Chapter 2: Performance Audits

HEALTH & FAMILY WELFARE DEPARTMENT

2.1 National Rural Health Mission

Executive Summary

The National Rural Health Mission (NRHM) was launched by the Government of India in April 2005 to provide accessible, affordable and quality health care to the rural population for ensuring reduction in child and maternal mortality, better accessibility to comprehensive primary health care and prevention and control of communicable and non-communicable diseases. The State Health Mission, with the State Programme Management Unit acting as its Secretariat, was in the overall charge of the mission. The West Bengal State Health & Family Welfare Samity was entrusted with the planning, supervision, monitoring and implementation of National Health Programmes. A performance audit of the NRHM, covering a period from 2011-12 to 2015-16, has thrown light on various areas of deficiencies, which call for immediate attention of the Government.

- The State had not set any benchmark of its own in respect of availability of health facilities *vis-à-vis* population or distances. However, as compared to the Indian Public Health Standards (IPHS) norms, there was shortfall in the number of health centres resulting in health centres being burdened with far larger population than recommended as per the IPHS norms. Even the existing health centres lacked basic facilities *e.g.* running water supply, uninterrupted electricity, staff quarters, etc.
- Progress in the construction of buildings for health facilities lagged behind the targets. Failure in sorting out land problems as well as under-performance of implementing agencies factored behind such slow progress. Even a good number of the created/ upgraded infrastructure like Primary Health Centres (PHCs) with round the clock delivery service etc. could not be made functional depriving the public of the emergency obstetric care. This had in turn put additional pressure of patients on the Sub-Divisional Hospitals/ District Hospitals affecting the quality of service at those points too.
- Round the clock services were further affected by reluctance of the health centre staff in staying in quarters attached to the hospitals. While a large number of quarters constructed for Auxiliary Nursing Midwives remained vacant, a number of staff quarters also remained in dilapidated conditions.
- Installation of New Born Care Corner and New Born Stabilisation Units without proper planning and necessary training of the doctors/ staff resulted in a number of such facilities remaining idle.
- Shortage of doctors, Nurse and other support staff were observed at every level. Not only the number of posts fell short of the posts required under IPHS norms, but also there were substantial vacancies against the sanctioned posts.
- Ante-natal and Post-natal care and other health related services could not be extended to a considerable number of villages due to shortfall in appointment of ASHA workers.
- Though the Quality Control Committee and the Quality Control Team were formed up to district level, these were yet to start functioning in a meaningful way. Village Health & Sanitation and Nutrition Committees and Rogi Kalyan Samities were found to have been either not formed or non-functional in the test-checked districts.

2.1.2 Introduction

The National Rural Health Mission (NRHM) was launched by Government of India (GoI) in April 2005 to provide accessible, affordable and quality health care to the rural population. The objectives of NRHM *inter alia* included

- Reduction in child and maternal mortality.
- Access to integrated comprehensive primary health care.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

In order to achieve the goals, the NRHM interventions aimed at improving the health indictors and included making the public health delivery system fully functional and accountable to the community, human resources management, rigorous monitoring and evaluation against standards in a decentralised way, convergence of health and related programmes, etc.

The finances are shared between the Central and State Governments in the ratio 75:25[1]. In West Bengal, during 2011-16, ₹ 7352.62 crore was available under NRHM out of which ₹ 4054.54 crore (55 *per cent*) was spent.

2.1.3 Organisational structure

At the State level, NRHM functions under the overall guidance of the State Health Mission headed by the Chief Minister of West Bengal. The State Programme Management Unit (SPMU) acts as the Secretariat to the State Health Mission and is headed by a Mission Director. The West Bengal State Health & Family Welfare Samity (State Samity), a society, is entrusted with the planning, supervision, monitoring and implementation of National Health Programmes and other Public Health Programmes, under the overall policy framework laid down by the Ministry of Health & Family Welfare, GoI. The Principal Secretary, Health & Family Welfare (H&FW) Department, West Bengal is the President of the Executive Committee of the State Samity. NRHM funds[2] received by the State Samity are onward transferred to the District Health & Family Welfare Samities (District Samities) and Block Health & Family Welfare Samities (Block Samities) which function under the overall supervision and guidance of the State Samity.

Each District Samity is headed by the District Magistrate and is responsible for planning, implementation, monitoring, evaluation and database management at the district level. Chief Medical Officer of Health (CMOH), the district level functionary of the H&FW Department, is the Member Secretary of the District Samity and is vested with the responsibilities of providing health care services to the people through health facilities. The health care infrastructure in rural areas has been developed as a three tier system - Community Health Centres (CHC) {which includes Rural Hospital (RH) and Block Primary Health Centre (BPHC)}, Primary Health Centres (PHC) and Sub-Centres (SC)[3].

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[1] *It was 85:15 during the 11th Plan period*

[2] *Up to the year 2013-14, the Ministry released funds directly to the State Health Societies. Thereafter the funds were routed through State budget.*

[3] *Block Medical Officer of Health (BMOH) looks after CHC; Medical Officer (MO) looks after PHC and Auxiliary Nursing Midwife (ANM) looks after SC.*

Besides, there are Rogi Kalyan Samities (RKS) at the Hospital/ CHC (RH/ BPHC)/ PHC level to ensure community ownership of delivery of quality health services.

A Performance Audit of NRHM covering the period from 2011-12 to 2015-16 was conducted between April and August 2016.

2.1.4 Audit objectives

The audit objectives were to

A) Assess the availability and sufficiency of physical infrastructure and manpower in the health facilities at the grass root level as well as various referral levels;

B) Assess the impact of NRHM on improving Reproductive and Child Health and

C) Assess the efficacy of the monitoring mechanism.

2.1.5 Audit criteria

The following are the sources of audit criteria/ performance impact indicators for the National Rural Health Mission:

- NRHM Frameworks for Implementation (2005-12) and 2012-17;
- NRHM Operational Guidelines for Financial Management;
- Operational Guidelines for Quality Assurance in public health facilities 2013 and
- Assessor's Guidebooks for Quality Assurance in District Hospitals, Community Health Centres and Primary Health Centres.

Besides the above, for assessing adequacy of health infrastructure at various levels of facilities, benchmarks set by the Indian Public Health Standards (IPHS) Guidelines (2007 and 2012) were also used, where no other norms were available.

2.1.6 Audit scope, coverage and methodology

The performance audit involved data collection and scrutiny of relevant records in the State Samity, State Project Management Unit, Directorate of Health Services and four[4] District Samities selected through Simple Random Sampling Without Replacement (SRSWOR) by stratifying districts into low, medium and high performing districts. Audit also covered three/ two[5] CHCs in each selected district, two PHCs in each selected CHC and three SCs in each selected PHC covering 11 CHCs, 22 PHCs and 66 SCs, all selected statistically. The list of the test-checked health centres is given in ***Appendix 2.1.1***. Test-check also encompassed the respective District Hospitals, District and Block Samities including the Rogi Kalyan Samities.

Further, Audit surveyed 660 beneficiaries[6] (ten in each selected SC selected by employing SRSWOR method).

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[4] *Paschim Medinipur, Murshidabad , Birbhum and Uttar Dinajpur*

[5] *Three CHCs were selected in districts where number of Blocks is more than ten and two CHCs in other districts.*

[6] *Women who have given birth within the last 24 months.*

An Entry Conference (April 2016) was held with the H&FW Department wherein the audit objectives, scope, criteria and methodology were explained. The observations arising out of the Performance Audit were also discussed in an Exit Conference (December 2016) with the Additional Chief Secretary of the Department and his team. The views expressed by the Department have been suitably included in relevant portion of the report.

A Performance Audit on National Rural Health Mission was featured (Paragraph 2.1) in the Report of the C&AG of India (Civil) for the year ended March 2009. The repot flagged issues such as deficiencies in planning, inadequate physical infrastructure, lack of man power, etc. some of which still persist. The replies to that report were, however, not given by the Department.

2.1.6.1 Acknowledgement: We acknowledge the co-operation and assistance rendered by the Additional Chief Secretary of the H&FW Department, State Programme Management Unit, the West Bengal State Health & Family Welfare Samity, CMOsH, District Health & Family Welfare Samities and all lower level functionaries during the course of audit.

Audit findings

2.1.7 Availability of physical infrastructure

2.1.7.1 Shortage of health care facilities vis-à-vis IPHS norms

The Government of West Bengal in its Plan of Action under the Health sector for the years 2011-15 had *inter alia* targeted for providing affordable and accessible health care facilities to all within five years with special focus on the poor, mother and child and those living in underserved areas. However, no population based norms for setting up of health facilities were spelt out by the Government. IPHS stipulates population based norms[7] of availability of health facilities. Compared to the said norms (based on population figures as per Census 2011), there was shortage in the number of health facilities in the State as well as in four test-checked districts as shown in the **Table 2.1.1** below:

Table 2.1.1: Shortage of health facilities

State/ District	SC			PHC			CHC		
	Required	Available	Shortfall (%)	Required	Available	Shortfall (%)	Required	Available	Shortfall (%)
West Bengal	18280	10369	7911(43)	3046	909	2137(70)	914	340	574 (62)
Paschim Medinipur	1183	858	325 (27)	197	82	115 (58)	59	29	13 (51)
Birbhum	700	484	216 (31)	117	58	59 (50)	35	19	16 (46)
Murshidabad	1421	832	589 (41)	237	70	167(70)	71	26	45 (63)
Uttar Dinajpur	601	344	257 (43)	100	18	82 (82)	30	09	21 (70)

Source: Reply furnished by the office of the Mission Director, NRHM and computation by Audit

Thus, the test-checked health facilities were burdened with far larger population than recommended as per IPHS norms. Further analysis showed the following:

- Out of the 66 test-checked SCs, 63 SCs (95 *per cent*) had been serving population of more than 5000 (up to 15000). Of these 63 SCs, 27 were

[7] *One Sub-centre for a population 5000 people in the plains and for 3000 in tribal and hilly areas, one Primary Health Centre (PHC) for 30,000 population in plains and 20,000 population in tribal and hilly areas and one Community Health Centre (CHC/ Rural Hospital) for a population of one lakh.*

serving population of between 5000 and 7000 souls, while nine SCs were serving population of more than 10000 souls each.

