HEALTH DEPARTMENT

1.2 National Rural Health Mission

Highlights

The National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India in all States to bring about significant improvements in the health system and the health status of the people, especially those in rural areas. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable and at the same time, responsive to the needs of the people. A performance audit of the implementation of NRHM in Goa brought out the following:

- Annual village, block and district level plans were not prepared by the State Health Society. The perspective plans for the Mission period (2007-12) had also not been prepared so far.

(Paragraph 1.2.7.1)

- An amount of ₹ 10.30 crore (41 *per cent*) out of ₹ 25.26 crore received by the State Health Society up to 2009-10 remained unspent.

(Paragraph 1.2.8.1)

- Out of 27 district hospitals/community health centres/primary health centres in the State, only 14 had Rogi Kalyan Samities. Funds were released to only three Rogi Kalyan Samities.

(Paragraph 1.2.8.3)

- Despite availability of funds, physical infrastructure and basic health care services were lacking in various health units.

(Paragraphs 1.2.9.2 and 1.2.9.3)

- There was shortage of specialists in community health centres as compared to NRHM norms and the supporting staff in primary health centres was in excess of the NRHM norms by 240 *per cent*.

(Paragraphs 1.2.10.1 and 1.2.10.2)

- An inefficient procurement and distribution mechanism resulted in distribution of 5.29 lakh substandard Iron Folic Acid capsules and 0.70 lakh Metochlopramide tablets to patients, including pregnant women.

(Paragraph 1.2.11)

- While the State had already achieved the targets in respect of Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate, there was over-reporting of figures in achievements in sterilisation, immunisation and the number of pregnant women registered. No survey of prevalence of blindness in the State had been conducted so far.

(Paragraphs 1.2.12.1, 1.2.13.1 and 1.2.18.3)

- The absence of a State Health Monitoring Committee and unsatisfactory functioning of Mother NGOs resulted in poor monitoring and evaluation of the Mission.

(Paragraphs 1.2.18.1 and 1.2.18.2)

1.2.1 Introduction

The National Rural Health Mission (NRHM) was launched by the Government of India (GOI) on 12 April, 2005 throughout the country with special focus on 18 States. In Goa, it was operationalised in April 2005. The key strategy of NRHM was to bridge gaps in health care facilities, facilitate decentralized planning in the health sector and provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health (RCH)-II, the NRHM Flexible pool, the Revised National Tuberculosis Control Programme (RNTCP), the National Vector Borne Disease Control Programme (NVBDCP), the Integrated Disease Surveillance Project (IDSP), the National Programme for Control of Blindness (NPCB) and the National Leprosy Eradication Programme (NLEP).

1.2.2 Organisational structure

In Goa, NRHM functions under the overall guidance of the State Health Mission (SHM), and is headed by the Health Minister. The State Health Society (SHS) was constituted in March 2006 with a governing body, headed by the Chief Secretary of the State. The Secretary, Health is the Mission Director who heads the Executive Committee of SHS. The Governing body of the SHS approves the annual State Action Plans for NRHM and reviews their implementation. The Executive Committee reviews the detailed expenditure and implementation, approves proposals from field health units and other implementing agencies and executes the approved State Action Plans, including release of funds for programmes at the State level. The State Government had not formed any District Health Society. The Organograms of the State Health Mission and the State Health Society are given in **Appendix 1.3**.

The implementation of all the national programmes is carried out by the respective Chief Medical Officers. Medical Superintendents are in-charge of the district hospitals. The Community Health Centres (CHCs), Urban Health Centres (UHCs) and Primary Health Centres (PHCs) are headed by Health Officers/Medical Officers and assisted by trained/qualified para-medical staff. The Rural Medical Dispensaries (RMDs) are headed by Rural Medical Officers (RMOs) and the Sub-Centres (SCs) are looked after by Auxiliary Nurse and Mid-wives (ANMs). The procurement of drugs, medicines, equipments for the health sector in the State is done centrally by the Medical Stores Depot (MSD) of the Director of Health Services (DHS).

1.2.3 Mission objectives

The main objectives of the Mission were:

- to provide accessible, affordable, accountable, effective and reliable health care facilities in the rural areas, especially to the poor and vulnerable sections of the population,
- to involve the community in planning and monitoring,

- to reduce the infant mortality rate, the maternal mortality rate and the total fertility rate for population stabilization and
- to prevent and control communicable and non-communicable diseases, including locally endemic diseases.

1.2.4 Audit Objectives

The objectives of the performance audit were to verify whether:

- planning at the level of Village, Block, District and State were adequate to achieve its principal objective of ensuring accessible, effective and reliable health care to the rural population,
- release, utilisation and accounting of funds were efficient and effective,
- the Mission achieved capacity building and strengthening of physical and human infrastructure at different levels as planned and targeted,
- the procedures and system of procurement of drugs and services, supplies and logistics management were cost-effective and efficient and ensured improved availability of drugs, medicines and services and
- the performance indicators and targets fixed specially in respect of reproductive and child health care, immunization and disease control programmes were achieved.

1.2.5 Audit Criteria

The audit criteria adopted were:

- the GOI framework on implementation of NRHM,
- guidelines issued by GOI for various components, disease control programmes, financial aspects, etc.,
- circulars issued by GOI containing directions for NRHM activities,
- Indian Public Health Standards (IPHS).

1.2.6 Audit coverage and methodology

In Goa, there are two district hospitals, one Cottage[1] hospital, five Community Health Centres (CHCs), four Urban Health Centres (UHCs), 19 Primary Health Centres (PHCs), 172 Sub-Centres (SCs) and 29 Rural Medical Dispensaries (RMDs). Records relating to implementation of the scheme for the period 2006-10 were test-checked at the Public Health Department, Directorate of Health Services, the State Health Society, one District hospital, one Cottage hospital, three CHCs, two UHCs, 10 PHCs, 45 SCs, eight RMDs, one Leprosy hospital including records of Rogi Kalyan Samities at selected CHCs, PHCs and district hospital and records of Village Health Sanitation Committees (VHSCs) in the selected Sub-Centres in the State as detailed in **Appendix 1.4.** The selection of units was done by the random sampling method. The performance audit was conducted between July and October

[1] The hospital at Chicalim is known as Cottage hospital and is equivalent to a CHC.

2010. Before the commencement of audit, discussions were held with the Secretary, Public Health and other functionaries of the Public Health Department involved, in an entry conference in July 2010 to explain the objectives and scope of audit. The exit conference with the Secretary was held in October 2010 to discuss the audit findings.

Audit Findings

Findings of the performance audit are discussed in the succeeding paragraphs.

1.2.7 Planning process

NRHM strived for decentralized planning and focused on the village as an important unit for planning. The Mission envisaged conducting of baseline facility and household surveys in CHCs, PHCs, SCs and district hospitals with timelines for completion of such activities. Based on the baseline surveys, Village Health Action Plans (VHAPs) were to be prepared by the Village Health and Sanitation Committees (VHSCs) headed by panchayat members. The VHAPs were to form the basis for preparation of health action plans at the block and district levels. A District Health Society was to be constituted in each district. This society was required to prepare Perspective Plans for the entire Mission period (2005-12) as well as Annual Plans consisting of all the components of the Mission. The Plans prepared by the District Health Societies were to be integrated in to the State Perspective Plan and the Annual State Programme Implementation Plans (PIP).

1.2.7.1 Framing of Action Plans

Village and Block level plans and perspective plans were not prepared

In Goa, baseline facility and household surveys were conducted every year by the Auxilliary Nurse and Midwives (ANMs) at the SCs. However, no health Action Plans were prepared at the village, block and district levels. Audit observed that while VHSCs were constituted, block and District Health Societies remained non-starters. The data collected during surveys were compiled by the CHCs, PHCs and district hospitals during the period 2008-10 which provided the basis for formulation of PIPs by the SHS. The PIPs for the period 2005-07 were prepared by the individual programme heads. The SHS had not prepared any Perspective Plan so far (October 2010).

The SHS replied (October 2010) that no district health Action Plan was prepared as the SHS was fully responsible for the administration of the entire State and the district level setup did not exist in the State. The VHAPs were also not prepared as the respective Health Officers/Medical Officers of the CHCs and PHCs were responsible for preparation of these Plans.

The reply is not acceptable as in the absence of village, block and district level Action Plans, the objective of decentralized planning through community participation, as envisaged in the Mission, was not achieved in the State.

1.2.7.2 Village Health Sanitation Committees (VHSCs)

NRHM envisaged constitution of VHSCs for better management and improvement of SC services with involvement of Panchayat Raj Institutions.

The VHSCs were responsible for village level planning and monitoring. VHSCs were formed in 43 out of 45 test-checked SCs during the years 2008-09 and 2009-10. The VHSCs formed in the test-checked SCs and the meetings held up to October 2010 are detailed in **Appendix 1.5.** Audit observed that out of total 53 VHSCs formed in 43 SCs, no meetings were held by six VHSCs, one to five meetings were only held by 40 VHSCs and more than five meetings were held by seven VHSCs during the period 2008-10. Thus, the participation of VHSCs in the planning process was negligible.

