HEALTH AND FAMILY WELFARE DEPARTMENT

1.3 National Rural Health Mission

Highlights

The National Rural Health Mission was launched in the State in November 2005. The review revealed that the Department did not achieve the goal set for the health indicators *i.e.* Maternal Mortality Rate, Infant Mortality Rate, and Total Fertility Rate by March 2010. Planning process was inadequate as it was prepared without baseline survey inputs. As of March 2010, the State was yet to carry out a comprehensive household and facility survey to identify the gaps in health care facilities. Up-gradation of Community Health Centres, Primary Health Centres and Sub-Centres to the level of Indian Public Health Standards had not been achieved. While the percentage of fully immunised infants ranged from 69 and 81 *per cent* during 2005-06 and 2007-10, it exceeded the target during 2006-07. There was an absence of internal audit, evaluation, weakness in internal control and monitoring mechanism. Some of the significant audit findings noticed is as under:

Perspective Plans and District Health Action Plans were not prepared during 2005-10 and 2005-07 respectively and community participation was not ensured in the planning process.

(Paragraph 1.3.7.2)

Non-upgradation of CHCs and PHCs and non-completion of the buildings of SCs resulted in failure of providing accessible and quality health care services to the rural people.

(Paragraph 1.3.9.2)

Acute shortage of manpower in the health institutions adversely affected the availability of health care services.

(Paragraph 1.3.11)

As of March 2010, 752 Village Health and Sanitation Committees were yet to be formed for ensuring community participation and implementation of the Mission at grass root level.

(Paragraph 1.3.17)

All the vertical disease control programmes had not merged with the Mission (December 2010) and hence, the desired architectural correction aimed in the health care delivery system remained unfulfilled.

(Paragraph 1.3.19)

1.3.1 Introduction

The National Rural Health Mission (NRHM) was launched by the Government of India (GoI) on 12 April 2005. In Manipur, it was launched in November 2005 by the Hon'ble Union Minister, Health & Family Welfare.

The main objectives of the Mission, to be achieved during 2005-12 are as follows:

- provide accessible, affordable, accountable, effective and reliable health care facilities in the rural areas, especially to the poor and vulnerable sections of society;
- involve community in planning and monitoring;
- reduce IMR, MMR and TFR[22] for population stabilisation and
- prevent and control communicable and non-communicable diseases, including locally endemic diseases.

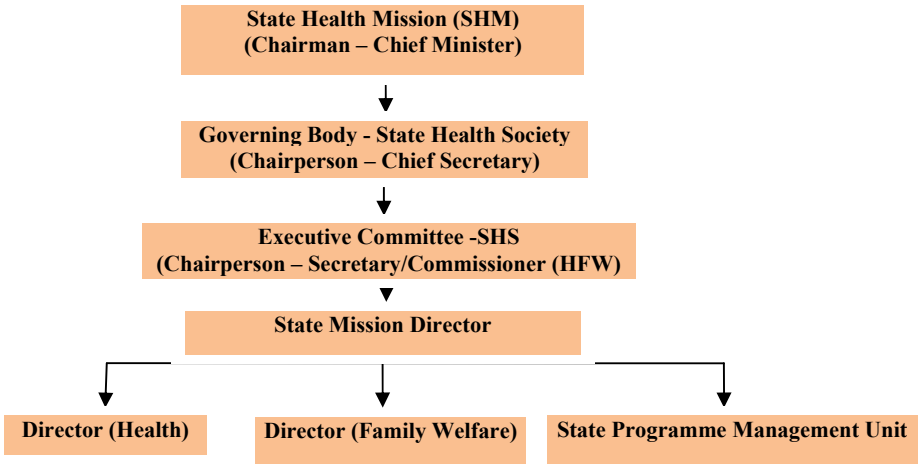
The Mission aimed at an architectural correction in health care delivery system by converging various existing stand alone programmes *viz*., National Disease Control Programmes (NDCP), Reproductive and Child Health-II (RCH-II), National Vector Borne Disease Control Programme, Tuberculosis, Leprosy, Blindness, Deafness Control Programme and Integrated Disease Surveillance Project with the exception of National AIDS and Cancer Control Programmes.

The salient features of NRHM include bridging gaps in healthcare facilities, facilitating decentralised planning in the health sector and addressing the issue of health in the context of a sector-wise approach encompassing sanitation hygiene, nutrition *etc*., as basic determinants of good health and convergence with related social sector departments like Women and Child Development, Ayurveda, Yoga, Unani, Sidha & Homeopathy (AYUSH) and Panchayati Raj.

1.3.2 Organisational set up

At the State level, the Mission functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The Chief Secretary and the Secretary/Commissioner, Health & Family Welfare (HFW) are the Chairmen of the Governing Body and the Executive Body of State Health Society[23] (SHS) respectively. A designated officer is identified as the State Mission Director who is directly supported by a State Programme Management Unit (SPMU). The organogram of the SHS is shown below:

[22] IMR: Infant Mortality Rate ; MMR: Maternal Mortality Rate and TFR: Total Fertility Rate
[23] formed during 2006-07



At the District level, the Deputy Commissioner is the Chairman of the Governing Body of the District Health Society (DHS) and the Chief Medical Officer is the head of the Executive Body and functions as District Mission Director (DMD). They are supported by the District Programme Management Unit (DPMU).

The organisational set up at the District level is given below:

Public health services in the rural areas are delivered through the CHCs, PHCs and SCs.

1.3.3 Scope of audit

The performance audit of NRHM for the period 2005-10 was conducted during May to September 2010. Four[24] out of the nine districts were selected

[24] (1) Bishnupur (2) Churachandpur (3) Imphal West and (4) Senapati

for detailed audit based on Probability Proportionate to size With Replacement method. All the three District Hospitals[25] (DHs), seven CHCs[26] in four sample districts were selected for a test check of records. Further, 19[27] out of 34 PHCs and 38[28] out of 216 SCs under the selected PHCs were also selected using Simple Random Selection Without Replacement. The records of the Mission Directorate, the Directorate of Family Welfare, the Nodal Officers under the Directorate of Health Services, four DHSs, three DHs, selected CHCs, PHCs and SCs were also test-checked during the review period. The test-checked covered an expenditure of ₹ 54 crore representing 47 *per cent* of the total expenditure of ₹ 114 crore of the Mission during 2005-10.

1.3.4 Audit objectives

The objectives of performance audit were to assess whether:

- planning, monitoring and evaluation procedures at all levels achieved their principal objective of ensuring accessible, effective and reliable healthcare delivery system to rural population;
- public spending on health sector over the years 2005-10 increased and release of funds, utilisation and accounting thereof was adequate;
- the level of community participation in planning, implementation and monitoring of the Mission was adequate and effective;
- convergence of the Mission activities with other Departments and programmes was ensured for achieving the broad objectives of the programme;
- the Mission achieved capacity building and strengthening of physical infrastructure and human resources at different levels as planned and targeted;
- the performance indicators and targets fixed especially in respect of reproductive and child healthcare, immunisation and disease control programmes were achieved.

[25] (1) Bishnupur (2) Churachandpur and (3) Senapati
[26] (1) Kangpokpi (2) Mao (3) Moirang (4) Nambol (5) Parbung (6) Sekmai (7) Wangoi
[27] (1) Phayeng (2) Phaibung (3) Kakwa (4) Mayang Imphal (5) Samurou (6) Henglep (7) Thanlon (8) Singzawl (9) Sagang (10) Saikot (11) Maphou Kuki (12) Saikul (13) Oinam Hills (14) Kalapahar (15) T. Waichong (16) Kumbi (17) Thanga (18) Leimapokpam and (19) Oinam
[28] (1) Iroisemba (2) Khamnam Bazar (3) Salam (4) Takyel Khongbal (5) Bengoon (6) Kokchai (7) Karam Haoreibi (8) Langthabal Phuramakhong (9) Nungshai (10) Charoi Khullen (11) Milongmun (12) Bukpi (13) Aibulon (14) Sumtuh (15) Khoirentak (16) Senpangjar (17) Leisang (18) Geljang (19) Bongbal Khullen (20) Salam Patong (21) Molkon (22) Chingdai Khullen (23) Khamsong (24) Thingba Khunou (25) Khongdei (26) Thiwa (27) Keithelmanbi (28) Parsain (29) Irang Part-I (30) Pani Kheti (31) Wangoo Ahaloop (32) Pombikhok (33) Karang (34) Keibul (35) Sanjenbam (36) Pukhrambam (37) Ngaikhong Khullen and (38) Naorem

1.3.5 Audit criteria

Audit findings were benchmarked against the following criteria:

- Guidelines issued by the GoI for implementation of NRHM and instructions issued from time to time;
- State Programme Implementation Plan (PIP) approved by the GoI;
- Memorandum of understanding between the GoI and the State Government and
- Indian Public Health Standards (IPHS) for upgradation of CHCs and PHCs.

