Preface

1. This Report of the Comptroller and Auditor General of India contains the results of performance audit of the 'National Rural Health Mission' (NRHM) in Assam. The Report has been prepared for submission to the Governor under Article 151 (2) of the Constitution of India.

2. The audit was conducted through a test check of the records of the State level implementing agency viz. State Health Society, Assam and various field level health care delivery centres covering the period 2005-08. Implementation of the programme relating to the period subsequent to March 2008 has also been commented upon wherever necessary.

3. The audit has been conducted in conformity with the Auditing Standards issued by the Comptroller and Auditor General of India.

Executive Summary

The National Rural Health Mission (NRHM) was launched in April 2005 throughout the country to provide accessible, affordable and reliable healthcare to the rural population, especially the vulnerable sections of the society. The programme envisaged convergence of various existing standalone health programmes, decentralization of the planning process with special emphasis on bottom-up approach in decision making and creating better linkages and cooperation among various social sector departments. A mid-term review of the implementation of the programme in the third year of the Mission period (2005-2012) is aimed at reviewing the initiatives taken by the State Government to bridge the gaps in healthcare facilities provided in the earlier programmes and highlight the areas and issues of concern, which need to be addressed for successful achievement of the objectives of the Mission by the target date.

The performance review brought out several positives relating to maternal and child care services like increase in institutional deliveries as envisaged in the programme guidelines. Diseases like polio were contained and there were no cases of kala azar during 2005-07. There was a significant improvement in the cure rate of tuberculosis and the overall achievement of primary immunization of children in the targeted age group was quite high.

- There were, however, many areas of concern which require the attention of the State Government on priority basis. Foremost among these is the planning process. Community owned, decentralized planning as envisaged by the Mission, was not achieved as yet in the State. Household survey was not completed at all the levels – village, block and district and time bound action plans were not drawn up to achieve the objectives of the programme. Community based monitoring committees were also not formed at various levels.

Planning process should be strengthened with community involvement in planning, implementation and monitoring the activities of the programme. Targets should be set for achieving various health indicators, breaking them into actionable items indicating need-based, locality specific requirement in terms of buildings, infrastructure and manpower. Monitoring committees should be set up expeditiously at various levels and their roles, responsibilities and accountability structure should be defined clearly.

- The State Government increased its outlay on healthcare during the review period in keeping with the programme guidelines. However, it failed to utilize the available funds optimally to strengthen the healthcare infrastructure and delivery at the grass root level. Fund management was quite poor and the State had not released its share of funds for implementation of the programme. Funds were released to the health centres in excess of the prescribed norms and in certain cases, funds were shown to have been released to non-existent dispensaries and subsidiary health centres. Basic accounting records were not maintained at both the State and the district level, leaving scope for fraud and misappropriation.

The State Government should assess the requirement of funds at various levels based on specific need and demand, having regard to the absorptive capacity of the lower level institutions and implementing agencies. It is important not only to increase the outlay on the health sector but utilize the funds for the intended purpose in a timely manner. Basic records of accounting should be maintained properly and grey areas of financial management should be identified and addressed appropriately.

- Infrastructure, both physical and human, is an area where the State fared badly in achieving the targets set by the Mission. The number of health centres, especially in the tribal areas, was woefully inadequate resulting in non-achievement of the primary objective of the programme to provide accessible health facilities to the rural population. There was a delay in completing the construction of health centres and the basic facilities and diagnostic services were not available in a number of health centres that were sampled during audit, affecting the quality and reliability of health services in rural areas. There was a shortage of medical and support staff at the health centres, impeding the goal of providing quality healthcare.

There is an urgent need to put in place adequate infrastructure to ensure accessible and reliable healthcare to the targeted beneficiaries. The State Health Society should map and rationalise the available infrastructural facilities at the health centres through extensive surveys and initiate measures to gear up the pace of construction of health centres based on prescribed norms, especially in the hilly and tribal areas. Basic services like in-patient services, diagnostic facilities and radiological services should be provided expeditiously where these are lacking, and operationalised where these are non functional. Support infrastructure like electricity, generators, telephone etc. should be strengthened to ensure improvement in the quality of health services. Essential services guaranteed under the NRHM framework like operation theatres and well equipped labour rooms should be provided at all the stipulated centres to improve the quality of health care delivery system in rural areas. Adequate number of specialists, medical, paramedical and support staff should be recruited, trained and deployed as envisaged in the Mission framework.

- Procurement of medicines and medical equipments in the State was ad-hoc and the quality of drugs procured remained questionable. Considering that drug management is a critical input, delays, shortages or poor quality of drugs are likely to jeopardize the implementation of the programme.

The State Health Society should streamline the procurement procedures and put in place a transparent procurement system and appropriate quality control and monitoring mechanism to ensure that the quality of healthcare is not compromised.

- Information, Education and Communication (IEC) activities are meant to promote behavioural changes, increase the awareness of the public about their rights and available health facilities. The State could not achieve this objective of spreading awareness and dissemination of information regarding availability of and access to

healthcare facilities for the rural population owing to lack of planning and implementation strategy in this regard.

IEC strategy should be planned properly to ensure impact on behavioural change with regard to preventive aspects of health and coverage should be improved, so that the targeted groups are aware of the available and accessible healthcare facilities being provided under NRHM. Periodical assessment/evaluation of the impact of the programme should be carried out to ensure that various remote and under served areas are not left out from the coverage of the programme.

- As regards maternal health, while there was a considerable improvement in the registration of pregnant women, they were not administered the prescribed dosage of medicines, due, apparently, to their non availability in sufficient numbers. The overall achievement in terms of maternal health was far from satisfactory and registration of pregnant women for systematic ante-natal check up and tracking was not in place. Scrutiny revealed that essential obstetrics care facilities were lacking in almost all the health centres. Reproductive healthcare was not accorded adequate attention and the complete details in this regard were not available with the district health authorities. There was a wide variation among the districts with regard to achievement of targets for immunization and the overall achievement, especially with regard to secondary immunization, was quite poor.

The maternal health programme needs to be implemented in its entirety, covering all the essential areas like registration, reporting and tracking of pregnancies, IFA administration, immunization, ante-natal and postnatal care. Adequate steps should be taken to provide better facilities to improve reproductive healthcare. Round the clock services should be operationalised at identified health centres. The targets fixed for immunization may be re-examined and designed with zero tolerance, to achieve universal immunization.

The targets and performance indicators prescribed for various services to be achieved during the Mission period require a re-look in the State where the infant mortality rate and maternal mortality rate are quite high compared to the national average. The State also needs to strengthen the monitoring mechanism at all levels to ensure that the programme objectives are achieved as per the prescribed timelines and necessary corrective action is taken in case of slippages.

Chapter 1 Introduction

1.1 The Mission

The National Rural Health Mission (NRHM) was launched in April 2005 throughout the country with special focus on eight Empowered Action Group (EAG) States, eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh, which had poor health indicators and weak infrastructure. In Assam, the NRHM was introduced in November 2005. The main objectives of the Mission, to be achieved during the period 2005-12, are as follows:

- provide accessible, affordable, accountable, equitable, effective and reliable healthcare facilities in all the rural areas of the country, especially to the poor and vulnerable sections of the society;
- involve community in planning and monitoring;
- reduce infant mortality rate, maternal mortality rate and total fertility rate for population stabilization; and
- prevent and control communicable and non-communicable diseases, including locally endemic diseases.

1.2 Salient Features

The thrust of the Mission is towards establishing a fully functional community owned decentralized healthcare delivery system with inter-sectoral convergence at all levels to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. This is sought to be achieved through the following:

- Carrying out necessary architectural correction in the basic health care delivery system by merging most of the schemes under National Family Welfare Programme pertaining to maternal health, child health, logistic improvement and contractual staff and services into the scheme “RCH-Flexible Pool”;
- Converging various existing standalone national disease control programmes like Vector Borne Disease Control Programme, Tuberculosis, Leprosy, Blindness and Iodine Deficiency Disease Control Programmes, and Integrated Disease Surveillance Project with the exception of the National AIDS and Cancer Control programmes;
- Promoting access to improved healthcare at household level through a trained female Accredited Social Health Activist (ASHA);
- Increase in public expenditure on health from the level of 0.9 *per cent* of Gross Domestic Product (GDP) to 2-3 *per cent* of GDP over the Mission period (2005-2012);
- Operationalising community health centres into functional hospitals meeting Indian Public Health Standards in every Block of the country;

- Addressing the issue of health through a sector wise approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health, and convergence with related social sector departments like Women and Child Development, Ayurvedic, Yoga, Unani, Siddha and Homoeopathy (AYUSH), Panchayati Raj etc.

1.3 Organisational Set up

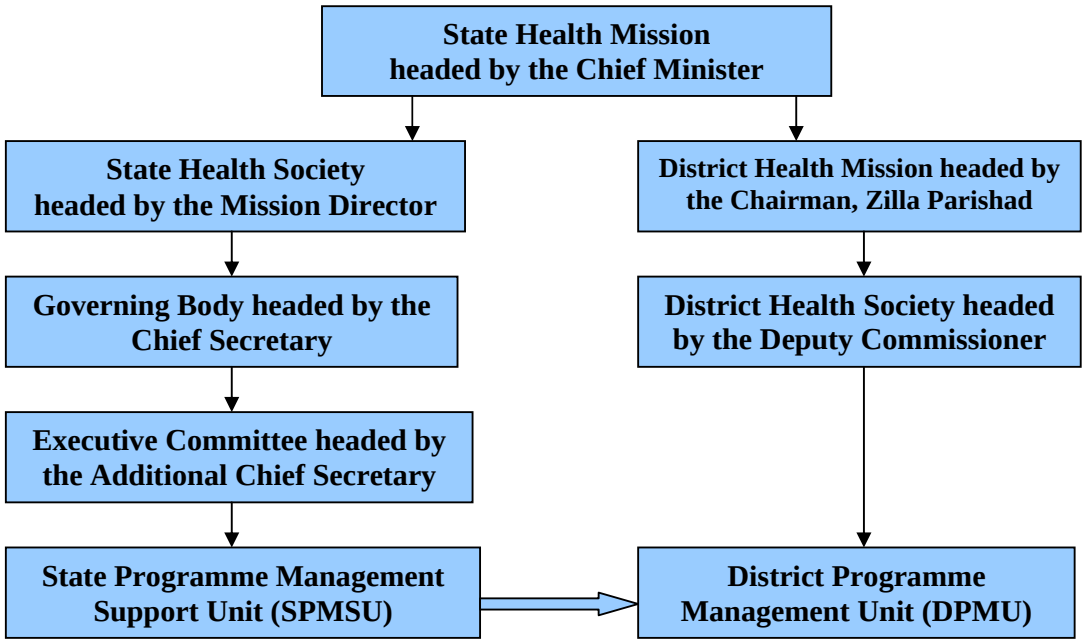
At the State level, the Mission functions under the overall guidance of the State Health Mission headed by the Chief Minister and the actual functions are carried out by the State Health Society (SHS), headed by the Mission Director. The Commissioner and Secretary, Health and Family Welfare, Government of Assam is the overall administrative head of the NRHM. The different components of the programme are being implemented independently by various Joint Directors of Health/Additional Directors of Health, under the Directors, Health and Family Welfare.

At the district level, the programme is implemented by the District Health Society (DHS) headed by the Deputy Commissioner of the district and backed, *inter-alia*, by Joint Director of Health Service as Member Secretary (NRHM) and the District Programme Management unit headed by District Programme Manager. Other vertical programmes like National Vector Borne Disease Control Programme (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP) etc. are implemented independently by various District Programme Officers under the control of Joint Director/Additional Chief Medical & Health Officer of the district.

The organizational structure for implementation of the programme is given below:

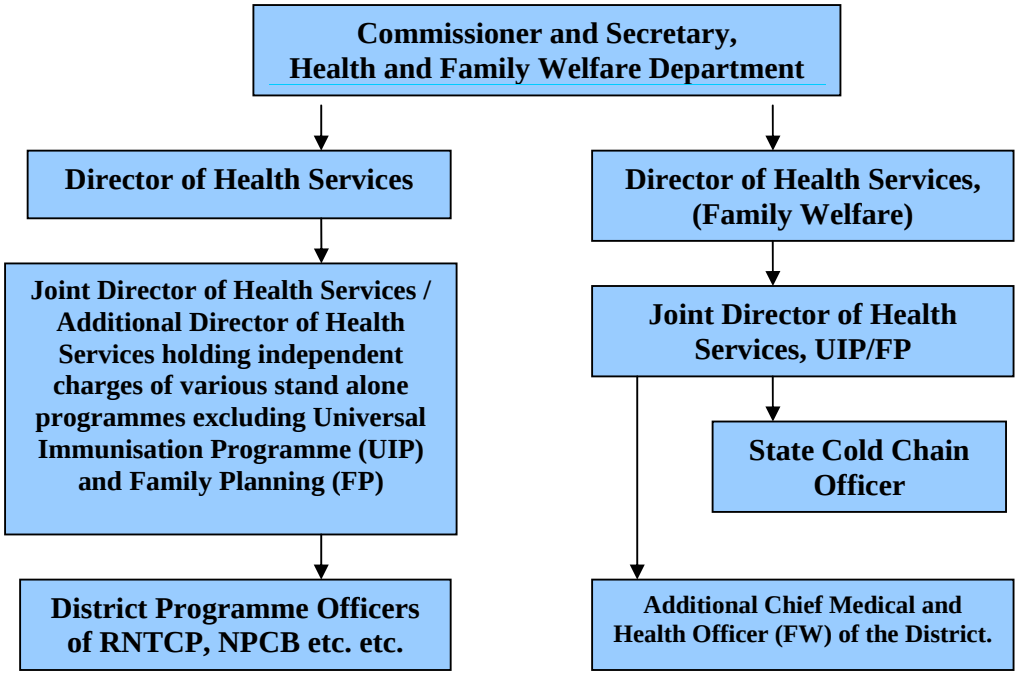
(A) For the components of Reproductive and Child Health (RCH), NRHM Flexipool, Immunisation (Finance only) & Integrated Disease Surveillance Project (IDSP).

Chart No.1



(B) For the components of National Vector Borne Disease Control Programme (NVBDCP), Revised National TB Control Programme (RNTCP), National Programme for Control of Blindness (NPCB) etc.

Chart No.2

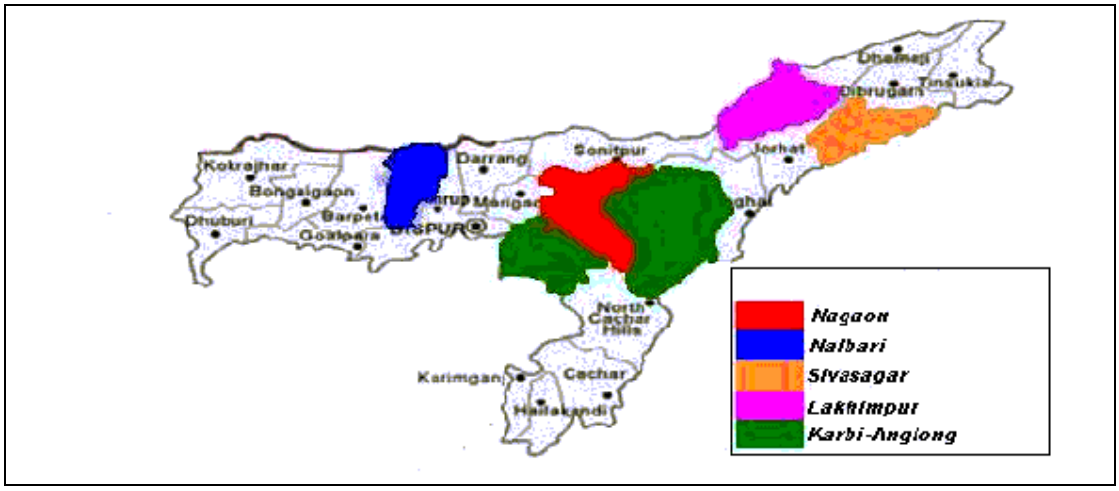


Chapter 2 Framework of Audit

2.1 Scope of Audit

Performance audit of NRHM was carried out during April to September 2008 and covered the implementation of the programme during 2005-08. Out of the 23 districts covered by the Mission, a sample of five districts[1] was selected for detailed examination. In each sampled district, three Community Health Centres (CHCs), six Primary Health Centres (PHCs), [Block Primary Health Centre (BPHC), Mini Primary Health Centre (MPHC), State Dispensary (SD), Subsidiary Health Centre (SHC)] and twelve Sub-Centres were selected on random sampling basis. Relevant records of the State Health Mission, Joint Director of Health Services in charge of various standalone programmes as well as at the selected districts and health centres (101) were scrutinized. Field audit of four[2] centres could not be undertaken due to amalgamation of centres (CHC, PHC) and adverse law and order situation (2 sub-centres). The districts covered as part of audit sample are highlighted in the map below:

Map-1



2.2 Audit Objectives

The objectives of the performance audit were to assess whether:

- Planning for the implementation of the Mission as well as monitoring and evaluation procedures at all levels led to an effective healthcare delivery system;
- Community participation in planning and implementation of the Mission activities was adequate and effective;
- Public spending on health sector during 2005-08 increased and release of funds, their utilization and accounting thereof was adequate;
- The Mission achieved the desired capacity building and strengthening of physical and human infrastructure at different levels;

[1] Nagaon, Nalbari, Sivasagar, Lakhimpur, Karbi-Anglong.
[2] Diphu CHC to Diphu Civil Hospital, Dhakuakhana PHC, two Sub-centres of Karbi-Anglong district.