1.2.8 Financial management

1.2.8.1 Funding pattern, release and utilisation

Funds were released by Government of India (GOI) directly to the SHS and to the State level disease control societies. Funds were provided to the SHS on the basis of approved State Programme Implementation Plans (PIPs) by GOI. The State was required to reflect its requirements in a consolidated PIP containing individual programmes. The Annual Plans approved during the years 2006-10 and the funds received, utilised and unspent balances with the SHS are shown in **Table-1**.

Table-1: Statement showing approved budgets and funds received from the GOI and the State

(₹ in crore)

Year	Approved Budget	Opening Balance	Funds received from GOI	Funds received from State	Total funds available	Expen-diture	Closing Balance (including bank interest & other receipts*)
2006-07	2.18	3.30	3.20	Nil	6.50	2.28	4.37
2007-08	4.86	4.37	4.64	Nil	9.01	3.42	5.70
2008-09	14.80	5.70	7.07	Nil	12.77	4.20	8.76
2009-10	19.61	8.76	7.35	3.00	19.11	10.99	8.47
Total	**41.45**		**22.26**	**3.00**		**20.89**	

(Source: Financial statements of SHS)
** includes registration fees, sale proceeds of forms etc. and other receipts.*

In addition to the above, funds to the tune of ₹ 37.50 lakh were received from GOI for the National Iodine Deficiency Disorder Control Programme (NIDDCP) during the period 2005-10. The expenditure incurred for implementation of the NIDDCP was ₹ 29.06 lakh up to March 2010.

During 2006-07, 100 *per cent* grants were provided by GOI to the State. From the Eleventh Plan period (2007-12) onwards, the State was to contribute 15 *per cent* of the funds required annually. There was no contribution by the State till 2008-09. During the year 2009-10, the State contributed ₹ three crore (15 *per cent* of the approved budget for the year).

Poor utilisation of funds resulted in large unspent balances. The unspent balance accounted for 41 per cent of the funds received during the four-year period 2006-10

It was seen that the SHS had a balance of ₹ 8.47 crore lying in its bank accounts as of March 2010. Further, advance payments totalling ₹ 1.83[2] crore

[2] RCH Flexi pool (₹ 0.33 crore), NRHM Flexible pool (₹ 1.24 crore), RNTCP (₹ 0.05 crore), NVBDCP (₹ 0.21 crore) and IDSP (₹ 0.17 lakh).

released during 2007-10 to its peripheral units were also pending utilization, making the total unutilised balance ₹ 10.30 crore as of March 2010. The unspent balance (₹ 10.30 crore) accounted for 100 *per cent* of the funds received during 2009-10 (₹ 10.35 crore) and 41 *per cent* of the funds received (₹ 25.26 crore) during the four-year period 2006-10.

The unspent balances were attributed (October 2010) by the DHS to non-availability of manpower, resulting in vacant posts and the peripheral units being apprehensive and reluctant to spend NRHM funds at the local level due to political situations at the villages and panchayats.

Programme-wise funds received from the Central and State Governments and funds utilised and disbursed to various peripheral units under NRHM in the State during the period 2006-10 are shown in **Appendix 1.6.**

Analysis of the programme-wise utilisation of funds revealed that the unspent balances as on 31 March 2010 ranged up to 66 *per cent* of the total funds received during the period 2006-10 as shown in **Table-2.**

Table-2: Programme-wise funds received and unutilised balances during the period 2006-10

(₹ in crore)

Programme	Funds received	Unutilised balance	Percentage of unutilised balance against funds received
RCH flexible pool[3]	6.82	4.52	66
NRHM flexible pool[4]	12.63	3.52	28
RNTCP	1.56	0.04	3
NVBDCP	1.52	0.24	16
IDSP	1.13	0.12	11
NPCB	1.33	*	0
NLEP	0.27	0.03	11
Total	**25.26**	**8.47**	

(Source: Figures compiled from financial statements) * *₹ 10,000 only*

As the GOI had considered the unutilised balances with the SHS while finalising the budgetary allocations under NRHM, the under-utilisation of funds released by GOI had an adverse impact on the allocations for the subsequent years. The Secretary (Health) stated (October 2010) at the exit conference that there was a trend of increase in expenditure over the years and efforts were being made to improve utilisation in the current year.

1.2.8.2 Funds given to field offices

The SHS distributes untied grants and maintenance grants to the CHCs, UHCs, PHCs and SCs. It was observed that the grants released by the SHS were not reconciled periodically. There was also no system in place for preparation of accounts by field units and reconciling the figures with the accounts of SHS.

[3] Reproductive Child Health (RCH) flexible pool includes immunization strengthening, pulse polio immunization, compensation for sterilization, MNGO scheme etc.

[4] National Rural Health Mission (NRHM) flexible pool covers Rogi Kalyan Samities, VHSCs, maintenance and untied grants to PHCs/CHCs etc.

The opening balances, expenditure incurred and the closing balances as seen in the records of the test-checked CHCs/PHCs/SCs were not tallying with the records of the SHS. The differences noticed in the test-checked units are shown in **Appendix 1.7.**

Audit observed that in five PHCs/CHCs/UHC[5], the entries in the cash book were written in pencil. The cash books were not checked periodically by the heads of offices in eight[6] of the test-checked PHCs/CHCs. Thus, the risk of manipulation/tampering of entries subsequently could not be ruled out.

1.2.8.3 Fund management by Rogi Kalyan Samities (RKSs)

Funds to 11 out of 14 Rogi Kalyan Samities were not released

NRHM strategises upgradation of CHCs as per Indian Public Health Standards (IPHS) to provide sustainable quality health care with accountability and people's participation along with total transparency. To ensure a degree of permanency and sustainability, a management structure called Rogi Kalyan Samities (RKSs) has been evolved to be established at PHCs, CHCs and district hospitals. The main functions of the RKS are to identify and redress the problems faced by the patients; acquire and maintain equipment, furniture, ambulances etc.; improve boarding/lodging arrangements for patients and their attendants; encourage community participation in maintenance of hospitals etc. As per the scheme guidelines, specified funds[7] are to be released by SHS to RKSs at district hospitals, CHCs and PHCs to carry out the functions devolving on them.

It was observed by Audit that out of two district hospitals, five CHCs and 19 PHCs, RKSs were formed in two district hospitals, three CHCs and nine PHCs only. The reasons for non-formation of RKSs in the remaining two CHCs[8] and 10 PHCs[9] were not furnished by SHS. The SHS distributed ₹ 67 lakh[10] to two RKSs at the district hospitals and ₹ one lakh to RKS at PHC, Sanquilim. No grants were given to the remaining 11 RKSs. The SHS stated that due to the absence of work proposals from the concerned CHCs/PHCs the funds were not released to them. Hence, although RKSs were formed in the remaining 11 centres[11], they could not perform the activities envisaged under NRHM due to non-provision of funds by the SHS.

As per the Mission guidelines, RKSs at district hospitals were to receive corpus grants of ₹ five lakh each every year. Besides, they were to receive

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5 PHC (1) Cortalim, (2) Curtorim, CHC, (3) Canacona, (4) Ponda and (5) UHC, Vasco.

6 PHC (1) Bicholim (2) Cortalim, (3) Curtorim, (4) Quepem, CHC, (5) Canacona, (6) Pernem, (7) Ponda and (8) UHC, Vasco.

7 RKS at District Hospital, CHC and PHC – annual untied grant of ₹ 1,00,000 ₹ 50,000 and ₹ 25,000 respectively and annual maintenance grant of ₹ five lakh, ₹ one lakh and ₹ 50,000 respectively.

8 (1) CHC, Canacona, (2) CHC, Valpoi.

9 PHCs at (1) Candolim, (2) Chinchinim, (3) Colvale, (4) Corlim, (5) Curtorim, (6) Cortalim, (7) Loutlem (8) Marcaim, (9) Quepem and (10) Shiroda.

10 ₹ 67 lakh includes ₹ 40 lakh released by GOI for upgradation of district hospitals/CHCs and PHCs.

11 CHCs at (1) Curchorem, (2) Pernem and (3) Ponda, PHCs at (4) Aldona, (5) Balli. (6) Betki, (7) Bicholim, (8) Canservarnem, (9) Cansaulim, (10) Sanguem and (11) Siolim.

grants from State Government and were supposed to generate their own resources through levying user charges, receiving philanthropic donations etc. The ratio to be maintained was 1:1:3 for own funds, State funds and Central funds. It was observed that no user charges were collected by the RKS formed in the test-checked district hospital (October 2010). The State's share was also not found credited to the RKS account till October 2010. Thus, the absence of funding affected the viability of the long-term goal of community ownership of the health centres through the RKS.

1.2.8.4 Strengthening of district hospitals/CHCs/PHCs

GOI released (2006-07) ₹ one crore for upgradation of district hospitals, CHCs and PHCs. Out of this amount, the SHS had released ₹ 40 lakh in 2006-07 to two RKSs at district hospitals and the balance amount of ₹ 60 lakh remained unutilised with SHS till date (October 2010). The State Programme Manager stated (October 2010) that due to the absence of work proposals from CHCs/PHCs, it was not possible to park funds in the concerned CHCs/PHCs. However, the fact remained that the funds had been parked in the bank accounts of the SHS.