- Out of the 22 test-checked PHCs, 15 PHCs (68 *per cent*) had been serving, populations beyond the stipulated norm of 30000 per PHC. Of these over-burdened PHCs, nine were serving a population of up to 50000, while in case of seven, the number of population being catered by each PHC ranged between 50000 and one lakh.
- Out of the 11 test-checked CHCs, 10 (91 *per cent*) had populations of between 1.68 lakh and 4.70 lakh souls in their jurisdiction *vis-à-vis* the stipulated one lakh.

As regards adequacy of the number of health facilities the Department stated during the Exit Conference (December 2016) that West Bengal being a State with high population density, the Government, while setting up new health facilities, focused more on accessibility and quality issues. It was also pointed out that adoption of IPHS norms would have resulted in further stretching of the already thin manpower. The reply may, however, be viewed with the fact that the State had not set any benchmark of its own, based on distances, either. Further, the issue of quality in services at lower levels of health facilities remained a matter of concern from the viewpoint of amenities and infrastructure, as discussed in the succeeding paragraphs.

2.1.7.2 Lack of amenities in SCs, PHCs and CHCs

Audit analysed the availability of various amenities like water, electricity, telephone, waste disposal, generator, etc. in the 99 test-checked facilities, the result of which is tabulated in **Table 2.1.2**. Audit noted that while the test-checked CHCs (which were the highest level of health facilities in a block) had these facilities by and large, an unsatisfactory picture presented itself in health centres (PHCs and SCs) of lower hierarchy.

Table 2.1.2: Availability of infrastructure in test-checked facilities

No. test-checked	Water supply	Electricity	Waste disposal	Telephone	Separate toilet for women	Computer	Standby generator	Boundary Wall
	Number of facilities in which available							
11 CHC	11	11	11	11	11	11	10	10
22 PHC	15	20	22	02	06	NA*	2	19
66 SC	58	61	49	01	17	NA*	NA*	28

*NA: Not applicable *Source: Data collected from test-checked facilities*

Audit further observed that in four test-checked districts, out of total 2718 Sub-Centres, 19 *per cent* (517) lacked water supply, 13 *per cent* (355) had no electricity and 10 *per cent* (262) had no toilet.

2.1.7.3 Non-achievement of targets for construction of health centre

During 2011-16, the State Samity released ₹ 168.85 crore to various implementing agencies[8] for construction and upgradation of various facilities namely, SC, PHC and CHC. The target for construction of and achievement thereof during 2011-16 are shown in **Table 2.1.3**.

[8] *For construction and upgradation of existing PHCs and SCs, the State Samity places funds with the Zilla Parishads and Panchayat Samities through the respective district Samities. For CHCs, funds are directly placed with other Government agencies viz. Public Works Department, West Bengal Industrial Infrastructure Development Corporation (WBIIDC), Mackintosh Burn Ltd., Asansol Durgapur Development Authority (ADDA), etc.*

Table 2.1.3: Target and achievement- construction of health facilities

Type of facility	Target		Achievement		Shortfall		Percentage of Shortfall	
	West Bengal	Test-checked districts	West Bengal	Test-checked districts	West Bengal	Test-checked districts	West Bengal	Test-checked districts
SC	613	165	517	133	96	32	16	19
PHC	79	13	38	4	41	9	52	69
CHC	122	29	84	20	38	09	31	31

Source: Data furnished by the office of the Mission Director, NRHM

As can be seen from **Table 2.1.3**, several health facilities could not be completed as targeted. While the main reason for non-construction of SCs was non-availability of land, in case of PHCs and CHCs the delay was attributable to the under-performance of implementing agencies. The implementing agencies took abnormally long time to complete work as no agreement had been executed with them by the State Society.

In two test-checked districts, 29 PHC buildings (Murshidabad: 16 and Paschim Medinipur: 13) were completed with delays of one to seven years; while in Murshidabad, 13 PHCs were yet to be completed even after lapse of five years from date of sanction for no recorded reasons.

2.1.7.4 Deficient performance in upgradation of infrastructure

(a) Upgradation to First Referral Unit: For providing referral services to the mother and child and for taking care of obstetric emergencies and complications including provisions for C-section[9] delivery and safe abortion services, 48 CHCs (out of total 340 in the State) had been identified (February 2014) for upgradation as First Referral Unit (FRU). However, as of March 2016 only 28 CHCs could be upgraded to FRU. In Murshidabad, Jalpaiguri and Coochbehar districts, there were no CHCs with facilities of FRU. In these districts, these facilities were available only in Sub-Divisional and District Hospitals. As a result, in case of emergencies the expectant mothers had to travel to Sub-Divisional and District Hospitals, rather than the nearest CHCs (FRUs). Moreover, the SDHs or District Hospitals were also over-burdened potentially affecting the quality of service.

(b) PHCs with round the clock delivery services: Out of the total 909 PHCs in the State, only 234 (26 *per cent)* were designated (February 2014) for providing 24x7 delivery services. However, out of the targeted PHCs for providing 24x7 services, only 157 PHCs (67 *per cent*) had been providing 24x7 delivery services as of March 2016. The remaining PHCs were providing only OPD services for seven hours for six days in a week for lack of adequate manpower.

Thus, 24x7 delivery services in PHCs remained far from being achieved.

2.1.7.5 Health infrastructure remaining unutilised

(a) PHC buildings remaining unutilised: During the period 2007-11, 332 PHC[10] buildings were planned for upgradation from non-bedded to 10 bedded centres providing 24x7 service. Mention was made in para 3.1 of the Report of the C&AG on General &Social Sector for the year ended March 2012 that owing to non-posting of medical and para-medical officials,

[9] *A C-section, or caesarean section, is the delivery of a baby through a surgical incision in the mother's abdomen and uterus*

[10] *Of this, 24 PHCs were to be financed from the 13th Finance Commission grant*

upgradation of PHCs had remained unfruitful. Further scrutiny showed (April-August 2016) that as of March 2016, 287 PHC buildings have been completed between November 2009 and April 2015. However, based on the population based norms of the Ministry for setting up delivery points in the rural areas, the H&FW Department revised its original plan of upgrading 332 PHCs and decided (February 2014) to designate only 95[11] of these PHCs as delivery points. Thus, 237 PHC[12] buildings constructed at a cost of ₹ 142.75 crore remained idle as the same were not identified in the changed plan. Nothing was forthcoming from records as to how these 237 newly constructed buildings would be utilized.

(b) Idle expenditure on vertical extension of Islampur Sub-Divisional Hospital: Government of West Bengal, Health & Family Welfare Department had accorded (May 2011) administrative approval and financial sanction[13] for vertical extension of Islampur Sub-Divisional Hospital at an estimated cost of ₹ 2.62 crore for accommodation of separate maternity and paediatric block with the facility of separate OT, labour room, Sick Neo-natal Care Unit (SNCU) and ward for infants. The work was executed by the Uttar Dinajpur Division of the PWD. As per records made available from the PWD office and Islampur, SDH, the work was completed (April 2014) at an expenditure of ₹ 1.99 crore and was handed over to the Hospital authority in August 2014.

As of July 2016, it was seen that the requisite equipment/ machinery and manpower were not provided and except the paediatric OPD, the infrastructure created remained idle.

2.1.7.6 Misuse/ improper use of health infrastructure

In Paschim Medinipur, four newly constructed CHC/ SC buildings were being used by Gram Panchayat (one SC) and Joint Police force (two SCs and one CHC). Thus, the intended benefits could not be derived from these infrastructures.

2.1.7.7 Impact of lack of infrastructure on service delivery

Short/ non-availability of infrastructure at every level of health facility resulted in overcrowding in health facilities which in turn caused deterioration of health services. At SC level, shortfall in Ante-natal Care service delivery (discussed later in this report under Reproductive and Child Health *vide para 2.1.10.2*) was observed putting pressure on the PHCs/ CHCs. As per the IPHS norms, number of patients expected to be checked daily by a Medical Officer (MO) posted in PHC/ CHC is 40. In the test-checked PHCs/ CHCs, average numbers of patients checked by an MO ranged between 43 and 522 per day as under:

Overcrowded Krishnapur RH, Murshidabad (August 2016)

[11] *This included five PHCs constructed with the 13th FC grant*

[12] *218 PHC buildings (308 minus 90) constructed at a cost of ₹122.56 crore and 19 PHC buildings (24 minus 5) constructed at an expenditure of ₹19.19 crore*

[13] *Out of the 13th Finance Commission grants under Head of A/cs "Strengthening District, Sub-Divisional and State General Hospital".*

Table 2.1.4: Patient load on an MO at test-checked PHCs/ CHCs

Number of PHC test-checked	Average number of patients expected to be seen by an MO *per* day	Number of CHC test-checked	Average number of patients seen by an MO *per* day
19	43 to 99	4	99 to 189
2	156	5	217 to 245
1	229	2	305 to 522

Source: Data collected from test-checked facilities.

