CHAPTER-I
PERFORMANCE AUDIT

PUBLIC HEALTH AND FAMILY WELFARE DEPARTMENT

1.1 National Rural Health Mission

Highlights

The National Rural Health Mission was launched in April 2005 with the aim of providing accessible, affordable, accountable, effective and reliable health care facilities in rural areas. The State Government spent Rs 634.55 crore from the inception of the scheme till March 2009. There were substantial savings of Rs 250.96 crore. The availability of health care infrastructure, doctors and supporting staff was not adequate. While there were significant achievements in some interventions, the indicators of maternal and infant mortality remained short of interim targets, even though the major expenditure under the scheme was for reproductive and child health. Some important audit findings are given below*:*

An amount of Rs 21.30 crore, including Rs 9.27 crore meant for Mobile Medical Units and Rs 1.90 crore for a Health Management Information System, remained unutilised.

(Paragraph 1.1.6.2)

Funds amounting to Rs 3.46 crore, received for health care of urban poor, were diverted.

(Paragraph 1.1.6.4)

There was excess expenditure of Rs 25.54 lakh on purchase of blood lancets.

(Paragraph 1.1.6.5)

There were delays of upto 730 days in the payment of cash incentives of Rs 59.64 lakh to 4,646 beneficiaries of the '*Janani Suraksha Yojna*'.

(Paragraph 1.1.9.1[ii])

Payments totalling Rs 4.83 crore for folk dance programmes organised to spread health awareness, were not supported by prescribed certificates and photographs.

(Paragraph 1.1.9.2)

Only 52 *per cent* of reports were being received in respect of the Integrated Disease Surveillance Project.

(Paragraph 1.1.12.2)

1.1.1 Introduction

The National Rural Health Mission (NRHM) was launched (April 2005) by the Government of India (GOI) with the aim of providing accessible, affordable, accountable, effective and reliable health care facilities in the rural areas. Various existing National Disease Control Programmes viz. the Reproductive and Child Health-II (RCH-II) Programme, the National Vector Borne Disease Control Programme (NVBDCP), the Revised National Tuberculosis Programme (RNTCP), the National Leprosy Eradication Programme (NLEP), the National Blindness Control Programme (NBCP) and the Integrated Disease Surveillance Project (IDSP), were being implemented by separate health societies, which were merged under NRHM into a single State Health Society (SHS) to implement the scheme. The successful implementation of NRHM involved decentralised planning in the health sector and monitoring by health monitoring and planning committees formed at the Primary Health Centre (PHC), Block, District and State levels.

1.1.2 Organisational Structure

At the State level, the Chief Minister heads the State Health Mission (SHM), which provides the overall guidance to the scheme activities. The SHS, which is chaired by the Chief Secretary of the State, executes the scheme with the assistance of the State Programme Management Support Unit (SMPU). The Mission Director (MD), NRHM is the coordinator of the SHS and is responsible for overall implementation of the scheme. The MD is assisted by the Joint Director, NRHM and the Director, Health Services.

At the district level, the District Health Societies (DHS) implement the project. They are headed by the District Collectors, who are assisted by the Chief Medical and Health Officers (CMHO) who act as Chief Executive Officers (CEO) of the DHS. Health care was extended to 2.08[1] crore people (including 1.66 crore rural people) of the State, through a network of 138[2] Community Health Centres (CHC), 719 PHCs and 4,741 Sub Health Centres (SHC). The SHCs are manned by Female Health Workers/Auxiliary Nursing Midwives (ANM) and Multipurpose Health Workers (Male) (MPWM). The PHC is the first contact point between the patient and the doctor in rural areas, the CHC is treated as a secondary care institution and the district hospital (DH) is treated as a tertiary care institution.

1.1.3 Audit Objectives

The objectives of the performance audit were to assess whether:

- stage-wise planning was done starting from surveys at the village level,
- accounting and utilisation of funds was efficient and effective,

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1 *Population as per census 2001.*

2 *As per data given by the Directorate of Health Services.*

- the scheme achieved strengthening of physical and human infrastructure at different levels as per the Indian Public Health Standard norms,
- the performance indicators and targets fixed in respect of reproductive and child health care as well as immunisation and disease control programmes were achieved and
- the scheme was being monitored as provided in the guidelines.

1.1.4 Audit criteria

The audit was conducted based on criteria derived from the following:

- Framework for implementation of NRHM issued by the Ministry of Health and Family Welfare, Government of India;
- National Programme Implementation Plans for RCH and other disease control programmes;
- State Programme Implementation Plans approved by GOI;
- Memorandum of Understanding between the GOI and the State Government;
- Indian Public Health Standards (IPHS) for upgradation of CHCs and PHCs;
- Chhattisgarh Store Purchase Rules, 2002.

1.1.5 Scope and coverage of Audit

The performance audit of the scheme was conducted during April 2008 to May 2009 for the period from April 2005 to March 2009. The coverage of audit included the SHS and four[3] districts of the State selected by the Simple Random Sampling Without Replacement (SRSWOR) method. The four selected districts had 47 CHCs, 204 PHCs and 1,429 SHCs, out of which 12 CHCs, 24 PHCs and 48 SHCs were selected, as shown in ***Appendix-1.1,*** by the SRSWOR method.

The performance audit commenced with an entry conference with the Secretary, Public Health and Family Welfare Department on 4 April 2008. An exit conference was held on 10 September 2009 to discuss the audit findings.

1.1.6 Financial Management

As per the funding arrangement, GOI was to provide 100 *per cent* grants to the State upto 2006-07 and thereafter, all the existing National Disease Control Programmes were to be merged under NRHM and the State was to contribute 15 *per cent* during the XI Plan period (2007-12)**.** The GOI grant was to be provided in two parts i.e. direct transfer to health societies and

[3] *Bastar, Kanker, Raigarh and Raipur.*

transfer of funds to the State Government. The total expenditure incurred on the scheme during the period of audit was Rs 634.55 crore as against funds availability of Rs 885.51 crore as detailed in ***Appendix-1.2***. Of the total expenditure of Rs 634.55 crore, the expenditure on Direction and Administration was Rs.256.06 crore (40 *per cent*) while Rs 378.49[4] crore (60 *per cent*) was spent on programme activities, of which RCH was the main focus area, under which expenditure of Rs 341.96 crore was incurred.

1.1.6.1 Persistent savings

It was observed that except for the year 2006-07, there were large savings during each financial year as depicted below:

Table – 1.1: Funds received and expenditure incurred under NRHM

(Rs in crore)

Year	Receipt	Expenditure	Savings	Percentage of savings
2005-06	165.58	112.19	53.39	32
2006-07	202.16	195.34	6.82	3
2007-08	260.88	177.52	83.36	32
2008-09	256.89	149.50	107.39	42
Total	**885.51**	**634.55**	**250.96**	**28**

(Source: Information furnished by SHS and Directorate of Health Services)

Note: *The above table does not include receipt and expenditure figures relating to the State Malaria Control Society as the society could not produce the information/records to Audit.*

Of the total savings of Rs 250.96 crore, Rs 217.67 crore (87 *per cent*) occurred under RCH-II. This included unspent balances of Rs 7.42 crore under RCH-Phase-I, Rs 24.19 crore under flexipool (*Janani Suraksha Yojana*[5], family planning, institutional strengthening and child health and training), Rs 127.28 crore under NRHM additionalities (untied funds, ASHA[6], mobile medical units, Health Management and Information System, procurement of drugs and equipment and public private partnerships) and Rs 59 lakh under immunisation. The State contribution of Rs 47 crore and interest amount of Rs 5.68 crore remained unutilised. During the exit conference, the Government stated that there were savings under the salary head as personnel had not been appointed and the State contribution was not utilised as it was released at the end of March 2008 and March 2009. However, it was observed by Audit that the savings on salaries, booked primarily under Direction and Administration, was only a small part whereas the bulk of the savings was under various interventions under RCH. The

[4] *RCH-Rs 341.96 crore (90 per cent), NLEP- Rs 4.77 crore (one per cent), RNTCP-Rs 16.75 crore (five per cent), IDSP-Rs 2.97 crore (one per cent) and NVBDCP-Rs 12.04 crore (three per cent).*

[5] *Janani Suraksha Yojana is a scheme to promote safe delivery at health centres by providing cash incentives to pregnant women, Auxiliary Nursing Midwives or ASHA*

[6] *ASHA (Accredited Social Health Activist): A trained community health worker to be provided in each village for assisting in neonatal care, prevention and cure of common childhood diseases, immunization and family planning activities and other activities for control of malaria, TB, leprosy etc.*

Government also agreed that the State Malaria Control Society had not kept its records properly and informed that an inquiry was being conducted as there were many irregularities in its running. The results of the inquiry were awaited (August, 2009).

