CHAPTER – I : PERFORMANCE REVIEWS

HEALTH AND MEDICAL EDUCATION DEPARTMENT

1.1 National Rural Health Mission

The Government of India launched the National Rural Health Mission (NRHM) in April 2005 to provide accessible, affordable and reliable health-care to the rural population, especially the vulnerable sections of the society. The Plan of Action includes increasing public expenditure on health, reducing regional imbalances in health infrastructure, decentralization and district management of health programmes, community participation and operationalising community health centers into functional hospitals. A mid-term review of the implementation of the programme was undertaken to highlight the areas of concern and issues that need to be addressed for successful achievement of the objectives set out for the Mission. Performance review of the Mission activities during the period 2005-09 showed that implementation plans were not based on proper surveys; basic facilities were lacking in a large number of health centres and various maternal/child health programmes and disease control programmes were not performing to the targeted levels.

Highlights

- **Household survey had not been conducted and base line survey was conducted partially. State level annual programme implementation plans were prepared without any inputs from districts, defeating the purpose of decentralised planning.**

  (Paragraph: 1.1.7.1)

- **No new health centre was constructed in the State. Basic facilities were also not available in many of the health centres audited. Though OPD services were running on daily basis, IPD, emergency, diagnostic and blood storage facilities were partial. Mobile medical units had not been procured, affecting targeted improvement of health-care service in remote/difficult areas.**

  (Paragraphs: 1.1.10.1 and 1.1.10.3)

- **Shortage of manpower against requirement as per sanctioned strength and NRHM norms ranged between six and 91 *per cent* in SCs, six and 100 *per cent* in PHCs and six and 94 *per cent* in CHCs.**

  (Paragraph: 1.1.11.1)

- **Maternal and Child health programmes and various disease control programmes have not been able to provide adequate satisfaction to the targeted beneficiaries.**

  (Paragraphs: 1.1.15.1 to 1.1.15.3)

- **Monitoring and planning committees had not been constituted at any level.**

  (Paragraph: 1.1.22.1)

1.1.1 Introduction

The National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India (GOI) throughout the country for providing integrated health-care services to the rural population, especially the poor and vulnerable sections of the society. The objectives of the Mission, to be achieved during the period 2005-12, are as follows.

- provision of accessible, affordable, accountable and reliable health-care facilities in the rural areas;
- involving community in planning and monitoring;
- reduction in child and maternal mortality and total fertility rate for population stabilisation;
- prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- revitalizing local health traditions and mainstreaming AYUSH and
- promotion of healthy life styles.

The Mission aims to bridge the gaps in rural health-care through increased community ownership, decentralization of the programmes, inter-sectoral convergence and improved primary health-care. It further envisages increasing expenditure on health, with a focus on primary health-care, from the level of 0.9 *per cent* of GDP (1999) to two to three *per cent* of GDP over the Mission period (2005-2012). Jammu and Kashmir is one of the 'high focus' States under the Mission.

1.1.2 Organisational structure

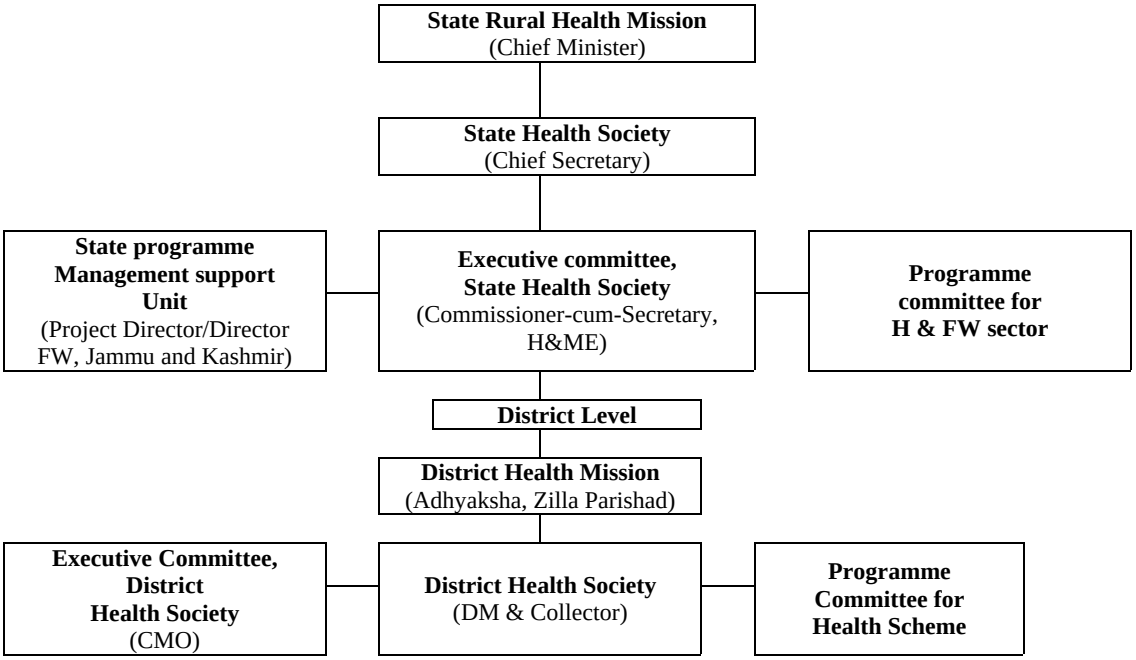
At the State level, the Mission is implemented under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. The activities are carried out in the State by the State Health Society (SHS). The Governing Body of the SHS, headed by the Chief Secretary, is responsible for approval/endorsement, review of implementation of Annual State Action Plans, inter-sectoral coordination, etc. The Executive Committee of the SHS, headed by the Principal Secretary, Health and Medical Education Department is responsible for approval of proposals received from districts and other implementing agencies, execution of the approved Action Plans including release of funds for the programmes. The State Programme Management Support Unit (SPMSU) acts as the Secretariat to the SHM as well as the SHS and is headed by a Mission Director. The SPMSU includes technical experts like Chartered Accountants, Masters of Business Administration and Management Information System specialists.

At the district level, every district has a District Health Mission (DHM), headed by the Chairperson of the District Development Board and an integrated District Health Society (DHS). The Governing body of DHS is headed by District Development Commissioner (DDC) and the Executive body is headed by DDC or Chief Medical Officer (CMO).

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

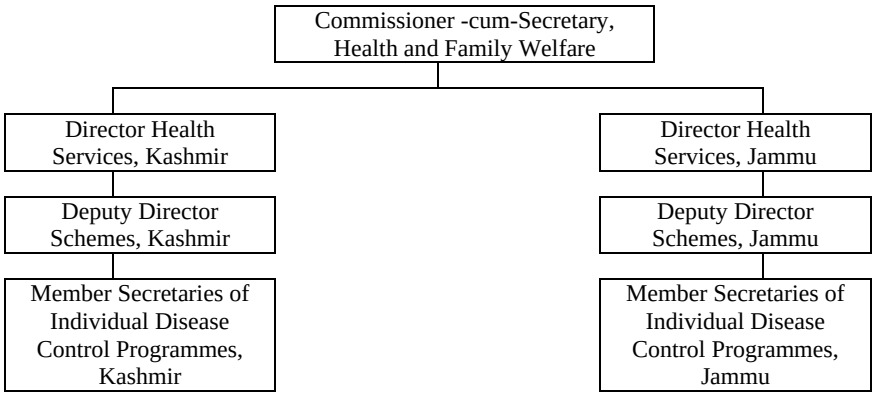
(A) For the components of Reproductive and Child Health (RCH), NRHM Flexipool, Immunisation, NVBDCP[1] (Finance only), NPCB[2] (Finance only).

Chart-1.1.1



(B) For the components of Revised National TB Control Programme (RNTCP), NVBDCP, NPCB etc.

Chart- 1.1.2



1.1.3 Scope of Audit

The performance audit was carried out during October 2008 to May 2009 and covered the implementation of the programme during 2005-09. Records of the State Health Society (SHS), six[3] out of 14 District Health Societies (DHSs), 18 out of 85 Community Health

1 National Vector Borne Disease Control Programme
2 National Programme for Control of Blindness
3 Anantnag, Baramulla, Leh, Rajouri, Poonch, Doda

Centres (CHCs), 34 out of 375 Primary Health Centres (PHCs) and 69 out of 1,907 Sub-Centres (SCs), were examined in detail. The audit covered an expenditure of Rs. 27.67 crore (11 *per cent*) out of the total expenditure of Rs. 252.63 crore during this period.

Districts were selected by PPSWR[4] method and CHCs, PHCs, and SCs were selected through SRSWOR[5] method.

1.1.4 Audit objectives

The objectives of the performance audit were to verify whether:-

- planning for the implementation of the Mission as well as monitoring and evaluation procedures at various levels led to an effective health-care delivery system;
- public spending on health sector during 2005-09 increased to the desired level and release of funds, utilization and accounting thereof was proper;
- the Mission achieved capacity building and strengthening of physical and human infrastructure at different levels as planned and targeted;
- the system of procuring drugs, supplies and logistics was efficient and effective and ensured improved availability of drugs, medicines and services etc.;
- the implementation of information, education and communication (IEC) programme was efficient, cost effective and result-oriented;
- the performance indicators and targets fixed, especially in respect of reproductive and child health-care, immunization and disease control programmes were achieved and
- accessible, affordable and accountable public health delivery system for the targeted population, especially socially and economically deprived groups, women and children, was created as envisaged.

