PERFORMANCE AUDIT

Medical Health & Family Welfare Department

1.2 National Rural Health Mission

Government of India launched National Rural Health Mission (NRHM) in April 2005 throughout the country with the objective to provide accessible, affordable, effective and reliable healthcare facilities in the rural areas. A special focus was on 18 States including Uttarakhand. Some of the significant findings of the audit are given below:

Highlights:

- ***Household surveys and facility surveys intended for identifying the healthcare needs of the people at bottom level were not conducted in the State. District Health Action Plans for the year 2008-09 to 2012-13 were prepared without aggregating the Block and Village Health Action Plans.***

[Paragraph 1.2.6]

- ***Against the availability of ₹778.28 crore during 2008-09 to 2012-13, ₹650.10 crore were spent and ₹12.41 crore were returned to GoI, thereby, leaving ₹115.77 crore unspent.***

[Paragraph 1.2.7.1]

- ***Despite incurring an expenditure of ₹64.23 crore, the Department failed to get any input in planning and monitoring of implementation of NRHM from VHSSCs, besides utilization certificates for ₹30.44 crore were also not obtained from VHSSCs.***

[Paragraph 1.2.7.2]

- ***Under Janani Suraksha Yojana, the Department made delayed payment of ₹2.98 crore to the beneficiaries.***

[Paragraph 1.2.8.2(iii)]

- ***Due to excessive procurement, Drug Kits (A&B) valued at ₹1.21 crore expired in Drug Warehouse and equipment worth ₹2.18 crore were lying idle in the test-checked CHCs and PHCs.***

[Paragraphs 1.2.9.1 & 1.2.9.2]

- ***An undue payment of ₹7.95 crore was made to a service provider (108- emergency response services) and operational cost of ₹3.20 crore was also not recovered from it.***

[Paragraph 1.2.9.4]

1.2.1 Introduction

The National Rural Health Mission (NRHM) was launched on 27th October, 2005 in Uttarakhand with the objectives to provide accessible, affordable, effective and reliable healthcare facilities in the rural areas, especially to poor and the vulnerable sections of the population. It aimed to involve community in planning and monitoring, reduce infant mortality rate, maternal mortality rate and total fertility rate for population stabilization and to prevent/control communicable/ non-

communicable diseases through its components[1]. The NRHM aimed at an architectural correction in the healthcare delivery system by converging various standalone existing National Disease Control Programmes[2] (NDCPs). The Mission envisaged increasing expenditure on health, with a focus on primary healthcare, from 0.9 *per cent* of Gross Domestic Product in 2005 to 2-3 *per cent* over the mission period (2005-12). NRHM is the sole centrally sponsored flagship scheme being implemented in Uttarakhand as no other parallel scheme like this has been launched by the State Government.

1.2.2 Organizational Set-up

At the State level, NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister Govt. of Uttarakhand. The activities under the Mission are carried out through the State Health Society (SHS) consisting of a Governing Body and an Executive Committee. The Governing Body of the SHS is headed by the Chief Secretary of the State. The Executive Committee of the SHS is headed by the Principal Secretary, Health and Family Welfare Department. The State Programme Management Support Unit (SPMSU) assists SHS and is headed by a Mission Director. At the district level, District Health Missions (DHMs) under chairmanship of respective Zilla Pramukhs and District Health Societies (DHSs) headed by respective District Collectors are responsible to implement the NRHM. The Executive Committee of DHS is headed by Chief Medical Officer (CMO). The overall organizational set-up of NRHM in the State is as shown in ***Appendix-1.2.1.***

1.2.3 Audit objectives

The objectives of the performance audit were to assess whether:

- planning processes of the Mission at Village, Block, District and State levels were adequate and effective;
- release and utilization of funds was adequate and efficient;
- the performance indicators and targets fixed under the Mission were achieved timely and efficiently;
- procurement of drugs, equipment and services was cost effective, efficient, timely, and procurement rules and procedures were followed;
- capacity building and strengthening of physical and human infrastructure at different levels was adequate and the information, education and communication (IEC) was effective; and
- Health Management Information System and monitoring mechanism were functional and effective.

1.2.4 Scope and methodology of Audit

The performance audit was conducted during April 2013 to August 2013 covering the period from 2008-09 to 2012-13. Out of 13 districts of the State, five districts[3] were selected by Probability Proportional to Size without Replacement (PPSWOR) method. In each sampled district, two Community Health Centre (CHC) and two Primary Health Centre (PHC) were

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[1] Reproductive and Child Health (RCH), NRHM Additionalities, Immunization and National Disease Control Programmes (NDCPs).

[2] National Vector-borne Disease Control Programme, Revised National Tuberculosis Control Programme, National Leprosy Eradication Programme, National Blindness Control Programme and Integrated Disease Surveillance Project.

[3] Almora, Chamoli, Haridwar, Pauri and Udham Singh Nagar.

selected for detailed analysis/ physical verification. Records of two Sub-Centers (SCs) of each selected CHC/PHC were also scrutinized during the course of audit. The selection of these CHCs/ PHCs/ SCs had been made using Simple Random Selection without Replacement (SRSWOR) method. Besides, the records of SHS, DHSs, District Hospitals (Male & Female) of each sampled district and Directorates of Ayurveda and Homeopathy were also scrutinized.

Before commencement of audit, the audit objectives, scope and methodology were discussed in an entry conference held on 18 April 2013 with the Additional Secretary, Department of Health and Family Welfare and other important officers of the State Government responsible for execution of the scheme in the State. Draft Report was sent (October 2013) to the Government for their reply/response and an exit conference was also held on 30 November 2013 with the Principal Secretary, Department of Medical Health & Family Welfare, Government of Uttarakhand to discuss the audit findings, but replies are still awaited. However, the response of the Department has been incorporated at appropriate places.

1.2.5 Audit Criteria

Audit criteria for the performance audit had been derived from the following sources:

- GoI guidelines on the Scheme and related instructions issued from time to time;
- State Programme Implementation Plans (SPIPs) as approved by the GoI;
- Memorandum of understanding (MoU) executed between the State Government and the GoI;
- Indian Public Health Standards (IPHS) norms; and
- Uttarakhand Procurement Rules, 2008.

Audit findings

1.2.6 Planning

The NRHM aimed at decentralized planning and implementing arrangements to ensure need based and community owned District Health Action Plan (DHAP) which would form the basis for interventions in the health sector. The guidelines envisaged conducting of household survey, facility survey, preparation of perspective plan for the entire Mission period (2005-12) and Annual Action Plans. A scrutiny of the records showed that there were deficiencies in the planning process which are discussed in the following sub-paragraphs:

1.2.6.1 Non-conducting of Household Survey and non-utilization of data gathered from Family Health Survey

Scrutiny of records showed that the prescribed household survey for assessing the healthcare and identifying underserved and unserved areas, was not conducted by the State Health Society (SHS). Further, for conducting a Family Health Survey through Accredited Social Health Activists (ASHAs) for the implementation of Mother & Child Tracking System, the State Health Society (SHS) released ₹ 68.22 lakh to all the districts of the State out of which, ₹ 53.95 lakh was spent and ₹ 14.27 lakh was lying unspent with District Health Societies (DHSs). However, the above said expenditure of ₹ 53.95 lakh on the Family Health survey remained unfruitful as the information collected by the ASHA and handed over to the outsourced agencies for computerized compilation was not used for any purpose by the DHSs and the SHS due to introduction of new software by the GoI.

While accepting the audit observation on non-utilization of data the Mission Director also stated (August 2013) that due to shortage of technical manpower and difficult terrain of the State, the household surveys could not be conducted.

Reply is not acceptable as it was admitted by the Department in PAC meeting (August 2010) on earlier Audit Report (2008) that order had been issued to conduct household survey through ASHA and it would be done after constitution of Village Health & Sanitation Committees (VHSC). Though, the VHSCs had been constituted in the entire State in 2008-09 but the household surveys were not conducted even after a lapse of four years of their constitution. Thus, in the absence of household survey, actual health care requirements remained un-assessed.

1.2.6.2 Non-conducting of Facility Survey

In order to upgrade the infrastructure and services of the existing Health Care Centres as per IPHS norms, a Facility Survey[4] was to be conducted by State Health Society in each health facility at regular intervals. Scrutiny of the records of SHS showed that the facility survey was not conducted at all.

