HEALTH AND FAMILY WELFARE DEPARTMENT

3.1 National Rural Health Mission

Highlights

The National Rural Health Mission (NRHM) was launched by the GOI in April 2005. A mid-term review of the implementation of the programme in the third year of the Mission period (2005-12) is an attempt to highlight areas of concern, which need to be addressed by the State Government for successful implementation of the Mission Objectives. Performance review of implementation of NRHM in the State revealed that the State Mission has performed satisfactorily in controlling of tuberculosis, leprosy and iodine deficiency. The review, however, also revealed that the State Mission failed to conduct household/facility survey to make rural health centres fully functional with the requisite manpower and other infrastructural facilities. Planning for the implementation of the programme was ineffective and consequently, the objectives of the scheme could not be fully realized even after three years of its implementation.

The major audit findings are:

Absence of complete household and facility surveys and without database on surveys indicates that a meaningful assessment of the pre-NRHM status of availability of health care services and the identification of the gaps for future interventions based on relative need analysis could not have been formulated.

(Paragraph 3.1.7.1)

The objective of providing accessible health care in hilly and remote areas however, was not achieved, since none of these centres were equipped with adequate staff as per norms and stocked with two months essential medicines.

(Paragraph 3.1.9.1)

There were mismatch of data between the State Mission and test checked Districts raising serious doubts on the credibility of the data furnished by the State Mission

(Paragraph 3.1.9.5)

Although the skewed distribution of funds for IEC was contrary to the prescribed norms, the intended impact of creating awareness by sponsorship of popular programmes through local media has had a State-wide impact.

(Paragraph 3.1.9.6)

3.1.1 Introduction

National Rural Health Mission (NRHM) was launched in the State during April 2005 with a view to provide accessible, affordable, accountable, effective and reliable healthcare facilities to poor and vulnerable sections of rural population. The mission envisages involvement of community in planning and monitoring with a view to reduce maternal mortality rate (MMR), infant mortality rate (IMR) and the total fertility rate (TFR) within a seven year period (2005-12). Prevention and control of communicable and non communicable diseases, including locally endemic diseases also constitute an important component of the mission.

3.1.2 Organisational Set up

At the State level, NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The activities of the Mission are carried out through the State Health and Family Welfare Society (Society) headed by the Chief Secretary (CS). The Executive Committee of the Society is headed by the Commissioner-cum-Secretary, Health and Family Welfare Department.

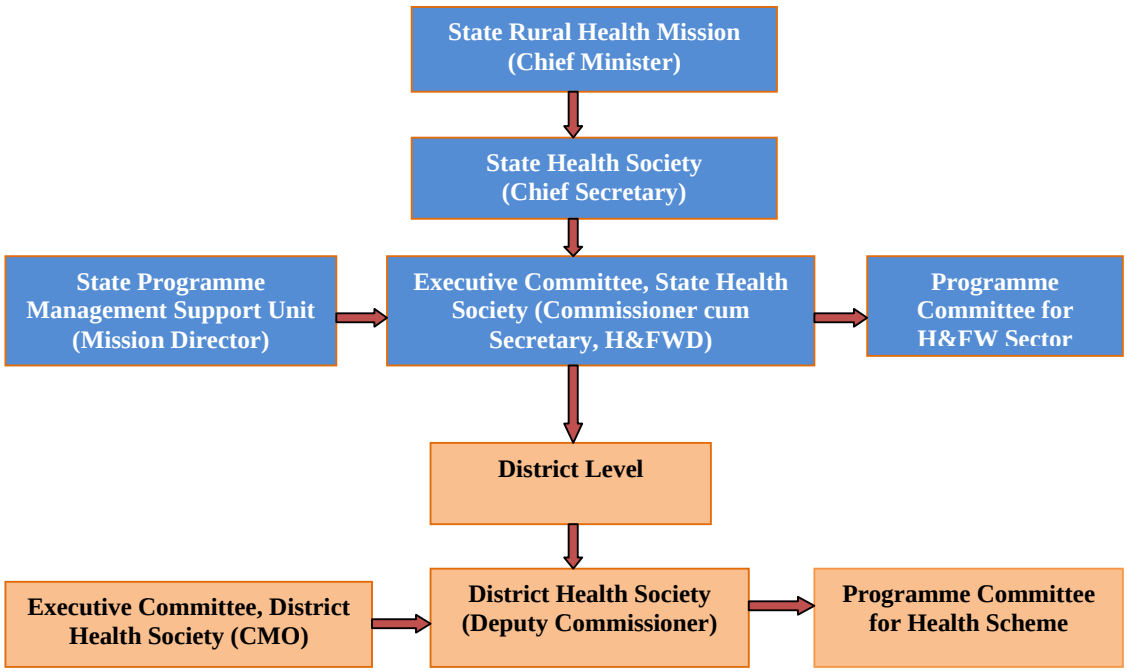
The Society integrates all the societies registered under the Societies Registration Act 1860, which were set up for implementation of various disease control programmes.

At the District level, there are District Health Societies (District Societies) headed by the respective District Deputy Commissioner to support it and its executive committee is headed by the Chief Medical Officer.

The guidelines also provide for programme committees for more focused planning and review of each activity at State and District Level if considered necessary for administrative convenience, which has also been formed in the state.

