HEALTH AND FAMILY WELFARE DEPARTMENT

3.3 National Rural Health Mission (NRHM)

The National Rural Health Mission(NRHM) was launched (April 2005) with the objective of converging different stand-alone health programmes, decentralising planning process with special emphasis on bottom-up decision making and to fill up the gaps in coordination between different social sector departments. The mission mainly aims at the rural poor with special attention to mother and child care. The successful implementation of the Mission objective involves an intense exercise in training and capacity building of the community representatives, health personnel and personnel from related departments on health issues.

A mid-term review of the functioning of the State machinery in the third year of the Mission period (2005-2012) was an attempt to highlight the areas and issues which need to be addressed, for successful achievement of the objectives set out for the Mission.

Highlights

Preparation of the State and District plans was outsourced and the objective of community participation in planning process could not be ensured. The basic village level data used for preparation of District and State plans were not available with the Society, casting doubts over the reliability of the inputs in the planning process.

(Paragraphs* 3.3.*8 and* 3.3.*9)

HMIS phase-1 could not be made functional even after expending the entire project funds and expiry of the stipulated time schedule.

(Paragraph* 3.3.*12.1)

ASHA network could not materialise even after three years of implementation of NRHM as the training requirements could not be completed.

(Paragraph* 3.3.*12.3)

Despite transferring funds to various implementing agencies (BDO, DM and PWD) for development of infrastructure, most of the construction works remained incomplete, due to non-stipulation of the timeframe for their completion.

(Paragraph 3.3.12.6)

3.3.1 Introduction

The National Rural Health Mission (NRHM) was launched on 12 April 2005 by the GOI for the period 2005-12 with special focus on 18 States including Tripura, with the aim of improving the quality of public health delivery services in rural areas throughout the country. The State Government signed a Memorandum of Understanding (MOU) with the GOI on 12 January 2006 for implementation of NRHM.

3.3.2 Objectives of the Mission

The main objectives of the Mission are to

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

To achieve the above objectives, some of the existing health care programmes *viz*. Reproductive and Child Health–II, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programme etc. were brought within its ambit and the Mission activities were divided into the following five essential components; i.e.

- Reproductive and Child Health (RCH II)
- Additionalities under NRHM
- Immunization
- National Disease Control Programme
- Inter sectoral convergence for effective management and implementation.

3.3.3 Organisational set up

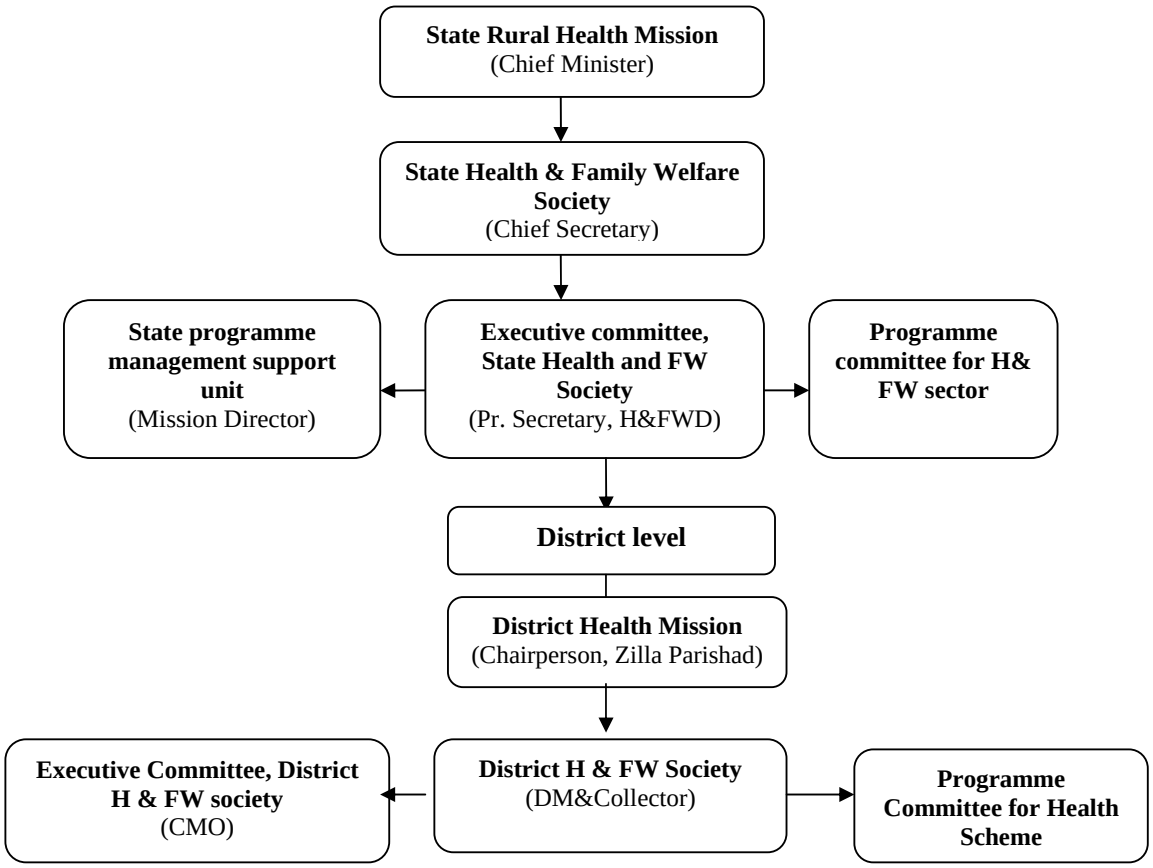
At the State level, NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The activities of the Mission are carried out through the State Health and Family Welfare Society (Society) headed by the Chief Secretary (CS). The Executive Committee of the Society is headed by the Principal 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 Missions headed by Chairperson of the Zilla Parishads and an integrated District Health Society (District Society) headed by the respective District Magistrates (DM) to support it and its executive committee is headed by the Executive Secretary (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 were, however, not formed in the State.