1.1.5 Audit criteria

Audit findings were benchmarked against the following criteria:

- Guidelines issued by the GOI/State Government and related instructions issued from time to time.
- Programme Implementation Plans for 2005-09.
- Memorandum of Understanding with GOI.

1.1.6 Audit methodology

An entry conference was held on 6th April 2009 with the Commissioner-cum-Secretary, Health and Medical Education Department, wherein audit objectives, scope, criteria and methodology were discussed. During the meeting, the Department also made a presentation on the status of implementation of NRHM in the State. At the conclusion of audit, the findings were discussed in an exit conference with the Principal Secretary,

[4] Probability Proportionate to Size With Replacement
[5] Simple Random Sampling Without Replacement

Health and Medical Education Department on 26 August 2009 and the replies of the Government have been incorporated in the report at appropriate places.

Audit findings

The important audit findings arising out of the review are discussed below.

1.1.7 Planning and project formulation

NRHM strives for decentralized planning and implementation arrangement to ensure that need-based and community-owned District Health Action Plans form the basis for interventions in the Health sector.

1.1.7.1 Baseline and facility surveys

The Mission envisages carrying out preparatory studies, mapping of services and household and facility surveys to be conducted at village, block and district levels. The household survey, besides identifying underserved/unserved areas, was to assess the health-care requirements at the grass root level and the aim of facility survey was to assess the baseline status of availability of existing health-care facilities in SCs/PHCs/CHCs. The State Health Society (SHS) was to conduct these surveys by March 2008 through local community action by involving trained Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs), Auxiliary Nursing Midwives (ANMs), etc. which were to be finalised by the State Health Resource Centre (SHRC). The DHS/SHS, apart from imparting training to ASHAs, AWWs and ANMs, were required to maintain an authentic central database and develop a mechanism for ensuring reliability and integrity of survey data and use the baseline survey results for future planning.

It was seen in audit that household survey had not been conducted. Facility surveys were got conducted partially through a private firm[6] which conducted the survey at block level only without visiting the health centres (SCs/PHCs). No database on the survey findings was maintained either at the SHS or in the audited DHSs.

1.1.7.2 Perspective and annual plans

The SHS was required to prepare a Perspective Plan for the entire Mission period (2005-12) and annual State level Programme Implementation Plans (PIPs) covering the gaps in the health-care facilities, areas of intervention and probable investment. At the districts level, a Perspective Plan as well as the Annual District Health Action Plans (DHAPs) were to be prepared by the DHS and approved by the District Health Mission (DHM). The State level Perspective Plan was to be prepared by aggregating the district level Perspective Plans.

The NRHM focuses on the village as an important unit for planning; however, the Mission did not insist on Village Health Action Plans (VHAPs) for the first two years (2005-07). Therefore, the DHAPs were to be prepared on the basis of Block Health Action Plans (BHAPs) in the first two years and subsequently on the basis of BHAPs and the VHAPs.

[6] M/S EPOS Health India Limited

The State level PIP is to be prepared every year by the SHS by aggregating the DHAPs for submission to the GOI by mid-December for approval and release of funds by mid-April every year.

It was seen in audit that annual plans were not prepared at the village, block and district levels. Therefore, annual State level PIPs were prepared (2005-09) by the SHS without inputs from the districts. Also, the PIPs were sent to GOI belatedly during all the years (2005-09).

State level and district level Perspective Plans (2005-12) were prepared belatedly (December 2007) through a private firm. As the plans were deficient in certain areas, the SHS directed (May 2009) the firm to revisit almost all activities for preparation of a comprehensive plan. This had not been done (October 2009).

1.1.8 Community participation

1.1.8.1 Village Health and Sanitation Committees (VHSCs)

Village Health and Sanitation Committees (VHSCs) had to be formed in each village within the overall framework of the *Gram Sabha* with representation from disadvantaged categories such as women, SCs/STs/OBCs/Minorities. The VHSC is responsible for village level health planning and monitoring and setting up of a revolving fund at the village level for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization, for which an annual untied grant of Rs. 10,000 is to be provided to each VHSC. The data collected by the ANMs, AWWs and other grass roots functionaries of the health facilities were required to be monitored and validated by the community before their submission to higher authorities for utilization in the monitoring and planning process.

Against 7,537 VHSCs to be constituted by the end of March 2008, 6,788 VHSCs had been constituted at the close of December 2008, which worked out to 90 *per cent* achievement.

For effective implementation of the programme, one of the pre-requisites for receipt of funds by the VHSCs was opening of a bank account by the VHSC. As seen from the progress reports, at the State level, 2,595 VHSCs had not opened their accounts as of December 2008. In five[7] out of six test-checked districts, 593 out of 1,441 VHSCs had not opened their accounts. It was, however, seen that no funds had been provided to the test-checked VHSCs, including the VHSCs which had opened their accounts, by the SHS with the result that revolving funds could not be set up in these VHSCs despite allocation of Rs. 7.54 crore by the GOI during 2007-08. The Block Medical Officers stated that the Village heads/*Sarpanchs* were reluctant to open accounts with their own money, as no provision for advancing money to VHSCs for opening of bank accounts had been kept in the Mission guidelines.

1.1.8.2 Rogi Kalyan Samitis (RKSs)

Rogi Kalyan Samitis (RKSs) were to be constituted at all health-care centres up to PHC level with representation from the legislature, health officials, leading members of the community, SCs/STs/OBCs/minorities, NGOs, local CHC/PHC in-charge and leading

[7] Anantnag, Doda, Leh, Poonch and Rajouri

donors. The Governing Body and the Executive Body of the RKSs were required to hold meetings quarterly/monthly for reviewing the functioning of health-care facilities and recommend improvements to the DHS, on which timely action was to be taken by the Society. Specific funds were to be released to the RKSs in a timely manner to enable them to carry out the functions entrusted to them and they were required to submit a monthly report to the DHS. One of the objectives of the RKS was to develop a Citizen's Charter for each level of health facilities and ensure its display appropriately to make health-care applicants aware of their health rights and facilities. Compliance with Citizen's Charter was to be ensured through operationalisation of a Grievance Redressal Mechanism.

Scrutiny of data relating to composition of RKSs in six test-checked districts showed that though the RKSs were formed at all levels, these did not have adequate representation from NGOs/SCs/STs/OBCs. In two[8] out of six test-checked districts, the executive bodies had not been formed. Regular meetings for reviewing the health-care facilities had not been held as per the schedule in any of the test-checked districts. As a result, no recommendation for improvement of health-care system had been sent to the DHSs.

- SHS/DHS provided Rs. 2.22 crore to 52 RKSs in the six test-checked districts, during 2005-09. These Samitis were able to utilise only 61 *per cent* (Rs. 1.36 crore) and the balance Rs 86.13 lakh have been lying unutilised with them as of March 2009.
- Though Citizen's Charter was developed in district hospitals, at CHC and PHC levels, it was mostly non-existent[9]. Though the system for receipt of suggestions/complaints was partially in place, the complaints received were not on record at any of the health facilities test-checked.
- User charges, to be levied by RKSs, were not being levied/collected at 10 out of 34 test-checked PHCs.

Citizens charter at DHS Rajouri

Thus, RKSs were virtually non-functioning after their formation, which adversely affected the regular management and monitoring of the activities of the health centres.

1.1.8.3 Community interaction

Community interaction was to be catalysed through conducting public hearings (*Jan Sunwai*) or public dialogues (*Jan Samvad*) which were required to be conducted at PHC, block and district levels once or twice in a year as events open to all. Health *Melas* were also to be organized to bring a range of health services to the community and make them aware of their entitlements.

8 Poonch and Rajouri

9 13 out of 18 CHCs and 5 out of 34 PHCs had Citizen's Charter

No health *Melas* been organized in four[10] out of the six audited districts with the result that the mechanism of interaction with the community and mid-course feedback could not largely be achieved. At the State level, four Health *Melas* had been organised by the end of March 2008. Information relating to conduct of Health *Melas* during 2008-09, though called for, was not provided by the SHS. This affected the intended objective of communitisation of activities of the Mission, thereby, weakening the goal of providing accountable health-care services to the rural public.

1.1.8.4 Integration of existing health programmes

The Mission aims at an architectural correction in the health-care delivery system through convergence of various existing stand alone disease control programmes of the Union Ministry of Health and Family Welfare (MoHFW). For this, financial integration of various health programmes/projects like (a) Reproductive and Child Health (RCH), (b) additionalities under NRHM, (c) immunisation and (d) disease control programmes, was to be done with effect from 1 April 2007 for ensuring centralised processing of funds, accountal of expenditure, monitoring of UCs and audit arrangements. However, actual merger with financial integration had taken place in respect of two programmes/projects viz., NPCB and NVBDCP[11] only whereas the integration of programmes like IDSP[12], NPCB[13] NIDDCP[14] had not taken place as of March 2009 and these vertical programmes continued to be funded by each programme division in the Ministry of Health and Family Welfare (MoHFW). The SHS was involved only in incorporating action plans of these societies in the Mission PIP. This resulted in implementation of these programmes outside the ambit of NRHM framework and in a disjointed manner at the State and the District levels. Hence, the desired architectural correction remained unfulfilled.

