उत्तराखण्ड शासन

PERFORMANCE AUDIT OF
NATIONAL RURAL HEALTH MISSION (NRHM)

REPORT OF THE
COMPTROLLER AND AUDITOR GENERAL OF INDIA

FOR THE YEAR ENDED MARCH 2008

GOVERNMENT OF UTTARAKHAND

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PREFACE

1. This Report of the Comptroller and Auditor General of India contains the results of Performance Audit of the 'National Rural Health Mission' (NRHM) in Uttarakhand. The Report has been prepared for submission to the Governor under Article 151 (2) of the Constitution of India.

2. The Audit was conducted through a test check of the records of the State level implementing agency viz. Uttaranchal Health and Family Welfare Society and various field level health care delivery centres covering the period 2005-08. Implementation of the programme relating to the period subsequent to March 2008 has also been commented upon wherever necessary.

3. The audit has been conducted in conformity with the Auditing Standards issued by the Comptroller and Auditor General of India.

EXECUTIVE SUMMARY

Executive Summary

The National Rural Health Mission (NRHM) was launched in Uttarakhand in October 2005 to provide accessible, affordable and reliable healthcare to the rural population, especially the vulnerable sections of the society. The programme envisaged convergence of various existing standalone health programmes, decentralization of the planning process with special emphasis on bottom-up approach in decision making and creating better linkages and cooperation among various social sector departments. A mid-term review of the implementation of the programme in the third year of the Mission period (2005-2012) is aimed at reviewing the initiatives taken by the State Government to bridge the gaps in healthcare facilities provided in the earlier programmes and highlight the areas and issues of concern, which need to be addressed for successful achievement of the objectives of the Mission by the target date.

Performance review of the Mission activities in the State for the period 2005-08 brought out several positives like introduction of 'Dial-108' emergency ambulance service, which has got overwhelming response from the public. In maternal and child health care, there was a marginal increase in institutional deliveries. 'ASHA-Plus' scheme introduced in two districts, is a unique feature run with NGO collaboration. The cure rate targeted for tuberculosis and cataract operations was achieved in all the three years, while the State has brought down the leprosy prevalence rate in the year 2005 itself. However, there were major areas of concern requiring corrective measures as brought out below:

- The objective of decentralized planning with community participation was not achieved. The community was not involved in any aspect of health care system- neither in planning nor in implementation and monitoring. Block and village plans, which were to form the basis for district plans, were not prepared. District health authorities did not own up the district level plans prepared with outside support. Baseline survey of availability of services at various levels of heath care system was incomplete. Household survey was not conducted. Convergence with other departments in implementation of the programme was also ineffective. The Village Health and Sanitation Committees (VHSC) at villages and Rogi Kalyan Samitis (RKS) at PHCs were not formed and public hearings (Jan Sunwai) were not conducted.

Planning process should be strengthened with community involvement in planning, implementation and monitoring of the activities of the programme. Household and facility survey should be completed to facilitate preparation of detailed plans. Effective community based monitoring mechanism should be established so as to receive the required feed back for future interventions. The roles and responsibilities of various departments should be clearly defined. VHSC should be set up in all the villages and RKS should be constituted at the PHC level to facilitate proper monitoring of the activities of the health centres.

- NRHM envisaged streamlining the fund flow for health care services and improving coordination by merging all the existing societies and providing a single window for

all the Mission activities. However, independent societies are functioning for disease control programmes in the State. Although the State has increased the expenditure on health in all the three years, it failed to contribute its share of 15 *per cent* to NRHM kitty in the year 2007-08. Fund releases to the districts were not proportionate to the population of the district and the State was unable to absorb the increased funding. 35 *per cent* of the funds remained unutilized even as the infrastructure in the health centres remained inadequate. Basic records of accounts were not maintained properly either at the State or the district level.

Fund flow to the districts should be based on well defined criteria, strictly in accordance with the AAPs of the districts. Key managerial posts should be filled with delegation of powers for speedy decision making, to increase the capacity of the system to absorb the funds. Basic accounting records should be maintained properly to track expenditure and establish internal control mechanism.

- Infrastructure creation/up-gradation- both physical and human, is an area where the State fared poorly in achieving the targets set by the Mission. In the absence of critical equipment in Operation Theatres and diagnostic and laboratory services, the viability of upgrading CHCs as the First Referral Unit (FRU) remained questionable and the provision of reliable and quality health service at an affordable cost remained unfulfilled. This also resulted in low bed occupancy at the PHCs and CHCs, thus shifting the burden to district hospitals. Mobile Medical Units (MMU) were not purchased despite availability of funds. Severe shortage of skilled manpower and skewed deployment of the available manpower appears to cripple health infrastructure in the State. Delay in completion of construction of health centres led to cost overrun.

There is an urgent need to improve infrastructure at the health centres by mapping the available services and supporting infrastructure for providing accessible and affordable service in rural areas and reduce the load on district hospitals. Sanctioned posts of medical and para-medical staff should be filled on priority basis. MMU should be provided in every district to ensure outreach medical services in remote/ difficult areas. Completion of construction projects should be ensured within the prescribed timeframe, to avoid escalation of cost.

- Centralized purchase of drugs, not linked to field level requirements, led to several anomalies. In all the sampled districts, the ANMs/ Pharmacists were distributed Schedule H drugs, which are to be issued only on the prescription of Registered Medical Practitioners. Expired ORS sachets were dumped in large quantities in the backyard of the State Health Society building.

VEN (Vital, Essential and Non essential) technique should be employed for estimating the requirements for procurement and centralised purchases must be linked to field requirements. Accountability must be fixed for wasteful purchases and issue of Schedule-H drugs to those other than Registered Medical Practitioners.

- RCH was plagued with considerable over-reporting in achievements especially in immunization and distribution of Iron Folic Acid (IFA) tablets among expectant mothers. 55 *per cent* of women in the State are reported to be anaemic and 300

women in every one lakh pregnancies die in labour in the State. In the three sampled districts, the stock of IFA tablets was sufficient to cover only 3.4 *per cent* of the registered pregnant women but the number reported was 25 times the actual. Janani Suraksha Yojana, meant to incentivize women to opt for institutional delivery through payment at the time of discharge from the hospital, could not ensure that payments were released to the beneficiaries on time, despite availability of funds.

Maternal health programme needs to be implemented in its entirety, covering all the essential areas like registration, reporting and tracking of pregnancies, IFA administration, immunization, ante-natal and postnatal care. Given the high incidence of anaemia among women in the State, the entire quantity of IFA tablets should be given to the pregnant women at the time of registration itself. Institutional framework should be strengthened to mitigate delays and irregularities in grant of cash compensation under JSY. Health Management Information System (HMIS) should be implemented to reduce the risk of over reporting. Annual targets should be fixed for achieving various health indicators/ goals set for the Mission.

The beneficiary-survey revealed that awareness of NRHM and benefits flowing through it were confined to a small section of the society, indicating ineffective coverage of IEC activities. Visits by the ANMs to the villages were not being undertaken at the prescribed intervals due to excess workload and topographical conditions of the areas and large population coverage. There were delays in payment to ASHAs and lack of facilities in the sub-district health centres and distance factor forced the beneficiaries to prefer home deliveries. Availability of medicines through the hospitals was inadequate and the beneficiaries had to partially pay for the medicines on each visit. Lack of coordination among AWW, ASHA and ANMs was also noticeable in some areas. Training to school teachers regarding NRHM is yet to be imparted. The findings of the performance audit indicate that the Mission goal of providing affordable, accountable, effective and reliable healthcare facilities is not moving at the desired pace. The State Government needs to initiate adequate measures and take appropriate corrective action expeditiously to ensure that the objectives of the Mission are achieved by the end of the Mission period (2012).

CHAPTER-1

INTRODUCTION

Chapter 1 Introduction

1.1 The Mission

The National Rural Health Mission (NRHM) was launched on 27th October, 2005 in Uttarakhand. The main objectives of the Mission, to be met during the period 2005-2012, are as follows:

- provide accessible, *affordable, accountable, effective and reliable healthcare* facilities in the rural areas especially to the poor and vulnerable sections of the population;
- *involve* community in planning and monitoring;
- *reduce* infant mortality rate (IMR), maternal mortality rate (MMR) and total fertility rate (TFR) for population stabilization; and
- *prevent* and control communicable and non-communicable diseases, including locally endemic diseases.

1.2 Salient features

The objectives of the Mission are to be achieved through the following measures:

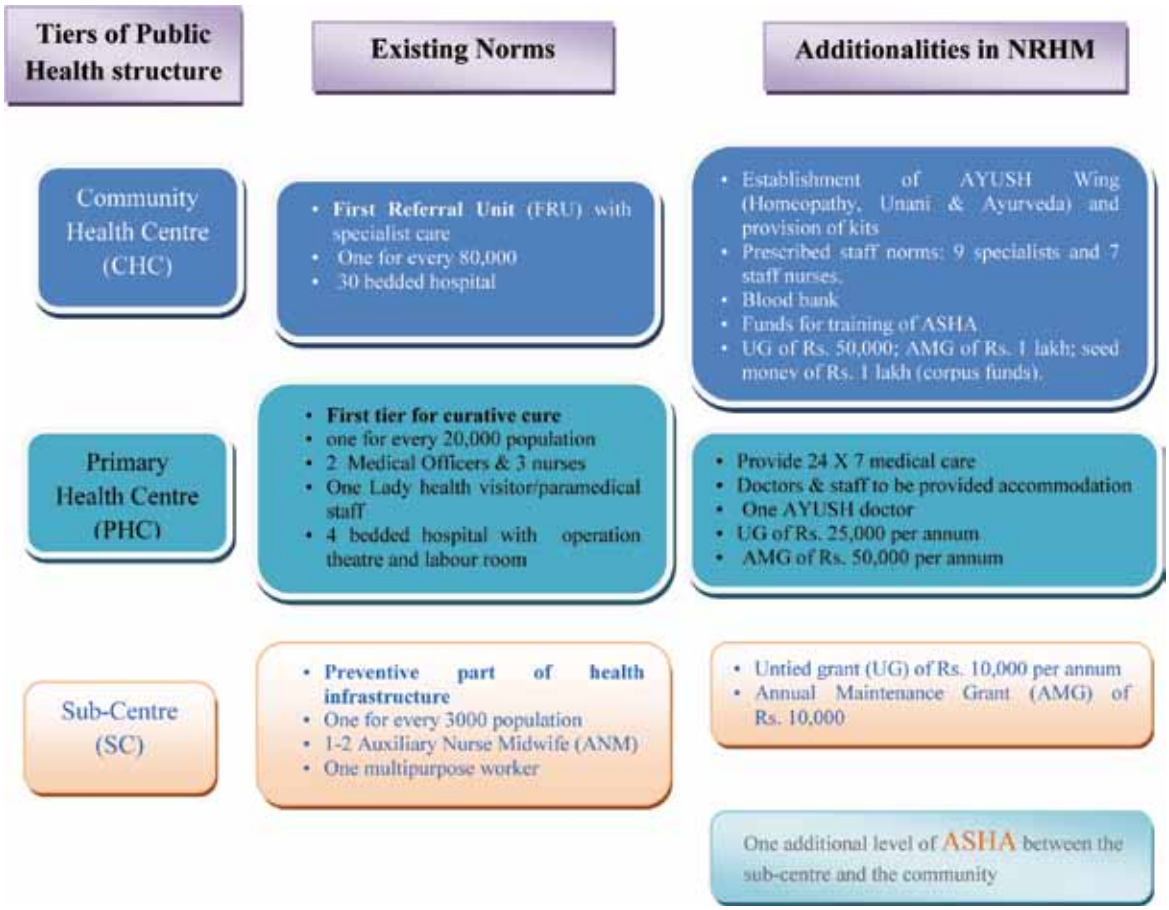
- Increase in public expenditure on health from the level of 0.9 *per cent* of Gross Domestic Product (GDP) to 2-3 *per cent* of GDP over the Mission Period (2005-12);
- Establish at the planning stage, convergence with other health programmes viz., Reproductive & Child Health (RCH) and immunization programme as well as with various national disease control programmes[1]. The perspective plans were also expected to reflect convergence with other departments, thus placing health in the larger context of other health determinants like drinking water, sanitation, nutrition and hygiene;
- Lay down norms for establishment of buildings and for resource allocation along the chain of public health infrastructure and upgrade them to Indian Public Health Standards (IPHS) to bridge the gaps in healthcare facilities;
- Promote access to improved healthcare at household level through a trained female Accredited Social Health Activist (ASHA) for every 1000 people in a village, who would act as a bridge between the sub-centre and the community;
- Provide institutional mechanisms for community participation at every level[2] and fund them adequately with untied grants and annual maintenance grants (AMG).

[1] National Vector Borne Disease Control Programme (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), National Programme for Control of Blindness (NBCP), National Leprosy Eradication programme (NLEP), National Iodine Deficiency Disorder Control Programme (NIDDCP) and Integrated Disease Surveillance Programme (IDSP).

[2] Village Health & Sanitation Committee (VHSC) in the Villages; Rogi Kalyan Samitis (RKS) at all other levels.

1.3 Public health infrastructure framework

The foundation of public health infrastructure in the country rests on its three tiers- the Sub-Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC). NRHM seeks to strengthen this infrastructure as shown below:



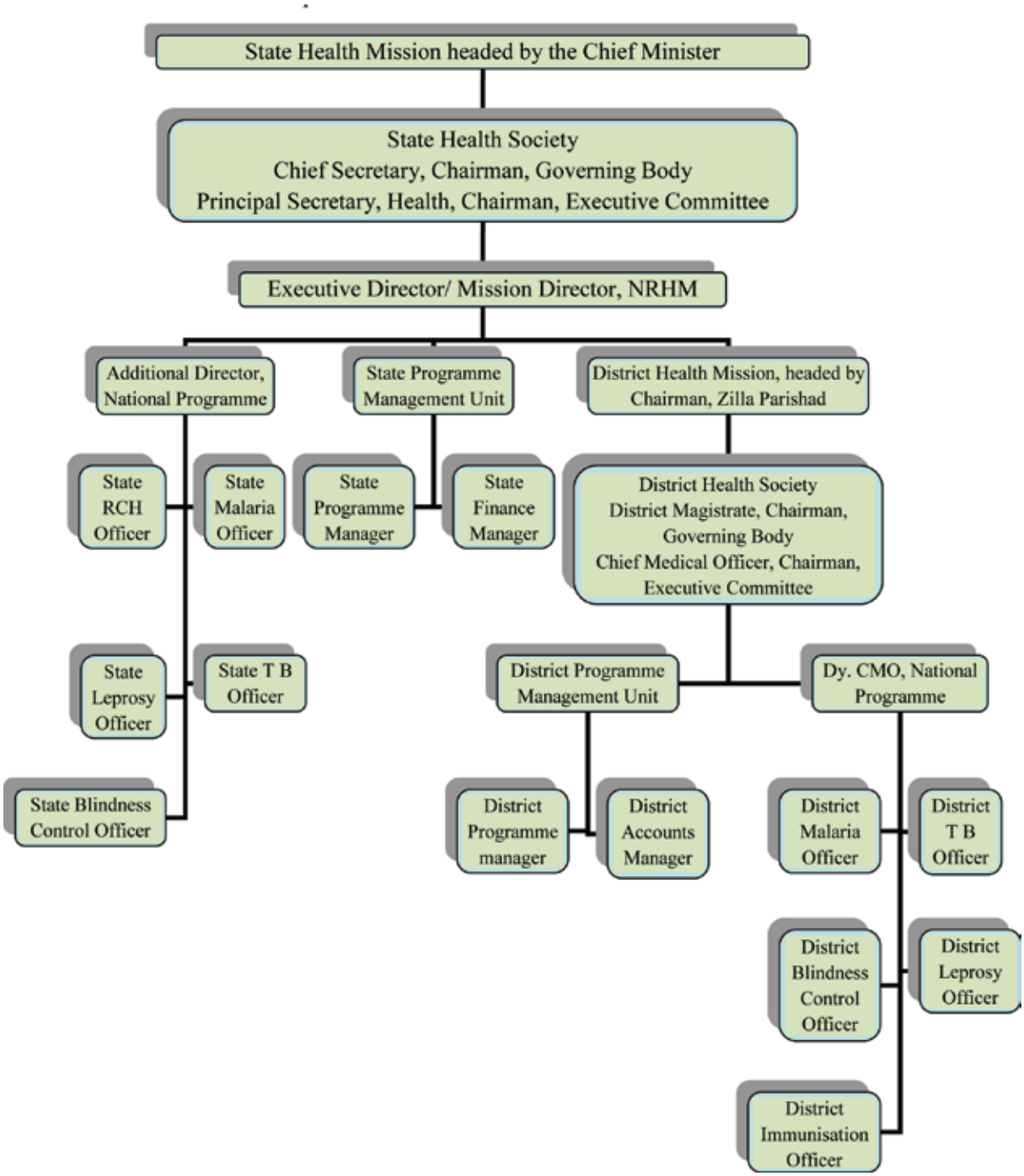
At the grass-root level, the Anganwadi worker (AWW) of Integrated Child Development Services (ICDS) works with the Auxiliary Nurse Midwife (ANM) in the SC. The ANM is responsible for primary medical care with focus on maternal and child care and disease surveillance. District hospitals form the top-end of the public health infrastructure.

