CHAPTER I

PERFORMANCE AUDIT

This chapter contains performance audit of National Rural Health Mission (1.1), Functioning of Osmania University (1.2), Third Party Quality Control/ Assurance in execution of irrigation projects (1.3) and Accelerated Irrigation Benefit Programme (1.4).

HEALTH, MEDICAL AND FAMILY WELFARE DEPARTMENT

1.1 National Rural Health Mission

Highlights

Government of India launched the National Rural Health Mission (NRHM) in April 2005 throughout the country for providing accessible, affordable, effective and reliable healthcare facilities in the rural areas. The programme was launched in Andhra Pradesh without conducting facility survey and without the preparation of perspective plan by the District Health Societies (DHS). The State Government did not pay adequate attention for creation/strengthening of infrastructure facilities in the Health Centres despite availability of funds. Majority of the test checked Community Health Centers (CHCs) and Primary Health Centers (PHCs) lacked the basic infrastructure facilities. The Mobile Medical Units were functioning without essential equipment/Medical Officers in all the eight test checked districts. The implementation of Reproductive and Child Health Scheme suffered in the areas of institutional delivery care, antenatal care, etc. The functioning of Rogi Kalyan Samithis was deficient and the coverage under Immunization Programme was inadequate. Monitoring of the Programme was poor.

As against the GOI releases of Rs 1,603 crore under the Programme during the 4-year period 2005-09, Rs 1,505 crore were utilised leaving 21 to 29 *per cent* of the available funds remaining unspent. State Health Society (SHS) and all the District Health Societies (DHS) did not maintain the accounts in the prescribed format envisaged in the guidelines. In all the eight DHSs, cash book and other initial records were not also properly maintained.

[Paragraphs 1.1.6.1 and 1.1.6.3]

Facility surveys intended for identifying the healthcare needs of the people were not conducted in the State. Perspective Plan for the whole mission period 2005-12 was not prepared by DHS and the SHS.

[Paragraphs 1.1.7.1 and 1.1.7.2]

There was a shortfall in setting up of 387 Community Health Centres (CHCs), 464 Primary Health Centres (PHCs) in rural areas of the State. In tribal areas the shortfall was 63 CHCs, 63 PHCs and 303 Sub-Centres with adverse implications with regard to accessibility of rural/tribal population to comprehensive primary healthcare.

[Paragraph 1.1.8.1]

Adequate attention was not paid by the State Government for strengthening of infrastructure in the Health Centres. Construction of 44 CEMONC Centers remained incomplete even two years after taking them up while the works of 30 centres were yet to be taken up despite availability of funds. The Physical infrastructure available at the existing centres was far below the desired level envisaged in Indian Public Health Standards. Majority of the CHCs/PHCs test checked lacked even the basic infrastructure facilities. Mobile Medical Units were functioning without essential equipment/Medical Officers.

[Paragraphs 1.1.8.2 and 1.1.8.3]

The implementation of Reproductive and Child Health (RCH) programme suffered from deficiencies in the areas of institutional delivery care, antenatal care, 24x7 delivery services and the Medical Termination of Pregnancy. The State was yet to evaluate the prevalent rate of Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate after launching of NRHM.

[Paragraph 1.1.9.1]

The objective of converging various National Disease Control Programmes remained unachieved. Thus, the planning process was deficient. The achievement of cataract operations in Government Hospitals was far below the prescribed target of 50 *per cent.* No survey was conducted after launch of NRHM to identify areas of iodine deficiency disorders.

[Paragraphs 1.1.7, 1.1.9.5 and 1.1.9.6]

Monitoring Committees under Rogi Kalyan Samithis (RKS) were not formed in 46 *per cent* of CHCs and 67 *per cent* of PHCs test checked. Even in the CHCs/PHCs where RKSs were formed their functioning was found to be deficient. There was significant shortfall (up to 39 *per cent*) in the Immunization Programme (Second stage of 10-16 age group).

[Paragraphs 1.1.9.2 and 1.1.9.4]

Implementation of the schemes by the NGOs was very poor, attributable to poor monitoring by the Department. The entire amount of Rs 7 crore released to eight municipal corporations for establishing First Referral Units (FRUs) remained unspent.

[Paragraph 1.1.9.7]

Financial management was deficient. There were significant variations (short receipt of GOI release: Rs 168 crore) between the figures of release as per the records of GOI and those stated to have been received by the State Health Society (SHS) which remained unreconciled (March 2009). Test-check revealed cases of avoidable extra expenditure on procurement of Vaccine/bed nets, wasteful expenditure, ineligible payments and diversion of programme funds amounting to Rs 23.36 crore in the eight districts alone.

[Paragraphs 1.1.6.2 and 1.1.10]

The Programme suffered from lack of adequate monitoring mechanism. This resulted in the planning process not receiving regular inputs on nature and direction of required future interventions. The Computer-based Management Information System intended for use of network for Integrated Disease Surveillance Project was defunct since 2005.

[Paragraph 1.1.11]

1.1.1 Introduction

In April 2005, Government of India (GOI) launched the National Rural Health Mission (NRHM) throughout the country with special focus on 18 States including Andhra Pradesh. The Mission aimed at providing accessible, affordable, effective and reliable healthcare facilities in the rural areas. The Mission also aimed at an architectural correction[1] in the healthcare delivery system by converging seven other stand alone existing National Disease Control Programmes (NDCP[2]) of the Ministry of Health and Family Welfare. The new components of the NRHM include bridging the gaps in healthcare facilities, facilitating decentralised planning in health sector and addressing the issue of health in the context of the sector-wise approach encompassing sanitation, hygiene and nutrition as basic determinants of good health by seeking convergence of related social sector departments like Women Development and Child Welfare, Panchayat Raj, etc.

In Andhra Pradesh the Mission was operationalised with effect from September 2005 through the formation of the State Health Society (SHS) in December 2005.

The objectives of the Mission for 2005-12 are:

(i) Access to integrated comprehensive primary healthcare

(ii) Prevention and control of communicable and non-communicable diseases including locally endemic diseases

(iii) Reduction of infant and maternal mortality rate

(iv) Population stabilisation, control, gender and demographic imbalances

1.1.2 Organisational Set-up

At the State level the scheme is implemented through State Health Mission (SHM) headed by Chief Minister. The State Programme Management Support Unit (SPMSU) headed by the Mission Director acts as Secretariat to the SHM and State Health Society (SHS). The governing body of the Mission headed by

[1] Modification or remedial measures in the healthcare delivery system

[2] Reproductive and Child Health (RCH)-II, National Vector Borne Disease Control Programme (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), National Leprosy Eradication Programme (NLEP), National Blindness Control Programmes (NBCP), Integrated Disease Surveillance Project (IDSP) and National Iodine Deficiency Disease Control Programme (NIDDCP)

Principal Secretary, Health, Medical and Family Welfare Department is entrusted with the task of scrutiny and approval of the annual State plans; monitoring the status of the follow-up action on decision of SHM, etc.; review of expenditure and implementation; approval of the accounts of the district and other implementing agencies and execution of approved action plans including release of funds for the programme. The Commissioner of Family Welfare (CFW) is the Member Secretary of the State Health Society.

At the district level, the District Health Society (DHS) is headed by District Collector. District Medical & Health Officer (DM&HO) as head of the Executive Committee is responsible for planning, monitoring, evaluation, accounting, database management and release of funds to health centres. The implementation of various national disease control programmes is supervised by the Additional Directors.

As of March 2009 there were 167 Community Health Centres[3] (CHCs), 1,570 Primary Health Centres[4] (headed by Medical Officer-in-Charge) and 12,522 Sub-centres in the State for providing healthcare services to the rural population.

1.1.3 Audit objectives

The performance audit had the following objectives:

- Whether planning was designed at State, district and village levels to effectively meet the mission objectives for ensuring accessible, effective and reliable healthcare to rural population;
- Whether public spending on health sector over the years 2005-09 increased to the desired level and assessment, release of funds in the decentralised set up and utilisation of funds released and accounting thereof was adequate;
- Whether the Mission achieved capacity building and strengthening of physical and human infrastructure at different levels as planned and targeted;
- Whether the systems and procedures of procurement and equipment were cost effective and efficient; and
- Whether the performance indicators and targets fixed specially in respect of reproductive and child healthcare, immunization and disease control programmes were achieved.

