CHAPTER 7

Implementation of Centrally Sponsored Schemes

7 Chapter Implementation of Centrally Sponsored Schemes

Audit Objective: Whether important National Health Programmes had been implemented effectively and Government of India assistance had been utilised to provide universal access to affordable and quality healthcare services, in the hospitals.

The progress and effectiveness of implementation of the National Programme for Control of Blindness & Visual Impairment (NPCB&VI) had not been assessed. Adequate Vision Centres had also not been set up. There had been no significant increase in the number of cataract surgeries conducted over the years. Adequate screening of population had not been done under the 'National Leprosy Eradication Programme (NLEP)' and 'National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)'. Around 10 to 15 per cent of the persons prima facie suspected for leprosy during screening, had not been medically examined for confirmation. Home-based care, provided to the elderly, was very low, under the 'National Programme for Healthcare of Elderly (NPHCE)'. Weekly Geriatric Clinics had not been organised by any of the Primary Health Centres. Geriatric Services had also not been provided by 67 per cent of the CHCs. There were significant shortages, in human resources, under all schemes.

National Health Mission (NHM)

Introduction

The National Rural Health Mission (NRHM) was launched in April 2005, to provide accessible, affordable, and quality healthcare to the rural population, especially the vulnerable groups. The National Urban Health Mission (NUHM) was launched in May 2013, as a Sub-mission of the overarching National Health Mission (NHM), with the National Rural Health Mission (NRHM) being the other Sub-mission of the National Health Mission.

NHM envisages achievement of universal access to equitable, affordable and quality healthcare services, that are accountable and responsive to people's needs and aims at attainment of IPHS standards, through implementation of different National Health Programmes.

Some of the major National Health Programmes, for which the State government had consistently received grants, during the period of audit, were:

i. Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A)
ii. National Programme for Control of Blindness & Visual Impairment (NPCB&VI)
iii. National Programme for Prevention and Control of Deafness (NPPCD)
iv. National Mental Health Programme (NMHP)
v. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)
vi. National Programme for Healthcare of Elderly (NPHCE)

vii. National Tobacco Control Programme (NTCP)
viii. Revised National Tuberculosis Control Programme (RNTCP)
ix. National Vector Borne Disease Control Programme (NVBDCP)
x. National Leprosy Eradication Programme (NLEP)
xi. Integrated Disease Surveillance Project (IDSP)

Apart from review of RMNCH+A, the issues under which (ante-natal care, child birth, post-natal care, neo-natal care and child care, immunisation, maternal death, neo-natal deaths *etc.*) have been covered and reported suitably across the report, the implementation status of four (4) other schemes, *viz.* the National Programme for Control of Blindness & Visual Impairment (NPCB&VI), National Leprosy Eradication Programme (NLEP), National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) and National Programme of Healthcare for the Elderly (NPHCE), were reviewed.

7.1. National Programme for Control of Blindness & Visual Impairment (NPCB&VI)

Blindness is a major public health problem in India, with an estimated 12 million blind persons in the country. To tackle this problem, the National Programme for Control of Blindness (NPCB) was launched in 1976, with the goal of reducing the prevalence of blindness, from 1.4 *per cent* (1974), to 0.3 *per cent*, by the year 2020, by developing eye care infrastructure and human resources and also by improving the accessibility and quality of eye care services.

(i) Effectiveness of implementation of programme not assessed in West Bengal

As per the survey of 2007, the level of prevalence of blindness was one *per cent*. However, no State-wide survey had been conducted since then. As per the National Blindness and Visual Impairment Survey: 2015-19, conducted using the Rapid Assessment for Avoidable Blindness strategy[171], between September 2015 and June 2018, by the All-India Institute of Medical Science, for population aged more than 50 years, the prevalence of blindness, for the surveyed districts, *viz.* Birbhum and Howrah was 1.73 *per cent* and 1.58 *per cent*, respectively.

The department was, however, unaware of the progress, if any, made under the programme.

In reply, the Department stated (February 2024) that the prevalence survey is usually conducted by Programme division, Government of India, involving State division/teams. The fact of ignorance of the State, as such, remained the same.

Scrutiny of records revealed the following:

(ii) Vision Centres not set up

- A Vision Centre (VC) is a small, community-based permanent centre, to provide primary eye care services, to semi-rural and rural communities. It

[171] *The National Blindness & Visual Impairment Survey 2015-19 was conducted in order to provide the evidence about the present status of blindness and visual impairment in India. Dr. Rajendra Prasad Centre for Opthalmic Science, AIIMS, New Delhi was responsible for planning and executing the field work. The survey was conducted in population aged > 50 years using a strategy called "Rapid Assessment of Avoidable Blindness(RAAB)"*

is the first contact point between an eye care seeker and a skilled eye care giver. Primary Health Centres in the State are generally expected to act as VCs. As per GoI guidelines, each 50,000 rural population should have one VC. Following this, the State needed to run more than 1,400 VCs, with corresponding supporting strength of Primary Medical Opthalmic Assistants (PMOAs), Optometry. However, only 99, out of the 916 PHCs in the State, were functioning as VCs (as of March 2022). The other PHCs had not been able to act as VCs due to non-availability of PMOAs. Urban PHCs were yet to act as VCs (as of March 2022).