1.4 Organisational set up

NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. The activities under the Mission are carried out through the Uttaranchal Health and Family Welfare Society (UAHFWS), also known as SCOVA (Special Committee for Voluntary Actions). The Governing Body of the Society, headed by the Chief Secretary of the State, approves the Plans and meets every quarter to review its implementation, while the Executive Committee (headed by the Principal Secretary (Health)) is required to meet every month. In each of the 13 districts of the State, District Health Mission (DHM) under the Chairmanship of Zilla Pramukh and District Health Society (DHS) under the

Chairmanship of District Collector were set up. The Executive Committees of DHS headed by the Chief Medical Officers (CMO), are responsible for planning, monitoring, evaluation and release of funds to sub-district level centres.

The other national disease control programmes are implemented and supervised by the respective heads (and societies) of these programmes. The organisational setup of the SHM and SHS is depicted in the chart below:



CHAPTER-2

FRAMEWORK OF AUDIT

Chapter 2 Framework of Audit

2.1 Scope of Audit

The performance audit was conducted during April to September 2008 and covered the implementation of various interventions under the Mission during 2005-08. Out of the 13 Districts, a sample of three[3] districts- one each from Garhwal and Kumaon regions and the Capital district, was chosen for detailed examination based on Probability Proportional to Size with Replacement (PPSWR) method. In each sampled district, 3 CHCs were selected and in each CHC, 2 PHCs were selected. In each PHC, 2 SCs have been selected for scrutiny. The selection of CHCs, PHCs and SCs has been done using Simple Random Sampling without Replacement (SRSWOR) method. Names of the districts, CHCs, PHCs and SCs sampled for audit scrutiny are given in *Annexure-I.*

2.2 Audit objectives

The objectives of the performance audit were to assess whether:

- Planning for the implementation of the Mission as well as monitoring and evaluation procedures at all levels led to an effective healthcare delivery system;
- The level of community participation in planning, implementation and monitoring of the Mission was adequate and effective;
- Public spending on health sector over the years 2005-08 increased to the desired level and assessment, release of funds, their utilization and accounting thereof was adequate;
- The Mission achieved capacity building and strengthening of physical and human infrastructure at different levels as planned;
- The procedures for procurement were cost effective, efficient and ensured improved availability of drugs, medicine and services;
- The information, education and communication (IEC) programme implementation was efficient, cost effective and resulted in increased awareness about preventive aspects of healthcare;
- The performance indicators and targets fixed specially in respect of reproductive and child healthcare, immunization and disease control programmes were achieved;
- Accessible, affordable and accountable public health delivery system for rural population was created as envisaged.

2.3 Audit Criteria

The audit was conducted with reference to the following:

- GOI guidelines on the Scheme and related instructions issued from time to time.
- State Annual Plans as approved by the GOI.

[3] Pauri Garhwal, Almora and Dehradun

- Memorandum of Understanding (MOU) between the State Government and the GOI.
- State Health and Population Policy, 2002.
- Centralized Health and Family Welfare Data released by Registrar General of India under Sample Registration System (SRS) and National Family Health Survey (NFHS).

2.4 Audit Methodology

Performance Audit of the programme commenced with an entry conference with the Secretary, Department of Health and Family Welfare, Government of Uttarakhand on 11 April 2008, in which the audit methodology, scope, objectives and criteria were explained. Records were checked in the sampled implementing units in three districts, along with physical verification and facility survey at CHCs, PHCs and SCs. An exit conference was held on 28 November 2008 with the Secretary, Department of Health and Family Welfare, where the audit findings were discussed in detail. The replies of the Department have been incorporated in the report at appropriate places.

In addition to the examination of the documents and facility survey, a beneficiary survey was commissioned through 3 Non Governmental Organisations (NGO) namely, SBMA, DRISTE and VARDAN in the three sampled districts of Pauri, Almora and Dehradun respectively, covering a total of 72 villages (2 villages from each of the sampled SCs) having an estimated population of 67,000. Within these 72 villages, a sample of 1434 people were selected at random and issued questionnaires to gauge their perception about the availability and quality of health care delivery services in their respective villages. The exercise was specifically undertaken to assess the impact of the programme and the satisfaction level of the beneficiaries.

The sample covered 10 Jananni Suraksha Yojana (JSY) beneficiaries and 10 general beneficiaries, in addition to those of ANM, ASHA, AWW and Primary School teachers of the concerned villages.

2.5 Acknowledgment

The office of the Accountant General (Audit), Uttarakhand acknowledges the cooperation and assistance extended by the Department of Medical, Health and Family Welfare, Government of Uttarakhand, the Executive Director of UAHFWS, Additional Director (National Programme), Joint Directors (State Programme Officers), District Health Societies and the officials at CHCs, PHCs and SCs during the conduct of the performance audit.

CHAPTER-3

PLANNING

Chapter 3 Planning

3.1 Baseline survey

NRHM strives for decentralised planning to ensure that need-based and community owned Health Action Plans become the basis for interventions in the health sector. The plans were to be prepared on the basis of household and facility surveys at village, block and district levels based on IPHS norms. Fifty *per cent* of household and facility surveys were required to be completed by 2007 and 100 *per cent* by 2008.

3.1.1 Facility survey

The United States Agency for International Development (USAID) commissioned a facility survey (2007-08) to map the gaps in health care infrastructure- both physical and manpower in the entire State. The survey however, covered only 19 out of the 35 hospitals[4] and 26 out of the 49 CHCs in the State. Infrastructure at the lower tiers of health care at the PHCs and SCs were not mapped as part of the exercise. Further, the survey covered only a few aspects relating to gaps in health infrastructure like lack of buildings, equipments, staff and emergency services and projected the probable lumpsum cost for upgrading these. The survey was therefore not only incomplete in its coverage, but also lacked the requisite information to facilitate preparation of detailed plans. During the exit conference, the Department informed that a comprehensive survey of hospitals has been conducted (November 2007 to March 2008) through the Uttaranchal Health System Development Project (UAHSDP), under a World Bank funded project and that the data so collected would form the basis for creation/ up gradation of the infrastructure in the health centres.

3.1.2 Household survey

Household survey was not conducted in the State within the deadline of 2008. The Auxiliary Nurse Midwife (ANM) in the SCs collects the detailed family-wise information on age, education, marital status, methods adopted for family planning, environment cleanliness, communicable diseases such as TB, leprosy etc. in an annual survey. However, this information was not compiled or validated, for use in the Plans. SHS informed (September 2008) that a household survey was on the anvil and would be carried out by the ASHAs, through a comprehensive format, which includes details on family and households, health & family welfare, diseases and available health services.

3.2 Preparation of plans

The SHS was required to prepare a Perspective Plan for the entire Mission period (2005-12) covering the gaps in the health care facilities, areas of interventions and probable investments. The districts are also required to prepare a Perspective Plan and get it approved by the SHS. NRHM focuses on the village as an important unit for planning. Financial and physical targets were to be framed in the form of Annual Action Plans (AAPs) at the block and village level to be further consolidated for preparing plans at the districts and State level.

[4] 11 District Male Hospitals, 6 District Female Hospitals, 3 Base Hospitals and 15 Combined Hospitals

3.2.1 State Plans

The SHS could provide only a copy of the Perspective Plan of RCH-II programme for 2005-10 and not for the entire programme. Even this plan was based on a study conducted in three[5] districts and did not encompass the whole State. The AAPs for the districts as well as the State were prepared for the first time only in 2006-07.

The AAP is to be prepared by 30 November of the preceding year and sent to the GOI by 15 December after the approval of the SHS. While the date of submission of the Plan in 2006-07 was not intimated, the plan for 2007-08 was sent to the GOI after a delay of 6 months, in July 2007. GOI approved the plan for 2006-07 subject to several caveats[6], on which no revision was carried out. The delays or the flaws in the plans did not deter the GOI in releasing the funds.

3.2.2 District Plans

The District Health Action Plans (DHAPs) were required to be prepared by the District Health Societies[7] (DHSs) on the basis of the Block Health Action Plans (BHAPs) and approved by the District Health Mission[8] (DHM). While the DHS and DHM were formed in all the 13 districts, the DHAPs were prepared for the first time only in 2007-08 through a private agency[9] and the DHS played no role in the planning process. In fact, the interventions proposed in the plans of all 13 districts were similar, general in nature and did not seem to reflect the specific health requirements of the district. The medical authorities in all three sampled districts failed to provide a copy of the DHAP and the plan documents were furnished to the Audit team by the SHS. The block and village plans were not prepared; no action had been initiated for their preparation for the year 2008-09 either. Clearly, DHAPs even for 2007-08 were prepared without the availability of Village and Block Plans, thus depriving the community of participating in the planning process and defeating the very purpose of decentralised planning as envisaged under NRHM.

Scrutiny of the plan process with reference to the recorded minutes of DHM meetings in two of the sampled districts (recorded minutes were not available in Pauri district) revealed the following:

- District authorities in Almora denied any role in the plan process and the minutes of the DHM meetings found no mention of DHAP;

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[5] Uttarkashi, Almora and Udham Singh Nagar

[6] These included suggestions for reduction of non-permissible items from RCH II flexi-pool budget, provision of current status & targets for all intermediate indicators, realistic targets for all outcome indicators for SC/ST, monitoring of quarterly performance as per the Operational Manual, mention of waste disposal plan required, inadequate coverage for giving nutritional supplements etc.

[7] District Magistrate, CMO, PD-DRDA, Dist Programme Managers for Health, AYUSH, Water & Sanitation, PHED, ICDS, Education, Social welfare and panchayati raj, representative from IMA and development partners.

[8] Zilla Panchayat Adhyaksh, District Magistrate, CMO, PD-DRDA, Dist Education Officer, Dist Programme Officer, Dist Panchayati raj Officer, Dist level officers from Jal Nigam & Jal Sansthan, Two representatives from NGOs and Representative from IMA.

[9] Sambodhi Research – Synovate India; the expenditure was funded by USAID

- In Dehradun, DHM meeting held (July 2007) for approval of DHAP revealed that the plan had no representation from the beneficiaries. The word 'stakeholders' implied only Departmental Officers. The Plan was prepared in English and not in Hindi, which could have ensured active participation from villagers and PRI representatives. Also, the Department did not give prior intimation to DHS and DHM while outsourcing the work of plan preparation.

During the Exit Conference, it was informed (November 2008) that districts would prepare the plans from 2009-10 onwards. 60 villages from Haridwar, Uttarkashi and Almora have also been selected in a pilot project, for preparation of village plans by 2009-10.

3.3 Convergence with other departments

The indicators of health depend as much on drinking water, female literacy, nutrition, early childhood development, sanitation, and women's empowerment as they do on hospitals and a functional health system. Hence a need for a convergent approach was emphasised in the district plans.

- District plans reflected feed back from other departments but the suggested interventions failed to provide clarity in roles or fix specific responsibility and accountability on each of the departments[10]. Although representatives of the concerned departments attended the NRHM meetings at various levels, there was no institutional mechanism in place to monitor the actual convergence in field and to follow-up on the directions to/ requirements from each department.

'Village Health and Nutrition Day' (VHND) was scheduled to be observed on Saturdays at Anganwadi Kendras with the aim of providing maternal and child health care, vaccination, family planning services, nutrition and personal hygiene. However, in the sampled villages, 37 *per cent* of the respondents reported that VHND was not being observed on a regular basis and only 23 *per cent* stated that it was being held as planned.

There was no facility for regular testing of water; ASHAs were not being provided water testing kits. However, distribution of chlorine tablets, collected from CHC/ PHC, for the purpose of water purification was taking place through ASHA. In response to the question whether water storage facilities and distribution system were being cleaned regularly, the situation was found satisfactory in district Almora (92 *per cent* with positive response) as against Dehradun and Pauri districts (57 *per cent* with a negative response).

'School Health Screening Programme' is run with the combined efforts of Medical and Education Departments. This programme covered primary schools and included general health check up, vision testing, detection of stomach ailments, distribution of nutritional supplements etc. However, referrals, if any, to hospitals for serious ailments were not documented and health cards were not issued. In a sample survey, 54 *per cent* of the 68

[10] It was envisaged in the broad guidelines issued by State Health Resource Centre (SHRC) that Health Department will provide health & medical services, Peyjal Department safe drinking water, Panchayati raj Department will ensure hygienic environment, ICDS will ensure safety of children and women against malnutrition, Education department will work in bringing awareness resulting in convergence towards the overall objective of healthy society. The Anganwadi centres under the ICDS at the village level were identified as principal hubs for health action.

school teachers surveyed were unaware of such a programme, indicating gaps in programme coverage.

3.4 Institutional arrangements for monitoring

3.4.1 Computerisation of MIS

Each DHS was to develop a computer based Health Management Information System (HMIS) to report the progress of the implementation of the programme to the SHS on a monthly basis for consolidation. It was noticed that though computers had already been provided to all the 13 districts prior to the launching of NRHM, they were not connected through MIS network and the data was being sent manually.

3.4.2 Health monitoring and planning committee

Monitoring and planning committees[11] at State, district, block and PHC levels were to be formed to ensure regular community based monitoring of activities and facilitating relevant inputs for integrated planning covering other determinants of health like drinking water, sanitation etc. These Committees were not constituted at any level, thereby diluting the objective of community participation in monitoring activities.

3.4.3 Public report on health

NRHM envisaged that each district should publish an annual report on health to provide information on the progress made under the programme in the district. However, none of the districts published the annual report during the period 2005-08, thereby, depriving the public of vital information on health infrastructure available in the district, on the basis of which they could form an opinion and decide on the use of the health facilities.

3.5 Technical support to the Mission

3.5.1 Programme Management Support Units

Programme Management Support Units (PMSUs) at State, district and block levels were to provide technical support to the Mission in accounting, management information system, human resource management etc.

Out of 13 districts, only 3[12] had a fully functional and adequately staffed PMSU; in 10 districts, PMSU was set up but key posts like that of the Programme Manager, Accounts

[11] **State Committee**:-30 *per cent* members- elected representatives, 25 *per cent*- health officials, 15 *percent*- members of DHC, 20 *per cent*-NGO/ eminent citizen, 10 *per cent* members of different departments.
District Committee:- 30 *per cent*-Zilla Parishad members, 20 *per cent*- health officials, 15 *per cent*- members of Block Health Committee, 20 *per cent*-NGOs/ eminent citizen, 10 *per cent*- members of CHC RKS
Block Committee:- 30 *per cent*- members of Block Panchayat, 20 *per cent*- members of PHC health committees, 20 *per cent*- NGO/ eminent citizen, 20 *per cent*- health officials and 10 *per cent*-members of PHC RKS
PHC Committee:- 30 *per cent* members of Panchayat Samities, 20 *per cent*- members of Village Health Committees, 20 *per cent*-NGO/ eminent citizen, 30 *per cent*- health officials

[12] Champawat, Haridwar and Rudraprayag

Manager and Data Manager, were not filled up. In 85 out of the 95 blocks in the State, the PMSUs were not fully functional (i.e., they had only one accountant) and in 10 blocks, PMSUs were not set up.

The State level PMSU was to be strengthened with experts in the areas of human resources, behavioural change communication (BCC), monitoring and evaluation, Chartered Accountants, MIS Specialists, and consultants for RCH and other National Disease Control Programmes. Three managerial posts were sanctioned which were filled up for intermittent periods during 2005-08 but were lying vacant since March 2008.

In the exit conference, it was informed that since September 2008, 7 DPMUs had been made functional and that the staff requirements of the SPMU had been addressed.

Conclusion

In the absence of a proper planning exercise at all levels- from the village to the State, with requisite inputs from the lower units, the aim of decentralised planning and implementation, which is need based and community owned, remained largely unfulfilled. Also, due to the absence of an effective monitoring mechanism, the planning process did not receive the required feedback for future interventions in the health sector.

DHAPs of the sampled districts did reflect convergence with various departments although the roles and responsibilities were left inchoate. The translation of the plans at the field level could not be verified in the absence of monitoring reports. Some level of convergence was established with ICDS (through village health & nutrition day) and with Education Department (through school health programme).

Recommendations

- The SHS should ensure completion of household and facility surveys without delay, to make the planning exercise meaningful.
- Planning process needs to be strengthened and perspective plan for the entire Mission period should be prepared expeditiously. The capacity for preparation of annual plans for the village, block and district needs to be built by providing training to teams constituted at the appropriate levels.
- SHS should establish an effective mechanism for coordination between various departments, with clear delineation of roles and responsibilities, followed by regular meetings/ appraisal and an effective feedback mechanism.
- School health programme needs to be strengthened, by developing firm linkages for referrals and maintenance of health cards for each child.
- Community based monitoring committees should be formed at all levels and should be encouraged to send monitoring reports regularly to the implementing agency. MIS prescribed under the Mission must be implemented without delay to provide real time information. Periodical reports on issues pointed out by the lower level monitoring committees and action taken thereon should be prescribed for DHS and SHS to ensure proper follow up action.