1.1.9 Financial Management

Funds are released by the GOI through two separate channels-(a) the State Finance Department for Direction and Administration, rural and urban family welfare services and grants to State Training Institutions and (b) directly to the SHS and other vertical societies, by the concerned Programme Division in the MoHFW under each programme. Vaccines, drugs, equipment, etc. are procured centrally and supplied to the State as grants-in-kind based on requirements.

The position of funds received and expenditure incurred thereagainst during the period (2005-09) is given below:

Table 1.1.1

(Rupees in crore)

Year	Opening balance	Releases by GOI	State share	Total	Expenditure (percent)	Closing balance
2005-06	21.92	69.72	-Nil-	91.64	30.49 (33)	61.15
2006-07	61.15	44.95	-Nil-	106.10	41.50 (39)	64.60
2007-08	64.60	162.70	-Nil-	227.30	71.03 (31)	156.27
2008-09	156.27	71.17	12.46*	239.90	109.61 (46)	130.29

(Source: Data provided by the SHS/Member Secretaries of individual disease control programmes/ Director, Family Welfare), *Includes Rs. 5.06 crore released on 18.03.2008 and accounted for in 2008-09

[10] Doda, Rajouri, Poonch and Leh

[11] National vector borne disease control programme

[12] Integrated disease surveillance Project

[13] National programme for control of blindness

[14] National iodine deficiency disorder control programme

The under-utilisation was due to delay in finalisation of annual PIPs as brought out in the preceding paragraphs and tardy implementation of various Mission components at health centre level. The under-utilisation resulted in non-achievement of targets in areas like infrastructure and services identified in the PIPs, as brought out in subsequent paragraphs.

1.1.9.1 Annual Maintenance Grant

Against the 'annual maintenance grant' of Rs. 0.50 lakh payable to each PHC housed in a Govt. building, the SHS had released Rs. 32.50 lakh and Rs. 52.50 lakh to 65 and 105 PHCs housed in rented private buildings during 2006-07 and 2007-08, respectively, resulting in avoidable extra expenditure of Rs. 85 lakh. The Project Director stated (November 2008) that the releases were made on the information furnished by the Directors, Health Services, Kashmir and Jammu. It was also stated that the excess amount would be recovered. The possibility of recovery was, however, remote as the PHCs had utilised these amounts on maintenance of the rented buildings as observed in three[15] out of 34 test-checked PHCs. However, the State Government projected the maintenance grant in respect of 375 PHCs in PIPs for 2008-09 and 2009-10, and received Rs. 1.08 crore in excess, which is held by the SHS (March 2009).

1.1.9.2 Maintenance of accounting records

NRHM guidelines prescribe maintenance of Cash Book on double entry system along with ledger accounts and audit by Chartered Accountants (CA). Cash Books were not maintained on double entry system at SHS (except in 2007-08) and in three[16] out of six districts test-checked (2005-09). Nor had any ledger account been maintained as envisaged under the guidelines. Cash book at DHS, Doda was written (May 2009) upto October 2008 and no Cash Books were maintained by Kandi Block and PHC Siot (Rajouri district), Mandi block (Poonch district) for 2008-09 and Sopore and Tangmarg blocks of Baramulla (except 2008-09). Reasons, though called for, were not assigned.

- A difference of Rs. 2.43 crore for the years 2005-06 to 2007-08 was noticed between the Financial Management Report (Rs. 60.56 crore) and funds actually utilised (Rs. 58.13 crore) by the SHS as of March 2008. The Project Director stated that part expenditure had been disallowed by the CA due to non-production of vouchers by the DHSs, at the time of audit by the CA. The Joint Director (P&S), H&MED stated (October 2009) that there existed a variation of Rs. 9.96 lakh and Rs. 4.61 crore for the years 2005-06 and 2006-07 respectively, out of which Rs. 2.26 crore were cleared during 2007-08, leaving a variation of Rs. 2.5 crore as of March 2008. However, the details of uncleared amounts pertaining to the period 2005-07, were not furnished, in absence of which audit could not verify whether the amounts having been left un-audited during these years were actually cleared in full or not.

- Supporting vouchers for Rs. 29.18 lakh spent at district and block level of Rajouri and Poonch districts[17] were not produced to audit. It was stated that the vouchers

[15] PHCs Changa, Malanoo, Bhalla of Doda District

[16] Doda, Poonch and Rajouri

[17] DHS Rajouri- Rs. 11.33 lakh, Block Kandi-Rs. 15.04 lakh, PHC Siot- Rs. 1.29 lakh, PHC Jamola-Rs. 0.07 lakh and SCs, PHCs Block Surankote Poonch- Rs. 1.45 lakh

were not traceable from the records. In the absence of supporting vouchers, the veracity of the expenditure of Rs. 29.18 lakh can not be vouched.

- No reconciliation was conducted between GOI, SHS, DHS, Blocks and with the banks, which resulted in excess release of Rs. 41.60 lakh[18]. It was stated that the excess amount released would be recovered.
- Rupees 6.95 lakh released (2007-09) by the SHS to District Hospital, Rajouri (Rs. Five lakh) and two health centres[19] by the DHS, Rajouri/Doda was not received (June 2009) by these health centres even after gaps of six months to one year. The Medical Superintendent, District Hospital, Rajouri and In-charge SC, Jawahar Nagar, Rajouri informed (May 2009) that they had no knowledge of any such amounts having been released by the SHS/DHS, whereas the MO, PHC, Bhagwah, Doda informed (April 2009) that the amount had been wrongly credited into a different bank account and efforts were on to recover the said amount. This is indicative of the fact that periodic reconciliation of accounts of SHS/DHS with that of the field units had not been conducted.

1.1.9.3 Untied funds

Untied funds were to be utilised for activities such as minor modifications, *adhoc* payment for cleaning, transportation of emergency cases to referral centres, purchase of bleaching powder and disinfectants, provision of running water, repair of soak pits, etc. Similarly, Annual Maintenance Grant was to be utilised for maintenance of SCs, PHCs and CHCs which include minor modifications to the health centres.

The intended purpose of untied funds and AMG is to facilitate health centres to meet urgent yet discreet activities that need small sums of money. Audit scrutiny showed that out of Rs 1.43 crore expended in the test-checked health centres, Rs. 18.24 lakh (13 *per cent*) were spent on purchase of furniture, stationery, office expenses, etc. which was prohibited under the guidelines. As the health centres used these funds to meet their routine requirements under office expenses, the intended purpose was defeated. The concerned BMOs/MOs/In-charge, CHC/PHC/SC stated that in the absence of guidelines, the funds could not be utilised on approved activities. The reply is incorrect, as the guidelines are appended with each release order while releasing the funds.

1.1.10 Capacity building

The Mission envisages creation of infrastructure/buildings for health centres (District hospitals, CHCs, PHCs and SCs) and strengthening of the existing ones after assessment of existing load and requirement for creation/up-gradation in view of potential increase in the number of patients after improvement of services.

1.1.10.1 Physical infrastructure

A target of providing one SC for a population of 4,000 (3,000 in tribal areas), one PHC for population of 25,000 (20,000 in hilly and tribal areas) and one CHC for population of 1,00,000 (80,000 in hilly and tribal areas) was set under the Mission.

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[18] Rs. 17 lakh by SHS to DHS Kupwara, Rs. 17.10 lakh by DHS Doda to 4 blocks and Rs. 7.50 lakh by Block Mandi (Poonch) to 6 PHCs

[19] Rs. 1.75 lakh to PHC Bhagwah, Doda and Rs. 0.20 lakh to SC Jawahar Nagar, Rajouri

The position of infrastructure required as per norms, available in the State as on 1st April 2007 and that to be created by the end of the Mission period and by March 2009, is as under:

Table 1.1.2

(In numbers)

Particulars	Sub centre	PHC	CHC	District hospital
Requirement as per norms Based on PIP 2007-08 projections. Total population of the State: 1.01 crore (2001 census)	3,381	489	121	22
Existing as on 1 April 2007	1,907	375	85	14
Additional requirement to be completed in the Mission period 2005-12	1,474	114	36	8
To be completed up to March 2009as per PIP 2007-08	Not targeted	80	21	8
Constructed up to March 2009	Nil	Nil	Nil	Nil

(Source: PIPs/Progress Reports of Director Health Services)

Against additional requirement of 1,474 SCs, 114 PHCs, 36 CHCs and eight District hospitals, the Department targeted construction of 80 PHCs, 21 CHCs and eight District hospitals by the end of March 2009. However, no new health centre had been constructed in the State during this period.

An amount of Rs. 20 crore earmarked (2007-2008) by the GOI for construction of new SCs/PHCs had not been utilised due to non-release of funds by the SHS to the line departments. There was an overall shortage of 44 *per cent* SCs, 23 *per cent* PHCs and 30 *per cent* CHCs in the State as of March 2009. Reasons for non-release of the funds, though called for in audit, were not assigned.