The Department eventually accepted the fact while stating (February 2024) that PHCs with high footfalls were given priority and same process was followed in case of Urban PHCs.

- As part of the strengthening agenda, retina units/ low vision units/ Paediatric Ophthalmic Units, were to be set up in the Medical College and Hospitals. However, no information, in regard to the availability of these units, was available centrally, with the Department.

  In reply, the Department accepted (February 2024) that such super speciality clinics are yet to be operational at all the MCHs.

(iii) Acute shortage of Para Medical Optometrists

- The staff strength of PMOA/ Medical Technologist (Optometry), in the State, as of March 2022, was as follows:

Table 7.1: MIP of MT (Optometry) Regular/ Contractual

Posts	Number of sanctioned posts	Men-in-position	Shortage
MT (Optometry) (regular)	503	277	226 (44.93%)
MT (Optometry) (contractual)	78	41	37 (47.44%)
Total:	**581**	**318**	**263 (45.26%)**

Source: National Programme for Control of Blindness & Visual Impairment under NHM (State level)

Thus, an overall vacancy of 45.26 *per cent* existed in the cadre of MT (Optometry), against the cadre strength.

As stated by the Directorate of Health Services, Govt. of West Bengal, the situation had worsened, as, due to high footfall at the Sub-Divisional/ District Hospitals and availability of eye surgeons there, the services of PMOA (Optometry) were also utilised being there, by rotation, aggravating the scarcity in the rural areas.

In reply, the Department accepted the fact by stating (February 2024) that the process of filling up of vacancies in MT (Optometry) has been initiated. All CHCs are attempted to bring under service coverage through rotational duty by the existing strength of MT (Optometry).

(iv) Cataract surgeries conducted were inadequate

It was the responsibility of the District Health & Family Welfare Societies[172] to organize screening camps, for identifying those requiring cataract surgery and other blinding disorders; and to organize transportation and conduct of free medical or surgical services, including cataract surgery, for the poor, in Government facilities or NGOs supporting the programme.

[172] *District Health & Family Welfare Society is a nodal body in charge of implementation of all health programmes in a district. District Magistrate and Chief Medical Officer of a district are members of the society, among others.*

The targets for cataract surgery, during 2016-22; the number of cataract surgeries actually done; and the shortfall during the same period, were as below:

Table 7.2: Cataract surgeries- Target and Achievement

Financial Year	Target of cataract surgeries	Number of surgeries done	Shortfall (*in per cent*)
2016-17	6,03,995	2,87,595	3,16,400 (52)
2017-18	5,52,810	3,03,294	2,49,516 (45)
2018-19	5,53,666	3,13,694	2,39,972 (43)
2019-20	3,92,951	3,58,302	34,649 (9)
2020-21	3,92,951	2,19,874	1,73,077 (44)
2021-22	3,92,951	3,72,936	20,015 (5)

Source: National Programme for Control of Blindness & Visual Impairment under NHM (State level)

Though the percentage of shortfall had reduced over the years (except for FY 2020-21), the target for surgeries had also been reduced drastically, from FY 2019-20 onwards, based on the average Cataract Surgery Rate of the State, *i.e.* 4,000 per million per annum. There had been no significant increase in the number of surgeries conducted over the years.

In reply, Department stated (February 2024) that the target was rationalized by the programme division in the year 2019-20. The dip in performance was due to COVID which has improved after 2022.

(v) Corneal transplantations

Corneal blindness constitutes one of the main reasons causing preventable blindness. Carrying out corneal transplantations was one of the major strategies under the programme. The position in regard to the targets of collecting corneas, actual collections thereof and the number of corneas grafted (keratoplasty), during 2016-22, was as follows:

Table 7.3: Targets of collecting corneas, *vis-à-vis* the actual collections

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Target of collecting cornea	3,000	NA	NA	3,000	4,400	3,140
Number of cornea collected	3,794	4,011	4,281	3,978	798	2,166
Number of Keratoplasties done	2,239	1,984	1,749	1,855	710	1,392

Source: National Programme for Control of Blindness & Visual Impairment under NHM (State level)

The differences between the number of corneas actually collected and the keratoplasties done may be attributed to the fact that not all the collected corneas were finally found fit for grafting. As a majority of eye banks are Kolkata-based, the distant locations of Eye Retrieval Centres caused delays in the transportation of corneas to Kolkata, resulting in the collected corneas becoming unfit for grafting. Eye banks, in all the districts, were yet to be developed[173].

The Department, in reply, stated (February 2024) that the development of the Eye Banks in the district based MCHs is being promoted. It also stated that the utilization rate of the collected corneas now is 50 *per cent* which is at par with national average.