CHAPTER-4

LEVEL OF COMMUNITY PARTICIPATION

Chapter 4 Level of community participation

4.1 Village Health and Sanitation Committees

Village Health and Sanitation Committees (VHSC) were to be formed in every village within the overall framework of the Gram Sabha, with adequate representation to the disadvantaged sections of the society. The VHSC is to be responsible for village level planning and monitoring.

The State Government did not initiate any action to form the VHSCs, ostensibly in view of the possible change in guard after the local bodies' elections in September 2008. On the other hand, Rs. 53.77 lakh was spent (2007-08) for 'Sensitisation of PRI Members on NRHM' on these very outgoing PRI members across the State. Since the VHSCs were not formed, the untied grants and revolving funds of Rs. 10,000 each were not released. SHS replied (September 2008) that a proposal for constituting VHSCs was awaiting approval of the Government. Thus the role of VHSC in taking initiative for nutrition, sanitation, IEC and other public health measures remained unfulfilled.

4.2 Rogi Kalyan Samitis

Community participation at the PHC and CHC level was to be achieved through the constitution of Rogi Kalyan Samitis (RKS). The RKSs were to comprise of the local representatives to the legislature, health officials, leading members of the community, local CHC/ PHC in charge, representatives from the Indian Medical Association, PRI representatives and leading donors. These bodies were expected to regularly review the functioning of healthcare facilities, fix user charges and decide on the use of funds (State grants, user charges or donations) and make recommendations to the DHS.

RKS was constituted in 30 out of 35 hospitals and all the CHCs in the State by 2007-08; they were not constituted at PHC level as yet. However, where these were constituted, meetings were not held regularly in the sampled facilities except at CHC Bhikiyasen in Almora, where regular monthly meetings were being held. RKSs are required to submit monthly reports on their activities to the DHSs but these were also not being sent. User charges were fixed by the State Government and not by the RKSs.

Annual Maintenance Grant (AMG) is provided to RKSs at CHC, PHC and SC at the rate of Rs. 1 lakh, Rs. 50,000 and Rs. 10,000 respectively for general upkeep of health facilities. In addition, NRHM provides untied funds annually to the CHCs, PHCs and SCs at the rate of Rs. 50,000, Rs. 25,000 and Rs. 10,000 respectively. These funds were, however, released to the health centres only in 2007-08. These grants were released to the PHCs although the RKSs were not formed at the PHC level and the funds so released were utilised by the respective Medical Officers in charge of the facility at their discretion. The Department informed (November 2008) that RKSs would be formed at the PHC level.

The SHS released Rs. 30.10[13] lakh to DHS Almora during 2007-08 as AMG for 4 CHCs, 27 PHCs and 41 SCs. As per the guidelines for utilisation of AMG, the funds were to be spent and supervised by the respective RKS, but the DHS, Almora spent Rs. 29.06 lakh on

[13] The amount comes to Rs. 21.60 lakh at the stipulated rates for the above mentioned facilities.

3 CHCs, 23 PHCs and 13 SCs without obtaining the consent of the respective RKSs/ Medical Officers In charge.

CMO, Almora replied (June 2008) that it was because of inadequate manpower that the works were centralised at the district level itself. Further, untied funds were provided to SCs at the rate of Rs. 7000 each against the prescribed norm of Rs. 10000 each. Regarding short release to SCs, Medical Officer in-charge intimated that this was done on the directions of the concerned CMO.

4.2.1 Citizens Charter

One of the objectives of the RKS is to develop a Citizens Charter for each level of health facilities and ensure its display appropriately to make the users aware of their rights as well as inform them of the facilities available there. In the sampled districts, Citizen Charter was not found displayed at 41[14] *per cent* of the health facilities visited. In all the CHCs and PHCs, the Charter did not mention the complaint redressal authority.

In the 9 hospitals, 9 CHCs and 13 PHCs sampled, there was no mechanism for redressal of complaints of the general public. Complaint boxes were kept in the hospitals but there was no record of the complaints received and action taken thereon. In the exit conference, the Secretary (Health) assured that necessary orders would be issued.

Citizens Charter at SC-Binta

4.2.2 Monitoring by RKS

RKS were to constitute monitoring committees to visit hospital wards and collect patient feedback and send monthly monitoring reports to the District Collector and Chairperson, Zilla Parishad. In none of the sampled hospitals and the CHCs, monitoring committees were constituted. SHS replied (August 2008) that RKSs are independent and are headed by DM and that no suggestions for improvement had been made by the RKS to the DHS.

4.3 Public hearings

The Mission envisaged community involvement in health system to ensure accountability for healthcare through public hearings (Jan Sunwai) or Public dialogues (Jan Samvad) to be conducted at the PHC, block and district levels once or twice in a year. Health camps were also to be organized to bring a range of health services to the community and make them aware of their entitlements.

Scrutiny revealed that no Jan Sunvai/ Jan Samvad were conducted at district, block and PHC levels. The SHS had also not formulated any guidelines for Jan Samvad/ Jan Sunvai. During the exit conference, the Department stated that Village Health &Nutrition Day (VHND) observed every Saturday could be treated as equivalent to Jan Sunwai, except that

[14] 1 CHC, 10 PHCs and 14 SCs

the meeting would need to be re-oriented accordingly and the community would need to be provided with the reports sent from the block level to the districts/ SCOVA.

Conclusion

Non-formation of VHSCs in the villages and RKSs in the PHCs not only denied the VHSCs of the untied grants, but also denied community participation in the implementation of the Mission activities at the grass root level. The envisaged monitoring structure and grievance redressal mechanism did not exist in the RKS and the goal of introducing accountability at this level remained unfulfilled.

Recommendation

- VHSCs should be set up in all the villages without any further delay, since these are critical to community participation.
- Complaint redressal mechanism and public accountability structures should be put in place and the SHS should formulate guidelines for conducting Jan Sunvai covering the frequency at which these would be organised, levels and list of officers, functionaries and PRI representatives who would conduct the hearing. The forum of Jan Sunvai may also be used for IEC activities to disseminate information on preventive and behavioural aspects of health care.
- RKSs should be constituted at all the PHCs to facilitate proper monitoring and community participation in decision making and AMGs should be released to them to fund their requirement.

CHAPTER-5

FINANCIAL MANAGEMENT

Chapter 5 Financial Management

5.1 Financing pattern

Central Government releases funds for implementation of NRHM to the State through two separate channels-through the State Finance Department and SCOVA[15]. The releases are based on the consolidated Programme Implementation Plan (PIP) prepared by the State.

NRHM envisages vertical integration of all the existing Societies into one Society i. e. State Health Society (SHS), also called SCOVA. However, various societies were functional in the State for different Disease Control Programmes (DCPs) and funds were being released to these DCPs separately by the respective divisions in the Union Ministry of Health and Family Welfare (MoHFW). The State Programme Officers of these Societies in turn deposit it in the main account of SCOVA, called main kitty, thus signifying only financial integration. Further, the accounts of these DCPs were audited separately by the CAs.

At the State and District levels, PMSU of the respective Societies of NRHM is responsible for centralised processing of fund releases and reporting of financial information from DHS to SHS and from SHS to GOI.

5.2 State expenditure on public health

One of the Mission goals was to increase public spending on health from the existing 0.9 to 2-3 *per cent* of GDP. The corollary of such a policy directive was not only an increased Central Government budgetary outlay on health, but that the States also made a matching increase i.e. by at least 10 *per cent* of budget annually and shift the Centre-State financing ratio from the current 80:20 to at least 60:40 ratio during the Mission period (2005-12). Another important corollary was that the State health sector developed the capacity to absorb such fund flows.

The table below shows the expenditure incurred by the State on the health sector from its own budget (exclusive of NRHM funds).

Table-1 **(Rupees in crore)**

Year	GSDP	Total expenditure (Revenue & Capital) of the State	Total expenditure incurred by the State on Health Sector			
			Expenditure	% of GSDP	% of total expenditure	Yearly increase in expenditure on health
2004-05	22765	6171.74	248.57	1.09	4.02	--
2005-06	25776	7316.35	351.72	1.36	4.80	42%
2006-07	29881	8176.07	411.51	1.38	5.03	17%
2007-08	34549	9489.38	462.26	1.34	4.87	12%
Total		**31153.54**	**1474.06**			

Source: Finance Accounts

[15] Funds for Direction & Administration, training, supplies in kind and Family Welfare (under Major Head-2211) are routed through the State Government. Funds for immunization, Reproductive & child health programme (RCH), flexi-pool grants, IEC and national disease control programmes are received by SCOVA

There has not only been an incremental increase in the State's investment on health after the launch of NRHM, but the share of health sector in the overall pie has also increased. The increased expenditure was on construction of facilities-both urban and rural health and under the revenue and capital heads on "Medical Education, Training & Research".

The Mission was entirely funded by the GOI during 2005-07; the State Government was expected to contribute 15 *per cent* of the funds from the XI Plan Period (2007-12). But against the total release of Rs. 88.71 crore in the year 2007-08, no contribution was made by the State Government in the NRHM kitty.

The Department stated that expenditure incurred on the construction activities from the State Budget under Tribal Sub-Plan, District Plan and State Plan could be treated as State Government contribution. This could not be treated as State's contribution, as these construction activities were not planned in the AAP of that year.

Thus, while the State Government made a substantial increase in spending on health sector, it failed to contribute its share of funding for NRHM.

5.3 Capacity to utilise funds

In utilising the grants, the State did not keep pace with NRHM releases resulting in idling of funds ranging from Rs. 17.97 crore to Rs. 63.52 crore, as shown in the table below:

Table-2 **(Rupees in crore)**

Year	Opening Balance	GIA received	Expenditure[16]	Closing Balance
2005-06	16.24*	32.23	30.50	17.97
2006-07	17.97	46.39	37.12	27.24
2007-08	27.24	88.71	52.43	63.52
Total		**167.33**	**120.05**	

Source: SHS

**- Includes closing balances under the existing programmes brought under the umbrella of NRHM*

Thirty five *per cent* of the funds available under NRHM remained unutilised with SCOVA itself. In the 3 sampled districts, utilisation of funds by the DHS averaged around 95 *per cent*.

The under-utilisation resulted in cuts in releases from the GOI to the tune of Rs. 29.93 crore and Rs. 21.26 crore during 2007-08 and 2008-09 respectively. The inability of the State to absorb the spurt in fund flow to the health sector was mainly because of absence of comprehensive plans (identifying specific projects) and delays in decision making. (The procurement of Mobile Medical Units (MMU) in the State was delayed by more than 2 years as explained in Paragraph 6.2.5). Since the PMSUs could not establish themselves completely in the absence of managerial staff, SCOVA could not function as a single window for clearance of all NRHM projects, thus defeating the very purpose of formation of SCOVA. In the exit conference, the Department stated that empowering SPMSUs/ DPMSUs would create multiple centres of power and hence the DGHS, Finance Controller etc., were kept in the loop of decision making. NRHM guidelines provide for delegation

[16] Includes state level expenses and releases to districts

of powers to these units to empower them to take decisions within the larger framework of General Financial Rules.

The State was required to refund the unutilised balances of the erstwhile national programmes (closed with the launch of NRHM but not merged with NRHM) but these balances amounting to Rs. 13.24 crore[17] were lying in the SHS kitty as of November 2008. These funds are not being shown in the SOEs sent to GOI.

GOI had directed that the interest accrued on NRHM grant in bank accounts must be refunded and not be treated as part of the grant. The interest accrued amounting to Rs. 2 crore approximately was not refunded to the GOI. The amount of interest accrued was also not being reflected in the SOEs submitted by the SHS to the GOI. The SHS assured (Aug 2008) that the balance amounts and interest accrued would be refunded to the GOI in the current year itself.

5.4 Allocation of funds to the districts

NRHM guidelines provide for delegation of financial and administrative powers at various levels to ensure successful implementation of decentralised plans. Fund allocation to the districts is largely to be in line with the proportion of population of the districts. However, the actual resource need for CHCs, PHCs and SCs was to be based on the likely utilisation of resources rather than routine allocation of resources. Every CHC, PHC and SC was to develop a baseline and annual plan of activities and their need/ requirement was to be specified in the Annual Work Plan and budget of the district. The GOI released Rs. 32.23 crore, Rs. 46.39 crore and Rs. 88.71 crore during 2005-06, 2006-07 and 2007-08 respectively.

The detail of fund allocation to the districts is given below:

Table-3 **(Rupees in lakh)**

Name of the district	% of population as per 2001 census	2005-06		2006-07		2007-08	
		Amount released	Percent-age	Amount released	Percent-age	Amount released	Percent-age
Dehradun	15.10	304.42	9.44	377.67	8.14	494.02	5.57
Haridwar	17.00	294.75	9.14	357.20	7.70	522.12	5.89
US Nagar	14.50	192.10	5.96	235.60	5.08	308.35	3.48
Uttarkashi	3.50	147.98	4.59	181.57	3.91	275.81	3.11
Tehri	7.10	199.10	6.18	244.30	5.27	319.36	3.60
Rudraprayag	2.70	145.02	4.50	177.94	3.84	232.80	2.62
Pauri	8.20	242.14	7.51	297.12	6.41	415.22	4.68
Chamoli	4.40	223.85	6.94	274.67	5.92	359.26	4.05
Bageshwar	2.90	107.62	3.34	132.50	2.86	211.54	2.38
Pithoragarh	5.50	235.42	7.30	288.87	6.23	403.69	4.55
Almora	7.40	208.51	6.47	255.85	5.52	357.55	4.03
Nainital	9.00	248.33	7.70	304.71	6.57	471.64	5.32
Champawat	2.70	141.25	4.38	173.32	3.74	242.21	2.73

Source: SHS data

[17] RCH-I:- Rs. 3.29 crore, EAG:- Rs. 5.33 crore, SPP:-Rs. 0.20 crore, NSPCD:- Rs. 0.15 crore, SIP:- Rs. 1.72 crore, Drug warehouse:- Rs. 0.20 crore, IFPS:- Rs. 2.35 crore

As can be seen from the above details, the allocation to the districts was neither proportionate to the population, nor was it in consonance with the budget estimates of the annual district plans.

The actual resource need and rationale guiding the allocation of funds to the CHCs, PHCs and SCs could not be verified in audit due to the absence of annual village and block plans.

5.5 Utilisation of Untied Funds

Untied fund at the SC level was to be utilized for activities such as minor modification of the Centre, ad-hoc payment for cleaning, transportation in case of emergencies to appropriate referral centre, transporting samples during epidemics, purchase of bleaching powder and disinfectants for use in common areas of the village, labour and supplies for environmental sanitation etc. duly approved by the Village Health Committee. Similarly, untied fund of PHC was to be used for minor modification to the Centre, provision of running water supply and electricity, repair/ operationalisation of soak pits, transportation in case of emergencies to appropriate referral centres, transporting of samples during epidemics, purchase of medical apparatus, and payment/ reward to ASHA for certain identified activities etc. The details of release and utilisation of untied funds to sub-district facilities during the period 2005-08 are given below:

Table-4 **(Rupees in lakh)**

Year	Number of health centres	Untied Funds released	Untied funds utilised	Unspent untied funds	
				Amount	%
SC level					
2005-06	1573	0	0	0	0
2006-07	1631	0	0	0	0
2007-08	1765	173.60	127.46	46.14	27
PHC level					
2005-06	225	0	0	0	0
2006-07	222	0	0	0	0
2007-08	232	58.50	46.45	12.05	21
CHC level					
2005-06	40	0	0	0	0
2006-07	49	0	0	0	0
2007-08	49	24.50	19.84	4.66	19
Total	**--**	**256.60**	**193.75**	**62.85**	**24**

Source: SHS data

It is evident from the above table that sub-district facilities were deprived of NRHM funds during 2005-07. Further, during 2007-08, the untied funds disbursed to health facilities down the line, were not used for various unauthorised purposes such as payment of salaries, recurring expenditure, expenses of Gram Panchayat, purchase of vehicles etc.

5.6 Reconciliation of funds

There was no system of regular reconciliation of the funds across the board to ensure that grants transferred and refunded back are accounted for properly. Variations between the funds reported to have been released by the GOI and amounts accounted for by the SHS are tabulated below:

Table-5 **(Rupees in lakh)**

Heads	Releases as reported by GOI			As reported by SHS in Audited Accounts/ statements		
	2005-06	2006-07	2007-08	2005-06	2006-07	2007-08
RCH	--	1291	--	--	1531	--
Training	100	--	--	0	--	--
Mission (Flexi-pool)	1754	1592	3409	878	1993	4309
Routine Immunisation(RI)	--	50	--	--	44	--
Pulse Polio Immunisation(PPI)	466	1417	586	546	470	586
IEC	49	--	--	25	--	--
Sectoral Investment Programme (SIP)	300	--	--	111	--	--
Disease Control Programmes (DCP)	526	501	679	391	340	--

Source: Audited Annual Accounts of SCOVA and information provided.