On this being pointed out, the Mission Director accepted (August 2013) the fact and stated that facility survey could not be conducted due to shortage of doctors and specialists in health facilities. The reply is not acceptable as there was no requirement of specific staff since the prescribed format for facility survey as per IPHS could have been filled by the local staff of the Health facility concerned. Thus, in the absence of facility survey, the need of actual health interventions could not be assessed.

1.2.6.3 Non-preparation of Perspective Plan

During the scrutiny of the records of SHS and in sampled districts, it was noticed that perspective plans for the entire Mission period were not prepared by SHS and DHSs. On this being pointed out, Additional Director stated that Perspective Plan in respect of Reproductive & Child Health for the period from 2005 to 2010 was prepared by the Department. However, the reply of Additional Director is not acceptable as it did not include all the components[5] of NRHM for the mission period.

1.2.6.4 Improper Preparation of Annual Action Plans

The District Health Action Plan (DHAP) should, as far as practicable, be an aggregation and consolidation of the Block and Village Health Action Plans. Scrutiny of the records of the sampled districts showed that DHAPs for the year 2008-09 to 2012-13 were prepared without aggregating the Block and Village Health Action Plans which had not been prepared. The DHAPs were submitted to SHS without the approval of the District Health Missions (DHMs). It was also seen that the State Programme Implementation Plan (SPIP), based on these DHAPs, was sent to the National Programme Co-ordination Committee (NPCC) without the approval of the Governing Body of the SHS.

This issue was raised (2008) in the earlier performance audit and the matter was also discussed (October 2010) in the Public Accounts Committee (PAC) wherein it was submitted by the Government that the DHAPs for the year 2011-12 were being prepared at the village level. On this being pointed out, the Mission Director stated (August 2013) that State does not have the capacity to get the Village Health Plans prepared from the VHSCs. Further, the Mission Director

[4] A survey for identifying requirement of specialist service, manpower, investigating facilities, equipment and other infrastructure, etc

[5] Reproductive & Child Health, NRHM Additionalities, Immunisation and National Disease Control Programme.

added that the SPIP was forwarded to the NPCC after its approval by the executive committee of the SHS and GOI had not raised any objection to this. Reply is not acceptable as SPIPs were deprived of the valuable suggestive inputs of Governing Body headed by Chief Secretary.

1.2.7 Funding Pattern and Financial Management

In the Eleventh Plan (2007-12), the contribution of the Centre and the State was to be in the ratio of 85:15. As per the approved SPIP for the year 2012-13, State share was fixed at 10 *per cent* by the GoI. Funds are received by the SHS mainly from two sources i.e. Grants-in-aid by MoHFW, GoI and the contribution made by the State Government. The vision of the Mission was to raise the public spending on health from 0.9 *per cent* of the GDP to 2-3 *per cent* of the GDP.

In Uttarakhand, the expenditure on health was almost consistent during the coverage period and remained between 0.68 *per cent* and 0.75 *per cent* of the Gross State Domestic Product (GSDP). The State did not contribute its share timely in the period 2008-09 to 2011-12 leaving a gap in its contribution of ₹ 18.16 crore. This was, however, released along with share of 2012-13.

1.2.7.1 Financial Position

The position of Grants-in-aid received from the GoI and the State Government and expenditure incurred there against during 2008-09 to 2012-13 is depicted in **Table 1.2.1.**

Table: 1.2.1
Position of funds released and expenditure incurred

(₹ in crore)

Year	OB	Funds received				Total Fund available	Expenditure	Refund to GOI	CB	Unspent balance (in %)
		GOI	State Govt.	Misc. Receipts[6]	Total					
2008-09	**93.18**	67.53	13.85	4.65	86.03	179.21	101.93	3.96	73.32	41
2009-10	73.32	103.44	13.80	1.82	119.06	192.38	94.23	0.09	98.06	51
2010-11	98.06	99.52	21.80	1.94	123.26	221.32	148.31	6.92	66.09	30
2011-12	66.09	128.89	35.65	2.45	166.99	233.08	133.35	0.90	98.83	42
2012-13	98.83	125.38	56.86	7.52	189.76	288.59	172.28	0.54	**115.77**	40
Total		524.76	141.96	18.38	**685.10**		**650.10**	12.41		**41**

Source: Information provided by the SHS (OB- Opening Balance, CB – Closing Balance)

It may be seen from the table that on an average, 41 *per cent* of the total available funds remained unutilized at the end of financial year during last five years. An amount of ₹ 115.77 crore remained unutilized at the end of 2012-13 which indicates a huge gap in State's capacity and infrastructure to utilize the earmarked funds. This has long term implications for the readiness of the State's health infrastructure in meeting health challenges and achieving laid down targets in health care. Audit also observed that one of the main reasons for under-utilisation of the allotted funds was absence of any input from DHSs and Sub-District Health Centres in the preparation of budget estimates at the State level.

As regards, non-utilisation of funds, the Mission Director stated (September 2013) that expenditure was not reported by DHSs well in advance while preparing the PIPs and activity wise annual budget was also not received from DHSs. The reply of the Mission Director itself indicates that the provisions for funds in the PIPs were made without input from DHSs.

[6] This constitutes interest earned on Grants received and loans taken from 'Family Planning Services'.

1.2.7.2 Improper functioning of VHSSCs

The Government of Uttarakhand accorded sanction (February 2009) to constitute Village Health and Sanitation Sub Committees (VHSSCs) in the State. The VHSSC members (14) were to be given orientation training by DHSs through NGOs to equip them to provide leadership as well as to plan and monitor the health activities at the village level. These VHSSCs were to perform various health activities including IEC, household survey, preparation of health register, organization of meetings at the village level, etc. Untied funds at the rate of ₹ 10,000 per annum were to be made available to each VHSSC to carry out these activities. The amount of untied funds was to be kept in a bank account to be operated by the Auxiliary Nursing Midwife (ANM)/ Health linked worker and Chairman of the VHSSC jointly.

Audit scrutiny showed that a total of 15,411 VHSSCs were constituted in the State in 2008-09 and untied funds amounting to ₹ 61.72 crore were released to the VHSSCs during 2009-10 to 2012-13. Further, an amount of ₹ 2.51 crore was spent on training of the VHSSC members in the State imparted by State and District ASHA Resource Centre. During audit scrutiny of the records of the sampled districts as well as the SHS, it was observed that the required joint bank accounts with the ANM was not opened by any of the VHSSCs and money was kept in Gram Panchayat accounts by concerned Gram Pradhans. Further, neither the prescribed household survey was conducted nor was the Village Health Action Plan prepared by any of the VHSSCs. No other input in planning and monitoring of health activities at the village level was given by any of the VHSSCs. Thus, despite incurring an expenditure of ₹ 64.23 crore, the Department could not get any input in respect of planning and monitoring of implementation of NRHM from VHSSCs. Further, Statements of Expenditure (SoEs) and Utilization Certificates (UCs) for ₹ 30.44 crore were also not submitted by the VHSSCs of nine districts[7]. The SHS did not provide any information regarding SoEs and UCs from the VHSSCs of the remaining four districts.

On this being pointed out, the Mission Director, while accepting the audit observations, stated (August 2013) that the VHSSCs had not played any active role in health planning and monitoring. The Mission Director further intimated that the release of untied funds to all the districts had been proposed to be withheld from the year 2013-14, but GoI said that release of untied fund to VHSSC is mandatory, hence, nominal fund (₹ 500 per VHSSC) would be released.

1.2.7.3 Diversion of funds

NRHM guidelines stipulate that the State shall not make any change in allocation amongst different approved components/ activities without the approval of GoI.

Audit scrutiny showed that during the years 2009-10, 2010-11 and 2011-12, the SHS incurred an expenditure of ₹ 3.28 crore by diverting funds from one activity to another without obtaining the approval of the GoI.

1.2.7.4 Excess grant to NGOs over norms

As per norms prescribed for NRHM activities, up to five *per cent* of the total NRHM budget can be released to the NGOs at the State and the District levels to operate the health activities like operationalisation of Mobile Medical Units, District ASHA Resource Centres etc. as per approved Annual Health Action Plans.

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[7] Pauri-₹ 12.45 crore, Chamoli- ₹4.53 crore, Almora-₹ 3.11 crore, Haridwar- ₹ 1.80 crore, Udham Singh Nagar- ₹ 1.42 crore, Nainital- ₹1.80 crore, Tehri- ₹3.83 crore, Uttarkashi-₹ 1.14 crore and Bageshwar-₹ 0.36 crore.

