Chapter 2 Planning

2.1 Planning

State level

2.1.1 Perspective Plan

Under NRHM guidelines, DHSs and SHSs had to identify gaps in health care facilities, areas of interventions, probable investment, the share of the Centre and State that would be required for the entire Mission period. They were to prepare a Perspective Plan (PP) for each district and an overall PP for the whole State for the Mission period (seven years: 2005-12) outlining the overall resource and activity needs.

Audit observed that NRHM was launched in the State without preparation for State level PP. Without identifying gaps in services, areas of interventions, probable investment in each area over the Mission period and requirement and availability of resources, the physical and financial targets remained unrealistic. Moreover, there was no ascertained baseline *vis-à-vis* which improvements were sought to be made and measured.

The Government in its reply stated that the State PP had been prepared in September 2005 itself. The reply was not convincing because SPMU was not even aware of the existence of PP and had earlier stated that there was no State PP. Moreover, the foreword of the document furnished states that it is a draft version. The draft PP was merely a reproduction of NRHM framework of GoI and did not find mention in any of State PIPs prepared during 2006-11 or district-wise PPs prepared in 2007.

2.1.2 Project Implementation Plan

NRHM envisaged a bottom-up, decentralised and community owned approach to public health planning. The State Project Implementation Plan (PIP)/Annual Action Plan was to be prepared on the basis of District Health Action Plans (DHAPs) and discussed/approved in SHS and submitted to Ministry of Health & Family Welfare (MoHFW), Government of India for appraisal/approval by 15 December of the preceding year. The State PIP was to be approved by the National Programme Coordination Committee (NPCC) by 31 January to ensure finalisation of State PIP before commencement of the financial year.

Audit observed that State PIPs were not prepared for 2005-06 and 2006-07. PIP for 2007-08 was submitted in June 2007, as against the target date of 15 December 2006. Moreover, PIP of 2007-08 was prepared without any inputs from districts, as DHAPs were not prepared during 2005-08.

The Government stated that PIP for 2006-07 was prepared and that PIPs were being prepared in accordance with GoI guidelines for each year. The reply was not convincing because scope of PIP of 2006-07 was restricted to existing programmes like RCH-II and NDCPs. Further PIPs of 2006-07 and 2007-08 were prepared without preparing DHAPs. The PIPs of later years were also deficient as brought out in subsequent paragraphs.

2.1.3 Quality of State PIPs

Test check of PIP related records and replies to audit queries revealed that:

a) SHS comprising the Chief Secretary and representatives of various departments, specialists form Public Health, Non-Governmental Organisations (NGOs) and Regional Director, MoHFW, GoI was to approve the State PIP. Not even a single PIP of the seven to be sent, (2005-12) was approved by SHS.

b) SHM comprising the Chief Minister and other people's representative was to decide policy issues and steer inter-departmental coordination. Thus, SHM's work had implications for preparation of annual PIP. However, SHM did not meet at all during 2005-11.

c) State level draft PIPs were prepared without obtaining inputs from other social sector departments like Women and Child Development, Education, *Panchayati Raj*, Rural Development *etc*., or from health experts and development partners. The preparation and approval of draft PIP was a routine bureaucratic exercise largely involving health department/SPMU officials. The Principal Secretary, Medical, Health and Family Welfare, approved it before sending it to GoI in contravention of NRHM framework and MoU with GoI, wherein the draft PIP was to be submitted to the Executive Committee (EC) or the Governing Body (GB) of SHS before sending it for GoI's approval.

d) SHS did not give any feedback to DHSs on the quality of district plans and forwarded the guidelines on decentralised planning only during 2009-11. It also did not intimate DHSs the size of plan in any of the years.

e) There was no formal, transparent and documented methodology for appraising DHAPs. Districts' proposals were amended in State PIPs but the districts were not informed of reasons for sanctioning more or less funds than those proposed in DHAPs. The Government accepted that it did not have the appropriate capacity to appraise DHAPs due to which it took technical support from State Innovations in Family Planning Services Project Agency (SIFPSA), ITAP but did not submit any documentary evidence in this regard.

f) There was no mechanism to ensure (i) compliance to NRHM's framework, the Memorandum of Understanding (MoU) between GoI and the State, GoI's conditionalities as approved in the previous year's PIP, record of proceedings, State level PP (2007-12) *etc*., (ii) validity and reliability of data and (iii) incorporation of lessons learnt during implementation of NRHM. In reply, the Government stated that NRHM framework document, MoU and proceedings of sub-group meetings at GoI have been referred to for implementing the programme in the State. The Government's reply was not convincing as no documentary evidence was furnished.

g) There was *adhocism* in introducing new schemes/projects such as *Jacha Bacha Suraksha Abhiyan* (2010-11), incentives for promotion of night deliveries (2008-09) and District Innovations (2008-09), which were introduced for one year, without any detailed appraisal or public demand and closed abruptly without conducting any

evaluation or impact assessment. The Government's reply did not address the issue raised by Audit.

h) PIPs (2006-11) did not mention the extent of utilisation of existing/new infrastructure, client satisfaction, results of independent evaluation and empirical evidence to show continued validity of strategies/interventions outlined in NRHM framework and State PP. There was likelihood of continuation of schemes/programmes incapable of producing desired outcomes.