[3] For a population of 1.20 lakh in rural and 0.80 lakh in tribal, there should be one CHC with a minimum 30 bedded accommodation and one operation theatre. In addition to two regular medical officers, there should be specialist services in surgery, gynaecology and paediatrics

[4] For a population of 0.30 lakh in rural areas and 0.20 lakh in tribal areas, there should be one PHC with a minimum six bedded accommodation and two medical officers

1.1.4 Audit criteria

The audit was conducted with reference to records maintained for implementation of NRHM. The audit criteria adopted were:

- GOI guidelines on the scheme and instructions issued from time to time;
- State Programme Implementation Plan (PIP) approved by GOI; and
- Indian Public Health Standards (IPHS) for up-gradation of CHCs/PHCs.

1.1.5 Scope and Methodology of Audit

The performance audit was conducted (March – August 2008 and February - March 2009 and May 2009)) covering the period from 2005-06 to 2008-09 by test check of records in the Mission Commissionerate, eight DHSs[5] (out of 23) along with 24 (out of 167) CHCs, 48 (out of 1,570) PHCs and 96 (out of 12,522) Sub-centres. The selection of sample was based on Simple Random Sampling without Replacement method. The details are given in *Appendix-1.1*. The percentage of expenditure covered in sample districts ranged from 11 to 32 *per cent* during 2005-09. An entry conference was held (May 2008) with the Mission Commissionerate, wherein audit objectives and criteria were explained. The exit conference was conducted in January 2009 with the Additional Director, NRHM and the Programme Officers. Replies of the Government have been considered and incorporated while finalising the Performance Audit review. The results of the Performance Audit are discussed in the succeeding paragraphs.

Audit findings

1.1.6 Release and utilisation of funds, accounting and auditing arrangements

1.1.6.1 Financial outlay and expenditure

Twenty one to twenty nine *per cent* of available funds remained unutilised every year during 2005-09

The Programme was fully funded by GOI during the years 2005-06 and 2006-07. From the year 2007-08 onwards, the funding was to be in the ratio of 85:15. During the period 2005-09 GOI released Rs 1,603.12 crore and with an inclusion of opening balance of Rs 17.53 crore relating to RCH-I programme which was under implementation prior to 2005-06 the total funds available with the State Government were Rs 1,620.65 crore. As against this, the expenditure was Rs 1,505.06 crore leaving Rs 115.59 crore unspent. The year wise details are given in Table-1.

[5]Adilabad, Khammam, Krishna, Kurnool, Nellore, Vizianagaram, Karimnagar and Kadapa

Table-1 (Rupees in crore)

Year	Opening Balance	GOI Releases[$] Grant-in-Aid	Expenditure*	Closing Balance	Unspent Balance Percentage
2005-06	17.53	255.85	214.31	59.07	22
2006-07	59.07	425.39	381.22	103.24	21
2007-08	103.24	556.96	470.39	189.81	29
2008-09	189.81	364.92	439.14	115.59	21
Total		**1603.12**	**1505.06**		

[$]These amounts are based on the records maintained by SHS and are less than the releases made by GOI as detailed in para 1.1.6.2

*Release to districts shown as expenditure: Rs 1,095.44 crore, Expenditure incurred at State level by SHS: Rs 409.62 crore

Thus, every year 21 to 29 *per cent* of the available funds remained unutilised in the bank accounts[6] while several gaps/shortfalls were noticed by Audit in creation/strengthening of infrastructure in the implementation of various schemes under NRHM as discussed in paras 1.1.8.1 to 1.1.8.3.

Audit also observed that the State did not contribute its share of 15 *per cent* during the year 2007-08 and 2008-09[7]. The deficiencies in utilisation of funds are discussed in para 1.1.10.

1.1.6.2 Discrepancies in figures relating to receipt of funds

Huge variations were noticed between the figures of releases by GOI and those received by SHS

There were significant variations (short receipt by SHS: Rs 168.23 crore to end of March 2008) between the releases made by GOI and the funds received by SHS as detailed in Table-2.

Table-2 (Rupees in crore)

Year	Funds released to SHS (GOI figures)*	Funds stated to have been received by SHS	Difference
2005-06	383.90	255.85	128.05
2006-07	424.70	425.39	0.69
2007-08	597.83	556.96	40.87
2008-09	Not available	364.92	-

Source: Information provided by Ministry of Health and Family Welfare, GOI

Similarly, substantial variations (amount involved: Rs 11.49 crore) were also noticed between the figures of releases by SHS and those received by DHS in all the eight sampled districts. The district-wise details are given in *Appendix-1.2*.

[6] ICICI Bank, a private entity benefited immensely from such large funds being maintained in SB accounts

[7] The amounts released and paid under the State sponsored schemes like Sukhibhava, Family Planning incentives and Rural Emergency Health Transport Service were shown as State share but as these schemes were in vogue prior to introduction of NRHM, the expenditure on these schemes can not be construed as contribution to NRHM

Government in its reply (June 2009) stated that the variations were due to release of the funds to Director of Health directly by Government of India who in turn was releasing to the Programme Officers at district level and the accounts being rendered by the Programme Officers to the Ministry through Director of Health. It was also stated that Chartered Accountants were instructed to take action to reconcile the discrepancies.

1.1.6.3 Accounting and auditing arrangements

The accounts of the SHS and DHS are based on commercial accounting system with a provision for certification by a Chartered Accountant. For ensuring accountability for expenditure incurred from Government funds, two kinds of audit are carried out (i) Certification of accounts which merely confines itself to whether accounts prepared are backed by vouchers (ii) the transaction audit to ascertain whether the utilisation of funds is in conformity with the principles of economy, efficiency, effectiveness and propriety including equality of opportunity for executing works or providing services.

The present arrangements are confined to activity (i) and there is no assurance with regard to conformity with vital conditions which are scrutinised in activity (ii).

The following deficiencies were noticed in maintenance of books of accounts in DHS and SHS:

1.1.6.4 Non-maintenance of accounts in double entry system

Though prescribed, the accounts at State and district level were not maintained in double entry system leading to non-drawing up of trial balance. Ledger, journal were also not maintained.

1.1.6.5 Non-maintenance of initial records at District Health Societies

In all the DHSs test checked, cash books and other initial records were not maintained properly and were not closed periodically due to which the DHSs were not able to ascertain the balance available with them on any given day. For this purpose, they were relying on statements furnished by the banks in which the scheme funds were deposited. The accounts of the scheme were not also certified at district level by CA though prescribed in the guidelines.

Reconciliation of SHS/DHSs figures with banks was also not being done as initial records at district level were not maintained properly.

1.1.7 Planning for Implementation of the Mission

Planning process was deficient. The objective of converging various National Disease Control Programmes remained unachieved

The NRHM is aimed at decentralised planning and implementing arrangements to ensure need based and community owned district health action plan which would form the basis for intervention in the health sector. The guidelines envisaged household survey, facility survey, preparation of perspective plan for the entire Mission period (2005-12), annual action plan, and the Project Implementation Plan (PIP). Scrutiny of the records revealed that household survey was completed in 21 districts (i.e. except Adilabad and East Godavari) in the State. There were deficiencies in the planning process, as follows:

1.1.7.1 Perspective plans for the Mission period

NRHM guidelines envisage preparation of perspective plans for the entire Mission period (2005-2012) outlining the year-wise resources and activity needs of the district. The annual plan was to be based on availability and prioritisation exercise.

DHSs in the State have not prepared the perspective plan for the entire Mission period. Thus, the requirement and availability of resources and physical and financial targets remained un-assessed. In fact, the funds earmarked for preparation of Perspective Plan were diverted by DM & HOs for other purposes (Para 1.1.10 refers).

1.1.7.2 Facility Survey

In order to set up a benchmark for quality service and utilisation and identify input needs, Facility Survey (Specialist service, manpower, investigating facilities, equipment and other infrastructure, etc.) was to be conducted in each facility i.e., CHC, PHC, and Sub-centres. These surveys were to provide critical information in terms of gaps in infrastructure and human resource which needed to be addressed through planning process.

No Facility Survey was however, conducted in the State. At a belated stage in April 2008, this was entrusted to Indian Institute of Health and Family Welfare requiring to be completed by October 2008 at a cost of Rs 46.50 lakh. No progress was noticed as of May 2009. Thus, the programme was implemented during the period 2005-09 without the benefit of facility survey. Due to non-conduct of facility survey, deficiencies in specialist services, manpower services and infrastructure facilities were not identified.

1.1.7.3 Preparation of Project Implementation Plan (PIP)

PIP for the State was to be prepared annually by the SHS by aggregating the annual District Health Action Plan of each district. The National Programme Co-ordination Committee (NPCC) at the Ministry under the Chairmanship of the National Mission Director was to evaluate the PIP.

After incorporation of the feedback of the NPCC the PIP was to be approved by the Secretary, Ministry of H&FW. The directives issued by the NPCC were to be complied with by the SHS.

