CHAPTER I

This chapter includes two performance audits, one of the National Rural Health Mission and the other of Financial Management in Commune Panchayats together with a long paragraph on the Modernisation of Police Force scheme.

HEALTH AND FAMILY WELFARE DEPARTMENT

1.1 National Rural Health Mission

Highlights

Government of India launched (April 2005) the National Rural Health Mission throughout the country for providing accessible, affordable, accountable, effective and reliable health care facilities in rural areas. In the Union Territory of Puducherry, poor planning, ineffective financial management and inadequate facilities in health centres affected the implementation of the Mission. The important findings are indicated below:

- **Out of the available funds of Rs 23.79 crore during 2005-09, only Rs 13.37 crore (56 *per cent*) were utilised by the State Health Society.**

(Paragraph 1.1.6.2)

- **The Perspective Plan for the Mission period and Village Health Plans were not prepared and the Mission's objective of long-term and bottom-up approach in planning was not attained.**

(Paragraph 1.1.7.1)

- **Even though funds were released in September 2005 for construction of an additional building for the Community Health Centre, Mannadipet, the work was started only in August 2009. Three Community Health Centres were not provided with the required operation theatre equipment.**

(Paragraph 1.1.8.1 (i))

- **Twenty-four hour delivery and emergency services were available in only six out of the 13 test-checked Primary Health Centres.**

(Paragraph 1.1.8.1(ii))

- **Posts of General Surgeon and Anaesthetist were not filled up in any of the four Community Health Centres in the Union Territory. Six test-checked Primary Health Centres functioned with one doctor, while 77 posts of Health Worker (Male) in sub centres had not been sanctioned.**

(Paragraphs 1.1.8.2 (i) to (iii))

- **There was a sharp decline in the number of in-patients treated and in the number of deliveries conducted in the Community Health Centres and Primary Health Centres.**

(Paragraph 1.1.8.3)

- **Due to non-provision of equipment, two mobile medical units procured at a cost of Rs 27.01 lakh could not be used for the intended purpose.**

(*Paragraph* 1.1.8.4)

- **Meetings of the State Health Mission, State Health Society and District Health Missions required to be held at least once in six months to monitor and review the implementation of National Rural Health Mission were not conducted regularly.**

(Paragraph 1.1.12.4)

1.1.1 Introduction

The Government of the Union Territory (UT) of Puducherry signed a Memorandum of Understanding (MoU) with the Government of India (GOI) on 9 December 2005 for implementation of the National Rural Health Mission (NRHM) in the UT. The rural population of the UT as projected by the State Health Mission was 3.71 lakh (2008) out of the total population of 11.11 lakh. Various activities under NRHM aimed at improving the existing health care services in the UT.

The main objectives of the Mission were to

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

Some of the existing health care programmes of GOI before introduction of NRHM, *viz.,* the Reproductive and Child Health Programme as well as the Vector-Borne Diseases, Tuberculosis, Leprosy and Blindness Control Programmes were brought within the ambit of NRHM.

1.1.2 Organisational set up

In the UT, NRHM functions under the guidance of the State Health Mission (SHM) headed by the Chief Minister. The Puducherry State Health Society, (SHS) constituted on 27 October 2005, carries out the activities of the Mission. The Governing Body and the Executive Committee of SHS are headed by the Chief Secretary and the Secretary, Health and Family Welfare Department respectively.

There are four health districts in the four regions (Puducherry, Karaikal, Mahe and Yanam) of the UT. There is no separate District Health Mission for Puducherry district and the Executive Committee of the SHS also functions as the Puducherry District Health Mission. Each of the other three districts has a District Health Mission and District Health Society headed by the Regional Administrator/Collector of the respective regions. Implementation of various disease control programmes is supervised by the respective Programme Managers under SHM. An organogram showing the administrative and monitoring set up of NRHM in the UT is given in **Appendix 1.1.**

The various activities of NRHM are implemented through four Community Health Centres (CHC)[1], 39 Primary Health Centres (PHC)[2] and 77 Sub Centres (SC)[3] in all the four regions of UT.

1.1.3 Audit objectives

The objectives of the performance audit were to assess whether :

- the planning processes at the village, block, district and Union Territory levels were adequate;
- the assessment, release and utilisation of funds were efficient and effective;
- capacity building and strengthening of physical and human infrastructure were as per the Indian Public Health Standard norms;
- the performance indicators and targets fixed, especially in respect of reproductive and child healthcare, immunisation and disease control programmes were achieved and
- the level of community participation, monitoring and evaluation was as per the guidelines.

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1 Two in Puducherry region, one each in Karaikal region and Mahe region.

2 27 in Puducherry region, 11 in Karaikal region and one in Mahe region.

3 52 in Puducherry region, 17 in Karaikal region and four each in Mahe and Yanam regions.

1.1.4 Audit criteria

The criteria adopted to arrive at audit conclusions were:

- Mission guidelines issued by the Union Ministry of Health and Family Welfare.
- Memorandum of Understanding between GOI and the UT.
- State Programme Implementation Plans approved by GOI and
- Indian Public Health Standard norms for upgradation of CHCs and PHCs.

1.1.5 Scope and Methodology of audit

The performance review was conducted during March-August 2008 and April-May 2009, covering the implementation of the programme during the period 2005-09, by checking the records of the Director of Health and Family Welfare Services, the State Health Society, three District Health Societies[4], all the four CHCs, 13 out of 39 PHCs and 26 out of 77 SCs in the UT. The list of test-checked units is given in **Appendix 1.2.**

Audit objectives and criteria were discussed in an entry conference held with the Secretary, Health Department on 16 July 2008. The audit findings were discussed with him in an exit conference on 24 September 2009.

