HEALTH AND FAMILY WELFARE DEPARTMENT

3.2 FUNCTIONING OF RURAL HOSPITALS AND PRIMARY HEALTH CENTRES

HIGHLIGHTS[·]

Healthcare is provided to rural people through a network of sub-centres, primary health centres (PHCs) and rural hospitals (RHs). There were huge shortages in numbers of RHs and PHCs as compared to the norm. Only 31* per cent *of doctors available were working in rural areas to serve 72* per cent *of the population. Specialist services were not provided in RHs. Most of the sub-centres were functioning without adequate infrastructure and health assistants (Male). Indoor treatment was not provided in most of the PHCs. Supply of medicines to RHs and PHCs was highly inadequate. In the PHCs, even routine treatment in out patient department was not provided.

During 1999-2003, scheme fund of Rs 8.73 crore were not released by the department for development of health care services. The department also failed to utilise 52 *per cent* (Rs 111.52 crore) of plan funds.

(Paragraphs 3.2.4 and 3.2.6)

As compared to national norms, only 20 *per cent* of RHs, 61 *per cent* of PHCs and 78 *per cent* of SCs were established against requirement while in the test-checked districts shortage of RHs ranged between 76 and 95 *per cent* and for PHCs it was between 32 and 50 *per cent* except in Bankura. During 1999-2004, only 10 PHCs were set up in the State.

(Paragraph 3.2.8)

Basic minimum health care services were not provided due to failure in providing requisite instruments, labour rooms, laboratory, electricity, toilet, etc. in sub-centres and PHCs.

(Paragraphs 3.2.9 and 3.2.10)

In four selected districts, 27 *per cent* of sanctioned posts of MOs, nurses and other para medical staff remained vacant as of March 2004. Out of 236 PHCs, 177 PHCs were functioning with only one MO each against the norm of minimum two and 54 PHCs remained non-functional for one to five years for want of MOs.

(Paragraph 3.2.11)

Only 31 *per cent* of doctors were deployed in rural areas to serve 72 *per cent* of total population leading to wide disparity between urban and rural areas. Against 20712 health assistants needed for the sub-centres at village level only 14155 (68 *per cent*) were available.

(Paragraphs 3.2.12 and 3.2.13

Bed occupancy in test-checked 11 RHs and 12 BPHCs ranged between five and 63 *per cent* during 1999-2004. Low bed occupancy was noticed in

[·] *Abbreviations used in this Review have been listed in the Glossary in Appendix 40 (page 216)*

all the test-checked RHs and BPHCs due to inadequate facilities, lack of doctors and non-operational Out Patient Departments. Further, out of 1013 beds in 182 PHCs of selected districts only 46 beds in five PHCs were functional. In the health centres, patients suffering from even routine ailments like fever, diarrhoea and vomiting were denied treatment in out patient department and referred to district or sub-divisional hospitals. Surgeons and anaesthetists were not deployed in fully equipped 15 OTs.

(Paragraph 3.2.14)

Equipment costing Rs 52.67 lakh was lying idle in the health centres for want of adequate infrastructure.

(Paragraph 3.2.15)

Medicines were procured without indents or assessment of requirement. In test-checked seven RHs and four BPHCs of two districts supply of medicines fell short by 24 to 47 *per cent.*

(Paragraph 3.2.16)

Four Zilla Parishads incurred expenditure of Rs 2.08 crore by diverting funds from the Pradhan Mantri Gramodaya Yojana. Furniture and medicines valuing Rs 14.91 lakh and Rs 34.79 lakh respectively remained unutilised due to imprudent purchases.

(Paragraph 3.2.20)

In the State, coverage of eligible couples adopting family planning measures was 33.62 *per cent* against the target of 60 *per cent* while in test-checked districts it ranged between 21 and 50 *per cent.*

(Paragraph 3.2.21)

During 1999-2003, out of 8.40 lakh childbirths in three test-checked districts 6.75 lakh deliveries were non-institutional and the incidence of child death increased two fold during 1999-2003.

(Paragraph 3.2.23)

3.2.1 Introduction

The State Government's objective is to provide primary healthcare services to rural people through a network of sub-centres (SCs), primary health centres (PHCs), block primary health centres (BPHCs) and rural hospitals (RHs). The major components of primary healthcare are (i) health education to the rural mass, (ii) family planning and child health, (iii) antenatal and postnatal services, (iv) preventive and curative services, and (v) implementation of national health programmes.