The SHS had no details of PIPs for the two year period 2005-07.

Audit observed that except DHS, Vizianagaram, the district health action plan was not prepared by any DHS in the State. This indicated that the PIPs were prepared without considering the DHAPs and the programme was implemented in an adhoc manner and is not need based. While approving (August 2007) the PIP in respect of 2007-08 NPCC gave the following directives:

- Provision of 10 *per cent* increase in budgetary outlay per year by the State
- Utilisation of not exceeding 25 *per cent* of funds for strengthening of infrastructure

- Drawing a monitoring plan for NRHM in consultation with National Health State Resource Centre (NHSRC)
- Construction of new CHCs and PHCs

It was observed that none of the above directives were complied with by the State Health Society (SHS) as of June 2009. Non-establishment of new CHCs and PHCs after launching NRHM had the adverse implications on delivery of healthcare to the targeted population (Para 1.1.8.1 also refers). Government replied (June 2009) that monitoring plan in consultation with NHSRC is under process. Government did not offer specific remarks on the other directives issued by NPCC.

1.1.8 Infrastructure and Capacity Building

In rural areas there was a shortage of 387 CHCs and 464 PHCs. In tribal areas the shortage was 63 CHCs, 63 PHCs and 303 Sub-Centres

The mandate of NRHM stipulates creation of infrastructure/buildings for health centres and strengthening the existing ones for improving accessibility and quality of healthcare services. Adequate attention was not paid by the State Government for creation/strengthening of physical infrastructure in CHCs/PHCs/Sub-centres as discussed in Paras 1.1.8.1 to 1.1.8.4 below:

1.1.8.1 Shortfall in number of Health Centres

NRHM framework seeks to provide one Sub Centre for 5,000 population (3,000 in tribal areas), one Primary Health Centre for 30,000 population (20,000 in tribal/desert areas) and one Community Health Centre for 1,00,000 population (80,000 in tribal/desert areas).

No new health centres had come up after launching NRHM in 2005-06, defeating the objective of accessibility of healthcare to rural/ tribal population

For the rural population of 554.01 lakh (Census 2001) in the State, there was a shortage of 387 CHCs and 464 PHCs. For tribal population of 50.24 lakh the shortage was 63 CHCs, 63 PHCs and 303 Sub-Centres. Audit observed that during the entire period 2005-09 i.e., after launching the NRHM no new CHCs or PHCs had come up in the State despite specific directive by the Ministry to propose the setting up of new CHCs, PHCs through PIPs from the year 2007-08. Government in its reply (June 2009) stated that construction of 250 Sub-centres would be taken up (outlay: Rs 36 crore) in 2009-10.

Non-setting up of the required number of health centres as per the population norms defeated the objective of the programme with adverse implication on the accessibility of health facilities to rural/tribal population.

1.1.8.2 Inadequate physical infrastructure at health centres

The physical infrastructure at health centres was inadequate and far below the desired level envisaged in Indian Public Health Standards. Majority of CHCs/ PHCs test checked lacked basic infrastructure facilities

The framework for implementation of the Mission has set the target of providing certain guaranteed services at Sub-centres, PHCs and CHCs. To achieve this, the Ministry of Health and Family Welfare, GOI has formulated the Indian Public Health Standards (IPHS) for different levels of health centres for ensuring availability of facilities.

Audit scrutiny revealed that even the basic infrastructure was not available in any of the health centres test checked (CHCs: 24, PHCs: 48, Sub centres: 96) as follows:

<table>
<tr><th>Item/ subject and requirement</th><th>Audit findings</th></tr>
<tr><td>Operation Theatres
According to IPHS norms major equipments are necessary to make an Operation Theatre (OT) functional.</td><td>Important equipments were not available in CHCs as mentioned below:
<table><tr><th>Nature of equipment</th><th>Number of CHCs (out of 24 CHCs test checked) where equipment was not available</th></tr><tr><td>Boyles apparatus to provide artificial respiration</td><td>11</td></tr><tr><td>Cardiac Monitors</td><td>21</td></tr><tr><td>Ventilators Verticals</td><td>19</td></tr><tr><td>High Pressure sterilizers 2/3 capacity drum</td><td>15</td></tr><tr><td>Shadow less lamps pedestal for minor OT</td><td>11</td></tr><tr><td>Gloves and dusting machines</td><td>7</td></tr><tr><td>Nitrous Oxide Cylinders</td><td>12</td></tr><tr><td>EMO machines for surgery</td><td>21</td></tr><tr><td>Defibrillators</td><td>23</td></tr><tr><td>Horizontal High Pressure Sterilizers</td><td>15</td></tr><tr><td>Shadow Less Lamp Ceiling Tract Monitors</td><td>9</td></tr><tr><td>OT Care/Fumigation Apparatus</td><td>9</td></tr><tr><td>Oxygen Cylinder 660 litres for one Boyles apparatus</td><td>7</td></tr><tr><td>Hydraulic Operation Table</td><td>11</td></tr></table>
Due to non-availability of important/essential equipment in Operation Theatres in the CHCs (supposed to be First Referral Unit) the targeted people in rural areas were deprived of quality surgical treatment. Government accepted the audit observations.</td></tr>
<tr><td>CEMONC Centre[8]
The objective was to provide life saving emergency care to mother and child and was designed to have 4 Obstetricians, one Paediatrician, and one Anaesthetist with Blood Storage Centre.</td><td>• As of March 2008 out of 329 and 546 sanctioned posts of Gynaecologists and Staff Nurses respectively, 183 (56 per cent) and 428 (78 per cent) posts were vacant.
• In Adilabad, Khammam, Krishna and Nellore Districts the CEMONC Centres were not functioning due to non-availability of Specialist doctors viz., Gynaecologist, Paediatrician and Anaesthetist. In the absence of doctors the Staff Nurses could not attend to emergency cases like caesarean, blood transfusion, administering anaesthesia. Government in its reply (June 2009) attributed the vacancies to experienced specialist doctors not generally willing to work at rural centres even after offering better remuneration.</td></tr>
</table>

[8] Comprehensive Emergency Obstetric and Neo-natal Care

Emergency Services The Mission provides for 24 hours emergency services for management of injuries and accident first aid, stabilisation of patients before referral, dog/snake/ scorpion bite cases, etc. by posting 3 staff nurses at PHCs.	Out of the 48 PHCs emergency services were available only in 18 PHCs. Lack of services in other PHCs was due to non-availability of the staff.
Diagnostic Services Mission provides for essential lab services at PHCs/CHCs level for routine urine, stool and blood test, blood grouping, bleeding time, clotting time, diagnostic for RTI/STD, Sputum testing for TB, Blood Smears examination for Malaria Parasites, rapid test for pregnancy/ malaria and RPR for Syphilis/Yarn.	• In all the 48 PHCs test checked lab services were available partially only. • In 24 CHCs and 48 PHCs though equipment for lab tests were present diagnostic services were not carried out due to absence of Technician/Reagents/Electricity. • In 3 CHCs and 15 PHCs facilities for diagnostic services were non-functional due to non-availability of lab technicians.
Labour Room The frame work of the implementation of the scheme provides for facility of labour room for safe delivery at PHC and CHC.	Labour rooms were available in 37 out of 48 PHCs test checked.
Radiological/X Ray services	In 10 out of 24 test checked CHCs, X-ray facilities were not available.
Blood storage facilities	Due to lack of equipment/staff, Blood storage facilities were not available in the 12 CHCs (out of 24) test checked.
Basic infrastructure Basic facilities such as buildings, vehicles, utilities, labour rooms, OTs, etc. at CHCs, PHCs and Sub-centres level are to be provided as per IPHS norms.	• 3 PHCs were functioning in private buildings. • In 38 PHCs and 11 CHCs no vehicle/ambulance were provided. • In 85 Sub-centres, 11 PHCs and 2 CHCs, there were no separate utilities for men and women. • In 8 PHCs and 1 CHC, out-patient department (OPD) rooms were not present. In 14 PHCs Operation theatres were not present. • In 9 PHCs Labour rooms were not functional. • In 10 CHCs Waiting Rooms were not available. • In 21 PHCs and 12 CHCs no standby power supply/ generator was available. • In 89 Sub-centres, 31 PHCs and 9 CHCs telephone connections were not available. • In 26 PHCs and 21 CHCs computers were not available.

