HEALTH AND FAMILY WELFARE DEPARTMENT

1.2 National Rural Health Mission

Highlights

The National Rural Health Mission was launched by the Government of India in April 2005. It aimed at strengthening rural health care institutions by provision of infrastructure facilities and funds. A review of the implementation of the National Rural Health Mission in the State revealed improvement in the flow of funds to rural health institutions, upgraded infrastructure in some of the institutions and better health awareness among the rural population. However, deficiencies like absence of a Perspective Plan, accumulation of huge unspent funds in banks, slow pace of upgradation work in some institutions, lack of medical and para-medical staff, etc., were noticed.

Although only sample household surveys were carried out in the three test-checked districts, facility surveys required for identifying the health care needs of rural areas were conducted only in Community Health Centres though the guidelines stipulated that these were also to be carried out in Primary Health Centres and Sub Centres.

(Paragraph 1.2.6)

No Perspective Plan for the Mission period was prepared by the State Health and Family Welfare Society to ensure execution of projects along a critical path.

(Paragraph 1.2.6.2)

National Rural Health Mission funds of Rs 1.48 crore were spent during 2007-08 and 2008-09 for activities not approved by Government of India in the annual Programme Implementation Plans and Rs 51.86 lakh was diverted without their approval.

(Paragraph 1.2.7.4)

Management expenditure during 2007-08 and 2008-09 exceeded the prescribed limit of six *per cent*.

(Paragraph 1.2.7.5)

Construction of buildings for only 70 out of 115 Community Health Centres had been completed. Construction of buildings for 50 Sub Centres had not been started as of September 2009.

(Paragraphs 1.2.8.1 and 1.2.8.2)

Accredited Social Health Activists selected during 2007-08 and 2008-09, were not imparted training in three out of five prescribed modules.

(Paragraph 1.2.8.4)

Manpower, infrastructure and equipment in Community Health Centres and Primary Health Centres did not meet the Indian Public Health Standards despite upgradation through National Rural Health Mission funds.

(Paragraph 1.2.8.6)

Guidelines and the Purchase Preference Policy prescribed by Government of India for procurement of medicines were not followed. No pre-despatch or post-despatch inspections of drug kits, surgical kits and Accredited Social Health Activists' drug kits were conducted. Non-levy of penalty for delayed supplies of medicines amounted to Rs 3.18 crore.

(Paragraph 1.2.9.1)

Supply of surgical kits and Accredited Social Health Activists' drug kits was made by M/s.Karnataka Antibiotics and Pharmaceuticals Limited after purchasing them from private firms at lesser prices. As a result, the supplier earned undue benefit of Rs 3.78 crore and the State Health and Family Welfare Society incurred extra expenditure of an equivalent amount.

(Paragraphs 1.2.9.2 and 1.2.9.3)

An effective Health Management Information System was not set up though hardware and software for Rs 4.70 crore were procured for the purpose.

(Paragraph 1.2.10.3)

Under the 'Integrated Disease Surveillance Project', hardware and accessories procured for video-conferencing units at the district level at a cost of Rs 54.82 lakh were lying idle as of March 2009 as the State level video-conferencing unit had not been set up due to non-provision of space by the Director of Health Services.

(Paragraph 1.2.10.4)

1.2.1 Introduction

The National Rural Health Mission (NRHM) was launched by Government of India (GOI) in April 2005 throughout the country with special focus on 18 States. The Mission aimed at providing accessible, affordable, accountable, effective and reliable health care facilities in the rural areas by reducing the infant and maternal mortality rates, stabilising the total fertility rate of the population as well as preventing and controlling communicable and non-communicable diseases, including locally endemic diseases by involving the community in planning and monitoring. The key strategy of the Mission was to bridge gaps in health care facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II and various disease control programmes. It sought to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. In Kerala, the State Health Mission (SHM) for implementation of various interventions under NRHM was set up in September 2006 and the State Programme Management Support Unit[20] was institutionalised in December 2006. The State Health and Family Welfare Society (SHS) and the District Health and Family Welfare Societies (DHS) were formed in April 2007. Prior to this, the activities under NRHM were being implemented by the Director of Health Services.

[20] Secretariat to the SHM as well as the SHS. It provides technical support on logistics, financial management, tracking of funds, etc.

1.2.2 Organisational Set up

At the State level, NRHM functions under the overall guidance of the SHM under the Chairmanship of the Chief Minister. The activities of the SHM are carried out through the SHS headed by the Health Minister. The Executive Committee of the SHS is headed by the Secretary, Health and Family Welfare Department.

At the district level, there are District Health Missions and DHSs headed by the Chairpersons of the District Panchayats. Their Executive Committees are headed by the District Collectors. The implementation of various disease control programmes is supervised by the respective heads of the Disease Control Programmes.

1.2.3 Audit Objectives

The objectives of the performance audit were to assess whether:

- the planning process at the village, block, district and State levels were adequate;
- the assessment, release and utilisation of funds were efficient and effective;
- capacity building and strengthening of physical and human infrastructure were as per the Indian Public Health Standards (IPHS)[21] norms;
- the systems and procedures of procurement and distribution of drugs and services were cost-effective and efficient and ensured improved availability of drugs and services;
- the performance indicators and targets fixed, especially in respect of reproductive and child health care, immunisation and disease control programmes were achieved and
- the level of community participation was as per the guidelines.

1.2.4 Audit Criteria

The audit criteria adopted for arriving at the audit conclusions were the following:

- The GOI framework on implementation of NRHM,
- Guidelines issued by GOI for various components, disease control programmes, financial aspects, etc.,
- Circulars issued by GOI, containing directions for NRHM activities,
- Orders and instructions issued by the State Government and
- IPHS for upgradation of health centres.

1.2.5 Scope and Methodology of Audit

The performance audit was conducted from April 2008 to June 2009, covering the period from 2005-06 to 2008-09 by test check of records in the Department of Health and Family Welfare, the Directorate of Health Services,

[21] A set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

the SHS and Disease Control Societies. In addition, three[22] out of 14 DHSs were selected for detailed review. In the above three districts, three Taluk Headquarters Hospitals, three District Hospitals, six Community Health Centres (CHCs), 12 Primary Health Centres (PHCs) and 24 Sub Centres (SCs) were also selected using the Simple Random Sampling Method. Besides, data relating to 71 CHCs and 83 PHCs from all the districts were collected and analysed.

An entry conference was held with the Secretary to Government, Health and Family Welfare Department in April 2008, during which the audit objectives and criteria were discussed. Another meeting was held with the Secretary in February 2009, wherein certain State-specific issues were discussed.

An exit conference with the Secretary was conducted on 10 August 2009 during which the audit findings were discussed.