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



3.3.4 Scope of Audit

The performance review was conducted during April-August 2008, covering the implementation of the programme during 2005-08 by a test-check of the records of the Director of Health and Family Planning and Preventive Medicine, State Health and Family Welfare Society, three out of four District Health and Family Welfare Societies, six out of eleven Sub-Divisional hospitals, three out of eleven Community Health Centres, 18 Primary Health Centres and 36 Sub-Centres selected through statistical sampling using PPSWR[25] method for districts and SRSWOR[26] method of sampling for other units. The selected samples included three[27] out of four districts in the State covering 41 *per cent* of the units at the Sub-District level implementing NRHM.

3.3.5 Audit objectives

The performance review was conducted to ascertain whether,

- planning and implementation of the Mission as well as monitoring and evaluation procedures at the level of Village, Block, District and State

[25] Probability Proportional to Size With Replacement.
[26] Simple Random Sampling Without Replacement.
[27] West, South and Dhalai districts.

have achieved the objective of ensuring community participation, accessible, effective and reliable health care to rural population;

- the performance indicators and targets fixed in respect of RCH, immunization and disease control programmes were achieved;
- the Mission achieved capacity building and strengthening of physical and human infrastructure at different levels as planned and targeted;
- the procedure and system of procurement of drugs and services, supplies were cost effective and ensured improved availability of drugs, medicines and services;
- Convergence and regulation of the mission activities with other departments, programmes and non-government stakeholders was ensured for achieving the broad objectives of the programme.

3.3.6 Audit criteria

Audit findings were benchmarked against the following criteria:

- Mission guidelines issued by the Union Ministry of Health and Family Welfare;
- RCH Phase – II programme – Finance and Accounts Manual;
- Financial Guidelines and framework for delegation of administrative and financial powers under NRHM;
- State Programme Implementation Plan (SPIP) approved by National Programme Co-Ordination Committee (NPCC);
- Guidelines for constitution of Rogi Kalyan Samiti/Hospital Management Society.

3.3.7 Audit Methodology

The performance audit commenced with an entry conference on 24 May 2008 with the Principal Secretary to the Government of Tripura, Heath and Family Welfare Department, wherein the objectives, approach and audit requirement were discussed. Records of the Health Department, the State and District Health Societies and the replies submitted by the Department/Society to audit memos, requisitions and questionnaires formed the basis of audit evidence and in turn, the audit findings.

The audit findings were discussed with the Principal Secretary in an exit conference on 30 September 2008. However, since the written replies to the audit observations are awaited (September 2008), the departmental replies to various audit observations during the exit conference, have been incorporated in the report at appropriate places.

3.3.8 Planning

NRHM envisaged a decentralized and participatory planning process following a bottom-up approach from village level to the State level. A Perspective Plan (2005-2012), and Action Plan for each year were to be

prepared for the State by consolidating all the district plans, which would be treated as the basis for interventions in the health sector.

For preparation of a comprehensive District Action Plan, systematic mobilization of community by involving representatives of Panchayati Raj Institutions (PRI) was necessary for conducting household and facility surveys at Sub-Divisional Hospital (SDH), Community Health Centre(CHC), Public Health Centre(PHC), Sub-Centre(SC) level. These were to play a pivotal role in the entire process of preparation of a realistic need based State/ District Action Plan.

However, considering the requirement of extensive capacity building to make the villages capable of undertaking the planning exercise, the Mission did not insist upon village plans for the first two years (i.e. 2005-06 and 2006-07) but allowed to take Block / District Action Plan as the basis for executing the works under NRHM for these two years. Scrutiny of records revealed that neither the Block Action Plan nor the District Action Plan was available in the State during 2005-07.

3.3.9 Reliability of basic data for planning

During 2006-07, Rs. 40 lakh was released by the GOI for preparation of District Action Plans. The preparation of District Action Plans and State Action Plan was outsourced to an agency[28] by the Society in January 2007.

Scrutiny revealed that the village level data was collected by the Agency which was used as the basic input for preparation of State and District Perspective Plan and the Annual Action Plans for the year 2007-08. A strategic framework for the State was also outlined by the Agency based on consultation and review at the State level and involving State/District/Sub-Division core groups set-up for planning purpose.

The basic village level data used for preparation of the State and District Plans was not available with the State Health Society. In the absence of their validation by the PRI representative, the reliability of the base data used for preparation of plan documents, could not be vouched and the reliability of the information compiled in the plan documents, therefore, remained doubtful.

Further, as of August 2008, final plan document developed by the Agency was not placed before the Governing Body of SH&FWS for approval.

3.3.10 Financial Management

3.3.10.1 Funding pattern

Funds for implementation of NRHM flow through two separate channels from the Central Government. One is through State budget and another directly to the State Health Societies.

The State is to reflect its component-wise[29] requirement in a consolidated Programme Implementation Plan (PIP). Funds are provided on the basis of

[28] Medica Synergie Private Limited, Kolkata.

[29] (a) RCH, (b) Aditionalities under NRHM, (c) Immunisation, (d) RNTCP, (e) NVBDCP, (f) Other NDCPs and Inter-sectoral issues.

approval of these PIPs by the GOI. During 2005-07, 100 *per cent* funds were provided to the State and from 2007-08, the State is to contribute its share of 15 *per cent* of the requisite funds.