1.2.8.5 *Non-setting up of revolving funds by Village Health Sanitation Committees*

The Mission envisaged setting up of a revolving fund at the village level by the VHSC for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization. It was, however, observed that no revolving fund was created in any of the VHSCs formed in the test-checked SCs. Absence of the revolving fund rendered VHSCs ineffective.

1.2.9 Capacity building

1.2.9.1 Creation of health centres

There was shortage of 14 CHCs, 58 PHCs and 341 SCs with reference to population norms

As per the Indian Public Health Standards (IPHS), for every 80,000 people, there should be a CHC, for population over 20,000, a PHC and for population over 3,000, one SC. In terms of these norms, the requirement of CHCs, PHCs and SCs in the State worked out to 19 CHCs, 77 PHCs and 513 SCs respectively. As against this, the State had a network of five CHCs, 19 PHCs and 172 SCs for delivery of health services. Despite the shortfall of 14 CHCs, 58 PHCs and 341 SCs, the Government projected the establishment of only five CHCs, 10 PHCs and Nil SCs in the Eleventh Five Year Plan (2007-12). The CHCs were to be designed to provide referral health care for patients from the PHCs, thus catering to approximately 80,000 people in tribal/hilly/desert areas and 1,20,000 people for plain areas. It was observed that the CHCs in Goa were not functioning as secondary level health care providers to the PHCs but performing functions similar to those of the PHCs, catering only to the population in their coverage area.

The State Programme Manager, NRHM replied (October 2010) that the existing set-up of CHCs/PHCs/SCs in the State was sufficient to cater to the needs of the State. As regards the low projection in the Eleventh Five Year

Plan, it was stated that due to better road connectivity between villages and cities, the patients often approached the district hospitals and the Goa Medical College. The availability of a well-developed private medical sector in the State was also one of the reasons for less projection of health centres in the Five Year Plan. The reply is not borne out of facts as the State Government approved (August 2009) 64 more SCs which were still to be started due to difficulties in getting human resources to man these centres.

1.2.9.2 Inadequate infrastructure and basic health care services

The framework for implementation of the Mission had set a target of providing certain guaranteed services to the public at SC, PHC and CHC levels. To achieve this, the Ministry of Health and Family Welfare, GOI had come forward with Indian Public Health Standards for different levels of health centres for ensuring availability of facilities. Audit reviewed the availability of facilities at 71 test-checked SCs, RMDs, UHCs, PHCs, CHCs and district hospital, which revealed deficiencies as detailed below.

(a) Infrastructure

Out of the test-checked units, it was found that in two[12] cases, the SCs and RMDs were located in the same premises covering the same population and three[13] SCs were located in the PHC/CHC itself. The non-availability of basic minimum infrastructure in the test-checked health centres is shown in **Appendix 1.8.** The condition of the some of the health centres is shown in the photographs given below:

1 2

Photographs (1) Dilapidated quarters in Curtorim; (2) Poor state of affairs of SC, Quelossim.

Audit observed that despite availability of funds, the SHS failed to provide required infrastructure to the existing health centres.

(b) Basic health care services

The basic health care services that were required to be provided in the health centres were not available at many of the centres visited by the audit team as tabulated in **Table-3**.

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[12] (1) RMD, Agonda and SC, Agonda; (2) RMD, Cuncolim and SC Cuncolim.

[13] (1) Deao SC in Quepem PHC; (2) Bali SC in Bali PHC and (3) Pernem rural SC in Pernem CHC.

Table-3: Statement showing non-availability of basic health care services

Services	District / Cottage hospital	CHCs	PHCs
Total health centres audited	**2**	**3**	**10**
Blood storage	1	3	10
Newborn care	Available	Available	4
24X7 deliveries	Available	Available	2
In patients	Available	Available	3
X-rays	Available	1	7
ICCU/ICU	2	2	10
Ultra-sound	Available	1	10
ECG	Available	1	7
Obstetric care	Available	1	6
Emergency services (24 hours)	Available	Available	3
Family planning (Tubectomy & Vasectomy)	Available	1	5
Intra-natal examination of gynaecological conditions	Available	1	3
Paediatrics	1	2	6
Cold Chain system	Available	Available	Available

(Source: Figures compiled from the records of test-checked units)
(The figures in the table indicates the number of District/Cottage Hospital, CHCs and PHCs where facilities were not available).

The State Programme Manager, NRHM replied (October 2010) that the funds made available under NRHM were insufficient to build up the infrastructure to the fullest extent.

The reply is not acceptable in the light of the objective of NRHM which aimed at creation of new infrastructure/public buildings and strengthening of the existing infrastructure for health centres so as to improve accessibility and quality of health care delivery. Further, huge funds received from GOI for upgradation of health units were lying unutilised with the SHS in their savings bank accounts.

1.2.9.3 Infrastructure in Cottage Hospital, Chicalim

Scrutiny of infrastructure in Cottage Hospital, Chicalim revealed that owing to poor maintenance, the ceiling of the hospital building was leaking. The isolation ward for controlling the spread of H1N1 (swine flu) could not be utilised due to its unhygienic condition. The cottage hospital also lacked space for beds. The corridor passages were utilised by placing beds for male patients. The table in the labour room was very old and was supported by a wooden piece. There was lack of adequate space for storage of medicines. The condition of the hospital can be seen in the photographs below.

1 2 3

Photograph (1) beds in corridor passage, (2) wooden support to labour table and (3) improper storage of medicines.

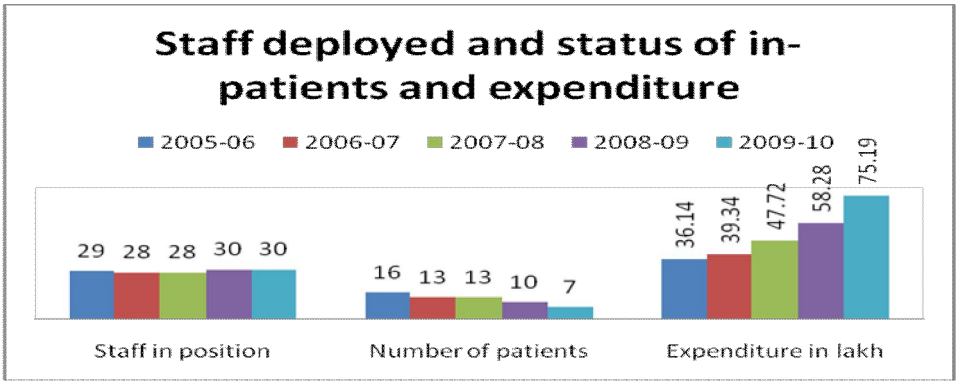
The Health Officer, Cottage Hospital, while confirming (July 2010) the above facts stated that the matter had been reported to higher authorities and the Public Works Department to repair the building. Further, it was stated that as regards the expansion of the casualty ward and supply of a new labour table, possibilities of getting assistance from the Indian Oil Corporation and the Goa Shipyard were being explored.

1.2.9.4 Leprosy hospital

Goa has an old leprosy hospital established under Portuguese rule situated at Macasana village in South Goa District. The hospital initially had a capacity of 150 beds which was reduced over the years. Between 2005-06 and 2009-10, the number of patients in the hospital reduced from 16 to seven. No new patients had been admitted in the hospital since 2005-06. The admission of new patients for isolation was not felt necessary due to the effective new drug regime (multi-drug therapy) which is a 100 *per cent* domiciliary treatment. The hospital was situated on 35 acres of land and the existing buildings were in a bad shape. Some of the buildings in the campus had collapsed as shown in the photograph.

Dilapidated condition of leprosy hospital

The number of staff deployed in the hospital had increased to 30 in 2009-10 from 28 in 2007-08 to cater to a total of only seven patients. The expenditure on the hospital[14] also increased from ₹ 36.14 lakh in 2005-06 to ₹ 75.19 lakh in 2009-10 as shown in the graph below:



[14] Salary and allowances, office expenditure, material and supply and dietary expenditure.

The Health Officer, PHC, Curtorim who was holding the administrative charge of the leprosy hospital, forwarded a proposal in July 2010 for shifting the existing patients to the vacant staff quarters in the PHC, Curtorim. Though the Director of Health Services stated (August 2010) that these patients could be brought to the mainstream of the society, the State Health Department had not taken any decision to rehabilitate them.

1.2.9.5 Minimal utilisation of operation theatre at CHC, Canacona and PHC, Bicholim

CHC, Canacona was shifted to a new building with facilities of operation theatre from 2005. However, it was observed that the Operation Theatre (OT) was not used on regular basis for conducting operations. The operations were performed only when laparoscope camps were organised. Further, a new laparoscope machine supplied (July 2009) by the DHS was transferred by the DHS to CHC, Pernem in November 2009. No reason was found on records for the transfer. CHC, Canacona, thus did not have any laparoscope machine for conducting sterilisation operations. All the cases were referred to the district hospital or to other CHCs situated approximately at a distance of 45 to 50 km where the facilities were available.