1.3.6 Audit methodology

The audit methodology included holding of an Entry Conference (May 2010) with the Commissioner (Health and Family Welfare) Manipur, the Mission Director-SHS (SMD), the Deputy Commissioner (Bishnupur), the District Mission Director (DMD)-Imphal West, the Deputy Director (Finance -SHS) and the State Programme Manager (SHS), issue of requisitions, questionnaire and obtaining replies thereof, checking of the relevant records, analysis of data and documentary evidences to arrive at audit findings, conclusions and recommendations.

The audit findings were discussed with the departmental officers *viz.* the Mission Director-SHS, the Deputy Director (Finance–SHS), the District Mission Director (Senapati), the Medical Superintendent (DH-Senapati) and the State Programme Manager in an Exit Conference (November 2010) and their views and reply, wherever available, had been incorporated in the review.

Audit findings

Important audit findings are discussed in the succeeding paragraphs.

1.3.7 Planning

1.3.7.1 Baseline survey

NRHM strives for a decentralised and participatory planning process with a bottom up approach from village level to ensure that need based and community owned Health Action Plans form the basis for interventions in health sector. The plans were to be prepared on the basis of household and facility surveys at village, block and district levels based on IPHS norms. 50 *per cent* of these surveys were required to be completed by 2007 and 100 *per cent* by 2008.

In the State a comprehensive household survey was not carried out except Imphal West district. The Department, therefore, failed to make a realistic assessment of healthcare requirement and to identify underserved and

unserved areas. The reasons for non conduct of the household survey was not recorded.

Facility survey to identify the gaps in the availability of infrastructure and human resource in respect of all seven CHCs were conducted during 2007-10 but no survey was conducted for PHCs and SCs to define the baseline. As a result, without baseline survey inputs, the Annual Action Plans were not realistic.

The Department stated (November 2010) facility surveys were conducted at PHCs and SCs levels. The reply was not acceptable as their reply could not be substantiated with relevant documents in support.

1.3.7.2 Perspective and Annual Action Plans

The SHS was required to prepare a Perspective Plan for the entire Mission period (2005-12) as well as Annual Plans covering the gaps in the health care facilities, areas of interventions and probable investments. The DHSs were also required to prepare Perspective plans as well as annual District Health Action Plans (DHAP), which were to be integrated into the State Perspective Plan and Annual State Programme Implementation Plans (SPIP) respectively. The DHAPs was to be prepared by the DHS and approved by the District Health Mission (DHM). Block Health Action Plan (BHAP) is the basis of the DHAP.

In the State DHSs were formed in all nine districts during 2006-07. While DHM was formed only in Bishnupur district during July 2008, the same was not formed in the remaining districts.

Audit noticed that the Perspective Plans for the Mission period were not prepared either at the State or at the district level. No SPIP and DHAPs were prepared for the year 2005-06. For the year 2006-07, the SPIP was prepared without inputs from DHAPs as no DHAP for 2006-07 were prepared. However, during the period 2007-10, the SPIPs were prepared on the basis of DHAPs for the said years. Though the BHAPs were prepared during 2008-10, the same was not prepared for the year 2005-08. Thus, DHAPs were not based on plans from block/periphery level for 2005-08. Hence, bottom up approach as envisaged in the NRHM guidelines was not adopted in the preparation of SPIP for 2005-08. Due to non-preparation of the Perspective Plans for 2005-10 and DHAP for 2005-07, the community participation in planning as envisaged in the Mission remained unachieved (March 2010).

The Department stated (December 2010) that the Perspective Plan was not prepared separately and it was integrated in the SPIP. The reply of the Department is not in consonance with the guidelines of the NRHM as Perspective Plan as well as SPIP was to be prepared separately.

1.3.8 Financial management

1.3.8.1 Funding pattern

GoI provided 100 *per cent* funds for implementation of the scheme through two separate channels *i.e.* through State Finance Department and directly to different programme implementing societies during 2005-07. From 2007-08 onwards, the contribution was to be in the ratio of 85:15 between the Centre and the State.

1.3.8.2 Financial performance

1.3.8.3 State level

The details of funds released by the GoI to the SHS and expenditure were as under:

Table 1

(₹ in crore)

Year	Opening Balance	Receipt			Interest	Funds available during the year	Funds utilised	Closing Balance
		GoI	State Government					
			Share due	Actual				
2005-06	0.13	11.88	Nil	Nil	0.09	12.10	1.31	10.79
2006-07	10.79	22.57	Nil	Nil	0.41	33.77	5.31	28.46
2007-08	28.46	37.00	6.95	Nil	1.16	66.62	18.48	48.14
2008-09	48.14	35.89	9.50	Nil	0.60	84.63	42.94	41.69
2009-10	41.69	64.39	13.87	5.00	0.81	111.89	45.96	65.93
Total:		**171.73**	**30.32**	**5.00**	**3.07**		**114.00**	

(Source: State Health Society)

- ***Non-utilisation of funds***

During the period covered by audit, total fund of ₹ 179.93[29] crore was available out of which ₹ 114 crore was utilised leaving an unspent balance of ₹ 65.93 crore (37 *per cent*) as of March 2010. The poor utilisation not only reflected unrealistic assessment of fund requirements but also depicted the limited absorption capacity by the State.

The Department failed to utilise the available resources fully thereby resulting in non-implementation of the various activities[30] of the Mission and depriving the targeted population of the healthcare services.

- ***Short release of State share***

As against the State share amounting to ₹ 30.32 crore for the period 2007-10, the State Government released only ₹ 5 crore during 2009-10, thereby resulting in short release of ₹ 25.32 crore (84 *per cent*). This is in violation of the guidelines of NRHM as the State Government was required to contribute its share proportionately.

The Department stated (December 2010) that the matter regarding short release of State share was taken up with the State Planning Department.

[29] ₹ 0.13 crore + ₹ 171.73 crore + ₹ 5 crore + ₹ 3.07 crore = ₹ 179.93

[30] Important activities: Capacity building of DHs, CHCs and PHCs, procurement of drugs, construction of infrastructure, untied funds *etc*.

➢ *Public spending on health sector*

The State Government signed (May 2006) an MoU with the GoI committing itself to increase its share of public spending on health sector from its own budgetary sources at the minimum rate of 10 *per cent* every year. The State's budget allocation and expenditure on health sector during the period 2005-10 is given in Table 2:

Table 2

(₹ in crore)

Year	State budget allocation	Expenditure	Savings(-)/Excess(+)
2005-06	86.02 (- 13)[31]	85.17 (+ 35)	(-) 0.85
2006-07	130.97 (+ 52)	96.16 (+ 13)	(-) 34.81
2007-08	147.19 (+ 12)	129.71 (+ 35)	(-) 17.48
2008-09	130.50 (- 11)	152.50 (+ 18)	(+) 22.00
2009-10	153.67 (+ 18)	148.23 (- 3)	(-) 5.44
Total:	**648.35**	**611.77 (94)**	

(Source: Appropriation accounts)
Figures in bracket indicate percentage of increase (+)/ decrease (-) in outlay and expenditure

The State Government's budget allocation in health sector and the public spending has declined by 13, 11 and 3 *per cent* during 2005-06, 2008-09 and 2009-10 respectively from the previous year against the commitment of 10 *per cent* increase every year.

Out of the savings of ₹ 58.58 crore, ₹ 12.89 crore[32] pertained to construction of infrastructure of health centres. Therefore, while the State complied with NRHM guidelines in terms of increasing its outlay on public health during 2006-08 and 2009-10, it failed to utilise the allocation for strengthening the healthcare infrastructure.

➢ *Delay in transfer of unutilised funds to the GoI*

The launch of NRHM, Reproductive and Child Health-II (RCH-II) and Janani Suraksha Yojana (JSY) in 2005-06 resulted in the termination of earlier operational programmes such as RCH-I Programme and National Maternity Benefit Scheme.