3.3.10.2 Financial position

Expenditure incurred under NRHM *vis-à-vis* funds directly made available to State societies during 2005-08 was as under (details in **Appendix 3.4 and 3.5**).

Table No. 3.3.1

(Rupees in crore)

Year	Opening balance	Funds received from GOI	Interest earned	Total funds available	Expenditure (percentage)	Closing balance
2005-06	2.37*	11.95	0.11	14.43	3.32 (23)	11.11
2006-07	11.11	26.44	0.18	37.73	15.29 (41)	22.44
2007-08	22.44	56.19	0.25	78.88	16.82 (21)	62.06
Total	**35.92**	**94.58**	**0.54**	**131.04**	**-**	**95.61**

Source: Information furnished by the Department and State Health Mission NRHM, Tripura.

* NLEP: Rs. 0.27 crore; Blindness Control Programme: Rs. 1.51 crore; RNTCP: Rs. 0.59 crore.

The above table shows that there were substantial unspent balances at the end of each financial year. During 2005-06, the Society had very little time to utilise the funds after signing the MOU in January 2006. But substantial savings in the subsequent years indicated inadequate preparedness of the Society in utilising the available funds and during 2007-08, the Society could not even spend the unspent balance of the previous years let alone, fresh funds. The inability of the Society to place the plan documents before the Governing Body was one of the reasons for slow progress in implementation, as expenditure was on an ad-hoc basis leading to huge unspent balances.

3.3.10.3 Non-release of State share

From the 1st year of Eleventh Plan period i.e. from 2007-08, as envisaged in the guidelines, the State was supposed to contribute 15 *per cent* of the funds required for implementation of NRHM.

Scrutiny of records revealed that the State share of Rs. 10.09 crore, for the year 2007-08, was not released by the Government to the State Health Society. The reason for non-release of State share was also not on record.

Programme Execution

3.3.11 Reproductive and Child Health (RCH) - II

3.3.11.1 Unspent balance of RCH-I programme

According to the 'Finance and Accounts Manual' of RCH-II the unspent balances of the RCH-I were to be carried forward to RCH-II. For this, the unspent balances under RCH-I was to be reported to the GOI for reallocation to RCH–II.

Scrutiny of records of State Health Society revealed that in contravention of the above instructions, the unspent balance of RCH–I amounting to Rs. 1.06 crore was kept idle with the Society till the date of audit (August 2008) without being utilised in RCH–II.

3.3.11.2 Health indicators

NRHM encompasses a wide range of health issues including the improvement in various health indicators.

Following are some of the indicators of the State's health status *vis-à-vis* the status before the commencement of the mission.

Table 3.3.2

Health Parameter	National average		State average		Source
	2005	2007	2005	2007	
Child Birth Rate (CBR)	23.80	NA	16	16.6	SRS-2005 & 2007
Infant Mortality Rate (IMR)	58	58	31	36	SRS-2005 & 2007
Maternal Mortality Rate (MMR)	4.37	4.37	4	NA	*SRS-2003/*SPP-2001
Total Fertility Rate (TFR)	2.85	2.68	1.87	2.22	*NFHS-II & III

*SRS: Sample Registration System in India; SPP: State Population Policy; NFHS: National Family Health Survey.

The details of home and institutional delivery achieved during 2005-08 were as under:

Table 3.3.3

Component	2004-05	2005-06	2006-07	2007-08
No. of registered pregnant women	60111	68805	55095	72631
No. of deliveries	48784	50935	45979	48195
Balance (untraced)	11327 (19%)	17870 (26%)	9116 (17%)	24436 (34%)
Institutional delivery	29924	31899	30724	33081
Home delivery	18860	19036	15255	15114
Percentage of Institutional delivery	61.34	62.63	66.82	68.64
Percentage of Home delivery	38.66	37.37	33.18	31.36

Source: Departmental figures

The above table shows an increasing trend in institutional delivery from year to year during 2005-06 to 2007-08. During the last three years of the Mission period, the percentage of institutional delivery increased by 7.30 *per cent* when compared to the total number of deliveries during those years. The Department could not track the fate of the balance registered pregnant women constituting about 17 *per cent* to 34 *per cent* during the last four years. When compared with the total registered pregnant women, the percentage of institutional delivery however shows a declining trend from 49.78 *per cent* in 2004-05 to 45.55 *per cent* in 2007-08. The State, however, fixed a target of raising it to 60 *per cent* in 2007-08.

3.3.11.3 Janani Surakshya Yojana (JSY)

Promotion of institutional delivery to reduce maternal and neo-natal mortality was the main objective of JSY. According to the programme, every registered would be mother (SC, ST and BPL) becomes eligible for the benefit of cash incentive as financial and institutional support during delivery. During the year 2005-07, no target was fixed for providing benefit under JSY by the State. Scrutiny of records however, revealed that while there were 12064 beneficiaries during 2005-07, the number of beneficiaries increased to 15543 during the year 2007-08 against the target of 27000 beneficiaries.

Test-check (Madhupur and Anandanagar PHC) revealed that the bonafide of the SC, ST and BPL families are ensured by the health centres from the SC/ST

certificates and BPL ration cards. Photocopies of the respective certificates/ ration cards systematically documented were produced to audit.

3.3.11.4 Referral Transportation

Provision of financial assistance for transportation of high risk pregnant women and high risk babies @ Rs. 700 per case was to be paid by the Medical Officer, In-charge of PHC, CHC and SDH. Test-check revealed that during 2007-08, 4594 beneficiaries were benefited against the target of 6700 representing 68.57 *per cent* achievement.