   The Government stated that before initiation of the planning process, meetings were held with the district and divisional officers and the usefulness of existing activities reviewed and need for new activities discussed, but no evidence was furnished.

i) PIPs gave physical and financial achievements in previous years without mentioning the quality of interventions. Without an assurance on quality, the chances of continuing with schemes and programmes with low client satisfaction, low capacity utilisation and increased resistance to behavioural change cannot be ruled out.

j) PIPs did not identify programme-wise risks of fraud, abuse and waste and corresponding risk mitigation measures. The Government stated that from July 2011 onwards, for JSY, details such as cheque number, beneficiary's mobile number, Accredited Social Health Activist's (ASHA) mobile number *etc*. were being electronically captured and that the information was available on a *web-site* created for this purpose. The Government, however, did not produce evidences for programme-wise fraud indicators or NRHM wide anti-fraud policy and vigilance mechanism.

k) The State PIP contained a chapter on 'lessons learnt', which talked more about achievements and less about the areas of and reasons for shortfall and the need to change strategy/intervention. As a result (***Appendix-2.1***) subsequent PIPs did not contain remedial measures. While accepting the audit observation, the Government stated that necessary action would be taken.

l) NRHM framework aimed at a 30:70 ratio of spending at the State and District levels, so that 70 *per cent* of expenditure was by institutions/organisations supervised by an institutional PRI/community group. PIPs did not give share of State and District spending, except in Fund A for 2008-09. The absence of demarcation of spending limits between State level agencies and districts was fraught with risk of centralisation of spending in State headquarters (SPMU, Directorates *etc*.), contrary to NRHM guidelines. The Government accepted the audit observations and stated that specific instructions in this regard intimating size of plan for the districts were being issued to districts from 2011-12.

m) Proposals involving convergence with other departments were made without consultation with other departments at any stage and PIPs did not elaborate on data sharing, planning for physical and human resources, mechanism for joint monitoring, coordination and dispute resolution. It was implicitly assumed that the District Magistrate would steer the convergence. Further, there was no convergence with District Planning Committee (DPC) and Standing Committees of *Panchayats* on health issues at the district, block and village levels. Though the Government stated that

different departments were involved while framing plans, no evidence was furnished to Audit. On the issue of convergence with DPC and standing committees of *Panchayats* on health issues, it stated that no guidelines for this were available. The fact remained that there was no convergence between the DPC and the standing committees of *Panchayats*.

n) The State PIPs ignored critical obligations of the UP Government, as per Memorandum of Understanding (MoU), as tabulated below:

Table 2.1: Non-inclusion of MoU conditionalities

Sl. No.	MoU conditionality with para number	Compliance Status
1.	8.3: Merger of the departments in the Health and Family Welfare sector.	At the Government and Directorate levels, the sector was divided among four departments *viz*., Medical, Health and Family Welfare, Medical Education and Training, AYUSH and Food and Drug Administration.
2.	8.3: Issue necessary orders for appointment of Mission Director.	A regular and full time MD was posted as late as the first quarter of 2011-12, when the Mission period is to end in March 2012.
3.	11.4: The State Government committed to take prompt corrective action in the event of any discrepancies or deficiencies noticed.	Various discrepancies/deficiencies such as non-preparation of need based village health plans, lack of community participation in planning, shortcomings in implementation and monitoring *etc*. had come to the notice of the State Government, but no effective/ corrective measures were initiated.

(**Source :** MoU between GoI and GoUP, dated 22 November 2006)

The MoU also envisaged a permanent secretariat for SHS manned by adequate and skilled staff. The Mission Director was to head this secretariat. The Government in its reply stated that appointment of full time Mission Director was not a condition of MoU. The fact remained that lack of appointment of Mission Director compromised the spirit of MoU conditionality. The conclusion is also backed by GoI's advisory in December 2010 to appoint a full time Mission Director.

o) The State PIPs neither mentioned stages of implementation of NRHM's accountability framework in terms of community based monitoring, monitoring tools, publication of annual public health reports and concurrent and external evaluations, nor proposed any remedies.

p) PIPs contained factually incorrect or irrelevant information on GoI's conditionalities. For instance, on the conditionality of monthly meetings for RKS, PIP (2010-11) merely stated that orders were issued to ensure holding of timely meetings and did not state whether meetings were actually held. Audit observed that RKS meetings were not held regularly. The Government did not reply on the above issue.

District, block and village levels

2.1.4 Overview of planning arrangements

NRHM focused on decentralised planning, with the village as an important unit. Village Health Action Plans (VHAPs) were to be prepared and consolidated into Block Health Action Plans (BHAPs). DHSs were to aggregate VHAPs and BHAPs and prepare PPs for the

Mission period, as well as annual PIPs, comprising all components. These were to form the basis for the State PP and annual State PIP respectively.

2.1.5 Perspective Plans

As per information made available by 14[1] out of 22 test checked districts, eight[2] districts had prepared PP as of March 2011. The following deficiencies were observed in PPs.