An organogram showing the administrative and monitoring set up of NRHM in the State is given below:

Chart-3.1



3.1.3 Scope of Audit

Implementation of NRHM during the period 2005-08 was reviewed in audit through a test check (March-July 2008) of the records of the Mission Director, NRHM, and three Health Administrative Districts *viz.* Lunglei, Lawngtlai and Kolasib. Three out of nine Community Health Centres, six out of 57 Primary Health Centres and 18 out of 366 Sub Centres were selected for detailed scrutiny.

3.1.4 Audit Objectives

The objectives of the performance review were to assess whether:

- the household and facility survey were conducted with the close involvement of the community;

- planning for implementation of various components of the programme was based on realistic and reliable data and there existed an effective monitoring and evaluation system at the Village, Block, District, and State level to ensure extension of effective and reliable healthcare in an economical and efficient manner;

- health service delivery infrastructure was created, appropriately equipped and provided with adequate trained manpower;

- the procedures and system of procurement of drugs and services, supplies and logistics management were cost effective, efficient and ensured availability of essential drugs for all the health centres;

- the performance indicators and targets fixed specially in respect of reproductive and child healthcare, immunization and disease control programmes were achieved; and

- the available funds were optimally utilized for the intended purpose.

3.1.5 Audit Criteria

Audit findings were benchmarked against the following criteria:

- Memorandum of understanding (MOU) signed between the Union Ministry of Health and Family Welfare and the State Government ;

- Mission Guidelines issued by the Union Ministry of Health and Family Welfare ;

- Financial Guidelines and framework for delegation of administrative and financial powers under NRHM; and

- Perspective Plan, Block Plan, District Health Action Plan and State Programme Implementation Plan approved by the National Programme Co-ordination Committee (NPCC).

3.1.6 Audit Methodology

Before commencement of the performance review, an entry conference was held (4 April 2008) with the Mission Director, NRHM, Mizoram wherein, the objectives of the review, scope, methodology and criteria of audit were explained. DHS[1]s, CHC[2]s, PHC[3]s and SC[4]s were selected for test check on the

[1] **DHS**-District Health Society (1.Lunglei, 2. Lawngtlai and 3. Kolasib)
[2] **CHC**-Community Health Centre (1.Hnathial, 2.Chawngte and 3.Vairengte)
[3] **PHC**-Primary Health Centre (1.Lungsen, 2.Hawlong, 3.Lungpher, 4.Bualpui, 5.Bilkathlir, 6.Lungdai.)
[4] **SC**-Sub Centre (1.Lungsen, 2.Haulawang, 3.leite, 4.Tuipui D, 5.Phairuang, 6.Hnahchang 7.Chawngte-P, 8.Chawngte-C, 9.Bualpui, 10.Siachangkawn, 11.Lungpher, 12.Lungzarhtum, 13.Vairengte, 14.Phaisen, 15.Bilkhawthir, 16.Chawnpui, 17.Lungdai, 18.Serkhan.)

basis of random sampling. An exit conference was held (4 November 2008) with the Joint secretary, Health Department and the replies of the Department have been incorporated in the review at appropriate places.

Audit Findings

The review of implementation of NRHM in the State revealed that the State Mission has done a commendable job in controlling tuberculosis and leprosy. The review also revealed short release of funds, non release of State matching share, under utilisation of the available funds, mismanagement of funds, shortage of manpower in key posts, inadequate infrastructural facilities, arbitrary procurement practices, insufficient stock of drugs and vaccines, lack of attention to endemic areas, undue financial benefit to the suppliers, diversion of funds and non fulfillment of the objectives of the scheme. Audit findings in detail are discussed in the succeeding paragraphs.

3.1.7 Planning

3.1.7 .1 Baseline Survey and Preparation of Plan

NRHM strives for decentralized planning and implementation arrangements to ensure that need based and community owned District Health Action Plans form the basis for interventions in the health sector. The districts were, thus, required to prepare a Perspective Plan for the entire Mission period (2005-12) as well as an annual plan consisting of (a) RCH, (b) Additionalities under NRHM, (c) Immunisation, (d) Revised National Tuberculosis Control Programme, (e) National Vector Borne Disease Control Programme, (f) Other National Disease Control Programmes and (g) Inter-sectoral issues of the mission based on a mapping of services, household and facility surveys. As per the NRHM framework, a Project Implementation Plan (PIP) was to be prepared annually by the State Health Society by aggregating the annual District Health Action Plan of each district. The National Programme Coordination Committee (NPCC) at the Union Ministry of Health and Family Welfare was to appraise the PIP and after incorporating the feedback of the NPCC, the PIP was to be approved by the GOI.

The performance review revealed that household surveys and facility surveys were not conducted during 2005-07. It was only in 2007-08 that the facility survey was conducted by the staff of the health department. These staff were, however, not imparted any specific training on the basic modalities of the survey. Further, the Perspective Plan (2005-12), State PIP for 2005-06 and District Health Action Plan for 2005-07 were not prepared. However, State PIP for 2006-07 was prepared based on the feedback received from the district level and the PIP for 2007-08 was prepared based on the appraisal of the District Health Action Plans.

In the absence of complete household and facility surveys and without database on surveys, a meaningful assessment of the pre-NRHM status of

availability of health care services and the identification of the gaps for future interventions based on relative need analysis could not have been formulated. At the very outset, this raises questions about the efficacy of the planning process of the State Mission.