Audit Findings

1.1.6 Financial Management

1.1.6.1 Funding pattern

The Mission was financed by GOI till 2006-07. From 2007-08, the funding was to be shared in the ratio of 85:15 between GOI and the UT Government. GOI released funds to the UT Government for seven components[5] and to the SHS for five components[6] and five[7] disease control programmes during 2005-09.

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4 Karaikal, Mahe and Yanam District Health Societies.

5 Direction and Administration, Training, Maternal and Child Health Programme, Transport, Compensation, Conventional Contraceptives and Maintenance of sub centres.

6 Janani Suraksha Yojana, NRHM Flexipool, Pulse Polio Immunisation, RCH Flexipool and Routine Immunisation.

7 Integrated Diseases Surveillance Project (IDSP), National Leprosy Eradication Programme (NLEP), National Programme for Control of Blindness (NPCB), National Vector-Borne Disease Control Programme (NVBDCP) and Revised National Tuberculosis Control Programme (RNTCP).

1.1.6.2 Financial performance

During 2005-09, GOI released Rs 15.17 crore[8] to the UT for implementing its family welfare programme under components such as direction and administration, maintenance of Sub Centres, and training. The UT spent Rs 15.06 crore[9] during the period. During 2005-06, Rs 74.47 lakh was released for imparting training to Auxiliary Nursing Midwives (ANM) and Lady Health Visitors. This amount was not utilised by the department and the grant was transferred to the component – 'Maintenance of Sub-Centres' during 2007-08, without the approval of GOI.

When this was pointed out in audit, the Government stated (November 2009) that the amount was utilised for payment of salaries to ANMs during 2008-09 as there was a shortage of Centrally Sponsored Scheme funds due to implementation of the recommendations of the Sixth Pay Commission.

The status of funds directly made available to the State Health Society and expenditure made thereagainst during 2005-09 is given in **Table 1.**

Table 1 : Details of receipt and utilisation of funds

(Rupees in lakh)

Year	Opening balance	Funds received from GOI	Interest and other items	UT share	Total funds available	Expenditure	Closing balance
2005-06	65.63	489.07	12.70	-	567.40	127.61	439.79 (78)
2006-07	439.79	560.93	13.58	-	1,014.30	270.54	743.76 (73)
2007-08	743.76	460.41	18.80	-	1,222.97	417.25	805.72 (66)
2008-09	805.72	583.86	24.30	150.00	1,563.88	532.65	1,031.23(66)
Total		**2,094.27**	**69.38 ***	**150.00**		**1,348.05 ****	

(Source : State Health Mission and Detailed Appropriation Accounts (2008-09) for UT share)

* includes Rs 2.01 lakh refunded by PWD

** includes Rs 10.76 lakh refunded to GOI (Rs 8.86 lakh in 2006-07 and Rs 1.90 lakh in 2007-08)

Forty four *per cent* of total funds provided during 2005-09 were not utilised

Component-wise details of expenditure are given in **Appendix 1.3**. Out of the total funds of Rs 23.79 crore[10] made available to the SHS during 2005-09, the SHS could spend only Rs 13.37 crore (56 *per cent*). There were substantial unspent balances at the end of each financial year. During 2005-06, the SHS had very little time to utilise the funds after signing an MoU with GOI in December 2005. However, savings in the subsequent years ranging between 66 and 73 *per cent*, as shown in **Table 1**, indicated inadequate preparedness of the SHS in utilising the funds.

[8] Rs 14.78 crore (2005-06), Rs 0.37 crore (2006-07), Rs 0.02 crore (2007-08) and Nil (2008-09).

[9] Rs 2.67 crore (2005-06), Rs 4.80 crore (2006-07), Rs 4.19 crore (2007-08) and Rs 3.40 crore (2008-09).

[10] Opening balance – Rs 65.63 lakh; Funds received from GOI – Rs 2,094.27 lakh; Interest – Rs 69.38 lakh; UT share - Rs 150 lakh.

1.1.6.3 Non-release of UT share

Fifteen *per cent* UT share on the GOI allocation of Rs 6.04 crore, which amounted to Rs 90.63 lakh, for the year 2007-08 was not released by the UT to the SHS.

When this was pointed out, the Government stated (November 2009) that the share of Rs 1.50 crore released by the UT during 2008-09 was 15 *per cent* of the total funds released (Rs 10.44 crore) by GOI during 2007-08 and 2008-09. This reply is not acceptable as the UT Government was directed (May 2008) by the Ministry of Health and Family Welfare, New Delhi to credit Rs 1.50 crore to SHS as its share for 2008-09.

1.1.6.4 Unspent balance of RCH-I Programme

Unspent balances of RCH-I amounting to Rs 24.81 lakh were not transferred to RCH Phase-II

The Reproductive and Child Health Programme Phase-I (RCH-I) was implemented by the State Committee on Voluntary Action prior to the introduction of NRHM in 2005. According to the 'Finance and Accounts Manual' of RCH Phase-II, the unspent balances (as on 31 March 2005) of RCH-I were to be carried forward to RCH-II. Scrutiny of records of the SHS revealed that in contravention of the above instructions, unspent balances of RCH-I amounting to Rs 24.81 lakh were not transferred to RCH -II.

The SHM replied (July 2009) that settlement of accounts with PWD for amounts deposited for minor and major works was awaited and that the unspent funds under 'Mother NGO[11]' and 'No Scalpel Vasectomy' would be utilised in the current programme or refunded to GOI.

Government accepted (November 2009) the views of audit and stated that steps were being taken to refund the unspent balance under RCH-I to GOI during 2009-10.

