CHAPTER II

PERFORMANCE AUDIT

This chapter contains performance audits on National Rural Health Mission (2.1), Development of Sports in Maharashtra (2.2), Working of District Rural Development Agencies (DRDAs) in Maharashtra (2.3), Minor Irrigation (Local Sector) Projects (2.4) and Computerisation in Police Department (2.5).

Public Health Department

2.1 National Rural Health Mission

Highlights

Government of India launched National Rural Health Mission(NRHM) in April 2005 throughout the country for providing reliable, affordable and accessible health care facilities in rural areas. With the rest of the country the programme was also started in Maharashtra since then. A comprehensive study by Audit revealed some important findings as indicated below:

Programme Implementation Plans for 2006-07 and 2007-08 were prepared without considering the needs of the districts, blocks and villages. Identification of the health care needs were inadequate as the facility survey was not conducted in 50 *per cent* Community Health Centres (CHCs), 75 *per cent* Primary Health Centres (PHCs) and 94 *per cent* Sub Centres. Also, household survey did not cover 19,911 villages.

(Paragraphs 2.1.6.1, 2.1.6.2 and 2.1.6.3)

Rugna Kalyan Samitis did not carry out some of the main responsibilities such as review of services at hospital and outreach works *etc*.

(Paragraph 2.1.7.1)

Underutilisation of funds (28 *per cent* to 73 *per cent*) adversely affected the scheme implementation. State Government did not contribute its share of Rs 115.90 crore for the year 2007-08, as required under NRHM.

(Paragraph 2.1.8.1)

Financial irregularities like improper maintenance of cash book, huge cash payment instead of cheque payment, delays in transfer of funds and irregular expenditure *etc*. were noticed. Delay in establishment of Financial Management Group in the State affected the accounting and control over expenditure.

(Paragraphs 2.1.8.2, 2.1.8.3 and 2.1.8.4)

Against the additional requirement of 2,627 Sub Centres, 394 PHCs and 95 CHCs to be set up during the Mission period, construction of only 161 Sub-Centres was completed and no new PHCs and CHCs were set up during 2005-09.

(Paragraph 2.1.9.1)

While there was overall shortfall in upgradation of health centres as per Indian Public Health Standards (IPHS), no focus was given to the first level health centres *i.e.* PHCs and SCs. Inadequate diagnostic services and other facilities like blood storage, operation theatre and X-ray clinics in CHCs were also noticed.

(Paragraphs 2.1.9.4 and 2.1.9.7)

There was shortages of Specialist Medical Officers (68 *per cent),* Medical Superintendents (69 *per cent*) and staff nurse (74 *per cent*) affecting the delivery of health care services. Selection of Accredited Social Health Activists was inadequate; shortfall was 36,000 as of March 2009.

(Paragraphs 2.1.9.8 and 2.1.9.9)

Mobile Medical Units were not operationalised despite receipt of funds from GoI in the year 2007-08, thus depriving the people of the intended medical facilities at their door step.

(Paragraph 2.1.9.10)

There was heavy shortfall in training of medical and paramedical staff which resulted in their inability to render quality health care services.

(Paragraph 2.1.9.11)

Declining trend of registration of pregnant women during twelve weeks of pregnancy, Iron Folic Acid Administration (IFA) and Tetanus toxoid dosages was noticed. The proportion of vasectomy to total sterilization was only four *per cent.* This indicated that male participation in family planning was inadequate.

(Paragraphs 2.1.10.1 and 2.1.10.3)

2.1.1 Introduction

The National Rural Health Mission (NRHM) was launched by the Government of India (GoI) on 12 April 2005 for the period 2005-2012 throughout the country with special focus on 18 States; Maharashtra comes under non-focus States[1]. The mission aimed at providing accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas by converging various stand alone existing National Disease Control Programmes (NDCP) of the Ministry of Health and Family Welfare with the exception of the National AIDS Control and Cancer Control Programmes. The components of the NRHM include bridging gaps in healthcare facilities, facilitating decentralized planning in health sector and advocating

[1] As Maharashtra State has a good network of CHCs, PHCs and Sub-Centres to provide health care facilities to the rural population and its IMR, MMR and TFR are better as compared to National averages, MoFW has categorised it as non-focus State

convergence with related social sector Departments like Women and Child Development, Panchayati Raj *etc*.

The objectives of the Mission are as under:

- Rural people's access to integrated comprehensive primary health care;
- Universal access to public services for food and nutrition, sanitation, hygiene and public health care services with emphasis on universal immunisation;
- Reduction in infant and maternal mortality rate;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Population stabilization and control on gender and demographic imbalances; and
- Revitalising local health traditions and mainstream AYUSH.

In Maharashtra, the Mission was operationalised in October 2005 and the State Health Society (SHS) was formed in November 2005.

2.1.2 Organisational set up

At the State level, the NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister for policy design in health sector, review of progress in implementation of NRHM and inter-sectoral co-ordination. The Chief Secretary as the head of its Governing Body exercises power to approve the State Annual Action Plan for the NRHM, reviews the implementation of the Annual Action Plan and the status of follow up action on decisions of the SHM *etc*. SHS is constituted for overall implementation, approval of proposals from districts and other implementing agencies, execution of the approved State Action Plan including release of funds for programmes at State level. The Principal Secretary, Public Health Department is the Chairperson and the Mission Director (MD) is the Member Secretary of the Executive Body of the SHS and both are responsible for State health planning, implementation and control as per the guidelines of the GoI, obtaining approval to annual action plan from GoI, providing guidance for preparation of District Health Action Plan, inter-department co-ordination to develop a system of release of funds to districts and lower level authorities. District Collector, the Chairperson of the Governing Body of District Health Society (DHS) and Chief Executive Officer (CEO) of Zilla Parishad (ZP), the Chairperson of the Executive Committee of DHS are responsible for planning, monitoring, evaluation, accounting, database management and release of funds to health Centres at sub-district level, Panchayat bodies.

The implementation of various disease control programmes was being supervised by the respective heads of the Disease Control Programmes. Various components/ activities of NRHM are being implemented through 33 DHSs, 23 District Hospitals, 464 Community Health Centres (CHCs), 1,816

Primary Health Centres (PHCs) each headed by Medical Officer-in-charge and 10,576 Sub-Centres (SCs) headed by ANM.

2.1.3 Audit objectives

The objectives of the performance audit were to assess:

- how far the planning and monitoring mechanism for implementation of the Mission led to delivery of effective and reliable healthcare services to rural population;
- the level of community participation in planning, implementation and monitoring of the Mission;
- the adequacy of public spending on State health sector and efficiency in assessment, release and utilisation of NRHM funds;
- whether the Mission has built adequate capacity and strengthened its healthcare infrastructure and human resources as planned; and
- whether the performance indicators and targets fixed in the key areas *viz*. reproductive and child healthcare, immunisation and disease control programmes were achieved.

2.1.4 Audit criteria

The audit criteria adopted were:

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

2.1.5 Scope and methodology of audit

The performance audit was conducted (February-May 2009) covering the period from 2005-06 to 2008-09 by test-check of records in the Mission Directorate, eight[2] DHSs along with 24 CHCs, 48 PHCs and 96 SCs (**Appendix 2.1**). Districts were selected by adopting Probability Proportional to Size with Replacement method and CHCs, PHCs and Sub Centres were selected using Simple Random Selection without Replacement method. An entry conference with the Secretary, Public Health Department was held on 16 June 2008 wherein the audit objectives and criteria were discussed. Government replies on the audit observations have been suitably incorporated in the review.

[2] Ahmednagar, Gondia, Nagpur, Nashik, Osmanabad, Pune, Thane and Yavatmal

Audit findings

2.1.6 Planning

The NRHM strives for decentralised planning and implementation arrangements to ensure that need based and community owned District Health Action Plans (DHAPs) become the basis for interventions in the health sector. The DHSs are, thus, required to prepare Perspective Plans for the entire Mission period (2005-12). Household survey and facility survey at the levels of village, block and district were to be conducted for comprehensive understanding of the needs and to decide the quantum of intervention needed.

2.1.6.1 Submission of State PIP and District Health Action plans

State PIPs were prepared without considering the needs of the districts, blocks and villages. Submission of State PIPs was delayed upto 137 days

As per the NRHM framework, the Programme Implementation Plan (PIP) for the State was to be prepared annually by the State Health Society (SHS) by aggregating the annual DHAP of each district. The PIP was to be submitted to GoI by 15th March of the previous finanacial year. It was, however, seen that no State PIP was prepared in 2005-06 and there were delays in final submission of the PIPs during 2006-09, as detailed in **Table 1**.

Table 1: Submission of State PIP and DHAPs

Year	Scheduled date of submission of final PIP by the State Government	Actual date of submission	Delay (in days)
2006-07	15 March 2006	July 2006	137
2007-08	15 March 2007	15 July 2007	120
2008-09	15 March 2008	25 March 2008	10

Delay in submission of final PIPs by the SHS resulted in delay in approval by GoI, consequent delay in release of funds and ultimately delay in implementation of the Mission.

It was noticed that State PIPs for the years 2006-07 and 2007-08 were prepared without considering the needs of the districts, blocks and villages. While no DHAPs were prepared during 2006-07, the DHAPs for 2007-08 were prepared without considering the needs of the blocks and the villages. However, Annual Plans were prepared at all levels for the year 2008-09. In the absence of block and village plans, the aim of decentralised planning under the NRHM remained unfulfilled.

Government stated (September 2009) that PIP for the year 2005-06 was submitted to GoI on 16 March 2005. It was not expected to consider District PIPs in 2006-07 and for preparation of State PIP for 2007-08, District perspective plan was considered.

The reply was not acceptable as the State PIP for 2005-06 was stated to be submitted on 16 March 2005 *i.e.* before implementation of NRHM and preparation of State PIPs without considering district, block and village level plans was not intended.

As per the NRHM framework, the Village Health and Sanitation Committee (VHSC) would be formed in each village within the overall framework of the

Gram Sabha by 2008. The VHSC would be responsible for village level health planning and monitoring. As of March 2009, VHSCs were formed in 39,392 villages (96 *per cent*) out of 40,910. In the test-checked districts, VHSCs were formed in 11,947 (98 *per cent*) villages out of 12,207.

2.1.6.2 Household survey

The objectives of assessing the health care needs were not fully achieved due to shortfall in household survey

The household survey, to be carried out in each and every district of the State (50 *per cent* by December 2007 and 100 *per cent* by December 2008), was aimed at understanding the health care needs of the rural population, resource mapping and also assessing as to how other determinants influenced health of households such as drinking water, sanitary latrine, employment and access to other requirements.

As per the information furnished (March 2009) by the State Government, household survey was conducted during 2006-07 in 23,965 villages of 20 districts, leaving 19,911 villages (45 *per cent*) in 13 districts[3] without any survey. Out of eight test-checked districts, household survey was not conducted in Nashik and Ahmednagar Districts. The survey data was not got verified by PRI members. Further, database of household survey was not prepared at SHS and DHS levels.

Government stated (September 2009) that household survey was completed in 2008.

However, Audit noticed in test-checked districts[4]and in selected sub centres that there was no consolidation of household survey data. The Member Secretaries of DHSs had also stated (May 2008) that no household database was prepared.

