SUPREME AUDIT INSTITUTION OF INDIA
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Report of the Comptroller and Auditor General of India on Public Health Infrastructure and Management of Health Services in West Bengal

Government of West Bengal

Report No. 3 of 2024

(Performance Audit - Civil)

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Preface

This Performance Audit Report for the year ended March 2022, has been prepared for submission to the Governor of West Bengal, under Article 151(2) of the Constitution of India, for being laid before the Legislative Assembly of West Bengal.

This Report contains significant results of the 'Horizontal Performance Audit on Public Health Infrastructure & Management of Health Services', in terms of the State's performance in achieving objectives based on Indian Public Health Standards, National Health Policy, Sustainable Development Goals, Norms issued by the World Health Organisation, relevant Regulations/ Acts/ Rules/ Accreditation Standards/ Guidelines/ Orders *etc.*, framed or issued in this regard.

The instances mentioned in this Report are those which came to notice in the course of test-audit, in regard to the Horizontal Performance Audit on Public Health Infrastructure & Management of Health Services, covering the period 2016-17 to 2021-22, in the State of West Bengal, as well as those which had come to notice in earlier years, but could not be reported in the previous Audit Reports; instances relating to periods subsequent to 2021-22, have also been included, wherever necessary.

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

Executive Summary

Performance Audit on Public Health Infrastructure and Management of Health Services

Executive Summary

Health is among the most important parameters for ascertaining the quality of human life. It is, therefore, essential to ensure a sound healthcare system which is easily available and accessible. A three-tier system, comprising of the primary, secondary and tertiary healthcare systems is in place in the State, to provide quality medical care services, to the people residing in the State. In view of the importance of the health sector, this performance audit on the 'Public Health Infrastructure and Management of Health Services', was conducted. Important findings, relating to different aspects of the healthcare infrastructure and services, are as under:

Human Resources

- The Department of Health & Family Welfare (Department) did not have the comprehensive position of cadre-wise sanctioned strength for different cadres of healthcare staff. Further, the Department failed to substantiate the data furnished relating to cadre-wise sanctioned strength by making available the relevant Government Orders.
- There was a significant shortage in the cadre of Medical Officers (Specialists & General Duty Medical Officers). At the State level, the shortage of Medical Officers (Specialists) was 36 *per cent* and that of Medical Officers (General Duty Medical Officers) was 49 *per cent*, while in the test-checked districts, the shortage in the cadre of Medical Officers was around 41 *per cent.*
- As many as 89 *per cent* of the Sub-Centres (SCs) in the State did not have any Health Worker (Male). The shortage of Medical Officers was 54.27 *per cent,* while shortage of specialist MOs was 91.14 *per cent,* in the Community Health Centres (CHCs) of the State. In the District Hospitals, the shortage of General Duty Attendants was 63.20 *per cent*.
- No pharmacists had been posted in 13 *per cent* of the PHCs. Shortages of Staff Nurses were 46 *per cent,* whereas 92.35 *per cent* of the PHCs in the State were running without either a male or a female Health Assistant. Shortages in respect of Laboratory Technicians (LTs) were 75 *per cent.*
- Of the 348 CHCs in the State, there were no Staff Nurses posted in 51 CHCs. Twenty-nine CHCs had no Pharmacists, 30 CHCs had no LTs, 251 CHCs had no Radiographer, 93 CHCs had no Ophthalmic Assistant and 341 CHCs had no O.T. Attendants, posted.
- Shortage of Administrative staff of almost 80 *per cent* and shortage of Para medical staff of 44 *per cent,* were a matter of concern in the District Hospitals (DHs).

(Paragraphs 2.1 – 2.7)

Delivery of Healthcare Services

At Sub-Centres (SCs):

- MOs did not visit 45 *per cent* of the SCs, even once a month. Though 55,000 deliveries had been conducted at homes, across the State, in the last three years, none of the SCs had been upgraded with facilities for conducting deliveries. The Traditional Birth Attendants and ASHA were not even trained with necessary skills, in 12 *per cent* of the SCs. Moreover, 99.56 *per cent* of home deliveries were not assisted by Skilled Birth Attendants.

(Paragraph 3.1.1)

At Primary Health Centres (PHCs):

- Accident and other Emergency/ Casualty services were not available in 71 *per cent* of PHCs; while, Emergency Obstetric Care, including surgical interventions like caesarean section and other medical interventions were not available in 90 *per cent* of the PHCs in the State. As high as 70 *per cent* of the PHCs did not have any functional beds. Of the pregnant women registered, 35 *per cent* had not got checked-up even once, by MOs-PHC, out of their four scheduled ante-natal check-ups.

(Paragraph 3.1.2)

At Community Health Centre (CHCs):

- Of the 348 CHCs in the State, Emergency Obstetric Care, including surgical interventions like caesarian sections and other interventions, were absent in 284 CHCs. There was no provision of new-born care in 22 CHCs, while emergency care to sick children had not been provided in 51 CHCs.

(Paragraph 3.1.3)

At District Hospitals (DHs):

- A number of essential and desirable services were not being rendered by the secondary level hospitals of the State. Super-specialty services (except oncology) were not available in 89 *per cent* to 100 *per cent* of the DHs of the State. In 13 *per cent* cases of childbirth of the five sampled districts, mothers had been discharged within 48 hours of delivery, involving risk of complications.

(Paragraph 3.1.4)

- As high as 285 CHCs of the State (81.89 *per cent*) did not have a Blood Storage Unit (BSU).

(Paragraph 3.2.5)

- The State did not have "108 - Emergency Response Ambulance Service", for providing integrated medical, police and fire emergency services.

(Paragraph 3.2.7)

Drugs

- The Department did not have any documented drug policy, as of March 2022.
- Quality testing reports of 30 *per cent* of the drugs samples sent for testing, had not been received from the laboratories, as of March 2022.
- Considerable delays in uploading the test result of samples found non-standard, had resulted in the consumption of non-standard drugs, by patients.
- In District Hospitals, 63 *per cent* of notified essential drugs had never been procured. Many of the other drugs had remained out of stock for long periods.

(Paragraphs 4.1 - 4.3)

Equipment

- Quality in providing health services, especially in diagnosis of patients, was compromised, as 23 *per cent* of bio-medical equipment had never been calibrated.

(Paragraph 4.4.4)

- The Sub-Centres suffered in the absence of 23 *per cent* to 88 *per cent* of essential equipment. In the test-checked PHCs, shortages of such equipment stood at 36 *per cent* to 92 *per cent*. Acute shortage of essential equipment in CHCs, coupled with complete absence of certain sets/ types of equipment, was also observed.
- The District Hospitals (test-checked) suffered shortages in crucial critical care equipment, in the Special Newborn Care Unit (SNCU), Intensive Care Units (ICU), OT, Cardiopulmonary, Radiology, laboratory, ENT *etc*.
- ICU ventilators and Oxygen Concentrators received under PMCARES were not made operational and were found lying packed in test-checked hospitals.
- In the State, 57.33 *per cent* of the Pressure Swing Absorption (PSA) oxygen generating plants, received under PMCARES and Corporate Social Responsibility (CSR) scheme, were either not commissioned and/ or not functional as of December 2023.

(Paragraph 4.5)

Healthcare Infrastructure

- There was a significant shortage of primary healthcare facilities in the State. The shortage of Primary Health Centres (PHCs) ranged up to 56 *per cent*.

(Paragraph 5.1)

- The State was running 16 *per cent* of its CHCs with less than the prescribed number of 30 beds. There was no provision of beds in 34 *per cent* of the PHCs. Further, In-Patient Departments (IPDs) were not functional, despite the availability of beds, in 35 *per cent* of the PHCs. Labour Rooms (LR) were not available in 52 *per cent* of the PHCs. Only 11 new sub-centers and three new Primary Health Centres had been set up in the State in the last six years.

(Paragraph 5.2)

- Of the 41 Multi/ Super Speciality Hospitals (SSHs), set up by the State for providing speciality and super-specialty healthcare services at the district/ sub-district levels, 63 *per cent* did not have any super-specialty services available. 50 *per cent* of the ICUs and 37 *per cent* of CCUs, planned to be set up in the SSHs, were not made functional.

(Paragraph 5.4)

- None of the five Trauma Care Facilities (TCFs), approved under 11th Five Year Plan, could be made optimally functional, even after 15 years, due to acute shortages of equipment and manpower. Instances of submission of false utilisation certificates (₹ 2.86 crore), incurring of doubtful expenditure (₹ 2.47 crore) and diversion of funds (₹ 2.42 crore), were noticed in the utilisation of central grants. The entire GoI grants, for construction of five TCFs (₹ 8.41 crore) and six Burn units (₹ 12.68 crore), under the 12th FYP, lay unutilised.

(Paragraph 5.5)

Financial Management

- Departmental spending showed that, while the revenue expenditure of the department had gradually increased (125 *per cent*) over 2017-22, capital expenditure, in the health sector, had experienced a consistent decrease (12 *per cent*) over the same period.

(Paragraph 6.1.1)

- As of 2021-22, the level of health sector expenditure in the State (1.23 *per cent* of GSDP) was far below the target (2.5 *per cent* by 2025) set in the National Health Policy (NHP). Further, health sector expenditure, during 2017-22, had ranged between 4.24 *per cent* and 6.37 *per cent,* of the overall budgetary expenditure of the State, against the target of achieving more than eight *per cent* by 2020.

(Paragraph 6.1.2)

Implementation of Centrally Sponsored Scheme

- Progress under the National Programme for Control of Blindness & Visual Impairment (NPCB&VI) had not been assessed. Adequate Vision Centres had not been set up. Vacancies of 44.26 *per cent* existed in the cadre of Medical Technologist (Optometry). Insufficient number of cataract surgeries and inadequate Corneal transplantation, were observed.

(Paragraph 7.1)

- Adequate screening of the population was not done, as prescribed under the National Leprosy Eradication Programme. A considerable number of persons, *prima facie* suspected for leprosy during the screening, were not medically examined for confirmation. The prevalence rate of leprosy was more than the norms prescribed, in six districts of the State.

(Paragraph 7.2)

- There was inadequate screening under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). Lack of investigation facilities, day care facilities, palliative care and capacity building initiatives, were observed across the

clinics. Prescribed approaches of public awareness activities had not been adequately adopted and there was lax monitoring.

(Paragraph 7.3)

- The District database on elderly had not been prepared by the District Cells, under the National Programme of Healthcare for the Elderly (NPHCE). Home-based care, provided to the elderly, was highly inadequate. Weekly Geriatric Clinics had not been organised by any of the Primary Health Centres. Services under the scheme had not been provided by 67 *per cent* of the CHCs, keeping the elder population of 16 districts out of coverage under the programme.

(Paragraph 7.4)

Enforcement of Regulatory Mechanism

- No comprehensive roadmap was devised under National Quality Assurance Scheme (NQAS), by the State Quality Assurance Committee (SQAC), for attaining the National Standards within any measurable timeframe.

(Paragraph 8.1)

- Defining of targets/ roadmaps for corrective actions could not be set, as conduct of review meetings, by the State level SQAC/ SQAU or district level DQACs, was grossly deficient and the assessed scores of the public health facilities, under NQAS, were not reviewed by the SQAC.

(Paragraph 8.1.1)

- Maternal deaths had not been reviewed in almost 39 *per cent* of cases, in the test-checked hospitals, in contrast to the State level figures. The prescribed mechanism of centrally reviewing maternal deaths by the State level Task Force, to identify gaps, prepare action plans and execute them, was not followed.

(Paragraph 8.2.1)

- Disregarding its own formulated guidelines, no child deaths had ever been reviewed by the Department, at any level. There was no documentary evidence of functioning of the State Level Task Force, for child death reviews.

(Paragraph 8.2.2)

Sustainable Development Goals (SDGs)

- There was no approved Sector Paper on Health and Family Welfare, to integrate the 2030 agenda of Sustainable Development Goals (SDG).

(Paragraph 9.1)

- Government of West Bengal (GoWB) had neither framed any Health Policy and/ or Standards, nor had it expressly followed the Indian Public Health Standards (IPHS) for the State. Consequently, no long/ short-term plans could be framed for implementation of the strategic goals, or for collating the Department's budgeting process with the plan. In the absence of any set of standards against which achievements could be gauged, no efforts were made to identify the gaps in various facets of healthcare services.

(Paragraph 9.2)

The State Government may ensure:

1. ***The H&FW Department may formulate and maintain definite sanctioned strength across cadres for each heath care facility on priority basis to ensure adequacy of human resources.***
2. ***The H&FW Department may ensure filling up of the vacant posts and engaging Medical and Para Medical Staff against the shortages, on priority basis, at the various healthcare facilities of the State.***
3. ***Redeployment of additional staff, from facilities with excess manpower, to facilities running with shortage of manpower, may be ensured.***
4. ***Availability of Emergency Obstetric Care, including surgical interventions like caesarean section and other medical interventions, may be ensured in selected PHCs and in all CHCs, in the State.***
5. ***Provisions for new-born care and emergency care, for sick children, may be ensured, in all CHCs.***
6. ***The H&FW Department may maximise coverage of institutional deliveries and also ensure that all home deliveries are attended by Skilled Birth Attendants.***
7. ***Basic essential diagnostic facilities may be ensured at all levels of healthcare units.***
8. ***The H&FW Department may formulate a Comprehensive Drugs Policy, ensuring continuing supply of essential and lifesaving drugs, monitoring of the quality of medicines and dissemination of the results of such tests to all health facilities, at the earliest, to avoid consumption of non-standard medicines, by persons consuming such medicines.***
9. ***Appropriate steps may be taken to make all essential equipment available in health facilities, to ensure proper diagnosis and treatment.***
10. ***Maintenance of bio-medical equipment may be ensured, to avoid instances of the equipment going out of order and lying non-functional, hindering services.***
11. ***Centralised monitoring may be carried out, to ensure that the bio-medical equipment undergoes periodic calibration, ensuring error-free diagnosis and treatment.***
12. ***The H&FW Department may ensure setting up of the required new health facilities, throughout the State to reduce the shortages of health facilities in the State. Infrastructure deficiencies, in the existing healthcare facilities, may also be plugged.***
13. ***Department may ensure that adequate funds are allotted in Health Sector and are utilized in a more efficient manner, as envisaged in the National Health Policy and other relevant guidelines.***
14. ***The H&FW Department may ensure that adequate Vision Centres are set up, vacancies in regard to Optometrists are addressed, and cataract and corneal surgeries are conducted at an optimal level.***

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

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

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

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

19. ***The H&FW Department may ensure conduct of regular meetings, by the State Level and District Level Committees, for discussion on the information received as Key Performance Indicators (KPIs), from the health facilities, for identifying and plugging gaps, for maintaining the healthcare services at an optimal level.***

20. ***The H&FW Department may ensure that all maternal deaths are reviewed, for detection of the underlying causes and take remedial measures for minimising maternal mortality in the State. The H&FW Department may also ensure immediate commencement of reviews of the child deaths in the State.***

21. ***The H&FW Department, Govt. of West Bengal (the nodal department) may either expressly follow the Indian Public Health Standards or set its own standards.***

22. ***The H&FW Department may conduct a 'Gap Analysis' exercise to arrive at the shortages in infrastructure, man-power and services, against the set standards and prepare long and short-term health action plans, based on the gap analysis exercise. The H&FW Department may ensure that the annual budgeting process is driven by long and short-term plans.***

23. ***The H&FW Department may ensure integration of SDG goals with the health action plans and setting of intermediate targets, ensuring achievement of SDG goals by 2030.***

CHAPTER 1

Introduction

1 Chapter Introduction

The Health & Family Welfare Department, Government of West Bengal (Department), is required to cater to the healthcare needs of a population of 9.13 crore[1] (comprising 6.22 crore rural and 2.91 crore urban population), which is fourth highest among all the States in India.

A three-tier system, comprising of the primary, secondary and tertiary healthcare system, is in place, to provide medical care services to the people of the State. The Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) {known as Rural Hospitals (RHs)/ Block Primary Health Centres (BPHCs) in West Bengal} are primary level healthcare units, which provide healthcare services to the rural population. As of March 2022, 10,368 SCs, 916 PHCs and 348 CHCs, had been created in the State.

Patients requiring more serious healthcare attention are referred to the second tier of the healthcare system, by the primary healthcare units, which comprises of District Hospitals (DHs), Sub-divisional Hospitals (SDHs) and State General Hospitals (SGHs). At present 18 DHs, 36 SDHs and 24 SGHs, are functioning in the State. Secondary Healthcare hospitals provide preventive, promotive and curative healthcare services, to the population.

A Tertiary healthcare hospital is a hospital that provides tertiary care, *i.e.* healthcare from specialists, in a large hospital, after referral from the Primary and Secondary healthcare hospitals. As of March 2022, 65 tertiary healthcare hospitals (Medical College and hospitals: 18, other teaching hospitals: six and Multi Super Speciality Hospital: 41), had been established in the State.

1.1 Norms and rules for health facilities in the hospitals

1.1.1 Indian Public Health Standards

The Indian Public Health Standards (IPHS), for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals, were published in January/ February 2007 and have been used as the reference point for public healthcare infrastructure planning and up-gradation in the States and UTs. IPHS are a set of uniform standards, envisaged to improve the quality of healthcare delivery in the country. IPHS norms were revised in 2012, keeping in view the changing protocols of the existing programmes and the introduction of new programmes, especially for Non-Communicable Diseases. IPHS guidelines act as the main impetus for continuous improvement in quality and serve as the benchmark for assessing the functional status of health facilities.

[1] *according to Census 2011*

1.1.2 Clinical Establishments Act

The West Bengal Clinical Establishments (Registration & Regulation) Act, 2010 was passed by the State legislature and notified[2] in October 2010, to provide for registration and regulation of all clinical establishments and to prescribe the minimum standards of facilities and services to be provided by them in West Bengal.

The Act aims at introducing a registration system to improve the quality of healthcare, through standardization of healthcare facilities, by prescribing minimum standards of facilities and services for all categories of healthcare establishments (except teaching hospitals) and ensuring compliance of other conditions of registration, like compliance to standard treatment guidelines, stabilization of emergency medical condition, display of range of rates to be charged, maintenance of records *etc.*

Subsequently, The Clinical Establishments (Registration, Regulation and Transparency) Act, 2017, was passed by the State legislature and notified[3] in March 2017. As per Section 62(1) of the new Act, the old Act, *viz.* the West Bengal Clinical Establishments (Registration & Regulation) Act, 2010, was repealed.

In exercise of the powers conferred by Section 59 of the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act, 2017 (West Bengal Act IV of 2017), in supersession of all earlier rules, the Government of West Bengal adopted the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Rules, 2017, notified[4] in August 2017.

1.2 Organizational set-up

The Health and Family Welfare (H&FW) Department is responsible for the management of Primary Healthcare centres, Secondary Healthcare centres and hospitals, including District hospitals and Tertiary level Healthcare hospitals.

The Principal Secretary, H&FW Department, at the Government level, and the following directorates under the H&FW Department, are responsible for different functions, for providing health services:

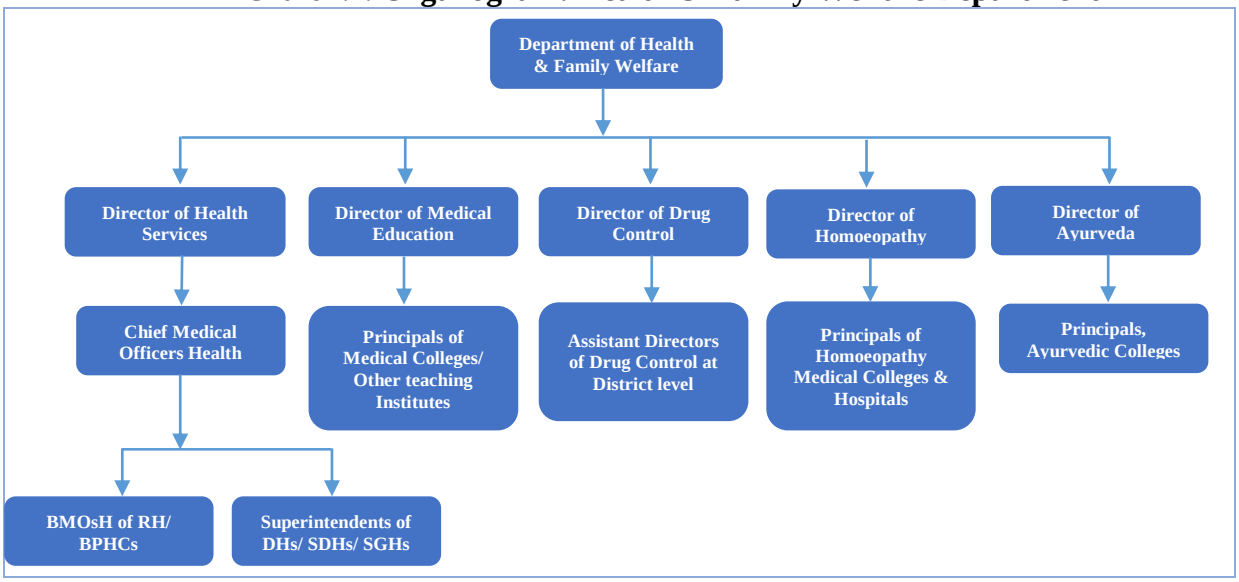
Table 1.1: Health Directorates and facilities thereunder

Sl. No.	Name of the Directorate	Responsible for functioning of
1	Directorate of Health Services	Sub-centres/ hospitals at Primary and Secondary level health services in the State
2	Directorate of Medical Education (DME)	Medical Colleges, hospitals attached to the Medical Colleges and other hospitals teaching certain specialities
3	Directorate of Drug control	Monitoring the quality, safety, efficacy and prices of drugs and licensing of drugs.
4	Directorate of Ayurveda	Ayurvedic Colleges and Dispensaries
5	Directorate of Homoeopathy	Homoeopathy Colleges and Dispensaries

Source: Administrative Report, 2010-11, H&FW Department

[2] *Gazette notification No.1412L dated 05.10.2010*
[3] *Gazette notification No. 301-L dated 17th March, 2017*
[4] *Gazette notification No. HF/ O/ GA/ 2603/ HF/ SPSRC/ 28/ 2017/ Pt.V-A Dated: 21.08.2017*

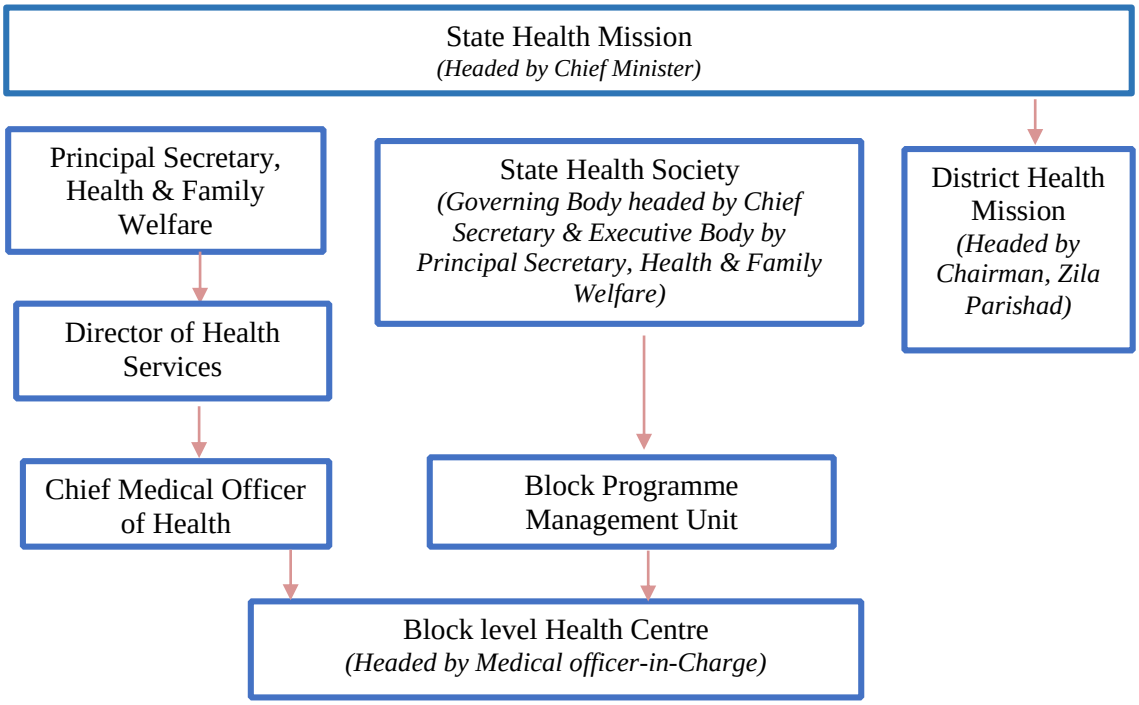
Chart 1.1: Organogram: Health & Family Welfare Department



At the district level, the Chief Medical Officer of Health (CMOH) remains in overall charge of the district. Additionally, Superintendents are responsible for the functioning of District hospitals/ Sub-Divisional Hospitals/ State General Hospitals. Under Primary level health services, Block Medical Officers, Health, (BMOH) are posted in every Block Primary Health Centres (BPHCs)/ Rural Hospitals (RHs). Primary Health Centres and Sub-Centres under BPHCs/RHs are to operate at village level. Sub-Centres at the village level are headed by Auxiliary Nurse Midwives (ANMs).

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

Chart 1.2: Structure of the National Health Mission (NHM)



1.3 Health Indicators

1.3.1 West Bengal indicators compared with National Health Indicators

A comparison of various indicators prevailing in West Bengal, with the National level figures arising out of the Sample Registration System (SRS[5]) and National Family Health Surveys-4 & 5 (NFHS-4 & 5), showed the following position:

Table 1.2: India and West Bengal Health Indicators, as per SRS & NFHS

Sl. No.	Indicator	SRS (2016-18)		SRS (2018-20)	
		West Bengal	India	West Bengal	India
1	Maternal Mortality Ratio (MMR)	98	113	103	97
		SRS 2019		SRS 2020	
2	Crude Death Rate	5.3	06	5.5	06
3	Crude Birth Rate	14.9	19.7	14.6	19.5
Sl. No.	Indicator	NFHS-4 (2015-16)		NFHS-5 (2019-21)	
		West Bengal	India	West Bengal	India
1	Sex ratio of the total population (females per 1,000 males)	1,011	991	1,049	1,020
2	Sex ratio at birth for children born in the last five years (females per 1,000 males)	960	919	973	929
3	Total fertility rate (children per woman)	1.8	2.2	1.6	2
4	Neonatal mortality rate (NNMR)	22	29.5	15.5	24.9
5	Infant mortality rate (IMR)	27.5	40.7	22	35.2
6	Under-five mortality rate (U5MR)	31.8	49.7	25.4	41.9
7	Mothers who had an antenatal check-up in the first trimester (in *per cent*)	54.9	58.6	72.6	70
8	Mothers who had at least 4 antenatal care visits (in *per cent*)	76.4	51.2	75.8	58.1
9	Mothers whose last birth was protected against neonatal tetanus * (in *per cent*)	95.4	89	94.6	92
10	Mothers who consumed iron folic acid for 100 days or more when they were pregnant (in *per cent*)	28	30.3	62.5	44.1
11	Mothers who consumed iron folic acid for 180 days or more when they were pregnant (in *per cent*)	6	14.4	30.8	26
12	Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card (in *per cent*)	97.4	89.3	98.4	95.9
13	Mothers who received postnatal care from a doctor/ nurse/ Lady Health Visitor (LHV)/ ANM/ midwife/ other health personnel within 2 days of delivery (in *per cent*)	61.1	62.4	68	78
14	Average out-of-pocket expenditure per delivery in a public health facility (₹)	7,919	3,197	2,683	2,916
15	Children born at home who were taken to a health facility for a check-up within 24 hours of birth (in *per cent*)	4.6	2.5	8.8	4.2
16	Children who received postnatal care from a doctor/ nurse/ LHV/ ANM/ midwife/ other health personnel within 2 days of delivery (in *per cent*)	NA	NA	76.8	79.1
17	Institutional births (in *per cent*)	75.2	78.9	91.7	88.6
18	Institutional births in public facility (in *per cent*)	56.6	52.1	72.4	61.9
19	Home births that were conducted by skilled health personnel ** (in *per cent*)	6.8	4.3	2.6	3.2
20	Births attended by skilled health personnel (in *per cent*)	81.6	81.4	94.1	89.4
21	Births delivered by caesarean section (in *per cent*)	23.8	17.2	32.6	21.5
22	Births in a private health facility that were delivered by caesarean section (in *per cent*)	70.9	40.9	82.7	47.4
23	Births in a public health facility that were delivered by caesarean section (in *per cent*)	18.8	11.9	22.9	14.3

*Source: NFHS 4 & 5 Reports; *Includes mothers with two injections during the pregnancy for their last birth, or two or more injections (the last being within 3 years of the last live birth), or three or more injections (the last being within 5 years of the last birth), or four or more injections (the last being within 10 years of the last live birth), or five or more injections, at any time prior to the last birth; **Doctor/ nurse/ LHV/ ANM/ midwife/ other health personnel*

[5] *The Sample Registration System is a large-scale demographic sample survey conducted in a random sample of villages and urban blocks.*

1.4 Audit Objectives

The Performance Audit on Public Health Infrastructure and Management of Health Services was taken up to assess:

- Whether comprehensive strategies and plans had been developed and adequate funding in the health sector had been made available, for ensuring accessible, affordable and quality health services;
- Whether the health sector had adequate resources, *viz.* infrastructure, human resources, drugs, consumables, equipment *etc.*, as per prescribed norms and whether these resources were utilized efficiently and effectively;
- Whether the management and delivery of the prescribed healthcare services was adequate, efficient and effective;
- Whether the important National Health Programmes had been implemented effectively and Government of India assistance had been utilised to provide universal access to affordable and quality healthcare services in the hospitals;
- Adequate monitoring and regulatory systems had been put in place and had been effectively followed, for ensuring delivery of quality healthcare to the public and
- Whether spending on health had improved the health and wellbeing of people.

1.5 Audit Criteria

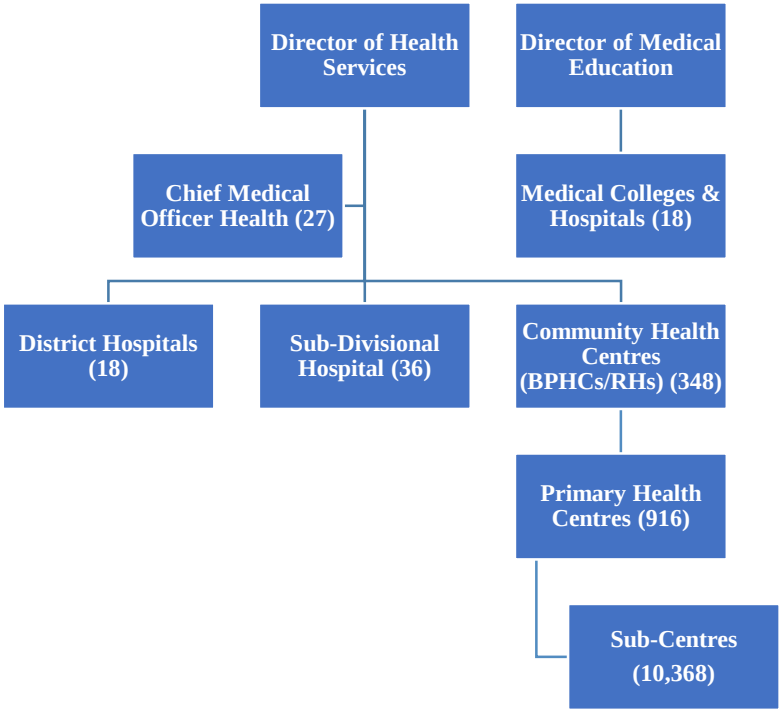
The audit comments are framed with reference to the following criteria:

- Indian Public Health Standards
- National Health Policy
- Sustainable Development Goals
- Professional Conduct, Etiquette and Ethics Regulation, 2002
- West Bengal Clinical Establishment (Registration, Regulation and Transparency) Act, 2017
- Drugs and Cosmetics Act, 1940
- Pharmacy Act, 1948 and Pharmacy Practice Regulations, 2015
- Bio-Medical Waste Management Rules, 2016
- Standards of National Accreditation Board for Testing and Calibration Laboratories
- Standards of National Accreditation Board for Hospitals and Healthcare providers
- Atomic Energy Radiation Protection Rules, 2004
- WHO norms
- Minimum Standards Requirement Regulations, 1999
- Guidelines/ Orders/ Rules (if any), issued by the State Govt., from time to time.
- NHM Assessors' Guidebook for Quality Assurance in public health facilities

1.6 Scope of the performance audit and methodology

The performance audit covered the period from FY 2016-17 to FY 2021-22. Records were checked in the Health and Family Welfare (H&FW) Department, at the Government level and the Directorate of Health services (DHS), Directorate of Medical Education (DME), Directorate of Drug Control, State Programme Management Unit (SPMU), State Health & Family Welfare Samiti for NHM and Central Medical Stores, under the Dy. Director (Equipment & Stores), for tendering and procurement of drugs at the State level.