3.2.2 Organisational set up

The Principal Secretary of Health and Family Welfare Department was in overall charge of health administration. At district level, the Chief Medical Officer of Health (CMOH) assisted by Deputy Chief Medical Officers of Health was in overall charge of RHs, BPHCs, PHCs and SCs.

3.2.3 Audit Objectives

Audit objective was to assess the effectiveness of provisions of primary healthcare to rural people. In particular, the following aspects were examined:

- adequacy of infrastructural facilities such as buildings and equipment,
- shortage of medical officers and paramedical staff,
- system of supply of medicines to medical institutions,
- provisions for supply of diet to patients,
- adequacy of training of multipurpose health workers, and
- implementation of National and State Health schemes.

3.2.4 Audit coverage

The performance of Health and Family Welfare Department in providing healthcare services to the people of rural areas of four selected districts[1] out of nineteen was reviewed in audit during January to July 2004 through test-check of records of the department, Directorate of Health Services and CMOsH of the selected districts including 11 RHs, 12 BPHCs [2], 49 PHCs and 95 SCs for the period 1999-2004. The results of review are mentioned in the succeeding paragraphs.

Financial outlay

The budget provisions and expenditure incurred on rural health services during 1999-2004 are indicated below:

Year	Budget provision		Expenditure		(+) Excess/(-) Savings	
	Non-Plan	Plan	Non-Plan	Plan	Non-Plan	Plan
	(Rupees in crore)					
1999-2000	168.65	21.07	172.75	11.98	(+) 4.10	(-) 9.09
2000-2001	185.14	53.21	175.58	35.24	(-) 9.56	(-) 17.97
2001-2002	192.33	34.23	176.49	8.61	(-) 15.84	(-) 25.62
2002-2003	201.18	59.05	189.15	18.05	(-) 12.03	(-) 41.00
2003-2004	193.97	45.55	193.58	27.71	(-) 0.39	(-) 17.84
Total	**941.27**	**213.11**	**907.55**	**101.59**	**(-) 33.72**	**(-) 111.52**

Source : Budget publications

Preparation of budget was unrealistic

It would be evident from above that there was persistent savings during all the years and out of budget provision of Rs 1154.38 crore during 1999-2004, Rs 145.24 crore could not be spent. Preparation of unrealistic budgets resulting from non-submission of budget proposals by CMOsH, non-release of scheme funds by the department and non-filling up of vacant posts were the main reasons for such savings.

[1] *North 24-Parganas, Paschim Medinipur, Cooch Behar and Bankura*

[2]

Paschim Medinipur	*North 24 Parganas*	*Bankura*	*Cooch Behar*
Chandra BPHC	*Amdanga BPHC*	*Anchuri BPHC*	*Pundibari BPHC*
Changual BPHC	*Ghoshpur BPHC*	*Chhatna BPHC*	*Boxirhat BPHC*
Khirpai BPHC	*Chotojagulia BPHC*	*Borjora BPHC*	*Ghoksadanga BPHC*
Salboni RH	*Taki RH*	*Amarkanan RH*	*Haldibari RH*
Keshpur RH	*Baduria RH*	*Sonamukhi RH*	
Hijli RH	*Madhyamgram RH*	*Kotulpur RH*	
Debra RH			

3.2.5 Budget proposals of CMOsH unrealistic

During 1999-2004, the CMOsH of Cooch Behar and Bankura districts prepared budget estimates on ad-hoc basis by adding 10 *per cent* to the previous year's allotments and CMOsH of North 24-Parganas and Paschim Medinipur districts did not prepare any budget estimates at all. Instead, they submitted previous year's quarterly expenditure statements to the Directorate.

The Department stated (January 2005) that proposal for creation of post of Accounts Officer under CMOH of each district had been initiated to strengthen the management of financial activities at the district level.

3.2.6 Non-release of scheme funds

Rupees 8.73 crore allotted for health care facilities under seven schemes were not released

No fund was released by the Department during 1999-2003 out of budget provisions of Rs 8.73 crore under schemes for (i) creation of health centres in scheduled castes areas and new homoeopathic dispensaries at block level, (ii) providing dental care services and facilities for treatment in unani system of medicine in rural areas, (iii) providing treatment facilities in ayurvedic system of medicines in scheduled castes areas, and (iv) developing rural health services in tribal areas. As a result, rural people were deprived of better healthcare services, though budgeted for.

Infrastructural facilities

Even minimum basic care services were not provided to the rural population due to failure of the department in providing requisite instruments, labour rooms, laboratories, electricity and toilets in the health institutions. There was also shortage of rural hospitals and primary health centres as discussed below :

3.2.7 Profile of health institutions (RHs, PHCs, SCs)

There were 95 RHs, 250 BPHCs, 923 PHCs and 10356 SCs in the State to cater to the medical needs of the rural population.