The Health Officer, Canacona, while confirming the above facts, stated (July 2010) that due to non-availability of a regular surgeon, anaesthetist and ancillary staff and blood storage equipment, major operations could not be carried out in the OT. Minor operations were conducted in the OPD/Casualty with sterile instruments obtained from the OT. Thus due to insufficient manpower, laparoscope machine and blood storage facility the new OT remained underutilised.

Similarly, no operations had been conducted in the OT at PHC, Bicholim since July 2007 due to non-availability of specialists and patients were being referred to the district hospital at Mapusa and CHC, Valpoi. The Health Officer, Bicholim confirmed (October 2010) the facts.

1.2.9.6 Blood storage unit at CHC, Canacona

One Blood Storage Unit (BSU) at CHC Canacona was installed in March 2010 at a cost of ₹ 8.54 lakh, which was not made operational as of October 2010. It was observed that for commencing the operation of the BSU, permissions were required from the Food and Drugs Administration (FDA), New Delhi. In order to obtain permissions from FDA, the CHC had to obtain the consent of the district hospital (where there was a blood bank which would act as the mother blood bank) that they would supply blood regularly to the CHC. The DHS stated (October 2010) that for starting the operation of BSU, unconditional consent was required. The consent given by the district hospital (Hospicio) was conditional which was being sorted out. Thus, due to delay in obtaining consent from the district hospital, the BSU could not be operationalised.

1.2.10 Manpower

There was shortage of specialists in CHCs as compared to NRHM norms

1.2.10.1 Vacancies in cadre of specialists in CHCs and Cottage Hospital

As per IPHS, there should be seven specialists[15] in each CHC. The number of posts sanctioned for each CHC and the Cottage Hospital are shown in **Table-4.**

Table-4: Statement showing posts of specialists sanctioned and persons-in position

Name of CHC	Norms as per IPHS	Sanctioned strength of specialists	Number of specialists present		
			Regular	On contract	Total
CHC, Canacona	7	7	2	2	4
CHC, Ponda	7	5	3	1	4
CHC, Curchorem	7	3	0	2	2
CHC, Pernem	7	3	3	0	3
CHC, Valpoi	7	5	1	1	2
Cottage hospital, Chicalim	7	5	2	0	2
Total	**42**	**28**	**11**	**6**	**17**

(Source: Figures supplied by SHS)

It was observed that all the seven specialists were not available in any of the CHCs. As against the required 42 specialists in five CHCs and one Cottage Hospital, the State had sanctioned posts for only 28 specialists. Only 17 of these posts were filled, which included six specialists appointed on contract basis.

The Director (Administration) in DHS while confirming the above facts, stated (October 2010) that a proposal for creation of posts of five specialists was submitted to the Government. Due to the shortage of qualified doctors in the State, it was proposed to advertise the posts in the neighbouring States. The fact remains that the shortage of specialists resulted in the populace being deprived of specialised medical attention.

The supporting staff in PHCs was in excess up to 240 per cent over the number prescribed as per NRHM norms

1.2.10.2 Over-staffing in PHCs

According to IPHS, a PHC should essentially have 15 support staff[16]. It was observed in the test-checked PHCs that the percentage of support staff provided was in excess of the IPHS norms, ranging between 33 and 240 as detailed in **Table-5**.

[15] (1) General Surgeon, (2) Physician, (3) Obstetrician/Gynaecologist, (4) Paediatrician, (5) Anaesthetist, (6) Public Health Programme Manager and (7) Eye Surgeon.

[16] Pharmacists (1), Nurse–Midwife (1), Health Worker (Female) (1), Health Assistant (Female) (1), Health Assistant (Male) (1), Ophthalmic Assistant (1), Clerks (2), Data Handler (1), Laboratory Technician (1), Driver (1) and Class IV (4).

Table 5: Statement showing support staff

Name of PHC	Population covered	Support staff		Excess	Excess in percentage
		As per IPHS norms	Actual		
Curtorim	77788	15	51	36	240
Bali	43843	15	45	30	200
Quepem	37703	15	25	10	67
Betki	56341	15	29	14	93
Colvale	30350	15	20	10	33
Shiroda	26517	15	20	5	33
Consarvarnem	23985	15	33	18	120
Bicholim	56600	15	43	28	186
Cortalim	48450	15	12	(-) 3	(-) 20

(Source: Figures provided by the PHC). The information in respect of PHC, Siolim was not furnished (October 2010).

The State should avoid overstaffing and should re-deploy the manpower as per IPHS standards.

1.2.11 Procurement

The procurement of medicines and equipments was done by the Medical Stores Depot (MSD) in the DHS. The requirements for the medicines were received from the field offices by the MSD and the annual rate contracts for medicines were entered into with different agencies by inviting tenders.

A total of 5.29 lakh sub-standard Iron Folic Acid capsules were distributed to pregnant women due to inefficient quality control mechanism

The State Health Society had procured medicines worth ₹ 2.15 crore under various schemes of NRHM during the period 2005-10. The quality of the medicines procured was checked by the Directorate of Food and Drugs Administration (FDA), Goa. Audit test-checked the procurements made under NRHM, and found that quality checking was not conducted by FDA, Goa in respect of all the medicines procured by the MSD. The FDA, Goa collected samples on 10 occasions during 2009-10 and the results indicated that 30 *per cent* of the samples checked were of sub-standard quality. Further, the test report of the samples checked by FDA, Goa was received late. By that time, a major quantity of medicines had already been distributed to field health units and had been consumed by the patients. The details of such instances noticed by Audit are shown in **Table-6**.

Table 6: Statement showing sub-standard drugs supplied, distributed and utilised by field health units

Name of medicine	Name of Supplier	Date of taking sample by FDA, Goa	Date of report submitted by FDA, Goa	Batch Nos. reported as sub standard	Quantity issued by MSD before receipt of FDA report to field health units (in numbers)	Quantity returned by field health units subsequent to DHS's directions (in numbers)
Cap Ferrous Fumerate, Folic Acid & Abosorbic acid (Iron Folic Acid)	M/s Goa Antibiotics & Pharmaceuticals Ltd., Goa	14-01-2008	07-02-2008	946007 946008 946009B 946021 947003 947001 946023 **Total**	99000 98800 98800 99700 77400 99000 99700 **672400**	143478
Tab Metochlopramide I.P. 10 mg	M/s Modern Laboratories, Indore	01-04-2009	11-3-2010	801 802 **Total**	50000 20000 **70000**	Not returned

(Source: Figures taken from the records of MSD)

Distribution of iron folic acid capsules is an important component under antenatal care aimed for safe motherhood and childbirth. It was observed that 5.29 lakh sub-standard capsules were utilized by the health units and only 1.43 lakh were returned to DHS. The Deputy Director (MSD) confirmed (October 2010) that the capsules were utilized by the health centres. In respect of Metochlopramide tablets, the FDA, Goa furnished the test report after a delay of 11 months and it subsequently (August 2010) suggested destruction of these tablets. The Deputy Director (MSD) stated that (October 2010) 70,000 Metochlopramide tablets distributed to the health units had not been returned by the health units so far.

The distribution of substandard medicines reflected inadequate quality control mechanism and inefficient monitoring of procurement and distribution. Remedial action must be taken to get test reports faster and medicines must be distributed only after clearance from FDA as the implications/consequences of consuming sub-standard medicines could be hazardous.

1.2.12 Performance indicators

1.2.12.1 Achievement of Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate

The State had already achieved the targets in respect of IMR, MMR and TFR

NRHM prescribed national targets for reducing Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR); reducing morbidity and mortality rate and increasing cure rate of different endemic diseases covered under various national programmes. The targets of IMR, MMR and TFR and achievements thereagainst in the State are given in **Table-7**.

Table-7: Statement showing achievements in IMR, MMR and TFR

Indicators	Target as per NRHM	Achievement as on March 2010
IMR	30 per thousand live births by the year 2012	15 per thousand
MMR	100 per lakh live births by the year 2012	20 per lakh
TFR	2.1 by the year 2012	1.8

(Source: Figures supplied by SHS)

The data indicates that the State had already achieved the targets prescribed under NRHM.

1.2.12.2 Status of out-patient and in-patient cases

The number of out-patient and in-patient cases attended in the health centres is an important indicator to assess the effectiveness of various interventions under the NRHM. It was observed that six[17] out of 19 PHCs in the State did not have the facility of in-patients. As per the information provided by the SHS, the overall status of increase/decrease in the number of patients coming to health centres for out-patient and in-patient services during the years 2006-10 was as shown in **Table-8**.