Audit Findings

1.2.6 Planning

Only sample household surveys were carried out in the three test-checked districts

NRHM envisaged a decentralised and participatory planning process with a bottom up approach from village level to the State level. The State and districts were, thus, required to prepare Perspective Plans for the Mission period (2005-12). Action Plans for each year were to be prepared by the SHS by consolidating all the district level plans to enable interventions in the health sector. Household surveys at the levels of CHC, PHC and SC were to be conducted for preparing comprehensive District Action Plans. Audit scrutiny revealed that only a sample household survey was conducted by the Department of Community Medicine of the Medical College, Kozhikode in selected panchayats and municipalities of three[23] out of 14 districts during February - March 2007. Consequently, the Annual Action Plans were prepared without adequate field data, rendering the planning process defective.

Facility surveys were conducted only in CHCs and not conducted in any of the PHCs and SCs

As per NRHM guidelines, facility surveys to ascertain the facilities available at the CHC/PHC/SC level were to be carried out in all the districts by 2008. It was seen in audit that facility surveys were conducted in all the 115 CHCs during September-December 2006. However, no facility survey had been carried out in any of the PHCs and SCs as of May 2009.

Government stated (September 2009) that as the State Programme Management Support Unit was institutionalised only in December 2006 and SHS started functioning from April 2007, there were delays in conducting necessary field surveys to collect essential data for preparing the Annual Plans. As regards the facility survey, the Government stated (September 2009) that such surveys had been conducted in all the CHCs in the first stage. Facility surveys in PHCs would be taken up in phases in due course and the entire exercise would be completed in stages.

However, the fact remains that the State Government took two years, since the launch of NRHM to establish the set up for NRHM and even after these two years, all the required household surveys and facility surveys, had not been

[22] Palakkad, Thiruvananthapuram and Wayanad.
[23] Kannur, Malappuram and Wayanad.

conducted (September 2009). Thus, the formulation of the Annual Action Plans was deficient to this extent.

1.2.6.1 Action Plans at Village, Block and District levels

Village, block, and district level Action Plans were not prepared for 2008-09 as envisaged in NRHM guidelines

Due to delays in setting up of the SHS and DHSs, no Action Plans were prepared for NRHM during 2005-06 and 2006-07. Only proposals for Reproductive and Child Health II (RCH II) were sent to GOI for these years and funds were released by GOI on the basis of these proposals. In 2007-08, Plans at the Sub Centre, block, district and State level were prepared as per the NRHM guidelines. However, in 2008-09, Action Plans below the State level were not prepared. Instead, fund requirements under various heads were collected from all the institutions and furnished to the SHS for preparation of a detailed State level Action Plan. Consequently, prioritization of issues at the district level and below the district level could not be done in the State Action Plan for 2008-09. Government stated (September 2009) that institution-based Action Plans were the basis for 2008-09. During 2010-11, ward would be the basis for preparation of Action Plans.

1.2.6.2 Perspective Plan

SHS had not submitted a Perspective Plan for the Mission period to GOI

The SHS did not submit a Perspective Plan, as envisaged in the NRHM guidelines, to GOI for the Mission period. No Perspective Plans had been prepared by the DHSs in the three test-checked districts of Palakkad, Thiruvananthapuram and Wayanad. Government stated (September 2009) that the SHS had a clear Perspective Plan in terms of clearly laid down technical targets for the Mission period and for each year. Action Plans were prepared by the State with reference to these targets and goals. It was, however, found that the SHS had only fixed targets to be achieved in the Annual Action Plans, but had not prepared a comprehensive Perspective Plan for the entire Mission period. In the absence of such a Plan, the convergence of vertical health programmes, monitoring with reference to performance indicators, rationalization of manpower and resources available, etc., was not possible. Thus, the SHS had not evolved a systematic Perspective Plan based on reliable inputs for scheduling each and every activity in a critical path to execute the same within the time frame to ensure economy, efficiency and effectiveness in the implementation of NRHM.

1.2.7 Financial Management

1.2.7.1 Fund management

GOI provided 100 *per cent* grant-in-aid to the State Government for the years 2005-06 and 2006-07. During the Eleventh Plan (2007-12), the contribution was to be in the ratio of 85: 15 between the Centre and the State. Funds released by GOI for the components[24] were credited to one single bank account while funds for the National Disease Control Programmes were credited to the bank accounts of the respective societies responsible for these programmes. The funds released by GOI to the SHS during 2005-09 *vis-à-vis* the expenditure incurred were as follows:

[24] RCH-II: Maternal health, child health, family planning, tribal health, etc., Additionalities: Hospital Management Committee, untied grant, maintenance grant, etc., and Immunisation: Pulse Polio immunisation and routine immunisation.

Table 1.8: Availability of funds and expenditure

(Rupees in crore)

Year	Opening balance	Funds received from GOI	State share received	Total funds available	Expenditure	Closing balance	Percentage of savings
2005-06	7.70[25]	44.90	Nil	52.60	11.14	41.46	79
2006-07	41.46	88.29	Nil	129.75	33.36	96.39	74
2007-08	96.39	229.95	Nil	326.34	154.52	171.82	53
2008-09[26]	171.82	151.29	53.25	376.36	290.54	85.82	23
Total		**514.43**	**53.25**		**489.56**		

Source: Annual accounts certified by Chartered Accountants

During the first three years, i.e., 2005-08, utilisation of funds was less than 50 *per cent*

In the first three years, ie., 2005-08, utilisation of funds was less than 50 *per cent*, mainly due to delays in setting up the SHS and the DHSs. During 2008-09, expenditure was 77 *per cent* of the available funds. The major items of expenditure were on *Janani Suraksha Yojana*[27] (Rs 12.84 crore), appointment of contractual staff (Rs 34.50 crore), procurement of drug kits (Rs 27.38 crore), grant-in-aid to SC, PHC, CHC and other hospitals (Rs 38 crore) and strengthening/upgradation of health centres (Rs 62.03 crore).

It was seen in audit that during 2007-09, the State Government contributed Rs 53.25 crore against its committed share of Rs 55.02 crore, resulting in short contribution of Rs 1.77 crore. There were unspent balances ranging from Rs 41.46 crore to Rs 171.82 crore at the close of each financial year during 2005-09.

Government stated (September 2009) that the State Programme Management Support Unit was institutionalised only in December 2006 and that the District Programme Managers were put in place only at the beginning of 2007. Also, the gestation period would be high since NRHM activities involved upgradation of facilities, etc. However, the fact remains that Government could utilise only 21 to 26 *per cent* of the funds during the first two years (2005-07) due to delay in establishing the set up for implementing NRHM in the State.

1.2.7.2 Low utilisation of funds

Government of India, Ministry of Health and Family Welfare, released funds to the State based on the progress of expenditure. Due to low utilisation of funds during the initial years of implementation of NRHM, Rs 5.51 crore and Rs 1.95 crore sanctioned for the National Immunisation Day, RCH II Flexible Pool[28], Mission Flexible Pool[29] and strengthening of immunisation were not released by the Ministry during 2006-07 and 2007-08 respectively. Government stated (September 2009) that the low utilisation of funds was due to delays in formation of the State Programme Management Support Unit and SHS.