Note: Rs. 10 lakh, earmarked for 'IEC activity' was re-appropriated to RCH flexi pool under the head 'sterlisation' without the approval of GOI.

The differences between the two sets of figures were mainly due to accounting errors due to incorrect linking of sanction orders with the actual releases at the year-end.

The SHS assured (Aug 2008) that reconciliation would be done with the help of Chartered Accountants.

5.7 Accounting system

- Subsidiary books of accounts like Ledger, Journal, Register for temporary advances to staff, contractors, suppliers, register for advance to voluntary agencies etc., were not maintained by the SCOVA or DHSs, showing inadequate accounting controls.
- CHCs at Bhikyasain, Sahia and Kalsi did not maintain cash book. In some other facilities like District Male and Female Hospital, Pauri, combined cash book was being maintained, in which NRHM transactions were also being recorded.

  Funds released by the SCOVA/ DHS to the respective line agencies are in the form of advances, to be adjusted on the basis of UCs received from these agencies. However, these moneys were being debited to Grant-in-aid account and thus booked as expenditure regardless of the actual amount spent, which was not only incorrect accounting, but also affords little control on utilisation. This lacuna needs to be plugged urgently since the UCs are not being submitted regularly by the implementing agencies. The accounts were to be compiled on accrual basis, but these were being maintained in SCOVA on single entry basis.

The SHS assured (August 2008) that advance register/ control register along with other subsidiary books would be maintained in the ensuing year.

- Grants released by the GOI in kind have not been accounted for in the annual statements.
- The closing balances in the annual financial statements for the year 2005-06 under the heads RCH, NRHM-Additionalities, Routine immunisation, EC SIP, EAG, RNTCP, NVBDCP, NBCP, IDSP, Leprosy do not tally with the opening balances under the same heads as shown in annual financial statement for the year 2006-07.
- The annual accounts of the SHS were to be submitted to the GOI by 31 July of the succeeding financial year, but were not submitted on time in any of the years under review. Accounts of 2005-06 and 2006-07 were submitted on 12 October 2006 and 3 January 2008 respectively. The accounts for the year 2007-08 have not been submitted by October 2008. The SHS admitted the facts and assured (Aug 2008) that timelines would be adhered to in future.

Conclusion

The State Health Sector finds itself flushed with funds which the under-staffed and under-equipped health infrastructure is unable to absorb. Although separate societies have been formed for using the NRHM funds, these could not utilise the available funds. On an average, out of every Rs. 100 received by the State, Rs. 38 lay unspent at State and District levels in the last three years. In the absence of proper accounting records and controls, the annual Financial Statements do not present a true and fair view of the affairs of the society.

Recommendations

- Releases to districts should be based on well defined criteria and funds should be provided in a timely manner strictly in accordance with the Annual Action Plans of the districts.
- Reconciliation of accounts from sub-district facilities to DHS, DHS to SHS as well as SHS to GOI should be taken up on a monthly basis to ensure better monitoring of the utilisation of available funds.
- SHS should ensure proper maintenance of basic accounting records at all levels to track expenditure and establish internal control mechanism.

CHAPTER-6

INFRASTRUCTURE

Chapter 6 Infrastructure

6.1 Physical infrastructure

The mandate of NRHM includes creation of new infrastructure/ buildings for health centres and strengthening of the existing ones for improving accessibility and quality of healthcare delivery services. The target was to complete 30 *per cent* of the work by 2007 but the Indian Public Health Standards (IPHS), which provided the norms for physical infrastructure, were approved only in 2007-08.

6.1.1 Public Health infrastructure in Uttarakhand

Public health facilities available in the State during the period 2005-08 were as under:

Table-6

Health Facility	2005-06	2006-07	2007-08
District Hospitals	16	16	17
Male	**10**	**10**	**11**
Female	**6**	**6**	**6**
Base Hospitals	3	3	3
Combined Hospitals	14	15	15
Community Health Centres	40	49	49
Primary Health Centres	225	222	232
Sub Centres	1573	1631	1765
State Allopathic Dispensaries	325	321	322
Ayurvedic Ausadhalayas	533	533	554
Homeopathic Dispensaries	96	96	96

Source: State Public Health Report

Note: The decrease in the number of PHCs and State Allopathic Dispensaries in the year 2006-07 is due to the up gradation of these facilities as CHCs and PHCs respectively.

Uttarakhand is predominantly a rural State in which 81 *per cent* habitations have population of less than 500. The demographic character of the State present a challenge in providing health services to a sparsely distributed population, especially in hilly terrain with difficult accessibility.

6.1.2 Requirement

As per the programme norms, there should be one SC for 3000 population, one PHC for a population of 20000 and one CHC for a population of 80000 in hilly States like Uttarakhand. Prior to the launch of NRHM, 1525 SCs, 229 PHCs and 36 CHCs existed in the State. For a total population of 85 lakh (2001 census) in the State, the total number of health centres required as per norms and actually existing are as under:

Table-7

Year	Requirement as per norm			Existing number of			Shortfall		
	SCs	PHCs	CHCs	SCs	PHCs	CHCs	SCs	PHCs	CHCs
2005-06	2833	425	106	1573	225	40	1260	200	66
2006-07	2833	425	106	1631	222	49	1202	203	57
2007-08	2833	425	106	1765	232	49	1068	193	57

Source: State Public Health Report

The status of infrastructure at the end of 2007-08 compared to the requirement was as under:

Table-8

Level	No. required to be created during 2005-12	No. required to be created during 2005-08 on pro-rata basis	No. created and made operational	No. where work was in progress	Gap (2005-08)
SC	1260	540	192	330	18
PHC	200	85	32	61	+8
CHC	66	28	9	40	+21

Source: SHS

The above table shows that the State was geared to meet the targets on creation of physical infrastructure.

6.1.3 Skewed distribution of health facilities

The distribution of sub-centres among the blocks in the sampled districts is uneven with reference to the population criteria, which is evident from the table given below:

Table-9

Block	Population	Normative requirement	Available	Excess (+)/ shortfall (-)
District Almora				
Hawalbagh	69258	23	18	-5
Lamgadha	47347	16	18	+2
Bhainsiachana	26410	9	11	+2
Takula	45325	15	17	+2
Tadikhet	69092	23	20	-3
Dwarahat	61556	21	20	-1
Chaukhutia	49020	16	15	-1
Bhikiasain	37893	13	17	+4
Sult	61540	21	19	-2
Deghat	49262	16	19	+3
District Dehradun				
Doiwala	235146	78	28	-50
Raipur	199828	67	27	-40
Sahaspur	227086	76	28	-48
Vikasnagar	149321	50	28	-22
Kalsi	62247	21	29	+8
Chakrata	68551	23	28	+5
District Pauri				
Parsundakhal	39053	13	14	+1
Kot	30119	10	14	+4
Ghandiyal	36024	12	15	+3
Pabau	46218	15	16	+1
Thalisain	61198	20	15	-5
Patisain	38076	13	16	+3

Pokhra	30845	10	13	+3
Bironkhal	52304	17	16	-1
Dugadda	120109	40	17	-23
Yamkeshwar	51143	17	15	-2
Rikhnikhal	34064	11	14	+3

Source: Sampled DHSs and DHAPs

The huge visible shortage of SCs in Dehradun district may be attributed to the fact that four out of six blocks of the district comprise of large plain areas where the population criteria of one SC for 5000 population can be applied. The other reason may be availability of better Government hospitals at comparatively shorter distances in the district. Twelve new SCs were established during the Mission period in District Almora but ANMs could not be posted there. These included 5 blocks which were in remote areas of the District. Pauri had nine SCs without ANMs but 9 more were established and none of the 18 had ANMs. Establishing new SCs without providing them ANMs or without meeting the need for ANMs in the existing SCs is imprudent. The Departmental authorities stated during the exit conference that five ANM training centres were being made operational, following which, ANMs could be posted in all the SCs in a phased manner.

6.1.4 Construction of facilities

In the absence of a comprehensive facility survey, the State could not assess the load on the existing health centres and the actual need systematically. Further, the AAPs did not propose creation and up gradation of health facilities from NRHM funds; instead, the work was carried out from the State budget through State Sector Plan, Tribal Sub Plan and District Plans. During the exit conference, the Department said that they were unable to utilize the State funds under health; as such the construction costs were neither charged to NRHM nor planned in the State PIP. Budgetary provision in this regard is tabulated below:

Table-10 **(Rupees in lakh)**

Year	Construction Activities					
	SCs		PHCs		CHCs	
	No.	Sanctioned Cumulative Cost	No.	Sanctioned Cumulative Cost	No.	Sanctioned Cumulative Cost
2005-06	43	264.03	9	479.57	29	3865.63
2006-07	230	2972.27	10	463.99	3	681.60
2007-08	174	1698.07	18	863.52	1	217.92

Table-11 **(Rupees in lakh)**

Year	Up gradation					
	SCs As per IPHS norms		PHCs (into CHC)		CHCs (into FRU / Expansion)	
	No.	Sanctioned Cumulative Cost	No.	Sanctioned Cumulative Cost	No.	Sanctioned Cumulative Cost
2005-06	-	-	29	3865.63	-	-
2006-07	-	-	2	434.10	1	410.40
2007-08	161	551.06	1	217.92	7	349.91

Source: SHS

Scrutiny revealed the following in respect of construction works undertaken by the Government:

- Rupees 12.41 crore was released to the construction agencies for 64 works without ensuring availability of land, resulting in blocking of funds varying from 6 months to 4 years.
- Seventy one construction works were in progress beyond the due date of completion, with the delay ranging from 1 to 10 years, resulting in cost overrun of Rs. 9.37 crore.
- Sub-centres at Jaskot in Almora district, State Allopathic dispensary at Syoli in Pauri district and CHC at Jayanti in Almora district were constructed in inaccessible and secluded places. Access to SC at Jaskot (See photograph alongside) involves a 3 km trek from the nearest habitation and patients were being brought on a palanquin.

Work on construction of PHC at Manthat, Dehradun was sanctioned (2005-06) at Rs. 51.80 lakh and Rs. 25 lakh was released[18] (February 2006) to the executing agency[19] as first instalment. By November 2007, the agency had utilised Rs. 10 lakh and also submitted a revised estimate of Rs. 81.54 lakh. During the site visit, we found that only few trenches had been dug up and a wall constructed, of which a large part had fallen during rains, as can be seen form the photograph alongside.

6.2 Facilities and services at health centres

The IPHS lay down norms for basic facilities that should be made available at different tiers of health centres. Many of these basic facilities were unavailable in the sampled health centres, as tabulated below:

Table-12

Sl. No.	Particulars	SCs		PHCs		CHCs	
	Total number audited		**30**		**13**		**9**
		No	**%**	**No**	**%**	**No**	**%**
1	No. where no ambulance was available	NA	--	10	77	1	11
2	No. with no electricity connection/power supply	5	17	1	8	1	11
3	No. with no working facility of standby power supply	30	100	10	77	2	22
4	No. where separate ward for male and female patients was not available	NA	--	12	92	2	22

[18] The technical and financial sanction was accorded by the competent authority vide letter No. 215/xx-viii-5-2005-24/ 2005 dated 18.08.2005

[19] Uttarakhand Peyjal Sansadhan Vikas avam Nirman Nigam

5	No. where separate utilities for men and women were not present	29	97	8	62	5	56
6	No. where waiting rooms for patients were not present/ not in good condition	NA	--	13	100	9	100
7	No. with no provision of water supply	16	53	3	23	1	11
8	No. of health centres with no provision of storage of water	24	80	10	77	2	22
9	No. with no telephone connection	30	100	8	62	2	22
10	No. with no accommodation facilities for attendants of admitted patients	NA	--	13	100	9	100
11	No. where accommodation facilities for staff were not available	12	40	1	8	1	11
12	No. where accommodation facilities for staff was partially present	2	7	5	38	3	33

Source: Facility Survey conducted by the Audit Team

The gaps in facilities are particularly critical in the following areas:

- Fifty three *per cent* of the SCs, 23 *per cent* of the PHCs and 11 *per cent* of the CHCs have no provision of water supply. Most of the remaining PHCs and SCs do not have facilities for storage of water to ensure 24x7 water supply. Seventeen *per cent* of the SCs, 8 *per cent* of the PHCs and 11 *per cent* of the CHCs have no electricity connection. Although power cuts in the State are not infrequent, but 77 *per cent* of the PHCs and 22 *per cent* of CHCs did not have back-up power supply either. Both water and electricity are crucial to providing health care. Continuous electricity supply is also critical to providing OT, emergency and laboratory/ X-ray services.
- Since the PHCs do not have adequate facilities for providing emergency services, ambulance/vehicle at this level is essential. However 77 *per cent* of the PHCs did not have any vehicle or ambulance for transportation of sick patients. They also did not have any tie-up with private agencies for referral transport although NRHM provides earmarked funds for referral transport.
- 24x7 emergency services are to be provided by PHCs and CHCs. On an average, the sampled PHCs are manned by 1 doctor and 0.6 nurses. Similarly, the sampled CHCs operate with 2.5 doctors and 2.3 nurses[20]. In such a situation, providing residential accommodation within the premises or in the vicinity of the health facility is essential. However, 46 *per cent* of the PHCs and 44 *per cent* of CHCs did not have accommodation or it was inadequate.
- Given the geographical conditions and the high maternal mortality rate (MMR) in the State, labour room in the PHCs is critical. 69 *per cent* of the PHCs either did not have a labour room or it was non-functional.
- Availability of medicines in the health centres is pivotal to the health delivery system. Seventy one *per cent* of the total 1434 respondents in the beneficiary survey intimated partial availability of medicines in the health centres. This was confirmed by the ANMs, as 28 *per cent* of the ANMs surveyed accepted non availability of general medicines at health centres.

[20] Excluding CHC at Doiwala

Dial 108 facility

Dial 108 emergency medical service is in operation in the State with private partnership with an NGO- Emergency Management & Research Institute (EMRI) by which 90 ambulances have been pressed into service as of March 2009. Public response to this service is overwhelming and this service has provided the much needed medical and referral help, particularly in trauma cases in remote blocks of hilly and plain districts.

6.2.1 Cold chain management

To support immunisation programme, cold chain maintenance was planned in all the CHCs and PHCs. In the sampled districts, covering 9 CHCs and 13 PHCs, the status of cold chain equipment was as under:

Table-13

Equipment	Temperature (degree celsius)		No. of CHCs where		No. of PHCs where	
	Maintained at	Needed for	Available	Working	Available	Working
Ice-lined freezers	2-8	BCG, DPT, TT	8	8	0	0
Deep freezers	-13 to -15	Polio/ measles	9	8	12	12

Source: Facility Survey conducted by the Audit Team

All the PHCs and 1 CHC did not have ice-lined freezers required to freeze the BCG, DPT and TT vaccines at the required temperature, which if not maintained, can reduce or destroy the efficacy of the vaccine. Further, there was no assurance on the quality of vaccines stored in cold chain equipment at 2 CHCs[21] (22 *per cent*) and 10 PHCs[22] (77 *per cent*) in the absence of continuous supply of power.

6.2.2 OPD and in-patient care

Out of 13 test checked PHCs and 9 test checked CHCs, OPD was operational in all except three[23] PHCs, which did not have doctors. Eight CHCs had functional inpatient services; IPD in one CHC (Jayanti, Almora) was not operational due to its inaccessibility and non-availability of manpower. Most of the sampled CHCs and PHCs had a patient bed ratio[24] of less than 0.5 even in plain areas, indicating under-utilisation of in-patient services which could be partly due to inadequate facilities at these centres. On the other hand, the district hospitals, especially in Dehradun, were over-loaded with a patient-bed ratio of 1:1.16-1:1.24.

6.2.3 Operation theatre

Only one CHC (Doiwala, Dehradun) out of the nine sampled across three districts, had a functional OT. The remaining 8 CHCs had OTs, but were not equipped adequately and were non- functional in the absence of surgeons and anaesthetists as tabulated below:

[21] Sahia, Dehradun and Jayanti, Almora
[22] 4 PHCs each in Dehradun and Almora and 2 PHCs in Pauri.
[23] Vinayak, Jalali and Manthat
[24] Patient –Bed Ratio= Total bed-days available divided by total patient-days occupancy

Table-14

Items	Number of CHCs where equipment		
	Available and functional	Available but not functional	Not available
Boyles' apparatus	1	8	--
Cardiac Monitor	1	--	8
Ventilator	--	--	9
Vertical High Pressure Sterilizer	1	7	1
Shadowless lamp pedestal for minor OT	1	6	2
Gloves and dusting machines	--	--	9
Nitrous oxide cylinder for Boyales apparatus	1	5	3
EMO Machine	--	--	9
Defribillator	--	--	9
Horizontal High Pressure Sterilizer	--	2	7
Shadowless lamp ceiling mounted	--	1	8
OT care/fumigation apparatus	1	--	8
Oxygen cylinder for Boyles' apparatus	1	5	3
Hydraulic operation table	--	8	1

Source: Facility Survey conducted by the Audit Team

NRHM provides for blood storage facilities at each CHC. However, none of the sampled CHCs had Blood Bank/ blood storage facility nor were they linked to the district Blood Bank.