Unspent funds under RCH-I as on 31 March 2005 were required to be transferred to the Ministry of Health and Family Welfare, GoI. However, ₹ 28.15 lakh remained as balance was transferred only in November 2009 with a delay of more than four years.

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[31] Year	State budget allocation	Expenditure
	(₹ in crore)	
2004-05	98.35	63.04

(Source: Appropriation Accounts)

[32] Year	Amount ₹ in lakh
2005-06	0.43
2006-07	295.67
2007-08	443.85
2009-10	549.22
Total:	**1289.17**

(Source: Appropriation Accounts)

1.3.8.4 District level

The details of funds released to the four test-checked DHSs and expenditure incurred there against are given below:

Table 3

(₹ in lakh)

District	Year	Opening Balance	Receipt	Interest accrued	Funds available during the year	Funds utilised during the year	Closing Balance
Bishnupur	2005-06	Nil	17.25	Nil	17.25	8.39	8.86
	2006-07	9.07[33]	63.01	Nil	72.08	43.43	28.65
	2007-08	28.65	212.35	0.21	241.21	75.87	165.34
	2008-09	165.34	199.20	0.86	365.40	264.24	101.16
	2009-10	101.16	190.72	0.33	292.21	205.99	86.22
Sub-total:			**682.53**	**1.40**		**597.92 (88)**	
Churachandpur	2005-06	Nil	26.58	Nil	26.58	12.17	14.41
	2006-07	Nil	117.34	0.01	117.35	78.60	38.75
	2007-08	38.75	318.91	0.52	358.18	277.61	80.57
	2008-09	80.57	405.05	1.77	487.39	332.48	154.91
	2009-10	154.91	396.61	2.17	553.69	487.00	66.69
Sub-total:			**1264.49**	**4.47**		**1187.86 (94)**	
Imphal West	2005-06	Nil	33.45	Nil	33.45	21.61	11.84
	2006-07	Nil	90.01	0.49	90.50	75.01	15.49
	2007-08	15.49	230.84	0.54	246.87	209.35	37.52
	2008-09	37.52	187.37	1.11	226.00	217.68	8.32
	2009-10	8.32	328.80	0.74	337.86	251.22	86.64
Sub-total:			**870.47**	**2.88**		**774.87 (89)**	
Senapati	2005-06	Nil	32.47	Nil	32.47	Nil	32.47
	2006-07	32.47	95.55	0.20	128.22	76.11	52.11
	2007-08	52.11	367.52	0.69	420.32	246.52	173.80
	2008-09	173.80	311.32	0.01	485.13	363.55	121.58
	2009-10	121.58	354.65	1.85	478.08	326.52	151.56
Sub-total:			**1161.51**	**2.75**		**1012.70 (87)**	

(Source: DHSs and SHS)
Figures in bracket indicate percentage of utilisation of funds

➢ *Accounting procedure*

The accounting procedure consists of recording in the books of original entry *i.e.* journal and cash book, classifying, grouping, valuing and preparing financial statements.

Neither the financial position for 2005-06 nor the relevant records like cash books, journals in respect of three districts[34] could be made available to audit. In absence of such vital records the implementation of the Mission activities could not, therefore, be ascertained in audit.

➢ *Non-accountal of closing balance*

Test check of the records of SHS revealed that closing balance of ₹ 14.41 lakh and ₹ 11.84 lakh for the year 2005-06 with Churachandpur and Imphal West districts respectively were not carried forward as opening balance in 2006-07 accounts of these districts. The reasons for non-accountal of the closing

[33] The discrepancy of ₹ 0.21 lakh between the closing balance of ₹ 8.86 lakh as on 31 March 2006 and opening balance of ₹ 9.07 lakh on 1 April 2006 not reconciled (November 2010).
[34] Bishnupur, Churachandpur and Imphal West.

balance, though called for, were not furnished by the DHSs concerned (December 2010).

➢ ***Non-utilisation of funds***

From Table 3, it is seen that in respect of the sample districts there was an unspent balance ranging from ₹ 0.67 crore to ₹ 1.52 crore which shows that a large portion of the Mission activities remained un-implemented thereby frustrating the Mission activities. The reasons for non-utilisation of allocated funds were not stated by the Departments/DHSs (December 2010).

1.3.9 Programme implementation

1.3.9.1 Infrastructure

As per NRHM guidelines one CHC is to be set up for population of 1,20,000 (80,000 for tribal areas), one PHC for population of 30,000 (20,000 for tribal areas) and one SC for 5,000 (3,000 for tribal areas) in general areas. Comparative position of requirement of these institutions on the basis of the prescribed norms and health care facilities actually set up in the State is detailed below:

Table 4

District (Rural population as per Census 2001)	CHC			PHC			SC		
	Requirement as per population	Position as on March 2010	Excess (+)/ Shortfall (-)	Requirement as per population	Position as on March 2010	Excess (+)/ Shortfall (-)	Requirement as per population	Position as on March 2010	Excess (+)/ Shortfall (-)
Tribal areas									
Churachandpur (2,27,905)	3	1	- 2	11	9	- 2	76	68	- 8
Senapati (2,83,621)	4	2	- 2	14	12	- 2	95	65	- 30
Chandel (1,03,365)	1	0	- 1	5	5	0	34	25	- 9
Tamenglong (1,11,499)	1	1	0	6	6	0	37	30	- 7
Ukhrul (1,40,778)	2	1	- 1	7	6	- 1	47	42	- 5
Total:	**11**	**5**	**- 6**	**43**	**38**	**- 5**	**289**	**230**	**- 59**
General areas									
Bishnupur (1,33,627)	1	2	+ 1	4	5	+ 1	27	33	+ 6
Imphal West (1,97,699)	2	2	0	7	8	+ 1	40	50	+ 10
Imphal East (2,86,566)	2	2	0	10	11	+ 1	57	47	- 10
Thoubal (2,32,868)	2	5	+ 3	8	12	+ 4	47	49	+ 2
Total:	**7**	**11**	**+ 4**	**29**	**36**	**+ 7**	**171**	**179**	**+ 8**

(Source: Data compiled by audit from departmental records)

As seen from the above table, in all five tribal areas there was a large shortage of health centres *i.e.* six CHCs against the requirement of 11 CHCs, shortage of five of 43 PHCs and shortage of 59 of 289 SCs.

While there was an acute shortage of health centres in the tribal areas, the general areas were provided with excess number of health centres.

Non setting up of required number of health centres resulted in failure to provide accessible and reliable health care facilities to rural people.

1.3.9.2 Non-upgradation and non-provision of health care facilities

NRHM envisages the upgradation of CHCs to Indian Public Health (IPH) standards and PHCs to 24x7 services. During the period 2006-10, 13 CHCs and 37 PHCs were planned for upgradation at a cost of ₹ 8.34 crore. After incurring an expenditure of Rs 6.98 crore (84 *per cent*) crore, none of the CHCs and PHCs was upgraded except Wangoo Laipham PHC.

The construction of buildings for 139 SCs was planned at a cost of ₹ 12.44 crore and after incurring an expenditure of ₹ 10.48 crore (84 *per cent*), 95 SCs only were completed (December 2010).

Non-upgradation of CHCs and PHCs and non-completion of the buildings of SCs resulted in failure of providing accessible and quality health care services to the rural people.

The Department attributed (December 2010) the non-completion of the infrastructure to the law and order situation in the State and further added that the SHS was trying to complete the works at the earliest.