---

[25] Opening balance of National Disease Control Programme and Information, Education and Communication activities.

[26] Financial Management Report (not certified by Chartered Accountants).

[27] A scheme to promote safe delivery at health centres by providing cash incentives to pregnant women and Auxiliary Nurse Midwives or Accredited Social Health Activists.

[28] RCH II Flexible Pool: Discretionary resources made available to the States with the flexibility to make plans and for utilisation for maternal health, child health, family planning, tribal health, etc., according to their needs.

[29] Mission Flexible Pool: Discretionary resources made available to the States with the flexibility to make plans and for utilisation for hospital management committee, untied grant, annual maintenance grant, etc.

Out of Rs 154.21 crore released to the 14 DHSs during 2005-06 to 2007-08, the actual expenditure was only Rs 86.13 crore while the balance of Rs 68.08 crore remained unutilised with them. The expenditure for 2005-06 and 2006-07 was below 20 *per cent* of the funds released. Government stated (September 2009) that there were delays in generating consensus on the action to be taken for utilising the funds released to the hospitals as well as in accounting of the expenditure as the hospital management committees were headed by elected members. Government also added that necessary orders had been issued to organise regional level workshops to collect statements of expenditure and utilisation certificates from the institutions concerned.

1.2.7.3 Release of corpus grant, untied grant and annual maintenance grant

Each CHC was entitled to receive Rupees one lakh, as a corpus and a maintenance grant and an untied grant totalling Rs 50,000. Each PHC was entitled to receive Rs 50,000, as a corpus and a maintenance grant and an untied grant Rs 25,000. During 2006-07 to 2008-09, Rs 81.12 crore[30] was sanctioned by GOI towards corpus grant (Rs 25.98 crore), maintenance grant (Rs 24.27 crore) and untied grant (Rs 30.87 crore).

Information collected from 71 out of 115 CHCs and 83 out of 929 PHCs through questionnaires revealed that one to 46 CHCs and four to 66 PHCs received the entitled grants during 2006-09 as detailed below:

Table 1.9: Number of CHCs/PHCs who received entitled grants

	Corpus grant		Maintenance grant		Untied grant	
	Number of CHCs	Number of PHCs	Number of CHCs	Number of PHCs	Number of CHCs	Number of PHCs
2006-07	1	4	9	17	13	26
2007-08	32	48	35	65	41	66
2008-09	40	45	44	52	46	57

Source: Details collected through proforma from CHCs and PHCs

It may thus be seen that the additional resources provided by GOI for the CHCs and PHCs did not reach a large number of these institutions, despite the availability of funds. Government stated (September 2009) that during 2006-07 and 2007-08, the entire amount approved by GOI for payment of grant was released to the CHCs/PHCs through the District Health Societies. But during 2008-09, grants were released only to those CHCs/PHCs which utilised 80 *per cent* of the funds released earlier. However, the information received by Audit from the CHCs/PHCs revealed that the grants were received by a few institutions as shown in the table above.

1.2.7.4 Lapses in budgetary control

GOI approved Rs 80 lakh towards selection and training of Accredited Social Health Activists (ASHA[31]) during 2006-08 and Rupees five crore for procurement of ASHA drug kits during 2008-09. However, the SHS spent Rs 6.81 crore and Rs 16.69 crore respectively for the above purposes against

[30] Figures adopted from the proceedings of meetings of National Programme Co-ordination Committee of GOI, Ministry of Health and Family Welfare during 2006-07 to 2008-09.

[31] A trained community health worker to be provided in each village for assisting in neonatal care, prevention and cure of common childhood diseases, immunisation and family planning activities and other activities for control of malaria, tuberculosis, leprosy, etc.

the approved amounts which resulted in excess expenditure of Rs 17.70 crore. Further, in the test-checked districts, it was noticed that NRHM funds were utilised for unapproved activities as described below:

Rupees 1.48 crore was spent on activities not approved by GOI in the Programme Implementation Plans and Rs 51.86 lakh was diverted for other services

- The SHS released Rs 91.20 lakh (2007-08 and 2008-09) towards stipend for BSc (Nursing) students, Rupees six lakh (2008-09) as maintenance grants to six CHCs where upgradation work was in progress and Rs 16.20 lakh (2007-08 and 2008-09) to Hospital Management Committees (HMC) of the General Hospitals at Thiruvananthapuram and Wayanad. In response to Audit, the State Mission Director (SMD) stated (July 2009) that stipends had been given to nursing students to resolve the shortage of nurses. Maintenance grants to CHCs under upgradation and funds to the HMCs of the General Hospitals were provided because these units were running short of funds. The reply is not acceptable as it was the responsibility of the State Government to provide adequate funds for such activities which were not covered under NRHM.
- As per NRHM guidelines, SCs attached to CHCs/PHCs were not entitled for untied grants. Contrary to this, DHS provided untied grants of Rs 14.50 lakh to SCs attached to CHCs/PHCs during 2007-08 and 2008-09. In response, the SMD stated (July 2009) that the districts concerned had been asked to explain the reasons for this action.
- A refundable loan of Rupees seven lakh was released (2007-08) to the Kerala State Institute of Virology and Infectious Diseases, Alappuzha. Rupees 13.30 lakh was released (2008-09) towards routine expenses (purchase of furniture, fuel charges, etc.) of the Kerala Medical Service Corporation. These activities were not covered under NRHM. The SMD stated (July 2009) that the institutions had been asked to refund the amounts.
- An amount of Rs 51.86 lakh, approved for the constitution of 14 Mobile Outreach Units and payment of salaries to Junior Public Health Nurses in urban wards, was diverted (2007-08 and 2008-09) for meeting expenses relating to ward health sanitation activities. In response, the SMD justified the diversion and stated (July 2009) that funds were released to selected urban wards in the State to enable them to initiate action for their designated activities, with a special focus on mothers. However, the diversion was made without the approval of GOI and hence was irregular.

1.2.7.5 Management expenditure

Expenditure on management during 2007-09 exceeded the prescribed limit of six *per cent* of the approved amount under Reproductive and Child Health II

As per NRHM guidelines, management expenditure should not exceed six *per cent* of the approved amount under RCH-II. During 2005-06 and 2006-07, the expenditure on management was below six *per cent*, whereas it exceeded the limit by Rs 3.08 crore during 2007-08 and 2008-09. Audit scrutiny revealed that inadmissible expenditure unconnected with the activities of NRHM like Nurses'/Doctors' day celebration, wages to drivers attached to the Minister's Office, wages to staff of the Kerala Medical Service Corporation Limited, entertainment of visitors, etc., was incurred during the period, contributing to the excess.