Chart 1.3: Number of three tier health care facilities at District level



Apart from the above, at the implementation level, records were also examined in the offices of the Chief Medical Officers of Health (CMOH), along with MCHs, DHs/ SDHs/ Block Primary Health Centres (BPHCs)/ Rural Hospitals (RHs), Primary Health Centres (PHCs)/ Sub-centres *etc*. Records of the West Bengal Medical Services Corporation Limited (WBMSCL), the executing agency for construction works, were also checked. Databases/ digital records, maintained at the State/ Directorate/ Hospital levels, were also examined.

Apart from scrutiny of records in the aforementioned offices/ hospitals, joint physical verification, with the departmental officials, to verify the position regarding delivery of services and progress of construction works, along with interview/ survey of the beneficiaries/ stakeholders *etc.*, have also been carried out. Photographic evidence was also collected, to support the audit observations.

1.7 Audit Sampling

Out of 27 Health Districts, five Districts[6], selected by adopting stratified sampling techniques, were covered in the review.

Selection of all units, within the selected districts, was also based on the simple random sampling technique, as detailed below. Health facilities run by Municipal Corporations/ Municipalities/ other ULBs, were excluded from the scope of the review.

[6] *Bashirhat Health District, Jalpaiguri, Uttar Dinajpur, Paschim Medinipur and Purulia*

- Five Offices of the Chief Medical Officers, Health (out of 27 CMOsH in the State), of the selected Districts were covered, as a compulsory selection.

➢ ***Selection of Primary Health Care Facilities:***

- Two of the CHCs, (known as BPHCs/ RHs in the State), in each of the five districts, were selected through simple random sampling which constituted a sample size of 10 CHCs, out of 348 in the State.
- Two Primary Health Centres, under each of the above BPHCs/ RHs were also selected by means of simple random sampling constituting 19 PHC[7]s out of 916 in the State.
- Total 38 Sub-Centres were further selected out of 10,368 SCs in the State, by selecting two SCs under each of the selected PHCs, using simple random sampling methods ***(Appendix 1.1)***.

Table 1.3: Selected districts along with selected BPHCs/ RHs/ PHCs

Sl. No.	Districts	Name of the BPHCs/ RHs		Name of the PHCs		Selected SCs
1.	Jalpaiguri	i.	Sulkapara RH (Nagrakata)	i.	Dhumpara	8 SCs by selecting 2 SCs under each selected PHC
				ii.	Looksan	
		ii.	Odlabari BPHC (Mal)	i.	Moulani	
				ii.	Rajdanga Dakshin Hanskhali	
2.	Uttar Dinajpur	i.	Itahar RH	i.	Marnai	6 SCs by selecting 2 SCs under each selected PHC
				ii.	Surun	
		ii.	Kunor BPHC (Kaliaganj)	i.	Majhiar (only one PHC)	
				ii.	--	
3.	Bashirhat HD	i.	Rudrapur RH (Baduria)	i.	Bajitpur	8 SCs by selecting 2 SCs under each selected PHC
				ii.	Masia	
		ii.	Sandelerbil RH (Hingalganj)	i.	Jogeshganj	
				ii.	Hingalganj	
4.	Paschim Medinipur	i.	Salboni RH	i.	Godapiasal	8 SCs by selecting 2 SCs under each selected PHC
				ii.	Pirakata	
		ii.	Sabang RH	i.	Kharika	
				ii.	Mohar	
5.	Purulia	i.	Kushtor RH (Purulia-II)	i.	Chayanpur	8 SCs by selecting 2 SCs under each selected PHC
				ii.	Hutmura	
		ii.	Muradih RH (Santuri)	i.	Balitora	
				ii.	Santuri	

➢ ***Selection of Secondary Health Care Facilities:***

- Out of total 54[8] Secondary Level Hospitals, two District Hospitals, falling in the two selected districts and three Sub-Divisional Hospitals, in other three selected districts, where Districts Hospitals were not present, were selected, as below:

Table 1.4: List of selected DHs & SDHs

Sl. No.	Selected District	Name of the DH/ SDH
1.	Jalpaiguri	Jalpaiguri District Hospital
2.	Uttar Dinajpur	Islampur Sub-Divisional Hospital
3.	Bashirhat	Bashirhat DH
4.	Paschim Medinipur	Ghatal SDH
5.	Purulia	Raghunathpur SDH

[7] *Kunor BPHC of Uttar Dinajpur had only one PHC under its control.*
[8] *18 District Hospitals and 36 Sub-Divisional Hospitals*

➢ *Selection of Tertiary Health Care Facilities:*

- For each of the selected districts, the Medical College & Hospitals, falling in the districts, were compulsorily selected. Out of 18 MCHs in the State, four were thus selected, as mentioned in **Table 1.5**.

Table 1.5: List of selected Medical College and Hospitals

Sl. No.	Selected District	Name of the Medical College and Hospital selected
1.	Kolkata	SSKM & IPGMER
2.	Jalpaiguri	No MCH
3.	Uttar Dinajpur	Raiganj Medical College
4.	Bashirhat	No MCH
5.	Paschim Medinipur	Medinipur Medical College & Hospital
6.	Purulia	Purulia District Medical College

CHAPTER 2

Human Resources

2 Chapter Human Resources

Audit Objective: Whether the health sector had adequate human resources as per prescribed norms and whether these resources were utilised efficiently and effectively.

The Department of Health & Family Welfare (Department) did not have the comprehensive position of cadre-wise sanctioned strength for different cadres of healthcare staff. Further, the Department failed to substantiate the data furnished relating to cadre-wise sanctioned strength by making available the relevant Government Orders. There were shortages of Medical Officer, Specialist Medical Officer, Nursing Staff, Pharmacist, Health Worker (Female)/ Health Assistant (Male) and Laboratory Technician (LT). Shortage was particularly acute in respect of Specialist doctors. Lopsided posting patter further worsened the availability scenario across all cadres in the health facilities of the State.

2.1 Sanctioned strength for different cadres of healthcare staff

In respect of the Performance Audit, the Department of Health & Family Welfare furnished the cadre-wise position of sanctioned strength for Human Resources to be deployed in healthcare facilities, from time to time. The Department, though, could not make available at any stage the Government Orders specifying the sanctioned strength for different cadres of healthcare staff. The basis of the furnished sanctioned strength, as stated, was a general guiding Order issued in 1991, which laid down a standard guiding scale for staffing pattern in different cadres based on bed-strength of the State hospitals. However, no supporting documentation based on the prescribed scale, showing derivation of the furnished position of sanctioned strength, could be shown to Audit. Further, the rationale that the sanctioned strength for different cadres was based on the Order issued in 1991, did not hold ground, as the Order *ibid* did not include the standard guiding scale for the sanctioned strength of the Teaching Hospitals & that of the Medical Colleges & Hospitals.

2.2 Acute vacancy in the posts of Specialist Medical Officers and General Duty Medical Officers

In the process of delivery of healthcare services, the cadre of Medical Officers {Specialist Medical Officers (Specialists)/ General Duty Medical Officers (GDMOs)} enact a very crucial role. So, it was essential that the position of sanctioned strength of this cadre was comprehensively available with the Department and that the sanctioned posts were duly filled up. Audit analysis in this regard disclosed the following:

- The data relating to sanctioned strength (SS) and Men-in-Position (MIP), as furnished by the Department from time to time, is as follows:
  - At the time of commencement of audit, no information (except for Professors/ Assistant Professors[9] *etc.*) of Specialists/ GDMOs could be

[9] *In respect of Medical Colleges & Hospitals, data of Professors/ Associate Professors, etc. have been compiled with Specialists and GDMOs*

provided by the Department about the Medical Colleges & Hospitals (MCHs).

- Further persuasion elicited a reply (26 June 2023) from the Department which showed the following status against the 18 MCHs in the State:

Table 2.1: SS *vis-à-vis* MIP: Specialists/ GDMOs

Specialists		GDMOs	
SS	**MIP**	**SS**	**MIP**
2,360	1,732	**1,871**	548

Source: Data furnished by the H& FW Department

The above data was also not in complete shape as, of the 18 MCHs, data was absent in respect of seven MCHs[10] for Specialists/ three MCHs[11] in respect of GDMOs.

- In a further reply (05 September 2023), it was stated that the Department did not have the figures of sanctioned strength in respect of Specialists/ GDMOs in MCHs and the men-in-position was only 806 (which excluded figures of Kalyani JNM MCH). The reply also stated that the bifurcation of Specialists and/or GDMOs was not available with the Department. It was not clarified though, as to how transfer posting of staff were being affected by the Department/ Directorate, without being aware of the sanctioned strength.

- In respect of other test-checked hospitals, the sanctioned strength (as per the data furnished by the Department) when verified against sanctioned strength (furnished by some of the test-checked units) and with Health Management Information System (HMIS), showed material variation in figures:

Table 2.2: Variation in sanctioned strength of Specialists & GDMOs

Name of test-checked units	Specialists			GDMOs		
	Departmental SS	SS as per the respective hospital	HMIS	Departmental SS	SS as per the respective hospital	HMIS
Bashirhat DH	48	52	60	19	24	23
Sulkapara RH (Nagrakata)	3	NA	0	2	5	8
Odlabari BPHC (Mal)	3	NA	1	2	NA	7
Itahar RH	3	0	0	2	10	0
Kunor BPHC (Kaliaganj)	3	5	0	2	8	0
Rudrapur RH (Baduria)	3	5	11	3	12	10
Sandelerbil RH (Hingalganj)	3	0	2	2	4	7
Salboni RH	3	16	3	3	10	0
Sabang RH	3	7	3	3	6	7
Kushtor RH (Purulia II)	3	0	0	2	NA	0
Muradih RH (Santuri)	3	NA	0	2	4	0
Total:	**78**	**85**	**80**	**42**	**83**	**62**

Source: Data furnished by the H& FW Department/ Respective hospital and HMIS data
** Departmental SS was as of August 2021, while SS (as per test-checked units) and HMIS was as of March 2022*

It would emerge from above that the data furnished by the Department regarding sanctioned strength was not comprehensive and even the data of Health

[10] *i) Bankura Sammilani MCH; ii) Kolkata National MCH; iii) SSKM, Kolkata; iv) Medinipur MCH; v) Kalyani JNM MCH, vi) College of Medicine and Sagar Dutta Hospital and vii) MJN MCH, Coochbehar*
[11] *i) Kolkata National MCH; ii) SSKM, Kolkata and iii) MJN MCH Coochbehar*

Management Information System (HMIS), as available up to the category of District Hospitals (from the lowest category of healthcare facilities), also had plenty of blank fields.

So, to assess the vacancy position, the following considerations were adopted, to ensure that the vacancy position was assessed in a conservative manner:

- The blank fields of HMIS were supplemented with data of respective health facilities as furnished by the Department to arrive at a HR status. This apart, where the aggregated essential strength of HR as prescribed by the IPHS was more than departmental sanctioned strength, IPHS figures were considered[12] for analysis in respect of the District Hospitals.
- In respect of Medical College & Hospital, figures of the teaching cadres (Professors/ Associate Professors/ Assistant Professors) have been compiled with Specialists and GDMOs as provided by the department for the analysis.

In cognizance of the considerations referred *ibid*, it was observed that there existed an overall shortage of 36.33 *per cent* in respect of Specialists and 49.19 *per cent* in respect of GDMOs in the State, as tabled below:

Table 2.3: Position of vacancies against Specialists and GDMOs

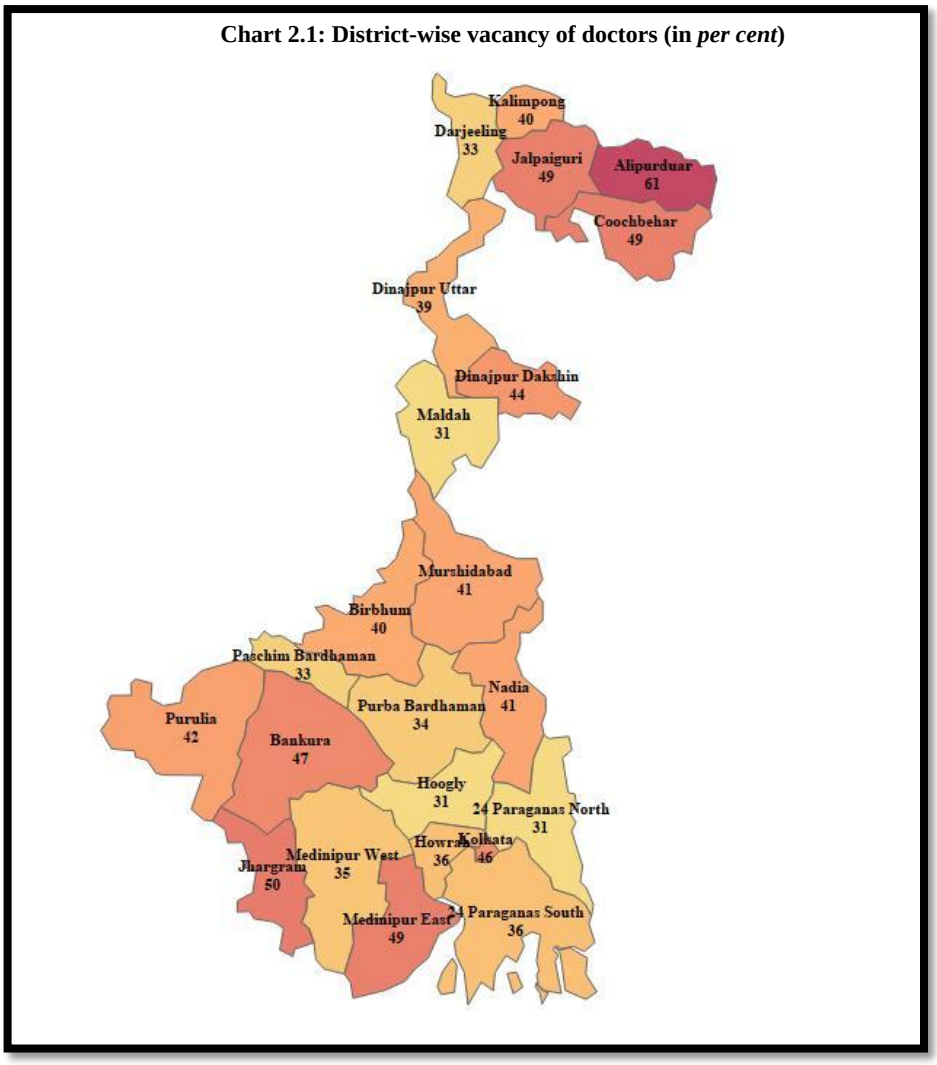
Type of Health Facility	Specialists				GDMOs			
	Sanctioned Strength (SS)	*Men-in-Position (MIP)*	Shortage	Percentage	Sanctioned Strength (SS)	*Men-in-Position (MIP)*	Shortage	Percentage
Public Health Centre	0	0	0	0	1,582	974	608	38.43
Community Health Centre	1,740	154	1,586	91.15	1,813	1,250	563	31.05
Sub-Divisional Hospital	1,469	1,061	408	27.77	672	300	372	55.36
District Hospital	958	727	231	24.11	394	145	249	63.20
Medical College and Hospital	6,926	5,121	1,805	26.06	1,871	548	1,323	70.71
Total	**11,093**	**7,063**	**4,030**	**36.33**	**6,332**	**3,217**	**3,115**	**49.19**
Total Sanctioned Strength								**17,425**
MIP								**10,280**
Vacancy (in *per cent*)								**41**

Source: Data furnished by the H& FW Department and HMIS data

As shown above, the overall shortage of Medical Officers (comprising both Specialists and GDMOs), constituted as high as 41 *per cent*, which when analysed district-wise through the following chart, showed an uneven vacancy position across the districts. The chart below would also show that in eight districts *viz.* Alipurduar, Jhargram, Jalpaiguri, Coochbehar, Medinipur East, Bankura, Dinajpur Dakshin and Purulia there was a shortage of doctors more than that of the overall shortage of 41 *per cent* in the State.

[12] *As 15 of the 18 DHs had bed strength far above the maximum strength of 500 as suggested in IPHS.*

Chart 2.1: District-wise vacancy of doctors (in *per cent*)



Source: Data furnished by the H& FW Department and HMIS data

The status of availability of Specialists, GDMOs, Nurses, Paramedics and other staff have been analysed separately (for each category of healthcare facilities) and observations made in subsequent *paragraphs 2.3 to 2.7*.

2.3 Human Resources of Sub-Centres

In order to provide the essential services, different categories of Sub-Centres were to have the following cadres and strength, as per IPHS:

Table 2.4: Requirement of Human Resources at the Sub-Centres

Type of Sub-Centre	Type-A Sub-Centre^		Type-B (MCH[13]) Sub-Centre^	
Staff	**Essential**	**Desirable**	**Essential**	**Desirable**
ANM/ Health Worker (Female)	1	2	2	-
Health Worker (Male)	1		1	
Staff Nurse/ ANM (if Staff nurse is not available	-	-	-	1*
Safai Karmachari#	1 (Part time)	-	1 (Full time)	-

Source: IPHS norms

^ Type-A: all services except conducting of deliveries; Type-B: all services including deliveries

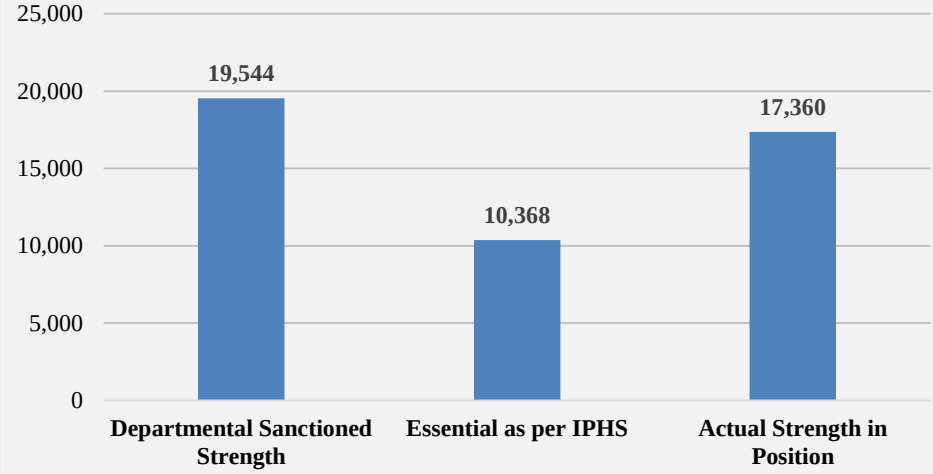
** If the number of deliveries at the SC was more than or equal to 20 in a month*

 # To be outsourced

[13] *Maternal & Child Health*

- Review of HMIS data in respect of 10,368 SCs showed that there was no shortage of ANMs/ Health Workers (Female), compared to the essential strength, as per IPHS. A shortage of 11.17 *per cent* was, however, noticed against the strength sanctioned by the department, as of March 2022, in the State, as shown below:

Chart 2.2: Position of ANMs/ Health Workers (Female)



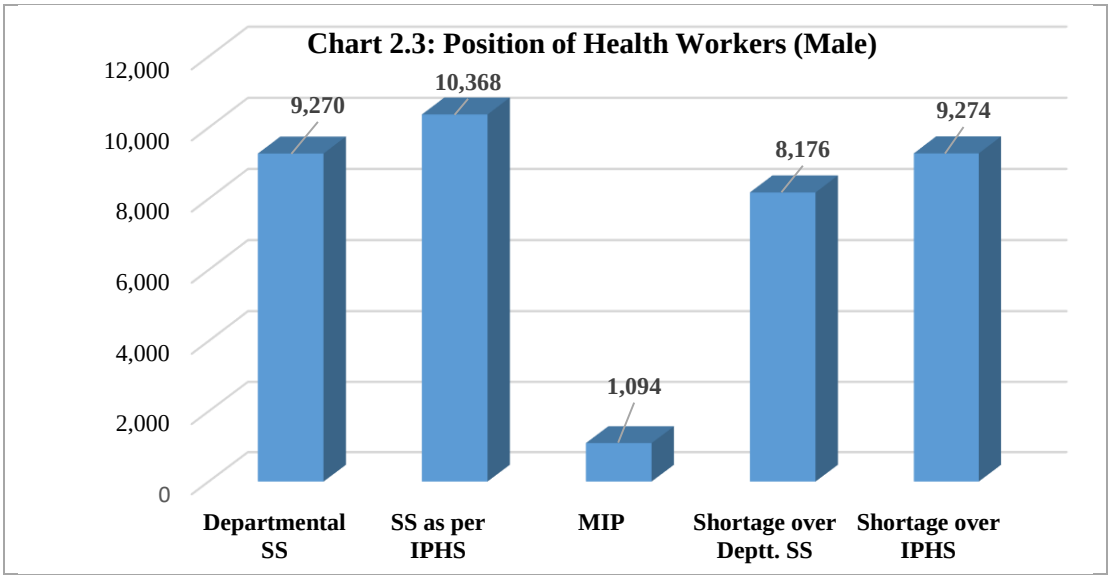
Source: HMIS data

Thus, there was a shortage of 11.17 *per cent* (2,184) against the departmental sanctioned strength, while the strength of ANM/ Health Workers (Female), compared to the IPHS, was in excess by 6,992 (67.44 *per cent*).

However, a unit-wise scrutiny of availability of the ANM strength revealed that:

- Though, the MIP of ANMs was more than one per Sub-Centre (SC) in the State, 357 SCs were running without posting of any ANM.
- There were two or more ANMs posted in 7,247 SCs. However, none of the SCs was rendering delivery (Type-B) services.
- In 140 SCs, the departmental sanctioned strength was more than that prescribed as desirable in the IPHS (2 ANMs). It was also noticed that, in 21 SCs, the number of ANMs posted was more than the strength sanctioned by the Department itself, by one or two ANMs.
- It was also noticed that, in six SCs, there was no sanctioned post for ANM and ANMs had been engaged through outsourcing, in these SCs. In the Kotulpur SC, Bankura, four ANMs had been posted through the outsourcing mode.
- Test-check of 38 SCs also revealed that there was no shortage of ANMs/ Health workers (Female), compared to the essential strength. However, though there were two ANMs, posted in 26 out of the 38 (68.42 *per cent*) test-checked SCs, none of them was rendering delivery (Type-B) services ***(Appendix 2.1)***.

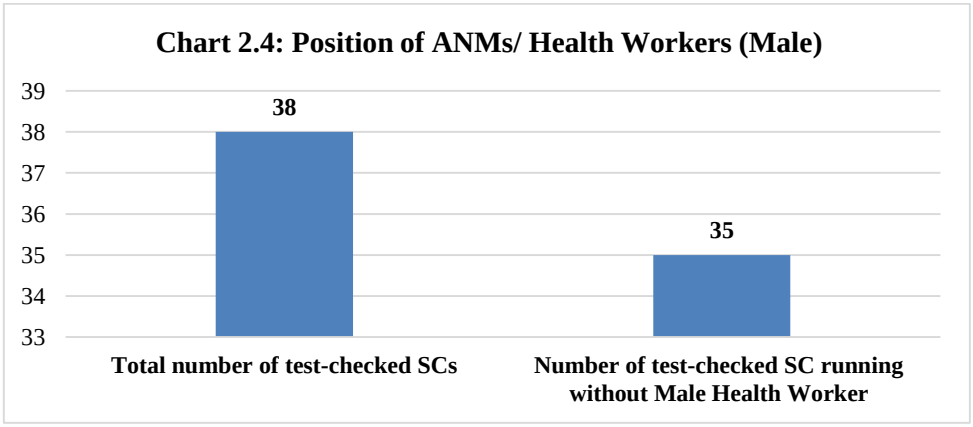
- Significant shortages were noticed in respect of Health Workers (Male) in the State, as shown in **Chart 2.3**.



Source: HMIS data

Thus, the shortage was 88.20 *per cent* against the departmental sanctioned strength and 89.45 *per cent* against IPHS.

- IPHS prescribes one Health Worker (Male) per SC. However, the Department had sanctioned posts only against 9,270 SCs[14].
- In 223 SCs, the strength of Health Workers (Male), sanctioned by the Department, was two, which was more than that prescribed in the IPHS.



Source: Records of the test-checked Sub-Centers

In the 38 test-checked SCs, 35 SCs (92.10 *per cent*) were running without any Health Worker (Male) ***(Appendix 2.1)***.

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

2.4 Human Resources of Primary Health Centres

IPHS suggested two types of PHCs. PHCs with a delivery load of less than 20 deliveries in a month are Type-A PHCs, while PHCs with a delivery load of 20 or more deliveries in a month are Type-B PHCs. The manpower requirements, for both these categories, was as follows:

[14] *Information furnished (September 2023) by Department*

Table 2.5: Requirement of Human Resources at the Primary Health Centres

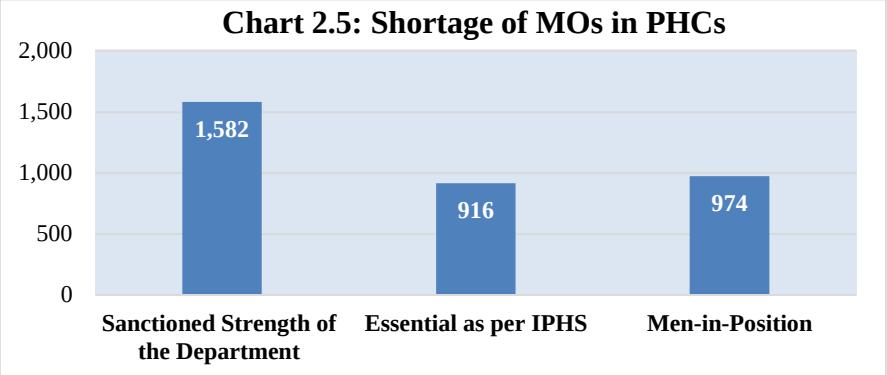
Staff	Type-A		Type-B	
	Essential	Desirable	Essential	Desirable
Medical Officer- MBBS	1	1	1	2#
Medical Officer- AYUSH		1^		1
Accountant-*cum*-Data Entry Operator	1	1	1	1
Pharmacist	1	1	1	1
Pharmacist- AYUSH		1		1
Nurse- Midwife (staff nurse)	3	4	4	5
Health Worker (Female)	1*	1*	1*	1*
Health Assistant (Male)	1	1	1	1
Health Assistant (Female)/ Lady Health Visitor	1	1	1	1
Health Educator		1		1
Laboratory Technician	1	1	1	1
Cold Chain & Vaccine Logistic Assistant		1		1
Multi Skilled Group D worker	2	2	2	2
Sanitary Worker cum Watchmen	1	1	1	2
Total:	**13**	**18**	**14**	**21**

*Source: IPHS norms; *For the Sub-Centre area of the PHC. # If the delivery case load is 30 or more per month, one of the two medical officers (MBBS) should be female. ^ To provide choices to the public, wherever an AYUSH public facility is not available in the near vicinity.*

The Department did not furnish the list of PHCs designated/ earmarked as Type-A or Type-B among the 916 PHCs in the State, though sought for. For the purpose of this analysis, the 229 PHCs, which had been categorised as Delivery Points'[15] in the HMIS data, were considered as Type-B PHCs, while the remaining PHCs (687) considered as Type-A PHCs.

- The analysis showed considerable shortage in the cadre of Medical Officers (MOs), in the PHCs of the State as shown below:

Chart 2.5: Shortage of MOs in PHCs



Source: HMIS data

- There existed a shortage of 38.43 *per cent* against the Departmental sanctioned strength.
- The total number of MOs, available in the State (974), was more than the prescribed essential strength of one MO per PHC (916). However, 180 PHCs (19.65 *per cent*) had been left without posting of any MO.
- Two or more MOs, were found to have been posted in 100 such PHCs which had not been categorised as Type-B PHCs (Delivery Points).
- In 186 PHCs, the strength of MOs, as sanctioned by the department, was more than the desirable strength suggested (two) in IPHS.

[15] *PHCs designated as 'Delivery Point' are equipped with infrastructure and facilities to conduct deliveries of child.*

- The sanctioned strength ranged between three and seven MOs in each PHC. In six PHCs, the MOs in position were more than the sanctioned strength of MOs in these PHCs.
- Seven of the test-checked PHCs (out of 19 test-checked PHCs), were running without any MOs, while two MOs each were found to have been posted in four such test-checked PHCs which had not been categorised as Type-B PHCs ***(Appendix 2.2)***.

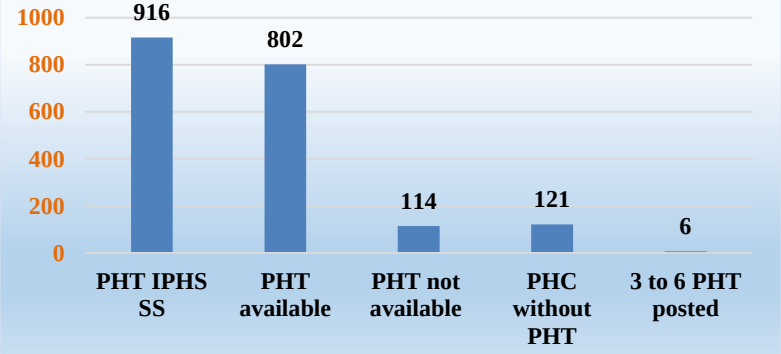
➢ Review of the availability of Pharmacists, in the PHCs of the State, showed as below:

Table 2.6: Availability of Pharmacists in the PHCs

Essential/ Desirable strength as per IPHS (1 Pharmacist/ PHC)	Total number of Pharmacists available in PHCs	Shortage of Pharmacists in PHCs	Percentage of Shortage
916	**802**	**114**	**12.44 *per cent***

Source: HMIS Data State Level

Chart 2.6: Position of Pharmacist (PHT) in PHCs



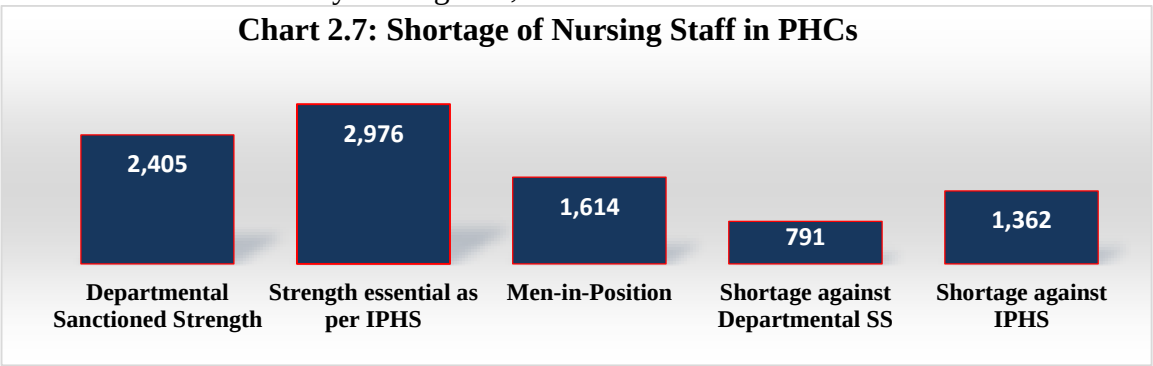
Source: HMIS data

With the shortage of 114 pharmacists, 121 PHCs were running without any pharmacists having been posted therein. This was because of excess posting (ranging up to three) of Pharmacists, in six PHCs.