1.3.9.3 Status on health facilities

Test check of selected health care units revealed the non provision of required facilities as shown in the table below:

Table 5

Sl. No.	Particulars	Number of centres where service was not available			
		DHs	CHCs	PHCs	SCs
	Total number of health centres audited	**3**[35]	**7**	**19**	**38**
1	Waiting room for patients	3	7	16	38
2	Functional Labour Room	0	0	15	37
3	Functional Operation Theatre	2	7	19	NR
4	Clinic Room	0	0	6	34
5	Emergency/Casualty Room	0	1	16	38
6	Residential facilities for staff	0	7	19	38
7	Separate utility for Male and Female	0	3	8	37
8	Blood storage	2	7	19	NR
9	New born care	3	1	8	26
10	24 x 7 delivery service	0	1	19	NR
11	X-ray facility	0	5	19	NR
12	In-patient service	0	0	17	38
13	Ultrasound	2	7	19	NR
14	ECG	2	6	19	NR
15	Family Planning (Tubectomy and Vasectomy)	2	7	19	38
16	Intra-natal examination of gynaecological conditions	0	5	19	38
17	Paediatrics	2	6	19	38

(Source: Data compiled by audit from test-checked health centres) NR: Not Required

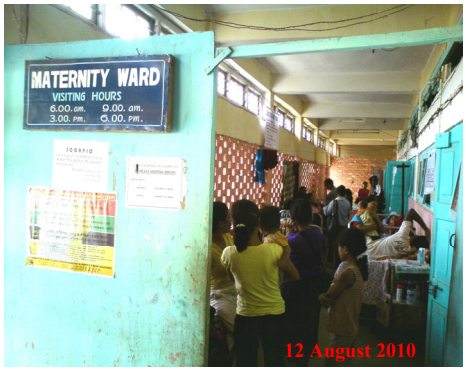
As can be seen from the above table, health facilities were quite inadequate in a large number of selected health centres. Thus, the targeted beneficiaries remained deprived of the health facilities.

[35] Imphal West District has no DH.

The photographs of working conditions of some health centres are given below:

A small shed serves as Primary Health Sub-Centre at Takyel Khongbal, Imphal West district

Primary Health Sub-Centre at Bengoon at Imphal West district functioning at a rented house



Corridor used as maternity ward in Churachandpur District Hospital

Poor state of Labour Room at PHC Thanlon, Churachandpur

1.3.9.4 Operation theatre

As per guidelines, every DH and CHC are required to be provided with functional operation theatre. While one[36] out of three selected DHs had a functional operation theatre none of the seven CHCs test-checked had functional operation theatre.

The status of availability of the various operation theatre equipments in the three DHs and seven CHCs test checked is as shown below:

[36] DHs Churachandpur

Table 6

Sl. No.	Particulars	Number of DHs where equipment was available and functional	Number of DHs where equipment was available but not functional	Number of DHs where equipment was not available
1	Boyales Apparatus	2	1	0
2	Cardiac Monitor for OT	0	0	3
3	Ventilator for OT	1	0	2
4	Vertical High Pressure Sterilizer 2/3 drum capacity	1	0	2
5	Gloves and dusting machines	1	0	2
6	Nitrous oxide cylinder 1780 ltrs 8 for one Boyales Apparatus	1	0	2
7	EMO Machine	0	0	3
8	Defibrillator for OT	0	0	3
9	Horizontal High Pressure Sterilizer	0	1	2
10	Shadowless lamp ceiling trak mounted	2	0	1
11	OT care/fumigation apparatus	1	0	2
12	Oxygen cylinder 660 ltrs 10 cylinder for one Boyales apparatus	2	0	1
13	Hydraulic operation table	2	0	1

(Source: Data compiled by audit from test checked health centres)

Table 6 (a)

Sl. No.	Particulars	Number of CHCs where equipment was available and functional	Number of CHCs where equipment was available but not functional	Number of CHCs where equipment was not available
1	Boyales Apparatus	1	4	2
2	Cardiac Monitor for OT	0	1	6
3	Ventilator for OT	0	1	6
4	Vertical High Pressure Sterilizer 2/3 drum capacity	0	2	5
5	Gloves and dusting machines	0	1	6
6	Nitrous oxide cylinder 1780 litres 8 for one Boyales Apparatus	0	1	6
7	EMO Machine	0	0	7
8	Defibrillator for OT	0	0	7
9	Horizontal High Pressure Sterilizer	1	1	5
10	Shadowless lamp ceiling trak mounted	0	3	4
11	OT care/fumigation apparatus	0	0	7
12	Oxygen cylinder 660 litres 10 cylinder for one Boyales apparatus	1	2	4
13	Hydraulic operation table	0	3	4

(Source: Data compiled by audit from test checked health centres)

Thus, despite launching of NRHM and availability of sufficient funds accessibility to health services for the rural people did not improve. The physical status of some of the test-checked health centres is given in photographs below:

Non-functional Operation Theatre used as store room at CHC Kangpokpi, Senapati district

Non-functional Operation Theatre at CHC Nambol, Bishnupur district

1.3.9.5 Poor occupancy rate of beds

Every CHC is provided with 30-50 beds and PHC with 6 beds for treatment of in-patients. However, scrutiny of the records of the seven test-checked CHCs revealed that the bed occupancy rate ranged between 0 to 46 *per cent* during 2005-10 whereas it was 0 *per cent* in all 19 selected PHCs. Audit noticed that such poor occupancy were due to non-availability of medical specialists and health facilities. Action taken by the Department for improvement of the situation was not on records.

1.3.10 AYUSH services

The Mission seeks to revitalise local health traditions and mainstream Ayurvedic, Yoga, Unani, Siddha and Homoeopathy (AYUSH) to strengthen the public health system by providing an AYUSH doctor at every PHC and by establishing AYUSH clinics at CHCs.

During physical verification of the CHCs and PHCs, audit noticed that AYUSH clinics were not set up in five out of seven test-checked CHCs and AYUSH doctors were not posted in three PHCs. This affected the aim of mainstreaming of AYUSH services as per NRHM framework.

The reasons for non-setting of AYUSH clinics were not recorded by the test-checked units.

1.3.11 Human resource

(i) As of March 2010 the acute shortage of manpower in the test-checked seven CHCs is given in the table below:

Table 7

(in Numbers)

Personal	Requirement as per IPHS norm for 7 CHCs	Current availability
General Surgeon	7	0
Obstetrician/Gynaecologist	7	0
Anaesthetist	7	0
Physician	7	0
Paediatrics	7	0
Eye Surgeon	7	0
Auxiliary Nurse Mid-wife (ANM)	7	14
Dresser	7	0
Lab. Technician	7	12
Ophthalmic Assistant	7	6
OPD attendant	7	9
Public Health Programme Manager	7	2
Staff Nurse (SN)	49	52
Public Health Nurse	7	7
Pharmacist/compounder	7	18
Radiographer	7	6
Ward boys/ nursing orderly	14	2
OT attendant	7	0

(Source: Data collected and compiled by audit from test checked health centres)

Audit scrutiny revealed the following shortcomigs:

- None of the Specialist as per IPHS requirements was posted in the test checked CHCs,
- There was shortage of 12 staff nurses in four CHCs while there was excess of 15 staff nurses in three CHCs.

(ii) The manpower position (March 2010) of 19 test-checked PHCs are detailed in the table below:

Table 8

Personal at PHC level	Requirement as per IPHS norm for 19 PHCs	Current availability
Medical Officer (MO)	38	35
Staff nurse	57	37
Health educator	19	2
Pharmacist	19	25
Health worker (Female)	19	45
Health Assistant (one male, one female)	38	6
Laboratory technician	19	13

(Source: Data collected and compiled by audit from test checked health centres)

While there was excess posting of six pharmacists and 26 female health workers, there were shortages of other personnel.

(iii) In 38 SCs, there was a shortfall of 28 voluntary workers against the required strength of 38 (one voluntary worker for each SC as per norm of IPHS).

Acute shortage of manpower in the health institutions adversely affected the availability of health care services.

1.3.11.1 Training of medical and para medical staff

During the period 2005-10, the SHS incurred an expenditure of ₹ 2.45 crore on training of medical and para-medical staff on various courses. Training plans for medical and para-medical staff and achievement thereof for the period 2005-08 involving ₹ 11.57 lakh were not available. For the years 2008-10 the position is shown below:

Table 9

Post	2007-08		2008-09		2009-10		Total	
	Target (T)	Achievement (A)	T	A	T	A	T	A
Skilled Birth Attendance for SN/ANM	NA	NA	360	238	60	60	420	298
Medical Termination of Pregnancy/Manual Vacuum Aspiration for MOs	NA	NA	40	39	60	13	100	52
Reproductive Track Infection(RTI)/Sexually Transmitted Infection (STI) for MOs	NA	NA	50	45	90	82	140	127
RTI/STI for SN/ANMs	NA	NA	Nil	Nil	270	191	270	191
Integrated Management of Newborn and Childhood Illness for MOs	NA	NA	100	99	100	84	200	183
Intra Uterine Device for MOs, SN, ANMs	NA	NA	Nil	38	300	220	300	258
Management Training for Programme Manager	NA	NA	Nil	Nil	125	46	125	46
ASHA	3000	3000	Nil	Nil	878	878	3878	3878

(Source: Departmental records)
NA: Not furnished by the Department

The details shown above depicted the shortfall in imparting training to the medical and para-medical staff. Non-achievement of targets earmarked for training at the State Level affected the human resource management under the Mission.