1.2.7.6 Accounting system

The annual accounts for the years 2005-06, 2006-07 and 2007-08 were audited and certified in December 2006, February 2008 and May 2009 respectively while accounts for 2008-09 had not been prepared till June 2009. The SMD stated (July 2009) that the Audit Report for 2008-09 was expected to be ready by July 2009. However, the audited accounts for 2008-09 had not been finalised as of August 2009.

1.2.8 Upgradation of Health Care Infrastructure and Capacity Building

Construction of buildings for only 34 out of 174 health care institutions had been completed as of March 2009

The core strategy of NRHM includes strengthening of health institutions through better human resource development and providing adequate infrastructure and equipment to raise them at par with Indian Public Health Standards. GOI approved upgradation of 174 health care institutions at a cost of Rs 142.40 crore during 2006-09. The construction works were entrusted to five Government agencies[32] and Rs 49.75 crore was released to them up to March 2009. Construction of buildings for only 34 institutions out of 174 had been completed as of March 2009.

GOI also released Rs 20.18 crore during 2006-09 for upgradation of the Institute of Maternal and Child Health, Kozhikode to a Centre of Excellence. Rupees 4.58 crore was released as advance to Hindustan Prefab Limited for installation of a sewage treatment plant for the institute during 2007-09. Only the work of the sewage treatment plant was completed. The remaining work of laying of a pipeline within the premises and external pipelines to carry the treated effluents was still to be completed (September 2009).

1.2.8.1 Delay in completion of upgradation of CHCs

Construction of buildings for 70 out of 115 CHCs had been completed

Hindustan Latex Limited (HLL) was appointed as the consultant for upgradation work of building infrastructure of CHCs in the State. As per the agreement signed for the purpose in February 2007, HLL was to prepare a detailed project report on the basis of a facility survey, get it approved by the hospital management committee of the CHCs and then prepare estimates for the works. Administrative sanction for the work was to be given by the SHS. During 2006-09, upgradation of 115 CHCs had been entrusted to HLL at an estimated cost of Rs 35.66 crore. Rupees 27.16 crore was paid as advance to HLL. It was observed that construction of only 22 CHCs had been completed as of March 2009. Work on 91 CHCs was in progress at various stages. Work was still to be started in the other two CHCs. None of the 22 CHCs which had been constructed had been upgraded as per the IPHS so far.

Government stated (September 2009) that the delay in upgradation of CHCs was due to various reasons such as delays in constitution of institutional level committees, revision of estimates to suit the budget, poor response of contractors to tender notifications, etc., which were beyond their control. The Government also stated that work had been completed in 70 out of 115 CHCs and work in the other CHCs was in progress. Government added that tendering procedures had almost been completed for procurement of

[32] Hindustan Prefab Limited, Hindustan Latex Limited, Kerala Health Research and Welfare Society, Kerala Police Housing Construction Corporation and Kerala State Nirmithi Kendra.

equipment for a few CHCs and equipment for the remaining CHCs would be given according to availability of funds.

1.2.8.2 Construction of buildings for Sub Centres

Construction of buildings for 50 Sub Centres had not yet been started

In order to provide their own buildings to 2020 SCs, which were functioning in rented buildings, GOI approved in the Programme Implementation Plan for 2007-08, construction of buildings for 50 SCs at an estimated cost of Rs 3.30 crore (Rs 6.60 lakh per SC) and for the balance 1970 SCs during the subsequent years (2008-09: 700 and 2009-10: 1270). However, the construction of buildings was not taken up as of September 2009 as priority was given to CHC upgradation.

Government stated (September 2009) that the District Programme Managers had been instructed to submit proposals for upgradation of SCs under their jurisdiction and the work would be prioritised after the receipt of these proposals.

1.2.8.3 Deficiencies in the selected institutions

During field visits to the selected institutions in the sample districts, the following deficiencies were noticed:

- The blood storage centre at the Taluk Headquarters Hospital, Ottappalam, Palakkad, for which Rs 1.55 lakh was spent during 2006-07, had not started functioning due to the absence of a trained blood bank technician. Government stated (September 2009) that the technician would be given training shortly.
- An outpatient block completed in March 2009 at a cost of Rs 25.26 lakh for CHC, Kadampazhipuram, Palakkad was not fully utilized due to shortage of specialist doctors and paramedical staff. Government stated (September 2009) that the outpatient wing was currently functional and an attempt was being made for getting the services of specialist doctors.
- Equipment viz., incubators, suction apparatus, etc., purchased in December 2008, at a cost of Rs 10 lakh, for renovation of the children's ward at the Taluk Headquarters Hospital, Ottappalam, Palakkad was not utilised as of April 2009, due to lack of three-phase electrification. Purchases were made without ensuring availability of space and usability of the equipment. Government stated (September 2009) that action was under way for getting three-phase electrical connection to operate the equipment and that furniture and other items had been distributed.
- A hospital building for the Taluk Headquarters Hospital, Sulthan Bathery, Wayanad, constructed at a cost of Rs 1.75 crore (Rs 50 lakh from NRHM funds) had started functioning from June 2008. However, the operation theatre, laboratory and Intensive Care Unit set up at a cost of Rs 34 lakh in October 2008 could not be made functional as of May 2009 due to shortage of staff. Government stated (September 2009) that staff had been posted under NRHM and the facilities were currently functioning.
- Non-posting of specialist doctors resulted in decrease of outpatients and non-utilisation of facilities viz., a fully equipped mini-operation theatre,

a labour room and an in-patient ward in PHC, Panamaram, Wayanad. Similarly, the operation theatre and labour room in CHC, Porunnannur, Wayanad was idling due to shortage of doctors. Government stated (September 2009) that efforts were being made to address the problem of shortage of doctors.

1.2.8.4 Accredited Social Health Activist scheme

ASHAs were not given five prescribed modules of training as provided in the guidelines

One of the key components of NRHM is to provide every village in the country with a trained female Accredited Social Health Activist (ASHA), accountable to the village. According to the guidelines, 28,757 ASHAs selected during 2007-08 and 2008-09, were to be imparted 23 days' training in five prescribed modules. However, training was imparted to 20,680 ASHAs in the first module, 16,180 ASHAs in the second module and 800 ASHAs in the third module during 2007-09. It was noticed that in the three selected districts, the third to fifth module training was not given to any of the selected ASHAs as of March 2009. The SMD stated that as of July 2009, 27,024 ASHAs were trained in the first module, 17,817 ASHAs in the second module and 1,720 ASHAs in the third module. As ASHAs were expected to create awareness on health and mobilise the community towards local health planning, it was necessary to give them training in all the five modules. Government stated (September 2009) that the training was in progress. Imparting training in five modules to a such a large number of ASHAs would take time. Lack of complete training could interfere with the purpose for which the ASHAs had been recruited.