Six of the test-checked PHCs (*32 per cent*) were running without any Pharmacists ***(Appendix 2.3)***.

➢ Considering 687 PHCs as Type-A and 229 PHCs as Type-B PHCs, the requirement of essential and desirable number of **Staff Nurses (SN)**, required for the 916 PHCs of the State, *vis-à-vis* the availability thereagainst, was as below:

Chart 2.7: Shortage of Nursing Staff in PHCs



Source: HMIS data

The shortage of staff nurses, in the PHCs, was nearly 46 *per cent*, as compared to the essential strength, as per IPHS norms.

Detailed scrutiny revealed that:

- No SNs had been posted in 109 Type-A and 20 Type-B PHCs. the deliverable services as prescribed in IPHS for a PHCs, especially the Type-B, which were supposed to manage deliveries, could not be rendered.

- On the other hand, the departmentally fixed sanctioned strength was even more than the prescribed desirable strength of four and five (as per IPHS), in 15 Type-A PHCs and 50 Type-B PHCs, respectively. In 38 Type-A PHCs, more than three SNs and in 56 Type-B PHCs more than four SNs were posted, which was more than the prescribed essential number, as per IPHS.
- Instances of posting of SNs in access of the strength sanctioned by the department, were noticed in nine Type-A and 08 Type-B PHCs.
- In the 19 test-checked PHCs, out of 12 Type-A PHCs, 6 PHCs had less than the essential number of three SNs while three Type-A PHCs had more than the essential number (ranging between four and five). One Type-B PHC (Hutmura, Purulia) had only two SNs posted in the PHC ***(Appendix 2.2)***.

➢ Acute shortages against the Health Worker (Female), Health Assistant (Male) and Health Assistant (Female) were noticed in the PHCs:

Table 2.7: Shortages of Health Workers/ Assistants in the PHCs

Post	No. sanctioned by Department	Essential No. as per IPHS	Total MIP	Shortage against Departmental SS	Shortage against IPHS
Health Worker (Female) (@1/ PHC)/ Health Assistant (Male) (@ 1/ PHC)/ and (Female) (@1/ PHC)	598	2,748	268	330 (55.18 *per cent*)	2,480 (90.25 *per cent*)

Source: HMIS Data

HMIS data revealed that no posts of HW(F) and HA (one Male and one Female) had been sanctioned by the department, against 725 and 742 PHCs, respectively. The shortage of posts, against the IPHS norms, was as high as 90 *per cent*.

No HW(F) had been posted in 850 PHCs (92.79 *per cent*). Further, 846 PHCs (92.35 *per cent*) did not have either a male or a female HA.

More than one HW(F) was posted in 24 PHCs; the number of HW(F) posted ranged up to 19 in Nijirhat PHC, Dinhata-II, Coochbehar. Seven and eight HA(M) were posted in two PHCs.

In the 19 test-checked PHCs of the selected districts, none had HW(F), while 17 of the PHCs were running without posting of either HA(F) and/ or HA(M) ***(Appendix 2.3)***.

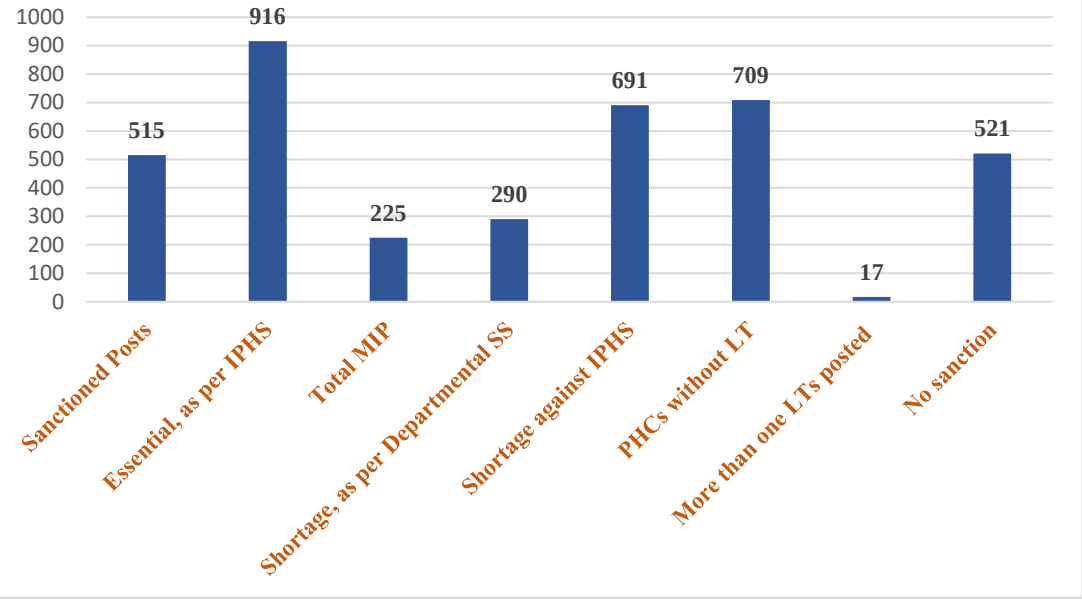
➢ The shortage in respect of **Laboratory Technicians (LTs)** was 75 *per cent*, as shown below:

Table 2.8: Shortage of Laboratory Technicians (LT) in the PHCs

Sanctioned Posts	Essential No. as per IPHS	Total MIP	Shortage against Departmental SS	Shortage against IPHS
515	916	225	290 (56.31 *per cent*)	691 (75.43 *per cent*)

Source: HMIS Data State level

Chart 2.8: Position of LAB Technicians (LTs) in the PHCs



Source: HMIS data

There was no LT in 709 PHCs, while 17 PHCs had more than one LT posted. No departmental sanction was found against the post of LTs, in the HMIS data, in case of 521 PHCs.

In the test-checked PHCs, 11 PHCs (63.15 *per cent*) had no LT posted, while two PHCs (Looksan and Dhumpara under Jalpaiguri) had two LTs (each) posted ***(Appendix 2.3)***.

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

2.5 Human Resources for Community Health Centres (CHCs)

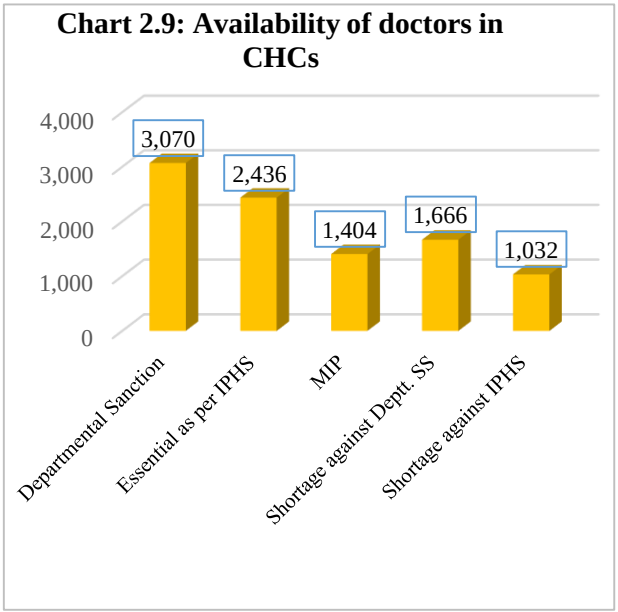
➢ Availability of Medical Officers

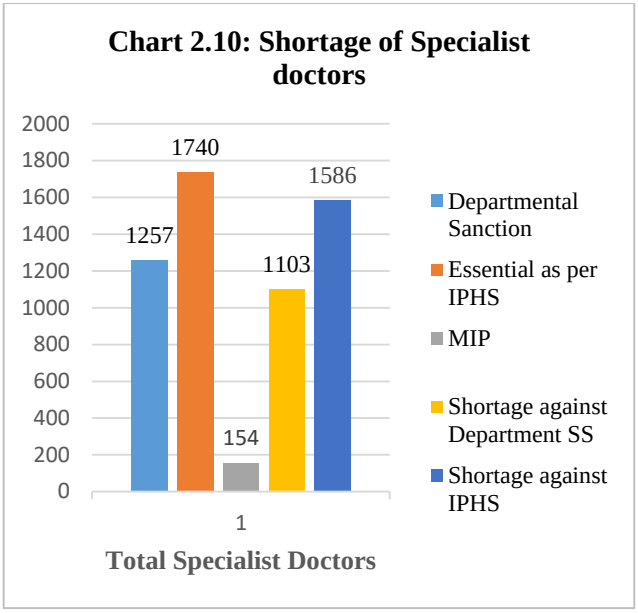
There was acute shortage of MOs, in the CHCs (348) of the State, as shown below:

Table 2.9: Shortage of Medical Officers (MOs) in the CHCs

Speciality	No. sanctioned by Department	Essential No. as per IPHS	Total MIP	Shortage against SS of Department	Shortage against IPHS (essential)
General Surgeon	61	1,740 *(@1 per specialty per CHC for 348 CHCs)*	7	54	341 (97.98 *per cent*)
Physician	82		38	44	310 (89.08 *per cent*)
Obstetric & Gynae	390		63	327	285 (81.89 *per cent*)
Paediatrician	360		21	339	327 (93.97 *per cent*)
Anaesthetist	364		25	339	323 (92.82 *per cent*)
Total of Specialists	**1,257**	**1,740**	**154**	**1103 (87.75 *per cent*)**	**1,586 (91.14 *per cent*)**
General Duty Medical Officers	1,813	696 *(@2 per CHC)*	1,250	563	(-) 554
Gr. Total	**3,070**	**2,436**	**1,404**	**1,666 (54.27 *per cent*)**	**1,032 (42.36 *per cent*)**

Source: HMIS data and IPHS norms





Source: HMIS data and IPHS norms

- It may be seen that, as per IPHS norms, the essential number of specialist doctors (except GDMOs) would have been 1,740, for serving at the CHCs of the State. However, the sanctioned posts, as entered against each CHC in the HMIS supplemented by data received from the Department, showed a strength of only 1,257 doctors. On the other hand, while the number of GDMOs[16] should have been 696 in the State (for CHCs), as per IPHS, the number of posts sanctioned was more than two times this number (1,813).

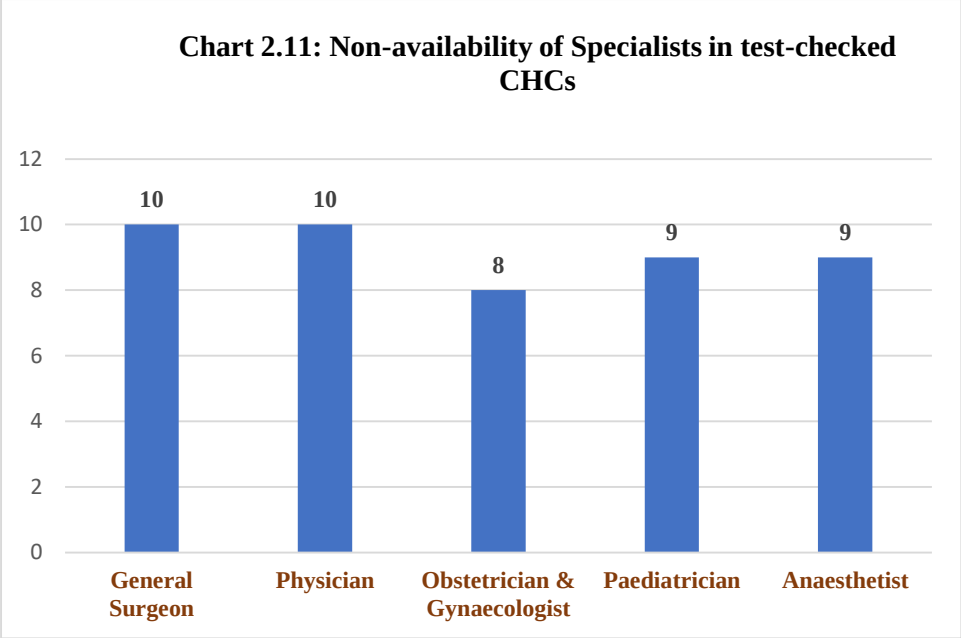
- The overall shortage of 42.36 *per cent*, in the cadre of MOs in CHCs, gave an adjusted figure of shortage, considering the excess engagement of GDMOs. The actual shortage of specialist MOs, in the CHCs of the State, was, however, very high and stood at 91.14 *per cent*, *vis-à-vis* the IPHS norms.

- The shortage was highest in the cadre of General Surgeon followed by Paediatrician, Anaesthetist, Physician and obstetrics and Gynaecology. Thus, the presence of specialist MOs was almost nil, in the CHCs.

- In the backdrop of this acute shortage, two and more (up to six) Physicians had been posted in nine CHCs; two and more (up to four) Obstetric & Gynaecologists had been posted in 16 CHCs; and three CHCs had more than two Paediatricians. This lopsided posting pattern further worsened the availability scenario in the CHCs.

- 239 CHCs had more than the prescribed number of two GDMOs (ranging up to 12 GDMOs). While there were no GDMOs posted in 28 CHCs of the State, in seven CHCs, posting of GDMOs exceeded the number sanctioned by the Department.

[16] *While a GDMO possesses MBBS degree, a doctor possessing a post-graduate degree is called a specialist.*



Source: Data furnished by test-checked CHCs

- In the 10 test-checked CHCs, there were no Physicians and General Surgeons in any of the CHCs, while, in nine CHCs each, there were no Paediatrician and Anesthetists, eight CHCs did not have Gynaecologist & Obstetrician posted.
- Excess Gynaecologist & Obstetricians (three) had been posted in one CHC (Rudrapur RH, Bashirhat HD).
- All CHCs had more than the prescribed number of two GDMOs posted (ranging up to 10 GDMOs) ***(Appendix 2.4)***.

In the backdrop of shortage of Medical Officers in all types of health facilities, a survey of 38 doctors, across the test-checked hospitals, indicated the following:

Table 2.10: Survey of Doctors in the test-checked hospitals

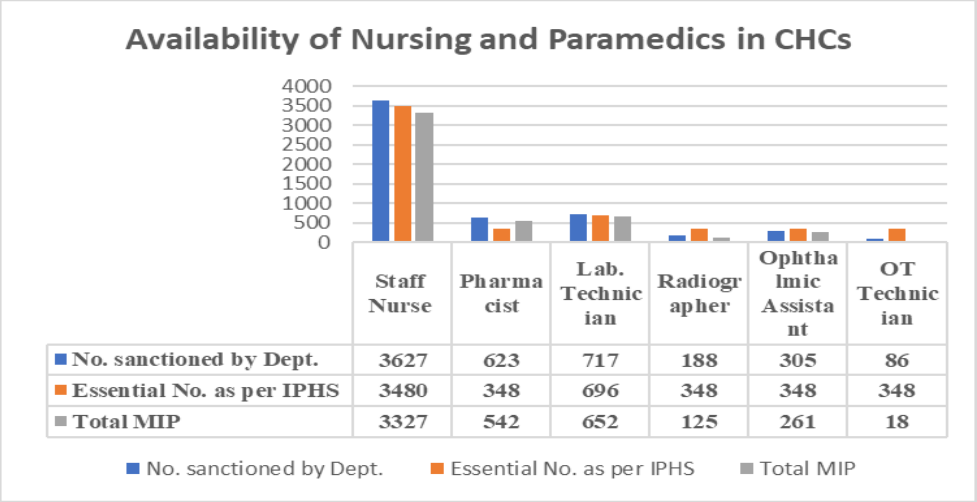
Issues raised through the survey	No. of Doctors confirming the issue	Percentage
Doctor posted in the Hospital for more than 3 years	10	26
Doctor posted in the Hospital for more than 7 years	12	32
Doctors had to attend more than 50 but less than 100 patients (OPD/ IPD) on an average, in a day	13	34
Doctors had to attend more than 100 patients (OPD/ IPD) on an average, in a day	24	63

Source: Replies furnished by test-checked CHCs

The irrational posting pattern had added to the crisis of non-availability of doctors in the hospitals. It was noticed that 32 *per cent* and 26 *per cent* of the surveyed doctors had remained stationary, in their place of posting, for more than seven years and three years, respectively. Resultantly, 63 *per cent* of the doctors mentioned that their patient load was more than 100 patients per day, while atleast 50 patients per day was the load mentioned by the remaining doctors (except one).

➢ Availability of Nurses and Paramedics:

Chart 2.12: Availability of Nursing and Paramedics in CHCs



Source: HMIS data and IPHS norms

As may be seen, the following shortages existed against the Nursing and Paramedic posts:

Table 2.11: Shortage of Nursing and Paramedical staff in the CHCs

Specialty	Shortage against Departmental SS	Shortage (in *per cent*)	Shortage against IPHS	Shortage (in *per cent*)
Staff Nurse	300	8.27	153	4
Pharmacist	81	13	(-)194	(-)56
Lab Technician	65	9.07	44	6
Radiographer	63	33.51	223	64
Ophthalmic Assistant	44	14.43	87	25
OT Technician	68	79.07	330	95

Source: HMIS data and IPHS norms

Audit noticed that no Staff Nurses had been posted in 51 CHCs. Further, no Pharmacists were posted in 29 CHCs, 30 CHCs had no LTs, 251 CHCs had no Radiographers, 93 CHCs had no Ophthalmic Assistants and 341 CHCs had no O.T. Attendants posted. It was also noticed that:

- More than 10 Nursing Staff (ranging up to 53), were posted in 132 CHCs, in excess of the minimum requirement of IPHS norms, while 134 CHCs were running with less than the required number of Nursing staff.
- No posts had been shown as sanctioned, in the HMIS data, in respect of Radiographers, Ophthalmic Assistants and OT Technicians, against 200, 67 and 287 CHCs, respectively.
- Eight of the 10 test-checked CHCs had more than 10 Nursing Staff, ranging up to 102 (in case of Salboni RH, Paschim Medinipur), while the other two CHCs (Sandelerbil RH-Bashirhat HD and Kunor BPHC-Uttar Dinajpur) were running with less than the required number of SNs.
- Postings of excess paramedical staff were noticed in test-checked CHCs. Eight of the 10 CHCs had more than one (ranging up to six) Pharmacists, five CHCs had more than two LTs, four Radiographers had been posted in Salboni RH, Paschim Medinipur, while, on the other hand Kunor BPHC

(Uttar Dinajpur) was running without LTs and five CHCs were running without any radiographer. There was no Ophthalmic Assistant in four CHCs. Further, OT Technician, had not been posted in any of the test-checked CHCs ***(Appendix 2.5)***.

In reply, the Department eventually accepted the fact by stating (February 2024) that the vacancies were due to superannuation. It was further stated that the process for filling up the vacancies has been initiated and all CHCs are attempted to be kept under service coverage by rotational arrangement.

➢ Availability of Administrative and Group D staff:

Table 2.12: Availability of Administrative and support staff in the CHCs

Specialities	No. sanctioned by Department	Essential No. as per IPHS	Total MIP	Shortage against SS of Department (*per cent*)	Shortage against IPHS (essential)
Registration Clerk	311	696 *(@2 per CHC)*	191	120 (38.58)	505 (72.55)
Data Entry Operator	602	696 *(@2 per CHC)*	588	14 (2.32)	108 (15.52)
Account Assistant	248	348 *(@1 per CHC)*	236	12 (4.84)	112 (32.18)
Dresser	103	348 *(@1 per CHC)*	28	75 (72.82)	320 (91.95)
Ward Boys	784	1,740*(@5 per CHC)*	447	337 (42.98)	1,293 (74.31)

Source: HMIS data and IPHS norms

- No Registration Clerks had been posted in 212 CHCs. In 87 CHCs, only one Registration Clerk had been posted. Against 181 CHCs, no posts for Registration Clerks had been sanctioned (as per the HMIS data).
- No DEOs had been posted in 63 CHCs; and 16 CHCs were running with less than two DEOs. At the same time, 28 CHCs had more than two DEOs posted. The Department had not mentioned the sanctioned strength of DEOs, in regard to 73 CHCs, in HMIS. Further, disregarding the IPHS norms, seven CHCs had only one DEO, whereas, 43 CHCs had a sanctioned strength of more than two DEOs each.
- In 128 CHCs, no Accounts Assistants (AAs) had been posted, while 14 CHCs had more than one AA posted. The sanctioned strength, against 128 CHCs, had not been specified in the HMIS.
- Dressers had not been posted in 341 CHCs and 279 CHCs did not have any Ward Boys. In 39 CHCs, more than five Ward Boys (ranging up to 24 Ward Boys) been posted. The sanctioned strength of Dressers and Ward Boys had not been specified against 237 and 286 CHCs, respectively.
- In the test-checked CHCs (10), no Registration Clerks had been posted in seven CHCs, no DEOs had been posted in five CHCs; and, in nine CHCs, no Accounts Assistants had been posted. Dressers and Ward Boys were not available in 10 and nine CHCs, respectively, while Sabang RH, in Paschim Medinipur, had 17 Ward Boys posted in the CHC ***(Appendix 2.6)***.

➢ Block Public Health Unit:

A Block Public Health Unit (BPHU) is required to integrate the functions of service delivery, public health action, strengthening laboratory services for diseases surveillance, diagnosis and public health and serve as the hub for health-related reporting. Each BPHU was responsible for performing Public Health Activities, at the Block Level, in regard to IDSP (Integrated Disease Control Programme), Vector Borne Disease (Malaria, Kala Azar, Fileria, Dengue *etc.*), Natural Calamity and Disaster, Animal Borne Diseases (Rabies *etc.*), Climate Change & Human Health, Snake bites and all other works relating to Public Health.

Significant shortages in man-power, in the BPHUs, were noticed, as below:

Table 2.13: Availability of BHOs/ PHMs/ PHNs, in the Block Public Health Units

Specialities	No. sanctioned by Dept.	Essential No. as per IPHS	Total MIP	Shortage against SS of Dept.	Shortage against IPHS (essential)
Block Health Officer	256	348	255	01	93 (26.72 *per cent*)
Public Health Specialists	69	348	13	56 (81.15 *per cent*)	335 (96.26 *per cent*)
Public Health Nurse	534	348	440	94 (17.60 *per cent*)	(-) 92

Source: HMIS data and IPHS norms

IPHS suggests one Block Health Officer (BHO), one Public Health Specialist and one Public Health Nurse (PHN) (desirable: two PHNs) as being essential, for running a Block Public Health Unit. Review, however, revealed that 95 Blocks had remained devoid of a BHO, while there were acute shortages of Public Health Specialists (PHSs). Further, though the number of PHNs available was more than one, in 135 CHCs, 45 CHCs were running without any PHNs in the blocks.

While Sabang RH in the Paschim Medinipur district, was running without a BHO, none of the test-checked CHCs had a PHS posted. Posting of more than one PHN was found, in four of the test-checked CHCs ***(Appendix 2.7)***.

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

2.6 Human Resources for District/ Sub-District (secondary level) Hospitals (DHs/ SDHs)

A District Hospital is a hospital at the secondary referral level, responsible for a district of a defined geographical area, containing a defined population. Its objective is to provide comprehensive secondary healthcare services to the people in the district, at an acceptable level of quality. It is expected to be responsive and sensitive to the needs of people in the district.

2.6.1 Position of Human Resources in the District Hospitals

As per IPHS, the following essential human resources along with some desirable specialties were prescribed for Medical Officers of different categories based on the number of beds of the District Hospitals:

Table 2.14: No. of Medical Officers as per IPHS norms

Specialty	100 Beds	200 Beds	300 Beds	400 Beds	500 Beds
Medicine	2	2	3	4	5
Surgery	2	2	3	3	4
Obstetric & Gynaecology	2	3	4	5	6
Paediatrics	2	3	4	4	5
Anaesthesia	2	2	3	3	4
Ophthalmology	1	1	2	2	2
Orthopaedics	1	1	2	2	2
Radiology	1	1	2	2	2
Pathology	1	2	3	3	4
ENT	1	1	2	2	2
Dental	1	1	2	3	3
MO	11	13	15	19	23
Dermatology	1*	1*	1	1	1
Psychiatry	1	1	1	1	1
Microbiology	1*	1*	1	1	1
Forensic Specialist	1*	1*	1	1	1
AYUSH Doctors	1	1	1	2	2
Total	**29+3**	**34+3**	**50**	**58**	**68**

*Source: IPHS norms; *Desirable*

An analysis against the required number of MOs, as arrived based on the bed strength of the 18 existing District Hospitals of the State, *vis-à-vis* the MIP exhibited that there existed acute shortage of MOs in the DHs of the State as shown below:

Table 2.15: Shortage of Medical Officers (MOs) in the DHs

Speciality	No. sanctioned by Department	Essential No. as per IPHS	Total MIP	Shortage against SS of Department (*per cent*)	Shortage against IPHS (essential)
Medicine	97	85	65	32 (32.99%)	20 (23.53%)
Surgery	89	69	64	25 (20.09%)	5 (7.25%)
Obstetric & Gynae	124	103	99	25 (20.16%)	4 (3.88%)
Paediatrics	86	87	92	--	--
Anaesthesia	110	69	71	39 (35.45%)	--
Ophthalmology	50	36	43	7 (14%)	--
Orthopaedics	58	36	40	18 (31.03%)	--
Radiology	55	36	26	29 (52.73%)	10 (27.77%)
Pathology	55	69	42	13 (23.64%)	27 (39.13%)
ENT	48	36	46	2 (4.17%)	--
Dental	44	52	44	--	8 (15.38%)
Dermatology	33	18	23	10 (30.30%)	--
Psychiatry	34	18	28	6 (17.65%)	--
Microbiology	27	18	14	13 (48.15%)	4 (22.22%)
Forensic Specialist	19	18	11	8 (42.10%)	7 (38.89%)
AYUSH Doctors	29	34	19	10 (34.48%)	15 (44.12)
Total of Specialists	**958**	**784**	**727**	**231 (24.11%)**	**100** (12.76%)**
General Duty Medical Officers	329	394	145	184 (55.93%)	249 (63.20%)
Gr. Total:	**1,287**	**1,178**	**872**	**415 (32.25%)**	**349 (29.63%)**

Source: HMIS data and IPHS norms

** MIP, as of March 2022 (HMIS-State level); **Excess manpower under some specialities has not been considered, while calculating the 'Shortage against IPHS'*

- District Hospital-wise shortage of specialist doctors have been analysed in ***Appendix 2.8***.
- Though 15 of the 18 DHs had sanctioned bed strength far above (reaching up to 1,500 beds) the IPHS limit of 500 beds, the overall number of staff sanctioned for the DHs was less than the number prescribed in the IPHS, for operating a 500-bedded DH.
- Even with the huge number of beds sanctioned for the DHs in the State, the strength of doctors could not meet the standards prescribed for 500-bedded DHs in the IPHS. The overall shortage constituted 29.63 *per cent* of the essential number, as prescribed in the IPHS, in the District Hospitals of the State.
- Though the shortage against specialists was moderate, there was an acute shortage (63.20 *per cent)* in case of General Duty Medical Officers.
- The shortages were conspicuous in respect of specialists in the Specialities of Medicine, Radiology, Pathology, Forensic Sciences and AYUSH.
- An analysis of burden of surgeries showed that 6 of the 18 DHs ***(Appendix 2.9)*** had average burden of surgeries more than 150 per annum on the surgeons posted in the DHs.

➢ Shortage in Nursing, Para Medical and Administrative staff in the DHs

Table 2.16: Shortage of Nursing, Para Medical and Administrative staff, in DHs

Post	Requirement as per IPHS	Men-in-position	Shortage (*percentage*)
Nursing Staff	3,825	2,595	1,230 (32.16)
Para Medical Staff	1,713	468	1,245 (72.68)
Total of Nurse and Paramedics	**5,538**	**3,063**	**2,475 (44.69)**
Administrative staff	467	94	373 (79.87)

Source: IPHS norms; For MIP of Nurses and Paramedical staff, as of March 2023, reply of H&FW Department and For MIP of Administrative staff, as of March 2022, as mentioned in HMIS data

In the backdrop of DHs operating with a far higher number of beds, the shortages in the nursing staff, paramedics and administrative staff, were matters of concern.

The shortages of administrative (almost 80 *per cent)* and Para medical staff (44 *per cent)* were significant.

Table 2.17: MIP *vis-à-vis* sanctioned strength, in the test-checked DHs

Cadre	Sanctioned strength	Men-in-Position in DHs (as of April 2019)			Shortage
		Regular	Contractual	Total	
Bashirhat DH:					
Medical Officer	76	54	12	66	10 (13%)
Para Medical	41	36	6	42	0 (0%)
Staff Nurse	240	171	0	171	69 (29%)

Source: Data furnished by test-checked DHs

There was an acute shortage of nursing staff (29 *per cent)* and Medical Officers (13 *per cent),* in the Bashirhat DH.

Lack of human resources for running CCUs: The West Bengal Health & Family Welfare Department prepared (2014) revised operational guidelines for CCUs, to act as a reference and guidance, to facilitate planning, establishment, operation and monitoring of Critical Care[17] units and High Dependency Units[18], with the objective of reducing mortality and ensuring zero out-of-pocket expenditure, for patients.

As per these guidelines, each CCU was to be manned by a dedicated/ earmarked core trained team of personnel. The human resource standards envisaged a 12-bedded CCU in those guidelines. The position of actual availability, in the two test-checked District hospitals, however, showed shortages, as below:

Table 2.18: Requirement and availability of staff for running CCUs

Sl. No.	Category of personnel	Required number	Actually available (Shortage)	
			JDH	BDH
1.	Medical Officer (MBBS)	8	5 (3)	6 (2)
2.	Nursing-in-Charge	1	2 (0)	1 (0)
3.	Nursing Staff	15	15 (0)	15 (0)
4.	Medical Technologists (MTs) (Critical care)	5	4 (1)	5 (0)
5.	General Duty Assistant (GDA)	8	4 (4)	8
6.	Sweeper	8	5 (3)	

Source: Data furnished by test-checked DHs; JDH: Jalpaiguri DH and BDH: Bashirhat DH

It could be seen that, though Bashirhat DH only had shortage of two Medical Officers, the CCU at Jalpaiguri DH had suffered shortage of staff in all cadres (except nursing staff). This was bound to have adverse effect on the functioning of the CCUs.

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

2.6.2 Position of Human Resources at the Sub-Divisional Hospitals

Sub-district (Sub-divisional) hospitals are below the district level hospitals and above the block level (CHC) hospitals and act as First Referral Units for the Tehsil/ Taluk/ block population in which they are geographically located.