Further, no health action plans at village level were prepared for the year 2007-08. Thus, due to shortfall in conducting household survey and non-preparation of database, the objective of assessing the health care needs of the rural population were not fully achieved.

2.1.6.3 Facility survey

Deficiencies in facilities in all the health care institutions could not be identified due to inadequate facility survey

In order to set up benchmark for quality of service and identify the input needs, facility[5] survey was to be conducted cent *per cent* by December 2008 in each facility in CHCs, PHCs and SCs. These surveys were to provide critical information in terms of infrastructure and human resource gaps which are needed to be addressed through planning process.

The Department conducted facility survey of 105 CHCs through NGOs and the remaining were surveyed departmentally. It was noticed that the facility survey was not conducted in 234 CHCs (50 *per cent*), 1,366 PHCs (75 *per cent*) and 9,926 Sub Centres (94 *per cent*)[6] as of March 2009.

[3] Akola, Ahmednagar, Bhandara, Buldhana, Hingoli, Jalna, Jalgaon, Latur, Nanded, Nashik, Parbhani, Pune and Washim

[4] Except Nashik District

[5] Specialist services, manpower, investigating facilities, equipment, other infrastructure *etc.*

[6] Total number of CHCs 464, PHCs 1,816 and Sub Centres 10,576

In the test-checked CHCs, PHCs and SCs the shortfalls were 63 *per cent*, 69 *per cent* and 94 *per cent* respectively (details in **Appendix 2.2**).

Government stated (September 2009) that facility survey would be completed by November 2009. However, the fact remains that Government could not adhere to the stipulated time line.

Due to inadequate facility survey, deficiencies in facilities in all the health care institutions were not identified. Further, in Sub Centres of the villages where the access to health care is minimal and therefore needing greater attention, there was only 6.15 *per cent* survey of the infrastructure need. In the absence of this basic data, planning could not be realistic.

2.1.6.4 Public report on health

The NRHM is committed to publishing Public Reports on Health at the State and the District levels to report to the community at large, on the progress made in Mission activities. However, it was seen that reports on Public Health were not prepared by the State (May 2009) as also in test-checked Districts. As a result, the community was not aware of the health care facilities available.

Government stated (September 2009) that reports would be published by March 2010.

2.1.7 Community participation

2.1.7.1 Rugna Kalyan Samiti (RKS) for hospital management

As per guidelines under NRHM, the Rugna Kalyan Samiti[7] (RKS) is to be constituted and registered under Societies Registration Act, 1860 for healthcare centres at PHC, CHC and DH levels under the Panchayat Raj framework for management of the hospital to review the performance of the Outpatient Department (OPD) and In-Patient Department (IPD) services and facilities at hospital and outreach work. The RKS is to redress the complaints of the beneficiaries and ensure access to quality health care service. Each RKS has one Governing Body for policy decisions and monitoring and one Executive Committee for the execution of the decisions.

The purpose of formation of RKS remained unfulfilled as RKS did not carry out their responsibilities

Out of total 2,290 RKSs (23 at District Hospitals, 451 at CHCs and 1,816 at PHCs) to be formed in the State, 2,248 RKS (98 *per cent*) were formed up to 2008-09. In eight test-checked districts, out of total 618 RKS to be formed, 615 RKS (99 *per cent*) were formed up to 2008-09. In 79 RKS test-checked out of 615, it was noticed that though GBs and ECs were formed they did not carry out the main responsibilities such as review of services at hospital and outreach works *etc.* except sanctioning expenditure. Thus, the purpose of formation of RKS remained largely unfulfilled.

Government while accepting the facts stated (September 2009) that measures had been taken for capacity building of RKS.

[7] The members of the RKS are PRI representatives, local representatives to the State Legislature, officials from Health Department, leading members of the community and In-charge of local CHC and PHC

2.1.7.2 Funding of RKS

User charges were not collected by RKS and they were entirely financed by GoI grants

As per the NRHM guidelines, funds are to be released by SHS to RKS in a timely manner to carry out their functions. From 2007-08 onwards the funds released to the corpus fund at different rates at DH, CHC and PHC levels of the RKS was proposed to be shared by State (20 *per cent*), internal resources of RKS i.e. user charges and donations (20 *per cent*) and GoI (60 *per cent*). Further, State Health Society (December 2007) empowered the RKS to levy, collect and deposit user charges in RKS bank account with effect from January 2008. It was, however, seen that in the test-checked units, no such user charges were collected by RKS and they were entirely financed by GoI grants. This would affect the viability of the long term goal of community ownership of the health centres through the RKS.

Government while accepting the facts stated (September 2009) that efforts were being made to deposit user charges in RKS accounts.

2.1.7.3 Inadmissible expenditure out of RKS funds

Expenditure of Rs 18.31 lakh was incurred on inadmissible items

In 28 out of the 79 RKSs test-checked, it was noticed that out of total grant of Rs 29 lakh released, an expenditure of Rs 18.31 lakh (**Appendix 2.3**) was incurred from RKS funds towards purchase of computers for office use, chairs, and payment of wages *etc* which were not admissible under NRHM.

Government stated (September 2009) that as CHCs and district hospitals were to be prepared for ISO certification, expenditure was made as per GoI guidelines. Reply was not acceptable as the expenditure incurred by the RKSs in the PHCs during 2007-08 was inadmissible.

2.1.8 Financial management

2.1.8.1 Receipts and utilisation of funds for Mission activities

Unspent balance of Rs 265.81 crore and Rs 166.20 crore were lying with SHSs and DHSs respectively at the end of 2008-09

The GoI provided 100 *per cent* grant-in-aid to the State Government for the years 2005-06 and 2006-07 (ending Tenth Five-year Plan period). From 2007-08 onwards, as per the terms of MOU executed in January 2006 with GoI, the State Government was to contribute 15 *per cent* of the share for NRHM. According to SHS, the total receipts and expenditure and closing balances during 2005-09 were as shown in **Table 2**.

Table 2: **Receipt and utilisation of funds** **(Rs in crore)**

Year	Allocation	Opening balance	Grant received from GoI	Other Receipts/ Interest *etc*.	Total receipts	Total expenditure	Unspent balance	Percentage of unspent balance to total receipts
2005-06	234.44	9.57	121.82	0.59	131.98	51.87	80.11	60.70
2006-07	358.12	80.11	314.71	0.68	395.51	106.30	289.21	73.12
2007-08	446.89	289.21	439.55	0.73	729.49	300.19	429.30	58.85
2008-09[8]	455.74	429.30	386.22	121.61*	937.13	671.32	265.81	28.37
Total	**1495.19**		**1262.31**	**123.61**	**1395.49**[9]	**1129.68**	**265.81**	

* including State's share of Rs 120.90 crore.

[8] Figures for the year 2008-09 are unaudited/ provisional, hence, differ from the GoI figures

[9] Rs 9.57 crore + Rs 1262.31 crore + Rs 123.61 crore=Rs 1395.49 crore

From the above it would be seen that during 2005-09 there was heavy unspent balance of Rs 265.81 crore at SHS level.

Apart from this, GoI grants[10] were also routed through State budget for Direction and Administration, Rural Family Welfare Services, Urban Family Welfare Services, Grants to State Training Institutes and health posts. The State Government received Rs 538.34 crore against allocation of Rs 776.62 crore and incurred a total expenditure of Rs 795.91 crore during the period 2005-09. State Government met the excess expenditure of Rs 257.57 crore on these components out of its own resources. Excess expenditure occurred mainly during 2006-07 (Rs 210.22 crore) when no GoI grant was received for these components.

The component wise details of receipt of funds and utilisation under NRHM are given in the **Appendix 2.4**.

It was reported by SHS that the grant amounting to Rs 166.20 crore was lying unspent at DHS level at the end of 2008-09 in respect of major components of NRHM *i.e.*, RCH-II, Immunisations and NRHM additionalities. Underutilisation of funds at State level and District level adversely affected implementation of NRHM.

State did not contribute 15 *per cent* share during 2007-08

Further, it was also noticed that State Government did not contribute State share of Rs 115.90 crore in the year 2007-08. In the year 2008-09, State Government had contributed Rs 120.90 crore against the due share of Rs 105 crore.

Government stated (September 2009) that Rs 120.90 crore contributed during 2008-09 includes Rs 15.90 crore for 2007-08.

As per MOU signed in January 2006, the State Government was to increase the spending on State Health Sector by 10 *per cent* every year. It was noticed that the increase in expenditure under State Health Sector was 8.46 *per cent* and 6.15 *per cent* during 2005-06 and 2006-07, while it was 15.75 *per cent* and 19.53 *per cent* during 2007-08 and 2008-09 respectively.

2.1.8.2 Delay in transfer of funds

There were significant delays in transfer of funds from SHS to DHS and from DHS to subordinate centres

For effective implementation of any programme, the funds should be transferred to the implementing agency without delay. However, it was seen that there was delay ranging between 17 and 290 days in transferring funds from SHS to DHS and between 48 and 235 days by DHS to CHC, PHC and sub-centres as detailed in **Appendix 2.5**. SHS stated that the delay was due to time required for ascertaining the balances available with the districts.

[10]

(Rs in crore)

Year	Allocation	Grant received	Expenditure
2005-06	151.61	113.70	144.23
2006-07	154.83	nil	210.22
2007-08	224.25	224.47	190.89
2008-09	245.93	200.17	250.57
Total	**776.62**	**538.34**	**795.91**

While accepting the facts, Government stated (September 2009) that fund could not be released to districts as sufficient unspent balances were available with them.

2.1.8.3 Accounting procedure

FMG at State level was established late

As per guidelines issued by GoI, Financial Management Groups (FMG) was to be established in the Programme Management Support Units (PMSUs) at State and Districts level which is responsible for centralised processing of fund release, accounting of expenditure reported by subordinate units, monitoring of UCs and audit arrangement. However, it was seen that FMG at State level was established late in August 2008. The SHS stated that the FMG would start functioning in June 2009. Belated establishment of FMG adversely affected the accounting and control over the expenditure. As a result, the SHS could not furnish the final figures of total funds received during the year and the closing balances as of March 2009 for the State.

2.1.8.4 Maintenance of cash books

Separate cash books were not maintained for NRHM

The Mission Director (MD) NRHM and Additional Director (AD), Health and Family Welfare Society (HFWS) were required to maintain two separate cash books for NRHM additionalities and RCH-II. However, they maintained a single tally account jointly for both the offices at Pune. Cash book was maintained only with effect from 1 April 2008 but no authentication by competent authority was done.

Government stated (September 2009) that only one cash book was maintained as only one bank account was operated and same has been authenticated.

The reply was not acceptable as two separate cashbooks were required to be maintained and authentication was not shown to Audit.

Heavy cash balances were maintained; payments were made in cash instead of cheques

GoM, in Finance Department, stipulated (January 1980) that payment to parties/payees in excess of Rs 1,000 should be made through cheques. It was, however, noticed that in DH, Thane, heavy cash in hand ranging between Rs 3.95 lakh and Rs 23.34 lakh was maintained for making cash payments instead of issue of cheques during the period February 2007 to December 2007. The CS, DH, Thane stated that in future, payments would be made by cheque.

While accepting the facts, Government stated (September 2009) that system of cash payment was discontinued from January 2008.