[173] *Eight districts, excepting Kolkata, had eight eye banks (as of March 2023). Out of these eight, seven are privately owned and the remaining one is at the Command Hospital (Eastern Command), located at North 24 Parganas. Kolkata has four eye banks, out of which three are Government eye banks.*

(vi) Unrealistic targets vis-à-vis shortfalls in the distribution of glasses to students

Another responsibility of the District Health Societies was to organize screening of school children, for detection of refractive errors and other eye problems and provide free glasses to poor children. The targets vs. achievement status, in regard to the distribution of free glasses to children, during the audited period, was as follows:

Table 7.4: Targets *vis-à-vis* achievement, in regard to distribution of free glasses to children

Financial Year	Target of children to be provided with free glasses	Number of free glasses provided
2016-17	NA*	47,415
2017-18	NA*	82,453
2018-19	70,000	1,08,576 (155.11%)
2019-20	70,000	91,353 (130.51%)
2020-21	77,000	19,416 (25.26%)
2021-22	65,000	17,009 (26.17%)

*Source: National Programme for Control of Blindness & Visual Impairment under NHM State level; *Note: The data for the target of the children to be provided free glasses for 2016-17 & 2017-18 was not made available to Audit.*

It may be seen that the number of free glasses, provided in FYs 2018-19 and 2019-20, was far above the targets set. Evidently, the set targets had been grossly understated.

In reply, Department stated (February 2024) that the targets were set based on the previous year performance and the sharp fall in in the year 2020-21 and 2021-22 was due to long closure of schools due to Covid.

(vii) Lacunae in capacity building and non-adoption of standard protocol of examination

No orientation training of Medical Officers of PHCs/ CHCs, in community opthalmology, had been conducted, during the audit period. Similarly, no standard protocols for doctors, for examination of blind children, had been adopted (as of March 2022).

In reply, the Department stated (February 2024) that no directive was ever received from GoI to arrange it locally.

The reply was not tenable as GoI guidelines for NPCB stipulated that carrying out orientation training for the MOs was the responsibility of the District Samities.

Recommendation:

14. The H&FW Department may ensure that adequate Vision Centres are set up, vacancies in regard to Optometrists are addressed, and cataract and corneal surgeries are conducted at an optimal level.

7.2 National Leprosy Eradication Programme (NLEP)

The National Leprosy Eradication Programme (NLEP) is one of the centrally sponsored schemes under NHM. The primary goal of the programme is to detect cases of leprosy at an early stage and to provide complete treatment, free of cost, in order to prevent the occurrence of disabilities in the persons affected and stop transmission of disease at the community level. The programme also aims to spread awareness about the disease and reduce the stigma attached with the disease.

(i) Adequate screening of population not done as prescribed

With a view to widening the coverage of population, screening for early case detection and strengthening the active surveillance under the NLEP, it is imperative to carry out search of active cases, on a regular basis, round the year, and not occasionally, in a campaign mode. As per the Operational Guidelines of NLEP, the entire population of a given village/ urban pocket, in a low endemic block, should be screened by Female/ Male Front Line Workers (FLWs) within 12 months, so as to cover the entire population in a year. For areas in high endemic blocks, there should be two rounds of screening, in such a manner that the entire population is screened twice a year. The screening rounds should be completed within the given financial year.

Though the Health & Family Welfare Department claimed that high endemic blocks/ villages/ urban pockets had been covered under routine surveillance, throughout the year, detailed information, in regard to the two rounds of screening, *vis-à-vis* the coverage of eligible population, in high/ low endemic blocks, was not furnished, though called for.

Out of the 38 test-checked SCs, it was found that screening had not been done in three SCs[174]. Further, data in regard to screening had not been made available by two SCs [175], while second round of screening had not been done in three SCs[176] located in the high endemic block of Paschim Medinipur, during 2016-22.

In reply, the Department accepted (February 2024) that two rounds of survey could not be conducted during COVID. In respect of 2019-20 and 2021-22, the Department while stating that Active Case Search Programme was carried out as per the guidelines, it did not specifically mention about conducting two rounds of survey for screening. However, while replying against *para 7.2 (iii)*, the Department accepted that it could not properly carry out active case search activity in 2021-22 also citing COVID. Further, the Department accepted that due to insufficient fund and unavailability of man power, the entire population could not be covered in one/ two rounds of search.

(ii) Suspected positive cases remaining unexamined for confirmation

NLEP guidelines envisaged that, if a F/ M FLW suspects that a person screened is a "Suspect case", she/ he is to issue a Referral Slip to the Suspect, with the advice to immediately visit the nearest PHC, for final diagnosis by the MO concerned. A copy of the said Referral Slip was also to be handed over by the F/ M FLW, to the CHO/ ANM of the Sub-Centre concerned, within a day of the screening of such a Suspect, in order to enable cross-checking in regard to all suspected cases having been medically examined.

Scrutiny, however, showed that a significant number of suspected new cases, referred for confirmation, had not been examined in the State, as shown in **Table 7.5**.