3.1.8 Financial Management

3.1.8.1 Funding Pattern

Funds were released by the GOI to the State through two separate channels, viz. the State Finance Department and directly to the State Health Society on the basis of approved PIPs. During 2005-07, the programme was entirely funded through grants from the GOI to the State. From the Eleventh Plan Period (2007-12) onwards, the State is to contribute 15 *per cent* of the required funds.

3.1.8.2 Financial Outlay and Expenditure

Funds released by the GOI and the Government of Mizoram (GOM) and expenditure incurred on NRHM during 2005-08 is shown in the table below:

Table 3.1

(Rupees in crore)

Year	Opening Balance	Funds received from		Interest accrued	Total Fund available	Expenditure	Unspent balances (out of State budget) surrendered to GOM	Unspent balance of GOI funds (+) Excess/ (-) Savings
		GOI	GOM					
2005-06	4.13	25.20	36.49	0.05	65.87	49.02	3.02	(-) 13.83
2006-07	13.83	31.40	40.83	0.07	86.13	66.74	1.14	(-) 18.25
2007-08	18.25	53.93	42.80	1.00	115.98	97.20	1.58	(-) 17.20
Total		**110.53**	**120.12**	**1.12**	**235.90**	**212.96**	**5.74**	**17.20**

Source: -Annual Accounts of State Mission, NRHM.
Information furnished by the Director, Health Services.
Reasons for savings were not on record.

3.1.8.3 Non release of State matching share

As per the MOU signed between the State Government and the GOI, the State Government was to contribute 15 *per cent* of the funds released by the GOI for 2007-08 and State share on health budget was to be increased by at least 10 *per cent* every year during the Mission period (2005-12). The State Government failed to release (2007-08) its share of Rs. 3.51 crore. The commitment on increasing its budgetary allocation was also not met, as the increment was well below four *per cent* for the years 2005-08.

3.1.8.4 Expenditure on management cost

As per the guidelines, up to six *per cent* of the total annual work plan for the year can be utilized for contractual engagement of personnel with new skills under management cost.

During the years 2006-08, Rs. 8.17 crore was incurred on management cost against the admissible limit of Rs. 2.91 crore (six *per cent* of 48.40[5] crore) on the salary of Medical Officer (MO), Auxiliary Nursing Midwife (ANM), Staff nurse, Lab Technician etc.

The Department stated (November 2008) that the management cost was not in excess of six *per cent* of total budget, and insisted that the expenditure incurred in respect of the salary of ANM, Lab Tech, Staff nurse and Medical Officer should not be booked under the management cost.

However, since this staff were employed on contractual basis, their salary will form part of management cost. The Department, therefore, exceeded the cost norm in this regard.

3.1.9 Programme Implementation

3.1.9 .1 Infrastructure facilities

According to the NRHM norms, one Sub Centre (SC), one Primary Health Centre (PHC) and one Community Health Centre (CHC) are to be established for every 3,000, 20,000 and 80,000 population respectively in tribal/desert areas.

There were 366 SCs, 57 PHCs and 9 CHCs prior to launching NRHM in the State against the rural population of 4.45 lakh, which was far in excess of the norms for which, the Mission had to bear an extra expenditure of Rs. 74.35 lakh per year as shown below:

Table-3.2

Details	Requirement as per norm	Actual number of centres	Excess	Annual Untied grant *plus* Annual maintenance grant (Rs)	Annual expenditure on excess centres (Rs)
SCs	148	366	218	10,000 + 10,000	43,60,000
PHCs	22	57	35	25,000 + 50,000	26,25,000
CHCs	6	9	3	50,000 + 1,00,000	4,50,000

Source: Mission Director, NRHM, Mizoram

The Department admitted during the exit conference that the centres are more than the norm due to hilly terrain, scattered villages and poor communication facilities. The objective of providing accessible health care in hilly and remote areas, however, was not achieved, since these centres were not equipped with adequate staff as per norms as brought out below:

[5] Rs. 48.40 crore was the total approved outlay for 2006-08 of the programme.

Based on the prescribed staffing norms of the Indian Public Health Standard (IPHS), the CHCs, PHCs and SCs are to be manned and equipped with sufficient basic physical infrastructure and essential equipment to provide essential/specialist services.

As against these norms, scrutiny of the test checked centres revealed shortages in manpower (especially medical officers including specialists and paramedical staff) for providing basic/ specialist services, as reflected in the table below:

Table: - 3.3

Category of Centres	**Manpower required (as per IPHS norm) in test checked centres**		**Manpower in position in test checked centres**		**(-) Shortage / (+) Excess**	
	Medical Officers/ Specialists	**Paramedical Staff**	**Medical Officers/ Specialists**	**Paramedical Staff**	**Medical Officers/ Specialists**	**Paramedical Staff**
Community Health Centres (CHCs)	21 (7 each x 3 CHCs)	39 (13 each x 3 CHCs)	9	47	(-) 12	(+) 8
Primary Health Centres (PHC)	12 (2 each x 6 PHCs)	54 (9 each x 6 PHCs)	5	33	(-) 7	(-) 21
Sub Centres (SC)	Nil	36 (2 each x 18 SCs)	Nil	43	Nil	(+) 7

Source: CHCs, PHCs and SCs

Scrutiny of the records also revealed that the test checked centres had not been provided with the requisite basic physical infrastructure and essential equipment as discussed below:

Community Health Centres (CHCs)

None of the three CHCs test checked had any accommodation facilities for families of admitted patients. Although Operation Theatres (OT) were available in all the three CHCs, except for some minor surgeries in Chawngte CHC, no surgeries were done in the other two CHCs mainly because of the absence of Surgeons and Anaesthetists. None of these OTs had been provided with any light and air-conditioning facilities, which are the essential features of any OT. Although labour rooms were available in all the three CHCs, there was no Gynaecologist. In two out of three CHCs, working space was inadequate, which indicated lack of proper planning and estimation of space. None of the CHCs had any male and female specialists, and all three centres inspected did not have the essential equipment[6] required to run the centres.