1.1.7 Planning

1.1.7.1 Village Health Plans and Perspective Plan

The National Rural Health Mission envisaged a decentralised and participatory planning process following a bottom-up approach from the village level to the State level. A Perspective Plan (2005-12) and an Action Plan for each year were to be prepared for the UT by consolidating all the district Plans, which would be adopted as the basis for interventions in the health sector. For preparation of a comprehensive District Health Plan, a systematic mobilisation of the community by involving representatives of Panchayati Raj Institutions was necessary for conducting household and facility surveys at the CHC, PHC and SC levels. The Village Health and

[11] NGO identified at District level to serve as nodal agency for selection of field NGOs at block level, distribution of funds and monitoring.

Sanitation Committees (VHSC) were responsible for planning and monitoring at village level and they were to prepare Village Health Plans.

Village and District Health Plans were not prepared. Perspective Plan for the Mission period was not prepared in any of the four districts

Scrutiny of records revealed that Village Health Plans were not prepared by the VHSC. Consequently, the District Health Plans and UT Plans were not prepared adopting the bottom-up approach in planning. Government stated (November 2009) that Programme Implementation Plans for 2005-09 were prepared on the basis of district level household surveys, conducted by the International Institute of Population Sciences during 2002-04 and 2007-08. Government also stated that the VHSC members did not have adequate understanding about the planning process and that a questionnaire on deficiencies in infrastructure, human resources and training had been sent to all VHSCs and based on their feedback, the Programme Implementation Plan for 2009-10 had been prepared for the districts.

No Perspective Plan had been prepared in any of the four districts in the UT and consequently, the Perspective Plan at the UT level for the Mission period was also not prepared.

1.1.7.2 State Level Health Resource Centre

The guidelines of NRHM specified that State level health resource centres with an annual corpus of Rs 50 lakh were to be set up for operationalising new ideas in the planning process and for strengthening delivery of services by hiring resource persons. However, it was observed that no such centre had been set up in the UT as on date.

1.1.8 Infrastructure and health care facilities at health centres

NRHM envisaged strengthening of all PHCs and upgradation of all CHCs to the Indian Public Health Standards (IPHS) by providing required buildings, infrastructure, manpower and equipment.

1.1.8.1 Health care Infrastructure

The IPHS prescribed establishment of one SC for 5,000, one PHC for 30,000 and one CHC for 1,20,000 people. On applying the norms prescribed for establishing health centres based on the rural population of 3.71 lakh, it was noticed that the status of health centres was as given in **Table 2.**

Table 2 : Status of health centres in UT

Category	No. of centres required	Actual number of centres available	Excess(+)//less (-)
CHC	3	4	(+)1
PHC	13	24	(+)11
SC	74	51	(-)23

(Source : State Health Mission)

On this being pointed out, the Government stated (November 2009) that six additional SCs were proposed to be set up in the coming years. Government also stated that the additional PHCs reduced the need for having more SCs in the rural areas.

(i) Community Health Centres

NRHM envisaged bringing all CHCs at par with IPHS to provide round-the-clock services to the rural people.

GOI released (September 2005) Rs 80 lakh (Rs 20 lakh per CHC) for upgradation of four CHCs[12] on the basis of IPHS. Out of the amount released, Rs 33.86 lakh were lying unspent with the SHS (March 2009). The SHS released (March 2006 and April 2009) Rs 10.28 lakh to the Public Works Department (PWD) for construction of an additional building for Mannadipet CHC. The estimate was revised (January 2009) for constructing another floor over the existing building. The work had been awarded to a contractor only in August 2009. The intended purpose of upgrading the CHC was not, therefore, achieved even after three and half years of the release of the upgradation grant. Government stated (November 2009) that the PWD had delayed the commencement of work and assured that the upgradation work would be completed in the year 2009-10.

- ***Availability of services***

Essential services such as emergency obstetric services, blood storage facilities, safe abortion services and facilities for caesarean deliveries were not available in any of the four CHCs. Ultrasound scanning facilities were also not available in three CHCs[13]. Operation theatre equipment such as ventilators and high pressure stabilisers were not available in two CHCs[14] and a cardiac monitor and shadowless lamps were not available in one CHC[15].

Government assured (November 2009) that ultrasound facilities would be provided in all CHCs during 2009-10. It also contended that providing ventilator services would require skill-based training and 24-hour anaesthetists in CHCs. This contention is not acceptable as the CHCs were required to provide optimal expert care and achieve and maintain an acceptable standard of quality of health care as per the IPHS. Despite availability of funds of Rs 42 lakh (March 2009) under 'upgradation of CHCs to IPHS', the SHM had failed to hire specialists including

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12 Mannadipet, Karikalampakkam, Thirunallar and Palloor.

13 Mannadipet, Thirunallar and Palloor.

14 Mannadipet and Palloor.

15 Palloor.

anaesthetists, thereby defeating the objective of ensuring quality health care delivery.

(ii) Primary Health Centres

NRHM aimed at strengthening PHCs for quality, preventive, promotive, curative, supervisory and outreach services.

As per IPHS, essential services such as 24-hour emergency services, 24-hour delivery services, in-patient services and operation theatres were to be available in each PHC. The status of essential services available in 39 PHCs in the UT is given in **Table 3**.

Table 3 : Status of essential services in PHCs

Facility/Essential services	Number of PHCs in which facility available	Number of PHCs in which facility not available
24-hour delivery	19	20
24-hour emergency services	20	19
Tubectomy and vasectomy	4	35
Medical termination of pregnancy	0	39
Operation theatre	6	33
Labour room	34	5
Cataract surgery	5	34

(Source : State Health Mission)

Only six out of 13 test-checked Primary Health Centres provided 24-hour delivery and 24-hour emergency services

In the 13 test-checked PHCs, it was noticed that 24-hour delivery and 24-hour emergency services were available in just six PHCs[16], out of which operation theatre and family planning services were available in only three PHCs[17]. Facilities for medical termination of pregnancy (MTP) were not available in any of the PHCs.

