Chapter 2

Performance Audit

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This chapter contains the findings of Performance Audit on National Rural Health Mission in the State.

HEALTH AND FAMILY WELFARE DEPARTMENT

2.1 National Rural Health Mission

Executive Summary

The National Rural Health Mission (NRHM), a Government of India (GoI) scheme launched in Odisha in April 2005, aimed to improve access of rural people, to equitable, affordable, accountable and effective primary healthcare services. Performance audit of NRHM revealed that basic objectives under the Mission to reduce rate of child and maternal mortality, provide access to integrated comprehensive primary health care facilities to rural population, were partially met due to deficiencies as discussed under.

Planning was deficient due to non preparation of perspective plans and annual action plans at the State, District and Block level, District Health Action Plan was prepared for only four out of 30 districts.

Gaon Kalyan Samiti (GKS) meant to work as community level platform to facilitate public health activities were belatedly formed and still 63 GKSs remained to be formed in targeted villages. Also delay in formation of GKS led to short receipt of GoI assistance of ₹18.52 crore.

There were delays in release of GoI instalments upto 157 days due to delay in submission of Project Implementation Plan (PIP) by State.

Spending efficiency at State Level ranged between 36 and 66 per cent of funds available during 2007-13. State healthcare spending remained below three per cent of total budget against prescribed eight percent due to less allocation by the State.

Though maternal mortality rate was reduced from 303 in 2007-08 to 237 in 2011-12, yet the same was above the national average. Similarly, infant mortality rate was reduced from 71 to 57 against the national average of 55 to 44 during 2007-12. Despite increasing trend of institutional deliveries in the State, position was not satisfactory in Koraput, Nabarangpur and Kalahandi districts where it remained between 13 to 64 per cent.

Delivery of Health care was affected due to absence of required health institutions in the State as per Indian Public Health Standards (IPHS) norms. There were shortages of 3284 SHCs (33 per cent) and 370 PHCs (23 per cent). Despite stipulation in IPHS to have their own buildings, 91 PHCs and 2969 SHCs were functioning in private buildings in the State.

Due to lack of adequate monitoring, progress on infrastructure was not satisfactory as only 2491 (50 per cent) works were completed out of 5028 works sanctioned during 2007-13. Of the above, 1051(21 per cent) works were

lying incomplete after incurring expenditure of ₹ 40.01 crore and the balance 1486 (29 per cent) works were not yet started.

Facilities for pathological tests were not available in 13 (54 per cent) test checked CHCs whereas X-ray and Electro Cardiogram (ECG) were not available in all the 24 test checked CHCs.

Against IPHS norms for posting of 10,594 doctors in the State, 5077 doctors were sanctioned and 3435 (32 per cent) were in position as of March 2013. Though 1075 specialist under 17 categories were essential for DHHs, only 603 specialists were available.

Similarly, as against requirement of 20,064 health workers for SHCs in the State, 10914 (54 per cent) were in position. No staff nurse and lab technicians (LTs) were posted despite stipulation in IPHS to post five Staff Nurses and two LTs in each PHC. Besides, 59 per cent (1534) of pharmacists were found short in PHCs.

Training programme for skill development fell short of the target by 29 per cent during 2007-13. Services of trained doctors were not utilised as 17 trained doctors in Skilled Birth Attendance (SBA) and 11 in Life Saving Anesthesia Skill (LSAS) were not deployed for respective service.

All types of essential drugs were not available in sampled DHHs, CHCs and PHCs. Drugs of Not of Standard Quality (NSQ) of ₹ 5.80 lakh and Life expired drugs of ₹ 0.74 lakh were administered to patients.

Monitoring was weak, inadequate holding of meetings by State and District Health Missions, non formation of Health Planning and Monitoring Committee were noticed.

Thus, the objectives of the mission to provide accessible, affordable, reliable and quality health care to the rural population sought to be achieved through NRHM remained largely unfulfilled.

2.1.1 Introduction

Government of India (GoI) launched National Rural Health Mission (NRHM) in April 2005 throughout the country with special focus on 18 states including Odisha, which had weak public health indicators, weak infrastructure. Mission sought to improve access of rural people to equitable, affordable, accountable and effective primary healthcare services. NRHM basically aimed to reduce rate of child and maternal mortality, universal immunisation, prevent and control communicable and non-communicable diseases, provide access to integrated comprehensive primary health care facilities, maintain population stabilisation, gender and demographic balance, revitalise local health traditions, mainstream AYUSH (Ayurveda Yoga Unani, Siddha and Homeopathy) and promote healthy life styles of rural population.

For implementing NRHM, a Memorandum of Understanding (MoU) was signed (February 2006) between the Government of Odisha (GoO) and the

Government of India (GoI) in which the State Government, *inter-alia,* agreed to increase health sector spending from State's own budgetary sources by 10 *per cent* every year and that was to be treated as a mandatory performance indicator.

2.1.1.1 Organisational Set-up

At the state level, the Mission functions under the overall guidance of the State Health Mission headed by the Chief Minister and its activities are carried out by the Odisha State Health & Family Welfare Society (OSHFWS) through a Governing Body (GB) headed by the Chief Secretary and Executive Body (EB) headed by the Principal Secretary, Health & Family Welfare (H&FW) Department, Government of Odisha. Besides, for day to day implementation of NRHM a State Programme Management Unit (SPMU) functions as Secretariat for both Mission and OSHFW Society which is headed by Mission Director. Apart from above, different National disease control programmes are being implemented under the Principal Secretary, H&FW Department through Director of Health Services and Director, Family Welfare.

For implementation of NRHM at the district level, there is a District Health Mission headed by the Chairman, Zilla Parishad. Its functions are carried out by District Health Society named as Zilla Swasthya Samiti (ZSS) with Executive Committee headed by the Collector as the Chairperson and CDMO as Member Secretary of the ZSS. Day to day Mission activities are carried out by District Programme Management Unit (DPMU) headed by CDMO with the assistance of District Programme Manager (DPM) and District Accounts Manager (DAM).

At Block level, the Medical Officers in-charge of the Community Health Centres (CHCs) are in charge of implementing NRHM with the assistance of Block Programme Managers (BPMs) and Block Accounts Managers (BAMs).

2.1.1.2 Audit objectives

The Performance Audit was conducted with the objective to assess whether:

- Planning was oriented towards the Mission's objectives; there was adequate community participation in planning and convergence with other departments and programme operated by non-governmental stakeholders was ensured for achieving the objectives of the Mission;
- Financial controls were in place to safeguard NRHM funds/ assets and the accounts fairly present financial state of societies under NRHM; and whether the assessment, release and utilisation of funds were prompt and adequate;
- Implementation including construction activities were undertaken to maximise coverage in terms of population and improve facilities and whether due procedures were followed while incurring expenditure thereof;
- Capacity building and strengthening of human resources at different levels were as planned and targeted;

- Procedures and systems of procurement of equipment, drugs and services, supplies and logistics management were cost effective and efficient; and
- Monitoring mechanism and evaluation procedure were in place to ensure that the Mission's objectives were achieved and whether the community was involved in monitoring as envisaged under NRHM.

2.1.1.3 Audit criteria

Criteria for the audit were drawn from the following documents:

- Mission document, GoI Guidelines on different components of NRHM;
- MoU signed between the State Government and the GoI for implementation of NRHM;
- NRHM framework for establishment of health centres/ sub-centres and facilities, functioning and delivery of health care services to patients;
- Indian Public Health Standards (IPHSs) regarding availability of quality infrastructure, medicos and paramedical staff;
- Orissa General Financial Rules (OGFR) and Orissa Treasury Codes (OTC), Orissa Public Works Division (OPWD) Code, Indian Standards (IS-12433 & 13808) issued by Bureau of Indian Standards (BIS), orders/ notifications/ Guidelines issued by the State and Central Government.

2.1.1.4 Scope and methodology of Audit

Audit objectives, scope and methodology of audit were discussed (05 October 2012) with the Additional Secretary, H&FW Department at an entry conference and Audit was conducted for the period 2007-13 during October 2012 to August 2013. Records of eight districts[1], 24 CHCs (three CHCs in each selected district), 48 Primary Health Centres (two Primary Health Centres in each CHC) and 96 Sub Health Centres (four Sub Health Centres from each selected CHC) selected on Simple Random Sampling Without Replacement method, were checked in audit.

Audit methodology included collection and analysis of data through examination of records, reply to questionnaires and audit observations, joint physical inspection of assets created/ facilities available in health institutions, interview of patients in the presence of authorised representatives of the audited organisation and photographs taken, wherever required. The findings of Audit were discussed in an Exit Conference with the Principal Secretary H&FW Department on 18 November 2013.

Audit Findings

2.1.2 Planning

The targets and timeline for 20 activities were set in NRHM 'Framework for Implementation' by the State Government. Out of these, targets in nine

[1] Bolangir, Cuttack, Jajpur, Kalahandi, Koraput, Mayurbanj, Nabarangpur and Sundargarh.

activities (45 *per cent*) were fully achieved, in five (25 *per cent*) partially achieved and six activities (30 *per cent*) were not even taken up (March 2013), the details of which are given in ***Appendix 2.1.1.*** Reason and impact of shortfall in achievement of targets are discussed in succeeding paragraphs.

2.1.2.1 Preparation of perspective plans and annual action plan by District Health Societies/ State Health Society

As per paragraph 10 of NRHM Framework, States will decentralise planning and implementation arrangements to ensure that need based and community owned District Health Action Plans (DHAPs) become the basis for interventions in health sector. Further, Perspective Plan (PP) were to be prepared for each district and for State for the Mission period (2005-12), now extended up to 2017, outlining the overall resource and activity needs.

Accordingly, villages were to develop draft plans to be consolidated and approved at block level. Similarly, Block plans to be consolidated at district level as DHAPs were to be aggregated and collated at the State level for preparation of State Programme Implementation Plan/ Annual Action Plan (AAP).

Scrutiny of records revealed that DHAPs, Block Health Action Plans (BHAPs) and Village Health Plans were not prepared as of March 2013 except in four districts (Cuttack, Dhenkanal, Puri and Mayurbhanj) out of 30 districts for 2011-12 and submitted to Mission Directorate after approval of respective Zilla Swasthya Samiti (ZSS). Records of preparation of DHAPs by remaining 26 districts were not available.

The Government stated (December 2013) that component wise requirement of the districts upto village level were being collected and compiled in format prescribed by GoI/ State Government. Further, compilation of village health plan over 45000 villages was not possible. However, the fact remains that village level planning was required as per NRHM guidelines.

Perspective plan required to be prepared for seven years timeframe (2005-12) outlining the year wise resource and activity needed for the districts, was not prepared during the Mission period. CDMOs of the sampled districts accepted (March 2013) the fact. Government stated (November 2013) that perspective plan for 2014-17 was under preparation. However, specific reply for non-preparation of the same for 2007-13 was not furnished.

2.1.2.2 Community involvement in planning, implementation and monitoring

As per para 12 under NRHM framework, Village Health and Sanitation Committee (VHSC) named as Gaon Kalyan Samiti (GKS) in Odisha was to be formed for each revenue village and registered under the Societies Registration Act, 1860. Every GKS was to receive a grant of ₹ 10,000 every year from GoI for undertaking development programmes as per the aspiration of the local community. As per NRHM framework, Government was to constitute 30 *per cent* of total GKS by 2007-08 and balance 70 *per cent* by

2008-09. As per Programme Implementation Plan (PIP) for 2012-13, Government targeted formation of GKS in 45470 villages.

Scrutiny of records revealed that only 9506 (21 *per cent*) of GKS against stipulation of 13641 (30 *per cent*) during 2007-08 were framed. So also against 100 *per cent* required to be formed during 2008-09, 84 *per cent* was achieved and the shortfall still existed as of March 2013 since 63 GKSs were not formed, as could be seen from the table below.