Test-check of referral cases from Anandanagar and Madhupur PHC to the IGM Hospital revealed that the referred cases during 2007-08 were properly recorded in the register of patients in the referred hospital.

3.3.12 Additionalities under NRHM

3.3.12.1 Health Management Information System (HMIS)

Since NRHM integrated many programmes, it was felt necessary to enhance the mechanism for collection, reporting and analysis of data of all the health centres up to Sub-centre level, by setting up a HMIS at a cost of Rs. 3.07 crore in the State in three phases.

During 2006-07, an amount of Rs. 1.33 crore was sanctioned by the GOI for Phase I of the work. An agreement was executed between the Society and an agency[30] (WECS) in January 2007 for implementing the system. The WECS was supposed to deposit 10 *per cent* of the project value as security in the form of bank guarantee prior to taking up the work.

Work order for Rs. 1.32 crore, for executing the phase I[31] of the project at West Tripura was issued in January 2007 without obtaining the security deposit of Rs. 30.72 lakh. The work was stipulated to be completed within 18 months i.e. July 2008.

An amount of Rs. 66.22 lakh (being 50 *per cent* of the value of the work of phase-I) was advanced in January 2007 while issuing work order against bank guarantee.

As of August 2008, the work was not completed. Implementation of one of the major components[32] of work costing Rs. 32.50 lakh was kept in abeyance by the State for reasons not on record. The company took up only 33 health institutions (out of the targeted 37) for development of HMIS and out of these, work of 10 centres was held up due to non-engagement of data entry operator by the State. The validity of the bank guarantee of Rs. 66.22 lakh had expired in July 2008.

Thus, HMIS which was considered to be one of the basic tools in planning, monitoring and evaluation of the activities of the mission, though taken up

[30] Webel Electronic Communication System Ltd. (WECS), a Government of West Bengal undertaking
[31] State headquarters, 6 State hospitals, 3 Sub-divisional hospitals, 5 Community health centres, 22 Public health centres and 243 Sub-centres).
[32] supply of battery operated SIMPUTER or Monochrome PDA Units' (which is required for field level entry in 243 sub-centres).

partially, remained incomplete despite incurring an expenditure of Rs. 66.22 lakh.

3.3.12.2 Urban Slum Health Project (USHP)

The State Government (2005-06) proposed to improve the health status of slum dwellers residing in urban slums, was not approved by the GOI. In 2006-07 the project proposal was modified and included in the State Programme Implementation Plan (SPIP) which was approved by GOI.

An amount of Rs. 30.89 lakh was placed by the Society with Agartala Municipal Council (AMC) in December 2006 through the District Society, West Tripura for strengthening nine dispensaries under the project @ Rs. 2.50 lakh each and supply of additional medicines. Renovation works in three units were completed (August 2008) at a total cost of Rs. 22.50 lakh. Besides, an amount of Rs. 2.86 lakh was spent on supply of medicine. The unspent balance of Rs. 5.53 lakh was lying with the AMC.

Though the Government was keen to improve the health services of the urban slum dwellers and made the required fund available, it did not follow up the completion of the work taken up through AMC.

3.3.12.3 Accredited Social Health Activist (ASHA)

The main aim of NRHM is to provide accessible, affordable, effective and reliable primary health care facilities to the poor and vulnerable sections of the population. For this purpose, operationalisation of the cadre of ASHA was considered most important.

As per NRHM guidelines, for each Anganwadi Centre (AWC), one married/widow/divorced woman in the age group of 25 to 45 years possessing formal education up to class VIII was selected by the Gram Panchayat as ASHA from the village, wherein she would render her services with close liaison with the PRI[33]. ASHA are not paid any formal salary but are compensated with incentives at prescribed rates. They act as a link between the Government health care system and the community for all health related services.

Considering the inaccessible tribal areas of the State, the induction criteria of one ASHA per 1000 population, as envisaged in NRHM guidelines, was modified by the State with the approval (June 2007) of NPCC and decided to have 6122 ASHAs against equal number of Anganwadi Centres (AWCs) in the State.

To provide fully trained ASHA to each AWC by March 2008, an amount of Rs. 4.76 crore was approved in SPIP 2007-08 to cover the cost of training, incentives, uniform, kit box and drug kits to the targeted 6122 ASHAs.

Scrutiny revealed that as of March 2008, only 5268 ASHAs were selected. None of them were deployed due to non-completion of the required training of five modules over 23 days spread over a period of 12 months (1st module for seven days followed by four days for subsequent four modules). Only 3784

[33] Panchayati Raj Institution.

and 666 ASHAs received training in First and Second modules (out of five modules) during 2006-07 and 2007-08 respectively. While the procurement of 6122 uniforms at a cost of Rs. 22.35 lakh and 3000 kit boxes /bags at a cost of Rs. 14.11 lakh was completed in January 2008, no drug kit for ASHA was purchased till date.

Thus, failure to engage trained ASHA along with drug kit in every AWC of the State even after a lapse of three years of introduction of NRHM, had deprived a large section of the community from getting the intended service.

3.3.12.4 Auxiliary Nursing Midwife (ANM)

As of March 2008, there were 638 ANMs on roll against 754 sanctioned posts, to run 579 Sub-Centres (SC) in the State. NRHM guidelines provide for two ANMs in every SC. The sanctioned posts of ANM should have been 1158.

Test-check in three districts (out of four) revealed that in 79 out of 483 Sub-Centres, no ANM was posted, while in 311 Sub-Centres, only one ANM was posted instead of two. 93 Sub-Centres had either two or more ANMs.