As per norms of the World Health Organisation there should be 1500 beds for every 10 lakh population. However, in view of limited public sector capacity, the Department had envisaged 500 beds for every 10 lakh population across all facilities of the district as a minimum commitment. A district-wise comparative analysis showed the following:

Table 2.1.5: Comparative analysis of requirement and availability of beds in the test checked districts

District	Total population as per Census 2011	Number of beds required as per WHO norms (1500 beds/ 10 lakh population)	Number of minimum beds required as envisaged by the Department			Actual number of beds in the district including all level of facilities in Government sector		
			Government sector	Private sector	Total	Government sector	Private sector	Total
Birbhum	3502404	5254	1751	NA	1751	2634	838	3472
Murshidabad	7103807	10656	3552	NA	3552	3957	1225	5182
Paschim Medinipur	5913457	8870	2957	NA	2957	4342	1752	6094
Uttar Dinajpur	3007134	4511	1504	NA	1504	1135	89	1224

Source: Data provided by the test-checked four DHFWS.

Thus, while number of available beds was way below the WHO approved level in all four districts, in Uttar Dinajpur, even the minimum number of beds fixed by the Government was not available.

Out of the 11 test-checked CHCs and four DHs/ MCHs, the bed occupancy level was more than 100 *per cent* in four CHCs while high level of bed turnover rate (discharge per bed during a given period of time) was seen in nine CHCs and three DHs. It was observed that normal delivery patients had to be discharged before the mandatory observation time of 48 hours owing to shortage of beds. During survey, out of 660 mothers 368 (56 *per cent*) stated that they were discharged within 48 hours of delivery. Overcrowding at each level of health facilities also compromised the cleanliness of the facilities.

2.1.7.8 Vacant staff quarters at various levels of health facilities

Neither the State Health Directorate nor CMOH office at district level maintained any data regarding availability of staff quarters at SC, PHC and CHC levels. In course of visits to the test-checked PHCs/ CHCs/ DHs, Audit observed that almost half of the quarters (277 out of 564 test-checked) attached to those facilities remained vacant which was mainly attributable to their dilapidated and uninhabitable conditions.

(a) ANM quarters in Sub-Centres: In West Bengal, delivery facility was not available at SC level and none of the SCs was functioning 24x7. However, out of the 66 test-checked SCs, in 29, ANM quarters had been constructed at the first floor. These, however, have been lying vacant since construction, as no ANM stayed there. Instead of giving the intended round the clock service, all the test-checked SCs were found to be open only for five to six hours a day. As

the quarters were not being utilised, State Government had given instructions to use first floor of SCs as meeting halls. However, no such utilisation was seen and these infrastructure remained unused.

(b) Staff quarters in PHCs and CHCs: The details regarding availability of staff quarters in bedded as well as non-bedded PHCs against IPHS norms were as detailed below:

Table 2.1.6: Availability of staff quarters at test-checked facilities as of March 2016

(Number of staff quarters)

Type of health facility (Number)	No. of quarters Required as per IPHS Norms	Available	Shortfall	Staff quarters remaining vacant	Reasons for non-occupancy
PHC (22)	110	76	34	53	Dilapidated condition of the buildings
CHC (11)	209	250	0	121	
DH (4)	416	238	178	103	

Source: Data collected from test-checked facilities.

Table 2.1.6 makes it evident that healthcare facilities did not have adequate accommodation for staff. Further, Staff quarters were lying vacant due to bad condition of the buildings and inadequate amenities like water, electricity, etc. Absence of boundary wall in some cases (57 *per cent* of the test-checked facilities) caused security concern. In Kuli PHC of Murshidabad, two quarters were found to have been occupied by outsiders. Even the quarters which were in use required urgent repair.

Mallarpur BPHC (Birbhum): Staff quarters lying in dilapidated and unoccupied condition since long (before 2008) (April 2016)

2.1.7.9 Availability of equipment at Health Centre

(i) Installation of New Born Care Corner and New Born Stabilisation Units: During 2012-16, the Department had issued 561 New Born Care Corners (NBCC) and 307 New Born Stabilisation Units (NBSU) to 307 health facilities for stabilisation and care of newborns. Scrutiny of records showed that out of 307 NBSUs, 94 were not made operational as of July 2016 as the doctors and staff were not trained. Further, Audit observed that in the four test-checked districts, 32 of the 561 NBCCs had been lying idle as the same were issued to health facilities where no deliveries were conducted.

(ii) Blood Storage Unit (BSU): The State Samity had sanctioned (upto March 2016) 104 BSUs for all districts in the State and supplied all the required equipment to these BSUs. Scrutiny showed that only 32 BSUs could be made functional till March 2016. The remaining 69 BSUs with equipment costing ₹ 2.14 crore were not made functional as the requisite licence from Drug Controller was yet to be obtained. Further, the services of 42 technicians posted in 42 of these 69 BSUs remained unutilized though they were paid a salary of ₹ 86.79 lakh per year. In September 2016, Department decided to cancel 21 BSUs installed at 16 BEmOC centres and five CEmOC centres as there was no requirement of BSUs there. In the Exit Conference, the Department clarified that 16 BSUs installed at CHCs were declared as BEmOCs, as BSUs were not needed in these Centres. Thus, there was idling of infrastructure.

(iii) Idle equipment: In test-checked districts, Audit observed the following instances of equipment not being utilized:

- In two test-checked CHCs (Labpur RH, Birbhum and Krishnapur RH, Murshidabad), one defective X-Ray machine each had been lying unused for long. In the absence of any other machine, the X-Ray service was discontinued in Krishnapur RH whereas in Labpur RH the service was continued with another machine.
- Two Boilers/ Autoclaves (one each in Labpur RH, Birbhum and Salboni RH, Paschim Medinipur) had been lying idle.
- In Raiganj District Hospital, 17 pieces of equipment and machines (valued at ₹ 17.84 lakh) received between 1999 and 2008 under the State Health System Development Project–II (SHSDP-II) had been lying idle (***Appendix 2.1.2***) in the hospital for years together since receipt till date of audit (June 2016). The Department had supplied these equipment to this hospital without ascertaining the requirement from the hospital authority.

2.1.7.10 Shortage of drugs vis-à-vis IPHS norms

The State Government has not specified the list of drugs to be available at various levels of health facilities (SC, PHC, CHC and DH). However, comparison of availability of the drugs at the test-checked facilities *vis-à-vis* IPHS norms showed that all the test-checked facilities had shortage of medicines as indicated in **Table 2.1.7** below:

Table 2.1.7: Shortage of drugs *vis à vis* IPHS norms

Type of facility	Type of drugs	No. of drugs recommended as per IPHS	Number of drugs not available against IPHS	Percentage of drugs not available against IPHS
SC	Kit A	9	1 8	11% 89%
	Kit B	9	2-8	22%-89%
PHC	Different essential drugs	110	50-104	45%-95%
CHC	Emergency obstetric care	71	28-65	39%-92%
	Sick New Born	25	6-21	24%-84%
	Other essential drugs	80	43-69	54%-86%
DH	Different essential drugs	370	223-245	60%-66%

Source: Data collected from test-checked facilities

Drugs which were not available also included essential obstetric care drugs, drugs for the sick new born and other essential drugs. Major drugs which were not available at the time of visit by Audit are indicated in the ***Appendix 2.1.3***.

2.1.7.11 Quality testing of drugs

As per Government norms, heads of the procuring units of the decentralised stores are to get the drugs tested at the designated laboratories. After receiving the quality control report from laboratories, only standard drugs should be issued and initiative should be taken by the authority. It was observed that in two test-checked districts, seven batches (Paschim Medinipur District Reserve Stores: four, Murshidabad Medical College & Hospital: three) of non-standard medicines had been administered to the patients by the time the test report was received. Further, the District Reserve Stores at Murshidabad did not send any of the batches for testing during 2011-15.

During the Exit Conference, the Department clarified (December 2016) that apart from statutory testing there were additional safeguards against use of

sub-standard medicines, namely selection of companies of good repute, every batch of medicine being accompanied with mandatory test report and stoppage of medicines reported as inferior from being issued through the store management software. It was, however, accepted by the Department that there were instances of medicines being issued before receipt of test results and attributed the same to patient pressure. The Department further added that a mechanism was being contemplated to avoid such instances.

2.1.7.12 Mobile Medical Unit

Mobile Medical Unit (MMU) consists of doctor and paramedical staff with equipment for pathological tests, X-Ray, etc. to enable delivery of medical care to people residing in remote areas. The status of implementation of MMU is indicated in the table below:

Table 2.1.8: Status of implementation of MMUs

Year	Total number of districts targeted	Number of districts with functional Mobile Medical Unit	Reasons for shortfall in MMU, if any
2012-13	6	6	--
2013-14	10	6	Selection of Implementing agency not done due to delayed approval from GoI.
2014-15	10	6	Process for selecting NGO was initiated. However, as there was only one bidder, the matter referred to Finance Department, GoWB
2015-16	10	9	Purba Medinipur district was unable to select site for MMU for want of electricity a pre-requisite for MMU to be functional.

Source: Data provided by the office of the Mission Director, NRHM

This facility was available in nine districts which included two test-checked districts *viz*. Paschim Medinipur and Uttar Dinajpur. In Paschim Medinipur, it was seen that against the targeted 11 Left Wing Extremist affected blocks, 10 were covered. The remaining one block was not covered due to non-selection of NGO for running the MMUs, which was attributed by the Department during the Exit Conference to a court case. Consequently, 12055 camps (80 *per cent*) could be organized out of 15024 targeted.