1.1.6.2 Non-utilisation of funds of Rs 21.30 crore

Mobile Medical Units were not provided for remote areas

(i) As per the State programme implementation plans (PIP), GOI provided Rs 7.22 crore in 2006-07, for establishment of 16 Mobile Medical Units (MMUs) to provide necessary medical care in remote areas of the State. Subsequently, Rs 2.40 crore was released during 2007-08 as operational cost. It was observed that only four chassis of trucks for establishment of MMUs had been purchased (November 2008) for Rs 35 lakh against the requirement of 16 MMUs, while the balance of Rs 9.27 crore was lying unutilised. During the exit conference, the Government stated that a prototype MMU had been provided by the supplier which was being changed as it was not as per the specifications. It was further stated that all the MMUs would be purchased by March 2010. It was evident that adequate efforts had not been made in the past and consequently, the aim of providing medical care in the remote areas was not achieved and the funds remained blocked. Similarly, an amount of Rs 1.90 crore was provided by GOI in 2007-08 for establishment of a Health Management and Information System (HMIS), to make public health care services more efficient by computerising all records and transactions, from the SHC level to the State level and to monitor the functioning of health centres. However, the entire amount was lying unutilised.

During the exit conference, the Government stated that hardware would be purchased and the software would be provided free of cost by the National Informatics Centre (NIC). This action should have been taken immediately after receiving the funds but due to delays, the regular monitoring envisaged in the scheme guidelines through HMIS had not been started.

(ii) It was observed that funds received from GOI in 2004-05 for encouraging institutional deliveries through public private partnership (Rs 50 lakh) and formation of a cell to plan the stabilizing of population (Rs 20 lakh) and in 2007-08 for village and panchayat capacity building (Rs 98.20 lakh) and alternate human resources development (Rs 2.83 crore) remained unutilised. Consequently, these initiatives as envisaged in the annual PIPs were delayed for one to three years.

During the exit conference, the Government stated that the funds would now be utilised.

(iii) Scrutiny of records of RCH societies in the test-checked districts revealed that funds of Rs 5.62 crore received during 2006-07 to 2007-08 under various components were not utilised by the DHSs of Bastar (Rs 1.34 crore), Kanker (Rs 27 lakh), Raigarh (Rs 1.46 crore) and Raipur (Rs 2.55 crore) for more than one year, as detailed in ***Appendix-1.3***. These funds were meant for purchase of drug kits, blood storage facilities, institutional strengthening, urban health programmes, formation of village health and sanitation committees etc.

At the exit conference, the Government stated that as drug kits were procured centrally by the Directorate of Health Services, the unspent amounts were retained by DHS Raipur and would be utilised for other activities. The unspent amount for blood storage facility and institutional strengthening would be utilised in 2009-10. The Village Health Sanitation Committees had not been set up as bank accounts had not been opened and they would now be started. It was evident that adequate action had not been taken in the past to utilise the funds, which resulted in delaying the intended benefits by one to two years.

1.1.6.3 Funds management and accounting

The following shortcomings were observed in the handling of funds, accounting and reporting utilisation of the same:

Funds amounting to Rs 7.42 crore were neither refunded to GOI nor spent by implementing agencies

- It was observed that an unspent balance of Rs 7.42 crore of RCH-I was neither refunded to GOI nor spent upto 31 March 2009. At the exit conference, the Government stated (September 2009) that the unspent balance would be refunded to GOI immediately. Had this action been taken in 2005-06, blockage of funds of Rs 7.42 crore for over four years could have been avoided.
- As per the MOU entered between GOI and the State Governments, the funds received under NRHM were to be kept in an interest-bearing account of a nationalised bank. Scrutiny of records revealed that funds received under RCH by DHS, Raigarh during April 2005 to June 2008 were kept in a current account. At the exit conference, the Government stated (September 2009) that a show cause notice would be issued to the concerned officials.
- During scrutiny of records at the SHS, the State Malaria Control Society (SMCS) did not produce vouchers and other records like cash book and stock registers. Therefore, their receipts and expenditure could not be ascertained by Audit. The Government accepted that the records had not been maintained properly by the society and informed that the accounts were being recast and an inquiry was also being carried out.

1.1.6.4 Diversion of funds

The SHS received Rupees four crore during 2005-06 to improve the health status of the urban poor community by providing quality primary health care with a focus on RCH services and to achieve population stabilisation. The programme was to be implemented by municipal bodies in coordination with the Health Department through social mapping of towns; identification of appropriate places for health care centres; appointment of two ANMs for urban slums to assist in deliveries and providing immunisation services, antenatal care and other services similar to the rural SHCs. An amount of Rs 3.45 crore had to be disbursed to the municipal bodies for executing these activities. In addition, Rs 26.25 lakh had to be utilized for organising health camps for identifying patients with serious illnesses and referring them to district hospitals. Another Rs 26.25 lakh had to be utilised for Information,

Education and Communication (IEC)[7] activities. It was observed that while expenditure was incurred on IEC activities as planned, the amount of Rs 3.46 crore meant for municipal bodies was diverted for purchase of equipment, which was issued to Chief Medical and Health Officers in all districts.

Due to the non-utilisation and diversion, the objective of improving the health status of the urban poor community was not fulfilled. The Government assured that an inquiry would be carried out to ascertain whether the expenditure was appropriate. However, the diversion was inappropriate as it resulted in non-initiation of the activities for improving urban health care.

1.1.6.5 Cases of irregular and extra expenditure

Scrutiny of records of the SMCS revealed the following:

(i) As per the guidelines of the National Vector Borne Disease Control Programme (NVBDCP), 2004, procurement was to be done as per Government rules. The Chhattisgarh Purchase Rules, 2002 provided that purchases above Rs 50,000 should be made by inviting open tenders. In contravention of these provisions, the SMCS invited (April 2005) quotations for laboratory and publicity material, finalized rates which were inclusive of all taxes and issued supply orders during September and October 2005. Based on these rates, blood lancets were purchased (March 2006) at the rate of Rs 1.45 each. During the same period, the Director, Health Services invited (October 2005) separate tenders and finalised the rates for blood lancets at Rs 0.26 each and circulated (February 2006) the approved rates to all the societies. The rate of Rs 1.45 finalised by the SMCS, was in contravention of purchase rules and was five times higher, when compared to the rate of Rs 0.26 finalised by the Director, Health Services. Therefore, by purchasing blood lancets at higher rates, the SMCS incurred excess expenditure of Rs 25.54 lakh as detailed in ***Appendix-1.4.*** It was also observed that though the approved rates were inclusive of all taxes, commercial tax of 4.6 *per cent* was paid on 17 invoices, which resulted in excess payment of Rs 4.40 lakh to a firm as detailed in ***Appendix-1.5.***

Excess expenditure of Rs 25.54 lakh on purchase of blood lancets

During the exit conference, the Government stated (September 2009) that the case has now been handed over to the Economic Offences Wing (EOW) for investigation.

Irregular expenditure of Rs 15.62 lakh

(ii) The SMCS issued (October 2005) a supply order for purchase of 29,000 slide boxes for Rs 14.94 lakh. It was observed that the ordered quantity was supplied twice against the same supply order, vide invoices dated 14 February 2006 and 21 March 2006 and payment of Rs 31.24 lakh (including taxes) was made. It was found that the stock entry for the second lot of 29,000 slide boxes was made in the stock register on 1 March 2006 though the material was supplied vide an invoice dated 21 March 2006. There

[7] *Information, Education and Communication is the activity by which health awareness is created in the general public through posters, banners, pamphlets, folk dances etc.*

was nothing available on record to explain the discrepancy, which raised doubts on the genuineness of the second supply. During the exit conference, the Government stated that case had been handed over to EOW for investigation.

1.1.7 Planning

Non-preparation of block action plans

As per the NRHM framework, the district action plans, the basis for interventions in the health sector, are to be prepared by consolidating the block action plans prepared on the basis of surveys at the village level by involving panchayat representatives.

It was observed that a community needs assessment survey and a facility survey were carried out at the village level by the Health Department through ANMs and health workers but the block action plans were not prepared. District plans were prepared using the survey data. Therefore, the stage-wise planning envisaged in the scheme was not carried out. During the exit conference, the Government agreed that the bottom up approach of planning should be introduced and stated that block action plans would be prepared from 2010-11 onwards.