(a) DHS prepared PPs in 2007-08 for 2007-12, after a lapse of two years from the start of NRHM;

(b) As per records made available by the test checked districts, no baseline survey or facility survey was conducted to map existing health facilities and people's health needs, prior to preparation of PP. Without first identifying gaps in healthcare services, a PP focussing on the gaps in healthcare services was not very relevant;

(c) SIFPSA prepared the district-wise PPs without much involvement of stakeholders and without necessary baseline data from household and facilities surveys. Thus, PP was merely a replication of NRHM framework/strategies with a token mention of District Level Household Survey (DLHS) and National Family Health Survey (NFHS). There was no record of detailed deliberations within Health Department or DHS, prior to preparation of PPs. Test check of PPs of eight districts[3] revealed that there were no baseline statistics or situation analysis and that the broad NRHM framework was adopted as such, without need based local modifications. Consequently there were no local strategies to overcome area specific problems and year-wise scheduling of activities was only partially done; and

(d) There was no mechanism to ensure compliance with PPs. Consequently, annual DHAPs were prepared without any reference to PPs.

In reply the Government stated that all the districts carried out district level survey for situational analysis for planning purposes at the beginning of the program. However, the fact remained that the districts had not conducted baseline surveys, which were a critical component of NRHM.

2.1.6 District Level Health Plan

2.1.6.1 Annual District Health Action Plan (DHAP)

According to NRHM framework, DHAP was to be prepared consolidating the village and block health plans, but DHAPs were not prepared in any of the sampled districts during 2005-08. As a result, all components of NRHM, like construction work, ASHA, *Rogi Kalyan Samiti* (RKS), mobile medical units, untied grants, engagement of contractual workforce, monitoring and MIS framework, human resources plan, procurement and logistics plan, management structure and accounting system, action plan for demand generation, non-governmental partnership (with NGOs, Medical Institutions, Medical Colleges) and other

---

[1] Allahabad, Azamgarh, Bahraich, Bulandshahar, Deoria, Etah, Gorakhpur, Jaunpur, Kanpur Nagar, Kushi Nagar, Mirzapur, Raebareli, Unnao and Varanasi.

[2] Allahabad, Bahraich, Bulandshahar, Gorakhpur, Kanpur Nagar, Mirzapur, Unnao and Varanasi.

[3] Allahabad, Bahraich, Bulandshahar, Gorakhpur, Kanpur Nagar, Mirzapur, Unnao and Varanasi.

determinants of health like sanitation, nutrition, drinking water *etc*. were not covered during 2005-08.

Test check of records of DHAPs for the period 2008-11 revealed the following:

- To promote decentralised approach including preparation of VHAPs and their consolidation at the block level for preparation of DHAPs for 2010-11, ₹ 3.55 crore was provided to all districts of the State (₹ 0.05 crore per district). The provision of fund for preparing plans had no impact as was evident from the fact that VHAPs and BHAPs was not prepared in the districts.

- DHAPs, prepared by District Programme Management Units (DPMUs), were never put up to District Health Mission (DHM) or DHS, for approval, before submitting to SHS. However, in some districts, DHAP was signed by District Magistrate (DM) in one or two years before submitting to SHS. In reply, the Government stated that necessary instructions in this regard had been issued to prepare DHAPs aggregating BHAPs and getting the plans approved by the district level committees.

- DHAP was to be prepared by 31 October every year, for the following year. Chief Medical Officers (CMOs) did not make available the date on which DHAPs were sent to SHS. During 2008-11, approval of DHAPs through PIPs was communicated by SHS to DHS with delays of three to four months, from the prescribed date i.e. 28 February every year; and

- DHS did not maintain prescribed database of the physical and human resources to support the planning process. DHS made little use of applications like Plan Plus, DISNIC and Gram++ of NIC, in preparation of DHAP. In reply, the Government stated that date of submission of PIP was intimated by GoI every year. The fact remained that DHSs received the PIPs with delays of three to four months as accepted by 10 out of 22 test checked districts.

The *Zila Panchayat* (ZP) at the district level was to be directly responsible for the budget of the health sector and for the planning for people's health needs. With the development of capacities and systems, the entire public health management at the district level was to devolve to DHSs, which would be under the leadership and control of ZP with participation of the Block *Panchayats*. Audit observed that ZP was not involved in the planning process.

In response to an audit query, SHS stated (October 2011) that various departments like Integrated Child Development Services (ICDS), *Panchayati Raj* Institution (PRI), Rural Development (RD), Education *etc*., which are members of DHS, provide feedback regarding health related issues of the community for preparing DHAPs. SHS's reply was not correct as minutes of meeting of none of the test checked districts disclosed discussion of DHAPs. Thus, no convergence with other departments was ensured while framing DHAPs.

The Government stated that DHAPs for 2007-09 were prepared with the technical help from outside agencies and these were very brief. For the years 2010-11 and 2011-12, DHAPs were prepared after discussion with district and block level officers, functionaries, other departments, NGOs and stakeholders.

The reply was not convincing as essential requirements for preparing need based and community owned decentralized plans were not fulfilled.