2.1.7.13 Emergency response system

The objective of the scheme is to devise a system by which the beneficiaries, even in rural areas, can have easy and timely access to an ambulance by dialling a toll free number (102). Transportation of pregnant woman was done through 'Nischoy Yan (NY)', the free referral transport under Janani Sishu Suraksha Karyakram. Under this scheme, ambulances/ vehicles (2490 as of March 2016 which were not owned by Government) were empanelled for providing transportation facility for mothers and infants. As per the Scheme provision, when a patient or his/ her relatives called 102/ District Control Unit (DCU), the operator would contact the driver located nearest to the residence of the patient. The contacted driver would pick up the patient from the address provided.
The following was observed by Audit in this regard:

- The toll free number worked only in the district Headquarters and its vicinity. In other areas, mothers were given the mobile number of the driver when they came for the third ante-natal check-up. The mother(s) directly

contacted the driver(s) for necessary transport. Thus, though there was arrangement for emergency transport, it was not functioning the way it was intended.

- As the times of receiving the calls and times of response (when vehicles were provided) was not mentioned in the DCU register, Audit could not assess the efficiency of response.
- All ambulances/ vehicles were to be fitted with GPS system, However, it was seen that 2222 (89 *per cent*) of the vehicles were not fitted with GPS system during 2015-16.
- In the test-checked BPHCs/ RHs, NY vehicles were not equipped with emergency life-saving equipment.
- Further, it transpired from the beneficiary survey of 660 mothers that
  - thirty one *per cent* did not avail of the *Nischoy Yan* facility pointing to the need for creating more awareness of the scheme;
  - fifteen *per cent* stated that the vehicle did not arrive on time and
  - four *per cent* stated that they had to pay for the service, ranging between ₹ 20 and ₹ 400, which should be viewed seriously, as the scheme envisaged free transportation of pregnant women.

While accepting the need of better professionalism in managing the emergency response services, the Department intimated during the Exit Conference (December 2016) that managing these services through a single number 102 throughout the State was under consideration.

2.1.8 Availability of Health Care personnel

2.1.8.1 Availability of medical personnel at CHCs and PHCs

Analysis of data collected from the test-checked districts and facilities (**Table 2.1.9**) indicated that the health facilities were running without adequate personnel, especially doctors and nurses.

Table 2.1.9: Position of medical/ paramedical personnel in various health facilities

Health Facilities	Type of personnel	West Bengal		Birbhum		Uttar Dinajpur		Paschim Medinipur		Murshidabad	
		SS*	MIP# (Shortfall in %)	SS*	MIP# (Shortfall in %)	SS*	MIP# (Shortfall in %)	SS*	MIP# (Shortfall in %)	SS*	MIP# (Shortfall in %)
All facilities											
CHCs	Doctor	2017	1199(41)	153	80(48)	108	41(62)	292	199(32)	NA	160
	Staff Nurse	4605	3115(32)	153	133(13)	155	118(24)	350	287(18)	NA	245
	Paramedics	1516	892(41)	156	110(29)	67	27(60)	202	163(19)	NA	52
PHCs	Doctor	1324	721(46)	147	52(65)	33	23(30)	165	119(28)	140	109(22)
	Staff Nurse	2305	1677(27)	180	145(19)	45	43(4)	214	162(24)	NA	68
	Paramedics	1294	877(32)	58	55(5)	18	18(0)	82	76(7)	NA	64
Test-checked facilities											
CHCs	Doctor	Not Applicable		28	13(54)	9	8(11)	35	24(31)	25	19(24)
	Staff Nurse			29	21(28)	16	14(12)	43	41(05)	29	21(28)
	Paramedics			18	11(39)	8	5(37)	22	20(09)	16	10(37)
PHCs	Doctor			14	7(50)	7	4(43)	15	11(27)	NA	7
	Staff Nurse			18	9(50)	12	8(33)	26	14(46)	NA	3
	Paramedics			9	7(22)	10	7(30)	24	19(21)	NA	11

** Sanctioned Strength; # Men in position*

Source: Data furnished by the office of the Mission director, NRHM and the respective CMOHs.

In this regard, Audit further observed that

- Seventeen PHCs in Paschim Medinipur[14], Murshidabad[15] and Birbhum[16] were running without any doctor.
- Out of 22 test-checked PHCs in four districts,
  - Only five[17] PHCs (23 *per cent*) had medical personnel available on call in case of emergency;
  - Only one[18] PHC (five *per cent*) had Lady Medical Officer and
  - Only five[19] PHCs (23 *per cent*) had doctor or nurse staying in the facility at night.

As is evident from above, the facilities were working with serious human resource constraints which potentially affected the delivery of health care.

2.1.8.2 Shortage of human resources vis-à-vis IPHS norms

The adequacy of man power was also assessed by comparing it with the IPHS norms (based on population to be covered by the facility), the results of which are depicted below:

Table 2.1.10: Human resources *vis-à-vis* IPHS norms

Level of health facility (Number of facilities test-checked)	Name of post	Strength required as per IPHS	No. of persons in position	Shortage w.r.t IPHS norms (%)
District hospitals (2)	Doctors	120	65	55 (46)
	Nurses	405	264	141 (35)
	Paramedics	168	52	116 (69)
CHCs in four test-checked districts (84)	Doctors	690	480	210 (30)
	Nurses	840	783	57 (07)
	Paramedics	924	352	572 (62)
PHCs in four test-checked districts (228)	Doctors	456	303	153 (34)
	Nurses	684	418	266 (39)
	Paramedics	556	213	343 (62)

** Excluding NA-Not Available for Murshidabad district*
(Source: Data provided by the test-checked four DHFWS and SHFWS)

In this regard, Audit observed that

- IPHS-recommended posts (one person in each CHC) for Dental Assistant, Cold Chain and Vaccine Logistic Assistant, OT Technician and Community-based Rehab Worker were not sanctioned for CHCs.
- The PHCs did not have IPHS-recommended posts (one person in each PHC) for Health Worker (Female), Health Assistant (Male) and Lab Technician sanctioned.
- There was shortage of specialist doctors in all the test-checked CHCs which ranged between 89 *per cent* and 100 *per cent* as illustrated below:

[14] *Dharampur, Sasra, Rajnagar, Gokulpur, Goatsandhya, Khasbarh, Makrampur and Mangrul (8)*
[15] *Faridpur, Margram, Putimari, Bahutali, Kharjuna and Kiriteswari (6)*
[16] *Banagram, Bipratikuri and Udaypur(3)*
[17] *Makrampur PHC (Narayangarh Block); Mohoboni PHC (Keshpur Block); Godapiasal PHC (Salboni Block); Panchthupi PHC (Burwan Block) and Azimganj PHC (MJ Block)*
[18] *Anandapur PHC (Keshpur Block)*
[19] *Makrampur PHC (Narayangarh Block); Mohoboni PHC (Keshpur Block); Godapiasal PHC (Salboni Block); Panchthupi PHC (Burwan Block) and Azimganj PHC (MJ Block)*

Table 2.1.11: Lack of specialists *vis-à-vis* IPHS norms

Name of test-checked district	Obstetrician & Gynaecologist		Paediatrician	
	IPHS recommended strength	Persons in position (shortfall *per cent*)	IPHS recommended strength	Persons in position (shortfall *per cent*)
Paschim Medinipur	29	3 (90)	29	2 (93)
Murshidabad	27	0 (100)	27	0 (100)
Uttar Dinajpur	9	1 (89)	9	0 (100)
Birbhum	19	2 (89)	19	1 (95)

Source: Data provided by respective DHFWS of test-checked districts

Shortage of doctors, nurses and paramedical staff hampered the smooth implementation of NRHM as would be evident from the following.

- Out of 141 Comprehensive Emergency Obstetric Care (CEmOC) Centres identified in the State, 20 (14 *per cent*) were not functional owing to man power shortages. Thus, the intended emergency obstetric care of complicated cases (including caesarean section) on 24x7 basis remained deficient.
- Out of the 234 PHCs identified for delivery points (24x7 service) in the State, 77 PHCs (33 *per cent*) were not functional due to shortage of medical personnel.

Thus, the Department's capacity to deliver quality health care services was severely constrained by dearth of man power.

2.1.8.3 Availability of personnel at Sub-Centres

Sub-Centre, the lowest tier of health facility is manned by Auxiliary Nursing Midwife (ANM) and Health Workers (Male). Availability (as of March 2016) of these personnel against sanctioned strength for all SCs (2518) in the four test-checked districts is indicated below:

Table 2.1.12: Availability of ANMs and Health Workers (Male) in all 2518 SCs in four test-checked districts (as of March 2016)

Name of test-checked district	Name of post	Sanctioned strength	No. of persons in position	Percentage of shortage
West Bengal	**ANM**	**8625**	**8429**	**2**
	ANM (contractual)	**NA**	**NA**	**NA**
	Health Worker (male)	**NA**	**NA**	**NA**
Birbhum	ANM	484	483	0
	ANM (contractual)	484	390	19
	Health Worker (Male)	484	70	86
Uttar Dinajpur	ANM	344	328	05
	ANM (contractual)	344	261	24
	Health Worker (Male)	344	19	94
Paschim Medinipur	ANM	858	849	01
	ANM (contractual)	858	NA	-
	Health Worker (Male)	858	88	90
Murshidabad	ANM	832	823	1
	ANM (contractual)	832	701	16
	Health Worker (Male)	314	91	71

NA-Not Available
(Source: Data provided by the test-checked four DHFWS and SHFWS)

Audit noted the following in this regard,

- As per norms, each SC requires one regular ANM and one contractual ANM. However, the State had only 8625 sanctioned posts of regular ANMs against the requirement of 10356. The Department did not clarify the inconsistency between the total number of SCs and sanctioned posts for ANMs, though called for. In the test-checked districts, though the shortage of regular ANMs was not significant (between one and five *per cent*), shortfall of contractual ANMs called for attention as it ranged between 16 and 24 *per cent.*

  The Department pointed out during the Exit Conference that the expenses of the contractual ANMs were to be borne by the Ministry of Health, GoI as part of NRHM framework.