2.1.8.5 Irregular expenditure

DHS, Nashik incurred expenditure on inadmissible items

Scrutiny of records of DHS Nashik revealed that expenditure of Rs 3.82 lakh was incurred on account of insurance of Janani Suraksha Yojana (JSY) beneficiaries which was not provided in NRHM. Besides, an expenditure of Rs 5.41 lakh was incurred on purchase of inverters supplied to Taluka Medical Offices (TMO) for office use.

While accepting the facts, Government stated (September 2009) that four *per cent* grant under JSY was admissible as contingent expenditure, which was

utilised for insurance. The expenditure was incurred for strenthening of TMOs. The reply was not acceptable as there was no provision of insurance under JSY and strenthening of offices under NRHM.

2.1.9 Capacity building

2.1.9.1 Creation of new infrastructure

The NRHM framework targets provision of one Sub-Centre for 5,000 population (3,000 in tribal areas), one Primary Health Centre for 30,000 population (20,000 in tribal/desert areas) and one Community Health Centre for 1,00,000 population (80,000 in tribal/desert areas). As per the perspective plan of the State approved in December 2006, there was additional requirement of 2,627 Sub-Centres, 394 PHCs and 95 CHCs to be set up during the Mission period of seven years (2005-12). The status of setting up of infrastructure at the end of fourth year *i.e.* 2008-09 compared to the requirements is as detailed in **Table 3**.

Table 3: Creation of infrastructure

Health care centres	Number in existence as of April 2005	Number required to be created during 2005-12 as per Perspective Plan	Number required to be created upto 2008-09 as per Perspective Plan	Number created during 2005-09	Shortfall in creation of new infrastruc-ture	Percen-tage of short-fall
Sub Centres	10535	2627	1970	161	1809	92
Primary Health Centres	1818	394	138	0	138	100
Community Health Centres (RH)	386	95	34	0	34	100

No new PHC and CHC was set up during 2005-09

From the above table it could be seen that no new PHC and CHC was set up up to 2008-09. Therefore, development of health infrastructure was much below the requirement of the rural community.

Delivery of health care services was affected due to delay in construction of health units

Scrutiny also revealed that during 2008-09, SHS released Rs 96.72 crore to 33 DHSs for construction of CHCs, PHCs and SCs. Out of 33 DHSs, six[11] had not utilised Rs 6.02 crore due to non-availability of land, change of site, non-availability of engineer *etc*. This affected delivery of health care services to the beneficiaries. It was stated (May 2009) that health services are made available by temporarily arranging the services of Zilla Parishad premises, Gram Panchayat premises, Anganwadi or school premises.

Non-setting up of the required number of infrastructure as per the population norms resulted in short achievement of the primary objective of improving accessibility to health facilities in rural areas.

Government while accepting the facts stated (September 2009) that there was a restriction of civil works upto 25 *per cent* of PIP size. Further, District Scheule of Rates increased by 2.5 times. The reply was not acceptable as the

[11] Bhandara, Dhule, Gondia, Nagpur, Solapur and Yavatmal

expenditure incurred on new construction was even less than 25 *per cent* and increase in cost was due to delay in construction.

2.1.9.2 Slow execution of new construction works

Diversion of funds resulted in slow pace in creation of new infrastructure

In the eight test-checked districts, grant of Rs 18 crore for new construction and Rs 70 lakh for maintenance and repairs (MR) works was received from the SHS during 2005-08. However, total expenditure of Rs 3.44 crore was incurred on MR works as against the allocation of Rs 70 lakh by diverting the funds for new construction. There was no new construction work. Thus, there was an unspent balance of Rs 15.26 crore at the end of March 2008. It was replied that expenditure on maintenance and repairs was incurred as per directives of Mission Director, NRHM, Mumbai.

During 2008-09, grant of Rs 19.07 crore for new construction and Rs 2.67 crore for MR works were received, out of which total expenditure of Rs 11.19 crore was incurred due to delay in transfer of funds and delay in establishment (August 2007) of Infrastructure Development Wing (IDW) leaving an unspent balance of Rs 10.55 crore at the end of March 2009.

This resulted in slow pace in creation of new infrastructure required under population norms and thereby depriving required medical facility to the needy people.

Government while accepting the facts stated (September 2009) that repair works of existing institutions were undertaken for optimum use of these institutions instead of creating new infrastructure.

2.1.9.3 Strengthening of nursing schools

In three test-checked districts, grants amounting to Rs 1.15 crore were released during 2007-08 by SHS for strengthening nursing schools. As against this, a meagre expenditure of Rs 6.64 lakh was incurred during 2007-08 and 2008-09, leaving a total unspent balance of Rs 1.08 crore as shown in **Table 4**.

Table 4: Strengthening of nursing schools (Rs in lakh)

District	Grant received in 2007-08	Expenditure incurred during		Unspent balance	Remarks
		2007-08	2008-09		
Gondia	45.00	--	--	45.00	No expenditure was incurred
Pune	22.50	--	2.00	20.50	Amount paid to PWD for construction of nursing school
Yavatmal	47.50	2.95	1.69	42.86	Payment made towards stipend to nurses in 2008-09
Total	**115.00**	**2.95**	**3.69**	**108.36**	

Blocking of funds due to release of grants without ascertaining requirement

Similarly, it was seen that the total grants of Rs 1.99 crore were released during 2007-08 for strengthening of infrastructure[12] of one nursing school each in Nashik, Osmanabad, Ahmednagar, Nagpur and Thane Districts

[12] Repair, renovation, extension of existing building, hiring of building for school and hostel, hiring of vehicle, workshop, training, stipend of students, payment to staff, *etc.*

without ascertaining the actual requirement, resulting in blocking of huge funds of Rs 81.81 lakh with the DHSs as detailed in **Table 5**.

Table 5 : Underutilisation of funds for nursing schools (Rs in lakh)

District	Grants received	Expenditure incurred		Unspent balance
		2007-08	2008-09	
Nashik	25.00	14.75	N.A.	10.25
Osmanabad	47.50	16.79	16.94	13.77
Ahmednagar	47.50	--	19.56	27.94
Nagpur	31.37	--	14.47	16.90
Thane	47.50	13.28	21.27	12.95
Total	**198.87**	**44.82**	**72.24**	**81.81**

The DHS stated that there was no much scope for improvement in the nursing school. Audit observed that there was significant shortage of nurses (864) as discussed in paragraph 2.1.9.8.

While accepting the facts, Government stated (September 2009) that due to acute shortage of nurses, grants were released to districts for new construction and strengthening of infrastructure. However, fact remains that grants were released without ascertaining the actual requirement.

2.1.9.4 Upgradation of health centres as per Indian Public Health Standards (IPHS)

Achievement in upgradation of Health Centres was low even after spending Rs 95.52 crore

The Mission has set the target of providing guaranteed services at the level of District Hospitals (DHs), CHCs, PHCs and Sub Centres by the year 2010. In this connection the Ministry has brought in the concept of Indian Public Health Standard (IPHS) for each level of health centre for ensuring availability of standard facility. Under NRHM, Health Centres (HCs) were to be upgraded to IPHS.

Scrutiny of the records of SHS revealed that low targets were fixed in respect of PHCs and Sub-centres till 2008-09. However, there was shortfall in achievements even after spending Rs 95.52 crore as in **Table 6**.

Table 6: Up gradation of health centres (Rs in crore)

Name of the HC	Number of the existing HCs	Up gradation of HCs		Grants released up to 2008-09	Expenditure reported	Upgraded to IPHS
		Targets to be fixed up to 31 March 2009	Selected for IPHS to 2008-09			
District Hospitals	23	10	23	23.00	95.52	23
CHCs (SDH/RH/ WH/CH)	464	209	230	68.85		98
PHCs	1816	817	450	22.50		104
Sub Centres	10576	4741	650	6.50		33
Total	**12879**	**5777**	**1353**	**120.85**	**95.52**	**258**

It would be seen from the above table that achievement for CHCs was less than half of the targets, while upgradation of PHCs and sub-centres was only

23 *per cent* and five *per cent* respectively. This indicated that people in the rural areas were deprived of adequate health facilities.

Although, 258 health centres were shown to have been upgraded to IPHS in the report submitted to GoI, the SHS had stated to an audit query that no hospital could be declared as IPHS because there was a huge shortage of specialists in many of the hospitals/ centres.

Upgradation of the PHCs and SCs was meagre compared to the improvement made in DHs and CHCs. Thus, no focus was given to the first level health centres.

While accepting the facts, Government stated (September 2009) that due to acute shortage of nurses and doctors, realistic targets were fixed.

2.1.9.5 Diversion of IPHS grant

IPHS grants were diverted for purchase of medicines

Scrutiny revealed that Civil Surgeon, General Hospital Nashik (CS) received Rs 60 lakh for the upgradation of three Sub District Hospitals at Kalwan, Niphad and Chandwad to IPH standards. Of this, the CS utilised Rs 21.92 lakh on purchase of medicines, which should have been spent from regular State budget. The CS stated (September 2008) that the diversion was made with the approval of the Executive Committee of the DHS Nashik.

No specific reply was furnished by Government.

2.1.9.6 Inadequate physical infrastructure at health centres

Many basic facilities did not exist in the health centres

Scrutiny revealed that basic facilities like operation theatre, air conditioner, generator, labour room, telephone *etc*. were not available in many health centres test-checked, as detailed in **Appendix 2.6.** Out of total 24 CHCs, 48 PHCs and 96 SCs test-checked, three CHCs, six PHCs and 29 SCs had not been established in their own building. In 32 sub centres, Auxiliary Nursing Midwives (ANMs) had no residential facility.

These indicate that people in the rural areas were deprived of adequate health facilities.

Government while accepting the facts stated (September 2009) that there was a restriction of civil works upto 25 *per cent* of PIP size. Hence, few buildings could be provided under NRHM funds.

2.1.9.7 Lack of facilities at health centre

Operation theatre (OT)

According to IPHS norms, fourteen major equipments are necessary to make an OT fully operational. Out of 24 test-checked CHCs, in four CHCs there were no OTs, while in three CHCs, OTs were either not working or defunct due to non-availability of manpower, generator and AC machine. In the remaining 17 CHCs though they were functional, the OTs did not have supportive equipment as detailed in **Appendix 2.7**.

Diagnostic services

The Mission provides for essential laboratory services at the PHCs and CHCs. At the PHC the services should include laboratory services for routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of RTI/STD, sputum testing for tuberculosis, blood smear examination for malaria parasites, rapid tests for pregnancy/malaria and RPR tests for syphilis/YAWS. Test-check revealed that out of 48 PHCs, 20 had no facilities for laboratory services.

Out of 48 PHCs, 22 PHCs did not have laboratory technician

At the CHCs, besides the aforesaid laboratory services, microscopy facilities for tuberculosis, diagnostic facilities for complicated cases of malaria, dengue and Japanese encephalitis, diagnostic facilities for leprosy *etc*. were to be provided. While the position was better in CHCs as out of 24 test-checked CHCs, 18 had all the diagnostic services and three had partial facilities. In 22 PHCs there was no laboratory technician. In the absence of minimum diagnostic services in the PHCs, the rural public was deprived of these facilities.

Radiological/X-ray services

The Mission provides for X-ray services at CHCs. Out of 24 test-checked CHCs, X-ray facilities were available at 19 CHCs. Of these 19 CHCs, radiographer was available only in five CHCs. In the absence of technician, X-ray facilities could not be used at the CHCs.

