- Stringent inspection of all on-going projects should be carried out regularly to avoid extra expenditure and to ensure timely utilisation of funds and derivation of benefits; and
- Monitoring mechanism should be more effective to ensure that intended benefits are derived by the Society/ targeted population and funds are utilised effectively for the intended purpose.

The matter was referred to the Department (August 2008); reply has not been received (October 2008).

HEALTH CARE, HUMAN SERVICES AND FAMILY WELFARE DEPARTMENT

3.4 National Rural Health Mission

A mid-term review of National Rural Health Mission (NRHM)in the third year of the Mission period (2005-2012) revealed that the State was performing fairly well in the areas of demographic goals (infant mortality rate, total fertility rate, immunisation etc.) and implementation of National Disease Control Programmes (NDCP) (control over blindness/ tuberculosis/ leprosy/ vector borne diseases etc.). The State has adequate physical infrastructure at the PHSC and PHC level and deployment of paramedical staff is adequate. However, the implementation of NRHM suffered from deficient financial management resulting in huge unspent balance to the tune of Rs. 44.43 crore (82 per cent) as on 31 March 2008. While the progress of civil works relating to the health infrastructure is very slow, health care remained mainly dependant on the health institutions of the Government due to very low number of private health facilities in the State and the number of referral cases to outside the State remained quite high.

Significant audit findings are given below:

Highlights:

Retention of huge unspent balance ranging from Rs. 1.60 crore to Rs. 44.43 crore at the year end indicated failure of the State Health Society (SHS) to optimally utilise the available funds.

(Paragraph 3.4.8)

The State Government had not released the State's share of Rs. 5.95 crore to the SHS indicating lower priority accorded to health sector.

(Paragraph 3.4.8.1)

The test-checked Community Health Centres (CHCs) were functioning with excess medical and paramedical staff, while five PHCs were functioning without the required paramedical staff.

(Paragraph 3.4.10.1)

The facility for indoor patients in CHCs and PHCs remained heavily underutilised due to lack of specialist medical care.

(Paragraph 3.4.11)

3.4.1 Introduction

The GOI launched (April 2005) the NRHM with the aim of providing accessible, affordable and quality health care to the rural population, especially the vulnerable sections of the society. It also sought to reduce the Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), Total Fertility Rate (TFR) and to bring about an improvement in the healthcare delivery system by converging various stand-alone disease control programmes under the umbrella of the Mission.

The key strategy of the NRHM was to bridge the gaps in healthcare facilities, facilitate decentralised planning in the health sector, provide an overreaching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programmes and Integrated Disease Surveillance Project. The Mission also advocated sanitation and hygiene, nutrition etc. as basic determinants of good health and thus emphasised convergence with related schemes/programmes for Women and Child Development, Allopathy, Yoga, Unani, Sidha and Homeopathy (AYUSH**)**, Panchayati Raj etc.

The Mission activities were divided into the following five essential components:

- Reproductive and Child Health (RCH II);
- Additionalities under NRHM;
- Immunisation;
- National Disease Control Programme;
- Inter-sectoral convergence for effective management and implementation.

3.4.2 Organisational set-up

At the State level, NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The activities of the Mission are carried out through the State Health and Family Welfare Society (Society) headed by the Chief Secretary (CS). The Executive Committee of the Society is headed by the Commissioner-cum-Secretary, Health and Family Welfare Department.

The Society integrates all the societies registered under the Societies Registration Act. 1860, which were set up for implementation of various disease control programmes.

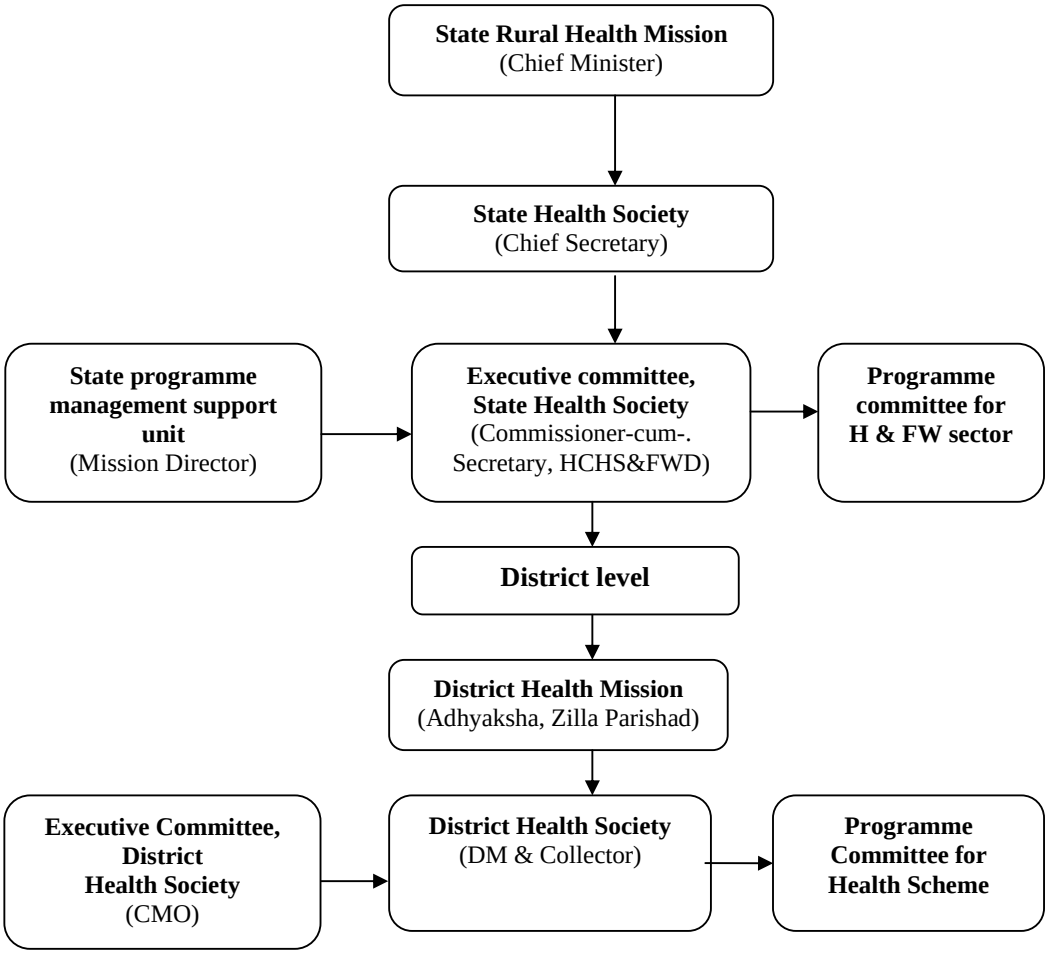
At the District level, there are District Health Missions headed by Adhyakshas of the Zilla Parishads and an integrated District Health Society (District Society) headed by the respective District Magistrates (DM) to support it and its executive committee is headed by the Chief Medical Officer.