- There was significant shortage of Health Worker (Male) against the sanctioned strength which ranged between 71 *per cent* and 94 *per cent.*

- Out of the 66 SCs test-checked, ANMs in only 25 SCs (38 *per cent*) had Skilled Birth Attendant (SBA) training.

2.1.8.4 Availability of Accredited Social Health Activists

Accredited Social Health Activists (ASHA) are voluntary health workers at the village/ community level instituted by the GoI as a part of NRHM. Each ASHA was expected to have three fold roles, namely, (i) to be a facilitator of health services and link people to health care facilities; (ii) to be a provider of community level health care and (iii) an activist helping people understand health rights and enabling them to access their entitlements. Accordingly, availability of trained ASHAs is significant to the success of NRHM. They are attached to SCs and work in one or more villages under the jurisdiction of the SC.

Audit observed that against 61008 ASHAs sanctioned for the whole State, there were 47566 (78 *per cent*) in position (as of March 2016) leaving a shortfall of 22 *per cent.* In the test-checked districts also the position was almost similar, with vacancy of 21 *per cent* (12586 ASHAs against sanctioned strength of 15983) owing to shortage of ASHAs. In the four test-checked districts, 106 out of 2518 SCs were running without ASHAs while 22 *per cent* (3647villages out of 16892) of the villages were not covered by ASHAs. Population-wise, ASHAs served only 63 to 85 *per cent* of the population in those test-checked districts.

During the Exit Conference (December 2016) the State Project Director stated that steps were being taken to address the shortage of ASHAs.

Training of ASHAs: ASHAs were to be imparted training in two phases (first to fifth modules of training in the first phase and then sixth and seventh modules in the second phase) to equip them with sufficient knowledge and skills for village/ community level health care. It was seen that out of 47566 ASHAs in position, 40056 (84 *per cent*) and 39367 (83 *per cent*) had attended the first and second phases of training respectively, leaving 15 *per cent* of the ASHAs untrained, which evidently affect the quality of health services delivered through them. This assumed significance considering that ASHAs were the first point of contact for health services in the rural areas. Inadequate knowledge level of ANM/ ASHA emerged as one of the reasons for maternal death in the Maternal Death Reviews conducted in the test-checked districts.

2.1.8.5 ASHA kit for all ASHAs and timely replacement of ASHA kits

ASHA kits were provided to ASHAs once during 2011-14. Thereafter, ASHA kit was replenished time to time from drug stocks of sub-centres. During the course of audit it was seen that

- In Birbhum, 84 *per cent* ASHAs (2662 out of 3165) were provided with drug kits. District authorities of Paschim Medinipur, Murshidabad and Uttar Dinajpur did not maintain any record regarding how many ASHAs were provided with drug kit.
- Non-availability of drugs (in terms of types of drugs) in ASHA kits against the IPHS norms ranged between 6 *per cent* and 76 *per cent* in the test-checked SCs in four test-checked districts.

2.1.9 Quality Assurance Mechanism

GoI had issued Operational Guidelines for Quality Assurance in public health facilities in 2013. It envisaged certification and accreditation of health facilities. This required a setting up of an organisational frame work for quality assurance (QA) activities, training and capacity building, facility level quality improvement, etc.

The H&FW Department (NHM) had notified the adoption of National Quality Assurance Programme (NQAP) in July 2014. The progress of West Bengal in QA activities is discussed in the following paragraphs.

2.1.9.1 Setting up of organization framework for Quality Assurance

The organisational framework for QA consisted of Quality Assurance Committees at the State level and District level, State and District Quality Assurance Units, facility level Quality Teams and identification and empanelment of State Quality Assessors.

(i) State level Quality Assurance Committee (SQAC)

The broad responsibility of this committee was to oversee the quality assurance (QA) activities across the State in accordance with the applicable guidelines and to ensure regular and accurate reporting of the various key indicators. It was to provide overall guidance, mentoring and monitoring of QA efforts in the districts.

In West Bengal, SQAC was formed in July 2014. SQAC was to meet at least once in six months and was to take decisions for corrective and preventive actions and ensure follow-up actions. The State Health Mission intimated that review meetings were held five times[20] in 2015-16. However minutes of these meetings were not available and the decisions taken in these meetings were not known.

State Quality Assurance Unit (SQAU): SQAU, the operation and implementation arm of SQAC was not made functional as of March 2016, as the requisite personnel were not recruited. The State health authority stated (March 2016) that recruitment process had been initiated.

(ii) District level Quality Assurance Committee (DQAC)

DQAC was to ensure that QA standards were achieved at public health care facilities. The Committee was to ensure that district level orientation and

[20] *22 September 2015, 23September 2015, 21 December 2015, 23 December 2015 and 8 January 2016*

trainings were accomplished in time for District Quality Assurance Unit (DQAU), the working arm of DQAC and also District Quality Team. DQAC was to meet at least once in a quarter and periodically review progress of QA activities and co-ordinate with State authority for quality improvement process.

District Quality Assurance Committees (DQACs), though formed (between January and May 2015) in the four test-checked districts, the Committees were not functioning as of March 2016 as they did not meet after their constitution meeting. State health authority also stated (March 2016) that DQACs were yet to be fully functional.

District Quality Assurance Unit (DQAU): The DQAU was also not functional as of March 2016 as the requisite personnel were yet to be recruited.

(iii) District Quality Teams

A District Quality Team (DQT) was to be formed at each district hospital and was to ensure adherence to quality standards and report regularly to the DQAC. Though it was stated that DQT meetings were held in 14 district hospitals (DHs) between May and October 2015, no minutes were made available by the test-checked DHs. Similarly, though it was stated that internal assessments were done in 14 DHs (between December 2014 and August 2015), no records to this effect were produced to Audit in the test-checked DHs. Further, it was doubtful whether the internal assessments served any purpose as DQACs, which were to consider the findings of internal assessments, were not meeting regularly.

2.1.9.2 Facility level quality improvement

Facility level quality improvement *inter alia* included Patient Satisfaction Survey, Key Performance Indicators (KPI), Death Audits, etc. While KPI was being regularly reported, it was seen that Patient Satisfaction Surveys[21] were not conducted in any of the facilities (as of March 2016). The position as to death reviews is indicated below:

Maternal Death Review (MDR): Maternal Death Review (MDR) is an important strategy to improve the quality of obstetric care and reduce maternal mortality. In case of maternal death in a health facility, investigations were to be conducted in the facility by the Medical Officer. The BMOH was also to depute a team for community based investigation. The MDR committee at the health facility reviews all the maternal death cases occurred in the facility for corrective measures. The findings of both the facility based and community based investigations were then to be reviewed by the district MDR committee. The information on MDRs in test-checked facilities is indicated in the table below:

Table 2.1.13: Maternal Death Reviews conducted

Name of district	Total No. of maternal deaths during 2011 16	No. of maternal death reviewed at the district level	Short-fall (%)	Remark
Paschim Medinipur	278	280*	--	*MDRs included review held on maternal deaths from previous year(s) which were not specified by the DHFWS.
Murshidabad	1026	178	83	During 2011-15, maternal death cases reviewed ranged between 6 and 26 *per cent*

[21] *Quarterly patient satisfaction surveys/ Patient feedback (OPD & IPD separately)*

Name of district	Total No. of maternal deaths during 2011-16	No. of maternal death reviewed at the district level	Short-fall (%)	Remark
Birbhum	321	240	25	MDR Committee was formed in February 2011.
Uttar Dinajpur	276	82	68	During the year 2011-13,126 maternal death cases were not reviewed as Committees had not been formed then.

Source: Data furnished by each test-checked DHFWS office

As can be seen from **Table 2.1.13**, during the years covered under audit, all maternal deaths were not reviewed as required. There was shortfall in maternal death review in the test-checked districts, ranging between 25 and 83 *per cent.*

The reasons for maternal death emerging from the review conducted in the test-checked districts, were medical complications (eclampsia, haemorrhage, cardio respiratory/ renal failure, etc.) non-availability of blood for emergency transfusion, non-availability of vacant bed in HDU[22], improper ante-natal check-up, ignorance/ negligence of health staff, insufficient equipment, inadequate knowledge of ANM/ ASHA, etc.

Infant Death Review: Though infant death reviews were required to be conducted, it was not done in any of the test-checked districts despite occurrence of 849 infant deaths in these districts during 2013-16.

The above indicated that the facility level improvement needed more attention from the authorities.

2.1.9.3 Training and orientation

It was seen that awareness workshop was held at the State level during December 2014 and December 2015. Though, as per information provided, 719 personnel had been imparted Internal Assessors' training, Service Providers' training and Introduction to Key Performance Indicators[23], in the absence of any training schedule or set targets, the adequacy of the training could not be assessed in audit.

Thus, the quality assurance mechanisms were evidently in a nascent stage as the institutional arrangements could not be fully put in place. This was also evidenced by the low level of spending of funds for quality assurance. The districts utilised only 40 *per cent* (₹ 63.36 lakh out of ₹ 159.20 lakh released during 2014-16) of the funds while the four test-checked districts utilised only 11 *per cent* of the funds made available to them (₹ 2.11 lakh out of ₹ 19.90 lakh).