- Procurement of equipment, drugs, services and supplies was cost effective, efficient and ensured improved availability of drugs, medicines and services etc.;
- The information, education and communication (IEC) programme implementation was efficient, cost effective and resulted in increased awareness in preventive aspects of healthcare;
- Performance indicators and targets fixed in respect of RCH, immunisation and other disease control programmes were achieved; and
- Accessible, affordable and accountable public health delivery system for the targeted rural population was created as envisaged.

2.3 Audit Criteria

Audit findings were benchmarked against the following criteria:

- GOI guidelines for implementation of NRHM and related instructions issued from time to time;
- Programme Implementation Plans for 2005-08.
- Report of Facility survey of Public Health Institutions in Assam, 2007.
- Reports of Reproductive Child Health District Household Survey 2002-04 (RCH-DHS), National Family Health Survey (NFHS) II and III and Sample Registration System (SRS) Data.
- MOU with the Government of India.

2.4 Audit Methodology

Performance audit of NRHM commenced with an entry conference with the Secretary, Department of Health & Family Welfare and Mission Director, SHS, in April 2008, wherein the audit methodology, scope, objectives and criteria were explained and inputs of the departmental officers were obtained. Records of the State Health Mission and office of the Joint Director of Health Services in charge of various stand alone programmes were examined in detail. Information and documents available in 14 CHCs, 29 PHCs and 58 SCs test-checked in the five sampled districts and health centres falling under these districts, and responses to audit questionnaires were analyzed. At the conclusion of audit, the findings were discussed in an exit conference in January 2009 with the Secretary, Health & Family Welfare cum Mission Director, NRHM and replies received from the Government and the Mission have been incorporated in the report at appropriate places.

2.5 Acknowledgements

The office of the Principal Accountant General (Audit), Assam, acknowledges the co-operation rendered by the State Health Society and other health functionaries of the State, District Health Societies and other district and local level health functionaries and departmental officers during the course of audit.

Chapter 3 Planning

3.1 Baseline survey

NRHM strives for decentralized planning and implementation arrangement to ensure that need-based and community owned District Health Action Plans form the basis for interventions in the health sector. For this purpose, the Mission envisages carrying out preparatory studies, mapping of services and household and facility surveys to be conducted at village, block and district level. Fifty *per cent* of the household and facility surveys were to be completed by 2007 and hundred *per cent* by 2008. Scrutiny revealed that household survey was conducted by the GOI at the district level during 2002-04 to assess the healthcare requirements and to identify the under-served and unserved areas. Partial household survey is being conducted by Auxiliary Nurse Midwives (ANMs) during March every year, in order to assess the target population of 0-1 year, 1-5 years, pregnant women and eligible couples. To assess the status of availability of healthcare facilities in rural areas, a facility survey was conducted by a private agency (ADVENT Group) in all 839 PHCs and 4,592 SCs of the State during 2007, and by Regional Resource Centre (RRC) in 102 out of 108 CHCs during 2008.

A central database was prepared at the State level consisting of (a) Routine data – prepared on the basis of monthly reports from districts, (b) Infrastructure data – based on Facility Survey (2007), District level Household Survey (2002-04) by the GOI and National Family Health Survey I and II and (c) Semi permanent data – based on Census report and village level partial surveys conducted by ANM once a year.

The data collected through partial household survey by the GOI as well as local health activists and facility survey by the private agency was, however, not ratified by the Panchayati Raj Institutions (PRIs) as was required to be done.

3.2 Perspective Plan and Annual Plans

The SHS was required to prepare a Perspective Plan for the entire Mission period (2005-2012) covering the gaps in the healthcare facilities, areas of interventions and probable investment. The districts are also required to prepare a Perspective Plan as well as Annual Action Plans (AAPs). The District Health Action Plans (DHAPs) are to be prepared by the DHS and approved by the District Health Mission (DHM). The NRHM also focuses on the village as an important unit for planning, although the Mission did not insist on village plans for the first two years. Therefore, DHAPs were required to be prepared on the basis of Block Health Action Plans (BHAPs).

Scrutiny revealed that Perspective Plan was not prepared either at the district or at the State level. However, DHAPs as well as the State Programme Implementation Plan (PIP) were prepared annually for the years 2006-08. BHAPs were also not prepared during 2005-08 except in eight blocks under Sivasagar district during 2007-08. Thus, DHAPs were not based on plans from block/periphery level.

Also, due to non establishment of Village Health and Sanitation Committees (VHSC) in the State as envisaged, the villages could not be equipped to take up planning exercise for

extensive capacity building. However, the State Health Action Plans-RCH-II for 2005-06 and NRHM for 2006-07 and 2007-08 were prepared on the basis of DHAPs, District Level Household Survey (RCH) 2002-04 conducted by the GOI, National Health Family Survey (NHFS)-II & III by the GOI, Facility Survey-2007, Sample Registration System (SRS) data, State Health Bulletin and the GOI guidelines.

While accepting (January 2009) the facts, the Department assured that the Perspective Plan would be prepared from 2008-09 onwards.

3.3 Convergence of programmes under NRHM

The Mission aimed at an architectural correction in the health care delivery system by converging various existing stand alone national disease control programmes of the Union Ministry of Health and Family Welfare (MOHFW). In the Memorandum of Understanding (MOU) signed between the State Government and the GOI in April 2006, it was declared that the State had completed the merger of the programmes in the Health and Family Welfare Sector and had ordered merger of all district level societies. However, after a lapse of more than two years, actual merger with financial integration of national disease control programmes like RNTCP, NPCB etc. had not taken place as of March 2008 and these vertical programmes continued to be funded separately by each programme division in the MoHFW in violation of the GOI guidelines. The absence of financial integration of all vertical disease control programmes resulted in implementation of these programmes independently, outside the ambit of NRHM framework and the SHS distanced itself from their activities. As a result, programmes were implemented in a disjointed manner at the State and district levels. The SHS was involved only in incorporating the action plans of these societies in the Mission PIP. Hence the desired architectural correction aimed for in the health care delivery system remained unfulfilled.

The Department accepted the audit observation and stated that merger of stand alone programmes with NRHM framework has been taken up during 2008-09.

3.4 Monitoring

3.4.1 Internal control and institutional monitoring

Institutional monitoring requires Mission Steering Group and Empowered Programme Committees both at the Central and the State levels, to monitor progress of the Mission activities periodically. In Assam, no such committee or group was constituted. It was only in April 2008 that the State Health Mission adopted a system for internal monitoring at the block and district levels, whereby it was to constitute District Monitoring Teams headed by Joint DHS and Block Monitoring Teams headed by Sub Divisional Medical & Health Officer, i/c Block Primary Health Centre for monthly monitoring of all institutions.

3.4.2 Health Monitoring and Planning Committees

The NRHM envisages an intensive accountability framework through a process of community based monitoring and stringent internal monitoring. It also prescribed formation of monitoring and planning committees at the village, PHC, block, district and State levels to ensure regular community based monitoring.

As of March 2008, community based monitoring and planning committees were not set up at any level i.e. from village to State against 868 Health Monitoring and Planning Committees (HMPCs) required to be formed in the State (State, District-23, Blocks-149 and PHCs-695). This adversely affected the planning process at the primary level and consequent upward flow of information and diluted the concept of monitoring the activities.

The Department accepted the audit observations and assured that HMPCs were in the process of being set up.

Conclusion

In the absence of a proper planning exercise at all levels-from the village to the State, with requisite inputs from the lower units, the aim of decentralized planning and implementation arrangement, which is need based and community owned, remained largely unfulfilled. Also, due to lack of a strong monitoring mechanism, the planning process did not receive the required feedback for future planning of Mission activities.

Recommendations

- ***The State Health Society needs to ensure completion of household survey at all levels viz. district, block and village.***
- ***Perspective plan for the entire Mission period should be prepared after consolidating the Block Health Action Plans covering all its components by prescribing long-term and medium term goals.***
- ***Community based monitoring committees need to be formed at all villages, blocks and districts with prescribed composition.***

Chapter 4 Community participation

4.1 Village Health and Sanitation Committees (VHSC)

As per NRHM framework, VHSC is to be constituted in every village within the overall purview of the Gaon Panchayat, to be responsible for village level planning and monitoring. However, VHSCs were not formed as of March 2008, in respect of any of the 26,247 villages, although Rs.26.24 crore were received by the SHS from the GOI for 13,124 and 13,123 villages for 2006-07 and 2007-08 respectively. The amount was not utilized for the purpose for which it was approved and Rs.40 lakh was diverted for expenditure under other activities (Health Day). The State Government did not initiate any action to form the VHSCs due to local bodies' elections in December 2007-January 2008. Non-formation of these committees resulted in non-participation of the village community in planning and monitoring in key areas such as nutrition, sanitation, IEC and other public health measures at the grass root level.

The Department stated that the requisite activities of VHSCs were undertaken by the SHS itself.

4.2 Rogi Kalyan Samitis (RKS)

NRHM guidelines stipulated formation of RKS for health centres up to the PHC level and Hospital Management Committees (HMCs) for District and Sub-Divisional Hospitals for effective monitoring and management of health care delivery. These were to be constituted under the Societies Registration Act, 1860 with PRI and community representation.

Out of 21 District Hospitals[1] (DHs), 3 Sub-Divisional Hospitals, 108 CHCs and 912 PHCs in the State, HMC/RKS were formed at all the DHs (registration expired for two hospitals) and Sub-Divisional Hospitals, 99 CHCs, and 844 PHCs by the end of 2007-08. In the five sampled districts, RKS was not set up at 29 out of 229 PHCs. Thus, community representation for management of health care delivery was only partial since these bodies were to regularly review the functioning of healthcare facilities, fix user charges and decide on the use of funds (State grants, user charges or donations) and make appropriate recommendations to the DHS.

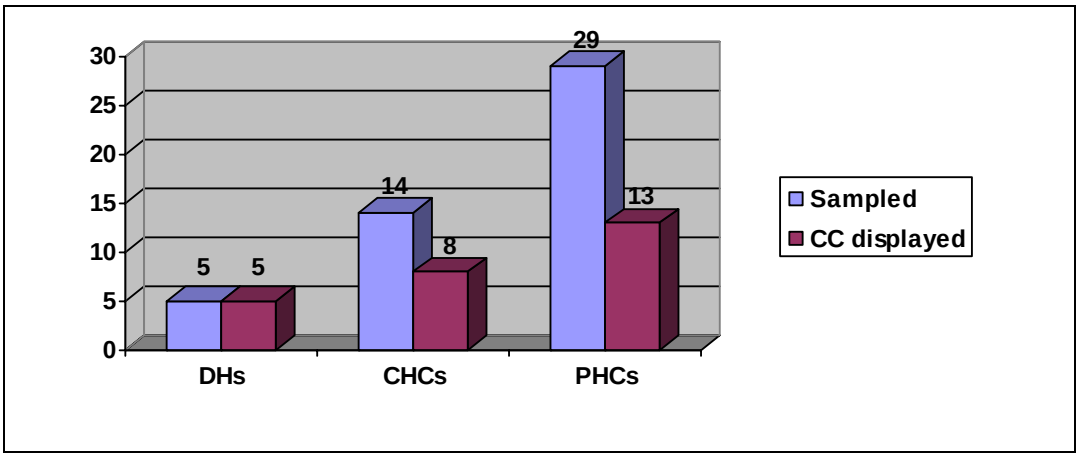
[1]District Hospitals are not available in Kamrup and Dibrugarh districts.

4.3 Citizen Charter

One of the objectives of RKS is to develop a Citizen Charter for every level of health facility and ensure that it is appropriately displayed to make healthcare applicants aware of their health rights and facilities available there. The Charter is also to give a specific and definitive commitment in writing to the citizens for delivering standardised services within a specified time frame. Compliance to Citizen's Charter was to be ensured through operationalization of a Grievance Redressal Mechanism. Scrutiny revealed that while the Citizen Charter was displayed in all 5 HMCs, it was displayed only in a few CHCs and PHCs test checked in the five sampled districts as can be seen from the following chart.

Citizen charter at Manja PHC

Chart No.3



In all five DHs, 14 CHCs and 29 PHCs sampled, there was no mechanism in place for redressal of complaints/grievances of the community regarding their need, coverage, access, quality, denial of care etc. Thus, healthcare campaign through the Citizen Charters was only partial and the grievances of the community regarding delivery of healthcare remained largely unaddressed.

4.4 Constitution of Monitoring Committee by RKS

Guidelines of RKS provided for a Monitoring Committee to be constituted by each RKS to visit hospital wards, collect patient feedback and send monthly monitoring reports to the District Collector and Chairman, Zilla Parishad. Scrutiny of functioning of RKS at 5 DHs, 14 CHCs and 29 PHCs revealed that no Monitoring Committee was constituted. The RKS also did not maintain records of patients feedback and action taken thereon. Thus, the monitoring mechanism for redressal of patients' complaints was rendered ineffective.

4.5 Funding of RKS

In terms of NRHM norms, specific funds are to be released to RKS in a timely manner to enable them to carry out the functions devolved on them. The position relating to funds received by the RKS from SHS in the audited districts and the expenditure incurred is shown below:

Table: 1

(Rupees in lakh)

District	Year	No. of RKS	Opening balance	Funds received during the year	Expenditure incurred during the year	Closing balance
Nagaon	2005-06	Nil	Nil	Nil	Nil	-
	2006-07	69	Nil	61.25	11.85	49.40
	2007-08	69	49.40	99.50	69.36	79.54
Nalbari	2005-06	Nil	Nil	Nil	Nil	-
	2006-07	45	Nil	50.00	Nil	50.00
	2007-08	45	50.00	111.50	48.60	112.90
Sivasagar	2005-06	Nil	Nil	Nil	Nil	Nil
	2006-07	37	NA	30.50	58.33	-
	2007-08	37	NA	57.50		29.67
Lakhimpur	2005-06	Nil	Nil	Nil	Nil	Nil
	2006-07	30	Nil	31.75	29.75	2.00
	2007-08	31	2.00	50.00	48.25	3.75
Karbi-Anglong	2005-06	Nil	Nil	Nil	Nil	Nil
	2006-07	50	Nil	43.50	38.75	4.75
	2007-08	50	4.75	76.25	74.75	6.25

Source: - Annual Accounts of the SHS.

In all the above cases, the books of accounts and subsidiary records like cash book, vouchers were not maintained properly and records like ledger etc. were not maintained by the RKS. It would be evident from the above that 52-100 *per cent* of funds received in three districts (Nagaon, Nalbari and Sivasagar) during 2006-08 remained unutilized as of March 2008. Thus, funds were released without assessing the capacity of the RKS to utilize them during the year, which affected the viability of the long-term goal of community ownership of the health centres through RKS.

While accepting the above facts during exit conference, the Department stated that the process of registration of RKSs under Societies Registration Act 1860 would be taken up, and that non-utilization of funds was mainly due to their belated release.

Conclusion

The HMCs and RKS, which were designed to ensure community ownership of the health centres, were not functioning in the prescribed manner since many of them were either not set up at all or not registered as required. The monitoring structure and grievance redressal mechanism was also absent in the RKS since no monitoring committees were set up. Citizens Charter had not been displayed in many centres. Further, funds were provided to many RKS without proper assessment and justification and also to doubtful centres as pointed out in Para 5.1.4. Thus, the goal of provision of health care in an accountable manner through community participation remained largely unachieved within the current set up of functioning of the RKS.