Table-8: Statement showing the number of out-patients and in-patients

Type of health centre	Year	Total number of health centres	Out-patients			In-patients		
			Number	Increase (+) or decrease (-) over previous years		Number	Increase (+) or decrease (-) over previous years	
				Number	Percentage		Number	Percentage
PHC	2006-07	19	258068			9841		
	2007-08	19	302974	44906	17	12324	2483	25
	2008-09	19	333099	30125	10	17276	4952	40
	2009-10	19	397422	64323	19	25017	7741	45
CHC	2006-07	5	122988			14356		
	2007-08	5	123590	602	negligible	11921	(-) 2435	(-) 17
	2008-09	5	143076	19486	16	14481	2560	21
	2009-10	5	176073	32997	23	14201	(-) 280	(-) 2
District hospital (Asilo, Hospicio)	2006-07	2	240779			36241		
	2007-08	2	258395	17616	7	38699	2458	7
	2008-09	2	279373	20978	8	39205	506	1
	2009-10	2	321125	41752	15	41201	1996	5
Cottage hospital, TB hospital and leprosy hospital	2006-07	3	21565			2778		
	2007-08	3	26530	4965	23	2846	68	2
	2008-09	3	30936	4406	17	3490	644	23
	2009-10	3	53741	22805	74	4189	699	20

(Source: Figures supplied by SHS)

Details of increase/decrease in out-patients in PHCs, CHCs, district hospitals and other hospitals revealed that there was increase in the out-patients as compared to the earlier years, ranging between 10 and 19 *per cent* in PHCs, 16 and 23 *per cent* in CHCs, seven and 15 *per cent* in district hospitals and 17 and

[17] (1) Chinchinim, (2) Corlim, (3) Cortalim, (4) Colvale, (5) Loutilem and (6) Quepem.

74 *per cent* in other hospitals. In respect of in-patients, there was an increase from 25 *per cent* in 2007-08 to 45 *per cent* in 2009-10 in PHCs. However, in CHCs, the number of in-patients decreased by 17 *per cent* and two *per cent* during the years 2007-08 and 2009-10 respectively as compared to the earlier years. In respect of district and other hospitals, there was an increase in in-patients as compared to the earlier years, ranging between two and 23 *per cent* and one to seven *per cent* respectively. The increase in in-patients at PHC level indicates a positive response due to the interventions of NRHM.

1.2.12.3 Maternal health

The Reproductive Child Health (RCH)-II project aims to reduce maternal and infant mortality rates to 100 per lakh and 30 per thousand respectively by 2010. The important services for ensuring maternal health care *inter alia* include antenatal care, institutional delivery, post-natal care, referral services etc.

(a) Antenatal care

One of the major activities to ensure safe motherhood is to register all pregnant women before they attain 12 weeks of pregnancy and provide them with services such as, three antenatal care (ANC) checkups, 100 days of Iron Folic Acid (IFA) tablets, two doses of Tetanus Toxoid (TT) and advise on correct diet and vitamin supplements. In case of complications they should be referred to more specialised gynaecological care. The details of pregnant women registered, the number of pregnant women who received three ANC checkups, 100 days of IFA and two doses of TT are given in **Table-9**.

Table-9: Statement showing number of pregnant women who received ANC checkups, 100 days IFA and TT immunisation

Year	Number of pregnant women registered	Three ANC checkups		100 days of IFA tablets			Tetanus Toxoid immunisation		
		Number	Perce-ntage	Target	Achieve-ment	Perc-entage	Target	Achiev-ement	Perce-ntage
2006-07	64732	45879	71	24870	21084	85	25562	23697	93
2007-08	67523	62333	92	25872	26230	101	29345	24323	83
2008-09	45463	39465	87	25555	15438	60	25553	22679	89
2009-10	43870	44900	102	24687	18828	76	24690	20204	82

(Source: Monthly performance report of SHS)

The number of pregnant women registered showed a decreasing trend. The percentage of registered pregnant women who received three antenatal checkups increased to 102 *per cent* in 2009-10 from 71 in 2006-07. The IFA administration in the State indicated a declining trend and the shortfall in achievement of TT immunisation as against the target ranged between 18 (2009-10) and seven *per cent* (2006-07) in the State.

The Chief Medical Officer (CMO), Family Welfare stated (October 2010) that there had been over-reporting of the number of pregnant women registered due

to the registering and reporting of the same pregnant women by various health centres. Further, Goa being socially and economically sound, the beneficiaries went to private institutions for their checkups which included antenatal checkups, provision of IFA tablets and TT Immunisations, which did not get reflected in the reports. The admission by the CMO regarding over-reporting is indicative of the fact that the figures of achievement are not reliable. There is a need to evolve a sound reporting system from the CHCs, PHCs and SCs.

(b) Institutional delivery care (Janani Suraksha Yojana)

The Janani Suraksha Yojana (JSY), one of the interventions in the RCH-II component under NRHM, was initiated to reduce maternal and neonatal mortality by promoting institutional deliveries among poor pregnant women. The Yojana is 100 *per cent* Centrally sponsored. Pregnant women aged 19 years and above, who are below the poverty line, are eligible for cash assistance of ₹ 700 and ₹ 600 per institutional delivery in rural and urban areas respectively and ₹ 500 for home delivery. Cash assistance has to be paid to women who deliver in Government health centres like CHC, PHC, district hospital, etc. The cash is to be disbursed at the centres at the time of registration/admission. For home deliveries, the money is to be given at the time of delivery or within seven days of delivery.

The details of pregnant women registered under JSY, institutional deliveries, home deliveries and cash assistance paid during the period 2005-10 are given in **Table-10**.

Table 10: Statement showing pregnant women registered, institutional deliveries, home deliveries and cash assistance paid to beneficiaries under JSY

Year	Number of pregnant women registered	Institutional deliveries for which cash assistance paid		Home deliveries for which cash assistance paid	Total cash assistance paid *(₹in lakh)*
		Urban	Rural		
2005-06	NA	0	56	1	0.37
2006-07	NA	0	483	0	3.38
2007-08	NA	13	885	0	6.27
2008-09	1056	42	646	0	4.77
2009-10	1147	61	589	0	4.49
Total	**2203**	**116**	**2659**	**1**	**19.28**

(Source: Figures supplied by SHS)

The SHS did not have figures of number of pregnant women registered under JSY for the period up to 2007-08. Audit observed that during 2008-09 and 2009-10, as against 1,056 and 1,147 pregnant women registered under JSY, no cash assistance was paid to 368 (35 *per cent*) and 497 (43 *per cent*) women respectively. It was also observed from the test-checked health centres[18] that

[18] (1) CHC Pernem (124 cases out 131 cases), (2) PHC Bicholim (39 cases out of 55 cases), (3) PHC Siolim (34 cases out of 40 cases) and (4) PHC Consavornam (165 cases out of 193 cases).

there were delays in payment of compensation in 362 out of 419 cases, i.e. 86 *per cent* ranging between one month and 12 months. The concerned Health Officers replied (September-October 2010) that the delays were due to beneficiaries not coming forward to claim the cash assistance in time. The reply is not acceptable as the cash assistance was payable at the time of delivery itself, which should have been ensured to avoid delays.

1.2.12.4 Immunisation and child health

Strengthening of services to improve child survival is one of the major components of the RCH-II programme. This mainly focuses on preventive aspects such as control of vaccine-preventable diseases, diarrhoea and acute respiratory infection among infants and children under five years of age. Immunisation of children against six preventable diseases, viz., tuberculosis, diphtheria, pertussis, tetanus, polio and measles has been the cornerstone of routine immunisation under the universal immunisation programme. The BCG[19] vaccine was to be administered at the time of birth or within one month of birth and the children who received measles vaccines along with other vaccines before age one were to be treated as fully immunized children. The achievements against the targets set for full immunisation in the State during 2005-06 to 2009-10 are shown in **Table-11**.

Table-11: Statement showing full immunisation with reference to BCG

Year	BCG Ist dose at the time of birth	Target set for full immunisation	Achievement (0 to 1 year age group)	Shortage with reference to BCG	Percentage of shortage
2005-06	28221	24580	23543	4678	17
2006-07	28536	22296	23018	5518	19
2007-08	27549	22355	23355	4194	15
2008-09	27813	23230	22423	5390	19
2009-10	24332	22895	22306	2026	8

(Source: Figures supplied by the SHS)

Based on the number of BCG vaccinations, the achievement of targets for full immunisation was short to the extent of eight to 19 *per cent.*

The performance of the State under the programme in respect of other vaccines is given in **Appendix 1.9.** As seen from the figures in the appendix, the performance of the State in respect of other vaccination programme was satisfactory.

1.2.12.5 Immunisation of Rubella

The Rubella vaccine is recommended as part of the MMR[20] vaccine for all children, adolescents and adults. Immunisation for Rubella was launched in the State from 2008-09 for the benefit of adolescent girls in the age group of 10-19 years. During the year 2008-09, the State had immunized 0.57 lakh (37

[19] Bacillus Calmette-Guerin.
[20] Measles, Mumps and Rubella.

per cent) as against the target of 1.53 lakh. The achievement during the year 2009-10 decreased to 0.15 lakh (10 *per cent*) as against the target of 1.53 lakh.

The CMO, Family Welfare stated (October 2010) that initially, mass campaigns were held in schools to immunise as many girls as possible and the shortfall in achievement of targets were to be met in subsequent years. However, it was seen that almost 53 *per cent* of the targeted adolescent girls in the State remained to be immunised against the Rubella virus.

