be submitted to the GOI. Funds would be released by the GOI for recruitment of additional manpower only after approval of the action plan.

[±] The health institutions, other than the DTC, implementing the programme. There are 61 PHIs in the State.

Treatment

3.1.19 As per objective of the programme 85 *per cent* of the TB cases detected were to be cured. The number of cases brought under treatment and cured between 1996-97 and 2000-2001 with other relevant details as supplied by the Department are shown below:

	Cases brought under treatment										
Year	**Old**	**New**	**Number of patients brought back under treatment**	**Number of patients trans-ferred from outside centres**	**Total (2 to 5)**	**Number of patients cured**	**No. of patients trans-ferred to outside centres**	**Number of patients who did not complete their treat-ment**	**Number of deaths**	**Total number of patients going out of treatment (7 to 10)**	**Number of patients remaining at the end of the year (6 *minus* 11)**
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**		**(8)**	**(9)**	**(10)**	**(11)**	**(12)**
1996-97	2,907	2,462	15	536	5,920	1,532	233	1,303	7	3,075	2,845
1997-98	2,845	2,511	118	196	5,670	1,465	348	1,733	7	3,553	2,117
1998-99	2,117	2,397	180	845	5,539	1,557	432	1,076	33	3,098	2,441
1999-2000	2,441	2,013	256	589	5,299	1,585	793	636	50	3,064	2,235
2000-2001	2,235	2,132	189	667	5,223	1,711	697	475	52	2,935	2,288
Total	**12,545**	**11,515**	**758**	**2,833**	**27,651**	**7,850**	**2,503**	**5,223**	**149**	**15,725**	**11,926**

It would be noticed that 14,422 patients (2,907+11,515) were brought under treatment during the period 1996-2001, out of which 12,258 cases were to be cured as per target of the programme. Against this, 7,850 cases only were cured indicating 54 *per cent* efficiency in curing the patients. It is also noticed that out of 5,223 cases where the patients did not complete their treatment, only 758 cases were brought back under treatment. Apparently, the Department failed in its role of counsellor and motivator of T.B. patients for taking up the prescribed treatment regularly. Given the nature of T.B. disease, this did not only result in wasteful expenditure on incomplete medication, but also to the contra purpose of making those patients immune towards simpler line of medication.

Supervision

3.1.20 According to the Manual of District Tuberculosis Programme, supervision of PHIs by a team set up by the District TB Centre should be systematic and thorough. The DTC team should visit each PHI once in every quarter to raise the work standard and to provide guidance. Test check of the records of 3 DTCs for the years 1999-2000 and 2000-2001 indicated that against the requirement of 244 visits per year in 61 PHIs at the rate of 4 visits per PHI per year, the visits actually paid were 77 in 1999-2000 and 101 in 2000-2001. The shortfall in visits ranged from 59 to 68 *per cent*. The DTOs, Udaipur and Kailashahar stated that due to shortage of manpower and non-availability of departmental vehicles, required number of visits to PHIs could not be made.

National Leprosy Eradication Programme

3.1.21 Leprosy is a chronic infectious disease caused by Mycobacterium Leprae. It affects mainly the nerves, skin, muscles, eyes, bones and internal organs.

Infrastructure

3.1.22 A sound infrastructure is required to be created for proper implementation of the programme. The target fixed for creation of infrastructure during the period ending 1996-97 and achievement thereagainst are shown below:

Name of the units	Target	Achievement
1. Leprosy Control Units (LCUs)	3	3
2. Urban Leprosy Centres (ULCs)	3	3
3. Survey, Education and Treatment Centres (SETs))	75	75
4. Temporary Hospitalisation Wards (THWs)	3	NIL
5. Re-constructive Surgery Unit (RSU)	1	NIL
6. Sample Survey-cum-Assessment Unit (SSAU)	1	NIL

In low endemic districts i.e. the districts with comparatively low incidence of leprosy, Multi Drug Treatment (MDT) services are required to be provided through Mobile Leprosy Treatment Units (MLTUs). In spite of the fact that all the districts in Tripura fall under this category, even the creation of infrastructure like MLTUs was never targeted in the programme. It was also seen that the State Government failed to create 3 Temporary Hospitalisation Wards (THWs), one Re-constructive Surgery Unit (RSU) and one Sample Survey-cum-Assessment Unit (SSAU) so far although the programme had been under implementation for more than four decades since 1954-55. The programme thus suffered due to lack of the temporary hospitalisation facilities for leprosy patients and a re-constructive surgery facilities for their rehabilitation.