Rural hospitals (RH) are 21 to 60 bedded hospitals functioning round the clock. Specialist services of civil surgeons and dental surgeons are also provided in the RH. Primary health centres (PHC) meant to provide basic healthcare services in rural areas at the primary level, are the initial contact point with a Medical Officer (MO). These centres also play an important role in providing curative services and managerial support for implementing all healthcare activities including health and family welfare programmes. Sub-centres (SC) are located at the village level. These are involved in providing basic minimum healthcare services such as immunisation of children and pregnant women, antenatal and postnatal care, motivation of rural couples to adopt family planning measures and creation of awareness among rural mass about health care programmes through door-to-door visits.

3.2.8 Huge shortage in number of RHs, PHCs and SCs

The number of health institutions required as per national norm and the number actually functioning in the State are as given below:

Institutions	Population to be served per institution		Number	
	Plain area	Hill and backward areas	Required	Available
RHs	1 lakh to 1.20 lakh		481	95
BPHCs/PHCs	30000	20,000	1923	1173
Sub-centres	5000	3,000	13230	10356

Huge shortage in the number of RHs (80 per cent) and PHCs (39 *per cent*) compared to norms

During 1999-2004, only 10 PHCs were set up in the state. There was huge shortage in the number of RHs (80 *per* cent), BPHCs/PHCs (39 *per* cent) and SCs (22 *per* cent) in the State affecting the quality of health care services to the rural population.

The position in the four sample districts was as follows:

District	Population (in lakh)	RHs		BPHCs/PHCs		SCs	
		Required	Available	Required	Available	Required	Available
Bankura	29.57	25	5 (20)	99	17/70=87 (88)	592	564 (95)
Coochbehar	22.53	19	1 (5)	75	11/29=40 (53)	460	406 (88)
Paschim Medinipur	45.74	38	9 (24)	152	20/84=104 (68)	914	858 (94)
North-24 Parganas	40.81	34	7 (21)	136	15/53=68 (50)	816	742 (91)
Total	138.65	116	22 (19)	462	63/236=299(65)	2782	2570 (92)

Note: Figures in parenthesis represent the percentage to required numbers

Shortages in health centres adversely affected services to rural people

Of the four selected districts, the position was alarming in Coochbehar with only one RH functioning against 19 required. The shortage of RHs in other three districts ranged between 76 *per cent* and 80 *per cent*. In three of the four selected districts, the shortage of BPHCs/PHCs was very high- North 24 Parganas was 50 *per cent* short, Coochbehar 47 *per cent* and Paschim Medinipur 32 *per cent*. The shortages of sub-centres in selected districts varied between 5 *per cent* and 12 *per cent*. Such shortages in RHs, PHCs and sub-centres adversely affected the objective of providing primary healthcare to rural people.

The department did not prepare any action plan to establish sub-centres, PHCs and RHs nor did take any action for creation of new RH during 1999-2004.

The Department stated (January 2005) that new construction works would be taken up in the rural areas of these districts.

3.2.9 Inadequate facilities in Sub-centres

Out of 2570 sub-centres in four selected districts, 655 sub-centres were functioning in very small space. Of these sub-centres, 95 were test-checked in Audit and it was noticed that 89 sub-centres were functioning in a room of about 70 to 80 square feet, which was not adequate for efficient functioning of the centres. Further, six sub-centres were functioning without any room or health assistants (HAs).

Requisite instruments like BP machine, weighing machine, anaemia measuring instrument, etc. and minimum facilities like electricity, toilet and drinking water were also not available in most of the sub-centres.

The HAs of 159 sub-centres were residing 5 km to 59 km away from the sub-centres in violation of service conditions affecting the quality of their services.

Rural people were deprived of minimum health care services in absence of HAs and infrastructure in SCs

Thus, in absence of adequate infrastructure and required number of HAs in the sub-centres, the rural population was deprived of basic minimum health care services like immunization of children and pregnant women, antenatal care of mothers, motivation of rural couples to adopt family welfare measures, etc. as discussed later in the review.

3.2.10 Inadequate facilities in PHCs

Scrutiny of records of 49 PHCs of the selected districts revealed that two PHCs were functioning in dilapidated buildings and the Department took no action for repair and renovation. Further in none of the PHCs, basic facilities like labour room or laboratory was available. As such, no delivery cases were taken up in the PHCs.