Audit noticed that an amount of ₹ 34.16 crore was released to various NGOs in excess of the prescribed norms during 2008-09 to 2012-13 in violation of the aforesaid provisions of NRHM guidelines. There was an excess release of grant ranging from three to seven *per cent* (₹ 4.58 to ₹ 8.14 crore). Moreover, up to 21 *per cent* (₹ 3.82 crore) out of the total released funds of ₹ 17.97 crore in 2012-13 were lying unspent with the NGOs.

On this being pointed out, the Mission Director replied (August 2013) that the grant for NGOs was released as per the approved SPIP. The reply is not acceptable as provisioning of grants for the NGOs in the SPIP was made in excess of the prescribed norms.

1.2.7.5 Inadmissible expenditure from Untied Funds

Audit scrutiny of records of the sampled CHCs/ PHCs showed that out of total untied fund of ₹ 32.64 lakh released during 2008-09 to 2012-13, an expenditure of ₹ 25.98 lakh (80 *per cent*) was incurred on inadmissible items like purchase of office stationery and equipment, engagement of full time or part time staff, payment of honorarium/incentives/ wages of any kind, purchase of drugs, consumables and furniture, payments towards advertisements in Newspaper/ Journal/ Magazine by these CHCs/ PHCs. On this being pointed out, the Mission Director stated (August 2013) that instructions would be issued to CHCs and PHCs to incur the expenditure out of untied funds on only admissible items.

1.2.8 Performance indicators and Disease Control Programmes

The NRHM prescribed national targets for reducing Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), reducing morbidity and mortality rate and increasing cure rate of different endemic diseases covered under various national programmes. The programme wise achievement level of the national targets is discussed in the following paragraphs:

1.2.8.1 Reproductive and Child Health programme

Reproductive and Child Health (RCH) is the biggest programme under NRHM and aims to reduce MMR, IMR and TFR and to promote family planning, etc. to achieve population stability. Targets of MMR, IMR, TFR and achievement there against in the State as well as in sampled districts are as shown in the **Table 1.2.2.**

Table: 1.2.2
Achievement targets of MMR, IMR, TFR

Particulars	Targets to be achieved by 2012	Targets achieved by						
		Country	State	Selected districts				
				Pauri	Chamoli	Almora	Haridwar	U S Nagar
IMR	30/1000 live births	50	43 (AHS 2011)	43 (AHS 2011)	27 (AHS 2011)	20 (AHS 2011)	72 (AHS 2011)	37 (AHS 2011)
MMR[8]	100/100000 live births	212	162 (AHS 2012)	155 (AHS 2012)	155 (AHS 2012)	181 (AHS 2012)	155 (AHS 2012)	181 (AHS 2012)
TFR	2.1	2.7	2.3 (AHS 2011)	2.4 (AHS 2011)	2.0 (AHS 2011)	2.0 (AHS 2011)	3.1 (AHS 2011)	2.4 (AHS 2011)

Source: Annual Health Survey 2011 & 2012 conducted by GoI

[8] State followed the indicators of Annual Health Survey conducted by the GoI in the absence of any State level survey conducted by the State Government. Figures mentioned in the table for MMR pertain to Garhwal (Chamoli, Dehradun, Haridwar, Pauri, Rudraprayag, Tehri and Uttarkashi) and Kumaon (Almora, Bageshwar, Champawat, Nainital, Pithoragarh and Udham Singh Nagar) regions as no district-wise indicators were available with the Department.

It can be observed from above that although the indicators of the State with reference to IMR, MMR and TFR are better than the national level, the prescribed targets are yet to be achieved at the State level. In the sampled districts, IMR and TFR statistics in Haridwar district and MMR in Almora and Udham Singh Nagar districts are far above from the fixed targets.

On this being pointed out, the Department admitted (August 2013) the facts and replied that Haridwar and Pauri districts are kept in high priority districts and State is giving more emphasis for improvement in these districts.

1.2.8.2 Implementation of Janani Suraksha Yojana

The Janani Suraksha Yojna (JSY) is a safe motherhood scheme under NRHM implemented with an objective of reducing maternal and infant mortality by promoting institutional deliveries. During scrutiny of records in test-checked districts as well as SHS, the following irregularities were noticed:

(i) Ante-Natal Care of pregnant women

In order to provide safe motherhood, at least three Ante-Natal Care (ANC) checkups, 100 days intake of Iron Folic Acid (IFA) and two doses of Tetanus Toxoid (TT) were to be provided to all registered pregnant women. Besides, to encourage the pregnant women to volunteer for ANCs, the distribution of IFA tablets was linked[9] to each check-up. The details of ANCs provided to registered pregnant women during audit period are shown in the **Table 1.2.3.**

Table: 1.2.3
Details of ANCs provided to registered pregnant women

Particulars	2008-09	2009-10	2010-11	2011-12	2012-13
Registered pregnant women	2,43,301	2,26,481	2,03,131	2,24,167	1,95,699
Provided with three ANCs	1, 78,273(73%)	1, 70,389(75%)	1, 52,838(75%)	1, 67,585(75%)	1, 39,410(71%)
Provided two doses of TT	2, 09,578(86%)	1, 94,789(86%)	1, 79,278(88%)	1, 89,984(85%)	1, 58,528(81%)
Provided with 100 IFA tablets	69,158(28%)	2, 05,734(91%)	1, 79,231(88%)	1, 01,732(45%)	1, 08,985(56%)

Source: Information extracted from the records of the Department

Thus, there was a shortfall of up to 29 *per cent* in providing three ANCs to pregnant women. In respect of administration of two doses of TT, the shortfall was up to 19 *per cent* whereas in respect of providing of IFA tablets, the shortfall was up to 72 *per cent* during the period 2008-09 to 2012-13.

Analysis of the ANC data provided by the SHS showed widespread discrepancies in the number of registered pregnant women provided with three ANCs *vis-à-vis* those provided with 100 IFA tablets. In the years 2008-09, 2011-12 and 2012-13, 71 to 75 *per cent* of the registered pregnant women were provided with three ANCs whereas IFA tablets were provided only to 28 to 56 *per cent.* In the years 2009-10 and 2010-11, 88 to 91 *per cent* of the registered pregnant women were provided with 100 IFA tablets whereas only 75 *per cent* were provided with three ANCs. The mismatch between the two sets of figures i.e. between the data regarding three ANCs and the data regarding hundred IFA tablets provided to registered pregnant women indicates misreporting as the mandatory IFA doses are administered during ANCs. In reply, the Additional Director while accepting the facts, assured that efforts would be made to provide IFA tablets to all pregnant women.

[9] 1st ANC- 30 IFA tablets, 2nd ANC- 30 IFA tablets, and 3rd ANC- 40 IFA tablets.

(ii) Institutional deliveries

One of the important interventions of the JSY under the Reproductive and Child Health (RCH) programme was to promote institutional delivery in order to reduce MMR and IMR. The details of institutional deliveries carried out in the State against the total registered pregnant women during 2009-13 are given in the **Table 1.2.4.**

Table: 1.2.4
Details of institutional deliveries

Year	Total registered pregnant women	Number of deliveries	
		Institutional deliveries	Domiciliary deliveries
2008-09	2,43,301	71,285 (29%)	Not Available
2009-10	2,26,481	74,731(33%)	4,729(2%)
2010-11	2,03,131	75,625(37%)	4,543(2%)
2011-12	2,24,167	80,562(36%)	7,375(3%)
2012-13	1,95,699	83,797(43%)	5,564(3%)
Total	**10,92,779**	**3,86,000 (35%)**	**22,211(02%)**

Source: Information provided by the Department

Out of the total 10.93 lakh registered pregnant women in the State during 2008-09 to 2012-13, data regarding only 3.86 lakh (35 *per cent*) institutional deliveries and 0.22 lakh (two *per cent*) domiciliary deliveries was available with the Department. The institutional deliveries carried out in the State at Government Health Centers against the registered pregnant women during 2008-09 to 2012-13 were a meager 29 to 43 *per cent*. In test-checked districts, shortfall in institutional deliveries in Haridwar was up to 86 *per cent*, in Pauri up to 63 *per cent*, in Chamoli up to 74 *per cent*, in Almora up to 58 *per cent* and in Udham Singh Nagar up to 71 *per cent* ***(Appendix-1.2.2)*** during the reported period. The SHS as well as the district health authorities were unaware about the delivery status of remaining 6.85 lakh registered pregnant women.