3.1.23 As stated (August 2001) by the Department, 3 THWs were constructed at Hapania, Manu and Santirbazar prior to 1996-97. The THWs at Hapania could not be commissioned due to setting up of a Communicable Disease Centre (CDC) while the THW of Manu could not be commissioned due to resistance by the local people. Further, the THW at Santirbazar was being utilised as LCU.

Shortage of staff

3.1.24 Each LCU was required to be manned by a Medical Officer, 4 Non-Medical Supervisors and 20 Para-Medical Workers (PMWs). Each ULC and each SET was to be served by a Para-Medical Worker. Records showed that against the requirement of 138 PMWs[ϕ] as per norms, 78 PMWs were in position due to non-sanction of more posts of PMWs by the GOI. It was noticed that the services of 5 Laboratory Technicians (out of 6), 2 Physiotherapists(out of 2), 2 Health Educators (out of 2) and 7 LD Clerks (out of 10) were utilised by the Health Department to maintain general health services and never made available in implementing the NLEP.

[ϕ] For LCUs : 60 ; for ULCs : 3 ; and for SETs :75.

Identification and treatment

3.1.25 The target fixed for identification of cases during 1996-2001 and achievement thereagainst, according to the Department, are detailed below :

		New cases			Discharged		
Year	**Old cases registered**[1]	**Target**	**Detected and treated**	**Total cases treated**[1] **(2+4)**	**Released after treatment**	**Other reasons**[2]	**Balance remaining under treatment**
(1)	**(2)**	**(3)**	**(4)**		**(6)**	**(7)**	
1996-97	883	100	212	1095	372	41	682
1997-98	682	100	201	883	402	80	401
1998-99	401	100	574	975	273	41	661
1999-2000	661	50	117	778	565	39	174
2000-2001	174	20	88	262	96	6	160
Total		**370**	**1,192**		**1,708**	**207**	

The above data indicate that 1,192 new leprosy cases were detected against a total target of 370, indicating fixation of very low target. To achieve the goal of elimination and to detect hidden cases of leprosy, Modified Leprosy Elimination Campaign (MLEC) was organised during 1998-99. Records of 2 LCUs (Santirbazar and Manu) showed that 4,910 suspected cases were identified during the campaign; but, due to lack of laboratory facilities and laboratory technicians, bacteriological tests of these suspected cases could not be conducted, confirmed, and brought under treatment.

3.1.26 "Bacterial Index was the only objective way of monitoring the benefit of treatment. It should be done at regular intervals[3]". But it was noticed that patients were released from treatment (RFT) by the District Leprosy Officers without identifying their bacterial index. The Leprosy Officers stated that due to lack of Laboratory Technicians bacterial index could not be done.

Surveillance

3.1.27 Bacteriological surveillance of all the cases after completion of treatment was an important part of MDT therapy and essential for successful treatment. As recommended by the GOI, the cases should be bacteriologically examined at least once in a year and for a period ranging from 2 to 5 years. But no such surveillance was carried out, indicating laxity in implementation of the programme.

National Blindness Control Programme

3.1.28 Blindness is one of the most significant health as well as social problems. The main diseases responsible for blindness in India[3] are cataract (55 *per cent*), trachoma (20 *per cent*), small pox (3 *per cent*), xerophthalmia (2 *per cent*), glaucoma (0.8 *per cent*) and other causes (19.2 *per cent*).