Recommendations

- ***The VHSC should be formed expeditiously with the prescribed representation to ensure community participation in planning, implementation as well as monitoring of the Mission activities.***
- ***All the RKSs should be registered under the Societies Registration Act, 1860 before any fund is released to them.***
- ***The State Health Society should define the composition of HMC / RKS at different levels, providing a permanent body to carry out its day to day functions and define their roles, responsibilities and accountability structure unambiguously.***

Chapter 5 Fund Management

Funds are released by the Central Government to the State through two separate channels - (i) State Finance Department for Direction and Administration, Rural and Urban Family Welfare Services and Grants to State Training Institutions and (ii) directly to the State Health Society and other vertical societies, by the concerned Programme Division in the MoHFW under each programme. Vaccines, drugs and equipment etc. are procured centrally and supplied to the State as grants in kind based on their requirement.

5.1 Adequacy and utilisation of funds at various levels

5.1.1 At State level

The States are expected to increase their contribution to public health budget by a minimum of 10 *per cent* per annum to support the Mission activities. The State Government signed (April 2006) an MOU with the GOI committing itself to increase its share of public spending on health sector from its own budgetary sources at least at the rate of 10 *per cent* every year. Scrutiny revealed that the State's allocation to health sector increased by 33.11 *per cent* in 2006-07 and by 21.93 *per cent* in 2007-08 in comparison to the previous years. The percentage increase in the State's actual spending, however, was 42.20 *per cent* and 7.52 *per cent* during 2006-07 and 2007-08 respectively, in comparison to the previous years.

Table 2 shows the expenditure incurred by the State on the health sector as a whole vis-à-vis on NRHM activities.

Table: 2

(Rupees in crore)

Year	Total expenditure incurred by the State on the entire Health Sector (primary, secondary, tertiary, health education etc.)*			Total expenditure incurred by the State on NRHM	
	State budget allocation	Expenditure	Gap	Central Government releases through State Finance Department channel**	Expenditure
2005-06	774.55	404.17	(-) 370.38	NA	49.77
2006-07	1031.03	574.72	(-) 456.31	NA	52.81
2007-08	1257.15	617.95	(-) 639.20	49.88	54.05
Total	**3062.73**	**1596.84**	**(-) 1465.89**	**49.88**	**156.63**

*****Source: Finance and Appropriation Accounts of Government of Assam.

**Excluding grants in kind (Supplies) of Rs.9.34 crore, Rs.23.51 crore and Rs.17.53 crore released by the GOI during 2005-06, 2006-07 and 2007-08 respectively.

As can be seen from the table above, the State Government could utilize only 52 per cent of its allocation to the health sector during the review period. Therefore, while the State complied with the NRHM guidelines in terms of increasing its outlay on public health, it failed to utilize the allocation on strengthening the healthcare infrastructure and delivery at the grassroot level.

In the Eleventh Plan period (2007-12), the State Government is to contribute 15 *per cent* of the share of NRHM implementation. However, as against Rs.72.65 crore determined by

the GOI for the purpose, only Rs.60 crore was contributed by the State Government. Thus, while the State Government made a substantial increase in 2006-07 and a marginal increase in 2007-08 in its budget and spending on health sector, it failed to contribute its share of funding for NRHM fully.

The Department stated during discussion that funds were released based on actual utilization on NRHM. This is in violation of the guidelines, as the State Government was required to contribute its share (15 *per cent*) proportionately.

5.1.2 Release of State share for upgradation of SCs

As per the Mission guidelines, the State Government was to contribute 25 *per cent* of the cost of creation and upgradation of the infrastructure of SCs. Scrutiny however, revealed that during 2005-08 an amount of Rs.10.53 crore was released by the GOI for construction and upgradation of 412 SCs, whereas the State's contribution was 'NIL'.

The Department stated that the State Government took up construction of SCs separately from its own source. In the absence of documentary evidence however, the contention of the Department could not be verified in audit.

5.1.3 Fund utilisation on Mission activities

Funds available under NRHM against all the components and expenditure incurred thereagainst during 2005-08 are shown below:

Table: 3

(Rupees in crore)

Year	Opening balance	Funds received	Total funds available	Expenditure	Percentage of expenditure	Closing balance
2005-06	102.10	139.47	241.57	83.36	34.51	158.21
2006-07	158.21	245.34	403.55	227.13	56.28	176.42
2007-08	176.42	742.35	918.77	542.35	59.03	376.42
Total		**1127.16**		**852.84**		

Source: Annual Accounts of SHS.

The above table shows that the SHS could utilize only 34.51 *per cent*, 56.28 *per cent* and 59.03 *per cent* respectively out of the total funds available during 2005-08, leaving huge balance unspent. Such poor utilization not only reflected unrealistic assessment of fund requirements or limited absorption capacity by the State, but also meant that large portions of programme activities remained un-implemented as is revealed from the fact that as many as 54 activities of NRHM involving Rs.8.35 crore remained unattended to. The reasons for non-utilisation of allocated funds were neither available on record nor stated by the Department.

5.1.4 Release of Central grants to health centres

As per NRHM norms, specific funds are to be released to HMC/RKS by the SHS in a timely manner to enable them to carryout the functions devolved on them. Annual untied grant of Rs.50,000/- and annual maintenance grant of Rs.1,00,000/- are to be released to each of the CHCs. Similarly, annual untied grant of Rs.25,000/- and annual maintenance

grant of Rs.50,000/- are to be released to the PHCs. The Sub-Centres (SCs) are also to receive annual maintenance grants @ Rs.10,000/-. Scrutiny revealed that maintenance grant was not released to the SCs during 2006-07 and no grant was released to 68 PHCs during 2006-07. Untied and maintenance grants were released at variable (excess/less) rates to 92 CHCs and 786 PHCs with a net excess release of Rs.58.50 lakh. Further, as per NRHM norms, corpus (one time support) grants were to be provided to the HMCs/RKSs at District and Sub-divisional Hospitals @ Rs.5,00,000/- and Rs.1,00,000/- respectively. The SHS, however, provided corpus grants @ Rs.1,00,000/- to 92 CHCs and 462 PHCs in addition to the usual untied and maintenance grants and to 3 Sub-divisional Civil Hospitals @ Rs.1.50 lakh in excess, totaling Rs.5.59 crore during 2007-08. Thus, there was an excess release of Rs.6.17 crore as grant, which was irregular.

The SHS released maintenance grants @ Rs. 10,000 per centre, as per norms, to 4,572 SCs during 2007-08. The PIPs for 2006-07 and 2007-08, however, showed that 2,794 out of 4,592 SCs were functioning in rented houses. Thus, release of maintenance grant of Rs.2.77 crore to the health centres not housed in own/ Government buildings was not only irregular but unauthorized, as maintenance of a rented house was not the responsibility of the Government. One such instance is depicted below:

Deodudi Sub-Centre functioning in Village Club

The SHS released maintenance grant @ Rs.50,000/- to 256 State Dispensaries (SD) and 80 Subsidiary Health Centres (SHC), (classified as PHCs) during 2006-07, while the PIP for 2006-07 shows that there were only 239 SDs and 71 SHCs. Further, untied grants were released to DHS for 4,726 SCs during 2005-06 and 2006-07 while during 2007-08 untied grants were released to only 4,572 SCs through centre specific bank drafts.

Thus, the whereabouts of the funds released to 180 doubtful centres (26 PHC + 154 SCs) involving Rs.43.80 lakh released during 2005-06 (SCs only) and 2006-07 (SCs and PHCs) was not on record with the SHS.

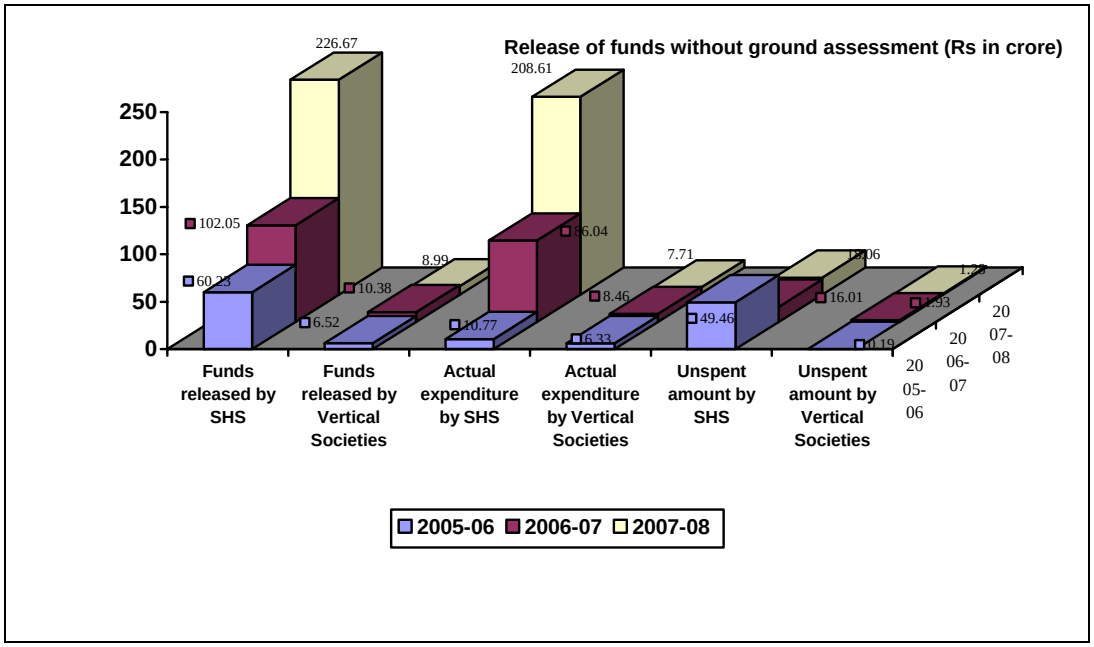
The Department stated (January 2009) that there is no case of non-existent PHC/SC in the State, but assured that the matter would be verified.

No further communication was , however, received from the Government in this regard, as of March 2009.

5.1.5 At District level

Scrutiny revealed that, funds were released to the districts in a routine manner without assessing their absorption capacity. The graph below shows the year wise position of funds released without prior allocation, the actual expenditure incurred and unspent funds.

Chart No.4



As can be seen from the above chart, 82 *per cent*, 16 *per cent* and 8 *per cent* funds released during 2005-06, 2006-07 and 2007-08 respectively for RCH-Flexipool and NRHM Flexipool remained unspent. For other vertical programmes, the unspent balances were 3 *per cent*, 19 *per cent* and 14 *per cent* for the years 2005-06, 2006-07 and 2007-08 respectively.

The unspent balance at different levels showed their limited absorptive capacities to utilize the funds. Such excess allocation without specific requirement from the districts and lower level institutions also reflected poorly on fund management under NRHM.

5.2 Accounting procedure

Guidelines on financial, accounting, fund flow and banking arrangements as approved (December 2006) by the Empowered Programme Committee (EPC) of the MoHFW envisaged that Financial Management Groups (FMGs) of the Programme Management Support Units (PMSUs) at SHS and DHS levels will be responsible for centralised processing of fund releases, accounting for the expenditure reported by subordinate units, monitoring of Utilisation Certificates (UCs) and audit arrangement. They will also be responsible for collecting, compiling and submitting Statements of Expenditure (SOEs), Financial Management Reports (FMRs), UCs, audit reports from the DHSs to SHS and

from SHS to the GOI. As regards audit arrangement, the guidelines envisaged that a single (common) Auditor would be appointed for the SHS and DHS from the list of auditors provided by the GOI and the selection of auditor for NRHM would be a one time process which will take care of the entire programme.

Scrutiny revealed that cash book with day-to-day attestation of transactions and monthly closing certificates by the Drawing and Disbursing Officer (DDO) was not maintained at SHS as well as in three[1] out of the five sampled districts. Basic records like expenditure register, fund register, other registers relating to grants, release of funds, SOE etc. were also not maintained at the State level. Instead, transactions were input in the computer periodically from the cheque issue register without validating or scrutinizing the data at any stage. The authenticity of entries in the cash book prepared from such data entry at the time of finalization of annual statements of accounts remained doubtful.

Scrutiny also revealed that the State and District Health Societies were audited by various Chartered Accountants (CAs) empanelled by the Comptroller and Auditor General (C&AG) of India. The statutory audit, to be conducted by the C&AG as envisaged in the MOU, has not yet been conducted due to non-entrustment of audit as required to be done in case of audit of Autonomous Bodies (ABs) constituted by executive orders.

5.3 Financial Management

Absence of proper financial management and defined accountability structure led to the following financial irregularities in the implementation of the programme.

- Unspent balances relating to RCH-I programme under the State Committee on Voluntary Agencies (SCOVA) amounting to Rs.1.48 crore was not brought forward as opening balance in the NRHM Cash Books for 2005-06 and remained unaccounted for.
- The Director of Health Services, on receipt of a Demand Draft for Rs.48.50 crore from the Mission Director, NRHM for procurement of drugs etc. deposited the entire amount in the Current Bank Account in violation of the programme guidelines as well as directives issued in regard to operation of Current Bank Account by the Government of Assam and thereby sustained loss of bank interest.
- For "Free Mega Eye Operation Camp" at Regional Institute of Ophthalmology (RIO) conducted in September 2006 and for travelling and treatment of 35 unsuccessful and badly affected patients with post operative 'Endophthalamitis' to Sankardeva Netralaya, Chennai, an amount of Rs.28.77 lakh was paid to the MD, RIO, Guwahati without any provision in the PIP.

Conclusion

While the State Government increased its outlay on healthcare during the review period, it failed to utilize the available funds optimally. It also failed to release its share of funds for implementation of NRHM as per the programme guidelines. Basic accounting records

[1] Sivasagar, Lakhimpur, Karbi-Anglong.

were not maintained at both the State and the district level leaving scope for fraud and misappropriation.

Recommendations

- ***The State Government should release its share of funding for the implementation of NRHM and ensure that the provision made in the budget is actually utilized.***
- ***The State Health Society should assess the requirement of funds by the CHCs/ PHCs/SCs based on their specific demands and population of the area and should ensure timely release of funds to the districts and lower level institutions on grounds of equity.***
- ***The State Health Society needs to prepare its annual PIPs on the basis of actual requirements and absorptive capacity of various implementing agencies and health centres.***
- ***The State Health Mission needs to identify the grey areas of financial management structure and define/revamp the accountability aspects and take prompt corrective action on the deficiencies/discrepancies pointed out.***

Chapter 6 Capacity Building

6.1 Physical Infrastructure

NRHM stipulates creation of new infrastructure/buildings for health centres and strengthening of the existing ones for improving accessibility and quality of healthcare delivery services after assessment of the load on the existing health centres and requirement for creation / upgradation in view of potential increase in the number of patients. However, the Indian Public Health Standards (IPHS), which provided the norms for creation of physical infrastructure, were approved only in 2007-08.

6.1.1 Adequacy of Health Centres

NRHM guidelines provided that one SC is to be set up for a population of 5,000 (3,000 in hilly and tribal areas), one PHC for 30,000 population (20,000 in hilly and tribal areas) and one CHC for 1,00,000 population (80,000 in hilly and tribal areas). For a total population of 2,66,55,528 (33,08,570 in tribal areas) in the State as per Census 2001, 4,344 SCs, 605 PHCs and 94 CHCs were existing (as per RCH-II PIP) before the commencement of NRHM. Hence, there was a requirement for setting up an additional 1,428 SCs, 338 PHCs and 180 CHCs during the Mission period (2005-12) to cover the gap as per the Census population, even without taking into account the increase in population since 2001 and intra-state variations. The status of creation of infrastructure at the end of 2007-08 compared to the requirement is shown below:

Table: 4

Level	No. required to be created during 2005-12	No. required to be created during 2005-08 on prorata basis	No. created and operationalised	Gap (2005-08) Excess (+) / Shortfall (-)
Sub Centres	1,428	612	248	(-) 364
Primary Health Centres	338	145	307	(+) 162
Community Health Centres	180	77	14	(-) 63
Total	**1,946**	**834**	**569**	

Source: - Statistical Handbook of Assam and data obtained from SHS.