On this being pointed out, Government replied (November 2009) that as most of the PHCs were near the Government General Hospital in each region, the patients were referred to the General Hospital for the services. Government also stated that there was no need for MTPs in PHCs as many private hospitals and Government Hospitals conducted the procedure free of cost. The reply is not acceptable as the objective of the Mission to provide accessible, affordable and effective health care to the rural population would be defeated if the PHCs functioned only as referral units for such services.

[16] Nettapakkam, Thirubhuvanai, Kalapet, Mettupalayam, Ambagarathur and Nedungadu.

[17] Nettapakkam, Thirubhuvanai and Nedungadu.

- ***Basic laboratory services***

Eight out of 13 test-checked Primary Health Centres did not have facilities for clinical tests

Twenty-five PHCs did not provide laboratory facilities as laboratory technicians were not posted there (March 2009). In eight[18] out of 13 test-checked PHCs, the posts of laboratory technicians were vacant. The patients were referred to district hospitals even for simple laboratory tests like haemoglobin, urine sugar, albumin etc.

Government stated (November 2009) that laboratory technicians were being recruited and posted in all rural PHCs from September 2009.

(iii) Sub Centres

Even though 31 out 77 Sub Centres in the UT were functioning in rented buildings, no proposal for construction of buildings was included in the Programme Implementation Plans

As per NRHM guidelines, upgradation of existing SCs, including construction of buildings for SCs functioning in rented buildings could be included in the Plan. Out of the 77 SCs, 31 SCs in Puducherry and Karaikal regions functioned in rented buildings as of March 2009. Despite that, no proposal was included in the UT's Programme Implementation Plans for the period 2005-09 for construction of buildings for SCs.

Government stated (November 2009) that Rs 81.64 lakh had been sanctioned during 2009-10 for construction of four SCs.

1.1.8.2 Manpower

(i) Community Health Centres

As against the requirement of one post each of general surgeon, anaesthetist, obstetrician and gynaecologist and eye surgeon in each CHC, no posts were sanctioned by the Health and Family Welfare Department for any of the four CHCs. While the posts of obstetrician and gynaecologist and paediatrician were filled on contract basis in three CHCs[19], these posts were not filled up in Thirunallar CHC. The posts of general surgeon, eye surgeon and anaesthetist were not filled up in any of the CHCs by the SHM (March 2009).

Government stated (November 2009) that despite efforts made to fill up the vacancies in CHCs, specialists had not come forward to work in the health centres.

[18] Sooramangalam and Thirubhuvanai in Puducherry region, Ambagarathur, Nalambal, Nallathur, Karaikal Medu and Kovilpathu in Karaikal region and Pandakkal in Mahe region.

[19] Karikalampakkam, Mannadipet and Palloor.

(ii) Primary Health Centres

Even though one post of Health Assistant (Female)/Lady Health Visitor is required per PHC, only 14 posts were sanctioned as against 39 posts required for the PHCs and two out of the sanctioned 14 posts were not filled up. Similarly, as against the requirement of 39 posts of Health Assistant (Male), only 22 posts were sanctioned and seven out of 22 sanctioned posts remained vacant (March 2008)[20]. Sixteen out of 39 PHCs functioned with one doctor as against a minimum requirement of two doctors per PHC.

Only one doctor was posted in six PHCs as against minimum of two doctors

Only one doctor was posted in six[21] out of 13 test-checked PHCs as against the requirement of minimum of two doctors in each PHC. It was, however, noticed that in Nedungadu PHC, six doctors were posted as against two sanctioned posts indicating uneven deployment of doctors in PHCs.

Government stated (November 2009) that the vacancies would be filled up on contractual/regular basis during 2009-10. The reply is not acceptable as the Government should follow the minimum standards prescribed by IPHS.

(iii) Sub Centres

Even though one post of Health Worker (Male) was required for each SC, no posts had been sanctioned and all 77 SCs functioned without any Health Worker (Male). Reasons for non-creation of posts are awaited from Government.

1.1.8.3 In-patient treatment

The number of in-patients treated in all CHCs and PHCs including the 13 test-checked PHCs during 2005-09 is given in **Table 4.**

Table 4 : Details of In-patients (IPs) treated

Year	No of IPs treated in		No of IPs treated in test-checked PHCs
	CHCs	PHCs	
2005-06	8,453	8,622	2,803
2006-07	10,468	7,059	2,747
2007-08	7,491	6,227	2,193
2008-09	NA	NA	2,017

(Source : Annual Report of Health and Family Welfare Department)

NA : Not available

A sharp decline was noticed in the number of in-patients treated in all CHCs and PHCs, including the test-checked PHCs from 2005-06 onwards.

Government attributed (November 2009) the decline to the opening of private medical colleges in the UT during recent years. It was, therefore,

[20] As mentioned in Sample Registration Survey Bulletin.

[21] Nettapakkam, Sooramangalam, Nalambal, Nallathur, Karaikal Medu and Kovilpathu.

obvious that some of the patients preferred private hospitals as compared to the Government hospitals.

1.1.8.4 Mobile medical units

With the objective of making health care available at the doorstep of the public in rural areas, NRHM envisaged the establishment of mobile medical units (MMU), each comprising two vehicles, one for mobility of staff and the other for equipment and diagnostic facilities. An amount of Rs 73.50 lakh (Rs 49 lakh in 2007-08 and Rs 24.50 lakh in 2008-09) was provided for the purpose. The SHM procured (December 2008) two sets of vehicles[22] for Rs 27.01 lakh for carrying equipment and medical staff. However, necessary medical equipment such as BP apparatus, oxygen cylinder, etc., had not been procured (July 2009) and the vehicles were being used for health visits without necessary equipment.