	• In 82 Sub-centres the accommodation facilities for doctors were not available. • Residential quarters were not available for 34 medical officers and 32 staff nurses at PHC level. In 16 CHCs partial accommodation only was provided to medical officers.
AYUSH services One of the objectives of the NRHM was to revive AYUSH (Ayurvedic, Unani, Siddha and Homoeopathy) services through revitalising local traditions, by providing an AYUSH doctor at PHCs and by establishing AYUSH clinics at CHC.	Out of 48 PHCs and 24 CHCs test-checked no AYUSH practitioner was provided in 41 PHCs and in all the CHCs either through regular posting or through contractual appointment. This would adversely affect the objective of providing AYUSH services at the health centres under NRHM. Government replied (June 2009) that although notification was issued in April 2008 for recruiting doctors, there was no response.
Mobile Medical Units (MMUs) To make healthcare available at the door steps of the public in the rural areas, Mobile Medical Units were to be provided for providing outreach service.	• 93 MMUs were launched in 23 districts in 2005-06. Of these, only 50 MMUs are functional in 17 districts as of May 2009; 43 MMUs were closed reportedly due to poor performance and lack of Medical Officers and equipments. • In all the 8 test checked districts MMUs were not provided with required equipments and hence were non-functional. • The equipment viz., Ultra Sound ECG, BP Apparatus, Lab equipment were not available in the MMUs. Interventions like RTI/STI, Blood smear, ECG investigation like Urine, Blood, Sputum were not carried out in MMUs. • In Krishna District MMUs were providing services in areas where accessibility to the healthcare centre was not a problem, leaving the remote/outreach areas un-covered. • In Adilabad, Nellore and Vizianagaram the MMUs were providing only curative services i.e., administering medicines for fever, cold etc., ignoring preventive and diagnostic services. In Adilabad, Krishna and Vizianagaram, MMUs were providing healthcare services in outreach areas without a Medical Officer. Government while accepting the audit points stated (June 2009) that the equipment could not be supplied promptly due to lengthy procurement tender process.

1.1.8.3 Construction of Health Centres

The building works taken up for construction during 2005-09 under NRHM are given in Table-3.

Table-3 (Rupees in crore)

Type of building	Number proposed to be constructed	Estimated/ Sanctioned cost	Amount released	Expenditure incurred up to February 2009	Number completed	Number of works in progress	No. of completed works handed over	No. of works not taken up
CEMONC[9] Centres	151	88.49	31.62	40.35	77	44	51	30[10]
Paediatric and Maternal ward at SVRR Hospital[11], Tirupati	1	12.50	5.00	4.23	-	1	-	-
Birth waiting homes	38	4.05	1.76	1.57	26	7	-	5
Maternal and child health control room	1	0.11	0.11	NA	NA	1	-	-

The following were observed:

Construction of 44 CEMONC Centres remained incomplete and works of 30 centres were not taken up

- Even though funds were released, 44 CEMONC centres remained incomplete. Construction of 30 CEMONC centres was not taken up due to site disputes and lack of response from bidders. Construction of 12 birth waiting rooms (all in tribal areas) also remained incomplete.
- The Paediatric and Maternal ward at SVRR Hospital, Tirupati still remained incomplete even after two years of its sanction and release of funds (pending completion of works the ward was inaugurated in February 2009)
- The Commissioner did not ensure establishment of Maternal and child health control room despite specific provision of funds, which were lying with APHMHIDC. Government replied (June 2009) that it had introduced 104 toll free 24X7 call centre service to provide Health Information Helpline in the State. The amount (Rs 11.50 lakh) was however, not yet remitted back to the NRHM account by APHMHIDC.

The delay in completion of civil works led to denial of intended benefit to the beneficiaries besides escalation in construction cost.

1.1.8.4 Manpower

Huge shortage of manpower in key areas had adverse implication on providing reliable and quality medical services to rural population

Provision of manpower is a key component of delivery of health services. The Mission aimed to provide adequate medical and other manpower at different health centres. The details of sanctioned strength vis-à-vis men in position and the vacancy position in the Medical and Health Department as of September 2008 are given in the *Appendix-1.3*.

[9] Comprehensive Emergency Obstetric and Neo-natal Care

[10] Vizianagaram-3, Visakhapatnam-6, West Godavari-2, Krishna-2, Chittoor-1, Anantapur-2, Kurnool-2, Mahboobnagar-2, Ranga Reddy-2, Nalgonda-2, Medak-1, Nizamabad-2, Warangal-1, Khammam-1, Adilabad-1

[11] Sri Venkateswara Ramnarain Ruia Government General Hospital

Shortfall was noticed in the key functions of Civil Surgeon Specialist (46), Dy. Civil Surgeon (120), Civil Assistant Surgeon (1,279), Non-Medical Supervisor (104), Non-Medical Assistant (660), Sr. Entomologist (14), Staff Nurses (865), Community Health Officer (201). The huge shortfall in manpower had wide ranging inter-health centre variations, with adverse implications on providing reliable and quality medical services to the targeted population in rural areas.

1.1.9 Implementation of schemes

The implementation of RCH programme suffered from deficiencies in the areas of institutional delivery care, antenatal care, delivery services 24x7 and MTP

1.1.9.1 Reproductive and Child Healthcare (RCH)

NRHM aimed to provide an overarching umbrella to the national level health and family welfare programmes including (a) Janani Suraksha Yojana (JSY), (b) Immunization routine and Pulse Polio (c) National Vector Borne Disease Control Programme (NVBDCP), (d) Revised RNTCP (e) NPCB, NLEP and IDSP.

Audit observed the following deficiencies in the implementation of RCH scheme:

<table>
<tr><th>Item/Subject and requirement</th><th>Audit findings</th></tr>
<tr><td>Milestones
NRHM prescribed national targets for reducing Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR).</td><td>The State also prescribed specific targets/intermediate goals/outcomes/ milestones by adopting the Contraceptive Prevalence Rate as indicator to measure the effectiveness of the implementation of activities of Family Welfare Programme for the Mission period 2005-12 as indicated below:
<table>
<tr><th>Particulars</th><th>2006-07</th><th>2007-08</th><th>2008-09</th><th>2009-10</th><th>2010-11</th><th>2011-12</th></tr>
<tr><td>Infant Mortality Rate (IMR) per 1000 live births</td><td>56</td><td>50</td><td>45</td><td>40</td><td>35</td><td>30</td></tr>
<tr><td>Maternal Mortality Rate (MMR) per 100000 live births</td><td>195</td><td>176</td><td>157</td><td>138</td><td>119</td><td>100</td></tr>
<tr><td>Total Fertility Rate (TFR)</td><td>1.80</td><td>1.74</td><td>1.68</td><td>1.62</td><td>1.56</td><td>1.50</td></tr>
</table>
However, the State did not evaluate the prevalent rate of IMR, MMR and TFR for the years 2005-06 to 2007-08. No bench marks were prescribed to measure the achievement with regard to accessible, affordable, accountable, effective and reliable healthcare. No mechanism also existed to measure the impact of the programme.</td></tr>
<tr><td>Antenatal care
To reduce MMR, NRHM aims for safe motherhood which was to be achieved by registering all pregnant women before they attain 12 weeks of pregnancy,</td><td>The following basic information was not maintained in all the CHCs, PHCs and Sub-centres test checked.
(i) Micro birth plan at the PHCs level (in Adilabad, Kurnool, Karimnagar and Nellore Districts).</td></tr>
</table>

provision of four antenatal checkups, issue of ninety or more Iron Folic Acid (IFA) tablets, administering two doses of TT, advising the correct diet and vitamin supplements and in cases of complication referring them to more specialised gynaecological care.	**(ii)** Details of registration of pregnant women (in Adilabad District). **(iii)** Systematic records of checkups.
Institutional Delivery Care Janani Suraksha Yojana (JSY) was started during 2005-06 with an objective to encourage pregnant women for Institutional delivery in Government/ Private institutions which contributes to reduction of maternal mortality and infant mortality.	To encourage institutional delivery, the Centrally sponsored Janani Suraksha Yojana (JSY) scheme provides all pregnant women in low performing States and BPL pregnant women in high performing States a cash compensation of Rs 700 for undergoing institutional delivery irrespective of their age and number of previous children with them. Of the total deliveries of 15.12 lakh, 15.01 lakh, 15.13 lakh and 15.59 lakh during 2005-09, the status of institutional delivery in the State was 12.55 lakh, 12.77 lakh 13.33 lakh and 14.20 lakh constituting 83, 85, 88 and 91 *per cent* of targets. In Vizianagaram District there was a delay of five months in payment of compensation to 1475 beneficiaries involving Rs 13.80 lakh due to non-release of State matching share of Rs 300 per delivery under Sukhibhava scheme.
Delivery Services 24x7 Under RCH-I, the State Government launched a strategy in March 1996 to make Emergency Maternal Healthcare Services available round the clock to the people in Rural Public Health Institutions, where at least a Staff Nurse and MPHA(F) was to be available 24 hrs a day and 7 days a week to provide normal delivery service. These PHCs have been authorised to obtain the services of Gynaecologist and a Paediatrician on a 'per–call' payment basis from the private sector, if specialists are not available.	Out of total 1570 PHCs in the State only 800 PHCs (29 out of 48 PHCs in the sampled districts) had the facility of 24x7 delivery services. Audit observed that these PHCs were not catering to the services satisfactorily due to non-availability of Gynaecologist and Paediatrician, required number of staff Nurses (3) and Labour room etc.
Essential Obstetric Care	In 14 out of 24 CHCs test checked the emergency obstetric care including caesarean facility was not available due to absence of specialists in obstetrics and gynaecology, anaesthesia though required as per IPHS norms and non-functional operation theatre, lack of adequate infrastructure, supporting staff, blood storage facility etc.