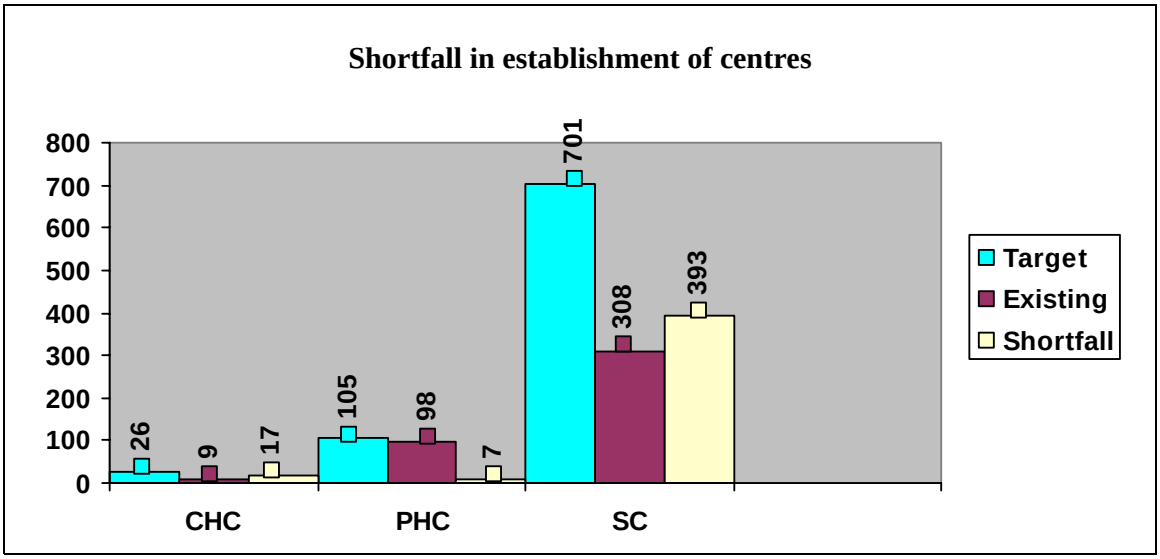
As can be seen from the table above, there was a shortfall of 59 and 82 *per cent* in the SCs and CHCs respectively during 2005-08, while there was an excess of PHCs (112 *per cent*) during the period.

Non-setting up of the required number of health centres as per the population norms resulted in non-achievement of the primary objective of improving accessibility to health facilities in rural areas.

In the tribal areas, health centres are to be set up as per different population norms as mentioned above. In the three districts of N.C. Hills, Karbi-Anglong and Kokrajhar with a total population of 21,01,819 (as per Census 2001) 415 health centres had been established as of March 2008 against the required number of 832.

The details of health centres are shown below:

Chart No.5



Shortfall of nearly 50 *per cent* in health centres in the tribal districts indicates that the areas with high concentration of socially and economically deprived population were not given adequate priority in the plans for creation of new infrastructure under NRHM.

6.1.2 Existence of two centres in the same locality

There were 44 cases of two health centres (CHC and PHC) in the same locality in 18 out of 23 districts. Further, in one[1] out of the five sampled districts, there were two CHCs in close proximity of four km within the same block. This indicates that health centres were set up without considering their actual necessity based on population norms and violates the concept of equity in providing health care in rural areas.

Demow CHC

Demow BPHC

6.1.3 Delay in construction of Sub-Centres

Construction of buildings for 404 existing SCs (rented) was taken up in 2006-07 at an approved cost of Rs.37.50 crore in 9 out of the 23 districts. Not a single building was completed and handed over to the concerned DHS as of March 2008, although an amount of Rs. 9.99 crore was expended on these works. This resulted in delay in providing quality healthcare services to the rural population through fully functional SCs.

[1] Nalbari.

Khanajan SC functioning in a rented house despite having newly constructed building

Newly constructed Khanajan SC yet to be functional due to lack of electrical connection

6.1.4 Status of infrastructure at health centres

The NRHM framework envisaged provision of certain guaranteed services at SCs, PHCs and CHCs as per the norms of IPHS. Physical verification and facility survey by the Audit team in the five sampled districts revealed that the basic facilities were not available in a number of health centres, as detailed below:

Table: 5

Sl. No.	Particulars	Sub Centres	Primary Health Centres	Community Health Centres
1	**Total number of health centres checked**	**58**	**29**	**14**
2	No. of health centres where the building was in a dilapidated condition	11	Nil	Nil
3	No. of health centres where cleanliness was poor	10	5	Nil
4	No. of health centres where required number of vehicles/ambulance were not available	58	19	Nil
5	No. of health centres where Citizen's Charter was not displayed prominently in local language	19	16	6
6	No. of health centres where suggestion/complaint box was not kept prominently	45	17	11
7	No. of health centres where separate utilities for men and women were not available	46	21	7
8	No. of health centres where OPD rooms/cubicles were not available	58	1	Nil
9	No. of health centres where operation theatre/minor operation theatre were not available (where applicable)	58	21	4
10	No. of health centres where labour room was not available (where applicable)	58	11	Nil
11	No. of health centres where labour room was available but not functional (where applicable)	Nil	2	Nil
12	No. of health centres where medical store was not present	58	Nil	Nil
13	No. of health centres where separate ward for male and female patients were not available (where applicable)	58	23	3
14	No. of health centres where waiting rooms for patients were not available/not in good condition	58	29	Nil
15	No. of health centres with no provision of water supply	58	Nil	Nil
16	No. of health centres with no provision for storage of water	58	9	1
17	No. of health centres with no facility of sewerage	58	10	Nil
18	No. of health centres with no facility of medical waste disposal	58	29	11

19	No. of health centres with no electricity connection/power supply	58	1	Nil
20	No. of health centres with no standby power supply/generator	58	15	2
21	No. of health centres with no telephone connection	58	16	9
22	No. of health centres with no computer	58	17	6
23	No. of health centres with no accommodation facilities for attendants of admitted patients	58	29	14
24	No. of health centres where accommodation facilities for staff were not available	58	7	Nil
25	No. of health centres where accommodation facilities for staff were partially available	Nil	2	14
26	No. of health centres where adequate furniture was not available/not in working condition	58	17	Nil

Source: - Data collected from centres test checked.

As can be seen from the above details, basic physical infrastructure was quite inadequate in a large number of PHCs and CHCs and was almost non-existent in the SCs.

The Department did not offer any comments in this regard.

Photographs of working condition of health centres are given below:

Unscientific storage of drugs and medicines in Centre Bazar PHC

Labour bed at Centre Bazar PHC

Radiant warmer remained unutilized at Panigaon SHC

Generator lying idle for two years for want of electrical works at Bokolia CHC

Lack of waste management at Panigaon SHC

Insecure maternal ward at Nowboicha CHC

Conclusion

The number of health centres in the State was far from the norms prescribed, leading to denial of healthcare services to the community in an equitable manner. Also, absence of the required infrastructure at the health centres affected the quality and reliability of health services in the rural areas.

Recommendation

There is an urgent need to create new health centres and to strengthen the existing ones. The State Heath Society needs to map and rationalize the available health facilities and other infrastructure at the health centres through extensive surveys and initiate measures to gear up the pace of construction of health centres. Support infrastructure like electricity, generators, telephone etc. also need to be provided to ensure improvement in the quality of health services.

6.2 Facilities at health centres

The gaps in facilities were particularly critical in the following areas:

6.2.1 In-patient services

The NRHM guidelines provide for six and thirty bed in-patient service at the PHC and CHC respectively. Out of the 29 test checked PHCs, only 11 were functioning with in-patient services with two to ten beds and 18 were functioning without in-patient service. In 16 PHCs, two to ten beds were available, while in 13 PHCs, no bed was available. In 5 PHCs, beds were available but in-patient services were not operational due to the absence of the required (i) medical specialists, (ii) infrastructure facilities like operation theatre etc. All the 14 test checked CHCs had in-patient services. While in 9 CHCs, the full compliment of 30 beds was available, in 5 CHCs, 10 to 25 beds were available and in 2 CHCs, beds were available but in-patient services were not operational due to the absence of the required (i) specialists (ii) infrastructural facilities and (iii) operation theatre.

Available beds at Manja PHC without in-patient services

In one out of 29 PHCs and 14 CHCs, the patient bed ratio was optimum (90 to 110 *per cent*) in 2007-08. In one CHC and five PHCs the patient bed ratio was between 50 and 90 *per cent* in 2007-08 while in 11 CHCs and 3 PHCs, it was below 50 *per cent*. This indicated under utilization of in-patient services in rural health centres, possibly due to lack of manpower and infrastructure facilities.

The lower patient bed ratio in rural hospitals affected the goal of providing reliable and quality health services in rural areas, while there was an overload on services in semi-urban and urban health centres, as well as in private hospitals.

Audit scrutiny revealed that 5,000 steel beds procured out of NRHM funds were shifted to the National Games Village at Guwahati, of which, 4,265 beds were transferred subsequently to various health centres in the districts without assessing the actual requirement for in-patient services, as was evident from the failure to fix the beds in the health centres due to non-availability of space. A test check of distribution of 2,711 beds revealed that as many as 177 beds could not be installed for want of space in four[2] centres (out of 126 centres). Only 11 out of 29 PHCs and 12 out of 14 CHCs sampled were functioning with in-patient services and the patient bed ratio was optimum (0.9 to 1.1) in only 1 PHC out of 14 CHCs and 29 PHCs. Further, out of the 2,711 beds distributed, 1,250 (46 *per cent*) beds were distributed to 14 District Hospitals. The whereabouts of the remaining 735 beds costing Rs. 52.94 lakh were not available on record. The Department confirmed that the beds procured out of NRHM funds were utilized in the Games Village with the approval of the State Government.

Unutilised beds in Dekhoumukh MPHC for want of manpower

Thus, the objective of providing in-patient services in rural health centres and to reduce the patient load in district hospitals remained unfulfilled.

6.2.2 Operation theatre

As per NRHM norms, every CHC is to have one operation theatre. However, out of the 14 CHCs checked, a functional operation theatre was available only in 5 CHCs. Four CHCs had no operation theatre, while 5 CHCs had a non-working/ defunct operation theatre. In 10 cases, the operation theatre was

Non-functional operation theatre at Bokolia CHC

Operation theatre at Bokolia CHC converted as in-patient ward

[2] Bongaigaon, Lakhimpur, Dhemaji Civil Hospitals and Lahorighat PHC.

not adequately equipped. The details of various equipments in the operation theatres of CHCs are shown below:

Table: 6

	Number of CHCs where equipment was available and functional	Number of CHCs where equipment was available but not functional	Number of CHCs where equipment was not available
Boyales apparatus	4	-	10
Cardiac Monitor for OT	4	1	9
Ventilator for OT	2	-	12
Vertical High Pressure Sterilizer 2/3 drum capacity	1	1	12
Shadowless lamp pedestal for minor OT	3	1	10
Gloves and dusting machines	3	1	10
Nitrous oxide cylinder 1780 ltrs 8 for one Boyales Apparatus	3	1	10
EMO Machine	-	-	14
Defribillator for OT	-	-	14
Horizontal High Pressure Sterilizer	1	-	13
Shadowless lamp ceiling trak mounted	2	-	12
OT care / fumigation apparatus	1	-	13
Oxygen cylinder 660 ltrs 10 cylinder for one Boyales apparatus	4	1	9
Hydraulic operation table	5	1	8

Source: - Data collected from centres test checked.

Further, in four[3] cases, the operation theatre was available and well equipped, but surgeries were not carried out due to non-provisioning of generator for the operation theatre/dilapidated condition of building of the operation theatre/absence of specialist/required number of beds.

The absence/non-functioning of the operation theatre and its poor quality were impediments in developing the CHCs as the First Referral Units (FRUs). This deprived the public of quality and affordable surgical treatment in the rural areas and increased the patient load on district hospitals.

6.2.3 Labour room

Under NRHM, every PHC and CHC is to have a labour room for safe delivery. However, out of 29 PHCs and 14 CHCs sampled, while labour room was available in all 14 CHCs, only 10 PHCs had this facility. In 4 PHCs, the labour room was available but not functioning mainly due to the absence of a specialist. In 12 PHCs, deliveries were carried out outside the labour room in a non-dedicated facility due to the absence of other infrastructural facilities.

[3] Dhakuakhana, Nowboicha, Bokajan, Kakaya.

The absence/non-functioning of labour room at PHCs hampered the goal of increasing the number of institutional deliveries and affected the aim of providing quality healthcare services.

6.2.4 Diagnostic services

The Mission provides for essential laboratory services at the PHCs and the CHCs. At the PHC level, the services should include routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of RTI/STI, sputum testing for tuberculosis, blood smear examination for malaria parasites, rapid tests for pregnancy/malaria etc. Out of 29 PHCs test checked, 4 had no laboratory services. At the CHCs, besides the laboratory services, microscopic facilities for tuberculosis, diagnostic facilities for complicated cases of malaria, fileria, dengue, Japanese Encephalitis, Kala azar and leprosy were to be provided. However, out of the sampled 14 CHCs, only 3 CHCs had full diagnostic services. In 11 CHCs and 25 PHCs, equipment for diagnostic services was available only partially. In the absence of the prescribed diagnostic services at CHCs and PHCs, the quality and reliability of health care services in the rural areas is open to doubt.

Laboratory services at Azad State Dispensary

6.2.5 Radiological/X-ray facilities

The Mission provides for X-Ray services at all the CHCs. Out of the 14 sampled CHCs, X-ray facilities were available only at 7 CHCs. At 3 CHCs, X-ray machines were available but were out of order, and at 2 CHCs, X-ray machines were in working condition but not used due to the absence of radiographer and the required electrical facility. In one CHC, the X-ray machine remained uninstalled due to lack of electrical connection. In all the CHCs, charges for X-ray were levied as per the rates prescribed by the Government.

X-ray machine out of order at Bokolia CHC

6.2.6 Blood storage facilities and emergency services

NRHM envisages blood storage facilities at every CHC. Scrutiny however, revealed that out of 14 CHCs, blood storage facilities were available only at two[4] CHCs. The absence of the facility was due to lack of equipment and specialist. There was no blood bank in any of the CHCs test checked.

The NRHM guidelines provide for 24 hours emergency services by posting three staff nurses at PHCs for management of injuries and accidents, stabilization of patients before referral, dog / snake bite cases etc. Scrutiny however, revealed that out of 29 PHCs, only 15 PHCs were providing emergency services. The lack of emergency services was due to non-availability of staff / required facilities.

[4]Kampur and Kawaimari CHCs

6.2.7 AYUSH services

The Mission seeks to revitalise local health traditions and mainstream Ayurvedic, Yoga, Unani, Siddha and Homoeopathy (AYUSH) infrastructure, including manpower, and drugs, to strengthen the public health system at all levels including an AYUSH doctor at every PHC and by establishing AYUSH clinics at CHCs. Out of the 29 PHCs sampled, AYUSH doctor was not provided in 20, either through regular posting or through contractual appointment. This affected the aim of mainstreaming of AYUSH services as per NRHM framework.

6.2.8 Mobile Medical Units (MMU)

A mobile medical unit was to be provided in every district to enable outreach services. These are particularly relevant in hilly areas like Assam. For procurement of MMUs for all 23 districts in the State, approval was accorded by the GOI in November 2006 for Rs.16.67 crore @ Rs.72.46 lakh per MMU and the entire amount was released in 2006-07. The SHS, however, after a delay of twelve months, could procure and distribute only 10 MMUs in November 2007 to ten districts. The other constituents of those MMUs were, however, sent to the concerned districts during the period from November 2007 to February 2008. The MMUs in complete form were thus received by the districts only in February 2008.

Thus, delay in procurement of MMUs as well as idling of MMUs have affected the NRHM's aim of providing specialized health care facilities to underserved areas.

Conclusion

Basic services like in-patient services, diagnostic facilities, X-ray services etc. were not fully functional at all the CHCs and PHCs. CHCs being the first referral units did not have fully functional operation theatre, blood storage facilities, etc. Similarly, the PHCs had insufficient in-patient services, labour room etc. The diagnostic services at health centres were inadequate with the possibility of patients suffering from poor quality treatment.

Recommendation

Essential services guaranteed under the NRHM at the CHCs and PHCs need to be provided on priority. Adequate diagnostic and radiological services need to be provided at all the health centres. Operation theatres and well-equipped labour rooms should be made functional at all the stipulated centres to ensure improvement in the quality of health care delivery system in rural areas at an affordable cost.