2.1.6.2 Functioning of Programme Management Support Units

NRHM guidelines provide for establishment of Programme Management Unit at district (DPMU) and block (BPMU) levels to function as secretariats to health societies and facilitate management of healthcare services by professionals. These units were to be manned by personnel with specialisation in management, accounting and computer application. NRHM specifically provided funds for this purpose.

Though DHSs were formed in September 2006, DPMUs came into existence only in October 2008 and remained almost non-functional as separate entities (October 2011). Though DPMUs were to act as full fledged secretariats to DHSs and DHMs for all activities of planning, financial management, monitoring and quality control, they confined themselves to works relating to preparation of DHAPs and compiling and feeding monthly progress data for preparation of Financial Management Reports.

At the block level, Block Programme Manager (BPM) and Block Accounts Assistant (BAA) were to be engaged. BPMU was responsible for preparing the Block Health Action Plan (BHAP). However, Audit observed that the State Government had nominated Health Education Officers to look after works of BPMs, till appointment of a regular BPM. BAAs were appointed only in 2010-11. Lack of competent full time staff hindered the effective functioning of BPMUs as was evident from the fact that BHAPs were not prepared during 2005-11. The Government in its reply discussed issues pertaining to block level planning and not the issue raised by Audit.

2.1.7 Annual Block Health Action Plan (BHAP)

Test check of records revealed that no Block Health Action Plan (BHAP) was prepared during 2005-11. It was also seen that the department did not provide even basic requirements for planning as:

- No block level monitoring and planning committee to review BHAP was constituted. The Block *Pramukh*, MOIC, BDO, NGOs' representative, head of CHC/PHC and members of RKS were to be members of block level monitoring and planning committee; and

- Professionals were not engaged on contract basis at State, District and Block levels to meet planning needs.

In reply, the Government stated that model BHAP had been prepared and would be used for the PIP 2011-12. The fact remained that BHAP was not prepared during audit period.

2.1.8 Annual Village Health Action Plan (VHAP)

Village Health and Sanitation Committees (VHSCs) were responsible for preparation of VHAPs. Accredited Social Health Activists (ASHAs) and *Anganwadi* Workers (AWWs), were to play a vital role in the household survey and preparation of health plan for each village. Test check of records revealed that in none of the districts in the State, facility surveys were conducted and no VHAPs were prepared during 2005-11.

NRHM framework prescribed certain essential requirements of context specific and habitation/household specific planning ***(Appendix–2.2).***

SHS/SPMU did not make effective efforts to ensure compliance to essential conditions for drawing up village, block and district plans, as envisaged in NRHM framework *viz*.:

(a) No planning team was constituted to frame VHAPs during 2005-11;

(b) DHSs did not hire technical and professional experts to facilitate decentralised planning process;

(c) DHSs did not draw upon experiences in decentralised planning process from DPC, decentralised plans under Backward Regions Grant Fund (BRGF), *Sarva Siksha Abhiyan*, Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS) and 15-point programme for minorities;

(d) DHSs did not prepare checklists and templates to facilitate decentralised planning and did not promote use of the Integrated Manual for District Planning, issued by the Planning Commission;

(e) SHS/DHSs did not develop any software to promote decentralised planning and neither was any standard decentralised planning software like Plan Plus, DISNIC (Districts NIC) *etc*. used;

(f) Training was not imparted to VHSCs for decentralised planning. While, there was no record to show that VHSCs' orientation training in 2007-08 had elements of decentralised planning process, the course content of a two-day VHSC orientation training programme in March 2011, costing ₹ 10 crore, had no inputs on the decentralised planning process;

(g) The Mission targeted completion of 50 *per cent* household and facility surveys by 2007 and 100 *per cent* by 2008. In all the sampled districts, though no specific household surveys were conducted during 2005-11, Village Health Index Registers (VHIRs) were introduced in 2006-07 to collect data/information, apart from basic family details, need and utilisation of RCH services and other health services, status of nutrition, water supply and sanitation. VHIRs were to be filled in by every ASHA for the population of the area under her coverage. Test check of records of VHIRs in the VHSCs (test checked) in 22 test checked districts revealed that:

   (i) Entries were incomplete in almost all districts and were filled-in with pencils and bore the appearance of casual and unconfirmed work;

   (ii) On the basis of household and facility surveys, DHSs and SHS were required to maintain an authentic central database and develop a mechanism for ensuring reliability and integrity of survey data and it's reporting by the State to the Ministry. Data collected through household and facility surveys was required to be validated by representatives of PRIs. Audit observed that the data entered in these registers was never validated by MOIC, VHSC or PRIs; and

(iii) VHIRs were to be computerised to utilise the data for improving supervision and verification and for monitoring the utilisation of services and outcomes. VHIRs were not computerised as of March 2011 in any of the test checked districts. Thus, the resources engaged in household survey became wasteful, as this data/ information was not used in the planning process, as envisaged.

On being pointed out in audit, DHSs of test checked districts accepted the audit comments in general.

The Mission's implementation was adversely affected as no detailed and systematic plans were formulated in initial years and also because delayed submission of PIPs, resulted in delayed release of funds to districts and implementing agencies. Besides, PIPs did not factor in the DHAPs, which would have increased the size of PIPs in terms of activities and, therefore, the allocations of funds. Thus, the State was deprived of the benefits of holistic State level planning, mindful of gaps, needs and required interventions at the village, block, district and State levels.

