CHAPTER 6: INFRASTRUCTURE DEVELOPMENT AND CAPACITY BUILDING

6 Capacity building of physical and human infrastructure

The NRHM aimed to bridge gaps in the existing capacity of the rural health infrastructure by establishing functional health facilities through revitalization of the existing physical infrastructure, such as health centre buildings and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning and infrastructure strengthening. The Mission had developed comprehensive Indian Public Health Standards (IPHS) defining infrastructural, personnel, equipment and management standards for different levels of health centres. Besides, the Mission also aimed to generate management capacity at every level of implementation of the Mission by creating a large pool of community health workers to act as an interface between the health centre and the rural population.

6.1 Release of funds for upgradation of CHCs to IPHS

The NRHM implementation framework stipulated upgradation of health centres to Indian Public Health Standards (IPHS). As per guidelines issued to States for preparation of PIP for 2005-06, the average cost of upgradation of a CHC to IPHS was fixed as Rs. 40 lakh. During 2005-06 and 2006-07, Rs. 720.20 crore was released as first instalment of grants to States for upgradation of CHCs. The Cabinet approved the IPHS for different levels of health centres in 2007-08.

The sanction orders releasing funds required the States to furnish a report on facility surveys for all CHCs and details of CHCs selected for upgradation. However, the States did not furnish the required information to the Ministry. Moreover, during 2005-07, Rs. 55.80 crore was released to six States @ Rs. 20 lakh per CHC, while as per RHS Bulletin 2007 these States had 169 CHCs and hence, were eligible for Rs. 33.80 crore. This resulted in excess release of Rs. 22.00 crore to these States (details in table 6.1).

Table 6.1: Excess release for upgradation of CHCs

(Rs. in crore)

Name of State/UT	No. of CHCs (RHS Bulletin 2007)	Funds released	Maximum funds to be released	Excess funds released
		@ Rs 20 lakh per CHC		
Bihar	70	30.80	14.00	16.80
Uttarakhand	49	10.40	9.80	0.60
Manipur	16	4.60	3.20	1.40
Mizoram	9	3.40	1.80	1.60
Nagaland	21	5.00	4.20	0.80
Sikkim	4	1.60	0.80	0.80
Total	**169**	**55.80**	**33.80**	**22.00**

Consequent to the Ministry's release of Rs. 20 lakh per CHC as the first instalment, a second instalment was to be released on the basis of actual cost identified per CHC. However, the same had not been released to most of the States even 12 to 31 months after the release of initial instalment as the States did not send the actual cost requirement for each CHC identified for upgradation and the Ministry failed to follow this up.

The State wise details on upgradation of CHCs to IPHS and expenditure incurred thereon were not made available by the Ministry. Out of Rs. 393.80 crore released during 2005-06 and Rs. 326.40 crore released during 2006-07 the Ministry had received utilisation certificates of only Rs. 109.95 crore (28 *per cent*) and Rs. 35.14 crore (11 *per cent*) from the SHSs for the respective years until July 2008.

The release of grant for upgrading CHCs to IPHS without receiving a requirement from the States and without analysis of the demand based on a facility survey and mapping of requirements, resulted in non-utilisation or at least absence of information on the use of Rs. 575.11 crore even after 24 to 36 months had passed from the time of release of funds.

The Ministry stated that the first instalment of funds was released to start the upgradation of CHCs without receiving a formal proposal from State/UT. Funds for this activity since 2007-08 had been released only as per annual PIP.

However, the reply of the Ministry did not indicate reasons for SHSs' failure to provide facility survey reports, details on CHCs upgraded, utilisation certificates etc. even after the initial period of fund release.

6.2 Inadequate planning for creation/strengthening of infrastructure

The NRHM aimed at creation of new infrastructure/buildings and strengthening of the existing infrastructure for health centres so as to improve accessibility and quality of healthcare delivery and targeted completion of 30 *per cent* of the works by 2007.

Complete data on the status of the existing infrastructure of health centres was not available with the SHSs and the DHSs due to non-completion/non-conducting of facility surveys in six States/UTs and only partial completion of the survey in 24 States/UTs. The assessment of work/patient load on the existing health centres and requirement for creation/upgradation of health centres to cater to the potential increase in the number of patients after improvement of services was not factored in before taking up the task of infrastructure creation/ strengthening. In 23 States/UTs, Rs. 827.81 crore was released to the DHSs and other executing agencies such as DRDA, PWD, State/Central PSUs etc. for creation and strengthening of infrastructure during 2005-08 without developing a proper plan based on demand, need and prioritization.

The audited DHS of 18 States/UTs had completed works for only Rs. 13.37 crore (9 *per cent*) out of Rs. 146.25 crore received for the creation and upgradation of the infrastructure at the health centres. In 16 States/UTs, works of Rs. 85.80 crore (60 *per cent*) were in progress for which advances had been given to the executing agencies and Rs. 30.07 crore (21 *per cent*) remained unspent with the DHS as of March 2008.

Uttarakhand: PHC Manthat, Dehradun under construction since 2005 (Rs. 56.10 lakh released till March 2008)

Moreover, cases of delay in completion of civil works were observed in 11 States (details in **Annex 6.1)** and cases of irregularities in execution of civil works were noticed in 11 States involving Rs. 232.46 crore (details in **Annex 6.2)**.

The considerable infusion of funds under NRHM aimed to create and upgrade infrastructure to the IPHS levels. It is, therefore, essential that adequate preparatory planning and prioritisation be done to achieve these objectives. It is necessary that the SHSs and DHSs take expeditious measures to survey requirements, plan and execute the task of creating/upgrading the health infrastructure.

6.3 Contribution of the States in creation and upgradation of infrastructure

State governments were to contribute 25 *per cent* of the cost of creation and upgradation of the infrastructure for Sub-centres. During 2005-08, 10 State governments (Arunachal Pradesh, Assam, Madhya Pradesh, Manipur, Meghalaya, Punjab, Rajasthan, Tripura, Uttar Pradesh and West Bengal) did not contribute the matching amount of Rs. 16.81 crore towards creation and upgradation of infrastructure at Sub-centres.

The Ministry stated that this issue had been discussed with State/UT Governments during the NPCC deliberations, while appraising their annual PIPs and need for appropriate contribution for health infrastructure had been impressed upon them. The recommendation of Audit for getting such information through Financial Management Reports (FMRs) had been noted for taking appropriate action and monitoring thereof.