6.3 Human Infrastructure

NRHM aims to provide adequate medical and other manpower at different health centres through filling up of the sanctioned regular posts and appointment of contractual staff on a priority basis for the delivery of healthcare services to rural population.

The status with regard to the availability of manpower at various health centres sampled, is given below:

Table: 7

Sl. No.	Particulars	Number of cases	Cases as percentage of total number audited
SUB-CENTRES (TOTAL NUMBER AUDITED 58)			
1	Sub Centres without two ANMs	30	52
2	Sub Centres without one MPW	52	90
PRIMARY HEALTH CENTRES (TOTAL NUMBER AUDITED 29)			
3	PHCs without an AYUSH Medical Officer	18	62
4	PHCs without three Staff Nurses	17	59
5	PHCs without even one Staff Nurse	1	3
6	PHCs without a Lab Technician	3	10
7	PHCs without a pharmacist	3	10
8	PHCs without a Lady Health Visitor	20	69
COMMUNITY HEALTH CENTRES (TOTAL NUMBER AUDITED 14)			
9	CHCs without a General Physician	6	43
10	CHCs without a General Surgeon	12	86
11	CHCs without an Obstetrics and Gynecologist	10	71
12	CHCs without a Paediatrician	13	93
13	CHCs without an Anaesthetist	12	86
14	CHCs without nine Staff Nurses (two of them may be ANMs)	9	64
15	CHCs without five Staff Nurses	1	7
16	CHCs without one Staff Nurse	1	7
17	CHCs without a radiologist	6	43
18	CHCs without a Pharmacist	1	7
19	CHCs without a Lab Technician	3	21

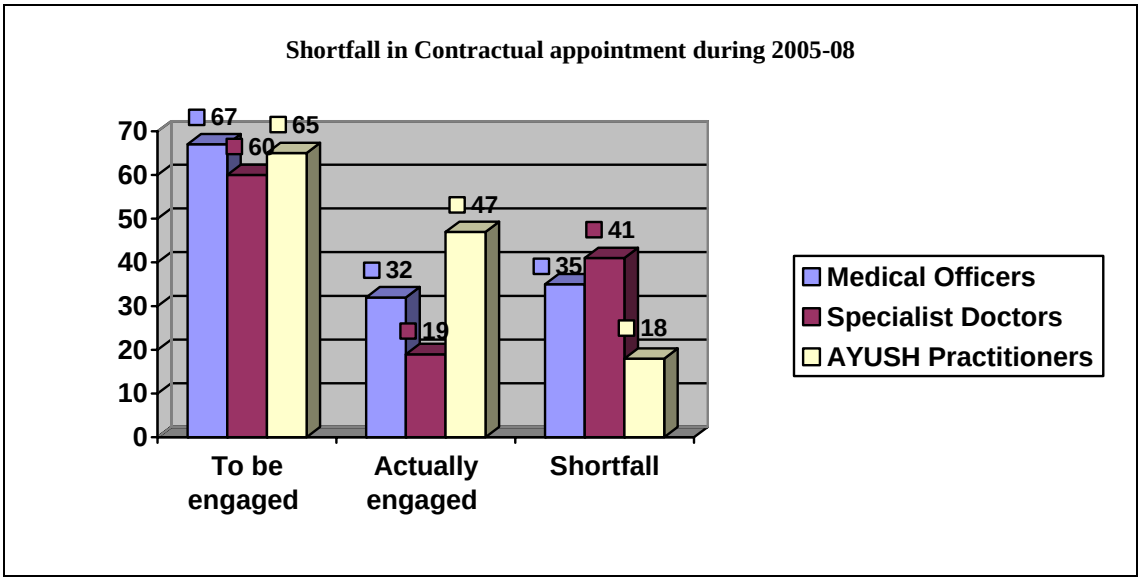
Source: - Data collected from centres test checked.

As is evident from the above table, there was a severe shortage of key health care personnel ranging from 7 to 93 *per cent.* The shortage of manpower had wide inter-health centre variations. In the absence of medical officers and specialists, especially in the CHCs, the aim of NRHM of providing adequate medical and specialist services remained unfulfilled.

6.3.1 Appointment of contractual staff

To meet the additional requirement of manpower as per NRHM norms, the implementation framework provides for engagement of medical and paramedical staff on contractual basis. Review of the status in the five sampled districts revealed shortfall in appointment in different categories vis-à-vis requirements as per norms as shown in the bar chart below:

Chart No.6



The reason for shortfall against the requirement was mainly due to the non-filling up of the regular sanctioned posts. The State Government did not indicate any specific timeframe to fill up the vacancies/posts.

6.3.1.1 Engagement of ASHA

One of the core strategies of NRHM was to promote access to improved healthcare at household level through a trained female community health worker called Accredited Social Health Activist (ASHA) to be provided in every village in the ratio of one per 1,000 people. The ASHA was expected to act as an interface between the community and the public health system. The status of engagement of ASHAs as of March 2008 is given below:

Table: 8

Name of the district selected	Total rural population (2001)	Number of ASHAs required	Number of ASHAs engaged (March 2008)	Gap Excess (+) Shortfall (-)
Sivasagar	9,54,557	955	955	Nil
Nalbari	11,21,338	1,121	693	(-) 428
Nagaon	20,36,342	2,036	2,038	(+) 2
Lakhimpur	8,23,857	824	825	(+) 1
Karbi-Anglong	7,21,381	721	813	(+) 92
Total	**56,57,475**	**5,657**	**5,324**	**(-) 333**
Total for the State	**2,32,16,288**	**23,216**	**26,235**	**(+) 3,019**

Source: - Statistical Handbook of Assam and data obtained from SHS

It would be evident from the above data that there were excess ASHAs in the State over the required number based on Census 2001 data. The excess may be attributed to lack of planning for engagement of ASHAs with reference to the rural population. Considering that there was a shortfall of 333 ASHAs in the five sampled districts despite an overall excess in the State, it is possible that the deployment of ASHAs may be skewed in various districts/villages. The Department stated that ASHAs were engaged as per the projected population. The reply of the Department is not justified as ASHAs were to be engaged

either on the basis of Census 2001 data, or as per the actual population based on latest survey.

6.3.2 Training

6.3.2.1 Shortfall in training

The NRHM envisaged capacity building of human resources through skill development of the medical and other support staff by imparting training periodically. Scrutiny revealed shortfall in imparting training as shown below:

Table: 9

Post	Target/Achievement	2005-06	2006-07	2007-08	Total
ASHA	T	NA	26,235	26,235	52,470
	A	Nil	26,225	Nil	26,225
ANM	T	5,972	NA	135	6,107
	A	4,065	NA	NA	4,065
Staff Nurse	T	1,090	NA	255	1,345
	A	291	NA	NA	291
Medical Officer	T	2,198	2,198	2,198	6,594
	A	495	24	14	533
Programme Manager	T	NA	NA	NA	NA
	A	NA	28	Nil	28
Total	**T**	**9,260**	**28,433**	**28,823**	**66,516**
	A	**4,851**	**26,277**	**14**	**31,142**

Source: - Data obtained from SHS

As can be seen from the table above, there was a shortfall of 57 *per cent* in providing training to important medical personnel/support staff. The shortfall was highest during 2007-08 (almost 99.87 *per cent*) and 48 *per cent* in 2005-06. The high shortfall is attributed to inadequate training infrastructure. In the five audited districts, it was noticed that action plan for training was not prepared by the DHS. In the absence of a plan for training, the requirement of training to various medical and support staff could not be determined. The status of training of the staff in the sampled districts is shown below:

Table: 10

Post	Total staff strength	No. of staff trained during 2007-08	Shortfall
RMP / TBA	No training conducted		
ANM	520	30	490
Public Health Nurse	No training conducted		
Staff Nurse	227	36	191
Medical Officer	23	9	14
Programme Manager	No training conducted		
Total	**770**	**75**	**695**

Source: - Data obtained from SHS

Non-achievement of targets set for training and non-determination of desirability for training through actions plans at the district level affected the human resource management under the Mission.

6.3.2.2 Training of IEC personnel

The NRHM provides for training of Information, Education and Communication (IEC) personnel at the State, district and block levels to create awareness among the masses about preventive and curative aspects of health. However, no training was imparted to IEC personnel at any level i.e. State, district and block during 2005-08. Status of IEC training imparted to other personnel like ASHA/Health Educator/Block Extension Educator during 2007-08 at only district level was quite good, as can be seen below:

Table: 11

Type of training	No. of districts	No. of personnel targeted to be trained	No. of personnel actually trained	Shortfall
BEE / HE	6	127	111	16
ASHA (with basic response to outbreak)	1	1,000	1,000	Nil

Source: - Data obtained from SHS

6.3.2.3 Training to ASHAs

The NRHM guidelines provide for training of ASHAs to equip them with necessary knowledge and skills. The guidelines provide for induction training as well as periodic trainings for skills enhancement. Scrutiny revealed that all the ASHAs in the sampled districts were provided with training in four out of the prescribed five modules as of March 2008. Required training of five modules, which was to have been completed by October 2006, was, however, not provided as of December 2008.

The shortfall in training provided to the ASHAs was due to non-preparation of plan for phasing the training modules by the SHS as well as inadequate training infrastructure. Lack of adequate training to ASHAs resulted in participation of ASHAs in health care activities in an *ad hoc* manner.

6.3.3 Involvement of NGOs

As per NRHM framework, Non-Governmental Organisations (NGOs) were to be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services and developing innovative approaches to health care delivery in underserved areas in collaboration with community organizations and PRIs. Rupees 1.53 crore, against Rs.2.43 crore released by the GOI, was released to twelve Mother Non-Governmental Organisations (MNGO) out of a total of eighteen MNGOs selected for twenty districts (as of May 2008). Of these twelve, two MNGOs in 4 districts were funded Rs.47 lakh and Rs.45 lakh each, against the admissible allotment of Rs.5 to 15 lakh per district.

Scrutiny revealed that, out of the total grants-in-aid to the tune of Rs.1.53 crore released to the MNGOs during the period 2005-08, Rs.12 lakh was utilized by the MNGOs and the remaining amount was lying with the latter as of May 2008. Although the MNGOs are required to submit UCs for the complete project before the end of the financial year, these were not submitted by them. Out of 12 MNGOs to which grants were released during 2005-08, only 1 MNGO submitted audited accounts. The unspent balance of Rs.1.41 crore

lying with the MNGOs shows that grants-in-aid was being released to the MNGOs in a routine manner without actually assessing their potential for performance.

The Department did not furnish any comments in this respect (March 2009).

Conclusion

There was a shortage of medical and other support staff at the health centres due to non-filling up of regular sanctioned posts. In the absence of the required staff at the health centres, the goal of providing reliable health care services was affected.

Due to lack of adequate infrastructure for training, the targeted training to medical and support staff could not be achieved, thereby affecting the quality of medical services through skilled manpower in tandem with new innovations in medical services.

The involvement of NGOs in building capacity in healthcare delivery system was at a primitive stage and funds were being released to MNGOs in a routine manner without assessing the actual potential.

Recommendations

- ***Vacant regular sanctioned posts of medical and paramedical staff should be filled up urgently. In addition, contractual staff should be engaged as per NRHM requirement.***
- ***Training infrastructure may be improved to cope with the requirement of training.***
- ***Necessary steps need to be taken for optimum utilization of the services of ASHAs, particularly the ASHAs appointed in excess of norms.***
- ***The State Health Society should take effective measures to involve NGOs at all levels of health care delivery system and ensure regular feedback and monitoring of activities performed by NGOs as envisaged in the NRHM framework.***

Chapter 7 Drugs and Equipment

7.1 Procurement and distribution of drugs

As per the bye-laws of the SHS, procurement of goods is to be made in the following order of preference:

a) Rate contracts of the Director General of Supplies and Disposals (DGS&D), failing which,

b) Rate contracts of other GOI agencies, failing which,

c) Tender procedure as recommended by the GOI.

In order to ensure good practices, detailed guidelines and procedure including wherever applicable, standardized forms were to be prepared. A limited list of essential drugs, also referred to as drug formulary, defining the drugs to be regularly purchased for stock, was also to be prepared by the SHS.

The SHS had not drawn up a detailed purchase procedure or manual outlining the procurement policy to be adopted. Drugs were procured during 2005 to 2008 through various authorities like SCOVA and Director of Health Services at rates approved by the State Government and also through supplier. In the absence of a uniform and well documented procurement policy, guidelines and purchase manual, the system of procurement was ad-hoc with no uniformity in the purchases made by SHS. The SHS had also not prepared any essential list of drugs to be procured, which led to wide variations in the number and type of drugs procured from time to time.

7.2 Utilization of funds for procurement of drugs/equipment

Funds received from the GOI for procurement of drugs and equipment and expenditure incurred thereagainst during 2005-08 are shown below:

Table: 12

(Rupees in crore)

Year	Particulars	Funds released by the GOI	Actual Expenditure Expenditure incurred/ Advances/ Deposits
2005-06	Equipment	-	Nil
	Drugs	10.80	Nil
	Supplies	-	0.26
	Others (computers etc.)	-	Nil
2006-07	Equipment	-	Nil
	Drugs	10.57	10.57
	Supplies	-	0.01
	Others (computers etc.)	24.17	6.59
2007-08	Equipment	7.86	6.51
	Drugs	48.50	50.50
	Supplies	-	5.48
	Others (computers etc.)	-	15.77
Total		**101.90**	**95.69**

Source: - Approved PIP and Annual Accounts of SHS

It is evident from the above data that an expenditure of Rs. 5.75 crore was incurred towards supplies during 2005-08 without allocation. This has not yet been regularized (March 2009).

7.3 Quality assurance for procurement of drugs

MoHFW guidelines provide for inspection, sampling and testing at pre-dispatch stage at the manufacturers' premises as well as at the consignees' end at the district headquarters. The inspection and sampling should be carried out by an independent authority.

The SHS procured 58,13,000 pieces of condoms worth Rs.73.24 lakh between February and July 2007 from M/S Hindustan Latex Ltd (HLL). The entire quantity was supplied in fifteen batches, out of which, samples of five batches were sent for quality test to Tamilnadu Medical Services Corporation Ltd (TNMSC) with whom the SHS signed an MOU for supply of drugs/medicines and condoms. These samples were tested in TNMSC approved laboratory and were found to be of substandard quality. Therefore, condoms of these five batches (15,13,000) were replaced by the manufacturer (HLL). These samples also failed the test quality and were replaced for the second time. Samples of the second replacement consignment were also tested and were cleared (March 2008) by TNMSC. Considering that the condoms failed the quality parameters twice, the quality of the balance quantity of 43,00,000 pieces of condoms worth Rs.54.18 lakh, already dispatched to districts is also doubtful, and would have an adverse impact on the implementation of family planning programme in the State.

7.4 Procurement/distribution of drugs/medicines

The SHS, despite repeated reminders and personal interaction, failed to produce the relevant records to the audit team regarding receipt, kitting and issue of medicines through kits. Therefore, the actual receipt and subsequent accountal of medicines worth Rs.9.40 crore, stated to have been procured during 2006-08, could not be verified in audit.

7.5 Procurement of equipment

7.5.1 Equipment for operationalisation of PHCs 24 X 7

NRHM emphasized the availability of and access to quality health care, safe motherhood and neonatal care through operationalisation of 50 *per cent* of PHCs to 24 hours, 7 days a week health centres.

The guidelines in this regard stipulate that the PHCs be carefully assessed and district wise priority list drawn up to select the potential PHCs possessing the basic infrastructure as per the scoring system devised for the purpose.

Scrutiny revealed that the SHS had not prepared any distinctive priority list on the basis of the scoring system as envisaged. However, equipment worth Rs.1.76 crore was procured (as of March 2008) for 227 PHCs[1] selected at random without assessing the actual availability of infrastructure required for designating them as 24x7 centres.

[1] BPHC-63; MPHC-85; SHC-12; SD- 67.

The Department stated that these equipments were procured as per future requirement.

Conclusion

The process of procurement of medicines and medical equipment in the State indicated that the procurement process was characterized by ad-hocism and the quality of the drugs procured remained questionable. Drug management is a critical input and delays, shortages or poor quality of drugs would jeopardize the programme implementation.