Table 2.1: Status of formation of GKS in the State during 2007-13

Year.	Target fixed as per NRHM	No. of GKS formed	Shortfall	Percentage of shortfall to target
2007-08	13641	9506	4135	30.31
2008-09	45470	38022	7448	16.38
2009-10	45470	45294	176	0.39
2010-11	45470	45361	109	0.24
2011-12	45470	45382	88	0.19
2012-13	45470	45407	63	0.14

Sources: Information as furnished by Mission Director, NRHM

Due to delay in formation of GKS the Government failed to get GoI assistance of ₹ 18.52 crore as discussed in paragraph ***2.1.4.4.***

The Government stated (November and December 2013) that in the initial years, process of formation of GKS took some time. However, the fact remained that all GKSs were not even formed till date and this ultimately affected the development programmes.

2.1.3 Institutional arrangements

2.1.3.1 Functioning of State Health Mission

State Health Mission (SHM) was constituted in June 2005 and was required to meet once every six months. Role of the SHM, as per MoU (February 2006), comprises providing health system oversight, consideration of policy matters on health sector, review of progress in implementation of NRHM, inter sectoral co-ordination and advisory measures required to promote NRHM.

Audit observed that despite decisions taken in five meetings of SHM during 2007-13 to upgrade health facilities to the level of IPH Standards; establish online monitoring of inventory in field; develop suitable transfer policy for doctors; and set up body to ensure timely procurement of drugs and equipment, no step was taken in this regard as of March 2013.

Due to non implementation of the decisions taken by SHM, large vacancies of doctors in Koraput Bolangir Kalahandi (KBK) area, absence of IPH Standards quality health care services at CHC, Primary Health Centre (PHC) and Sub Health Centre (SHC) health institutions etc., were noticed as discussed in succeeding paragraphs.

The Government stated (November 2013) that the SHM is convened only for policy matters and monitoring. However, the fact remains that the frequency of meetings for SHM was not as per guidelines. Further, no reply was furnished regarding non implementation of the decisions taken by SHM.

2.1.3.2 Delay in formation of District Health Mission

As per MoU, every district is required to have a District Health Mission (DHM) on lines of the State Health Mission. Accordingly, the H&FW Department issued (June 2005 and December 2005) instructions with intimation to Collectors/ President, Zilla Parishad of all districts to form DHM and hold its meeting as frequently as necessary or at least once in three month.

Scrutiny of records revealed that out of eight sampled districts, the DHMs were formed in Cuttack district during November 2005 and in the remaining seven districts during July 2012 to March 2013. No reason for delay in formation of DHM was furnished. It was further noticed that in five districts only one meeting of each DHM was held so far (March 2013) against the requirement of two during 2012-13, whereas no meetings of DHM took place in remaining three districts.

Thus, due to delay in formation of DHMs during 2005-13, preparation of Annual Action Plan could not materialise during the period at district level.

Government stated (December 2013) that meetings of DHMs were not held regularly as there was commonality in membership of both ZSS and DHM. All matters related to DHM were discussed in meetings of ZSS and all policy decisions were taken in meetings of ZSS with regard to implementation of PIP.

However, DHMs in seven out of eight sample districts were formed only between July 2012 and March 2013 and could not fulfil the primary role of providing guidance for successful planning and implementation of activities under NRHM at the district level. Further, ZSS is not an implementing agency, rather a facilitating mechanism at the district level.

2.1.3.3 Non formation of Health Monitoring and Planning Committee

Para 13 and 53 of NRHM framework envisaged formation of Health Monitoring and Planning Committee at all levels i.e. SHC, PHC, CHC, District and State to ensure a community based monitoring framework undertaking continuous assessment of planning and implementation of NRHM. Such committees at respective level would provide opportunities for civil society representatives to suggest special situations or needs that should be addressed in the planning process.

Scrutiny of records of test checked SHCs, PHCs, CHCs, districts and State by Audit revealed that Health Monitoring and Planning Committee was not formed at any level. Thus, the planning process at primary level was affected and community participation was not ensured.

The Government stated (December 2013) that as per NRHM framework, Swasthya Shikshya Samitis had been formed at GP, Block and district level in five out of 30 districts during 2012-13 which were equivalent to Health planning & Monitoring Committees. During 2013-14 another five districts are under process for forming Swasthya Shikshya Samitis at GP, Block and district level. However, these Samitis were formed as late as during 2012-13.

Hence, community based monitoring framework that would allow continuous assessment of planning and implementation of NRHM was not available up to 2011-12.

2.1.4 Fund management and Financial Control

2.1.4.1 Poor utilisation of Fund

The receipt and utilisation of funds by the State Health Society (SHS) are summarised in Table below:

Table 2.2: Receipt, expenditure and utilisation of NRHM funds ***(₹in crore)***

Year	O.B	Fund from GoI	Fund from GoO	Other receipts	Total	Refund to GoI	Utilisation	Closing Balance	*Percent-age utilised*
2007-08	154.47	252.17	37.84	-	444.48	0	159.71	284.77	36
2008-09	284.77	274.28	50.44	-	609.49	0	235.87	373.62	39
2009-10	373.62	311.30	61.00	-	745.92	1.35	467.62	276.95	63
2010-11	276.95	353.34	64.00	-	694.29	0	453.14	241.15	65
2011-12	241.15	417.93	100.00	18.73	777.81	0	500.28	277.53	64
2012-13	277.53	368.97	283.26	1.57	931.33	1.65	610.55	319.13	66
Total		**1977.99**	**596.54**	**20.30**		**3.00**	**2427.17**		

Source: Information furnished by Mission Director

It would be seen from the above table that utilisation of funds during 2007-13 ranged between 36 and 66 *per cent* against funds available. Further, it was also observed that expenditure under Mission Flexible pool being an important component under NRHM containing provisions for infrastructure development, was utilised only 29 *per cent* during 2007-08 and 45 *per cent* during 2008-09.

Government attributed (December 2013) low fund utilisation during 2007-13 to lack of absorption capacity of the State, non-filling up of approved posts of paramedics, lack of proper understanding with the implementing agencies. Government further stated that the State could absorb 88 *per cent* of the funds made available to the State during 2007-13. However, the Department failed to address the deficiencies to ensure optimal utilisation of funds.

2.1.4.2 Public spending on healthcare

The National Health Policy, 2002 recommended that State Healthcare spending should be seven *per cent* of the budget by 2005 and eight *per cent* by 2010. The Mission, vide para-2 of NRHM frame work envisaged increasing the public spending on health, from 0.9 *per cent* of Gross Domestic Product (GDP) to 2-3 *per cent* of GDP over the Mission period (2005-12). Besides, the States were required to increase their spending on health sector by at least 10 *per cent* Year on Year (YoY) basis during the Mission period. The year-wise details of total public spending, including NRHM funds, Gross State Domestic Product (GSDP), total State Budget and State spending on healthcare during 2007-12 were as given in Table below:

Table 2.3: Details of year-wise spending on health sector *(₹in crore)*

Year	GSDP	Total spending including NRHM	Spending to GSDP *(per cent)*	Total Budget Outlay	State spending through Budget	*Per cent* of spending (6) to (5)	Increase in YoY State spending (*per cent*)
1	2	3	4	5	6	7	8
2006-07	101839.47	679.02	0.67	23767.19	590.55	2.48	--
2007-08	129274.45	875.02	0.68	27871.41	715.31	2.57	21.13
2008-09	148490.71	1134.99	0.76	36334.77	899.12	2.47	25.70
2009-10	163726.56	1600.11	0.98	37801.04	1132.49	3.00	25.96
2010-11	195027.68	1679.23	0.86	42803.30	1226.08	2.86	8.26
2011-12	226236.14	1809.10	0.80	50772.37	1313.50	2.59	7.13

Source: Appropriation Accounts and Economic Survey of Odisha

From the above table it is observed that

- during 2007-12, the state healthcare spending to the total outlay remained below three *per cent* against the targeted eight *per cent*;
- spending on public health including NRHM spending *vis-a-vis* GSDP remained below one *per cent.*
- increase in YoY spending on health sector, though remaining above 10 *per cent* during 2007-10, decreased to 7.13 *per cent* as of March 2012.

Thus, financial commitment of the State as per National Health Policy, 2002 could not be scrupulously achieved.

Government while confirming the facts stated (December 2013) that the Government was committed to provide better health care to the population with higher spending in the coming years and the YoY expenditure would witness a quantum jump.

2.1.4.3 Delay in release of funds

As per paragraph 83 of NRHM framework, the first instalment of funds to the states was to be made in April/ May of the year. The second instalment was to be released in September/ October based on the progress of expenditure in the previous year received through UCs including submission of audited statement.

Scrutiny of records of Mission Director revealed that during 2007-13, the first instalments of funds of ₹ 999.20 crore were released by GoI with delays ranging between three and 120 days, whereas second instalments of ₹ 906 crore during the period were delayed by two to 157 days. The balance amount of ₹ 72.79 crore was released on time. Audit observed that delayed submission of PIP to GoI in the month of February instead of 15 December of previous year resulted in delay in release of fund.

GoI released large part of the funds (10 to 38 *per cent*) at the fag end of the year (March) during 2007-13. Consequently, State government too released its matching share during the period with corresponding delay which included

four to 44 *per cent* of State funds released in March. Due to inordinate delay in release of fund by both GoI and State Government, ₹ 319.13 crore remained unutilised as of 31 March 2013.

Government while confirming the facts stated (December 2013) that PIP of the State had been submitted in the month of February/ March of the preceeding year and approval to the same was accorded in the month of May/ June. The fact, however, remained that due to delay in submission of PIP, release of fund by GoI was delayed resulting in subsequent curtailment of fund.

2.1.4.4 Availing of GoI assistance for formation of Gaon Kalyan Samiti (GKS)

As per GKS guidelines, the State Government was to receive ₹ 10,000 every year from the GoI for each GKS for undertaking development programmes. As per NRHM frame work, the Government was to constitute 30 *per cent* of total GKS by 2007-08 and balance 70 *per cent* by 2008-09.

Scrutiny of records revealed that against ₹ 240.99 crore due for formation of 45470 GKSs (13641 during 2007-08 and 45470 during 2008-13), ₹ 222.47 crore was received leading to short receipt of ₹ 18.52 crore[2] due to non formation of GKS as explained in paragraph ***2.1.2.2.***

Government confirmed (December 2013) that shortfall in receipt of grants was mainly due to shortfall in formation of GKS during 2007-09.

2.1.4.5 Diversion of funds from one programme to another under NRHM

As per Section-6 of Financial Management under NRHM, the funds allotted are strictly to be spent in the interest and service of the programme for which provisions have been made.

Scrutiny of records revealed that the Mission Director diverted ₹ 15.29 crore from RCH and Mission Flexipool to Disease Control Programme during 2011-13 out of which ₹ 40 lakh was not recouped as of July 2013. Besides, three sampled DHS and six CHCs diverted funds amounting to ₹ 2.05 crore from one programme to others like Flexipool to JSY, GKS to Disease Control Programme etc. during 2009-12 which had not been recouped as of March 2013 (***Appendix 2.1.2).*** This affected implementation of programme and violated financial principles under NRHM.

Government stated (November 2013) that such diversion within NRHM was allowed as GoI released the fund under NRHM Flexi pool with flexibility to State authorities to utilise the same in needy areas. However, no such relaxation existed in financial guidelines.

[2] ₹ 227.35 crore: 45470 GKSs * ₹ 10000/ year * 5 years (2007-13) + ₹ 13.64 crore: 13641 GKSs * ₹ 10000/ year * 1 year (2007-08) less ₹ 222.47 crore received (2007-13).