Similar to the DHs, all the Sub-Divisional Hospitals of the State also had sanctioned bed numbers much higher than the IPHS limit of 100 beds. All the 36 SDHs in the State had bed strengths over 100, with 29 of them having had bed strengths of over 200 (ranging up to 600 beds). In this backdrop, Audit noticed that there were acute shortage of MOs in the SDHs, as shown below:

Table 2.19: Shortage of Medical Officers (MOs) in the SDHs

Speciality	No. sanctioned by Department	Essential No. as per IPHS	Total MIP*	Shortage against SS of Dept.	Shortage against IPHS
Medicine Specialist	152	72 *(@2 for 36 SDHs)*	122	30 (19.74%)	--
Surgery Specialist	124		94	30 (24.19%)	--
O&G specialist	215		187	28 (13.02%)	--
Dermatologist/ Venereologist	52	36 *(@1 for 36 SDHs)*	29	23 (44.23%)	7 (19.44%)
Paediatrician	150	72 *(@2 for 36 SDHs)*	130	20 (13.33%)	--
Anaesthetist	177		108	69 (38.98%)	--

[17] *Critical care is medical care for people who have life-threatening injuries and illnesses.*
[18] *A department of a hospital, where patients who are seriously ill but do not require intensive care, receive special medical treatment.*

Speciality	No. sanctioned by Department	Essential No. as per IPHS	Total MIP*	Shortage against SS of Dept.	Shortage against IPHS
ENT Surgeon	82	36 *(@1 for 36 SDHs)*	63	19 (23.17%)	--
Ophthalmologist	97		82	15 (15.46%)	--
Orthopaedics	78		63	15 (19.23%)	--
Radiologist	86		31	55 (63.95%)	5 (13.89%)
Dental Surgeon	68		64	4 (5.88%)	--
Public Health Manager	17		0	17 (100.00%)	36 (100.00%)
Forensic Expert	25		9	16 (64.00%)	27 (75.00%)
AYUSH Physician	62		25	37 (59.68%)	11 (30.56%)
Pathologist	84		54	30 (35.71%)	--
Total Specialists:	**1469**	**720**	**1,061**	**408 (27.77%)**	**86 (11.94%)**
General Duty Doctors	672	324 *(@9 for 36 SDHs)*	**300**	372 (55.36%)	24 (7.41%)
Gr. Total:	**2,141**	**1,044**	**1,361**	**780 (36.43%)**	**110 (10.54%)**

*Source: HMIS data; * MIP as of March 2022*

- Even though all the SDHs had more than 100 beds, shortages against IPHS standards (which is prescribed for 100 beds only), were noticed in regard to of various specialties. Moreover, no Public Health Managers were posted in any of the SDHs. Shortage of General Duty Doctors was also high (7.41 *per cent* against IPHS norms).
- The overall shortage of doctors, against the departmental sanctioned strength, was 36 *per cent*, while shortages against General Duty Doctors (55 *per cent*), AYUSH (60 *per cent*), Forensic Experts (64 *per cent*), Radiologists (64 *per cent*), and Dermatologists *(*44 *per cent)*, were more acute.
- In the backdrop of such acute shortage (36.43 *per cent*) of specialists/ MOs at the DHs and the SDHs, it is pertinent to mention that consultation time that could be afforded by the doctor to the patients was less than even five minutes per patient, as emerged from a beneficiary (patient) survey (68 *per cent*) carried out in the test-checked DHs and SDHs.

➢ Shortages in Nursing, Para Medical and Administrative staff in SDHs

Table 2.20: Shortages in Nursing, Para Medical and Administrative staff, in SDHs

Post	Requirement as per IPHS	Men-in-Position	Shortage (percentage)
Nursing Staff	1,260	1,221	39 (3.10%)
Para Medical Staff	864	671	193 (22.34%)
Total of Nurse and Paramedics	**2,124**	**1,892**	**232 (10.92%)**
Administrative staff	720	189	531 (73.75%)

Source: HMIS data

Significant shortages of Para-Medical Staff and in the cadre of Administrative staff, were noticed in SDHs, operating with much higher bed strength when compared against the requirement of a 100 bedded hospital.

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

2.7 Human Resources for Medical Colleges and Hospitals (Tertiary Sector)

The Medical Council of India (MCI), a statutory body, was set up, under Medical Council Act, 1956, with the objective of regulating the medical education in the country. Under regulations, no medical college can either be established or increase its capacity, without prior approval of the Government. As per Section 10A of the Indian Medical Council Act, 1956; the Central Government's permissions to such colleges are granted initially for one year *i.e.* for admitting only one batch of students in a calendar year. Permissions are to be renewed on an yearly basis, after verification of the achievements against the annual targets. The process is continued till such time as the full required infrastructure is created and recognition is granted under the relevant Act. Admissions made without requisite permission from the Government of India are to be deemed as irregular. MCI was subsequently replaced by the National Medical Commission (NMC) which came into existence by the NMC, Act of Parliament, in 2019.

The Centrally Sponsored Scheme of establishment of new medical colleges attached with district/ referral hospitals' of the Ministry of Health & Family Welfare, established new medical colleges, attached with the existing District/ Referral hospitals in underserved areas of the country. Under Phase-I of the scheme, 56 colleges had been approved in 20 States, as of February 2018. Under Phase-II of the said scheme, 24 new medical colleges had been approved in January 2018. The objective of Phase-II of the scheme was ensuring the availability of one medical college in every three Parliamentary Constituencies and one Government Medical College in each State.

Following the above principle, the number of medical colleges in West Bengal has increased over the period covered under the present Audit. Consequently, the number of seats in MBBS courses have also increased, as shown below:

Table 2.21: Number of Government Medical colleges and seats in Undergraduate and Postgraduate courses

Financial Year	Number of government medical colleges offering Under Graduate courses	Number of Under Graduate seats	Number of government medical colleges offering Post Graduate courses	Number of post graduate seats
2016-17	13	1,850	12	1,027
2017-18	13	1,900	12	1,130
2018-19	13	2,050	12	1,214
2019-20	17	2,900	13	1,240
2020-21	18	3,000	16	1,359
2021-22	18	3,000	16	1,403

Source: Data furnished by the Director of Medical Education, West Bengal

It may be seen from the above that the number of Government medical colleges offering both Under Graduate and Post Graduate courses, have increased, resulting in 62 *per cent* increase in the seats for undergraduate courses and 37 *per cent* increase in the seats for Post Graduate courses, during the period covered under audit.

The number of medical college other than State Government medical colleges, has also increased, with a corresponding increase in both Under Graduate and Post Graduate seats, during 2016-22, as shown below.

Table 2.22: Number of non-Government Medical Colleges & Seats of Under Graduate and Post Graduate courses

Financial Year	Number of Medical Colleges other than State Govt. offering Under Graduate courses	Number of Under Graduate seats	Number of Medical Colleges other than State Govt. offering Post Graduate courses	Number of Post Graduate seats
2016-17	5	650	6	122
2017-18	3	400	8	153
2018-19	4	550	8	180
2019-20	7	925	8	183
2020-21	8	1,075	8	195
2021-22	9	1,225	8	261

Source: Data furnished by the Director of Medical Education, West Bengal

There was an increase of 88 *per cent*, in the number of seats in respect of undergraduate courses offered by other than Government Medical Colleges.

- **Shortage of Manpower**

Scrutiny of records revealed that there was considerable shortage of teaching staff in the Medical Colleges under the administrative control of the State Government. In respect of 18 Government Medical Colleges in the State, the position is furnished below:

Table 2.23: Shortage of Manpower in the 18 Govt. Medical Colleges in the State

Financial Year	Sanctioned strength of all categories of staff (Professors/ Associate Professors/ Assistant Professors *etc.*)	Men-in-position	Shortage (*per cent*)
2020-21	4,747	3,495	1,252 *(26)*
2021-22	4,753	3,562	1,191 *(25)*

Source: Data furnished by Director of Medical Education, West Bengal

It is seen that, against the sanctioned strength of 4,747 of all categories of staff, including Professors/ Associate Professors *etc.*, during FY 2020-21, the men-in-position as of March 2021, were 3,495, indicating a shortage of 1,252 (26 *per cent*). This position further deteriorated in the ensuing year, as the percentage of shortage was 25, as of March 2022, against the sanctioned strength of 4,753.

Shortage of Specialists and General Duty Medical Officers posted in the Medical Colleges of the State also showed acute shortage:

Table 2.24: Shortage of Specialists and GDMOs in Medical College & Hospitals

Particulars	Sanctioned Strength		MIP		Shortage (*percentage*)	
	Specialist	GDMO	Specialist	GDMO	Specialist	GDMO
As of March 2023	2,173	1,871	1,559	548	614 (28)	1,323 (71)

Source: Reply furnished by H&FWD; Note: Data on Specialists in respect of six MCHs (Bankura Sammilani MCH; Kolkata NMCH; SSKM; MMCH; Sagar Dutta MCH and MJN, Coochbehar) and on GDMO in respect of four MCHs (Kolkata NMCH, SSKM, RG Kar MCH and MJN, Coochbehar) could not be provided by H&FWD.

The West Bengal Health Recruitment Board, constituted (August 2012) by the H&FW Department, for direct recruitment against different type of posts (119 in number) under the Department, recommended, in FY 2021-22, the appointment of only 145 Assistant Professors against a vacancy of 307, as of March 2021.

The trend of shortage of staff, continued in the test-checked Medical Colleges, *i.e.* Institute of Post Graduate Medical Education & Research (IPGME&R) at Kolkata (200 UG seats), Medinipur Medical College & Hospital (MMC&H) (200 UG seats), Raiganj Medical College & Hospital (RMC&H) (100 UG seats) and Deben Mahato Medical College & Hospital (DMMC&H) at Purulia (100 UG seats), as shown below:

Table 2.25: Shortage of Manpower in the test-checked Govt. Medical Colleges

Financial Year	Medical College	All categories of staff (Professors/ Associate Professors/ Assistant Professors and other staff)		Shortage (Percentage)
		Sanctioned strength	Men-in-position	
2020-21	IPGME&R	725	410	315 *(43)*
	MMC&H	197	198	NIL
	RMC&H	126	67	59 *(47)*
	DMMC&H	126	109	17 *(13)*
2021-22	IPGME&R	572	407	165 *(29)*
	MMC&H	197	186	11 *(6)*
	RMC&H	126	97	29 *(23)*
	DMMC&H	126	104	22 *(17)*

Source: Data furnished by the Director of Medical Education, West Bengal

Thus, IPGME&R had shortage of all categories of staff of 43 *per cent* in FY 2020-21(when compared with the sanctioned strength), which decreased to 29 *per cent* in FY 2021-22, mainly due to change in the sanctioned strength of staff from 725 to 572. RMC&H had shortage, of all categories of staff, of 47 *per cent* in FY 2020-21 which decreased to 23 *per cent* in FY 2021-22.

Test-check of records, in regard to the staff strength of Professors, Associate Professors, Assistant Professors and Tutors/ Demonstrators, of six (6) selected Departments, *i.e.* Anatomy, Bio-chemistry, Microbiology, Dentistry, Dermatology and Opthalmology, as of March 2022, at IPGME&R, Kolkata, and MMC&H, each having 200 seats, revealed the following:

Table 2.26: Staff strength in six Departments, at IPGME&R, Kolkata and MMC&H (as of March 2022)

Department	Medical College	Sanctioned strength as per NMC	Professors, Associate Professors, Assistant Professors and Tutors/ Demonstrators	Shortage (Percentage)
Anatomy	IPGME&R	10	10	*Nil*
	MMC&H		8	2 *(20)*
Bio-chemistry	IPGME&R	10	10	NIL
	MMC&H		9	1 *(10)*
Microbiology	IPGME&R	10	11	NIL
	MMC&H		4	6 *(60)*
Dentistry	IPGME&R	9	7	*2 (22)*
	MMC&H		5	4 *(44)*
Dermatology	IPGME&R	5	8	NIL
	MMC&H		5	NIL
Opthalmology	IPGME&R	10	10	NIL
	MMC&H		8	2 *(20)*

Source: Data of Directorate of Medical Education, West Bengal

Thus, against the sanctioned strength, as per the National Medical Commission (NMC) norms, IPGME&R, Kolkata, had no shortage of Professor, Associate Professor, Assistant Professor and Tutors/ Demonstrator at all the Departments mentioned above, except for Dentistry. However, the percentage of shortage of staff, at Medinipur MC&H, ranged from 60 in Microbiology, to 20 in Anatomy and Ophthalmology.

The shortage of staff, in respect of above mentioned categories, in these six (6) Departments, as of March 2022, was also noticed at RMC&H and DMMC&H (Purulia), having 100 seats each, where in the percentages ranged from 17 to 60 in different departments of both the MCHs, as shown below:

Table 2.27: Shortage of Staff of six Departments, as of March 2022, at RMC&H and DMMC&H

Department	Medical College	Sanctioned strength as per NMC	Professors, Associate Professors, Assistant Professors and Tutors/ Demonstrators	Shortage (percentage)
Anatomy	RMC&H	6	NA	NA
	DMMC&H		4	2 *(33)*
Bio-chemistry	RMC&H	6	5	1 *(17)*
	DMMC&H		5	1 *(17)*
Microbiology	RMC&H	6	3	3 *(50)*
	DMMC&H		5	1 *(17)*
Dentistry	RMC&H	4	2	2 *(50)*
	DMMC&H		NA	NA
Dermatology	RMC&H	4	NA	NA
	DMMC&H		NA	NA
Opthalmology	RMC&H	5	2	3 *(60)*
	DMMC&H		4	1 *(20)*

Source: Data furnished by Director of Medical Education, West Bengal

The shortage of staff was more prominent at Medical Colleges located away from the State capital (Kolkata). This trend was not in consonance with the intention of making available specialty medical services at the district level.

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

Recommendations:

1. ***The H&FW Department may formulate and maintain definite sanctioned strength across cadres for each heath care facility on priority basis to ensure adequacy of human resources.***
2. ***The H&FW Department may ensure filling up of the vacant posts and engaging Medical and Para Medical Staff against the shortages, on priority basis, at the various healthcare facilities of the State.***
3. ***Redeployment of additional staff, from facilities with excess manpower, to facilities running with shortage of manpower, may be ensured.***

CHAPTER 3

Healthcare Services

3 Chapter

Healthcare Services

Audit Objective: Whether the management and delivery of the prescribed healthcare services, were adequate, efficient, and effective.

Audit observed that none of the SCs of the State had been upgraded to facilitate delivery facilities, which was necessary to prevent instances of deliveries, in homes, unattended by Skilled Birth Attendants (SBAs). PHCs did not have assured referral services (Govt. ambulances/ PPP arrangements), in cases of complications, needing specialist services. Essential diagnostic services/ tests were not available in the test-checked CHCs. No inspections had been conducted, by the Food Safety Officers, in the hospital kitchens of seven CHCs. Bio-Medical Waste authorisation, from the WBPCB, had also not been obtained by most of the CHCs.

3.1 Line Services

3.1.1 Services delivered by the Sub-Centres

(i) General Services:

Sub-centres are expected to provide promotive, preventive and a few curative primary healthcare services. Given that the main function of the health Sub-centres is to provide outreach facilities, most services were not delivered in the Sub-centre building itself. The site of service delivery were instead, generally in the villages, through the Village Health and Nutrition Days (VHNDs)/ Immunization sessions, during house visits, house-to-house surveys and meetings and events with the community.

VHNDs were to be organised at least once in a month, in each village, with the help of the Medical Officer, Health Assistant Female (Lady Health Visitor) of the PHC, HWM, HWF, ASHA, AWW and their supervisory staff, PRI, Self Help Groups *etc.*, in order to reach every habitation/ Anganwadi centre, to deliver the following essential services:

i. Early registration and Antenatal care for pregnant women
ii. Immunization and Vitamin-A administration
iii. Supplementary nutritional services, health check-up and referral services
iv. Family planning counselling and distribution of contraceptives
v. Symptomatic care and management of persons with minor illnesses
vi. Health Communication to mothers, adolescents and other members of the community and
vii. Providing training/ support to ASHAs, as well as Registration of Births and Deaths.

These apart, the following services were to be delivered through Home Visits and House to House Surveys:

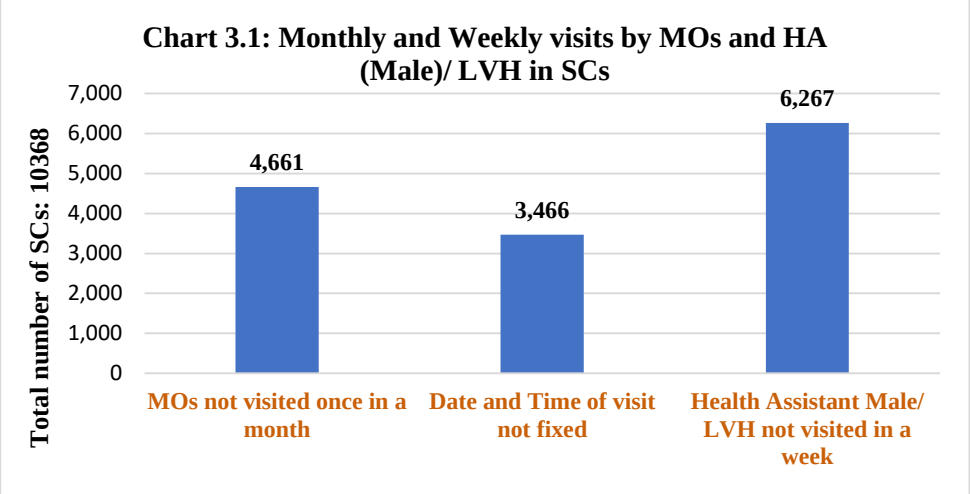
- Skilled attendance at birth
- Post-natal and newborn visits
- checking disease incidences
- Notifying the M.O., PHC, immediately, about any abnormal increase in the cases of diarrhoea/ dysentery, fever *etc.*, and taking necessary measures to prevent their spread
- Listing of the age and sex of all family members
- Assessment and listing of eligible couples and their unmet needs for contraception
- Identifying persons with skin lesions or other symptoms, suspicious of leprosy and referring them to higher health care facilities
- Identifying persons with blindness, listing them and referring them to higher health care facilities
- Identify persons with hearing impairment, deafness, listing them and referring them to higher health care facilities
- Annual mass drug administration, in filaria endemic areas.

Review, however, revealed that:

- Out of the 38 SCs test-checked in audit, in 14 SCs[19], Village Health and Nutrition Days had not been held, during the period from FYs 2016-17 to 2021-22. Records of annual surveys conducted, were not available, in three of the test-checked SCs[20], for the entire period.
- The ANM was to prepare a monthly work schedule, in the meeting of all Accredited Subsidiary Health Assistants (ASHA) workers, to be held on the 3rd Friday of every month, which was mandatory. In addition, the ANM was to take weekly/ fortnightly meetings with all ASHAs, of her area, to guide and monitor them.

  Review of records showed that, out of 38 test-checked SCs, 13 SCs[21] had conducted inadequate number of monthly meetings. No monthly meetings were found to have been conducted in four SCs[22], during 2019-2020, and/ or during 2021-2022. Weekly meetings were also not of adequate number in case of 28 SCs[23]. Weekly meetings had never been held in two SCs[24], during the entire period ***(Appendices 3.1 & 3.2)***.
- To run clinics in the SCs, the Medical Officer (MO) of the PHCs was to visit the SC, atleast once every month. The day and time of such visit needed to be fixed, so that the villagers were aware of the same.

[19] *Kankrasuti, Buruj, Jogeshganj South, Sridharkati, Boltala, Bishpur, Golamara SSK, Chayanpur SSK, Dhansura SSK, Hutmura SSK, Santuri, Pirorgoria, Balitora and Dandahit*
[20] *Surun, Majhiar and Hilla Tea Estate*
[21] *Bhadutala, Arabari, Garhmal, Satpati, Kharika PHC attached, Paschim Joynagar, Kankrasuti, Buruj, Indran, Marnai, Borote, Sulkapara and Santuri*
[22] *Bhadutala, Arabari, Garhmal and Satpati*
[23] *Bhadutala, Arabari, Garhmal, Satpati, Lokepith, Nimki Mohar, Adasimla, Kharika, Aturia, Paschim Joynagar, Kankrasuti, Buruj, Jogeshganj South, Sridharkati, Boltala, Bishpur, Indran, Marnai, Borote, Dilwarpur, Anandpur Tea Estate, Karaibari, Kalabari, Sulkapara, Looksan, Hilla Tea Estate, Pirorgoria and Dandahit*
[24] *Sridharkati and Anandapur Tea Estate*



Source: HMIS data

Review of data of SCs (10,368) of the State showed that the MOs did not visit 4,661 SCs atleast once in a month, while the days and times of visit, in respect of 3,466 SCs, had not been fixed and made known to the local population. Even the Health Assistant (Male)/ Lady Health Visitor (LHV) did not visit 6,267 SCs atleast once in a week.

- Accredited Social Health Activists (ASHA), who were engaged to support ANMs in implementing the preventive and promotive healthcare services ensuring maternal health, newborn and child health and disease control in the community, suffered a shortage of 11 to 21 *per cent*.

Table 3.1: Shortage of ASHA

As of	Sanctioned Position	In-Position	Vacancy (*per cent*)
March 2017	61,008	48,402	20.66
March 2018	61,008	50,046	17.97
March 2019	60,664	51,864	14.51
March 2020	60,664	53,149	12.39
March 2021	60,664	54,051	10.90
March 2022	63,164	55,245	12.54

Source: Records furnished by the H&FW Department

Moreover, mandatory trainings, enabling the ASHA workers to understand and discharge their responsibilities, could not be imparted to 19 to 43 *per cent* of the ASHA workers during the period 2016-2022:

Table 3.2: Shortfall in imparting training to ASHA

Sl. No.	Training programmes	2016-22		
		Target	Imparted	Shortfall (*per cent*)
1	Induction Round	11,194	9,043	19.22
2	1st to 4th round of 6th & 7th Module	98,023	59,044	39.77
3	Refresher Round	19,161	10,855	43.35
4	NCD (Non-communicable disease) Training	68,783	44,617	35.13
	Total	**1,97,161**	**1,23,559**	**37.33**

Source: Records furnished by the H& FW Department

(ii) Maternity and neonatal services

A. Non-availability of delivery facilities

As per IPHS, States were required to categorize their Sub-centre into two types and provide services and infrastructure accordingly. This was for optimum use of available resources. Type-A Sub-Centre was to provide all recommended services, except conducting delivery. However, the ANMs were to be trained in midwifery, so that they could conduct normal deliveries in cases of need. If the requirement for this service went up, the sub-centre could be considered for upgradation to Type-B, which included facilities for conducting deliveries.

Categorisation of Sub-Centres, into Type-A and Type-B, was not been provided to Audit, by the Department, though sought for. Scrutiny of records (HMIS database), however, showed that none of the 10,368 Sub-Centres of the State had any beds sanctioned and/ or functional in the SCs.

Evidently, though 55,000 deliveries had been conducted at home, across the State, during 2019-22, none of the SCs had been upgraded as Type-B, in the State.

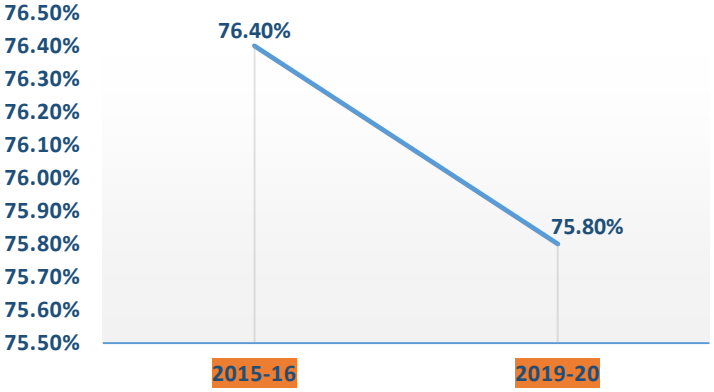
B. Ante-natal care

The SCs were to ensure early registration of all pregnant women; provide four ante-natal care services and render general examination services, like weight, BP, anaemia, iron folic acid supplements, tetanus toxoid injection *etc.*

Minimum laboratory investigations, like urine test for pregnancy confirmation, haemoglobin estimation, urine for albumin and sugar and linkages with PHCs, for other required tests, were to be ensured.

Review, of the 38 test-checked SCs, however, revealed that 1,394 (5.64 *per cent*) mothers, out of the total 24,734 number of mothers, registered between FYs 2016-17 and 2021-22, had not been registered in the 1st trimester. Further, 3,384 mothers (13.68 *per cent*) had not received four ANC check-ups ***(Appendix 3.3)***.

Chart 3.2: Percentage of mothers received at least four ANC check-ups as per NFHS-5



Source: NFHS-5 data

As per the 5th National Family Health Survey (NFHS 5), the percentage of mothers, who had received at-least four ANC check-ups, had fallen from 76.4 *per cent* in FY 2015-16, to 75.8 *per cent* in FY 2019-20.

Urine testing facility, urine test for albumin and urine test for sugar (using dipstick) was not available in Santuri SC. Haemoglobin estimation facility was

also not available in two SCs[25], out of the 38 SCs test-checked. Further, 14 SCs[26] did not have linkages with PHCs, for the required tests**.**

C. Continuation of Unassisted Non-institutional deliveries

Although the focus was on promoting institutional deliveries, the facilities for attending to home deliveries were to remain available at both types of Sub-centres. The ANMs were to be mandatorily Skilled Birth Attendant (SBA) trained.

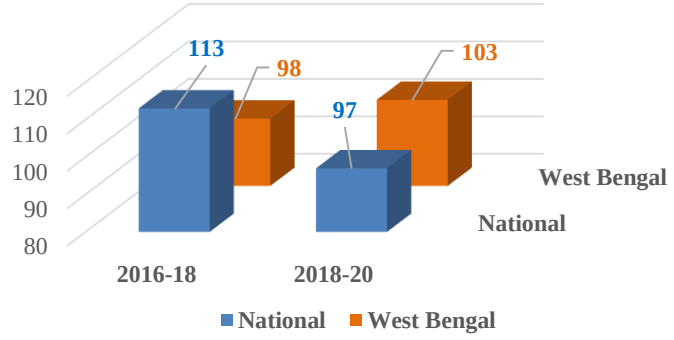
Records, however, showed that the State had failed to achieve the target of ensuring institutional deliveries. Further, out of the total 55,000 home deliveries, from FYs 2019-20 to 2021-22, 54,759 (99.56 *per cent*) deliveries at home, had remained unattended by SBAs.

Although, in HMIS data, 172 SCs were shown to have a labour room (within the SCs), 112 of them had never conducted any deliveries, while information on the rest was not available. Though none of the SCs had any functional beds, it was observed that 164 SCs had claimed to have conducted deliveries. Moreover, of these 164 SCs, 146 SCs did not have a labour room, as per HMIS. HMIS data showed that as many as 6,746 SCs did not have Intra-natal services[27]. Moreover, the Traditional Birth Attendants and ASHA had not even been trained, in 1,294 SCs.

In the test-checked SCs, no deliveries had been conducted in six years (*i.e*. the period covered under audit). Against 454 cases of home deliveries, in areas covered by these SCs, only 49 home deliveries had been assisted by ANMs ***(Appendix 3.4)***.

Under this backdrop, it is pertinent to mention here that Maternal Mortality Ratio of the State had increased not only from its earlier level but also rose above the National level in 2020:

Chart 3.3: Increase in Maternal Mortality Ratio



Source: Sample Registration System (SRS) Report

D. Referral Services

Appropriate and timely referral of such identified delivery cases which are beyond the management capacity of the SCs, were to be made.

[25] *Lokepith and Santuri*
[26] *Bhadutala, Arabari, Garhmal, Lokepith, Nimki Mohar, Kharika PHC attached, Surun, Indran, Marnai, Majhiar, Hilla Tea Estate, Dhansura SSK, Hutmura SSK and Santuri*
[27] *Care taken for mothers and newborn at the time of child birth*

However, there were 5,737 SCs which did not have 24-hour referral services, for complicated pregnancy cases. Moreover, out of 4,405 SCs (information in regard to 226 SCs was not available), where referral services were shown as being available, in 260 SCs, the mothers had not been accompanied by any ANM, or by trained personnel, during referral.

In the 38 test-checked SCs, nine SCs[28] (23.68 *per cent*) did not have assured referral services in cases of complications, during pregnancy and childbirth.

E. Post-natal care

Post-natal care includes initiation of early breastfeeding, within one hour of birth, ensuring post-natal home visits on the 0, 3rd, 7th and 42nd day for the mother and child, with additional visits being made on the 14th, 21stand 28th days, in cases of low birth weight babies *etc*.

The HMIS database, however, showed that 113 Sub-Centres had not rendered post-natal services at all. In the test-checked SCs, post-natal visits (within seven to 10 days) had not been made in 7,881 (39.69 *per cent*) deliveries, in 34 of the test-checked SCs (excluding four SCs of the Purulia district, for which no data of Post-natal visits, was provided to Audit). Further, in case of 5,687 deliveries (28.64 *per cent*), no post-natal visits had been made on the 42nd day, out of the total 19,854 deliveries, in the Sub-Centre areas for the period from FYs 2016-17 to 2021-22 ***(Appendix 3.4)***.

F. New-born, Child and Adolescent Care

The New-born Care Corner, in the Labour Room of the SC, was to provide essential newborn care. The SC was to assess the growth and development of the infants and under-five children and make timely referrals. Full immunization of all infants/ children and identification and follow-up, referral and reporting of Adverse Events Following Immunization (AEFI), were to be ensured.

Adolescent care included education, counselling, and referral; prevention and treatment of Anaemia; and counselling on the harmful effects of tobacco and its cessation.

New-born care facilities were not available in 1,231 SCs and there were no immunisation services in 53 SCs. Adolescent healthcare was not being provided in 285 SCs. None of the test-checked SCs had newborn care facilities.

In reply, against Adolescent Care, the Department mentioned (February 2024) about activities undertaken by ASHA in general like distribution of sanitary napkins, organising quarterly and monthly peer educators meeting under Rashtriya Kishore Swasth Karyakram *etc*. The Department, however, did not contradict the fact of non-availability of adolescent healthcare service in 285 SCs, as pointed out in audit.

3.1.2 Services delivered by Primary Health Centre

PHCs are the cornerstone of rural health services. They are the first point of call to a qualified doctor of the public sector, in rural areas, for the sick and those who directly report or are referred from Sub-Centres, for curative, preventive, and promotive healthcare. They act as referral units for six Sub-Centres and refer out cases to Community Health Centres (CHCs-30 bedded hospitals) and

[28] *Paschim Joynagar, Kankrasuti, Buruj, Jogeshganj South, Bishpur, Chakmoulani, Golamara, Dhansura SSK and Dandahit*

higher order public hospitals, at sub-district and district hospitals. They need to have four to six indoor beds for patients. West Bengal had[29] 916 PHCs in the State.

The following services have been classified as 'Essential' or 'Minimum Assured' Services:

(i) Medical care

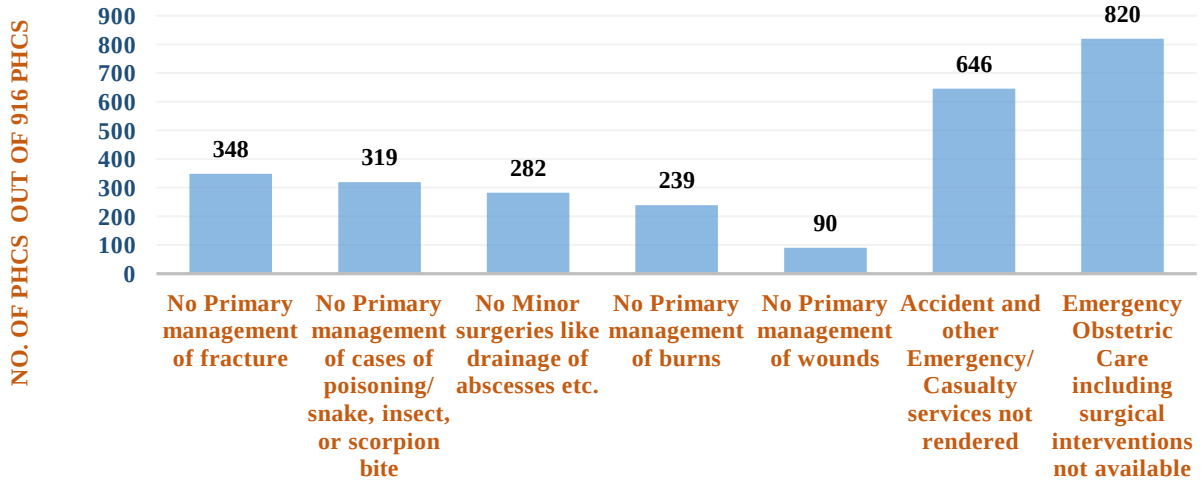
A. OPD and 24 hour emergency services

As per IPHS norms, PHCs were required to provide a total of six hours of OPD services. These included four hours in the morning and two hours in the afternoon, for six days in a week. The minimum OPD attendance was expected to be 40 patients per doctor per day.