6.4 Shortfall in establishment of new health centres

The NRHM framework had set the target of providing one Sub Centre for 5000 population (3000 in tribal areas), one PHC for 30000 population (20000 in tribal/desert areas) and one CHC for 100000 population (80000 in tribal/desert areas).

While the required number of health centres at each level was available in Mizoram, A and N Islands and Puducherry, in the remaining States/UTs[29] the health centres required/prescribed as per population norms did not exist. There was a shortfall of 43,987 Sub Centres (27 *per cent*) in 22 States/UTs, 8613 PHCs (31 *per cent*) in 21 States/UTs and 4200 CHCs (55 *per cent*) in 23 States/UTs, which are required to be created during the NRHM period (2005-12).

The shortfall of health centres was noteworthy in the eight EAG States, which had 74 *per cent* of the total shortfall in Sub Centres, 60 *per cent* of PHCs and 70 *per cent* of CHCs countrywide. These States, where the health and family welfare indicators were already poor, received fewer grants from the Ministry, as the grants were linked to the total number of health centres functioning in the State.

As the Mission targeted creation of 30 *per cent* of the proposed new infrastructure by 2007, 13196 Sub Centres, 2585 PHCs and 1261 CHCs were required to be constructed. However, during 2005-08, 14 States/UTs[30] had not taken up the work of

[29] Except six states, viz. Goa, Nagaland, Arunachal Pradesh, Sikkim, Delhi and Chandigarh

30 Haryana, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Manipur, Punjab, Tamil Nadu, Uttar Pradesh, West Bengal, D & N Haveli, Daman & Diu and Lakshadweep

setting up of infrastructure for new health centres to bridge the gap. Only 19 per cent Sub Centres in seven States, 26 *per cent* PHCs in four States and 11 *per cent* CHCs in seven States were created, while the work was in progress for 7 *per cent* Sub Centres in six States, 7 *per cent* PHCs in five States and 5 *per cent* CHCs in four States. Only one State, Chhattisgarh, had created the targeted number of health centres. The State wise details on shortfall and consequent setting up of new centres are at **Annex 6.3**.

The Ministry stated that the State Government had now started indicating their requirements for establishment of new health centres in their annual NRHM PIPs.

6.5 Physical infrastructure at health centres

6.5.1 Building

A health centre requires a building in good condition. Three years after the launch of the Mission, several health centres, particularly sub-centres were operating without buildings.

Among audited units, 216 Sub Centres (16 *per cent*) of 10 States and 19 PHCs (3 *per cent*) of four States were operating without buildings. Further, 435 Sub Centres (32 *per cent*) of 28 States/UTs and 102 PHCs (15 *per cent*) of 17 States and seven CHCs of four States were operating in a rented building/ panchayat bhawan/others for want of a designated government building. Further, 217 Sub-centres (16 *per cent*) of 16 States/UT, 86 PHCs (13 *per cent*) of 16 States/UTs and 23 CHCs (7 *per cent*) of five States/UT were functioning in dilapidated buildings. The State wise details on the condition of buildings are given in **Annex 6.4**. In four States, there were instances of misuse or improper use of health infrastructure, as detailed below:

Bihar	In a PHC, the operation theatre was used as a medical store, while in 3 PHCs minor operations were carried out in wards.
Jharkhand	In Hazaribagh district, a portion of the building of a Sub Centre was used for distribution of foodgrains by the public distribution system dealer. In Barharwa PHC of Sahebganj district, labour room was used as medical store and deliveries were carried out in the General Ward.
Uttar Pradesh	In Banda and Etawah districts, the premises of Sub Centres at Baragaon and Akbarpur respectively were used as a cattle shed for villagers. In Bahraich district, three out of four wards of CHC Risia were used as a meeting hall and store for vaccines and one OT was used as a delivery room. In Barabanki district, at PHC Suratganj, Leprosy clinic was running while the PHC, Jaswantnagar in Etawah district was under the occupation of the Tehsil.
West Bengal	In four districts, the staff quarters of 24 PHCs were in a dilapidated condition and were being used by villagers for storing straw, cow dung cakes, etc.

The deficit in primary infrastructure for health centres, coupled with the non-availability of health centres in rural areas, poses a serious challenge to the future course of the Mission and the progress made under it.

CHC Shirur, Distt. Pune, Maharashtra functioning in PHC building

Newly constructed Khanajan Sub Centre in Assam

Sub Centre Dhanidhar, Jammu and Kashmir in rented building

6.5.2 Hygiene and sanitation at health centres

A large number of health centres were functioning in unhygienic conditions due to various infrastructural deficiencies.

Audit teams carried out test-checks in CHCs, PHCs and Sub Centres in different States/UTs. In many cases, centres were functioning in an unhygienic environment since they were located in the close vicinity of garbage dumps, cattle sheds, stagnant water bodies or polluting industries. Audit checks also revealed that many health centres lacked essential infrastructure viz., water supply and storage tanks; sewage disposal facilities; disposal facilities for biomedical waste and separate utilities for men and women. The details are as under:

Table 6.2: Status of hygiene and sanitation at sample health centres

Infrastructural attributes	Sub Centres			PHCs			CHCs		
	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved
Substandard environment	159	12	21	69	10	16	24	7	10
Poor cleanliness	322	24	22	91	13	15	25	8	10
Lack of separate utilities for men and women	1108	81	28	431	63	26	102	32	22
No arrangement for water supply	529	39	27	120	17	18	14	4	6
No infrastructure for water storage	1008	74	28	287	42	24	60	19	15
No sewage disposal facility	668	49	18	241	35	23	58	18	13
No facility for disposal of bio-medical waste	1000	73	28	332	48	21	142	42	20

(Source: Information collected from health centres)

The State-wise position of hygiene and sanitation at different health centres, as revealed in the sample examined, is in **Annex 6.5**.

There was a wide inter-State as well as inter-level variation in hygiene awareness and facilities. While, health centres at Sikkim, Daman and Diu, Uttarakhand, Tamil Nadu, Puducherry, Manipur, Lakshadweep, D & N Haveli, Andhra Pradesh and A &

N Islands maintained a relatively acceptable level of hygiene with deficiency in only a few determinants of sanitation; hygiene at many of the health centres of Bihar, Karnataka, Madhya Pradesh and Orissa was poor. Further, while CHCs in almost every State had maintained a certain minimum level of sanitation, the condition at Sub Centres was not up to a minimum standard.

Unhygienic water storage facility at Sub Centre Madavoor, Kerala

Lack of waste management at Nowboicha CHC, Assam

6.5.3 Support infrastructure at health centres

The Indian Public Health Standards (IPHS) stipulated a number of infrastructural parameters for the health centres, among which minimum necessities such as provision of electricity, telephone, vehicles and computers were test checked.