2.1.4.6 Unauthorised expenditure out of Rogi Kalyan Samiti grants

As per paragraph 13 of Memorandum of Association (MoA) of Rogi Kalyan Samiti (RKS), non-recurring expenditure out of RKS grants exceeding ₹ 10,000 should be approved by its Executive Committee.

Audit noticed that in two districts (Mayurbhanj and Sundargarh) expenditure of ₹ 19.73 lakh[3] was incurred out of RKS grants in 73 cases without obtaining the approval/ sanction of RKS though expenditure exceeded ₹ 10,000 in each case resulting in unauthorised expenditure.

Mission Director assured (November 2013) that appropriate action would be taken in the matter.

2.1.4.7 Non-utilisation of funds by State Institute of Health & Family Welfare (SIHFW)

Mission Director provided funds to SIHFW during 2006-13 to carry out various activities under NRHM like conducting training programmes, printing of OPD prescription slips with NRHM logo and booklets for IEC activities.

Scrutiny of records revealed that the funds were not properly utilised and no proper financial reporting was ensured as indicated in Table below:

Table 2.4: Statement of audit observation on non-utilisation of funds

Date/ Period	Amount provided to SIHFW (₹ in lakh)	Fund allotted for component	Audit observation
2009-10	388.84	NRHM training	SIHFW instead of incurring expenditure on training programmes refunded ₹ 50.08 lakh to Mission Director during July 2007-10 and diverted (2007-13) ₹ 43.58 lakh to Corpus accounts of Swasthya Sikhaya State Society, an independent State society under Health & Family Welfare Department, for meeting administrative expenses. But the society invested (June 2008 and May 2009) ₹ 34.89 lakh in fixed deposit which was renewed annually with current due date of maturity, i.e. April/ May 2014.
November 2006	73.31	Printing of 2.44 crore OPD prescription slips with NRHM logo	An amount of ₹ 24 lakh was still lying unspent (May 2013) with the SIHFW for printing of pending 80 lakh prescription slips. But, SHS submitted Utilisation Certificate for entire amount to GoI in February 2007

[3] Mayurbhanj -Kosta CHC: ₹ 2.99 lakh (11 Cases) and Manada CHC: ₹ 3.57 lakh (13); Sundargarh - Sargipali CHC: ₹ 0.60 lakh (two), Lephripara PHC ₹ 1.36 lakh (six), Hemgiri CHC: ₹ 4.98 lakh (19), Kanika PHC(N): ₹ 0.83 lakh (three), Koira CHC: ₹ 5.40 lakh (19)

Date/ Period	Amount provided to SIHFW (₹ in lakh)	Fund allotted for component	Audit observation
2005-2012	79.39	printing of booklets on prevention of disease and creation of awareness among masses under different disease control programmes	Out of total fund, the Director SIHFW utilised ₹ 34.90 lakh for printing of booklet/ leaflets and the balance amount of ₹ 44.49 lakh was lying with the Printing press society as of June 2013 without use and without assigning any reason for retaining the amount.

Source: Related records of SIHFW

Due to non utilisation of fund, the IEC activities were not adequately addressed and required awareness among the masses on various disease control programmes and health care could not be ensured to optimal extent.

The Director, SIHFW stated (May 2013) that UCs were submitted to avoid lapse of grant for printing of prescription slips. H&FWD stated (December 2013) that the interest accrued on funds available for training programme was given to the Society which was kept as fixed deposit without making any expenditure out of it. However, funds were meant to be utilised for the purpose and not for investment.

2.1.4.8 Non-Preparation of Bank Reconciliation Statement

Section-6 of financial guidelines of NRHM envisaged that bank reconciliation statement (BRS) was to be prepared on monthly basis by 10th of the following month.

Scrutiny of records revealed that such reconciliation statement was not prepared month wise and as of March 2013, ₹ 2.03 crore remained unreconciled in three DHSs and in one CHC as indicated in table below:

Table 2.5: Details of difference between cash book and passbook as of March 2013

(₹in lakh)

Name of the Units	Balance as per Pass Book	Balance as per Cash Book	Difference	Un-reconciled difference
DHS, Mayurbhanj	177.26	365.13	(-)187.87	187.87
DHS, Nabarangpur	38.78	33.95	4.83	1.05
DHS, Sundargarh	102.85	31.86	70.99	13.30
CHC, Tangi	15.50	9.61	5.89	0.47
Total				**202.69**

Source: Related records of CDMO, CHC, PHC

Despite availability of specific accounting staff at district and block level and concurrent audit system, preparation of BRS was not ensured. This indicated lapses in internal control and weak financial management of the concerned CDMOs.

Government stated (December 2013) that all CDMOs were instructed to prepare bank reconciliation statement for every month by 10th of the following month.

2.1.5 Programme Implementation

The Mission objectives included reduction in child and maternal mortality rate, population stabilisation, gender and demographic balance, universal access to public services for food and nutrition, sanitation and hygiene, public health care services with emphasis on women's and children's health and universal immunisation. Some of the components of the Mission and their performance were as follows.

2.1.5.1 Maternal Mortality Rate and Infant Mortality Rate

NRHM aimed at bringing down the maternal as well as infant mortality rate by way of various interventions like providing physical and human infrastructure in CHCs, PHCs and SHCs for safe delivery, establishing Sick New Born Care Unit (SNCUs), Emergency Obstetric Care (EmOC), providing referral service, providing of full 100 days of Iron Folic Acid (IFA), postpartum care to all eligible women and free transport to pregnant women etc. The expected outcome of the NRHM is to reduce the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) to 100/ 100000 pregnant women and 30/ 1000 live births respectively by March 2012. The MMR and IMR of the state and country as surveyed by Sample Registration System and Annual Health Survey are represented in the Table below.

Table 2.6: Maternal Mortality Rate and Infant Mortality Rate in the state

Year	MMR of the state	IMR of the State			MMR in India	IMR in India
		Total	Rural	Urban		
2007-08	303	71	73	52	254	55
2008-09	NA	69	71	49	NA	53
2009-10	258	65	68	46	212	50
2010-11	277	61	63	43	NA	47
2011-12	237	57	58	40	NA	44
2012-13	NA	NA	NA	NA	NA	NA

Source- Data furnished by the Mission Director, HMIS, SRS Bulletin and Annual Health Survey

As evident from the above table, the MMR of the State decreased from 303(2007-08) to 237(2011-12) but remained above the target set by NRHM. The IMR of the state decreased from 71 (2007-08) to 57(2011-12) but remained higher than the national average of 44 as of March 2012. There existed wide gap between the IMR in rural area and urban area despite implementation of NRHM and completion of first Mission period.

It was also observed that maternal death in two districts (Nabarangpur and Jajpur) increased during 2007-13. Similarly, increase of infant death in Jajpur ranged between 474 and 837 during 2007-13.

The reasons for non-achievement of target of MMR and IMR in the State was attributed to non-registering the pregnant women within first trimester (within 12 weeks of pregnancy), non-providing of 100 days of IFA and three antenatal check-ups. Audit observed that of the total 34.44 lakh pregnant women registered during 2009-13, 21.27 lakh (62 *per cent*) women were not registered within first trimester, 7.68 lakh (22 *per cent*) women were not provided with full 100 days of IFA and 4.38 lakh (13 *per cent*) women were

not provided with three antenatal check-ups due to which as many as 7.07 lakh pregnant women were found to be anaemic as observed from the records. The Mission Director failed to achieve the target of MMR and IMR as of March 2012 and bridge the gap between rural and urban areas.

The Government stated (November 2013) that the State through NRHM interventions succeeded in bringing down MMR drastically and was making efforts to bring down IMR to national average soon.

2.1.5.2 Janani Suraksha Yojana

The Janani Suraksha Yojana (JSY) was introduced in 2005-06 as a key intervention to enable women to access institutional deliveries and thereby to reduce MMR and IMR in the State. Through JSY, it was to encourage institutional deliveries by providing financial package to all pregnant women who deliver in health centres. Women were eligible for a cash incentive of ₹ 1400 (in rural areas) and ₹ 1000 (in urban areas) to meet both direct and indirect expenses incurred towards delivery. BPL women who delivered at home were also eligible for a cash incentive of ₹ 500. Audit scrutiny of JSY programme revealed the following irregularities.

2.1.5.3 Target and Achievement

The scheme targeted 70 *per cent* institutional deliveries by March 2012. The target and achievement of institutional deliveries and cash compensation paid under JSY in the state during the period of audit were indicated in Table below:

Table 2.7: Details of institutional deliveries in the state.

Year	Nos. of pregnant women registered	Expenditure incurred on JSY (₹ in lakh)	Nos. of institutional deliveries		*Per cent* of institutional delivery to pregnant women registered	Nos. of institutional deliveries done in accredited institutions
			Target	Achievement		
2007-08	876026	6993.67	450000	440234	50.25	NA
2008-09	905282	8392.86	608175	504823	55.76	NA
2009-10	860149	9673.94	573788	500024	58.13	3501
2010-11	932786	10089.47	678515	583606	62.56	27740
2011-12	880415	11122.81	632900	623241	70.78	22643
2012-13	770676	9981.41	672878	602062	78.12	33972
Total	**5225334**	**56254.16**	**3616256**	**3253990**	**62.27**	

Source: Data as per HMIS. Target for institutional delivery was as per the PIP

In five out of eight test checked districts[4], increasing trend was noticed in institutional deliveries during 2007-13 which was above the target of 70 *per cent* during 2007-13 except in Jajpur, where it remained at 67 *per cent* during 2007-08 and 2009-10 and in Cuttack, where it ranged between 50 *per cent* and 63 *per cent* during 2007-10.

[4] Bolangir, Cuttack, Jajpur, Mayurbhanj and Sundargarh.

In remaining three sampled districts (Koraput, Kalahandi and Nabarangpur) the position of institutional delivery was not satisfactory as the same remained below the target of 70 *per cent*. In Koraput district it ranged between 29 and 56 *per cent,* in Nabarangpur it remained between 13 and 61 *per cent* and in Kalahandi within 49 and 64 *per cent.*

The Government replied (December 2013) that low percentage of institutional deliveries in Kalahandi, Koraput and Nabarangpur districts was with reference to number of pregnant women registered. There are cases of abortions, still birth, death before delivery, migration of women before delivery to other places. However, steps are being taken to promote institutional delivery. It is pertinent to mention that the achievement of Government in tribal areas (i.e. Koraput, Kalahandi and Nabarangpur) were low even after intervention of NRHM.

2.1.5.4 Non-payment/ delayed payment of JSY incentive

All registered pregnant women in rural area undertaking delivery in health institutions are eligible for cash incentive of ₹ 1400 under JSY immediately after delivery or within seven days to meet the delivery expenses. Audit observed that in Sundargarh and Nabarangpur districts 157 eligible registered pregnant women undertaking institutional delivery in three CHCs (Koira-137, Hatabharandi-11 and Tentulikhunti-9) during 2008-12 were not paid assistance amounting to ₹ 2.20 lakh.

Test check revealed that that in six out of 24 test checked CHCs, incentive of ₹ 14.78 lakh to 1056 beneficiaries[5] was paid with delay ranging between eight and 800 days. The health institutions wise delay is given in table as under.

Table 2.8: Details of delayed payment of JSY benefits.

Name of the districts	Name of the CHCs	No. of beneficiaries	Amount (In ₹)	Period of delay in days
Sundargarh	Koira	86	120400	63-332
Jajpur	Sukinda	5	7000	11-118
	Mangalpur	5	7000	11-118
Nabarangpur	Hatabharandi	17	23800	10-67
	Tentulikhunti	308	431200	8-800
	Papadahandi	635	889000	9-421
Total		**1056**	**1478400**	

Source: Data from payment register of incentive maintained by MO/ CHCs

The Government stated (December 2013) that steps had been taken to streamline JSY payment in the State through direct benefit transfer (DBT) under Central Plan Scheme Monitoring System (CPSMS) which has been started in four districts and would be extended to all districts in a planned manner.