Deployment details revealed that shortage of ANMs is more prevalent in remote localities than comparatively well placed Sub-Centres. This indicates that rationalization in deployment of ANMs in Sub-Centres required for extending better health services to the rural population, did not get due attention of the State.

Infrastructure development

3.3.12.5 Status of Rural Health Institutions

The Indian Public Health Standard (IPHS) envisage the requirement of one SC for every 5,000; one PHC for every 30,000; and one CHC for every one lakh rural population.

The actual requirement and availability of SC, PHC and CHC are as under:

Table No.3.3.4

Category	Requirement	Available	Excess (+) Shortage (-)	Upgradation / new proposal in the P.P
Sub-centre	530	579	(+) 49	324
Primary Health Centre	88	76	(-) 12	11
Community Health Centre and Sub-Divisional Hospital	27	22	(-)5	6

The marginal shortfall in PHC and CHC has been addressed in the Perspective Plan and the construction and upgradation of the SCs, PHCs and CHCs have been phased out during 2007-12. The progress of works is discussed in the next paragraph.

3.3.12.6 Progress of work

Test-check of records of the State Health Mission and three districts revealed the following:

- Rupees 1.80 crore was placed during 2005-07 with different implementing agencies for upgrading nine CHCs to IPHS by providing full-fledged Operation Theatre and Labour Room, 24 hour warm and

cold water supply, blood bank facility and staff accommodation without specifying any time to complete the work. It was however, noticed that works of only three out of nine CHCs were found to have been completed and there was an unspent balance of Rs. 62.62 lakh (Rs. 22.62 lakh with five BDOs and Rs. 40 lakh with Chief Engineer, PWD), as of March 2008.

- Rupees 2.01 crore was placed during 2006-07 with different implementing agencies for executing renovation works in seven Sub-Divisional Hospitals (SDH) and in 19 Primary Health Centres (PHC) without specifying any time schedule to complete the works. As of March 2008, the renovation works of only one SDH and six PHCs were completed. The unspent balance of Rs. 68.39 lakh (Rs. 57.13 lakh with eight BDOs and Rs. 11.26 lakh with Executive Engineer R.D. Kumarghat) were lying with the implementing officers.
- During 2007-08 (December 2007), an amount of Rs. 5.40 crore was placed with four DMs for construction of 60 SCs without specifying any timeframe for completion. Construction works for 13 SCs (out of 60) was not taken up till the date of audit for reasons not on record and construction of the remaining 47 SCs were under progress.

As of March 2008, the physical achievement against the target fixed for up-gradation of CHC to the prescribed IPHS norms was 33 *per cent* and renovation of SDH and PHC was 27 *per cent.*

During exit conference, the Principal Secretary emphasised the need for adoption of effective system for following up the construction works by specifying the time schedule for completion while issuing the sanction order.

3.3.12.7 Key health personnel

To strengthen the whole range of public health infrastructure including Sub-district/Sub-divisional hospitals for improving the availability and accessibility of affordable quality services, formulation of IPHS was done by an expert group headed by the Director General of Health Services, Union Ministry of Health & Family Welfare.

The availability of key health personnel *vis-à-vis* the sanctioned strength as of September 2008 was as under.

Table No. 3.3.5

Category	Sanctioned strength	Staff in position	Vacancy	Percentage of vacancy
Medical Officer	811	641	170	21
Multipurpose Health Supervisor Female & Male	222	220	2	-
Multipurpose health worker (ANM) Female & Male, ANM (Fixed pay)	1324	1022	302	23

Source: Plan document.

While the overall vacancy of key health personnel in the State varies between 21 to 23 *per cent*, the availability in rural areas was comparatively insufficient.

A comparative study of the availability of Doctors and Nurses (including ANM) *vis-à-vis* norms in the institutions test-checked revealed wide deficiency. The actual deployment is detailed below:

Table No. 3.3.6

Category of Staff	Category of Health Institution	No of Units test-checked	Requirement in each institution as per IPHS norms	Total requirement (4x3)	Staff in position	Shortage (5-6)	Percentage of shortage w.r.t IPHS norms
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*
Doctors	SDH	6	32	192	69	123	
	CHC	3	15	45	14	31	**61.49**
	PHC	18	04	72	36	36	
	Total	**27**	**51**	**309**	**119**	**190**	
Nurses (including ANMs)	SDH	6	50	300	67	233	
	CHC	3	21	63	22	41	**63.58**
	PHC	18	05	90	76	14	
	Total	**27**	**76**	**453**	**165**	**288**	

Source: IPHS guidelines published by the Ministry of H&FW, GOI and departmental figures.

The above table shows large shortages between the requirement and the actual availability of key health functionaries required at basic functional level of health care services.

Further, vacancies were also noticed in respect of posts created under NRHM as 16 posts of specialist doctors, four General Duty Medical Officers, 24 Nurses, were not filled up till the date of audit.

The vacancy in the post of Medical Officers in Ayurvedic and Homeopath system was 59 *per cent*, Dental surgeon was 47 *per cent*, Multipurpose Worker was 28 *per cent*. In all other supporting staff taken together (27 in number) the vacancy was 35 *per cent*. Filling up of these key posts are essential for improving quality of health services in rural areas.

3.3.12.8 Training

Training of every category of health personnel is one of the thrust areas of NRHM. Though there was no integrated and comprehensive training plan for the districts and the State as a whole, ad-hoc training programmes were taken up for some categories of staff during 2005-08.

Skill upgradation training of the existing staff on specific disciplines (Training of Trainers, Medical Officers, Staff Nurses, ANMs and MPWs etc.) was included in the annual plan for the year 2007-08. Though some of the planned training had taken place during the year, most of the training of key functionaries like Medical Officers and Staff Nurses and other paramedical staff is yet to be taken up.