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[174] *Boltala SC of Bashirhat HD, Kharika PHC attached SC of Paschim Medinipur and Dilwarpur SC of Uttar Dinajpur*
[175] *Golmara SC and Chayanpur SC of Purulia*
[176] *Bhadutala SC, Arabari SC and Lokepith SC*

Table 7.5: Suspected new cases (referred for confirmation) not examined

Year	No. of suspected new cases referred for confirmation	No. of suspected new cases examined	Suspected new cases not examined	Percentage of suspected new cases not examined
2019-20	82,368	70,416	11,952	14.51
2020-21	No active case search activity conducted due to Covid 19 pandemic			
2021-22	1,00,058	90,151	9,907	9.90

Source: National Leprosy Eradication Programme (NLEP) under NHM (State level)

It could be seen that around 10 to 15 *per cent* of the persons, *prima facie* suspected for leprosy during the screening, had not been medically examined for confirmation. A district-wise analysis ***(Appendix 7.1)*** further revealed that the percentage of persons not examined, was alarming high in certain districts. In FY 2019-20, more than 25 *per cent* persons had not been examined in 11 districts. Of these, two districts had not examined more than 50 *per cent* of the suspect cases.

In reply, the Department accepted (February 2024) that the gaps have been identified and necessary steps have been taken for proper examination of suspects identified. The identified districts have also been communicated in this regard and the Department claimed that most of the suspect cases have been examined by the concerned MOs for confirmation subsequently. However, no documents in support were provided.

(iii) High incidence of Grade-II deformity

One of the objectives of the programme was to reduce the percentage of Grade II disabilities[177], to less than one (1) among new cases and overall, to less than 1 case per million, at the national level.

Review, however, showed that the incidence of Grade-II deformity, per million population, was more than one (1), in seven districts of the State, during FY 2021-22, as shown below:

Table 7.6: Districts having Grade-II Deformity per Million population

District	Grade-II deformity per million
Bishnupur Health District	8.49
Alipurduar	3.09
Howrah	1.79
Purba Medinipur	1.38
Nandigram Health District	1.33
Nadia	1.22
Rampurhat Health District	1.16

Source: National Leprosy Eradication Programme (NLEP) under NHM (State level)

It could be seen that incidence of Grade-II deformity was quite high in the Bishnupur and Alipurduar Districts.

The Department, in reply, stated (February 2024) about the various routine activities that are taken to reduce Grade-II deformity. The Department also accepted that active case search could not be performed properly in the year 2020-21 & 2021-22 due to COVID pandemic.

[177] *Visible deformity or damage*

(iv) Rate of prevalence of leprosy more than prescribed

The ultimate objective of the programme was to reduce the Prevalence Rate (PR) of leprosy to less than 1 per 10,000 population, at the sub-national and district levels.

Review of records revealed that Prevalence Rate, in six districts of the State, during FY 2021-22, had remained more than 1 per 10,000 population, as shown below:

Table 7.7: Prevalence Rate in six districts of the State

District	Prevalence Rate during FY 2021-22
Bankura	1.31
Birbhum	1.04
Paschim Bardhaman	1.01
Jhargram	1.41
Purulia	1.01
Kolkata	1.02

Source: National Leprosy Eradication Programme (NLEP) under NHM (State level)

Thus, the objective of the programme had not been fully achieved. While accepting the status, the Department attributed (February 2024) the high rates of prevalence to COVID-19 pandemic and inadequate fund and human resources. Further, the Department communicated a list of measures taken by it to reduce the PR like i) contact tracing of each new leprosy case and administration of Single Dose Rifampicin (PEP), ii) early case detection, supervised dose, treatment completion *etc*., iii) engaging trained Lab-tech in each district and MCHs, iv) strengthening tertiary level hospitals, v) training of staff *etc*.

Recommendation:

15. Department may ensure that adequate screening of the population is carried out under the NLEP and all persons, prima facie suspected of leprosy during the screening, undergo the required medical examination for confirmation.

7.3 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

Government of India (GoI) had launched the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS), in the year 2010. The programme aims to prevent and control common Non-Communicable Diseases (NCDs), through early detection, treatment, behaviour, and life-style changes.

Common cancers (breast, cervical and oral), diabetes and high blood pressure screening of the target population (age 30 years and above) was to be conducted through an opportunistic and/ or camp approach, at different levels of health facilities, from sub-center and above. The suspected cases were to be referred to higher health facilities, for further diagnosis and treatment.

(i) Inadequate screening and treatment

The status of screening of the eligible population and referring of suspected cases to higher facilities, for treatment, showed the followings position:

Table 7.8: Referal of suspected cases to higher facilities, for treatment

Year	Districts covered*	Eligible population	Population screened	Percentage	Referred for treatment			Total	Percentage
					Diabetes	HT	Cancer		
2016-17	4	NA	1,67,704	NA	10,943	21,949	26	32,918	***19.63***
2017-18	19	NA	13,42,340	NA	1,85,075	2,82,645	7,679	4,75,399	***35.42***
2018-19	27	NA	33,81,393	NA	3,85,072	5,44,630	19,024	9,48,726	***28.06***
2019-20	27	NA	3,35,630	NA	34,949	46,842	3,873	85,664	***25.52***
2020-21	27	3,42,83,000	33,68,463	9.83	6,29,018	4,14,299	55,131	10,98,448	***32.61***
2021-22 (up to 02/ 22)	27	3,42,83,000	1,56,69,205	45.71	11,02,753	8,94,497	1,10,129	21,07,379	***13.45***

*Source: NPCDCS under NHM State level; * Including Health Districts*

Though the scheme had been rolled out in 2010, only four (4) districts had been covered under the scheme, in the State, up to FY 2016-17. The scheme covered all districts only from FY 2018-19 onwards.