6.2.4 Emergency services

24 hours emergency services for management of injuries and accidents, first aid, stabilization of patients before referral, dog/ snake/ scorpion bite cases etc, were to be provided by posting three staff nurses at PHCs. Out of 232 PHCs in the State, 64 PHCs have been declared functioning on 24x7 basis and 45 with 24x7 delivery services, of which only 23 PHCs had 3 Staff Nurses posted for emergency services. In the sampled districts, only 2[25] out of 13 PHCs were able to provide emergency services.

6.2.5 Mobile medical units

A mobile medical unit (MMU) was to be provided in every district for outreach services. Although Rs. 5.08 crore was provided for this purpose under NRHM in 2006-07, it was lying unutilised. However 2 MMUs operational in Tehri and Chamoli were financed through SIP programme, with the recurring expenditure of Rs. 31.13 lakh being met from RCH-II Flexi pool account. MMUs are of particular significance in hilly areas in Uttarakhand. SHS replied (August 2008) that procurement was under process.

6.2.6 Diagnostic services

The Mission provides for essential laboratory services at PHCs and CHCs. At the PHC, the services should include laboratory services for routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of sexually transmitted diseases, sputum testing for tuberculosis, blood smear examination for malaria parasites and rapid tests for

[25] Tiuni and Raipur

pregnancy / malaria. Out of 13 checked PHCs, 10 PHCs (*77 per cent*) had no facilities for laboratory services, and in 3[26] PHCs, services were available only partially.

The CHC is required to have additional laboratory services like microscopy facilities for tuberculosis, diagnostic facilities for complicated cases of malaria, dengue, leprosy etc. However, out of 9 test-checked CHCs, only 4[27] had full diagnostic services, while 3[28] had partial facilities available and 2[29] CHCs had no services at all. The main problem was absence of Lab Technicians in the facility.

6.2.7 Radiological/ X-ray services

Out of 9 test checked CHCs, X-ray facilities were available only at 5[30] CHCs, while at 4[31] CHCs, X-ray machines were in working order but not used due to electricity shortage/ absence of technicians. In 3[32] CHCs, X-ray facility was available but was not utilised fully; average daily cases during 2005 to 2007 were less than one X-ray per day, representing under-utilisation of the facility. The reasons for under-utilisation were absence of the required number of specialists/ technicians.

6.3 Facilities for detection and treatment of diseases

6.3.1 Tuberculosis

The overall cure rate of 85 *per cent* had been achieved during the last three years as envisaged under RNTCP.

Under NRHM, full coverage for detection and treatment of tuberculosis is guaranteed at CHCs and PHCs. 31 CHCs and 74 PHCs out of 49 CHCs and 232 PHCs in the state were covered under the DOTS[33] scheme of the programme. Out of 9 test checked CHCs and 13 PHCs, full services for detection of tuberculosis were present only in 4[34] CHCs (*45 per cent)* and 3[35] PHCs (*23 per cent*) due to absence of lab facilities and lack of man-power. This has had an adverse impact on achievement of targets set for detection of new sputum positive cases; against a target of 70 *per cent* of the estimated 95 sputum positive cases per lakh per year (i.e., 67 per lakh) for Uttarakhand, the achievement ranged from 49 to 61 *per cent* during the period 2005-08 as shown in the table below:

[26] Raipur, Kalsi and Lamgardha
[27] Doiwala, Bhikyasain, Dwarahat and Bironkhal
[28] Chakrata, Pabo and Sahiya
[29] Thalisain and Jayanti
[30] Doiwala, Chakrata, Pabo, Dwarahat and Bhikyasain
[31] Sahiya, Jayanti, Thalisain and Bironkhal
[32] Chakrata, Pabo and Dwarahat
[33] Direct Observed Treatment Short Course
[34] Doiwala, Sahiya, Bhikyasain and Bironkhal
[35] Raipur, Kalsi and Lamgardha

Table-15

Year	Sputum examination			Detection of new Sputum positives		
	Target	Achievement		Target	Achievement	
		Number	Percent		Number	Percent
2005	NA	NA	NA	70%	4429	51
2006	57403	59751	2.08	70%	4279	49
2007	64411	65842	2.04	70%	5398	61
Total	**121814**	**125593**			**14106**	

Source: State TB society

The overall cure rate of 85 *per cent* was prescribed under the RNTCP. The cure rate ranged between 87 and 89 *per cent* in the State during 2005-08 as tabulated below:

Table-16

Year	TB patients registered	No. of cases evaluated	Cured + treatment completed	Cure Rate percentage	Died	Failures	Defaulters	Transferred out
2005	3361	3361	2925	87	134	101	201	0
2006	4419	4419	3844	87	146	97	309	23
2007	4277	4277	3808	89	119	68	256	26
Total	**12057**	**12057**	**10577**	**--**	**399**	**266**	**766**	**49**

Source: State TB society

The survey results were alarming, as 90 *per cent* of the respondents in district Dehradun, which happens to be the capital district, reported non-availability of diagnostic facilities for TB at health centres.

6.3.2 Vector Borne Diseases

Facilities for diagnosis and treatment of various vector borne diseases is available only at 3[36] CHCs (*33 per cent*) and 2[37] PHCs (*15 per cent).* The National Vector Borne Diseases Control Programme stipulated to achieve ABER of 10 *per cent*[38]. Due to inadequate facilities for testing, the State's achievement on ABER was substantially less than the targets at 3.5, 3.22 and 2.51 during 2005-06, 2006-07 and 2007-08 respectively. During 2005-08 morbidity and mortality due to various vector borne diseases were as under:

Table-17

Year	Kala Azar		Malaria		Filaria		JE		Dengue	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
2005	0	0	1242	0	0	0	0	0	0	0
2006	0	0	1108	0	0	0	58	0	6	1
2007	2	0	953	0	0	0	2	0	46	0
Total	**2**	**0**	**3303**	**0**	**0**	**0**	**60**	**0**	**52**	**1**

Source: State Programme Officer, Malaria

[36] Doiwala, Dwarahat and Bironkhal

[37] Kalsi and Lamgardha

[38] ABER-Cumulative sum of monthly rate per 100 population under surveillance of blood examination during the year. API-Positive malaria cases per thousand population.

It is evident that morbidity and mortality due to vector borne diseases is negligible in the State and the lone death due to Dengue was that of a pilgrim to this State.

6.3.3 National Leprosy Eradication Programme (NLEP)

The State has achieved Leprosy Prevalence Rate (PR) of less than 1 per thousand in the year 2005-06.

The NLEP aimed to eliminate leprosy by the end of 11th plan. It also aims to ensure leprosy prevalence rate of less than one per thousand. The Leprosy PR in the State during 2005-06, 2006-07 and 2007-08 were 0.71, 0.64 and 0.56 with incidence of 0.97, 8.1 and 7.96 new cases respectively.

6.3.4 RTI and STI facilities

With large-scale prevalence of reproductive tract infections (RTI) and sexually transmitted infections (STI) especially among women in the country, it was envisaged that RTI and STI clinics will be established at each district hospital and first referral units/ CHCs. However, no separate RTI/ STI clinics were functioning in the sampled CHCs and PHCs.

6.4 Adequacy of skilled manpower in centres

NRHM aims to provide adequate medical and other manpower at different health centres. The status of manpower in the State is tabulated below:

Table-18

Grade	Sanctioned Posts			Men-in-position			Vacancies		
	05-06	06-07	07-08	05-06	06-07	07-08	05-06	06-07	07-08
Medical Officers	1669	1812	1823	912	893	948	757	919	875
Dentists	63	62	64	42	39	45	21	23	19
X-ray Technician	98	117	106	70	70	70	28	47	36
Lab Technician	286	281	266	131	107	132	155	174	134
Staff Nurse	724	788	808	607	654	756	117	134	52
Health Supervisor (M)	552	552	552	417	417	417	135	135	135
Health Supervisor (F)	345	345	345	343	343	343	2	2	2
ANM	2039	2173	2173	1925	1912	1900	114	261	273
Health Worker (M)	855	855	855	511	417	417	344	344	438
Total	**6631**	**6985**	**6992**	**4958**	**4852**	**5028**	**1673**	**2039**	**1964**

Source: State Public Report on Health

The above table reveals that shortage of doctors and paramedical staff ranged between 45 to 51 *per cent* and 25 to 31 *per cent* respectively during 2005-08. The shortage of manpower in the sampled facilities is shown in the following table:

Table-19

Sl. No.	Particulars	Number	As % of sample
SUB CENTRE (Sample size:30)			
1	without two ANMs	27	90
2	without one regular ANM	3	10
3	without one Multipurpose worker	22	73
PRIMARY HEALTH CENTRE (Sample size:13)			
4	without a Medical Officer (Allopathic)	3	23
5	without an AYUSH Medical Officer	12	92
6	without any Medical Officer	3	23
7	without three Staff Nurses	11	85
8	without one Staff Nurse	9	69
9	without a Lab Technician	10	77
10	without a pharmacist	4	31
11	without a Lady Health Visitor	4	31
COMMUNITY HEALTH CENTRE (Sample size:9)			
12	without a General Physician	8	89
13	without a General Surgeon	8	89
14	without an Obstetrician & Gynaecologist	8	89
15	without a Paediatrician	4	44
16	without an Anaesthetist	8	89
17	without a Pathologist	9	100
18	without nine Staff Nurses (two of them may be ANMs)	8	89
19	without five Staff Nurses	8	89
20	without one Staff Nurse	1	11
21	without a radiologist	6	67
22	without a Pharmacist	1	11
23	without a Lab Technician	5	56

Source: Facility Survey conducted by the Audit Team

23 *per cent* PHCs were found without any medical officer, 69 *per cent* without a staff nurse and 77 *per cent* without a lab technician. 89 *per cent* of CHCs were running without any physician, surgeon, gynaecologist, anaesthetist and none of them had a pathologist. The support staffs were either not posted or was inadequate.

Individuals make the difference.....

We found the sub-centre at Manthat, Dehradun one of the best managed on many parameters including availability of medicines, regularity of check-ups, maintenance of the facility etc. It may be borne in mind that this is a remote and inaccessible block and the village lacked basic amenities. ANM at SC, Manthat is posted here since the last 19 years.

ANM at SC, Manthat

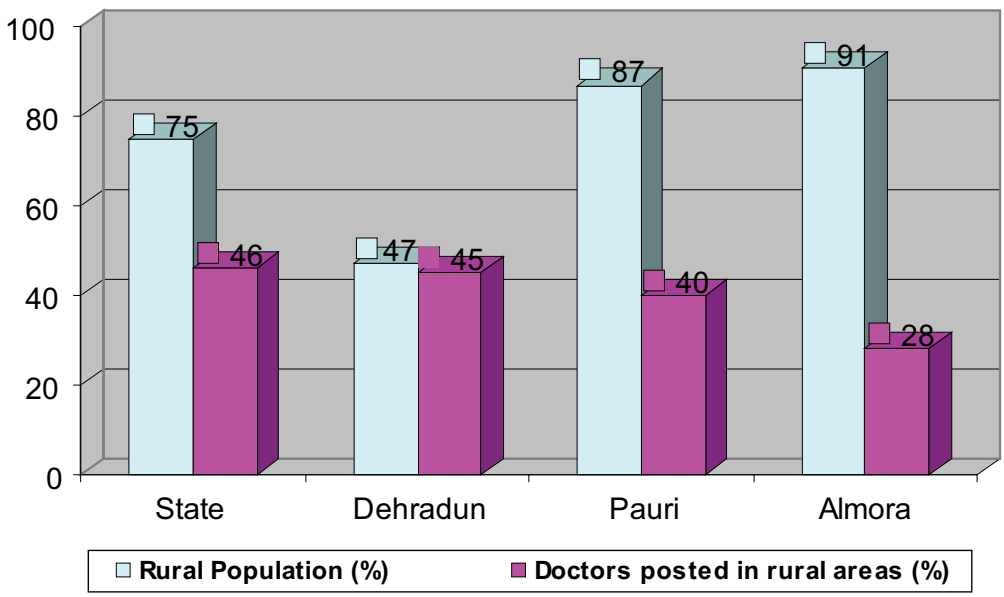
SC at Johdi, Dehradun was also very well managed.

PHC at Baijro, Pauri, had a total staff of a doctor and a sweeper. The doctor plays multiple roles- as a registration clerk, a fee collector, compounder as well as pharmacist, apart from general upkeep and field visits. The number of OPD visits in this PHC is high and despite meagre resources, is very well managed.

6.4.1 Skewed deployment

There was wide disparity in the posting of doctors in urban and rural areas. Only 46 *per cent* (548) of the doctors were posted (as on 30 September,2008) in rural areas to serve 75 *per cent* (63.10 lakh: 2001 census) of the population; the position in the sampled districts was worse as shown below.

Chart No. 1



Source: SHS

The issue of actual vacancies in the district was rarely considered during transfers, resulting in inter-district as well as intra-district variation of medical service providers.

6.5 Adequacy of training

One of the aims of NRHM is capacity building of human resources through skill up gradation of the medical and support personnel by imparting periodic training to them. The targets set for training remained largely under-achieved during the period 2005-08 as shown below:

Table-20

Post	T/A[39]	2005-06	2006-07	2007-08	Total
ASHA-Training of trainers	T	NA	NA	NA	NA
	A	44	83	0	127
Trained birth attendants	T	NA	120	216	336
	A	14	9	41	64
ANM	T	NA	1200	400	1600
	A	NA	0	0	0
Staff Nurse	T	NA	NA	100	100
	A	6	10	30	46
Medical Officer	T	NA	200	442	642
	A	24	87	220	331
TOTAL	**T**	**NA**	**1520**	**1158**	**2678**
	A	**88**	**189**	**291**	**568**

Source: State Plan and SHS reply

Thus there was an overall shortfall of 79 *per cent* in providing training to medical personnel/ support staff. The target for providing training was reduced in 2007-08 inspite of increasing health demands and an increase of Rs. 81.83 lakh in budgetary provision for 'training' in 2007-08 as compared to 2006-07. With institutional or assisted deliveries forming a small proportion of deliveries in the State, training of birth attendants was critical. The targets in this area were low; yet the achievement was only 15 *per cent*.

One of the reasons for the shortfall in training is the inadequacy of institutions for training in the health sector with only one Regional Training Centre (RTC) available in the State.

6.6 Work load on ANMs: engagement of ASHAs

Auxiliary Nurse Mid-wife (ANM) forms the very foundation for rural health delivery system. She has to perform a wide range of services, which include immunization, primary medical care, maternal and child health, family planning, awareness programmes, communicable diseases surveillance, track vital events like record of births and deaths occurring in her area and keep records and prepare reports on all these activities. The week is packed with duties. In order to discharge her duties, she must visit the areas under her fold and in a hilly terrain like in

Weekly Tour schedule of ANM

[39] T:- Target, A:- Achievement

most parts of Uttarakhand, this is difficult. There is a need to rationalise the work-load of each ANM to ensure efficient delivery of health services. The beneficiary survey revealed that 44 *per cent* ANMs were catering to more than 11 villages with distance ranging between 3 to 21 kms. Sixty six *per cent* ANMs reported that they are over-burdened due to large area and difficult terrain forcing them not to adhere to fixed day programme. This was further confirmed from the beneficiary responses that 60 and 49 *per cent* respectively in Almora and Pauri reported visits by ANM on monthly basis. Seventy six *per cent* of the ANMs denied any role of GPs in health delivery system.

ANMs have been provided with mobile phones in all the districts, the objective being that the job involves a lot of mobility and the ANM should be available to the area she caters to. In Almora, the list of all facilities, block-wise, area-wise, including that of the ANM was circulated to all key stakeholders like PRI representatives, district authorities etc.

One initiative in this direction is engagement of a trained female community health worker called Accredited Social Health Activist (ASHA) in every village in the ratio of one per 1000 population (less for hilly regions having difficult accessibility). The ASHA was expected to act as an interface between the community and the Sub-centre and is to be paid honorarium on achievement of targets under RCH. The State Government was successful in filling up this level, more than the requirement in most districts, as shown in the table below:

Table-21

Name of the district	Total population (2001)	Number of ASHAs required	Number of ASHAs engaged			
			2005-06	2006-07	2007-08	Total
Almora	630567	631	627	0	94	721
Uttarkashi	295013	295	0	413	0	413
Chamoli	370359	370	0	385	0	385
Tehri	604747	605	530	0	0	530
Dehradun	1282143	1282	734	684	0	1418
Pauri	697078	697	45	790	0	835
Rudraprayag	227439	227	103	160	06	269
Haridwar	1447187	1447	260	577	609	1446
Pithoragarh	462289	462	0	363	340	703
Nainital	762909	763	432	412	03	847
US Nagar	1235614	1236	1235	0	0	1235
Bageshwar	249462	249	110	178	0	288
Champawat	224542	225	28	223	0	251
State	**8489349**	**8489**	**4104**	**4185**	**1052**	**9341**

Source: SHS

The ASHAs were required to be provided with drug kits containing medicines for minor ailments, Oral Rehydration Salt (ORS), contraceptives etc. Only 2221 kits out of required 9341 ASHA drug kits, were purchased since the inception of the programme and had been provided to ASHAs in two districts- Dehradun and US Nagar in 2007-08. No kits were made available to ASHAs in Upper and Mid Himalayan districts where the need was most due to difficult topographical conditions. SHS replied (September 2008) that the kits were provided to ASHAs in plain areas because their training had been completed. The reply

does not reflect the reality that training on all four modules had been provided in all the districts and the fifth module was yet to be taken up in the State.