[1] All the old cases registered were shown as treated.
[2] Other reasons include number of patients who died and who were not traceable.
[3] 'Preventive and Social Medicine' by Park and Park.

Infrastructure

3.1.29 The programme envisaged to upgrade 4 District Hospitals, 2 Sub-Divisional Hospitals, 4 District Mobile Units and 36 PHCs within 2000-2001 by providing required infrastructure for eye care. The Department claimed (January 2001) that upgradation of all the above health institutions had been completed. But it was seen (June 2001) that 29 PHCs out of 36 were yet to be provided with Ophthalmic Assistants❤. Absence of trained paramedical workers, may adversely affect the quality of the eye care services in these PHCs.

Shortage of manpower

3.1.30 As per norms of NPCB, 8 Ophthalmic Surgeons, 44 Ophthalmic Assistants and 4 Camp Co-ordinators were required for the State to man the infrastructure already created. But records showed that the Department was yet to fill up 25 posts of Ophthalmic Assistants and all the 4 posts of Camp Co-ordinators, as of June 2001. As a result the performance of the programme had been affected adversely. As stated (August 2001) by the Programme Officer, State Ophthalmic Cell, the vacant posts of Ophthalmic Assistants could not be filled up due to non-availability of qualified persons.

Physical performance

(a) Cataract surgery

3.1.31 As per norms of the GOI, 250 cataract surgeries per lakh population were required to be conducted.

3.1.32 The details given in the **Appendix-XVI,** as furnished by the Department, show that against the total of 43,891 cataract operations required to be done during 1996-97 to 2000-2001 as per norms, a target of 30,760 operations was fixed, against which 33,551 operations were actually conducted. The shortfall worked out to 24 *per cent* with reference to the norm although achievement of the target had been shown as over-achieved.

(b) Camps organised

3.1.33 Each District Mobile Unit was required to conduct 1500 cataract operations each year.

3.1.34 Data obtained for the years 1996-97 to 2000-2001 from 4 DMUs compiled in **Appendix-XVII** indicate that, against the requirement of 30,000 cataract operations as per norm, a target of 26,000 operations was fixed against which 13,723 operations only were conducted during the period. Thus, the performance of the DMUs fell short of the prescribed norm by 54 *per cent*. The DMUs were also required to hold camps in underserved areas including tribal and geographically difficult areas. It was noticed that against 60 PHCs located in different rural areas, camps were held by covering only 38 PHCs.

❤ As per norm, each PHC was to be provided with one Ophthalmic Assistant.

The shortfall in covering the areas was attributed (March 2001) by the Department to shortage of manpower and insurgency problems.

Vitamin A prophylaxis

3.1.35 The diseases like Xerophthalmia and Keratomalacia often leading to blindness are caused by Vitamin A deficiency and are largely limited to the children in the age group of 1-6 years. For this purpose, Vitamin A prophylaxis was introduced under the National Family Welfare Programme to provide 2 lakh International Units (IU) of it every six months to the children of this age group.

3.1.36 Records of the National Family Welfare Programme showed that against the estimated number of children ranging from 1,91,640 (1996-97) to 2,14,500 (2000-2001) in the age group of 1-6 years, the number of children covered by Vitamin A ranged between 76,024 and 96,784, indicating a coverage of 37 to 49 *per cent* (detailed in **Appendix-XVIII**), though a large number of cases of Xerophthalmia (765 Nos.) was detected as per ophthalmic records test checked.

3.1.37 To be able to contain Xerophthalmia, the whole family should be kept under surveillance for one year and the children for 5 years. But no such surveillance was being carried out.

National AIDS Control Programme

3.1.38 AIDS is a fatal disease caused by HIV and is transmitted through sexual contact, STD patients, blood transfusion, contaminated needles and from HIV infected mother to her foetus or to her child during breast feeding. Since AIDS is not curable, the objective of the programme was to bring down the spread of HIV infection. The programme was to be implemented through (i) intervention for high risk group, (ii) STD control, (iii) intervention for general community,(iv) blood safety, (v) voluntary testing centres, and (vi) sentinel surveillance.