Government stated (November 2009) that equipment would be procured to make the MMUs operational.

1.1.9 Reproductive and Child Health care

The Reproductive and Child Health programme (RCH) aimed to reduce the maternal mortality rate (MMR), infant mortality rate (IMR) and total fertility rate (TFR) through improved antenatal care, family planning and immunisation. The achievements against the targeted levels of MMR, IMR and TFR, as made available by the SHM, are indicated in **Table 5**.

Table 5 : Targets and achievement of Health Indicators

	Target for UT 2011-12	Status prior to NRHM	Status during NRHM
IMR	15/1000 live births	24	25
MMR	10/10000 live births	20	18
TFR	1.5 children per woman	1.8	1.8

(Source : State Health Mission)

The IMR and TFR did not show any improvement after inception of NRHM in the UT.

Government, while admitting the audit observation on IMR, stated that (November 2009) 60 *per cent* of deliveries reported in the UT were by women from neighbouring States, which accounts for the shortfall in achievement under MMR/TFR.

1.1.9.1 Supply of IFA tablets to pregnant women

Anaemia is considered to be a leading cause of maternal mortality. The RCH-II programme, therefore, emphasised administration of iron-folic tablets (IFA) to pregnant women. Prevention against nutritional anaemia in a pregnant woman required a daily dose of IFA tablets for a period of

[22] One for PHC Bahour in Puducherry and another for PHC Vizhidiyur in Karaikal.

100 days. As per the District Level Household Survey-II conducted during 2002-04, 96 *per cent*[23] of pregnant women in the UT were anaemic.

The details of pregnant women registered and medically checked and those who received IFA tablets for 100 days during 2005-09 are given in **Table 6**.

Table 6 : Registration of pregnant women and supply of IFA tablets

Year	Number registered	Number who received IFA tablets for 100 days	Shortfall (percentage)
2005-06	41,109	18,029	23,080 (56)
2006-07	44,524	15,537	28,987 (65)
2007-08	69,398	19,499	49,899 (72)
2008-09	82,594	27,022	55,572 (67)

(Source : State Health Mission)

Shortfalls ranging from 56 to 72 *per cent* were noticed in the supply of IFA tablets to registered pregnant women. No specific reply was furnished by Government for the shortfall.

1.1.9.2 Deliveries in CHCs and PHCs

According to the norms prescribed, PHCs were to be equipped to handle normal deliveries while CHCs were to be equipped to handle both normal and caesarean deliveries. The details of deliveries conducted at the CHCs and PHCs during the last four years are given in **Table 7**.

Table 7 : Number of deliveries in Union Territory

Institutions	2005-06	2006-07	2007-08	2008-09
CHCs	339	352	219	199
PHCs	571	526	393	286
Test-checked PHCs	158	191	108	100

(Source : State Health Mission)

The number of deliveries conducted in Primary Health Centres and Community Health Centres declined steadily

The table above depicts that the number of deliveries in CHCs and PHCs (including the 13 test-checked PHCs) were on the decline.

Government attributed (November 2009) the decline to proximity of district hospitals with 24-hour specialised services and provision of free transportation to the pregnant women by the PHCs for admission to district hospitals. The reply is not acceptable as all the CHCs/PHCs were required to have 24-hour delivery facilities, emergency services and operation theatres as per IPHS. The failure of SHM to address the deficiencies in respect of manpower and infrastructure in the health centres resulted in the targeted rural populace preferring other hospitals for specialised services.

[23] Mild (75 *per cent*), moderate (17 *per cent)* and severe (4 *per cent*).

1.1.9.3 Family planning

Family planning includes terminal methods (vasectomy for male and tubectomy and laparoscopy for females) to control the total fertility rate. The details of achievements in respect of the terminal methods during 2005-09 are given in **Table 8.**

Table 8 : Details of sterilisation

Year	Number of sterilisations performed in the UT			Number of sterilisations in test-checked centres		
	Vasectomy	Tubectomy	Laparoscopy	Vasectomy	Tubectomy	Laparoscopy
2005-06	19	10,085	109	2	176	Nil
2006-07	24	10,281	178	2	148	Nil
2007-08	14	10,153	136	Nil	123	Nil
2008-09	25	9,578	177	Nil	139	Nil
Total	**82**	**40,097**	**600**	**4**	**586**	**Nil**

(Source : Health and Family Welfare Department)

The proportion of vasectomies to the total sterilisations done in the UT was negligible (0.20 *per cent*) during 2005-09. Out of a total of 43 vasectomies performed during 2005-07, four[24] were performed in the two test-checked PHCs. Sterilisations were performed in two CHCs[25] and two PHCs[26] in the Puducherry region. In Karaikal region, none of the CHCs/PHCs performed any sterilisation. The SHM, in reply to an audit query, attributed (July 2009) the poor performance to the inclination of the patients to undergo sterilisations in well-equipped Government hospitals and also stated that majority of the post-natal mothers opted to undergo sterilisations in such hospitals immediately after childbirth.

Grant of Rs 5.30 lakh by GOI in 2005-06 for 'No Scalpel Vasectomy', an innovative scheme, remained unspent for more than three years.

The Government stated (November 2009) that male participation in family planning was low in the UT in line with the all-India pattern.

1.1.9.4 Vitamin A administration

The RCH-II Programme emphasised administration of Vitamin A solution to all children under three years of age. Prevention of blindness amongst children due to deficiency of Vitamin A requires the administration of the first dose of Vitamin A solution at nine months of age along with the measles vaccine, the second dose along with the oral polio vaccine or DPT and three doses subsequently at six-monthly intervals.