Recommendations

- ***The SHS should streamline the procurement procedures and put in place a transparent procurement system.***
- ***An appropriate quality control and monitoring system should be instituted to ensure that quality of healthcare is not compromised.***

Chapter 8 Information, Education and Communication

The Information, Education and Communication (IEC) strategy under NRHM aims to facilitate awareness and dissemination of information regarding availability of and access to quality health care for the poor, women and children in rural areas. The main focus of the strategy is to promote behavioural changes, awareness and to introduce well defined and culturally appropriate progress for specific regions. The focus of IEC activities during the period 2005-08 was on schemes like Janani Suraksha Yojona (JSY) and institutional deliveries, routine immunization, post-natal diagnostic test (PNDT) and breast feeding, positioning of ASHA, disease control programmes, contraceptive choice, spacing etc. Hoardings in rural areas, advertisements in print and audio-visual media, and printed material in local languages are being utilized for IEC activities as can be seen from the photograph alongside. Scrutiny of IEC activities revealed the following:

Immunisation campaign at Veleuguri Sub-Centre

8.1 IEC funding and expenditure

As per the NRHM implementation framework under IEC, allocation up to rupees ten per capita is to be made at the National, State and district levels for carrying out a variety of activities involving communities and also media. Further, the allocations are to be spent equally at all three levels - National, State and district. No funds were separately earmarked for IEC activities at the block and village levels.

The position relating to funds earmarked for IEC activities, funds released and expenditure incurred is given below:

Table: 13

(Rupees in crore)

Year	Funds earmarked	Opening balance	Funds released	Total funds available (3 + 4)	Expenditure		Total expenditure (6 + 7)	Unutilized amount i.e. closing balance (5 – 8)
					State level	District level		
1	2	3	4	5	6	7	8	9
2005-06	NA	1.07	0.36	1.43	0.10	-	0.10	1.33
2006-07	9.99	1.33	0.37	1.70	4.29	0.39	4.68	(-) 2.98
2007-08	15.00	(-) 2.98	25.00	22.02	19.74	2.80	22.54	(-) 0.52
Total	**24.99**		**25.73**		**24.13**	**3.19**	**27.32**	

Source: - Annual Accounts of SHS.

As can be seen from the table above, there was no equitable spending of funds at different levels, with most of the expenditure being incurred at the State level, implying that the IEC activities were centralised.

8.2 IEC coverage

Table 14 shows the extent of coverage of the IEC plan in the State during 2007-08. Information with regard to IEC activities for the years 2005-06 and 2006-07 (target and achievement) was not available.

Table: 14

	No. planned	No. achieved (as on December 2007)
Wall painting	3,450	800
Rallies	23	1
Quiz	46	38
Folk shows	221	51
IPC workshop	23	14
Meeting at Zilla Parishad	23	01
Orientation camp for NGOs and Mahila Mandals	46	25
Health Melas	23	05
IPC meetings at block level	1,360	263

Source: SHS Data

The status of other activities like advertisements through print and audio-visual media as approved in the PIP for 2007-08, including outsourcing for creativity in print media, production of radio and TV advertisements and advertising in local Mobile Theatres etc. was not made available to audit.

Also, as per the Annual Action Plans for the years 2006-07 and 2007-08 the target vis-à-vis achievement was below average in terms of performance, as can be seen below:

Table: 15

Year	Health Nutrition Days organized			Health Melas Organized (No. of Districts)		
	Target	Actual	IEC Activities	Target	Actual	IEC Activities
2005-06	Nil	Nil	Nil	Nil	Nil	Nil
2006-07	52,000	17,460	NA	23	17	17
2007-08	3,04,992	1,63,799	NA	23	23	22
Total	**3,56,992**	**1,81,259**		**46**	**40**	**39**

Source:- SHS data.

Further, no School Health check up camp was organized during 2005-2008. Evaluation of IEC activities was not undertaken at any level to assess its impact and take necessary corrective steps.

Conclusion

IEC activities were neither planned properly nor implemented strategically with periodical assessment/evaluation of impact, resulting in insufficient coverage in different regions of the State. Thus the objective of spreading awareness and dissemination of information regarding availability of and access to health care facilities for the rural population remained largely unachieved.

Recommendation

IEC strategy should be planned properly to ensure impact on behaviour change with regard to preventive aspects of health and coverage should be improved so that the rural population are aware of the availability and access to health care facilities being provided under NRHM.

Chapter 9 Performance Indicators

The impact of NRHM would largely be reflected through performance indicators, such as the TFR, IMR, MMR, the position of institutional deliveries, status of immunization, availability and use of contraceptives – both termination and spacing, number of OPD and IPD patients etc. While the GOI has fixed overall targets for the country and the States to be achieved during the Mission period, the SHS has not fixed the year wise targets for the districts, to enable monitoring and corrective action where necessary. In the absence of year wise targets for the State and districts level for impact and performance assessment the progress achieved in implementation of the programme cannot be assessed with any level of accuracy.

9.1 Maternal Health

The TFR of the State as per Census 2001 was 2.4 compared to the national average of 2.7. The IMR and MMR were 68 and 490 compared to the national average of 58 and 301 respectively. Implementation of various components of maternal and child health care is discussed below:

9.1.1 Antenatal care, registration and check ups

One of the major aims of safe motherhood is to register all the pregnant women within 12 weeks of pregnancy and provide them with services like four antenatal check ups, 100 days Iron Folic Acid (IFA) tablets, two doses of Tetanus Toxoid (TT), advice on the correct diet and vitamin supplements and in case of complications, refer them for more specialized gynaecological care. Early detection of complications during pregnancy through the prescribed anti-natal checkups is an important intervention for preventing maternal mortality and morbidity. However, records of ante-natal checkups were not maintained properly in any of the sampled health centres. Details of registration as well as the Maternity and Child Health (MCH) register were not maintained systematically, although registration of pregnant women and antenatal care had increased over the period of implementation of NRHM, as revealed during discussion with the Medical Officers (MOs), in charge of the centres test checked. Sound reporting system from CHCs, PHCs and SCs to the DHS was also absent.

While admitting the facts, the Department stated (January 2009) that the position is being improved and rectified.

9.1.2 Iron Folic Acid Administration

Anaemia is considered as the leading cause of maternal mortality. The RCH-II programme therefore emphasized administration of IFA tablets for pregnant women for a period of 100 days. The details of pregnant women provided with IFA tablets in the State as a whole were as follows:

Table: 16

Year	No. of pregnant women registered at all the health centres	No. of pregnant women who received 100 days of IFA tablets
2005-06	6,77,812	76,160
2006-07	5,89,897	82,842
2007-08	6,42,535	4,64,022
Total	**19,10,244**	**6,23,024**

Source: - Data furnished by DHS (FW)

In the sampled districts, the status of pregnant women who received IFA tablets was as shown in Table:

Table: 17

Name of the District	Year	No. of pregnant women registered	No. of registered pregnant women who were administered IFA tablets	
			Prophylaxis	Therapeutic
Nagaon	2005-06	57,849	32,957	11,635
	2006-07	53,493	4,880	2,878
	2007-08	47,012	6,721	1,390
Nalbari	2005-06	29,672	11,223	4,763
	2006-07	30,834	10,013	5,854
	2007-08	29,464	17,995	7,630
Sivasagar	2005-06	19,959	16,489	3,470
	2006-07	25,055	9,681	2,016
	2007-08	20,899	5,739	194
Lakhimpur	2005-06	7,536	--	--
	2006-07	17,692	--	--
	2007-08	22,783	8,417	
Karbi-Anglong	2005-06	15,495	2,093	6,083
	2006-07	19,923	9,357	3,128
	2007-08	20,918	6,525	2,515
Total	**2005-06**	**1,30,511**	**62,762**	**25,951**
	2006-07	**1,46,997**	**33,931**	**13,876**
	2007-08	**1,41,076**	**45,397**	**11,729**

Source: - Data furnished by DHS (FW)

As can be seen from the above table, the number of pregnant women, who were provided with the prescribed level of IFA tablets-both in the sampled districts as well as the State as a whole-was woefully inadequate. While the shortfall in this regard ranged from 32 to 67 per cent during 2005-08 in the sampled districts, it was 28 to 89 per cent during the period for the State overall.

While accepting (January 2009) the facts, the Department attributed the low coverage to inadequate supply of IFA tablets. The reply is not acceptable, as it was the Department's responsibility to ensure that adequate quantity of drugs are procured on a timely basis.

9.1.3 Tetanus Toxoid Immunisation

To immunize the mother and neonates from tetanus, two doses of tetanus toxoid have been prescribed for all pregnant women. As per the information provided by the Joint Director of Health Services (UIP), 5,99,344, 6,52,089 and 6,35,384 lakh women were fully immunized from tetanus during 2005-06, 2006-07 and 2007-08 respectively, against the target of 8,19,403, 7,17,747 and 8,48,430 lakh for these years respectively, in the State.

Details of immunization against tetanus in respect of the sampled districts is shown below:

Table: 18

District	2005-06		2006-07		2007-08		Total	
	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
Nagaon	67,576	48,267	70,794	48,812	71,291	62,350	2,09,661	1,59,429
Nalbari	37,078	28,738	39,679	30,351	35,383	23,975	1,12,140	83,064
Sivasagar	33,297	17,486	36,214	18,345	32,375	20,807	1,01,886	56,638
Lakhimpur	27,860	22,202	31,218	25,760	27,379	24,061	86,457	72,023
Karbi Anglong	24,796	13,327	23,768	18,535	25,061	15,367	73,625	47,229
Total	**1,90,607**	**1,30,020**	**2,01,673**	**1,41,803**	**1,91,489**	**1,46,560**	**5,83,769**	**4,18,383**

Source: - Data furnished by DHS (FW)

As can be seen from the above table, in three[1] districts, the achievement vis-à-vis target was fairly high varying from 74 *per cent* to 83 *per cent* while in two[2] districts, the achievement ranged from 56 *per cent* and 64 *per cent*.

The reasons for lower achievement in two districts were neither on record nor stated by the Department.

9.1.4 Institutional delivery care

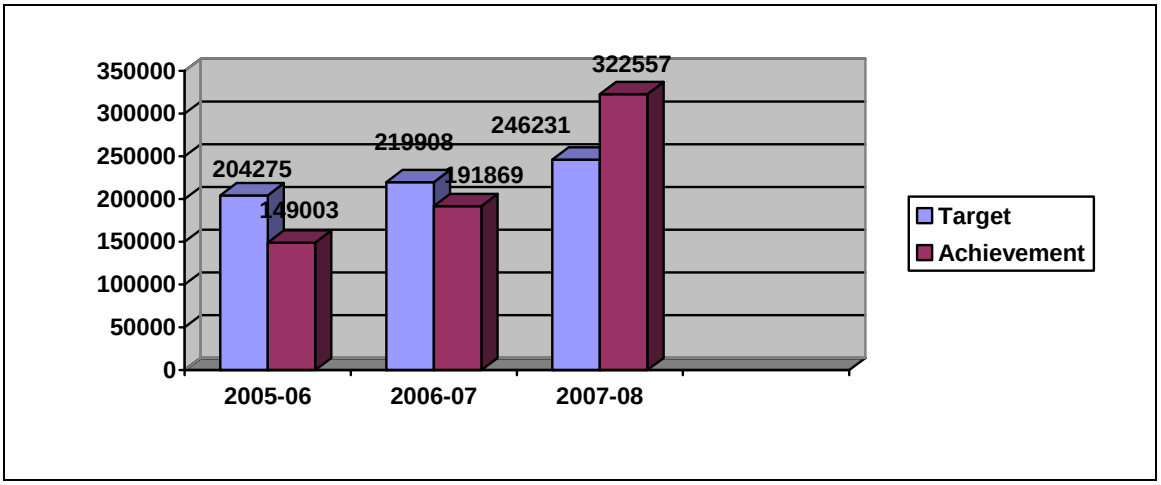
NRHM, with its programme of RCH-II, aims to encourage the prospective mothers to undergo institutional deliveries. To encourage institutional delivery, the Janani Suraksha Yojana (JSY) was launched to provide all pregnant women cash assistance of Rs.1,400/- irrespective of their age and number of previous deliveries and Rs.600/- to ASHA per case for bringing pregnant women to the health centre.

Campaign for institutional delivery at Manja PHC

The targets for institutional deliveries in the State and the achievement thereagainst during 2005-08 is given below:

[1] Nagaon, Nalbari and Lakhimpur.
[2] Sivasagar and Karbi-Anglong.

Chart No.7



Source: Data supplied by SHS

As can be seen from the chart above, the achievement with regard to institutional deliveries was 70, 87 and 147 *per cent* of the target. The status of domiciliary deliveries for the State as a whole for the above period is not available. Thus, the percentage of institutional deliveries has been increasing over the period of implementation of NRHM, which is encouraging.

This is also evident from the status of pregnant women who had institutional/ domiciliary deliveries as verified from the Maternity and Child Health Registers in the sampled districts as shown below:

Table: 19

Year	No. of pregnant women registered	Institutional deliveries	Domiciliary deliveries
2005-06	1,30,511	22,824	39,658
2006-07	1,46,997	43,352	36,576
2007-08	1,41,076	80,082	25,830

Source: - Data collected from DHS

The table above confirms that institutional deliveries were on the rise compared to domiciliary deliveries, as envisaged by NRHM.

According to the Facility Survey, out of a total of 912 PHCs, only 227 PHCs had the facility of 24 X 7 delivery services. The facility assessment at 29 PHCs revealed that the facility of 24 hour delivery services was available only at 18 PHCs. The reasons for non-availability of delivery services was attributed by the Department to absence of medical officers, staff nurses, labour room etc. at the PHCs.

9.1.5 Obstetrics care

Essential obstetrics care includes antenatal care, supply of essential obstetric drugs, neonatal resuscitation, equipment for newborns etc. Scrutiny revealed that out of 58 SCs,

29 PHCs and 14 CHCs, equipment for neonatal care and neonatal resuscitation were available only in 14 PHCs and 5 CHCs and none of the 58 SCs.

Of the 108 CHCs in the State, 29 were upgraded as First Referral Units (FRU). Out of the 14 sampled CHCs, in 4 CHCs, emergency obstetric care including the facility of caesarean section was not available. This was due to the absence of specialists in obstetrics and gynaecology, anaesthesist, non-functional operation theatre, lack of adequate infrastructure, support staff, blood storage facility etc. as brought out in paragraph 6.2.

9.1.6 Postnatal care

Postnatal care includes immunization, monitoring the weight of the child, physical examination of the mother, advice on breast-feeding, family planning etc. The health centres in the sampled districts failed to furnish the information regarding postnatal care provided. It is therefore presumed that proper attention was not paid to postnatal care. The rate of postnatal care in the State as a whole, however, was 13.8 *per cent* in 2005-06 (NFHS-3) compared to antenatal care of 36.3 *per cent* in the same year, which shows a drop out of cases from receiving services of ANC, to institutional delivery and postnatal care. This indicated that tracking of the registered pregnant women was not done adequately.

9.1.7 Referral services

The RCH-II programme included the scheme for lump sum assistance to Panchayats to transport pregnant women from BPL families from their residence to the health centre and back. During 2005-08, no fund was provided to Panchayats/VHSC for referral services. Out of the five sampled districts, while the expenditure details were not available in two[3] districts, in three[4] districts, Rs.1.64 crore were released for referral services. Out of this amount, only Rs.40.07 lakh was utilized by various health centres, primarily by Block Public Health Centres, and Rs.1.24 crore remained unutilized.

Under the scheme, the referring centre should get feedback from the referral centres regarding the progress of treatment given by the specialists. In addition, records of such referred women should be maintained at all the levels and ANMs should visit the referred women every week during their antenatal, natal and postnatal periods for follow up. Scrutiny revealed that at 58 SCs, 29 PHCs and 14 CHCs test checked, registers for referral cases were not maintained and feedback from the referral centres was also not obtained.

9.1.8 Maternal / neonatal mortality

One of the most important goals of NRHM is bringing down the Maternal Mortality Rate (MMR) to 100 per 1,00,000 pregnant women by 2012.The rate of maternal deaths and neonatal deaths in the State was 490 and 68 respectively as per the Sample Registration System (SRS)-03 and SRS-06 respectively. The status of actual number of maternal deaths and neonatal deaths during 2005-08 was not available with the Sate Health Society.

[3] Karbi-Anglong ,Nagaon
[4] Nalbari, Sivasagar and Lakhimpur.