2.2 Convergence

2.2.1 Convergence framework for effectiveness

Contrary to the framework of NRHM, the Minister in-charge of the district was made the chairperson of DHM instead of the Chairman, ZP in November 2006. Even after issue of the Government order, DHMs were either not constituted or remained non-functional. There was no evidence to establish that any Minister in-charge ever participated in finalisation of DHAPs. Besides, the Standing Committee on Health and Sanitation (ZP, Block *Panchayat*) was not associated in planning, implementation and monitoring of NRHM. Thus, the objective of empowering PRIs at district level to take leadership and control and manage public health infrastructure, make them directly responsible for budget of the health sector and planning for people's health was not achieved.

In fact, the organisational set up of DHMs never came out of the orbit of the Government control. Audit observed that in most cases, the District Magistrate functioned as the *de-facto* Chairperson of DHM. Thus, the objective of community participation remained a distant goal as the new mechanism continued to be administered by the existing administrative setup rendering the entire NRHM effort ineffective.

In reply the Government stated that it had convergence with the Women & Child Development, Education Department. The reply of the Government did not address the issue of lack of convergence as envisaged in NRHM framework and pointed out in Audit.

2.2.2 Lack of convergence within the Health Department

Against NRHM framework, Audit observed that there was absence of structural integration and convergence within Health department. Initially, the erstwhile Departments of Medical, Health and Family Welfare were merged into a single department of Health and Family Welfare after the execution of MoU in November, 2006. Subsequently, the Government moved away from integration by appointing two Ministers during January 2009 to April 2011 and by appointing two administrative Secretaries during December 2010 to April 2011 in erstwhile Department of Medical, Health and Family Welfare. Further, under the existing

arrangement at the State level, the Central Medical Store Depot (CMSD) was functional under the DGMH. Instead of reorienting it to meet the requirements of Family Welfare programmes, another CMSD was established (July 2009) under the Director General, National Programmes, Monitoring and Evaluation (DGNPME) for NRHM. At the district level also, the posts of District Programme Officers (DPOs) and Deputy DPOs were created under the DGNPME in May 2010. Consequently, two parallel posts of CMO became operative in the districts. However, the Government had to withdraw the earlier orders due to institutional problems arising out of the creation of parallel posts of CMOs. This indicated that the issue of integration of funds, functions and functionaries even within the department was not resolved as of March 2011. Moreover, the objective of effective and efficient utilisation of available human resources, within the same financial allocation, was defeated. In reply, the Government accepted the audit observations.

2.2.3 Convergence with *Panchayati Raj* Institutions

Audit observed that PRI had a limited role. As noted earlier, Minister in-charge of district headed DHM in place of the Chairperson, ZP. Similarly, the Standing Committees on health related issues in all the tiers of *Panchayats* was not given a prominent role in NRHM structures and processes. Thus, the critical role of PRIs in the success of NRHM–planning, implementing, monitoring, inter-sectoral convergence and community ownership–remained a theoretical construct.

2.2.4 Convergence for drinking water, sanitation, food, nutrition, social security *etc*.

NRHM viewed health through the prism of a sector-wide approach, encompassing sanitation and hygiene, nutrition and convergence with related social sector departments and sought to adopt a co-ordinated approach for intervention under the umbrella of the district plan. The *Anganwadi* Centre under ICDS at the village level was to be the principal hub for health action. Likewise, wherever village committees had been effectively constituted for drinking water, sanitation and ICDS, NRHM was to move towards one common Village Health Committee covering all these activities.

During Exit Conference the Government stated that AWW could not be the hub of convergence for health oriented scheme and that ASHAs were better suited for the task at hand. This, however, was not in accordance with the NRHM framework.

2.2.5 Non-involvement and regulation of NGOs

NRHM identified NGOs as critical for its success. Efforts were to be made to involve NGOs at all levels of the health delivery system. To support/facilitate action by NGO network in the State, five *per cent* of total NRHM funds were to be released as grants-in-aid to NGOs at district and State levels.

During 2005-11, services of NGOs were limited to only National Programme for Control of Blindness (NPCB) and National Leprosy Eradication Programme (NLEP). Test check of records revealed that in NLEP, out of 10 NGOs engaged for survey, education and treatment, eight were working only in the eastern districts of the State. Thus, the objective of covering the entire State was not achieved. The Government admitted that though the process for selection of Mother NGO for the State and district level NGOs was initiated, it was not finalised.

2.2.6 Convergent approach in State PIPs and DHAPs

Audit observed that PIPs did not contain plans and strategies for convergence with different associated departments. Further, there was no indication of any convergent action in DHAPs of test checked districts.

Perhaps the only area where some convergence was achieved was the School Health Programme for providing spectacles to children with impaired vision, IFA supplements, biannual de-worming tablets and training for health related issues to teachers in primary schools (classes 1 to 5) for 40 schools[4] *per* block. However, there was nothing on record at DHS level to indicate the school-wise details of children, who participated in the camps or regarding the distribution of IFA tablets and their authentication by school authorities.