The comparison of data pertaining to the period 2008-13 regarding domiciliary deliveries as provided by the SHS (**Table: 1.2.4**) and the sampled DHSs (***Appendix-1.2.2***) showed that the difference in number of domiciliary deliveries stood at 1.31 lakh with the sampled DHSs depicting it at 1.53 lakh and the SHS at 0.22 lakh. The huge difference in the figures of domiciliary deliveries needs to be looked into and reconciled.

On this being pointed out, the Department replied (August 2013) that there was an increasing trend in institutional deliveries but it would have to be improved. It was further assured that functional delivery points were being identified and strengthened and IEC for promotion of institutional deliveries was in process.

(iii) Cash assistance to JSY beneficiaries

According to JSY guidelines, JSY card should be filled at least 16-20 weeks before the expected date of delivery and completed JSY card should be submitted to the Health Centre for verification by the authorized Medical Officer at least before two weeks of expected date of delivery. Under the scheme, a cash assistance of ₹ 1,400 in rural areas and ₹ 1,000 in urban areas is admissible to meet out the post delivery expenses which was to be paid at the time of delivery. Further, all such payments made to the beneficiaries after seven days of delivery were to be treated as illegal.

Audit scrutiny of the records of five test-checked districts showed that an amount of ₹ 31.33 crore was paid to the JSY beneficiaries during 2008-09 to 2012-13 without adhering to

the guidelines i.e. JSY cards were filled up on or after the delivery in all cases, micro birth plan for any beneficiary was not drawn and identity proof was not obtained from the beneficiaries. Further, a payment of ₹ 2.98 crore to 22,873 beneficiaries (38 *per cent*), out of total 60,758 beneficiaries of the selected CHCs and PHCs in the aforesaid five districts was made beyond seven days or more after the delivery and the delay ranged up to 20 months. The main reason for delay in payment was non-filling of JSY cards along with other necessary documents required for availing benefits in time by ASHAs/ANMs which could help the beneficiary to receive the cash assistance at the time of discharge from the health centre.

On this being pointed out, the Mission Director replied (August 2013) that justification for non-adhering to the guidelines would be asked from the districts.

1.2.8.3 Family Planning

The family planning includes terminal method to control total fertility rate and spacing methods to improve couple protection ratio.

(i) Terminal method

The terminal method of family planning includes vasectomy for males and tubectomy/laparoscopy for females. Audit scrutiny noticed shortfall in achievement of sterilization targets was between 23 and 43 *per cent* during 2008-09 to 2012-13. The proportion of vasectomy to the total sterilization was only seven *per cent* during 2008-09 to 2012-13.

(ii) Spacing method

Oral pills, condoms and intra uterine device (IUD) insertion are the three prevailing spacing methods of family planning to regulate fertility and promote couple protection ratio. Fifty, 21 and 42 *per cent* targets of oral pills, IUD insertions and distribution of condoms respectively remained unachieved.

The main reason for shortfall in achieving the targets were shortage of manpower, service providers and improper road connectivity. On this being pointed out, the Joint Director stated that awareness would be increased to achieve the targets.

1.2.8.4 Revised National Tuberculosis Control Programme

The main objective of the Revised National Tuberculosis Control Programme (RNTCP) was to detect at least 70 *per cent* of the smear positive cases and to ensure cure rate of at least 85 *per cent* of such cases through Direct Observed Treatment Short Course (DOTS).

Under NRHM, full coverage for detection and treatment of tuberculosis is guaranteed at CHCs and PHCs. Out of 59 CHCs and 254 PHCs in the State, 53 CHCs (90 *per cent*) and 54 PHCs (21 *per cent*) were provided with laboratory facilities under the DOTS scheme. At State level, against the target of detection of 70 *per cent* of the estimated 95 sputum positive cases per lakh per year, the detection rate was only 57 to 59 *per cent* during January 2008 to December 2012. The cure rate remained between 80 and 83 *per cent* during 2008-12. On this being pointed out, the Department replied (August 2013) that the State is considerably short on doctors and lab technicians which is hampering the work of microscopy centres.

1.2.8.5 National Vector Borne Disease Control Programme

The National Vector Borne Disease Control Programme (NVBDCP) aimed to control vector borne diseases by reducing mortality and morbidity due to Malaria, Filaria, Kala Azar, Dengue and Japanese Encephalitis in the respective endemic areas. During the coverage period, 26 deaths occurred due to Dengue in the State; out of which, 13 cases pertained to Dehradun district alone while one death occurred due to Malaria in the State.

The NVBDCP further stipulated to achieve ABER (Annual Blood Examination Rate) of 10 *per cent* of the target population under surveillance. Due to shortage of Lab Technicians and Multi Purpose Workers required for carrying out the tests, the State's achievement on ABER was substantially less than the targets and stood at 2.52, 2.20, 2.24, 2.43 and 2.64 during 2008-09 to 2012-13 respectively.

1.2.8.6 National Programme for Control of Blindness

The objective of National Programme for Control of Blindness was to reduce prevalence of blindness cases through various activities like Cataract operations, distribution of free spectacles to children diagnosed with refractive errors, school eye testing programme etc.

(i) Cataract Operations

The State achieved 92 *per cent* to 100 *per cent* of targets fixed for Cataract operations during the coverage period. Cataract operations were to be shared equally between Government health facilities, NGOs and private clinics but it was observed that Government Hospitals performed only 27 to 30 *per cent* Cataract operations during last five years whereas NGOs and private practitioners performed 70 to 73 *per cent* Cataract operations during the same period. On this being pointed out, the Department replied (April 2013) that due to posting of inadequate number of Eye Surgeons in Government Hospitals, less number of operations were conducted.

(ii) Distribution of Free Spectacles

The programme envisaged screening of students for refractive errors and free distribution of spectacles to poor children. During 2008-09 to 2012-13, out of 31,314 students detected with refractive errors in the school health programme, only 9,070 students were provided with spectacles in the entire State thereby leaving 71 *per cent* of the students unattended. Whereas in test-checked districts, 44 to 80 *per cent* of eligible students were deprived of free spectacles during the aforesaid period.

On this being pointed out, the Department, while accepting the facts, stated (August 2013) that the targets for distribution of free spectacles were fixed by GoI and poor students were given preference.

1.2.8.7 National Leprosy Eradication Programme

The National Leprosy Eradication Programme (NLEP) aimed to eliminate leprosy by the end of eleventh Five Year Plan. It also aimed to ensure leprosy prevalence rate to less than one per ten thousand. The leprosy prevalence rate in the State during 2008-09, 2009-10, 2010-11, 2011-12 and 2012-13 was 0.45, 0.38, 0.30, 0.28 and 0.25 respectively which was well within the prescribed targets.

1.2.9 Procurement of medicines, equipment and services

All the procurements in the State are governed by the Uttarakhand Procurement Rules, 2008 in which detailed provisions have been mentioned for purchase of goods and services. During the coverage period ₹ 19.47 crore, ₹ 16.39 crore and ₹ 67.50 crore were spent on procurement of medicines, equipment and services respectively under NRHM in the State. The major irregularities noticed in the procurement of goods and services are discussed in the following paragraphs:

1.2.9.1 Excessive procurement and expiry of drug kits

Government of India released (April 2008) an amount of ₹ 11.40 crore under NRHM for procurement of identified drugs, kits, and equipment under RCH-II to the SHS. On the basis of rates obtained from five Central Public Sector Undertakings[10], Director General, Medical Health & Family Welfare (DGMH&FW) placed (December 2008) supply order to Hindustan Antibiotics Ltd. (HAL) for supply of Kit-A (2,500 kits), Kit-B (2,050 kits) and ASHA Kit (10,000 kits) at the unit rates of ₹ 32,105, ₹ 3,822 and ₹ 3,007 respectively, however, no tendering process was followed. All the 13 CMOs and the Joint Director (RCH) DG-MH&FW, Dehradun were made consignees by the DGMH&FW.

During scrutiny of the records, it was observed that a consignment of 726 Kit-A and 276 Kit-B was made available to the Joint Director (RCH) DGMH&FW Dehradun but due to non-availability of space at Drug Warehouse-Dehradun, these kits were delivered (February 2009) at Drug Warehouse-Roorkee. Of these, 364 Kit-A and 146 Kit-B were delivered to three CMOs[11] and the remaining 362 Kit-A and 130 Kit-B costing ₹ 1.21 crore expired at the Drug Warehouse-Roorkee.