1.3.12 Accredited Social Health Activist

One of the core strategies of the NRHM was to promote access to improved healthcare at household level through a trained female community-health worker called Accredited Social Health Activist (ASHA) to be provided in every village with the ratio of one per 1000 population. For tribal and hilly areas, the norm could be relaxed for one ASHA depending on the workload. The ASHA was expected to act as an interface between the community and public health system.

The number of ASHAs required and engaged as on March 2010 is detailed below:

Table 10

Name of District	Total rural population (2001 census report)	No. of ASHAs required	No. of ASHAs selected and engaged	Excess
Bishnupur	133627	134	235	101
Imphal West	197669	198	329	131
Imphal East	286566	287	431	144
Thoubal	232868	233	365	132
Senapati	283621	284	787	503
Churachandpur	227905	228	627	399
Ukhrul	140778	141	302	161
Chandel	103365	103	550	447
Tamenglong	111499	111	252	141
Total:		**1719**	**3878**	**2159**

(Source: Compiled by audit from departmental records)

It would be evident from the above table that there was an excess of 2159 ASHAs against the required number of 1,719 based on census 2001 data. The Department incurred a sum of ₹ 4.22 crore on selection and training, ASHA kit, radio, uniform, umbrella and payment of performance related incentives during 2008-10.

The Department stated (November 2010) that ASHAs had been selected as per GoI guideline based on the revenue villages of census 2001. Hamlet villages were also considered besides revenue villages in respect of the selection of ASHAs in the hilly districts. The reply of the Department was not acceptable as the GoI's guidelines are silent regarding selection of ASHA as per revenue and hamlet villages and selection of ASHA was not purely based on the norms.

1.3.13 Mobile medical units

As per guidelines, a Mobile Medical Unit (MMU) was to be provided in each district for ensuring outreach of healthcare services in medically unserved/underserved areas. During 2007-08, 18 Mobile Vans were procured at a cost of ₹ 3.89 crore and two MMUs were issued (February 2008) to each of the nine districts. Test-check of the records maintained by the sample districts revealed that though the DHS, Bishnupur maintained log books for the period from December 2009 no operational records were maintained. The DHS, Imphal West maintained operational records of the MMUs only after June 2009. The MMUs were kept idle for a period ranging from sixteen months to twenty-two months. Neither the log books nor the operational records were maintained by the DHS, Churachandpur and the DHS, Senapati. Thus, idling of the MMUs and non-maintenance of log books and operational records certainly affected the NHRMs aim of providing specialised health facilities to the unserved/underserved areas.

1.3.14 Family welfare activities

The achievement of targets for reduction of Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR) and Total Fertility Rate (TFR) by 2009-10 is depicted in the table below:

Table 11

Indicators	Target 2009-10	Current status	
	Manipur	Manipur	Nation (India)
Maternal Mortality Rate (MMR)	<100/1,00,000 live births	160/1,00,000 live births (SRS – 2005)	254 (SRS 2009)
Infant Mortality Rate (IMR)	<13/1,000 live births	14/1,000 live births (SRS – 2009)	53 (SRS 2009)
Total Fertility Rate (TFR)	2.1	2.8 (NFHS – 3)	2.7 (NFHS – 3)

(Source: State Health Society)

As would be seen from the table, the Department did not achieve the targets earmarked. While admitting the fact, DHS further stated (December 2010) that the status on health indicators of the State is better than that of the national level.

1.3.14.1 Janani Suraksha Yojana

The Janani Suraksha Yojana (JSY) aims at safe motherhood, reduction of maternal and neo-natal mortality by promoting institutional deliveries. The BPL, SC and ST pregnant women aged 19 years and above upto two live births and who have three completed Antenatal Checkups (ANCs) are entitled for incentive of ₹ 700 in case of delivery in a Government health centre or accredited private institution and ₹ 500 in case of domiciliary delivery.

The ASHA incentive for accompanying a pregnant woman for ANC, institutional delivery and post partum period in a health centre was @ of ₹ 200 per delivery case for the period upto 2008-09 and this was revised to ₹ 600 during 2009-10. For tracking each pregnancy, ANC, post delivery care, payment of incentives to the mothers and ASHA, the health centres should mandatorily prepare a micro-birth plan.

During 2005-06, no incentive was paid. For the period 2006-10, the expenditure on incentive under JSY including ASHA package for the State was ₹ 2.68 crore. In respect of test-checked units, the position of payment of incentive under JSY and ASHA package made during 2006-10 are as shown below:

Table 12

Year	Pregnant women registered	Institutional deliveries (ID)		Domiciliary deliveries (DD)		Cash assistance given (₹ in lakh)	
		Number of mothers opting for ID	Number of Mothers benefited	Number of mothers opting for DD	Number of Mothers benefited	Mother	ASHA
Bishnupur							
2005-06	1548	573	Nil	NA	Nil	Nil	Nil
2006-07	2021	762	345	NA	NA	2.42	Nil
2007-08	2933	1,236	586	58	58	4.39	Nil
2008-09	2558	1,237	915	59	59	6.70	1.27
2009-10	2594	1,481	1450	155	114	10.72	7.01
Sub-total:	**11654**	**5289 (45)**	**3296**	**272**	**231**	**24.23**	**8.28**
Churachandpur							
2005-06	27	Nil	Nil	NA	Nil	Nil	Nil
2006-07	92	NA	Nil	20	20	0.10	Nil
2007-08	541	NA	Nil	20	20	0.10	Nil
2008-09	540	Nil	Nil	82	70	0.35	Nil
2009-10	1482	6 (0)	6	431	429	2.19	0.04
Sub-total:	**2682**	**6 (0)**	**6**	**553**	**539**	**2.74**	**0.04**
Imphal West							
2005-06	1234	15	Nil	41	Nil	Nil	Nil
2006-07	1619	320	320	30	30	2.39	Nil
2007-08	1499	310	300	43	32	2.26	Nil
2008-09	2260	350	325	221	119	2.87	0.45
2009-10	2421	98	98	73	19	0.78	0.59
Sub-total:	**9033**	**1093 (12)**	**1043**	**408**	**200**	**8.30**	**1.04**
Senapati							
2005-06	2078	528	Nil	20	Nil	Nil	Nil
2006-07	2217	517	285	261	9	2.04	Nil
2007-08	4467	827	600	536	94	4.67	Nil
2008-09	4690	897	800	723	162	6.41	1.52
2009-10	4993	668	600	512	64	4.52	2.47
Sub-total:	**18445**	**3437 (19)**	**2285**	**2052**	**329**	**17.64**	**3.99**
Grant total:	**41814**	**9846 (23)**	**6630**	**3284**	**1299**	**52.91**	**13.35**

(Source: Data compiled by audit from the test checked units including DHs)
Figures in bracket indicate percentage of Institutional Delivery
NA: Not furnished by the department.

As would be seen from the above table, the test-checked units incurred an expenditure of ₹ 66.26 lakh on payment of JSY incentive and ASHA package to 7,929 mothers and 3,308 AHSA respectively during 2006-10. Scrutiny of the records, however, revealed that the health centres had not prepared the mandatory document of micro birth plan and the payment of the incentives was made without ensuring the fulfilment of eligibility criteria and mandatory documentation as prescribed in the said plan. In absence of such vital record, audit could not ascertain the veracity of payments.

1.3.14.2 Institutional delivery

NHRM aims to encourage the prospective mothers to undergo institutional deliveries. The State Government targeted to achieve 60 *per cent* deliveries in health centres or accredited private institutions by March 2010. The number of pregnant women registered during 2005-07 and achievement of the institutional delivery was not available with the Department. The status for the year 2007-10 is shown below:

Table 13

Year	Pregnant women registered	Institutional deliveries (ID)	Domiciliary deliveries	Pregnant women whose status of delivery not on record	Percentage of achievement (ID)
2007-08	71,394	19,925	7,102	44,367	28
2008-09	1,05,361	20,422	7,496	77,443	19
2009-10	1,11,670	24,206	7,535	79,929	22
Total:	**2,88,425**	**64,553**	**22,133**	**2,01,739**	

(Source: State Health Society)

As could be seen from the above table the achievement of institutional delivery ranged from 19 to 28 *per cent* during 2007-10. Hence under the intervention of JSY the percentage of pregnant women opting for institutional facilities for delivery had not been achieved to the prescribed level of 60 *per cent*.