The guidelines also provide for programme committees for more focused planning and review of each activity at State and District Level if considered

necessary for administrative convenience, which has also been formed in the State.

An organogram showing the administrative and monitoring set up of NRHM in the State is given below:

Chart No- 3.4.1



3.4.3 Scope of Audit

Performance review of NRHM for the period 2005-08 was conducted between April and June 2008 through a test check of the records of three out of four District Hospitals/Community Health Centres, six out of 24 Primary Health Centres and 12 out of 147 Primary Health Sub Centres. These samples were selected on the basis of allocation of funds by using Simple Random Sampling Without Replacement (SRSWOR) method**.** Besides this, records maintained by the State Health Society were also checked.

3.4.4 Audit objectives

The objective of the performance review was to assess whether accessible, affordable and quality health care was provided to the rural population through

the implementation of NRHM in the State. Besides, the following were also assessed:

- Adequacy and effectiveness of planning for effective programme implementation;
- Adequacy and effectiveness of fund management;
- Whether all the components of NRHM were implemented efficiently and effectively;
- Adequacy and effectiveness of the information, education, communication and community monitoring of the programmes;
- Adequacy and effectiveness of evaluation and monitoring mechanism.

3.4.5 Audit criteria

The following criteria were used to arrive at audit conclusions:

- Memorandum of Understanding (MoU) signed between the Union Ministry of Health and Family Welfare and the State Government;
- Programme guidelines issued by the GOI and approved Programme Implementation Plan;
- Finance and Accounts Manual;
- Sikkim Public Works Code Manual and Sikkim Financial Rules;
- Prescribed monitoring mechanism.

3.4.6 Audit Methodology

The performance review commenced with an entry conference (April 2008) with the Commissioner-cum-Secretary, HCHS & FW, Mission Director, SHS and departmental officers wherein the audit objectives, scope, criteria and methodology were discussed. Audit conclusions were drawn after a scrutiny of records relating to the implementation of various components of the programme for the years 2005-08 at SHS, CHCs, PHCs and PHSCs, analysis of available data, physical verification wherever found necessary, issue of questionnaires and replies of the Department. The report was finalised after taking into consideration the views put forth by the Department and the State Health Society (SHS) during an exit conference (September 2008).

Audit findings

Audit findings are enumerated in the succeeding paragraphs:

3.4.7 Planning

The Department delivers health care facilities through a network of public health care infrastructure[24]. Besides, health facilities are also available in the State through one Hospital-cum-Medical College[25], one hospital of NHPC,

[24] *147 PHSCs, 24 PHCs and 4 DH/CHCs and State Referral Hospital, Gangtok*
[25] *Central Referral Hospital, Tadong (a joint venture between the Manipal group and the State Government)*

one Regional Research Institute (Ayurveda) (GOI) and some[26] private medical practitioners.

The NRHM guidelines provided for decentralised planning and implementation to ensure that need based community owned District Health Action Plans (DHAP) become the basis for interventions in the health sector. The districts were thus required to prepare perspective plans for the entire mission period (2005-12) as well as annual plans by consolidation of Village Health Action Plans (VHAP). Audit noticed that:

- Prior to 2007-08 DHAP was not prepared. VHAP was also not prepared by Village Health Sanitation committees (VHSC)[27];
- Representatives of villages were not involved in preparation of DHAP;
- Household survey was conducted in 2007-08 without involvement of Accelerated Social Health Activists (ASHA), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers and PRIs as stipulated in the guidelines;

Thus, the entire expenditure of Rs. 3.63 crore released during 2007-08 in the three test-checked DHs/ CHCs was incurred without any VHAP. Besides, DHAP did not mention about the activities on strengthening of PHCs, ANM/General Nurse Midwife training schools, ambulance services, provision for telephones etc. Further, belated submission of PIP (144 days in 2007-08)[28] led to eventual savings of Rs. 44.43 crore as mentioned in paragraph 3.4.8.

The State Health Society (SHS) while accepting the fact stated (July 2008) that due to time constraints and deficiency in the training and capacity building of manpower, the district wise perspective plan and VHAP were not prepared prior to 2007-08 and that during 2007-08 the VHAP has been prepared with the involvement of ASHA, ANMs, Anganwadi Workers (AWW) and PRI members.

3.4.8 Fund Management

The expenditure under NRHM was fully financed by GOI till 2006-07 (in the Tenth Plan period) and thereafter in the ratio of 85:15 between the GOI and the State Government. Funds received and expenditure incurred under the programme during 2005-08 were as under:

[26] *East district=11, South district=7 and West district=2*

[27] *Village Health Sanitation Committee (VHSC) comprising of Panchayat representatives, Auxiliary Nurse Midwife (ANM), Multipurpose Health Worker (MHW), Aanganwadi Worker, Teacher, Accredited Social Health Activist (ASHA), Community Health Volunteers (CHV).*

[28] *PIP for 2007-08 submitted on 6 August 2007 against stipulated date of 15 March 2007. Date of submission of PIP for the year 2005-06 and 2006-07 were not available with SHS.*

Table 3.4.1

(Rupees in crore)

Year	Approved outlay	Opening balance	Funds received		Total funds available (Col.3+5)	Expen-diture	Unspent balance (Col. 6-7)
			Central	State			
1	2	3	4	5	6	7	8
2005-06	1.82	0.09	2.34	0.00	2.43	0.83	1.60 (66)
2006-07	33.18	1.60	10.28	0.00	11.88	3.08	8.80 (74)
2007-08	43.77	8.80	41.35	0.25	50.40	5.97	44.43 (88)
		Total	**53.97**	**0.25**		**9.88**	