- The Department initiated up-gradation of existing CHCs to bring those up to Indian Public Health Standards (IPHS). 68 CHCs (estimated cost: Rs. 8.94 crore) out of 85 CHCs, taken up (April 2006 to January 2008) for up-gradation within three to four months, only 22 CHCs (32 *per cent*) had been up-graded as of March 2009. Of the 22 up-graded[20] CHCs, only 18 had been handed over[21] to the Department as of March 2009. The Director Health Services, Jammu stated that the executing agencies would be requested to expedite completion of remaining works. The Director Health Services, Kashmir, did not furnish any reasons for the delayed executions.
- Works on five[22] out of 68 CHCs taken up for up-gradation (estimated cost: Rs. 86.14 lakh), on which Rs. 26.50 lakh (out of Rs. 84.41 lakh) had been spent were held up for the last one to three years due to change in site, land dispute, lack of designs, etc. The Director Health Services, Jammu, while stating (September 2008) that the works would be started soon, was silent about the reasons for non-identification of proper sites to avoid land disputes and non-framing of designs in time to accomplish the task.
- Out of Rs. 96.33 crore released (2006-09) for 157 works relating to strengthening/up-gradation of PHCs/CHCs/Sub-district hospitals/district hospitals,

[20] Jammu Division: 14, Kashmir Division: 08

[21] Jammu Division: 10, Kashmir Division: 08

[22] Bani, Darhal, Kalakote, Kandi and Mandi

the DHSs[23]released Rs. 83.51 crore[24] to the implementing agencies during 2007-09, retaining Rs. 12.83 crore (Director Health Services, Kashmir: Rs. 5.04 crore; Jammu: Rs. 7.79 crore) which had been lying unspent as of March 2009. The Director Health Services, Kashmir stated that land was not identified for construction. The reply should be viewed in the light of the fact that the land was to be identified by the Department while projecting the demand in the PIP. The Director Health Services, Jammu stated that funds could not be released due to non-finalisation of Detailed Project Reports (DPRs).

1.1.10.2 Status of infrastructure at health centres

The Mission targeted provision of certain guaranteed services for different levels of health centres as per the norms of Indian Public Health Standards (IPHS). However, critical gaps in infrastructure could not be filled to a significant extent despite availability of funds as can be seen from the position of availability of services in the test-checked health centres depicted below.

Table 1.1.3

Particulars	Sub-centres	PHCs	CHCs
Number of health centres test-checked	**69**	**34**	**18**
Centres housed in private buildings	46	8	1
Buildings in bad condition	45	11	5
Poor cleanliness	19	8	1
Citizen's charter not displayed	66	29	5
Complaint box not maintained	69	27	5
Separate utilities for men and women not present	67	24	6
Operation theatres not existing	NA	33	5
Labour rooms not present	66	13	2
Separate male/female wards not present	NA	28	3
No waiting rooms	NA	20	12
No provision for water supply	45	8	1
No provision for water storage	69	20	6
No sewerage facilities	NA	21	7
No bio-waste disposal facility	69	34	18
No electricity	62	2	-
No standby power	NA	23	-
No telephone facility	69	33	7
No computers	NA	32	4
No accommodation for staff	67	22	11

Source: Data furnished by the SCs/PHCs/CHCs,
*Percentage with reference to audited health centres

While the envisaged guaranteed services at CHCs were partial, at the SC and PHC level, a majority of these services were not being provided despite availability of funds.

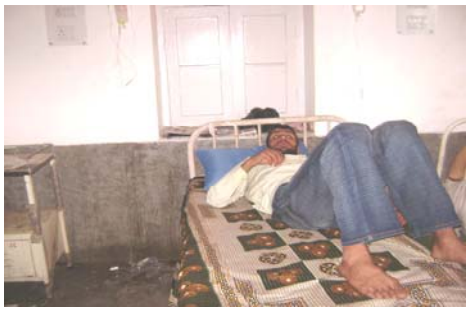
[23] Jammu and Kashmir

[24] Jammu: Rs. 38.38 crore; Kashmir: Rs. 45.13 crore

Illustrative photographs of working conditions of health centres are given below:

Unhygienic waste disposal at CHC Gandoh, Doda (Left), CHC Bhaderwah, Doda (Right)

Clean Medical wards (CHC Bhaderwah)



Unclean medical ward (DH Rajouri)

OPD room at PHC Hariwatnoo, Tangmarg

Make-shift Labour room at PHC Hariwatnoo

1.1.10.3 Facilities at health centres

The status of various facilities in the 69 SCs, 34 PHCs and 18 CHCs test-checked in audit was as under:

- The Mission provides for daily OPD services at each PHC and CHC. It was encouraging to see that the OPD service was running on daily basis in all the PHCs and CHCs.

OPD in CHC Sunderbani

- The Mission provides for six and 30 bed in-patient services at the PHC and the CHC respectively. Only eight out of the 34 PHCs (Jammu: 0, Kashmir: 8) had functional in-patient service with full bed strength. Remaining 20 PHCs (Jammu: 12, Kashmir: 8) had in-patient service with only one to five beds and in the remaining six PHCs (Jammu: 6) the service was not available.

  Further, only 11 CHCs (Jammu: 5, Kashmir: 6) had functioning in-patient service with full complement of 30 beds. Availability of beds in the remaining seven CHCs (Jammu: 4, Kashmir: 3) ranged between 10 and 24.

- The Mission stipulates an operation theatre at each CHC. However, only ten CHCs (Jammu: 4, Kashmir: 6) had a functional operation theatre, three CHCs (Jammu: 2, Kashmir: 1) had a non-working/defunct operation theatre and five (Jammu: 3, Kashmir: 2) had no operation theatre.

Functional Pathological Laboratory at PHC Hariwatnoo, Tangmarg

Under-construction Labour room, operation theatre and blood bank at CHC Gandoh, Doda. Equipment already received.

- Under the Mission, every PHC and CHC is to have a labour room for safe delivery. Labour room was available in 21 out of 34 PHCs (Jammu: 10, Kashmir: 11) and in 16 out of 18 CHCs (Jammu: 8, Kashmir: 8) checked in audit.

- Essential diagnostic services were envisaged to be provided by the PHCs and CHCs. It was seen in audit that in 23 PHCs, (Jammu: 12, Kashmir: 11) diagnostic services were available whereas remaining 11 PHCs (Jammu: 6, Kashmir: 5) had no

facilities for laboratory services. Full diagnostic services were available in all 18 test-checked CHCs (Jammu: 9; Kashmir: 9).

The Mission provides for blood storage facilities at every CHC. However, only two CHCs (Jammu: 0, Kashmir: 2) out of 18 test-checked had this facility.

	
Non-functional blood bank at CHC Sunderbani, Rajouri	*Labour room at CHC Gandoh, Doda*
	
Well maintained OPD room PHC Siot, Sunderbani, (Rajouri)	*Well maintained wards PHC Balshama, Rajouri*

- NRHM provides for 24 hour emergency services for management of injuries and accidents, first-aid, dog/snake/scorpion-bite cases, etc. and stabilization of patients before referral by posting three staff nurses at PHCs.

  It was seen in audit that only 18 out of 34 PHCs (Jammu: 5, Kashmir: 13) were providing emergency services. The lack of services in other PHCs was due to non-availability of staff/equipment, etc.

- The Mission aims to provide AYUSH services in accordance with the local tradition by providing an AYUSH doctor at PHCs and at CHCs. However, no AYUSH practitioner was provided at 15 out of 34 PHCs (Jammu: 0, Kashmir: 15) and 9 out of 18 CHCs (Jammu: 0, Kashmir: 9). Thus, the aim of mainstreaming of AYUSH services in NRHM has largely remained un-achieved.

- A Mobile Medical Unit (MMU) was to be provided in every district, particularly in hilly districts, to enable outreach services. Records showed that no Mobile Medical Unit was procured by the State despite the GOI releasing Rs. 6.94 crore during 2007-08 for the purpose. The amounts has been lying unspent with the SHS as of

March 2009, which seriously affected the goal of providing reliable and quality medical care at the doorstep of rural population.

1.1.11 Human resource

The NRHM aims at providing adequate qualified/trained manpower at all levels of health centres.

1.1.11.1 Shortage of manpower

As per the norms, every SC should have at least two ANMs, each PHC must have at least two Medical Officers and three Staff nurses and each CHC should be provided with seven Specialists. The status of manpower at the audited SCs/PHCs/CHCs is detailed below:

Table 1.1.4

Particulars	Total cases found	As percent of total number audited
SUB CENTRES (TOTAL NUMBER AUDITED 69)		
Without two ANMs	63	91
Without one regular ANM	4	6
Without one MPW	24	35
PRIMARY HEALTH CENTRES (TOTAL NUMBER AUDITED: 34)		
Without a Medical Officer (Allopathic)	11	32
Without an AYUSH Medical Officer	15	44
Without any Medical Officer	2	6
Without three Staff Nurses	26	76
Without one Staff Nurse	10	29
Without a Nurse Mid-wife	34	100
Without a Lab Technician	6	18
COMMUNITY HEALTH CENTRE (TOTAL NUMBER AUDITED: 18)		
Without a General Physician	12	67
Without a General Surgeon	10	56
Without an Obstetrician & Gynaecologist	17	94
Without a Paediatrician	14	78
Without an Anaesthetist	10	56
Without nine Staff Nurses (two of them may be ANMs)	15	83.
Without one Staff Nurse	1	6
Without a radiologist	10	56

(Source: Data furnished by the SCs/PHCs/CHCs)

The above table indicates the widespread shortage of critical manpower at the health centres. Status of availability of manpower at State level was not maintained by the State.