1.1.8 Facilities at health centres

Health care facilities in rural areas are provided through Community Health Centres (CHCs), Primary Health Centres (PHCs) and Sub Health Centres (SHCs).

1.1.8.1 Infrastructure

(i) Community Health Centres

The CHCs are located at the block level and constitute the secondary level of the health care design to provide referral as well as specialised health care to the rural population.

As per the framework for implementation of NRHM, a CHC was to be established for every 1,20,000 persons (80,000 in tribal areas). The IPHS norms envisaged that the CHCs would provide assured medical services[8] and had prescribed the requisite infrastructure and facilities. Scrutiny of records of the 12[9] test-checked CHCs revealed the following shortcomings against the prescribed IPHS norms:

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[8] *Routine and emergency surgeries, 24-hour normal and assisted delivery services, essential and emergency obstetric care including surgical interventions like caesarean sections and other medical interventions.*

[9] ***Districts - Bastar** -(Bakawand, Lohandiguda and Tokapal) **Kanker**- (Amoda, Bhanupratappur and Charama), **Raigarh** -(Chaple, Pussore and Tamnar) and **Raipur**-(Abhanpur, Arang and Dharsinwa)*

Shortage of CHCs in the State

- As per the data provided by the Directorate of Health Services, there were 138 CHCs in the State as on March 2009 against the requirement of 173 CHCs based on the 2001 census, which estimated the rural population of 1.68 crore. Thus, there was a shortage of 35 CHCs.

Basic infra-structure was inadequate in CHCs

- None of the 12 CHCs test-checked had accommodation for patients' attendants, 67 *per cent* had no in-patient service, 50 *per cent* were without accommodation facilities for ANM, 42 *per cent* had no separate wards for male and female patients, 33 *per cent* had no standby power supply and 25 *per cent* had no accommodation facilities for general duty medical officers and staff nurses. The CHCs had adequate infrastructure for services such as ambulances, diagnostic facilities, labour rooms, water supply etc. The available infrastructure and facilities in CHCs are given in ***Appendix-1.6.***

Essential OT equip-ment not provided

Even though operation theatres were available in the 12 test-checked CHCs, out of the 14 items essential for operation theatres, eight items were not present in 8 to 12 CHCs as detailed in ***Appendix-1.7.***

Blood storage facilities not available

Blood storage facilities were not available at any of the 12 test-checked CHCs even though funds of Rs 65 lakh were released (2007-09) to the DHSs.

(ii) Primary Health Centres

The PHCs are located in the villages to provide 24-hour emergency services such as general medical care, family welfare and maternity and child health care services. They are referral centres for SHCs. The IPHS norms prescribed the equipment and facilities required in the PHCs such as standby power supply/generator, minor operation theatre, labour room etc.

Inadequate infrastructure in PHCs

Scrutiny of records of the 24[10] test-checked PHCs revealed that there was non-provision of standby power supply, 92 *per cent* were without any operation theatre and accommodation for staff nurses, 79 *per cent* had no separate utilities and wards for men and women, 71 *per cent* could not provide inpatient services, 67 *per cent* had no accommodation for medical officers, 54 *per cent* had no diagnostic services, 46 *per cent* had no provision for water supply, 42 *per cent* had no facilities for medical waste disposal and 29 *per cent* had no labour rooms. The PHCs were, however, adequately equipped with OPD rooms and 24x7 emergency and delivery services. The details of infrastructure and facilities available in PHCs are given in ***Appendix-1.8.***

(iii) Sub-Health Centres

The SHCs located at the village level, are the first contact point of the health care system with the rural community. They are expected to provide promotional, preventive and a few curative primary health care services such

[10] ***Bastar****-(Alnar, Belar, Jaibel, Malgaon, Maulibhata and Tahakapal),* ***Kanker****-(Basanvahi, Halba, Hatkarra, Korar, Kottara and Sarwandi),* ***Raigarh****-(BadeBhandar, Binjkot, Jobi, Kodatarai, Saraipali and Urba) and* ***Raipur****-(Champaran, Labhandi, Mandhar, Mandirhasaud, Rewa and Uparwara).*

as antenatal and post-natal care, family planning and contraception. The SHCs should have facilities such as labour rooms, accommodation for staff, adequate water supply etc.

Inadequate infrastructure in SHCs

Scrutiny of records of the 48[11] test-checked SHCs in four districts revealed that 71 *per cent* were without separate utilities for men and women, 67 *per cent* were without provision for water supply, 58 *per cent* did not have facilities for disposal of medical waste, 42 *per cent* were without labour rooms and accommodation for staff and 38 *per cent* had no Government building as detailed in ***Appendix-1.9***

In the absence of the minimum prescribed infrastructure and facilities, the health centres at various levels were not fully equipped to deliver assured services as envisaged in the IPHS norms. Since 38 *per cent* of the SHCs were running from rented premises, there was little scope for their upgradation and provision of the prescribed facilities such as waste disposal and labour rooms.

During the exit conference, the Government stated that mapping of the population was being done to assess the total requirement and additional CHCs would be constructed as per the assessment. The Government also stated that action would be taken to construct buildings for SHCs, to equip the OTs adequately and to introduce a Chhattisgarh Equipment Management System to ensure minimum stock of medicines and equipment at all health centres. The State would also start a Medical Corporation for procurement of equipment and outsource the testing of equipment and medicine. These initiatives were required to be implemented expeditiously to improve the quality of health care in the State.

1.1.8.2 Manpower

(i) Community Health Centres

The IPHS norms provided that every CHC should have a general physician, a gynaecologist, a paediatrician, an anaesthetist, a pharmacist, a laboratory technician, a radiographer and nine staff nurses to cater to a bed occupancy of 60 *per cent*.

[11] ***Bastar-****(Badanji, Burungpal, Chindgaon, Dharaur, Garenga, Irikpal, Karanji Napawand, Nainnar, Potanar, Targaon and Ulnar),* ***Kanker****- (Barvi, Bhainsakanhar, Bheja, Choria, Dudhava, Jepra, Kotela, Lilejhar, Musurputta, Puri, Samtara and Selegaon)* ***Raigarh****- (Bhupdeopur, Chhatamuda, Gorpar, Gurda, Jaridih, Jibri, Khadgaon, Khamhariya, Khokhra, Nandeli, Samaruma and Supa) and* ***Raipur****-(Barbanda, Girod, Kachna, Kendri, Lakholi, Mowa, Nawagaon, Nimora, Palod, Paragaon Parsada, and Rakhi).*

Shortage of doctors in CHCs

Against the 1,104 sanctioned posts of qualified doctors in the State, there was a shortage of 514 (47 *per cent*) as detailed below**:**

Table-1.2 : Status of manpower in CHCs in the State

Sl. No.	Name of the Post	Sanctioned	In position	Shortage	Percentage of shortage
1.	Medical Officer	414	376	38	9
2.	General Physician	138	51	87	63
3.	Gynaecologist	138	36	102	74
4.	Pediatrician	138	60	78	56
5.	Surgery specialist	138	28	110	80
6.	Anaesthetist	138	39	99	72
Total		**1104**	**590**	**514**	**47**

(Source: Information provided by the Directorate of Health Society)

It was observed that none of the 12 test-checked CHCs had an anaesthetist and staff nurses, 92 *per cent* were without general physicians, 83 *per cent* were without gynaecologists, 67 *per cent* were without paediatricians, 50 *per cent* were without general surgeons, 42 *per cent* were without radiographers and 33 *per cent* were without any general duty medical officer (MO). The shortage of staff is depicted in ***Appendix-1.10.***

(ii) Primary Health Centres

Shortage of manpower in PHCs

As per the IPHS norms, a PHC should have an MO, a staff nurse, a pharmacist and a laboratory technician. Out of the 24 PHCs test-checked, 88 *per cent* were without any staff nurse, 75 *per cent* were without an ANM, 67 *per cent* were without laboratory technicians, 50 *per cent* were without pharmacists and 29 *per cent* were without any medical officers as detailed in ***Appendix-1.11.***

The shortage (29 *per cent*) of MOs in the test-checked PHCs was quite close to the overall shortage in the State. Against the requirement of 1,414 MOs for the whole State, only 1,092 were deployed, resulting in a shortage of 322 (23 *per cent*).