The survey responses of 60 ASHAs revealed that 37 *per cent* of them were catering to a population of more than 1000. Seventy two *per cent* reported receiving Janani Suraksha Yojana (JSY) incentive, however, only 28 *per cent* of them received it on time. Thirty two *per cent* reported lack of cooperation from health staff. In fact, the ASHAs were not aware of all the incentives available to them under NRHM.

A unique feature in Uttarakhand is the 'ASHA plus' scheme run by NGOs in selected blocks in two districts – Uttarkashi and Chamoli. In the ASHA+ scheme, honorarium for antenatal care to pregnant women is higher and is paid for intermediate stages, instead of a one-time payment at the time of delivery.

6.7 Training to ASHAs

A provision of 23 days training in five phases was made for equipping the ASHAs with necessary knowledge and skills. 19 days training over four modules has been imparted in the State to 8877 out of 9341 ASHAs; 464 have dropped out. The fifth module of four days is yet to be completed. The status on training of ASHA is as under:

Table-22

District	Number of ASHAs selected	Number of ASHAs provided with induction training (Module wise)					Dropouts(from selection to 4th)
		1st	2nd	3rd	4th	5th	
Almora	721	715	691	688	686	--	35
Bageshwar	288	288	288	275	275	--	13
Chamoli	385	385	385	385	385	--	0
Champawat	251	251	251	251	251	--	0
Dehradun	1418	1418	1232	1232	1232	--	186
Pauri	835	835	835	835	823	--	12
Haridwar	1446	1419	1419	1406	1403	--	43
Nainital	847	846	813	813	813	--	34
Pithoragarh	703	703	703	703	703	--	0
Rudraprayag	269	269	269	269	269	--	0
Tehri	530	530	530	530	530	--	0
US Nagar	1235	1135	1124	1124	1124	--	111
Uttarkashi	413	412	405	383	383	--	30
Total	**9341**	**9206**	**8945**	**8894**	**8877**		**464**

Source: SHS

Of the 60 ASHAs surveyed in the beneficiary survey, 28 *per cent* did not have any knowledge on the symptoms of common diseases while a majority felt the need for training in different areas viz. delivery services-58%, immunisation-77%, ANC services-58%, personal hygiene-42%, TB/ AIDS-48%.

Establishment of a State ASHA Resource Centre (SARC) was sanctioned (2007-08) by the GOI, to meet their training needs.

6.8 Involvement of NGOs

NGOs were identified as critical for the success of NRHM especially to build capacity at all levels, develop innovative approaches to health care delivery for marginalized sections or in underserved areas and ensure community participation to ensure accountability.

The SHS appointed 8 Mother NGOs (MNGOs) in 2005 to serve in 11 districts (details are given in *Annexure-II*) on RCH activities relating to maternal and child health care and in creating awareness among the community. The MNGOs enter into an agreement (MOU) with the District RCH Committee after approval of the project proposal at the State level. An upper limit of Rs. 15 lakh per MNGO per year was set on these grants.

The table below shows the releases and utilisation of funds to MNGOs by the SHS during the period 2005-08:

Table-23 **(Rupees in lakh)**

Year	Total NRHM release	Grant-in-aid released to MNGOs during the year	% of total NRHM release	Amount of UC furnished by the MNGO
2005-06	3223.00	6.00	0.18%	Nil
2006-07	4639.00	174.25	3.76%	Nil
2007-08	8871.00	20.41	0.23%	109.00
Total	**16733.00**	**200.66**		**109.00**

Source: SHS

The table reveals that out of total release of Rs. 2.01 crore, MNGOs could utilise only Rs. 1.09 crore and Rs. 91.66 lakh was lying unutilised with them as of March 2008. Clearly, grants-in-aid were being released to them as a routine activity without actually assessing their potential to spend. No monitoring mechanism is in place to verify the expenditure of the MNGOs.

The DHSs could not provide the records relating to MNGOs to the audit team for scrutiny.

Scrutiny of the periodical reports submitted by the MNGOs in the sampled districts to the SHS revealed the following:

- The reports spoke of achievements in general terms and did not lend themselves for collation, data validation and evaluation of the performance of the NGO. Only in Pauri district did the District authorities seem to have some co-ordination with MNGOs; in the other two districts – Dehradun and Almora, district authorities were unaware of the MNGO activities.
- The work of MNGOs was to be monitored through quarterly physical and financial reports, quarterly physical verification of the works done, by the State NGO coordinator and analysis of Annual Accounts and UCs submitted by the NGOs. There was, however, no evidence of physical verification through field visits by district authorities or by the State level functionaries. There was also no evidence of the State NGO Co-ordinator having played a pro-active role in monitoring the work of the NGOs.
- The work of HIHT[40] was evaluated (September 2008) by the National Institute of

[40] Himalayan Institute of Hospital Trust, MNGO for Dehradun and Pauri District

Health and Family Welfare (NIHFW). The study showed that the statistics on all aspects of RCH had improved in the blocks covered by the MNGO and that the beneficiaries were, by and large, aware of the MNGOs in the area. However, the study did not provide data to substantiate the contribution made by the MNGO distinct from that of other participants in the field-ANM, AWW, ASHA and PHC staff.

During the exit conference, the Department agreed that in order to increase the sense of ownership at the District level, CMOs would henceforth be involved in the selection of MNGOs.

6.9 Management of bio medical waste

Bio-medical waste is waste generated by hospitals and other health providers and consists of discarded drugs, waste sharps, microbiology & biotechnology waste, human anatomical waste, animal waste etc. Wastes represent a threat to the environment and human health if not handled or disposed off properly. Non handling of these wastes may lead to surface water contamination, ground water contamination, soil contamination and air contamination. For proper management of bio-medical waste, The Bio-Medical Waste (Management and Handling) Rules were notified in 1998. The institutions generating bio medical waste were given the responsibility of ensuring that all such waste is segregated, transported, processed and disposed without any adverse effect to human health and environment. During the course of physical verification of the facilities at different CHCs and PHCs in the selected districts, the audit team found the following interesting facts:

Doon Hospital, Dehradun

Base Hospital, Srinagar, Pauri

District Male Hospital, Pauri

- Bio medical waste management in the District Hospitals was satisfactory and Bio Medical Waste (Management and Handling) Rules were being followed.
- In Base Hospital, Srinagar BMW was being thrown in the open and proper segregation of waste was not being done as required.
- BMW management in CHC Chakrata, Dehradun, Pabau, Pauri and PHC Kalsi, Dehradun was better whereas CHCs Dwarahat and Jayanti, in Almora were poorly managed.

CHC, Dwarahat, Almora

CHC, Jayanti, Almora

The above facts point that more attention is required towards BMW management especially in CHCs and PHCs.

Conclusions

The State was geared to meet the targets for construction of health facilities although the distribution of facilities was skewed to the detriment of inaccessible areas. Delays in construction work led to cost overruns.

Infrastructure at the health centres was inadequate, with many PHCs and CHCs functioning without adequate provision of drinking water or uninterrupted supply of electricity. Efficacy of vaccines stored in PHCs/ CHCs without electricity supply or any stand-by power supply, representing 85 per cent of the PHCs and 33 per cent of CHCs, cannot be assured. In the absence of the prescribed diagnostic services at PHCs and CHCs, their viability as the first referral unit remained questionable and quality of reliable health services at an affordable cost remained unfulfilled in rural areas. This increased the load on district hospitals with concomitant under-utilisation of facilities at lower levels as reflected in the low patient bed ratio. Mobile medical units which could fill the gap in remote and hilly areas, were not procured despite availability of funds.

Severe shortage of skilled manpower, especially doctors, appears to cripple the health infrastructure. 89 per cent of the CHCs operate without specialist doctors, rendering the concept of first referral unit meaningless. The existing doctors tend to seek postings in plain areas, leaving the under-served hill areas to bear the burden of shortages disproportionately. Training facilities were also inadequate.

ASHA was designed as an interface between the community and health care delivery system. The State has done well in hiring ASHAs but equipped the ASHAs with drug kits in plain areas only.

The participation of NGOs is essential in providing health care, especially in inaccessible and hilly areas and they have added incremental value to the programme. However,

involvement of multiple players in the sector performing the same roles i.e., ASHA, ANM, AWW, NGOs etc., does pose a risk of over-reporting. That the risks are indeed palpable is evidenced by the fact that there was over-reporting of achievements against all activities –immunisation, distribution of iron folic acid tablets and Vitamin A drops. Management of bio-medical waste at the CHC, PHC and SC level needs urgent attention.

Recommendations

- There is an urgent need to improve infrastructure at the health centres by mapping the available services and supporting infrastructure at the health centres and the existing load on the available infrastructure. The support infrastructure such as electricity, generator, telephone, ambulance, computer etc should also be provided at the health centres to ensure improvement in the quality of services at these centres.
- Sanctioned posts of manpower required for providing medical services should be filled on a priority basis.
- Infrastructure of training institutions should be revamped to cope with the increased need of training after the launch of NRHM. Every District Health Society should prepare a plan for training based on desirability of training, number of trainings received by the staff during previous years and need of training to a group of staff with certain changes in technology/ new innovation.
- The model of ASHA plus scheme may be adopted to provide assured earnings even in intermediate stages instead of lumpsum payments. For efficient utilisation of their services, the ASHAs must be trained adequately and drug kits should be provided to them.
- A fully equipped Mobile Medical Unit should be provided in every district to ensure outreach medical services in remote/ difficult areas.
- Steps should be taken to operationalise diagnostic services at all the sub-district facilities, by providing equipment as well as manpower, to achieve the prescribed target of new sputum positive detection cases.
- Urgent steps should be taken to create waste treatment and disposal infrastructure at sub-district facilities as this could go a long way in effective management of waste and reduce the threat posed to environment and public health.

CHAPTER-7

PROCUREMENT OF SERVICES, MEDICINES AND EQUIPMENT

Chapter 7 Procurement of services, medicines and equipment

7.1 Procurement policy

SHS developed (November 2005) a procurement manual specifying the procedures to be followed for different categories of goods (viz. capital assets, operational material and consumable & miscellaneous items) and services. Scrutiny revealed that the prescribed procedures were followed by the SHS. Purchase of medicines is governed by Medicine Purchase Policy of September 2001.

7.2 Procurement of services

In order to streamline the system for drug procurement, storage and distribution, SHS engaged a consultant[41] (August 2007) at a cost of Rs. 34.43 lakh. The consultant suggested (November 2007) construction of drug warehouse and strengthening of training, but the report was yet to be adopted. Similarly, another consultancy assignment [42] costing Rs. 58.58 lakh on revision of "Essential Drug List' led to its notification (February 2007) but was not adopted by the Department as of date (October 2008). In all, SHS hired six consultancy firms[43] at a cost of Rs. 1.30 crore, whose recommendations have not been put to use by the Government.

7.3 Purchase of drugs

Of the total budget allocation for procurement of medicines, *60 per cent* is spent by CMOs based on district-level needs; the remaining *40 per cent* of the budget is for centralised purchases through the DG. The central purchases are done on the recommendations of a Purchase Committee[44] presided by DG. Rupees 16.21 crore was spent on purchase of medicines by the Directorate during the last three years.

The field units informed the Audit team that the medicines were supplied by the Directorate without demand, which was denied by the latter. Copies of the indents raised by the districts were not available in the district offices. The supplies were made by a letter from the Directorate intimating a date on which the medicines can be lifted, along with a list of medicines available in the central stores. In the supply memos shown to us, the column for indent number or letter number by which the requirements were indicated, was left blank. This leads to the conclusion that the centralised purchases were not linked to the indents raised by the district offices. Some corrections were made in the system in 2007-08, when the Directorate began to intimate the districts of the medicines proposed to be purchased in the ensuing year.

[41] Delhi Society for Promotion of Rational Use of Drugs (DSPRUD)

[42] Delhi Society for promotion of rational Use of Drugs

[43] In addition to the two consultancies, there were four others on Rational Use of Infrastructure, Rational Use of Drugs, Drug Procurement & Storage and Distribution System, Workforce Management and Hospital Autonomy

[44] Representatives from Dept of Industry, Dept of Health & Dept of Finance, Drug controller, Additional Director, Medical Treatment & Stores, Finance Controller, Dept of Health

The following findings further corroborate the inherent flaws in the system:

- In all the sampled medicine store depots, Schedule-H drugs, [45] which were to be given only on the prescription of Registered Medical Practitioners (RMP), were issued (2006-08) to SCs and SADs (State Allopathic Dispensaries), which are manned by pharmacists and ANMs who possess only a diploma in 'Pharmacy' and 'Nursing' respectively. On an average, 395 numbers of such drugs were supplied per year per SC/ SAD. This was an alarming issue that merits decisive action by the Government. CMO, Almora confirmed (June 2008) that the medicines were meant for distribution only on medical prescriptions but as to how the Department ensured this condition after issuing them to ANMs remained unanswered.

In the exit conference, Principal Secretary (Health) took a serious view of the matter and assured that it would be investigated further.

- GOI norms require that AYUSH kits, containing patent Ayurvedic formulations, should be provided only to functional AYUSH wings in CHC and PHC. However, the kits were supplied on the basis of sanctioned strength of doctors and pharmacists (instead of the actual number posted) resulting in excess procurement of Rs. 1.01 crore. The kits contain medicines that have an expiry date within one year.

Expired ORS Sachets

Ayurveda Directorate replied (Oct 2008) that funds for procuring AYUSH kits were allocated in 2007-08 and were to be utilised in the same year and that the selection process for doctors/ pharmacists was underway.

ORS Sachets thrown in the open

- SHS procured 7.5 lakh sachets of ORS worth Rs. 19.50 lakh for further distribution[46]. Normally, purchase orders for drugs are issued FOR destination but in this case, it was FOR SCOVA, which was anomalous. While receipt of 1.92 lakh sachets in four districts[47] was found in the SHS records, there was no indication of their distribution in the remaining nine districts. Stock book was not made available to Audit. However, the Audit team noticed huge quantity of expired ORS sachets, dumped in the backyard of SCOVA

[45] Drugs like tablet Alprazolam, tablet Atenolol, tablet Diazepam and Injection Diazepam

[46] Headquarters:-200000 sachets, Almora, Chamoli, Dehradun, Haridwar, Nainital, Pithoragarh, Pauri, Tehri, Uttarkashi and US Nagar:-46000 sachets each and Bageshwar, Champawat and Rudraprayag:- 30000 sachets each.

[47] Bageshwar, Dehradun, Nainital and Rudraprayag

building as shown in the photographs above. During the exit conference, the Department accepted that SCOVA did not have storage facility, making the purchase FOR SCOVA imprudent, leading to loss.

7.4 Purchase of equipment

Equipment worth Rs. 38.87 crore and Rs. 2.06 crore was purchased during 2005-06 and 2006-07 respectively. Scrutiny of purchase orders revealed that the prices of the equipment were inclusive of Comprehensive Maintenance Contract (CMC) for three years after expiry of the warranty period of one year. The rate of CMC ranged from 2.5 to 11 *per cent* of the total cost of the equipment; calculated on the conservative rate of 2.5 per cent, the cost of CMC would be Rs. 1.02 crore. Under the CMC the company was under obligation, as part of the agreement, to visit the installation site of the equipment on quarterly basis for preventive maintenance apart from attending the breakdown calls. Scrutiny revealed that the firms did not provide quarterly preventive maintenance for any of the equipment purchased. Further details on the exact amount of CMC paid to the firms and action taken against the defaulting firms, were not provided to Audit.

Conclusion

Six consultants were engaged at a total cost of Rs. 1.30 crore, but their reports were not accepted or put to use. The purchase procedures were in consonance with the manual. However, centralised purchase of drugs that were not linked to the actual field requirements, resulted in issue of Schedule H drugs to ANMs and pharmacists, excess purchase of AYUSH drug kits worth Rs. 1.01 crore and of ORS sachets, that were dumped in the backyard of the Society building. The SHS failed to enforce the conditions on maintenance in the contracts for procurement of equipment.

Recommendations

- Based on past consumption of drugs, VEN technique (vital, essential and non-essential) should be employed for estimating the requirements for procurement. Centralised purchases must be linked to field requirements.
- Maintenance of medical equipment must be accorded high priority to ensure availability of uninterrupted services.
- Accountability must be fixed for wasteful purchases and for issue of Schedule H drugs to those other than the RMPs. Internal controls in this regard need to be strengthened.