In the five sampled districts, the status of maternal deaths and neonatal deaths were available only in three districts[5] for 2005-06 and 2006-07 and four districts[6] in 2007-08 as shown below:

Table: 20

Year	No. of districts	No. of maternal deaths	No. of neonatal deaths
2005-06	3	189	119
2006-07	3	87	87
2007-08	4	74	130

Source: - Data collected from DHS

Conclusion

While there was considerable achievement in the areas of tetanus toxoid immunization and institutional delivery, the overall achievement in terms of maternal health was far from satisfactory since registration of pregnant women for systematic ante-natal check up and tracking was not in place. There was poor coverage of IFA administration due to inadequate supply of tablets; 24 X 7 delivery services were not in place; essential obstetrics care facilities were lacking in almost all the health centres. Thus maternal health care was not implemented effectively. The targets and performance indicators may require a re-look in a State like Assam, where the MMR and IMR is quite high compared to the national average.

Recommendation

Maternal health programme needs to be implemented in its entirety covering all the essential areas like registration, reporting and tracking of pregnancies, IFA administration, immunization, antenatal and postnatal care and referral matters etc.

9.2 Reproductive Healthcare

Reproductive health care is aimed at countering Reproductive Tract Infection (RTI) and Sexually Transmitted Infection (STI) and ensuring safe Medical Termination of Pregnancy (MTP).

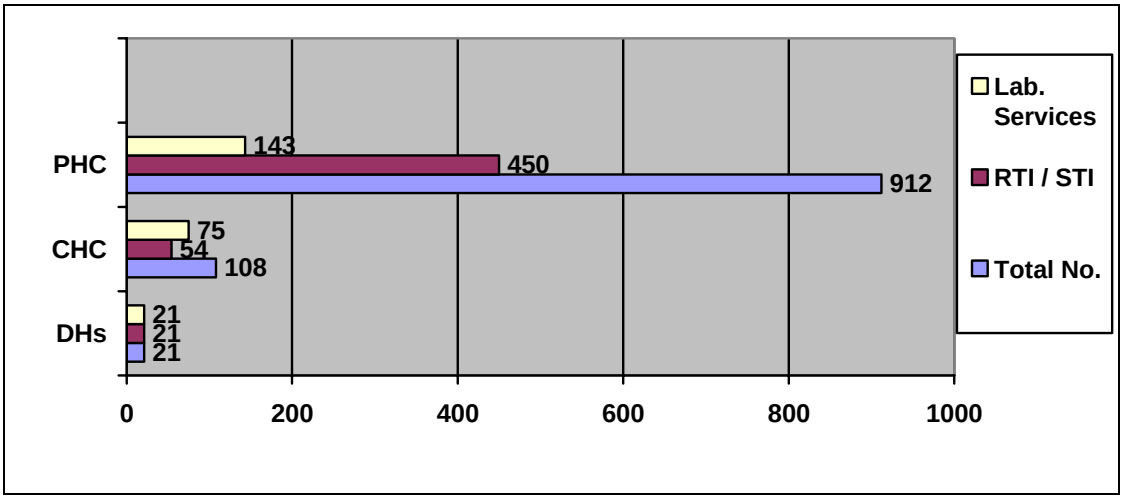
9.2.1 RTI and STI services

The RCH programme envisaged establishment of RTI and STI clinics in all the district hospitals and FRUs/CHCs.

Scrutiny revealed that RTI/STI management facilities were available at all 21 district hospitals. The status of availability of these facilities in the other health centres is given below:

[5] Karbi Anglong, Lakhimpur and Nagaon
[6] Karbi Anglong, Lakhimpur, Nagaon and Nalbari

Chart No.8



Out of 29 sampled PHCs in five districts, the RTI/STI facilities were available in 22 PHCs. In one district there was no laboratory technician and in 3 districts, there were no gynaecologists. In the five sampled districts, there were 59 laboratory technicians and 24 gynaecologists against the requirement of one laboratory technician and one gynaecologist in each of the five district hospitals, 29 CHCs and 229 PHCs. Due to partial availability of RTI/STI facilities in the health centres, the objective of management of such cases especially among women, remained unfulfilled.

9.2.2 Medical termination of pregnancy (MTP)

One of the important components of NRHM is to increase the number and quality of MTP. The programme envisaged need based training to medical officers and nurses, provision of equipments and operation theatre and MTP kits at district hospitals, CHCs and PHCs. As per the information provided by the SHS, 21 district hospitals, 64 CHCs and 188 PHCs had the MTP facilities.

In the sampled districts, 23 out of 27 CHCs and 64 out of 229 PHCs had the facility of MTP services. In 4 CHCs and 165 PHCs, MTP services were not available due to the absence of either the necessary equipment or trained doctors/nurses. Thus, availability of MTP services was not up to the mark in the health centres.

9.2.3 Spacing methods

Oral pills, condoms and intra-uterine device insertion are the three prevailing spacing methods of family planning to reduce the total fertility rate. The year wise details of targets and achievement in the use of spacing contraceptives in the State are shown below:

Table: 21

Year	IUD insertion		Oral pills cycle		Condom distribution	
	Target	Achievement	Target	Achievement	Target	Achievement
2005-06	NA	NA	NA	NA	NA	NA
2006-07	NA	3,256	60,600	37,766	NA	NA
2007-08	40,000	29,083	46,000	32,274	NA	23,029

Source: - Data furnished by DHS (FW)

Among the total spacing method users during 2007-08, 38 and 35 *per cent* accounted for IUD users and oral pills respectively, while around 27 *per cent* accounted for condom users.

Conclusion

RTI/STI facilities were not adequate in the health centres. MTP facilities were also inadequate and the DHSs do not have the complete details relating to the spacing methods adopted by the rural population. In the absence of such details, focused targeting of user groups would not be possible.

Recommendation

Adequate steps should be taken to provide better facilities to counter RTI and STD and also provide for MTP in the health centres.

9.3 Immunisation and child health

9.3.1 Routine Immunisation

Immunization of children against six preventable diseases viz. tuberculosis, diphtheria, pertussis, polio and measles etc., has been the cornerstone of routine immunization under the universal immunization programme. Tables 22-A and B give a summary of the targets and achievements under this programme.

Table: 22-A

Year	Target	Achievement				FI[7]
		BCG[8]	Measles	DPT[9]	OPV[10]	
2005-06	6,54,912	6,72,731	5,70,715	5,81,214	5,79,718	4,90,301
2006-07	7,17,747	7,02,868	6,12,258	6,21,956	6,37,402	5,38,014
2007-08	6,89,922	7,29,154	6,09,718	6,49,927	6,36,749	5,68,665
Total	**20,62,581**	**21,04,753**	**17,92,691**	**18,53,097**	**18,53,869**	**15,96,980**

Source: - Data furnished by DHS (FW)

Table: 22-B

Year	DT[11]		TT[12] (at the age of 10)		TT (at the age of 11 to 16)	
	Target	Achievement	Target	Achievement	Target	Achievement
2005-06	6,83,142	4,79,148	6,88,788	2,22,975	5,98,455	1,86,410
2006-07	7,07,850	4,88,001	7,13,700	3,41,981	6,20,100	2,71,439
2007-08	7,19,660	3,77,280	7,25,607	3,34,549	6,30,446	2,41,803
Total	**21,10,652**	**13,44,429**	**21,28,095**	**8,99,505**	**18,49,001**	**6,99,652**

Source: - Data furnished by DHS (FW)

The overall achievement of full immunization of children between 0 to 1 year age group covering BCG, Measles, DPT and OPV ranged from 75 to 82 *per cent* during 2005-08.

[7] Fully Immunised
[8] Bacillus of Calmette and Guerin
[9] Diptheria Pertusis Tetanus
[10] Oral Polio Vaccine
[11] Diptheria Tetanus
[12] Tetanus Toxoid

Besides, for secondary immunization, children in the age group of 5 to 6 years were required to be administered DT, and two doses of TT at the age of 10 and 16 respectively. The shortfall in achievement of the targets in the secondary immunization ranged from 30 to 48 *per cent* for DT, 52 to 68 *per cent* for TT (10) and 52 to 68 *per cent* for TT (16). In the sampled districts, targets were not fixed annually on the basis of the projected population. The status of targets and achievements for immunization in the districts are shown below:

Table: 23

Name of district	Year	Target for complete Immunization	Actual achievement				
			Up to one year (Complete course)	Above one and a half years (DPT & OPV booster)	Above five years (DT only)	Above 10 years (TT)	Above 16 years (TT)
Nagaon	2005-06	57,502	38,674	26,708	11,625	5,363	6,205
	2006-07	59,853	36,665	43,933	21,968	14,024	5,829
	2007-08	59,926	51,553	58,309	18,361	13,238	8,426
Nalbari	2005-06	31,866	26,024	12,233	12,058	8,256	6,385
	2006-07	33,546	25,794	29,847	6,327	9,412	3,012
	2007-08	29,742	21,078	26,704	4,025	4,138	4,100
Sivasagar	2005-06	28,688	18,864	20,408	15,079	8,589	4,906
	2006-07	30,617	18,821	20,135	8,022	8,552	5,925
	2007-08	27,214	20,670	24,667	14,610	4,906	5,920
Lakhimpur	2005-06	24,117	15,615	24,290	14,070	3,001	12,014
	2006-07	26,393	19,537	23,078	18,297	12,873	14,262
	2007-08	23,014	19,973	26,130	6,044	11,701	7,082
Karbi Anglong	2005-06	21,542	12,999	58,668	12,345	4,906	3,001
	2006-07	20,095	15,736	17,444	12,676	13,355	1,004
	2007-08	21,066	13,983	17,037	11,777	12,130	3,929
Total	**2005-06**	**1,63,715**	**1,12,176**	**1,42,307**	**65,177**	**30,115**	**32,511**
	2006-07	**1,70,504**	**1,16,553**	**1,34,437**	**67,290**	**58,216**	**30,032**
	2007-08	**1,60,962**	**1,27,257**	**1,52,847**	**54,817**	**46,113**	**29,457**

Source: - Data furnished by DHS (FW)

The above data indicates wide inter-district variations in achievement of immunization targets. Inadequate supply of vaccines was the main reason for shortfall in achievement, which resulted in prevalence of vaccine preventable infant and child diseases in the sampled districts, as shown below:

Table: 24

Name of District	Year	Number of cases				
		Neonatal tetanus	Diphtheria	Tetanus	Whooping cough	Measles
Nagaon	2005-06	2	4	2	0	545
	2006-07	0	0	0	0	150
	2007-08	5	26	5	0	547
Nalbari	2005-06	0	0	0	9	267
	2006-07	0	0	0	0	413
	2007-08	0	0	0	6	319
Sivasagar	2005-06	0	3	0	0	34
	2006-07	0	0	0	0	57
	2007-08	0	0	0	0	118
Lakhimpur	2005-06	1	0	1	0	812
	2006-07	0	0	0	0	934
	2007-08	5	0	5	0	1494

Karbi-Anglong	2005-06	0	0	0	0	479
	2006-07	0	0	0	0	370
	2007-08	0	2	0	0	172
Total	**2005-06**	**3**	**7**	**3**	**9**	**2137**
	2006-07	**0**	**0**	**0**	**0**	**1924**
	2007-08	**10**	**28**	**10**	**6**	**2650**

Source: - Data furnished by DHS (FW)

During the exit conference, the Department stated that immunization dosage was given to the actual target groups rather than projections. However, in the absence of any authentic documents in this regard, the Department's contention could not be verified.

9.3.2 Pulse polio immunization

In pursuance of the World Health Assembly Resolution of 1988, in addition to the Universal Immunisation Programme, Pulse Polio Immunisation (PPI) was launched in 1995-96 to cover all the children below the age of five years to eradicate polio and ensure zero transmission by the end of 2008.

The year wise details of polio cases in the State during the review period are tabulated below.

Table: 25

Year	No. of new Polio cases	No. of children given Polio drops	
		Target	Achievement
2005-06	Nil	46,66,527	45,45,186
2006-07	2	46,78,538	45,08,353
2007-08	Nil	47,38,280	45,72,881
Total	**2**	**1,40,83,345**	**1,36,26,420**

Source: - Data furnished by DHS (FW)

The details of polio cases and immunization in the sampled districts are shown below. Targets were, however, not set as regards the number of children to be administered the required dosage.

Table: 26

District	Year	No. of new Polio cases	No. of children given Polio drops	
			Target	Achievement
Nagaon	2005-06	Nil	Not set	58,668
	2006-07	Nil		43,933
	2007-08	Nil		58,309
Nalbari	2005-06	Nil	Not set	27,829
	2006-07	Nil		30,248
	2007-08	Nil		27,914
Sivasagar	2005-06	Nil	Not set	24,310
	2006-07	Nil		21,056
	2007-08	Nil		24,667
Lakhimpur	2005-06	Nil	Not set	18,502
	2006-07	Nil		24,119
	2007-08	Nil		26,130

Karbi-Anglong	2005-06	Nil	Not set	12,233
	2006-07	Nil		18,523
	2007-08	Nil		17,037
Total	**2005-06**	Nil		**1,41,542**
	2006-07	Nil		**1,37,879**
	2007-08	Nil		**1,54,057**

Source: - Data furnished by DHS (FW)

While the overall achievement of PPI was about 97 *per cent* in the State as a whole, in the sampled districts, the achievement ranged from 12,223 to 58,668 during 2005-08. There were no new cases of polio in the sampled districts.

9.3.3 Vitamin A solution

RCH-II programme emphasized administration of Vitamin A solution for all children less than 3 years of age. The first dose of Vitamin A should be administered at 9 months of age alongwith measles vaccine, the second dose alongwith DPT/OPV, and subsequently three doses at six monthly intervals. In the five sampled districts, the status of achievement of administration Vitamin A solution is shown below.

Table: 27

District	Year	Target (FI)	Actual achievement		
			1st dose	2nd dose	3rd to 5th dose
Nagaon	2005-06	NA	11,620	19,201	12,632
	2006-07		18,094	11,612	15,429
	2007-08		18,094	11,612	15,429
Nalbari	2005-06	NA	18,240	8460	13201
	2006-07		15,744	15216	15386
	2007-08		13,601	11543	20079
Sivasagar	2005-06	NA	22,756	3,478	14,210
	2006-07		12,756	14,698	18,301
	2007-08		12,845	17,121	14,579
Lakhimpur	2005-06	NA	2,746	4,579	7,121
	2006-07		5,380	14,021	7,486
	2007-08		21,017	19,578	12,601
Karbi-Anglong	2005-06	NA	12,097	4,599	4,697
	2006-07		4,100	5,821	10,777
	2007-08		13,566	5,263	18,943
Total	**2005-06**		**67,459**	**40,317**	**51,861**
	2006-07		**56,074**	**61,368**	**67,379**
	2007-08		**79,123**	**65,117**	**81,631**

Source: - Data furnished by DHS (FW)

While specific targets for administration of Vitamin A solution were not set, the main reason for variation in achievement during 2005-08 when compared to the total number of children who had been given the 1st dose, was short supply of Vitamin A solution to the health centres. In addition, the Department stated (January 2009) that in view of certain probable death cases, Vitamin A was not forcefully administered in the State.

Conclusion

There was a wide variation among the districts with regard to achievement of targets for immunization. The overall achievement, especially secondary immunization was quite poor.

Recommendation

The targets fixed for immunization may be re-examined and the targets may be designed with zero tolerance to achieve universal immunization.

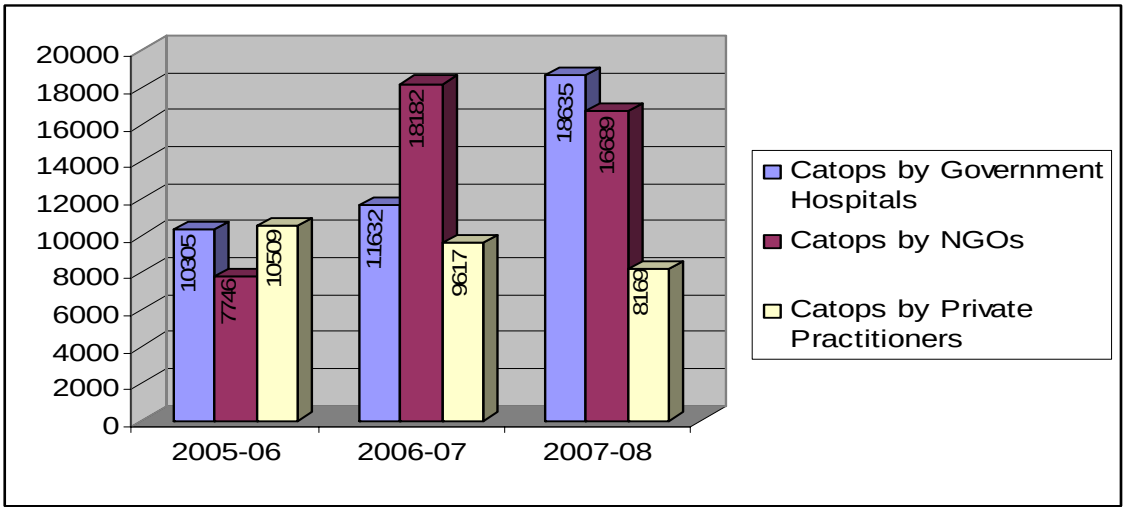
9.4 National Programme for Control of Blindness (NPCB)

The NPCB aimed at reducing the prevalence of blindness cases to 0.8 *per cent* by 2007 through increased cataract surgery (46 lakh by 2012), school eye screening and free distribution of spectacles, collection of donated eyes and creation of donation centres and eye banks and strengthening of infrastructure by way of supply of equipment and training of eye surgeons and nurses.