1.2.8.5 Mobile medical units

Under NRHM, financial assistance[33] was to be provided for establishment of one Mobile Medical Unit[34] (MMU) for every district for improving health services in medically under-served remote areas. In the Programme Implementation Plan for 2006-07, GOI approved Rs 1.55 crore towards the capital cost of one MMU and recurring costs for 14 MMUs including the 13 MMUs already in use in seven districts. In the Programme Implementation Plan for 2007-08, GOI approved Rs 5.12 crore for 13 MMUs. However, no allocation of funds was made to the DHSs for purchase of the vehicles and for meeting the recurring charges of the MMUs, which resulted in the amount remaining unutilised. Government stated (September 2009) that Rs five crore had been released during 2008-09 to the Kerala Medical Services Corporation Limited for procurement of MMUs.

1.2.8.6 Deficiencies in upgradation of CHCs and PHCs compared to IPHS norms

NRHM envisages bringing of health institutions at par with IPHS to provide round-the-clock services. In order to ascertain the facilities available, Audit obtained relevant information through questionnaires from 71 CHCs and 83 PHCs from all the districts. Audit scrutiny revealed the following:

---

[33] Rupees 25.25 lakh per MMU towards capital cost and Rs 9.25 lakh per annum towards recurring charges.

[34] Two vehicles (a 10-seater passenger carrier to transport medical/ para-medical personnel and the second vehicle for carrying equipment/accessories with basic laboratory facilities) with Medical Officer: 2; Nurse:1; Laboratory Technician:1; Pharmacist: 1; Helper:1 and Driver: 2.

- ***Manpower***

Forty nine CHCs did not have any specialists as per norms

As per IPHS norms, seven specialists[35] and nine staff nurses with supporting staff were required in each CHC. Forty nine CHCs did not have any specialists, while 21 CHCs had less than the prescribed number of specialists and only one CHC had the full complement of specialists. As regards staff nurses, nine CHCs had nine or more staff nurses, 57 had less than nine and four CHCs had no staff nurse.

Ten PHCs did not have a full time Medical Officer

According to IPHS norms, each PHC was required to have a Medical Officer, three staff nurses, one Pharmacist and one Laboratory Technician. Ten PHCs did not have a full time Medical Officer. Eleven PHCs had three or more staff nurses, while 42 had less than three and 30 did not have any staff nurse. It was also noticed that 79 PHCs did not have a Laboratory Technician, while 10 did not have a Pharmacist.

Government stated (September 2009) that every effort would be made to ensure adequate number of doctors in the institutions and to fill up regular vacancies.

- ***Infrastructure***

NRHM envisages providing of 30 beds for in-patients in each CHC together with other facilities[36]. Information furnished by 71 out of 115 CHCs revealed that 22 CHCs had bed strength in excess of 30 and 35 CHCs had bed strength less than 30. Fourteen CHCs did not furnish the relevant information. The number of CHCs out of these 71 CHCs, where infrastructural facilities were not available, are given in the following table:

Table 1.10: Non-availability of infrastructural facilities

Facilities not available	Number of CHCs
Blood storage	70
ECG	60
Labour room	29
Operation theatre	39
X-ray	62
24 hour emergency services	30

Source: Details collected through questionnaires from 71 CHCs

- ***Equipment***

Twenty seven CHCs did not have even 50 *per cent* of the major equipment required for operation theatres

According to IPHS norms, 10[37] major types of equipment are necessary to make an operation theatre (OT) operational. Out of 32 CHCs which had operation theatres, 27 did not have even 50 *per cent*[38] of equipment in the OTs.

Government stated (September 2009) that the deficiencies in infrastructural facilities and equipment pointed out by Audit were being addressed.

---

35 One post each of Anaesthetist, General Surgeon, Gynaecologist/Obstetrician, Ophthalmic Surgeon, Paediatrician, Physician and Public Health Programme Manager.

36 Operation theatre, labour room, X-ray, blood storage facility, 24 hour emergency services, wards, telephone, etc.

37 Air conditioner, Boyle's apparatus, cardiac monitor, defibrillator, emergency lamp, EMO machine, fumigation apparatus, generator, oxygen cylinder and ventilator.

38 Boyle's apparatus, cardiac monitor, defibrillator, oxygen cylinder and ventilator.

1.2.9 Procurement

A standardized procurement procedure was essential for the SHS to operationalise best practices to ensure transparency and public accountability and to facilitate a systematic approach in decision-making. During 2007-08 and 2008-09, the SHS purchased surgical kits, ASHA drug kits and other drug kits from M/s. Karnataka Antibiotics and Pharmaceuticals Limited (KAPL), a Central Public Sector Enterprise. Details are given in the table below:

Table 1.11: Details of purchase of kits

Sl. No	Details of item	Quantity supplied (numbers)	Period of supply	Date of agreement	Due date of completion of supply as per agreement	Amount (Rs in crore)
1.	Surgical kits	245[39]	August to September 2007	17 May 2007	28 July 2007	33.54
2.	Surgical kits	245[39]	April 2008	24 November 2007	12 March 2008	
3.	ASHA drug kits	8450	November 2008 to January 2009	29 September 2008	30 November 2008	6.69[40]
4.	Drug kits	6218[41]	April to May 2007 November and December 2007 August to November 2008	3 February 2007 (First supply order) 3 August 2007 (Second supply order) 17 June 2008 (Third supply order)	31March 2007 31 October 2007 31 July 2008	26.14

Source: Records from the State Health and Family Welfare Society

1.2.9.1 Procedural irregularities

Guidelines prescribed by GOI for procurement were not followed

- The procurement guidelines issued by the Ministry of Health and Family Welfare in July 2006 for the RCH II project envisages different methods for procurement like open tenders, limited tenders, global tenders, etc. However, the single tender system was to be adopted only for drugs and equipment which were of proprietary nature or where only one particular firm was the manufacturer of the item demanded. Also, the Purchase Preference Policy approved by GOI in August 2006, envisaged procurement of 102 medicines manufactured by Pharma Central Public Sector Enterprises (CPSEs) and their subsidiaries, either by inviting limited tenders or by purchasing directly at rates certified by the National Pharmaceuticals Pricing Authority with discounts up to 35 *per cent*. However, for purchase of surgical kits and drug kits, the single tender system was adopted and for ASHA drug kits, the limited tender system was adopted, though various options were available as per the procurement policy. Moreover, the entire purchase was made from a single firm, viz. KAPL.

No pre-despatch or post-despatch inspection was conducted

- Conditions of agreement for supply of surgical kits, ASHA drug kits and drug kits specify pre-despatch and/or post-despatch inspection by the purchaser. Final payments are to be made only after the receipt of final acceptance certificates from the district Stores-in-charges. Scrutiny of records in the Family Welfare Stores at the three districts test-checked revealed that no pre-despatch or post-despatch inspections

[39] One kit per CHC for 115 CHCs and two kits per First Referral Unit (FRU) for 65 FRUs.
[40] Rs 7923 per kit (Basic price: Rs 7370 plus Central Sales Tax of Rs 295 plus administration charges of Rs 258 at 3.5 *per cent* of basic price).
[41] SCs: 5094 kits, PHCs: 829 Emergency Obstetric Care (EOC) kits, CHCs and Block PHCs: 230 RTI/STI drug kits and FRUs: 65 EOC kits.

were conducted by the SHS or by the DHSs to ensure quality, quantity and workability of the supplied material. However, the final payments were released by the SHS/DHSs despite getting reports of short supply and damages. In reply, Government stated (September 2009) that the damaged items of the kits had been immediately replaced by KAPL.