Audit checks revealed that many Sub Centres and some PHCs were functioning without provision of electricity. A standby source of power (generator) was yet to be made available in many sample CHCs and PHCs which was necessary for maintaining indoor patient services, operation theatre, labour room, emergency services and cold chain equipment for storing vaccines, all of which require uninterrupted power supply. Telephone connectivity[31], computers and vehicles, including ambulance, were yet to be made available in many health centres. The details are as under:

Table 6.3: Lack of support infrastructure at health centres

Infrastructural attributes	Sub Centres			PHCs			CHCs		
	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved
Electricity connection	657	48	22	93	14	18	2	0.3	2
Standby power source/ generator	NOT APPLICABLE			446	65	27	87	27	24
Telephone connection	1107	81	28	375	55	25	54	17	12

[31] Tamil Nadu's example of providing mobile phones to ANMs of Sub Centres was a positive initiative, worthy of emulation.

Required number of vehicle/ambulance	NOT APPLICABLE	441	64	26	74	23	16
Computer	NOT APPLICABLE	446	65	25	100	31	17

(Source: Information collected from health centres)

The State-wise status of gaps in various kinds of support infrastructure is given in **Annex 6.6**.

The inadequate infrastructural support to health centres adversely affected the quality of healthcare available to the rural population, particularly the emergency and indoor services. This also weakened the control structure which required connectivity between the DHS and health centres for real time monitoring and quality MIS reporting.

6.5.4 Subsidiary infrastructure

The subsidiary infrastructure, which was required to optimise the functioning of health centres, was yet to be set up at many health centres as detailed in the following table:

Table 6.4: Lack of subsidiary infrastructure at health centres

Infrastructural attributes	CHCs			PHCs			Sub Centres		
	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved	Number	Per cent	States/UTs involved
Accommodation facilities for staff NOT present/ occupied	50	16	17	305	44	25	803	59	28
Accommodation facilities for staff PARTIALLY present/occupied	227	71	24	215	31	24	226	17	12
Adequate furniture NOT present	95	30	13	321	47	20	815	60	21
Suggestion/complaint box NOT present	190	59	29	514	75	30	1130	83	30
Medical store NOT present	38	12	10	170	25	19	NOT APPLICABLE		
Waiting room for patients NOT present	131	41	22	346	50	27	NOT APPLICABLE		
Facility for stay of attendants NOT present	261	81	27	NOT APPLICABLE					

(Source: Information collected from health centres)

It is evident that more focussed efforts are required to be made by SHS/DHS in the States to provide critical infrastructure and overall hygiene and sanitation in the health centres. Support infrastructure including electricity, telephones, ambulances etc. need to be provided so as to improve health care services in rural areas.

The Ministry stated that implementation of IPHS while upgrading rural health centres would take some time. It would also consider demands of State governments of establishment of rural health centres at specific places to meet local needs.

6.6 Services and facilities

6.6.1 Essential services at health centres

NRHM aimed to guarantee essential healthcare services at CHCs and PHCs such as outpatient service; inpatient service with 30 beds at CHCs and six beds at PHCs with separate wards for male and female; labour room; diagnostic facilities with stipulated laboratory tests and AYUSH services. Operation theatre, blood storage facility and x-ray facilities were essential at CHCs and emergency services with 24x7 delivery

services were required at PHCs. Further, the programmes to control leprosy and tuberculosis aimed at ensuring availability of diagnostic facilities at CHCs and PHCs. The status of availability of services guaranteed under the NRHM was as under:

Table 6.5: Availability of essential services at CHCs and PHCs

Services/Facilities	Total test checked units		No. of units where facilities were available	No. of units where facilities were not available	Per centage of units where facilities were not available
Out-patient services	1003	CHCs and PHCs	947	56	5.58
Inpatient services	971		770	201	20.70
Separate wards for male and female	770		330	440	57.14
Labour room	1007		772	235	23.34
Diagnostic services	976		628	348	35.66
AYUSH services	858		154	704	82.05
Operation theatre	321	CHCs	261	60	18.69
X-ray facilities	317		232	85	26.81
Blood storage facilities	317		29	288	90.85
Minor operation theatre	686	PHCs	242	444	64.72
Emergency services	648		273	375	57.87
24x7 delivery facilities[32]	21377		4868	16509	77.23

The following points were also observed regarding delivery of guaranteed services:

- OPD at 161 health centres was functioning without a separate room/cubicle.
- 137 CHCs had less than 30 beds and 161 PHCs had less than six beds, as prescribed under the Mission.

[32] As per information provided by SHSs.

A. Separate AYUSH clinics in two states (Achievement)

In Delhi there were three specialised AYUSH hospital and 263 dispensaries and in Kerala 1422 separate AYUSH health centres were functioning independent of the allopathic system to cater to the requirements of alternative system of medicines.

B. Outsourcing diagnostic and x-ray services in Bihar

SHS, Bihar signed an agreement with two private agencies in the last quarter of 2005-06 for outsourcing of pathological services on public private partnership basis. Both firms (in 19 districts each) were to establish diagnostic laboratories in District Hospital and run collection centres at Sub-divisional Hospitals, Referral Hospitals and PHCs and make them operational by June 2006. Similarly x-ray facilities, along with x-ray technicians in all PHCs, Referral Hospitals, Sub-Divisional Hospitals and Districts Hospitals were outsourced to a private agency in April 2006 with a stipulation to complete the work by December 2006.

As per information furnished by the SHS in August 2008, out of total 516 different level of hospitals, only in 133 hospitals (DH: 11, RH: 20 and PHC: 102) a pathological test-facility/collection centre was set up and in 151 hospitals x-ray centres were opened, out of which 88 (PHC-53; CHC-09 and others-26) x-ray facilities were put into operation. Due to suitable space not being provided by hospitals, pathological centres could not be opened. The SHS did not intervene to provide space and other facilities as per the agreement.