Medical Termination of Pregnancy (MTP) Medical Termination of Pregnancy is permitted in certain conditions under the MTP Act, 1971.	Enhancing number and quality of facilities for MTP is an important component of the programme. The programme envisaged need based training to medical officers and nurses, provision of equipment and operation theatre and MTP kits at District Hospitals, CHCs and PHCs. It was observed that none of the 24 CHCs and 48 PHCs test checked in the six districts had the facilities of MTP.

Government while accepting the above audit observations promised to take remedial action.

1.1.9.2 Rogi Kalyan Samithis (RKS)

Functioning of Rogi Kalyan Samithis was found to be deficient. RKSs were yet to be formed in one CHC and 54 PHCs

NRHM guidelines envisaged constitution of RKSs with the representatives of legislature, health officials and leading members of the community and PRI Representatives, to be registered under Societies Registration Act, 1860 for healthcare centres up to PHC level. Audit observed the following deficiencies in implementation of RKSs:

- Out of 19 District Hospitals, 167 CHCs and 1,570 PHCs in the State, RKSs were not constituted in one CHC and 54 PHCs to end of 2007-08.
- A monitoring committee has to be constituted by RKS to collect patient's feed back and complaints if any, for taking remedial action. In eight District Hospitals, 24 CHCs and 48 PHCs test checked monitoring committees were not constituted in 11 CHCs (46 *per cent*) and 32 PHCs (67 *per cent*).
- In eight District Hospitals, 17 CHCs and 21 PHCs no report on patients' feed back and complaints on presence and conduct of healthcare personnel was submitted to DMHO/Collector. Thus, the monitoring mechanism for redressal of complaints was rendered ineffective.
- The source of funds for RKSs was to be in the ratio of 1:1:3 (Internal: through own resources, donations, levy of user charges; State and Central). However, neither the grants were received from the State Government nor the RKSs have generated the internal resources during 2007-08. This would adversely affect the viability of the long term goal of community ownership of the health centres through RKSs.

Government did not offer specific remarks on the above audit observations.

1.1.9.3 Family planning

The RCH II has launched a number of initiatives under the family planning component to achieve the goal of population stability through reduction of total fertility rate by 2012. The family planning includes terminal method to control total fertility rate and spacing methods to improve couple protection ratio.

The target and achievements in various terminal methods in the State is indicated in *Appendix-1.4*. The following observations are made:

Item/subject	Audit findings
Vasectomy	The proportion of vasectomy to the total sterilization was very low ranging from 3.53 *per cent* to 4.25 *per cent* of the targets during 2005-09.
Tubectomy	The proportion of tubectomy to the total sterilization ranged from 79.51 *per cent* to 84.63 *per cent* and this is a manifestation of the gender imbalance that plagues the programme. The proportion of vasectomy has not increased even after the launch of the non-scalpel vasectomy. In Krishna, Kurnool and Nellore Districts, vasectomy operations constituted a meagre 0.03 to 2.86 percentage of total sterilizations.
Laparoscopic tubetcomy	While female sterilization is the most adopted method, the programme emphasises laparoscopic tubetcomy as preferable to conventional tubetcomy. The performance of laparoscopic tubetcomy was low at 11.79 *per cent* of total female sterilizations.

No specific remarks were offered by the Government on the above points.

1.1.9.4 Immunization

Huge shortfalls (up to 39 *per cent*) were noticed in respect of second immunization (age group 10-16 years)

Vaccines like BCG, OPD, TT, DPT, DT and measles under universal immunization programme were envisaged under RCH programme. Immunization strengthening project was aimed at achieving complete vaccination of 80 *per cent* infants by strengthening routine immunization to realise the desired reduction in infant morbidity and mortality rate.

Audit scrutiny revealed that immunization of children between 0 and 1 age group ranged from 93 *per cent* to 101 *per cent* during the period 2005-09. However, shortfall was noticed up to 39 *per cent* in respect of second immunization (age group 10-16 years) as shown in Table-4.

Table-4 (Number in lakh)

Year	DT			TT (10)			TT (16)		
	Target	Achieve-ment	Percen-tage	Target	Achieve-ment	Percen-tage	Target	Achieve-ment	Percen-tage
2005-06	14.63	13.49	92.20	19.20	12.83	66.82	18.40	11.15	60.59
2006-07	17.80	12.76	71.68	20.23	12.32	60.89	17.00	10.34	60.82
2007-08	18.17	14.09	77.54	20.65	13.17	63.77	17.35	11.37	65.53
2008-09	18.23	12.06	66.15	20.72	12.57	60.66	17.40	10.87	62.47

Government attributed (June 2009) the shortfall in second immunization of children (above 5 years) to the children not being available in their homes due to admission in schools and migration in some cases. The reply is not acceptable as both the targets and achievements were inclusive of the number of children covered under School Immunization Programme.

1.1.9.5 National Programme for Control of Blindness (NPCB)

The achievement of Catops in Government hospitals was far below the prescribed target of 50 *per cent*

The NPCB aimed to reduce prevalence of blindness cases to 0.8 *per cent* (the prevalent rate of blind is 1.84 *per cent*) by arranging cataract surgeries (46 lakh by 2012), and collection of donated eye balls and by arranging school eye screening and free distribution of eye spectacles 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.

Fifty *per cent* of the total Cataract Operations (catops) were to be performed by the Government Hospitals as envisaged in the guidelines. However, the achievement in Government hospitals ranged from 15 to 18 *per cent* of total catops as shown in Table-5.

Table-5

Year	Number of catops conducted		Break-up of catops					
			Government sector		NGOs		Private practitioners and others	
	Target	Achievement	Number	Percentage	Number	Percentage	Number	Percentage
2005-06	460000	513508	92431	18	205403	40	215674	42
2006-07	460000	510705	83615	16	239055	47	188035	37
2007-08	500000	547899	98622	18	219160	40	230117	42
2008-09	550000	582318	89773	15	276622	48	215923	37
Total	**1970000**	**2154430**	**364441**		**940240**		**849749**	

The programme contemplated that cataract operations performed in eye camps should be in the range of 20 *per cent* as it was felt that greater reliance on the camp methodology could be counter productive. It was however, observed that catops performed through camp approach far exceeded the prescribed percentages as shown in Table-6. Government attributed (June 2009) the poor achievement of catops in Government institutions to non-availability of the posts of eye surgeons and operation theatres in area hospitals/district hospitals/ CHCs and also non-availability of Para-Medical Ophthalmic Assistants (PMOA) posts in 350 PHCs (out of 1570). It was stated that Director of Health was instructed in February 2009 to outsource the services of 100 PMOAs. Government did not however, indicate the steps taken/proposed to be taken with regard to recruitment of eye surgeons.

Table-6

Year	No. of catops performed			Percentage of catops in Camps
	Total	In camps	No. of Camps	
2005-06	513508	143558	2266	27.95
2006-07	510705	159279	2728	31.18
2007-08	547899	203621	3401	37.16
2008-09	582318	213941	3713	36.70

1.1.9.6 National Iodine Deficiency Disorder Control Programme (NIDDCP)

No survey was conducted after launching NRHM to identify areas of iodine deficiency disorder

The NIDDCP aims to control iodine deficiency disorder (IDD) through production and distribution of iodised salt, analysis of salt samples and analysis of urinary iodine excretion etc.

The NIDDCP was launched in the State during 1962. During 1986 to 2003, 14 out of 23 districts were surveyed for locating areas of IDD and all these districts were identified as areas endemic to IDD. No survey was however, conducted during the period 2005-09.