Blood storage facilities

The NRHM provides for blood storage facilities at each CHC. Test check, however revealed that out of 24 CHCs, blood storage facilities were available only in five CHCs. Due to non-installation of blood storage unit in 19 CHCs, the needy rural patients were deprived of easy access to blood.

Emergency services

As per NRHM norms, the Primary Health Centres providing 24 hours emergency services should have three staff nurses. In none of the test-checked PHCs full strength of staff nurses were available. Out of 48 PHCs providing emergency services, 13 PHCs had two nurses, 15 PHCs had only one nurse and 20 PHCs had no nurse.

In the absence of prescribed diagnostic, radiological, blood storage facilities *etc* in CHCs and PHCs, delivery of reliable health care services at an affordable cost remained largely unfulfilled in the rural area.

While accepting the facts, Government stated (September 2009) that slow pace was due to inadequate funds and after launch of NRHM, IPHS funds were being utilised to complete the upgradation. Reply was not tenable as the achievement in upgradation of the health centres was also low.

2.1.9.8 Manpower management

There were huge shortages of medical and paramedical staff

The NRHM aimed at providing adequate medical and other related manpower at different health centres. The contractual staff should be engaged in addition to the sanctioned strength as required under the NRHM and not as a substitution to the sanctioned strength. It was, however, noticed that there were acute shortages of doctors and nurses as discussed below:

The men-in-position against the sanctioned posts of medical and para medical staff (both regular and contractual) as on 31 March 2009 are shown in **Table 7**.

Table 7: Shortfall in manpower

Regular				
Name of the post	**Sanctioned strength**	**Men-in-position**	**Shortfall**	**Percentage of shortfall**
Class I Medical Officers (Specialists)	519	165	354	68
Medical Superintendent for SDH & RH (class I)	438	136	302	69
Class II Medical Officers	7281	6707	574	8
Staff Nurse	6938	6074	864	12
Lady Health Visitor (LHV)	2266	2030	236	10
Auxiliary Nursing Midwife (ANM)	12543	12004	539	4

Contractual					
Categories of paramedical staff	**Total number required by 2012**	**Number required till March 2009**	**Number filled in as of March 2009**	**Shortfall**	**Percentage of shortfall**
Additional ANM per Sub Health Centre	10579	5078	4191	887	17
Three Staff Nurse per PHC	5448	2615	675	1940	74
One LHV per PHC	1816	1816	1152	664	37
Nine Staff Nurse per CHC	3942	1734	Information not furnished		

In 24 sample CHCs, the percentage of shortfall of medical staff *i.e.,* General Surgeon, Physician, and other specialists ranged between 71 and 88. Shortfall was high in case of paramedical staff *i.e.,* Public Health Nurses (PHN) (96 *per cent)*, radiographers (79 *per cent*) and dressers (92 *per cent)*. In case of 48 test-checked PHCs, the percentage of shortfall of staff nurses was 72 and health educators 81 as detailed in the **Appendix 2.8**.

Out of 96 test-checked SCs, two ANMs as required under NRHM were not posted in 66 SCs.

Thus, in view of this widespread shortage of medical and paramedical staff providing quality health care services would be severely affected.

While accepting the facts, Government stated (September 2009) that due to huge gap between demand and availability of doctors and nurses in government sector, there were intra-health centre differences.

2.1.9.9 Engagement of Accredited Social Health Activist (ASHA)

Under the NRHM a trained female community health worker called Accredited Social Health Activist (ASHA) had been provided in each village in the ratio of one per 1,000 population (or less for large isolated habitations) in the State. The ASHA was expected to act as an interface between the community and the public health system.

The position of appointment of ASHAs and their training is shown in **Table 8**.

Table 8: Engagement and training of ASHA

	Number of ASHAs engaged up to 2008-09			Number of ASHAs provided with training				
	Target	Achievement	Shortfall	1st Module	2nd Module	3rd Module	4th Module	5th Module
For Tribal Area	9000	8657	343	8242	7753	6944	1694	Nil
For Non Tribal Area (with effect from September 2008)	51741	16045	35696	No training was imparted though basic training was to be provided within seven days of appointment.				
Total	**60,741**	**24,702**	**36,039**					

It is evident from the above that there was a shortfall in the achievement of selection and training to ASHAs which would affect the programme implementation.

2.1.9.10 Mobile Medical Units

Despite availability of funds, no MMU was set up

With the objective to make health care available at the doorstep of the rural people, GoI sanctioned (August 2007) Rs 15.79 crore for procurement of 35 Mobile Medical Units (MMUs). Although funds were released by the GoI in the year 2007-08, SHS did not purchase any mobile unit as of May 2009 as type design for vehicles for MMU was not finalised. SHS have failed to operationalise MMUs so far, though National Programme Coordination Committee (NPCC) had ordered that the operationalisation of the MMUs should be ensured during the same year *i.e*., 2007-08.

While accepting the facts, Government stated (September 2009) that there was a delay in taking decision for setting up of MMUs. However, the funds were utilised for other approved activities. The reply was not tenable as NPCC while approving the funds for MMUs had categorically instrcted to ensure the operationalisation during 2007-08.

Non-operationalisation of MMUs has deprived the people of the intended medical facilities at their door step.

2.1.9.11 Training to medical and paramedical staff

There was heavy shortfall in training of medical and paramedical staff

Capacity building through regular training and exposure of ANMs, Public Health Nurses (PHNs), Staff Nurses and Medical Officers was to be done according to the needs as well as for upgradation of their skills. This was an important module of NRHM. Analysis of data obtained from SHS, however, revealed that there was a heavy shortfall in achievement of training targets.

During 2007-08 and 2008-09, shortfall varied between 30 and 74 *per cent* in respect of ANM, for Staff Nurse from 57 to 86 *per cent* and for medical officer from 44 to 78 *per cent* as detailed in **Appendix 2.9**. It was stated that the DHOs did not nominate the Medical Officers for training, as many of the PHCs were manned by a single doctor.

While accepting the facts, Government stated (September 2009) that due to lack of training facilities, training could not be completed as per the needs.

2.1.10 Performance indicators

2.1.10.1 Reproductive and child health care (RCH), immunisation and various disease control programme

The NRHM prescribes national targets for reducing infant mortality rate (IMR)[13] maternal mortality rate (MMR)[14], total fertility rate (TFR)[15], reducing morbidity and mortality rate and increasing cure rate of different endemic diseases covered under various national programmes. Targets of MMR, IMR and TFR and achievement there against in the State are as shown in **Table 9**.

Table 9: Performance indicators

Particulars of indicators	Targets to be achieved as per NRHM	Targets fixed by the State	Year wise targets fixed by the State		Achievement at the end of each year
			Year	Target	
IMR	30/1000 live births up to 2012	25/1000 live births by 2010	2005	Not fixed	36
			2006	Not fixed	35
			2007	32	34
			2008	32	34
MMR	100/100000 live births up to 2012	100/100000 live births by 2010	2005	Not fixed	149
			2006	Not fixed	Not compiled
			2007	125	130
			2008	125	Not compiled
TFR	2.1 up to 2012	2.0 by 2010	2005	Not fixed	Not compiled
			2006	Not fixed	2.11
			2007	2.0	Not compiled
			2008	2.0	Not compiled

It would be seen from the above table that while in respect of IMR and TFR, the State position is almost at par with the norm, in MMR it is yet to achieve the target of 100.

Government stated (September 2009) that the target of 100 for MMR would be achieved by 2012 as per NRHM norms.

One of the major aims of the safe motherhood is to register all the pregnant women before they attain 12 weeks of pregnancy and provide them with

[13] IMR is the number of infant deaths (one year of age or younger) per thousand live births

[14] MMR is the number of deaths of women per lakh while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management

[15] TFR is the total number of children, the average women in a population is likely to have, based on current birth rates throughout her life

There was continuous shortfall in registration of pregnancy, administration of IFA tablets and Tetanus Toxoid

services, such as, four antenatal check-ups, 100 or more Iron Folic Acid (IFA) tablets, two doses of Tetanus Toxoid (TT) and advice on the correct diet and vitamin supplements and in case of complications referring them to specialised gynecological care.

The number of pregnant women registered during 12 weeks of pregnancy for check up as against the total pregnancies were in declining trend as detailed in **Table 10**.

Table 10: Registration of pregnant women

Year	No. of total pregnant women registered at health centre	No. of pregnant women registered during 12 weeks of pregnancy	Shortfall	Percentage of shortfall
2005-06	22,35,950	20,61,763	1,74,187	7.79
2006-07	22,29,445	20,07,729	2,21,716	9.94
2007-08	22,26,174	19,52,056	2,74,118	12.31
2008-09 (up to February 2009)	20,28,314	11,58,883	8,69,431	42.86

Similarly, Iron Folic Acid (IFA) administration and Tetanus toxoid dosages to pregnant women were also in declining trend as detailed in **Table 11**.

Table 11: Administration of IFA tablet and TT dosages

Year	No. of pregnant women registered at health centre	No. of pregnant women not receiving 100 days of IFA tablets	Percentage of pregnant women not receiving 100 days of IFA tablets	No. of women not given Tetanus toxoid dosages	Percentage of women not given Tetanus toxoid dosages
2005-06	22,35,950	9,13,263	40.84	1,74,187	7.79
2006-07	22,29,445	15,23,765	68.35	2,21,716	9.94
2007-08	22,26,174	12,18,733	54.75	2,74,118	12.31
2008-09 (up to Feb 09)	20,28,314	Not compiled		3,28,794	16.21

From the above table it could be seen that the number of needy and pregnant women receiving IFA was decreasing which indicated less access to needed iron supplement. As regard gap between registration and immunisation the SHS stated (May 2009) that all the registered women are not coming forward for immunisation.

Government stated (September 2009) that 100 and 200 IFA tablets were prescribed for non-anaemic and anaemic pregnant women respectively. The Expected Level of Achievement (ELA) was 50 *per cent* and same was achieved during last two years in respect of non-anaemic women. The reply was not acceptable as no data was available in support of distribution of 200 IFA tablets to anaemic women.

2.1.10.2 Institutional deliveries

An important component of the RCH II programme was to encourage mothers to undergo institutional deliveries. The goals set in 10th Plan objective were to

Shortfall in institutional deliveries was significant in some districts like Gondia

achieve 80 *per cent* institutional/safe deliveries by 2007. Further, in the State PIP for RCH for the year 2008-09, State had targeted to achieve 80 *per cent* in institutional deliveries. However, scrutiny of records of SHS revealed that this target had not been achieved as of February 2009, as detailed in **Table 12**.

Table 12 : Institutional deliveries

Year	Total deliveries	No. of institutional deliveries	*Per cent* of institutional deliveries
2004-05	16,43,063	10,26,853	62.5
2005-06	16,82,766	11,03,685	65.59
2006-07	14,25,940	10,00,853	70.19
2007-08	18,02,857	13,46,693	74.7
2008-09 (up to Feb 09)	16,19,516	12,33,074	76.13

In the eight test-checked districts it was observed that the position during 2005-2009 varied widely between 36 *per cent* (Gondia 2005-06) and 90 *per cent* (Pune 2008-09)(**Appendix 2.10**). Institutional deliveries above 80 *per cent* were achieved by Thane in 2007-09 and Pune during 2005-06 and 2007-09. However, Gondia, a tribal inhabitated district, presented a grim picture of 36.07 to 65.37 *per cent* institutional deliveries during the last four years.