Infrastructure

3.1.39 For implementation of the programme, the target fixed for creation of infrastructure and achievement thereagainst (1996-97 to 2000-2001) are shown below :

Name of the units	Target	Achievement
Blood Banks	6	5
STD Clinics	3	3
Sentinel Surveillance Centres	4	1
Blood Component Separation Facilities	1	NIL
Zonal Blood Testing Centres	3	1
Voluntary Testing Centres	3	1

Intervention for groups at high risk

(a) Targeted intervention

3.1.40 Sex workers, truck drivers, injecting drug users, STD patients, industrial workers etc are the groups at high risk and vulnerable to spread HIV. The project aims to reduce the spread of HIV in groups at high risk by

identifying target population and providing peer counselling and condom promotion.

3.1.41 It was noticed that the Department did not take any steps to identify the target groups, nor was there any arrangement for providing peer counselling or for condom promotion.

(b) Control of sexually transmitted diseases (STD)

3.1.42 In view of the similarities in the dominant modes of transmission, it is utmost important that STD prevention and care facilities should be strengthened and upgraded by providing laboratory testing facilities and technical manpower. Three STD clinics were claimed to have been strengthened by the Department in 3 district hospitals, which meant that the clinics should have had the above facilities.

3.1.43 But, test check of records of Tripura Sundari Hospital, Udaipur, revealed that laboratory testing facilities were not provided for detecting diseases like syphilis, gonorrhoea etc. In RGM Hospital, Kailasahar, it was noticed that no specialist was posted, nor were there any laboratory testing facilities. Reasons for these shortfalls were not stated.

3.1.44 Family Health Awareness Campaigns were taken up during April 1999, December 1999 and June 2000 by organising camps at various places for detection and treatment of STD patients. Records of 24 health institutions spread over three districts test checked indicated a very poor performance of Health Awareness Campaigns as shown below:

Period of campaign	Population targeted (40 to 50 *per cent* of total population of the areas covered)	Actual attendance in camps	Percentage of attendance	STD patients identified and referred to clinics	Patients that actually attended STD clinics	Percentage of coverage by treatment
April 1999	5,63,848	28,214	5	6,099	1,787	29
December 1999	7,58,151	34,976	4	8,726	2,252	26
June 2000	7,73,909	34,591	4	8,607	1,540	18

This indicates that against the targeted population ranging from 5.64 lakh to 7.74 lakh, actual attendance in the camps was between 4 and 5 *per cent* and the STD patients covered by treatment ranged from 18 to 29 *per cent* of the cases identified inspite of incurring expenditure of Rs. 36.59 lakh in the campaigns. The amount allocated for the campaigns during 1999-2000 and 2000-2001 could not be indicated by the Department (June 2001), though asked for in audit.

Intervention for general community

(a) Blood Safety

3.1.45 As per national blood safety policy, testing of every unit of blood against syphilis, hepatitis B, malaria and HIV by all blood banks was mandatory. The Department claimed to have modernised 5 Blood Banks. But it was noticed that against 40 items of equipment required to be provided in modern blood banks, only 11 items were provided. Even Elisa reader machine,

essential for detecting HIV, was not provided in 3 blood banks at Udaipur, Dharmanagar and Kailashahar.

3.1.46 There are 40 components in our blood. As per National Blood Policy, only the component which is required by a patient should be transfused. If separation facilities are available, transfusion of undesirable component can be avoided. The State Government was, therefore, required to establish blood component separation facilities in all blood banks for rational use of blood. It was seen that infrastructure for blood component separation, though targeted in 1996-97 for one Blood Bank (at GB Hospital), was not provided, as of March 2001.