Further, it was observed that GoI approved the contents and quantity of drugs under Kit-A which included 300 packets of ORS, 15,000 large IFA tablets and 400 bottles of IFA Syrup but the Department increased (December 2008) the quantity of ORS, large IFA tablets and IFA Syrup from 300 to 1,000, 15,000 to 20,000 and 400 to 1,000 respectively. Audit observed that 1,00,150 large IFA tablets were found to be beyond their expiry dates at the nine sampled Sub Centres due to supply in excess of requirement.

On this being pointed out, the Department accepted (August 2013) the facts and stated that indent from the CMOs were not received and quantity of contents of Kit-A was increased at the State level without approval of GoI. Thus, due to the lack of assessment of requirement of medicines and negligence in utilization of medicines kits procured, not only medicines costing ₹ 1.21 crore expired, but the needy people were deprived of the said medicines.

1.2.9.2 Non-utilization of equipment

During the physical verification of sampled DHs/CHCs/PHCs, it was noticed that 142 medical equipment like X-ray Machine, Baby Warmer, Boyles Apparatus, Radiant Heat Warmer, Auto Clave, etc. worth ₹ 2.18 crore were lying idle from the period ranging March 2006 to July 2012 for want of installation/ technicians/ operators.

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[10] 1. Indian Drugs & Pharmaceuticals Limited, 2. Hindustan Antibiotics Limited, 3. Bengal Chemicals & Pharmaceuticals Limited, 4. Rajasthan Drugs & Pharmaceuticals Limited and 5. Karnataka Antibiotic & Pharmaceuticals Limited.

[11] Rudraprayag, Uttarkashi and Pauri.

On this being pointed out, the Department replied (August 2013) that all the Medical officers in-charge will be directed to use the supplied equipment.

1.2.9.3 Operation of Pandit Deen Dayal Upadhyay Arogya Rath (DDUARs)

The Deen Dayal Upadhyay Arogya Rath (DDUAR) was launched under NRHM by providing one health van to each district of the State. In addition, Sehat Ki Sawari was also launched under NRHM in Tehri and Chamoli districts for the same purpose. Memorandum of Understandings (MoUs) for operation of Arogya Rath were executed with Society of People for Development (SPD), for five districts[12], with M/s Rajbhara Medicare Private Limited (RMPL) for seven districts[13] and with M/s GVK-108 for Pithoragarh district. MoUs for operationalization of Sehat Ki Sawari were executed with Hindustan Latex Family Planning Promotion Trust (HLFPPT). As per terms and conditions of MoUs, the operator was to operate the Vans on a predetermined route plan for at least 22 days in a month, failing which, penalty[14] was to be levied at the time of payment.

Audit scrutiny of records of the SHS showed that against total numbers of 3,848 and 3,938 camps required to be organized during June 2011 to May 2012 and August 2012 to July 2013 respectively by these private partners in the State, only 3,357 and 2,631 camps[15] were organized. As per provision of the MoUs, an amount of ₹ 1.08 crore as liquidated damages was to be recovered from the service providers for shortfall in organizing the health camps but only a deduction of ₹ 1.58 lakh and ₹ 1.32 lakh was made from RMPL in Tehri and Udham Singh Nagar districts respectively. Thus, an amount of ₹1.05 crore[16] was outstanding for recovery from these service providers. On this being pointed out, Additional Director (RCH) replied (September 2013) that the recovery of the outstanding amount would be made from the service providers.

1.2.9.4 Arbitrary selection of service provider for Emergency Response Services

Government of Uttarakhand launched (March 2008) 108 Emergency Response Services (ERSs) in the State. An MoU for this purpose was signed (March 2008) between the Department of Health & Family Welfare, Government of Uttarakhand and Emergency Management & Research Institute (EMRI), Secundarabad, Andhra Pradesh. The EMRI was to provide ERSs with reference to medical, police and fire to entire population of State for a period of ten years. Similarly, another parallel MoU was signed with EMRI (October 2011) for one year which was extendable for another one year for providing Drop Back Facility (DBF) to Mother and Neonate (less than 30 days old) after delivery/ undergoing treatment at Government Hospitals. Further, the validity of this agreement had been linked (September 2012) to State Government's MoU dated 8 March 2008 with erstwhile EMRI for providing ERSs. The 108 ERSs was being funded from State and NRHM Budget whereas DBF was being funded from NRHM. Both the assignments were awarded to EMRI on nomination basis i.e. without adopting tendering process. On this being pointed out, the Mission Director replied (August 2013) that selection of service provider was done at the Government level.

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[12] Dehradun, Haridwar, Nainital, Bageshwar and Champawat.
[13] Almora, Chamoli, Pauri, Rudraprayag, Tehri, Udham Singh Nagar and Uttarkashi.
[14] At a rate of ₹ 6,000 per day for non organizing the camp, ₹ 2,000 per day for absence of MBBS Doctor and ₹ 500 per day for absence of each paramedical staff.
[15] SPD- 2,303 camps, RMPL-2,384 camps, GVK 108- 420 camps and HLFPPT- 881 camps.
[16] SPD-₹ 20.22 lakh, RMPL-₹73.18 lakh, GVK-₹ 6.48 lakh and HLFPPT- ₹5.10 lakh.

Further, audit also observed that no bank guarantee and indemnity bond was obtained by the Department from the service provider against handing over the assets (vehicles and other assets) valued at ₹ 20.08 crore which it was required to do under provisions of the Uttarakhand Procurement Rules, 2008. Apart from above, the following irregularities were also noticed in contract management of the ERSs:

(a) Non-recovery of operational cost

As per clause-7(c) (i) of the MoU with EMRI, the firm was to bear five *per cent* of annual operational expenses of the ERSs. Scrutiny of records showed that the operational expenses of the EMRI during the period 2008-09 to 2012-13 was ₹ 73.84 crore against which Grants-in-aid of ₹ 99.74 crore was released to the EMRI as advance. Further, the EMRI was to bear ₹ 3.69 crore being five *per cent* of annual operational cost against which only an amount of ₹ 0.49 crore was borne by it in the year 2008-09 thereby, leaving an amount of ₹ 3.20 crore unadjusted till the date of audit (August 2013). On this being pointed out, the Department stated (September 2013) that a letter regarding revision of terms and conditions of the MoU was sent to the Government and the MoU was to be amended at Government level. The reply furnished by the Department is not acceptable as it failed to recoup, as per the agreement clause, the outstanding amount from the EMRI and also provided undue advantage of ₹ 3.20 crore to the EMRI.

(b) Undue payment to service provider

As has been discussed above, the Department executed two separate MoUs with EMRI, i.e. one for providing Emergency Response Services (ERSs) with reference to medical, fire and police and another in respect of Drop Back Facility (DBF) to mothers and neonates. As per the MoUs, reimbursement of actual operational cost including capital expenditure was to be done to the service provider in both the assignments. During scrutiny of the records it has been noticed that during the years 2011-12, 2012-13 a separate payment of ₹7.95 crore at the rate of ₹1,000 was made to EMRI to pick up 79,505 expectant mothers from their home and drop them to the health center for delivery whereas these cases were covered under ERSs. This was in violation of the terms and conditions of the MOUs as there was no such clause in both the MOUs.

On this being pointed out, the Additional Director (RCH) accepted (September 2013) the fact that pick up of pregnant women was a part of ERSs and no provision of payment of ₹ 1,000 per case was made in the MOU. Thus, in view of the facts, undue payment of ₹ 7.95 crore was made to EMRI.