As per IPHS, 24 hour emergency services; where appropriate, management of injuries and accidents; first aid; stitching of wounds; incision and drainage of abscesses; management of patients with dog bite/ snake bite/ scorpion bite cases, and other emergency conditions, were to be provided, for stabilization of the condition of the patients, before referral. These services were to be provided primarily by the nursing staff. However, in cases of need, MOs would be available, to attend to emergencies on call basis.

HMIS data revealed that, though only six PHCs did not have OPD services, the following basic ailments were found to have not been managed, in a considerable number of PHCs, as detailed below:

Chart 3.4: PHCs not rendering Services in State

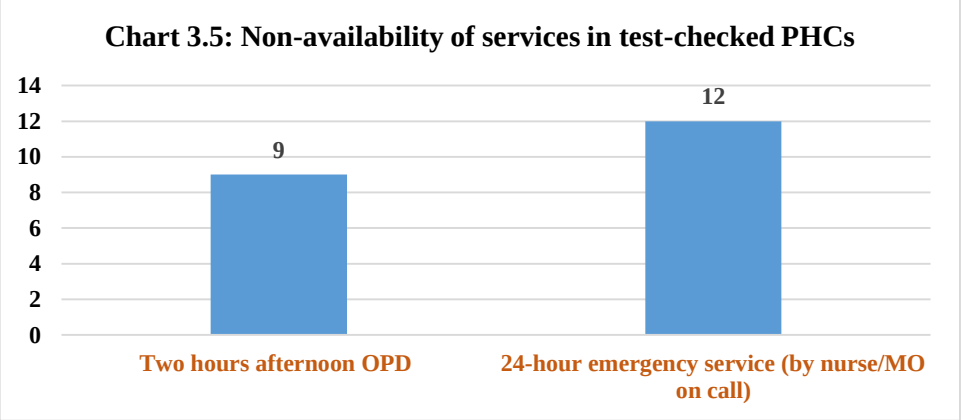


Source: HMIS data

Accident and other Emergency/ Casualty services were not rendered in 646 PHCs, while Emergency Obstetric Care, including surgical interventions like caesarean sections and other medical interventions were not available in 820 PHCs in the State.

Further, the following services were not available, in different test-checked PHCs, as detailed in ***Chart 3.5***.

[29] *As of March 2022*



Source: Reply furnished by test-checked PHCs

In the 19 test-checked PHCs, two hours afternoon OPDs were not conducted in nine PHCs (47.37 *per cent*) and 24-hour emergency services (by nurse/ MO on call) were not available in 12 PHCs[30] (63.16 *per cent*).

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

B. In-patient services

A typical Primary Health Centre covers a population of 20,000, in hilly, tribal, or difficult areas and a population of 30,000, in plain areas, with six indoor/ observation beds.

Review, however, showed that 585 of the 916 PHCs were serving more than 30,000 population due to a shortage in the number of PHCs in the State (as discussed earlier), besides, it was also noticed that the Indoor Patient Departments of the existing PHCs were non-operational, as shown below:

Table 3.3: Non-operational IPDs in the existing PHCs

PHC status	No. of PHCs	Sanctioned bed strength	PHCs with non-functional beds	No. of PHCs having functional beds	Functional bed strength
With sanctioned bed strength	600	4,955	324	276	1,892
Without sanctioned bed strength	316	--	316	--	--
Total:	**916**	**4,955**	**640**	**276**	**1,892**

Source: HMIS data

Thus, out of the 4,955 beds, sanctioned in the existing 916 PHCs, the State department had not made 3,063 beds (4,955 *minus* 1,892) functional which is 61.82 *per cent* of the sanctioned beds. The State department had not fixed the number of sanctioned beds for 316 PHCs while, 640 PHCs, constituting 69.86 *per cent* of the PHCs, did not have functional beds.

Analysis of the HMIS database showed that 697 PHCs (including information not available against 34 PHCs) did not have IPD services. This showed that apart from the 640 PHCs which did not have functional beds, 57 such PHCs (697 *minus* 640) which had beds, were not rendering IPD services. Of the PHCs wherein beds had been sanctioned, 146 PHCs had less than 40 *per cent* of bed occupancy rate, in all 12 months, during the test-checked year (FY 2021-22).

[30] *Pirakata, Kharika, Bajitpur, Masia, Hingalganj, Majhiar, Surun, Looksan, Chayanpur, Hutmura, Santuri and Balitora*

In the 19 test-checked PHCs, 15 PHCs[31] (78.95 *per cent*) served population of more than 30,000 each and 12 PHCs (63.16 *per cent*)[32] did not have any functional bed while Mohar PHC of Paschim Medinipur and Hinganganj PHC of Bashirhat Districts though had functional beds, no deliveries actually took place.

Further, it was observed that, out of the 108 beds, sanctioned in 12 PHCs, the department could not make 52 beds (48.14 *per cent*) functional, in the 19 test-checked PHCs ***(Appendix 3.5)***.

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

C. Maternal and Child Healthcare including Family Planning

As per IPHS, from the Service delivery angle, PHCs may be of two types, depending upon the delivery case load – Type-A and Type-B. Type-A PHCs have delivery loads of less than 20 deliveries in a month, while Type-B with delivery loads of 20 or more deliveries in a month.

The categorisation of PHCs was not provided to Audit, though sought for. Scrutiny of the HMIS database showed that 229 PHCs had been categorized as 'Delivery Points'. However, only 157 of these PHCs had functional IPD beds.

In the test-checked PHCs, eight PHCs (66.67 *per cent*)[33] did not have any functional beds, out of the 12 PHCs[34] designated as Health and Wellness Centre.

1. Ante-natal care

As per IPHS, antenatal care included early registration of all pregnancies, ideally in the first trimester (*i.e.* before the 12th week of pregnancy). Antenatal care included a minimum of four antenatal checkups; and minimum laboratory investigations, like Haemoglobin, Urine albumin and sugar, RPR test for syphilis, Blood Grouping and Rh typing and chemoprophylaxis for Malaria in high malaria endemic areas, for pregnant women *etc.*

- HMIS data showed that 168 PHCs (including information not available against 40 PHCs) had not rendered antenatal care services to the pregnant women.
- In the test-checked PHCs, 3537 registered mothers had not registered within the 1st trimester, out of the total number of 74,649 registered mothers[35], for the period from FYs 2016-17 to 2021-22.
- If not more, at least the third check-up, of the 4 Ante-Natal Care check-ups of a pregnant woman, was to be done by the MO of the PHC, instead of by the ASHA/ANM. Review, however, showed that 35 *per cent* (11,623) of the registered pregnant women, of seven PHCs, had not been checked even once by the Medical Officer, in their ante-natal phase. Further, 12,040 (16.13 *per cent*) registered mothers had not received four ANC check-ups.

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[31] *Godapiasal, Pirakata, Mohar, Kharika, Bajitpur, Masia, Jogeshganj, Hingalganj, Marnai, Surun, Moulani, Rajdanga Dakshin Hanskhali, Dhumpara, Looksan and Balitora*

[32] *Pirakata, Kharika, Bajitpur, Masia, Majhiar, Surun, Moulani, Looksan, Chayanpur, Hutmura, Santuri and Balitora*

[33] *Pirakata, Kharika, Bajitpur, Masia, Surun, Moulani, Looksan,and Santuri*

[34] *Godapiasal, Pirakata, Mohar, Kharika, Bajitpur, Masia, Jogeshganj, Surun, Moulani, Rajdanga Dakshin Hanskhali, Looksan and Santuri*

[35] *In 15 PHCs, except four PHCs in the Jalpaiguri district*

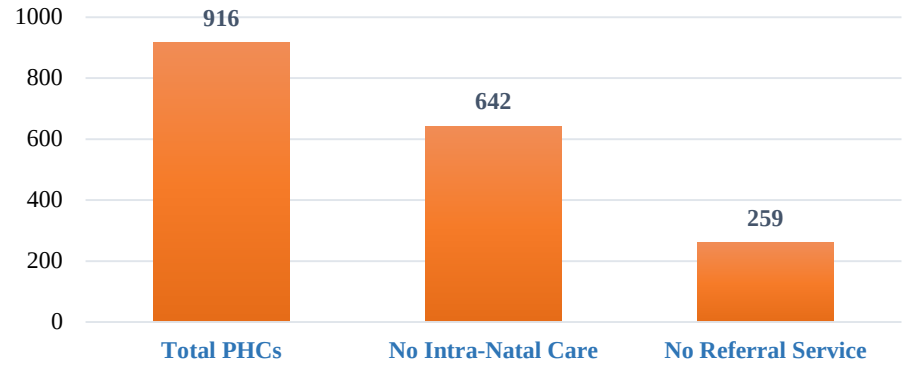
- Out of the total 74,649 registered mothers, Hb of 5,041 (6.75 *per cent*) and BP of 20,145 (26.99 *per cent*) registered mothers was not monitored. Against 54,848 registered mothers of 11 PHCs, Urine of 1,456 (2.65 *per cent*) was not examined for sugar and protein. Further, 22,018 mothers (30.42 *per cent*), against 72,384 registered mothers, had not received the 2nd dose of the Tetanus Toxoid (TT) booster ***(Appendix 3.6)***.

  The Department did not furnish any reply except stating the fact (February 2024) that the booster dose of TT/ Tetanus and adult diphtheria (Td) vaccine is given as single dose in subsequent pregnancy occurring within three years. However, the actual number of such pregnancies was not furnished.

2. Intra-natal care

As per IPHS, PHCs are required to render 24-hour delivery services, both normal and assisted, to promote institutional deliveries. Appropriate and prompt referral is to be made for cases needing specialist care. Minimum 48 hours of stay is required after delivery and labour is to be managed using partograph.

Chart 3.6: PHCs having no intra-natal and referral services



Source: HMIS data

Records showed that 642 PHCs (70.09 *per cent*) had not provided Intra-natal care services. It is pertinent to mention, that while 697 PHCs which were shown in HMIS as not having IPD services *{paragraph 3.1.2(i) B},* the figure of 642 PHCs not having Intra-natal care service was inconsistent. Moreover, 289 PHCs (31.55 *per cent)* did not have referral services for appropriate and prompt referral of needy mothers to higher facilities.

In the 19 test-checked PHCs, 16 PHCs[36] (84.21 *per cent*) did not have assured referral services (Govt. ambulance/ PPP arrangement), in cases of complications needing specialist service.

The Department in reply stated (February 2024) about availability of the ANC services but remained silent about Intra-natal services. Further, though the HMIS data of the department showed non-availability of referral services in 289 PHCs, the Department claimed to have referral transport[37] facilities in PHCs, in its reply.

[36] *Pirakata, Kharika, Bajitpur, Masia, Jogeshganj, Hingalganj, Majhiar, Surun, Marnai, Moulani, Rajdanga Dakshin Hanskhali, Looksan, Chayanpur, Hutmura, Santuri and Balitora*
[37] *102 under Janani Shishu Suraksha Karyakram scheme*

3. Post-natal Care

As per IPHS, PHCs are required to ensure post- natal care for the day 0 (*i.e.*, the day of delivery) and the 3rd day, at the health facility, both for the mother and new-born and to instruct the ANM of the concerned area, to ensure post-natal home visits on the 7th and 42nd days. Additional visits are to be paid for a low-birth-weight baby (less than 2,500 gm) on the 14th, 21st and on 28th days. As per HMIS data, 349 PHCs (38.10 *per cent*) had not provided post-natal care services to the mother and/ or the infant.

In the test-checked PHCs, postnatal services were not available in four[38] test-checked PHCs in the Purulia district and in three[39] PHCs in the Jalpaiguri district. Further, no records were available regarding the availability of postnatal care in case of three[40] PHCs in Uttar Dinajpur.

The Department only furnished replies (February 2024) against the observations of test-checked PHCs by generally stating that post-natal care is provided at delivery points for two to seven days and rest of the post-natal care are provided by ANMs and ASHA at home. However, no specific data in this regard was furnished.

4. Newborn and Child Care

As per IPHS, Facilities for Essential Newborn Care (ENBC) and resuscitation {Newborn Care Corner in Labour Room/ OT and management of neonatal hypothermia (provision of warmth/ Kangaroo Mother Care (KMC))} were also to be ensured.

Routine and emergency care of sick children, including Integrated Management of Neonatal and Childhood Illnesses (IMNCI) strategy and inpatient care, was to be provided, with provisions for prompt referral of sick children requiring specialist care, to assess the growth and development of the infants and under-five children. Timely referrals were to be made in such cases. Besides, full immunisation of all infants and children was to be done, against vaccine preventable diseases, as per GoI guidelines.

No Newborn care services were available in 497 PHCs (54.26 *per cent*), as shown in HMIS. However, when 642 PHCs were not rendering intra-natal (delivery) services, it was not clear how new born care could have been provided in 145 PHCs (642 *minus* 497), which were not conducting deliveries in the centres.

Childcare services, including immunisation of children, were not provided in 375 PHCs (40.94 *per cent).* Nutrition services were not available in 553 PHCs (60.37 *per cent*).

Among the test-checked PHCs, PHCs[41] in the Purulia district had not carried out immunization programmes. Immunization data was not available in case of one PHC in Uttar Dinajpur and three PHCs[42] in Jalpaiguri.

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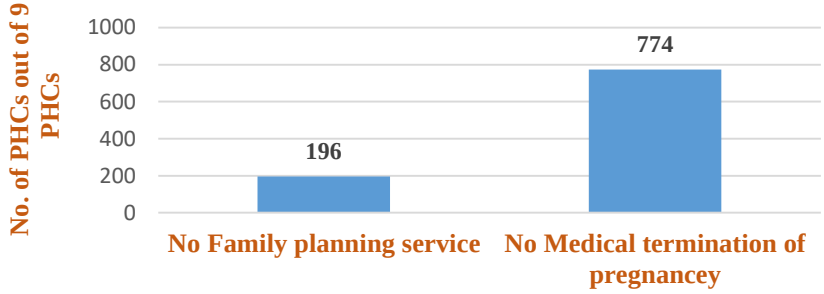
[38] *Chayanpur, Hutmura, Santuri and Balitora*
[39] *Moulani, Rajdanga Dakshin Hanskhali and Looksan*
[40] *Marnai, Majhiar and Surun*
[41] *Chayanpur, Hutmura, Santuri and Balitora*
[42] *Moulani, Rajdanga Dakshin and Looksan*

5. Family Planning

As per IPHS, Family planning services included education, motivation and counselling to adopt appropriate family planning methods. Besides, provision of contraceptives, such as condoms, oral pills, emergency contraceptives, IUCD insertions, referral and follow-up of eligible couples adopting permanent methods (Tubectomy/ Vasectomy) was to be made. In addition, counselling services and appropriate referral for couples having infertility issues, were to be provided. Permanent methods, like Tubal ligation and vasectomy/ Non-Scalpel Vasectomy (NSV), were also to be provided, where trained personnel and facility existed. Medical Termination of Pregnancy (MTP), using the Manual Vacuum Aspiration (MVA) technique was also to be provided in PHCs.

HMIS exhibited that 196 PHCs (21.40 *per cent*) had not rendered family planning services (in the PHCs), while services for Medical Termination of Pregnancy (MTP) were not available in 774 PHCs (84.50 *per cent*).

Chart 3.7: Non-availability of Family Planning Services in the State



Source: HMIS data

In the 19 test-checked PHCs, 17 PHCs[43] had not provided permanent family planning services and no PHC had conducted medical termination of pregnancy, using Manual Vacuum Aspiration (MVA).

6. School Health Programme

As per IPHS, Teachers were required to screen students on a continuous basis and ANMs/ Health Workers (Male) were to visit one school every week, for screening, treatment of minor ailments and referral. Doctors from CHCs/ PHCs were also required to visit one school per week, based on the screening reports submitted by the teams.

Review showed, that ANMs/ HW(M)/ doctors of 419 PHCs had not made the stipulated visits to any school, under the School Health Programme[44], resulting in deprivation of the school going children, under the jurisdictions of these PHCs, from screening for general health, assessment of Anaemia/ Nutritional status, visual acuity, hearing problems, dental check-up, common skin conditions, heart defects, physical disabilities, learning disorders, behaviour problems *etc.* Weekly supervised distribution of Iron-Folate tablets, biannually supervised de-worming and administration of Vitamin-A in needy cases, also remained unattended to, as a result.

[43] *Godapiasal, Pirakata, Mohar, Kharika, Masia, Hingalganj, Majhiar, Surun, Marnai, Moulani, Rajdanga Dakshin Hanskhali, Dhumpara, Looksan, Chayanpur, Hutmura, Santuri and Balitora*

[44] *To detect and treat diseases early in children and adolescents including identification of malnourished and anemic children with appropriate referrals to PHCs and hospitals.*

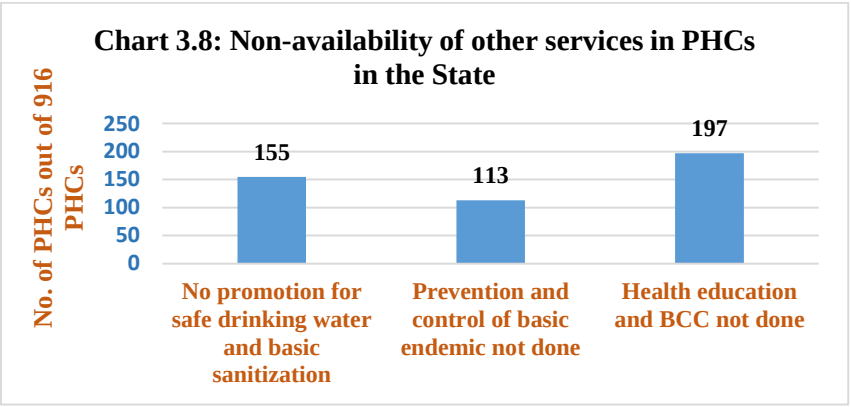
In the test-checked PHCs, the ANMs/ HWMs had not visited at least one school every week, to screen students for ailments, treatment and referral, in nine PHCs[45]. In case of 17 PHCs[46], none of the MOs, attached to the PHCs, had visited one school per week, based on the screening report.

In reply, Department stated (February 2024) that under Rashtriya Bal Swasthya Karyakram (RBSK), teams visit every school and Anganwadi Centers (AWCs) periodically for screening and identifying any defects. However, no information about actual coverage was furnished nor was it clarified that the requirements of School Health Programme were met by RBSK in entirety.

D. Other services

These apart, as per IPHS, PHCs were to render services like promotion of safe drinking water and basic sanitation; prevention and control of locally endemic diseases like malaria, Kala Azar, Japanese Encephalitis, provide health education and promote Behaviour Change Communication (BCC) *etc.*

Chart 3.8: Non-availability of other services in PHCs in the State



Source: HMIS data

Records showed that no promotion of safe drinking water and basic sanitation, had been made in 155 PHCs. Prevention and control efforts of basic endemics had not been done in 113 PHCs, while 197 PHCs had not rendered services like health education and Behaviour Change Communication (BCC) to their covered populations.

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

E. Non-operationalisation of the Health & Wellness Centres (Su-Sasthya Kendras)

The National Health Policy, 2017, denoted an important change, from a very selective to a comprehensive primary healthcare package, which included geriatric healthcare, palliative care and rehabilitative care services. The facilities which started providing the larger package of comprehensive primary healthcare were to be called Health and Wellness Centres' (HWCs). This necessitated upgradation of the existing sub-centres and reorienting PHCs, to provide a comprehensive set of preventive, promotive, curative and rehabilitative services.

Review of the status of operationalization of HWCs (re-named as *Su-Sasthya Kendras*), in West Bengal, is given in **Table 3.4**.

[45] *Pirakata, Masia, Majhiar, Marnai, Surun, Dhumpara, Looksan, Hutmura and Santuri*
[46] *Godapiasal, Pirakata, Kharika, Bajitpur, Masia, Jogeshganj, Majhiar, Marnai, Surun, Moulani, Rajdanga Dakshin Hanskhali, Dhumpara, Looksan, Chayanpur, Hutmura, Santuri and Balitora*

Table 3.4: Status of operationalization of *Su-Sasthya Kendras*

	Target*	Functional#	Yet to be made functional
Upgradation of SCs to HWCs	8,579	4,850	3,729 (43.47%)
Re-orientation of PHCs to HWCs	913	00	913
Total:	**9,492**	**4,850**	**4,642 (48.90%)**

*Source: Target from: 'A compendium of HWC operationalization' and Functional status from: Reply of the H&FWD; * As of December 2022; #As of July 2022*

Though almost 51 *per cent* of the targeted number of conversion/ up-gradation of primary health facilities to HWCs, was shown to have achieved, in departmental records, works in regard to up-gradation/ new constructions, of none of the projects, were found to have been completed, from the status obtained from the department.

In reply, Department stated (February 2024) that, by December 2022, 7,330 SCs and 915 PHCs were made functional as HWCs. It was thus evident that target for upgradation of SCs to HWCs still remained unachieved.

3.1.3 Services delivered by Community Health Centres

CHCs, constituting the First Referral Units (FRUs), were designed to provide referral healthcare for cases from the PHC level and for cases in need of specialist care, approaching the Centre directly. Four PHCs are included under each CHC, thus catering to approximately 0.80 lakh populations in tribal/ hilly/ desert areas and 1.20 lakh population for plain areas. A CHC is required to be a 30-bedded hospital, providing specialist care in Medicine, Obstetrics and Gynaecology, Surgery, Paediatrics, Dental and AYUSH. West Bengal had[47] 348 CHCs in the State.

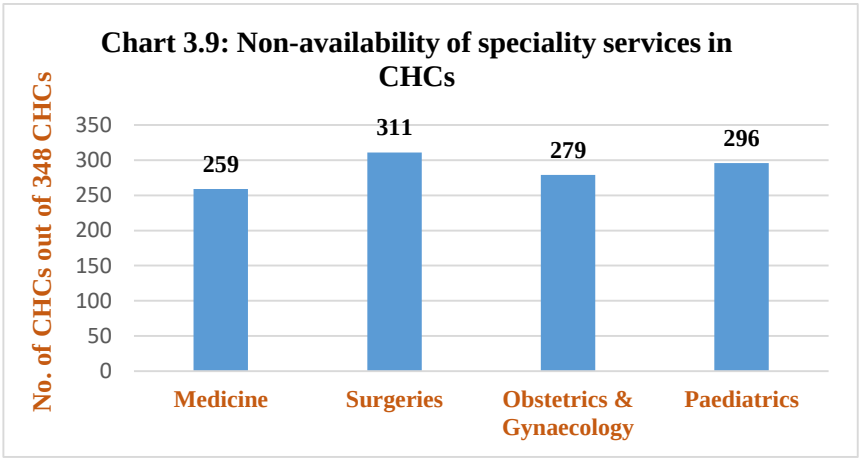
The following services, as per IPHS norms, which have been classified as 'Essential' or 'Minimum Assured' Services, are to be available in the CHCs:

(i) OPD Services and IPD Services

The CHCs should provide for General Medicine, Surgery, Obstetrics & Gynaecology, Paediatrics and Dental services.

Analysis of HMIS records as regards Medicine, Surgery, Obstetrics & Gynaecology and Paediatrics services, showed that a majority of CHCs (BPHCs/ RHs), had not rendered these services, as shown below:

Chart 3.9: Non-availability of speciality services in CHCs



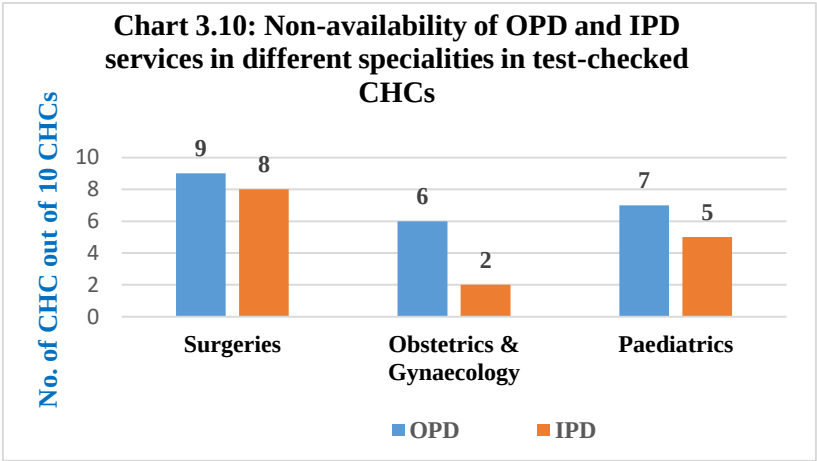
Source: HMIS data

[47] *As of March 2022*

The bed occupancy rate of 36 CHCs remained less than 40 *per cent*, while, in 80 CHCs, it remained between 40 *per cent* and 60 *per cent*, in all the 12 months, during the test-checked financial year 2021-22.

In the test-checked CHCs, OPD services for Surgeries were not rendered in nine CHCs[48], six CHCs[49] had not rendered OPD services for Obstetrics & Gynaecology and Paediatrics OPD services had not been rendered in seven CHCs[50]. Further, IPD services for Surgeries at eight CHCs[51], Obstetrics & Gynaecology at two CHCs[52] and Paediatrics at five CHCs[53], had also not been provided.

Chart 3.10: Non-availability of OPD and IPD services in different specialities in test-checked CHCs



Source: Data furnished by test-checked CHCs

It was observed in audit that a patient with breast tumor, had been treated by a Dental Surgeon in Itahar RH, Uttar Dinajpur, while, in the same RH, cases of manning of OPDs by Pharmacists were also noticed, who had issued medicines to the patients, in slips.

Thus, the population under the coverage of the CHCs had not received the essential OPD and IPD services.

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

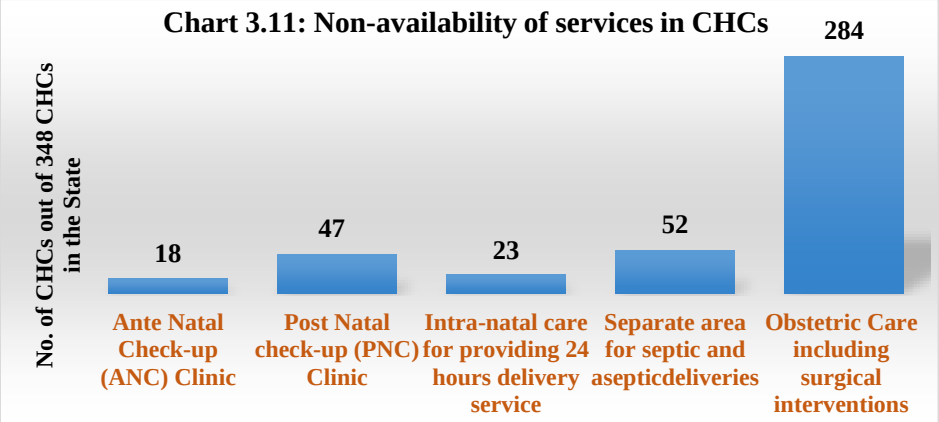
(ii) Maternal Health

The services provided in CHCs included a minimum of four ANC check-ups, including Registration & associated services; as well as 24-hour delivery services, including normal and assisted deliveries. It also included management of labour using Partographs, all referred cases of complications in pregnancy, ensuring post-natal care and providing a minimum stay of 48 hours after delivery. Proficiency in identification and management of all complications, including PPH[54], Eclampsia, Sepsis *etc.*, and ensuring essential and emergency obstetric care, including surgical interventions like caesarean sections and other medical interventions, was also included in the services.

[48] *Sulkapara RH, Odlabari BPHC, Itahar RH, Kunor BPHC, Rudrapur RH, Sandelerbil RH, Sabang RH, Kushtor RH and Muradih RH*
[49] *Sulkapara RH, Itahar RH, Kunor BPHC, Sandelerbil RH, Kushtor RH and Muradih RH*
[50] *Sulkapara RH, Odlabari BPHC, Kunor BPHC, Sandelerbil RH, Sabang RH, Kushtor RH and Muradih RH*
[51] *Sulkapara RH, Itahar RH, Kunor BPHC, Rudrapur RH, Sandelerbil RH, Sabang RH, Kushtor RH and Muradih RH*
[52] *Kushtor RH and Muradih RH*
[53] *Sulkapara RH, Kunor BPHC, Sabang RH, Kushtor RH and Muradih RH*
[54] *Post-Partum Hemorrhage*

Scrutiny of HMIS data showed that 18 CHCs did not hold Ante-Natal Clinics (ANCs) and 47 CHCs did not hold Post-Natal Clinics (PNCs) (March 2022). Intra-Natal Care, for providing 24 hours delivery services, including normal and assisted deliveries, had not been provided by 23 CHCs. Moreover, in 52 CHCs, there were no separate areas for septic and aseptic deliveries.

Chart 3.11: Non-availability of services in CHCs



Source: HMIS data

Emergency Obstetric Care, including surgical interventions like caesarean sections and other interventions, were absent in 284 CHCs in the State.

Further scrutiny showed that, though 51 CHCs[55] had Emergency Obstetric Care services, no caesarean deliveries had been conducted in 24 CHCs, during FY 2021-22.

In the test-checked CHCs, it was observed that, in Sulkapara RH of the Jalpaiguri district, the minimum period of 48 hours stay by the mothers had not been followed and in all the 7087 cases during the audit period, mothers had been released before 48 hours. Further, in test-checked CHCs in Paschim Medinipur and in Uttar Dinajpur district and Odlabari RH of the Jalpaiguri district, it was observed that the percentage of mothers discharged within 48 hours of delivery, varied between 0.06 to 24.49 *per cent* ***(Appendix 3.7)***.

Scrutiny showed that, out of the test-checked CHCs, which claimed to have Emergency Obstetric Care services, no caesarean deliveries had been conducted in two CHCs[56] of the Jalpaiguri District and Itahar RH of the Uttar Dinajpur district, during the entire period of audit. However, the Salboni RH of Paschim Medinipur had started performing caesarean deliveries w.e.f. FY 2021-22 and Sabang RH in Paschim Medinipur had started caesarean deliveries from FY 2019-20.

Scrutiny of the information furnished by the CHCs also revealed that managing labour using Partograph, was not very common and had only been followed in Itahar RH of the Uttar Dinajpur district and in the Paschim Medinipur District.

The Department furnished reply (February 2024) only against the audit observation of not having ANC, PNC and INC services in CHCs. It stated that clinics under Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) were being held in 440 rural facilities and 172 urban facilities where pregnant women are examined by doctors/ specialist (G&O) on 9th of every month. The Department, however, did not furnish the list of such facilities. Further,

[55] *Information against 13 CHCs was not available in HMIS*
[56] *Sulkapara RH and Odlabari BPHC*

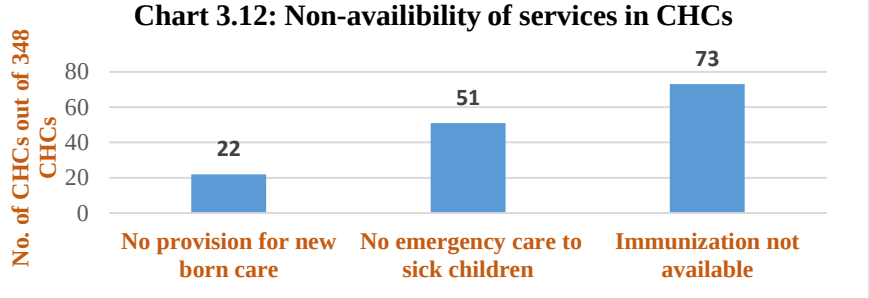
PMSMA was only meant to extend ANC services to pregnant women and not PNC and/or INC services. Moreover, non-availability of services in CHCs remained a fact.

(iii) New-born Care and Child health

To ensure essential new-born care and resuscitation a CHC was required to provide a New-born Corner in the Labour Room, an Operation Theatre (where caesarean deliveries could take place) and a New-born Stabilisation Unit. This also included routine and emergency care of sick children, by providing facilities based on the IMNCI[57] strategy and ensuring full immunisation of infants and children against Vaccine Preventable Diseases and Vitamin-A prophylaxis.