3.1.47 Records of all the 5 blood banks indicated that 48,101 blood units were tested between 1996-97 and 2000-2001, against which 86 HIV seropositive cases were detected. The matter had been kept secret and no counselling was provided to the patients. Even the patients concerned were not informed of the results of blood testing• . This increased the risk of spreading of HIV infection from the infected persons to the members of their families, expectant/lactating mothers and the would be/newly born babies. This was not at all conducive to the programme objective of bringing down the spread of HIV.

(b) Voluntary testing and counselling

3.1.48 This would involve increasing availability and demand for voluntary testing especially joint testing of couples and providing counselling services. It was envisaged in the programme that one voluntary testing centre would be set up in each district and the target for setting up 3 centres by 1996-97 was fixed. It was noticed that only one such centre started functioning at GB Hospital, Agartala, in 1999-2000, though stated to have been established in 1996-97 i.e., three years earlier.

3.1.49 The performance of voluntary testing centre is shown below :

Year	Number of sites offering the services	Number of volunteers targeted for screening	Attendance per site	Number of couples jointly tested	HIV positive cases detected
1999-2000	1	250	83	NIL	1
2000-2001	1	250	99	NIL	-

It was also noticed that the voluntary testing centre was established without providing any Elisa Reader for detection of HIV. Not turning up of any couples for joint testing was also an indication of poor performance of awareness campaign taken up by the Department.

(c) Sentinel Surveillance

3.1.50 Limiting the spread of HIV infection requires constant surveillance by screening high risk groups (sex workers, injecting drug abusers, migrated labourers, tru9ck drivers etc.). For this purpose, one surveillance centre was

• In addition, one such case under the component 'voluntary testing, and counselling' and 17 others under the component 'sentinel surveillance' were also detected without informing the patients of the results of blood testing.

set up in 1996-97 at GB Hospital, Agartala. The staff members of the surveillance centre were required to collect samples of blood from the high risk groups for HIV screening. But, it was noticed that no such active surveillance was carried out by the centre. The number of blood units screened and HIV seropositive cases detected are shown below :

Year	Name of group	Number of blood units tested	Number of HIV positive cases detected
1996-97	STD patients	1,029	1
1997-98	-Do-	1,177	2
1998-99	-Do-	1,511	5
1999-2000	-Do-	888	4
2000-2001	-Do-	794	5

3.1.51 Counselling was an essential part of AIDS Control Programme for prevention of spreading HIV infection and taking care of the patients. Under the programme, annual recurring grant from the GOI for salary of 2 Counsellors was admissible. But it was noticed that no Counsellors were appointed and no counselling was being done. Thus, the objective of the programme was frustrated.

Monitoring

3.1.52 State AIDS Control Society established in April 1999 under the National AIDS Control Programme was to be manned for effective implementation as well as monitoring of the programme. It was noticed that out of 26 posts[@] sanctioned for the society, only one post of the Project Director was filled up so far (March 2001).

3.1.53 Under National Tuberculosis Control Programme, PHIs are required to send the monthly reports to the DTO in time. It was noticed that 7 PHIs out of 24 under the DTC (North), Kailashahar, did not send their monthly reports during the years 1999-2000 to 2000-2001 in spite of visits by the DTC team.

3.1.54 Evaluation should be an integral part of intervention programme to measure the extent to which the diseases have been contained and to assess how effectively the infrastructure was working. But no such evaluation was carried out during the period from 1996-97 to 2000-2001. As a result, the Department is in the dark as to whether leprosy cases were reduced to less then 1 per 10,000 population and blindness cases were reduced to 0.3 *per cent* of the total population by 2000, as envisaged under the respective programmes.

Recommendations

3.1.55 To improve detection of leprosy cases, the special drive like Modified Elimination Campaign should be taken up periodically.

3.1.56 Supervisory activities organised by the District Tuberculosis Centres in relation to peripheral health institutions should be strengthened.

[@] This includes key posts like Addl. Project Director ; Jt. Director (Surveillance); Dy. Director (STD); Dy. Director (Surveillance); Dy. Director (Blood Safety); Asstt. Director (STD), etc.