2.1.10 Implementation of Reproductive and Child Health Programme

The major components of this programme are maternal health care, access to safe abortion services, care for Sexually Transmitted Infections (STI), Newborn and Child Health, Universal Immunization, Family Planning, etc.

[22] *High Dependency Unit*

[23] *Key Performance Indicators pertaining to Reproductive, Maternal, Newborn, Child Health (RMNCH) viz. Maternal Mortality Ratio, Mothers who have received Ante-natal care, Institutional Deliveries, Mothers who have received Post-Natal Care, Infant Mortality Rate, Immunisation coverage, etc.*

2.1.10.1 Institutional Deliveries

Target and achievement: One of the important interventions was to promote institutional delivery in order to reduce Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). The position in this regard is indicated in the **Table 2.1.14**.

Table 2.1.14: Institutional and home deliveries in the State during 2011-16

Year	Total registered pregnant woman	Total delivery	No. of deliveries (*per cent*)	
			Institutional delivery	Delivery at home
2011-12	1957713	1492952	1071509 (72)	421443 (28)
2012-13	1879037	1449007	1071312 (74)	377695 (26)
2013-14	1966304	1527662	1186842 (78)	340820 (22)
2014-15	1866097	1398144	1153207 (82)	244937 (18)
2015-16	1757141	1375738	1205967 (88)	169771 (12)

Source: Data furnished by the office of the Mission Director, NRHM

As can be seen from **Table 2.1.14**, percentage of Home Delivery with respect to total number of deliveries showed a decreasing trend during 2011-16. A similar trend [24] was observed in all the four test-checked districts also. Introduction of *Nischoy Yan* played an important role in reducing the number of home delivery. Audit, however, noted that 99 *per cent* of total domiciliary delivery cases were not attended by skilled birth attendants and 24 *per cent* cases were not visited by any health personnel within 24 hours of delivery, due to shortfall in man power. One of the reasons for domiciliary delivery was instant discharge of pregnant woman in case of false pain. The discharged women sometimes failed to turn up at the health facilities in due time for the actual delivery. Lack of health facilities, manpower, awareness and poor road conditions in some pockets of the districts also contributed to domiciliary delivery.

Though there was noticeable improvement in institutional deliveries, the State was yet to achieve the ideal target of *cent per cent* institutional delivery. This may be seen in the context of non-upgradation of PHCs and CHCs to the desired level to conduct deliveries/ C-Sections. Audit also found that the institutions identified as delivery points did not perform up to the standard.

Poor performance of delivery points: CHCs/ SDHs, identified as delivery points were to conduct at least 20 deliveries per month while in case of PHCs it was at least10. It was seen that due to lack of infrastructure and non-deployment of adequate man power these delivery points were not conducting delivery upto the minimum benchmark. During 2015-16, out of 574 delivery points (CHCs: 340, PHC: 234), only 326 (CHCs: 298, PHC: 28) had achieved the minimum benchmark. During joint survey of mothers conducted by Audit, it was observed that inadequate infrastructure, shortage of nurses and doctors, non-availability of diet service, etc. contributed to lack of interest among the mothers in attending the nearest delivery points.

Further, PHCs were not equipped to conduct mandatory tests required in respect of delivery like Blood Grouping, Rh typing, etc. Though there was provision to tie up with private laboratory and sufficient funds were allocated for this

[24] *Percentage of home delivery reduced from 25 to13 per cent in Paschim Medinipur, 32 to 25 per cent in Birbhum, 43 to 11 per cent in Murshidabad and 56 to 42 per cent in Uttar Dinajpur.*

purpose under JSSK, six out of the 11 test-checked CHCs did not avail of this facility thereby depriving the intended beneficiaries.

2.1.10.2 Ante-natal care (ANC)

In order to provide safe motherhood, at least three ANC check-ups, 100 days intake of Iron Folic Acid tablets (IFA) and two doses of Tetanus Toxoid (TT) were to be provided to all registered pregnant women (PW). Besides, to encourage pregnant women to volunteer for ANC, the distribution of IFA tablets was linked to each check-up. The details of ANC provided to registered pregnant woman are shown in table below:

Table 2.1.15: Ante-natal care in the State during 2011-16

Particulars	2011-12	2012-13	2013-14	2014-15	2015-16
Registered pregnant woman	1957713	1879037	1966304	1866097	1757141
Registration within 1st trimester	1132413	1183229	1347372	1364466	1352423
1st and 2nd Tetanus Toxoid (TT) immunization	1523342	1472528	1547895	1493494	1452888
Given100 IFA tablets	1361718	1305990	1444167	1521857	1584121
Detected with hypertension	31215	23252	24025	28817	34509
Detected with eclampsia	3442	4793	4823	9581	9363
Detected with severe anaemia	10883	5246	2749	3333	4708
Three ANC check-up done	1440585	1377277	1502571	1532039	1501127

Source: Data furnished by the office of the Mission Director, NRHM

There was shortfall in various components of ante-natal care in the State as well as in the test-checked districts as shown below:

Table 2.1.16: Achievement in various interventions of Ante-natal care during 2011-16

Name of the component	Shortfall in the State as a whole	Shortfall in the four test-checked districts
Three ANC check-up to pregnant woman	15 to 26 *per cent*	17 to 28 *per cent*
Administration of two doses of TTs	18 to 22 *per cent*	08 to 21 *per cent*
Providing of IFA tablet	10 to 30 *per cent*	19 to 34 *per cent*

Source: Data provided by the WBHFWS and test-checked four DHFWS

Such shortfall may be attributed to delay in registration of pregnant women, shortage/ under-performance of ASHA, limited awareness/ motivation among the pregnant women, etc.

Thus, there is significant scope for improvement in respect of providing ante-natal care.

2.1.10.3 Post-natal care

Post-natal care (PNC) includes identification and management of all post-delivery complications like *post-partum* haemorrage, eclampsia, sepsis, etc. by ensuring a minimum 48 hours of stay of the mother in health facilities after delivery and three to seven days stay for managing complications.

It was observed that due to shortage of beds in public health institution during 2011-16, 35 to 57 *per cent* mothers were discharged after delivery, without keeping them under observations for the stipulated minimum period of 48 hours. Thus, PNC care was being compromised to accommodate other pregnant mothers.

2.1.10.4 Performance of Janani Shishu Suraksha Karyakram

Janani Shishu Suraksha Karyakram (JSSK) launched in June 2011 is an initiative to assure free services to all pregnant women and sick neonates having access to public health institutions. The scheme envisages free and cashless

services (drugs, diagnostics, diet, transport, etc.) to the pregnant women including normal deliveries and caesarean operations and also treatment of sick new born (up to 30 days after birth) in all Government health institutions. The performance of JSSK during 2013-16 was as under:

Table 2.1.17: Ante-natal care in the State during 2013-16

Year	No. of delivery in public institutions	Free service given			
		Drugs & consumables (*per cent*)	Diet (*per cent*)	Diagnostics (*per cent*)	Transport (*per cent*)
2013-14	899009	801000 (89)	811133 (90)	582048 (65)	355915 (40)
2014-15	889924	860289 (97)	883158 (98)	670208 (75)	419110 (47)
2015-16	932050	960002 (100*)	937166 (100*)	779647 (84)	471895 (51)

** Excess number of achievement was attributable to spill-over cases of previous year*
Source: Data furnished by the office of the Mission Director, NRHM

As is evident from the above Table, there was an upward trend in the percentage of beneficiaries availing the free services. However, there was much scope for improvement in respect of extending free diagnostic and transport services. There was no attempt by the department to identify the reasons for these services not being availed of even when they were given free of cost. The shortfall in diagnostic services, however, can be viewed with the fact that in five test-checked PHCs, 24x7 laboratory service was not available though delivery took place. Moreover, at test-checked 11 CHCs, laboratory service was available only to those patients attending ANC clinic, not to the patients getting direct admission.

Further, during beneficiary survey, 23 mothers[25] (four *per cent* of those surveyed) who had institutional delivery reported that they had to pay for their diet.

2.1.10.5 Referral service

A comprehensive First Referral Unit (FRU) is a hospital where all complications are managed including Caesarean sections and blood transfusions. An FRU is a CHC with a Comprehensive Emergency Obstetric Care (CEmOC) unit.

As of March, 2016 out of 183 FRUs required as per population norms, only 118 (64 *per cent*) could be developed as FRUs. In Murshidabad, Jalpaiguri and Coochbehar districts, there were no CHCs providing CEmOC services. CEmOC service in these districts was available only in SDHs and DHs. As a result, not only were these hospitals over burdened with pregnant mothers compared with sanctioned bed strength affecting quality of service, but also the pregnant mothers had to travel all the way to SDHs/ DHs, rather than the nearest FRU, in case of emergency.

2.1.10.6 Janani Suraksha Yojana

The Janani Suraksha Yojana (JSY) was introduced in 2005-06 as a key intervention to enable women to access institutional deliveries and thereby to reduce MMR and IMR in the State. JSY envisaged encouraging institutional deliveries by providing cash incentive (₹ 1000 for institutional delivery and ₹ 500 for home delivery) to pregnant women belonging to SC/ ST/ BPL families. Audit scrutiny of JSY showed the following irregularities.