1.1.11.2 Appointment of contractual staff

The NRHM guidelines fixed the range for posting of medical/para-medical staff in CHCs, PHCs and SCs. The position of the number of staff required and that posted thereagainst during 2005-08 in four[25] out of the six audited districts is detailed in the table below. The position of the staff as of March 2009 was not provided.

[25] Rajouri, Poonch, Doda and Leh

Table 1.1.5 Targets and achievements/Requirement of staff in four test-checked districts as on 31.3.2008

Name of the post	Staff required as per NRHM norms	Men in position (31.3.2006)	Shortage as on 31.3.2006 (percentage)	Contractual staff		Overall shortage ending March 2008
				Targeted for engage-ment during 2005-08	Actually engaged during 2005-08	
Medical Officer	156	64	92 (59)	83	10	82 (53)
Specialist Doctor	147	43	104 (71)	6	0	98[26] (67)
AYUSH practitioner	78	22	56 (72)	42	42	14 (18)
ANM	1,041	471	570 (55)	102	63	507 (49)
Staff Nurse	381	129	252 (66)	88	42	210 (55)
Pharmacist	99	127	(-) 28	0	0	0
Lab Technician	99	104	(-) 5	11	11	0
Other medical/ paramedical staff	-	-	-	84	44	0
District Programme Manager (DPM)	4	0	4 (100)	4	4*	0
District Finance Manager (DFM)	4	0	4 (100)	4	3*	1 (25)
District Data Manager (DDM)	4	0	4 (100)	4	3*	1 (25)
Block Programme Manager	23	0	23 (100)	23	17	6 (26)
Total	**2,036**	**960**	**1,076 (53)**	**451**	**239**	

(Source: Data furnished by the DHS)
* One each DPM, DFM and DDM left the job in District Doda during 2008-2009

As on 31 March 2006, there was a shortage of 1,076 (53 *per cent*) personnel in four test-checked districts. While the shortage of doctors and specialists ranged between 59 and 71 *percent*, the shortage of technical staff was in the range of 55 and 72 *per cent.* In the remaining two test-checked districts, the shortages could not be ascertained due to overlapping of manpower between general and NRHM. As per the Mission guidelines, the Department could appoint contractual staff to fill the vacancies. However, as against targeted recruitment of 451 personnel, only 239 (53 *per cent)* personnel had been appointed during 2006-08, due to non-recruitment by the concerned District Development Commissioners (DDCs), who are vested with powers to recruit the contractual staff. It was also seen that local residence criteria in appointments, envisaged under the Mission guidelines in 103 cases, had not been adhered to. The DHSs stated that the appointment of the contractual staff was the responsibility of the DDCs to whom the matter had been referred to from time to time.

1.1.11.3 Engagement of ASHAs

Under the Mission, a trained female community health worker called Accredited Social Health Activist (ASHA) is to be provided in each village in the ratio of one per population of 1,000 people (or less, for large isolated habitations). The ASHA was expected to act as an interface between the community and the public health system. The job of ASHA included mobilisation of children for vaccination, encouraging institutional deliveries, increasing anti-natal checkups (ANCs), etc. No fixed remuneration has been fixed for ASHA under the Mission. However, they are to be paid on the basis of number

[26] Six regular specialist doctors posted during 2006-08 in Leh

of cases of immunisation, institutional deliveries, etc. brought by them out of funds provided under Immunisation and *Janani Suraksha Yojana* (JSY).

The status of engagement of ASHAs in the test-checked districts as of March 2009 is given below.

Table 1.1.6

Name of the district	Total rural population (2001) (In lakh)	Number of ASHAs required	Number of ASHAs engaged (March 2009)	Gap Excess(+)/ Shortfall (-)
Total for the State	**76.27**	**7627**	**9764**	**2137**
Anantnag	10.04	1,004	1,281	(+) 277
Baramulla	9.73	973	1,365	(+) 392
Leh	0.89	89	241	(+) 152
Doda	6.44	644	700	(+) 56
Rajouri	4.50	450	410	(-) 40
Poonch	3.49	349	294	(-) 55
Total	**35.09**	**3,509**	**4,291**	**(+) 782**

(Source: Data furnished by the DHS)

Against a requirement of 3,509 ASHAs, 4,291 ASHAs had actually been engaged in the six audited districts as of March 2009. The overall position at the State level, based on census 2001, too showed that there was excess deployment of ASHAs against the target numbers. The excess deployment may be attributed to scattered population in the hilly districts of the State.

The following shortcomings in engagement of ASHAs were seen in audit.

- In 118 cases, ASHAs were selected in contravention of the norms (formal education upto eighth class).
- The role/responsibility of ASHAs were required to be popularised by the facilitators in the villages through interaction with the community; however, it was not done in any of the villages of audited districts.
- Block facilitators were not engaged to evaluate the performance of ASHAs. Further, closure of *Janani Suraksha Yojna* (JSY) scheme from April 2007 to January 2009 and subsequent non-payment of incentive to beneficiaries resulted in under-performance by the ASHAs in bringing cases for institutional deliveries and other allied activities entrusted to them during this period. This can be gauged from the fact that the antenatal care (ANC) check-ups fell from 48 *per cent* in 2005-06 to 40 *per cent* in 2008-09.

Meeting of ASHAs in progress, CHC Gandoh

1.1.11.4 Training

One of the aims of the NRHM was capacity building of human resources through skill up-gradation of the medical and support personnel by imparting periodical training to them. The details in this regard are tabulated below:

Table 1.1.7: Details of training provided

Post	2006-07		2007-08	
	T*	A**	T	A
ASHA	700		9,500	
	Module I	685		8,815
	Module II	Nil		7,091
RMP/TBA	2,000	1,658	-	29
ANM	498	549	164	63
Staff Nurse	200	132	-	20
Medical Officer	322	262	78	64
Programme Manager	0	0	28	25
Total	**3,720**	**3,286**	**9,770**	**9,016**

(Source: Status reports of SHS), # Data for 2008-09 not provided by the SHS
* Targets; ** Achievements

The Department had not set any target for training in 2005-06 and data relating to training for 2008-09 was not provided to audit.

1.1.12 Procurement of drugs and supplies

The Mission norms provide for preparation of a drug policy/formulary list of drugs with an objective of procuring drugs that are economically priced, safe and effective. Under the Mission, the aim of a drug policy/formulary list of drugs is to use a limited number of carefully selected medicines, based on the agreed clinical guidelines for better supply of medicines and rational prescriptions. It also aims at controlling expenditure and allowing procurement of drugs economically with competitive drug prices and simplified supply management procedures.

It was noticed in audit that neither a drug policy nor a common formulary or essential drug list had been formulated for ensuring better and rational supply of medicines. However, the purchases were made through the centralised State Level Purchase Committee.

Further, out of Rs. 6.23 crore released for procurement of medicines, during the years 2005-09, Rs. 5.28 crore had been utilised by the State Government and the balance Rs. 95.33 lakh had remained unutilised due to inability of the SHS to procure drug kits ordered in June 2007. Order for supply of various drug kits (First Referral Unit (FRU) Kits- 28, CHC Kits–52, PHC Kits-334, RTI/STI Kits-28, SC Kits-3814 and ASHA Kits-9500) at a cost of Rs. 5.79 crore was placed (June 2007) with a firm[27] for supply within 45 to 60 days. The supplier had not supplied the entire lot of the ordered quantity and kits worth Rs. 86 lakh (FRU Kits-28 and CHC-52) had not been received as of March 2009. The Department had not pursued the matter with the supplier for supply of the balance quantity for about one and a half years despite availability of funds which had affected the delivery of health-care services at health centres.

1.1.13 Information, Education and Communication

The Information, Education and Communication (IEC) strategy under the Mission aims to facilitate awareness and dissemination of information regarding availability of and

[27] M/S Karnataka Antibiotics Limited

access to quality health-care for the poor, women and children in rural areas. The focus of IEC activities during the period 2005-08 was on themes like *Janani Suraksha Yojana* and institutional deliveries, routine immunisation, Post Natal Diagnostic Test and girl child breast feeding, positioning of ASHA, diseases control programmes, contraceptive choice, spacing, etc.

As per the norms, allocations upto Rs. 10 per capita are to be made at national, state and district levels for carrying out a variety of activities involving communities and also the media. Further, the allocations are to be spent equally (one third) at the three levels i.e. national, state and district level. Funds available at the district level were meant for carrying out the activities at the block and village levels also.