The Government stated that convergence was being achieved with a few departments on various issues. However, the fact remained that there was no concerted strategy driven approach to convergence, which would have resulted in accelerated improvement in health and sanitation parameters across the State.

2.2.6.1 School Health Programme

The School Health Programme (SHP) was started under NRHM in 2008-09. Under SHP, primary schools were to be selected[5] for providing health check to students. The components of the programme included sensitisation workshop at district level[6], training to teachers of selected schools, health check of students and providing logistics to selected schools[7].

During 2008-11, against the provision of ₹ 50.07 lakh in Allahabad, ₹ 34 lakh was spent on different components of SHP.

As per guidelines, an annual action plan was to be framed at the start of the year mentioning the targets for covering schools/students. On the basis of targets, different arrangements like logistics for schools, training to teachers, procurement of medicines *etc*. were to be made.

Highlights of the audit of SHP in Allahabad district are presented as a case study.

Case Study

Inflated Projections

In 2010-11, it was planned to cover 1.62 lakh students of 1,200 selected schools in 20 blocks. Test check of available records in respect of blocks Mauaima and Manda in Allahabad revealed the following:

- In Mauaima, 10,081 students in 60 selected primary schools were shown to be covered. As per records of Education Department, the actual enrolment in these schools was only 7,758. Thus, the projection of student enrolment was inflated by 2,323 students (23 *per cent*). It is pertinent to mention that purchase of drugs, medicines and other logistics were made on the basis of above projections. Inflated projection caused excess

[4] From 2010-11, 60 schools per block.
[5] In 2008-09, 10 schools under each PHC/CHC and Additional PHC; in 2009-10, 40 schools in each block; and in 2010-11, 60 schools in each block were to be covered under the programme.
[6] Included in 2010-11.
[7] Included in 2010-11.

purchase which could not be ascertained in monetary/quantity terms as records called for, were not produced to audit.

- In Manda, the overall position of enrolment in the selected schools was not made available to audit. Audit test checked five schools[8] and it was observed that enrolment in these schools during 2010-11 was 1,347, but CMO projected the enrolment at 1,490. Excess projection of 143 students (10 *per cent*) resulted in excess expenditure on logistics, purchase of drugs *etc*.

Selection of Junior High Schools

SHP was to be run in primary schools. Audit observed that in 2010-11, against the target of selection of 60 primary schools in each block, 20 junior high schools were selected in Kaundhiyara block and five were selected in Pratappur block (***Appendix-2.3***). Junior high schools were selected instead of primary schools, in violation of guidelines.

Training of teachers

Two teachers, in each selected school in all 20 blocks of Allahabad, were to be trained for serving children, round the year. ₹ 0.06 crore was allotted for training of teachers in 2009-10 and ₹ 0.03 crore was allotted in 2010-11. No training was imparted in 2009-10 leaving entire allocation unspent. In 2010-11, training was to be imparted to two teachers each in all 60 selected schools in each block. Audit observed that teachers of only 40 schools selected earlier in each block were trained, exhausting the entire available fund (₹ 0.06 crore + ₹ 0.03 crore) and consequently teachers in 20 new schools to be selected in each block remained untrained.

In 2010-11, training was imparted to teachers of 16 other schools (nine in Kaundhiyara and seven in Mauaima (***Appendix-2.4***)) and teachers of selected schools remained untrained.

Non-availability of logistics

Logistics such as weighing machines, height measuring tapes, vision charts, torches, child health cards, referral cards and health registers were to be provided to selected schools. Health cards and health registers were to be maintained by the schools, for each student and the health status of the children was to be mentioned therein. Records revealed that these logistics were purchased at CMO's level during 2008-11. Joint inspections of 12[9] schools of three selected blocks revealed that:

- In Mauaima, all three schools inspected did not have any of the logistics; and
- In Manda and Pratappur, none of the test checked schools had Child Health Cards, Health Registers or Referral cards.

[8] Bangalia, Islampur, Jharwania, Nahwai and Rajapur.

[9] Manda: Primary Schools – Bangalia, Islampur, Jharwania, Nahwai and Rajapur
Mauaima: Primary Schools – Bagi, Katra Dayaram and Maudostpur
Pratappur: Primary Schools – Bagheri, Bela Khas, Sarai Mumrej and Sarjupatti.

Non-availability of drugs

In nine[10] of 12 test checked schools, prescribed drugs were not available.

In PHC, Mauaima, 49,490 de-worming and 3,55,560 IFA tablets were made available in 2010-11. The de-worming tablets had not been distributed and remained at PHC.

No health checkups by doctors

- Of 12 schools test checked in audit, no health checkups were carried out in nine[11] schools during 2008-11.
- In Maudostpur Primary School of Mauaima block, it was stated that health checkups were carried out once in 2009, but no supporting records were available at the school.
- In two primary schools of Manda (Islampur and Nahwai) health checkups were carried out only in 2010-11.The Government accepted the facts mentioned above.

2.3 Community Participation

2.3.1 Community involvement under the Mission

NRHM envisaged involvement of PRIs and the community in planning, management and monitoring of the Mission through SHM, DHM, community based Planning and Monitoring Committees at State, district, block and village levels, *Rogi Kalyan Samitis* (RKSs) at hospital level and VHSCs.