Penalty was not levied for belated supplies amounting to Rs 3.18 crore

- According to the agreement conditions, a penalty equivalent to one *per cent* of the price of the delayed goods for each week of delay in supply was leviable from the suppliers, subject to a maximum of 10 *per cent* of the cost of delayed goods. There were delays of three to eight weeks in supply of surgical kits, one to five weeks in the case of ASHA drug kits and one to fourteen weeks in the case of drug kits. The penalty, leviable from KAPL in the above cases was Rs 3.18 crore[42]. Government stated (September 2009) the Governing Body of the SHS had resolved to exempt KAPL from the penalty clause as there were only minor delays in supplies for reasons like transport bottlenecks, strikes, lack of raw materials, etc. The reply cannot be accepted because the delay ranged from two to fourteen weeks (excluding the delay of one week) and Government should have invoked the penalty clause as per the agreement conditions.

1.2.9.2 Surgical kits and drug kits

Extra expenditure of Rs 1.99 crore was incurred due to indirect purchase

- Though the supply order was placed with KAPL, it was seen that the actual supply was made by another firm, viz. M/s.Plasti Surge Industries Private Limited, Amaravati, Maharashtra, on behalf of KAPL though there was no provision in the contract for subletting the contract. KAPL was allowed 6.8 *per cent* discount as per the invoice of M/s.Plasti Surge Industries kept in the records of three test-checked District Family Welfare Stores. However, KAPL had not passed on this discount to the SHS. The indirect purchase resulted in extra expenditure of Rs 1.99 crore[43] to the SHS and undue benefit of an equivalent amount to KAPL. Government stated (September 2009) that the in-house purchase policy of KAPL was not enquired into and the SHS had no knowledge of any private company through which KAPL had procured surgical kits and drugs kits. However, the fact remains that Government had incurred extra expenditure of Rs 1.99 crore.
- The SHS did not assess the actual requirement based on the sample survey conducted in September 2006 in all the CHCs before placing the order. In the Family Welfare Stores of the three districts test-checked, 26 out of 102 surgical kits had not been distributed to CHCs/First Referral Units as of March 2009. Physical verification done by Audit in two First Referral Units and three CHCs also revealed idling of seven surgical kits costing Rs 31 lakh.
- GOI instructed (December 2006) the State Government to procure the drugs from primary manufacturers following the Purchase Preference Policy for 102 medicines. The kits were to be formed by the State after procuring the drugs separately and this process was to be completed by

[42] ASHA drug kits: Rs 0.13 crore, surgical kits: Rs 1.75 crore and drug kits: Rs 1.30 crore.
[43] 6.8 *per cent* of Rs 29.29 crore = Rs 1.99 crore.

15 February 2007. However, the State Government purchased (January 2007) drug kits from KAPL directly instead of purchasing the drugs separately from primary manufacturers and making their own kits. In response, Government stated (September 2009) that kitting required a long process i.e. procuring the stores, assembling them in godowns, and kitting using semi-skilled and unskilled labourers. This would involve huge investment and therefore readymade kits were purchased. The reply of the Government is not acceptable because the purchase of readymade kits was against the instructions of GOI.

1.2.9.3 ASHA drug kits

- Limited tenders were invited from Pharma CPSEs[44] in April 2008 by the SHS. After opening the technical bids, the Technical Committee rejected the bids of three Pharma CPSEs because a criminal case was pending against HAL and the required documents had not been submitted by IDPL and BCPL. However, the technical bid of KAPL was accepted as it had furnished product permits for two tablets (Albendazole and Paracetamol) and had agreed to supply the other items from reputed Good Manufacturing Practice (GMP) Companies. It was seen that the financial bid of KAPL was accepted without any negotiations to reduce the rates as envisaged in the Purchase Preference Policy because it was the only firm which qualified for the financial bid. Moreover, the need for going in for the two-bid system of selection of vendor in the purchase of common medicines for ASHA kits was not justifiable. This clearly indicated that KAPL was favoured by the SHS. Government stated (September 2009) that all the three CPSEs whose bids were examined did not submit product permits for all the products. The Technical Committee decided to open the financial bid of KAPL based on an undertaking given by it that it would procure the drugs from reputed GMP companies. Though negotiations were held with KAPL, it did not agree to reduce the rates. The procurement order was issued to KAPL based on the decision of the Governing Body of SHS.

Extra expenditure of Rs 1.79 crore was incurred due to indirect purchase

- Though the supply order was placed with KAPL, it was seen that the actual supply was made by M/s.Vimal Labs Private Limited, Indore on behalf of KAPL. As per the invoices of the Indore based firm kept in the stores of the three test-checked District Family Welfare Stores, the rate quoted for each ASHA drug kit was Rs 5250 and this amount was entered as the cost in the stock register. However, the basic price quoted by KAPL and paid by the SHS was Rs 7370. Thus, the SHS incurred extra expenditure of Rs 1.79 crore[45] and provided undue benefit of an equal amount to KAPL. Government stated (September 2009) that the in-house purchase of KAPL had not been enquired into by them.

[44] Bengal Chemicals and Pharmaceuticals Ltd (BCPL), Hindustan Antibiotic Ltd (HAL), Indian Drugs and Pharmaceuticals Ltd (IDPL) and Karnataka Antibiotics and Pharmaceuticals Ltd.

[45] Rs 2120 x 8450 kits = Rs 1.79 crore.

The SHS did not apply the principles of financial propriety in the selection of KAPL for the supply of surgical kits and ASHA kits as procedures were violated, quality of materials were not assessed and finally the procured surgical and drug kits were not utilised in full.

1.2.10 Performance Indicators

NRHM prescribes national targets for reducing the Infant Mortality Rate (IMR), the Maternal Mortality Rate (MMR) and the Total Fertility Rate (TFR), as well as reducing the morbidity and mortality rate and increasing the cure rate of different endemic diseases covered under various national programmes. State-specific targets were not prescribed by GOI, as different States were at different levels of achievement/performance at the beginning of the Mission period. The targets fixed by the SHS for 2007-08 to 2011-12 were as below:

Table 1.12: Performance indicators

Indicator	2006-07 Current level (actual figures)	2007-08	2008-09	2009-10	2010-11	2011-12
Infant Mortality Rate (per 1000 live births)	12	12	12	11	10	9
Maternal Mortality Rate (per 1,00,000 live births)	110	75	65	50	40	30
Total Fertility Rate (per woman)	1.9	1.8	1.8	1.7	1.7	1.6

Source: Reproductive and Child Health Project Implementation Plan of SHS for the year 2007-08

As the SHS had not evolved a mechanism to ascertain whether the targets fixed were achieved at the close of the respective years, audit could not ascertain the extent of achievement against the targets fixed.