(iii) Sub Health Centres

Shortage of manpower in SHCs

The IPHS norms prescribed that each SHC should have two ANMs and a male health worker to provide basic health care services. It was observed that two ANMs were posted only in two *per cent* of the SHCs, a single ANM was posted in 92 *per cent* of the SHCs, while in six *per cent* of the SHCs, no ANM was posted at all. Fifty eight *per cent* of the SHCs were without any male health worker as detailed in ***Appendix-1.12.*** Since ANMs were required to make field visits and conduct weekly immunisation, it would not be possible to deliver the services at SHCs properly with just one ANM. The non-availability of ANMs implied that the concerned SHCs were not equipped to deliver the level of health care as envisaged under NRHM.

In the absence of the minimum prescribed numbers of doctors and paramedical staff at all levels, the health centres were not fully equipped to deliver the assured services as envisaged in the IPHS norms.

During the exit conference, the Government stated that redistribution of posts and rationalisation of current deployment would be done for all the health centres and efforts would be made to increase the manpower. It also stated that some posts of doctors would be surrendered. Over 300 nurses had recently been appointed and more posts of nurses would be proposed. The redeployment was required to be done and appointments made expeditiously to improve the quality of health care.

1.1.9 Reproductive and Child Health

Under NRHM, health care was targeted through two major areas:

- Reproductive and Child Health (RCH) programme.
- Other disease control programmes.

Improvement in MMR, IMR and TFR

The RCH programme aimed to reduce the maternal mortality rate (MMR), infant mortality rate (IMR) and total fertility rate (TFR) through improved antenatal care, family planning and immunization. The achievements against the targeted levels of MMR, IMR and TFR are indicated below:

Table-1.3 : Status of MMR, IMR and TFR

Item	Status in year 2005	Target up to 2012	Target upto 2008-09	Achievement upto 2008-09
MMR	**379/1,00,000 live births** *(SRS-2001-03)*	**100**	**300**	**335** *(SRS-2004-06)*
IMR	**70/1000 live births** *(SRS-2003)*	**30**	**Less than 55**	**59** *(SRS-2007)*
TFR	**2.62** *(NFHS-2005-06)*	**2.1**	**2.2**	**2.62** *(NFHS-2005-06)*

(Source: Data provided by SHS)
SRS: Sample registration system, NFHS: National Family Health Survey

While there were improvements in the indicators from the year 2005 onwards, they were lagging behind the interim targets envisaged under NRHM.

1.1.9.1 Achievements and shortcomings under RCH- Phase II

The scrutiny of records and information collected from the department and test-checked health centres revealed that there were significant achievements as well as shortcomings as described in the following paragraphs.

(i) Antenatal care

The maternal health strategies in RCH provide that pregnant women should be registered and given three antenatal checkups, iron-folic acid (IFA) tablets for 100 days and two doses of tetanus toxide (TT). The information collected revealed that 82 *per cent* of pregnant women in the whole State were provided three antenatal check-ups while the percentage was 89 in the test-checked districts. Immunization of pregnant women against tetanus was 95 *per cent* both in the whole State and in the test-checked districts. While the administration of IFA tablets to pregnant women in the State was 82 *per cent*, it was only 75 *per cent* in the test-checked districts. It was also observed that 7.80 lakh pregnant women were registered in the test-checked districts but

Thirty *per cent* shortage of IFA tablets

IFA tablets were available for only 5.47 lakh (70 *per cent*) of women, leading to a shortage of 30 *per cent* ***(Appendix-1.13)***. The shortage of IFA tablets implied that iron and vitamin supplements would not be available to all pregnant women. Thus, the administration of IFA tablets was to be stepped up to counter the incidence of anaemia and reduce the MMR. During the exit conference, the Government stated that sufficient IFA tablets would be obtained and administered.

(ii) Institutional delivery

Institutional deliveries in the State showed a gradual increase but remained at 32 *per cent* in 2008-09 ***(Appendix-1.14)***.This could be attributed to various factors including shortcomings in facilities and medical staff in health centres as detailed in paragraph 1.1.8 and also the shortcomings in the implementation of the *'Janani Suraksha Yojana' (JSY)* which, as explained earlier, was an incentive scheme aimed to increase institutional deliveries by providing cash incentives to women who got the deliveries done at Government health centres.

Government of India guidelines provided that all expectant mothers should get cash incentives under JSY in one go at the time of delivery. Further, GOI would not consider the payments under JSY legitimate if payments beyond 25 *per cent* were made in advance or seven days after the delivery. Scrutiny of records in the four test-checked districts revealed that there were delays ranging from seven to 730 days in payment of cash incentives of Rs 59.64[12] lakh to 4,646 beneficiaries. During the exit conference, Government stated that JSY payments were now being made through bearer cheques and timely payments were being ensured. However, it could not explain the reasons for the delays pointed out by Audit and the action it proposed to take.

Enhanced payment of JSY not made to 2,523 beneficiaries

Government of India had enhanced the rates of incentives in October 2006 from Rs 700 to Rs 1,400 for rural areas and from Rs 600 to Rs 1,000 for urban areas but payments at the enhanced rates were made only from June 2007 onwards, which led to less payment of Rs 15.77[13] lakh to 2,523 beneficiaries for the period November 2006 to May 2007 in the test-checked districts. In reply, the DHSs, Bastar, Kanker and Raipur stated that they had paid the enhanced rates as soon as they had received directions of the Directorate of Health Services. During the exit conference, the Government stated that timely issue of orders by the Directorate would be ensured in future.

(iii) Family Planning

Overall sterilization fell short by 22 *per cent*

Use of spacing methods e.g. Oral Pill Cycle, Inter Uterine Device (IUD) insertions and distribution of condoms was 90 *per cent* in the State. However, the overall sterilization in the State fell short by 22 *per cent* and the shortfall ranged from 11 to 31 *per cent* in the test-checked districts during 2008-09.

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[12] ***Bastar****-Rs 14.81 lakh (1,702 women),* ***Kanker****-Rs 2.56 lakh (312 women),* ***Raigarh****-Rs 21.36 lakh (1,315 women) and* ***Raipur****-Rs 20.91 lakh (1,317 women).*

[13] ***Bastar****-Rs 6.44 lakh ,* ***Kanker****- Rs 2.65 lakh and* ***Raipur****-Rs 6.68 lakh.*

During the exit conference, the Government stated that necessary measures would be taken to increase family planning activities.

NRHM also lays thrust on promoting male sterilisation but it was observed that the percentage of male sterilisation in the State was only six during last four years. Moreover, information collected from the SHS revealed that most of the male sterilisations had occurred in Bastar (30 *per cent*), Dantewada (66 *per cent*) and Kanker (29 *per cent*), which had increased the overall percentage of male sterilization which was otherwise very low in the other districts (0.25 to 6.76 *per cent*). During the exit conference, the Government agreed that efforts would be made to increase the number of male sterilisations.

(iv) Immunization and Child Health

Ninety six *per cent* achievement of immunization targets

The scheme had a very significant achievement of 96 *per cent* of the target in respect of routine immunizations for prevention of six diseases. The administration of vitamin A solution to children was also significant at 90 *per cent* of the target.

1.1.9.2 Information, Education and Communication activities

As stated earlier, the Information, Education and Communication (IEC) strategy under NRHM aims to facilitate awareness and dissemination of information through print media, printed material, street plays etc., regarding the availability of and access to quality health care.

The IEC Bureau[14] of the Director, Health Services approved three Samitis[15] for executing IEC work, at the rate of Rs 1,940 per programme, through *Kalajathas*[16], to create health awareness in all the villages of the State.

Accordingly, the Joint Director, RCH issued (July 2005 to March 2006) work order to all the three Samitis with directions to submit the bills to the IEC Bureau along with photographs of the programmes and certificates from the *Sarpanches* of the villages and local workers, which would verify that the programmes had actually been held. While the RCH society made payment of Rs 4.16 crore to the three Samitis, the IEC Bureau was unable to produce any photographs or certificates from *Sarpanches* and local workers to Audit.

The RCH society issued another work order to M/s Reliable Associates during March 2006 for executing 3,456 folk dance programmes in 16 districts without any specific instructions for submitting proof of execution and made a payment of Rs 67.04 lakh to them.