The Department stated (January 2005) that a strategic framework had already been chalked out for health sector reforms with broader objectives and certain specific goals for the development of rural healthcare services in the State.

Manpower management

The basic health care services were severely impaired due to disparity in posting of staff between urban and rural areas coupled with shortage of manpower at all levels as discussed below :

3.2.11 Huge shortage in key personnel

Huge vacancies in the posts of MOs and other staff adversely affected health care

As against 11360 sanctioned posts in all cadres for 22 RHs and 299 PHCs and BPHCs in four selected districts, 8238 posts were filled up as of March 2004 indicating shortage of 3122 staff (27 *per cent*). The sanctioned strength vis-à-vis men in position in respect of MOs, paramedical staff (including nurse) and non-medical staff in these four districts are given below:

District	Medical Officers		Paramedical staff		Non-medical staff	
	Sanctioned	Deployed	Sanctioned	Deployed	Sanctioned	Deployed
Bankura	157	117 (25)	1981	1452 (27)	860	669 (22)
Coochbehar	64	57 (11)	1144	845 (26)	382	289 (24)
Paschim Medinipur	176	174 (1)	2638	1833 (29)	937	723 (23)
North-24 Parganas	118	109 (8)	2065	1507 (27)	838	463 (45)
Total	515	457 (11)	7828	5637 (28)	3017	2144 (29)

Note: Figures in parenthesis represent the percentage of shortfall to sanctioned strength

Vacancies in the cadre of Medical Officer was very high (25 *per cent*) in Bankura district and vacancies in other cadres varied between 22 and 45 *per cent* in all the four selected districts affecting adversely primary healthcare for the rural population.

Out of 11 RHs test-checked, in five RHs there were four MOs in each and in one RH there were only two MOs against the norm of minimum five.

No MOs were deployed in 54 PHCs for one to five years

Out of 236 PHCs in the selected districts, no MOs were posted in 54 PHCs for one to five years rendering these PHCs non-functional. Out of the balance of 182 PHCs there was only one MO in each of 177 PHCs against the norm of minimum two MOs. Further, 28 PHCs were running without pharmacists.

The Department stated (January 2005) that necessary steps were being taken for appointment of Medical Officers.

3.2.12 Disparity between rural and urban healthcare

Only 31 *per cent* of doctors were posted in rural areas to serve 72 *per cent* of population

There was wide disparity in the posting of doctors in urban and rural areas. Only 31 *per cent* (12198) of doctors were posted in rural areas to serve 72 *per cent* (5.77 crore) of total population (8.02 crore) of the State. While there was one doctor for a population of 2033 in the State as of March 2004, the doctor-population ratio (1:4733) was far below the state average in rural areas, which was indicative of deficient healthcare in rural areas.

According to the conditions of recruitment of medical officers in the State a doctor should work in rural areas for a minimum period of three years. It was noticed in audit that this condition was not watched or monitored by the Directorate of Health Services.

3.2.13 Shortage of Health Assistants

Each sub-centre was to have one health assistant (male) and one health assistant (female). The HA (M) was to visit each family once in a fortnight to motivate persons to take regular treatment besides taking care of minor ailments. The HA (F) besides assisting the HA (M) in identifying cases under different health programmes, was also to carry out functions relating to maternal and child health, family planning, medical termination of pregnancy and dais' training.

Huge shortage (32 *per cent*) of health-assistants in Sub-centres of the State

Against 20712 HAs needed for 10356 sub-centres in the State, 17926 were sanctioned and 14155 posts were operated as of March 2004 resulting in shortage of 6557 HAs (32 *per cent*).

In four selected districts, 1396 posts were vacant against the requirement of 5140 HAs for 2570 sub-centres as of March 2004 as shown below:

District	Number of SCs	Number of posts sanctioned		Number of posts vacant		Number of posts not sanctioned as compared to norm	
		HA (M)	HA (F)	HA (M)	HA (F)	HA (M)	HA (F)
Bankura	564	530	564	202	122	34	-
Coochbehar	406	351	406	119	73	55	-
Paschim Medinipur	858	852	858	335	163	6	-
North-24 Parganas	742	691	691	343	39	51	51
Total	**2570**	**2424**	**2519**	**999**	**397**	**146**	**51**

As large number of posts of health assistants remained vacant, the rural population to be covered by the sub-centres were deprived of basic healthcare facilities.

The Department stated (January 2005) that for filling up the vacancy of health assistants (Female), 18 Nursing Training Schools had been entrusted with running auxillary nurse cum mid wife (ANM) courses and total student intake capacity of these schools was about 520 per year. The reply was, however, silent about vacancy in the posts of health assistants (male).