- At 37 per cent CHCs and 54 per cent PHCs more than half of the beds remained unoccupied. At 25 per cent of the test checked PHCs and CHCs, the patient-bed ratio was more than 1.5 indicating substantial over-load on the system resulting in use of one hospital bed by more than one patient at a time. The under-utilisation of indoor facilities was attributable to absence of doctors, non-functional operation theatre, poor condition of wards and presence of a nearby civil hospital/CHC with better inpatient services etc. The overload on indoor services at some health centres was attributable to a spurt in indoor patients after the launch of Janani Suraksha Yojana and non-availability of adequate beds/indoor facilities for the patients.
- 92 health centres had no functional labour room and in 33 health centres deliveries were carried out in wards, vacant staff quarters etc.
- 476 health centres were not able to provide all the stipulated laboratory tests. At 313 PHCs and 91 CHCs the full range of equipment was yet to be made available in the lab.
- Leprosy diagnostic facilities were not available in CHCs and PHCs of Bihar, Haryana, Kerala, Manipur, Punjab and Tamil Nadu and PHCs in West Bengal and in 19 CHCs and 104 PHCs of Jammu & Kashmir, Jharkhand, Gujarat, Rajasthan and Uttar Pradesh. TB diagnosis facilities were not available in 2 CHCs and 98 PHCs of Andhra Pradesh, Madhya Pradesh, Mizoram, Punjab, Tamil Nadu, Uttar Pradesh and West Bengal (SHS of these States had reported full coverage of diagnosis of TB). In Bihar, against a target of 188 TB units and 940 microscopy centres, only 168 TB units and 743 microscopy centres had been set up.
- In Bihar and Uttar Pradesh, AYUSH doctors were prescribing allopathic medicines due to non-availability of AYUSH medicines, in a departure from norms.

- Operation theatre of 50 CHCs was non-functional and in 88 CHCs operations were not conducted despite the presence of an operation theatre for want of surgeon/anaesthetist or electricity/generator etc. Most of the CHCs did not have stipulated equipment for OTs.
- 41 CHCs had non-functional X-ray facilities. Utilisation of X-ray facilities at 26 CHCs was sub-optimal where average daily cases remained below four.
- At 35 PHCs, minor OTs were non-functional.
- A strength of three staff nurses, which was essential for running emergency services, was not posted at 533 PHCs.

The facilities provided at the CHCs and PHCs were not always in consonance with the services guaranteed under the framework of implementation of the NRHM. Basic services like in-patient services, diagnostic facilities, X-ray services etc. were not fully functional at all the CHCs and PHCs. The CHCs were to be rechristened as the first referral unit, but had no fully functional operation theatre, blood storage facility, labour room etc. Similarly, the PHC, which is the first interface of the patient with a doctor, often had insufficient in-patient services, labour room and emergency facilities. The inadequate infrastructure, especially equipment, and absence of doctors and para-medical staff were common reasons for inadequate healthcare facilities.

The Ministry stated that the funds were now being released to all State/UTs as per their requirements reflected in the annual PIPs. Regarding 24x7 emergency services it stated that States need to link operationalisation of 24x7 PHC with rational deployment of human resources like doctors, nurses and ANMs and their training and skill development. As regard mainstreaming of AYUSH, it stated that the States had been advised to co-locate AYUSH facilities at PHCs/CHCs and DHs. Department of AYUSH, through Centrally Sponsored Scheme of Hospital & dispensaries, would provide financial assistance for infrastructure, equipment and medicines for creating AYUSH units at these public health care facilities. Under NRHM Mission flexipool, the Ministry stated that the States were being supported for the contractual hiring of AYUSH doctors and supporting staff and also for their training.

Indoor Ward at Referral Hospital (CHC) Sandesh, Bihar

Good condition of ward at Referral Hospital (CHC) Nimgaon Distt. Pune, Maharashtra

Labour room of Referral Hospital (CHC) Sahpur, Bihar

Well equipped labour room at a NGO run health centre in Gujarat

Operation Theatre at PHC-Kendur, Distt. Pune, Maharashtra

Unequipped Operation Theatre of PHC Piro, Bihar

6.6.2 Essential obstetric care

In a positive development all test checked health centres in Andhra Pradesh and Chandigarh had adequate supplies of Kits A and B as well as equipment for normal delivery. However, none of the sample health centres had adequate supplies of Kit A and Kit B as well as equipment for normal delivery in 11 States and less than 50 per cent health centres in seven States/UTs. Equipment for neonatal care and neonatal resuscitation were yet to be made available in any of the audited health centres in five States. While in other five States only 23 per cent health centres had equipment for neonatal care and neonatal resuscitation.

Only 1007 CHCs (45 *per cent*) out of the total 2239 CHCs had been upgraded as first referral units (FRUs) in 13 States/UTs. None of the CHC had been upgraded as FRUs in 12 States/UTs. Emergency obstetric care including the facilities of caesarean section was yet to be set up in any CHC in 8 States/UTs. In another 17 States/UTs, only 39 *per cent* of CHCs had emergency obstetric care including the facility of caesarean section available. (State-wise details in **Annex 6.7**)

The reasons of non-availability of emergency obstetric care at the CHCs were varied with absence of specialists in obstetrics and gynaecology, anaesthetist, non-functional operation theatre, lack of adequate infrastructure, support staff, blood storage facility being among them. Inadequate supply of Kit A and B as well as equipment for normal delivery, neonatal care, non up-gradation of the CHCs as FRU and non availability of emergency obstetric care in the CHCs adversely affected essential obstetric care services in the health centres.

6.6.3 RTI and STI management

With the large-scale prevalence of Reproductive Tract Infection and Sexually Transmitted Infection, especially among women, the RCH II programme envisaged establishment of RTI and STI clinics at each district hospital and CHC.

However, RTI/STI clinics had not been established in district hospitals and CHCs in Bihar, Uttarakhand, Sikkim and Lakshadweep. Further, in Uttar Pradesh, Orissa, Tripura, Punjab, West Bengal, Himachal Pradesh Madhya Pradesh and Dadra & Nagar Haveli clinics had been established at CHCs. As per the SHS, RTI/STI clinics had been established in all the CHCs in Gujarat and Mizoram. However, test checks showed that these clinics had not been established in 11 out of sampled 12 CHCs and one out of three sampled CHCs in Gujarat and Mizoram respectively. In Jharkhand, though RTI/STI clinics were established in 22 district hospitals, they were non-operational due to absence of gynaecologist and diagnostic facilities.

The Ministry stated that STI and RTI facilities are covered under National AIDS Control Programme and there was no provision for separate STI clinics at sub-district level facilities under the RCH programme.

However, the Framework for Implementation of the NRHM clearly mandated management of RTI/STI as a guaranteed service at CHCs.

6.6.4 Medical termination of pregnancy (MTP) services

Enhancing the quality and number of facilities for MTP is an important component of the RCH II. The programme envisaged need based training to medical officers and nurses, provision of equipment and operation theatre and MTP kits at district hospitals, CHCs and PHCs.