[6] Essential equipment (like Boyles apparatus, EMO machine, Cardiac machine for OT, Defibrillator for OT, Ventilator for OT, Horizontal High Pressure sterilizer, OT care/ fumigation apparatus, Oxygen Cylinders, Stretcher on trolley and Medicine cabinet etc)

Primary Health Centres (PHCs)

Counter for distribution of family welfare materials like contraceptives, intra uterine devices, condoms etc., was not available in the test checked PHCs. Services pertaining to cataract surgery, ante-natal clinics, facilities for tubectomy and vasectomy, management of low birth weight women, extension of AYUSH services and indoor beds for pediatric patients were also not available. Only two of the PHCs had OT facilities, and none of the six PHCs had conducted immunisation services.

Sub Centre (SC)

A majority of the SCs test checked did not have the wherewithal to render essential/ specialist services like intra-natal care (10 SCs), new born care (seven SCs), school health programme (12 SCs), adolescent health care (11 SCs) and 24 hours service for referral of complicated cases of pregnancy/ delivery (12 SCs). None of the centres were stocked with two months essential medicines, and 14 of the 18 SCs test checked were yet to record a doctor's visit.

Thus, though the number of centres were above the prescribed norms, yet they were not able to function effectively due to the absence of the required manpower and other infrastructural facilities.

The Department admitted the facts and stated (November 2008) that the absence of required manpower had impeded the performance of the mission and that creation of posts and procurement of equipment and infrastructure was already under process.

3.1.9.2 Reproductive Child Health (RCH)

RCH programme is being implemented in the State since 1998 with a view to improving the coverage of timely and quality antenatal care (ANC) services, strengthening maternal health services to ensure safe delivery, promoting immediate and exclusive breastfeeding and complementary feeding for children, increasing timely and quality immunisation services, increasing access to and utilisation of family planning services, and improving adolescent health. The RCH programme provides for a trimester antenatal care check up. The first at the time of suspected pregnancy followed by the second and the third check up at an interval of 26 weeks and 32 weeks. A minimum of two postnatal care (PNC) after delivery is prescribed under the programme. As per the information furnished by the State Mission (July 2008), the physical performance under RCH for the years 2005-08 is shown in the table below:

Table – 3.4

Component	Status		
	2005-06	**2006-07**	**2007-08**
Pregnant Women /ANC Registered	20958	22610	26006
No. of 3 ANC/ (percentage)	18010 (86)	19315 (85)	18800 (72)
Total Deliveries (Home + Institutional)	18847	20309	24813
Institutional Deliveries/(percentage)	12689 (67)	14418 (71)	18922 (76)
No. of Maternal Deaths /(MMR *per* Lakh)	5 (27)	4 (20)	15 (60)
No of PNC/ (percentage)	16851 (89)	18096 (89)	12469 (50)
No. of Infant Deaths/(IMR *per* 1000)	184 (10)	258 (13)	608 (25)
No. of Child Deaths (1 year – 5 years)	NA	122	130
No. of Sterilizations	2217	2223	2133
No. of cases where >3 child births / (percentage)	7478 (40)	8039 (40)	9137 (37)
No. of IUD insertions	2479	2468	2199

Source: Mission Director, NRHM.

It can be seen from the above table that against the norms prescribed, the coverage of at least three ANC services for registered pregnant women and thereafter PNC check up after delivery, has declined between the years 2005-06 and 2007-08, while the MMR[7], IMR[8] and infant and child deaths have increased. The number of sterilization cases has also decreased to 2133 (2007-08) from 2217 (2005-06), and IUD insertions too have fallen to 2199 (2007-08) from 2479 (2005-06).

The performance of RCH programme was reportedly impeded by the lack of adequate ANMs[9] and MPWs[10], inadequate motivation and lack of utilisation of trained female community health workers i.e. Accredited Social Health Activist (ASHA) network to be provided in each village, insufficient and irregular supply of essential drugs, contraceptives, vaccines, equipment etc. to health centres, low IEC activities, and shortage of manpower in key functional posts.

3.1.9.3 Routine Immunisation

Immunisation programme was launched in the State to raise the level of immunisation for reducing morbidity and mortality rates due to vaccine preventable diseases (VPD), and also to eradicate polio to ensure zero transmission. A fully immunized infant is one who has received BCG, three doses of DPT, three doses of OPV and Measles before one year of age.