In India, as per a WHO Report (2015), one in four Indians has a risk of dying from an NCD, before reaching the age of 70. There had been an increase in the contribution of NCDs, from 30 *per cent* of the total disease burden- 'disability-adjusted life years' (DALYs[178]) in 1990, to 55 *per cent* in 2016 and also an increase in the proportion of deaths due to NCDs, from 37 *per cent* in 1990, to 61 *per cent* in 2016.

Under the backdrop of this rapid epidemiological transition, with a shift in the disease burden to NCDs, it was noticed that only 9.83 *per cent* of the eligible population had been screened prior to FY 2020-21. This number had increased to 45.71 *per cent* in FY 2021-22. Moreover, against the predominant growth of NCDs, while 19.63 *per cent* of the screened population had been referred to higher health facilities, for treatment, in 2016-17, the corresponding number was only 13.45 *per cent* of the screened population, in FY 2021-22.

In reply, the Department while acknowledging (February 2024) the fact of low screening, stated that it has been trying to improve the performance. It was also stated that the screening had improved to 57 *per cent* in the year 2022-23 mainly due to introduction of telemedicine in 2021-22 and 17 *per cent* of the screened people put on treatment in the year 2022-23.

(ii) Shortage of Human Resource

As per NPCDCS guidelines, District NCD Cells were to be supported by the following contractual staff:

a. Epidemiologist/ Public Health Specialist
b. District Programme Officer
c. Programme Assistant
d. Finance-*cum*-Logistics Officer
e. Data Entry Operator

Scrutiny revealed that, in none of the Cells, had a Programme Assistant or Programme Coordinator, been posted. Twelve (12) district NCD cells[179], out of 27 in the State, had been running without any Data Entry Operator, during FYs 2016-22. Paschim Bardhhaman and Bankura had no Epidemiologist/ Public Health Specialist, posted in the district NCD cells.

[178] *A time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health, or years of healthy life lost due to disability (YLDs).*
[179] *Paschim Bardhhaman, Bashirhat, Birbhum, Bishnupur, Coochbehar, Diamond Harbour, Hooghly, Malda, Nadia, Murshidabad, 24 Parganas (North) and 24 Parganas (South)*

The HR position of the test-checked two NCD clinics, in the District Hospitals of Jalpaiguri and Bashirhat, is shown in **Table 7.9** below.

Table 7.9: HR position of the two test-checked NCD clinics, in the District Hospitals of Jalpaiguri and Bashirhat

Sl. No.	Name of Posts (sanctioned strength)	Men-in-Position	
		Jalpaiguri	Bashirhat
1.	General Physician (1)	Nil	Nil
2.	General Nursing & Midwifery [GNM (2)]	Nil	Nil
3.	Technician (1)	Nil	Nil
4.	Physiotherapist (1)	01	Nil
5.	Counsellor (1)	01	01
6.	DEO (1)	01	Nil

Source: NPCDCS under NHM (State level)

Thus, the NCD clinics had not been able to deliver the desired services, due to shortages of core personnel like physician, nurse and technicians.

In reply, the Department claimed (February 2024) the following without furnishing any documents in support:

(i) Presently all District NCD cell have one District Epidemiologist, NCD;

(ii) In regard to non-availability of DEOs in 12 NCD cells, it was stated that it was as per State NHM policy decision. However, the decision was in contravention to the NPCDCS guidelines; and

(iii) District Epidemiologist are posted at present in Paschim Bardhaman and Bankura.

(iii) Inadequate capacity building through training

Under NPCDCS, health professionals and healthcare providers, at various levels of healthcare, were to be trained for programme management and also for health promotion, NCD prevention, early detection and management of Cancer, Diabetes, CVDs and Stroke. The State NCD Cell was to organise State and district level trainings, for capacity building. The status of conduct of training programmes relating to NPCDCS, during the audited period, was as below:

Table 7.10: Status of training programmes under NPCDCS

Year	PBS* & NPCDCS		ASHA		VIA#		Chemotherapy		IHCI^		Total		
	Planned	Attended	Planned	Attended	Planned	Attended	Planned	Attended	Planned	Attended	Planned	Attended	Shortfall (*per cent*)
2016-17	4,320	3,970	0	0	0	0	0	0	0	0	4,320	3,970	**8.1**
2017-18	2,171	1,950	3,046	2,996	0	0	140	119	0	0	5,357	5,065	**5.45**
2018-19	6,200	5,862	13,779	8,182	0	0	0	0	0	0	19,979	14,044	**29.71**
2019-20	100	88	18,029	15,936	0	0	0	0	30	22	18,159	16,046	**11.64**
2020-21	12,646	11,223	20,207	5,808	2,437	1,830	0	0	0	0	35,290	18,861	**46.55**
2021-22&	0	0	12,920	12,032	1,575	1,225	0	0	4,880	3660	19,375	16,917	**12.69**
Total:	**25,437**	**23,093**	**67,981**	**44,954**	**4,012**	**3,055**	**140**	**119**	**4,910**	**3682**	**1,02,480**	**74,903**	**26.91**