However, none of the audited CHC and PHC had MTP facilities in Andhra Pradesh, Bihar, Lakshadweep, Manipur, A & N Islands and Puducherry. Further, only 62 *per cent* CHCs and 25 *per cent* PHCs had facilities for MTP in 18 States/UTs[33]. The non-availability of service was mainly due to absence of MTP kits, doctors/ nurses and equipment.

The Ministry stated that States needed to link the operationalisation of FRUs and 24x7 PHCs with training of doctors on Safe Abortion Services and provision of equipment. The Ministry further added that the same was reiterated to the States many times.

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[33] Assam, Jharkhand, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh, Chhattisgarh, Jammu & Kashmir, Meghalaya, Himachal Pradesh, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu and West Bengal

6.6.5 Cold chain management

To support the immunisation programme, cold chain maintenance was visualised in all CHCs and PHCs. Out of 220 audited CHCs, the essential equipment to maintain cold chain i.e. ice lined freezers, refrigerators and deep freezers were available in 205 CHCs (93 *per cent*), 156 CHCs (71 *per cent*) and 209 CHCs (95 *per cent*) respectively in 21 States/UTs (details in **Annex 6.8-A**). In none of the 12 sample test checked CHCs in Bihar, was cold chain equipment available.

While out of 217 PHCs test checked, ice lined freezers, refrigerators, and deep freezers were available in 110 PHCs (51 *per cent*), 90 PHCs (41 *per cent*) and 104 PHCs (48 *per cent*) respectively (details in **Annex 6.8-B**). However, none of the cold chain equipment was available in any of the 124 test checked PHCs in Haryana, Meghalaya, Madhya Pradesh, Puducherry and West Bengal (5 States/UTs).

Further, the equipment available was not put to efficient use for want of continuous power supply and due to non-functioning/non-availability of standby power sources. Besides, in Bihar, Lakshadweep and Uttar Pradesh, 31 to 68 *per cent* of cold chain equipment was non functional.

The Ministry stated that GOI provided budgetary support for maintenance of cold chain equipment to the States/UTs under Strengthening of Routine Immunization as well as supplied spare parts. Further, in case of disruption of power supply, the GOI also provided for POL for generator for PHC/CHC for alternate power supply which can be used for maintenance of cold chain.

However, it appears that SHSs were not utilizing the resources provided by the Ministry effectively. The absence of cold chain management could adversely impact on the effectiveness of the Universal Immunization Programme, a high priority area under the Mission.

6.7 Staff availability and deployment

6.7.1 Sub Centres

Each Sub Centre under the NRHM was to be run by two Auxiliary Nursing Midwives (ANM, female) and a Multipurpose Worker (MPW, male). The Mission aimed to ensure two ANMs at 30 *per cent* Sub Centres by 2007 and 60 *per cent* by 2008 with the second ANM being appointed on a contract basis. While the ANMs were to be paid out of central grants, the MPWs were to be paid by the State Government.

Among sample units, 116 Sub Centres (9 *per cent*) of 20 States/UTs were functioning without an ANM. At 992 Sub Centres (77 *per cent*) of 29 States/UTs two ANMs were not posted and in Himachal Pradesh, Karnataka, Madhya Pradesh, Manipur, Meghalaya, Sikkim, Tamil Nadu, Uttar Pradesh, West Bengal and Lakshadweep none of Sub Centres had two ANMs. The deployment of MPWs was inadequate and 775 Sub Centres (60 *per cent*) of 27 States/UTs had no MPW. In Bihar, Uttar Pradesh, Lakshadweep, Chandigarh and Puducherry none of the test checked Sub Centres had an MPW. In contrast, in Meghalaya, Mizoram, Sikkim and Daman & Diu all the tested Sub Centres had an MPW. The State-wise status of non-availability of required staff at Sub Centres is detailed in **Annex 6.9**.

6.7.2 Primary Health Centres (PHCs)

The PHC was the first point of interaction of the rural population with a doctor and was to be manned by a medical officer. Besides, the Mission aimed to provide an AYUSH doctor at each PHC on contract basis. Since the NRHM aimed to run the PHCs on 24x7 basis, three staff nurses were to be appointed at each PHC (at 30 *per cent* PHCs by 2007 and 60 *per cent* by 2008). Support para medical staff such as Nursing Mid-wife, Pharmacist, Lab Technician and Lady Health Visitor were also to be appointed at the PHCs.

71 PHCs (11 *per cent*) of 15 States were functioning without an allopathic doctor. In 518 PHCs (86 *per cent*) of 28 States/UTs an AYUSH doctor had never been appointed. 69 test-checked PHCs were functioning without an allopathic doctor or an AYUSH doctor. This meant that population residing in their sphere of coverage had no doctor available at all in the public domain. In Andhra Pradesh, Haryana, Himachal Pradesh, Kerala, Madhya Pradesh, Mizoram, Punjab, Sikkim, Tripura and Lakshadweep none of the test checked centres had an AYUSH doctor.

The availability of support/para-medical staff was also far from satisfactory as depicted in table 6.6:

Table 6.6: Status of support staff at PHCs

Post/ Designation	Number (per cent) of PHCs where required support staff was not posted	Number of States/UTs involved	States where all the tested PHCs had required staff (Positive indicator)
One Staff Nurse[34]	285 (44)	24	
Three Staff Nurse[35]	535 (82)	29	A & N Islands
Nursing Mid-wife[36]	179 (46)	15	Tamil Nadu, Sikkim, A & N Islands, D&N Haveli, Puducherry
Lab Technician	336 (52)	25	Tripura, A&N Islands, D&N Haveli, Daman & Diu, Lakshadweep
Pharmacist	191 (29)	21	Jammu & Kashmir, Maharashtra, Mizoram, Punjab, Tamil Nadu, A&N Islands, D&N Haveli, Daman & Diu, Lakshadweep
Lady Health Visitor[37]	312 (53)	19	Maharashtra, Punjab Tamil Nadu, A&N Islands, D&N Haveli, Daman & Diu, Puducherry

The State-wise status of non-availability of manpower at the PHCs is at **Annex 6.10**.

6.7.3 Community Health Centres (CHCs)

The NRHM aimed to develop the Community Health Centres as the First Referral Unit for the rural population by providing seven specialist doctors and nine staff nurses under the IPHS (30

Positive development

In A & N Islands, Chandigarh, D & N Haveli, Daman & Diu and Puducherry the full strength of nurses was available at all the test-checked CHCs.