[7] MMR-Maternal Mortality Rate
[8] IMR- Infant Mortality Rate
[9] ANM-Auxiliary Nursing Midwife
[10] MPW-Multipurpose Worker

The year wise target and achievement of routine immunization is shown in table below:

Table-3.5

Year	Nos. of total live birth	Target	Achievement				
			BCG	Measles	DPT	OPV	Fixation of target w.r.t infants available
2005-06	18847	20918	20890	19041	19563	19536	(+) 2071
2006-07	20309	20968	22242	18884	22359	22329	(+) 659
2007-08	24813	20699	21820	20273	20903	20555	(-) 4114

Source: Mission Director, NRHM, Mizoram

It would be seen that against 18847, 20309, and 24813 nos. of infants in the age group of 0-1 years during the years 2005-06, 2006-07 and 2007-08 respectively, the target fixed for 2007-08 was far below the actual number of children in the State. Notwithstanding the fact that the target fixed for 2005-06, 2006-07 were in excess of the total live births for these years, the achievement on immunisation doses administered on record were incredibly on the higher side. During 2007-08 although the Department claimed over 97 *per cent* achievement, actual achievement was much lower than projected as can be inferred from the table above wherein for the year 2007-08 the exclusion amounted to as many as 4114 children.

The Department stated (November 2008) that the target includes total live births in a year and a number of children below one year, born in the previous year, who had not been fully immunized were also included, which indicates that the target fixed for 2007-08 was far below the requirement.

Scrutiny of the records also revealed that the number of AD syringes utilised was much less than the immunisation coverage during the years 2006-08, as shown in the table below:

Table-3.6

Year	Requirement of AD Syringes against achievement (0.5 ML)							AD Syringes actually used	Shortfall in AD Syringes used
	TT-I & II (PW)	DPT	DT	TT 16	TT 10	Measles	Total AD Syringes needed w.r.t. achievement		
2006-07	39952 (19976x2)	67077 (22359x3)	25377	18335	22180	18884	191805	76770	115035
2007-08	41306 (20653x2)	62709 (20903x3)	18853	17964	19099	20273	180204	63721	116483
Total	81258	129786	44230	36299	41279	39157	372009	140491	231518

Source: State Mission, NRHM.

As can be seen from the table above, against the total requirement of 3,72,009 AD syringes for immunisation, the Mission actually used 1,40,491 syringes during the years 2006-08. With the prescription of single syringe usage per child, the actual immunisation coverage could not have exceeded 1,40,491.

This alone raises serious doubts on the veracity of the achievement of the immunisation coverage claimed by the State Mission.

The Department stated (November 2008) that due to short supply of AD syringes by the GOI, re-usable glass syringes were used instead. The contention of Department could not be verified. If indeed the Department was using reusable glass syringes, it was exposing the rural population to the risk of transmission of diseases like HIV and compromising on the basic principle of safety and disposal of syringes, especially when adequate funds were available with the State Mission.

3.1.9.4 Pulse Polio Immunisation

The basic aim of conducting Supplementary Immunisation Scheme (SIS) is to reach all under 5 years children with potent vaccine in each round. The main strategy to achieve it is by offering (i) immunization to all children at booth on the first day, (ii) follow up on missed children through house to house immunization teams and (iii) immunize children in transit through transit teams deployed throughout the duration of booth and house to house immunization activities.

Intensive Pulse Polio Immunisation (IPPI) is to be conducted in the State every year in two rounds. The Mission had not conducted any survey to identify the number of children (0-5) and in the absence of baseline survey, the basis for fixation of targets remained adhoc. However, based on population of the State, the number of children of different age groups during 2005-06 to 2007-08 was higher than the target fixed and the achievement claimed by the Department was not correct, as shown in the table below:

Table-3.7

Year	Popula-tion	Target to be fixed for 0-5 year as per evaluation based on population (number of children – 0-5 years = 0.14 x population)	Target fixed by the State	Shortfall in the target	Achievement	Shortfall in achieve-ment
2005-06	876304	122683	117318	5365	115032	7651
2006-07	944802	132272	115397	16875	115114	17158
2007-08	948390	132775	123809	8966	117423	15352

Source: Mission Director, NRHM, Mizoram

The Department has accepted the fact and stated (November 2008) that shortfall is being covered in the subsequent round.

3.1.9.5 Mismatch of data between State Mission and test checked Districts

A comparison of records of the State Mission with those of the three test checked districts revealed that the achievement figures reported under the RCH by the State Mission did not agree with those furnished to audit by the three District Health Societies as shown in the table below raising serious

doubts on the credibility of the data furnished by the State Mission. Similar discrepancies were also noticed in respect of Pulse Polio Immunisation and routine immunisation between the data reported by the State Mission and that reported to audit by the three test checked District Health Societies.

Table-3.8

Component	Status of Test checked districts as reported by Mission Director to audit			Data as reported by test checked Districts to audit		
	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
ANC /PW Registered	5663	6589	7994	5854	6893	7560
No. of 3 ANC	4329	5055	5615	2817	3285	3918
Total Deliveries	5217	5888	6108	5263	5713	5532
Institutional Deliveries	3167	3835	4117	3233	4002	3799
No. of Maternal Deaths	2	1	5	NA	NA	NA
No of PNC	4932	5339	-	4566	5201	4949
PNC within 48 hrs. of delivery	NA	NA	1751	NA	NA	NA
PNC 2-14 days of delivery	NA	NA	2078	NA	NA	NA
No. of Infant Deaths	77	72	223	NA	NA	NA
No. of Child Deaths	NA	56	47	NA	NA	NA
No. of Sterilizations	697	662	605	714	638	554
No. of cases where >3 child births	2113	2298	2262	NA	NA	NA
No. of IUD insertions	410	368	554	428	373	767

Such discrepancies in achievement figures indicate lack of effective monitoring of the performance at grass root levels. Further, in the absence of reliable data, the reported achievement under these programmes could not be authenticated in audit.

The Department admitted the facts and stated (November 2008) that close monitoring will be done henceforth.