9.4.1 Cataract operations

Cataract operations are performed by the Government doctors in Government hospitals, by NGOs and private practitioners in clinics and eye camps. The status of cataract surgeries performed in the State is given below:

Chart No.9



The distribution of workload (catops to be performed) aimed at reducing blindness was expected to be shared equally by the private and public sectors. While the NGOs and private sector together carried out 57.15 to 70.50 *per cent* of the total number of Catops performed (1,11,484) during 2005-06 to 2007-08, the Government sector could perform only 29.50 to 42.85 *per cent* of the cataract operations.

The programme contemplated cataract operations (catops) performed in eye camps to be in the range of 20 *per cent*. The details of catops performed in the camps are given below:

Table: 28

Year	No. of catops performed		In camps as percentage of total
	Total	In camps	
2005-06	28,560	7,746	27.12
2006-07	39,431	18,182	46.11
2007-08	43,493	16,689	38.37
Total	**1,11,484**	**42,617**	**38.22**

Source: - Data furnished by Society for NPCB

From the above table it is seen that cataract operations in camps were performed far in excess of the norm.

9.4.2 Availability of Eye Surgeons

As per information provided by State Programme Officer (NPCB), there were 98 Eye Surgeons (as of April 2008) in various district hospitals, and other health centres (CHCs and PHC), out of which, 58 were operating Eye Surgeons including 49 trained surgeons. This indicates that 9 Eye Surgeons were performing catops without any training. Scrutiny, however, revealed that 13 out of the 49 trained Eye Surgeons were posted in various health centres where operation (catops) facilities were not available.

Further, out of 58 operating Eye Surgeons, 55 were posted in various district hospitals while 3 were posted in a PHC, CHC and in Government Ayurvedic College. Out of a total of 40 non-operating surgeons, including 13 trained, one was posted as Zonal Malaria Officer, 3 were posted in CHC and PHC but working in District Hospitals.

These indicated poor manpower management by the State.

9.4.3 Catops failure

In the 'Mega Eye Operation Camp' held at Regional Institute of Opthalmology, Guwahati during September to November 2006, 509 cataract operations were performed against the target of 5,000 cases. The authorities were compelled to stop operations in September 2006 due to the occurrence of post-operative endopthalmitis in 38 cases out of which, 35 cases had to be referred to Shri Sankardeva Netralaya, Chennai for further treatment. All these patients finally lost their vision and had taken recourse to law seeking compensation. This was evidently due to setting up of Mega Camp for the sake of fulfillment of the unrealistic targets set, without having proper infrastructure and logistic requirements for such a Camp.

9.4.4 Refractive errors and free distribution of spectacles

The programme envisaged training of teachers in Government and Government aided schools, for screening refractive errors among students and free distribution of spectacles to the students having refractive errors. As against the total number of 43,455[13] such schools in the State, only 16,898 teachers were trained during 2005-08. The number of free spectacles issued did not correspond to the students having refractive errors. During 2005-06, 2006-07 and 2007-08 288, 1,764 and 2,153 spectacles were distributed against the total detection of 2,499, 9,867 and 5,032 cases of refractive errors respectively.

[13] Higher Secondary (620), High (4629), Middle (8143) and Primary (30063) schools.

In the five sampled districts, out of 14,10,470 students in 11,651 schools, 1,56,913 students were screened during 2005-08 and 1,339 were provided with free spectacles against the detection of 4,416 cases of refractive errors.

9.4.5 Eye banks

Development of eye bank is an important activity to address corneal blindness. As of March 2008, only 4 eye banks were operational in the State out of which, 2 were in the Government sector and the other two in the voluntary sector. Further, none of the 21 district hospitals had facilities for eye donation. The performance of the eye banks is tabulated below:

Table: 29

Year	No. of eyes						
	Opening balance	Donated	Utilized	Transferred to other banks	Rendered unfit	Used for research	Closing balance
Government sector							
2005-06	NA	NA	NA	NA	NA	NA	NA
2006-07	-	19	17	-	-	-	-
2007-08	-	20	17	-	-	-	-
Total	-	39	34	-	-	-	-
Voluntary sector							
2005-06	NA	NA	NA	NA	NA	NA	NA
2006-07	-	81	49	-	-	-	-
2007-08	-	241	96	-	-	-	-
Total	**-**	**322**	**145**	**-**	**-**	**-**	**-**
Grand total	**-**	**361**	**179**	**-**	**-**	**-**	**-**

Source: - Data furnished by Society for NPCB.

Conclusion

Performance of catops both in Government and Private Sectors was poor primarily due to the non-availability of Eye Surgeons and infrastructure facilities in rural health centres.

Recommendations

- ***Eye Surgeons may be appointed in all the CHCs and trained appropriately in addition to providing infrastructural facilities in rural health centres for catops. To address corneal blindness, more eye banks may be established in the State.***
- ***School children should be screened at prescribed intervals to detect cases of refractive errors early and provide spectacles in a timely manner.***

9.5 Revised National Tuberculosis Control Programme (RNTCP)

The main objective of the RNTCP is to diagnose as many cases of TB as possible by detecting at least 70 *per cent* cases and ensure a cure rate of at least 85 *per cent* of smear positive cases through Direct Observed Treatment Short Course (DOTS).

9.5.1 Targets and achievements under RNTCP

The year wise details of targets and achievements under the RNTCP regarding sputum examination and case detection are given below:

Table: 30

Year	Sputum examination		Detection new Sputum '+' ve cases		
	Target	Achievement	Target (70% of sputum examination)	Achievement	
		Number		Number	*Per cent*
2005-06	2-3% of OPD attendants[14]	1,08,397	75,878	11,659	15.36
2006-07		1,22,353	85,647	13,785	16.09
2007-08		1,43,067	1,00,147	16,192	16.17

Source: - Data furnished by Society for RNTCP

The cure rate ranged between 78 and 81 *per cent* in the State against 85 *per cent* prescribed under RNTCP during 2005-08, which is encouraging. The details are shown below:

Table: 31

Year	TB patients registered	No. of cases evaluated	Cured/Treatment completed	Died	Treatment failure	Treatment discontinued	Transferred out
2005-06	21,224	21,224	17,115	1,008	378	2,488	235
2006-07	24,155	24,155	19,179	1,075	336	3,332	233
2007-08	26,581	26,581	20,624	1,117	339	4,314	187

Source: - Data furnished by Society for RNTCP

9.5.2 Availability of diagnostic facilities

As per NRHM framework, full treatment of tuberculosis is guaranteed at CHCs and PHCs. 92 out of 108 CHCs and 267 out of 912 PHCs were covered under the DOTS scheme of the programme.

Scrutiny of 14 CHCs and 29 PHCs revealed that full services like existence of DOTS centres having laboratory services for sputum examination etc. for treatment of tuberculosis were available in 12 CHCs and 7 PHCs. In 2 CHCs and 22 PHCs, full diagnostic services were not available due to non-availability of technician or microscope.

Conclusion

Detection of new sputum positive cases in the State was below the RNTCP goal of 70 per cent. While the cure rate was quite good, full facilities for tuberculosis treatment were not available in the CHCs and PHCs.

[14] OPD cases for the State were not available at SHS (NRHM).

Recommendation

The State Government should make available the full complement of diagnostic facilities at all the CHCs and PHCs and fix realistic targets for sputum examination.

9.6 National Vector Borne Disease Control Programme (NVBDCP)

The NVBDCP aims to control vector borne diseases by reducing mortality and morbidity due to malaria, filaria, kala azar, dengue, chikungunia and japanese encephalitis in endemic areas through close surveillance, controlling breeding of mosquitos, indoor residual spray of larvicides and insecticides and improved diagnostic and treatment facilities at all health centres.

9.6.1 Annual Blood Examination Rate (ABER) and Annual Parasitic Incidence (API) for malaria

The programme stipulated to achieve ABER of 10 *per cent* and API of less than 0.5 per thousand. ABER was 7.92 *per cent*, 9.75 *per cent* and 8.09 *per cent* and API was 2.34, 4.30 and 3.19 *per thousand* during 2005-06, 2006-07 and 2007-08 respectively, for the State as a whole. The records regarding ABER and API in the sampled districts indicated that in two[15] districts, ABER was less than the State average of 8.59 *per cent* and in three[16] districts, API was more than the State average of 3.28 per thousand during 2005-08 which indicates that vector control measures are not achieving results to the desired extent. The reasons for ABER below 10 *per cent* was due to inadequate surveillance because of the large number of vacancies in the field.

The Department during discussion stated that rapid diagnostic strips are being used for early diagnosis.

9.6.2 Population protected with insecticides

Under the NVBDCP, all the areas having API of 2 and above were required to be covered under compulsory indoor residual spray of Dichloro-Diphenyl-Trichloroethane (DDT) and anti larva solution. Scrutiny revealed that residual spray of DDT (50 *per cent*) was carried out once in 2005-06 and two rounds each in 2006-07 and 2007-08 throughout the State against the stipulation of two rounds of spray every year.

The details of population targeted and covered under indoor residual spray of DDT (50 *per cent*) is given below:

Table: 32

Year	Round	Period of spray	Population targeted (in lakh)	Population covered (in lakh)	Percentage covered
2005-06	1st	04/2005 to 10/2005	129.65	101.01	78
	2nd	No DDT spray operation performed			
2006-07	1st	04/2006 to 08/2006	125.35	92.67	74
	2nd	07/2006 to 11/2006	128.20	117.21	91
2007-08	1st	02/2007 to 06/2007	133.65	109.23	82
	2nd	04/2007 to 08/2007	102.98	77.45	75

Source: - Data furnished by Society for NVBDCP

[15] Nalbari and Sivasagar.
[16] Nagaon, Lakhimpur and Karbi-Anglong.

9.6.3 Incidence of vector borne diseases

The status of morbidity and mortality due to various vector borne diseases during 2005-08 is given below:

Table: 33

Year	Kala Azar		Malaria		Filaria		Japanese Encephalitis		Dengue	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
2005-06	Nil	Nil	67,885	113	80	Nil	145	52	Nil	Nil
2006-07	Nil	Nil	1,26,178	304	24	Nil	392	119	Nil	Nil
2007-08	65	Nil	94,853	152	490	Nil	424	133	Nil	Nil
Total	**65**	**Nil**	**2,88,916**	**569**	**594**	**Nil**	**961**	**304**	**Nil**	**Nil**

Source: - Data furnished by Society for NVBDCP

As can be seen from the above table, the detection of cases with respect to Malaria, Filaria and Japanese Encephalitis (JE) showed wide inter-year variation and the deaths due to Japanese encephalitis had increased. The Society however, could not provide reasons for such variations. To combat the incidence of vector borne diseases, micro-plan for routine immunisation in the entire State was planned and 88 *per cent* of villages (over 1,000 population) were to be covered one or more times a month and 12 *per cent* of villages were to be covered one or more times a quarter during the year 2007-08. In addition, 62 *per cent* of slums/high risk areas were planned to be covered monthly. Scrutiny revealed that vaccination for JE was carried out in two[17] districts during July 2006 and two[18] other districts during March 2007 in selected areas. The reasons for high mortality may be due to emergence of drug resistance.

Recommendation

Diagnostic facilities for detection of various vector borne diseases need to be provided in all CHCs and PHCs. Compulsory indoor residual spray of DDT and anti larva solution should be taken up in endemic areas.

9.7 National Leprosy Elimination Programme (NLEP)

The NLEP aimed at eliminating leprosy by the end of Eleventh plan and the State was to ensure leprosy prevalence rate of less than one per thousand. The total number of leprosy cases in the State during 2005-06, 2006-07 and 2007-08 were (NA), 2,165 and 2,294 respectively with incidence of 1,176, 1,067 and 1,268 new cases. The Prevalence Rate (PR) and Annual New Case Detection Rate (ANCDR) per 10,000 in the State were 0.38 and 0.41, 0.35 and 0.36 and 0.38 and 0.42 during 2005-06, 2006-07 and 2007-08 respectively, which indicated that the State has achieved the goal of Leprosy Elimination i.e. PR below 1 per 10,000 population.

9.8 Cold Chain Management

To support the immunization programme, cold chain maintenance was visualized in all CHCs and BPHCs. As per the information furnished by the Director of Health Services (FW), cold chain equipment was provided in 102 CHCs and 818 PHCs and all these were

[17] Dibrugarh and Sivasagar.
[18] Jorhat and Golaghat.

functional. However, scrutiny of the facilities in the five sampled districts (29 CHCs and 229 PHCs) revealed that most of the equipment required in this regard was not available in the health centres, as can be seen from the table below:

Table: 34

Equipment	No of CHCs having the equipment		No of PHCs having the equipment	
	Available	Working	Available	Working
Walk-in-coolers	Nil	Nil	Nil	Nil
Icelined freezers	29	29	191	191
Refrigerators	Nil	Nil	Nil	Nil
Walk-in-freezers	Nil	Nil	Nil	Nil
Deep freezers	29	29	191	188

Conclusion on Performance Indicators

Anaemia, being the leading cause of maternal mortality was not addressed adequately by the SHS leading to a high MMR and IMR and there is much to be achieved in terms of immunization of the target groups. While there has been an improvement in institutional deliveries, there are several drawbacks in providing the requisite antenatal and postnatal care. Reproductive healthcare was not accorded the required priority and the shortfall in the supply of drugs was not tackled.

Recommendations

- ***The targets and performance indicators prescribed for various services to be achieved during the Mission period require a re-look in a State like Assam where the MMR and IMR is quite high compared to the national average and more realistic targets need to be worked out.***
- ***The State needs to plan its requirements for universal immunization in a systematic manner so as to cover all the target groups within a specified timeframe.***
- ***Reproductive healthcare should be given adequate attention and the required drugs should be procured and provided on a timely basis.***

Chapter 10 Monitoring

10.1 Health Monitoring and Planning Committees

NRHM envisages an intensive accountability framework through a process of community based monitoring, external surveys and stringent internal monitoring. Despite having a clear reporting structure, the activities of the Mission were not reviewed/reported at various levels in a systematic manner. As mentioned in Chapter 4, community based monitoring committees were to have been constituted at village, block, district and State level. These committees were, however, not constituted during the first three years of implementation of the programme. It was only in April 2008 that the State Health Mission constituted district and block monitoring teams for monitoring the Mission activities and reporting on a monthly basis. Routine immunization and institutional delivery components of the programme were, however, monitored at regular intervals and evaluated by the Regional Resource Centre.

10.2 Management Information System

NRHM envisaged the development of a computer based Management Information System (MIS) at the DHS level, to report the monthly progress on the implementation of the programme to the SHS. The SHS in turn is to consolidate the information and report to the MoHFW. This involved provision of network facilities upto the block level through the Integrated Disease Surveillance Project (IDSP).

Scrutiny revealed that all the districts and blocks had been computerized as of March 2008. However, only the districts were connected to the MIS network. Although routine immunization data was captured at the district level, it was not being analyzed at regular intervals due to the lack of expertise and training at the operational level.

Recommendation

Monitoring needs to be strengthened at all levels - village, block, district and State – with the involvement of the community, so that the objectives of the programme are achieved as per the prescribed timelines and appropriate corrective action is taken on a timely basis.

Guwahati **(Sword Vashum)**
The **Principal Accountant General**

Countersigned

New Delhi **(Vinod Rai)**
The **Comptroller and Auditor General of India**