[5] 894 cases (Eight to 90 days), 81 cases (91-180 days), 50 cases (181-365 days), eight cases (366-632 days) and 23 cases (above 632 days).

2.1.6 Implementation of National Programme of Control of Blindness

The objective of National Programme of Control of Blindness (NPCB) was to reduce prevalence rate of blindness from 1.4 *per cent* to 0.5 *per cent* by 2010. Audit noticed the following irregularities in implementation of programme.

2.1.6.1 Refractive errors of school children

As per guidelines of NPCB the District Health Society is to organise screening of school children for detection of refractive errors and other eye problems and provide free glasses to poor children. The status of school children screened and glasses provided in the state during 2007-13 stated in the Table below.

Table 2.9: Refractive errors, eye check-up of school children and free distribution of spectacles

Year	Number of student eye screened	Number of student found with refractive errors	Number of glasses supplied to student
2007-08	302128	14680	7355
2008-09	483409	26078	10942
2009-10	419274	19922	9186
2010-11	564225	22906	11624
2011-12	388703	19705	11787
2012-13	467368	28889	17586
Total	**2625107**	**132180**	**68480**

Source: Joint Director of Health Services (Ophth.), Odisha, Bhubaneswar

From the above, it was observed that though during 2007-13 the eye sight of 1.32 lakh children was detected with refractive errors, 0.68 lakh children only were provided with glasses. No records were maintained by the test checked CDMOs regarding reasons of non supply of glasses to remaining 0.64 lakh children.

The Government stated (December 2013) that most of the time procurement becomes a major problem as the optical shops in the rural areas did not have the authentic documents to participate in tender process. So, in many cases the districts were unable to provide spectacles to children.

However, spectacles could also have been procured centrally and distributed through district authorities.

2.1.6.2 Cataract operation of patients

Scheme for Participation of Voluntary Organisation under National Programme for Control of Blindness and condition of MoU with NGOs provides for screening of people aged fifty and above for conducting cataract operation. Further, patients who have undergone cataract operation are to be provided spectacles as follow up service for best possible correction.

- ***Conducting operation below 50 years of age:*** Audit noticed that in two (Jajpur and Cuttack) out of eight sampled districts, a sum of ₹ 33.76 lakh was paid to NGOs for cataract operations on 5241 patients (Jajpur 799 and

Cuttack 4442) below 50 years of age in violation of scheme guidelines and condition of the agreement executed with the NGOs.

In reply, Department stated (December 2013) that the eye surgeons had operated a good number of cases below 50 years for the greater interest of the poor patients as well as for the national programme. However, the same is not as per the guidelines.

- ***Non supply of spectacles to beneficiaries:*** Further, patients undergoing cataract operation by NGOs are to be supplied with spectacles costing ₹ 125 for which cost is reimbursed to the NGOs. Audit observed that in Jajpur and Cuttack district the cost of 628 spectacles amounting to ₹ 0.78 lakh was reimbursed to the NGOs against purchase vouchers bearing earlier serial number with later date and the later serial numbers vouchers of the same supplier. Further, the cash memo of the supplier also did not have Taxpayer Identification Number (TIN) and Small Retailers' Identification Number (SRIN) for tax deduction purpose. This indicated that there was possibility that neither were the spectacles purchased nor distributed. During beneficiary interview of 22 persons (Cuttack: 10 and Jajpur: 12) audit found that eight persons of Cuttack and 12 persons of Jajpur districts had not received any spectacles from the concerned NGOs. This indicated that both District Programme Managers of NRHM and District Blindness Control Society did not ensure supply of spectacles to patients before reimbursement to NGOs.

  The Government in its reply (December 2013) accepted that supply of spectacles to operated patients were made with some deviations in Cuttack and Jajpur districts. Further, NGOs have subsequently supplied eight spectacles in Cuttack. The fact, however, remained that Government failed to ensure supply of spectacles to all the patients after their surgery. Further supplying spectacles after considerable period does not serve the purpose of distribution as their use is immediate.

2.1.7 Infrastructure

Revamping of health infrastructure is one of the important requirements under NRHM. Position regarding shortfall in creation of health centres, strengthening of CHCs, PHCs, and SHCs and up gradation of CHCs and PHCs is discussed in the succeeding paragraphs.

2.1.7.1 Creation of new Health facilities.

As per NRHM Framework, one SHC was to be provided for 5000 population in plain areas and 3000 population in tribal areas. One PHC was to be provided for 30000 population in plain areas and 20000 population in tribal/ desert areas. One CHC was to be provided for 120000 population in plain areas and 80000 population in tribal/ desert areas.

The State had a network of 377 Community Health Centres 1226 PHCs and 6688 SHCs as on 31 March 2013. As of April 2007, 6688 SHCs, 1162 PHCs and 231 CHCs were available in the State. As per 2011 census, the state had deficit of 31 *per cent* (3676) health institutions to provide adequate and

effective health service facilities to the people as is evident from the table below.

Table 2.10: Status of health institutions as per census 2011

Level of Units	Requirement as per Census 2011	Existing position of availability of Health Institutions as of March 2013	Shortage	Percentage of shortage
SHC	9972	6688	3284	33
PHC	1596	1226	370	23
CHC	399	377	22	6
Total	**11967**	**8291**	**3676**	**31**

Sources: Information as furnished by Mission Director, NRHM

Government did not sanction and create any new SHCs although there was a requirement of 3284 additional SHCs as per Census 2011. Apart from this 64 PHCs and 146 CHCs were newly created increasing the numbers of PHCs to 1226 and CHCs to 377 as against the requirement of 1596 and 399 respectively. Thus, total percentage of increase in health institutions was only 2.60 *per cent* and the State was still having a shortage of 31.60 *per cent* of health institutions as of March 2013. In the test checked districts, as per 2011 census, the shortage of CHCs ranged between six to 27 *per cent*, shortage of PHCs ranged between 3 to 45 *per cent* and that of SHCs was between 29 to 44 *per cent* as detailed in ***Appendix 2.1.3.*** During 2007-13 there is negligible increase of health institutions which failed to meet the requirement of the people.

Government stated (December 2013) that State Government is aware of such shortage State as per the population norm. Due to acute shortage of doctors and paramedics in the State, Government is facing difficulties to fill up existing sanctioned posts.

2.1.7.2 Shortage of building and construction of health facilities.

As per IPH Standards, all PHCs and SHCs should have their own buildings. NRHM Framework para 62 and 67 provides that construction of the buildings for PHCs and SHCs would be taken up as a mission activity.

Audit observed that 91 PHCs/ Government Hospitals and 2969 SHCs were functioning in private/ Panchayat buildings. The position of health institutions that were available on April 2007, and infrastructure created as of March 2013 is indicated in Table below:

Table 2.11: Status of infrastructure as on March 2013 ***(₹in crore)***

Type of Health Institutions (HIs)	HIs running in private building (2007)	HIs newly created	Total	HIs building construction planned and taken up	HIs building construction completed and handed over	Percentage to the total requirement
SHCs	3225	0	3225	411	256	8
PHCs	113	64	177	86	86	49

Source: Compiled by Audit from the records of NRHM

As seen from the table above, Mission Director planned for construction of only 411 SHCs (12 *per cent*) out of 3225 SHCs functioning in the private building prior to mission period and constructed only 256 (eight *per cent*)

SHCs buildings during the Mission period. So far as PHCs are concerned, though 86 PHCs were constructed, no PHC from NRHM grant was planned and constructed.

In eight sampled districts, audit observed that out of 3055 SHCs/ PHCs, 1937 units (63 *per cent*) were having their own buildings and 1118 units were functioning in private/ other buildings as per details given in ***Appendix 2.1.4.***

Government while admitting (November 2013) the delay in completion of construction works attributed the reason to non-availability of separate civil works cell/ wing under NRHM. It was also stated that the Government had now decided to have separate wing in RD and PWD Divisions specifically to execute/ monitor the execution of construction works of Health Institutions under NRHM.

2.1.7.3 Funds allotted/ utilised for construction of Health institutions

Mission Director allotted ₹ 307.91 crore for 5028 works including 1489 new works[6] during 2007-13; of which 2491 works were completed, 1051 works after incurring of expenditure of ₹ 40.01 crore were lying incomplete and 1486 works were not started as of March 2013.

The physical and financial status of all projects/ works (including repair and renovation) in eight sampled districts during 2007-13 are given in Table below:

Table 2.12: Details of physical and financial status of projects/ works *(₹in crore)*

Name of the district	Number of projects/ works sanctioned	Fund allotted (₹ in crore)	Expenditure incurred (₹ in crore)	No. of projects/ works completed	No. of projects/ Works remain incomplete	No. of projects/ works not started	Expenditure incurred on incomplete works (₹ in crore)
Bolangir	218	12.76	5.52	80	92	46	0.98
Cuttack	115	8.42	1.12	32	27	56	1.35
Jajpur	132	13.46	4.36	59	17	56	0.45
Kalahandi	248	27.96	11.14	142	45	61	2.42
Koraput	201	16.54	2.79	54	136	11	NA
Mayurbhanj	136	17.05	6.58	79	5	52	0.84
Nabarangpur	283	12.72	6.58	125	29	129	NA
Sundargarh	324	36.55	10.65	93	97	134	2.17
Total	**1657**	**145.46**	**48.74**	**664**	**448**	**545**	**8.21**

Source: Information as furnished by CDMOs

In eight sampled districts, against the allotment of ₹ 145.46 crore for construction of 1657 works during 2007-13, only 40 *per cent* (664) of works were completed with expenditure of ₹ 40.53 crore. Though 14 works were shown as completed, their assets were not put to use leading to unfruitful expenditure of ₹ 0.97 crore as detailed in table below.

[6] New construction of different items of new works in 1489 (SHC-411/ PHC-179/ CHC-899) health institutions (₹ 145.22 crore) during 2007-13; Completed 539 (SHC-256/ PHC-52/ CHC-231); Incomplete 950 buildings (SHC-155/ PHC-127/ CHC-668); Expenditure on incomplete works ₹ 10.70 crore.

Table 2.13: Details of works that remained unfruitful in eight test checked districts

Level of Units	*No of unit*	*Number of works*	*Expenditure incurred as on March 2013 (₹ in lakh)*	*Present status*
CHC	3	3	40.93	Incomplete and lying idle due to want of OT equipment/ want of PH and electrification
PHC	3	3	15.82	Incomplete due to want of PH and electrification
SHC	8	8	39.85	Remained incomplete/ incomplete due to want of PH and electrification.
Total	**14**	**14**	**96.60**	

Source: Information furnished by CDMOs

Non-functional CHC building at Boipariguda

Out of the remaining works, 448 works, despite expenditure of ₹ 8.21 crore, remained incomplete though sanctioned during 2008-13. Of these works, 23 *per cent* of works (94)[7] pertained to two to five years. Similarly, the balance 545 works had not yet started (March 2013) though 69 of such works[8] were sanctioned since 2007-08 onwards. The works remained incomplete or were not started due to delay in tender process, site selection and non-completion by contractors etc.

Scrutiny of records of CDMO, Koraput revealed that Mission Director, NRHM awarded eleven works estimated at ₹ 7.84 crore to Orissa Police Housing & Welfare Corporation (OPH&WC) between October 2008 and July 2011 with stipulation to complete the works within 12 months. Only five works were completed. Remaining six works[9] were still lying incomplete. The reasons for the delay in execution were site dispute, not handing over of the old building by the concerned MOs and non-clearance of trees from site by the OPH&WC.