3.3.12.9 Procurement of Medicine

In January 2007, with a view to procure 40 items of medicines, an amount of rupees one crore was advanced to the Chennai based M/S Tamil Nadu Medical Services Corporation Ltd.(TNMSC), exempting it from depositing any security money. The stipulated date for completion of the supply was fixed at four months from the date of placement of the supply order along with cent *per cent* advance payment of anticipated cost of medicine to be supplied.

Audit scrutiny revealed that as of August 2008, the TNMSC supplied medicines worth Rs. 75.21 lakh. Medicines worth Rs. 18.49 lakh were supplied after the stipulated date. Though the supplier failed to complete his assignment even after 12 months of the stipulated date of completion, the State Mission Authority had not cancelled the supply order nor did it take any effective steps to get back the unadjusted advance amount of Rs. 24.79 lakh lying with it. The penalty leviable for delay in supply in accordance with the agreement (worked out to Rs. 0.29 lakh till date) was also not imposed upon the supplier.

As no penalty clause was incorporated for non-execution of supply against the money advanced, the TNMSC availed undue benefit on the outstanding advance amount of Rs. 24.79 lakh since July 2007.

During exit conference the Principal Secretary assured that legal action would be initiated against the supplier, the contract would be terminated and the possibility of imposing penalty would be explored.

3.3.12.10 Expansion of Laboratory Services

For expansion of laboratory services in 39 Health Institutions of the State, the GOI accorded approval for an amount of Rs. 73.32 lakh in SPIP during 2006-07 which involved renovation of the proposed site of the laboratory at the existing Health Institutions, recruitment of laboratory technicians and procurement of microscopes, accessories and other reagents.

Scrutiny of records disclosed that as of August 2008, except completion of renovation works in nine PHC laboratories (out of 39 planned) and recruitment of 20 laboratory technicians during December 2007 to January 2008, no other progress was made for improvement of laboratory services.

3.3.12.11 BPL friendly Anti Rabies Vaccine (ARV) Scheme

Rabies, known to cause Hydrophobia, is an acute and highly fatal viral disease which affects the central nervous system of human beings and is caused by bites of dogs, cats and wolves. At present, Tissue Culture Anti Rabies Vaccine (TCARV) is used for its treatment and the average cost of treatment is Rs. 1050 for each patient.

Considering the financial burden required to be borne on such treatment by the families belonging to BPL, the NRHM took care of such families by approving an amount of Rs. 68.25 lakh. The fund was placed (March 2007) with the Medical Superintendent of the IGM Hospital for procurement of 32500 TCARV vials for the treatment of an estimated 6500 patients (approximately) throughout the State during 2006-07.

Audit scrutiny revealed that as on 31 March 2008, only 16000 vials were procured at a cost of Rs. 33.57 lakh and utilised fully. An unspent amount of Rs. 34.68 lakh was lying in the CD Account of MS, IGM Hospital. The reason for shortfall in procurement and its eventual affect on public life was not assessed by the Department.

3.3.12.12 Hospital waste management

During 2005-06, an amount of Rs. 1.15 crore was sanctioned by GOI under NRHM for hospital waste management. The entire amount was placed with the Director of Health Service (DHS), during October-November 2005 for establishment of Hospital Waste Management Units throughout the State Health Centres.

Scrutiny of records revealed that the DHS placed an amount of Rs. 48.31 lakh (November 2006 to January 2007) with four DMs for construction of 95 'deep burial pits' at different hospitals and spent Rs. 29.36 lakh on procurement of items related to bio-medical waste management. As of August 2008, an unspent balance of Rs. 37.33 lakh was lying in the CD Account of the DHS.

From the progress reports made available to audit, it was noticed that out of 95 units planned, construction of 21 Deep Burial Pits has not started (August 2008). No field visit was conducted by DHS authority to see whether the pits constructed were user friendly or not. None of the four DMs had furnished utilisation certificates for the funds utilised by them.

Thus, due to lack of proper planning and monitoring, Rs. 1.15 crore earmarked for hospital waste management, could not be utilised effectively.

3.3.12.13 Mobile Medical Unit

Considering the existence of difficult hilly terrain, non-approachability of public transport, difficult accessibility (long distance) of the nearby Health Centre, GOI sanctioned Rs. 2.91 crore during 2006-08 for providing health care to the door step of residents of inaccessible areas through four Mobile Medical Units (MMU) (one for each district) equipped with specialized facilities.

Four MMUs were procured in June 2008 at a cost of Rs. 1.70 crore but these are yet to be put to use (August 2008). An expression of interest was floated in May 2008 inviting interested NGO/charitable organization/MNGO to operationalise the MMUs. The MMUs are thus yet to be operationalised.

3.3.13 Immunization

3.3.13.1 Coverage

The Immunization coverage during 2005-08 was as under:

Table 3.3.7

Year	BCG		DPT		OPV		Measles	
	Target	Achieve-ment	Target	Achieve-ment	Target	Achieve-ment	Target	Achieve-ment
2005-06	70312	64956	70312	62312	70312	61731	70312	58500
2006-07	54848	69047	54848	59216	54848	59541	54848	59841
2007-08	55,696	58276	55696	51336	55696	50308	55696	51292

Source: Departmental figures.

The above table shows that during 2006-07 and 2007-08, the target fixed for coverage of vaccination of children has been reduced as compared to 2005-06. Consequently, the achievement had also decreased during 2007-08, by 10.28 *per cent* for BCG, 17.61 *per cent* for DPT, 18.50 *per cent* for OPV and 12.32 *per cent* for measles.