The targets and achievements for Vitamin A solution administration during 2005-09 are given in **Table 9.**

[24] Nettapakkam – 2 (2005-06) and Thirubhuvanai – 2 (2006-07).

[25] Mannadipet and Karikalampakkam.

[26] Nettapakkam and Thirubhuvanai.

Table 9 : Targets and achievements in administration of Vitamin A solution

Year	Target	Achievement in administration of Vitamin A Solution		
		1st dose	2nd dose	3rd to 5th dose
2005-06	16,000	15,224	14,165	23,840
2006-07	16,000	14,101	11,852	25,499
2007-08	16,000	16,042	14,818	38,327
2008-09	16,000	13,874	13,538	52,075

(Source : State Health Mission)

A low target was fixed for administration of Vitamin A solution

Even though the number of institutional deliveries in Government health institutions ranged between 40,000 and 45,000 per year, a very low annual target of 16,000 was fixed throughout the period and shortfalls in achievement were noticed in all the years.

The Government contended (November 2009) that the target was fixed considering the deliveries by the residents of UT and that 60 to 65 *per cent* of institutional deliveries in UT were by women of adjoining States. In view of the increase noticed in the number of pregnant women registered in the UT as given in **Table 6**, the reply of the Government is not sustainable.

1.1.10 Disease Control Programmes

The performance under various Disease Control Programmes during 2005-09 is discussed in the following paragraphs:

1.1.10.1 National Leprosy Eradication Programme

The National Leprosy Eradication Programme (NLEP) aimed to eliminate leprosy by the end of the Eleventh Plan. It also aimed to ensure a leprosy prevalence rate of less than one per thousand. The UT reported that leprosy had been eliminated in March 2004 and that programme activities had been undertaken to sustain the status of elimination and eradication of the disease completely. The leprosy prevalence rate in the UT, however, increased from 0.26 per thousand in 2005-06 to 0.37 per thousand in 2008-09 as given in **Table 10**.

Table 10 : Prevalence of Leprosy in UT

Year	New cases detected	Leprosy prevalence rate (per thousand)
2005-06	47	0.26
2006-07	57	0.36
2007-08	50	0.22
2008-09	57	0.37

(Source : Programme Manager (Leprosy), State Health Mission)

1.1.10.2 National Vector-Borne Disease Control Programme

The National Vector-Borne Disease Control Programme (NVBDCP) aimed to control vector-borne diseases by reducing mortality due to malaria, filaria, dengue, chikungunya etc., in endemic areas through close surveillance, controlling breeding of mosquitoes and flies by spraying larvicides and insecticides and improving diagnostic and treatment facilities at health centres.

Details of blood smear collection and testing, annual blood examination rate (ABER) and annual parasitic incidence (API) are given in **Table 11**.

Table 11 : Prevalence of malaria in UT

Year	Population (in lakh)	Blood smears collected (BSC) and tested	Malaria positive (MP)cases	ABER[27]	API[28]
2005-06	10.30	2,18,563	44	21.22	0.043
2006-07	10.49	1,96,371	50	18.71	0.048
2007-08	10.69	1,25,463	68	11.73	0.064
2008-09	10.75	1,27,963	72	11.91	0.067

(Source : Health and Family Welfare Department)

Though collection of blood smears declined from 21.22 *per cent* in 2005-06 to 11.91 *per cent* in 2008-09, the number of cases tested positive increased from 44 to 72 during the period, indicating higher incidence of malaria.

The Government stated (November 2009) that samples were collected only from highly suspicious cases and attributed the decline in the number of samples collected to the shortage of manpower during the past three years.

1.1.10.3 National Programme for Control of Blindness

The National Programme for Control of Blindness (NPCB) aimed to reduce the prevalence rate of blindness to 0.3 *per cent* by 2010 through increased cataract surgeries, school eye screening and free distribution of spectacles. The UT had achieved a prevalence rate of 0.4 *per cent.*

The details of school children screened, those found with refractive errors under the school eye screening programme and those provided with free spectacles are given in **Table 12**.

[27] ABER = BSC/Population x 100.

[28] API = MP/Population x 1000.

Table 12 : Eye screening for school children

Year	No of school children screened	No of children with refractive errors detected	No of children provided with free spectacles
2006-07	55,572	2,743	1,300
2007-08	33,832	1,506	1,506
2008-09	47,094	5,104	2,015

(Source: Programme Manager (National Programme for Control of Blindness), State Health Mission)

Only 47 and 39 *per cent* children identified with refractive errors were provided spectacles during 2006-07 and 2008-09 respectively

As may be seen, only 47 and 39 *per cent* of children identified with refractive errors during 2006-07 and 2008-09 respectively were provided free spectacles. The SHM replied that supply of free spectacles to children involved procedural delays in ordering and supply of spectacles and that the parents preferred to procure the spectacles for their children on their own to avoid delays.

1.1.10.4 Revised National Tuberculosis Control Programme

Under the Revised National Tuberculosis Control Programme, the UT had to maintain a cure rate of 85 *per cent* of new sputum positive cases during the Mission period. It was observed that the actual cure rate increased from 73 *per cent* in 2005 to 86 *per cent* up to the first quarter of 2008.