Review showed that there was no provision of new-born care in 22 CHCs, while emergency care to sick children was not being provided in 51 CHCs. Immunisation had not been done in 73 CHCs, as of March 2022.

Chart 3.12: Non-availibility of services in CHCs



Source: HMIS data

In the test-checked CHCs in Sandelerbill RH of Basirhat DH, there was no New-born Care Corner for emergency care of sick children.

In reply, Department stated (February 2024) that there were 286 Sick Newborn Stabilisation Units (SNSU) functional in the State and most of those were at CHC level. Considering 348 CHCs in the State, a bigger gap appeared to exist from the reply of the department. The Department also stated that New-born Care Corner (NBCC) in Sandelerbill RH of Bashirhat HD has now been made functional.

(iv) Family Planning

CHCs are required to ensure full range of family planning services, including IEC, counselling, provision of contraceptives, Non-Scalpel Vasectomy (NSV), Laparoscopic Sterilisation Services and their follow-up. They should also provide safe abortion services, as per the MTP[58]Act and abortion-care guidelines of MOHFW.

The full range of family planning services, including Laparoscopic Services, were not available in 179 CHCs. Safe abortion services, *i.e.* MTP, were not being rendered by 105 CHCs. In the test-checked CHCs, Non-Scalpel Vasectomy (NSV) was not being performed in three CHCs[59] and Laparoscopic Sterilization Services (LSS) were also not being conducted in three CHCs[60], during the period covered under audit.

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

[57] *Integrated Management of Neonatal and Childhood illness*
[58] *Medical Termination of Pregnancy*
[59] *Itahar RH, Kunor BPHC and Kushtor RH*
[60] *Kunor BPHC, Kushtor RH and Rudrapur RH*

Recommendations:

4. ***Availability of Emergency Obstetric Care, including surgical interventions like caesarean section and other medical interventions, may be ensured in selected PHCs and in all CHCs, in the State.***
5. ***Provisions for new-born care and emergency care, for sick children, may be ensured, in all CHCs.***

3.1.4 Services delivered by District/ Sub-District (DH/ SDH) level hospitals

The District/ Sub-District hospital is an essential component of the district health system and functions as a secondary level of healthcare, which provides curative, preventive and promotive healthcare services to the people in the district/ sub-division. Every district is expected to have a district hospital, linked with the health centres down below the district, such as Sub-district/ Sub-divisional hospitals, Community Health Centres, Primary Health Centres and Sub-centres. West Bengal had[61] 18 District Hospitals and 36 Sub-Divisional Hospitals in the State.

(i) Non-utilisation of sanctioned beds

The standards of IPHS have been made for up to 500 beds for a District Hospital and up to 100 beds for a Sub-Divisional Hospital. In West Bengal, most of the DHs and SDHs had sanctioned beds more than that indicated in IPHS.

However, a review of the number of beds sanctioned and the number of beds actually functional in the hospitals, showed the following scenario:

Table 3.5: Number of functional beds *vis-à-vis* sanctioned beds in DHs

Name of DH	Sanctioned bed	No. of functional bed	No. of non-functional bed	Percentage of non-functional beds
M.R. Bangur DH/ SSH	1,125	717	408	36.27
Alipurduar DH/ SSH	594	500	94	15.82
Bishnupur DH/ SSH	620	433	187	30.16
Jhargram DH	600	543	57	9.50
Suri DH/ SSH	1,042	766	276	26.49
Darjeeling DH/ SSH	500	398	102	20.40
Balurghat DH/ SSH	930	751	179	19.25
Jalpaiguri DH	1,500	975	525	35.00
Nadia DH	1,018	856	162	15.91
Howrah DH	642	636	6	0.93
Bashirhat DH/ SSH	600	549	51	8.50
Siliguri SH	400	365	35	8.75
Imambara Sadar DH	650	625	25	3.85
Nandigram DH	300	211	89	29.67
Barasat DH	600	600	0	0.00
Kalimpong DH	370	370	0	0.00
Tamluk DH	500	500	0	0.00
Asansol DH	750	750	0	0.00
Total:	**12,741**	**10,545**	**2,196**	**17.24**

Source: HMIS data

While the overall non-utilisation of sanctioned beds was 17.24 *per cent*, non-utilisation was very high in respect of the M.R. Bangur, Bishnupur, Suri, Jalpaiguri and Nandigram DHs.

In respect of SDHs, the status was shown in **Table 3.6**.

[61] *As of March 2022*

Table 3.6: Number of functional beds *vis-à-vis* sanctioned beds, in SDHs

Name of SDH	Sanctioned beds	Functional beds	Non-functional beds	Percentage of non-functional beds
Barrackpore SDH (DR. B.N. Bose)	277	277	0	0.00
Bongaon SDH & SSH	600	600	0	0.00
Salt Lake SDH	122	100	22	18.03
Baruipur SDH & SSH	368	368	0	0.00
Canning SDH	166	331	-165	-99.40
Kakdwip SDH & SSH	414	414	0	0.00
Khatra SDH	146	106	40	27.40
Bolpur SDH & SSH	520	428	92	17.69
Dinhata SDH	328	277	51	15.55
Mathabhanga SDH	300	196	104	34.67
Mekhliganj SDH	120	120	0	0.00
Tufanganj SD Hospital	170	192	-22	-12.94
Kurseong SDH	120	120	0	0.00
Gangarampur SDH & SSH	600	469	131	21.83
Islampur SDH & SSH	500	373	127	25.40
Arambagh SDH (P C SEN GOVT. MCH)	594	594	0	0.00
Serampore SDH & SSH	586	570	16	2.73
Chandannagore SDH	270	254	16	5.93
Uluberia SDH (S. Ch. Chattopadhyay MCH)	442	442	0	0.00
Mal SDH & SSH	400	335	65	16.25
Chanchal SDH & SSH	426	100	326	76.53
Contai SD Hospital	300	300	0	0.00
Egra SDH & SSH	476	476	0	0.00
Haldia SD Hospital	300	200	100	33.33
Ghatal SDH & SSH	550	527	23	4.18
Kharagpur SDH	311	325	-14	-4.50
Domkol SDH	400	400	0	0.00
Kandi SDH	331	331	0	0.00
Lalbagh SDH	300	300	0	0.00
Jangipur SDH & SSH	632	632	0	0.00
Ranaghat SDH	286	251	35	12.24
Tehatta SDH	100	126	-26	-26.00
Durgapur SDH	283	350	-67	-23.67
Kalna SDH & SSH	534	503	31	5.81
Katwa SDH	284	254	30	10.56
Raghunathpur SDH/ SSH	300	300	0	0.00

Source: HMIS data

A disproportional sanction of beds was evident from the above. It could be seen that, while the SDHs at Khatra, Mathabhanga, Islampur, Chanchal, Haldia *etc.*, were not utilising the beds sanctioned for them, the SDHs at Canning, Tufanganj, Kharagpur, Tehatta and Durgapur were operating significantly higher beds, over the sanctioned number.

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

(ii) Non-availability of OPD and IPD Services

- ***Essential services not available:***

As per IPHS, a DH was supposed to render certain minimum assured services, like General Medicine, General Surgery, Obstetrics & Gynae, Paediatrics, Emergency, ICU, Anaesthesia, Ophthalmology, ENT, Orthopaedics, Geriatric, Radiology, Dental care and Public Health services *etc.*

Review of the HMIS data, in respect of 18 DHs, showed that Paediatric services was not available in Siliguri DH and Public Health Management services were not available in the Nandigram DH, Nadia and Suri DHs ***(Appendix 3.8)*** (no information against Bishnupur DH had been uploaded in HMIS).

In regard to SDHs, it was observed that some basic essential services were not available in respect of the following SDHs ***(Appendix 3.9)***.

Table 3.7: Services not rendered by SDHs

Essential Basic Services	SDHs not rendering the services	
	Number	Name
Radiologist & Ultrasonologist	05	BN Bose, Kakdwip, Mathabhanga, Mal, Chanchal
Ayush	11	Khatra, Domkol, Lalbagh, Jangipur, Ranaghat, BN Bose, Canning, Serampore, Haldia, Kharagpur, Tehatta
Orthopaedics	02	Khatra, Kurseong
General Surgery	01	Mekhliganj
ENT	01	Tufanganj
Community Health	17	Salt Lake, Kakdwip, Khatra, Bolpur, Tufanganj, Islampur, & Chandannagar, Uluberia, Mal, Ghatal, Domkol, Lalbagh, Jangipur, Ranaghat, Kalna, Katwa and Raghunathpur

Source: HMIS data

In reply, the Department stated (February 2024) that at Tufanganj SDH, two ENT Surgeons were posted in 2022 and basic ENT services made available, though, major surgical services were not available in absence of OT equipment including operating microscope. The Department, however, remained silent about non-availability of other services.

- ***Non-availability of desirable services:***

Of the services which were desirable for a DH to render, services like Radiotherapy, Allergy and Dermatology & Venereology, were not rendered in a number of DHs, as shown below:

Table 3.8: Services not rendered by the DHs

Services	Number of DHs not having the services	Names of DHs not rendering services
Radiotherapy	12	Bashirhat, Asansol, Nadia, Tamluk, Jhargram, Jalpaiguri, Howrah, Imambara, Siliguri, Darjeeling, Suri and Alipurduar
Allergy	10	M. R. Bangur, Alipurduar, Suri, Siliguri, Bashirhat, Imambara, Jalpaiguri, Jhargram, Nandigram and Asansol
Skin & VD	1	Alipurduar

Source: HMIS data; Note: Information in regard to Bishnupur DH and Kalimpong DH had not been uploaded in HMIS

The two test-checked desirable services out of the seven services prescribed in IPHS, showed that Critical Care Services were not available in six SDHs, while eight SDHs did not have Dermatology & Venerology services.

- ***Super-speciality services not initiated:***

As per IPHS, District Hospitals were to be in a position to provide all basic speciality services and were to aim to develop super-specialty services gradually. IPHS also prescribed 16 super-specialty services, which a district hospital was to strive to render.

However, a review of HMIS data, against 13 such super-speciality/ diagnostic services, revealed:

Table 3.9: Super-Speciality services not provided in DHs

Super-Specialty service	No. of DHs not having the service	Super-Specialty service	No. of DHs not having the service
Cardiology	17	Neurology	18
Cardio thoracic & Vascular Surgery	18	Neurosurgery	18
Gastro-enterology	18	Oncology	6
Surgical Gastro-enterology	18	Endocrinology/ Metabolism	16
Plastic Surgery	17	Angiography	16
Nephrology	17	Echocardiography	16
Urology	18		

Source: HMIS data confirmed by the H&FWD

It was evident from the above table that, except for Oncology (to some extent), non-availability of super-specialty services was prevalent in 89 *per cent* to 100 *per cent* of the existing District Hospitals of the State.

In the test-checked DHs/ SDHs, the status of non-availability of essential (20), Desirable (8) and Super Specialty (16) OPD/ IPD services, was as below:

Table 3.10: Essential/ Desirable/ Super-Speciality services not provided in DHs/ SDHs

Sl. No.	Name of the hospital	No. of services not available at the hospital					
		Essential		Desirable		Super Speciality	
		OPD	IPD	OPD	IPD	OPD	IPD
1.	Jalpaiguri DH & SSH	1	0	1	2	15	15
2.	Bashirhat DH	1	1	2	2	15	15
3.	Islampur SDH	2	7	5	7	NA*	NA*
4.	Ghatal SDH	1	14	7	Not Available	NA*	NA*
5.	Raghunathpur SDH	3	2	6	6	NA*	NA*

*Source: Test-checked DHs & SDHs; **Not Applicable*

It may be mentioned here that some of the services as stated below which were found non-existent in the test-checked DHs/SDHs, were shown as available in the HMIS data ***(Appendices 3.8 and 3.9)***:

- Anesthesia OPD in Jalpaiguri DH,
- Radiology OPD/ IPD services in Bashirhat DH,
- Anesthesia OPD service and IPD services of Radiology, AYUSH and Community Health in Islampur SDH,
- IPD services of Anesthesia, Ophthalmology, ENT, Radiology, AYUSH and Community Health in Ghatal SDH, and
- AYUSH OPD services in Raghunathpur SDH

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

(iii) Maternity services

The position of Maternal and Child Care services in the DHs and availability of beds is shown in ***Appendix 3.10***.

- ***Discharge of mothers within 48 hours:*** The first 48 hours after delivery are the most critical and most of the major complications of the post-partum period, which could lead to maternal death, occur during this period. Hence, a woman who has just delivered, needs to be closely monitored during the first 48 hours and should not be discharged in case of institutional deliveries.

However, review of records of the five selected test-checked districts (*i.e.*, excepting Uttar Dinajpur) showed that 1,00,404 (12.97 *per cent*) mothers, out of the 7,74,246 number of institutional deliveries, had been discharged within 48 hours of delivery. The rate of such discharges was highest in the Jalpaiguri district (21.74 *per cent*), which cited constraints of space and bed capacity, enforcing discharge within 48 hours.

- ***Non-institutional Deliveries:*** The objective was to ensure institutional delivery of all pregnant women. However, in the five test-checked districts 0.70 lakh (6.04 *per cent*) deliveries, out of the total 11.60 lakh deliveries, had taken place at home during 2016-22. Uttar Dinajpur district reported the highest number of home deliveries (0.48 lakh) during the period. It was followed by Purulia (0.10 lakh) and Paschim Medinipur (0.06 lakh).

  In reply, the Department (February 2024) stated that the State is promoting and striving to achieve 100 *per cent* institutional deliveries.

- ***Home deliveries not attended by Skill Birth Attendants (SBA):*** To avoid pregnancy related complications, every home delivery was required to be cared for by a Skilled Birth Attendant (SBA).

However, in the five test-checked districts, 65,614 deliveries (93.71 *per cent*), out of 69,842 home deliveries, had taken place without the assistance of Skilled Birth Attendants, during the period from FY 2016-17 to FY 2021-22. No home deliveries in four districts (Bashirhat, Jalpaiguri, Purulia and Uttar Dinajpur) had been attended by SBAs.

- ***Non-availability of Eclampsia and Septic Labour Room with New-Born Care Corner (NBCC):*** SDH, Islampur suffered from non-availability of Eclampsia and Septic Labour Room with NBCC.

- ***Doctors/ Nurses not trained:*** Doctors and nurses posted at the neonatal stabilization unit of SNCU, at Bashirhat DH and Islampur SDH, had not been trained with facility-based care.

  In reply, the Department stated (February 2024) that the care providers of SNCU were subsequently trained in 2022-23.

- ***Adolescent Friendly Health Clinic (AFHC):*** Bashirhat DH and Islampur SDH had no full time Adolescent Friendly Health Services (AFHS) trained MO, nor did they have a full-time AFHS trained ANM/ LVH. Ghatal SDH, did not have an AFHS clinic.

  In reply, the Department (February 2024) while accepting the fact of absence of full time ANM/ LVH, stated that process of recruitment of full-time medical officer in Bashirhat DH and Islampur SDH have been initiated. Non-availability of AFHC in Ghatal SDH was also accepted by the Department.

(iv) Non-availability of facilities under Emergency Services

Bashirhat DH and 3 test-checked SDHs did not have provision of separate X-ray and basic laboratory facilities at their emergency wards, neither had the hospitals allocated 5 *per cent* of the total beds as emergency beds.

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

(v) Intensive Care Units (ICUs)/ Critical Care Units (CCUs)

The CCU of the Bashirhat DH had no facility of USG. The SDHs at Islampur and Ghatal did not have facility of ICU/ CCU. Though Raghunathpur SDH had an ICU/ CCU, it had not adopted the checklist for monitoring the quality of care like i) errors, ii) adverse drug reactions, iii) performance of individual staff *etc.* It also did not have a facility level monitoring committee, to monitor the activities of CCU.

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

3.1.5 Services delivered by Medical College & Hospitals

(i) Non-availability of Services at Raiganj Medical Collage & Hospital (RMC&H)

Delivery of the following services in District Hospitals were prescribed in IPHS However, the following procedures, under different services, were not available in the different departments/ wards even at the RMC&H, for the reasons noted against each:

Table 3.11: Non-Availability of services/ procedures in different wards, at the RMC&H

Sl. No.	Service	Procedure	Non-availability
1	Dental	Malocclusion	Orthodontic faculty unavailable
		Light cure	Instrument unavailable
		luxation and Arthritis of Temporomandibular Joints	Faculty unavailable
		Intra oral X-ray	Technician unavailable
2	Endoscopic	--	No endoscopic service
3	Medical	Bronchoscopy	Instrument unavailable
		Pericardial tapping	Cardiologist unavailable
		Liver Biopsies	Gastroenterologist unavailable
		Fibrotic Endoscopy	Instrument unavailable
		Peritoneal Dialysis	Nephrologist unavailable
4	Paediatric	Exchange Transfusion	MO not trained
		Cut down	MO not trained
		Plural/ Ascities Tap	MO not trained
		Live Biopsy u/ s guided	MO not trained
5	Psychiatry	Modified ECT	Instrument & other facilities unavailable
		Narco analysis	Instrument & other facilities unavailable
6	ENT	Nasal Endoscopy & Endoscopic Sinus	Instrument unavailable
		Inter Nasal Antrostomy	Instrument unavailable
		Transantral procedures	Instrument unavailable
		Transantral Biopsy	Instrument unavailable
		Rhinoplasty	Instrument unavailable
		Broncoscopic Diagnostic	Instrument unavailable
		Broncoscopic & FB removal	Instrument unavailable
7	Surgical	Arthroscopy	Instrument unavailable
		Stapedotomy	Instrument unavailable
		Hip Surgery	Implant not available
		Gride stone Arthroplasty	Implant not available
		Arthroplasty	Implant not available
		Excision Arthroplasty of elbow & other major joint	Implant not available
		Operation of hallus valgua	Implant not available

Sl. No.	Service	Procedure	Non-availability
		Bone surgery	Implant not available
		Bone Grafting	Implant not available
		Arthrotomy of hip	Implant not available
		Carpal tunnel Release	Implant not available
		Dupuytrens contracture	Implant not available

Source: Test-checked MCHs

The Department in respect of non-availability of ENT equipment stated that (February 2024) that such high-end equipment are supplied based on demand/ requisition and availability of fund. However, the Department remained silent about non-availability of other services as pointed out in audit.

(ii) Other observations on services in SSKM and other test-checked MCHs

- Due to space constraints and non-availability of alternative space at the RGMC&H, the Trauma Care Unit could not be established.
- Well-equipped and updated Intensive Care Burn Unit and Surgical Post Operative Critical Care Unit were not available in the 'Surgery and Allied Specialities Department', at RMC&H.
- There was no Dental OPD, accompanied by a Dental Lab at RMC&H.
- While Audit was informed that maternal death reviews were being conducted at both SSKM and RMC&H, minutes of such meetings were not produced before Audit.
- As per provisions contained in the notification issued (September 2007) by the Ministry of Health & Family Welfare regarding compensation package to acceptors of sterilisation and IUD insertions at public and accredited private health facilities, the persons undergoing such services are to be paid monetary compensation on the same day at the facility where procedures have taken place. In the test-checked months[62], out of 129 beneficiaries, there had been delays in regard to 107 beneficiaries, in awarding monetary compensation, for adopting family planning measures, at the SSKM Hospital, having ranged between four days to 266 days.
- Beneficiaries under Pradhan Mantri Matru Vandana Yojana (PMMVY)[63] are allowed monetary benefit for institutional deliveries at Government health facilities, as per provisions contained in the guidelines of the scheme. Out of 140 test-checked cases, during 2016-22, delays in payments, at the SSKM Hospital, were observed since 2020 onwards. In 60 cases of payments made during 2020-22, the delays ranged between 10 days and 111 days.
- At RMC&H, Out of 21 test-checked cases pertaining to FY 2019-20, the delays in PMMVY payment were between 19 days and 128 days. Similarly, such delays ranged between four days and 79 days, for 19 cases, during FY 2020-21 and between 13 days and 87 days, for 21 cases, during FY 2021-22.

[62] *December 2016, June 2018, March 2018, September 2019 and December 2020*

[63] *Government of India implemented Pradhan Mantri Matru Vandana Yojana with effect from 1.1.2017. The scheme provides for financial support for pregnant and lactating mothers to improve the health and nutrition for mother and child as well as compensation for wage loss, if any*

- Patients and visitors were not being sensitized and educated through appropriate Information, Education & Communication/ Behaviour Change Communication (IEC/ BCC) approaches, at the SSKM Hospital
- The SSKM hospital did not have any enquiry window, for seeking information about available hospital services.

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

3.1.6 Findings of beneficiary survey

- A survey of patients randomly selected in the test-checked PHCs and CHCs, carried out by Audit, depicted the following, in regard to the quality of line services of the healthcare facilities:

OPD Services:

Table 3.12: Beneficiary survey on quality of OPD services

Sl. No.	Issues raised through Survey	No. of patients surveyed	Patients confirming the issue	Percentage
1	Time for registration was more than 20 minutes	366	44	12.02
2	Waiting time for patients to consult a doctor being more than 15 minutes	179	70	39.10
3	Waiting time for patients to consult a doctor being more than 30 minutes	179	46	25.70
4	Waiting time patients to consult a doctor being more than an hour	179	9	5.02
5	Consultation time taken by the doctor being less than 10 minutes	179	98	54.75
6	Consultation time taken by the doctor being less than 5 minutes	366	83	22.68
7	Doctor not explaining the nature of the ailment in an understandable way	366	45	12.29
8	Behaviour and attitude of hospital staff being ranked below "good"	187	18	9.63

Source: Test-checked PHCs and CHCs

IPD Services:

Table 3.13: Beneficiary survey on quality of IPD services

Sl. No.	Issues raised through Survey	No. of patients surveyed	Patients response/ Patients confirming the issue	Percentage
1	Instances where admission/ information about the ongoing treatment was not shared with patients or attendants, regularly	96	16	16.67
2	Instances where consent was not taken from family member/ attendant before treatment and procedures	96	22	22.92
3	Instances where patients were not informed about his/ her rights and responsibilities	96	44	45.83
4	Instances where the doctors were not available for service during day and night, especially during emergent situations	96	17	17.71
5	Instances where the services of an attendant were not provided for patients requiring trolley/ wheelchair	96	31	32.29
6	Instances where the behaviour of staff was not dignified and respectful, during service delivery	182	20	10.99
7	Regularity of doctor's attention being ranked below “good”	86	16	18.60
8	Time spent on examination and counselling of patients being ranked below "good"	86	20	23.26

Source: Beneficiary Survey in test-checked PHCs and CHCs

It may be seen from the above that almost 31 *per cent* of the patients opined that waiting time for the patients to consult a doctor, after registration in OPD, was more than 30 minutes; while 23 *per cent* patients opined that the doctor took less than 5 minutes for examination, consultation, and advising the patient, in the OPD clinics.

Ignorance of patients about their rights and responsibilities was conspicuous. Patients requiring trolleys/ wheelchairs did not receive attendants for the services.

Further, as per the Professional Conduct, Etiquette and Ethics Regulation, 2002, of the Indian Medical Council, every physician was to maintain the medical records, pertaining to his/ her indoor patients, for a period of three years from the date of commencement of the treatment, in a standard proforma, laid down by the Medical Council of India. However, doctors' survey showed that 16 (42 *per cent*) of the 38 doctors surveyed[64] had not maintained such records. The same regulation also prescribed that, at all times, the physician was to notify the constituted public health authorities, of every case of communicable disease under his care. 14 (36.84 *per cent*) of the doctors surveyed had not complied with the same.

- A survey of patients randomly selected in the test-checked DHs and SDHs, carried out by Audit, depicted the following in regard to the quality of line services of the healthcare facilities:

Table 3.14: Patient Survey in the test-checked DHs & SDHs, regarding quality of line services

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue in Patient Satisfaction Survey (PSS)	Percentage
OPD:				
1	Neat and clean toilet facility not available	81	8	9.88
2	No. of registration counters not adequate	81	21	25.93
3	Time for registration being more than 30 minutes	81	14	17.28
4	Patient calling system not satisfactory	81	44	54.32
5	Patients having to wait more than an hour for consulting the Doctor	81	11	13.58
6	Consultation time taken by the doctor being less than 5 minutes	81	55	67.90
7	Doctor not explaining the nature of the ailment in an understandable way	81	20	24.69
IPD:				
1	Time taken by the doctor to visit the patients after admission being more than an hour	79	36	45.57
2	Admission/ information about the ongoing treatment not being shared with patients or attendants, regularly	79	8	10.13
3	Doctors visit to the patient being less than twice in a day	79	17	21.52
4	Responses of the Nurses in the ward not being prompt	79	4	5.06
5	Intravenous/ insertions like Saline drips and catheters *etc.*, not being monitored and changed, whenever needed and other prescribed medications not being given periodically by the nursing staff	79	5	6.33

Source: Beneficiary Survey in test-checked PHCs and CHCs

[64] *A survey of willing doctors of the selected DHs were carried out in audit*

In the course of Audit at SSKM hospital, a Patient Satisfaction Survey was conducted by the Audit team, on 18 indoor patients. The results of the survey were as follows:

- A majority of the patients surveyed (14 out of 18) stated that the waiting time, at the registration/ admission counter, was more than one hour. Four patients stated that it was more than 45 minutes.
- Only four out of 18 patients stated that sufficient information (regarding direction & location signage, registration counter, laboratory, Radiology Dept., dispensary *etc.*) was not available in the Hospital.
- Eight patients (44 *per cent*) stated that the time of supply of the diet and its quality ranked below "good".

Similarly, a Patient Satisfaction Survey was conducted by Audit, on 23 outdoor patients of the hospital. The results of survey were as follows:

- All of them stated that the seating arrangements, at the registration/ OPD counters, were not adequate.
- Fourteen patients who were surveyed stated that drinking water facility was not available for patients. Similarly, eight patients stated that neat and clean toilet facilities were not available at the hospital.
- Sixteen patients stated that number of registration counters was not adequate considering the patients load at the hospital.
- Considerable time was spent for registration, as 22 patients stated that they had to wait for more than 30 minutes for registration.
- The patient calling system was not satisfactory, as stated by 10 patients.
- More than 50 *per cent* of the patients surveyed (14 out of 23) said that they had to wait for more than one hour, for consulting a doctor.
- All the patients surveyed stated that not all the prescribed medicines had been made available to them, by the hospital pharmacy. Ten of them stated that the time taken for receiving the prescribed medicines was more than 30 minutes and an equal number stated that it was more than hour.
- Sixteen patients stated that the time taken by the hospital, for delivery of the test-reports, was more than five days.
- Almost all of the patients surveyed (22 out of 23) stated that complaint boxes were not available at the OPD.

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

Recommendation:

6. The H&FW Department may maximise coverage of institutional deliveries and also ensure that all home deliveries are attended by Skilled Birth Attendants.

3.1.7 Deprivation of weaker sections from Free Treatment

As per Section 7(3)(s) of the West Bengal Clinical Establishments (Registration, Regulation and Transparency*)* Act, 2017, read with Rule 20(1)(b) of the West Bengal Clinical Establishments (Registration, Regulation and Transparency) Rules, 2017, any Clinical Establishment (CE), which has received land or any other facility from the Government, during its initiation, and in the course of continuance of its projects, shall be responsible for providing completely free treatment to 20 *per cent* of OPD patients and 10 *per cent* of IPD patients for persons belonging to weaker sections.

Furthermore, the CE has to mandatorily furnish annual return on free treatment and concessions, if any, as mentioned in Para 1.4 of Schedule-VI of the Rule[65].

Scrutiny, however, revealed that the Department had provided land to 44 CEs at different times, however, the CEs never extended the benefits to the weaker sections as per Act. Moreover, neither were the copies of the agreement with the CEs available in respect of 43 hospitals and nursing homes[66] with the Department nor the Department initiated any action to fetch the benefits receivable under the Rules.

3.2 Support Services

3.2.1 Diagnostic Services

Sub-Centres (SCs): As per IPHS, an SC is required to ensure minimum laboratory investigations, like urine test for pregnancy confirmation, haemoglobin estimation, urine for albumin and sugar and linkages with Primary Health Centres (PHCs), for other required tests.

In the 38 test-checked Sub-Centres (SCs), it was observed that 14 SCs[67] had no linkages with the concerned PHCs, for ensuring essential diagnostic facilities.

Primary Health Centres (PHCs): As per IPHS, in PHCs, the minimum laboratory investigations listed below were to be ensured

i) Routine urine, stool, and blood tests (Haemoglobin estimation, platelets count, total RBC[68], WBC[69], bleeding and clotting time and blood sugar)
ii) Diagnosis of RTI[70]/ STDs[71], with wet mounting, Grams stain *etc.*
iii) Sputum testing for mycobacterium (as per guidelines of RNTCP[72])
iv) Blood smear examination malaria
v) Blood for grouping and Rh typing
vi) RDK[73] for malaria, in endemic districts
vii) Rapid tests for pregnancy
viii) RPR test[74] for Syphilis/ Yaws[75] surveillance (endemic districts)
ix) Rapid test kit for faecal contamination of water
x) Estimation of chlorine level of water using ortho-toludine reagent.

Review of records showed that there were no laboratory facilities available in 549 of 916 PHCs in the State. Of the 269 PHCs[76] having the laboratory facility, 64 PHCs were running with inadequate numbers of equipment and chemicals, while the laboratories of 43 PHCs had not been maintained in an orderly manner.

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[65] *under Rule 20 of the Rules*
[66] *except for KPC Medical College & Hospital, Jadavpur*
[67] *Bhadutala, Arabari, Garhmal, Lokepith, Nimki Mohar, Kharika, Surun, Indran, Marnai, Majhiar, Hilla Tea Estate, Dhansura SSK, Hutmura SSK and Santuri*
[68] *Red Blood Cell*
[69] *White Blood Cell*
[70] *Respiratory Tract infection*
[71] *Sexually Transmitted diseases*
[72] *Revised National Tuberculosis Control Programme*
[73] *Rapid Diagnostic Kit*
[74] *Rapid Plasma Reagin test*
[75] *A chronic childhood infectious disease*
[76] *Information of 98 PHCs out of 916 PHCs were not available in HMIS.*

None of the 19 test-checked PHCs had diagnostic test facilities for Routine Urine tests, Routine Stool tests, Routine Blood tests (Hb *per cent*, Platelet count, total RBC, WBC, bleeding and clotting time), Diagnosis of RTI/ STD with wet mounting, Grams stain *etc.*, which were stipulated as 'essential' services under IPHS norms. 'Desirable' services, like Blood Cholesterol and ECG, were also not available.