3.1.9.6 Information, Education and Communication (IEC)

For the purpose of conducting healthcare awareness, a variety of activities involving communities as well as media is to be undertaken, for which, funds are to be equally spent at State, District and Sub- District level. Out of Rs. 75.33 lakh spent on IEC during 2005-08, Rs. 61.41 lakh (81.5 *per cent*) was spent at State level. Although the skewed distribution of funds for IEC was contrary to the prescribed norms, the intended impact of creating awareness by sponsorship of popular programmes through local media has had a State-wide impact.

3.1.10 Disease control programmes

The disease control programme under NRHM comprises of six[11] components. The findings on implementation of the disease control programmes are discussed in the succeeding paragraphs.

3.1.10.1 Revised National Tuberculosis Control Programme (RNTCP)

The RNTCP was launched and implemented in the State from March 2003. The outcome of treatment under RNTCP is shown in the table below:

Table:-3.9

Year	TB patients registered	Cured + treatment completed	Died[12]	Failures[13]	Defaulters[14]	Transf - erred out	Cure rate (percentage)
2005-06	591	509	27	28	27	NIL	86
2006-07	551	501	12	15	23	NIL	91
2007-08	548	498	13	26	11	1	91

Source: State Mission, NRHM.

It is evident from the above table that the percentage of patients cured has increased from 86 *per cent* (2005-06) to 91 *per cent* (2007-08), which indicates satisfactory achievement in control of tuberculosis in the State.

3.1.10.2 National Leprosy Eradication Programme (NLEP)

The NLEP, Phase -II was launched in the State from 2001 with a view to eradicating leprosy from the State. Year wise physical achievement under NLEP is shown in the table below:

Table:-3.10

Year	Total no. of cases at the beginning of the year	Total no. of cases detected	Total no. of cases treated/cured (percentage)	Total no. of cases at the end of the year
2005-06	10	24	18 (53)	16
2006-07	16	20	23 (64)	13
2007-08	13	26	21 (54)	18

Source: State Mission, NRHM.

It would be seen from the above table that the percentage of cases treated/cured increased from 53 *per cent* in 2005-06 to 64 *per cent* in 2006-07,

[11] Six components. i) National Programme for Control of Blindness (NPCB), ii) National Vector Borne Disease Control Programme (NVBDCP), iii) National Leprosy Eradication Programme (NLEP) iv) National Iodine Deficiency Disorder Control Programme (IDDCP), v) Integrated Disease Surveillance Project (IDSP) and vi) Revised National Tuberculosis Control Programme (RNTCP).

[12] Patient died from the TB disease

[13] Patients not successfully treated

[14] Patients left the treatment in between

but came down to 54 *per cent* in 2007-08. The overall trend of physical achievement was, however, satisfactory.

3.1.10.3 National Iodine Deficiency Disorder Disease Control Programme (NIDDCP)

The NIDDCP was launched in the State since 1987. The main objective of the programme was to conduct survey of IDD prevalence; ensure consumption of iodised salt with not less than 15 PPM (Part per million) by creating public awareness.

Year wise physical achievement under NIDDCP is shown in table below:

Table:3.11

Year	Monitoring of Iodised salt			
	No. of samples tested (By MBI Kit)	Samples above 15 PPM (percentage)	No. of samples tested (By Titration method)	Samples above 15 PPM (percentage)
2005-06	27,030	26,050 (96)	430	413 (96)
2006-07	35,647	34,500 (97)	480	465 (97)
2007-08	Nil	NIL	582	571 (98)

It would be seen from the above table that percentage of sample test above 15 PPM has been increased from 96 *per cent* (2005-06) to 98 *per cent* (2007-08) which represents a positive achievement.

3.1.10.4 National Programme for Control of Blindness (NPCB)

The NPCB was launched (1976) in the State with 100 *per cent* Central assistance with the objectives of (a) providing quality eye care to the affected population; (b) expanding coverage of eye care services to the underserved areas; (c) reducing the back log of blindness by identifying and providing services to the affected population; and (d) developing institutional capacity for eye care services by providing support for equipment and material and training of personnel.

The physical achievement of cataract surgeries during 2005-08 is shown in the table below:

Table-3.12

District	2005-06		2006-07		2007-08	
	Target	**Achievement**	**Target**	**Achievement**	**Target**	**Achievement**
Aizawl West	200	195	300	306	400	55
Aizawl East	200	308	300	151	400	245
Serchhip	60	45	80	66	300	86
Lunglei	200	171	250	231	400	204
Lawngtlai	60	21	80	49	300	97
Saiha	60	23	80	85	300	84
Champhai	100	36	150	148	400	190
Kolasib	60	77	80	51	300	126
Mamit	60	15	80	65	300	59
Total	1000	891	1400	1152	3100	1146
Achievement in *per cent*		89		82		37

Source: State Mission, NRHM.

With regard to the targets, the percentage of achievement fell from 89 *per cent* (2005-06) to 37 *per cent* (2007-08), even though sufficient funds were lying unspent every year with the State Mission. The basis for fixing of targets, however, could not be ascertained in audit, in the absence of the basic survey and surveillance data.

The Department accepted the fact and stated (November 2008) that shortfall in cataract surgeries against the target was due to the non availability of Eye surgeons.