Functioning of RHs and BPHCs/PHCs

The health institutions had low bed occupancy due to inadequate infrastructural facilities, non-deployment of doctors and failure to provide treatment at OPDs. Medicines were procured without indents; equipment, furniture were lying uninstalled as discussed below :

3.2.14 Low bed occupancy

Bed occupancy rate ranged between 5 and 63 *per cent*

Average bed occupancy in test-checked 11 RHs and 12 BPHCs ranged between five *per cent* and 63 *per cent* during 1999-2004. Inadequate infrastructural facilities, non-deployment of adequate number of MOs and denial of treatment at OPD were the main reasons for such low bed occupancy.

Audit scrutiny revealed the following:

Surgeons, physicians and doctors were not deployed in OTs

Out of fully equipped 15 operation theatres (OTs) in eight RHs, five were not functioning. Only ligation operation was done in nine OTs and in one OT only 'minilap' eye operation was conducted during eye camp as specialist physicians, surgeon and anaesthetists were not deployed to make the OTs functional in all respects.

Patients were denied treatment in RHs and BPHCs

In six RHs and five BPHCs, 24462 patients requiring treatment for minor ailments like fever, diarrhoea, vomiting, anaemia, etc. were denied treatment during 1999-2003 and referred to sub-divisional hospital or district hospitals despite availability of MOs, nurses and beds in these RHs and BPHCs.

The Department stated (January 2005) that necessary guidelines for referral system of patients from primary level to secondary and onwards to tertiary level had been circulated to all concerned.

Further, out of 1013 beds in 182 PHCs (excluding 54 non-functioning PHCs) of the selected districts only 46 beds in five PHCs were functional as shown in the following table:

District	Number of PHCs	Number of beds available	Number of beds in operation
Bankura	56	309	20 (2 PHCs)
Coochbehar	29	158	26 (3 PHCs)
Paschim Medinipur	47	252	None
North 24 Parganas	50	294	None
Total	**182**	**1013**	**46 (5 PHCs)**

Only out patient departments were in operation in 177 PHCs with one doctor (Medical Officer) of general medicine against the requirement of minimum two MOs. Indoor patient departments in these PHCs were not functioning for want of doctors as per norm.

The Department stated (January 2005) that the proposal for upgrading the PHCs was under active consideration of the Department which would help better healthcare services in rural areas.

3.2.15 Idle equipment

Equipment remaining unutilised/ uninstalled

In test-checked districts equipment[3] valuing Rs 52.67 lakh supplied by the District Project Officers to the RHs, BPHCs and PHCs between May 1999 and December 2003 under the State Health System Development Project-II for improving healthcare services specially for the people of rural areas, remained uninstalled or were not functioning as of March 2004. Reasons for this were failure to complete civil works and electrification of PHCs, operation theatres not being opened and non-posting of surgeons, anaesthetists, dentists, laboratory technicians and X-ray technicians.

3.2.16 Supply of medicines

CMOsH of the districts were to obtain indent of medicines from each RH and BPHC and to assess actual quantity needed for procurement. District Reserve Stores (DRS) under CMOsH of a district was responsible for procurement and supply of medicines.

In the selected districts, it was noticed that medicines were procured by DRS on ad-hoc basis without obtaining indents and also without assessing the requirement of RHs, BPHCs, PHCs, which resulted in short supply of essential medicines as would be evident from the following.

Supply of medicines fell short by 24 to 47 *per cent* due to procurement of medicines without assessment

In three RHs and one BPHC of North 24 Parganas, short supply of vital medicines[4] ranged from 33 to 47 *per cent* of required quantities. For example, in Baduria RH, basic medicines viz. iron tablet (Ferrous Sulphate) required for anaemic patients was not in stock during September 2002 to March 2004 and Vita-A oil required for prevention of blindness among children was not in stock during January 2002 to December 2003.