Source: Figures furnished by the SHS

It is evident from the above table that the funds received from GOI were not fully utilised by the SHS. The unspent balance ranged between 66 and *88 per cent* of the available funds during the period 2005-08. The unspent balance was due to the fact that many of the interventions under the programme like upgradation of STNM hospital (Rs. 22.74 crore)**,** construction of residential quarters and conversion of PHCs to CHCs (Rs. 7.23 crore), release of untied funds (Rs. 1.24 crore), annual maintenance grant (Rs. 0.79 crore), timely issue of medicines (Rs. 1.25 crore), development and implementation of 'Routine Immunisation Monitoring System Software' (RIMSS) etc. were not implemented properly. This was due to poor monitoring and budgetary control besides unrealistic PIPs. Thus, SHS was unable to anticipate the expenditure realistically leading to unspent balance of Rs. 44.43 crore as on 31 March 2008, affecting the programme implementation and negative response of health care services envisaged under NRHM.

The SHS stated (September 2008) that the funds were not fully utilised due to their late receipt and belated approval of PIPs. The reply is not acceptable as the unspent balance of 2006-07 was not fully utilised even in 2007-08. Besides, the SHS failed to utilise the entire funds of Rs. 41.60 crore received in subsequent year i.e. during 2007-08. The SHS could not provide the details relating to date of submission of PIP during 2005-07. Therefore it could not be verified if indeed there was a delay in approval of the PIPs.

3.4.8.1 State's matching contribution

As mentioned in paragraph 3.4.8, the programme expenditure was to be shared between the GOI and the State in the ratio of 85:15 from 2007-08. As against its share of Rs.6.20[29] crore, the State Government released only Rs. 25 lakh indicating low priority accorded to provision of health care facilities.

The SHS stated (September 2008) that the matching contribution was not made in full due to the delayed approval of PIP (July 2007) and the consequent difficulty in anticipating the required provision to be made in its budget. But the fact however, remains that the State's matching contribution fell short by 96 *per cent*.

3.4.8.2 Untied funds and annual maintenance grant

Every year untied fund at the rate of Rs. 10,000 to each VHSC and PHSC, Rs.25,000 to PHCs and Rs.50,000 to CHCs of the State was to be provided for undertaking nutrition, education and sanitation, environmental protection,

[29] *15 per cent of Rs.41.35 crore = Rs.6.20 crore*

public health measures and community activities. Similarly, annual maintenance grant of Rs. 10,000, Rs. 50,000 and Rs. 1,00,000 was to be paid to the PHSCs, PHCs and CHCs respectively.

The following was observed in this regard:

- During 2005-06 and 2006-07 no untied fund was released to any of the 452 VHSCs in the State. However, an amount of Rs.45.90 lakh was released to VHSCs from December 2007 to March 2008.
- There are four CHCs, 24 PHCs and 147 SCs in the State. Accordingly,

untied grant of Rs. 68.10 lakh and annual maintenance grant of Rs. 92.10 lakh was required to be released during 2005-08. However, the SHS released untied grant of Rs. 33.50 lakh and annual maintenance grant of Rs. 12.75 lakh to CHCs, PHCs and PHSCs. Further, it would be seen from the photographs that if timely annual maintenance grants were released to CHCs and PHCs, proper up keep of facilities like kitchen, toilet etc. could have been done. Thus non-release of grant affected the objectives of the programme. The SHS stated (September 2008) that non-release of untied fund and maintenance grant was due to delayed formation of VHSC.

3.4.8.3 Delay in release of funds

Out of Rs. 53.97 crore released by the GOI during 2005-06 to 2007-08, Rs. 33.78 crore (63 *per cent*) was released at the fag end of the respective financial years. As per the programme guidelines, funds received from GOI should be released to the implementing authorities within 15 days of receipt. But the SHS released the amount to the executing authorities after delays ranging from 23 to 201 days. Delay in release of funds by the Central to the SHS and its release to the executing authorities created uncertainties in implementation of programme activities at the field level. The SHS stated (July 2008) that delay occurred due to non-receipt of funds from GOI on time and its subsequent reallocation to various major and minor heads. The reply ignores the fact that there was an unutilised balance at the end of each year with the SHS which could have been utilised for the programme after obtaining approval from the GOI.

Programme Implementation

3.4.9 Infrastructure

3.4.9.1 Establishment of health centres

Effective implementation of a programme for delivery of rural health care services depends upon proper planning for establishment of health centres and provision of requisite manpower and infrastructure. According to GOI norms for establishment of rural health centres in hilly and tribal areas, one SC, one PHC and one CHC are to be established for every 3,000, 20,000 and 80,000 population respectively. The position in the State in this regard is tabulated below:

Table 3.4.2

Institutions	Particulars	State	Districts			
			East	North	South	West
Population as per 2001 census		4,80,488	1,91,803	39,775	1,27,560	1,21,300
CHCs	Required	6	2	1	2	1
	Existed	4	1	1	1	1
	Shortage (-) /Excess (+)	**(-) 2**	**(-) 1**	-	**(-) 1**	-
PHCs	Required	24	10	2	7	6
	Existed	24	8	3	7	6
	Shortage (-) /Excess (+)	-	**(-) 2**	**(+) 1**	-	-
PHSCs	Required	160	64	13	46	40
	Existed	147	48	19	41	39
	Shortage (-) /Excess (+)	**(-) 13**	**(-) 16**	**(+) 6**	**(-) 5**	**(-) 1**

Source: Sikkim Health Information Bulletin, Sikkim 2005

It would be seen from the above that there was a shortage of PHSCs and DHs/ CHCs in the State, especially in the East district affecting easy accessibility of health care to rural populace.

The SHS stated (September 2008) that there is no shortage of health centres in three districts[30] if the urban population is excluded from the total population. Reply is not tenable as only the rural population of 4,80,488 in the State has been taken into account in audit to arrive at the shortage.