3.1.10.5 National Vector Borne Disease Control Programme (NVBDCP)

The NVBDCP was launched in the State to reduce morbidity and mortality due to malaria and other vector borne diseases, and to increase Annual Blood Examination Rate (ABER), to cover targeted population by indoor residual spray of DDT, and to provide diagnosis and treatment facilities in all villages, blocks, PHCs and SCs.

The incidence of malaria in the State indicated an upward trend from 2004 onwards and the number of deaths due to malaria increased from 72 in 2004 to 120 in 2006. The details of Blood Slide Examination (BSE), ABER, positive cases, P. Falciparum cases and death cases during 2004 – 2008 are shown below:

Table-3.13

Year	Malaria					
	BSE	**ABER (in *per cent*)**	**Positive**	**PF**	**PF *(per cent)***	**Deaths**
2004	217316	24	7830	4170	53	72
2005	218961	24	10741	6290	59	74
2006	218072	24	10650	6956	65	120
2007	154045	16	6081	4189	69	75
2008 (up to 03/08)	28781	3	711	554	78	11

Source: Mission Director, NRHM.

As per guidelines, the ABER was to be increased to 10 *per cent* of the target population under surveillance. The programme has fallen short on this count. This has also distorted the performance in terms of Positive and PF case detection. For instance, the apparent drop in terms of absolute number of cases for positive and PF cases detected can be attributed to the ABER rate falling from the previous years *i.e.* had the number of blood sample examination increased significantly, the number of cases detected as malaria positive and PF cases would have also been higher. Although some indicators seem to reflect a positive trend *e.g*. deaths due to Malaria dropping to 75 (2007) from 120 (2006) in absolute terms, the incidence of drop in deaths due to malaria proportionate to the number of PF cases has not been significant. That is, the percentage of deaths due to malaria vis-à-vis the total number of PF cases in 2006 is actually 1.73 *per cent* as compared to 1.79 *per cent* in 2007.

3.1.10.6 Short receipt of DDT Powder

Adequate and timely spraying of DDT is an important component of the vector borne disease control programme. Of the total number of 2412 bags (120.60 MT) of DDT issued during 2005-08 to the three CMOs (Lunglei, Lawngtlai and Kolasib) for the coverage of targeted villages with a mandatory requirement of two rounds of spraying schedule, only 1069 bags (53.45 MT) were reported as received by the CMOs. Despite the short receipt of DDT powder, the Department claimed that it had fully covered the 186, 161 and 53 villages for 2005-08. The Department could not furnish information on the targeted population for 2007-08. However, even with the available information for two years i.e. 2005-2007, the claim of the Department of having covered the entire targeted population appears to be doubtful.

Table 3:14

District	**Targeted population**		**DDT Requirement[15] (MT)** 2 round @ 15MT *per* lakh population	**Quantity issued Error! Not a valid link.**		**Error! Not a valid link.(DDT in MT)**		**Error! Not a valid link.(DDT in MT)**	
	2005-06	**2006-07**	**2005-07**	**2005-06**	**2006-07**	**2005-06**	**2006-07**	**2005-06**	**2006-07**
Kolasib	0.79	0.79	23.70	16.40	8.20	4.40	6.50	12.00	1.70
Lawngtlai	0.68	0.68	20.40	16.55	16.85	2.95	8.20	13.60	8.65
Lunglei	1.22	1.22	36.60	27.80	28.30	4.00	20.90	23.80	7.40
Total	**2.70**	**2.70**	**80.70**	**60.75**	**53.35**	**11.35**	**35.60**	**49.40**	**17.75**

The Department stated (November 2008) that the balance DDT powder (1343 bags) issued to the districts was dumped enroute at the CHCs and PHCs to avoid further transportation from district headquarters. The reply was not substantiated with any records indicating separate center-wise receipt

[15] For coverage of one lakh population with two round of spray, 15 tonnes of DDT-50% is required. (2 years @ 15MT /1 Lakh population)

accompanied with their utilization. The shortfall in receipt of DDT by the CMOs against the required amount as per prescribed norms for 2005-07, was 33.75 MT which would have adversely affected the achievement of insecticide spray programme for control of malaria in this high risk State.

3.1.11 Village Health and Sanitation Committees

Village Health and Sanitation Committees (VHSC) were created mainly to generate public awareness on health and nutrition activities, maintain village health registers, health information board and prepare village health plan etc. Although 786 VHSCs were formed (March 2008) with an expenditure of Rs. 77.30 lakh (2007-08) towards untied fund (meant for creating revolving fund), the VHSCs had not maintained village health registers nor was any revolving fund created by the test checked VHSCs in the three districts.

The Department accepted the facts mentioned above and assured (November 2008) that all VHSCs would be instructed to carry out their mandated functions henceforth.

3.1.12 Rogi Kalyan Samiti

Rogi Kalyan Samitis (RKS) were to be formed in each health centre to upgrade the rural hospitals, CHCs, PHCs and SCs to the Indian Public Health Standard (IPHS) to provide sustainable quality health care with people's participation and to make the community accountable and responsible for running these centres. Financial support of Rupees five lakh to each rural hospital and Rupees one lakh to each CHC and PHC was to be released annually by the GOI, only when the State Government authorised the RKSs to retain the user charges.

Scrutiny of the records of the Mission Director revealed that Rs. 1.10 crore was released to the RKSs (74[16]) in 2006-07 (Rs. 11 lakh) and 2007-08 (Rs. 99.64 lakh) without insisting on the retention of user charges which was in contravention of the NRHM guidelines. Records of essential activities to be performed by the RKSs (e.g. formation of monitoring committee, collection of patient's feedback, displaying citizens' charter, etc) were non- existent.