1.2.10.1 Maternal health

Micro-birth plan for each beneficiary of *Janani Suraksha Yojana* was not drawn up

The important services which ensure maternal health are antenatal care, institutional delivery, post-natal care and referral services. It is essential to register all the pregnant women before they attain 12 weeks of pregnancy and provide them with three antenatal check-ups, 90 or more iron-folic acid (IFA) tablets, two doses of Tetanus Toxoid (TT) and advice on correct diet and vitamin supplements. It is mandatory for a Junior Public Health Nurse to prepare a micro-birth plan at the SC level for each beneficiary of the *Janani Suraksha Yojana* (JSY), containing dates of antenatal checkups and TT injections, identification of the health centre for referral services, the place of delivery, expected date of delivery, etc. Audit scrutiny revealed that micro-birth plans were not drawn up in any of the selected 24 SCs.

- In the selected districts (Palakkad, Thiruvananthapuram and Wayanad), out of 5,14,139 pregnant women registered, only 4,30,156 received three antenatal check ups during 2005-06 to 2008-09. In these districts, there were no significant variations over the years in the number of pregnant women receiving three antenatal check ups.
- Although all the pregnant women registered were required to be provided with IFA tablets for 100 days, shortfalls ranging from 16 to 44 *per cent* were noticed during 2005-06 to 2007-08.

- During 2007-08 and 2008-09, Rs 23.95 lakh was disbursed to 7,985 beneficiaries in three Taluk Hospitals and two District Hospitals towards transportation cost under JSY, which was inadmissible.
- The percentage of institutional deliveries of pregnant women registered at the hospitals in the selected districts ranged from 77 to 96 in Palakkad, 61 to 104 in Thiruvananthapuram and 85 to 89 in Wayanad.

1.2.10.2 Immunisation

Routine immunisation

The immunisation of a child against six preventable diseases, namely, tuberculosis, diphtheria, pertussis, tetanus, polio and measles has been the cornerstone of routine immunisation in the State. During 2005-06 to 2007-08, the State had achieved 95 to 99 *per cent* success in pulse polio immunisation. However, immunisation in respect of other diseases showed wide variations ranging from 53 to 85 *per cent* in the test-checked districts during 2007-09. The targets and achievements of Diphtheria (DT) and TT immunisation carried out during 2005-09 are given in **Appendix I**.

During 2005-09, 2,82,887 children between 0-1 age group were not fully immunised

As per information furnished by the Director of Health Services, during 2005-06 to 2008-09, 19,30,592 out of 22,13,479 children between the 0-1 age group were administered full vaccines *viz.* BCG, Measles, Diphtheria, Pertussis and Tetanus (DPT) and Oral Polio Vaccine (OPV), leaving 2,82,887 children uncovered. The percentage of fully immunised children was in the range of 85 to 88 *per cent* during the period and did not show significant variations.

It was seen that DT coverage of children above five years declined steadily during 2005-06 to 2008-09 from 94 to 60 *per cent*. TT to children of 10 years and 16 years also declined during 2005-06 to 2007-08, but showed an increase during 2008-09.

Government stated (September 2009) that long periods of vaccine shortage occurred in 2007-08 and 2008-09 due to inadequate supply from GOI.

Shortfall in administering Vitamin A solution

The RCH-II programme emphasizes administering of Vitamin A solution to all children below three years of age. Prophylaxis against blindness amongst children due to deficiency of Vitamin A requires the first dose at nine months of age along with the measles vaccine, the second dose along with DPT/OPV and the subsequent three doses at six-monthly intervals.

Percentage of children supplied with all five doses of Vitamin A solution declined

Scrutiny of records in the three test-checked districts revealed a steady decline in the percentage of children supplied with all five doses during 2005-06 to 2008-09, the details of which are given in **Appendix II**. The main reason for the steady decline was the short supply of Vitamin A at health centres.

Government stated (September 2009) that the shortfall in administering Vitamin A solution was due to stoppage of supply by GOI from 2007-08.

1.2.10.3 Health Management Information System

An effective Integrated Health Management Information System was not set up though hardware and software were procured for Rs 4.70 crore

As per NRHM guidelines a health information system is to be in place for facilitating the smooth flow of information and for effective decision-making. The SHS purchased 1033 computers along with printers and UPS at a cost of Rs 3.64 crore for this purpose and supplied them to CHCs and PHCs in February 2008. The application software (MS Office 2007) was procured at a cost of Rs 1.06 crore during July 2008.

The SHS adopted the following multiple software applications:

- Health Management Information System (HMIS) viz., DHIS 2 developed by M/s HISP India Limited, a non-government organisation working in collaboration with the University of Oslo, Norway.
- A dynamic web-based surveillance system for monitoring disease incidence for the Integrated Disease Surveillance Project on a weekly basis.
- A Geospatial Kerala Health Information System developed by the Kerala State Remote Sensing and Environment Centre for tracking the spread and frequency of diseases and
- An MS-excel based format for data collection on diseases on daily basis by the State Disease Control and Monitoring Cell.

All these applications were independently operated by various users despite requiring common data sets relating to health parameters for their operation.

Instead of integrating various vertically driven information systems to create a single window system for data entry and report generation, the SHS developed multiple applications with common modules that resulted in data redundancy, duplication in data entry and increase in the workload at all levels. The State Data Officer stated (July 2009) that action was under way to integrate the systems of the Integrated Disease Surveillance Project and the State Disease Control and Monitoring Cell with the SHS.

1.2.10.4 Integrated Disease Surveillance Project

The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect early warning signals of impending outbreaks and to help initiate an effective response in a timely manner. Surveillance units were set up at the Central, State and district levels with linkages with all State headquarters, district headquarters and all government medical colleges on a Satellite Broadband Hybrid Network. Data is collected on a weekly (Monday–Sunday) basis. Whenever there is a rising trend of illness in any area, it is investigated by the Medical Officers/Rapid Response Teams to diagnose and control the outbreak. Data analysis and action are to be undertaken by the respective districts. The total cost of the project was Rupees nine crore, of which GOI released Rs 4.82 crore up to 2008-09. The expenditure incurred on the project was Rs 2.74 crore.