In four RHs and three BPHCs of Paschim Medinipur, short supply of vital medicines[5] was 24 to 47 *per cent* of required quantities. During 2001-2003, against requirement of 22995 ml of anti-rabies vaccine only 1960 ml

[3] *Autoclave (vertical), Autoclave (Horizontal), Anesthetic Machine, Blood donor table, Dental chair, Mortuary cooler, Opthalmoscope, 60 MA X'ray machine, Binocular microscope, Hydraulic dental chair, OT table (hydraulic), oxygen cylinder, Nitrous cylinder, 100 MA X'ray Auto clave HP (Horizontal), Surgical instrument cabinet, Gynae elis cantery, Focusing light, Shadow less OT light, Emergency trolley, Refrigerator, Microscope, Foetal monitor, Emergency Reservation kit, Generator - 15 KVA, Mayos Trolley, Dressing trolley.*

[4] *Tablet Paracetamol, Brufen, Salbutamol, Vitamin B Complex, Septran, Injection Derriphyline, Diazepam, Gentamycin, Decadron, Capsules Amoxycillin, Ringer lactate as well as ORS*

[5] *Paracetamol, Amoxycillin, Doxycycline, Septran, Norflox, Tetanus Toxoid, Ringer Lactate, CP Maliate, Vitamin B Complex and Antacid*

(9 *per cent*) were supplied. As a result, 16434 dog-bite patients were denied treatment in these RHs and BPHCs.

Thus, poor purchase planning adversely affected health care services.

The Department stated (January 2005) that in order to ensure procurement and supply of required medicines, a special software package had been developed and installed in DRSs recently and after full fledged functioning of the system, procurement and distribution of medicines would be need based.

3.2.17 Non-realisation of cost of diet

The system of supplying cooked food to indoor patients through diet contractors was introduced in November 2002. According to Government's order, (November 2002) contractors would supply cooked food to patients and no departmental cooking arrangement would be made. For taking hospital diet, patients belonging to non-BPL families were to pay 50 *per cent* of diet charges (Rs 28.50 per day) and patients belonging to BPL families were to be supplied diet free of charge.

Diet charges not recovered resulting in loss to Government

Out of 22 RHs and 63 BPHCs in selected districts, cooked food was supplied through contractors in 58 RHs/BPHCs and no food was supplied to the patients of 13 BPHCs. In the remaining 14 RHs/BPHCs arrangement for cooking was made at the hospitals or health centres in contravention of the Government's order.

In one RHs and four BPHCs, diet charges aggregating Rs 4.25 lakh was not recovered from non-BPL patients during September 2002 to March 2004.

The Department stated (January 2005) that necessary instructions would be issued to the RHs and BPHCs to collect diet charge from non-BPL patients.

3.2.18 Community Health Guide Scheme

Community Health Guide Scheme launched by GOI in 1979 was funded by the State Government in full since April 2002. Under this scheme, every village or community having a population of approximately 1000 should have a Community Health Guide (CHG). The CHG was to be provided with a drug kit and dressing materials valuing Rs 50 and remuneration of Rs 50 per month (Rs 100 per month up to March 2002) for rendering healthcare services.

CHGs were not provided with drug kits depriving rural people of medical services

There were 8747 CHGs as of March 2004 in four test-checked districts. It was noticed in audit that necessary drug kits and dressing materials were not supplied to CHGs. As a result, the CHGs could not render any healthcare service to the rural people. Thus, the payment of remuneration of Rs 44.53 lakh to CHGs during 1999-2003 proved to be unfruitful.

Five BMOsH of Cooch Behar district paid remuneration to CHGs at the rate of Rs 100 per month instead of Rs 50 per month during April 2002 to January 2004 resulting in overpayment of Rs 4.07 lakh. No action was taken by the BMOsH for recovery of the same.

3.2.19 Non-functioning Training Centres

Of 320 trainees targeted 206 were trained. No training was imparted in three training centres

There were three regional (at Kolkata, Kalyani, Jalpaiguri) and two rural (at Bardhaman and Kalyani) training centres for imparting training to multipurpose health workers in order to improve their knowledge and skill. It was noticed in audit that the Rural Training Centre at Kalyani and Regional Training Centres at Jalpaiguri and Kolkata remained non-functional during 1999-2001, 1999-2002 and 1999-2004 respectively as no guidelines and funds were provided by the Department for conducting training during these years. Against the target of imparting training to 320 multipurpose health workers during 2002-2004, only 206 were trained due to non-placement of trainees by CMOHs.

Implementation of health schemes

The Department had been implementing both State and Central schemes to provide healthcare services to rural population. A review of implementation of five schemes revealed the following.

3.2.20 Pradhan Mantri Gramodaya Yojana

This Centrally sponsored scheme was introduced in 2000-2001 to provide basic minimum health care services to rural people by opening new sub-centres in gram panchayats having no sub-centres, shifting of sub-centres to better accommodation and improvement of quality of services in sub-centres by providing adequate infrastructure facilities. The scheme was to be implemented by the Zilla Parishads (ZPs). Out of GOI assistance of Rs 12.02 crore received by ZPs of four test-checked districts during 2000-2003, Rs 10.08 crore were spent up to March 2004.