Source: NPCDCS under NHM (State level)
**Population Based Screening; # Visual Inspection with Acetic Acid; ^ Indian Hypertension Control Initiative; & up to February 2022*

It could be seen from the above that the planned targets and attendance of trainings on programme management (PBS & NPCDCS), had been drastically low in FY 2019-20 and had not been conducted at all in FY 2021-22. Training on cancer detection and treatment (VIA and Chemotherapy), as also on Hypertension, had not carried out at all, in four and five years respectively, out

of the six test-checked years. Moreover, there had been a shortfall of 26 *per cent*, over the targeted number of personnel to whom, training was planned to be imparted, over the years.

In reply, the Department while acknowledging (February 2024) the fact of 26 *per cent* shortfall in training stated that reasons for shortfall were mainly the difficulties faced by the doctors to attend training by avoiding their duties at the PHC/ CHC.

The Department stated that training on PBS/ NPCDCS training was not planned in 2021-22.

In regard to not carrying out training on cancer detection and treatment (VIA and Chemotherapy), no specific reasons have been cited by the Department in its reply.

(iv) Lack of investigation facilities

As per NPCDCS guidelines, laboratory investigation and diagnostic facilities, such as pathology (blood sugar, lipid profile, liver function test and kidney function test) and radio-diagnosis services (X-Ray, ECG, USG, ECHO, CT scan, MRI, *etc.*), should be available in the District NCD Clinics.

Review showed that pathology tests, like LFT, KFT and Lipid Profile, were not available in the NCD clinic at Bashirhat DH. While BT&CT[180] was not available at the Purulia district, during 2016-22, Radio-diagnosis facilities, like ECHO and MRI, were not available in the NCD clinics at the Purulia, Jalpaiguri and Bashirhat Health districts.

In reply, the Department stated (February 2024) that POC tests (point of investigation) like Glucostrip & Glucometer, five *per cent* acetic acid for VIA tests *etc.*, are provided under NPCDCS programme. Other investigations are guided by State policy and availability of equipment and HR.

However, there was no specific reply about non-availability of the stipulated services at District NCD clinics as pointed out in audit.

(v) Absence of Day Care and Palliative Care Units

As per NPCDCS guidelines, district hospitals are required to provide home-based palliative care, for chronic, debilitating, and progressive patients. A team, consisting of nurses and counsellors, is to be trained in identifying symptoms, pain management, communication, psychosocial & emotional care, and the nursing needs of the terminally ill, keeping in view the ethics of palliative care.

Review revealed that three district NCD clinics, at Siliguri DH, Kalimpong DH & Bashirhat SSH, had no District Day Care Centres, while Rampurhat DH had no Palliative Care Centre.

In reply, Department stated (February 2024) that the day care facility at Siliguri and Bashirhat has now been made functional while initiatives have been taken for making the facility functional at Kalimpong DH. In respect of non-availability of Palliative Care Centre, the Department stated that, now the services are provided by the oncology department of Rampurhat MCH.

[180] *Bleeding Time & Clotting Time*

(vi) Non-adoption of the prescribed approaches for public awareness activities

As per NPCDCS guidelines, the major determinants to hypertension, obesity, high blood glucose and high blood lipid levels, are unhealthy diet, physical inactivity, stress and consumption of tobacco and alcohol, awareness was to be generated, in the community, to promote healthy lifestyle habits. For such awareness generation and community education, various strategies were to be devised/ formulated, for behaviour change and communication.

It was the responsibility of the State NCD Cell to generate public awareness, regarding health promotion and prevention of NCDs, through specified approaches. Review, however, showed that, except for printing of IEC materials for Celebration of World Cancer Day, World Diabetes Day, World Hypertension Day, self-breast examination and distribution of some pamphlets and handouts, no activities, under the following prescribed modes, had been undertaken, during the audited period, for adoption of healthy habits as below :

i. Development of communication messages for audio-visual and print media
ii. Campaigns through mass media channels (electronic and print media)
iii. Social mobilization through involvement of women's self-help groups, community leaders, NGOs *etc.*
iv. Advocacy and public awareness, through media (Street Plays, folk methods, wall paintings, hoardings *etc.*)

The other printing activities undertaken, as per the information furnished by the Department, were printing of forms/ registers *etc.*, for running of the programme and material to aid the health worker in carrying out his/her assigned functions.

In reply, Department stated (February 2024) that the State NCD cell has started campaigning IEC through TV spot and audio jingles in FM radio from 2022-23. Districts, as claimed in the reply, are also organising FGDs (Focussed Group Discussions) in the community and other modes of publicity for awareness generation.

(vii) Lax monitoring and review

Monitoring and evaluation of the programme was to be carried out at different levels, through NCD cells, reports, regular visits to the field and periodic review meetings. A Management Information System (MIS) was also to be developed, for capturing and analysis of data.