Scrutiny revealed that though an IEC bureau was set up, it had not undertaken any activity at the block/village levels. Against an amount of Rs. 2.18 crore provided (2005-08) by the GOI under IEC to the SHS, only Rs. 92 lakh (42 *per cent*) had been expended on 18 different activities[28] covering IEC and balance was lying with the State/District authorities. The expenditure was in the ratio of 67:33 at State and district levels against the permissible ratio of 50:50. No funds were spent at block/village level thereby violating the provisions of the guidelines. No data for 2008-09 was made available by the SHS. As per the information provided by the SHS, no training in IEC activities for State and block level officers had been planned or provided. Only 17 district level officers had been trained in the State (2005-08). No evaluation of IEC activities had been conducted.

1.1.14 Performance Indicators

The impact of NRHM would largely be reflected through various performance indicators like the total fertility rate (TFR), infant mortality rate (IMR), material mortality rate (MMR), institutional deliveries, status of immunisation, etc.

The State indicators vis-a-vis national indicators for the health sector are given in the table below.

Table 1.1.8

Item	Jammu and Kashmir	India
Crude Birth Rate (SRS 2007)	19.0	23.1
Crude Death Rate (SRS 2007)	5.8	7.4
Total Fertility Rate (SRS 2007)	2.3	2.7
Infant Mortality Rate (SRS 2007)	51	55
Maternal Mortality Ratio (SRS 2004-2006)	NA	254

(Source: Web site of NRHM)

While the status of health profile of the State has been quite encouraging vis-à-vis the performance indicators available for the country, these can be further improved if there is proper fund management/utilisation and various sectors involved are covered in conformity with the guidelines issued for implementation of the Programme.

[28] Activities like display of advertisements through electronic and print media, exhibitions, health *melas*, seminars, wall hangings, etc.

1.1.15 Reproductive and Child Health II (RCH-II) programme

The RCH-II under the Mission aims to reduce maternal/infant mortality and total fertility rate and promote family planning, immunisation, etc. to achieve population stability and register all the pregnant women before they attain 12 weeks of pregnancy to provide them necessary services/medicines. Under the maternal health, the RCH II aims to reduce maternal and infant mortality rates to 100 per lakh and 30 per thousand respectively, by 2010. The important services for ensuring maternal health and care include antenatal care (ANC), institutional delivery care, post natal care and referral services.

1.1.15.1 Maternal health

Registration of pregnant women is the basic requirement for delivery of services. Besides, early detection of complications during pregnancy by four prescribed antenatal check-ups is an important intervention for preventing maternal mortality and morbidity. The RCH II programme emphasised Iron Folic Acid (IFA) administration for pregnant women. Prophylaxis against anaemia in a pregnant woman requires a daily dose of large Iron Folic Acid tablets for a period of 100 days. It was seen in audit that while the ANC check-ups have still to cover extensive ground, the IFA administration declined alarmingly.

It was seen that the number of registered pregnant women increased during 2005-08 but decreased marginally during 2008-09. At the State level[29], the number of registered pregnant women, who got three/four ANC check-ups, declined from 48 *per cent* in 2005-06 to 40 *per cent* during 2008-09. However, in the audited districts the position had increased from 25 to 37 *per cent*. The number of registered pregnant women, at the State level, who were provided with 100 days of IFA tablets, witnessed a declining trend from 63 to 23 *per cent* during 2005-09 due to poor response of pregnant women which can primarily be attributed to stoppage of JSY payments to beneficiaries as brought out in paragraph 1.1.11.3 and non-availability of tablets during 2008-09 due to non-receipt of these tablets from the GOI. In the audited districts, it declined from 59 to 36 *per cent*. The district level and State level data is given in **Appendix 1.1.**

Year-wise details for the State, as a whole, are depicted in the following table.

Table: 1.1.9

Year	No. of pregnant women		
	Registered at any health centre	Received third/fourth antenatal checkups	Received 100 days of IFA tablets
2005-06	3,05,121	1,47,391 (48)	1,92,701 (63)
2006-07	3,95,571	1,44,767 (37)	1,77,323 (45)
2007-08	4,01,464	1,27,912 (32)	1,63,373 (41)
2008-09	3,90,266	1,56,637 (40)	89,485 (23)

(Source: Progress Reports/Data furnished by the SHS)
(Figures in parenthesis indicate percentage)

1.1.15.2 Tetanus Toxoid immunization

Two doses of tetanus toxoid have been prescribed for all pregnant women to immunise the mother and neonates from tetanus. It was seen in audit that no improvement was

[29] Data furnished by SHS

achieved; however, there was a slight decline as detailed below.

At the State level, the number of targeted pregnant women, who were provided with two doses of TT immunization during 2005-09, declined from 70 to 64 *per cent*.

Table 1.1.10: State level TT immunisation

Year	Target	Achievement (Percentage)
2005-06	3,44,239	2,40,410 (70)
2006-07	3,75,800	2,69,468 (72)
2007-08	3,84,800	2,68,331 (70)
2008-09	3,71,657	2,37,947 (64)

(Source: Progress Reports/Data furnished by the SHS/DHS)

In the audited districts, the TT immunization declined from 80 to 70 *per cent* as depicted in the following table.

Table: 1.1.11: District level TT immunisation

District	TT immunisation (in thousand)							
	2005-06		2006-07		2007-08		2008-09	
	T	A	T	A	T	A	T	A
Leh	2,306	2,173	2,713	2,700	3,489	3,300	1,342	954
Anantnag	62,954	62,954	64,262	64,262	56,143	56,143	19,468	19,468
Rajouri	13,235	13,041	17,745	14,155	18,271	14,331	19,190	16,270
Doda	23,885	11,998	24,363	15,491	24,850	13,801	25,347	16,594
Baramulla	29,062	14,731	38,072	11,625	25,245	15,229	31,815	12,676
Poonch	NA	10,170	11,210	11,368	14,656	12,958	13,360	11,360
Total	**1,31,442**	**1,04,897 (80)**	**1,58,365**	**1,19,601 (76)**	**1,42,654**	**1,15,762 (81)**	**1,10,522**	**77,322 (70)**

(Source: Progress Reports/Data furnished by the SHS/DHS)

1.1.15.3 Institutional delivery

To encourage institutional delivery, the Janani Suraksha Yojana provided all pregnant women in low performing States and BPL pregnant women in high performing States a cash compensation[30] for undergoing institutional delivery irrespective of their age and number of children with them. The ASHA who helped the pregnant woman also received a cash compensation of Rs. 600 per case.

It was seen that at the State level, the number of targeted pregnant women who underwent institutional delivery during 2005-09 ranged between 58 and 86 *per cent* and women who received cash assistance ranged between one and 10 *per cent* as depicted in following table.

Table 1.1.12

Year	Target	Achievement	JSY Payment
2005-06	1,20,000	85,135 (71)	663 (01)
2006-07	1,31,925	1,13,698 (86)	11,462 (10)
2007-08	1,77,263	1,51,144 (85)	10,038 (07)
2008-09	2,62,609	1,51,783 (58)	No data

(Source: Data furnished by the Director Family welfare and status report of SHS)

[30] Rs. 700 upto 31.03.2007 and Rs. 1400 with effect from 01.04.2007

In the audited districts, only one to 11 *per cent* of the total women who underwent institutional deliveries during 2005-09 had been paid cash assistance and that too with delays ranging between one to seven months due to non-provision of imprest with ANM and non-availability of funds under the JSY scheme.

It was seen in audit that the aim of encouraging institutional delivery was hampered by large scale non-availability of 24x7 delivery services at PHCs. At the State level, out of total 375 PHCs, only 96 PHCs had facility of 24x7 delivery services. The facility assessment at 34 audited PHCs revealed that the facility of 24 hour delivery services was available only at 18 PHCs. The non-availability of delivery services was attributed to insufficient staff and non-availability of labour rooms at the PHCs.

1.1.15.4 Obstetric care

Essential obstetric care includes antenatal care, supply of essential obstetric drugs, neonatal resuscitation and equipment for new born, etc. Information made available to audit shows that 15 out of 18 CHCs test-checked had no emergency obstetric care, including the facility of caesarean section, due to absence of specialists in obstetrics and gynaecology, anaesthetist, functional operation theatre, adequate infrastructure, support staff, blood storage facility, etc.

1.1.15.5 Postnatal services

Postnatal services include immunisation, monitoring the weight of the child, physical examination of the mother, advice on breast feeding and family planning, etc. It was seen in audit that customer response to postnatal services was poor and in two[31] out of the six audited districts, the number of registered women who visited health centre for postpartum care during 2005-09 ranged between five and nine *per cent* only. No records in this regard were maintained in any of the health centres in the remaining four[32] test-checked districts.

1.1.16 Reproductive health care

1.1.16.1 Reproductive Tract Infections and Sexually Transmitted Infections

The scheme envisages establishment of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI) clinics at each district hospital and first referral unit/CHC.

Information regarding RTI/STI clinics established in district hospitals and CHCs in the State was not available at SHS. However, all the audited district hospitals and 10 out of 18 test-checked CHCs had RTI/STI clinics. In four CHCs, the laboratory for RTI/STI diagnosis was not fully equipped.

1.1.16.2 Medical termination of pregnancy

Medical termination of pregnancy (MTP) is permitted in certain conditions under the MTP Act, 1971. 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. The relevant records of the facilities for MTP in health centres were not

[31] Anantnag and Leh

[32] Poonch, Rajouri, Doda and Baramulla

made available by SHS. However, the facility of MTP was found to be available in 12 out of 18 CHCs and 14 out of 34 PHCs audited.