Further, scrutiny of records revealed that new CHC building at Boipariguda in Koraput district was completed at a cost of ₹ 1.30 crore and handed over to Medical Officer on 2 March 2012. However, the CHC was not functioning in the newly constructed building from November 2012. The reason was its remote location (three kilometres away from the town). There was no approach road to the new building. New cots, beds and other accessories supplied to the new CHC were also lying idle in the old building.

[7] 2008-09: 12 works, 2009-10: 12, 2010-11: 35 and 2011-12:35.

[8] 2007-08: 3 works, 2008-09: 12, 2009-10: 23, 2010-11: 13 and 2011-12: 18

[9] (1) Renovation of OT/ OPD, Laxmipur; (2) OPD/ OT, CHC, Kotpad; (3) OPD/ OT, Boriguma; (4) OT/LR ,Dasmantapur; (5) Office store, conference hall at CHC Ravanguda; and (6) OPD, Pattangi.

Further, Joint Inspection (November 2012) revealed that two quarters constructed at a cost of ₹ 12.25 lakh within the new CHC building premises and handed over to Medical Officer in August and October 2012 were also lying vacant. Thus the infrastructure created at a cost of ₹ 1.42 crore was lying idle without any utility.

Regarding new building at CHC Boipariguda, the Government stated (December 2013) that the medical authorities of CHC, Boipariguda shifted to the new building and funds have been provisioned for construction of approach road, compound wall etc. The Government attributed (November 2013) the delay in completion of construction works to non-availability of separate civil works cell under NRHM. It was further stated that the Government had now decided to have a separate wing in RD and PWD Divisions specifically to execute/ monitor the construction works of Health Institutions under NRHM. However, assets even after completion were not put to use.

2.1.7.4 Laboratory facilities

As per Indian Public Health Standards (IPHS) guideline, every District Headquarters Hospitals (DHH) should have facilities for pathological tests, X-ray, Ultra Sonography (USG), Endoscopy and Electro Cardio Gram (ECG) and every CHC should have facilities for pathological tests, X-ray and Electro Cardio Gram (ECG).

Audit scrutiny regarding status of availability of these facilities in 24 CHCs and eight DHHs revealed the following.

Table 2.14: Status of availability of Laboratory facilities

Sl.No.	Facilities	District Headquarters Hospitals	Community Health centres
1	Pathological Tests	Available in all test checked District Headquarters Hospitals	Not available in 13 out of 24 test checked CHCs
2	X-ray	Available in all test checked District Headquarters Hospitals	Not available in all the 24 test checked CHCs
3	ECG	Available all DHH and are functional	Not available in all the 24 test checked CHCs
4	Ultra sonography	Available in all DHHs except two DHHs (namely Bolangir and Nabarangpur	Not required
5	Endoscopy	Available in three DHHs (Koraput, Kalahandi and Mayurbhanj) only. In Bolangir available but not functional. In Sundargarh, Cuttack, Nabarangpur and Jajpur not available.	Not required

Source: Information furnished by DHH and CHC

Non-availability of diagnostic services in CHCs were due to absence of Laboratory Technicians (LTs) and required infrastructure, in the test checked CHCs/ DHHs largely affecting quality and accessible health care services to rural poor. During interview of 240 OPD patients in 24 test checked CHCs, 12 OPD patients of five CHCs stated that they had to incur personal expenditure for pathological tests advised by the doctors of concerned CHCs.

The Government stated (November 2013) that for study of LTs, few seats are available in the institutions approved by concerned Regulatory bodies in the State and the Government is promoting private sector to set up such institutions and in next few years, this problem would be over. The fact, however, remained that rural people failed to get laboratory facilities even after implementation of NRHM.

2.1.7.5 Idle Equipment/ instruments

Para 4 of IS: 13808 (Part-4) for quality management for hospital services, read with para 9 under section 4 of IS: 12433 (Part-I) for basic requirements of hospital planning states that hospitals are to be equipped with various instruments and equipment governed by the actual local needs. IPH Standards provide for procurement of equipment to ensure assured service recommended for district hospitals.

Scrutiny of records of eight test checked districts revealed that in six DHHs and 18 CHCs, 71 equipment/ instruments worth of ₹ 2.20 crore were lying idle for five to 12 years as shown in Table 2.15 below.

Table 2.15: Statement of idle equipment/ instruments

Name of the District including selected CHCs	Number of equipment/ instruments remained idle	Type of equipment	Amount involved (₹ in lakh)
Jajpur	11	Biomedical waste Auto clave, Foetal Monitor, audiometer etc.	24.40
Koraput	32	Electrolyte Analyser, Blood cell counter etc.	126.08
Sundargarh	2	SNCU Equipment etc	27.52
Cuttack	8	Cystoscope etc.	18.95
Kalahandi	4	Radiant warmer, Digital EEG Machine etc	8.51
Mayurbhanja	14	Haemodialysis Machine	14.05
Total	**71**		**219.51**

Sources: Information as furnished by CDMOs

As ascertained, the equipment were lying idle due to non completion of building, non availability of technical manpower and non provision of funds for repair. It was noticed that SNCU equipment costing ₹ 20.66 lakh was lying idle at Sundargarh since March 2012 without installation. Due to non-availability of required technician and physical infrastructure the SNCU equipment/ instruments remained idle and adequate care to new born babies was not provided.

Government stated (November 2013) that all these equipment were purchased earlier under different schemes and World Bank assisted project prior to implementation of NRHM. Government has already decided and is in the process of setting up a Medical Corporation for purchase/ maintenance of medical equipment/ instruments which would address these issues.

2.1.7.6 Non functioning of Blood Storage Unit

As per IPHS guidelines, each referral unit should have a Blood Storage Unit (BSU). After CHC Papadahandi being declared as First Referral Unit (FRU) in May 2009, the CDMO, Nabarangpur allotted ₹ 25,000 in June 2010 for establishing a Blood Storage Unit in CHC, Papadahandi by repairing and furnishing the existing room with generator, air conditioner and pathology table.

Blood storage unit at CHC, Papadahandi

Audit noticed that the Medical Officer (MO) converted an existing room at a cost of ₹ 2.12 lakh by undertaking special repair (₹ 1.14 lakh) and procuring Air conditioner and invertors (₹ 0.98 lakh) out of RKS fund for functioning of Blood Storage Unit. However, after completion of the building in August 2011, the MO did not apply for Blood Storage Licence so far as required under Rule 122F of Drugs and Cosmetics Rules 1945 and said room was being utilised as dumping yard for instruments and equipment.

2.1.8 Capacity Building

Human Resources

As per para-21 of NRHM framework, the Mission aims at increasing the availability of manpower as per IPHS through provision of minimum of two Health Worker (Female) at each SHC and three staff nurse at every PHC to ensure availability of services round the clock. Outpatient Department (OPD) at PHC was to be strengthened through posting/ appointment of AYUSH doctors over and above the Medical Officers posted. At par with IPHS norms, 15 doctors and 15 staff nurses were to be posted in every CHC. The minimum requirement of availability of manpower at different level under IPHS is detailed below.

Table 2.16: Status of requirements of manpower at different level as per IPHS.

Level	Speci-alist/ Doctor	AYUSH Doctors	Pharm-acist	Staff Nurse	Laboratory Technician	Radiog-raphers	Lady Health Visitor	Health Worker (Female)	Health Worker (Male)
DHH[10]	31	1	5	45	6	2	-	-	-
CHC	14	1	3	15	3	2	-	-	-
PHC	2	1	2	5	2	-	1	-	-
SHC	-	-	-	-	-	-	-	2	1

Source: Indian Public Health Standards

Adequacy or otherwise of staff is discussed in the succeeding paragraphs.

[10] The requirement has been taken for minimum 100 bedded DHH.

2.1.8.1 Availability of doctors

As per IPHS guidelines, 10594 doctors are required for management of 32 DHHs, 377 CHCs and 1305 PHCs functioning across the State. Availability of doctors in the health institutions at various levels in the state is given in Table 2.17.

Table 2.17: Availability of doctors and specialists at different health institutions as of March 2013

Level	Requirement as per IPHS	Sanctioned Strength	Men in position	Vacancy as per SS (Percentage)	Shortage as per IPHS (Percentage)
DHH	1024	903	603	300(33)	421(41)
CHC	5655	1695	867	828(49)	4788(85)
PHC	3915	2479	1965	514(21)	1950(50)
Total	**10594**	**5077**	**3435**	**1642(32)**	**7159(68)**

Source: IPHS and RHS report 2013

As indicated above, vacancies of doctors as per sanctioned strength ranged between 21 to 49 *per cent* and it was much below IPH Standards. The peripheral units like PHCs and CHCs were mostly affected due to shortage of doctors ranging from 50 to 85 *per cent*.

Audit further noticed that despite large vacancies of doctors in the State, available doctors were not rationally deployed to provide health care services uniformly throughout the State. It was observed in test checked districts that due to absence of a rational transfer policy of health personnel, more vacancies in the cadre of doctors in CHCs and PHCs of far off districts from Capital i.e. Bhubaneswar were noticed as detailed in Table 2.18.

Table 2.18: Vacancies in the cadre of specialists/ doctors in CHCs and PHCs of far off districts

Name of the far off district selected	Number of vacancy (percentage) against sanctioned strength		Name of the nearest district selected	Number of vacancy (percentage) against sanctioned strength	
	Specialist (in CHCs)	Doctors (in PHCs/ CHCs)		Specialist (in CHCs)	Doctor (in PHCs/ CHCs)
Bolangir	16 (47)	34(81)	Cuttack	15(35)	8(14)
Kalahandi	34(71)	38(84)			
Koraput	32(100)	11(23)			
Nabarangpur	28(97)	13(33)			

Source: information furnished by CDMOs

The vacancies of specialists were more acute in CHCs and PHCs of far off districts like Koraput and Kalahandi than nearest district (Cuttack).

Confirming the facts, the Government stated (November 2013) that the State was facing acute shortage of doctors and attributed the reason to non-setting up of Medical Colleges during last 50 years. It was also stated that Government was trying to increase medical seats in existing colleges and setting up more medical colleges in the State.

Regarding rationalisation of posting of doctors, Government stated that a policy on posting of doctors in specific areas was under consideration.

2.1.8.2 Availability of Health Workers in Sub Health Centre

IPHS for SHCs envisage that a SHC is the most peripheral and first contact point between the primary health care system and the community. IPHS guidelines prescribe deployment of two Health Workers (Female) and one Health Worker (Male) in each SHC by 2010. As of March 2013, the State had 6688 SHCs which were running short of HWs against the above standards as detailed in table below.

Table 2.19: Status of requirement and availability of HWs in SHCs

Name of post	Requirement as per IPHS	Men in position	Shortage as per IPHS	Percentage
HW(F)	13376	6851	6525	49
HW(M)	6688	4063	2625	39
Total	**20064**	**10914**	**9150**	**46**

Sources: IPH Standards and information furnished by Mission Director, NRHM

Test check in the eight sample districts revealed that as against the requirement of 5270 HW(F)s and 2635 HW(M)s, only 2704 and 1069 were available and there was shortage of 2566 (49 *per cent*) HW(F)s and 1566 (59 *per cent*) HW(M) as of 31 March 2013. Audit observed that due to substantial shortage in the post of HWs, these SHCs were not equipped to provide service delivery as per IPHS norm to rural people. Health Workers stated that they were facing difficulties to attend to health care services properly due to assignment of more population areas ranging between 7,247 and 9,997 against the prescribed limit of 5,000. Thus, shortage of Health Workers affected quality health services delivered in the State.

Government stated (December 2013) that they had created posts of two Health Workers (F) and one Health Worker (M) per SHC and all CDMOs had been instructed (June 2013) to recruit and fill up the vacancies.