CHAPTER-8

INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Chapter 8 Information, Education and Communication (IEC)

IEC activities form a vital part of health programme as these create awareness and disseminate information regarding availability of and access to quality health care. In addition, these seeks to correct the behaviour patterns that have an adverse impact on health, particularly of the weaker sections of the society. In Uttarakhand, social issues such as early marriage, concepts of defilement that leads to seclusion of women after delivery and rejection of the first milk (it fortifies the child against infection and is rich in nutrition) before commencement of breast feeding are some of the areas that require IEC intervention.

Rupees 3.30 crore was spent on IEC activities during the period 2005-08. Major activities undertaken were:

- Media campaign on JSY through bus panels.
- Advertisements in newspapers for popularising the health programmes.
- Telecast of video spots on routine immunisation & institutional delivery through regional electronic media.
- Distribution of brochures and pamphlets and other modes like workshops, health melas.

JSY bus panel

Nutritional support campaign

Immunisation campaign

8.1 Planning

Annual action plans for IEC activities under NRHM are being drawn since the inception of the Mission. For the first time, a detailed action plan was being drawn indicating the proposed activities, time schedules, the estimated quantity and estimated cost, for the year 2008-09.

8.2 IEC Bureau

NRHM envisages the establishment of IEC Bureau for proper execution of the IEC activities in the State. The Bureau was not established in the State and all the positions of IEC personnel to be posted at the district and block level were lying vacant. At the State level, the IEC

officer was supported by one cameraman only and no accounts personnel is posted with the IEC officer. No basic records are found maintained for receipt and issue of IEC materials. In reply, the IEC officer intimated (October 2008) that organisational structure of the State IEC Bureau will be established after the service rules for different cadres are framed.

8.3 Distribution of funds

NRHM framework provides for IEC funds to be separately earmarked for district, block and village level in equal proportion. This was not in vogue; major part of IEC activities was being carried out in a centralised manner. Out of Rs. 3.30 crore released for IEC activities, Rs. 3.03 crore was expended at the State level.

Further, funds for IEC activities were routed through different State Programme Officers of RCH and Disease Control Programmes, instead of State IEC Officer, who was not in a position to keep track of funds received for IEC activities.

8.4 Impact assessment of IEC

None of the 1434 beneficiaries surveyed was aware of the programmes being run under NRHM, its objectives and the benefits available to the society, though a few of them had heard about NRHM and JSY, indicating poor coverage through IEC. Activities like magic show, folk show, nukkad natak, printed material, film shows, talk shows, wall paintings etc. were not conducted in any of the surveyed villages.

Conclusion

IEC assumes special emphasis in Uttarakhand in view of behavioural interventions required in the health sector. IEC Bureau was not established in the State and positions at various levels are vacant. There was lack of co-ordination between IEC programmes undertaken by different programme officers leading to inchoate control. IEC funds were utilised mainly at the State level.

Recommendation

- There is an urgent need for setting up IEC Bureau and filling up the posts lying vacant in the district and sub-district level. Funds should be routed through the State IEC Officer to marshal the efforts till the Bureau is established and impact assessment should be carried out to incorporate need based interventions in the State PIP.

CHAPTER-9

ACHIEVEMENT AGAINST PERFORMANCE INDICATORS

Chapter 9 Achievement against performance indicators

NRHM provides an overarching umbrella to most of the national programmes of health and family welfare. It also quantified the targets for reducing infant mortality rate (IMR), maternal mortality rate (MMR), total fertility rate (TFR), reducing morbidity and mortality rate and increasing cure rate of different endemic diseases covered under various national programmes.

The baseline indicators for most diseases presented a satisfactory picture for Uttarakhand. The areas of concern in the State were the MMR (number of deaths during pregnancies per 1 lakh), IMR (infant deaths per 1000) and TFR (number of children borne by a woman during her fertile period i.e. 15-45 years) which stood at 300, 41 and 2.5 against the NRHM targets of below 100, below 30 and 2.1 respectively.

9.1 Reproductive and child health (RCH) programmes

RCH-II is the biggest programme under NRHM and aims to reduce MMR, IMR and TFR and promote family planning, immunisation, etc. to achieve population stability.

The parameters that impact on IMR and MMR and the State's performance in relation to those parameters (as captured in NFHS-III data) are as follows:

Table-24

Indicators	Impact on		State level
	IMR	MMR	
I Maternal care			
Percentage of mothers below 18 years of age	√	√	16%
Percentage of women who are underweight	√	√	30%
Percentage of women who are anaemic	√	√	55%
Mean gap between children	√	√	32 months
Percentage of expectant mothers getting antenatal care (>2 check-ups)	√	√	45%
Percentage of mothers getting medical care after delivery-postnatal care (1 visit)		√	32%
Percentage of institutional deliveries to the total deliveries	√	√	36%
Percentage of assisted deliveries to the total deliveries	√	√	42%
II Child care			
Percentage of infants being breast-fed upto 6 months	√		>95%
Percentage of children covered under routine immunisation	√		60%
Percentage of infants (below 6 months) who are underweight			
a) Stunted	√		29%
b) Wasted	√		24%
c) Under-weight	√		31%
Percentage of children who are anaemic (6 months-59 months)	√		61%
III Family planning			
Percentage of married women not using any family planning method			41%
Percentage of women with 2 children and not wanting any more			86%
Percentage of currently married women who want to space their next child birth or stop child bearing entirely but are not using contraceptives (unmet need)			15%
Percentage of families where one spouse is sterilised			34%

Source: NFHS-III

The above data shows that the problem areas in the State leading to high IMR and MMR and the required interventions are:

- *Inadequate provision of antenatal care which was lower than the national average of 52 per cent.* One of the major aims of safe motherhood is to register all the pregnant women before they attain 12 weeks of pregnancy and provide them with services, such as, four antenatal check-ups for early detection of complications, 90 or more Iron Folic Acid (IFA) tablets, two doses of tetanus toxoid (TT) and advice on the correct diet and vitamin supplements and in case of complications refer them to more specialised gynaecological care.
- *Continued preference for home deliveries; the percentage of institutional deliveries being 36 per cent as compared to the national average of 39 per cent*. To encourage institutional delivery, JSY under NRHM provided all pregnant women in Empowered Action Group (EAG) States like Uttarakhand, cash compensation of Rs. 1400 for rural and Rs. 1000 for urban areas for undergoing institutional delivery irrespective of their age and number of previous children. The ASHA who encouraged the pregnant woman to have institutional delivery also received a cash compensation of Rs. 600 per case for rural and Rs. 200 per case for urban areas.
- *High incidence of malnutrition and anaemia in mothers and infants.* Anaemia is identified as an aggravating factor to haemorrhage, sepsis and toxaemia. The RCH II programme therefore emphasised administration of IFA for pregnant women daily for a period of 100 days.

9.2 Adequacy of antenatal care and institutional deliveries

The ANM is required to draw up a micro-birth plan comprising dates of ANC and TT injection, health centre for all referrals, place of delivery and expected date of delivery. The micro birth plan was not prepared in any of the three sampled districts. However, pregnant women, who were registered at health centres received at least one check-up. Details of other three check ups carried out at regular intervals were maintained only in district Pauri.

In district Pauri, around 96 *per cent* women received all four mandatory ante-natal check-ups.

The data collected from Pauri and Almora districts is tabulated below:

Table-25

	Years			
	2005-06	**2006-07**	**2007-08**	**Total**
District: Pauri				
1. No of registered pregnant women	13009	12541	12471	38021
2. No of institutional deliveries	2179	2954	4429	9562
3. Percentage of institutional deliveries (2 as % of 1)	16.7%	23.6%	35.5%	25.1%
4. No of assisted deliveries	7330	7289	5990	20609
5. Total recorded deliveries (2+4)	9509	10243	10419	30171
6. No of women registered but got no assistance (1-5)	3500	2298	2052	7850
7. Expected number of births on the basis of birth rate (2001 census as the base year; 21 % being birth rate)	16039	16320	16601	48960

District: Almora				
1. No of registered pregnant women	13021	12870	12193	38084
2. No of institutional deliveries	963	3193	4098	8254
3. Percentage of institutional deliveries (2 as %of 1)	7.4%	24.8%	33.6%	21.7%
4. No of assisted deliveries	9683	8262	7139	25084
5. Total recorded deliveries (2+4)	10646	11455	11237	33338
6. No of women registered but got no assistance (1-5)	2375	1415	956	4746
7. Expected number of births on the basis of birth rate (2001 census as the base year; 21 % being birth rate)	14510	14765	15019	44294

Source: DHS records, NFHS-III and Census-2001

Note: A similar analysis for Dehradun district was not done because of high levels of floating population in the district, which may make the analysis erroneous.

There has been an increase in the institutional deliveries over the first three years of implementation of NRHM from 16.7 *per cent* to 35.5 *per cent* and from 7.4 *per cent* to 33.6 *per cent* in Pauri and Almora respectively. However, what is worrisome is that on an average, every year 2617 and 1582 pregnant women registered in the health centres in Pauri and Almora districts respectively, went off the radar of the Government later and were not given any assistance. In the three sampled districts, the total number of such cases was 18922 annually. The number of unassisted births would be higher considering the reality that not all pregnant women would register themselves at the health facilities. The expected births as per the birth rate indicate a ball park figure for the incidence[48] of unregistered pregnant women (22 *per cent* and 14 *per cent*). Since the percentage of institutional deliveries was calculated on the number of registered pregnant women, the achievement against promotion of institutional deliveries would be lower than the reported figure of 25.1 *per cent* and 21.7 *per cent* respectively.

Moreover, registration of pregnant women showed a dip, although marginal, in two sampled districts in 2007-08 as compared to the figures for 2006-07, the difference being 677 in Almora district, which is a matter of concern.

Responses of 715 pregnant women were collected during the course of beneficiary-survey. It revealed that 3 *per cent* of pregnant women were not registered with any of the health facilities; while 39 *per cent,* 37 *per cent* and 21 *per cent* were registered in first, second and third trimester of pregnancy respectively. This implies that a majority of pregnant women were deprived of proper ante-natal care. Even in the case of registered women, the required number of check-ups and tests were not carried in 49 *per cent* of the cases.

9.3 Janani Suraksha Yojana (JSY)

Co-relation of JSY payments (incentive for opting for institutional deliveries) with the number of institutional deliveries showed that 31893 women, representing 27 *per cent* of the institutional deliveries did not receive the JSY payments as shown in the table below. The situation improved in 2007-08.

[48] Expected number of births on the basis of birth rate- number of registered pregnant women/ expected number of births* 100

Table-26

Year	No of institutional deliveries	JSY benefit received	
		Number of women	% of total institutional deliveries
2006-07	44830	25788	58 %
2007-08	71433	58582	82 %
Total	**116263**	**84370**	

Source: SHS

GOI had conveyed that payments made beyond 7 days or more after the delivery, amounted to "illegitimate utilisation of available funds". In the sampled districts, 183 payments were released beyond 7 days or more after the deliveries. The delays ranged from 8 days to 23 months as shown in the table below:

Table-27

Delays	No of cases delayed	% of total cases
7 days to 1 month	39	21%
1 month-3 months	42	23%
3 months-6 months	54	30%
6- 12 months	46	25%
12-24 months	2	1%

Source: DHS records

Individual JSY cards are required to be filled in by the ANMs/ ASHAs at the time of registration of the pregnant woman. In all the three sampled districts, it was only at the time of discharge of the woman after delivery, that these formalities were initiated and JSY payments were withheld/ delayed due to bureaucratic red tape. The other reason for non-payment and delay was because the health centres did not have funds under JSY. The allocation to the DHS and further down to the facilities for JSY was on an ad-hoc and lump sum basis with no correlation to the number of pregnant women registered at the health centres. NRHM allows the Government to provide an imprest of Rs. 10,000 with the ANMs to ensure payment of JSY money at the time of discharge. NRHM also suggested a voucher scheme by which a mother who is admitted for delivery will receive a voucher at the time of admission which can be encashed on discharge, thus obviating delays in processing of payments through doctors/ accountants etc. This was also not adopted; a pilot project through NGOs in two blocks of Haridwar district was taken up (2006).

There were instances where a woman who opted for delivery at a centre other than the one where she was residing, was turned away and asked to get the payment from the place she was residing. While this was against the objective of JSY, there does exist a risk of double payment if the payments are not linked to the original discharge slip. The voucher scheme, however, mitigates this risk.

JSY guidelines allow accreditation of private hospitals to cover them for payments under JSY. This was not done as of March 2008. The programme also requires that the facilities display the names of JSY beneficiaries on the notice board. In none of the sampled facilities, was this requirement met.

JSY is a very important component of the strategies to promote institutional deliveries and thus reduce MMR/ IMR. The instances of non-payment and delays defeat the objectives of the scheme. District authorities admitted (July 2008) to shortage of funds that led to delays in payment in JSY although in the exit conference, the Department blamed the district authorities for the lapse.

The responses of 715 pregnant women covered in the survey revealed that,

- 297 women (42 *per cent*) opted for institutional deliveries of which only 250 received the cash incentive; 23 received less than the due amount of Rs. 1400.
- 123 beneficiaries (49 *per cent*) received the cash incentive within the stipulated time i.e. within 7 days from the date of delivery, whereas cash incentives to 127 beneficiaries were disbursed with a delay ranging between 15 days to 180 days.
- Of the total institutional deliveries, cost of transportation was borne by the beneficiary herself in 96 *per cent* (286 cases) of the cases.
- Of the 386 home delivery cases, 62 *per cent* (239 cases) were conducted by 'untrained dais' and relatives and disposable delivery kits (DD kits) were not used in 73 *per cent* (280 cases) of the total home deliveries.
- Reason attributed by the beneficiaries for preferring home delivery were (i) poor financial condition, (ii) lack of transportation, (iii) non availability of facilities and lady doctor at health centres, (iv) traditional taboos and lack of motivation by health workers etc.
- Many pregnant women reported 'tips' being demanded by the hospital staff out of the JSY benefit.

9.4 Administration of Iron Folic Acid (IFA)

The SHS reported that over 53 *per cent* of the pregnant women received full coverage - one dose of IFA for 100 days during the three years (2005-08). The status of IFA distribution at the State level is tabulated below:

Table-28

Year	No. of pregnant women registered at health centres	No. of pregnant women who received 100 days of IFA tablets
2005-06	223440	191456
2006-07	226164	87489
2007-08	183902	57262
Total	**633506**	**336207**

Source: SHS

In the sampled districts, the status of pregnant women who received IFA administration was as under:

Table-29

Name of District	Year	No. of pregnant women registered	Stock position of IFA	No. of registered pregnant women received IFA administration	
				Prophylaxis	Therapeutic
Dehradun	2005-06	34719	63000	30248	769
	2006-07	30732	68000	13573	NA
	2007-08	36265	89600	14226	NA
Pauri	2005-06	13009	58000	13009	8556
	2006-07	12541	62100	12541	7560
	2007-08	12471	57400	6550	6320
Almora	2005-06	13021	52000	12452	NA
	2006-07	12870	63500	11177	NA
	2007-08	12193	81100	9522	NA
Total	**2005-06**	**60749**	**173000**	**55709**	**9325**
	2006-07	**56143**	**193600**	**37291**	**7560**
	2007-08	**60929**	**228100**	**30298**	**6320**

Source: DHS

Scrutiny revealed a trend of over-reporting in administration of IFA in the sampled districts. The stock position of IFA tablets in the three districts showed that there was a shortage of 93 to 98 *per cent* in the three districts during all the three years. With the available stock, only 5947 women (covering only 3.4 *per cent* of pregnant women registered in the three districts in three years) could have been given the full dose for 100 days, against the total reported figure of 146503 women, the reported figures being 25 times the actual.

The ANMs interviewed during the beneficiary survey also reported short supply of IFA tablets confirming the audit finding. Shortage of IFA tablets in the State with high incidence of anaemia is distressing. Further, the supply of IFA tablets was more to male hospitals as compared to female hospitals in the ratio of 74:26.

9.5 Other aspects of RCH

9.5.1 Tetanus toxoid injections (TT)

Two dosages of tetanus toxoid have been prescribed for all pregnant women to immunise the mother and neonates from tetanus. The three sampled districts reported coverage of 1.79 lakh pregnant women during 2005-08, which was marginally more than the number of registered pregnant women in these districts. However, in the immunisation cards attached with JSY cards, the date of administering the TT injections were not filled in. The beneficiary survey revealed that 12 *per cent* of the pregnant women were not administered the TT doses.

9.5.2 Postnatal care (PNC)

Postnatal services (PNC) include immunisation, monitoring the weight of the child, physical examination of the mother, advice on breast feeding and family planning etc. It was informed during field audit (April-June 2008) that PNC services were provided along with the OPD services but no separate records were found to be maintained for our verification.