The number of iodine salt samples analysed during 2005-06, 2006-07, 2007-08 and 2008-09 is given in Table-7.

Table-7

Year	No. of samples tested	Less than 15 PPM*	More than 15 PPM*
2005-06	810656	394567	409124
2006-07	612413	218292	324126
2007-08	735617	256818	325692
2008-09	658364	223564	309247

* Parts Per Million (PPM)

No action was however, taken on the analysis of Urinary iodine excretion (May 2009). Government while accepting the audit point attributed this to non-availability of qualified lab technicians and necessary equipment with Director of Health. The information with regard to patients with Iodine Deficiency Disorders was not available with the SHS or with the Additional Director, NIDDCP.

1.1.9.7 Poor implementation of schemes by NGOs

Implementation of schemes by the NGOs was poor. The entire amount of Rs 7.01 crore released to municipal corporations for establishing First Referral Units remained unspent

There were in all 87 NGOs[12] (including the Municipal Corporations) in the State which received assistance under the programme. The table below shows the position of funds released to the NGOs by the SHS during the period 2005-09 and utilisation of the grants by them. It was observed that none of the NGOs have implemented the programme during the years 2005-06 and 2006-07. Although the NGOs stated to have spent Rs 5.96 crore (out of Rs 20.69 crore released) during 2007-08, UCs were submitted only to the extent of Rs 1.14 crore as detailed in Table-8.

Table-8 (Rupees in crore)

Year	Grant-in-aid released to NGO during the year	Expenditure incurred by NGO	Amount for which UC furnished by the NGOs
2005-06	2.25	Nil	Nil
2006-07	11.10	Nil	Nil
2007-08	7.33	5.96	1.14
2008-09	NIL	NIL	---
Total	**20.69**	**5.96**	**1.14**

[12]Releases to municipal corporations are categorised as releases to NGOs

Further Rs 7.01 crore was released (2005-09) to Municipal Corporations viz., Kakinada (Rs 82.71 lakh), Guntur (Rs 91.01 lakh), Nellore (Rs 73.90 lakh), Tirupati (Rs 81.86 lakh), Kadapa (Rs 113.03 lakh), Kurnool (Rs 152.95 lakh), Warangal (Rs 87.61 lakh), Ranga Reddy District (Rs 18.11 lakh) for establishment of First Referral Units (FRUs), to meet medical requirements of urban slum people especially for women and children. However, the municipal corporations failed to utilise these amounts. The Commissioner had asked (December 2008) the municipal corporations to refund the money to SHS account. Government in its reply stated (June 2009) that out of Rs 7.01 crore pointed out by Audit, a sum of Rs 2.30 crore was refunded by the Municipal Corporations and the balance Rs 4.71 crore was outstanding.

1.1.10 Deficiencies in utilisation of funds

Cases of avoidable extra expenditure/ ineligible payments/ wasteful expenditure and diversion of NRHM funds amounting to Rs 23.36 crore were noticed

Scrutiny revealed avoidable extra expenditure in procurement of vaccine (Rs 7.91 crore), procurement of bed nets (Rs 2.51 crore), ineligible payment of incentives to pregnant women (Rs 5.22 crore), wasteful expenditure in provision of free bus passes (Rs 0.52 crore) and diversion of NRHM funds of Rs 7.20 crore for other purposes, totalling to Rs 23.36 crore as per the following details.

Nature of deficiency/ irregularity	Audit findings
Avoidable extra expenditure in procurement of JE Vaccine	The CFW procured (April 2007) 17.50 lakh doses of Mouse Brain JE Vaccine from M/s Vabio Tech, Vietnam at Rs 38 per dose and another batch of 3.50 lakh doses from Central Research Institute, Kasauli at Rs 55.42 per dose. Scrutiny of records revealed that a similar vaccine viz., SA-14-14-2A, of China make was available at Rs 12 per dose from M/s Hindusthan Latex Ltd. Further, it was observed from the technical committee recommendations that it was a single dose giving protection for 10 years, whereas Mouse Brain JE Vaccine was costlier and has to be administered three times (1st phase – 1st and 2nd dose in a fortnight and Booster dose – after six months in 2nd phase). Thus, due to procuring Mouse Brain JE Vaccine instead of a similar and cheaper vaccine ignoring the recommendations of the technical committee, the department had to incur an extra expenditure of Rs 7.91 crore in procurement of 21 lakh doses of the vaccine.
Avoidable extra expenditure in procurement of Mosquito Bed Nets	As a preventive measure it was decided to procure mosquito bed nets. APHMHIDC was entrusted with the procurement task which did not invite tenders and procured (November 2007) two lakh bed nets at a cost of Rs 240 per bed net. When tenders were called for the subsequent procurement in May 2008 the price per net was Rs 69 which was far lower. Thus, due to non-adopting competitive bidding procedure an avoidable extra expenditure of Rs 2.51 crore was incurred. Audit also observed that the expenditure on procurement of bed nets had no approval of the Ministry (Point below also refers).

Incurring of expenditure without approval of NPCC	The State Government decided (May 2007) to procure 5 lakh mosquito bed nets for tribal population and the CFW requested the NPCC, MOHFW, GOI for allotment of Rs 10.15 crore in PIP for 2007-08 for meeting the expenditure. However, even prior to receipt of funds, the CFW released (May 2007) Rs 4.90 crore in favour of MD, APHMHIDC to procure 5 lakh mosquito bed nets from M/s APCO. Accordingly the MD, APHMHIDC procured 2 lakh bed nets @ Rs 240 per bed net (deficiencies in procurement enlisted above) and rendered a bill for Rs 4.90 crore. The expenditure of Rs 4.90 crore incurred in procurement of bed nets had no approval of the Ministry of Health and Family Welfare, GOI.
Ineligible payment of incentives	To promote institutional deliveries among Rural BPL women, Government fixed (November 2005) cash incentive of Rs 700. Though this facility was not applicable to urban areas prior to April 2006, incentive was paid to 38,065 women in urban areas for this period resulting in ineligible payment of Rs 2.66 crore. Further, due to payment of incentive of Rs 700 instead of Rs 600 to 1,15,068 and 1,40,942 beneficiaries during the years 2006-07 and 2007-08, there was an excess payment of Rs 2.56 crore to the beneficiaries in urban areas.
Wasteful expenditure in provision of bus passes	For providing free travel passes for 3 round trips to 8 lakh BPL pregnant women at nearest health centres for health check-up/referral services, the department paid Rs 3.10 crore (Rs 1.55 crore each in the year 2006-07 and 2007-08). The cost of each bus pass was Rs 19.36. The passes were to be distributed through PHCs/Sub-centres to the beneficiaries. During 2007-08, out of 8.00 lakh passes given to 23 DHSs, distribution details for only 5,29,670 passes have been received by SHS. The balance of 2,70,330 passes valued Rs 52.33 lakh remained undistributed with DHSs. Thus, the expenditure was rendered wasteful. Besides, the benefit of bus passes was denied to the intended beneficiaries. Distribution details for 8.00 lakh passes issued during the year 2006-07 were not made available to Audit. Government did not give specific reply with regard to non-distribution of 2.70 lakh bus passes valuing Rs 52.33 lakh.
Diversion of NRHM funds	For preparation of Perspective Plan for the districts for the entire Mission period 2005-12, the CFW released (2006-07) Rs 2.30 crore to 23 DM&HOs at Rs 10 lakh per district. Audit observed that the DM&HOs, without the approval of the Government, diverted the entire amount towards control of epidemic of Dengue and Chickungunia, the expenditure on which should have been met from out of the State funds. The diversion has resulted in non-preparation of the perspective plan for the districts with adverse implications on the assessment of year-wise data on the needs of the districts and the resources as well. (Para 1.1.7 also refers). Government in its reply sought to justify the diversion of NRHM funds stating that it was done in public interest to overcome health emergencies. The contention is not acceptable as the expenditure on this account should have been met from the regular budget of the Health Department. The diversion has resulted in critical component of preparation of Perspective Plan of NRHM getting badly affected.