3.4.9.2 Non-commencement of construction works

Construction of CHCs/PHCs/PHSCs buildings and residential quarters costing Rs. 7.23 crore was approved by the GOI during 2007-08. However, construction of these works could not be taken up as of March 2008 for want of administrative approval, tendering etc. The main works where the construction had not commenced include conversion of two PHSCs into PHC at Bermoik and Hee-Gyathang, construction of residential quarters at East, West and South district[31] for doctors and staff. This affected health care

[30] *East, West and South district*

[31] *East district: Pakyong, Samdong, West district: Rinchempong, Hee-Gaythang, Sombaria, Yuksom , South district: Namthang, Bermoik, Namthang*

facilities like basic emergency obstetric care and sick neonatal and child care. The SHS accepted (July 2008) the audit observation.

3.4.9.3 Non-utilisation of Mobile Medical Units (MMUs)

In order to deliver health care facilities in rural areas of the State, National Programme Coordination Committee (NPCC) approved (December 2006) procurement of four Mobile Medical Units (MMU) at a cost of Rs. 2.72 crore. The SHS procured (April 2008) four MMUs equipped with the essential equipment at a cost of Rs. 1.92 crore. However, from the date of their receipt, the MMUs were lying unutilised due to non-availability of adequate and skilled manpower[32] for sonography and other supportive services. As a result, the targeted beneficiaries were deprived of the health care facilities at their doorsteps as intended in the programme guidelines.

The SHS stated (September 2008) that requisite manpower has been recruited and MMUs have been functional from August 2008.

3.4.9.4 Upgradation of STNM hospital

To augment the medical facilities of STNM hospital at Gangtok in terms of equipment/instruments under NRHM, a project amounting to Rs. 22.74 crore was prepared and submitted to the GOI (September 2006) for financial sanction. The GOI released Rs. 22.01 crore (Rs. 11.01 crore in March 2007 and Rs. 11 crore in March 2008). It was observed that Notice Inviting Tenders (NIT) was issued for but the purchase of medical equipment/instruments had not materialised as of March 2008 due to delay in finalisation of bid document and tender formalities. Thus, the objectives of the mission for providing health care facilities were not achieved. While accepting this, the SHS stated (September 2008) that tender formalities have since been completed and supply orders issued (August 2008).

3.4.10 Human infrastructure

3.4.10.1 Deployment of Manpower

According to Indian Public Health Standards (IPHS), there should be four Medical Officers (MOs) and 19 para medical staff in each CHC, one MO and 12 para medical staff in each PHC and two Health Workers (one male and one female) in each PHSC. The actual deployment and shortfall vis-à-vis the requirement of manpower in DHs/ CHCs, PHCs and PHSCs of the three selected districts is shown in **Appendix-3.2.**

It would be seen from the Appendix that in the CHCs there was excess deployment of MOs and paramedical staff ranging from 125 to 550 *per cent* and 76 to 433 *per cent* respectively. This excess deployment resulted in under utilisation of MOs and paramedical staff. In two PHCs out of 24, there was excess deployment of MOs ranging from 100 to 300 *per cent*. In five PHCs, the shortfall in deployment of paramedical staff ranged between 7 and 71 *per cent*. In two PHSCs, there was 100 *per cent* excess deployment of health workers (Male and Female). This unequal deployment of paramedical staff led to irrational workload on the existing work force besides affecting the quality of work and service delivery relating to health care at the places where there

[32] *Two medical officers, one radiologist or one medical officer*

was shortfall in deployment of staff. The SHS stated (September 2008) that redeployment would be made.

3.4.10.2 Deployment of Doctors and Nurses

Analysis revealed that deployment of doctors, para-medicals and others in PHSCs, PHCs and CHCs had no relation with that of total population, patients' turnout or even the identified cases as shown below:

Table- 3.4.3

Particulars	GOI norms*	Deployment ratio**				
		State as a whole	East	West	North	South
Population/Doctor	3,500	2018	1354	4402	2735	2989
Population/Nurse	5,000	2908	1929	5869	2931	5480
Population/ANM	1,000	1494	1467	1926	1578	1253
Population/Health Workers	3,000	2075	2188	1688	1001	1906
Population/Health Assistant	20,000	20404	17503	20543	13677	18789
Population/Lab Technician	10,000	10931	8751	12326	10257	11957

Source: Annual Report of 2007-08

** One post catering to the designated population size.*

*** Figures indicate the population catered to by one post.*

It can be seen from the table above that there were wide inter-district variations in deployment of doctors, nurses, health workers etc. While East district had higher concentration of nurses (1929:1), South and West districts were deprived due to less deployment of nurses.

Further, test check of three CHCs and six PHCs also confirmed irrational deployment of nurses and ANMs as shown below:

Table 3.4.4

Name of the District	Name of the CHCs/PHCs	Requirement		Actually deployed		Excess (+) Shortfall(-)	
		SN	ANM	SN	ANM	SN	ANM
East	Singtam CHC	9	-	10	-	(+)1	-
	Machang	-	3	-	3	-	-
	Sang	-	3	-	3	-	-
West	Geyzing CHC	9	-	8	10	(-)1	(+)10
	Dentam	-	3	-	4	-	(+) 1
	Yuksam	-	3	-	-	-	(-) 3
South	Namchi CHC	9	-	23	47	(+)14	(+)47
	Yangang	-	3	-	4	-	(+)1
	Jorthang	-	3	-	5	-	(+)2
Total		**27**	**18**	**41**	**76**	**(+) 14**	**(+) 58**

Source: Figure furnished by the concerned health institution

It would be seen from the above table that 41 SNs and 76 ANMs were posted against the requirement of 27 SNs and 18 ANMs in three CHCs (three CHCs test checked out of four in the State) and six PHCs (six PHCs test checked out of twenty four in the State). The excess was more pronounced in CHC, Namchi (23 against nine SNs and 47 against nil ANMs) and followed by CHC Gyalshing (10 against nil ANMs). Thus, excess posting of 14 SNs and 58 ANMs resulted in extra outgo of Rs. 24.60 lakh per annum towards pay and allowances[33]. While admitting the excess deployment of ANMs, the SHS

[33] *Calculated at the minimum of the pay scale: SN Rs.5000 plus DP, DA, HRA and SBHA =*

stated (September 2008) that ANMs would be redeployed when sufficient SNs would be available in the State.