The following shortcomings were noticed in audit:

Four ZPs diverted Rs 2.08 crore in implementation of the yojana

The ZPs diverted scheme fund of Rs 2.08 crore for construction of rest house for patients' relatives at sub-divisional and district hospitals, renovation of District Hospitals, Tuberculosis Sanatorium and Homoeopathic Medical College, etc, in deprivation of the norms of the scheme.

Furniture valuing Rs 2.55 crore remained idle

ZP, Paschim Medinipur purchased furniture costing Rs 2.55 crore during 2002-2003 without assessing the requirements and space capacity of sub-centres. Test-check of records of seven BPHCs revealed that furniture costing Rs 8.71 lakh procured for 195 sub-centres and 248 labour tables purchased at Rs 6.20 lakh in October 2002 were lying idle in the BPHCs and DRS respectively although no delivery case was entertained in the sub-centres.

Imprudent purchase of AVS valuing Rs 34.79 lakh

The injection AVS (anti venom serum) for treatment of snake bite was required to be stored in refrigerator and was to be administered only by doctors. There was neither any system of storing AVS in the sub-centres nor any scope of administering at sub-centre level as no MO was posted there. In October 2002, ZP, Paschim Medinipur procured 9036 vials of AVS with date of expiry in May 2005 at a cost of Rs 34.79 lakh for distribution to sub-centres but, in the absence of storing facilities AVS was not issued to the sub-centres.

ZP did not also take any action for distribution of such medicine to health centres or hospitals. As a result, the entire stock of AVS was lying idle as of July 2004. In the absence of storing facility, possibility of loss of potency of the medicine could not be ruled out.

3.2.21 Sterilisation

Of 135.57 lakh eligible couples, 89.99 lakh were not covered under family welfare measures

Performance of various family welfare measures for protection of eligible couples revealed that out of 135.57 lakh eligible couples in the State 89.99 lakh did not adopt any family planning measures as of March 2003. Thus, couple protection rate was only 33.62 *per cent* against the target of 60 *per cent*. The number of eligible couples and couples protected during the years 2000-2003 in the State and also in four sample districts are indicated in the ***Appendix 34***.

In four selected districts, 50 to 79 *per cent* of eligible couples did not adopt any family planning measures. Shortage of surgeons in BPHCs and PHCs and short supply of IUD and conventional contraceptives, etc. were the main reasons for shortfall in couple protection.

3.2.22 Immunisation

Immunisation programme was being implemented by the Department to achieve low and stable infant mortality rate by administering two dosages of TT to pregnant women, three dosages each of DPT and one dosage of BCG and measles to infants for preventing diseases.

Shortfall in immunisation ranged between 46 and 57 *per cent* in case of BCG

In the test-checked units, the shortfall in immunization was 46 to 57 *per cent* in case of BCG, 11 to 19 *per cent* in case of DPT and 6 to 14 *per cent* in case of measles and the shortfall in administering TT to pregnant women ranged from 20 to 57 *per cent* during 1999-2004. The shortfall in coverage of 100 *per cent* immunization was attributable to non-functioning of PHCs, SCs and irregular supply of vaccines.

3.2.23 Reproductive and child health scheme

Of 8.40 lakh deliveries 6.75 lakh were non-institutional

The primary objectives of the scheme were to ensure safe and institutional deliveries to reduce maternal and infant mortality rate. In three out of four test-checked districts during 1999-2003, out of 8.40 lakh deliveries, 6.75 lakh deliveries (80 *per cent*) were non-institutional and incidence of child death increased from 1120 in 1999 to 2417 in 2003. Non-availability of beds in PHCs, absence of supportive supervision and awareness generation in information, education and communication activities at sub-centre level were the main reasons for high rate of non-institutional deliveries.

The Department stated (January 2005) that it was going to tie up with the Department of Panchayats and Rural Development for proper monitoring and supervision of different family welfare programmes.

3.2.24 Treatment of arsenic affected people

71 lakh people remained exposed to arsenic pollution due to failure in supplying arsenic-free water

Ground water of 75 blocks with population of 1.61 crore in eight districts'[6] contained arsenic contamination beyond the permissible limit of 0.05 mg/litre, of which 0.71 crore people were not yet covered under the scheme of supplying arsenic-free water. Against the target of setting up 89 clinics in eight districts for treatment of arsenic-affected patients, only 51 were established as of March 2004.

Test-check of North 24 Parganas district revealed the following:

Out of 12.42 lakh people in arsenic-affected areas, 2.80 lakh people remained outside the purview of arsenic-free water supply schemes.