2.1.8.3 Availability of Doctors and Paramedical staff in PHC

IPHS for PHCs envisages that the PHC should have three doctors (two Allopathy and one AYUSH). Besides para-medical staff like Staff Nurse, Pharmacist, Laboratory Technician (LT), Lady Health Visitors (LHV) were also to be appointed. Details of requirement for 1305 PHCs for the State as well as sample districts *vis-à-vis* availability of these health providers are indicated in the Table below:

Table 2.20: Availability of personnel at PHCs in the State

Category of Staff	Posts required as per IPH standard		In-position		Shortfall against IPH Standard		*Percentage* of shortfall	
	State	Eight sampled districts	State	Eight Sampled districts	*State*	*Eight sampled districts*	*State*	*Eight sampled districts*
Allopathic doctors	2610	854	1027	287	1583	567	61	66
AYUSH doctors	1305	427	938	339	367	88	28	21
Staff Nurse	3915	1281	0	0	3915	1281	100	100
Pharmacist	2610	854	1076	356	1534	498	59	58
LT	2610	854	0	0	2610	854	100	100
LHV	1305	427	629	312	676	115	52	27

Source-IPHS norm, RHS data 2013 and information furnished by test checked CDMOs

It may be seen from the above table that there were shortages in all cadres in PHCs in the State. No staff nurse and LT were posted despite stipulation in IPHS to post five Staff Nurses and two LTs in each PHC.

Audit observed that 88345 patients of Khairamada, Badajambela, Gopinathpur and Atta PHCs (N) were given treatment in absence of allopathic doctors during 2007-12 by the pharmacists/ attendant. Thus in the absence of allopathic doctors, patients of rural areas were deprived of getting reliable and quality Allopathy health care services. In reply MO CHC, Maniabandha and Sukinda stated (March 2013 and November 2012 respectively) that in the absence of regular doctor the pharmacist treated the patients.

Government stated (December 2013) that allopathic doctors will be recruited through Adhoc/ Odisha Public Service Commission (OPSC) process, soon after the MBBS students pass out from Government and private medical colleges.

2.1.8.4 Availability of doctors and paramedical staff in CHC

CHCs were designed to provide referral health care for cases from the Primary Health Centres level and for cases in need of specialist care approaching the centre directly. As per IPHS norm 15 doctors of 11[11] categories and 15 staff nurses and two Radiographers were to be provided in each CHC. There were 377 CHCs in the State. As per Rural Health Survey (RHS) 2013, the sanctioned strength in some important category of staff *vis-à-vis* the shortages as of 31 March 2013 at CHCs were as given in Table below:

Table 2.21: Shortage of personnel at CHCs of the State

Category	Require-ment as per IPHS	Sanctioned strength	Men-in-position	Shortfall as per IPHS	Shortfall as per Sanctioned strength
Doctors	5655	1695	867	4788(85)	828(49)
Staff Nurses	5655	903	911	4744(84)	0
Radiographers	754	61	41	713(95)	20(33)

Source: IPHS norm and RHS data 2013 **Figures in the bracket denotes the percentage**

Audit observed that 4788 (85 *per cent*) doctors were required to be posted as per the IPHS norm. There was shortfall of 49 *per cent* in the post of doctors. In eight sampled districts, against sanctioned strength of 332 doctors, only 126 (38 *per cent*) were available. The shortfall of staff nurses, radiographers and Laboratory Technicians in those districts ranged from six to 100 *per cent* as detailed in ***Appendix 2.1.5.*** Even, posts for Eye surgeon, Anesthesia specialist and Public Health Programme Manager were not yet created for any CHC of the sampled districts.

Out of 24 sampled CHCs in eight districts, there was not a single specialist in 11 CHCs of Koraput and Nabarangpur districts. Only one specialist was available in seven CHCs, two specialists were available in four and three specialists were available in two CHCs as detailed in ***Appendix 2.1.6***. Scrutiny of records by audit revealed that there was 423 deliveries in the year 2010-11

[11] Medicine, Surgeon, Paediatrician, Gynaecologists, Eye Surgeon, Anaesthesia, Public Health Manager, Block Health Officer, Dental, MO and AYUSH.

at the Kanpur CHC due to presence of O&G specialist. But the same came down to 274 (64 *per cent)* and 120 (28 *per cent*) during 2011-12 and 2012-13 due to absence of the specialist.

Government stated (December 2013) that adequate specialists are not available to fill up all vacancies. Government has taken steps to increase the posts in different disciplines and after availability of qualified personnel, posts will be filled up. Government has sanctioned the posts of staff nurse in line of IPHS norm and the posts will be filled up over a period of four years i.e. by the end of year 2017.

2.1.8.5 District Headquarters Hospital

As per IPHS Guidelines, 17 categories of specialists were required to be posted in DHHs on the basis of bed strength of the hospitals. There were 30 DHHs (100 bedded: 27 and 200 bedded: 3) and similar other two special hospitals (100 bedded: one and 500 bedded: one) also existing at Bhubaneswar and Rourkela.

Scrutiny of records revealed that out of 1075 specialists essential for DHHs, the Government sanctioned 903 such posts of which only 603 specialists (56 *per cent*) existed as on March 2013. Similarly, in eight test checked DHHs, 232 posts of specialists were sanctioned against requirement of 261 specialists of 17 categories and only 179 were available. Shortfall of specialists stood at 31 *per cent* against the IPH Standards.

Further, audit observed that only five posts for psychiatrist, two for microbiologist were sanctioned and no forensic specialist was created for the 32 DHHs against the minimum requirement of one each such specialist for each DHH. No anesthesia specialists were appointed in four sample districts (Bolangir, Kalahandi, Nabarangpur and Sundargarh), against requirement of two such specialists for each DHH.

Government stated (September 2013) that steps were being taken to minimise the gap between demand and supply of such human resources by declaring entry level post of doctors as class one and raising the retirement age to 60 years. Besides, Government is also sincerely taking action against prolonged absentee doctors.

Training

Paragraph 23 and 24 of NRHM framework stipulates that the implementation teams particularly at District and State level would require development of specific skills. Further, the State level resources centre would also be identified to enable innovations and impart due new technical skills. Further, the investment required was to be identified to successfully carry out the training/ sensitisation programme.

2.1.8.6 Non achievement of target

The State utilised an amount of ₹38.39 crore[12] towards various training programme conducted during 2007-13.

Scrutiny of records by audit in SIHFW revealed that during 2007-13, the State

[12] Director, SIHFW: ₹ 3.24 crore + Districts: ₹ 35.15 crore

and district training institutes could organise merely 62 to 87 *per cent* of the targeted NRHM trainings to persons/ batch as detailed in the table below.

Table 2.22: Status of target and achievement of training during 2007-13 ***(figures in lakh)***

Year	Target	Achievement	Shortfall	Percentage of shortfall
2007-08	0.66	0.48	0.18	27
2008-09	1.35	0.93	0.42	31
2009-10	0.31	0.27	0.04	13
2010-11	1.11	0.69	0.42	38
2011-12	1.72	1.35	0.37	22
2012-13	1.12	0.76	0.36	32
Total	**6.27**	**4.48**	**1.79**	**29**

Source: Information furnished by SIHFW

It would be seen from the above table that against the target of imparting training to 6.27 lakh persons during 2007-13, only 4.48 lakh (71 *per cent*) persons were trained despite availability of requisite funds. Similarly, scrutiny of records of CDMOs of eight test checked districts revealed that against the target for imparting trainings to 0.50 lakh personnel, the achievement was 0.28 lakh (56 *per cent*) during 2007-12.

Thus, the objective of capacity building in increasing the skill and efficiency among health personnel under NRHM remained under achieved.

Government stated (December 2013) that non achievement of maximum physical coverage during the above years is due to inability to depute all the trainees, delay in approval of PIPs and cancellation of training programmes due to National disaster like cyclone, flood and sometimes due to epidemics.

2.1.8.7 Non utilisation of trained personnel

As per National Training Strategy 2008, follow up of trained persons to assess extent of utilisation of skill is essential after completion of training. Audit observed that follow up of trained persons to assess the extent of utilisation of their skill was inadequate in Jajpur and Cuttack districts. Out of 47 AYUSH doctors trained in Skilled Birth Attendance (SBA), services of 17 trained doctors could be utilised by posting them at different delivery points.

Further out of 11 MBBS doctors trained in Life Saving Anaesthesia Skill (LSAS), services of only two doctors were utilised. Reasons for non-utilisation of the remaining trained doctors were attributed to non-availability of blood storage units, instrument and equipment, lack of patients at their place of posting.

The Government stated (December 2013) that during 2013-14, strategy has been developed to utilise skills of remaining trained doctors through strengthening of delivery points (DPs) and functionalisation of DP. The Government further stated that they have passed order to all the CDMOs to rationalise the posting of SBA trained Staff Nurses (SNs) and ANMs based on the requirement of DPs.

2.1.9 Procurement of drugs and equipment

Government of Odisha framed Drug Management Policy in 2003 with the objective to procure quality drugs and medical consumables at the right time as per requirement and to supply all Government Health Institutions. Of the total budget available for purchase of drugs, 80 *per cent* of fund would be utilised for central purchase drugs/ equipment through State Drug Management Unit (SDMU) and remaining 20 *per cent* by indenting officers of the districts on purchase of drugs not supplied by SDMU.

Receipt, utilisation and balance of funds under NRHM for procurement of drugs/ medical consumables by SDMU from 2007-08 to 2012-13 are given in Table below.

Table 2.23: Receipt and utilisation of funds *(₹in crore)*

Year	Opening balance	Receipt	Total fund available	Expen-diture	Surren-der	Balan-ce	Percentage of utilisation
2007-08	21.30	31.73	53.03	20.51	0	32.52	39
2008-09	32.52	3.82	36.34	21.10	0	15.24	58
2009-10	15.24	26.12	41.36	23.67	0.02	17.67	57
2010-11	17.67	1.48	19.15	4.65	14.41	0.09	24
2011-12	0.09	11.56	11.65	7.34	0.09	4.22	63
2012-13	4.22	41.94	46.16	16.71	5.42	24.03	36
TOTAL		**116.65**		**93.98**	**19.94**		

Sources: Information as furnished by SDMU, Odisha

As evident from above, utilisation of funds ranged between only 24 and 63 *per cent*. Irregularities noticed in procurement and management of drugs equipment are discussed as under.

2.1.9.1 Non-availability of essential drugs

NRHM Framework emphasises timely supply of drugs of good quality which is of critical importance in any health system. The Mission seeks to provide access to good hospital care through assured availability of doctors, drugs and quality services at all levels.

Audit observed that the hospitals were not provided with adequate number of essential drugs during Mission period. Government prepared the Essential Drug List (EDL) in 2002 containing 280 drugs and 10 consumables which were to be updated every two years keeping in view the prevalence of disease pattern in the State. EDL of 2002 was updated in 2009 only *i.e.,* after a lapse of seven years enhancing the items up to 310 (293 drugs and 17 consumables). Government approved a separate EDL for children in 2011 containing 165 drugs. SDMU was required to supply drugs listed in EDL well in advance after receipt of the requirements from 30 CDMOs for DHHs/ CHCs/ PHCs and three Medical Colleges of the State to ensure its availability at all levels.

Scrutiny of records by audit in eight test checked districts revealed that 72 to 245 drugs were available in District Headquarters Hospitals and 41 to 243 essential drugs were available in sampled CHCs and PHCs as given in table below.

Table 2.24: Status of availability of essential drugs.