3.4.10.3 Periodical visits by doctors

According to IPHS, doctors of PHCs were required to visit each PHSCs at least once in a month. It was noticed during audit of 12 selected PHSCs that periodical visit of doctors was ranging between two and eight days in a year.

The Medical Officers in-charge stated (May 2008) that due to work load, regular visits could not be carried out. Reply is not tenable as assessment of the work load on PHCs revealed that the average number of outdoor patients per day in PHCs/CHCs ranged between 15 and 124[34] and average number of indoor patients per day was less than one in the PHCs (except Jorethang PHC). The MOs were not overburdened and thus due to their irregular visits, the rural people of 12 PHSCs were deprived of medical facilities.

3.4.11 Poor outturn of patients

The PHCs and CHCs were established to provide health care facilities to both indoor and outdoor patients. The position of indoor patients in the test checked PHCs and CHCs in three selected districts during 2005-08 is given below:

Table 3.4.5

Name of the district	Name of the Health Centres (No. of beds available	Availability of beds in a year	No. of beds occupied by patients during 2005-08	Average no. of beds occupied	Percentage with reference to no. of beds available	Shortfall in utilisation with reference to column No. 3 (per centage)
1	2	3	4	5	6	7
East	Singtam CHC (100)	36500	37638	12546	34%	23954 (66)
	Machong PHC (10)	3650	546	182	5 %	3468 (95)
	Sang PHC (10)	3650	473	161	4 %	3489 (96)
West	Gayzing CHC (100)	36500	4225	1408	4 %	35092 (96)
	Dentam PHC (9)	3285	2362	787	24%	2498 (76)
	Yuksam PHC (10)	3650	1282	427	12%	3223(88)
South	Namchi CHC (100)	36500	90640	30213	83%	6287 (17)
	Jorthang PHC (10)	3650	5287	1762	48 %	1888 (52)
	Yangang PHC (8)	2920	1314	483	15%	2437 (85)

Source: Figure furnished by the concerned health institution

The position of outdoor patients in the test checked PHCs and CHCs in three selected districts during 2005-08 is given below:

Rs.12,600 X 14= Rs.1,76,400
ANM Rs.4300 plus DP, DA, HRA and SBHA = Rs.11,095 X 58 = Rs. 6,43,510
[34] Considering 282 days in a year. Wherein Jorthang PHC average number of outdoor patients were 73 and indoor patients six

Table 3.4.6

Name of the district	Name of the health Centre	No. of outdoor patients attended during 2005-08	Average no. of patients	
			In a year	In a day (considering 282 days in a year)
East	Singtam CHC	104041	34680	123
	Machong PHC	15748	5249	19
	Sang PHC	13542	4514	16
West	Gayzing CHC	63852	21284	75
	Dentam PHC	12960	4320	15
	Yuksam PHC	14039	4680	17
South	Namchi CHC	105310	35103	124
	Jorthang PHC	61460	20486	73
	Yangang PHC	19802	6600	23

Source: Figure furnished by the concerned health institution

It would be seen from the above table that the average number of outdoor patients in a day in the CHCs ranged between 75 and 124 and the average out-turn of outdoor patients in a day in the PHCs ranged between 15 and 73. Poor outturn of patients was due to non-availability of specialist doctors as pointed out in paragraph 3.4.10.2 in district hospitals except South district, absence of blood bank facilities, basic Emergency Obstetric & Neonatal Care in the PHCs, shortage of medicines, non-working X-ray machines (in Machung and Dentam PHCs) etc. Outturn was further affected by the absence of facilities required for patients suffering from cancer, nephrological problems, neuro-surgical disorders, MRI etc. for which 3542 patients out of 42,621 indoor patients i.e. 8.31 *per cent* was referred outside the State for their treatment during 2005-08 at the cost of Government expenses.

Procurement and utilisation of medicines

3.4.12 Procurement and distribution of drugs

Basic information on the incidence of diseases in an area, number of patients treated (disease-wise) in a year are essential in assessing the requirement of medicines for a particular district or area. As per guidelines, all the PHSCs, PHCs and CHCs should have at least two months' medicines in their stock.

It was observed that after two years of implementation of the programme the SHS procured 154 items of required medicines worth Rs. 94 lakh during 2007-08. The medicines procured were distributed equally to STNM hospital (State Referral Hospital), Gangtok and all CHCs except 16 items of medicines without assessing their requirement. Due to equal distribution, medicines valuing Rs. 1.73 lakh not required in CHCs Singtam and Namchi remained unutilised. It was further seen that the requisite medicines were not available in the stock during 2005-08. Thus, the objective of the programme for providing basic medicines in time to the rural people could not be fully achieved. The SHS stated (September 2008) that supply of medicines is inadequate because the demand is more than the supply. The reply is a pointer towards lack of proper planning in assessment of requirement depriving the rural poor of health care facilities.

Communitisation

3.4.13 Rogi Kalyan Samiti (RKS)/Hospital Management Committee (HMC) and Village Health Sanitation Committee (VHSC)

The programme guidelines provided for formation of HMC/ RKS in all CHCs and PHCs for day-to-day management of the affairs of the hospital. No RKS/HMC was registered in any CHCs and PHCs as of February 2008. Further, to control and manage the public health infrastructure at PHC level, the VHSC with adequate representation to the disadvantaged sections of the society like women, SCs, STs, minority and OBCs was required to be formed in 452 villages of the test checked districts. However, only 427 VHSCs[35] were formed during 2007-08 in three test-checked districts.

3.4.14 Information, Education and Communication

Information, Education and Communication (IEC) activities play a significant role in NRHM. To generate awareness among the masses about the preventive and curative aspects of health, IEC activities were to be implemented through various agencies like television, advertisements, film shows, distribution of printed materials, health melas, health check up camps etc. These activities were not carried out as envisaged because of inadequate coverage through the electronic media. Assessment/evaluation of impact of IEC activities was not conducted, though an expenditure of Rs. 64.30 lakh was incurred.