1.1.11 Monitoring

The programme suffered from inadequate monitoring mechanism

NRHM guidelines prescribe formation of Monitoring and Planning Committees at State, District, Block and PHC level so as to ensure regular community base monitoring of activities and facilitate relevant inputs for planning. Audit observed the following deficiencies in monitoring of the activities under the programme at various levels:

Item/subject and requirement	Audit findings
Computerisation and Management Information System NRHM guidelines envisaged development of computer based Management Information System (MIS) at DHS up to Block level and use of network for Integrated Disease Surveillance Project for furnishing the MIS report to Union Ministry on monthly basis through DHS/SHS.	The Department provided (April 2003) from State funds computers to 23 DHSs and 1387 PHCs and these were connected through MIS network under Family Welfare and Health Information Management System (FHIMS) with an outlay of Rs 21.87 crore. Scrutiny revealed that the MIS remained defunct since June 2005. Out of 1,387 computers procured, Computers were installed in 1,359 PHCs (January 2009). These were not used effectively for the intended purpose as the usage was restricted to data entry in 447 PHCs and generation of reports without networking in 273 PHCs. Further, 183 PHCs which were set up during the year 2004-05 i.e., before launch of the NRHM were not provided with computers (March 2009). Government did not offer specific remarks on the audit observation.
Adequacy and Efficacy of Community Participation "Communitisation" of planning, implementation and monitoring through participation of representatives of PRIs, NGOs and community based organisations at each level is envisaged in NRHM.	Health Monitoring and Planning Committee was not constituted at State level and no action was initiated to establish community based monitoring through the people's representatives, local body representatives, NGOs and Community Based Organisations. It was observed that in none of the 24 CHCs, 48 PHCs, and 96 Sub-centres were the planning and monitoring committees formed.
Non-establishment of State Health System Resource Centre	As per the NRHM guidelines a State Health System Resource Centre (SHSRC) was to be established in each State to provide technical support to the Mission with an annual corpus fund of Rupees one crore in a large State and Rs 50 lakh in a small State. Though an amount of Rs 1 crore was released by GOI during 2007-08, the SHSRC had not been established as of March 2009.
Public Report on Health As per NRHM guidelines each district is required to publish a Public Report on Health annually.	Out of 23 districts, one district (Vizianagaram) published reports annually. In the absence of public reports on health by the DHSs the information and direction of development taking place in the districts was not readily available.

While accepting the above audit points, Government stated that efforts are being made for establishment of SHSRC, and DM & HOs are being instructed to ensure compliance on the audit observations. In the absence of adequate monitoring mechanism, the planning process did not receive regular inputs on the nature and direction of required future interventions.

1.1.12 Constraints and achievements

The basic constraint in underutilisation of funds during the period 2005-09 and under-achievement of the targets as explained by the Health, Medical and Family Welfare Department was that the programme was new. Despite this constraint the following were the achievements:

- 70,700 Accredited Social Health Activists (ASHAs) have been selected and positioned in all the habitations across the State through the Gram Panchayat Health Committees to act as health resource person of first resort. Their presence ensures wide coverage of all Mother and Child Health (MCH) Services.
- Out of 1,570 PHCs, 800 PHCs have been converted as 24 Hours MCH centres to provide round the clock services to promote institutional deliveries with basic emergency obstetric care.
- Out of 151 CEMONC centers proposed to be established to provide life saving emergency care, 77 have been established and functioning.
- There was increase in the institutional deliveries as a percentage of total deliveries from 83 *per cent* to 91 *per cent* during 2005-09 i.e., after introduction of NRHM.
- Rogi Kalyan Samithis (RKS) have been established in 166 CHCs, 1,516 PHCs and 19 district Hospitals (out of 167 CHCs, 1,570 PHCs and 19 district Hospitals) which led to improvement in up-gradation of Health Services.
- Village Health and Sanitation Committees (VHSC) have been established in all 21,916 villages with Panchayat Sarpanchas as Chairman and Ward members, Angan Wadi Workers and ASHAs to ensure optimal use of Health Services in the village.
- Rural Emergency Health Transportation Scheme (108) was introduced to provide emergency health transportation of the public in the Rural areas of the State especially for emergencies relating to pregnant women, infant/ children. 802 Ambulances are in operation covering 1.3 to 1.5 lakh population.
- Significant achievements have been made in administering Iron Folic Acid tablets to the pregnant women.
- Hundred *per cent* achievements were made in first immunization of Tetanus Toxoid and Pulse Polio.
- During the four year period 2005-09 achievement of Cataract Operations was 100 *per cent.*

1.1.13 Conclusions

The implementation of the NRHM in the State suffered mainly due to lack of comprehensive planning and absence of adequate monitoring mechanism. The programme was implemented in the State without conducting facility surveys and there was no Perspective Plan for the whole Mission period 2005-12. Twenty one to twenty nine *per cent* of the available funds remained unspent during 2005-09. No new Community Health Centers (CHCs) and Primary Health Centers (PHCs) were set up in the State after launch of the NRHM and the State Government did not pay adequate attention for creation/strengthening of infrastructure. The physical infrastructure available in the health centres was far below the desired level prescribed in Indian Public Health Standards and majority of the test checked CHCs and PHCs lacked basic infrastructure facilities. The Mobile Medical Units were functioning without essential equipment/Medical Officers in all the eight test checked districts. The implementation of healthcare services like institutional delivery care, antenatal care, 24x7 delivery services and the Medical Termination of Pregnancy etc. under RCH Programme was far from satisfactory. Functioning of Rogi Kalyan Samithis was deficient. There were shortfalls (up to 39 *per cent*) in the immunization programme (second stage/10-16 years). The objective of converging all the National Disease Control Programmes remained unachieved. Implementation of the Programme by the NGOs was not adequately monitored. Due to lack of adequate monitoring mechanism the planning process did not receive regular inputs on the nature and direction of required future interventions.

1.1.14 Recommendations

- Facility surveys should be conducted to identify the gaps in infrastructure and human resources.
- The number of Health Centres should be increased as per NRHM norms in all the districts so as to improve the accessibility of healthcare to rural and tribal population.
- Government should take immediate steps to provide adequate infrastructure at all health centres as per IPHS norms.
- Required number of doctors and other paramedical staff should be positioned in all the Health Centres for providing quality services to rural population.
- Essential equipment and Medical Officers should be provided to all the Mobile Medical Units to make them fully functional for treatment and diagnosis.
- Emphasis may be given to increased number of institutional deliveries to reduce maternal and infant mortality. All the eligible children should be covered under Immunization programme.
- Rogi Kalyan Samithis need to be strengthened by constituting monitoring committees at the different levels of Health Centres.

- The Commissioner should take immediate steps to reconcile the figures of releases by GOI and those credited by banks to SHS account and resolve the issue of short receipts in SHS account. Similar exercise needs to be undertaken in respect of releases to the DHSs by SHS.
- Government need to evaluate the prevalent rate of IMR, MMR and TFR to measure the impact of the programme.
- Adequate monitoring mechanism may be evolved by ensuring community participation and generation of public reports on health.

The above audit observations were discussed in the exit conference held in January 2009 with the Additional Director, NRHM and all the Programme Officers. The recommendations of audit were accepted.

Appendix-1.1
(Reference to paragraph 1.1.5 page 5)

List of Districts, CHCs, PHCs and Sub-Centres selected for Test Check

District	CHC/Block	PHC	Sub-centre
Vizianagaram	Saluru	Marupalli	Logisa
	Bobbili		Madhupada
	S.Kota	Kothavalasa	K.dabalu
			Denduru
		Pakki	Pakki
			Sivadavalasa
		Peddamajjipalem	Psr puram
			Vasadi
		Vepada	Nkr puram
			C. Dungada
		Viyyampeta	Viyyampeta
			Thummakapalli
Krishna	Mylavaram	Kondapalli	Kondapalli-II
	Nandigama		Guntupalli-III
	Vuyyuru	Unguturu	Unguturu
			Telaprolu-II
		Kruthivennu	Kruthivennu
			Matlam
		Koduru	Puligadda
			Koduru-II
		Veeravalli	Sirivada
			Bandarugudem
		Lakshmipuram	Chinnagollapalem
			Nidamarru
Nellore	Atmakur	Guttikonda Varipalli	Kalavalapudi
	Rapur		Venkatagiri-I
	Sullurpeta	Mallam	Mallam-I
			Mallam-II
		Manubolu	Cherlapalli
			Kommalapudi
		Mypadu	Korutla
			Somarajupally
		Seetharamapuram	Ayyavaripally
			Gundupally
		Yellayapalem	Chowkicherla
			Mudivarthi
Kurnool	Atmakur	Bethamcherla	Cementnagar-I
	Dhone		Cementnagar-II
	Pattikonda	Kolimigundla	Petnikota
			Bellum
		Kothapalli	Chakarajuvemula
			W.kothapalli
		Krishnagiri	Amakathadu
			Yerukulacheruvu
		Perisomula	Akumalla
			Kavala
		Puchakayalamada	Devanabanda
			Dudekonda