1.2.10 Health infrastructure

The mandate of NRHM includes creation of new infrastructure/buildings for health centres and strengthening of the existing ones as per IPHS norms for improving accessibility and quality of healthcare delivery services. As per the programme norms, there should be one SC for 3,000 population, one PHC for a population of 20,000 and one CHC for a population of 80,000 in hilly States like Uttarakhand. Based on the rural population of the State, there should be 88 CHCs, 351 PHCs and 2,343 SCs against which only 59 CHCs, 254 PHCs and 1,848 SCs were established in the State as on 31 March 2013. The shortcomings noticed in infrastructure facilities are discussed in the following paragraphs:

1.2.10.1 Inadequate Health infrastructure at health centres

As per the Indian Public Health Standards norms, basic facilities i.e. electricity connection, separate wards for male and female patients, separate utilities for men and women, waiting rooms for patients, provision of water supply and provision of storage of water should be

available at each tiers of health centres. During the joint physical inspection of sampled CHCs, PHCs and SCs, 38 *per cent* of the SCs and 10 *per cent* of the PHCs had no provision of water supply, 73 *per cent* SCs and 20 *per cent PHCs* had no facilities for storage of water to ensure 24x7 water supply, and 50 *per cent* of the SCs had no electricity connection. To provide 24x7 emergency services at Community Health Centres and Primary Health Centres, residential accommodation for staff within or in the vicinity of the health facility is essential. It was seen that 30 *per cent* of the PHCs did not have residential accommodations.

On this being pointed out, the Department assured (August 2013) that these issues would be discussed with the CMOs in monthly meetings and State authorities would also personally monitor the availability of these facilities at SCs, PHCs and CHCs of the districts.

1.2.10.2 Diagnostics services

The Mission provides for essential laboratory services at PHCs and CHCs. At the PHC, the services should include laboratory services for routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of sexually transmitted diseases, sputum testing for tuberculosis, blood smear examination for malaria parasites and rapid tests for pregnancy / malaria. Out of 10 test-checked PHCs, 06 PHCs[17] (60 *per cent*) had no facilities for laboratory services. The CHC is required to have additional laboratory services like microscopy facilities for tuberculosis, diagnostic facilities for complicated cases of malaria, dengue, leprosy, etc. Out of 10 test-checked CHCs, only one CHC at Dwarahat, Almora did not have RNTCP and other facilities. On this being pointed out, Additional Director stated that due to shortage of Doctors and Lab technicians these services were not available. Thus, in absence of these services routine medical examination such as urine, stool and blood tests etc. were not being conducted.

1.2.10.3 Operation theatres

The Community Health Centres (CHCs), which constitute the secondary level of health care, were designed to provide referral as well as specialist health care to the rural population. According to IPHS norms, CHCs should have fourteen major equipment necessary to make an Operation Theatre (OT) fully operational. During the physical inspection of CHCs, audit observed that out of 10 test-checked CHCs, in four CHCs, there was no OT, while six CHCs (Tharali, Bhikiasen, Ghandiyal, Bhagwanpur, Kichcha and Bajpur) had a functional OT but the same were running with inadequate essential equipment. In six functional OTs; Ventilator, EMO Machine and Defibrillator were not available at all. Boyle's Apparatus in one CHC and Vertical High Pressure Sterlizer in two CHCs were available but these were non-functional.

On being asked, CMOs of sampled districts stated that due to non-availability of anaesthetists and surgeons major operations were not being conducted.

1.2.10.4 Construction of facilities

During 2010-11 to 2012-13, an amount of ₹ 27.67 crore for execution of 70 works was released. Out of the 70 planned works, 60 works were completed at a cost of ₹ 21.01 crore and construction of remaining 10 works was under progress.

Physical verification of constructed buildings in the selected CHCs/PHCs/SCs disclosed that the following two buildings constructed at a cost of ₹ 2.03 crore were lying idle:

[17] PHC: Malsi (Chamoli), Kimsar & Khirsu (Pauri), Manakpur (Haridwar), Masi (Almora) and Mohanpur (Udham Singh Nagar).

(i) The construction of building for Auxiliary Nurse and Midwife Training Centre (ANMTC) in Chamoli district was completed (May 2011) at a cost of ₹ 1.95 crore and handed over (July 2011) to the Department. The building was lying unutilized for more than two years after its completion. It was further observed that old building of General Nursing Training Centre (GNTC), which was in good condition, was also lying unutilized since 1990.

(ii) It was also found in physical inspection (July 2013) by audit that a building of Sub-Centre Khanjarpur (Haridwar) constructed at a cost of ₹ 8.40 lakh and handed over to the Department (March 2012) was lying unutilized and the SC was being operated from a private house.

On this being pointed out, the Department stated (August 2013) that matter would be investigated and efforts would be made to make the ANMTC functional at the earliest. Regarding non-functioning of Sub-Centre Khanjarpur, it was assured (July 2013) by the CMO-Haridwar that efforts would be made to make the Sub Centre functional.

1.2.10.5 Management of hazardous Bio Medical Waste (BMW)

The Bio-Medical Waste (Management and Handling) Rules, 1998 provided that the institutions generating bio medical waste should ensure that all such waste be segregated, transported, processed and disposed off as per guidelines.

During the course of joint physical verification of eight DHs (Male & Female), 10 CHCs, 10 PHCs and 40 SCs in the sampled districts, it was noticed that one PHC and 22 SCs did not have any bio medical waste disposal system. In addition, some interesting facts like Bio Medical Waste (BMW) being burnt openly in District Hospital, Pauri, BMW and medicines being thrown in open at CHC Dwarahat, Almora and expired medicines being burnt openly at SC Barhani under PHC Kelakhera, Udham Singh Nagar, were also noticed.

On this being pointed out, the Department replied (August 2013) that repeated instructions had been issued to districts and concerned officials for proper disposal of Bio Medical Waste. The Department further assured that instructions would be again issued to the concerned officials.

1.2.11 Human Resource Management and Information, Education and Communication

1.2.11.1 Inadequate deployment of staff

NRHM aims to provide adequate medical and other manpower at different health centres of the State.

As per information provided by the Department, there was shortage of staff in each cadre which was to the extent of 765, 812 and 946 in Class I, Class II and Technician cadres respectively. Similarly, in the sampled districts, it was noticed that there was shortage of staff in each cadre ***(Appendix-1.2.3)*** with 48 (38 *per cent)*, 514 (58 *per cent)*, 530 (24 *per cent)* vacancies, in the Class-I, Class-II and Technician cadres respectively. Out of these, the vacancies of Surgeons, Physicians, Pathologists and Anaesthetists were 28, 24, 16 and 24 respectively. Further, it was also noticed in selected districts/CHCs/PHCs that despite availability of funds, salaries to the Ayurveda contractual employees was being disbursed at Directorate level with a delay of two to five months.

On this being pointed out, the Department replied (August 2013) that payment of salaries were delayed due to late receipt of attendance of contractual staff from the districts.

1.2.11.2 Improper distribution of staff

Despite an acute shortage, staff was not deployed rationally in the hilly and plain areas of the State. In the sampled hilly districts (Almora, Pauri and Chamoli) where health facilities are scarce and difficult to reach, 43 *per cent* and 65 *per cent* of Class I & II posts respectively were lying vacant whereas in the sampled plain districts (Haridwar & Udham Singh Nagar), the vacancies were 31 and 44 *per cent* respectively. Similarly, 33 *per cent* posts of Technicians/ LHVs/ Pharmacists were lying vacant in hilly districts whereas the vacancy stood at eight *per cent* in plain districts. On this being pointed out, the Department replied that new transfer policy is under process.

Thus, due to shortage and improper distribution of staff, health services were inadequate as detailed in paragraphs 1.2.10.2 and 1.2.10.3.

1.2.11.3 Training of medical, para-medical and other staff

As per the NRHM framework, a comprehensive plan and policy to provide support for capacity building at all levels including PRIs/Community was required. Out of total 7,893 participants targeted to be trained under various programmes, 6,776 (86 *per cent*) participants attended the trainings.

1.2.11.4 Information, Education and Communication

The Information, Education and Communication (IEC) strategy under the NRHM aimed to spread awareness on the preventive aspects of healthcare and to disseminate information regarding availability of and access to quality healthcare for the poor, women and children in rural areas. The Mission envisages the establishment of IEC Bureau for proper execution of the IEC activities in the State. However, audit scrutiny showed that the IEC Bureau was not established at the State level. District IEC wings were also not established at district level.

This issue was also raised (2008) in last performance audit and the matter was also discussed in Public Accounts Committee (PAC) where the Government, in its reply, had stated (October 2010) that for filling up of vacant posts under IEC at State, District and Block levels, framing of Service Rules is under progress. On this being pointed out, the Department replied (May 2013) that the State has constituted an IEC cell in place of State IEC Bureau. Reply was not acceptable as no staff was deployed to the IEC cell till the completion of audit. Thus, it remained non-functional.