3.1.57 Adequate laboratory testing facilities should be provided under both the National Leprosy Control and AIDS Control Programmes.

3.1.58 Since expectant mothers constitute one of the vulnerable groups for spreading HIV, greater vigilance and surveillance are called for on the part of programme authorities.

3.1.59 Treatment and counselling of HIV infected persons, hitherto ignored, should be introduced.

3.1.60 The above points were reported to the Government in July 2001, their replies have not been received as of November 2001.

APPENDIX– XIII

(Reference: Paragraph 3.1.11)

Statement showing outlay and expenditure under ' Prevention and Control of Diseases'

Name of the programme	Year	Opening balance	Funds released by GOI under CSS			Funds under State Plan	Total funds available	Expenditure under CSS (including society)	Expenditure under State Plan	Total expenditure	Closing balance of Central share
			To State	Society	Total						
						(Rupees in lakh)					
AIDS Control	1996-97	16.79	50.00	-	50.00	-	66.79	55.72	-	55.72	
	1997-98		50.00	-	50.00	-	50.00	41.36	-	41.36	
	1998-99		-	-	-	-	--	20.10	-	20.10	
	1999-2000		-	70.00	70.00	-	70.00	36.60	-	36.60	
	2000-2001			40.00	40.00	-	40.00	76.73	-	76.73	
Total		16.79	100.00	110.00	210.00	-	226.79	230.51	-	230.51	(–) 3.72*
TB Control	1996-97	NIL	1.91	-	1.91	12.55	14.46	1.91	12.16	14.07	
	1997-98		7.57	-	7.57	6.40	13.97	6.38	2.70	9.08	
	1998-99		8.75	-	8.75	1.52	10.27	1.23	1.50	2.73	
	1999-2000		12.55	-	12.55	6.95	19.50	17.00	6.81	23.81	
	2000-2001		-	-	-	8.00	8.00	4.26	7.73	11.99	
Total		NIL	30.78	-	30.78	35.42	66.20	30.78	30.90	61.68	NIL
Leprosy Control	1996-97	22.24	19.00	6.00	25.00	65.80	113.04	24.72	36.06	60.78	
	1997-98		20.00	16.62	36.62	86.10	122.72	35.06	34.75	69.81	
	1998-99		24.00	50.35	74.35	82.77	157.12	50.74	79.51	130.25	
	1999-2000		23.80	23.18	46.98	96.58	143.56	44.45	53.20	97.65	
	2000-2001		10.00	10.00	20.00	95.05	115.05	14.23	82.84	97.07	
Total		22.24	96.80	106.15	202.95	426.30	651.49	169.20	286.36	455.56	55.99
Blindness Control	1996-97	6.73	11.46	7.55	19.01	20.05	45.79	23.57	18.40	41.97	
	1997-98		7.92	13.60	21.52	27.35	48.87	24.73	21.43	46.16	
	1998-99		26.30	15.00	41.30	16.13	57.43	32.40	16.37	48.77	
	1999-2000		17.39	11.65	29.04	24.15	53.19	30.81	23.00	53.81	
	2000-2001		54.80	12.00	66.80	18.97	85.77	23.32	16.27	39.59	
Total		6.73	117.87	59.80	177.67	106.65	291.05	134.83	95.47	230.30	49.57
Grand Total		**45.76**	**345.45**	**275.95**	**621.40**[#]	**568.37**	**1,235.53**	**565.32**	**412.73**	**978.05**	**101.84**

[#]Total grants received from GOI = Rs. 6.67 crore
Spillover funds = (-) Rs. 0.46 crore
Net funds received during the period Rs. 6.21 crore

*Expenditure booked by the Department in excess by Rs. 3.72 lakh to be regularised during the next year.