Convergence with other departments, non-government stakeholders

3.4.15 Role of other departments, programmes and non-governmental organisations

The programme seeks to improve outreach of health services for common people through convergent action involving all health sector interventions like Integrated Child Development Services (ICDS) Scheme, Mid Day Meal Scheme (MDMS), Total Sanitation Campaign (TSC) etc. Further, guidelines provide for involvement/association of Non-Governmental Organisations (NGOs) in implementation of various components of the programme. In three districts selected for test-check, neither NGOs nor any of the implementing departments of the above schemes were involved in the preparation of District Annual Plan. Three MNGOs[36] were engaged and paid Rs. 45 lakh[37] as grants-in-aid for providing health care services in remote areas of the State. However, neither any report relating to the healthcare facilities provided by the MNGOs nor inspection/evaluation report of activities of MNGOs was available with the SHS. Thus, the role of MNGOs in the implementation of the programme activities remained unassessed. The SHS stated (September 2008) that orientation workshop with the concerned NRHM line departments and MNGOs and PRIs was held in August 2007. It was further stated that health care activities of East and West districts were taken up by one MNGO[38]. The

[35] *154 in East Sikkim, 120 in South Sikkim and 153 in West Sikkim.*
[36] *Mother Non-Governmental Organisation (MNGO)*
[37] *East District Rs. 15 lakh in January 2007 and Rs. 6.50 lakh in December 2007, West District : Rs. 15 lakh in March 2007 and Rs. 6.50 lakh in November 2007, Rs. 1 lakh in South District and Rs. 1 lakh in North District.*
[38] *Voluntary Health Association of Sikkim (VHAS)*

contention of the SHS is not satisfactory as the SHS failed to ascertain the follow up activities of the workshop. Further, health care activities of only six PHSCs of East and West districts were assigned to MNGO against 48 PHSCs in East district and 39 PHSCs in West district.

Implementation of components under NRHM

3.4. 16 Reproductive and Child Health programme (RCH-II)

The Reproductive & Child Health Programme was launched in 2005 as the principal vehicle for reducing Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR). It also includes upgradation of CHCs as first referral units for dealing with emergency obstetric care, 24x7 delivery services at PHCs, operationalising of sub-centres, multi-skilling of doctors, contractual appointment of Medical Officers and AMOs, training of Medical Officers in different streams, partnerships with voluntary organisations, RCH camps and accreditation of non-profit organisations and Information Education Communication (IEC) activities as the major interventions in reducing MMR.

The programme also envisaged involvement of ASHAs, Anganwadi workers and ANMs at the village level with focus on both preventive and promotional aspects of health care, accelerated immunisation programme, advocacy on age of marriage and against sex determination, spacing of births, institutional delivery, breast feeding, meeting unmet demands for contraception, besides providing a range of RCH services to have a positive impact on the health indicators as discussed below:

3.4.16.1 Physical performance

Demographic goals

During 2005-08 Sikkim fared well in respect of general health indicators such as Infant Mortality Rate (IMR), Total Fertility Rate (TFR) etc. with reference to the targets set in NRHM**.** However, data regarding Maternal Mortality Maternal Rate (MMR) was not available with the State.

Immunisation coverage

Under RCH-II, Universal Immunisation Programme (UIP) will continue to provide vaccines for Polio, Tetanus, DPT, DT, Measles etc. During 2005-08, the target of immunisation was not achieved in any of the years in respect of any activity except TT to be given at 10 years of age and vitamin dose. Further, there were shortfalls in achievements against the targets of supply of Vitamin 'A' solution by 47 *and 29 per cent* during 2006-07 and 2007-08 respectively.

IFA tablets (Mother)

During the years 2006-07 and 2007-08, the shortfalls in achievements with reference to targets for IFA tablets (Mother) fell short by 37 to 59 *per cent* respectively**.** The SHS stated (September 2008) that the shortfall in achievement was due to change of policy in supply of IFA tablets and its inadequate supply from GOI in 2007-08. The fact however, remains that though supply of IFA tablets was one of the essential ingredients of RCH programme, the same could not be supplied in the State.

Vasectomy, laparoscopic tubectomy, Intra Uterine Device (IUD), Oral Pills Users (OPU)

There was shortfall in achievements against targets fixed for 2005-08 under vasectomy, laparoscopic tubectomy, IUD and OPU in almost all the years ranging from three to 47 *per cent*.

The Department stated (September 2008) that the targets under these components can not be seen in isolation and has to depend on the choice of the user beneficiaries. While it is true that the method of contraception will depend on the individual choice of persons, the targets for various components should have been fixed after taking all this into account.

3.4.16.2 Status of institutional deliveries (child birth)

The programme envisaged priority of institutional deliveries for reducing maternal and child deaths. During test check of three CHCs, it was seen that institutional deliveries ranged from 69 to 79 *per cent*, 33 to 49 *per cent* and 48 to 53 *per cent* in East, West and South districts respectively, as shown below:

Table 3.4.7

Component	East			West			South		
	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
Total deliveries	475	481	490	2021	2002	2168	2360	2426	2013
Domiciliary deliveries	148 (31)	130 (27)	102 (21)	1395 (69)	1286 (64)	1114 (51)	1232 (52)	1184 (48)	946 (47)
Institutional deliveries	327 (69)	351 (73)	388 (79)	686 (31)	716 (36)	1054 (49)	1128 (48)	1242 (51)	1067 (53)

Source: Information furnished by CHCs.
Figures in brackets represent percentage

It is clear from the table that institutional deliveries in West and North are very low compared to East district indicating that SHS failed to motivate the rural population in these two districts. This was accentuated by the absence of basic Emergency Obstetric & Neonatal Care (BEmOC) in the PHCs and effective awareness campaign in the rural areas.

3.4.16.3 Training

Under NRHM, training programmes were to be strengthened to ensure skill upgradation of health functionaries. Training proposal was submitted through PIPs by the SHS to GOI for conducting training in various fields and an amount of Rs. 46 lakh was received during 2005-08 for the purpose. It was seen that against the expenditure of Rs. 8.55 lakh, records relating to name of the training courses conducted, place of training, period of training, name of the faculty members, number of persons trained, attendance register of the trainees and feedback from the trainees as to the usefulness of the training programmes for expenditure of only Rs. 2.30 lakh could be produced to Audit. In the absence of documents the expenditure of Rs. 6.25 lakh recorded in the books of accounts could not be vouched in Audit.