In respect of the sample districts, the percentage of institutional delivery ranged from 0[37] to 45 *per cent* as depicted in Table 12.

There was no mechanism in place to monitor the status of delivery in respect of 2,01,739 pregnant women registered during 2007-10.

The Department stated (December 2010) that they would enhance the awareness programme for increasing institutional delivery through Information, Education and Communication (IEC), ASHA *etc*.

1.3.14.3 (i) Antenatal care, registration and check-ups (ANC)

One of the major aims of safe motherhood is to register all the pregnant women within 12 weeks of pregnancy and provide them with services like four antenatal checkups, 100 days Iron Folic Acid tablets (IFA), two doses of Tetanus Toxoid (TT), advice on the correct diet and vitamin supplements and

[37] Only 6 mothers opted for ID.

in case of complications, refer them for more specialised gynaecological care for early detection of complications during pregnancy and for preventing maternal mortality and morbidity. However, the number of registered pregnant women who had received three ANCs and administered two doses of TT for the State for the period 2005-08 was not available with the Department. During 2008-10, out of 2,88,425 registered women, 88,141 (31 *per cent*) received three ANCs and 1,04,266 (36 *per cent*) were administered two doses of TT. The reason for non-provision of four ANCs were not recorded in the departmental records.

(ii) Administration of IFA and TT

In the test-checked districts, the position of pregnant women to whom IFA was provided and TT were administered during 2005-10 is shown below:

Table 14

(In numbers)

District	Year	Pregnant women registered	No. of pregnant women to whom IFA was Administered (percentage of achievement)	No. of pregnant women to whom TT was Administered) (percentage of achievement)
Bishnupur	2005-06	NA	NA	NA
	2006-07	3658	Nil	2590
	2007-08	5662	Nil	3141
	2008-09	5903	288	3426
	2009-10	7128	1773	3000
Sub-total:		**22351**	**2061 (9)**	**12157 (54)**
Churachandpur	2005-06	27	27	25
	2006-07	92	53	51
	2007-08	541	162	441
	2008-09	540	339	304
	2009-10	1482	874	630
Sub-total:		**2682**	**1455 (54)**	**1451 (54)**
Imphal West	2005-06	26,953	6661	5528
	2006-07	21,655	3957	9048
	2007-08	33,872	Nil	6136
	2008-09	48,887	4961	9627
	2009-10	50,599	2532	8294
Sub-total:		**181966**	**18111 (10)**	**38633 (21)**
Senapati	2005-06	NA	NA	1665
	2006-07	1635	529	3011
	2007-08	6572	979	7563
	2008-09	8510	1301	5050
	2009-10	10326	3678	5977
Sub-total:		**27043**	**6487 (24)**	**23266 (86)**
Grand-total:		**234042**	**28114 (12)**	**75507 (32)**

(Source: DHSs)
NA: Not furnished by the Department

In the test-checked districts, out of 2.34 lakh pregnant women registered during the period, 28114 women (12 *per cent*) were provided with IFA tablets and 75507 women (32 *per cent*) were administered TT. Hence, 88 *per cent* of the registered women were not administered with IFA tablets and 68 *per cent* with TT, which resulted in failure to ensure safe motherhood.

1.3.14.4 Spacing methods

Intra-uterine device (IUD) insertion, Oral pills, and condoms are the three prevailing spacing methods of family planning to reduce the total fertility rate.

The targets and achievement for the period 2005-07 were not available with the department. The status on actual distribution of spacing contraceptives during 2007-10 are shown below:

Table 15

Year	IUD insertion		Oral pills cycle		Condom distribution	
	Target	Actual	Target	Actual	Target	Actual
2007-08	NA	4,376	NA	9,582	NA	1,15,327
2008-09	NA	3,993	NA	10,461	NA	1,90,538
2009-10	NA	5,183	NA	29,821	NA	2,11,741
Total		**13,552**		**49,864**		**5,17,606**

(Source: State Health Society)

As seen from the above table, among the total spacing method users during 2007-10, 2 and 9 *per cent* accounted for IUD and oral pills respectively while 89 *per cent* for condom users.

In the absence of annual targets achievement of the activities could not be assessed in audit.

1.3.15 Universal Immunisation Programme

Immunisation of children against six preventable diseases *viz.,* tuberculosis, diphtheria, pertussis, tetanus, polio and measles has been the cornerstone of routine immunisation under the programme.

To give an infant a healthy life, full immunisation by administration of one dose each of BCG and Measles and three doses each of DPT and OPV to an infant is necessary.

1.3.15.1 Routine immunisation

The achievement against the targets set for routine immunisation for the State during 2005-10 is as given below:

Table 16

Year	Target	Achievement (0 to 1 year age group)				Fully immunised (infants who have been administered full course of immunisation
		BCG	Measles	DPT	OPV	
2005-06	48,200	41,893	33,268	36,443	36,485	33,268 (69)
2006-07	45,825	55,225	47,360	48,064	48,064	47,360 (103)
2007-08	45,299	53,822	41,306	45,472	45,184	36,821 (81)
2008-09	48,353	47,706	37,700	43,538	43,556	36,681 (76)
2009-10	51,132	50,460	41,319	45,713	45,599	40,345 (79)

(Source: Directorate of Family Welfare)
Figures in bracket indicate percentage of achievement
BCG:- Bacillus Calamide Guerin, DPT:- Diphtheria Pertussis Tetanus, OPV:- Oral Polio Vaccine

While the percentage of fully immunised ranged from 69 to 81 *per cent* during 2005-06 and 2007-10, it exceeded the target during 2006-07.

1.3.15.2 Secondary immunisation

The children in the age of 5-6 years were required to be administered DT and 2 doses of TT at the age of 10 and 16 years respectively. The status on administration of secondary immunisation during 2005-10 is shown below:

Table 17

Year	DT (up to 5 years age group)		TT (10 years)		TT (16 years)	
	Target	Achievement	Target	Achievement	Target	Achievement
2005-06	47429	20811	46561	17176	45983	17002
2006-07	44050	39674	44267	37141	40594	29249
2007-08	44050	19381	43958	17660	43412	15956
2008-09	44976	14508	43449	20273	41451	22252
2009-10	49521	21176	47607	21347	45265	20714
Total	**230026**	**115550 (50)**	**225842**	**113597 (50)**	**216705**	**105173 (49)**

(Source: Directorate of Family Welfare)
Figures in bracket indicate percentage of achievement
DT: Diphtheria Tetanus, TT:- Tetanus Toxoid

During the period, the achievements of targets for DT for 5 years of age and TT for 10 years age group were 50 *per cent*, while TT for 16 years age group was 49 *per cent*.

The Department stated (December 2010) that the shortfall in achievement in secondary immunisation was due to non-conduct of school health programme.

1.3.15.3 Pulse Polio Immunisation

In pursuance of the World Health Assembly Resolution of 1988, in addition to the Universal Immunisation Programme, Pulse Polio Immunisation (PPI) was launched in 1995-96 to cover all the children below the age of five years to eradicate polio and ensure zero transmission by the end of 2008.

The year wise details of polio immunisation in the State and sample districts during 2005-10 are given below:

(a) State

Table 18

Year	PPI Achievement		
	Target	1st round	2nd round
		Achievement (*per cent*)	Achievement (*per cent*)
2005-06	349517	341875	331949
2006-07	361057	337712	337560
2007-08	351849	342951	344442
2008-09	344709	349053	348871
2009-10	344980	349007	349388
Total:	**1752112**	**1720598 (98)**	**1712210 (98)**

(Source: Directorate of Family Welfare)
Figures in bracket indicates percentage of achievement.