APPENDIX– XIV

(Reference : Paragraph 3.1.14)

Statement showing the target and achievement in identification of TB cases

Year	Total number of outpatients who visited hospitals and other health institutions working under the programme*	Estimated No. of chest symptomatic patients	Estimated number of sputum positive cases	75 *per cent* sputum positive cases (to be identified as per norm)	Detection of sputum positive cases		Sputum examination	
					Target fixed by the Department.	Achievement	Target	Achievement
1996-97	6,98,214	17,455	1,746	1,310	1,617	299	48,510	10,846
1997-98	7,01,041	17,526	1,753	1,315	1,617	513	48,510	11,270
1998-99	6,06,171	15,154	1,515	1,136	1,617	628	48,510	14,812
1999-2000	5,80,098	14,502	1,450	1,088	1,660	912	16,630	15,290
2000-2001	5,91,374	14,784	1,478	1,109	1,890	960	18,910	14,906
Total	**31,76,898**	**79,421**	**7,942**	**5,958**	**8,401**	**3,312**	**1,81,070**	**67,124**

* Compiled and supplied by the State TB Officer, Agartala

APPENDIX– XV

(Reference : Paragraph 3.1.17)

Statement showing the target and achievement of sputum examination in Peripheral Health Institutions of West Tripura District

Year	No. of PHIs under the DTC (West)	Estimated population in PHIs (as furnished by the Department)	Estimated number of chest symptomatic patients to be examined @ 500 cases per lakh population	Number of sputa required to be examined	Sputum examination	
					Target	Achievement
1996-97	18	10.00 lakh	5,000	15,000	12,650	4,011
1997-98	19	10.20 lakh	5,100	15,300	12,650	4,935
1998-99	20	10.45 lakh	5,225	15,675	12,650	6,805
1999-2000	20	10.70 lakh	5,350	16,050	10,775	6,346
2000-2001	20	11.00 lakh	5,500	16,500	10,775	6,609
Total			**26,175**	**78,525**	**59,500**	**28,706**

APPENDIX– XVI

(Reference : Paragraph 3.1.32)

Statement showing details of cataract surgeries

Year	Population in lakh▲	Cataracts to be operated as per norm @ 250 per lakh population	Target fixed for cataract surgeries	Cataract surgeries conducted	No. of cases in which vision not restored
1996-97	32.75	8,187	5,000	5,249	No complication reported by the patients as stated by the Programme Officer.
1997-98	33.89	8,472	5,600	6,504	
1998-99	35.05	8,762	6,160	6,165	
1999-2000	36.30	9,075	7,000	7,415	
2000-2001	37.58	9,395	7,000	8,218	
Total		**43,891**	**30,760**	**33,551**	

▲ Estimated population as supplied by the Department.

APPENDIX– XVII

(Reference : Paragraph 3.1.34)

Statement showing details of camps organised and cataract operations done by the DMUs

Year	Number. of DMUs[+]	Number of cataract operations required to be done	Planned / proposed			Actually organised		
			Eye camps	Patients to be checked	Cataract operations	Eye camps	Patients checked	Cataract operations
1996-97	4	6,000	130	52,000	4,500	91	36,400	2,466
1997-98	4	6,000	130	52,000	5,000	110	44,000	2,975
1998-99	4	6,000	130	52,000	5,500	70	28,000	2,846
1999-2000	4	6,000	140	56,000	5,500	111	44,400	2,644
2000-2001	4	6,000	144	57,600	5,500	109	43,600	2,792
Total		**30,000**	**674**	**2,69,600**	**26,000**	**491**	**1,96,400**	**13,723**

[+] DMUs : District Mobile Units

APPENDIX– XVIII

(Reference : Paragraph 3.1.36)

Statement showing details of vitamin A prophylaxis

Year	Estimated population of children in the age group of 1-6 years	Target for coverage with Vitamin A solution	Children actually covered by Vitamin A solution	Percentage of estimated population
1996-97	1,91,640	85,000	76,024	40
1997-98	1,97,340	1,47,664	96,784	49
1998-99	2,03,220	1,49,987	87,529	43
1999-2000	2,09,280	89,473	76,858	37
2000-2001	2,14,500	94,065	80,220	37