3.4.16.4 Organising Health days to increase health care services

The SHS neither fixed any target nor organised any health days during 2005-06 and 2006-07 for creating awareness of health care services amongst the rural population. The achievement of health and nutrition days against the targets set by the SHS during 2007-08 are given below:

Table 3.4.8

Name of the district	Year	No of health days organised		Excess(+) Shortfall (-)	Percentage of Excess(+)/ Shortfall (-)
		Target	Achievement		
East	2007-08	2907	1191	(-) 1716	(-) 59
West	2007-08	1080	1080	-	-
South	2007-08	1836	1530	(-) 306	(-) 17

Source: Figure furnished by the SHS

It would be seen from the above table that achievements in organising of health days fell short by 17 to 59 *per cent*. Thus, due to failure in organising health days in the PHSCs, (Anganwadi Centre) a large part of the rural population remained unaware of health care services. The SHS stated (September 2008) that other health camps and IEC activities covering all the villages had been organised in all the 24 PHCs. But the Department could not show any documentary evidence in support of this claim.

3.4.17 National Disease Control Programme

Performance review of the implementation of various National Disease Control Programmes (NDCP) revealed that the achievement of the Department is fairly good in the areas of Revised National Tuberculosis Control Programme (RNTCP) and National Leprosy Eradication Programme (NLEP). Diseases like Kala Azar, Filaria/Microfilaria, Dengue etc. under NVBDCP were not found in the State. Findings in respect of National Blindness Control Programme (NBCP) and Integrated Disease Surveillance Programme (IDSP) are given below:

3.4.17.1 Financial performance

The grants received from GOI and expenditure incurred thereagainst during 2005-06 to 2007-08 is given in **Appendix-3.3.**

It would be seen from Appendix that unspent balance at the end of 2005-08 was Rs. 2.25 crore against grants of Rs. 4.85 crore[39] received during three years period ended March 2008. Thus, timely health care facilities were not extended to the rural populace. The SHS stated (September 2008) that the funds for the programme provided under NPCB could not be utilised due to their late receipt from GOI.

[39] *Opening Balance for the year 2005-06 of Rs. 32.59 lakh is included in the figure.*

3.4.18 Physical performance

National Programme for control of Blindness

3.4.18.1 Shortfall in Cataract surgery

The achievement against targets fixed under NBCP is given below:

Table 3.4.9

Year	Target	Achievement	Shortfall
2005-06	500	351	149 (30)
2006-07	500	366	134 (27)
2007-08	600	402	198 (33)
Total:	**1600**	**1119**	**481 (30)**

Source: Figure furnished by the SHS

Cataract surgery being solely dependant upon the incidence of cataract, fixing targets for it without assessment of the number of persons requiring the same was not realistic. Fixing the targets without assessing the requirement coupled with non-establishment of a full fledged ophthalmic unit resulted in shortfalls in achievement ranging from 27 to 33 *per cent* during the period 2005-06 to 2007-08.

3.4.19 Management Information System

Under NRHM, Integrated Disease Surveillance Programme (IDSP) and Routine Immunisation Monitoring System Software (RIMSS) was prescribed by GOI for surveillance and reporting system of diseases. Audit findings in respect of implementation of these aspects are enumerated below:

- ***Integrated Disease Surveillance Programme*:** IDSP is a decentralised surveillance programme to cover the entire country in a phased manner. Sikkim has been included in Phase III, which started from April 2006. The main objectives of the programme are to:

(i) Establish a decentralised district-based surveillance system for communicable and non-communicable diseases so that timely and effective public health action can be initiated in response to health challenges in the urban and rural areas and

(ii) Integrate existing surveillance activities to avoid duplication and facilitate sharing of information across all disease control programmes.

The GOI released Rs. 62.80 lakh during 2005-08 for the programme. An amount of Rs. 9.90 lakh was spent mainly for purchase of furniture and fixtures, laboratory equipment and renovation of Malaria office at Singtam and Rs. 15.93 lakh was spent on IEC activities, civil works, purchase of office equipment and furniture and operational cost. Out of the balance Rs. 36.97 lakh, Rs. 13.72 lakh was released in August 2007 to four Chief Medical Officers of the districts for implementation of the programme. However, no work regarding surveillance was done as of March 2008. Besides, Rs. 23.25 lakh remained unutilised with Project Office, IDSP, Gangtok. Thus, surveillance to ascertain diseases, if any, and timely action for containing them could not be taken up. The Programme Officer, IDSP stated (July 2008) that surveillance work could not be started earlier as there was no infrastructure and manpower to do the same.

- ***Routine Immunisation Monitoring System Software***: The programme envisaged development and implementation of RIMSS and establishment of a computerised network at CHCs, PHCs, PHSCs and SHS with a view to enhance the standard of reporting and effective supervision and monitoring. The SHS purchased nine laptops, eight desktop computers and three printers at a cost of Rs. 11.55 lakh. The laptops were issued to programme officers. The desktops were installed at Headquarters office, CHCs, and PHCs. However online connectivity between Headquarters, CHCs, and PHCs is yet to be provided. Further, RIMSS could not be developed by the SHS. Thus, the objective of the MIS to enhance reporting was not fulfilled. The SHS stated (September 2008) that the RIMSS was not implemented properly because there was problem with the software which could not be operated.

3.4.20 Monitoring and evaluation

The guidelines provided for conducting periodical evaluation studies of the implementation of the scheme by the Centre and States through reputed institutions[40], visit of supervision teams constituted by the National Mission in partnership with State Steering Group twice a year for quality assessment and the Planning, Monitoring and Evaluation Cell (PME) to monitor the activities of health care and evaluate the work done by the State Health Society. No evaluation studies had been conducted by any agency to ascertain the impact of the programme and desired outputs as envisaged under the programme. While accepting the fact the SHS stated (September 2008) that monitoring and evaluation would be undertaken from 2008-09.