[25] *Birbhum:2; Uttar Dinajpur:5; Murshidabad:15 and Paschim Medinipur:1*

(i) Non-payment of incentive to beneficiaries: All registered pregnant women in rural area attending health institutions for delivery were eligible for cash incentive of ₹ 1000 under JSY immediately or within seven days after delivery to meet the delivery expenses. Since July 2013, Government had decided to make payments through cheques and it was observed that during 2014-16, 37 to 59 *per cent* of registered JSY beneficiaries could not receive the benefit of the scheme as they had no bank accounts to encash the cheques. In 2014-15, cheques amounting to ₹ 6.95 crore to JSY mothers became time-barred and had to be written back into the account.

(ii) Non-payment of cash benefit to JSY beneficiaries in Ayushmati Scheme: Under Ayushmati scheme a BPL/ SC/ ST pregnant mother could avail of the delivery facilities at earmarked private facilities. These mothers are also entitled to cash incentive of ₹ 1000. In Murshidabad and Birbhum districts 41616 Ayushmati beneficiaries were not paid this incentive.

2.1.10.7 GP Camp/ RCH outreach Camp

In order to provide medical services to Gram Panchayats (GPs) having no PHC, health camps were to be conducted in GP headquarters once in a week. A medical officer along with support staff was to man the camp. It was seen in audit that during 2011-16, GP camps could not be conducted in desired numbers in the State as shown below:

Table 2.1.18: GP/ RCH outreach camp conducted during 2015-16 in the State

Year	No. of GP without any PHC	No. of camp need to be held	No. of camp held	Shortfall (*per cent*)
2011-12	2093	108836	55380	53456 (49)
2012-13	2093	108836	32926	75910 (70)
2013-14	2093	108836	20818	88018 (81)
2014-15	2093	108836	15709	93127 (86)
2015-16	2093	108836	10980	97856 (90)

Source: Data provided by the State Mission Director, NRHM

There was shortfall in organization of GP camp ranging from 49 *per cent* to 90 *per cent* with a steady fall in performance every year. Shortfall in conducting GP camps limited the access of patients to registered Medical Practitioners. Scarcity of Medical Officers was one of the factors attributable to shortfall in holding camps.

2.1.10.8 MTP service

Medical Termination of Pregnancy (MTP) services were to be provided at least in every 24x7 facility in every block and in every facility upgraded for FRU services. Access to safe abortion services is key to reduction of MMR. The focus was to be on improving access to comprehensive abortion care, including post-abortion contraceptive counselling. However, MTP service was not available at any of the test-checked five 24x7 PHCs or 11 CHCs of test-checked districts.

2.1.10.9 Management of RTI/ STI

Key strategies for prevention and management of Reproductive Tract Infections (RTI) and Sexually Transmitted Infections (STI) included Behavioural Change Communication (BCC) interventions for community health education, provision of diagnosis and treatment services at health facilities, syndromic

management[26] at 24x7 PHCs and lower levels and laboratory and diagnostic based services at FRU facilities. Special focus was to be given on linking up with Integrated Counselling and Treatment Centres (ICTCs) and establishing appropriate referrals for HIV testing and RTI/ STI management. In test-checked districts, RTI/ STI management service was available only at four PHCs out of the 22 test-checked. In nine CHCs out of 11 test-checked, except HIV testing no other service for management of RTI/ STI was available.

2.1.10.10 Immunization and Vitamin A Administration

Immunisation of children against preventable diseases had been the cornerstone of routine immunisation under universal immunisation programme. Audit observed that the overall achievement of primary immunisation of children belonging zero to one year age group, covering BCG, Measles, DPT and Hepatitis B hovered between 80 and 91 *per cent* during 2011-16. The achievement of targets in the secondary immunisation of children was as under:

Table 2.1.19: achievement of targets in the secondary immunisation during 2011-16

Immunisation	Achievement
DPT (for the age group of five to six years)	42 to 61 *per cent*
TT (above 10 years of age group)	43 to 58 *per cent*
Administration of polio vaccine	97 to 99 *per cent*
First dose of prophylaxis vaccination against blindness amongst children due to Vitamin A deficiency	17 to 67 *per cent*

Source: Data provided by the State Mission Director, NRHM

Thus, there was scope for improvement in universal immunisation programme, especially in the secondary immunisation.

2.1.10.11 Family Planning

As per NRHM framework, implementation of family planning services was to be utilized as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilizing population. The initiatives in this direction are discussed below.

(i) Target and achievement of sterilization

Terminal method of family planning includes vasectomy for male and Tubectomy/ laproscopy/ minilap for female. Audit observed that shortfall in conducting vasectomy and tubectomy during 2011-16 ranged between 15 and 63 *per cent* against the target.

(ii) Failure of male and female sterilization procedures

Quality of sterilization is an important issue to ensure success in sterilisation programme. During 2011-16, 45 persons died owing to complications arising from sterilization. Of this, eight men died while undergoing vasectomy sterilisation operation. During the same period 6486 persons were reported to have faced complication after sterilization. There were also 709 failure cases. This indicated that the quality of service was highly questionable.

[26] *Syndromic management refers to the approach of treating STI/ RTI symptoms and signs based on the organisms most commonly responsible for each syndrome.*

2.1.11 Monitoring & evaluation

The West Bengal State Health & Family Welfare Samity[27] is responsible for the supervision and monitoring of National Health Programmes and other Public Health Programmes, under the overall policy framework laid down by the Ministry of Health, GoI. The districts and block level Samities function under the overall supervision and guidance of the State Samity.

Further, Rogi Kalyan Samities (RKS) were to be constituted at the health facilities with the purpose to provide sustainable quality care with accountability, transparency and people's participation. RKSs were responsible for smooth functioning of health centres and maintaining the quality of services. The functioning of these organisations are discussed below:

2.1.11.1 Monitoring meeting by State Samity and District Samities

Meetings of the Executive Committee of the State Samity were to be held at least once in a month. Test-check of relevant records showed that shortfall in meetings of State Samity ranged between 75 *per cent* and 83 *per cent* as it had held only two to three meetings in a year against the required 12 (**Table 2.1.20**).

Table 2.1.20: Meetings held by WBSHFWS during 2011-16

Year	Number of meetings to be held by SHFWS *(at least once a month)*	Number of meetings held	Shortfall *(per cent)*
2011-12	12	02	83
2012-13	12	03	75
2013-14	12	03	75
2014-15	12	03	75
2015-16	12	NA	--

(Source: Data/ information provided by SHFWS office)

Similarly, meetings were to be held by each District Samity[28] at least once in three months. Test-check of records in four selected districts showed shortfall in meetings of DHFWS ranging between 20 *per cent* and 80 *per cent*. While the Samities in Paschim Medinipur and Uttar Dinajpur met four and seven times, respectively during 2011-16 against the requisite 20, the positions in Murshidabad and Birbhum were comparatively better with the Samities having met 15 and 16 times, respectively.

2.1.11.2 Rogi Kalyan Samities

Though Rogi Kalyan Samities were formed in the test-checked health care facilities, regular meetings (at least once a month) were not held during 2011-16. In Illambazar[29], Raiganj[30] and Keshpur[31] CHCs, out of a requirement of at least 60 meetings to be held in each block during 2011-16, only five meetings of RKS were held, leaving shortfalls of 92 *per cent* each. In Labpur CHC [32] RKS meetings were not held during 2014-16. Four test-checked DHFWS did

[27] *Pr. Secretary, H&FW Department, GoWB: President, Executive Committee, SHFWS Director of Health Services, GoWB: Vice-President*
[28] *District Magistrate is the President of the Executive Committee, DHFWS while CMOH is the Secretary*
[29] *Birbhum*
[30] *Uttar Dinajpur*
[31] *Paschim Medinipur*
[32] *Birbhum*

not produce reports of the RKS meetings held at health care facilities and follow-up actions taken by the District authority. In test-checked DHs/ MCHs, against the requirement of 60 RKS meetings to be held during 2011-16, the number of RKS meetings held ranged between eight and 13 (shortfall ranging from 78 *per cent* to 87 *per cent*).

2.1.11.3 Village Health & Sanitation and Nutrition Committee

Audit found that Village Health & Sanitation and Nutrition Committee (VHSNC) had not been constituted in all the Gram Sansads. Out of the four test-checked districts, VHSNC were constituted in all Gram Sansads only in one district (Birbhum) while in other districts, they were yet to be formed in several villages. (**Table 2.1.21**).

Table 2.1.21: Formation of VHSNC in test-checked districts.

Name of district	Number of *gram sansads*	Number of *gram sansads* in which VHSNC formed	Number of VHSNC with Bank A/c opened
Paschim Medinipur	3846	2257 (59)	1421 (63)
Murshidabad	4164	1693 (41)	1620 (96)
Birbhum	2242	2242 (100)	1161 (52)
Uttar Dinajpur	1632	1491 (91)	1435 (96)
Total	**11884**	**7683 (65)**	**5637 (73)**

Source: Data furnished by respective CMOHs/ Zilla Parishads

Further, only 73 *per cent* had opened bank accounts for keeping the funds required for planning and monitoring activities. Neither were funds[33] released to the VHSNC for their activities[34]. This pointed to the fact that many of the VHSNC were not in a position to undertake monitoring and planning activities. Moreover, none of the test-checked SCs were aware of monitoring activity done by these Committees. Audit also did not come across any records as to the meetings and other activities by the VHSNC in the test-checked districts.

2.1.11.4 Visit of SCs by medical officers

SCs are to be visited once a month by Medical Officer of the PHC to which they are attached. Out of the test-checked 66 SCs, 59 SCs[35] (89 *per cent*) were not visited at least once a month by medical officers indicating lax monitoring of these facilities.