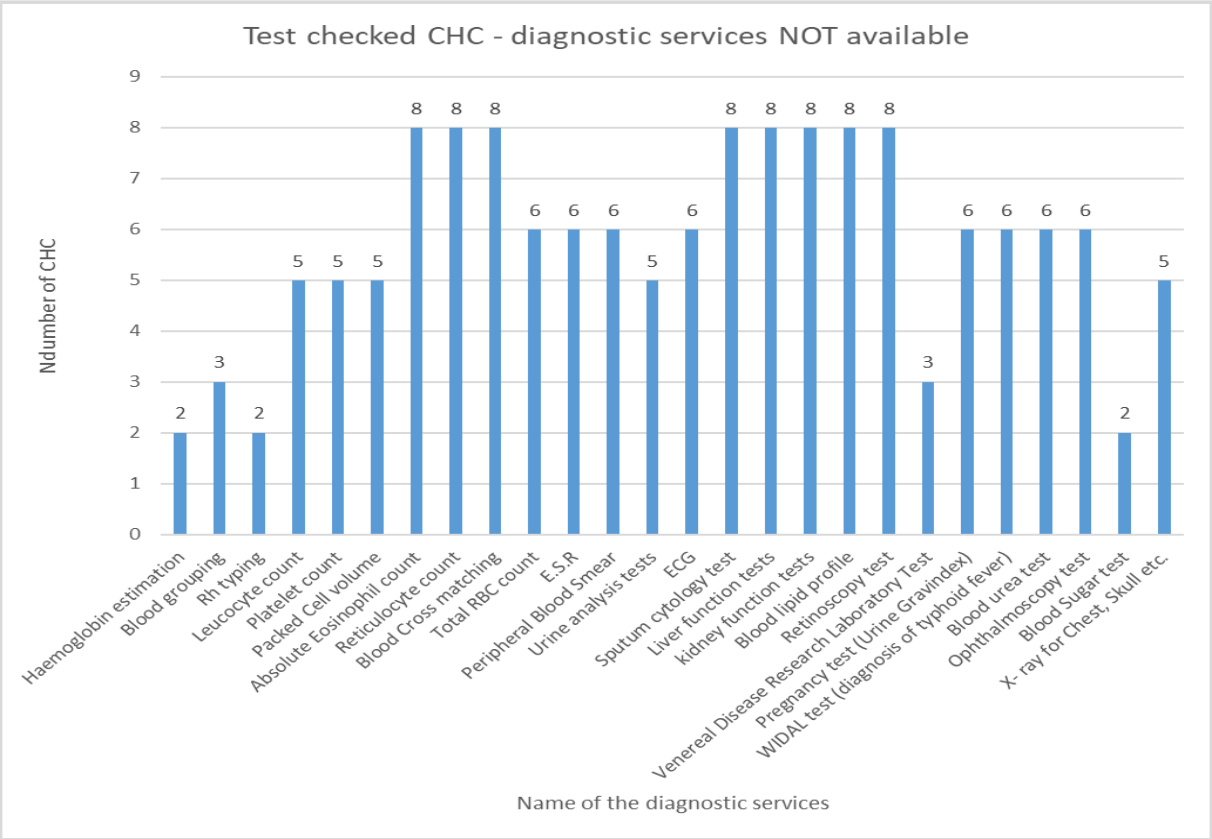
Diagnostic facilities, like Blood for Grouping and Rh Typing, RPR test for Syphilis/ Yaws surveillance (endemic districts) and Faecal contamination of water (Rapid Test Kit), were available in only one[77] PHC, out of the 19 test-checked PHCs.

Community Health Centres (CHCs): A CHC was required to ensure diagnostic facilities for various tests relating to Haematology, Urine Analysis, Stool Analysis, Pathology, Microbiology, Serology, Biochemistry, Cardiac investigations, Ophthalmology and Radiology.

Review of records showed that such laboratories were not available in nine CHCs. Out of the 323 CHCs with laboratories (the status of 16 CHCs had not been entered in HMIS), 52 CHCs suffered shortages of equipment and chemicals, while the laboratories of 34 CHCs had not been maintained in order. 128 CHCs did not have X-Ray rooms.

In the 10 test-checked CHCs, essential diagnostic facilities, under Haematology, were not available in a majority of the CHCs, as shown **Chart 3.13**.

Chart 3.13: Diagnostic services not available in the test-checked CHCs



Source: Reply furnished by test-checked CHCs

[77] *Moulani in Jalpaiguri district*

In nine of the 10 test-checked CHCs[78], diagnostic test facilities on Stool Analysis, Occult blood, Sputum cytology, Dental x-ray, Grams Stain for Throat swab, sputum *etc.*, was not available. Status of unavailability of numerous other diagnostic facilities, in CHCs, is plotted in **Chart 3.13**.

Overall, it was detected in audit that, out of 36 essential diagnostic services, tests ranging from 41.66 *per cent* to 86.11 *per cent*, were not available in the nine test-checked CHCs, as shown in ***Appendix 3.11.***

None of the CHCs had maintained register/ records relating to the Down Time of critical laboratory equipment. 90 *per cent* of the CHCs had never calculated Turn Around Time[79] (TAT) for routine laboratory investigations/ emergency investigations.

District/ Sub-Divisional (Secondary level) hospitals: The District Hospitals (DHs) were supposed to ensure the availability of 97 types of diagnostic tests, while the Sub-Divisional Hospitals (SDHs) were required to ensure the availability of 49 types of diagnostic tests, under the Haematology, Urine Analysis, Stool Analysis, Semen Analysis, CSF Analysis, Aspirated fluids, Pathology, Microbiology, Serology, Biochemistry, Cardiac investigations, Ophthalmology, ENT, Radiology, Endoscopy and Respiratory specialities.

A review of the availability of diagnostic services, across the 54 secondary level hospitals (18 DHs and 36 SDHs), showed that a number of these hospitals (ranging from 2 to 47) were not providing the prescribed essential diagnostic/ testing facilities, under the following specialities:

Table 3.15: Hospitals not providing the prescribed essential diagnostic/ testing facilities under the 54 Secondary level hospitals

Sl. No.	Specialty	No. of SDHs where services were not available	No. of DHs where services were not available
1	Haematology	5	-
2	Urine analysis	5	2
3	Stool analysis	8	3
4	Pathology	5	-
5	Microbiology	16	6
6	Serology	15	-
7	Biochemistry	4	-
8	Cardiac investigation	25	3
9	Ophthalmology	5	-
10	Radiology	5	-
11	ENT	10	1
12	Endoscopy	32	15
13	Pulmonary Function test	34	12
14	Sputum testing	-	2

Source: HMIS Data

Thus, none of the secondary level hospitals was delivering the full package of essential diagnostic services.

In these test-checked three SDHs and two test-checked DHs, the tests/ diagnostic services were not available ***(Appendices 3.12 & 3.13)***, to the extent shown in **Table 3.16**.

[78] *Information was not available in respect of Kushtor RH, Purulia.*
[79] *TAT: Time from receipt of the sample in the laboratory, to the final delivery or dispatch of the report of said test.*

Table 3.16: Diagnostic Services not available at SDHs/ DHs

SDH/ DH	Number of essential tests	No. of diagnostic services not available
Ghatal SDH	49	14 (28.57%)
Raghunathpur SDH		9 (18.37%)
Islampur SDH		16 (32.65%)
Jalpaiguri DH	97	35 (36.08%)
Bashirhat DH		50 (51.55%)

Source: Test-checked SDHs & DHs

Thus, that 18 *per cent* to 52 *per cent* of the essential diagnostic facilities were not available in the test-checked SDHs/ DHs. Further, diagnostic tests for Reticulocyte counts, Hanging drop for V. Cholera; CSF for protein and sugar; and Laparoscopy, were not being performed by any of the three test-checked SDHs. The Turn Around Time (TAT) for diagnostic and radiological services, had not been assessed by the Bashirhat DH while such information in respect of other DHs were not available.

Findings of the beneficiary survey

- A survey of patients, randomly selected in the test-checked PHCs and CHCs, conducted by Audit showed the following in regard to the quality of diagnostic facilities for the OPD and IPD patients of these PHCs and CHCs:

Table 3.17: Beneficiary survey on the quality of diagnostic services

Sl. No.	Issues raised through survey	No. of patients surveyed	Number of Patients confirming the issue	Percentage
OPD:				
1	Radiology (X-ray, Ultrasonography/ CT scan *etc*.) tests recommended by the doctors not being done by the hospital	179	161	89.94
2	Time taken by the hospital for delivery of the test reports being more than two days	179	10	5.59
IPD:				
3	Prescribed investigations (lab/ radiology) to facilities being not available at the Hospital	96	66	68.75
4	Patients having to pay out-of-pocket for diagnostic tests/ lab services	96	18	18.75
OPD & IPD:				
	Quality of diagnostic services provided in the hospitals being ranked below "good"	273	128	46.89

Source: Beneficiary Survey in the test-checked PHCs & CHCs

It emerged from the survey that services like costly radiological and other diagnostic/ laboratory tests as prescribed to the patients, were not being rendered by the hospitals. Due to this, patients had to go out and get the tests done, by incurring their own expenditure. This was true even for the IPD patients. A majority of patients were dissatisfied with the quality/ standard of the lab/ diagnostic services, being rendered by the hospitals.

- A survey of patients, randomly selected in the test-checked SDHs and DHs, carried out by Audit, showed the following in regard to the quality of diagnostic facilities for the OPD and IPD patients of these hospitals:

Table 3.18: Patient Survey in the test-checked DHs/ SDHs regarding quality of diagnostic services for OPD & IPD patients

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue in PSS	Percentage
OPD:				
1	All pathological tests recommended by the doctors not being done by the hospital	81	14	17.28
IPD:				
1	Facilities for the prescribed investigations (lab/ radiology) not being made available by the hospital	79	17	21.52
2	Patients having to pay out-of-pocket for diagnostic tests/ lab services	79	27	34.18

Source: Beneficiary Survey in the test-checked SDHs & DHs

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

3.2.2 Dietary Services:

As per the Janani Shishu Suraksha Karyakram[80] (JSSK), a pregnant mother is entitled to free diet, during her stay in public health institutions (up to three days for normal deliveries and up to seven days for caesarean deliveries).

IPHS for PHCs prescribes that a nutritious and well-balanced diet be provided to all IPD patients. Suitable arrangements in this regard, are to be made, with a local agency, like a local women's group/ NGO/ Self-Help Group, wherever feasible and possible, for provision of nutritious and hygienic food, at reasonable rates. IPHS for CHCs states that the diet may either be outsourced or an adequate space for cooking may be provided in a separate space within the premises of the heath care facility.

Chart 3.14: Dietary Services at PHCs

Source: HMIS data

Analysis of the HMIS database showed that, though 276 PHCs had functional beds in the IPDs in the State, only 103 PHCs had provided diets to their patients. Of these 103 PHCs out of these 276, only 59 had provisions for kitchen within the Centres.

Dietary services were not being provided in 35 CHCs in the State, while there were no provisions for a kitchen, in 40 CHCs.

[80] *Entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section.*

Non-availability of diet services was likely to have impacted the patients adversely in their healing/ treatment and it could have caused them to incur out-of-pocket expenditure, to bear the diet personally.

In the test-checked PHCs and CHCs ***(Appendix 3.14)***:

- Only one[81] of the 19 test-checked PHCs had dietary services. The other 18 PHCs had no facilities for dietary services for their indoor patients.
- While one[82] of the 10 CHCs had no dietary services, dietary services in six CHCs were being provided by outsourced agencies, without statutory licences.
- Five CHCs had no policy/ procedure in place, for checking the raw materials, utensils, cooked food *etc.*, for ensuring the quality and hygiene of the supplied food.
- There was no grievance redressal cell in three CHCs. There were no records/ registers, relating to grievances in regard to the diet provided, in two CHCs, while five CHCs could not produce any related records.
- Out of the nine CHCs providing dietary services, no inspections, for ensuring that nutritious, hygienic and qualitative food was being provided therein, had been conducted by the Food Safety Officers, in the hospital kitchens of seven CHCs.
- Though dietary services were available in all the DHs/ SDHs of the State, the following violations against the clause(s) of agreements executed by the hospitals and the vendor, were noticed, in the three test-checked SDHs:
  - None of the SDHs had formed Diet Committee, for ensuring the overall monitoring of dietary services.
  - Regular quality checking of raw material, equipment, kitchen sanitation and cooked food, had not been ensured in two SDHs.[83]
  - Inspection of kitchen sites had not been done by two SDHs[84].
  - Two SDHs[85] had no grievance redressal cell, for registering patient grievances regarding the quality of supplied food.
- The status of availability of support services in the DHs of the State has been provided in ***Appendix 3.15***.
- Findings of the beneficiary survey are mentioned below:

Table 3.19: Beneficiary survey in regard to dietary services

Sl. No.	Issue raised in survey	No. of patients surveyed	Number of Patients confirming the issue	Percentage
1	Sufficient food not being provided	96	15	15.63
2	Food not being provided as per the diet prescribed by the Doctor	96	36	37.50
3	Quality and timeliness of supply of the diet being ranked below "good"	86	10	11.63

Source: Beneficiary Survey in the test-checked DHs/ SDHs

It could be seen that many of the IPD patients surveyed had confirmed not being served with the diet suggested by doctor.

[81] *Jogeshganj in Basirhat HD*
[82] *Itahar RH in Uttar Dinajpur*
[83] *Ghatal SDH and Raghunathpur SDH*
[84] *Ghatal SDH and Raghunathpur SDH*
[85] *Ghatal SDH and Raghunathpur SDH*

Dietary services at the Medical College and Hospital

- Although it was required, in terms of the operational guidelines issued by the Ministry of Health & Family Welfare for quality assurance in Public Health facilities, 2013, two hospitals, *i.e.* SSKM and RMC&H, had not prepared and adopted any standard procedures for preparation, handling, storage and distribution of clean, hygienic and nutritious diets to their indoor patients, as per their caloric requirements. Diet is prepared at the hospital but persons involved in the preparation of diet are outsourced. Financial and infrastructural requirements, based on bed occupancy and other factors, had not been assessed by the hospital authorities. Both hospitals had not adopted any system of diet counselling for their patients, formulation of caloric requirements and setting diet for their patients accordingly.

- The SSKM hospital had no policy and procedure for regular quality checking of raw materials, cooked food, equipment *etc.* The quality and quantity of food was not checked, either in the kitchen, or in the wards, before it was served to the patients. No evaluation of dietary services, in RMC&H, had been done, on indicators such as the number of complaints on food received, number of cases of food poisoning, instances of false diet *etc.* There had not been any dietician, in the SSKM hospital, since 2018.

There was no grievance redressal cell at the SSKM hospital and no complaint cell had been formed to register patients' grievances.

Pictures 3.1 & 3.2: Kitchen of SSKM hospital (March 2022)

Picture 3.3 : Spilled over flour in the SSKM Hospital (March 2022)

- During Joint Physical Verification (March-April 2022) by Audit with the hospital authorities, it was observed that the floor area of the kitchen of SSKM hospital was dirty. In some places, there were holes on the floor, filled with dirty water.

- Sacks of rice were found stacked one above another, on the floor in the SSKM hospital. The store room had no window or ventilator, to allow entry/ passage of fresh air. Rodents had cut open sacks of rice, wheat *etc.*, resulting in their being spilled on the floor.

- Persons who were outsourced for the purpose of preparation of diet in the SSKM hospital were found to be cooking food items, using their bare hands, standing barefoot on the dirty floor, without any gloves or aprons. Food items were found stored in baskets, which were rarely cleaned.

- At the entrance of the kitchen at the SSKM hospital, the roads were found to be cracked and uneven, resulting in food items getting spilt and getting mixed with one another, while they were being moved in hand driven carts.
- The minimum number of staff, required for cooking and distribution of food to IPD patients, at the SSKM hospital, had neither been specified nor had the staff been deployed accordingly.

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

3.2.3 Bio-Medical Waste Management

As per the Bio Medical Waste Management Rules 2016, every facility handling BMW has to obtain BMW authorisation from the West Bengal Pollution Control Board (WBPCB), for the appropriate number of beds operational in the facility. Each such facility is to properly segregate the BMW, at the point of generation, in earmarked and colour coded bags and clear the same within 24 hours, from the wards and stores, in a Common Collection Site (CCS-storage for BMW) of the facility.

In case BMW treatment facilities are not available with the concerned healthcare facilities, they are required to execute agreements with Common Bio-Medical Waste Treatment Facilities (CBMWTFs), for daily collection and treatment of BMW, within 48 hours.

Each facility is also required to ensure that laboratory waste is pre-treated, before being sent to the CCS and liquid waste is treated in an Effluent Treatment Plant, before its discharge to general sewerage. Further, each facility is required to prepare and submit monthly and annual reports, on BMW, to the WBPCB.

Review of the 10 test-checked CHCs and five SDHs/ DHs showed the followings:

- BMW authorisation had not been obtained by four CHCs, from the WBPCB, out of 10 the CHCs test-checked.
- Four CHCs had no facility for pre-treatment of laboratory waste, before it was sent to the CCS.
- In three CHCs and one SDH,[86] liquid waste was not being treated in an Effluent Treatment Plant, before it was discharged to general sewerage.
- Three CHCs, out of the six CHCs which had obtained BMW authorisation from WBPCB, as well as Ghatal SDH, had not prepared any monthly and annual reports on BMW generation, for submission to the WBPCB.
- Waste was not being collected on a daily basis in five CHCs, for ensuring its treatment within 48 hours, in CBMWTFs.
- 30 IPD patients (31 *per cent*), among 96 surveyed, across the different test-checked hospitals stated that garbage was not being removed from the patient care area, on a regular basis.

[86] *Islampur SDH*

Picture 3.4: BMW lying in the open, in Sandelerbill RH, Bashirhat (April 2022)

Picture 3.5: BMW disposed in the open and irrgularly burnt, in Dhumpara PHC, Jalpaiguri (March 2022)

The following observations were made in regard to the test-checked Medical College & Hospitals:

- Bio Medical Waste (BMW) was being segregated at the point of generation, *i.e.* in the wards itself, in SSKM Hospital, from the municipal waste. It was being segregated in four colour coded (white, blue, yellow and red) plastic bags.
- SSKM hospital was maintaining (category-wise) the position in regards daily generated BMW, in a separate register. A printed receipt was being obtained, while handing over the waste to M/S Green Tech Environ Management Pvt. Ltd., a Common Bio Medical Waste Treatment Facility (CBMWTF). However, it did not have any weighing facility of its own. CBMWTF was using its own weighing facility, while lifting waste from the common collection point.
- Officers dealing with BMW management in the SSKM hospital had occasionally been imparted training, in this regard, by the Department of Health & Family Welfare, with the last such training having been held in 2018. CBMWTF management had organised an orientation programme, in this regard, for staff members.
- Liquid waste, generated in the SSKM hospital, was not being treated in any Effluent Treatment Plant, before it was discharged to the KMC sewer line.

Excess payment of ₹ 8.34 lakh towards security-scavenging services and BMW management:

- As per the decision of the department and suggestion of the District Health Committee (DHC), 119 personnel were engaged (January 2020), by outsourcing, from an agency, for housekeeping (99 personnel) and maintenance (20 personnel) of the Salbani SSH, Paschim Medinipur. The scope of work and/ directions *etc.*, in regard to the engagement of 20 maintenance staff, on the recommendations of the DHC, could not be produced before Audit, though sought for.

  During review of records, it was noticed that the West Bengal Medical Services Corporation Limited (WBMSCL) had appointed an agency namely M/s Kranti Service & Engineering Works, for the Operation, Repair and Maintenance of different systems in the Salboni SSH, from

November 2020. As a result, the services of 20 maintenance personnel were no longer required from this time onwards. However, scrutiny showed that no manpower had been reduced by the hospital, resulting in excess payment of wages of ₹ 6.26 lakh,[87] for the period from November 2020 to March 2021, to the private agency.

- Further, as per the agreement with the CBMWTF, M/s Medicare Environmental Management Pvt. Ltd., was entitled to a rate of ₹ 8 per bed per day, for 330 sanctioned beds for collection of BMW from the Salboni SSH. With the spread of the COVID pandemic, the SSH was transformed into a Level IV 150-bedded COVID hospital, in June 2020, which was then discontinued from September 2021 to December 2021, with the decrease in cases before it was again converted to a 200-bedded COVID hospital, in January 2022. As per the order of the State health department, for collection of BMW of COVID hospitals, higher charges, at the rate of ₹ 14 per bed per day, was allowed.

  Scrutiny, however, showed that, though Salbani SSH had functioned as a 150-bedded COVID hospital, from June 2020 to September 2021, CBMWTF had claimed higher charges for 200 beds. Moreover, the agency had continued to claim the charges during the period from September 2021 to December 2021, at the same rate, even though Salbani SSH had not functioned as a COVID hospital during this period. This had resulted in excess payment of ₹ 2.08 lakh,[88] during this period.

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

3.2.4 Linen and Laundry Services

IPHS provided that provision for clean linen was to be made for admitted patients. Adequate number of lines, specially bed linen,[89] were to be maintained by the hospitals. The guidelines for the 'Kayakalp' scheme, under NHM, suggested maintaining of at least six sets of linen[90] by a hospital. Hospitals were required to adhere to the system of changing the patient's bed/ Operation Theatre linen, at the prescribed intervals. Further, the Government of West Bengal issued a bed linen changing norm (July 2017) for use of different coloured bed lines (as prescribed), in the IPD wards of hospitals on different days of the week, ensuring changing of bed linen, with fresh ones, every day.

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[87] *Total Remuneration of 99 personnel @10,000 per head per month = ₹ 9,90,000 + 9.78 per cent of ₹ 9,90,000 (service charge) i.e. ₹ 96,822 = ₹ 10,86,822*
Remuneration actually paid to 157 persons = ₹ 12,11,971
Excess payment = (12,11,971- ₹ 10,86,822) x 5 (From November 2020 to March 2021) = ***₹ 6,25,745***

[88]

Month	*Excess rate claimed per bed per day (in ₹)*	*Claimed for extra number of beds*	*Claimed for total number of days*	*Excess amount claimed (in ₹)*
May 2021	*6*	*50*	*31*	*9,300*
June to December 2021	*6*	*50*	*214*	*64,200*
September to December 2021	*6*	*200*	*112*	***1,34,400***
TOTAL				***2,07,900***

[89] *Bedsheets, pillow covers, blankets etc.*

[90] *One already in use (on bed), one ready to use (in the sub-store), one in transit route to laundry or to ward, one in the washing cycle in laundry and two in stock (in the central store).*

Of the test-checked facilities, it was observed that there was a shortage of various items of hospital linen, ranging from 24 *per cent* to 96.67 *per cent*, in Bashirhat DH, while bed linen changing norms were not being followed in Ghatal SDH.

Laundry Services were to be ensured either in-house, or they could be outsourced, to ensure uninterrupted supply of clean linen for patients, as well as protective gear for the doctors and other staff. Hospitals were required to adhere to the process of cleaning and washing of linen, as provided in the operational guidebook for Quality Assurance/ Accessors Guidebook, under the National Quality Assurance Scheme (NQAS).

Scrutiny of records of the test-checked CHCs revealed that clean bed linen, which was dry and had been iron pressed, had not been provided in three CHCs. In four CHCs, the procedure of disinfection and sluicing of soiled linen, before it was handed over to the laundry for washing, had not been followed. Further, 20 (22 *per cent*) among 86 patients surveyed in audit stated that bed linens were unclean.

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

3.2.5 Blood Storage facility

As per the IPHS, a CHC is required to have a Blood Storage Unit (linked with the District Blood Bank), with a capacity for storing atleast 50 units of blood. One of the existing doctors and technicians, with training, is to be designated for the blood bank. The necessary equipment, consumables and reagents, for such storage units, have been prescribed in IPHS. The Blood Storage Unit must have 24 hours power backup.

Scrutiny of HMIS data showed that 285 CHCs of the State (81.89 *per cent*) did not have a Blood Storage Unit (BSU) in the Centre.

Scrutiny of records of the test-checked CHCs ***(Appendix 3.16)*** showed that in none of the CHCs, except Sabang RH of Paschim Medinipur, BSUs were available. However, the BSU at Sabang RH did not have a dedicated doctor.

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

3.2.6 Miscellaneous

Apart from the above, the following points were observed during scrutiny of records of the Medical College and Hospital:

- **Fire Safety Arrangements at the SSKM Hospital**

(i) No Objection Certificate (NOC), from the Fire Department, had not been obtained by the hospital authorities (as of March 2022). The process of obtaining NOC from the Fire Department was under process. To meet various statutory obligations in connection with fire protection and fire safety requirements, necessary steps were being taken individual building-wise of the hospital.

(ii) In new buildings, smoke detectors and alarms had been installed at the time of construction itself. However, the older buildings had not been fitted with these devices, as such work would have to be undertaken without hampering patient safety and services.

(iii) Sand buckets and underground backup water, for fighting fires were not available at the hospital complex. However, evacuation plan routes for the fire exits, had been displayed.

(iv) No fire extinguisher had been installed in the power back up (DG room) area. However, a small set-up of fire station had been positioned at the hospital premises, for 24 hours.

- **Ambulance Services**

(i) SSKM hospital had two (2) Basic Life Support (BLS)[91] and two (2) Advanced Life Support[92] type of ambulances, during the period covered under Audit. These were being used only to carry patients from one building of the hospital to another, according to the need of the patients.

(ii) Ambulances at SSKM hospital had neither pollution control certificate nor insurance certificate.

- **Grievance/ Complaint Redressal**

(i) No institutionalised grievance/ complaint redressal system existed at the SSKM hospital, during the period covered under Audit. Further, no specific committee/ officer existed for this purpose.

(ii) No complaint register was being maintained and made available to the beneficiaries of the SSKM hospital. Complaints were being enquired into, only if the beneficiaries made written complaints.

- **Citizen's Charter**

(i) The SSKM hospital had no established citizen's charter. Notice boards, detailing the location of all services/ departments/ wards, had been placed, in the Bengali and English languages but not in adequate numbers considering the area of the hospital.

(ii) The services and entitlements available to beneficiaries in various Departments of the SSKM hospital, were displayed in a few places. The 'Rights of patient' had, however, not been displayed anywhere.

(iii) Information in regard to the department-wise OPD services available, along with their timings, had not been displayed. Similarly, lists of different type of diagnostic services had not been displayed, in the SSKM hospital.

(iv) Information about family welfare, maternity and childcare services, immunisation services *etc.*, was not visible in the hospital premises. The number of signages was also inadequate, considering the area of the Hospital.

(v) Information about the responsibilities of users had also not been displayed.

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

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[91] *Ambulances having necessary medical support (e.g. oxygen cylinder, suction machine, patient monitoring system, stretcher, first aid kit etc.) during the transit till the patient is transported to the hospital*

[92] *Ambulance in which Advanced Life Support (ALS) is provided in situations where the patient being transported is in a more critical condition and a paramedic is required to assist in the treatment of the patient before and/or during transport to the emergency facility*

3.2.7 Non-operation of 108-Ambulance Services

Though services under '102- Ambulance services' were operational in the State, for providing transport facilities to pregnant women, there was no '108-Emergency Response Service', for providing integrated medical, police and fire emergency services in the State.

The Govt. of West Bengal had invited proposals (June 2022) for selection of an agency, for supply, operation, maintenance and management of 'Dial-108 Ambulance Services'. However, the same had not been finalised (as of February 2023).

Recommendation:

7. Basic essential diagnostic facilities may be ensured at all levels of healthcare units.

CHAPTER 4

Availability of drugs, medicines, equipment and other consumables

4 Chapter *Availability of drugs, medicines, equipment and other consumables*

Audit Objective: Whether the health sector had adequate resources, viz., drugs, consumables, equipment etc., as per prescribed norms and whether these resources were utilised efficiently and effectively.

Health & Family Welfare Department, GoWB, had no documented Drug Policy and there was no central monitoring over suppliers regarding delay/ non-supply of medicines/ consumables, in different health facilities of the State. Instances of non- receipt of Quality Testing Reports of drug samples and delays in uploading the test-checked cases of non-standard medicines, were noticed. Non-procurement of essential drugs, out of the 'Essential Drug List (EDL)', was noticed. Undue favour to agencies, in procurement of bio-medical equipment, bypassing safety standards and quality, were also observed. Essential items of Equipment, in most of the test-checked primary and secondary care giving hospitals, were not available. Calibration of most of the Bio-medical Equipment had also not been done.

A. Drugs

4.1 Lack of a specific drug Policy

The Government of West Bengal selected (December 2021) M/s Price Waterhouse Coopers Private Limited (PwC), as the transaction advisor, for preparing Drugs & Equipment policies and the Drugs & Equipment maintenance policies, at a cost of ₹ 38.25 lakh. The contract was extended for three months, upto June 2022. The said firm was also directed to prepare and consolidate, *inter-alia*, an Essential Drugs List (EDL), for each tier of health facilities and procurement policies. The Department did not have any documented drug policy, before award of the contract to PwC.

It was noticed that, on earlier occasions, the Department had prepared (with the help of experts from the Department, Directorate and Medical Colleges & Hospitals), facility–wise EDLs, under catalogued drugs and circulated the same, during April 2016 and January 2018. Later, in November 2021 and December2021, the Department notified an EDL, for six sub-tiers of primary healthcare, Sub-divisional hospitals and State General hospitals, respectively, in supersession of all previous orders. The Department again circulated (July 2022) an EDL, alongwith two *addendums* for each level of health facilities, right from the primary tier to the tertiary tier, in supersession of all its previous orders. Thus, the absence of a drug policy resulted in frequent changes in the availability of Essential Drugs at all three tiers.

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

4.2 Absence of a central monitoring system over supply

The Central Medical Store (CMS) is the authority for finalising rates for different type of medicines and consumables, to be used at all three tiers of health facilities in the State. However, there was no central monitoring over

suppliers, regarding delay/ non-supply of medicines/ consumables, to different health facilities. This resulted in non-availability of medicines to the public, at times of need (*as elaborated at paragraph 4.3.6 in this Report*) and also put pressure on the exchequer, due to the purchase of the required medicines being made locally.

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

4.3 Quality Control Mechanism

Quality control of medicines involves testing of medicines and determining if they are as per the specifications for the final product. It involves a testing mechanism and testing units. Having a good quality control system is essential in ensuring the quality of medicines procured by the State, which, in turn, are consumed by the public in general. The Quality Control section, under the CMS, is the authority for collecting samples, including the consumables and reagents through selected couriers/ transport agents, from all health facilities, spread across primary, secondary and tertiary level healthcare. Dispatch of such samples, by various field units, is tracked in the Store Management Inventory System (SMIS), which is primarily used for managing the inventory of all medicines and equipment, after observing due procedures, such as recording the batch numbers of the medicines, making work orders, arranging samples as per the work orders *etc.* These samples are sent by courier agents, for testing, to NABL accredited laboratories, selected through the tender process, for testing purposes. The results of testing of samples, including those where samples are found sub-standard, are also uploaded by the CMS authorities, in SMIS, for appropriate actions to be taken by different stakeholders. Scrutiny of records, regarding testing of drugs, revealed the following:

4.3.1 Collection of samples for testing

Drugs purchased from different manufacturers are required to be tested for ensuring their quality, before their consumption by the public. The testing arrangements for drugs are administered centrally, by the Quality Control Section, under the Central Medical Store. However, no standing order was made available to Audit, in regard to the number of samples to be collected from different field units[93] including Fair Price Shop (FPS)[94] for testing purpose. In the absence of such an order, it was not clear whether the field units were compulsorily required to send samples of all medicines and consumables received, to CMS, which, in turn, would forward the samples to the laboratories, for testing. It was also not clear whether they were required to send samples to CMS soon after receiving the same from suppliers or whether any time period, between receipt and dispatch of samples, was allowed. Test-check of records, in connection with dispatch of samples, by the SSKM Hospital, Raiganj; Medical College & Hospital (MC&H), Purulia; MC&H, Medinipur MC&H, and the District Reserve Stores (DRSs) of the Jalpaiguri, Uttar Dinajpur, Purulia, Paschim Medinipur and Bashirhat districts, revealed the following:

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[93] *Field units include different hospitals such as District hospital, Sub-divisional hospital, State General hospital and Medical College & Hospital. It also includes District Reserve Store which keeps medicines and consumables/equipment for the entire primary sector of that district.*

[94] ***'Fair Price Shop'** is an initiative of the Government of West Bengal under Public Private Partnership (PPP) with private parties where the private party offering the maximum discount over MRP of the medicines is selected.*

Table 4.1: Drug Samples collected and sent for testing

Indenting unit	Number of samples received by CMS for testing during 2016-22	Number of samples sent to laboratories during 2016-22[95]	Number of samples declared standard out of column no. (3)	Number of samples declared non-standard out of column no. (3)[96]
(1)	**(2)**	**(3)**	**(4)**	**(5)**
IPGME&R and SSKM Hospital	113	108	84	2
Raiganj MC&H	1	1	1	0
Purulia MC&H	49	41	30	0
Medinipur MC&H	139	123	82	0
DRS of Jalpaiguri	524	493	328	2
DRS/ Uttar Dinajpur	1,260	1,213	849	25
DRS/ Purulia	1,446	1,364	957	12
DRS/ Paschim Medinipur	3,327	3,056	2,173	37
DRS of Bashirhat	464	418	306	4
DH Jalpaiguri	168	159	102	2
Total:	**7,491**	**6,976**	**4,912**	

Source: CMS Data

As may be seen from the above, that the number of samples sent by the Purulia MC&H, Medinipur MC&H and IPGME&R (SSKM Hospital), was considerably less, as compared to those sent by various DRSs[97]. The Raiganj MC&H had forwarded only one sample, during 2016-22. None of the Super Speciality Hospitals (SSH),[98] located at Jalpaiguri, Islampore, Bashirhat, Debra and Hatuara, had forwarded any sample to CMS, during 2016-22. Similarly, the DHs at Bashirhat, SDHs Islampore, Ghatal and Raghunathpur, had not forwarded any samples to CMS, during this period. This indicates that the field units were sending samples as per their own decision and there was no monitoring over this aspect.