1.2.12.6 Pulse Polio immunisation

Pulse polio immunisation was launched under the RCH-II project to eradicate polio and ensure zero transmission by the end of the year 2008. No polio cases were reported in the State during the period 2005-10.

1.2.12.7 Family planning

Family planning included terminal methods to control the total fertility rate and the spacing method to improve the couple protection ratio[21].

a) Terminal methods

The terminal method of family planning included vasectomy for men and tubectomy for women. The targets and achievements in respect of various terminal methods in the State during the period 2005-10 are shown in **Table-13.**

Table-13: Statement showing targets and achievements in respect of terminal methods of family planning

Year	Vasectomy			Tubectomy			Total
	Targets	Achieve-ments	Percentage	Targets	Achieve-ments	Percentage	
2005-06	54	20	37	5800	5331	92	5351
2006-07	51	39	76	5555	5286	95	5325
2007-08	70	21	30	5735	5045	88	5066
2008-09	63	28	44	4797	5258	110	5286
2009-10	62	26	42	3546	4114	116	4140
Total	**300**	**134**	**45**	**25433**	**25034**	**98**	**25168**

(Source: Figures furnished by SHS)

The proportion of vasectomies to the total number of sterilisation operations was only 0.53 *per cent* during the period 2005-10. About 98 *per cent* of the sterilisations were tubectomies. The CMO, Family Welfare attributed (October 2010) less vasectomies to cultural and social reasons. This indicated that gender imbalance still plagued the programme, which needed to be addressed.

[21] The Couple Protection rate is usually expressed as the percentage of women in the age group of 15-49 years, protected from pregnancy/child birth in the year under consideration for a specific area.

b) Spacing methods

Oral pills, condoms and inter uterine devices (IUD) are the three prevailing spacing methods of family planning to regulate fertility and promote the couple protection ratio. Year-wise details of targets and achievements of use of spacing methods in the State are shown in **Table-14.**

Table-14: Statement showing targets and achievements of use of spacing methods

Year	Oral pill users			IUD insertions			Condom users		
	Targets	Achieve-ment	Percen-tage	Targets	Achieve-ment	Percen-tage	Targets	Achieve-ment	Percen-tage
2005-06	4467	3157	71	3190	2819	88	10103	8357	83
2006-07	4026	3339	83	3020	2539	84	9270	10158	110
2007-08	4354	3429	79	3132	2617	84	11583	11328	98
2008-09	3370	3248	96	2875	2615	91	8900	10508	118
2009-10	3086	3311	107	2518	2139	85	8560	10379	121
Total	**19303**	**16484**	**85**	**14735**	**12729**	**86**	**48416**	**50730**	**105**

(Source: Monthly performance reports of SHS)

As seen from the table, among the total users (79,943) of spacing methods around 63 *per cent* accounted for condom users and 21 and 16 *per cent* accounted for oral pills and IUD users respectively. Low usage of feminine spacing methods i. e., oral pill and IUD meant that the decision-making role of women in family planning was limited.

1.2.13 National Programme for Control of Blindness (NPCB)

1.2.13.1 No statistics on number of blind persons and eye donation

Survey of blind persons in the State was not conducted

The main objective of NPCB was to reduce the prevalence of blindness to 0.8 *per cent* by 2007 and to 0.5 and 0.3 *per cent* by 2010 and 2020 respectively. The strategies of the programme included conducting of cataract surgeries, collection of donated eyes, creation of donation centres and eye banks and strengthening of infrastructure by way of supply of equipment and training of eye surgeons and nurses. The programme was implemented at the primary level through PHCs and CHCs, at the secondary level through district hospitals and at the tertiary level through the Goa Medical College hospital, Bambolim.

The State had not conducted any survey to identify blind persons and ascertain the prevalence rate of blindness in the State so far (October 2010). As such, the impact of the NPCB was not ascertainable. The CMO, NPCB replied (October 2010) that the surveys would be taken up in future. GOI had fixed a minimum target for collection of 100 donated eyes per year. As no Government-owned eye banks were established in the State, statistics of collection of donated eyes were not available.

1.2.13.2 Cataract operation performance

The year-wise position of cataract operations performed in the State during the period 2005-10 is given in **Table-15.**

Table-15: Statement showing cataract operations performed in the State

(In numbers)

Year	Target fixed by GOI	Target fixed by the State	Achievement			
			Performed at Government hospitals (Percentage achievement)	Performed at private hospitals	Total	Percentage achievement
2005-06	7000	7200	2662 (37)	3639	6301	87
2006-07	7000	7200	2671 (37)	3663	6334	88
2007-08	7000	7200	3645 (51)	3544	7189	99
2008-09	3000	7200	3353 (47)	3873	7226	100
2009-10	3000	7200	3650 (51)	4012	7662	106

(Source: Figures supplied by NBCP)

The percentage of achievement by the Government hospitals ranged between 37 and 51 *per cent* during the period 2005-10. Considering the cataract operations conducted at private hospitals in Goa, the achievements ranged between 87 and 106 *per cent* during the above period. Reasons for fixing lower targets by GOI during the years 2008-09 and 2009-10 were not available with NPCB.

The CMO stated (October 2010) that the matter would be taken up with GOI to revise the targets.

1.2.13.3 Refractive errors and distribution of spectacles to school-children

The NPCB envisaged screening of schoolchildren for refractive errors and distribution of spectacles to students having refractive errors. The year-wise position of detection of refractive errors and distribution of spectacles to students having refractive errors is given in **Table-16.**

Table-16: Statement showing detection of refractive errors and distribution of spectacles to students having refractive errors

Year	Children checked	Children found with refractive errors	Percentage found	Children provided with glasses		
				Target	Achievement	Shortfall
2005-06	23037	770	3	No targets were fixed	296	474
2006-07	25884	971	4		728	243
2007-08	23206	953	4		796	157
2008-09	21127	931	4		615	316
2009-10	24881	1056	4		385	671
Total	**118135**	**4681**	**4**		**2820**	**1861**

(Source: Figures supplied by NBCP)

It was observed that during the period 2005-10, 4681 children were found with refractive errors. However, the number of free spectacles issued did not

correspond with the number of students having refractive errors. Thus, the objective of the programme to provide free spectacles to school-children was not fully achieved.

1.2.14 National Leprosy Eradication Programme (NLEP)

NLEP aimed to eradicate leprosy by the end of the Eleventh Plan (2007-12). It also aimed to reduce the leprosy prevalence rate to less than one per 10 thousand people. The State had already achieved this target and the prevalence rate also showed a declining trend over the years as detailed in **Table-17.**

Table-17: Statement showing prevalence rate of leprosy

Year	Cases detected	Prevalence rate per 10,000 population
2005-06	186	0.99
2006-07	146	0.78
2007-08	156	0.78
2008-09	117	0.57
2009-10	86	0.38

(Source: Figures supplied by NLEP)

1.2.15 National Iodine Deficiency Disorder Control Programme (NIDDCP)

The NIDDCP aims to control iodine deficiency disorders to below 10 *per cent* by 2012. The important objectives and components of NIDDCP are surveys to assess the magnitude of iodine deficiency disorders, distribution of iodised salt, analysis of salt samples, analysis of urinary iodine excretion etc. GOI had released amounts totalling ₹ 37.50 lakh during the period 2005-10. Expenditure of ₹ 29.06 lakh had been incurred so far consisting of salary, advertisements and office expenditure. Audit observed that no surveys had been conducted in the State during the period 2005-10. The Chief Medical Officer (CMO) analysed 1,191 salt samples and 1,193 urinary excretions in the year 2005. Thereafter, no analysis had been conducted (October 2010). The CMO stated (October 2010) that surveys were conducted once in five to six years and the next survey is planned in the year 2011. In the absence of yearly analysis, the impact of the implementation of the scheme could not be ascertained.

1.2.16 Revised National Tuberculosis Control Programme (RNTCP)

The objectives of the RNTCP are to achieve and maintain a cure rate of at least 85 *per cent* among newly detected infectious (newly sputum smear positive) cases and achieve and maintain detection of at least 70 *per cent* of such cases in the population. The State had achieved the cure rate of 81 *per cent* during the year 2009.

1.2.17 National Vector Borne Disease Control Programme (NVBDCP)

Malaria Control Programme

The main objective of the Malaria Control Programme in the State is to reduce the malaria mortality rate by 30 *per cent* by 2010 and to bring the mortality rate to zero by 2012. However no year-wise targets had been fixed by the State. The year-wise details of the number of deaths due to malaria reported are given in **Table-18.**

Table-18: Statement showing number of deaths due to malaria

Year	Number of deaths reported
2005-06	1
2006-07	7
2007-08	11
2008-09	20
2009-10	10

(Source: Figures supplied by NVBDCP)

The CMO, NVBDCP attributed (October 2010) the increase in the number of death cases to i) delays in availing of health facilities and ii) other associated illnesses, which contributed to death. However, the fact remains that instead of reduction there has been an increase in the mortality rate thereby jeopardising the achievement of zero level mortality by the end of the Mission period, i.e. 2012.