(b) Sample districts

Table 19

District	Year	Target	1st round	2nd round
			Achievement (*per cent*)	Achievement (*per cent*)
Bishnupur	2005-06	31361	NA	29685
	2006-07	32030	31827	31852
	2007-08	33234	30283	30506
	2008-09	30506	30098	30291
	2009-10	30506	30362	30221
		157637	**122570 (78)**	**152555 (97)**
Churachandpur	2005-06	32742	NA	33234
	2006-07	35897	33101	32870
	2007-08	34334	33460	33455
	2008-09	33460	33476	33524
	2009-10	33460	34187	34024
		169893	**134224 (79)**	**167107 (98)**
Imphal West	2005-06	62708	NA	58061
	2006-07	67842	59263	57471
	2007-08	60377	59075	60090
	2008-09	60090	63756	62612
	2009-10	60090	62597	62321
		311107	**244691 (79)**	**300555 (97)**
Senapati	2005-06	51498	NA	48746
	2006-07	45299	48890	49342
	2007-08	51451	52075	51877
	2008-09	51717	53574	52698
	2009-10	51717	50957	51991
		251682	**205496 (82)**	**254654 (101)**

(Source: Directorate of Family Welfare)
Figures in brackets indicates percentage of achievement
NA: Not furnished by the Department

The above table shows that while the overall achievement of the State was 98 *per cent*, the achievement in respect of the sample districts ranged between 78 and 82 *per cent* for the first round of immunisation and 97 and 101 *per cent* for the second round.

1.3.16 Disease Control Programmes

Seven[38] National Disease Control Programmes were taken up for implementation under NRHM. The programme-wise performance of five programmes test-checked in audit is discussed below:

1.3.16.1 Revised National Tuberculosis Control Programme

The NRHM sets a target of 85 *per cent* cure rate under Revised National Tuberculosis Control Programme (RNTCP) during 2005-10. The year-wise details of targets and achievements under the RNTCP regarding sputum

[38] (i) Revised National Tuberculosis Control Programme (ii) National Vector Borne Disease Control Programme (iii) National Leprosy Elimination Programme (iv) National Programme for Control of Blindness (v) National Programme for Prevention and Control of Deafness, (vi) National Iodine Deficiency Disorder Control Programme and (vii) Integrated Disease Surveillance Project

examination, case detection and status on treatment for the State were as shown below:

Table 20

Status on Sputum Examination

Year	Sputum Examination		Detection new Sputum +ve			
	Target	Achievement	Target for detection in NSP set for RNTCP (*per cent*)	Achievement (No. of NSP cases registered)	Population covered by RNTCP (in lakh)	Percentage (NSP Detection Rate)
2005	14,400	14,682	70	1026	24.52	56
2006	14,400	19,180	70	1141	24.52	62
2007	14,400	16,004	70	1065	25.60	55
2008	14,400	14,196	70	976	26.38	49
2009	14,400	14,668	70	1069	26.59	54
2010 (up to March 2010)	14,400	3,261	70	233	24.27	51

(Source: The State TB Society)
Figures in calendar year *i.e.* January to December

Table 21

Status on Treatment

Year	TB patients	No. of cases evaluated	Successfully treated	Died	Failures	Defaulters	Trans-ferred (nos.)	Cure rate (*per cent*)	Death rate (*per cent*)	Failure rate (*per cent*)	Defaulter rate (*per cent*)
2005	3831	5042	3831	163	66	519	9	86	3	1	10
2006	3762	4614	3762	130	56	566	17	84	3	1	12
2007	4022	3634	3849	118	71	571	16	84	3	2	12
2008	4293	4870	4068	151	67	447	12	82	3	1	9
2009	4239	4291	3572	147	65	490	18	83	3	2	11
2010	807	842	807	24	24	88	3	85	3	3	10

(Source: The State TB Society)
Figures in calendar year *i.e.* January to December

Table above shows the cure rate during 2006 to 2010 ranged between 82 to 85 *per cent* in the State as against 85 *per cent* prescribed under RNTCP. The cure rate in respect of 2005 was, however, 86 *per cent* which was above the target set.

1.3.16.2 National Vector Borne Disease Control Programme

The National Vector Borne Disease Control Programme (NVBDCP) aims to control vector borne diseases by reducing mortality and morbidity due to malaria, filarial, kala azar, dengue, chikungunia and Japanese encephalitis in endemic areas through close surveillance, improved diagnostic and treatment facilities at all health centres.

The programme stipulated to achieve Annual Blood Examination Rate (ABER) of 10 *per cent* and Annual Parasitic Incidence for Malaria (API) of less than 0.5 per thousand. The status on ABER and API as well as morbidity were as shown below:

Table 22

(Numbers)

Year	Malaria				Japanese Encephalitis	
	No. of cases	No. of deaths	ABER (*per cent*)	API (*per cent*)	No. of cases	No. of deaths
2005	2071	3	5.5	0.8	Nil	Nil
2006	2709	8	3.5	1.0	Nil	Nil
2007	1194	4	4.5	0.4	65	Nil
2008	708	2	4.8	0.2	4	Nil
2009	1069	1	4.0	0.3	64	Nil
2010	108	Nil	NA*	NA*	Nil	Nil

(Source: Information furnished by State Malaria Office)
NA: Not furnished

As would be seen from above that ABER ranged from 3.5 to 5.5 *per cent* and API was 0.2 to 1.0 per thousand.

1.3.16.3 National Leprosy Elimination Programme

The National Leprosy Elimination Programme (NLEP) aimed at eliminating leprosy by the end of March 2012; and the State was to ensure leprosy prevalence rate of less than one per ten thousand.

Audit scrutiny revealed the annual new case detection and the prevalence rate per ten thousand in the State were 45, 44, 54, 38, 31 and 0.13, 0.09, 0.15, 0.09 and 0.06 respectively during 2005-10 which indicated that the State could achieve the goal of leprosy elimination.

1.3.16.4 National Programme for Control of Blindness

The National Programme for Control of Blindness (NPCB) aimed at reducing the prevalence of blindness cases to 0.8 *per cent* by 2007 through increased cataract surgery, school eye screening and free distribution of spectacles, collection of donated eyes, creation of donation centres and eye bank, strengthening of infrastructure and training of eye surgeons and nurses.

The status on implementation of the programme for the State during 2005-10 was as shown below:

- ***Cataract operations***

The status of cataract operation for the State during 2005-10 was as under:

Table 23

(Numbers)

Year	Target	Achievement
2005-06	1,000	1,014
2006-07	1,000	1,156
2007-08	1,200	638
2008-09	2,000	1,746
2009-10	2,000	2,393

(Source: The State Blindness Control Society)

During 2007-09, the targets of cataract operations could not be achieved. The reasons for non-achievement of targets were not found on departmental

records. The facility for eye donation and its preservation was not available in the State.

➢ ***Failure of cataract operations***

Scrutiny of the records revealed that as a part of National Programme for Control of Blindness, an eye camp was held at DH, Bishnupur from 22 to 25 February 2007 during which 16 patients were operated for cataract. Out of these 16 patients, five patients got post operative infection of their eyes resulting in lost vision on right eye and both eyes of two and three patients respectively.

The Government of Manipur served (July 2007) show cause notices to two doctors and two para medical staffs for dereliction of duties and lapses on their part while discharging their duties and conducting the operation. The further progress of the case was not intimated to audit (December 2010).

The objective of the NPCB of reducing the prevalence of blindness cases was therefore, defeated.

➢ ***Refractive errors and distribution of spectacles to school children***

During 2009-10, 71,392 students of 114 schools were screened of which 2,114 students were found having refractive errors and were provided spectacles. The list of the schools and students with refractive errors had not been furnished to audit (December 2010) despite audit requisition made in this regard.

1.3.16.5 National Programme for Prevention and Control of Deafness

It aims at preventing and controlling major causes of hearing impairment and deafness, so as to reduce the total disease burden by 25 *per cent* of the existing burden by the end of March 2012.

During the review period, fund of ₹ 60.56 lakh was received from the GoI, out of which ₹ 11.67 lakh was utilized for capacity building, leaving a balance of ₹ 48.89 lakh for the programme. However, the status of the capacity created was not available with the SHS. Non-utilization of 81 *per cent* of funds received frustrated the implementation of the scheme.

1.3.17 Village Health and Sanitation Committees

A Village Health and Sanitation Committee (VHSC) was to be formed in each village to create public awareness on health, maintenance of village health register and preparation of village health plan. Each VHSC was entitled to get an annual untied grant of ₹ 10,000 for providing referral transport facilities. The VHSCs have to operate their bank accounts as per guidelines.