While accepting the facts, Government stated (September 2009) that schemes implemented under NRHM and through Tribal Welfare Department showed positive impact on institutional deliveries.

2.1.10.3 Family planning

The family planning includes terminal method to control total fertility rate and spacing method to improve couple protection ratio(CPR)[16]. The terminal method of family planning includes vasectomy for male and tubectomy for female.

There was shortfall in both male and female sterilisation

Analysis of data obtained from SHS revealed that as against the target of 2.63 lakh vasectomies in 2005-09 (up to February 2009) in the State, the achievement was only 1.19 lakh leading to shortfall of 54.83 *per cent.* Further, the proportion of vasectomy to the total sterilisation was only 4 *per cent* during 2005-09. This showed that male participation in family planning did not come up as per targets of NRHM. It has been stated that low performance of vasectomy was due to lower acceptance in the society, low female literacy *etc*. During 2005-08 the achievement under tubectomy was 22.71 lakh against the targets of 18.27 lakh.

Targets *vis-à-vis* achievement during 2005-09 of family planning operations in eight test-checked districts were detailed in **Appendix 2.11**.

In eight test-checked districts, while shortfall in achievement of target under vasectomy was highest in Thane District (85 to 94 *per cent*), the targets were

[16] CPR is the percentage of the women in the age group of 15-49 years, protected from pregnancy/child birth in the year under consideration for a specific area

low in Osmanabad and Gondia Districts. However, in respect of female sterilisation *i.e.* tubectomy and laparoscopic, it was noticed that in respect of Osmanabad the target of 10,647 in 2005-06 was gradually reduced to 8,791 in 2008-09. In this connection, SHS stated (May 2009) that family welfare services were purely voluntary and they could not compel any one to accept any particular method and that all efforts were being made through Information, Education and Communication (IEC) to motivate for family planning.

While accepting the facts, Government stated (September 2009) that though the vasectomy was recommended as first choice, proportion of families accepting vasectomy was very low. However, because of newer techniques, the vasectomy acceptance had started improving.

2.1.10.4 Immunisation and Child Health

There was shortfall in child immunisation

Strengthening of services to improve child survival is one of the major components of the RCH II programme. This mainly focuses on preventive aspects. In this connection, for secondary immunisation, children in the age group of 5 to 6 years were required to be administered three doses of DT (Diphtheria and Tetanus) and two doses of Tetanus Toxoid (TT) at the age of 10 and 16 respectively. However, scrutiny of records revealed that there was shortfall against targets for secondary immunisation ranging from 6.55 to 19.30 *per cent* for DT, 9.78 to 24.63 *per cent* for TT (10) and 10.68 to 25.03 *per cent* for TT (16) during 2005-06 to 2008-09 as detailed in **Appendix 2.12**.

While accepting the facts, Government stated (September 2009) that the performance had improved.

2.1.10.5 Vitamin A administration

There was shortfall in Vitamin A administration to children

The RCH II programme emphasised Vitamin A solution for all children less than three years of age. Prophylaxis against blindness amongst children due to Vitamin A deficiency requires the first dose at nine months of age along with measles vaccine and second dose along with DPT/OPV and subsequently three doses at six monthly intervals. There were shortfalls ranging between 8.11 *per cent* and 23.36 *per cent* against the targets of first dose and between 22.94 *per cent* and 45.72 *per cent* during 2005-06, to 2008-09 as detailed in **Table 13**.

Table 13 : Vitamin A administration

Year	Targets	Achievement	Shortfall	Percentage of shortfall
1st dose				
2005-06	20,93,721	19,23,895	1,69,826	8.11
2006-07	20,98,904	16,08,698	4,90,206	23.36
2007-08	19,74,378	18,05,625	1,68,753	8.55
2008-09	19,27,574	15,05,108	4,22,466	21.92
2nd dose				
2005-06	17,03,089	17,51,442	-	-
2006-07	20,14,740	14,54,787	5,59,953	27.79
2007-08	22,54,431	17,37,331	5,17,100	22.94
2008-09	19,74,375	10,71,676	9,02,699	45.72

Government stated (September 2009) that in order to achieve 100 *per cent* coverage, the State was implementing mass Vitamin A supplementation drive.

2.1.10.6 National Programme for Control of Blindness (NPCB)

The NPCB aimed at reducing prevalence of blindness cases to 0.8 *per cent* by (March) 2007 through increased cataract surgery (46 lakh by 2012), school eye screening and free distribution of spectacles, collection of donated eyes and creation of donation centres and eye-banks and strengthening of infrastructure by way of supply of equipment and training of eye surgeons and nurses.

Cataract operation

Government sector fell behind in performing cataract operation

Cataract operations (catops) are performed by Government doctors in Government hospitals, by NGOs and private practitioners in clinics and eye camps. The distribution of workload between private and public sectors was expected to be in the ratio of 1:1. While the NGOs and private sector exceeded the 50 *per cent* mark, the Government sector fell behind, and it was ranging from 19 to 23 *per cent* as detailed in **Table 14**.

Table 14: Cataract operations

Year	Performance of catops in Government hospitals		Performance of catops by NGOs		Performance of catops by private practitioners and others		Total cataract operations
	Number	Perce-ntage	Number	Perce-ntage	Number	Perce-ntage	
2005-06	1,48,236	23	1,24,816	19	3,83,343	58	6,56,395
2006-07	1,37,557	20	1,56,516	23	3,89,631	57	6,83,704
2007-08	1,52,456	21	1,60,114	23	3,99,735	56	7,12,305
2008-09	1,34,454	19	1,75,580	24	4,08,572	57	7,18,606
Total	**5,72,703**	**21**	**6,17,026**	**22**	**15,81,281**	**57**	**27,71,010**

The shortage of eye surgeons in the Government hospitals contributed to the shortfall in Government sector, as 13 eye surgeons were posted against 38 sanctioned posts.

Government further stated (September 2009) that ceiling of number of operations per surgeon had also contributed to the shortfall in Government sector.

Eye donation

The percentage of eyes actually utilised was much less than donated eyes as detailed in **Table 15**.

Table 15 : Eye donation

Year	Number of eyes				
	Donated	**Utilised**	**Transferred to other bank**	**Rendered unfit**	**Used for research**
2005-06	3946	1476	639	172	1533
2006-07	4192	1396	732	209	1457
2007-08	4987	1869	1033	117	1796
2008-09	5885	1878	672	1492	1579
Total	**19010**	**6619**	**3076**	**1990**	**6365**

Government stated (September 2009) that 35 *per cent* utilisation was acceptable as per international norms.

Refractive error and free distribution of spectacles

The programme envisaged imparting training to school teachers in Government and Government aided schools, for screening refractive errors among students and free distribution of spectacles to the students having refractive errors. The position is shown in **Table 16**.

There was shortfall in providing spectacles to school children

Table 16: Distribution of spectacles

Year	Refractive error detected	Spectacles supplied	Shortfall
2005-06	87,878	57,286	30,592
2006-07	1,10,934	81,815	29,119
2007-08	1,15,876	90,619	25,257
2008-09	1,05,203	74,062	31,141

All the students who had refractive errors were not provided with free spectacles and the shortfall ranged between 25,257 and 31,141 during last four years. The programme requires further improvement.

2.1.10.7 Revised National Tuberculosis Control Programme

The State is fully covered under RNTCP

Average detection of new sputum positive cases during 2005-09 worked out to 95 *per cent* which was much higher than the prescribed target of 70 *per cent.* The cure rate ranged between 86 and 87 *per cent* which was higher than the desired level of 85 *per cent* as detailed in **Table 17**. The State is fully covered under Revised National Tuberculosis Control Programme (RNTCP).

Table 17: Cure rate of TB patients

Year	TB patients registered	Cured + treatment completed	*Per cent* cure rate	Died	Failures	Defaulters	Transfe-rred out
2005-06	54,944	47,800	87.00	2747	1248	2690	275
2006-07	53,816	46,820	87.00	2691	1266	2794	319
2007-08	57,900	49,717	85.87	2956	1288	2874	474
2008-09	55,290	47,384	85.70	3096	1106	3096	608

2.1.10.8 National Vector Borne Disease Control Programme

Annual Blood Examination Rate (ABER) and Annual Parasitic Incidence (API) for malaria

The programme stipulated ABER of 10 *per cent* and API of less than 0.5 per thousand for the country. As per information available with the State the ABER was 14.5, 16.6, 12.6 and 14.1 and API was 0.43, 0.5, 0.6 and 0.8 during the years 2005-06 to 2008-09.

Government stated (September 2009) that increase in API was due to nine districts in the State.

Impact of vector borne diseases

During 2005-08 morbidity and mortality due to various vector borne diseases were as in **Table 18**.

Table 18: Cases of morbidity and mortality

Year	Malaria		Filaria		Japanese Encephalitis		Dengue	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
2005-06	45,614	104	9294	0	60	0	31,508	56
2006-07	56,852	133	6211	0	62	0	11,096	27
2007-08	67,844	176	5167	0	10	0	4243	25
2008-09	68,977	160	6386	0	1	0	3782	20

The above table indicated increasing number of Malaria cases and deaths thereof.

Government accepted (September 2009) the facts.

2.1.10.9 National Leprosy Elimination Programme (NLEP)

The NLEP aimed to eliminate leprosy by the end of 11th plan (2012). It also aims to ensure leprosy prevalence rate (PR) of less than one per ten thousand. The total number of new cases of leprosy and PR in the state during 2005-09 was as in **Table 19**.

Table 19: Leprosy Elimination Programme

Year	New cases	Prevalence Rate
2005-06	13,844	0.64
2006-07	11,189	0.61
2007-08	12,397	0.71
2008-09	14,274	0.87

The NRHM stipulated facilities for diagnosis and treatment of leprosy at all health centres up to PHC level. As per data available at the SHSs the facility for diagnosis of leprosy was available in all CHCs and PHCs.

The facility for diagnosis of leprosy was available at all the test-checked CHCs and PHCs.

Though leprosy prevalence rate is below one per ten thousand the number of persons affected has increased in the years 2007-08 and 2008-09.

Government accepted (September 2009) the facts.

2.1.11 Conclusion

The implementation of the NRHM in the State suffered mainly due to lack of comprehensive planning as well as inadequate monitoring. The programme was implemented in the State without the aid of a reliable household database and adequate facility surveys for understanding and identifying the health care needs of the rural population. Perspective Plan for the mission period was not prepared by the DHSs initially. The RKSs did not review the services at hospitals and outreach works.

Underutilisation of the Mission funds resulted in huge unspent balances. Maintenance of cash books and accounts was deficient. No new CHC and PHC were set up. There were large unspent funds meant for strengthening of nursing schools. No focus was given for up gradation of standards of the PHCs and Sub Centres to IPHS. Mobile Medical Units were not in operation. Diagnostic services were inadequate. Blood storage units were not started in most of the CHCs. There were shortages of doctors, nurses and paramedics for providing health care services. In respect of IMR and TFR, the State position is almost at par with the norm; in MMR it is yet to achieve the target of 100. There was shortfall in registration of pregnancy. Family planning targets were not achieved; male participation in family planning was inadequate. As far as RNTCP is concerned the performance of the State Government was appreciable.