1.2.18 Monitoring and Evaluation

1.2.18.1 Failure to set up State Health Monitoring Committee (SHMC)

The absence of a State Health Monitoring Committee, unsatisfactory functioning of MNGOs and reporting of incorrect statistics resulted in poor monitoring and evaluation

As per the guidelines of NRHM, a State Health Monitoring Committee (SHMC) consisting of representatives of the Legislative Assembly, NGOs, Health, Women and Child Development, Water, Sanitation and Rural Development departments was to be set up under the Chairmanship of an MLA. The main role of the SHMC was to discuss the programme and policy issues related to access to health care and to suggest necessary changes. The committee was to review and contribute to the development of the State health Plan, including the Plan for implementation of NRHM at the State level. It was observed that the SHMC had not been set up in the State (October 2010). The State Programme Manager (NRHM) replied (October 2010) that the State of Goa being small in size, the DHS conducted the overall supervision, monitoring and planning of activities of all units. Hence, the need for an SHMC was not felt in the State. The reply is not acceptable as non-constitution of SHMC defeated the NRHM objective for more participation of community leaders in the process of planning and monitoring.

1.2.18.2 Mother NGO Scheme

The Mother NGO (MNGO) Scheme was introduced in the Ninth Five Year Plan to strengthen NGOs' participation in the RCH programme. The NRHM guidelines envisaged identification of NGOs for establishing the rights of households to health care, monitoring and evaluating the health sector, delivering of health services, etc. GOI sanctions grants to the SHS for MNGO schemes and the MNGOs, in turn, release grants to field NGOs. Out of ₹ 50 lakh released (2007-08) by GOI to the SHS, grants of ₹ two lakh during the year 2007-08 and ₹ 30 lakh during the year 2008-09 were sanctioned to two MNGOs in the State. These MNGOs released amounts totalling ₹ 17.07 lakh to six field NGOs during the period 2007-10.

The SHS stated (October 2010) that as the achievements of these MNGOs were found unsatisfactory, it was decided (April 2010) to discontinue their services. The SHS however, did not identify any other NGOs to continue the scheme and the unutilised balance of ₹ 15.53 lakh (including bank interest) with these MNGOs was still to be recovered.

1.2.18.3 Reporting of incorrect statistics

The monthly performance reports compiled by the SHS in respect of sterilisation, immunisation and pregnant women registered were incorrect due to over-reporting of achievements by field offices. The achievements reported by the SHS included data reported by PHCs, CHCs, UHCs and district hospitals. It was observed that the PHC figures represented the figures collected by the Auxiliary Nurse and Midwives (ANMs) who collected the figures during field visits. It also included the statistics in respect of sterilisation and immunisation conducted in the district hospitals and at the hospitals outside Goa. The statistics of registered pregnant women were also over-reported as the same women visited the PHCs, district hospitals, the Goa Medical College and private hospitals for antenatal checkups. The SHS confirmed (October 2010) the facts and stated that there was over-reporting of figures in achievements.

1.2.18.4 Shortfall in conducting meetings

The periodicity of meetings to be conducted and the nature of business to be transacted in the meetings by the State Health Mission (SHM) and the SHS were prescribed in the NRHM guidelines. The shortfall in conducting of meetings of the SHM, the SHS Governing Body (GB) and Executive Committee (EC) at the State level during 2006-10 was as indicated in **Table-19.**

Table-19: Shortfall in conducting of meetings

Name of the committee	Periodicity of meetings prescribed	Date of registration	Number of meetings to be held	Meetings actually held	Shortfall (Percentage)
SHM	Twice every year	20-06-2005	8	1	7 (88)
SHS - GB	Twice every year	07-02-2006	8	6	2 (25)
SHS - EC	Once every month	07-02-2006	48	6	42 (88)

(Source: Figures supplied by SHS)

Thus, the shortfall in conducting meetings of the SHM, the GB and EC of SHS defeated the very objective of having meaningful deliberations on policy issues and implementation as well as monitoring and evaluation.

1.2.19 Conclusion

NRHM is a programme that attempts to consolidate all existing disease control programmes while improving the health care system, infrastructure and capacity in the State. In Goa, the objective of decentralised planning remained a non-starter in the absence of village, block and district Action Plans. Infrastructure in CHCs, PHCs and district hospitals was inadequate in terms of the standards of the IPHS. Shortfalls in manpower, equipment/infrastructure and basic health services impacted the delivery of quality health care.

However, the programme showed considerable achievements in the areas of infant mortality rate, maternal mortality rate, total fertility rate, eradication of polio and progress towards eradication of leprosy.

1.2.20 Recommendations

- The process of community participation at the village, block and district levels should be accelerated with Action Plans formulated at every level.
- Village Health Sanitation Committees and Rogi Kalyan Samitees should receive adequate financing to enable them to carry out the functions envisaged under the programme.
- The State Health Society must map the available services and supporting infrastructure at the health centres as well as the existing load on the available infrastructure. On this basis, the requirements for setting up of new infrastructure and strengthening of existing ones as per IPHS may be assessed.
- Effective data reporting systems should be put in place and over-reporting/misreporting should be identified and corrected.

APPENDIX – 1.3

(Referred to in paragraph 1.2.2)

Organogram of State Health Mission and State Health Society

STATE HEALTH MISSION

Chairperson	: Minister for Health and Family Welfare, Government of Goa
Convenor	: Secretary, Health and Family Welfare Department
Mission Director	: Secretary, Health and Family Welfare Department
Member Secretary	: Director of Health Services
Members	: Chairmen of Zilla Parishads, Chief Town Planner, Dean, Goa Medical College, Directors of Women and Child Development, Dy. Director of Health Services and Chief Medical Officer, Education, Food and Drugs Administration, Family Welfare Social Welfare, North and South Goa Districts, Municipal Administration, Principal Chief Engineer, PWD, Representative of Ministry of Health and Family Welfare GOI, Tourism and Information and Publicity Departments.

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STATE HEALTH SOCIETY

Governing Body

Chairperson	: Chief Secretary
Co-Chairman	: Secretary, Health and Family Welfare
Convener	: Mission Director of State Health Mission (Secretary, Health and Family Welfare)
Members	: Secretary, Women and Child Development, Jt. Secretary, Finance Department, Government of Goa, Dy. Director of Health Services (Medical),
Member Secretary	: Director of Health Services, Goa

Executive Committee

Chairperson	: Secretary, Health and Family Welfare Department
Vice Chairman	: Director of Health Services, Goa
Convener	: Mission Director
Member Secretary	: Dy. Director of Health Services (Medical)
Members	: Chief Medical Officer, Family Welfare, RNTCP, NLEP, STDCP, NBCP, Dy.Director, NVBDCP, State Epidemiologist, Regional Director of Health and Family Welfare, Govt. of India, Technical Officer from NRHM related sectors, Physician (Homeopathy) of UHC, Panaji and Representative of PWD

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State Programme Management Support Unit headed by State Programme Manager

APPENDIX – 1.4

(Referred to in paragraph 1.2.6)

List of test-checked units

Health Centres	Total number selected	Selected health centres
District Hospital	1	Margao
Urban Health Centre	2	Margao and Vasco
Cottage hospital	1	Chicalim
Community Health Centres	3	Canacona, Ponda and Pernem
Primary Health Centres	10	Bali, Betki, Bicholim, Cansarvarne, Camurlim, Colvale, Cortalim, Curtorim, Quepem, Shiroda and Siolim.
Sub Centres	45	Agonda, Ambaulim, Arambol, Assonora, Bhatpal, Borim, Cansavernem, Chandor, Chicalim, Chimbel, Consua, Cotombi, Deao, Dramapur, Gantamorod (Aquem), Gowal (Cola), Guirim, Hasapur, Macazana, Mayem, Morpila, Mulgao, Nanora, Naquelim-Sindolum (Sancoale), Orgao, Paaz, Parsem, Pernem, Pirna, Poinguinim, Queula, Quitol, Savoi-verem, Siolim, Sodiem, Tamboxem, Tuem, Usgao, Velim, Verla, Vazangal, Vaddi-Talaulim, Vagurben-Murdi and Voroda (Cuncolim).
Rural Medical Dispensaries	8	Cuncolim, Durbhat, Maxem (Loliem), Molorem (Cola), Morjim, Rivona, St. Estevem and Volvoi.
Leprosy Hospital	1	Leprosy Hospital, Macasana

APPENDIX – 1.5

(Referred to in paragraph 1.2.7.2)