On verification in the districts, the DHS, Bastar stated that the records of 2005-06 were not available while the DHS, Kanker stated (November 2008)

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[14] *The agency for managing the work relating to IEC component under NRHM.*

[15] *Chhattisgarh Lok Kala Samiti; Dhamtari, Nav Jagriti Kala Samiti, Bilaspur and Suman Saurabh, Raipur.*

[16] *Plays and folk dance programmes in local language.*

that no such programmes had taken place. As the work orders included 850 programmes for Kanker district, involving a total payment of Rs 16.49 lakh, the matter required investigation. The DHS, Raigarh stated (September 2008) that photographs and certificates relating to *Kalajatha* programmes during 2005-06 had been sent to Raipur and were kept at the State level. The DHS, Raipur stated (July 2008) that the programmes were held but did not produce to Audit, the photographs and certification by *Sarpanches*.

Payment of Rs 4.83 crore for folk dance programmes was not authentic

Thus although payment of Rs 4.83 crore was made to *Kalajatha Samitis* and M/s Reliable Associates, photographs and certificates, which would have provided assurance that the programmes had indeed been held, were not traceable either at the State level or in the districts and there was no way to ascertain how the RCH society/ IEC Bureau had verified actual execution of the programmes before making the payments.

During the exit conference, the Government stated (September 2009) that the work of the *Kalajatha* Samitis had now been handed over to EOW for investigation.

1.1.10 Other disease control programmes

Various existing disease control programmes were integrated under NRHM to eradicate and eliminate the prevalence of the diseases. Significant achievements and shortcomings were noticed in the following programmes as described below:

1.1.10.1 National Vector Borne Disease Control programme

High API in Bastar and Kanker due to shortfall in insecticides

The guidelines of the Malaria Action Plans, 1995 provided that the Annual Blood Examination Rate (ABER)[17] should be at least 10 *per cent* and the Annual Parasitic Incidence (API[18]) should be brought down to 0.5 per thousand. For areas where the API was more than two, indoor residual spraying of DDT and anti-larvae solution was to be carried out. While the programme achieved the targets for ABER of more than 10 *per cent,* API of less than 0.5 per thousand was not achieved although it showed a decreasing trend from 8.01 in 2005-06 to 4.99 in 2008-09. All the test-checked districts showed a decreasing trend in API but it was very high in Bastar (20.72) and Kanker (16.28). One of the main contributing factors for the high API in these two districts was the high shortfall of upto 86 *per cent* in the targets of spraying as detailed in ***Appendix-1.15***. The DHS, Kanker and Bastar stated (July 2009) that the targets of spraying could not be achieved due to short supply of insecticides by GOI. During the exit conference, the Government stated (September 2009) that indoor residual spray was not the sole remedy for reducing API but agreed that the insecticides should have been purchased by the State despite short supply by the GOI.

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17 *ABER-Total blood slides collected in a year/ total population * 100.*

18 *API- Falciparum cases detected per thousand in a year.*

While spraying was not the sole remedy, it was one of the prescribed methods of prevention and inadequate spraying was likely to have raised the API in these two districts.

1.1.10.2 Revised National Tuberculosis Programme

Thirteen test-checked PHCs did not have diagnostic facilities

While achievement of the overall cure rate of tuberculosis under the Revised National Tuberculosis Programme was 83 to 84 *per cent* against the target of 85 *per cent*, the detection of new sputum positive cases was only 55 to 62 *per cent* against the target of 70 *per cent* **(*Appendix-1.16*).** Deaths due to tuberculosis increased from 658 to 835 and defaulter cases increased from 1,362 to 2,004 during the period of audit. It was observed that out of the 24 test-checked PHCs, 13 PHCs did not have diagnostic facilities. This indicated that there was scope to improve the diagnostic facilities which could contribute to better detection rates.

1.1.10.3 National Leprosy Eradication Programme

Prevalence of leprosy increased

Though the detection of new leprosy cases decreased from 9,040 to 7,984, the prevalence rate of leprosy increased from 1.99 to 2.34 per 10,000 population against the target of less than one by the year 2012. This was due to the reduction in the number of patients treated and cured from 12,519 in 2005-06 to 5,000-8,000 during subsequent years ***(Appendix-1.17)***. In reply, the Deputy Director, Leprosy stated (July 2009) that the prevalence rate was higher due to the higher number of new cases detected and improved surveillance, including receipt of NGOs' reports. This did not clarify the position as the detection of new cases had actually decreased. During the exit conference, the Government stated that the matter would be looked into and a detailed reply for increase in prevalence would be provided. The reply was awaited (September 2009).

1.1.11 Role of ASHAs /Mitanins

As explained earlier, an ASHA, called *Mitanin* in Chhattisgarh, is a trained community health worker to be provided in each village for assisting in neonatal care, prevention/cure of common childhood diseases, immunisation and family planning activities and other activities for control of malaria, TB, leprosy etc. An ASHA is entitled for performance based incentives as per prescribed norms under programmes such as JSY, sterilisation and immunization.

59,489 ASHAs were posted as against norms of 16,648

As per the framework of NRHM, one ASHA is to be provided in each village in the ratio of one per thousand population. As per the information collected from SHS, 59,489 ASHAs were posted in the State against the norms of 16,648 which was more than three times the prescribed number. Further, 48,430 ASHAs had been imparted training. Therefore, the deployment of ASHAs in Chhattisgarh was much higher than the norms and strengthened the delivery of health services at the village level.

1.1.12 Monitoring and Evaluation

1.1.12.1 Community participation

Active community participation was not ensured

The NRHM framework states that community action is the only guarantee for exercising the right to health care and putting community pressure on the health care system. The framework provides for participation of NGOs in capacity building and monitoring; formation of village health and sanitation committees (VHSC) for village level monitoring and planning and monitoring committees at the State, district and block levels.

- It was observed that during 2006-07, funds of Rs 2.32 crore were received in April 2006 for conducting base line survey and monitoring of RCH activities in unserved and under-served areas and Rs 2.25 crore was released to six Mother NGOs[19] at the end of March 2008 but the entire amount remained unutilised (June 2009). During the exit conference, the Government stated that NGOs would not be engaged in future as their working was not satisfactory.
- As per information provided by the SHS, out of 20,639 villages, VHSCs were formed in 18,452 villages. This was required to be extended to all the remaining villages.
- As per the information collected from the SHS, community based monitoring committees had been started on a pilot basis at the district level in Bastar, Kawardha and Koriya districts in 2007-08 to monitor health services. Health planning and monitoring committees had not been formed at the State, district and block levels.

Therefore, against the various kinds of community participation envisaged in the scheme for planning and monitoring, only village health and sanitation committees had been formed.

1.1.12.2 Reporting under IDSP

The Integrated Disease Surveillance Project (IDSP) is a weekly reporting system on symptoms of diseases such as high fever, vomiting, dysentery etc. The data is furnished by SHCs, PHCs and CHCs at the district level every Tuesday. The objective is to identify the outbreak of diseases and control them at early stages. Analysis of reporting under IDSP for 15 weeks in the year 2008 revealed that on an average, only 52 *per cent* of the units were entering the required data (***Appendix-1.18***)**.** Consequently, the data was largely incomplete and the objective of surveillance of diseases was not being fulfilled as envisaged.

[19] *Mother NGOs are appointed to undertake the activities of RCH at unserved and under-served areas. They are meant to get the activities executed through field NGOs.*

1.1.13 Conclusion

Implementation of the National Rural Health Mission in the State had various shortcomings. There were cases of under-utilisation and diversion of funds as well as instances of irregular expenditure. Stage-wise planning was not done. The health centres did not have adequate infrastructure, facilities, doctors and support staff. While there were significant achievements in some interventions and the health indicators accordingly showed improvements, there were shortfalls in administration of iron-folic acid tablets, gender imbalance in sterilisation, low institutional deliveries, low detection of sputum positive cases and non-achievement of the norms of annual parasitic incidence. The indicators of maternal and infant mortality remained behind the interim targets. The level of community participation as envisaged in the scheme had not been achieved.

1.1.14 Recommendations

- The prescribed stage-wise planning process starting with block level health plans should be adopted.
- Unspent amounts relating to various scheme initiatives may be utilised expeditiously.
- Doctors, support staff, and facilities should be ensured at health centres as per the Indian Public Health Standards norms.
- Interventions under Reproductive and Child Health may be stepped up to achieve improvements in the maternal mortality rate, infant mortality rate and total fertility rate. Grant of cash incentives under the '*Janani Suraksha Yojna*' may be streamlined.
- Interventions such as spraying may be stepped up to reduce the Annual Parasitic Incidence.
- The monitoring system should be strengthened by implementing the Health Management Information System and ensuring timely reporting under the Integrated Disease Surveillance Project.