No data in respect of number of arsenic-affected patients in the district or in the arsenic affected blocks was maintained at any level.

There was no doctor in three arsenic clinics

Out of 19 clinics in the district, three were not functioning as of March 2004 for want of doctors. The actual periods of non-functioning were not ascertainable as no such record could be produced to Audit by the CMOH. During 2000-2004, only 385 arsenic-affected patients were provided treatment in these 16 clinics and 20 patients were referred to the Institute of Post-Graduate Medical Education and Research in Kolkata.

Other points of interest

3.2.25 Non-functioning of Sub-divisional hospital

Non-utilisation of newly constructed sub-divisional hospital

The Khatra BPHC of Bankura district was upgraded to sub-divisional hospital in May 2002 at a cost of Rs 2.89 crore but, it was functioning as BPHC for want of water supply. The additional assets created for functioning of Sub-divisional hospital were not utilised as of March 2004. Records revealed that before taking up construction of the building, no survey was conducted to ascertain availability of water considering drought-prone character of the area.

3.2.26 Staff quarters kept vacant

The medical and paramedical staff of RHs, BPHCs and PHCs were to be provided with staff quarters near the hospitals or health centres to make health care services available to patients round the clock.

Test-check revealed that out of 330 quarters available in four RHs and two BPHCs, 97 remained vacant as of March 2004, of which 68 quarters were lying vacant for years together in dilapidated condition. No action was taken by the CMOH for repairing the quarters and allotment thereof. The reasons for such poor utilisation of staff quarters were not stated.

[6] *Malda (7 out of 15 blocks), Murshidabad (18 out of 26 blocks), Nadia (17 out of 17 blocks), North 24 Parganas (19 out of 22 blocks), South 24 Parganas (9 out of 29 blocks), Howrah (2 out of 14 blocks) Hooghly (one out of 18 blocks) and Bardhaman (2 out of 31 blocks)*

3.2.27 Monitoring and evaluation

CMOH being the nodal authority responsible for effective implementation of health care services in rural areas did not draw up any schedule of supervision and monitoring over functioning of RHs, BPHCs, PHCs and SCs. The Department did not evaluate the performance of these centres for taking remedial measures to improve the quality of health care services in rural areas.

3.2.28 Conclusion

The objective of providing healthcare system at the doorstep of rural people could not be achieved due to huge shortage of RHs, BPHCs and PHCs as well as medical and paramedical staff. Only 31 *per cent* of required doctors were posted in rural areas to serve 72 *per cent* of total population. In four sample districts 75 *per cent* PHCs were manned by a single medical officer. Fully equipped 15 OTs and 54 PHCs were not functioning for years together for want of medical officer, surgeons and anesthetists. Majority of sub-centres were functioning without health assistants (male). Specialist services were not provided in the RHs. Out of 182 PHCs in sample districts indoor treatment was provided only in five PHCs. Unplanned procurement resulted in short supply of medicines to the health centres.

3.2.29 Recommendations

- Adequate number of RHs and PHCs should be opened as per norms to cover the entire rural population.
- Equipment lying idle at the BPHCs and PHCs should be put to use.
- Steps need be taken to ensure procurement and supply of adequate quantities of required medicines.
- Functioning of BPHCs and PHCs should be monitored by the CMOH to avoid refusal of treatment and unnecessary referral.
- Family planning, sterilisation and immunisation programmes should be geared up.

Government stated (January 2005) that the observations of Audit would be taken care of for different policy decisions to be taken by the Department in future.

Appendix 34

(Refer to in Paragraph 3.2.21, Page 65)

Statement showing number and percentage of couples protected during 2000-2001 to 2002-2003

(Figures in lakh)

District	Eligible couple as on 31.03.01	Couples effectively protected by all methods		Eligible couple as on 31.03.02	Couples effectively protected by all methods		Eligible couple as on 31.03.03	Couples effectively protected by all methods	
		Number	Percentage		Number	Percentage		Number	Percentage
North 24-Parganas	13.40	3.25	24.29	13.61	3.32	24.42	15.01	3.17	21.14
Paschim Medinipur	8.43	3.35	39.74	8.56	3.32	38.76	8.80	3.34	37.89
Cooch Behar	3.97	1.95	41.10	4.04	2.03	50.32	4.20	2.03	48.31
Bankura	5.15	2.25	48.75	5.23	2.29	43.81	5.42	2.32	42.90
West Bengal	**125.11**	**44.21**	**35.34**	**127.12**	**44.26**	**34.82**	**135.57**	**45.58**	**33.62**