In the absence of community participation in monitoring the patient's welfare activities, the sustainability and permanency of the proposed decentralized community ownership remained largely unfulfilled.

The Department, while admitting the facts stated (November 2008) that necessary corrective action would be initiated on the functioning of the RKSs. However, as regards the retention of users charges at institutional level, the Department stated that this could not be done in the absence of the State Government concurrence.

[16] 8 district hospitals, 9 RKSs at CHCs and 57 RKSs at PHCs level

3.1.13 Availability of medicines

Procurement of medicines is centralised under the Mission. The Mission Director entered into (January 2007) a Memorandum of Understanding (MOU) with a Chennai based firm for purchase and supply of medicines and an advance payment of Rs. 1.11 crore was made. Although there were delays[17] in supply of medicines ranging from 1 month to 11 months, no penalty was imposed on the firm by invoking the penal clause incorporated in the MOU.

Of the required 152 items of medicines to be supplied by the firm, the firm supplied only 85 items of which, 25 items of medicines were received short of the ordered quantity. It was also noticed that the quantity of 25 items of medicines were entered in the stock by inflating the quantities actually received/supplied by the firm and were recorded as issued to different CMOs. Neither stock certificate was recorded on the body of the bills nor any physical verification of stock made (July 2008). This was apparently done with the deliberate intention of recording a wider coverage of beneficiaries.

On further scrutiny, it was observed that 47 items of medicines were not labeled with manufacturing date and 5 items without manufacturing and expiry date.

The above facts point at serious flaws in the procurement process of essential items like medicines. Failure of the firm in meeting its supply commitments obviously had an adverse impact on the availability of medicines in various CHC, PHC SCs.

3.1.14 Diversion of funds

During March 2006, the Mission Director procured different equipment worth Rs.1.14 crore for nine First Referral Unit (FRUs), without calling for tenders and ascertaining the market rate. Despite the fact that not a single CHC was upgraded to a First Referral Unit (FRU), all the equipment procured was distributed to different District Hospitals, CHCs and PHCs which were not eligible as these were yet to be upgraded to FRUs.

The Mission Director stated (April 2008) that the upgradation of CHCs to FRUs staffed with adequate manpower was under way. However, the Director could not explain the reasons for procurement of these equipment in advance well before the establishment of FRUs. As a result, the equipment procured at an expenditure of Rs. 1.14 crore, remained idle and unproductive for more than two years.

[17] The Mission Director entered in to MOU in January 2007. No specific supply order was placed to firm. The firm placed order to different laboratory in April 2007 and presumed that tender process was completed in April 2007. Therefore, liquidated damages at the rate of 0.5 per cent per month was calculated for 11 months (September 2007 to July 2008).

The Department accepted the facts and stated (November 2008) that due to the skeletal infrastructure in health centres, the necessary equipment was procured to upgrade the health institutions. The reply is not acceptable as the equipment was procured for the FRUs. Clearly, the equipment was procured only to utilize the available funds.

3.1.15 Procurement of instruments

Between March 2006 and November 2007 the Mission Director purchased instruments of different specifications worth Rs.1.49 crore without floating any tenders or ascertaining the market rate and without assessment of requirements of equipment for the health centres.

The instruments, issued to different health centres, were lying unutilized since their supply, rendering the entire expenditure unproductive.

The Department accepted the facts and stated (November 2008) that due to the skeletal infrastructure in health centres, the equipment was procured with Government approval so that CHCs could be upgraded to FRUs. The reply does not disclose the reasons for the equipment lying unutilised.

3.1.16 Monitoring and evaluation

NRHM envisages an intensive accountability framework through a three tier process of community based monitoring, external surveys and stringent internal monitoring. The Management Information System (MIS) has to incorporate a provision for correlation of village level data with community based information from micro-planning and surveys. However, such an MIS had not been developed.

The Department admitted the facts and stated (November 2008) that all the concerned officers had been instructed to monitor and evaluate the activities in their respective fields. It was further stated that a specific monitoring and evaluation system was being developed for proper monitoring of the programme.

3.1.17 Conclusion

The overall performance of the Mission at the mid-course was not very satisfactory. The review underscored glaring gaps in planning and programme implementation. The State Mission failed to conduct household / facility survey, which constitutes the most crucial element of the planning process upon which the very edifice of the Mission rests. The credibility and the basis on which the State PIP was formulated is questionable. In terms of infrastructure readiness, the majority of the centres did not have the basic equipment and drugs. The set back experienced by the Mission till date is largely attributable to the manpower shortage and the absence of appropriate

functionaries at all tiers of the implementation structure. The overall management of the Mission was also impeded by the absence of baseline data and other relevant indices to facilitate performance evaluation.

3.1.18 Recommendations

For delivery of quality rural health care services in the State, the State Mission should take the following steps:

- Planning should follow a bottom-up approach and community involvement should be ensured in the planning process;
- Household and facility surveys at village, block and district level need to be conducted at regular intervals and gaps in health care services should be identified and appropriate corrective action taken;
- Awareness should be created among the public to ensure accountability at various levels;
- The State Government should ensure availability of the required manpower before establishment and/ or upgradation of health centres; and
- Monitoring and supervision of the Mission activities should be strengthened by establishing monitoring and planning committees at all levels, as envisaged in the Mission guidelines.