Review, however, revealed that only seven meetings had been held, during the period covered under audit, as below:

Table 7.11: Periodic review meetings of the State NCD Cell

Financial Year	Number of meetings carried out
2016-17	0
2017-18	2
2018-19	0
2019-20	3
2020-21	0
2021-22 (up to Feb. 2022)	2
Total:	**07**

Source: NPCDCS under NHM (State level)

Further review showed that the meetings had been organised at different levels, by different officers. However, none of the meetings had been held for the purpose of reviewing the performance of the programme. They had, instead, been convened to address certain other issues, like formation of an Expert Committee on 'COPD and ASHA under NPCDCS', 'Training on Chemotherapy Administration', Meeting of the Financial Management Group on upkeep of overall accounts *etc.* It was observed that a 'Multisectoral Convergence Committee on NCD' had been formed at State level, but had met only once (27-07-21), as of February 2022.

Moreover, no Management Information System (MIS), for capturing and analysing the programme information, had been developed by the State NCD Cell as of December 2022.

Though specified in NPCDCS guidelines, none of the district NCD Cells had prepared District Action Plans, for implementation of NPCDCS strategies, during FYs 2016-17 to 2021-22.

The Department claimed (February 2024) in its reply that since 2020, the authority had organized its review meetings through online mode which might not have been recorded. However, no comments for period prior to COVID and after COVID was offered. Further, though the Department claimed to discuss the performance of the programme through major indicators, the minutes of meeting did not reflect the same. The Department has further stated that an online MIS has been made operational from 2023-24.

(viii) No database of NCDs developed for the State

As per NPCDCS guidelines, the State NCD Cell, with the help of District NCD cells, was required to develop a district-wise database of NCDs, including sentinel sites[181], through a Surveillance System and to monitor the NCD morbidity and mortality and risk factors.

Review, however, showed that no such database of NCDs like Cancer, Diabetes, Cardiovascular Diseases and Stroke, had been developed, for the State. It had also not earmarked any sentinel sites for the State.

In reply, Department stated (February 2024) that all data were captured in Form-6 since 2019-20 as per guideline and there was no guideline in the programme regarding sentinel site.

Reply of department is not tenable as Form 6 is meant for reporting performance to National NCD cell, whereas the audit pointed out non-maintenance of database of NCDs, as per scheme guidelines. Further, development of sentinel site was clearly mentioned under "Roles and responsibilities of the State NCD cell" in Operational guidelines of NPCDCS.

Recommendations:

16. A proper monitoring mechanism may be established, to ensure adequate screening of the population, under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS).

[181] *A sentinel site is a community from which in-depth data are gathered and the resulting analysis is used to inform programs and policies affecting a larger geographic area.*

17. The H&FW Department may identify and plug in the gaps in investigation facilities, day care facilities, palliative care and capacity building initiatives, across all clinics.

7.4 National Programme for Healthcare of the Elderly (NPHCE)

Non-Communicable diseases, requiring large quantum of health and social care, are extremely common in old age, irrespective of the socio-economic status. Disabilities resulting from these non-communicable diseases are very frequent and affect functionality, compromising the ability to pursue the activities of daily living. The treatment management of these chronic diseases is also costly, especially in regard to cancer treatment, joint replacements, heart surgery, neurosurgical procedures *etc.*, thereby making it out of bounds for elderly patients whose income decreases post-retirement and, more so for the elderly in the unorganized sector and dependent elderly women.

The National Programme for Healthcare of the Elderly (NPHCE) was launched (2011) by the Ministry of Health and Family Welfare, to address this issue, by way of introducing a comprehensive healthcare set-up, that was completely dedicated and tuned to the needs of the elderly.

(i) Non-execution of MoU

As per NPHCE Guidelines, it was the responsibility of the State/ UT, to enter into an MoU, with the Ministry of Health & Family Welfare, GoI, committing to the appointment of a State nodal officer, contribution of the State share, provisioning of land and space for Geriatric wards and OPD, appointment of faculty in specialities, starting PG courses in Geriatric Medicine, setting up rehabilitation units for elderlies at CHCs *etc.*

No such MoU, as stated, had, however, been entered into by the State, committing to these deliverables.

The Department, in reply, while admitting (February 2024) the fact of non-execution of MoU, stated that all commitments on part of the State in execution of the scheme, however, are fulfilled. In respect of setting up of rehabilitation units in CHCs, it was stated that procurement of equipment and manpower for all CHCs are under process.

(ii) No database of the elderly, for monitoring and analysis

NCD Cells were to be established at the district level. They were to be responsible for overall planning, implementation, monitoring and supervision of different activities and achievement of the physical and financial targets, planned under the programme, in the districts. It was the responsibility of the District NCD Cells to prepare and maintain district databases on the elderly.

Review, however, showed that no such databases were available with the State, indicating poor execution of the programme.

In reply, Department admitted (February 2024) that database of elderly is only maintained at District level.

(iii) Programme benefits not extended by Sub-Centres

The ANM/ Male Health Workers, posted in the sub-centres, were to be suitably trained, to make domiciliary visits to the elderly persons, in the areas under their jurisdiction. The role of ASHAs included mobilizing of the elderly, to attend camps and conserving home-based care for bed-ridden elderly.