1.1.11 Ayurveda, Unani, Siddha and Homeopathy services

One CHC and 15 Primary Health Centres in the UT were not provided AYUSH practitioners and 98 *per cent* of funds remained unutilised

One of the objectives of NRHM was to mainstream Ayurveda, Unani, Siddha and Homeopathy (AYUSH) services through revitalising local traditions. The Mission aimed to provide AYUSH services by posting an AYUSH doctor at each PHC. It was noticed that AYUSH practitioners were posted in three CHCs and 24 PHCs only through regular posting or by contractual appointment. AYUSH services were not available in six[29] PHCs and one[30] CHC out of the test-checked health centres. Though Rs 79.47 lakh out of Rs 80.88 lakh received from GOI under NRHM during 2007-09 remained unspent with SHS as on 31 March 2009, the SHM asked for Rs 1.03 crore from GOI for 2009-10 for mainstreaming of AYUSH and received GOI approval for Rs 83.24 lakh. The intended objective of mainstreaming of AYUSH services in rural health areas was not fully achieved despite the availability of sufficient funds.

Government stated (November 2009) that selection of doctors and pharmacists for AYUSH clinics had been completed and orders for their appointments were under issue.

[29] Sooramangalam in Puducherry region, Ambagarathur, Nalambal, Nallathur, Karaikal Medu and Kovilpathu in Karaikal region.

[30] Palloor in Mahe region.

1.1.12 Monitoring and evaluation

1.1.12.1 Health Monitoring and Planning Committee

The guidelines of NRHM envisaged the formation of Health Monitoring and Planning Committees at the PHC, district and UT level to participate in the planning process and to monitor the progress of NRHM. It was found that no committee had been formed at any level. Government stated (November 2009) that the monitoring of the programme was done at the UT level by the programme committee. The reply is not acceptable as the Mission envisaged monitoring and planning at village, block and district levels.

1.1.12.2 Community participation

The guidelines of NRHM stated that community action was the only guarantee for exercising the right to health care and putting community pressure on the health care system. It also envisaged a critical role for non-government organisations (NGOs) in the implementation of NRHM for the success of the Mission. The Mother NGO (MNGO) was to identify and select Field NGOs[31] (FNGO) to support and monitor such selected FNGOs in community need assessment, developing proposals based on line data and convergence with other departments. It was noticed that only one[32] MNGO was involved in Puducherry district and for the remaining three districts, no NGO had been identified. Though Rs 23.50 lakh were received by SHS from GOI in 2005-06, SHS belatedly released Rs 22.50 lakh to the MNGO (Rs 5 lakh in 2007-08 and Rs 17.50 lakh in 2008-09). Government replied (October 2009) that the MNGO utilised the entire funds during 2008-09. It was, however, noticed that MNGO released only Rs 18 lakh to field NGOs in March 2009 and reflected the amount released as expenditure.

1.1.12.3 Rogi Kalyan Samiti

As per NRHM guidelines, Rogi Kalyan Samitis (RKS) was to be constituted in all CHCs and PHCs for managing health related assets. The RKSs, had to be registered as societies with groups of trustees drawn from NGOs, Panchayat Raj Institutions and the Government. It was found that the meetings of the RKSs were not conducted regularly. There was no representation from the vulnerable and disadvantaged sections of the society. No grievance redressal mechanism was developed to get feedback from the public. In view of the above deficiencies, the objective of community ownership of health centres through RKS remained unachieved.

Government did not give any specific reply for not conducting the meetings regularly. It, however, assured (November 2009) that RKSs would be registered as societies shortly.

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[31] Block level NGOs selected by Mother NGO.

[32] SOJAHUR - Society for Social Justice and Human Rights.

1.1.12.4 Monitoring at highest levels

The SHM and the three District Health Missions (DHM) constituted in October 2005 were required to meet at least once in every six months. However, only one meeting of the SHM and 11 meetings of DHMs were conducted during 2005-09. The Governing Body of the SHS had not met even once since its inception in October 2005. Despite the availability of sufficient funds for the implementation of the scheme, utilisation of funds to achieve the objectives of the SHM was not effectively monitored by conducting regular meetings at the State and district levels, resulting in lack of quality health care services for the poor and vulnerable sections of the population. Government's reply was awaited.

1.1.13 Conclusion

The State Health Society could spend only 56 *per cent* of funds released to them during 2005-09. Village Health Plans were not prepared by the Village Health and Sanitation Committees and the Perspective Plan for the Mission period for the UT was not prepared. Twenty-four hour emergency and delivery services and laboratory facilities were available only in few PHCs. In six PHCs, only one doctor was posted as against the requirement of two doctors in each PHC. Funds provided for Ayurveda, Unani, Siddha and Homeopathy services remained unutilised. The meetings of the State Health Mission, the State Health Society and the District Health Societies were not conducted regularly, resulting in lack of monitoring at UT and district levels.

1.1.14 Recommendations

- Planning should be done at village, block and district levels to ensure bottom-up approach in planning.
- Manpower and infrastructure should be strengthened and essential equipment required in CHCs/PHCs/SCs for quality health care services should be provided.
- Twenty-four hour emergency and delivery services and laboratory facilities should be made available in all PHCs.
- Effective monitoring mechanism should be established at all levels.

Appendix 1.1

(Reference : Paragraph 1.1.2 ; Page 3)

Organogram of State Health Mission and State Health Society

State Health Mission

Chairperson	:	Chief Minister
Co-Chairperson	:	Minister for Health and Family Welfare
Convenor	:	Secretary for Health and Family Welfare
Members	:	Minister for Women and Child Welfare, Member of Parliament, Chief Secretary, Director, Health and Family Welfare Services, Representative, Ministry of Health and Family Welfare, Government of India etc.

State Health Society

Governing Body

Chairperson	:	Chief Secretary
Co-Chairperson	:	Development Commissioner
Vice Chairman	:	Secretary, Health and Family Welfare
Convenor	:	Mission Director
Mission Director	:	Director, Health and Family Welfare Services
Members	:	Secretary, Women and Child Welfare, Deputy Director, Family Welfare, Deputy Director, Public Health, Deputy Director, Information, Education and Communication. Representative, Ministry of Health and Family Welfare, Government of India, Mother NGO, All Programme Managers of Disease Control Programme Units etc.