Statement showing VHSCs formed in the test-checked Sub Centres

Name of the test-checked Sub Centres	No. of VHSCs formed	Formation of VHSCs	Number of Meetings Held by VHSCs
Consua	1	December 2008	2
Naquelim-Chicalim	2	December 2008	3
Sindolum (Sancoale)	1	December 2008	3
Deao	Not formed	NA	NA
Ambaulim	1	September 2008	2
Cotombi	2	October 2009	4
Veroda (Cuncolim)	Not furnished	Not furnished	Not furnished
Morpila	1	November 2008	0
Velim	1	November 2008	0
Quitol	1	November 2008	0
Gantamorod (Aquem)	1	December 2008	2
Dramapur	2	February 2009	2
Chandor	3	January 2009	2
Macazana	1	April 2009	2
Gowal (Cola)	1	November 2008	12
Agonda	1	January 2009	9
Poinguinim	1	November 2008	14
Bhatpal	1	November 2008	9
Assonora	2	Not furnished	Not furnished
Pirna	3	Not furnished	Not furnished
Camurlim	1	Not furnished	Not furnished
Pernem	1	April 2009	8
Parsem	1	April 2009	3
Tuem	1	September 2008	5
Arambol	1	February 2009	6
Vazangal	1	May 2008	1
Borim	1	April 2008	Not furnished
Paaz	Not furnished	April 2008	Not furnished
Usgao	2	November 2008	3
Queula	1	May 2009	1
Vaddi-Talaulim	2	May 2008	5
Savoi-verem	2	March 2009	1
Vagurben-Murdi	2	May 2009	1
Cansarvarne	3	August 2008	3
Tamboxem	1	Not furnished	Not furnished
Hasapur	1	February 2009	1
Mulgao	1	December 2008	8
Nanora	1	December 2008	4
Mayem	1	October 2008	2
Siolim	Not formed	NA	NA
Sodiem	1	March 2009	2
Gurim	Not formed	NA	NA
Verla	Not formed	NA	NA
Orgao	1	September 2008	4
Chimbel	1	October 2008	2

(Compiled from records of test-checked units)
NA : Not applicable

APPENDIX – 1.6

(Referred to in paragraph 1.2.8.1)

Statement showing programme-wise utilization of funds

(₹ in lakh)

Programme	Opening Balance as on April 2006	2006-07			2007-08			2008-09			2009-10		
		Funds received	Funds Utilised and disbursed	Closing balance with interest	Funds received	Funds Utilised and disbursed	Closing balance with interest	Funds received	Funds Utilised and disbursed	Closing balance with interest	Funds received	Funds Utilised and disbursed	Closing balance with interest
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
RCH Flexible Pool[1]	163.47	66.59	80.12[2]	161.10	94.73	76.95	182.69	267.45	138.34	320.32	253.05	134.63	452.22
NRHM Flexible Pool	97.20[3]	*167.70*[4]	38.75	216.02[5]	179.31	120.47	280.93	252.12	147.29	395.36	663.70[6]	719.41[7]	351.48
RNTCP	11.43	29.80	31.18	10.43	28.00	33.68	5.11	45.43	46.73	4.14	53.14	53.13	4.42
NVBDCP	20.43	19.82	17.47	22.78	108.09	49.52	81.35	0.00	29.05	52.70	23.91	59.74	24.01
IDSP	35.44	33.30	55.95	13.34	21.11	27.67	7.06	25.00	20.97	11.56	33.83	33.75	11.79
NPCB	0	0	0	12.75	26.60	28.43	10.92	107.05	31.26	86.82	0.00	88.81	0.10
NLEP	1.81	2.83	4.40	0.49	6.68	5.17	2.04	9.54	6.84	4.75	7.67	9.48	3.03
Total	**329.78**	**320.04**	**227.87**	**436.91**	**464.52**	**341.89**	**570.10**	**706.59**	**420.48**	**875.65**	**1035.30**	**1098.95**	**847.05**

(Source: Compiled from the financial statements of SHS and other Societies)

[1] Including immunization, MNGO, population stabilization, IEC.
[2] Including ₹ 0.71 lakh refunded to GOI.
[3] Kept in the account of RCH initially and transferred to NRHM.
[4] Including ₹ 14.78 lakh transferred from State Family Welfare Bureau.
[5] ₹ 12.75 transferred to NPCB.
[6] Including ₹ 300.00 lakh from the State Government.
[7] Including payments to Emergency Management and Research Institute ₹ 4.20 crore and ₹ 9.76 lakh refunded to GOI.

APPENDIX – 1.7

(Referred to in paragraph 1.2.8.2)

Statement showing the difference in amounts shown by test-checked PHC/CHCs and SHS records

Name of Unit	Particulars of grant	Year	Differences noticed in	As per SHS records	As per test-check units' records	Differences
PHC Quepem	Maintenance Grants	2009-10	Grants released	75000	85000	(+) 10000
		2009-10	Expenditure	60555	82281	(+) 21726
		2009-10	Closing Balance	30812	19086	(-) 11726
	Contingencies	2009-10	Expenditure	8653	1450	(-) 7203
		2009-10	Closing Balance	1347	8550	(+) 7203
	Telephone Bills	2009-10	Expenditure	Nil	13303	(+) 13303
		2009-10	Closing Balance	24000	10697	(-) 13303
CHC, Canacona	Maintenance and Untied Grants	2009-10	Expenditure	344287	300492	(-) 43795
	Maintenance and untied grants to SCs	2009-10	Expenditure	47677	39508	(-) 8169
	Grant to VHSCs	2009-10	Expenditure	Nil	57478	(+) 57478
	Training Support	2009-10	Expenditure	Nil	520	(+) 520
	Untied grants to RMDs	2009-10	Expenditure	Nil	1000	(+) 1000
	Contingency	2009-10	Expenditure	Nil	5225	(+) 5225
PHC, Balli	Maintenance Grants	2009-10	Expenditure	82883	73500	(-) 9383
			Closing Balance	21971	31354	(+) 9383
	Untied Grants	2009-10	Expenditure	Nil	9731	(+) 9731
			Closing Balance	46308	35885	(-) 35885
	Telephone	2009-10	Grants received	6000	7000	(+) 1000
			Expenditure	1640	1955	(+) 315
	Sub centre maintenance	2009-10	Expenditure	28108	20897	(-) 7211
	Village Health Sanitation Committee	2009-10	Expenditure	25627	21257	(-) 4370
UHC, Margao	Contingency support	2009-10	Expenditure	6500	4547	(-) 1953
PHC, Curtorim	Maintenance Grants	2009-10	Expenditure	73984	51317	(-) 22667
	Untied Grants	2009-10	Expenditure	46736	104817	(+) 58081
Cottage Hospital, Chicalim	Untied Grants	2009-10	Expenditure	35941	38441	(+) 2500
PHC, Cortalim	Telephone	2009-10	Expenditure	1019	11114	(+) 10095
	Maintenance Grants + Untied Grants	2009-10	Expenditure	54022	75618	(+) 21596
CHC, Ponda	Maintenance Grants + Untied Grants	2009-10	Expenditure	134999	134177	(-) 822
	Grant to VHSCs	2008-09	Grants received	140000	Nil	(-) 140000
		2009-10	Grants received	110000	200000	(+) 90000
			Expenditure	9280	Nil	(+) 9280
	Salary of Homeopathy Physician	2009-10	Expenditure	140000	120000	(-) 20000

(Source: complied from the records of SHS)

(+) indicates excess amount and (-) indicates less amount in the test checked units over SHS figures.

APPENDIX – 1.8

(Referred to in paragraph 1.2.9.2(a))

Statement showing non-availability of physical infrastructure

Particulars	District Hospital/ Cottage Hospital	CHCs	PHCs	SCs	RMDs	UHCs
Total Health Centres audited	2	3	10	45	8	2
Government Building	Av	Av	Av	28	5	1
Water Supply	Av	Av	Av	5	1	Av
Waiting room for patients	1	Av	2	7	1	1
Labour Room	Av	Av	3	NA	7	2
Operation Theatre	Av	1	6	NA	NA	NA
Clinic room	Av	Av	Av	3	Av	1
Emergency/Casualty Room	Av	Av	3	NA	NA	NA
Residential Facilities for staff	1	1	4	44	7	2
Separate Utility for Male & female	Av	Av	Av	19	6	1
Suggestions/Complaint Box	Av	Av	2	45	5	1
Office room	Av	Av	Av	43	5	Av
Store room	Av	Av	1	40	6	1
Kitchen	Av	1	Av	44	7	2
Telephone	Av	Av	Av	13	5	Av

(Source: Figures compiled from the records of test-checked units)

Av = Available, NA = Not applicable, ***The Numbers indicated the facilities not available in the health centres***

APPENDIX – 1.9

(Referred to in paragraph 1.2.12.4)

Statement showing performance in the State under the immunization programme in respect of other vaccines

Year	DPT			DPT (Booster)			DT(5)			DT(10)			DT(16)		
	Target	Achieve-ment	Perc-entage	Target	Achieve-ment	Percen-tage	Target	Achieve-ment	Percen-tage	Target	Achieve-ment	Percen-tage	Target	Achieve-ment	Percen-tage
2005-06	24580	28821	117	21320	23567	111	24473	24409	100	27664	23737	86	22168	19685	89
2006-07	22096	24238	110	22827	23187	102	22576	24511	109	26673	24114	90	23399	20029	86
2007-08	22355	23768	106	24235	22536	93	26750	25580	96	27921	25165	90	24854	19920	80
2008-09	24020	24552	102	23230	21752	94	24817	19142	77	26437	23918	90	23879	19070	80
2009-10	22895	19046	83	22895	20696	90	23046	20297	88	25498	20541	81	25535	16375	64

(Source: Figures from monthly performance reports of SHS)