District	CHC/Block	PHC	Sub-centre
Adilabad	Chennur	Ada	Ada
			Ankusapur
	Luxetipet	Lakshmanachanda	Parapally
			Vellamal
	Sirpur	Lonevally	Chintakunta
			Dabba
		Vemanapally	Gillada
			Vemanapally
		Wankidi	Gambiraopet
			Pangidimadra
		Pittabongaram	Kondapur
			Walagonda
Khammam	Penuballi	Pinapaka	Uppaka
			Thoggudem
	Sattupalli	Jeediguppa	Kolluru
			Pocharam
	Yellandu	Kamepally	Utukuru
			Mucherla
		Kutur	Karmankonda
			Marrigudem
		Chandrugonda	Ravikampadu
			Ayyanapalem
		Chintakani	Kudumuru
			Prodduturu
Karimnagar	Pedapally	Kothapalli	Kothapalli-1
			Asifnagar
	Jammikunta	Bejjanki	Kallepalli
			Begampet
	Sultanabad	Kesavapatnam	Molungur
			Metpally
		Saidapur	Vennampally
			Bommakal
		Yellareddypet	Thimmapur
			Venkatapur
		Velgatur	Chegyam
			Pathagudur
Kadapa	Kamalapuram	Chilmakur	Malepadu
			Chirrajupally
	Proddutur	Vallur	Ambavaram
			Peddaputha
	Siddavatam	CK Dinne	Kolumalapally
			Bodeddulapalli
		Thottigaripally	TV Puram
			Badvel-III
		Khajipet	B. Kothapalli
			Ravulapally
		Gopavaram	Brahmanapally
			Sastrinagar

Appendix-1.2
(Reference to paragraph 1.1.6.2 page 6)

Variation between SHS and DHS figures (NRHM) in respect of test checked districts

(Rupees in lakh)

District	Year	Funds released to DHS by SHS	Funds received by DHS	Difference
Vizianagaram	2005-06	263.95	226.95	(-) 37.00
	2006-07	843.66	858.48	14.82
	2007-08	1008.68	1019.83	11.15
	2008-09	784.87	811.74	26.87
Krishna	2005-06	282.68	221.60	(-) 61.08
	2006-07	894.65	879.01	(-) 15.64
	2007-08	954.64	876.55	(-) 78.09
	2008-09	957.88	961.13	3.25
Nellore	2005-06	223.39	173.92	(-) 49.47
	2006-07	819.43	579.27	(-) 240.16
	2007-08	743.53	765.69	22.16
	2008-09	666.45	712.05	45.60
Kurnool	2005-06	282.40	233.72	(-) 48.68
	2006-07	1046.27	898.19	(-) 148.08
	2007-08	1032.12	1058.86	26.74
	2008-09	1131.13	951.75	(-) 179.38
Adilabad	2005-06	246.91	197.54	(-) 49.37
	2006-07	782.59	762.31	(-) 20.28
	2007-08	920.69	1071.94	151.25
	2008-09	669.11	691.89	22.78
Khammam	2005-06	248.24	210.93	(-) 37.31
	2006-07	849.18	833.79	(-) 15.39
	2007-08	985.53	1000.10	14.57
	2008-09	707.26	714.84	7.58
Kadapa	2005-06	247.92	217.45	(-) 30.47
	2006-07	901.39	875.63	(-) 25.76
	2007-08	952.48	736.05	(-) 216.43
	2008-09	854.92	900.20	45.28
Karimnagar	2005-06	261.56	NIL	(-) 261.56
	2006-07	905.82	789.04	(-) 116.78
	2007-08	1031.35	834.39	(-) 196.96
	2008-09	731.31	1017.78	286.47
	Total	**23231.99**	**22082.62**	**(-) 1149.37**

Appendix -1.3
(Reference to paragraph 1.1.8.4 page 13)

Sanctioned strength of Medical and Health Department as of September 2008

Sl. No	Cadre	Sanctioned strength				Existing	Vacancy	
		Permanent	Temporary	Super-numorary	Total		Regular	Out-sourcing
1	Civil Asst Surgeon	60	13	-	73	69	4	-
2	Civil Surgeon Specialist	10	166	-	176	130	46	-
3	Deputy Civil Surgeon	157	126	-	283	163	120	-
4	Civil Asst. Surgeon	1530	1886	200	3616	2337	1279	182
5	Dental Asst Surgeon	18	172	-	190	165	25	1
6	Sr. Entomologist	22	5	-	27	13	14	-
7.	Statistical officer	68	-	-	68	63	5	-
8.	Dy. Statistical officer	50	20	-	70	49	21	-
9.	Statistician	78	40	-	118	90	28	-
10	Biologist	7	2	-	9	9	-	-
11.	Physiotherapist	51	52	-	103	92	11	-
12	Paramedical officer	23	-	-	23	20	3	-
13.	Dy P.M.O/Non medical supervisor	285	181	-	466	362	104	-
14.	Pharmacy Supervisor	22	-	-	22	16	6	-
15.	Head Nurse	10	144	-	154	123	31	-
16	Ophthalmic Asst	131	183	-	314	278	36	16
17	A.P.M.O/N.M.A	1480	680	-	2160	1500	660	-
18	M.P.H.E.O	1112	396	-	1508	1096	412	-
19	Staff Nurse	1437	1075	-	2512	1647	865	150
20	H.E.O	23	-	-	23	21	2	-
21	Health Educator	150	-	-	150	109	41	-
22	MPHS(M)	1973	772	-	2745	2120	625	-
23	PH Nurse	22	7	-	29	20	9	-
24	Pharmacist Gr II	1211	580	-	1791	1494	297	336
25	MPHA (M)	3902	3553	-	7455	5797	1658	2943
26	ANM	-	-	-	-	11572	-	-
27	MPHA (F)	774	1251	-	2025	1814	211	75
28	Radiographer	75	124	-	199	107	92	-
29	Lab technician Gr II	1550	289	-	1839	1418	421	278
30	C.H.O	337	169	-	506	305	201	-
31	Refractionist	-	1	-	1	1	-	-
32	Dark room Asst	54	125	-	179	84	95	-
33	Lab-Attendant	35	10	-	45	39	6	-

Appendix-1.4
(Reference to paragraph 1.1.9.3 page 17)

Number of sterilizations conducted during 2005-06 to 2008-09

Year	Target	Achievement	Percentage	Break-up of operations		
				Vasectomy	Tubectomy	Laparoscopy
2005-06	800000	745117	93.14	26542	630664	87911
2006-07	800000	769253	96.16	27221	630955	111077
2007-08	800000	711748	89.00	27285	573718	110745
2008-09	790000	700273	88.64	29763	556811	113699

Appendix-1.5
(Reference to paragraph 1.2.6.1 page 29)

Statement showing the receipts and expenditure of the University during the period 2004-09

(Rupees in crore)

Year	Receipts					Expenditure			
	Block grant	Internal Sources	UGC Grant	Non-UGC Grants	Total	University Funds	UGC	Non-UGC	Total
2004-05	67.32	21.09	7.73	6.35	102.49	88.71	6.23	5.64	100.58
2005-06	71.70	24.76	6.45	5.32	108.23	96.45	6.99	6.26	109.70
2006-07	93.20	21.86	19.49	5.40	139.95	115.06	19.79	4.34	139.19
2007-08	93.25	33.38	22.57	8.43	157.63	126.63	21.38	9.78	157.79
2008-09*	98.44	31.18	11.60	4.84	146.06	138.07	11.59	6.43	156.09
Total	**423.91**	**132.27**	**67.84**	**30.34**	**654.36**	**564.92**	**65.98**	**32.45**	**663.35**

*Estimated figures (Accounts yet to be prepared)

Appendix-1.6
(Reference to paragraph 1.2.10 page 45)

Incorrect preparation of estimates

Name of the work	Standard Schedule of Rates (SSR) per Cum (Rs)	Rates adopted per Cum (Rs)	Difference of rates per Cum (Rs)	Quantity of work done (in Cum)	Excess expenditure (Rs)
Construction of Girls hostel building for Engineering and Technology Students at University campus					
Filling of basement with carted earth	134.32	208.52	74.20	978.96	72,639
Refilling of foundation with excavated earth	10.11	28.54	18.43	1,546.19	28,496
Coursed rubble stone masonry	1,858.60	1,936.27	77.67	559.53	43,459
				Total excess expenditure	**1,44,594**
Construction of a Building for Central Facilities Complex					
Filling with carted gravel in trenches	155	189.85	34.85	11,993.61	4,17,977
Filling foundation with excavated earth	9.24	26.33	17.09	928.68	15,871
Coursed rubble stone masonry	1,632.49	1,670.25	37.76	1,112	41,989
				Total excess expenditure	**4,75,837**