Executive Committee

Chairperson	:	Secretary, Health and Family Welfare
Vice Chairman	:	Director, Health and Family Welfare Services
Convenor	:	Deputy Director, Family Welfare and Maternal Child Health
Members	:	Deputy Director, Public Health, Deputy Director, Information, Education and Communication. Director, Indian System of Medicine (AYUSH), All Programme Managers of Disease Control Programme Units, etc.

State Programme Management Support Unit headed by Deputy Director, Family Welfare and Maternal Child Health

District Health Mission

Karaikal			Mahe and Yanam		
Chairperson	:	Collector	Chairperson	:	Regional Administrator
Co-Chairperson	:	Medical Superintendent, GH	Convenor	:	Deputy Director, GH
Convenor	:	Deputy Director (Immunisation)	Members	:	Joint Block Development Officer Commissioner, Municipality, Deputy Director, Family Welfare, Puducherry, Member, Hospital Advisory Committee, etc.
Members	:	Block Development Officer, Medical Officer in-charge, Chief Educational Officer, etc.			

District Health Society

Governing Body					
Karaikal			**Mahe and Yanam**		
Chairperson	:	Collector	Chairperson	:	Regional Administrator
Co-Chairperson	:	Medical Superintendent, GH	Co-Chairperson	:	Medical Superintendent, GH
Chief Executive Officer	:	Deputy Director (Immunisation)	Chief Executive Officer	:	Deputy Director, GH
Members	:	Block Development Officer Commissioner, Karaikal Municipality, Medical Officer in-charge, CHC, Deputy Director, Family Welfare, Puducherry, etc.	Members	:	Joint Block Development Officer Commissioner, Municipality Deputy Director, Family Welfare, Puducherry, etc.

Executive Committee					
Karaikal			**Mahe and Yanam**		
Chairperson	:	Collector	Chairperson	:	Regional Administrator
Co-Chairperson	:	Medical Superintendent, GH	Co-Chairperson	:	Medical Superintendent, General Hospital
Convenor	:	Deputy Director (Immunisation)	Convenor	:	Deputy Director, GH
Members	:	Medical Officer in-charge, CHC, Deputy Director, Family Welfare, Puducherry, etc.	Members	:	Medical Officer in-charge, CHC, Residential Medical Officer, GH, Deputy Director, Family Welfare, Puducherry, etc.

GH: General Hospital

Appendix 1.2

(Reference : Paragraph 1.1.5 ; Page 4)

List of test-checked health centres

Community Health Centres

1. Mannadipet
2. Karikalampakkam
3. Thirunallar
4. Palloor

Primary Health Centres

1. Nettapakkam
2. Sooramangalam
3. Katterikuppam
4. Thirubhuvanai
5. Kalapet
6. Mettupalayam
7. Ambagarathur
8. Nalambal
9. Nallathur
10. Nedungadu
11. Karaikal medu
12. Kovilpathu
13. Pandakkal

Sub Centres

1. Aranganur
2. Korkadu
3. Pandasohanallur
4. Nathamedu
5. Kodathur
6. Sandaipudukuppam
7. Kalitheerthalkuppam
8. Sanyachikuppam
9. Kanapathi Chettikulam
10. Pillaichavady
11. Kurumampet
12. Thattanchavady
13. Karukankudy
14. Pettai
15. Sethur
16. Vadakattalai
17. Kurumbagaram
18. Vadamattam
19. Chalakkara
20. East Palloor
21. Chembra
22. Cherukallayee
23. Darialthippha
24. Ferampetta
25. Guriampetta
26. Kanakalapetta

Appendix 1.3

(Reference : Paragraph 1.1.6.2 ; Page 5)

Statement showing component-wise expenditure during 2005-09

(Rupees in lakh)

Component	2005-06		2006-07		2007-08		2008-09	
	Funds available	Expenditure	Funds available	Expenditure	Funds available	Expenditure	Funds available	Expenditure
Reproductive and Child Health - I	84.03	7.68	77.61	10.42	67.66	0.19	67.98	43.17
Reproductive and Child Health - II Flexible pool	86.63	31.91	197.91	109.65	216.25	131.75	177.99	164.68
Mission Flexible pool	213.54	15.19	365.80	57.63	572.13	110.78	748.35	213.89
Information, Education and Communication activities	22.80	18.75	23.05	5.92	17.32	12.20	5.12	2.70
Immunisation	25.93	10.38	29.62	22.94	26.46	14.15	39.75	20.59
Disease control programme								
(i) Integrated Disease Surveillance Project	57.41	4.76	53.75	14.20	41.61	22.32	35.18	14.71
(ii) National Blind Control Programme	11.77	4.63	70.28	13.66	65.14	49.61	108.19	8.45
(iii) National Leprosy Eradication Programme	9.67	6.31	11.82	9.88	8.20	7.33	7.06	6.00
(iv) National Vector Borne Disease Control Programme	31.88	15.21	157.97	9.30	167.37	50.93	120.00	37.18
(v) Revised National Tuberculosis Control Programme	23.74	12.79	26.49	8.08	23.83	16.09	21.98	18.48
AYUSH	--	--	--	--	17.00	--	82.28	2.80
Total	**567.40**	**127.61**	**1,014.30**	**261.68**	**1,222.97**	**415.35** *	**1,413.88** **	**532.65**

* Excluding Rs 1.90 lakh refunded to GOI

** Excluding UT share of Rs 150 lakh