1.1.16.3 Spacing methods

Family planning under the Mission includes terminal method to control total fertility rate (TFR) and spacing method to improve couple protection ratio, to achieve the goal of population stabilisation. The terminal method of family planning includes vasectomy for male and tubectomy for female. At the State level, no targets were fixed for 2005-08. For 2008-09, the shortfall ranged between 19 and 33 *per cent* against targets set for tubectomy and vasectomy.

During 2005-09, at the State level, the proportion of vasectomy to the total sterilisation was only five *per cent*. In audited districts, vasectomy operations constituted 0.4 to 28 *per cent* of the total sterilisation, indicating a gender imbalance impacting the programme. The proportion of vasectomy has not increased even after the launch of the non-scalpel vasectomy.

While female sterilisation is the most commonly adopted method, the programme emphasises laparoscopic tubectomy as preferable to conventional tubectomy. At the State level, the performance of laparoscopic tubectomy was at 67 *per cent* of total female sterilisations, whereas in audited districts, it stood at 70 *per cent*. The reason for low performance was seen to be lack of trained doctors in all PHCs and CHCs and lack of adequate equipment.

Oral pills, condoms and Intra Uterine Device (IUD) insertions are the prevailing spacing methods of family planning to regulate fertility and promote couple protection ratio. Even though the use of spacing methods as such was low, among the total spacing method users, around 92 *per cent* accounted for condom alone and seven *per cent* for oral pills and only one *per cent* for IUD, as depicted in the following table.

Table 1.1.13

Year	Oral pills cycle		IUD insertion		Distribution of condoms	
	T	A	T	A	T	A
2005-06	1,63,127	1,44,976	37,836	29,076	22,94,000	11,78,673
2006-07	1,76,580	1,51,124	33,940	29,890	19,24,700	19,75,934
2007-08	2,03,589	1,81,299	38,284	26,173	22,35,528	30,55,446
2008-09	2,30,621	1,90,113	30,301	26,093	38,88,417	21,85,972
Total	**7,73,917**	**6,67,512**	**1,40,361**	**1,11,232**	**1,03,42,645**	**83,96,025**

(Source: Progress Reports/data furnished by SHS/DHS)

Free distribution of condoms and oral pills were found satisfactory and were available at all the audited SCs, PHCs and CHCs.

The position stated in the foregoing paragraphs is indicative of the fact that significant deficiencies in the Maternal and Child health programmes exist and these have not been able to attract adequate customers as they may not be entirely satisfied with the services being rendered.

1.1.17 Immunisation and child health

Strengthening of services to improve child survival with focus on preventive aspects such as control of vaccine preventable diseases, diarrhoea, and acute respiratory infection among infants and children of less than five years, is a major component of the Mission.

At the State level, the overall shortfall in achievement of full immunisation of children between zero to one age group covering BCG, Measles, DPT and OPV ranged from six to 25 *per cent* during 2005-09. Similarly, for secondary immunisation, children in age group of five to six years were required to be administered Diphtheria and Tetanus (DT) and two doses of Tetanus Toxoid (TT) at the age of 10 and 16 respectively. The shortfall in achievement of the targets in the secondary immunisation ranged from nine to 31 *per cent* for DT, 25 to 54 *per cent* for TT (above 10 years) and 38 to 60 *per cent* for TT (above 16 years) during the same period as depicted in the following table.

Table 1.1.14

(In thousands)

Year	Target	Achievement				FI[33]	DT		TT(10)		TT(16)	
		BCG	Measles	DPT	OPV		T	A	T	A	T	A
2005-06	332	312	278	284	284	278	255	233	204	152	190	109
2006-07	344	316	286	296	296	286	337	245	328	163	310	125
2007-08	354	310	276	299	299	276	341	263	316	144	329	204
2008-09	360	295	270	275	275	270	347	240	347	185	323	135
Total	**1,390**	**1,233**	**1,110**	**1,154**	**1,154**	**1,110**	**1,280**	**981**	**1,195**	**644**	**1,152**	**573**

(Source: Progress Reports/Data furnished by SHS/DHS)

In the case of the audited districts, the overall shortfall in achievements of full immunisation of children between zero to one age group covering BCG, Measles, DPT and OPV ranged from 16 to 35 *per cent* during 2005-09. The shortfall in achievement of the targets in the secondary immunisation ranged from 12 to 48 *per cent* for DT, 40 to 56 *per cent* for TT (above 10 years) and 63 to 70 *per cent* for TT (above 16 years) during the same period.

The shortfall in immunisation resulted in incidences of vaccine preventable infant and child diseases. Out of six audited districts, in Leh and Anantnag Districts, incidence of diseases like Whooping Cough and Measles was reported during 2005-09. However, there is no trend of increase in incidences.

The Pulse Polio Immunisation campaign stipulated conducting of two National Immunization Days (NIDs), six Sub-National Immunization Days (SNIDs) and additional rounds during 2005-09, which had been conducted fully. However, one new pulse polio case was detected in Jammu district during the period.

None of the audited CHCs and PHCs had been provided with complete sets of cold chain maintenance equipment[34] as of March 2009 to support immunisation programme as per the Mission document.

[33] Fully immunised

[34] Walk-in coolers, Icelined freezers, Refrigerators, Walk-in freezers, Deep freezers

Table 1.1.15

Equipment	Availability of functional cold chain maintenance equipment	
	(Out of 18 audited CHCs)	(Out of 34 audited PHCs)
Walk-in coolers	4	Nil
Icelined freezers	16	6
Refrigerators	11	Nil
Walk-in freezers	2	Nil
Deep freezers	17	3

(Data furnished by CHCs/PHCs)

The Mission emphasises Vitamin 'A' solution for all children less than three years of age. Prophylaxis against blindness amongst children due to deficiency of Vitamin 'A' requires the first dose at ninth month of age alongwith measles vaccine and the second dose alongwith DPT/OPV and subsequently three doses at six monthly intervals.

At the State level, there was a shortfall between 38 and 76 *per cent* in first dose and between 59 and 88 *per cent* in second to fifth Vitamin doses against the target of immunisation during 2005-09. In the audited districts, the overall shortfall ranged between 57 and 94 *per cent*. The main reason for short supply of Vitamin A at health centres during 2005-09 was due to inadequate supply by the GOI.

1.1.18 National Programme for Control of Blindness (NPCB)

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

Scrutiny revealed the following:

- At the State level (population: 1.01 crore), the number of cataract surgeries[35] performed annually during 2005-09 ranged between 15,209 and 20,931, which is in the range of 150 and 206 operations per lakh of population. In the six audited districts (population: 39.85 lakh), the number of catops performed annually during 2005-09 ranged between 1,014 and 2,373, which was in the range of 25 to 60 operations per lakh of population which was much lower than the desired level of 600 catops per lakh population per annum under the Mission. The under performance in catops can be directly linked to non-availability of eye-surgeons. In the six audited districts, as against a requirement of 24 eye-surgeons, only six eye-surgeons were posted in 18 CHCs and 6 district hospitals.
- The programme envisages training of teachers in Government and Government-aided schools, for screening refractive errors among students and free distribution of spectacles to the students having refractive errors. None of the teachers was trained in the State. 34,382 cases[36] of refractive errors were detected among 4,13,295 students[37] screened by the various health centres in the State during

[35] Includes catops conducted by Government hospitals, NGOs, catops camps and by others (private practioners)

[36] Jammu region : 7,399 cases, Kashmir region : 26,983 cases

[37] Jammu region : 2,37,259 students, Kashmir region : 1,76,036 students

2005-09. However, only 972 (three *per cent*) free spectacles[38] were distributed among the students in the State due to their non-procurement despite availability of funds. No free spectacle was issued in Kashmir region. In the six audited districts, there was no information available with the DHSs regarding distribution of free spectacles.

- Development of eye bank is an important activity to address corneal blindness. As of March 2009, no eye bank was set up in any of the audited districts.

Evidently, very little has been done to reduce prevalence of blindness under the Mission which has mainly been due to non-posting of adequate number of eye-surgeons at the hospitals, non-imparting of training to the teachers and non-establishment of eye banks as envisaged under the Mission guidelines.

1.1.19 Revised National Tuberculosis Control Programme (RNTCP)

The main objective of RNTCP was to diagnose and detect at least 70 *per cent* of tuberculosis cases and to ensure a cure rate of at least 85 *per cent* of smear positive cases through Direct Observed Treatment Short course (DOTS). The year-wise details of targets and achievement under the RNTCP regarding sputum examination and case detection were as under:

Table 1.1.16

Year	Sputum examination			Detection of new Sputum positive cases		
	Target	Achievement		Target	Achievement	
		Number	*Per cent*		Number	*Per cent*
2005-06	39,003	56,905	146	3,900	3,279	84
2006-07	40,504	77,206	191	4,050	4,188	103
2007-08	41,663	70,377	169	4,166	6,035	145
2008-09	71,732	74,769	104	7,173	5,904	82
Total	**1,92,902**	**2,79,257**	**145**	**19,289**	**19,406**	**101**

(Source: Progress Reports/Activity Reports of RNTCP)

It is heartening to note that in the areas of sputum examination and detection, the achievements were exceptionally high and can be justly termed as a resounding success.