As per the Memorandum of Understanding (MoU), a review meeting between Ministry of Health & Family Welfare (MoHFW) and the State of Sikkim, was required to be held six monthly/annually. Only one meeting was held (22 September 2007) during 2005-08. Similarly, the meeting of the Governing Body was required to be held at least twice a year and that of Executive Committee at least once in each quarter of the year. However, it was noticed that against the required six and 12 meetings of the Governing Body and Executive Committee, only two meetings of the Executive Committee were held (18 April and 12 October 2007) during the above period. The SHS stated (July 2008) that the meetings could not be held due to other ongoing activities and meetings at state and district level. The contention is not tenable as conducting of meetings was essential to monitor the achievement of goals under NRHM.

3.4.21 Conclusion

The State performed well in the areas of demographic goals (infant mortality rate, total fertility rate etc.) and implementation of National Disease Control Programmes. It was however found deficient in programme management resulting in huge unspent balances during all the years under review. Many of the communitisation activities like decentralised planning through formation of VHSC, RKS, DHAP, flexible funding by release of untied funds and annual maintenance grant to VHSCs, PHSCs, PHCs and CHCs were belatedly taken

[40] *Institute of Public Auditors of India, IIMs, International Population Research*

up. Health care facilities to rural population were affected due to shortage of specialists and irrational deployment of doctors and nurses. Lack of training of medical and para-medical personnel, absence of timely issue of medicines further compounded the lacunae in extending the health care facilities. Surveillance and reporting system of diseases and immunisation were not made functional. While the progress of civil works relating to the health infrastructure was very slow, upgradation of equipment in STNM hospital had not commenced. Monitoring and evaluation of the scheme was never conducted to gauge its success.

3.4.22 Recommendations

- Planning should follow a bottom-up approach and community involvement should be ensured in the planning process;
- Household and facility surveys at village, block and district levels need to be conducted at regular intervals and gaps in health care services should be identified and appropriate corrective action taken;
- The State Government should ensure rational deployment of manpower;
- Awareness should be created among the public to ensure accountability at various levels; and
- Monitoring and supervision of the Mission activities should be strengthened by establishing monitoring and planning committees at all levels as envisaged in the Mission Guidelines.

APPENDIX-3.2

(Ref.: Paragraph 3.4.10.1, Page 92)

Statement showing the deployment of MO and paramedical staff in CHC, PHC and PHSC

CHCs

Name of CHCs	Requirement		Actual deployment		(-) Shortfall/ (+) Excess		Percentage of (-) Shortfall/(+)Excess	
	MO	Para medical staff	MO	Para medical staff	MO	Para medical staff	MO	Para medical staff
East Sikkim	4	21	14	18	(+) 10	(-) 03	(+) 250	(-) 14
West Sikkim	4	21	09	37	(+) 05	(+) 16	(+) 125	(+) 76
South Sikkim	4	21	26	119	(+) 22	(+) 91	(+) 550	(+) 433
North Sikkim	4	21	4	21	-	-	-	-

PHCs

No. of PHCs	Requirement		Actual deployment		(-)Shortfall/ (+)Excess		Percentage of (-)Shortfall/(+)Excess	
	MO	Para medical staff	MO	Para medical staff	MO	Para medical staff	MO	Para medical staff
Machong	01	14	01	04	00	(-) 10	00	(-) 71
Sang	01	14	02	14	(+) 01	00	(+) 100	00
Yuksam	01	14	01	05	00	(-) 09	00	(-) 64
Dentam	01	14	01	08	00	(-) 06	00	(-) 43
Jorthang	01	14	04	13	(+) 03	(-) 01	(+) 300	(-)07
Yangang	01	14	01	09	00	(-) 05	00	(-) 36

PHSCs

No. of PHSCs	Requirement		Actual deployment		(-)Shortfall/ (+)Excess		Percentage of (-) Shortfall/ (+)Excess	
	Health Worker		Health Worker		Health Worker		Health Worker	
	Male	Female	Male	Female	Male	Female	Male	Female
Tarathang	01	01	01	01	Nil	Nil	Nil	Nil
Linkey	01	01	01	02	Nil	(+) 01	Nil	Nil
Ranipool	01	01	02	01	(+) 01	Nil	(+) 100	Nil
Ranka	01	01	01	02	Nil	Nil	Nil	Nil
Thingling	01	01	01	01	Nil	Nil	Nil	Nil
Melli-Aching	01	01	01	01	Nil	Nil	Nil	Nil
Uttaray	01	01	01	01	Nil	Nil	Nil	Nil
Hee-Yangthang	01	01	01	01	Nil	Nil	Nil	Nil
Vok	01	01	01	01	Nil	Nil	Nil	Nil
Omchu	01	01	01	01	Nil	Nil	Nil	Nil
Neya-Broom	01	01	01	01	Nil	Nil	Nil	Nil
Manglay	01	01	01	01	Nil	Nil	Nil	Nil

Source: Figure furnished by the concerned health institutions

APPENDIX-3.3

(Ref.: Paragraph 3.4.17.1, Page 99)

Statement showing the fund position of NDCP

(Rs. in lakh)

Year	Opening balance	Fund received from GOI	Expenditure	Unspent balance
National Vector Borne Disease Control Programme				
2005-06	0.0	20.95	13.05	7.90
2006-07	7.90	8.71	12.38	4.23
2007-08	4.23	4.00	8.19	0.04
Nation Leprosy Eradication Control Programme				
2005-06	12.37	3.31	15.57	0.11
2006-07	0.11	23.96	23.06	1.01
2007-08	1.01	20.35	20.38	0.98
Integrated Disease Surveillance Project				
2005-06	0.0	12.80	3.16	9.64
2006-07	9.64	30.00	6.59	33.05
2007-08	33.05	20.00	16.08	36.97
Revised National Tuberculosis Control Programme				
2005-06	14.72	50.13	49.97	14.88
2006-07	14.88	65.34	58.39	21.83
2007-08	21.83	50.43	56.82	15.44
National Iodine Deficiency Disorder Control Programme				
2005-06	2.74	8.25	8.75	2.24
2006-07	2.24	7.00	10.12	00
2007-08	00	13.00	12.83	0.17
National Blindness Control Programme				
2005-06	2.76	10.74	6.74	6.76
2006-07	6.76	18.74	18.68	6.82
2007-08	6.82	84.52	28.62	62.73
Total		**452.23**	**369.38**	**224.80**

Source: Figure furnished by the concerned NDCP Offices