1.2.12 Health Management Information System and Monitoring Mechanism

Health Management Information System (HMIS) is an important constituent in the efficient and effective functioning of the Scheme. The centralized data plays a crucial role in providing management inputs necessary to monitor, evaluate and direct all the aspects of the Scheme.

1.2.12.1 Mismatch between the data uploaded in HMIS website with figures reported through MPR

As the HMIS was primarily based on inputs by block level officials through the website at different levels of the implementation hierarchy, the data uploaded in the website was examined to ensure the veracity of information flow. A detailed analysis of data ***(Appendix-1.2.4)*** related to Immunization and Family Planning of the State showed that there was mismatch between the figures uploaded in the HMIS website and figures reported through MPR. This is a serious issue and puts the reliability of the HMIS data at stake, which is being used by GoI for showcasing the achievements and is also relied upon by intelligentsia.

On this being pointed out, the Mission Director stated (August 2013) that the irregularities noticed by audit had also been noticed by the SHS and corrective measures in the form of review/ timely check/ validation were being done.

1.2.12.2 Mismatch between ANC Registration reported through HMIS and actual records of SCs

Data of ANC registration for the year 2012-13 of 40 SCs of test-checked districts was cross checked and it was noticed that the base records of ANC registration varied with the data uploaded on HMIS ***(Appendix-1.2.5)***. On this being pointed out, the Department replied (August 2013) that ANMs always liked to show a greater achievement than their actual performance shown in MPRs. The reply of the Department indicated that the data received from ANMs were not cross checked before being uploaded in the website.

1.2.12.3 Delayed constitution of District Health Monitoring and Planning Committee

As per the NRHM framework, monitoring and planning committees at the district level were to be formed at the start of implementation of NRHM (2005) to ensure regular community based monitoring of activities and facilitating relevant inputs for integrated planning covering other determinants of health like drinking water, sanitation, etc. As per norms, quarterly meetings were required to be held by the monitoring and planning committees. During the scrutiny of records of test-checked districts, it was noticed that these committees were constituted with delays of six to seven years. It was also noticed that no meetings were organised since their constitution in Pauri, Almora, Haridwar and Udham Singh Nagar districts whereas only two meetings were held in Chamoli district but minutes of the meetings were not made available to audit. In reply, it was assured by the Additional Director that State would make efforts to organize the meetings of these committees and maintain the records of meetings.

Thus, delay in constitution of committees and non-arranging the required meetings affected community based monitoring of activities and facilitating relevant inputs for the integrated planning.

1.2.12.4 Inadequate monitoring of SCs

As per IPHS norms, Medical Officer in Charge of CHCs/ PHCs have to visit SCs once in a month. During the scrutiny of records of test-checked SCs, it was noticed that there was a shortfall of 91 to 98 *per cent* in the visits to the SCs by the MOICs. On this being pointed out, the Department replied (August 2013) that it could not be done due to intense shortage of Medical Officers and they have to deal with administrative, clinical and other works.

1.2.12.5 Non-display of Citizen Charter and inadequate Public hearings/dialogues

In the sampled districts, Citizen Charter was not found displayed at 30 (44 *per cent*) of the health facilities physically verified. On this being pointed out, the Department replied (August 2013) that CMOs would be enquired about such discrepancies and action will be initiated accordingly. Further, the NRHM framework also stipulates that public hearings (Jan Sunwai) or public dialogues (Jan Samwad) would need to be conducted. Audit scrutiny showed that during 2008-11, no Jan Sunwai and Jan Samwad were organised. However, 1,474 Jan Sunwai at SC level, 223 at PHC level and 11 at district level were organised during the period 2011-12 and 2012-13.

Conclusion

The programme was implemented in the State without conducting household and facility surveys for understanding and identifying the health care needs of the rural population. DHAPs for the

year 2008-09 to 2012-13 were prepared without aggregating the Block and Village Health Action Plans and SPIP was sent to NPCC without the approval of the Governing Body of the SHS. Funds remained unutilized at the end of financial year during last five years. There were shortfall in providing three ANCs to pregnant women and shortfall of institutional deliveries against the registered pregnant women. Payments to JSY beneficiaries were made without adhering to the guidelines. Bio Medical Waste was not being disposed off as per the norms and provisions of guidelines. Posts were lying vacant in Class-I and Class-II cadres and there was acute shortage in critical posts like Surgeons, Physicians, Pathologist and Anesthetists. The Pandit Deen Dayal Upadhyay Arogya Raths were functioning without adequate monitoring. Mandatory camps were also not organized. Selection of EMRI was made without adopting tendering process. Five *per cent* operational cost was not recovered from EMRI and undue payment was also made to it. There was mismatch between the figures uploaded in the HMIS website with figures reported through MPR. State and District level Monitoring and planning committees were constituted with delay of six to seven years.

Recommendations

The Government may consider to ensure:

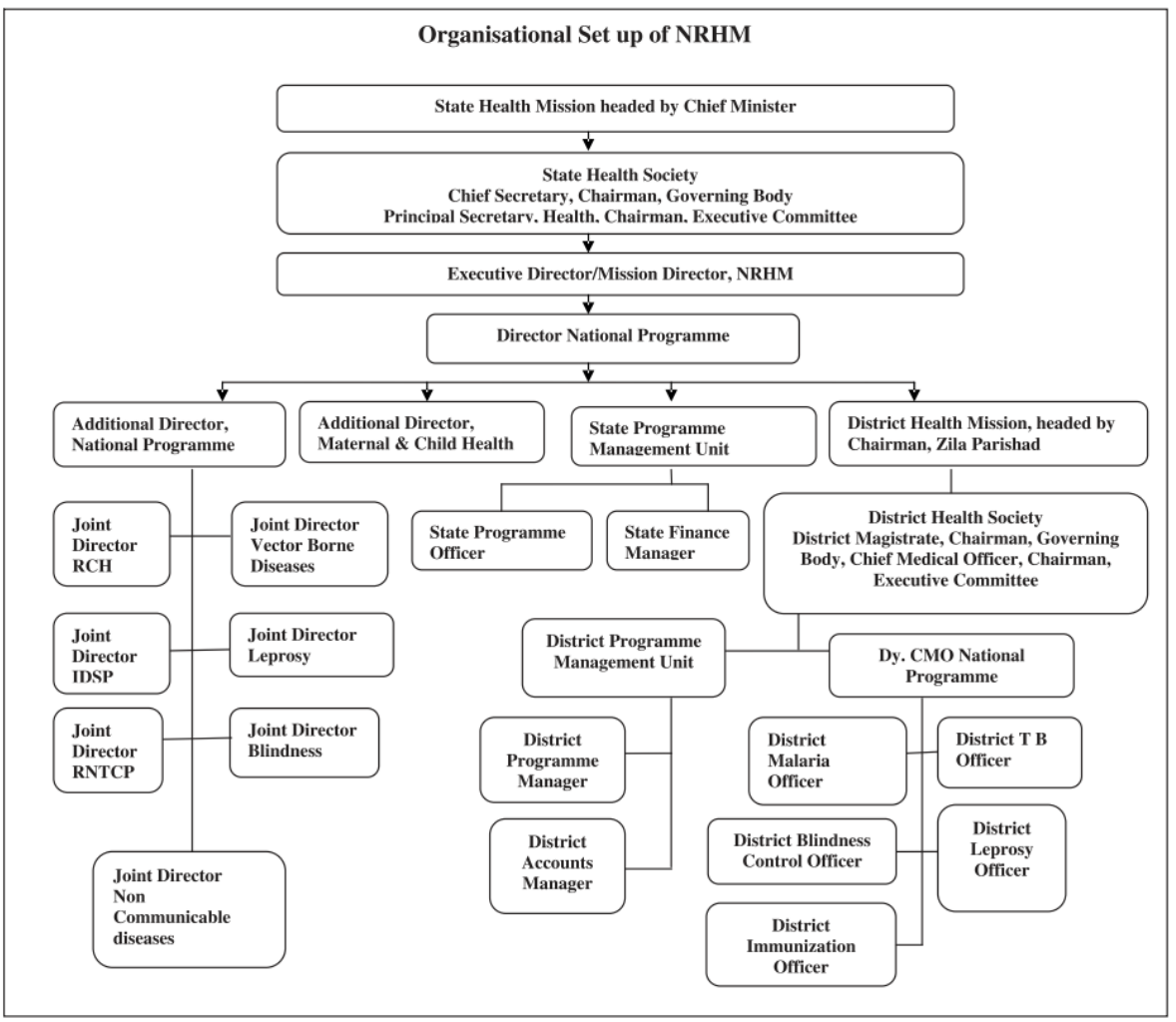
- compliance of NRHM Guidelines with regard to completing household surveys, facility surveys and preparation of Village and Block level annual health action plans;
- increasing the number of institutional deliveries to reduce maternal and infant mortality;
- adequate infrastructure, required number of doctors and other paramedical staff for providing quality services to rural population at all health centers as per IPHS norms; and
- establishing IEC wings at district levels and IEC Bureau at State level and make them functional at the earliest.