The reason for reduction in the target in 2006-07 and 2007-08 with reference to 2005-06 was not on record.

3.3.14 National Disease Control Programme

As per NRHM guidelines the following six National Disease Control Programmes were taken up for implementation.

(i) National Vector Borne Disease Control Programme (NVBDCP)

(ii) National Programme for control of Blindness (NPCB)

(iii) Revised National Tuberculosis Control Programme (RNTCP)

(iv) National Leprosy Eradication Programme (NLEP)

(v) National Iodine Deficiency Disorder Control Programme (NIDDCP)

(vi) National Integrated Disease Surveillance Project (NIDSP)

Out of the above six programmes, one item i.e. Intensified Malaria Control Project under National Vector Borne Disease Control Programme (NVBDCP) was test-checked and the following were observed.

3.3.14.1 Incidence of Malaria

The incidence of malaria in the State during 2005-08 is tabulated below:

Table No. 3.3.8

Year	Total population in the State	Positive cases of Malaria parasite	Cases of death due to Malaria
2005-06	31,99,203	18,637	21
2006-07	31,99,203	22,369	41
2007-08	31,99,203	18,669	52

Source: 2001 Census and Departmental figures.

The above table shows that while the incidence of malaria parasite was static during the last three years, the death cases increased by 148 *per cent* in 2007-08 compared to the death cases in 2005-06. The State authority neither analysed the reason for increase in the cases of death nor furnished the number of *Plasmodium Falciporum* cases noticed out of the positive cases of malaria.

The district wise break-up of above cases revealed the following.

Table No. 3.3.9

Year	Positive cases				Death cases			
	West	South	North	Dhalai	West	South	North	Dhalai
2005-06	1848	10975	1638	4176	2	10	5	4
2006-07	2714	10162	2696	6797	6	5	4	26
2007-08	3570	8612	1800	4687	24	5	3	20
Total	**8132**	**29749**	**6134**	**15660**	**32**	**20**	**12**	**50**

Source: Departmental figures.

Dhalai district was the worst affected area recording 50 death cases out of 114 (44 *per cent*) in the State during last three years.

The death rate in Dhalai was 3.19 per 1000 of positive cases, while it was only 0.67 in respect of South, 3.94 in West and 1.96 in North District. The high death rate in West district where comparatively advanced medical facilities were available needs to be addressed by the State Health Authority.

3.3.14.2 Implementation of Intensified Malaria Control Project (IMCP)

To have a systematic control over the problem relating to malaria, IMCP was implemented in the State by the registered society of NVBDCP.

The main objectives of the project (2005-10) are (a) early case detection and prompt treatment in remote and inaccessible areas through community participation (b) malaria transmission risk reduction (c) enhancement of awareness about malaria control through promotion of community, NGO and private sector participation.

Out of Rs. 1.36 crore released by the GOI during 2005-08, Rs. 81.54 lakh was utilised for implementation of the six components[34] of the project leaving an unspent balance of Rs. 54.87 lakh (40 *per cent*) as of 31 March 2008. The reason for non-utilisation of fund as revealed during audit was as under.

As of March 2008, the sanctioned contractual posts of Monitoring and Evaluation (M&E) consultant (1), IEC consultant (1), Laboratory Technician (2) and Multi Purpose workers (235) remained vacant since their creation in 2005 resulting in unspent balance of Rs. 9.78 lakh under the component of Human Resource.

Further, Rs. 17.52 lakh, out of Rs. 46.10 lakh against the operational cost of treatment of bed nets and Rs. 4.36 lakh, out of Rs. 16.53 lakh against training were lying unspent which indicated inadequate implementation, resulting in the saving as discussed above.

3.3.14.3 Supply of Bed nets

Supply of medicated bed nets to control malaria was one of the risk reducing steps spelt out in the programme guidelines. During 2005-08, the GOI supplied (June 2006) one lakh and (November 2007) 1.15 lakh pieces of bed nets against a requisition (June 2005) for 20,000 double size bed nets placed by the State Government on a rough estimation. On receipt of the first supply, the State Government intimated the GOI in December 2006 that the supplied bed nets are of smaller size compared to the average size of beds used in the locality and requested to supply double the present size of bed nets in future. Even after this communication, the GOI supplied in November 2007 another consignment of 1.15 lakh pieces of bed nets of small size to the State. A photograph showing the average bed size and the bed net supplied is given below:

[34] (1) Human resource (2) Training (3) Planning and Administration (4) Monitoring and Evaluation (5) IEC (6) Operational cost of treatment of bed nets.

The bed nets were distributed to the BPL families of all the four districts by the health authorities through the Block Development Officers. The total value of the bed nets received worked out to Rs. 1.96 crore @ Rs. 91 each. The State Government has no information about the purpose for which the bed nets so supplied were used by the beneficiaries.

This indicates total indifferent approach of the supplying authority in deciding the size of the bed nets without ascertaining or taking into account the local requirement. State authority instead of rejecting the consignment had accepted and distributed the quantity of supplied nets without ascertaining its utility.

3.3.15 Inter-sectoral convergence

The objectives of the programme were to formulate inter-sectoral convergence between Health and other departments like Social Welfare, Drinking Water and Sanitation, Education, Panchayat and Autonomous District Council etc. so as to monitor the working on common objectives of different departments.

An amount of Rs. 47 lakh was approved by the GOI in 2007-08 for the purpose but no funds were released till the date of audit (August 2008).

3.3.16 Monitoring and Evaluation

Community based monitoring and planning committees at Village, PHC, CHC, District and State Level, as envisaged in the Mission Guidelines were not constituted.