[34] In Bihar and Sikkim, none of 42 test-checked PHCs had even one staff nurse.
[35] None of the sample PHCs of Bihar, Gujarat, Himachal Pradesh, Madhya Pradesh, Meghalaya, Orissa, Rajasthan, Sikkim, Uttar Pradesh, D & N Haveli and Lakshadweep had three staff nurses.
[36] None of the sample PHCs of Himachal Pradesh, Sikkim, Uttar Pradesh, Lakshadweep had Nursing Mid-wife.
[37] In Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Manipur, Mizoram, Orissa, Uttar Pradesh none of the sample PHCs had Lady Health Visitor.

per cent by 2007 and 50 *per cent* by 2009). Support staff such as pharmacist and lab technicians was also to be provided at the CHCs.

Availability of specialist doctors at the CHCs was very low at the test-checked CHCs as depicted in table 6.7. The State wise status of availability of specialist doctors is in **Annex 6.11**.

Table 6.7: Number of CHCs where specialist doctors were not available

Specialist doctor	Number of CHCs	Per cent of the sample	Number of States/UTs involved
General Physician	219	72	23
General Surgeon	224	74	28
Obstetrician & Gynaecologist	226	74	28
Paediatrician	236	78	28
Anaesthetist	272	89	29

Note: Data not received from Arunachal Pradesh and Delhi

As regards availability of nine staff nurses (two of whom might be ANMs), 245 CHCs (81 *per cent*) of 25 States/UTs did not have the full strength of nurses, out of which 145 CHCs (48 *per cent*) of 23 States/UTs did not have even five staff nurses. Further, 14 CHCs (5 *per cent*) of 11 States were functioning without a nurse. All the test checked CHCs of Bihar and Lakshadweep had less than five nurses and all the test checked CHCs of Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Mizoram, Orissa, Tamil Nadu, Tripura and Uttar Pradesh had less than nine staff nurses. The status of support staff at test-checked CHCs is depicted in the following table:

Table 6.8: Status of support staff at CHCs

Post/ Designation	Number (per cent) of CHCs where required support staff was not posted	Number of States/ UTs involved	States where all the tested CHCs had required staff (Positive indicator)
Radiologist[38]	209 (69)	25	D & N Haveli, Daman & Diu, Lakshadweep, Puducherry
Pharmacist	55 (18)	16	Jammu & Kashmir, Meghalaya, Mizoram, Punjab, Tamil Nadu, Tripura, Uttar Pradesh, West Bengal, A & N Islands, Chandigarh, D & N Haveli, Daman & Diu, Lakshadweep, Puducherry
Lab Technician	60 (20)	19	Himachal Pradesh, Mizoram, Punjab, Tripura, Sikkim, A & N Islands, Chandigarh, D & N Haveli, Daman & Diu, Lakshadweep, Puducherry

The State-wise details of shortfall of medical and paramedical staff at test checked CHCs is given in **Annex 6.12**.

The deployment of medical care providers such as specialist doctors, nurses, ANMs and support staff like pharmacist, lab technician, lady health visitors, multi purpose workers requires to be accelerated, in order to provide health care to the rural population.

The Ministry stated that all the State/UT Governments had taken a range of steps to improve the availability of manpower in health centres. Under NRHM, funds were also released for contractual appointment of medical and para-medical staff to improve the situation of manpower availability.

[38] In Andhra Pradesh, Himachal Pradesh, Meghalaya, Orissa, Punjab, West Bengal and A & N Islands none of the sample CHCs had a radiologist.

However, it appears that steps taken by the States Governments were not adequate to effectively address the shortfall in medical care providers in rural areas.

6.8 Appointment of contractual staff

To fill the gaps and provide additional manpower for the delivery of healthcare services, NRHM provides for engagement of medical and support manpower on contractual basis. However, shortfall was noticed in the appointment of the contractual staff vis-à-vis targets set under the PIPs as depicted in 19 States/UTs[39].

The shortfall was high in engagement of contractual manpower at medical levels of doctors and nurses and support staff at block level. The shortfall was relatively less with regard to engaging support staff at district level. The reasons for this divergent trend may be lack of qualified people to serve in the rural areas and delayed/non-initiation of the process of recruitment of contractual staff by the SHS and the DHS.

Further, in five States/UTs (Chhattisgarh, D & N Haveli, Gujarat, Madhya Pradesh and Puducherry) 29 to 57 *per cent* of contractual staff left before completion of their contract period. As the delivery of public health services requires continuous presence of service personnel, high turnover of the contractual manpower especially of medical officers would make quality service delivery difficult.

In four States, test check revealed following irregularities in appointment of contractual staff:

Kerala	The SHS appointed in-service doctors on contract basis to perform evening shift duty in contravention of the rule that the Government employees, while in service, were not allowed to enter into any type of contractual appointments. After being pointed out by Audit, the State Mission terminated their evening shift services.
Bihar	During 2007-08, contractual ANMs were selected on the basis of marks obtained in their matriculation examination. The mark-sheets of 14 candidates were found doubtful, when compared with the records of Bihar School Examination Board (BSEB), as candidates were selected on identical mark-sheets or their actual marks were different or no such roll codes were available in the records of the BSEB. DHS, Nalanda, did not reply to the audit query issued in August 2008.
Jammu & Kashmir	In 92 out of 384 cases, the criterion of local residence was not adhered to while appointing contractual staff.
Orissa	20 Block Programme Organisers were appointed by diluting the required qualifications after publishing an advertisement and by reducing the prescribed minimum pass marks after conducting a test.

6.9 Programme Management Support Units

The guidelines on the NRHM provide for establishment of Programme Management Support Units (PMSUs) at State, district and block levels to function as secretariats for health societies and facilitate management of healthcare services by professionals. The State Programme Management Support Unit (SPMSU) was required to be manned by experts in the areas of human resources, behavioural change

[39] Assam, Gujarat, Himachal Pradesh, Jammu & Kashmir, Kerala, Madhya Pradesh, Manipur, Punjab, Tripura, Uttar Pradesh, Uttarakhand, West Bengal, D&N Haveli, Lakshadweep, Bihar, Chhattisgarh, Haryana, Rajasthan and Puducherry

communication, monitoring and evaluation, MBAs, Chartered Accountants, MIS Specialists, and consultants for RCH and other National Disease Control Programmes. District and block PMSUs were also to be manned by personnel with specialisation in management, accounting and computer application.