Hardware and accessories procured for Rs 54.82 lakh for IDSP were lying idle

All the 14 District Surveillance Units (DSU) were supplied with hardware accessories costing a total of Rs 21.06 lakh. Civil works for video-conferencing units were also completed in the districts at a cost of Rs 19.60 lakh. Accessories were also supplied to State Surveillance Units

(SSU) and seven[46] medical colleges at a cost of Rs 33.76 lakh. Necessary manpower was also provided to all DSUs and SSU. However, the video-conferencing unit at the State level had not been set up as of March 2009 as the Director of Health Services had not provided space for this. Consequently, hardware and accessories procured for Rs 54.82 lakh and the civil works executed at an expenditure of Rs 19.60 lakh, besides the manpower, remained idle. Moreover, the intention of the Government of detecting impending outbreaks and initiating an effective response could not be achieved. Government stated (September 2009) that the video-conferencing unit would be set up as soon as the civil works were completed within two months' time.

1.2.11 Information, Education and Communication activities

'Radio Health' launched by DHS, Thiruvananthapuram in September 2008 aimed to create positive changes in the health habits and behaviour of people by ensuring wider community participation through interactive and innovative radio programmes. It mainly focussed on primary health care and preventive aspects of health by giving importance to all medical systems and alternative health practices. Up to 31 March 2009, 108 programmes of 30 minutes duration had been broadcasted. Ten Radio Health Clubs were also established in schools, colleges, residential associations, etc., in different locations and 31 meetings were also conducted. This model could be adopted in other districts also to propagate health care programmes. Other activities under the Information, Education and Communication like Health Melas in Assembly constituencies, school health camps, street plays, cultural programmes, etc., were also conducted by the SHS. Government stated (September 2009) that the Radio Health Programme had been well received by the community and had been appreciated at various fora of the Ministry of Health and Family Welfare as a true innovation.

1.2.12 Community participation

NRHM envisages involving communities in planning, implementation and monitoring through representatives of Panchayati Raj Institutions and community based organisations at each level. It also envisages formation of Village Health and Sanitation Committees in each village within the overall framework of the Grama Sabhas. However, the State Government decided (February 2007) to constitute Ward Health and Sanitation Committees (WHSC) at the ward level instead of at the village level. In all the 24 SCs under the three test-checked districts, WHSCs, had been constituted. However, no revolving funds for providing referral and transport facilities on emergency deliveries had been set up in any of the WHSCs though envisaged under the scheme. Government stated (September 2009) that it was a conscious decision to constitute Ward Level Committees within the overall framework of the local bodies in lieu of Village Level Committees as improved community participation was the key to success of the scheme.

[46] Co-operative Medical Colleges at Ernakulam and Pariyaram, Medical College Hospitals at Alappuzha, Kottayam, Kozhikode, Thiruvananthapuram and Thrissur.

1.2.13 Conclusion

Introduction of NRHM in Kerala has improved the fund flow to health institutions at various levels, upgraded infrastructure in health institutions and helped in facilitating their routine management. It has led to the creation of Ward Health and Sanitation Committees and Hospital Management Committees and innovations like 'Radio Health' in Thiruvananthapuram district to create health awareness.

Decentralised planning was crucial for implementation of the scheme but the planning process was flawed as Annual Action Plans were prepared without preparing the State Perspective Plan and without using field level data, obtained through household and facility surveys.

The execution of projects by the SHS without the Perspective Plan by specifying the project activities in a critical path resulted in the projects being implemented without adhering to the time schedule. Thus, the SHS could not spend the funds released by GOI, huge amounts were kept in bank deposits and the accounts were not finalised in time. Though funds were available, the entitled grants were not released to all the CHCs and PHCs. Release of funds to activities not approved by GOI was also noticed. Upgradation work of CHCs and SCs were proceeding at a slow pace and even the facilities created were not fully utilised. There were deficiencies in medical and para-medical manpower, infrastructure facilities and equipment in CHCs and PHCs in the State. Procurement of drugs, surgical equipment and computers for Rs 70.01 crore was made without observing the principles of financial propriety and distributed without assessing the requirements of institutions.

1.2.14 Recommendations

- The Perspective Plan should be prepared for the remaining Mission period by incorporating all the required strategies to achieve the objective of convergence of all health initiatives under one umbrella. Each activity should be executed along a critical path to achieve the desired result within the Mission period.
- The SHS and the DHSs should synchronise all their activities and integrate structurally to ensure sustainability of NRHM initiatives even after the Mission period.
- The State level Action Plan should be a part of the Perspective Plan and prepared only on the basis of consolidated Action Plans at the village, block and district levels so that actual requirements are projected.
- Proposals in the Action Plan should be made on the basis of the absorption capacity of the Mission and the funds released should be utilised without undue delays to avoid retention of huge balances in bank deposits.
- Corpus grants, maintenance grants and untied grants should be released annually to all the entitled health care institutions.
- Priority should be accorded to complete all the upgradation works for which GOI approvals have been received.
- Steps should be taken to fill up the regular vacancies of medical and para-medical staff in the CHCs and PHCs and post contractual staff

under NRHM as per requirements to achieve Indian Public Health Standards.

- The principles of financial propriety should be observed in all the procurement processes to avoid undue favour to the suppliers.
- The SHS should integrate various vertically driven information systems to create a one-point system for data entry and report generation that covers all its activities like accounting, manpower, health profile, stores, disease surveillance, etc. to provide online information for planning, execution and monitoring of the Mission.

Appendix I
Status of immunisation of children above five years
(Reference: Paragraph 1.2.10.2; Page: 35)

Year	DT (five years and above)			TT (10 years)			TT (16 years)		
	Target	Achieve-ment	Per-centage of achieve-ment	Target	Achieve-ment	Per-centage of achiev-ement	Target	Achieve-ment	Per-centage of achieve ment
2005-06	511619	481521	94	511619	510971	100	511619	499793	98
2006-07	529720	412516	78	540674	351349	65	534042	381515	71
2007-08	510667	379557	74	499154	318494	64	500816	263749	53
2008-09	531867	321659	60	462923	392050	85	462412	333149	72

Source: Health Statistics brought out by the Director of Health Services every year

Appendix II
Status of administration of Vitamin A solution to children
(Reference: Paragraph 1.2.10.2, Page: 35)

District audited	Year	Target	Actual achievement					
			1st dose	Per-centage	2nd dose	Per-centage	3rd to 5th dose	Per-centage
Palakkad	2005-06	48500	39435	81	37999	78	41564	86
	2006-07	47475	12222	26	11802	25	11767	25
	2007-08	47095	21742	46	22344	47	17044	36
	2008-09	47430	21523	45	18442	39	13955	29
Thiruvananthapuram	2005-06	59900	50061	84	49090	82	48042	80
	2006-07	60485	20698	34	19985	33	23700	39
	2007-08	61920	28010	45	27187	44	21355	34
	2008-09	57630	21305	37	20628	36	19108	33
Wayanad	2005-06	75180	13542	18	12498	17	12733	20
	2006-07	77480	4518	6	4132	5	7430	9
	2007-08	65418	8712	13	8428	13	5845	9
	2008-09	72125	7622	11	9227	13	7446	10

Source: Records of District Medical Officer of Health