The State Health Mission, constituted in July 2005, was required to meet at least once every six months. But only two meetings were held during 2006-07 and one meeting during 2007-08. The four District Health Missions in the State, also constituted in July 2005, headed by the Chairperson of the Zilla Parishads of the concerned districts were required to meet at least once every quarter, but only 15 meetings were held during 2005-08 against 40 required.

3.3.17 Conclusion

The overall performance of NRHM in the State at mid-course was not very satisfactory with reference to its declared objectives, despite expending Rs. 35.45 crore. Delay in planning process, outsourcing of preparation of the State and District Plans with inadequate community involvement contributed to failure in preparing a comprehensive and focused plan indicating demand based and locality specific infrastructural requirements. Besides, the Department failed to operationalise ASHA network in time, fill up vacancies of key functionaries like Doctors, Nurses, ANM etc. Adequate infrastructure was not developed within the specified time frame and Health Management Information System was also not set up despite the lapse of three years since the commencement of the programme. Thus, performance during the first half of its seven year implementation period, has thrown a major challenge for the Mission towards achieving the targeted objectives by 2012.

3.3.18 Recommendations

- A comprehensive plan should be prepared breaking down the targets into actionable items, indicating need-based, locality specific requirements of infrastructure including human resource requirement.
- Health Management Information System (HMIS) should be completed on a priority basis for collecting, reporting and analysing the grass-root level data relating to health care facilities.
- Steps should be taken for speedy completion of all the construction works undertaken, to provide committed benefits under the programme in a time bound manner.
- Projects taken up during the year should be widely publicised to ensure awareness, accountability and public scrutiny.
- 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.

APPENDIX 3.4

(Reference: Paragraph 3.3.10.2)

Statement showing the availability of funds under NRHM and expenditure incurred there against during 2005-08

(*Rs. in lakh*)

Sl. No.	Items	Opening balance			Fund received during			Expenditure incurred during			Closing balance		
		2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
1	RCH II	Nil	586.54	919.23	600.00	769.00	740.00	13.46	436.31	615.55	586.54	919.23	1043.68
2	Additionalities under NRHM	Nil	148.25	908.04	198.73	1076.96	4370.53	50.48	317.17	584.48	148.25	908.04	4696.09
3	Immunization (i) Routine Immunization	Nil	17.74	34.41	17.74	43.05	14.77	Nil	26.38	22.05	17.74	34.41	27.13
	(ii) Pulse Polio Immunization	Nil	45.43	2.23	76.03	184.10	79.16	30.60	227.30	51.50	45.43	2.23	29.89
	Sub-Total	**Nil**	**797.96**	**1863.91**	**892.50**	**2073.11**	**5204.46**	**94.54**	**1007.16**	**1273.58**	**797.96**	**1863.91**	**5796.79**
4	National Disease control programme												
A	Integrated Disease Surveillance Programme (IDSP)	Nil	65.10	53.98	65.10	Nil	Nil	Nil	11.12	40.70	65.10	53.98	13.28
B	NLEP	26.56	12.15	14.19	Nil	10.26	3.85	14.41	8.22	11.56	12.15	14.19	6.48
C	Blind Control Programme	151.36	151.25	169.73	50.25	290.59	199.63	50.36	272.11	98.96	151.25	169.73	270.40
D	NVBDCP	Nil	43.09	89.72	183.58	245.59	167.13	140.49	198.96	200.58	43.09	89.72	56.27
E	RNTCP	58.89	30.07	22.84	Nil	20.65	33.84	28.82	27.88	52.59	30.07	22.84	4.09
F	NIDDCP	Nil	(-) 0.36	(-) 0.34	3.50	4.00	9.75	3.86	3.98	4.41	(-) 0.36	(-) 0.34	5.00
	Sub-Total	**236.81**	**301.30**	**360.12**	**302.43**	**571.09**	**414.20**	**237.94**	**522.27**	**408.80**	**301.30**	**350.12**	**355.52**
	Add interest	Nil	11.29	29.13	11.29	17.84	24.70	Nil	Nil	Nil	11.29	29.13	53.83
Grand Total		**236.81**	**1110.55**	**2243.16**	**1206.22**	**2662.04**	**5643.36**	**332.48**	**1529.43**	**1682.38**	**1110.55**	**2243.16**	**6206.14**

APPENDIX 3.5

(Reference: Paragraph 3.3.10.2)

Statement showing the funds received from Government of India *vis-à-vis* funds released by State Finance Department for implementation of Family Welfare Programme during 2005-06 to 2007-08

(*Rupees in lakh*)

SL. No.	Name of the Scheme	2005-06			2006-07			2007-08		
		Funds received from G.O.I	Funds released by State FD	Expendi-ture	Funds received from G.O.I	Funds released by State FD	Expendi-ture	Funds received from G.O.I	Funds released by State FD	Expenditure
1	Direction & Administration	144.00	Nil	286.68	115.48	Nil	277.05	299.46	Nil	317.43
2	Health Sub-Centre	728.00	1215.90	754.92	393.84	918.17	736.39	707.37	1061.67	823.94
3	Training	9.72	Nil	11.25	9.40	NIl	6.66	7.29	Nil	6.87
	a. ANM b. MPW(M)	10.40	Nil	10.06	9.04	Nil	7.27	7.80	Nil	2.73
4	KFWC	43.00	Nil	9.68	48.00	Nil	10.56	39.75	Nil	8.61
Total		**935.12**	**1215.90**	**1072.59**	**575.76**	**918.17**	**1037.93**	**1061.67**	**1061.67**	**1159.58**