The outcome of treatment under RNTCP as of March 2009 is detailed in the following table.

Table 1.1.17

TB Patients							
Year	**Registered**	**Cases evaluated**	**Cured + treatment completed**	**Died**	**Failures**	**Defaulters**	**Transferred out**
2005-06	1,638	1,585	616	27	4	37	7
2006-07	8,199	7,648	3,212	198	87	296	48
2007-08	11,159	10,511	8,758	493	177	621	127
2008-09	12,773	12,773	11,205	553	121	507	387
Total	**33,769**	**32,517**	**23,791**	**1,271**	**389**	**1,461**	**569**

(Source: Progress Reports/Activity Reports of RNTCP)

The cure rate was encouragingly very high at 88 *per cent* in 2008-09, though at the State level, the facility was available in 162 (out of 460) PHCs/CHCs only. Services for treatment of tuberculosis were available at 17 (out of the 18) test-checked CHCs and only

[38] Jammu region : 972 spectacles (2005-06: 882 and 2008-09: 90), Kashmir region: Nil

at seven (out of 34) PHCs. Evidently, much higher cure rate can be achieved with wider availability of treatment facility in PHCs/CHCs in the State.

1.1.20 National Leprosy Elimination Programme (NLEP)

The NLEP aims to eliminate leprosy by the end of the 11th Plan. It also aims to ensure leprosy prevalence rate of less than one per ten-thousand of population. There were 1,973 cases of leprosy in the State as of March 2009 with decline in incidence of new cases from 264 in 2006-07 to 205 cases in 2008-09.

The Mission envisages facilities for diagnosis and treatment of leprosy at all health centres up to PHC level. However, as per data available at the Societies for disease control, only 25 out of 85 CHCs and 160 out of 375 PHCs in the State had the facility for diagnosis of leprosy as of March 2009. None of the 34 audited PHCs had the facility for diagnosis of leprosy, though it was available in 15 out of 18 CHCs.

1.1.21 Integrated Disease Surveillance Project (IDSP)

The IDSP aims to establish a decentralized State-based system of surveillance for communicable and non-communicable diseases, so that timely and effective public health action can be initiated in response to health challenges. The project has four components, viz. (a) establishing and operating a central level disease surveillance unit, (b) integrating and strengthening disease surveillance at the state and district levels, (c) improving laboratory support and (d) training for disease surveillance and action.

The project was launched in the State during 2007-08. The State Surveillance Unit (SSU) was established in October 2007 and District Surveillance Units (DSU) were established in all the districts. None of these was, however, operational as of 31 March 2009 due to non-installation of requisite network. Ten persons were trained during 2008-09.

The goal of setting up a network of surveillance units was not fulfilled as computers, V-Sat and allied equipment to be provided to these District Surveillance Units (DSUs), were not installed (March 2009) by GOI. Strengthening of laboratories for sustaining surveillance activities by way of networking was incomplete with the result that the activities of the project had not been undertaken during 2005-2009.

1.1.22 Monitoring

1.1.22.1 Monitoring committees

The Mission envisages planning, implementation and monitoring through participation of NGOs and community-based organizations (CBOs). As per the NRHM framework, Health Planning and Monitoring Committees were to be formed at State, District, Block and PHC levels to ensure regular community-based monitoring of activities and facilitating relevant inputs for planning with representatives from *Gram Panchayats*, self help groups, user groups, legislature and NGOs/CBOs. It was seen in audit that monitoring through these channels prescribed by the Mission was non-existent.

No Health Planning and Monitoring Committees were formed at any level. Non-formation of committees adversely affected community-based monitoring as well as the planning process at all levels.

Monitoring committees were to be constituted by the Rogi Kalyan Samitis to visit hospital wards and collect patient feedback. The reports of the monitoring committees were to be considered by the RKS for remedial action. The committees were to send monthly monitoring reports to the District Development Commissioner. No monitoring committees had been constituted and records of patient feedback and action taken thereon had not been maintained.

Every district was required to publish annually a public report on health. However, none of the districts had published the public report. In the absence of the district report, the communities, which were to be involved in planning and monitoring of the activities under the Mission, did not have adequate information on the developments taking place in the district.

1.1.22.2 Management Information System (MIS)

Each District Health Society was to develop a computer-based Management Information System and report monthly to the State Health Society. The SHS was to consolidate the MIS reports of the districts and send them to the GOI on monthly basis.

No targets were set for computerisation of districts/blocks to be connected through MIS network. Though all 14 districts were connected through network, except 107 blocks (March 2009), these were not generating and furnishing monthly MIS reports to higher levels. Only status reports were being sent by districts to SHS through E-mail.

In the absence of effective and regular MIS reporting, watch of higher authorities on the progress made under various activities of the Mission suffered and internal control mechanism got diluted.

The Ministry of Health and Family Welfare had prescribed a model MIS for all the districts and States. It was, however, seen in audit that the reports were being collected by health centres and submitted to the District Health Society/State Health Society without any analysis of data collected at health centre and district level.

1.1.23 Conclusion

The performance audit review showed that the status of health profile of the State has been quite encouraging vis-à-vis the performance indicators available for the country. These can be further improved if there is proper fund management/utilisation and various sectors involved are covered in conformity with the guidelines issued for implementation of the Programme. There are large gaps in planning as well as implementation of the Mission activities in the State even after four years of launching the programme. This is evidenced by the findings that no new health centre was put in place, essential services and amenities were not available in many centres and there was critical shortage of technical manpower. Maternal and child health programmes have not made much headway. Planning, implementation and monitoring of the programme through participation of NGOs and community-based organisations was non-existent.

1.1.24 Recommendations

- The State Health Society, besides completing the facility survey, needs to ensure completion of household surveys to formulate the district and lower level plans.

- The SHS needs to map the available health facilities and infrastructure at health centres and initiate measures to expedite the pace of construction of health centres. Support infrastructure like electricity, standby power, adequate water supply, staff accommodation and telephones, etc. need to be provided to ensure improvement in quality of health services.
- Critical diagnostic and radiological services as well as blood storage facility, operation theatre and labour room need to be made functional at all centres. Posts sanctioned for providing medical services need to be filled on a priority basis.
- The design of ASHA scheme may be revised to provide assured earnings to them to ensure their effective participation.
- Maternal health programme needs to be implemented in its entirety covering all the essential areas like registration, reporting and tracking of pregnancies, IFA administration, immunization, antenatal and postnatal care and referral matters.
- Mobile Medical Units may be provided in each district to ensure outreach of medical services in remote/difficult areas.
- Drug policy/formulary drug list needs to be formulated.
- Monitoring and reporting mechanism under the programme should be activated.

Appendix-1.1

(Reference: Paragraph: 1.1.15.1; Page: 21)

Statement showing status of treatment of pregnant women at district levels who received check-ups under NRHM

Name of District	Year	Number of pregnant women registered						
		Actual	who received alternate check-ups				who received IFA administration	
			At registra-tion stage	At around 26th week	At around 32nd week	At around 36th week	Prophylaxis	Therapeutic
Leh	2005-06	2306	715	516	856	970	1164	2388
	2006-07	2713	950	619	989	1151	236	79
	2007-08	3489	1105	789	1120	1270	510	69
	2008-09	1342	1342	NA	NA	NA	695	63
Anantnag	2005-06	62954	62954	50363	12590	11016	31477	31477
	2006-07	64262	64262	51409	12852	11245	32131	32131
	2007-08	56143	56143	44914	11228	9825	28071	28071
	2008-09	49468	49468	49150	17223	14342	7287	7903
Rajouri	2005-06	21881	21881	13041	9051	4032	14990	Nil
	2006-07	21876	21876	14155	9662	8195	10666	Nil
	2007-08	20785	20785	14331	12922	4558	9667	Nil
	2008-09	19512	19512	Not available -		8465	10114	Nil
Doda	2005-06	16511	16511	11998	9006	2442	12112	Nil
	2006-07	15827	15827	15491	12734	3772	9893	Nil
	2007-08	13331	13331	13331	11949	3798	3854	Nil
	2008-09	16500	16500	Not available		5131	4363	Nil
Baramulla	2005-06	29062	29062	28982	28702	14731	14431	14631
	2006-07	38072	38072	36442	36428	11625	18072	20000
	2007-08	25245	25245	24146	24042	15229	14145	11145
	2008-09	31815	31815	31333	30442	12646	17330	14285
Poonch	2005-06	11846	11846	-	-	2720	11576	Nil
	2006-07	12723	12723	-	-	3504	9730	Nil
	2007-08	14460	14460	-	-	5237	10713	Nil
	2008-09	13507	13507	-	-	8000	8029	Nil
Total	**2005-06**	**144560**				**35911 (25)**	**85750 (59)**	**48496**
	2006-07	**155473**				**39492 (25)**	**80728 (52)**	**52210**
	2007-08	**133453**				**39917 (30)**	**66960 (50)**	**39285**
	2008-09	**132144**				**48584 (37)**	**47818 (36)**	**22251**

(Source: Progress Reports/Data furnished by the SHS/DHS)