Sl No.	Name of the District.	DHHs		CHCs and PHCs	
		Norms	Available of Essential Medicines.	Norms	Availablity of Essential Medicines.
1	Balangir	310	226 to 225	310	41 to 64
2	Cuttack	310	72 to 135	310	46 to 134
3	Jajpur	310	108	310	26 to 66
4	Kalahandi	310	118 to135	310	69 to108
5	Koraput	310	182	310	79 to 138
6	Mayurbhanj	310	110 to 243	310	45to 243
7	Nabarangpur	310	143 to186	310	72 to 109
8	Sundargarh	310	200 to245	310	30 to 116

Source: Records of DHHs, CHCs and PHCs

Though central procurements were made, only 26 to 245 variety of drugs were made available to DHH/ CHC/ PHC. Further, the drugs were also not uniformly supplied to the DHH/ CHC/ PHC. Though 245 variety/ types of drugs were supplied to certain DHH, the DHH like Jajpur received only 108 types of drugs. Due to non supply of essential drugs, quality treatment could not be ensured.

The Government stated (December 2013) that the Odisha State Medical Corporation has already been set up to look after procurement and distribution of drugs, consumables and equipment. There will be online/ web based inventory system up to CHC level for all drugs. The essential medicine list 2013-14 is being updated and revised, which will be DHH/ CHC/ PHC wise.

2.1.9.2 Receipt and administration of Not of Standard Quality (NSQ) medicines

As per NRHM Framework, State should build up capabilities to get into rate contract of drugs, its quality testing to supply drugs of good quality to the hospitals. Besides, as per IPH Standards, hospital should have standard operating procedure for stocking drugs, receiving, inspecting, checking quality of drugs, date of expiry etc.

Audit observed that drugs of Not of Standard Quality (NSQ) were procured by Government and administered to the patients defeating the objective of supply of quality drugs under Mission period. There is a Drug Management Policy 2003 which provides for replacement or refund of cost of Not of Standard Quality (NSQ) medicines by the supplier within a period of 30 days of receipt of intimation from the Deputy Director, SDMU on return of such medicines. The SDMU is to send the samples of drugs for quality testing within three days of receipt and the testing reports are to be received within 15 days for non-sterile and 21 days for sterile drugs. Testing reports are to be sent to the field levels to stop utilisation of NSQ drugs. Audit noticed that:

- SDMU procured 42 essential drugs at ₹ 93.78 lakh which were found NSQ during 2007-13. Further, audit observed (May 2013) that delay of testing reports in respect of six such drugs from Testing Laboratories ranged between 17 and 55 days and the SDMU intimated the fact of NSQ to the field institutions belatedly ranging between 17 and 48 days of receipt of the testing reports. By this time such NSQ drugs were already administered to the patients.

- Scrutiny of Stock register maintained by the sample CDMOs revealed that 24.57 lakh tablets, 0.27 lakh bottles of syrups/ vials of injections, 0.06 lakh bottles/ units of medical consumables and 1.09 lakh tubes of ointments received during 2007-13 valued at ₹ 11.28 lakh distributed to Bolangir, Cuttack, Jajpur, Mayurbhanj, Koraput and Sundargarh districts were declared as NSQ by Drug testing Laboratory of which NSQ medicines of ₹ 5.80 lakh were administered to the patients before/ after receipt of NSQ report and remaining medicines worth ₹ 5.48 lakh were lying in the State without being replaced by the supplier as indicated in ***Appendix 2.1.7.***
- The CDMO, Jajpur received (August 2011) NSQ reports from testing laboratory through SDMU, but did not intimate the fact to the CHCs and PHCs due to which 20 vials of NSQ injections and 181 bottles of NSQ surgical spirit were administered to patients between September 2011 to March 2012.
- The CDMO Cuttack intimated (February 2011) MOs of Maniabandh, Tangi and Kanpur CHCs for not using Inj. Dextrose Sodium Chloride (DNS) in which fungus was found but 480 bottles of such DNS despite intimation, continued to be administered to the patients upto February 2012.

This indicated that the Department was not serious about NSQ drugs even after receipt of reports. However, the Government stated (December 2013) that better coordination amongst CDMO, SDMU and Drugs Controller will be ensured, so that information relating to NSQ drugs is intimated to all health institutions.

2.1.9.3 Administration of time expired medicine

In order to ensure that expired/ time barred medicines are not administered to patients, MOs are required to conduct physical verification of stock of medicines and weed out time expired medicines.

Scrutiny of records revealed that 31 types of time expired medicines valuing ₹ 0.74 lakh were administered during 2007-13 to patients in four out of eight test checked districts. The details are given in the Table below:

Table 2.25: Status of administration of time expired drugs

Name of the District	Items of medicine (in nos)	Quantity administered			Month of expiry	Period of administration	Cost (in ₹)
		Tablets	inj vials/ bottles	Other			
Cuttack	8[13]	1400	173	1845	December-2008 to August-2011	March-2009 to January 2013	10855.00
Jajpur	7[14]	1424	733	10	July-2007 to December-2011	August-2007 to February-2012	7736.00

[13] Tab. Salbutamol Sulphate 4 mg, Inj. Adrenaline, Povidine Iodine Lotion, Povidine Iodine ointment, Sus. Amoxycillin powder.125 mg/5ml, Tinidazole 300 mg, Cream Clotrimazole 1% w/v, Cap. Amoxycillin, 250 mg.

[14] Povidine Iodine Lotion 5% W/V, Gention Violet, Inj. Metocloramide, Tab Metronidazole 400mg, Ointment Povidone Iodine, Tab. Misoprost(200mg), Inj. Pheniramine Meleate, Tab paracetamol Kid (Disp)

Name of the District	Items of medicine (in nos)	Quantity administered			Month of expiry	Period of administration	Cost (in ₹)
		Tablets	inj vials/ bottles	Other			
Mayurbhanj	11[15]	9975	262	196	August-2008 to November 2011	August-2008 to November 2012	29171.00
Sundargarh	5[16]	7000	90	100	September-2010 to December 2011	October-2010 to May-2012	26666.00
Total	**31**	**19799**	**1258**	**2151**			**74428.00**

Source: Stock and issue registers of CHCs

On being pointed out, concerned MOs stated that time expired medicines were used due to excess supply of drugs lying in stock, non-recording batch number, expiry date of medicines in Stock registers and receipt of short life span drugs.

Government stated (December 2013) that steps are being taken through online Drug Inventory Management System up to CHC level with FEFO (First Expiry First Out) method and alert system so that consumption of drugs can be monitored three months before expiry date and further stated that once Medical Corporation becomes fully operational, all the above deficiencies would be sorted out.

2.1.9.4 Procurement of medicine without requirement

Para 10.1 of Drug Management Policy 2003 of GoO provides that the procurement of drugs and medical consumables will be made by SDMU as per the requirement submitted by 30 districts and three medical colleges to SDMU. If requirement of any institution is not available then the previous years requirement will be taken into consideration.

Audit observed that 11.67 lakh units of Tab Misoprostol (200 mg) valuing ₹ 63.62 lakh were procured (May 2009) against the actual requirement of 9.07 lakh during 2009-10 for entire State. Of the purchase of 11.67 lakh, 9.28 lakh units of drugs (79.53 *per cent*) costing ₹ 50.60 lakh were issued (June 2009) to CDMO, Cuttack without any indent. The position of receipt, issue and balance of Tab Misoprostol during 2007-12 by CDMO, Cuttack is shown in Table below:

Table 2.26: Details of Misoprostol Tablets received by CDMO, Cuttack.

Year	Opening stock	Qty. received from SDMU(O)	Qty. returned back from peripheral institutions	Total	Qty. issued to the peripheral institutions	Balance
2007-08	Nil	10200	Nil	10200	10200	Nil
2008-09	Nil	51000	Nil	51000	37600	13400
2009-10	13400	956400	46000	1015800	1001800	14000
2010-11	14000	2300	62600	78900	78900	Nil

[15] Syp.promethazine, Tab.Enalapril, Tab.Cetrizin, Tab.Famotidine, Inj.Dipamine, Tab.Paracetamol kid, Syp.Dicyclomine, Inj.Adrenaline, Inj.PPF 4, Inj.Rabies Antiserum, Inj.Menadian Sodium

[16] Clotimazole cream, Inj.Dicylomine HCL,Tab.Metronidazole 400mg, Tab.Norfloxscin 400mg, Inj.Adranaline

Year	Opening stock	Qty. received from SDMU(O)	Qty. returned back from peripheral institutions	Total	Qty. issued to the peripheral institutions	Balance
2011-12	Nil	3500	Nil	3500	2000	1500

Sources: Information as furnished by CDMO, Cuttack

The CDMO issued (2009-10) Misoprostol tablets to peripheral institution without assessing their actual requirement and receiving indent from them. As a result MOs of Jorum CHC (14,000), Salepur CHC (34,000) and Berhampur CHC (28,000) returned tablets during 2009-10 and 2010-11 as they were unable to utilise the same.

Besides, audit found that 1.37 lakh tablets worth ₹ 7.45 lakh issued to the CHCs were misutilised/ expired due to not returning the same to CDMO as detailed in Table below:

Table 2.27: Details of mis-utilised/ expired drugs during 2008-10.

Name of the CHC	Year	Qty received from CDMO	Qty. Not utilised/ Misutilised	Cost (₹ 5.45 per tablet.) (₹ in lakh)	Remarks
CHC, Kanpur	2008-10	101400	48236	2.63	Misutilised by showing excess issue/ utilisation over recommended doses(3-4 tablets)
		0	6000	0.33	Expired in two SHCs
CHC, Tangi	2008-10	31000	7496	0.41	Misutilised by showing excess issue/ utilisation
CHC, Maniabandh	2008-10	76000	74800	4.08	Expired in the store and disposed of
Total		**208400**	**136532**	**7.45**	

Sources: Information as furnished by MO of CHCs

Thus, improper assessment of actual requirement of the said drug by CDMO and non-returning excess stock to SDMU resulted in mis-utilisation/ potency expiry of medicines worth ₹ 7.45 lakh.

Government stated (December 2013) that the CDMO, Cuttack submitted additional requirement of 50 lakh tablets. However, during verification of records it was seen that CDMO furnished nil requisition which was changed to 50 lakh at SDMU level without any recorded justification.

2.1.9.5 Distribution and administration of medicines without quality testing

MoHFW guidelines provide for inspection, sampling and quality testing of drugs at pre-dispatch stage at the manufactures premises as well as at consignee end. In order to ensure procurement of quality medicines, the Drug Management policy of the State Government further stipulated that samples of supplies in each batch would be chosen at the point of supply or distribution/ storage point for listing. Random sample of each batch would be sent for quality testing within three days of receipt of drugs and inspection and sampling be carried out by an independent authority.

Scrutiny of records, however, revealed that 19 essential drugs valued at ₹ 14.84 lakh procured under NRHM funds during 2008-09 were distributed to various rural medical institutions through CDMOs without any quality testing at consignee end. Similarly, essential drugs valued at ₹ 459.81 lakh procured through SDMU and locally under NRHM funds during 2007-08 to 2011-13 were distributed to various rural medical institutions in six sampled districts without any quality testing at consignee end which had been administered to rural patients.

Government stated (December 2013) that above deficiencies would be sorted out once the Medical Corporation fully becomes operational in the near future. The fact, however, remained that Government failed to ensure supply of quality medicine to patients.

2.1.9.6 Procurement of drugs/ medical consumables with less than 5/6th of shelf life

Drug Management Policy of the State Government envisages that Drugs and Medical consumables should arrive at the distribution point with remaining shelf life of at least 5/6th of the stipulated shelf life from the date of manufacturing of that product.

Audit, however, observed that during 2007-13 SDMU procured 14[17] items of drugs/ medical consumables worth ₹ 42.84 lakh with less than 5/6th of shelf life and 5 drugs worth ₹ 31.90 lakh having no date of manufacture on the body of invoice/ medicines but only expiry date was mentioned and remaining shelf of life of these drugs could not be ascertained.