All States, except Jharkhand, Uttar Pradesh, West Bengal and Chandigarh had set up State PMSUs. In Andhra Pradesh, Punjab and Tamil Nadu while a PMSU was set up at the State level, it was not set up at district and block levels. Further, in Chhattisgarh, Haryana and Karnataka it was not set up at block level and in Bihar, Maharashtra, Orissa, Rajasthan and Uttarakhand block level units were only sporadically established.

Further, in 12 States/UTs[40] sanctioned strength of staff at the State PMSU ranged between three to six, generally comprising a programme manager, an accounts manager and a data manager. Given the wide range of responsibilities attributed to the SHS and funds at their disposal, the SPMSUs were not functioning with a sustainable level of staff in these States/UTs. This also indicated that merger of societies implementing various disease control programmes with the SHS had not taken place effectively; as the guidelines on the institutional set up at State level under the NRHM stipulated that the SPMSU was to consist of consultants for RCH and other National Disease Control Programmes. Besides, in four States/UT, (Bihar, Kerala, Tamil Nadu, Lakshadweep) where the SPMSU had adequate sanctioned staff strength, some important posts remained vacant.

At district level, three essential management personnel, viz. Programme Manager, Accounts Manager and Data Manager were yet to be engaged at the DPMSU of 12 States/UTs[41]. At block level also, the PMSUs were set up only partially, i.e. without support of the norm of three management staff, in 12 States[42].

The partial setting up/non-formation of PMSUs in health societies at three levels of the Mission's implementation and the shortage of managerial staff indicated that the purpose of managing varying jobs by experts in their relevant field was only beginning. The quality of management functions such as accounting, MIS reporting, manpower management etc. necessitated that the task be approached more holistically.

The Ministry stated that it was correct that a wide range of responsibilities were being discharged by the PMUs with limited staff. However, the situation was fast changing and in most States these units had been made fully functional.

6.10 Accredited Social Health Activists (ASHA)

Under the NRHM a trained female community health worker called Accredited Social Health Activist (ASHA) was to be placed in each village in the ratio of one per 1000 population (or less for large isolated habitations) in the 18 high focus States using the

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[40] Chhattisgarh, Haryana, Himachal Pradesh, Maharashtra, Meghalaya, Punjab, Orissa, Rajasthan, Sikkim, Uttarakhand, Dadra and Nagar Haveli and Daman and Diu

[41] Bihar, Chhattisgarh, Himachal Pradesh, Karnataka, Madhya Pradesh, Meghalaya, Rajasthan, Tripura, Uttarakhand, A & N Islands, Delhi and Puducherry

[42] Assam, Bihar, Gujarat, Himachal Pradesh, Jammu and Kashmir, Madhya Pradesh, Maharashtra, Meghalaya, Orissa, Rajasthan, Uttarakhand and West Bengal

Mission Flexible Pool funds. States were given the freedom to relax the population norms prescribed for ASHA so as to suit their local conditions. The ASHA was expected to act as an interface between the community and the public health system.[43] About 6.16 lakh ASHAs have been engaged under the Mission in the States/UTs.

The ASHA had been engaged in all high-focus States, except Himachal Pradesh. In six high focus States shortfall in the selection of ASHA ranged between 4 to 24 *per cent*[44], when compared with the requirements as per population norms. In five high focus States a larger number of ASHAs were engaged when compared with the requirements as per population norms, but as long as this had been in response to a felt need this was a proactive development[45]. Further, among non-high focus States, Andhra Pradesh had engaged 28 *per cent* more ASHAs than required as per population norm. Maharashtra had engaged ASHAs only for the tribal areas. Few State specific findings on selection of ASHAs are given in **Annex 6.13-A.**

6.10.1 Training of ASHAs

The NRHM guidelines provided for training of ASHAs to equip them with necessary knowledge and skills. The guidelines provided for five modules of induction training, as well as periodic trainings for skill enhancement. ASHAs were to be provided with drug kits containing medicines for minor ailments, ORS, contraceptives etc.

In none of the States/UTs had all the five modules of induction training been given to all the selected ASHAs as shown in the following table:

Table 6.9: Training of ASHAs

Training up to	States (figures in bracket indicate the per cent of ASHAs receiving the training
5th modules	Andhra Pradesh (86%), Chhattisgarh (99%) and West Bengal (68%)
4th modules	Assam (100%), Mizoram (100%), Orissa (100%), Sikkim (100%), Gujarat (31%) and Uttarakhand (96%), Arunachal Pradesh (19%) and Madhya Pradesh (24%)
3rd modules	Jharkhand (13%)
2nd modules	Haryana (6%), Jammu & Kashmir (73%), Kerala (38%), Rajasthan (75%), Tripura (13%), Uttar Pradesh (66%), Delhi (12%)
1st modules	Bihar (86%), Maharashtra (36%), Punjab (100%), D & N Haveli (81%), Lakshadweep (100%), Manipur (100%)
No training	Meghalaya, A & N Islands

Incomplete training was a major problem in mainstreaming the workers. Moreover, inconsistencies in district-wise data provided by the SHS regarding training and selection of ASHAs and data provided by the DHSs of the audited districts were observed in some States/UTs as detailed in **Annex 6.13 B and 6.13 C** respectively.

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[43] The ASHA was to be supported in the non-high focus states in very remote, backward/ tribal regions. Further, the non-high focus states/UTs were also free to opt for the ASHA from the grants released under RCH-II Flexible Pool.

[44] Arunachal Pradesh-18%, Bihar-9%, Madhya Pradesh-9%, Rajasthan-24%, Tripura-14% and Uttar Pradesh-4%

[45] In Assam and Uttarakhand 13 and 10 per cent more ASHAs were selected respectively, while in Jharkhand, Meghalaya and Chhattisgarh 95, 217 and 222 per cent more ASHAs were selected respectively. Chhattisgarh had decided to engage one ASHA for the population of 250, in Meghalaya the population norm was relaxed in view of the large number of smaller villages in the state.

Further, ASHAs were not provided with a drug kit in Bihar, Gujarat, Haryana, Jharkhand, Kerala, Meghalaya, Mizoram, Sikkim, Tripura, Uttar Pradesh, West Bengal, A & N Islands and D & N Haveli. Non-completion of induction training of the ASHA was the main reason behind this, making their full utilisation difficult.

The Ministry stated that all high focus States except Bihar had since distributed drug kits. The Ministry also stated that there were delays in commencing training in many States because different States had to adopt the ASHA scheme after an internal process of discussions and consultations. While noting the discrepancies between DHS and SHS figures; the Ministry stated that the difference was less than five *per cent*, as a rule. This may occur since these health workers were volunteers and, at any time, there were changes with some ASHAs ceasing to function, new recruitments taking place. Discrepancies may also merely reflect the time period to which the data relates.