Review, however, showed that home-based care, provided to the elderly, had been very low, indicating non-percolation of the benefits of the scheme to elderly persons. In the last four years, *i.e.* from FYs 2018-19 to 2021-22, home-based care had been provided in only 679 cases.

Out of the 38 test-checked SCs, Male Health Workers/ ANMs/ ASHAs of only four (4) test-checked SCs, had made home visits, to the bed-ridden elderly people, in the areas under their jurisdiction.

The ANMs/ Male Health Workers of the SCs were also required to provide elderly persons or the family, information on various interventions, such as health education related to healthy ageing, environmental modifications, nutritional requirements and lifestyle and behavioural changes. They were also required to arrange suitable callipers and supportive devices from the PHC and provide the same to the elderly disabled persons, to make them ambulatory.

Scrutiny revealed that only 12, out of the 38 test-checked SCs, had maintained records of elderly people and, accordingly, followed-up their annual health check-ups. None of the test-checked SCs had made any arrangements for suitable calipers and supportive devices, from the PHC, to the elderly disabled persons, to make them ambulatory. Items like Walking Sticks, Calipers, Infrared Lamps, Shoulder Wheels, Pulleys or Walkers were also not available at any of the test-checked SCs.

In reply, Department while admitting (February 2024) the fact regarding low home-based care provided during 2018-19 to 2021-22, stated that the programme had been strengthened after 2021-22 wherein 17,989 persons had been provided home based care in the last two years. No details or supporting documents were, however, provided to corroborate the contention. In regard to supporting devices, the Department stated that, these are not proposed in the Project Implementation Plan for HWCs.

(iv) Geriatric Clinics not held in PHCs

Weekly Geriatric Clinics were to be organised at each Primary Health Centre, by trained medical officers, for conducting health assessments of the elderly persons, based on simple clinical examination, relating to vision, joints, hearing, chest, BP, and simple investigations, including blood sugar *etc.*

However, none of the 916 PHCs in the State had operationalised the services in the State.

In reply, Department claimed (February 2024) that presently geriatric clinics have been made functional in 667 PHCs. No details/ documents in support, however, have been provided.

(v) Geriatric services not provided in majority of the CHCs

The basic activities and role of the CHCs, under NPHCE, were to act as a first medical referral unit, for patients from PHCs and below. CHCs were to arrange dedicated and specialized Geriatric Clinics, for the elderly persons, twice a week; provide physiotherapy, medical rehabilitation and domiciliary visits, by rehabilitation workers, for bed-ridden elderly persons; and also provide counselling to family members, for care of such patients.

Review, however, showed that only 108 CHCs, out of the 348 CHCs in the State, were providing services under NPHCE. Services under the scheme had not been provided by 233 CHC[182]s (67 *per cent*), keeping the elder population of 16 districts out of coverage under the programme.

The Department in its reply stated (February 2024) that it has expanded the services from 108 CHCs to 291 CHCs at present. No details/ documents in support, however, have been provided.

(vi) Shortage of human resources

District Geriatric Units were to be set up in each district, at the District level hospitals, with provision for 10-bedded indoor Geriatric Wards and Geriatric OPD clinics. For this purpose, the programme guidelines envisaged sanction of additional manpower.

Review, however, revealed that, though all the 27 districts (including health districts), were shown as having functional District Geriatric Units (*i.e.* 10-bedded indoor wards and OPD clinics), the availability of contractual manpower showed gross shortages, as below:

Table 7.12: Availability of Contractual MIP, in the Geriatric units of different districts

Sl. No.	Posts sanctioned	Total sanctioned for 27 DGU	MIP	Shortage
1.	Consultant Medicine (@2/ DGU)	54	1	53
2.	Nurses (@6/ DGU)	162	Not submitted	NA
3.	Physiotherapist (@1/ DGU)	27	5	22
4.	Hospital Attendant (@2/ DGU)	54	10	44
5.	Sanitary Attendants (@2/ DGU)	54	12	42
	Total:	**189***	**28**	**161 (85.19 %)**

*Source: NPHCE under NHM (State level); * Excluding the sanctioned strength of Nurses, as MIP was not furnished.*

Each CHC was also supposed to contractually engage one rehabilitation workers for physiotherapy and rehabilitation of elderly persons. However, out of the 108 CHCs rendering services under NPHCE, only 3 CHCs had engaged rehabilitation workers. Further, though the guidelines envisaged only one worker, two of the CHCs had three and four number of rehabilitation workers posted.

Thus, not only had a majority of the health facilities remained non-functional for the purpose of delivering services under the NPHCE, the small number of health facilities, which had claimed that they were rendered services under the programme, could not have actually done so, due to the significant shortage of manpower.

The Department in its reply (February 2024) offered no response in this regard.

Recommendation:

18. The H&FW Department may ensure that the district database on the elderly is prepared and home-based care is provided to all needy elderly persons. Weekly Geriatric Clinics, at the PHCs, and services as envisaged under the programme, may also be ensured, at all CHCs.

[182] *Information regarding the remaining seven CHCs was not available.*