The audit findings were referred to the Government in October 2013. The reply had not been received (December 2013).

Appendices

Appendix-1.2.1

(Reference: paragraph 1.2.2; page 7)



Appendix-1.2.2

(Reference: paragraph 1.2.8.2 (ii); page 14)

Institutional deliveries

Year	District	Total registered pregnant women	Number of deliveries		
			Institutional deliveries	Domiciliary deliveries	Total deliveries
2008-09	Pauri	16580	6138 (37%)	466(3%)	6604(40%)
	Chamoli	8982	2325(26%)	00(0%)	2325(26%)
	Almora	12447	5183(42%)	7402(59%)	12585(101%)
	Haridwar	51489	7044(14%)	18456(36%)	25500(50%)
	U.S.Nagar	42975	12495(29%)	18420(42%)	30915(72%)
2009-10	Pauri	13279	6990 (53%)	344(3%)	7334(55%)
	Chamoli	8091	2458(30%)	00(0%)	2458(30%)
	Almora	11725	6005(51%)	5557(47%)	11562(99%)
	Haridwar	37460	8166(22%)	12848(34%)	21014(56%)
	U.S.Nagar	39981	16889(42%)	13658(34%)	30547(76%)
2010-11	Pauri	13859	6999 (51%)	283(2%)	7282(53%)
	Chamoli	7732	2937(38%)	156(2%)	3093(40%)
	Almora	10944	5832(53%)	4531(41%)	10363(95%)
	Haridwar	33017	7475(23%)	13737(42%)	21212(64%)
	U.S.Nagar	37904	19759(52%)	9731(26%)	29490(78%)
2011-12	Pauri	7766	7399 (95%)	211(3%)	7610(98%)
	Chamoli	7940	3565(45%)	110(1%)	3675(46%)
	Almora	10298	6573(64%)	4115(40%)	10688(104%)
	Haridwar	32799	10029(31%)	11744(36%)	21773(66%)
	U.S.Nagar	40458	19951(49%)	8862(22%)	28813(71%)
2012-13	Pauri	9096	7666 (84%)	00(0%)	7666(84%)
	Chamoli	7144	3570(50 %)	67(1%)	3637(51%)
	Almora	9757	5986(61%)	3392(35%)	9378(96%)
	Haridwar	32694	7947(24%)	9990(31%)	17937(55%)
	U.S.Nagar	37646	22420(60%)	8871(24%)	31291(83%)
Total		**542063**	**211801**	**152951**	**364752**

Appendix-1.2.3

(Reference: paragraph 1.2.11.1; page 21)

Staff position at District Level

Name of the district	Designation→	Class I	Class II	Contractual Medical Officer	Technicians/ LHV/Pharmacist	Contractual Staff Nurse/ANM
Pauri	Sanctioned	13	196	36	505	33
	In-Position	05	45	36	261	16
	Vacant	08	151	Nil	244	17
	Vacant (in %)	*62*	*77*	*00*	*48*	*52*
Chamoli	Sanctioned	22	140	NA	383	NA
	In-Position	07	31	19	291	32
	Vacant	15	109	NA	92	NA
	Vacant (in %)	*68*	*78*	*NA*	*24*	*NA*
Almora	Sanctioned	42	251	NA	543	97
	In-Position	32	127	17	412	57
	Vacant	10	124	NA	131	40
	Vacant (in %)	*24*	*49*	*NA*	*24*	*41*
Total (Hilly districts)	Sanctioned	77	587	NA	1431	130
	In-Position	44	203	72	964	73
	Vacant	33	384	NA	467	57
	Vacant (in %)	*43*	*65*		*33*	*44*
Haridwar	Sanctioned	34	142	NA	394	70
	In-Position	19	63	24	350	52
	Vacant	15	79	NA	44	18
	Vacant (in %)	*44*	*54*	*NA*	*11*	*26*
U.S.Nagar	Sanctioned	15	156	NA	399	53
	In-Position	15	105	36	380	31
	Vacant	00	51	NA	19	22
	Vacant (in %)	*00*	*33*	*NA*	*05*	*42*
Total (Plain districts)	Sanctioned	49	298	NA	793	123
	In-Position	34	168	60	730	83
	Vacant	15	130	NA	63	40
	Vacant (in %)	*31*	*44*		*08*	*33*
G. Total (Hilly +Plain)	Sanctioned	126	885	NA	2224	253
	In-Position	78	371	132	1694	156
	Vacant	48	514	NA	530	97
	Vacant (in %)	*38*	*58*		*24*	*38*

Appendix-1.2.4

(Reference: paragraph 1.2.12.1; page 22)

HMIS (Immunisation)

Contents	Year	2008-09	2009-10	2010-11	2011-12	2012-13
DPT	**MPR**	206869	207249	202702	203223	MPR not maintained
	HMIS	190376	201066	182047	185064	160767
	Difference	**16493**	**6183**	**20655**	**18159**	
Polio	**MPR**	205434	204620	202034	202221	MPR not maintained
	HMIS	192661	194584	176023	182580	160434
	Difference	**12773**	**10036**	**26011**	**19641**	
Measles	**MPR**	200311	200545	198841	197263	MPR not maintained
	HMIS	171828	181577	172996	174859	172645
	Difference	**28483**	**18968**	**25845**	**22404**	
TT	**MPR**	220149	211156	204309	214084	MPR not maintained
	HMIS	209578	194789	179278	189984	158528
	Difference	**10571**	**16367**	**25031**	**24100**	
BCG	**MPR**	211703	207356	204250	207696	MPR not maintained
	HMIS	201903	198703	187416	192886	176723
	Difference	**9800**	**8653**	**16834**	**14810**	

HMIS (Family planning)

Contents		2008-09	2009-10	2010-11	2011-12	2012-13
Male Sterlization	**MPR**	2985	2752	2625	2474	1356
	HMIS	3763	2912	3742	1923	1632
	Difference	**778**	**160**	**1117**	**551**	**276**
Female Sterlization	**MPR**	33861	31370	30951	29778	25200
	HMIS	24802	18885	26543	17610	19333
	Difference	**9059**	**12485**	**4408**	**12168**	**5867**
MTP (Medical Termination of Pregnancy)	**MPR**	9062	8320	6888	8061	MPR not maintained
	HMIS	10892	8540	8300	6857	6456
	Difference	1830	220	1412	1204	

Appendix-1.2.5

(Reference: paragraph 1.2.12.2; page 23)

Mismatch of ANC

Name of the district	Name of the Sub centre	Year 2012-13	
		ANC as per ANC Register	ANC reported in HMIS
U.S.Nagar	Keshowala	210	238
	Barhani	120	238
	Maheshpura	283	291
	Ram Nagar	173	163
	Surya Nagar	52	58
	Gokul Nagar	139	111
	Jafarpur	214	241
	Mohanpur	377	412
Haridwar	Belada	137	215
	Khanjarpur	79	66
	Mundlana	83	261
	Mandawali	Records not provided	74
	Khubbanpur	Records not provided	182
	Ruhalki	129	104
	Bhedki	Records not provided	87
	Dhilli Majra	Records not provided	79
Pauri	Pokhri	17	19
	Dharkhola	07	12
	Bhenti	15	16
	Kaljikhal	08	14
	Pharsari	32	34
	Bhagwati Talia	40	49
	Laxman Jhula	15	48
	Dharikhal	0	17
Chamoli	Pagna	0	25
	Kandai	12	24
	Talwari	19	49
	Vijaipur	0	51
	Bachuaban	101	104
	Adibadri	52	54
	Chorda	18	133
	Sainji	79	72
Almora	Sunoli	40	42
	Basoli	27	31
	Sanra	32	35
	Bhatrojkhan	100	55
	Binta	195	76
	Kama	46	56
	Masi	48	69
	Dhanad	27	29