Appendix-1.1

(Referred to in paragraph 1.1.5; page 3)

Units selected for test check

District	CHC/Block	PHC	SHC
Bastar	Bakawand	Jaibel	Chindgaon
			Garenga
		Malgaon	Napawand
			Ulnar
	Lohandiguda	Maulibhata	Burungpal
			Nainnar
		Tahakapal	Potanar
			Karanji
	Tokapal	Alnar	Irikpal
			Taragaon
		Belar	Badanji
			Dharaur
Kanker	Amoda	Basanvahi	Dudhava
			Shamtara
		Sarwandi	Choria
			Musurputta
	Bhanupratappur	Hatkarra	Barvi
			Bheja
		Korar	Bhainsakanhar
			Selegaon
	Charama	Halba	Jepra
			Kotela
		Kottara	Lilejhar
			Puri
Raigarh	Chaple(Kharsia)	Binjkot	Bhupdeopuri
			Gurda
		Jobi	Gorpar
			Khadgaon
	Pussore	Bade Bhandar	Nandeli
			Supa
		Kodatarai	Chhatamuda
			Khokhra
	Tamnar	Saraipali	Jebri
			Samaruma
		Urba	Jharidih
			Khamhoriya
Raipur	Abhanpur	Champaran	Nawagaon
			Paragaon
		Uparwara	Kendri
			Nimora
	Arang	Mandir Hasod	Palod
			Rakhi
		Rewa	Lakholi
			Parsada
	Dharsiwa	Labhandi	Kachna
			Mowa
		Mandhar	Girod
			Barbanda
Total Districts: 04	**Total CHCs: 12**	**Total PHCs: 24**	**Total SHCs: 48**

Appendix-1.2

(Referred to in paragraph 1.1.6; page 4)

Details of grant received and expenditure incurred on implementation of NRHM

(Rupees in crore)

Year	Receipt of State Health Society					Grant received by State Govern-ment from GOI	Total fund available	Expenditure incurred during the year		Total expenditure	Closing balance			Percentage of balance to total amount available
	Grant received from GOI	State Share	Other receipts[1]	Refund from districts	Total receipt			By State Health Society	By State Government		With State Health Society	With State Govern-ment	Total	
1	2	3	4	5	(2+3+4+5) =6	7	(6+7)=8	9	10	(9+10)=11	(6-9)=12	(7-10)=13	(12+13)=14	15
2005-06	88.91	--	1.46	2.30	**114.38**[2]	51.20	**165.58**	70.36	41.83	**112.19**	44.02	9.37	**53.39**	32.24
2006-07	125.41	--	1.97	2.02	**129.40**	72.76	**202.16**	124.22	71.12	**195.34**	5.18	1.64	**6.82**	3.37
2007-08	113.34	12.00	8.59	50.19	**184.12**	76.76	**260.88**	100.00	77.52	**177.52**	84.12	-0.76	**83.36**	31.96
2008-09	138.88	35.00	3.41	0.57	**177.86**	79.03	**256.89**	83.91	65.59	**149.50**	93.95	13.44	**107.39**	41.80
Total	**466.54**	**47.00**	**15.43**	55.08	**605.76**	**279.75**	**885.51**	**378.49**	**256.06**	**634.55**	**227.27**	**23.69**	**250.96**	28.34

(Source: Information provided by State Health Society)

[1] *Other receipts include interest received on fund*

[2] *Opening Balance of societies Rs 21.71 crore (RCH - 18.81, LEP - 0.99, TB - 0.87, IDSP- 0, and BLIND - 1.04.) is included in the total receipt of 2005-06.*

Appendix-1.3

(Referred to in paragraph 1.1.6.2(iii); page 5)

Details of unutilised funds under NRHM in test-checked districts

(Rupees in lakh)

Name of district	Component name	Year of receipt	Amount received	Amount not used for more than one year
Bastar	Urban Health Programme	2007-08	10.00	10.00
	VHSC	2007-08	156.30	103.70
	Blood storage facility	2007-09	22.50	20.74
	Total – A		**188.80**	**134.44**
Kanker	IUCD Training	2007-08	1.04	1.04
	Training of paramedical on SBA	2007-08	10.36	5.04
	Blood storage facility	2007-09	22.50	20.74
	Total – B		**33.90**	**26.82**
Raigarh	District Action Plan	2007-08	10.00	10.00
	Nursing Training centre	2007-08	15.00	15.00
	FRU Up gradation	2007-08	10.00	10.00
	ANM kit A &B	2007-08	47.99	47.99
	Strengthening Routing S.S.	2007-08	24.60	7.64
	Untied Fund for District Hospital	2007-08	40.00	40.00
	Urban Health Programme	2007-08	15.00	15.00
	TOTAL –C		**162.59**	**145.63**
Raipur	Urban RCH	2006-07	25.00	23.64
	Institutional Strengthening	2006-07	43.17	41.18
	GNT Training	2006-07	15.00	15.00
	Procurement	2007-08	116.99	116.99
	Strengthening Mitanin programme	2007-08	65.90	47.91
	Blood storage	2007-08	10.00	10.00
	TOTAL-D		**276.06**	**254.72**
Total (A+B+C+D)			**661.35**	**561.61**

(Source : Information provided by District Health Societies)

Appendix-1.4

(Referred to in paragraph 1.1.6.5(i); page 7)

Details of excess expenditure on purchase of blood lancets at higher rate

(In Rupees)

Sl. No	Supply Order No./ Date	Invoice No. and date	Quantity	Purchase Rate	Available lowest rate	Difference rate	Excess expenditure
1	188/ 29.09.05	6529/ 31.03.06	396000	1.45	0.26	1.19	471240
2	188/ 29.09.09	6530/ 21.03.06	393800	1.45	0.26	1.19	468622
3	188/ 29.09.05	6531/ 21.03.06	10200	1.45	0.26	1.19	12138
4	219/ 03.10.05	6532/ 21.03.06	396000	1.45	0.26	1.19	471240
5	238/ 04.10.05	6535/ 21.03.06	386191	1.45	0.26	1.19	459567
6	238/ 04.10.05	6537/ 21.03.06	396000	1.45	0.26	1.19	471240
7	238/ 04.10.05	6538/ 21.03.06	167801	1.45	0.26	1.19	199683
TOTAL:			**2145992**				**2553730**

(Source: Invoices provided by State Malaria Control Society)

Appendix-1.5

(Referred to in paragraph 1.1.6.5(i); page 7)

Details of excess payment of commercial tax

(In Rupees)

Supply order no. date	Invoice no. and date	Item	Quantity	Rate	Admissible Amount inclusive of all taxes	Amount of tax paid extra	Actual Payment made
307/08.10.05	6542/21.03.06 6543/21.03.06	Slide box	29000	51.50	1493500	**68701**	1562201
238/04.10.05	6538/21.03.06 6535/21.03.06 6537/21.03.06	Lancet	950000	1.45	1377500	**63365**	1440865
188/29.09.05	6529/21.03.06 6530/21.03.06 6531/21.03.06	Lancet	800000	1.45	1160000	**53359**	1213359
188/29.09.05	6532/21.03.06	Lancet	396000	1.45	574200	**26413**	600613
280/07.10.05	6497/15.03.06 6498/15.03.06	JSB Stain Conical flask (F)	4000 5000	250.0 43.00	1000000 215000	**55890**	1270890
143/26.09.05	6491/15.01.06 6492/15.01.06	JSB Stain	4000	250.00	1000000	**46000**	1046000
240/04.10.05	6494/15.01.06	JSB Stain	2000	250.00	500000	**23000**	523000
307/08.10.05	6323/14.02.06 6324/14.02.06	Slide box	29000	51.50	1493500	**68701**	1562201
172/28.09.05	6321/14.02.06	Slide box	14500	51.50	746750	**34351**	781101
TOTAL					**9560450**	**439780**	**10000230**

(Source: Invoices provided by State Malaria Control Society)

Appendix-1.6

(Referred to in paragraph 1.1.8.1(i); page 9)