9.5.3 Immunisation

Under the immunisation programme, infants are immunised against six preventable diseases, viz. tuberculosis, diphtheria, pertussis, tetanus, polio and measles. Table below gives the details on immunisation in Pauri and Almora districts:

Table-30

	Years			
	2005-06	**2006-07**	**2007-08**	**Total**
District Pauri				
No of registered pregnant women	13009	12541	12471	**38021**
Total number of children reported as immunised	16023	14930	14331	**45284**
Estimated no. of immunised children @ 70% immunization with registered pregnant women as the base	9106	8779	8730	**26615**
Expected number of births on the basis of birth rate (2001 census as the base year; 21 % being birth rate)	16039	16320	16601	**48960**
Expected level of immunization with expected number of births as the base	11227	11424	11621	**34272**
District Almora				
No of registered pregnant women	13021	12870	12193	**38084**
Total number of children reported as immunised	12109	11697	11168	**34974**
Estimated no. of immunised children @ 70% immunization with registered pregnant women as the base	9115	9009	8535	**26659**
Expected number of births on the basis of birth rate (2001 census as the base year; 21 % being birth rate)	14510	14765	15019	**44294**
Expected level of immunization with expected number of births as the base	10157	10336	10513	**31006**

Source: DHS records, NFHS-III and Census-2001

Note: A similar analysis for Dehradun district was not done because of high levels of floating population in the district, which may make the analysis erroneous

NFHS-III survey (2005-06) showed an immunization level of only 60 *per cent*. We assumed 70 *per cent* immunization level in the analysis in order to make conservative estimates of number of children who would have received routine immunisation by 2007-08, since the launch of NRHM. If the number of registered pregnant women was taken as the base, there was 70 *per cent* and 31 *per cent* over-reporting[49] of immunization achievements in Pauri and Almora districts respectively. Even if the expected births as per the birth rate were taken as the base, there would be an over-reporting[50] of 32 *per cent* and 13 *per cent* in the immunization level in Pauri and Almora district respectively.

Even by the most conservative estimates, the immunization levels being reported in the sampled districts, was exaggerated. During the exit conference, the Department admitted that there might be duplication in reporting of achievements and assured that the situation would improve after introduction of a networked MIS system.

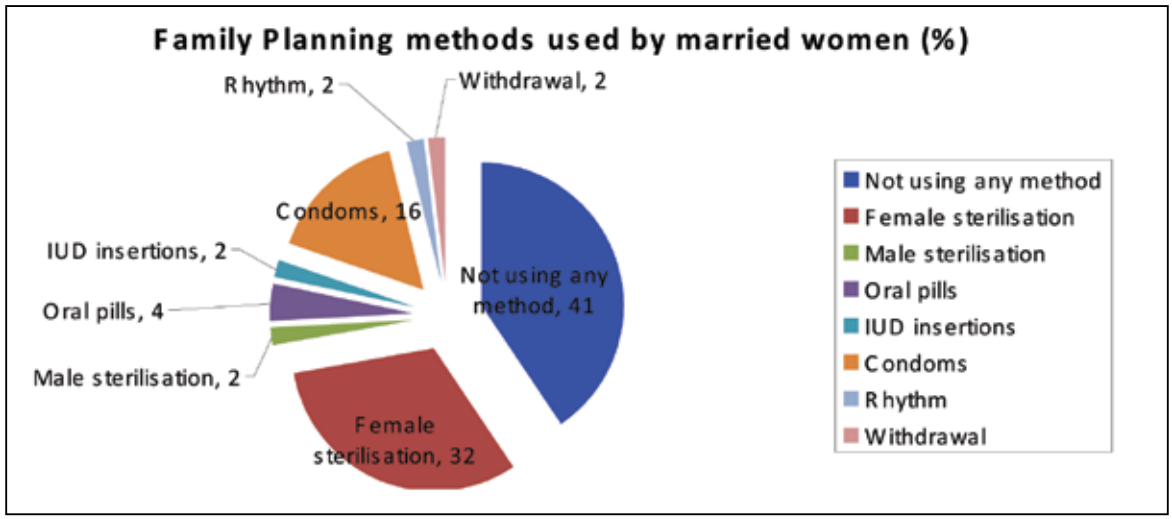
[49] Difference between expected levels of immunization with registered pregnant women as the base (A) and the reported immunization figures (B) as a % of A

[50] Difference between expected levels of immunization with expected births as the base (C) and the reported immunization figures (B) as a % of C

The State observed the stipulated number of programmes under pulse polio immunisation in all the three years; achievement against targets was almost 100 *per cent*. Out of three audited districts, two new polio cases were reported in district Dehradun.

9.5.4 Family planning

The family planning methods used by married women (NFHS-III) are depicted in the pie diagram below:



(a) Terminal method

The terminal method of family planning includes vasectomy for males and tubectomy for females. The status of target and achievement in various terminal methods in the State was as under:

Table-31

Year	Vasectomy		Tubectomy		Laparoscopy	
	T	A	T	A	T	A
2005-06	2713	1735	37529	33245	--	23145
2006-07	2720	1417	45563	31350	--	21423
2007-08	2476	2108	37147	32691	--	19730
Total	**7909**	**5260**	**120239**	**97286**		**64298**

Source: SHS

Audit findings in this regard are as under:

- Shortfall in achievement of sterilisation targets was maximum in two districts[51] at 56 and 33 *per cent*; in the other 11 districts, the shortfall ranged between 7 to 14 *per cent*.
- The proportion of vasectomy to the total sterilisation was only 3 *per cent* during 2005-08. Currently, 97 *per cent* of sterilisations are tubectomies which is a manifestation of the gender imbalance that plagues the programme. The proportion of vasectomy has not increased even after the launch of the non scalpel vasectomy.

[51] Haridwar and US Nagar

- While female sterilisation is the most commonly adopted method, the programme emphasises laparoscopic tubectomy as preferable to conventional tubectomy. The performance of laparoscopic tubectomy was 40 *per cent* of total female sterilisation during 2005-08 in the State.

(b) Spacing method

- NFHS figures show that 41 *per cent* of the married women do not use any family planning method; the unmet need was 15 *per cent*. However, the records in the three sampled districts showed a higher figure (ranging from 69 to 77 *per cent*) which needs reconciliation. The Uttarakhand Health and Population Policy targeted increase in modern contraceptive prevalence (CPR) to 49 *per cent* by 2006 and to 55 *per cent* by 2010.

Oral pills, condoms and intra uterine device (IUD) insertion are the three prevailing spacing methods of family planning to regulate fertility and promote couple protection ratio. Among the total spacing method users, around *39 per cent* accounted for condom users alone and 16 and 45 *per cent* accounted for oral pills and IUD users.

9.5.5 Administering Vitamin A

RCH II programme emphasised Vitamin A solution for all children less than 3 years of age. Prophylaxis against blindness amongst children due to deficiency of Vitamin A requires the first dose at 9 months of age along with measles vaccine and second dose along with DPT/ OPV and subsequently three doses at six monthly intervals. It was found that the supply of Vitamin A to the test checked districts during the last four years was sufficient only for 118000 doses (per dose of Vitamin A is 2ml) whereas the administration reported 326605 doses, over-reporting being 2.77 times the actual availability. In the beneficiary survey, 24 *per cent* of the ANMs reported non availability of Vitamin 'A' in the sub centres, which endorsed the audit findings.

9.6 National Programme for Control of Blindness (NPCB)

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

9.6.1 Cataract operations

Cataract operations are performed by Government doctors in Government hospitals, by NGOs and private practitioners in clinics and eye camps. The State achieved the targets fixed for cataract operation by GOI in the past three years. 600 cataract surgeries per 1 lakh population were performed in 2007-08. The following table gives the picture of cataract surgeries performed in the State:

Table-32

Year	Number of catops in Government sector		Number of catops by NGOs		Number of catops by private practitioners/ others		Total catops
	Number	Percentage	Number	Percentage	Number	Percentage	
2005-06	13897	33	15982	37	12672	30	42551
2006-07	12748	30	19109	45	10707	25	42564
2007-08	17315	31	25551	46	12416	23	55282
Total	**43960**	**31**	**60642**	**43**	**35795**	**26**	**140397**

Source: SHS

The workload was expected to be shared equally by the private and public sectors. While the NGOs and private sector exceeded the 50 *per cent* mark, Government lagged behind accounting for only 30 to 33 *per cent.*

The programme contemplated cataract operations performed in eye camps to be in the range of 20 *per cent* as it was felt that greater reliance on the camp methodology could be counterproductive[52]. However, 43 *per cent* of the operations were performed through camps during 2005-08.

9.6.2 Distribution of free spectacles

The programme envisaged screening for refractive errors among students and free distribution of spectacles to the students having refractive errors. During 2005-08, 26141 refractive errors were detected in the school health programme against which, 4677 spectacles were issued, thus covering less than 18 *per cent* of the need. In the sampled districts, the achievement was higher, covering 28 *per cent* of the need.

9.6.3 Eye bank

Establishment of eye bank is an important activity to address corneal blindness. The State has not established any eye bank as yet.

Conclusion

Infant and maternal mortality rates in the State were high and the coverage of pregnant women for antenatal care was inadequate. The State has high incidence of anaemia, the levels being 55 per cent and 61 per cent among women and children respectively. Erroneous reporting by the field units with the objective of over-stating their achievements undermines the objectives of the Mission and exposes the weakness of the monitoring mechanism. Achievements with regard to administering IFA tablets, Vitamin A drops and immunisation were grossly overstated.

Women continue to prefer home deliveries in the State although the percentage of institutional deliveries to total deliveries has increased with the introduction of JSY. Delays in payment of incentives beset the JSY programme. Much needs to be done to create awareness regarding adoption of family planning as 41 per cent of married couples are not using any family planning method. There was an unmet need of 15 per cent among those women who want to opt for family planning but have not adopted any method.

The State achieved the targets of cataract operations during the period 2005-08, with the NGOs and private practitioners accounting for 69 per cent of the total operations. Free

[52] In a cataract surgery camp (July 2008) at Kadavanur village, 50 out of 66 beneficiaries complained of complications such as pain, vomiting and blurred vision after the operation. Some of the patients may have lost their vision completely. This was apparently the result of poor oversight in the camp (Economic & Political Weekly: October 11-17, 2008)

Spectacles were not issued to all the students found with refractive errors in the school health programme. Eye bank was not established in the State.

Recommendations

- The data received from the field units must be validated and cross-verified and accountability should be fixed for false-reporting. The monitoring and reporting mechanism under the programme should be strengthened to ensure availability of reliable information with the State and District Health Societies.
- Institutional framework should be strengthened to mitigate delays and irregularities in grant of cash compensation under JSY. The voucher scheme, if implemented in the letter and spirit of JSY guidelines, will speed up the process and mitigate the risk of double payment.
- Funds for JSY to the DHSs (and to sub-district facilities) should be linked either to the targets or to the average achievement in the last quarter (indexed to anticipated increases) in order to ensure adequacy of funds and timely payment to the beneficiaries.
- There is a need to orient sterilisation of women through tubectomy to non-scalpel vasectomy of men. New technologies such as laparoscopy in tubectomy, new spacing methods etc. should be made available at prescribed levels in the health centres.
- In view of large number of unassisted births, it is recommended that dai kits with gloves, blade etc, may be given to the mothers opting for home deliveries, at the time of registration, to ensure at least minimum care. Birth attendants could be identified and co-opted into the system by providing adequate training.
- Given the high incidence of anaemia among women, the entire quantity of IFA tablets should be given to a pregnant woman at the time of the first visit, instead of providing them in batches at each antenatal visit.
- Eye surgeons should be posted on priority at CHCs to provide eye services to rural masses and students found with refractive errors should be provided with free spectacles. Efforts should be made to establish eye bank in the State.

Dehradun **(DEEPAK ANURAG)**
The **Accountant General (Audit), Uttarakhand**

Countersigned

New Delhi **(VINOD RAI)**
The **Comptroller and Auditor General of India**

ANNEXURE

Annexure-I (refer to Paragraph-2.1)

Sampled Districts and Health Centres for Performance Audit of NRHM

Sl. No.	Name of District	Name of CHC	Name of PHC	Name of SC
1.	**Dehradun**	Doiwala	Bhaniyawala	Jollygrant
				Harrawala
			Raipur	Nathuawala
				Ranipokhri
		Sahiya	Kalsi	Johdi
				Haiya
				Sainj
				Korwa
		Chakrata	Manthat	Quwansi
				Manthat
			Tyuni	Anu
				Virnad
2.	**Pauri Garhwal**	Pabau	Sikoo	Sikoo
				Pokhrikhet
		Thalisain	Chakisain	Paithani
				Syoli
		Bironkhal	Bainjro	Bainjro
				Syusi
3.	**Almora**	Dwarahat	Jalali	Jalali
				Kafda
			Binta	Binta
				Kuwali
		Bhikiyasain	Bhatronjkhan	Bhatronjkhan
				Sinar
			Vinayak	Sinora
				Vinayak
		Jayanti	Lamgadha	Jayanti
				Saharfatak
				Jaskot
				Jalna

Annexure II (refer to paragraph-6.8)

District wise details of MNGOs serving in the State

Sl. no	District	Name of MNGO serving
1	Almora	INHERE (Institute of Himalayan Environment Research and Education)
2	Bageshwar	Gramin Utthan Samiti
3	Champawat	Himalayan Study circle
4	Chamoli	Shri Bhuvneshwari Mahila Ashram
5	Dehradun	HIHT (Himalayan Institute and Hospital Trust)
6	Nainital	HIMANI
7	Pithoragarh	Himalayan Study circle
8	Pauri Garhwal	HIHT (Himalayan Institute and Hospital Trust)
9	Rudraprayag	Gomti Prayag Jan Kalyan Parishad
10	Tehri Garhwal	Garhwal community Development Society
11	Uttarkashi	Shri Bhuvneshwari Mahila Ashram

Glossary

AAP	Annual Action Plan
ABER	Annual Blood Examination Rate
AMG	Annual Maintenance Grant
ANC	Ante natal check
ANM	Auxiliary Nurse Mid-wife
API	Annual Parasitic Incidence
ASHA	Accredited Social Health Activist
AWW	Aanganwari Worker
AYUSH	Ayurvedic Unani Siddha Homeopathy
BCC	Behaviour change Communication
BPL	Below Poverty Line
CBO	Community Based Organization
CHC	Community Health Centre
CMC	Comprehensive Maintenance Contract
CMO	Chief Medical Officer
CMS	Chief Medical Superintendent
CPR	Contraceptive Prevalence Rate
DG	Director General
DGHS	Director General Health Services
DHAP	District Health Action Plan
DHM	District Health Mission
DHS	District Health Society
DOTS	Direct Observed Treatment Short Course
DPMSU	District Programme Management Support Unit
DPT	Diphtheria Polio Tetanus
DRDA	District Rural Development Agency
DSPRUD	Delhi Society for Promotion of Rational Use of Drugs
DSU	District Surveillance Unit
EAG	Empowered Action Group
FMG	Financial Management Reports
FNGO	Field Non Government Organization
FRU	First Referral Unit
GDP	Gross Domestic Product
HIHT	Himalayan Institute and Hospital Trust
HMC	Hospital Management Committee
ICDS	Integrated Child Development Scheme
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education and Communication
IFA	Iron Folic Acid
IFPS	Innovation in Family Planning Service
IMR	Infant Mortality Rate
INHERE	Institute of Himalayan Environment Research & Education
IPD	In Patient Department
IPHS	Indian Public Health Standards

IUD	Intra Uterine Device
JSY	Janani Suraksha Yojana
MCH	Mother and Child Health
MIS	Management Information System
MLA	Member Legislative Assembly
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MNGO	Mother Non-Government organization
MO	Medical Officer
MOIC	Medical Officer In-charge
MOU	Memorandum of Understanding
MPW	Multi Purpose Worker
MTP	Medical Termination of Pregnancy
NDCP	National Disease Control Programme
NFHS	National Family Health Survey
NGO	Non-Government Organization
NID	National Immunization Day
NIDDCP	National Iodine Deficiency Disorder Control Programme
NIHFW	National Institute of Health and Family Welfare
NLEP	National Leprosy Eradication Programme
NPCB	National Programme for Control of Blindness
NPCC	National Programme Coordination Committee
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
OT	Operation Theatre
PHC	Primary Health Centre
PHED	Public Health Engineering Department
PIP	Perspective Implementation Plan
PNC	Post Natal Check
PNDT	Post Natal Diagnostic Test
PPSWR	Probability Proportional to Size with Replacement
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RMP	Registered Medical Practitioner
RNTCP	Revised National Tuberculosis Control Programme
RTC	Regional Training Centre
RTI	Reproductive Tract Infection
SAD	State Allopathic Dispensary
SARC	State ASHA Resource Centre
SC	Sub Centre
SCOVA	Special Committee for Voluntary Action
SHM	State Health Mission
SHRC	State Health Resource Centre

SIP	Sector Investment Project
SNID	Sub National Immunization Day
SOE	Statement of Expenditure
SPMSU	State Programme Management Support Unit
SPP	State Population Project
SRS	Sample Registration System
SRSWOR	Simple Random Sampling without Replacement
SSU	State Surveillance Unit
STD	Sexually Transmitted Disease
STI	Sexual Transmitted Infection
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UAHFWS	Uttarakhand Health and Family Welfare Society
UC	Utilization Certificate
USAID	United States Agency for International Development
VEN	Vital, Essential and Non-essential
VHSC	Village Health and Sanitation Committee

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