6.11 Mobile Medical Units (MMUs)

Achievement

The MMUs were rendering the full prescribed range of services in outreach areas of Assam, Mizoram and tribal districts of Madhya Pradesh.

Under NRHM, one Mobile Medical Unit (MMU) was to be provided in each district to serve outreach areas with the aim of taking the health care to the doorstep of needy people. The ceiling of the capital cost was Rs. 49 lakh for the North Eastern States and hill States of Jammu and Kashmir and Himachal Pradesh and Rs. 25.25 lakh for other States for one MMU. The Ministry released Rs. 199.84 crore in 2006-07 and Rs. 116.78 crore in 2007-08 to SHSs for operationalisation of MMUs in 27 States/UTs and 21 States/UTs respectively.

However, the release of funds for MMUs did not follow a defined pattern. During 2006-07, Rs. 19.95 crore and Rs. 5.13 crore were released to Uttar Pradesh (for 70 districts) and to Punjab (for 18 districts) respectively as capital cost of the MMUs, which included excess release of Rs. 2.28 crore (Uttar Pradesh) and Rs. 58.50 lakh (Punjab). Further, Rs. 22.33 crore was released to Rajasthan for 52 MMUs (at the rate of two MMUs per district for 20 tribal districts and one MMU per district for remaining 12 districts) and Rs. 9.66 crore was released to Andhra Pradesh for 23 districts (at the rate of 2 MMUs per districts). This resulted in excess release of Rs. 8.59 crore (Rajasthan) and Rs. 4.83 crore (Andhra Pradesh). Further, during 2007-08 Rs. 12.56 crore was released by the Ministry to five SHSs (Karnataka, Rajasthan, Uttar Pradesh, Manipur and Tripura) as recurring cost of MMUs, without ascertaining that the MMUs were not made operational in these States at all.

The MMUs were not operational in any district of 13 States (Bihar, Himachal Pradesh, Jammu and Kashmir, Karnataka, Maharashtra, Meghalaya, Orissa, Punjab, Rajasthan, Sikkim, Tamil Nadu[46], Uttar Pradesh and West Bengal) and all UTs. In the remaining 12 States, out of 223 districts the MMUs were available only in 123 districts, of which again 22 districts of five States had non-functional MMUs. Funds

[46] In Tamil Nadu against the requirement of one MMU per district 100 MMUs (ambulances) were present, which were not equipped as per norms for MMUs.

released for procurement of MMUs were lying unspent in most of the States. Few State specific findings on MMUs are given in **Annex 6.14**.

The non-operationalisation/inadequate functioning of the MMUs affected the goal of improving accessibility to health care services in outreach areas, leaving the remote and difficult areas without any reliable and quality medical care. These funds were lying unspent in States. The Ministry did not follow guidelines, while approving the State PIPs for release of funds to SHS for operationalisation of MMUs.

The Ministry stated that if the requirement on the basis of specific need of a particular district was more than one MMU, then the same was allowed e.g. more than one MMU was allowed in tribal area in some States. However, only EPC/MSG was empowered to relax the provisions of the Framework of Implementation and not the NPCC.

6.12 Health System Resource Centre

As per the NRHM framework, a National Health System Resource Centre at the centre and a State Health System Resource Centre in each State were to be established to provide technical support to the Mission by providing and operationalising new ideas to improve effectiveness of service delivery and efficiency of resources.

The NHSRC provided technical support and capacity building for strengthening public health systems and functioned as a focal point in the identification, documentation and dissemination of knowledge and experiences in health systems and health programmes. The Ministry released the annual corpus of Rs. 15 crore for NHSRC in March 2007. During 2007-08, the NHSRC spent Rs. 1.68 crore, out of which Rs. 1.1 crore was released to the Regional Resource Centre, Guwahati. Instead of investing the corpus fund to earn returns, the balance was kept in the current account.

As per the information provided by the Ministry SHSRCs were established in Chhattisgarh, Maharashtra, Uttarakhand, Bihar, Orissa, Rajasthan, Jharkhand, Haryana, Punjab and one RRC at Guwahati catering to the needs of eight North East States. The SHSRCs were not set up in remaining States and UTs. The Ministry had released funds to three States [Jammu and Kashmir (Rs. 1crore), Madhya Pradesh (Rs. 1.68 crore) and Tamil Nadu (Rs. 1.47 crore)] for setting up a resource centre, but the funds remained unspent at the SHSs. In West Bengal although the SHSRC was established, the annual corpus of Rs 1 crore was not created. In Gujarat construction work was under process.

The Ministry stated that the Cabinet approval for setting up of the NHSRC had not mandated for investing the corpus and run NHSRC from interest accrued.

The reply of the Ministry is not correct. By definition, corpus funds are required to be invested for keeping the corpus intact and using the interest accrued to the principal for expenditure, as is also indicated in Rule 208 (iv) of the GFRs.

Recommendations

- ***The Ministry may ask the States to report on their contribution of the matching amount under the Mission and link up State funds with their contribution.***
- ***The Ministry may ask the SHSs to map available services and supporting infrastructure at the health centres as well as the existing load on the***

available infrastructure. On this basis, relative need for setting up of new infrastructure and strengthening the existing ones as per IPHS may be assessed.

- ***The essential services such as OPD and in-patient services at the CHCs and PHCs need to be ensured on a priority basis across all health centres countrywide.***
- ***Adequate diagnostic and radiological services should be provided at all health centres.***
- ***Operation theatre at CHCs and labour room at CHCs and PHCs must be made functional with all essential equipment and manpower.***
- ***States should be instructed to fill sanctioned posts of medical and support staff at health centres and revise the sanctioned strength to meet the NRHM requirements. Release of further grants under the Mission Flexible Pool may be linked with achievements/progress on this count.***
- ***SHSs may segregate medical services and the management functions and ensure that the latter be strictly performed by management professionals. The Ministry has noted this for consideration.***
- ***Steps may be taken to fill up the management posts at the earliest as this would positively impact on the functioning of the Mission.***
- ***Complete induction training may be given to all ASHAs to make their services effective and viable.***
- ***The issue of inconsistency between data given by the SHSs and data obtained from DHSs may be taken up with the concerned States to ensure data integrity.***
- ***The Ministry may ask the SHSs to purchase and operationalise MMUs at the earliest.***
- ***SHSRC should be established in all States, especially in the EAG States where the requirement for technical support to the Mission was greatest.***