2.1.12 Recommendations

The following recommendations are made for improving NRHM implementation in the State:

- For realistic planning, complete household and facility surveys should be carried out soon.
- Provision of diagnostic services in PHC and blood bank facility in CHC should be improved.
- Construction of new CHCs, PHCs and SCs should be given priority along with strengthening of nursing schools for better coverage of health care services.
- More women in rural and tribal areas should be brought under institutional delivery facility through extensive use of IEC.
- Mobile Medical Units should be operationalised to take health care facilities to the doorstep of people in rural areas.
- Sanctioned posts of doctors and nurses are required to be filled in on a priority basis for providing essential medical services. Training of doctors and para medical staff should be given due importance to achieve the desired quality of health care delivery services.

Appendix-2.1
(Reference Paragraph: 2.1.5; Page:12)
Details of units selected for audit

Sr. No.	Selected			
	District	**3 CHCs in each district**	**2 PHCs in each CHC**	**2 SCs in each PHC**
(1)	**(2)**	**(3)**	**(4)**	**(5)**
1.	Thane	Badlapur (Ambarnath)	Badlapur	Ashele
				Adiwali
			Sonawal	Mulgaon
				Umroli
		Manor (Palghar)	Satpati	Shirgaon
				Tembhode
			Somata	Borsheti
				Velgaon
		Vikramgad	Kurze	Dadade
				Gadade
			Talwada	Chambashet
				Khadaki
2.	Nashik	Deola	Khamkheda	Bhaur
				Savki
			Meshi	Khuntewadi
				Pimpalgaon
		Girnare (Nashik)	Girnare	Ganeshgaon
				Gowardhan
			Shinde	Odha
				Sansari
		Igatpuri	Kaluste	Devale
				Talogh
			Khed	Ambewadi
				Take Bk
3.	Pune	Nimgaon (Indapur)	Kalas	Pilewadi
				Rui
			Sanasar	Lakadi
				Tavashi
		Rui (Baramati)	Hol	Vagalvadi
				Vajevadi
			Loni (Lonibhopkar)	LoniBhapkar
				Muthalane
		Shirur	Kendur	Dahmari
				Pimpalgaon Dumal
			Talegaon Dhamdhere	Kondapuri
				Parodi
4.	Osmanabad	Ter (Osmanabad)	Jagaji	Jagaji
				Palsap
			Kond	Arani
				Kond
		Tuljapur	Mangarul	Bori
				Sindphal
			Salagara	Devsinga Tu
				Kakramba
		Washi	Para	Kadaknath Wadi
				Ratanpur
			Pargaon	Pimpalgaon K
				Saramkundi

Appendix-2.1(concld.)				
1	**2**	**3**	**4**	**5**
5.	Yavatmal	Digras	Harsul	Isapur
				Shkhara
			Vasantnagar	Lakh
				Withala
		Ghatanji	Bhambora	Belara
				Pardi Naskari
			Shiwani	Murli
				Titwi
		Maregaon	Mardi	Buranda(gaund)
				Mardi
			Vegaon	Navargaon
				Pisgaon
6.	Gondia	Chichgad(Deori)	Ghonadi	Mohadi
				Singandoh
			Mulla	Pindkepar
				Purada
		Rajegaon(Gondia)	Morwahi	Adasi
				Nawargaon (K)
			Rawanwadi	Garra (B)
				Khamari
		Salekasa	Kawarabandh	Khedepar
				Sonpuri
			Vijepar	Bijepar
				Managad
7	Ahmednagar	Akole	Khirwire	Kombhalane
				Padosi
			Kotul	Chas
				Pinpalgaon Khand
		Newasa	Sonai	Landewadi
				Shinganapur
			Toka	Ranjangaon
				Murume
		Parner	Aalakati	Padaliaade
				Vadzire
			Nighocha	Ralegan Thorpal
				Vadner Buduruk
8	Nagpur	Kamptee	Gumthala	Dighori
				Gumthala
			Gumthi	Godhani
				Mahadula
		Kuhi	Mandhal	Dongarmauda
				Mandhal-2
			Veltur	Shirshi
				Veltur-2
		Parshivani	Dorli	Dorli
				Mehandi
			Kanhan	JuniKamptee
				Pipari

Appendix 2.2

(Reference Paragraph: 2.1.6.3; Page: 15)

Details of Facility Survey conducted in the selected units

Sr. No.	Name of the District	Name of the test checked CHC	Whether Facility Survey conducted	Name of the the test checked PHC	Whether Facility Survey conducted	Name of the the test checked SC	Whether Facility Survey conducted
1	2	3	4	5	6	7	8
1.	Thane	Badlapur (Ambarnath)	No	Badlapur	No	Ashele	No
						Adiwali	No
				Sonawal	No	Mulgaon	No
						Umroli	No
		Manor (Palghar)	Yes	Satpati	Yes	Shirgaon	No
						Tembhode	No
				Somata	Yes	Borsheti	No
						Velgaon	No
		Vikramgad	No	Kurze	No	Dadade	No
						Gadade	No
				Talwada	Yes	Chambashet	No
						Khadaki	No
2.	Nashik	Deola	No	Khamkheda	Yes	Bhaur	No
						Savki	No
				Meshi	No	Khuntewadi	No
						Pimpalgaon	No
		Girnare (Nashik)	No	Girnare	No	Ganeshgaon	No
						Gowardhan	No
				Shinde	Yes	Odha	No
						Sansari	No
		Igatpuri	Yes	Kaluste	No	Devale	No
						Talogh	No
				Khed	No	Ambewadi	No
						Take Bk	No
3.	Pune	Nimgaon (Indapur)	No	Kalas	No	Pilewadi	No
						Rui	No
				Sanasar	Yes	Lakadi	No
						Tavashi	No
		Rui (Baramati)	Yes	Hol	No	Vagalvadi	No
						Vajevadi	No
				Loni (Lonibhopkar)	No	LoniBhapkar	No
						Muthalane	No
		Shirur	No	Kendur	No	Dahmari	No
						Pimpalgaon Dumal	No
				Talegaon Dhamdhere	Yes	Kondapuri	No
						Parodi	No
4.	Osmanabad	Ter (Osmanabad)	No	Jagaji	Yes	Jagaji	No
						Palsap	Yes
				Kond	No	Arani	No
						Kond	No
		Tuljapur	Yes	Mangarul	No	Bori	No
						Sindphal	No
				Salagara	Yes	Devsinga Tu	No
						Kakramba	Yes
		Washi	Yes	Para	No	Kadaknath Wadi	No
						Ratanpur	No
				Pargaon	Yes	Pimpalgaon K	Yes
						Saramkundi	Yes

Appendix 2.2 (Concld.)							
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
5	Yavatmal	Digras	Yes	Harsul	Yes	Isapur	No
						Shkhara	No
				Vasant nagar	No	Lakh	No
						Withala	No
		Ghatanji	No	Bhambora	No	Belara	No
						Pardi Naskari	No
				Shiwani	No	Murli	No
						Titwi	No
		Maregaon	No	Mardi	No	Buranda (gaund)	No
						Mardi	No
				Vegaon	No	Navargaon	No
						Pisgaon	No
6	Gondia	Chichgad (Deori)	No	Ghonadi	No	Mohadi	No
						Singandoh	No
				Mulla	No	Pindkepar	No
						Purada	No
		Rajegaon (Gondia)	No	Morwahi	No	Adasi	No
						Nawargaon (K)	No
				Rawanwadi	Yes	Garra (B)	No
						Khamari	No
		Salekasa	No	Kawarabandh	No	Khedepar	No
						Sonpuri	Yes
				Vijepar	No	Bijepar	No
						Managad	No
7	Ahmed-nagar	Akole	Yes	Khirwire	No	Kombhalane	No
						Padosi	No
				Kotul	No	Chas	No
						Pinpalgaon Khand	No
		Newasa	Yes	Sonai	No	Landewadi	No
						Shinganapur	No
				Toka	No	Ranjangaon	Yes
						Murume	No
		Parner	No	Aalakati	Yes	Padaliaade	No
						Vadzire	No
				Nighocha	Yes	Ralegan Thorpal	No
						Vadner Buduruk	No
8	Nagpur	Kamptee	Yes	Gumthala	No	Dighori	No
						Gumthala	No
				Gumthi	No	Godhani	No
						Mahadula	Yes
		Kuhi	No	Mandhal	No	Dongarmauda	No
						Mandhal-2	No
				Veltur	Yes	Shirshi	No
						Veltur-2	No
		Parshivani	No	Dorli	No	Dorli	No
						Mehandi	No
				Kanhan	No	Juni Kamptee	Yes
						Pipari	No

Appendix 2.3
(Reference Paragraph:2.1.7.3; Page: 16)

Statement showing inadmissible expenditure from RKS fund

Sr. No.	Name of the District	Name of Health Centre	Details of inadmissible expenditure	Amount involved (Rs)
1	2	3	4	5
1	**Thane**	PHC Sonawala	Computer for office use	38000
2		PHC Satpati	Computer for office use	49324
3		PHC Talwala	Computer for office use	43744
4		PHC Kurze	Computer for office use	43744
5		CHC Vikramgad	Cleaning by hiring private three person for nine months	140423
6	**Gondia**	KTS General Hospital, Gondia	Payment of visit of P M and inauguration of ward building	57450
7		PHC Mulla	Computer & revolving chair for office use	42650
8		PHC Kawarabamdha	Computer for office use	41500
9		PHC Bijepar	Computer for office use	41500
10		PHC Ghonadi	Computer & revolving chair for office use	42200
11		PHC Morwahi	Computer & revolving chair for office use	75537
12	**Osmanabad**	PHC Kond	Furniture	20450
13		PHC Paragaon (2007-08)	Leveling of soil and music system	40350
14		PHC Paragaon (2008-09)	Purchase of stationery and repair work	66000
15		PHC Salagara	Construction material and CFL bulbs	38248
16	**Nashik**	PHC Khamkheda	Computer & revolving chair	45300
17	**Yavatmal**	PHC Vasantnagar	Painting, electrification, water supply, purchase of medicine, repair and renovations etc.. Expenditure incurred without sanction of Competent Authority	175373

Appendix 2.3 (Concld.)				
1	**2**	**3**	**4**	**5**
18	**Nagpur**	Rural Hospital Kuhi	Purchase of invertors even though already having generator facilities	17475
19		PHC Gumthala	Purchase of furniture printing work and Computer charges *etc*	142737
20		PHC Gumthi, Mandhal & Dorli	Child Development Centre (CDC) activities, should have been incurred by Woman and Child welfare Deptt.	86439
21		PHC Mandhal	Purchase of computer	39117
22		PHC Veltur	Purchase of computer , furniture and colour TV	75507
23	**Ahmednagar**	PHC Khirwire, Kotul & Sonai	CDC, should have been incurred by Woman and Child welfare Deptt.	282999
24		PHC Toka	Purchase of Colour TV, DVD, Dish Antenna and watch-man salary	21080
25		PHC Alkuti & Nighocha	Purchase of adjustable stick for old persons	164225
			Total	**1831372**

Appendix 2.4

(Reference Paragraph: 2.1.8.1; Page: 17)

Statement showing component-wise receipt and expenditure under NRHM during 2005-06 to 2008-09