As evidenced by the foregoing paragraphs, much more needs to be done to improve the oversight of NRHM activities.

2.1.12 Conclusions

Performance Audit on implementation of National Rural Health Mission has thrown light on various areas of deficiencies, which call for immediate attention of the Government.

- There was shortfall in number of health centres against the IPHS norms. Even the existing health centres lack basic facilities *e.g.* running water supply, uninterrupted electricity, staff quarters, etc.

[33] *As per Untied Fund guidelines (NRHM) VHSNC constituted is entitled to untied fund (₹10000/-)*

[34] *Village level public health activity like cleanliness drive, sanitation drive, school health activities, Anganwadi level activities, household surveys; VHSNC is also expected for involvement in preparation of annual Village Health Plan and submission to block office.*

[35] *Birbhum: 18; Uttar Dinajpur: 10; Paschim Medinipur: 14 & Murshidabad: 17.*

- Construction of buildings for health facilities needs to be expedited as progress of construction lags behind target. Failure in sorting out land problems as well as under-performance of implementing agencies factored behind such slow progress. Even a good number of the created/ upgraded infrastructure like PHCs with round the clock delivery service, First Referral Units, etc. could not be made functional. Thus, the Department could not upgrade the health facilities as planned depriving the public of the emergency obstetric care. This had led to additional pressure of patients on Sub-Divisional Hospitals/ District Hospitals affecting quality of service at those points too.
- Round the clock services were further affected by reluctance of the health centre staff in staying in quarters attached to the hospitals. While a large number of quarters constructed for Auxiliary Nursing Midwives remained vacant, a number of staff quarters also remained in dilapidated conditions.
- Installation of New Born Care Corner and New Born Stabilisation Units without proper planning and necessary training of the doctors/ staff resulted in a number of such facilities remaining idle.
- Shortage of doctors, nurse and other support staff were observed at every level of health facility. Not only the number of posts fell short of the posts required under IPHS norms, but also there were substantial vacancies in the sanctioned posts.
- Ante-natal and Post-natal care and other health related services could not be extended to a considerable number of villages due to shortfall in appointment of ASHA.
- Though Quality Control Committee and Quality Control Team were formed upto district level, these were yet to start functioning in a meaningful way. Village Health & Sanitation and Nutrition Committees and Rogi Kalyan Samities were found to have been either not formed or non-functional in test-checked districts.

2.1.13 Recommendations

Government may consider ensuring

1. ***Improvement of infrastructure needed at the health care centres and availability of medical and para-medical staff as per IPHSs norms on priority.***
2. ***Operationalization of the New Born Care Corners and New Born Stabilisation Units through imparting necessary training among the staff.***
3. ***Time-bound completion of the construction works through proactive pursuance with the implementing agencies.***
4. ***Proper functioning of quality control and monitoring mechanism at each level of health facilities.***

Appendix 2.1.1

(Refer paragraph 2.1.6, page 9)

List of test-checked Districts with Blocks and other units

Name of district with name of district hospital/ MCH	Name of Block	Name of CHC	Name of PHC	Name of SCs
Paschim Medinipur *(Medinipur Medical College & Hospital)*	Salboni	Salboni RH	Godapiasal Pirakata	Madhupur SC, Sarasbedia SC, Tilaboni SC, Mandalkupi SC, Dakinsole SC and Jara SC
	Keshpur	Keshpur RH	Anandapur PHC Mohoboni PHC	Amrakuchi SC, Anandapur SC, Keshpur SC, Piasala SC, Sasaboni SC and Jagannathpur SC
	Narayangarh	Belda RH	Makrampur PHC Barakalankai PHC	Birbira SC, Pakurseni SC, Bankibazar SC, Jalhari Sankarkara SC, Deuli SC and Kushbasan SC
Murshidabad *(Murshidabad Medical College & Hospital)*	Jiaganj	Jiaganj BPHC	Ajimgunj PHC Lalkuthi PHC	Asanpur SC, Kurulpara SC, Benipur SC, Lalkuthi SC, Mukundabagh SC and Pirtala SC
	Burwan	Burwan RH	Panchthipu PHC Kuli PHC	Badua SC, Monaai Karidra SC, Kuli SC, Panchthupi SC, Sibrambati SC and Srihatta SC
	Lalgola	Krishnapur RH	KD para PHC Rajarampur PHC	KD para SC, Jhowbona SC, Bhagwanpur SC, Chuapukur SC, Rajarampur SC and Paikpara SC
Birbhum *(Suri Sadar Hospital)*	Mayureswar-I	Mallarpur BPHC	Ratma PHC, Talwan PHC	Shibogram SC, Dakhingram SC, Fatehpur SC; Sekpur SC, Kamra SC and Sonj SC
	Illambazar	Illambazar BPHC	Joydeb PHC, Batikar PHC	Joydeb SC, Sugarh SC, Tarapur SC; Kurmitha SC, Batikar SC and Mongaldihi SC
	Labpur	Labpur RH	Thiba PHC, Bipratikuri PHC	Kurunnahar SC, Bunia SC, Panchpara SC; Indus SC, Nowapara SC and Tantinapara SC

Name of district with name of district hospital/ MCH	Name of Block	Name of CHC	Name of PHC	Name of SCs
Uttar Dinajpur *(Raiganj District Hospital)*	Raiganj	Raiganj BPHC	Bindole PHC, Durgapur PHC	Bisahar SC, Bindole SC, Balaigaon SC, Durgapur SC, Poaltore SC and Kasba SC
	Itahar	Itahar RH	Churamon PHC, Surun PHC	Gopalpur SC, Kapasia SC, Churamon SC, Surun SC, Indran SC and Kotar SC

Appendix 2.1.2

(Refer paragraph 2.1.7.9 (iii), page 16)

Idle equipments in Raiganj District Hospital valued ₹ 17.84 lakh

Sl. No.	Name of Machine	Date of Receipt	Qty.	Book value (₹)	Lying idle since (year)
1	Analytical Balance	09.09.1999	1	64526	1999
2	Binocular Microscope	07.11.2000	1	21000	2000
3	Dry Heat Sterilizer	15.09.2001	1	42000	2001
4	ER Resuscitation Kit	29.03.2000	1	13000	2000
5	Incubator (Path)	18.02.2001	2	26500	2001
6	Labour Table	22.03.2001	3	27000	2001
7	Sigmoidoscope	06.11.2003	1	376943	2003
8	Slit Lamp	15.05.2000	1	75000	2000
9	Ventilator	08.01.2000	4	166560	2000
10	X-Ray Machine 100 MA	27.07.2002	2	476000	2002
11	Cardiac Monitor	07.09.1999	1	12576	1999
12	Tissue processor	13.03.2000	1	225000	2000
13	Distilled water steel	2003	3	39000	2003
14	Microtome	2003	2	70000	2003
15	Diathermy	08.11.2004	3	24000	2004
16	Centrifuge Machine	01.01.2008	2	50000	2008
17	Audiometer	06.05.2000	1	75000	2000
TOTAL				**1784105**	

Source: Information collected from the hospital

Appendix 2.1.3

(Refer paragraph 2.1.7.10, page 16)

Major drugs which were not in stock during the visit of Audit

CHCs: Halothane BP, Bupivacaine Inj IP, Frusemide Injection IP, Methylergometrine Inj IP, Hydrocortisone Acetate Inj IP, Neostigmine Injection, Ergometrine Tablets IP, Magnesium Sulphate Injection IP Dextrose, etc. Injection IP (I.V. Solution), Sterile water for Injections IP, Hypodermic Syringe for single use-10 ml BP/ BIS, Compound Sodium Lactate Injection IP.

Availability of Drug kit for Sick Newborn and child care as per IPHS guidelines ranged between 28% -88% *per cent*. Drugs such as Diazepam Inj IP, Inj Cloxacillin, Ringer Lactate, Phenytoin, Inj Gentamycin, Inj Lasix, Inj Quinine, Inj Calcium Gluconate, Ciprofloxacin, Inj Dopamine.

Availability of other Essential Drugs as per IPHS guidelines ranged between 56%-86% *per cent*. Drugs such as Lignocaine Hydrochloride, Paracetamol Injection, Paracetamol Syrup, Promethazine HCL, Phenytoin Sodium, Clotrimazole, Gentain Violet, Dicyclomine Hydrochloride, Fluoxetine, Bisacodyl, Tab Captopril, Inj Potassium Chloride, Inj Buscopan, Inj Manitol, Inj Anti Rabies Vaccine, Inj Anti Snake Venom (Polyvalent), etc.

Availability of other Emergency Obstetric Care Drugs kit (essential) against the state list ranged between 26%-78% *per cent*. Drugs such as Cerviprimgel, Inj Betamethasone, Inj Ampicilin + Di-cloxacin, Cefexime, Ventouse with Sialastic Cups, Inj Sensorcain Heavy, Inj Mefentin, Inj Scoline, etc.

PHCs: Dizepam, Ampicillin, Cephalexin, Gentamycin, Amoxycillin, Methyldopa, Silver Nitret, Nystatin, Dextram, Glycerin, Ethyl Alcohol, etc. Besides that essential obstetric care drugs as per IPHS guidelines e.g. Pentazocine Inj IP, Promethazine Inj IP, Phenytocin Inj BP, Cephalexin Capsules IP, Lindane Lotion USP, Dextran 40 Inj IP were not available during the visit by Audit.

SCs: Iron & Folic Acid Tablets (IFA)- small (as per the standard provided), GV Crystals (Methyl rosanilinium Chloride BP), Zink Sulphate Disposable Tablets, USP, etc.