2.3.2 District Health Mission

DHM, under the Chairperson, ZP, was to be the apex body at district level to control, guide and manage all public health institutions in the district. DHS, under District Magistrate was to prepare DHAP and proposals for consideration and approval of DHM.

Audit observed that DHM was constituted only in three[12] out of 13 test checked districts that furnished information as of March 2011. The State Government reiterating its earlier order (November 2006), issued directions (November 2010) to constitute DHMs in case these had not been constituted and to make them functional immediately. Despite the Government orders, DHMs were yet to be constituted in most of the districts. The Mission itself is to end in March 2012 but the framework envisaged to implement the Mission was largely not in place. Even in districts, where DHMs were constituted, they remained non-functional. Thus, the objective to make ZPs responsible for the budget of the health sector and planning for and addressal of public health needs at the district level remained unachieved.

The Government in its reply stated that instructions had been issued to DMs and CMOs for constitution of DHM. It did not reply on non-involvement of ZPs in planning process. The reply of the Government were to be seen in light of the fact that DHMs, which were to spearhead the implementation at the district level, were being constituted when there was hardly 3-4 months left for the Mission period to end.

---

[10] Manda block: PS Jharwania, Rajapur and Bangalia; Mauaima block: PS Bagi, Katra Dayaram and Maudostpur; Pratappur block: PS Belakhas, Saraimumrej and Bagheri.

[11] Manda block: PS Jharwania, Rajapur and Bangalia; Mauaima block: PS Bagi, Katra Dayaram and Maudostpur; Pratappur block: PS Bela Khas, Sarai Mumrej and Bagheri.

[12] Allahabad, Budaun and Bareilly.

2.3.3 Status of constitution of committees at different levels

To implement and monitor NRHM through community participation, various committees were to be constituted at different levels.

Audit observed that Health Planning and Monitoring Committees at village, block and district levels had not been constituted even after six years of inception of NRHM. Consequently, the objective of bottom-up planning, implementation, community based monitoring and accountability framework and ownership was not achieved. It would also be seen that those committees essential for flow of funds have been created, while most of the monitoring committees have not been created.

Furthermore, the committees were so structured under NRHM framework that their membership would be drawn from a limited common pool and then perform two sets of functions – (i) planning and monitoring and (ii) implementation, creating a possible overlap and also possibly a conflict of interest. The Government accepted that District, Block and PHC level monitoring and planning committees were not constituted as of December 2011. Further the proposal for implementing the community monitoring plan had been drafted, but a final decision on the issue had not been taken (December 2011).

2.3.4 Village Health and Sanitation Committees

As per NRHM framework, a VHSC is to be formed for every village with a population of 1,500 within the framework of the *Gram Sabha* and was to be responsible for village level planning and monitoring. As per information made available by 13[13] out of 22 test checked districts, against the requirement of 13,455 VHSCs, only 13,414 VHSCs were reportedly formed as of October 2011. Audit observed that no documentary evidence regarding constitution of VHSCs was available either at CHC/PHC/sub centre or at village level.

SHS informed that VHSCs had been formed in all villages of the State as of March 2011, however, representation of SCs/STs/OBCs/minorities including women in VHSCs could not be verified in audit.

Further, the Mission envisaged setting up of a revolving fund at village level by VHSC for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalisation. However, no revolving fund was at the disposal of any of VHSCs of the test checked districts.

2.3.4.1 Utilisation of untied grant to VHSCs

Transfer of fund

A sum of ₹ 10,000 *per annum* was to be transferred to each VHSC's bank account. Audit observed the following shortcomings:

(a) Funds for VHSCs to be transferred directly to their bank accounts by the District (DHS), were transferred to CHCs/PHCs in contravention of provisions, in all 22 test checked districts;

(b) According to GoI's order dated 4 February 2009, fund related to untied fund, Annual Maintenance Grant (AMG), corpus fund were to be spent by the CHCs/PHCs/sub

[13] Allahabad, Azamgarh, Ballia, Bahraich, Bulandshahar, Deoria, Etah, Gorakhpur, Jaunpur, Kushi Nagar, Raebareli, Unnao and Varanasi.

centres/VHSCs only after framing a plan and getting the plan approved by DHS. No such plan was framed at CHC/PHC/sub centre levels in any of the test checked districts and entire fund was spent without approval of DHS; and

(c) DHSs were treating funds released to VHSCs as expenditure as soon as they were released, without ensuring/monitoring actual expenditure on the basis of UCs, SOEs *etc*. The State Government during Exit Conference stated that this was in accordance with GoI guidelines. It is, however, against the fundamental tenets of financial propriety. Thus, DHSs did not ensure whether such funds have actually been spent and for the avowed purpose.

On being pointed out in audit, the test checked DHSs in general accepted the above facts.