Facilities at test-checked CHCs

Sl. No	Description of facilities required at each CHC as per IPHS norms	No. of CHCs test - checked	Facility available		Facility not available	
			No. of CHCs	*Per cent*	No. of CHCs	*Per cent*
1	Accommodation facilities for attendants of admitted patients	12	00	00	12	100
2	Blood storage facility	12	00	00	12	100
3	Inpatient services with 30 beds	12	04	33	8	67
4	Accommodation for ANM	12	06	50	06	50
5	Separate ward for male and female	12	07	58	05	42
6	Accommodation for General Surgeon	12	07	58	05	42
7	Working facility of standby power supply/generator	12	08	67	04	33
8	Accommodation for General duty Medical Officer	12	09	75	03	25
9	Accommodation for Staff Nurse	12	09	75	03	25
10	Separate utilities for men and women	12	10	83	02	17
11	Waiting rooms for patients not in good condition	12	10	83	02	17
12	Telephone connection	12	10	83	02	17
13	Computer	12	10	83	02	17
14	OPD rooms/ cubicles	12	11	92	01	08
15	Diagnostic Services for routine urine, stool and blood tests, RTI/STI, sputum testing.	12	11	92	01	08
16	Operation theatre/ minor operation theatre	12	12	100	00	00
17	Labour room	12	12	100	00	00
18	Ambulance service	12	12	100	00	00
19	Provision for water supply	12	12	100	00	00

(Source: Information provided by test-checked CHCs)

Appendix-1.7

(Referred to in paragraph 1.1.8.1(i); page 9)

Shortfall/ Non-availability of Operation Theatre equipment

Sl. No.	Equipment required at each CHC as per IPHS norms	Total CHCs	No of CHCs where equipment	
			Available	Not available
1	Boyales apparatus	12	2	10[3]
2	EMO machine	12	1	11[4]
3	Cardiac Monitor for OT	12	2	10[5]
4	Defribillator for OT	12	0	12[6]
5	Ventilator for OT	12	3	09[7]
6	Horizontal High pressure sterilizer	12	4	08[8]
7	Vertical High Pressure Sterilizer 2/3 drum capacity	12	6	06[9]
8	Shadowless lamp ceiling trak mounted	12	3	09[10]
9	Shadowless lamp pedestal for minor OT	12	9	03[11]
10	OT care/fumigation apparatus	12	6	06[12]
11	Gloves and dusting machines	12	8	04[13]
12	Oxygen cylinder 660 ltrs for Boyales apparatus	12	7	05[14]
13	Nitrous oxide cylinder 1780 liters for one Boyales apparatus	12	1	11[15]
14	Hydraulic operation table	12	11	01[16]

(Source: Information provided by test-checked CHCs)

[3] *Abhanpur, Amoda, Arang, Bakawand, Bhanupratappur, Chaple, Charama, Dharsiva, Lohandiguda and Tamnar*

[4] *Abhanpur, Amoda, Arang, Bakawand, Bhanupratappur, Chaple, Charama, Dharsiva, Lohandiguda, Tamnar and Tokapal*

[5] *Abhanpur, Amoda, Bakawand, Bhanupratappur, Chaple, Charama, Lohandiguda, Pussore, Tamnar and Tokapal*

[6] *Abhanpur, Amoda, Arang, Bakawand, Bhanupratappur, Chaple, Charama, Lohandiguda, Pussore, Tamnar and Tokapal*

[7] *Abhanpur, Amoda, Arang, Bhanupratappur, Chaple, Dharsiva, Lohandiguda, Tamnar and Tokapal*

[8] *Arang, Bhanupratappur, Chaple, Charama, Dharsiva, Pussore, Tamnar and Tokapal*

[9] *Arang, Bhanupratappur, Chaple, Dharsiva, Lohandiguda and Tamnar*

[10] *Abhanpur, Amoda, Chaple, Charama, Dharsiva, Lohandiguda, Pussore, Tamnar and Tokapal*

[11] *Arang, Charama and Dharsiva,*

[12] *Abhanpur, Arang, Chaple, Charama, Dharsiva, Pussore and Tamnar*

[13] *Arang, Bhanupratappur and Dharsiva*

[14] *Arang, Bhanupratappur, Dharsiva, Lohandiguda and Pussore*

[15] *Abhanpur, Amoda, Arang, Bakawand, Bhanupratappur, Chaple, Dharsiva, Lohandiguda, Pussore, Tamnar and Tokapal*

[16] *Amoda*

Appendix-1.8

(Referred to in paragraph 1.1.8.1.(ii); page 9)

Facilities at test-checked PHCs

Sl. No.	Description of facilities required at each PHC	No. of PHCs test - checked	Facility available		Facility not available	
			No. of PHCs	*Per cent*	No. of PHCs	*Per cent*
1	Standby power supply/generator	24	00	00	24	100
2	Minor operation theatre	24	02	08	22	92
3	Accommodation for staff nurse	24	02	08	22	92
4	Accommodation for other staff	24	04	17	20	83
5	Separate utilities for men and women	24	05	21	19	79
6	Separate ward for male and female	24	05	21	19	79
7	Telephone connection	24	07	29	17	71
8	Inpatient services with 6 beds	24	07	29	17	71
9	Accommodation for Medical officers	24	08	33	16	67
10	Diagnostic services for routine urine, stool and blood stets, RTI/STI, sputum testing etc.	24	11	46	13	54
11	Provision of water supply	24	13	54	11	46
12	Facility of sewerage	24	14	58	10	42
13	Facility of medical waste disposal	24	14	58	10	42
14	Labour room	24	17	71	07	29
15	Government building	24	18	75	06	25
16	Electricity connection/power supply	24	21	88	03	12
17	OPD rooms/cubicles	24	21	88	03	12
18	24x7 Emergency services	24	21	88	03	12

(Source: Information provided by test-checked PHCs)

Appendix-1.9

(Referred to in paragraph 1.1.8.1.(iii); page 10)

Facilities at test-checked SHCs

Sl. No.	Facilities required at each SHC as per IPHS norms	No. of SHCs test -checked	Facility available		Facility not available	
			No of SHCs	*Per cent*	No of SHCs	*Per cent*
1	Separate utilities for men and women	48	14	29	34	71
2	Provision of water supply	48	16	33	32	67
3	Facility of medical waste disposal	48	20	42	28	58
4	Citizen's Charter displayed prominently in local language	48	27	56	21	44
5	Labour room	48	28	58	20	42
6	Accommodation facilities for staff was partially present/occupied	48	28	58	20	42
7	Government building	48	30	62	18	38
8	OPD rooms/cubicles	48	37	77	11	23
9	Cleanliness was poor	48	38	79	10	21

(Source: Information provided by test-checked SHCs)

Appendix-1.10

(Referred to in paragraph 1.1.8.2.(i); page 11)

Manpower in test-checked CHCs

Sl. No.	Description of manpower required in each CHC as per IPHS norms	No of test - checked CHCs	No. of CHCs where manpower available	No of CHCs where manpower not available	Shortfall in percentage
1	Anaesthetist	12	00	12	100
2	Nine Staff Nurses (two of them may be ANMs)	12	00	12	100
3	Eye Surgeon	12	00	12	100
4	General Physician	12	01	11	92
5	Five Staff Nurses	12	01	11	92
6	Obstetrician & Gynaecologist	12	02	10	83
7	Pediatrician	12	04	08	67
8	General Surgeon	12	06	06	50
9	General duty Medical officer	12	08	04	33
10	Radiologist	12	07	05	42
11	Pharmacist	12	08	04	33
12	One Staff Nurse	12	10	02	17
13	Lab Technician	12	11	01	08

(Source: Information provided by test-checked CHCs)

Appendix-1.11

(Referred to in paragraph 1.1.8.2(ii); page 11)

Manpower in test-checked PHCs

Sl. No.	Requirement of manpower in each PHC as per IPHS norms	No. of test -checked PHCs	No of PHCs where manpower available	No of PHCs where manpower not available	Shortfall in percentage
1	Medical Officer (Allopathic)	24	17	07	29
2	AYUSH Medical Officer	24	00	24	100
3	Staff Nurse	24	03	21	88
4	Health Worker Female (ANM)	24	06	18	75
5	Lab Technician	24	08	16	67
6	Pharmacist	24	12	12	50
7	Three Staff Nurses	24	01	23	96
8	One Staff Nurse	24	02	22	92

(Source: Information provided by test-checked PHCs)

Appendix-1.12

(Referred to in paragraph 1.1.8.2(iii); page 11)

Manpower in test-checked SHCs

Sl. No.	Manpower required in each SHC as per IPHS norms	No.of test - checked SHCs	No of SHCs with manpower available	No of SHCs with manpower not available	Shortfall in percentage
1	One MPW	48	20	28	58
2	Any ANM	48	45	3	06
3	One ANM	48	44	04	08
4	Two ANMs	48	01	47	98

(Source: Information provided by test-checked SHCs)

Appendix-1.13

(Referred to in paragraph 1.1.9.1(i); page 13.)