(Rs in crore)

Sr. No.	Components	2005-06						2006-07					
		Opening Balance	Grant Received from GOI	Other receipts/ interest etc.	Total receipts	Expenditure incurred	Closing Balance	Opening Balance	Grant received from GOI	Other receipts/ interest etc.	Total receipts	Expendi-ture incurred	Closing Balance
1	2	3	4	5	6	7	8	9	10	11	12	13	14
A	**RCH-II**	0	5301.50	0	5301.50	1431.36	3870.14	3870.14	12434.54	0	16304.68	4053.13	12251.55
B	**Addl. Under NRHM**	0	2372.70	0	2372.70	202.00	2170.70	2170.70	13624.25	0	15794.95	889.14	14905.81
C	**Immunisation**												
	RI	0	497.42	12.33	509.75	141.21	368.54	368.54	531.03	0	899.57	190.35	709.22
	PPI	587.10	1515.00	0	2102.10	1423.00	679.10	679.10	2069.00	0	2748.10	2656.00	92.10
D	**NDCPs**												
	RNTCP	115.51	1300.00	40.91	1456.42	1197.27	259.15	259.15	1025.00	16.39	1300.54	1199.77	100.77
	NVBDCP	10.04	196.00	0	206.04	195.75	10.29	10.29	785.00	10.79	806.08	385.68	420.40
	NPCB	30.14	387.00	1.41	418.55	360.15	58.40	58.40	789.10	9.69	857.19	782.58	74.61
	NLEP	214.13	34.80	1.36	250.29	177.12	73.17	73.17	205.34	3.59	282.10	211.68	70.42
	IDSP	0.34	569.97	0.46	570.77	49.00	521.77	521.77	0	20.50	542.27	246.00	296.27
	IDDCP-Treasury	0	8.00	2.37	10.37	10.37	0	0	8.00	7.27	15.27	15.27	0
	Total	**957.26**	**12182.39**	**58.84**	**13198.49**	**5187.23**	**8011.26**	**8011.26**	**31471.26**	**68.23**	**39550.75**	**10629.6**	**28921.15**

Appendix 2.4 (Concld.)

1	2	2007-08						2008-09					
		3	4	5	6	7	8	9	10	11	12	13	14
A	**RCH-II**	12251.56	18620.70	0	30872.26	9852.61	21019.65	21019.65	8295.00	0	29314.65	17602.18	11712.47
B	**Addl. Under NRHM**	14905.81	19232.75	0	34138.56	13293.83	20844.73	20844.73	19363.00	12090.00	52297.73	40187.47	12110.26
C	**Immunisation**												
	RI	709.22	227.08	0	936.30	628.43	307.87	307.87	704.85	0	1012.72	1125.89	-113.17
	PPI	92.10	2198	0	2290.10	2178.00	112.10	112.10	5100.00	0	5212.10	3356.00	1856.10
D	**NDCPs**												
	RNTCP	100.77	1495.00	61.05	1656.82	1565.28	91.54	91.54	2053.00	54.00	2198.54	1966.05	232.49
	NVBDCP	420.40	763.31	0	1183.71	993.79	189.92	189.92	847.00	0	1036.92	656.26	380.66
	NPCB	74.61	1299.50	7.51	1381.62	1105.66	275.96	275.96	1800.00	8.52	2084.48	1812.18	272.30
	NLEP	70.42	92.92	4.34	167.68	156.35	11.33	11.33	333.30	8.94	353.57	303.22	50.35
	IDSP	296.27	10.00	0	306.27	234.57	71.70	71.70	115.00	0	186.70	106.48	80.22
	IDDCP-Treasury	0	15.84	0	15.84	10.93	4.91	4.91	11.00	0	15.91	15.79	0.12
	Total		**43955.10**	**72.90**	**72949.16**	**30019.45**	**42929.71**	**42929.71**	**38622.15**	**12161.46**	**93713.32**	**67131.52**	**26581.80**

Appendix 2.5

(Reference Paragraph: 2.1.8.2; Page: 17)

Delay in transfer of funds by SHS to DHS

Year	Activity	Grant Received (Rs in lakh)	Date of receipt	Date of release	Delay in days
2005-06	Sub Centre strengthening	972.70	26.08.2005	20.12.2005	116
	IPHS	1400.00	25.10.2005	10.03.2006	136
	Routine Immunization	497.42	19.07.2005	21.09.2005	64
2006-07	DHAP	350.00	08.04.2006	23-01.2007	290
	IEC	107.16	09.05.2006	15.11.2006	190
	Sub Centre strengthening	387.00	05.08.2006	21.12.2006	137
	IPHS	5540	05.08.2006	21.12.2006	137
	RKS	196.00	23.12.2006	23.01.2007	31
2007-08	Tele-Medicine	100.00	08.02.2008	25.03.2008	45
	JE	107.67	04.04.2007	22.06.2007	79
	NRHM Flexipool	845.75	04.04.2007	31.08.2007	149
	IPHS	700.00	13.04.2007	31.08.2007	140
	Health Mela	384.00	08.05.2007	31.08.2007	114
	IEC	87.50	12.06.2007	16.10.2007	126
	NRHM Flexipool	247.00	18.08.2007	22.11.2007	96
	--Do--	14715.00	27.09.2007	22.11.2007	55
2008-09	SNID	340.45	06.09.2008	27.10.2008	52
	--Do--	315.75	do	24.02.2009	171
	NID	1089.17	11.12.2008	22.01.2009	41
	Mission Flexipool	8742.00	12.06.2008	07.07.2008	26
	--Do--	3770.00	04.10.2008	20.10.2008	17
	--Do--	6851.00	04.03.2009	23.03.2009	20

Delay in transfer of grants by test checked District Health Societies to CHCs/PHCs/SCs

District	Activity	Grant Received (Rs in lakh)	Date of Receipt	Date of release	Delay in days
Nashik	JSY	25.94	3/1/2006	23/3/2006	80
	NSV Camp	9.24	3/1/2006	23/3/2006	80
	Sub Centre Strengthening	53.00	3/1/2006	NA	
	Sub Centre Strengthening	53.68	6/8/2007	23/10/2007	77
Gondia	Sub Centre Strengthening	23.70	20/12/2005	6/2/2006	48
	RKS	15.00	13/2/2007	29/5/2007	104
	AMG	21.00	19/1/2007	7/8/2007	200
	Untied fund	10.50	19/1/2007	7/8/2007	200
	IPHS	20.00	29/6/2006	20/2/2007	235
Yavatmal	Untied fund (PHC)	16.00	17/1/2007	3/9/2007	229
	AMG (PHC)	32.00	17/1/2007	3/9/2007	229
	AMG (PHC)	17.32	7/1/2008	5/4/2008	88

Appendix 2.6

(Reference : Paragraph: 2.1.9.6; Page: 22)

Statement showing non-availability of infrastructure in the selected CHCs (24) and PHCs (48)

Sr. No.	Particulars	No. of PHCs	No. of CHCs
	Infrastructure for health centres		
1	No Designated Government building	6	3
2	No OT available	5	4
3	OT with not enough space	6	7
4	No AC in OT	NA	9
5	Generator not available for OT	NA	7
6	Emergency light not available in OT	NA	5
7	No Labour room available	4	2
8	No separate public utilities for men and women	19	6
9	No separate areas for septic and aseptic deliveries available	32	
10	No waiting room for patients	9	4
11	No emergency room/ casualty	22	9
12	No separate ward for male and female	21	5
	Facilities for health care services		
13	No surgeries carried out in OT	9	7
14	OT not used for obstetric/ gynecology purpose	23	9
15	AC in OT not working	NA	10
16	Deliveries not carried out in Labour room	3	3
17	No suggestion/ complaint box available	22	6
18	No family welfare clinic	16	10
19	No incinerator	NA	9
20	No stand by facility available for electricity	6	5
21	No vehicle available	4	
22	No telephone available	16	
	Laboratory Services		
23	No Laboratory available	20	3
24	No adequate equipments and chemicals available	26	4
25	X ray room not available	NA	5
26	No routine urine, stool and blood tests facility	26	
27	No sputum testing facility for TB patients.	29	
28	No blood smear examination facility for malaria parasites	14	

Appendix 2.6 (Concld.)

Statement showing non-availability of Health Care facilities in the selected RHs

Sr. No.	Particulars	No. of CHCs
1	24 hrs delivery services not available	3
2	Emergency Obstetric Care not available	13
3	New born care not available	5
4	No emergency care of sick children	7
5	No Family planning service	6
6	No safe abortion services	11
7	No Treatment of STI/ RTI	5
8	No blood storage facility	19
9	No referral transport services	2
10	No ECG facilities	18
11	No X ray facilities	5
12	No Ultrasound facilities	21
13	No lab test facilities	1

Statement showing non-availability of infrastructure in the selected Sub Centres (96)

Sr. No.	Particulars	No. of SCs
1	No designated Government building	29
2	No residential premises for ANM	32

Appendix 2.7

(Reference Paragraph:2.1.9.7; Page: 22)

Statement showing number of selected CHCs not having fully equipped Operation Theater

Sr. No.	Particulars	Number of selected CHC	Not available	Available but not working	Available and working
1	Boyales apparatus	24	15	1	8
2	EMO machine	24	21	1	2
3	Cardiac monitor for OT	24	21	0	3
4	Defibrillator for OT	24	23	0	1
5	Ventilator for OT	24	22	1	1
6	Horizontal high pressure sterilizer	24	16	1	7
7	Vertical high pressure sterilizer	24	10	4	10
8	Shadow less lamp ceiling track mounted	24	13	0	11
9	Shadow less lamp pedestal for minor OT	24	7	1	16
10	OT care/ fumigate on apparatus	24	4	1	19
11	Gloves and dusting machines	24	17	1	6
12	Oxygen cylinder 660 ltrs 10 cylinders for one boyales apparatus	24	9	2	13
13	Nitrous oxide cylinder 1780 ltrs 8 for one boyales apparatus	24	19	0	5
14	Hydraulic Operation Table	24	14	0	10

Appendix 2.8

(Reference Paragraph: 2.1.9.8; Page: 24)

Statement showing vacancy position in the selected CHCs

Medial Staff				
Details	**Requirement as per IPHS norms**	**Present position**	**Shortfall**	**Percentage of shortfall**
General surgeon (1 per CHC)	24	7	17	71
Physician (1 per CHC)	24	3	21	88
Obstetrician/ Gynecologist (1 per CHC)	24	11	13	54
Pediatrics (1 per CHC)	24	11	13	54
Anesthetist (1 per CHC)	24	10	14	58
Eye surgeon (1 per CHC)	24	3	21	88
Other specialist (if any)	24	4	20	83
General Duty Officers (6 per CHC)	144	41	103	72
Paramedical staff				
Staff Nurse (7 per CHC)	168	143	25	15
ANM (1 per CHC)	24	14	10	42
Public Health Nurse (1 per CHC)	24	1	23	96
Dresser (1 per CHC)	24	2	22	92
Pharmacist/ Compounder (1 per CHC)	24	25	+1	+4
Lab Technician (1 per CHC)	24	24	0	0
Radiographer (1 per CHC)	24	5	19	79
Ophthalmic Assistant (1 per CHC)	24	18	6	25