Similarly, 104 items of drugs/ medical consumables worth ₹ 45.17 lakh were procured/ received from government during 2007-13 by District Health Society with less than 5/6th of shelf life, the details are given in Table below:

Table 2.28: Details of procurement/ receipt of medicine with less than 5/6thof shelf life

Sl. No.	Name of the district.	Items of Drugs.	Value of the medicine procured/ received (₹ in lakh)
1	Balangir	16	1.72
2	Kalahandi	33	6.75
3	Mayurbhanj	18	18.52
4	Sundargarh	37	18.18
	Total	**104**	**45.17**

Sources: Information as furnished by CDMOs

Besides, 20 types of medicines valuing ₹ 9.82 lakh procured by CDMO Cuttack and 14 types of medicines worth ₹ 2.20 lakh procured by CDMO Jajpur were having no manufacturing date. Out of these, 24 medicines (CDMO Cuttack: 16 and CDMO Jajpur: eight) without expiry date and five medicines procured by CDMO Jajpur without batch number were also found.

[17] Metronidazole (batch no. 2MT/0111,314), Methylergometrine, Silver suphadiazine, Gentamycine, Tetracyclline (batch no. 5TC25007, 6TC25007, 8047), Metronidazole (batch no. 02027B), Syringe (batch no. RP593, RP603), Cotton bandage (batch no. 09 333j21) and paracetamol

Government stated (December 2013) that above deficiencies would be sorted out once the Medical Corporation fully becomes operational in the near future.

2.1.10 Monitoring

NRHM envisaged an intensive accountability framework through a three pronged mechanism like community based monitoring, external evaluations and internal monitoring. The deficiencies noticed in monitoring are discussed below.

2.1.10.1 Monitoring by State and District Health Missions

As per MoU (February 2006), State Health Mission (SHM) at State level and District Health Mission (DHM) in each district shall conduct at least one meeting in every six months interval to review progress in implementation of NRHM, issues related to inter-sectoral co-ordination and advisory measures required to promote NRHM. Audit, however, noticed that:

- the SHM met only seven times as against requirement of 16 times since its constitution (June 2005). Though in the meetings, issues relating to improvement of health care and policy matters such as development of suitable transfer policy of doctors, improvement of infrastructures in health institutions, online monitoring of inventory of medicines in field, achievement of major goals of NRHM etc., were discussed the follow up action taken on the issues were not discussed and reviewed.

  Government stated (December 2013) that besides seven meetings of SHM since its inception, there were series of inter sectoral meetings also at the highest level of Government from time to time on different issues.

- Though DHM was constituted in Cuttack in November 2005, yet, only two meetings were held (November 2005 and December 2007) and thereafter no meetings were held as of March 2013. In remaining seven sample districts, DHMs were constituted during 2012-13 and remained almost non-functional due to conduct of only one meeting in five districts and no meeting in two districts (Bolangir and Sundargarh) during 2012-13.

  In reply, Government stated (December 2013) that meetings of DHMs were not being organised regularly as members of both ZSS and DHM are common and there was no adverse impact on Mission activities at the district level.

  However, the role of DHM was distinct and guidance for successful planning and implementation of activities under NRHM was deficient due to its delayed constitution and non-holding of regular meetings.

2.1.10.2 Monitoring and Supervision by composite monitoring team

As per instruction of Mission Director (January 2012) to strengthen monitoring and supervision of the field level activities of Health and Family Welfare Department, five teams were constituted to look into programmatic activity, financial expenditure & propriety, consistency of reporting along with validation, progress and problems of the construction activities at field level.

A composite field monitoring team with officials and consultants from all disciplines (Programme Management, Finance and MIS) was formed to carry-out concurrent monitoring of health activities at all levels through weekly visits.

Scrutiny of records by audit revealed that composite monitoring team visited (February 2012- February 2013) health care units of 25 out of thirty districts and issued observations pointing out various gaps in programme implementation, financial management, infrastructure etc. Compliance note furnished by CDMOs (Balasore, Nuapada, Cuttack and Malkanagiri) were not specific in some cases. In many cases, district authorities replied that instruction issued/ letters were written for addressing gaps but failed to furnish any supporting evidence. Mission Director, NRHM did not further pursue the matter for follow up action.

Due to lack of proper follow up action on supervision notes, rectification of deficiencies observed by the composite committee remained unascertained.

The Government stated (December 2013) that major gaps are rectified before next visit but some gaps still remain which is followed up in next visit for addressing them at the earliest. Recently, a Monitoring Coordination Team has been formed consisting of senior officials and consultants from SPMU.

2.1.10.3 Community Based Monitoring

As per Memorandum of Association (MoA) of RKS, Rogi Kalyan Samiti (RKS)/ Hospital Management Committee was to be constituted consisting of members from the local Panchayati Raj Institutions (PRI), NGO's, local elected representatives and officials from Government sector for facilitating proper functioning and management of DHHs/ CHCs/ PHCs. As per para 6 and 10 *ibid* the Governing Body (GB) meetings of RKS shall be held at least once in every quarter and Executive Committee meeting should be held once in every month. As per para 12 *ibid*, a monitoring committee would be constituted by the GB to visit hospital wards and collect patient feedback.

Audit noticed that at all levels, Health planning and monitoring committee was not formed and quality and effectiveness of health care delivery system could not be reviewed and monitored as required under NRHM. Scrutiny of records of sample eight DHHs/ 24 CHCs/ 47 PHCs revealed that meetings of RKS were not conducted regularly. Besides, RKS of test checked DHHs/ CHCs/ PHCs did not constitute any monitoring committee to review the performance of IPD and OPD except at DHH Cuttack, where the committee reviewed the issues of patient welfare and hospital management only on two occasions and thereafter became non-functional.

Thus, due to non-conduct of regular meetings of RKS and non constitution of its monitoring committee, participation of society in running hospital and ensuring accountability of public health providers to the community remained under achieved.

While CDMO (Jajpur) stated (December 2013) that meetings could not be held due to shortage of time and manpower, three CDMOs (Koraput,

Cuttack and Mayurbhanj) stated they would hold regular meetings in future and remaining CDMOs did not give specific replies.

2.1.10.4 Public Hearing & Public Dialogue

As per para 128 of NRHM framework, most of public participation in the monitoring process would be mediated by representative of the community or community-linked organisations. However, to enable interested community members to be directly involved in exchange of information, and to improve transparency and accountability of health care system "Public dialogue" (Jan Sambad) or "Public hearing" (Jan Sunwai) need to be organised at regular intervals at block and district level.

Audit observed that public hearing and dialogue were not organised at any level of the eight sampled districts as of March 2013. Besides, no provisions were made for organising the same in the state PIP. Thus, communities were deprived of direct involvement in eliciting information on health care system and failed to ensure accountability of the health providers.

Government stated (December 2013) that during 2012-13 this programme was implemented in five districts. It was decided that the programme would be facilitated by NGO partners at block and district level for which the process of NGO partner selection is going on.

2.1.10.5 Vigilance Mechanism

As per the proposal of MoH&FW, GoI, Managing Director, NRHM, GoO directed (December 2010) CDMOs of districts to constitute the District level Vigilance and Monitoring Committee (DLVMC). The Committee was to review the progress of implementation of District Health Action Plan (DHAP), release of funds and its utilisation, to undertake regular monitoring visits to field and assess their performance, to recommend corrective measures to ensure that the programme objectives are fulfilled.

Scrutiny of records by audit revealed that DLVMC was constituted in all sampled districts (March 2012 to November 2012) and only one to three meeting of each monitoring committee were held up to August 2013 against four meetings due in a year. Proposal for creation of SHCs in each Panchayat, review of RKS activities, review of civil construction works etc. were taken up in these meetings. However, due to non conduct of regular meeting and undertaking any visit to field for monitoring programme implementation, the objective of vigilance mechanism remained under achieved.

2.1.11 Conclusion

- Planning was deficient due to non preparation of perspective plans and annual action plans at the State, District and Block level. District Health Action Plan was prepared for only four out of 30 districts.
- Gaon Kalyan Samiti (GKS) meant to work as community level platform to facilitate public health activities were belatedly formed and still 63 GKSs remained to be formed in targeted villages. Also delay in formation of GKS led to short receipt of GoI assistance of ₹ 18.52 crore.

- There were delays in release of GoI instalments upto 157 days due to delay in submission of Project Implementation Plan (PIP) by State.
- Spending efficiency at State Level ranged between 36 and 66 *per cent* of funds available during 2007-13. State healthcare spending remained below three *per cent* of total budget against prescribed eight percent due to less allocation by the State.
- Though maternal mortality rate was reduced from 303 in 2007-08 to 237 in 2011-12, yet the same was above the national average. Similarly, infant mortality rate was reduced from 71 to 57 against the national average of 55 to 44 during 2007-12. Despite increasing trend of institutional deliveries in the State, position was not satisfactory in Koraput, Nabarangpur and Kalahandi districts where it remained between 13 to 64 *per cent*.
- Delivery of Health care was affected due to absence of required health institutions in the State as per Indian Public Health Standards (IPHS) norms. There were shortages of 3284 SHCs (33 *per cent*) and 370 PHCs (23 *per cent*). Despite stipulation in IPHS to have their own buildings, 91 PHCs and 2969 SHCs were functioning in private buildings in the State.
- Due to lack of adequate monitoring, progress on infrastructure was not satisfactory as only 2491 (50 *per cent*) works were completed out of 5028 works sanctioned during 2007-13. Of the above, 1051(21 *per cent*) works were lying incomplete after incurring expenditure of ₹ 40.01 crore and the balance 1486 (29 *per cent*) works were not yet started.
- Facilities for pathological tests were not available in 13 (54 *per cent*) test checked CHCs whereas X-ray and Electro Cardiogram (ECG) were not available in all the 24 test checked CHCs.
- Against IPHS norms for posting of 10,594 doctors in the State, 5077 doctors were sanctioned and 3435 (32 *per cent*) were in position as of March 2013. Though 1075 specialist under 17 categories were essential for DHHs, only 603 specialists were available.
- Similarly, as against requirement of 20,064 health workers for SHCs in the State, 10914 (54 *per cent*) were in position. No staff nurse and lab technicians (LTs) were posted despite stipulation in IPHS to post five Staff Nurses and two LTs in each PHC. Besides, 59 *per cent* (1534) of pharmacists were found short in PHCs.
- Training programme for skill development fell short of the target by 29 *per cent* during 2007-13. Services of trained doctors were not utilised as 17 trained doctors in Skilled Birth Attendance (SBA) and 11 in Life Saving Anesthesia Skill (LSAS) were not deployed for respective service.

- All types of essential drugs were not available in sampled DHHs, CHCs and PHCs. Drugs of Not of Standard Quality (NSQ) of ₹ 5.80 lakh and Life expired drugs of ₹ 0.74 lakh were administered to patients.
- Monitoring was weak, inadequate holding of meetings by State and District Health Missions, non formation of Health Planning and Monitoring Committee were noticed.
- Thus, the objectives of the mission to provide accessible, affordable, reliable and quality health care to the rural population sought to be achieved through NRHM remained largely unfulfilled.

2.1.12 Recommendations

Government may:

- undertake a comprehensive baseline survey to assess health services needs, plan effectively for creation of requisite physical and human infrastructure to meet the gap in health services within a reasonable timeframe by involving local community;
- enhance health budget and ensure timely utilisation of fund;
- ensure timely completion of all health centre buildings;
- ensure proper staffing in adherence to IPHS norms;
- streamline procurement and administration of drugs to obviate administration of sub-standard/ life expired drugs and to ensure availability of all essential drugs in PHCs/ CHCs; and
- ensure that SHM Governing Body and Executive Committee of SHS regularly meet and undertake focused monitoring.