Expenditure of untied fund

As per information made available by 12[14] out of 22 test checked districts, position of transfer and utilisation of untied fund for VHSCs are given below:

Table 2.2: Details of Transfer and Utilisation of untied fund for VHSCs

(₹ in crore)

Sl. No.	Year[15]	Fund made available to VHSC	Expenditure incurred at VHSC level	Unspent balances lying at VHSC level
1	2007-08	3.66	2.74	0.92
2	2008-09	5.82	5.55	0.27
3	2009-10	18.48	17.40	1.08
4	2010-11	13.11	10.83	2.28
	Total	**41.07**	**36.52**	**4.55**

(**Source:** CMOs' records)

Further, in two[16] test checked districts, ₹ 1.97 crore was spent by MOICs at their own level, which was not permissible under the NRHM framework. The Government did not furnish any response on the above observation.

2.3.5 *Rogi Kalyan Samitis*

2.3.5.1 Setting up of RKS

As per NRHM guidelines, RKSs were to be constituted for efficient community management of healthcare centres up to PHC level under the *Panchayati Raj* framework. RKSs were to be registered under the Societies Registration Act, 1860. RKSs were to receive specified amounts under corpus grant, Annual Maintenance grant and Untied grant in each year, besides generation of own resources through user charges, philanthropic donations *etc*.

2.3.5.2 Proceedings of RKS

As per guidelines for constitution of RKS, the Governing Body and Executive Body of RKS are to hold quarterly and monthly meetings respectively to review the functioning of

[14] Allahabad, Azamgarh, Ballia, Bulandshahar, Deoria, Etah, Gorakhpur, Jaunpur, Kanpur Nagar, Kushi Nagar, Mirzapur and Varanasi.
[15] Information pertaining to the years 2005-06 and 2006-07 were not furnished.
[16] Allahabad and Ballia.

healthcare facilities. RKS did not meet regularly/at prescribed intervals as was noticed in 11[17] (information not furnished for other 11) out of 22 test checked districts, where 29 to 98 meetings of the executive bodies of RKS were held against 216 meetings due during 2005-11 in CHCs/PHCs. RKSs were to submit monthly reports to DHS giving recommendations for improvement of the healthcare system. In 11[18] out of 22 test checked districts, from where information was received, no RKS at District Hospitals, CHCs and PHCs sent the monthly report to DHS. Non-submission of monthly reports by RKSs to DHSs hindered the monitoring of RKS activities by DHS. Further, recommendations were to be given by RKSs to the concerned DHSs for improvement of the healthcare system on which timely action was to be taken by the Society. However, no recommendation was made to DHS for improvement of healthcare system. No specific reply was furnished by the Government.

2.3.5.3 Fund flow to RKS

As per information made available by 19[19] out of 22 test checked districts, year-wise position of fund released to CHCs/PHCs and expenditure there against was as under:

Table 2.3: Details of fund flow to RKSs during 2005-11

(₹ in crore)

Year	Funds made available to CHCs/PHCs	Expenditure	Unspent balances
2007-08	5.27	3.29	1.98
2008-09	21.36	20.29	1.07
2009-10	22.41	20.47	1.94
2010-11	23.54	22.08	1.46
Total	**72.58**	**66.13**	**6.45**

(**Source**: CMOs' records)

2.3.5.4 Irregular allotment of Corpus funds to Additional PHCs (APHCs)

Corpus funds were to be released to health centres where RKSs were formed. As per information made available by eight[20] out of 22 test checked districts, corpus funds of ₹ 7.18 crore were released to CHCs/PHCs for 395 APHCs though they did not have RKSs. The funds were released to block PHCs and not the APHCs. The Government did not furnish specific reply on the above issue.

2.3.5.5 Utilisation of RKSs funds

Test check of records revealed that expenditure incurred by RKSs were largely irregular for reasons such as non-conformity with NRHM guidelines for expenditure, improper vouching, expenditure on unauthorised items such as mobile phones *etc*. The detailed findings for a few districts are in ***Appendix-2.5.***

---

[17] Allahabad, Azamgarh, Bahraich, Ballia, Deoria, Gorakhpur, Jaunpur, Kushi Nagar, Raebareli, Unnao and Varanasi.
[18] Allahabad, Azamgarh, Bahraich, Ballia, Deoria, Gorakhpur, Jaunpur, Kushi Nagar, Raebareli, Unnao and Varanasi.
[19] Allahabad, Agra, Azamgarh, Ballia, Bahraich, Bareilly, Bulandshahar, Deoria, Etah, Gorakhpur, Jalaun, Jhansi, Jaunpur, Kanpur Nagar, Mirzapur, Raibareli, Sahjahanpur, Unnao and Varanasi.
[20] Allahabad, Ballia, Etah, Gorakhpur, Jaunpur, Raebareli, Unnao and Varanasi.

2.4 Recommendations

The Government should:

- *undertake a comprehensive baseline survey for village, Block and District Health Action Plans in order to draw up a need based State Health Action Plan;*

- *create the required number of VHSCs, sub centres, PHCs and CHCs; and provide effective training to foster professionalism and skills to meet the health needs of the people;*

- *focus on Village Health Action Plans, Block Health Action Plans and District Health Action Plans;*

- *actively and effectively encourage convergence of health related activities being undertaken by various departments of the Government from village to the State levels; and*

- *ensure that community ownership of NRHM becomes a reality by emphasising on various relevant and related activities/interventions.*