Statement showing vacancy position in the selected PHCs

Medical and Paramedical staff

Details	**Requirement as per IPHS norms**	**Present position**	**Shortfall**	**Percentage of shortfall**
Medical Officer (2 per PHC)	96	94	2	2
Pharmacist (1 per PHC)	48	48	0	0
Staff Nurse (3 per PHC)	144	41	103	72
Health Educator (1 per PHC)	48	9	39	81
Laboratory Technician (1 per PHC)	48	26	22	46

Appendix 2.9

(Reference Paragraph: 2.1.9.11; Page:26)

Statement showing shortfall in training

POST	DETAILS OF TRAINING	2007-08				2008-09			
		T	A	S	Percentage of Shortfall	T	A	S	Percentage of Shortfall
1	2	3	4	5	6	7	8	9	10
ANM	Skill attendent at birth	810	409	401	49.51	1436	1329	107	7.45
	Integrated Management of Neonatal and childhood illness (Health & Nutrition)	8462	1786	6676	78.89	2244	275	1969	87.75
	Intra-utrine Contraceptive Device	7648	1995	5653	73.91	2381	881	1500	63.00
	Induction Training of Contractual Nursing Staff	5105	2840	2265	44.37	2289	1435	854	37.31
	Strengthening of Routine Immunization	30094	7148	22946	76.25	22769	18823	3946	17.33
	Sickle Cell Disease Control Programme	2030	0	2030	100.00	2030	297	1733	85.37
	MSACS Refresher training.	49	0	49	100.00	49	38	11	22.45
	Total	**54198**	**14178**	**40020**	**73.84**	**33198**	**23078**	**10120**	**30.48**
Public Health Nurse	IMNCF	40	34	6	15.00	55	41	14	25.45
	Strengthening of Routine Immunization	40	38	2	5.00	54	50	4	7.41
	MFS	40	40	0	0.00	54	50	4	7.41
	Total	**120**	**112**	**8**	**6.67**	**163**	**141**	**22**	**13.50**

* T= Target; A= Achievement; S= Shortfall

Appendix 2.9 (Concld.)									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Staff Nurse	Skill attendent at birth	860	352	508	59.07	860	117	743	86.40
	Comprehensive Abortion Care (MTP/MVA)	240	98	142	59.17	240	33	207	86.25
	Integrated Management of Neonatal and childhood illness (Health & Nutrition)	292	120	172	58.90	292	40	252	86.30
	Minilap	172	70	102	59.30	172	23	149	86.63
	Intra-utrine Contraceptive Device	774	317	457	59.04	774	105	669	86.43
	Induction Training of Contractual Nursing Staff	12	49	-37	-308.33	120	16	104	86.67
	Strengthening of Routine Immunization	421	172	249	59.14	421	57	364	86.46
	Total	**2771**	**1178**	**1593**	**57.49**	**2879**	**391**	**2488**	**86.42**
Medical Officer	Basic emergency Medical and Obstetric Care	2359	797	1562	66.21	1491	1052	439	29.44
	Comprehensive Emergency Medical and Obstetric Care	96	5	91	94.79	48	21	27	56.25
	Life saving skills in Anesthesia	150	19	131	87.33	81	31	50	61.73
	Comprehensive Abortion Care (MTP/MVA)	1889	233	1656	87.67	671	356	315	46.94
	Integrated Management of Neonatal and childhood illness (Health & Nutrition)	2894	721	2173	75.09	1228	1063	165	13.44
	Minilap	1914	359	1555	81.24	629	247	382	60.73
	Non-Scalpel Vasectomy	2075	377	1698	81.83	930	170	760	81.72
	Laprescopic Sterlization	236	51	185	78.39	236	11	225	95.34
	Sickle Cell Disease Control Programme	626	89	537	85.78	626	384	242	38.66
	Total	**12239**	**2651**	**9588**	**78.34**	**5940**	**3335**	**2605**	**43.86**

* T= Target; A= Achievement; S= Shortfall

Appendix 2.10

(Reference Paragraph: 2.1.10.2; Page: 28)

Statement showing details of institutional deliveries in selected districts

Name of District audited	Year	No. of pregnant women registered	No. of institutional deliveries	Domiciliary deliveries	Total deliveries	Percentage of institutional deliveries
Thane	**2005-06**	87733	39192	33789	72981	53.70
	2006-07	86684	42070	27795	69865	60.22
	2007-08	115002	81885	20121	102006	80.27
	2008-09	73182	44348	11043	55391	80.06
Nashik	**2005-06**	88005	34030	33169	67199	50.64
	2006-07	87951	41063	22585	63648	64.52
	2007-08	87633	39873	20553	60426	65.99
	2008-09	89091	48314	23750	72064	67.04
Pune	**2005-06**	87461	67963	16549	84512	80.42
	2006-07	87419	70915	19010	89925	78.86
	2007-08	83949	72759	17582	90341	80.54
	2008-09	76205	68944	7589	76533	90.08
O'bad	**2005-06**	34211	15981	12097	28078	56.92
	2006-07	33608	15253	10244	25497	59.82
	2007-08	33432	17057	8648	25705	66.36
	2008-09	3109	24940	7225	32165	77.54
Yavatmal	**2005-06**	56093	26036	23326	49362	52.75
	2006-07	55732	29606	17828	47434	62.42
	2007-08	58764	30952	15412	46364	66.76
	2008-09	59257	41283	11594	52877	78.07
Gondia	**2005-06**	24364	7585	13445	21030	36.07
	2006-07	24115	9555	12813	22368	42.72
	2007-08	21923	9704	10350	20054	48.39
	2008-09	24326	5365	2842	8207	65.37
Nagpur	**2005-06**	45053	22527	11981	34508	65.28
	2006-07	45053	21679	12338	34017	63.73
	2007-08	40618	26277	7829	34106	77.05
	2008-09	35191	12744	4009	16753	76.07
Ahmednagar	**2005-06**	**information not furnished**				
	2006-07					
	2007-08					
	2008-09	13488	7725	1489	9214	83.84

Appendix 2.11

(Reference Paragraph: 2.1.10.3; Page: 28)

Statement of Targets and achievement of family planning operations during 2005-09, in eight test checked districts

Name of the district	Year	Vasectomy				Tubectomy		Laproscopy		Total female sterlization			
		T	A	Shortfall	Percent-age	T	A	T	A	T	A	Shortfall	Percent-age
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Thane	**2005-06**	3378	510	2868	84.90	0	0	19142	21711	19142	21711	--	--
	2006-07	3450	445	3005	87.10	0	0	19550	21565	19550	21565	--	--
	2007-08	3450	216	3234	93.74	0	0	19450	14661	19450	14661	4789	24.62
	2008-09	2063	269	1794	86.96	20632	2118	20632	12986	20632	15104	5528	26.79
Nashik	**2005-06**	2678	1310	1368	51.08	24102	22435	0	4019	24102	26454	--	--
	2006-07	4247	1179	3068	72.24	24072	24163	0	3845	24072	28008	--	--
	2007-08	4290	1506	2784	64.90	24310	21544	0	3392	24310	24936	--	--
	2008-09	2830	2543	287	10.14	25465	20848	0	1515	25465	22363	3102	12.18
Pune	**2005-06**	5270	3300	1970	37.38	14935	19039	14935	12859	29870	31898	--	--
	2006-07	4500	500	4000	88.89	12750	16933	12750	12593	25500	29526	--	--
	2007-08	4500	775	3725	82.78	12750	9298	12750	20369	25500	29667	--	--
	2008-09	3054	695	2359	77.24	9950	9949	19950	19903	29900	29852	48	0.16
O'bad	**2005-06**	1183	59	1124	95.01	10647	7599	0	3228	10647	10827	--	--
	2006-07	1134	19	1115	98.32	10205	6185	0	2898	10205	9083	1122	10.99
	2007-08	1016	27	989	97.34	9145	6428	0	2524	9145	8952	193	2.11
	2008-09	977	235	742	75.95	4395	4755	4396	3319	8791	8074	717	8.16
Yavatmal	**2005-06**	2014	1889	125	6.21	18126	15676	0	1181	18126	16857	1269	7.00
	2006-07	1832	1202	630	34.39	16483	14945	0	331	16483	15276	1207	7.32
	2007-08	1793	1370	423	23.59	16136	14133	0	1153	16136	15286	850	5.27
	2008-09	1760	2390	--	--	15842	14247	0	103	15842	14350	1492	9.42
Gondia	**2005-06**	1739	1777	--	--	9851	6658	0	260	9851	6918	2933	29.77
	2006-07	1350	1313	37	2.74	7650	6921	0	0	7650	6921	729	9.53
	2007-08	1275	2086	--	--	7225	5963	0	0	7225	5963	1262	17.47
	2008-09	865	2916	--	--	7787	6133	0	0	7787	6133	1654	21.24

Appendix 2.11 (Concld.)													
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Nagpur	**2005-06**	0	790			0	7108	0	8431	0	15539		
	2006-07	0	466			0	5428	0	8869	0	14297		
	2007-08	0	599			15500	5265	0	6472	15500	11737	3763	24.28
	2008-09	1374	1423			13741	5895	0	3784	13741	9679	4062	29.56
Ahmed-nagar	**2005-06**	-	231			31300	19377	0	11703	31300	31080	220	0.70
	2006-07		83			31550	16495	0	11320	31550	27815	3735	11.84
	2007-08	2910	92	2818	96.84	26252	14226	0	8412	26252	22638	3614	13.77
	2008-09	2970	129	2841	95.66	26744	11715	0	9692	26744	21407	5337	19.96

Appendix 2.12

(Reference Paragraph: 2.1.10.4; Page: 29)

Target and achievement of Immunisation coverage in respect of BCG, Measles, DPT and OPV

Year	Target	Achievement											
		BCG	Short-fall	Percentage of Shortfall	Measles	Shortfall	Percentage of Shortfall	DPT	Short-fall	Percentage of Shortfall	OPV	Short-fall	Percen-tage of Short-fall
2005-06	2093721	2139148	Nil	Nil	1984167	109554	5.23	2079367	14354	0.69	2072128	21593	1.03
2006-07	2098904	2033616	65288	3.11	1891520	207384	9.88	1984169	114735	5.47	1985957	112947	5.38
2007-08	1974378	2041582	Nil	Nil	1873324	101054	5.12	1968089	6289	0.32	1957610	16768	0.85
2008-09(up to Feb 09)	1927574	1862225	65349	3.39	1566191	361383	18.75	1664999	262575	13.62	1742422	185152	9.61

Details of DT, TT (10) and TT (16) Immunization

	DT				TT(10)				TT(16)			
Year	Target	Achievement	Shortfall	Perce-ntage of Short-fall	Target	Achievement	Shortfall	Perce-ntage of Short-fall	Target	Achieve-ment	Shortfall	Perce-ntage of Short-fall
2005-06	2301437	2150579	150858	6.55	2311947	2085794	226153	9.78	2492831	2226557	266274	10.68
2006-07	2458596	2091699	366897	14.92	2244801	1871235	373566	16.64	2458596	2040481	418115	17.01
2007-08	2467968	2021749	446219	18.08	2253361	1698405	554956	24.63	2467968	1880055	587913	23.82
2008-09(up to Feb 09)	2150681	1735503	415178	19.3	2150681	1794522	356159	16.56	2281650	1710571	571079	25.03