(a) Administration of Iron Folic Acid tablets at State level

	Administration of IFA tablets				
Year	**Target in number of women**	**Achievement**	**Shortfall**	**Percentage of achievement**	**Percentage of shortfall**
2005-06	663356	674427	--	--	--
2006-07	670201	444045	226156	66	34
2007-08	670786	557894	112892	83	17
2008-09	708483	551150	157333	78	22
Total	**2712826**	**2227516**	**496381**	**82**	**18**

(Source - Information provided by test State Health Society)

(b) Statement showing availability of Iron Folic Acid tablets in test-checked districts

Name of districts	Year 2005-06 to 2008-09				Number of deprived women	Percentage of shortage	Percent-age of achieve-ment
	Registered pregnant women	Required IFA tablet @ 100 per person	Available IFA tablet	Shortage of IFA tablets			
1	**2**	**(2x100)=3**	**4**	**5**	**6**	**7**	**8**
Raipur	392280	39228000	31284760	7943240	79432	23	77
Raigarh	143142	14314200	8130000	6184200	61842	43	57
Kanker	71481	7148100	4001000	3147100	31471	44	56
Bastar	173487	17348700	11298235	6050465	60505	35	65
Total	**780390**	**78039000**	**54713995**	**23325005**	**233250**	**30**	**70**

(Source: Information provided by test-checked District Health Societies)

Appendix-1.14

(Referred to in paragraph 1.1.9.1 (ii); page 13)

Statement of institutional deliveries at State level

Year	No. of pregnant women registered	No. of institutional deliveries	No. of home deliveries	Total deliveries	Percentage of institutional deliveries
2005-06	672823	102811	465970	568781	18
2006-07	675802	131334	464913	596247	22
2007-08	651226	149025	414599	563624	26
2008-09	658429	179859	387276	567135	32
Total	**2658280**	**563029**	**1732758**	**2295787**	**25**

(Source: Information provided by test State Health Society)

Appendix-1.15

(Referred to in paragraph 1.1.10.1; page 15)

Details of areas covered under indoor residual spray in test-checked districts

Name of the district	Year	ABER	API	No. of villages where spray was to be done	Actual spraying done	Percentage of spray	Percentage of shortfall
Bastar	*2005-06*	25.77	31.13	*1520*	*713*	*47*	*53*
	2006-07	21.94	28.19	*1520*	*211*	*14*	*86*
	2007-08	21.04	25.43	*1520*	*555*	*37*	*63*
	2008-09	19.80	20.72	*1520*	*753*	*50*	*50*
Kanker	*2005-06*	43.59	33.87	*1032*	*591*	*57*	*43*
	2006-07	32.17	23.53	*964*	*154*	*16*	*84*
	2007-08	32.49	18.88	*703*	*651*	*93*	*07*
	2008-09	28.38	16.28	*848*	*571*	*67*	*33*
Raigarh	2005-06	13.11	9.44	412	412	100	0
	2006-07	7.27	5.97	648	642	99	1
	2007-08	11.07	5.83	935	935	100	0
	2008-09	9.87	4.5	598	598	100	0
Raipur	2005-06	10.40	0.69	510	510	100	0
	2006-07	12.77	0.92	486	486	100	0
	2007-08	12.89	0.64	583	583	100	0
	2008-09	11.57	0.45	672	672	100	0
Total	**2005-06**			**3474**	**2226**	**64**	**36**
	2006-07			**3618**	**1493**	**41**	**59**
	2007-08			**3741**	**2724**	**73**	**27**
	2008-09			**3638**	**2594**	**71**	**29**

(Source : Information provided by District Health Societies)

Appendix-1.16

(Referred to in paragraph 1.1.10.2; page 16)

(a) Details of sputum examination and detection of new sputum positive cases at State level

Year	Total OPD	Sputum examination			Detection of new Sputum positives	
		Target (percentage of OPD)	Achievement		Target (*in per cent*)	Achievement (*in per cent*)
			Number	*Per cent*		
2005-06	4135826	2-3	90361	2	70	62
2006-07	4301322	2-3	109289	3	70	55
2007-08	4702938	2-3	110679	2	70	59
2008-09	5173506	2-3	108439	2	70	57

(b) Outcome of treatment under Revised National Tuberculosis Control Programme as on March 2009 at State level

Year[17]	TB patients registered	Total new sputum positive	Treatment completed	Cured	Died[18]	Failures[19]	Defaulters[20]	Transferred out	Cure rate
2005-06	23530	8046	161	6678	658	241	1362	81	83
2006-07	28209	9704	243	8072	887	153	1733	66	83
2007-08	27504	10737	322	9019	962	179	1796	283	84
2008-09	27280	10598	424	8775	835	141	2004	63	83

(Source: Information provided by State TB Society)

Appendix-1.17

(Referred to in paragraph 1.1.10.3; page 16)

Details of prevalence of Leprosy at State level

Sl. No.	Particulars	2005-06	2006-07	2007-08	2008-09
1	Population	22580282	22866957	22955117	23336169
2	Cases at the beginning of the year	7994	4515	3322	5465
3	New cases detected	9040	6056	7784	7984
4	Treatment completed/cured	12519	7249	5641	7996
5	Balance of cases at the end of the year	4515	3322	5465	5453
6	Prevalence rate at the end of the year	2.03	1.45	2.38	2.34

(Source: Information provided by the State Leprosy Society)

[17] *The data is maintained from January to December every year.*
[18] *Patients died of TB (positive, negative, extra pulmunory)*
[19] *Patients not successfully treated*
[20] *Patients who left the treatment in between*

Appendix-1.18

(Referred to in paragraph 1.1.12.2; page 17)

Details of reporting by all the districts for 15 weeks under IDSP during the period January to December 2008

Particulars	Week	Total reporting units	Number of units from which reports received	Number of units from which reports not received
DETAILS OF REPORTING DONE UNDER IDSP-S (Surveillance at SHCs)	31	4741	2083	2658
	32	4741	2237	2504
	33	4741	2083	2658
	34	4741	2456	2285
	35	4741	1972	2769
	36	4741	1796	2945
	37	4741	2023	2718
	38	4741	1993	2748
	39	4741	1995	2746
	40	4741	1677	3064
	46	4741	2340	2401
	47	4741	1755	2986
	48	4741	2080	2661
	49	4741	2556	2185
	50	4741	2290	2451
Total	**15 weeks**	**71115**	**31336 (44 *Per cent*)**	**39779 (56 *Per cent*)**
DETAILS OF REPORTING DONE UNDER IDSP-P (Presumptive)	31	734	255	479
	32	734	243	491
	33	734	213	521
	34	734	251	483
	35	734	235	499
	36	734	200	534
	37	734	221	513
	38	734	226	508
	39	734	222	512
	40	734	196	538
	46	734	238	496
	47	734	233	501
	48	734	240	494
	49	734	258	476
	50	734	230	504
Total	**15 weeks**	**11010**	**3461 (31 *Per cent*)**	**7549 (69 *Per cent*)**

Particulars	Week	Total reporting units	Number of units from which reports received	Number of units from which reporting not received
DETAILS OF REPORTING DONE UNDER IDSP-L1 (Laboratory at CHCs)	31	146	96	50
	32	146	93	53
	33	146	106	40
	34	146	112	34
	35	146	105	41
	36	146	110	36
	37	146	118	28
	38	146	111	35
	39	146	129	17
	40	146	86	60
	46	146	139	07
	47	146	102	44
	48	146	117	29
	49	146	103	43
	50	146	92	54
Total	**15 weeks**	**2190**	**1619 (74 *Per cent*)**	**571 (26 *Per cent*)**
DETAILS OF REPORTING DONE UNDER IDSP-L2 (Laboratory at District Hospital)	31	16	09	07
	32	16	09	07
	33	16	09	07
	34	16	08	08
	35	16	09	07
	36	16	06	10
	37	16	08	08
	38	16	08	08
	39	16	14	02
	40	16	07	09
	46	16	11	05
	47	16	10	06
	48	16	15	01
	49	16	13	03
	50	16	09	07
Total	**15 weeks**	**240**	**145 (60 *Per cent*)**	**95 (40 *Per cent*)**
Average Percentage			**52**	**48**

(Source: Information provided by State IDP society)