In the State, 4250 VHSCs were required to be formed, out of which 3,498 were constituted leaving 752 VHSCs to be formed as of March 2010. Audit noticed that out of 3,498 VHSCs 2,711 VHSCs only had opened their own bank accounts for untied grant. But neither village health registers were

maintained nor village health plans were prepared in the State. The reasons for less number of VHSCs operating their bank accounts were not recorded by the Department. Thus, the community participation and implementation of the Mission at grass root level was not ensured.

1.3.18 Hospital Management Committee/Rogi Kalyan Samitis

The Rogi Kalyan Samitis (RKS) were to be formed to upgrade DHs, CHCs and PHCs to the IPH standards to provide sustainable quality healthcare with people's participation. In the State, the required 188[39] RKSs were formed during 2007-10.

1.3.18.1 Funding of RKS

The RKS at district hospital was entitled to a corpus grant of ₹ 5 lakh per year. The RKSs at CHC and PHC levels were entitled to a corpus grant of ₹ 1 lakh each, besides annual untied grant of ₹ 50,000 and ₹ 25,000 and annual maintenance grant of ₹ 1.00 lakh and ₹ 50,000 respectively.

During 2007-10, the GoI released Mission Additionalities/Mission Flexi Pool Funds of ₹ 65 crore out of which ₹ 3.72 crore was incurred by the RKSs of the State and ₹ 1.74 crore by the RKSs of the four sample districts. Vital documents like statement of expenditure, Utilisation Certificates (UCs) could not be produced by the sample districts to audit.

1.3.18.2 Citizen Charter

One of the objectives of RKS is to develop a Citizen Charter for every level of health facility and to ensure that it is appropriately displayed to make healthcare applicants aware of their health rights and facilities available there. The Charter is also to give a specific and definite commitment in writing to the citizens for delivering standardised services within a specified time frame. Compliance to Citizen's Charter was to be ensured through operationalisation of a Grievance Redressal Mechanism.

Audit scrutiny revealed that the Citizen Charters in local language was not displayed in any of the DHs, CHCs, PHCs test-checked. In all the DHs, CHCs and PHCs there was no mechanism in place for redressal of complaints, grievances of the community regarding their need, coverage, access, quality, denial of care *etc*. Thus, there was no healthcare campaign through the Citizen Charter and the grievances of the community regarding delivery of healthcare remained unaddressed.

1.3.18.3 Functioning of RKSs

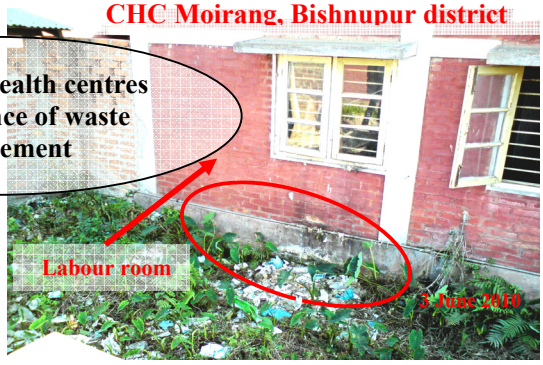
1.3.18.4 DHs, CHCs and PHCs

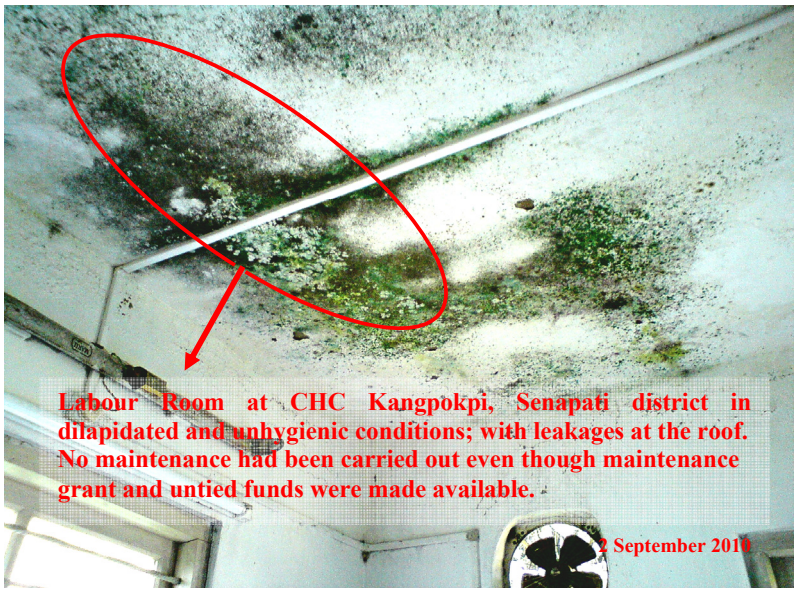
As per guidelines, the RKSs governing body were required to meet quarterly, executive body on monthly basis to review the OPD and IPD services, performance of the hospital, review reports of the Monitoring Committee and

[39] DHs-10, CHCs-32 and PHCs-146

status of utilisation of funds, equipment, drugs *etc*. The RKSs were responsible for keeping hygienic environment in the health centres/hospitals.

But regular meetings were not held and none of the aforesaid activities was being carried out resulting in unhygienic environment and dilapidated condition of health centres as shown below:





1.3.18.5 RKS of DHs

The RKSs should prepare a hospital development plan to achieve the service guarantees as per IPHS and equity of access to health care facilities. But no such plan was prepared in the State to achieve the desired goals.

1.3.19 Convergence with other programmes and departments

The Mission aimed at an architectural correction in the health care delivery system by convergence of various existing stand alone national disease control programmes.

However, all vertical disease control programmes had not merged with the Mission as of December 2010. Inputs from related Departments were not

obtained for planning purpose. Hence, the desired architectural correction aimed in the health care delivery system remained unfulfilled.

1.3.20 IEC

The IEC strategies aim to facilitate awareness, dissemination of information regarding availability of and access to quality healthcare by the poor, women and children in rural areas.

During the period 2005-10, ₹ 2.08 crore received from the GoI was incurred on IEC coverage *i.e.* exhibitions, health *melas* and advertisements in electronic and print media. An amount of ₹ 48.75 lakh advanced (2007-08) to the Directorate of Family Welfare and districts for IEC purpose remained unadjusted as of November 2010.

1.3.21 Procurement of drugs/medicines

As per guidelines, SHS was required to develop a drug procurement policy and plan consistent with the Department's long term goals. But no such policy and plan were formulated. During the period, 2006-10 ₹ 4.61 crore was received from the GoI and ₹ 0.79 crore was utilised for purchase of drugs in March 2009, leaving an unutilised balance of ₹ 3.82 crore as of December 2010.

Non-procurement of drugs deprived the patients of getting the essential drugs and medicines.

1.3.22 Monitoring and evaluation

The Mission envisages a five tier system of monitoring and supervision at Village, PHC, Block, District and State levels to ensure its effective implementation. In the State except Bishnupur district, Village, PHC and Block level health monitoring and planning committee were not formed. In Bishnupur district, none of the monitoring committees was formed.

Further, Mission Steering Group and Empowered Programme Committees at the State level required for institutional monitoring were not constituted in the State. There is no system of internal audit of accounts at district and State level.

1.3.23 Conclusion

The review underscored glaring gaps in planning, implementation and monitoring activities. The planning process proved futile in the absence of the Perspective Plans and a comprehensive household survey. Some of the key initiatives of NRHM like RKS and VHSCs have not received the required attention.

Failure in timely procurement of drugs, non-completion of infrastructures, non-upgradation of CHCs, PHCs and SCs to the level of IPHS, non-utilisation of substantial amount of funds, weakness in monitoring and absence of evaluation of activities from the grass root level disclosed serious deficiencies

in the implementation of the various activities of the Mission, thereby depriving the targeted beneficiaries of the intended benefits.

1.3.24 Recommendations

- Planning process needs to be strengthened;
- There is an urgent need to identify grey areas of financial management, structure and define/revamp the accountability aspect and take prompt corrective action;
- Upgradation of health centres to IPH standards needs to be expedited and sanctioned posts of medical and para-medical staff should be filled up on priority;
- Maternal health programme needs to be monitored closely;
- To achieve convergence of mission activities with other departments the State Government should ensure adequate focus on determinants of health;
- Monitoring and supervision mechanism should be established immediately so that check on effective implementation of Mission activities is exercised at all levels.