Further, it could be seen that 30 *per cent* of the samples sent to testing laboratories were not received at all. The State-wide position in this regard is discussed in the following paragraph.

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

4.3.2 Non-receipt of report of samples sent for testing

It was revealed in audit that, during the period from 2016 to 2022, against 50,988 samples received by CMS, 49,779 samples were sent for testing and reports for 33,501 samples (67 *per cent* of the samples sent for testing) were received, as shown below:

Table 4.2: Non-receipt of reports of samples sent for testing

Financial Year	Samples received by CMS for testing	Samples sent by CMS for testing	Number of test reports received	Number of samples found standard	Number of samples found non-standard
From Govt. establishments					
2016-17	8,759	8,568	8,199	8,103	96
2017-18	9,443	9,281	8,734	8,555	179
2018-19	7,307	7,096	3,097	3,091	6

[95] *The differences between column (2) and (3) are due to wrong batch/ same batch or damaged condition*

[96] *Result of tests in respect of the remaining samples, were not received in the CMS*

[97] *The District Reserve Store (DRS) is a store house of medicines, where medicines supplied by the Department/ Directorate, for the entire primary tier of the district, are stored and, subsequently, distributed to various RHs/ BPHCs and PHCs. It functions under the administrative control of one of the Deputy Chief Medical Officers of Health.*

[98] *41 SSHs were functional in the State*

Financial Year	Samples received by CMS for testing	Samples sent by CMS for testing	Number of test reports received	Number of samples found standard	Number of samples found non-standard
2019-20	6,987	6,868	3,121	3,089	32
2020-21	4,302	4,107	3,066	2,994	72
2021-22	3,754	3,432	1,393	1,391	2
TOTAL	**40,552**	**39,352**	**27,610**	**27,223**	**387**
From Fair Price (FPS) Shop [99]					
2016-17	1,819	1,779	1,593	1,563	30
2017-18	1,533	1,502	1,591*	1,562	29
2018-19	1,796	1,614	709	707	2
2019-20	2,757	2,545	1,059	1,052	7
2020-21	1,363	1,094	414	406	8
2021-22	1,168	1,893	525	499	26
Total	**10,436**	**10,427**	**5,891**	**5,789**	**102**
Grand Total	**50,988**	**49,779**	**33,501**	**33,012**	**489**

Source: CMS & FPS Data

** Receipt of higher number of reports, compared to the number of samples sent, was due to the fact that reports of some of the samples sent in the previous year, were received during this year.*

It is seen from **Table 4.2** above, that, out of 40,552 samples collected by CMS, from different Government establishments[100], during 2016-22, 39,352 (97 *per cent*) samples were sent for testing. The difference between the two figures is due to factors such as samples having been received from the same batch or from a wrong batch, or in insufficient quantity, in damaged condition *etc*. Out of the 39,352 samples sent for testing, reports were received only for 27,610 samples (70 *per cent*). Quality testing reports for the remaining 11,742 samples were to be received (as of March 2022).

Similarly, out of 10,427 samples collected from different Fair Price shops sent for testing during 2016-22, reports of 5,891 samples (57 *per cent*) only, had been received (as of March 2022). Scrutiny of records revealed that 3,999, 3,747 and 2,039 test reports were yet to be received, against samples sent for testing from Government establishment, during FYs 2018-19, 2019-20 and 2021-22, respectively. Similarly, in respect of samples collected from Fair Price Shops; 905, 1486, 680 and 1,368 test reports, were yet to be received against samples sent for testing, during the four years from FYs 2018-19 to 2021-22, respectively. No analysing of the reason(s) for non-receipt of report of the samples sent, had been carried out by Dy. Director of Health Services (Equipment & Store). Neither had it taken up the matter with the laboratories concerned.

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

4.3.3 Non-receipt of testing reports from the State Drug Control Research Laboratory (SDCRL)

Against 12,429 samples collected from different Government establishments and sent to the State Drug Control Research Laboratory (SDCRL), for testing, during 2016-2022, reports of only 2,984 (24 *per cent*) samples had been

[99] *'Fair Price Shop' is an initiative of the Government of West Bengal, under the Public Private Partnership (PPP) made with private parties, where the private party, offering the maximum discount over MRP, of the medicines, is selected.*

[100] *Various Government hospitals such as District hospital, Sub-divisional hospital, State General hospital, Medical College & Hospital, Super Speciality hospital etc. It also includes District Reserve Stores.*

received (as of March 2022). Similarly, reports of only 700 (14 *per cent*) samples had been received from SDCRL, till March 2022, against 5,003 samples collected from different Fair Price Shops, during 2016-2022, as shown in **Table 4.3**.

Table 4.3: Non-receipt of testing reports from SDCRL

Financial Year	Samples sent for testing to SDCRLs	Number of test reports received from SDCRL	Number of samples found standard	Number of samples found non-standard
From Govt. establishment				
2016-17	804	557	490	67
2017-18	1,008	697	677	20
2018-19	4,865	954	953	1
2019-20	4,147	600	595	5
2020-21	607	69	69	NIL
2021-22	998	107	103	4
TOTAL	**12,429**	**2,984**	**2,887**	**97**
From Fair Price Shops				
2016-17	325	155	140	15
2017-18	438	210	201	9
2018-19	1,036	141	139	2
2019-20	1,664	123	122	1
2020-21	615	38	38	NIL
2021-22	925	33	33	NIL
Total	**5,003**	**700**	**673**	**27**
Grand Total	**17,432**	**3,684**	**3,560**	**124**

Source: CMS Data

Thus, test reports of only 3,684 (21 *per cent*) samples had been received, during 2016-2022, from SDCRL, against 17,432 samples sent to SDCRL, during the said period. Thus, a major part of the medicines had been consumed, without being tested. The CMS authorities concerned had not raised this issue with SDCRL.

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

4.3.4 Delays in uploading the test results of samples

Samples of drugs and chemicals & laboratory chemicals are dispatched by the CMS, to the approved testing laboratories as per provisions contained in Government Order issued in July 2003 and the report of tests are to be mandatorily sent by e-mail, followed by hard copy by courier/ post (whichever is earlier). Seven working days are permissible for submission of test reports, in case of drugs, chemicals & laboratory chemicals, as well as consumables[101] which do not undergo sterility test[102], counted from the dates of receipt of the relevant samples, upto the dates of uploading the report to the designated authorities. Similarly, 14 working days are allowed in case of injectables and IV Fluids, as well as other drugs, like eye drops *etc.*, which require sterility test counted from the dates of receipt of the relevant samples, up to the dates of uploading the reports to the prescribed authority.

Scrutiny of records revealed that there were a delays, ranging from five days to 275 days, in respect of 77 test-checked cases, in excess of the permissible 14 days, in uploading the test results, in respect of samples which had been

[101] *Tablet/ Capsule/ Powder/ Ointment etc.*

[102] *Sterility testing is designed to demonstrate the presence or absence of extraneous viable contaminating microorganisms in biological parenterals designed for human use.*

found non-standard. This had resulted in consumption of such non-standard drugs by the public, during the intervening period. Details in this regard, are shown, in respect of the test-checked units ***(Appendix 4.1)***. The office of the Deputy Director of Health Service (Equipment & Store) had not enquired into the matter, or taken up the matter with the concerned laboratories.

Cross-checking of the records of medicines of the District Reserve Stores (which cater to medicines up to the secondary level hospitals of the district), of the selected districts *vis-à-vis* the list of drugs found to be of Non-Standard Quality (NSQ), revealed that 18 batches[103] of the 14 NSQ drugs,[104] had been distributed during the audit period 2016-22, to various Healthcare Facilities (HCFs), from the DRSs, either owing to delayed uploading of test reports in the portal, or due to non-verification of the test reports, as detailed in ***Appendix 4.2***.

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

4.3.5 Inadequate manpower for Quality control under CMS

Against the sanctioned strength of eight, in the Quality Control Section, under CMS, only four officials were in position, as of March 2022. The post of Inspector of stores had been lying vacant since FY 2019-20. There was no pharmacist in position, during 2016-2022, except for the financial years 2018-2019 and 2019-2020.

In the test-checked districts, incidences of consumption of non-standard drugs (Ibuprofen Oral Suspension 100 mg/ 5 ml; Batch No. IBS 1901) by patients, were noticed in the Sabang RH of Paschim Medinipur, while the non-standard drug was found being distributed though OPD in two phases (500 tablets in each phase), between August 2019 and November 2019 and again, between February 2020 and August 2020.

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

4.3.6 Non-availability of Essential Drugs in health facilities

Government formulated (2018) 'Essential Drug Lists', to be prescribed by doctors, specific to the different tiers of Government run hospitals across the State, for implementation of the free drug initiative of the National Health Mission and of the State.

Review of the availability status of the essential drugs, at the 38 selected SCs, 19 PHCs and 10 CHCs, showed that a wide range of essential drugs had never been procured by the health facilities, as shown below ***(Appendix 4.3 to 4.5)***:

Table 4.4: Non-availability of essential drugs at the health facilities

Category of Hospital	No. of essential drugs as per EDL	Percentage of drugs never procured
Sub-Centres*	53	41 to 85 *per cent*
Primary Health Centres	229	52 to 80 *per cent*
Community Health Centres (BPHC/ RH)	271	43 to 69 *per cent*

Source: Test-checked SCs, PHCs, CHCs & Essential Drugs list of SCs, PHCs & CHCs prepared by the State
** In 34 SCs as data of Purulia district was not available.*

[103] *Jalpaiguri: Six batches, Basirhat: Eight batches and Purulia: Four Batches*
[104] *Jalpaiguri: Three drugs, Basirhat: Seven drugs and Purulia: Four drugs*

Moreover, out of the essential drugs that had been procured, a number of drugs had remained out of stock for prolonged periods, during the test-checked period. In 23 SCs, essential drugs, ranging from 1 to 10 in number, had remained out of stock, for more than 300 days, while the out of stock position was more than 100 days, in respect of another 1 to 10 drugs, in 22 SCs, during the audit period. Similarly, up to 61 types and 83 types of drugs, had remained out of stock, for more than 100 days, in the PHCs and the CHCs, respectively.

A District Hospital (DH), being a secondary level hospital, was required to procure and maintain essential stocks of 480 drugs, including life-saving drugs, so that desired services could be rendered.

Review of data of the test-checked two DHs showed that 57 *per cent* and 63 *per cent* of the 480 essential drugs, had never been procured by the selected DHs, during the test-checked years, *i.e.* 2019-20 and 2021-22.

Table 4.5: Position of procurement of Essential drugs, in the test-checked DHs

Sl. No.	Name of the DH	No. of Essential Drugs as per State EDL	No. of drugs procured	No. of drugs never procured (percentage)
1.	Jalpaiguri	480	207	273 (56.88)
2.	Bashirhat		179	301 (62.71)

Source: Test-checked DHs & Essential Drugs list for DHs of the State

Essential drugs remaining out of stock: Of the small percentage of EDL drugs procured by the selected DHs, 446 drugs and 26 drugs had remained out of stock, in Jalpaiguri DH and Bashirhat DH, for different periods of time, during 2019-20 and 2021-22 as shown below:

Table 4.6: Position of essential drugs remaining out of stock, in the test-checked DHs

Name of DH	No. of drugs that had remained out of stock for the given range of days				
	<30 days	31-100 days	101-200 days	201-300 days	>300 days
Jalpaiguri	163	127	91	38	27
Bashirhat	1	0	1	1	23

Source: Test-checked DH's Data

Further, the Assessor's Guidebook of NHM specified that availability of certain drugs was to be ensured in the OT Emergency. The NRHM Maternal and Newborn health Tool Kit (2013) also cited that the emergency drugs tray, at the Labour Rooms should contain certain drugs. Audit scrutiny in Bashirhat DH, regarding the status of availability of the specified drugs, during FY 2019-20, 2020-21 and 2021-22, revealed that important drugs were out of stock, as below:

- **OT:** Out of the 23 essential medicines, four medicines, namely Gentamycin, Magsulf (Inj.), Hydrocortisone Succinate (Inj.) and Ceftriaxone, had been out of stock for a total of 365 days, 525 days, 30 days and 315 days, respectively, during the aforementioned period.
- **Emergency:** Of the eight essential medicines, two medicines, *viz.* Atropine Sulphate (Inj.) and Magsulf, had been out of stock, for a total of 644 days and 525 days respectively.
- **Labour Room:** Out of the 28 essential drugs, four drugs, *i.e.* Gentamycin, Misprostl 200mg, Magsulf (Inj.) and Ceftriaxone, had been out of stock for a total of 365 days, 1,122 days, 525 days and 315 days, respectively, during the aforementioned period.

Beneficiary survey, carried out by Audit, among patients across the primary care healthcare facilities that had been test-checked in audit, showed the following picture:

Table: 4.7 Beneficiary survey on Drugs at the OPDs & IPDs

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patients confirming the issue in PSS[105]	Percentage
OPD:				
1	Non-availability of the prescribed medicines at the hospital pharmacy	366	170	46.45
IPD:				
1	Prescribed drugs not being available at the Pharmacy and wards	96	56	58.33
2	Patient having to pay out-of-pocket for the medicines	96	22	22.92

Source: Beneficiary survey on drugs

Further, the beneficiary survey, carried out by Audit, among patients of the DHs and SDHs, test-checked in audit, showed the following picture:

Table 4.8: Beneficiary Survey among patients of DHs & SDHs

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue in PSS	Percentage
OPD:				
1	All the prescribed medicines not being made available by the hospital pharmacy	81	37	45.68
IPD:				
1	All the drugs prescribed not being made available at the Pharmacy and wards	79	28	35.44
2	Patient having to pay out of pocket for the medicines	79	25	31.65

Source: Beneficiary survey of the test-checked DHs & SDHs

Thus, non-availability of medicines in the hospitals was also evident from the results of the survey.

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

Recommendation:

8. The H&FW Department may formulate a Comprehensive Drugs Policy, ensuring continuing supply of essential and lifesaving drugs, monitoring of the quality of medicines and dissemination of the results of such tests to all health facilities, at the earliest, to avoid consumption of non-standard medicines, by persons consuming such medicines.

B. Equipment

4.4 Inventory control, maintenance and calibration of Bio-medical equipment

4.4.1 Maintenance of bio-medical equipment

IPHS (for DHs) states that the department is supposed to have a system of preventive maintenance, breakdown repair and periodic calibration of equipment.

[105] *Patient satisfaction survey*

The responsibility of inventory control, maintenance and calibration of bio-medical equipment was vested on the West Bengal Medical Services Corporation (WBMSCL), a company formed under the H&FW Department. M/s HLL Infratech Services Ltd. (HITES), an outsourced agency, was engaged, by execution of an agreement (June 2018), by WBMSCL, for maintenance of all bio-medical equipment, in all public health care facilities, up to the PHC level {except for Super Specialty Hospitals, wherein such maintenance is done by another agency, *i.e.* M/s AOV International LLP (engaged from November 2021), supported by a web-based application, with a web-based call logging system, called the Equipment Management Information System (EMIS)}.

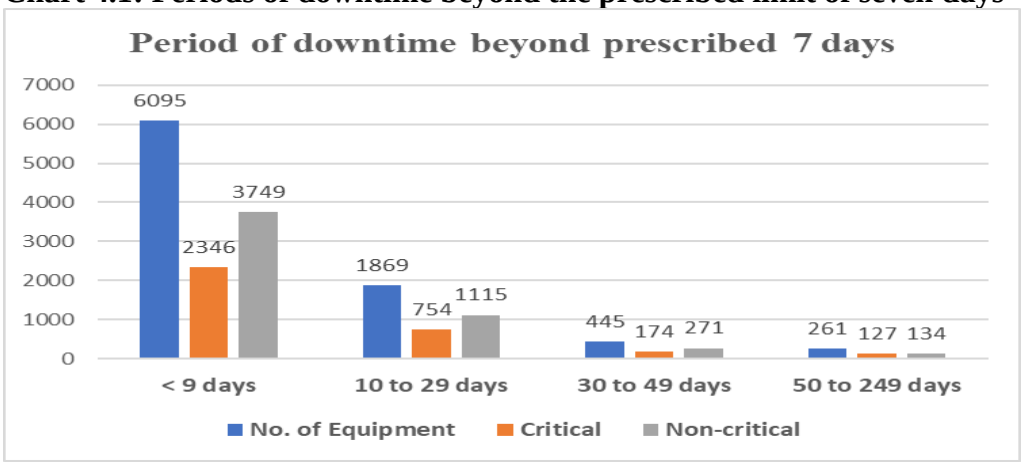
The agency was also assigned to update the Equipment Inventory on a bi-annual basis, *i.e.* on 1st January and 1st July every year.

4.4.2 Downtime of bio-medical equipment beyond the agreed period

It was agreed. between WBMSCL and M/s HITES (June 2018), that, at no point of time, in a single breakdown, should the unserviceable period exceed 120 hours from the time of registration of fault; and. if the equipment remained dysfunctional beyond seven days, penalties could to be imposed on the service provider, as specified in the agreement.

From the records relating to the status of call logs of complaints, regarding maintenance of out of order machines and their resolution, from October 2018 to March 2022, Audit observed that, 8,670 (*12.5 per cent*) items of medical equipment, in want of repair, out of 69,104 items of medical equipment, had remained non-functional, for periods ranging between one and 249 days, beyond the agreed period of seven days, as shown below:

Chart 4.1: Periods of downtime beyond the prescribed limit of seven days



Source: WBMSCL data

Though penalties were duly deducted, provision of health services was hindered for downtime of biomedical equipment (Critical[106] and Non-critical[107]), at different hospitals, for want of repair.

[106] *Critical Equipment like USG Machine (Basic), Semi-auto Biochemistry Analyzer, ECG Machine, Anaesthesia Machine, Oxygen Concentrator, ICU Ventilator, ABG Analyzer, Auto Hematology Analyzer, Mortuary Cooler, Horizontal Autoclave Machine, Surgical Laproscopic Unit, Multi-para Monitor, Tele Cobalt Unit, Radiant Warmer etc.*

[107] *Non-critical equipment like Pulse Oximeter, Basic Sterilizer, X-ray Machine, Incubator, Fumigator, Dental chair, Surgical Operating Microscope, Basic Hematology Analyzer, Hemoglobin meter, Centrifuge, Blood Bag Tube Sealer etc.*

In the test-checked Sabang RH of the Paschim Medinipur district, it was observed that the Blood Bank Refrigerator of the Blood Storage Unit had malfunctioned and HITES had attended the complaint, for repair of the said equipment, on four occasions, in a span of seven months (17-9-2021, 27-9-2021, 29-10-2021 and 11-4-2022). Yet, the machine had remained out of order, as on the date of audit (March 2022). It was observed that, as a result of such malfunctioning, 49 *per cent* of the blood units of its stock had been damaged and discarded.

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

4.4.3 Excess payment of ₹ 131.97 lakh, towards maintenance charges of unserviceable bio-medical equipment

As per the payment clause of the agreement, M/s HITES was to submit invoices, complete in all respects, by the 7th day of every month, to WBMSCL, for the previous month. On receipt of such monthly invoices, WBMSCL was to pay 80 *per cent* of the invoiced amount and balance 20 *per cent*, after further verification, within three months.

Audit observed, in the latest equipment inventory prepared by the agency, that at least 400 [108] items of equipment had been declared as "Recommended Beyond Economic Repair' (RBER), between 2018 and 2020. However, it was observed that WBMSCL had paid ₹ 131.97 lakh, towards maintenance charges of 400 items of RBER equipment, in full, from June 2018 to July 2021 and 80 *per cent* of the invoiced amount, up to November 2021.

Payments made on those 400 unserviceable bio-medical equipment, that had been declared as RBER, amounting to ₹131.97 lakh, was inadmissible and in excess.

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

4.4.4 Calibration of bio-medical Equipment not done

Calibration of equipment is an important element of maintenance[109], for minimizing the errors and bringing measurements to an acceptable level, for clinical diagnosis or therapy. Medical equipment, used in hospitals for monitoring and treatment of patients, require calibration, in order to have confidence in their functioning and operation. Calibration of equipment should be done either quarterly, biannually, or annually, depending on its category. Further, the service provider providing services for maintenance of bio-medical equipment was required to arrange a third-party annual audit by an NABL accredited laboratory, for the calibration process.

Analyzing records of equipment valuing ₹ 5.00 lakh and above, Audit observed that 1,330 (23 *per cent)* items of equipment, out of 5,810 items of equipment in the State (excluding SSHs) had never been calibrated ***(Appendix 4.6)***, as of March 2022, since the engagement (June 2018) of M/s HITES as the service provider for maintenance of bio-medical equipment.

Thus, the quality of provision of health services especially, in regard to the diagnosis of patients was compromised as the probability of erroneous diagnosis, leading to wrong treatment, could not be ruled out.

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

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[108] *ICU Ventilator, Anaesthesia Machine, Autoclave (Horizontal) Machine, Oxygen Concentrator, X-Ray Machine, Dental X-Ray Machine, ECG Machine, Endoscopic Unit, Blood Bank Refrigerator, Auto Biochemistry Analyzer, Phaco Machine, Radiant Warmer etc.*

[109] *Maintenance includes preventive and corrective maintenance of biomedical equipments.*

4.4.5 *Excess payment of ₹ 59.55 lakh towards maintenance fee of SSH equipment*

A. For comprehensive maintenance of 4,450 items of equipment, of 42 SSHs, with an overall asset value of ₹ 152.88 crore, an agreement was executed (November 2021) between WBMSCL and M/s AOV International LLP, for a period of three years. As per the agreement, payment of maintenance fee (at the rate of 3.6 *per cent* of the asset value) would be made on a monthly basis, wherein 80 *per cent* of the invoice value was to be paid on receipt of monthly invoices, along with monthly reports and the balance. 20 *per cent* was to be paid within three months, after verification of correctness of claims. The agreement also clearly stipulated that the commencement date of services would be the date of signing the Agreement.

From the records, however, Audit found that WBMSCL had paid maintenance fee, amounting to ₹ 45.86 lakh, for the month of October 2021, to M/s AOV International LLP, *i.e.* for one month, before the scheduled commencement of services, in violation of the Agreement.

B. Further in terms of the Award of Contract (23.09.2021), the detailed inventory of Medical Equipment, for each hospital, was to be cross checked and validated by the respective Superintendents/ Bio- Medical Engineers of Districts/ MSVPs of the Medical Colleges, for determination of the final value of the contract, for the purpose of arriving at the maintenance fee, which was to be paid at the rate 3.6 *per cent* of the asset value.

In this regard, it was observed that M/s AOV has tagged 3,660 items of equipment, valuing ₹ 136.08 crore, in place of 4,450 equipment, valuing ₹ 152.88 crore, in 42 SSHs. Out of those 3,660 items of equipment, 290 items of equipment, valuing ₹ 1.50 crore, were lying in the stores of the concerned SSHs, evidently not requiring service maintenance.

However, M/s AOV International LLP submitted bills for the months from November 21 to March 22, on the asset value of ₹ 152.88 crore, instead of ₹ 136.08 crore. WBMSCL also paid ₹ 215.56 lakh[110], without considering the asset value of the tagged equipment of ₹ 136.08 crore and equipment of ₹ 1.50 crore lying in store. As a result, ₹ 13.69[111] lakh was paid in excess, to the agency, for the months from November 2021 to March 2022, towards the maintenance fee of the equipment of SSHs.

As such, payment of ₹ 59.55 lakh (₹ 45.86 lakh + ₹ 13.69 lakh) towards maintenance fee to M/s AOV International LLP was inadmissible and in excess.

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

4.4.6 *Procurement of bio-medical equipment, valuing ₹ 2.27 crore, compromising safety standards and quality, by extending undue favour to the agency concerned*

WBMSCL floated (April 2016) an e-tender, for purchase of Anaesthesia Workstations with ventilators, with definite technical specifications, for 12 SSHs. As per the Safety Standards as detailed in the tender document, the equipment was to be US FDA[112] and CE[113] approved. US FDA certification of

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[110] *excluding GST, IT & TDS; Nov-Dec 21: Full and Jan-March 22: 90 per cent*

[111] *₹ 215.56 lakh minus {3.6 per cent of ₹ 134.58 crore (₹ 136.08 crore plus ₹ 1.5 crore) X 5/12}*

[112] *Food and Drug Administration.*

[113] *Conforfite Europeene: Compliance of product with all applicable European health safety performance and environmental requirement.*

medical equipment/ product safety and efficacy of the equipment as well as security of the patients.

In order to receive FDA approval for a high-risk medical device, a device must prove to the FDA that the 'item is safe and effective'. This process requires the manufacturer to work with the FDA, during the human trials of the device, to ensure that the trials meet rigorous scientific standards and that human subjects are protected from unnecessary risks. Firms involved in manufacturing, packaging or processing a device are required to register with the USFDA, list their devices and pay an annual fee.

While analyzing records, Audit observed that work order had been issued (July 2016) to M/s BPL Medical Technologies Pvt. Ltd., for supply of 12 items of equipment, at a cost of ₹ 1.70 crore (at a rate of ₹ 14.18 lakh). It was further observed that the equipment had only been registered and enlisted as applying for certification under US FDA, at that point of time, which did not denote approval by the FDA. The Technical Experts of the H&FW Department also substantiated (July 2018) this fact, stating that enlistment of medical equipment/ products under FDA did not ensure the quality & safety of the product.

Further, the device had been recalled (March 2012) for several problems and the manufacturer itself had issued (November 2011) a Technical Bulletin on the identified problems, relating to the device.

However, without floating any fresh e-tender, another AOC (Award of Contract) was issued (January 2018) to the same supplier, *i.e.* M/s BPL Medical Technologies Pvt. Ltd., for the same machine (four Anaesthesia Work Stations with ventilators), after expiry of the validity period of one year of the previous e-tender at the same rate (₹ 14.18 lakh each) for the NRS Medical College & Hospital at a cost of ₹ 56.70 lakh.

Thus, WBMSCL had placed orders on M/s BPL Medical Technologies Pvt. Ltd, for supply and installation of 16 Anaesthesia Workstations with ventilators[114], at a cost of ₹ 2.27 crore[115], despite non-fulfilment of the criteria (*i.e.* US FDA certification) relating to the safety standards stipulated in the e-tender, compromising safety standards and quality, by extending undue favour to the agency concerned.

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

4.5 Non-availability of equipment as per IPHS

The IPHS prescribed equipment norms for different levels of hospitals. Though there are Essential Drugs Lists, for different levels of health facilities, the H&FW Department had not devised any essential equipment norm/ list, for maintenance in the health facilities (except for the equipment to be maintained at the Critical Care Unit (CCU) and Sick Neonatal Care Unit (SNCU), which was specified).

However, an analysis of the availability of equipment, in the test-checked health facilities, against the essential lists of equipment, as prescribed in the IPHS, revealed that the facilities had been operating without a majority of the essential equipment being available therein.

114 SSHs-12 and NRS MCH-4
115 ₹ 170.10 lakh plus ₹ 56.70 lakh

- **Sub-Centres:** Against the 43 essential types of equipment, 10 *per cent* to 67 *per cent* types of equipment were not available in the test-checked SCs (data of four SCs in Purulia was not made available). Of the available equipment, up to 22 equipment were found to have been non-functional, in 27 SCs. Effectively, the SCs suffered the absence of 23 *per cent* to 88 *per cent* of essential equipment ***(Appendix 4.7)***.

  In reply, Department admitted (February 2024) that procurement of essential equipment has been completed in respect of 34 *per cent* SCs and is under process for the rest of the SCs. It further stated that due to non-availability of funds, equipment remained non-functional.

- **Primary Health Centres (PHCs):** Out of the 36 types of essential equipment, 36 *per cent* to 92 *per cent* types of equipment were not available in 18 PHCs. The shortage was 50 *per cent* or more, in 15 of these PHCs ***(Appendix 4.8)***. Of the test-checked PHCs, none had the required number of items of Pap Smear equipment, required for tests indicative of cervical cancer.

  In reply, Department did not specifically provide any details/ status of the test-checked PHCs while commenting (February 2024) that equipment were supplied to 551 PHCs out of 916 PHCs.

- **Community Health Centres (CHCs):** The following was the status of availability of various categories of equipment in the 10-test-checked CHCs ***(Appendix 4.9 to 4.11)***:

Table 4.9: Availability of equipment in the test-checked CHCs

Sl. No.	Type of Equipment	Status of availability
1	Standard Surgical Sets I-VI	Non-availability ranged from 62.30 *per cent* to 100 *per cent* in all the CHCs ***(Appendix 4.9)***.
2	IUD Insertion Kits	Non-availability ranging from 21.05 *per cent* and 100 *per cent* in all the 10 test-checked CHCs ***(Appendix 4.9)***
3	Normal Delivery Kit	More than 50 *per cent* of various types of equipment were not available in 2 CHCs ***(Appendix 4.9)***
4	Anaesthesia equipment of required 17 types	All the equipment were unavailable in 6 CHCs ***(Appendix 4.9)***
5	Neonatal Resuscitation	Absent, ranging from 20 *per cent* to 68 *per cent*, in all 10 CHCs ***(Appendix 4.9)***
6	Equipment for Operation Theatre	More than 50 *per cent* were not available in 3 CHCs ***(Appendix 4.9)***
7	Radiology equipment of 10 types	8 CHCs did not have any of the 10 types ***(Appendix 4.10)***
8	Immunization equipment	33 *per cent* to 100 *per cent* were not available in 8 CHCs ***(Appendix 4.10)***
9	Equipment for New-born Corner in OT/ Labour Room	14.29 *per cent* to 71.43 *per cent* were not found in all 10 CHCs ***(Appendix 4.10)***
10	Equipment for Stabilization Unit	Not available between 25 *per cent* and 100 *per cent* in 8 CHCs ***(Appendix 4.10)***
11	Laboratory Equipment	30 *per cent* and more were not available in 6 CHCs ***(Appendix 4.10)***
12	Equipment for Prevention and Control of Deafness (NPPCD)	Not available in any of the 10 test-checked CHCs ***(Appendix 4.10)***
13	National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS) equipment	No equipment was found in 4 CHCs, while shortages ranging between 55 *per cent* to 82 *per cent*, were noticed in 6 CHCs ***(Appendix 4.11)***
14	Equipment for Physical Medicine and Rehabilitation (PMR) (18 types)	No equipment was found in 9 CHCs, one CHC suffered a shortage of 50 *per cent* ***(Appendix 4.11)***
15	NVBDCP* related Equipment	4 CHCs suffered more than 50 *per cent* shortage ***(Appendix 4.11)***

Source: data provided by test-checked CHCs
** NVBDCP: National Vector Borne Disease Control Programme*

With such shortages of essential equipment, the CHCs could not have delivered the essential services they were supposed to deliver to the population. Further, no Downtime Registers were maintained for Critical Equipment, in nine CHCs, out of the10 CHCs test-checked.

The Department furnished no reply except stating that under NPPCD some basic ENT equipment were supplied to 174 CHCs in the State and claimed to have the immunisation equipment in all facilities. The contention of the Department, however, was inconsistent *vis-à-vis* the observation noted in the test-checked CHCs as detailed above.

4.5.1 Non-availability of essential equipment in secondary level hospitals

A review of the speciality-wise availability of equipment, in the test-checked five secondary level hospitals (two DHs & three SDHs), showed significant shortages, as below:

- ***Non-availability of equipment for newborn care:*** The Indian Public Health Standards (IPHS) stipulated the list of equipment for use in Special New-born Care Units (SNCUs) of a District Hospital. Though the list had been framed for running a minimum 12-bedded SNCU, a comparison of equipment, against this list, in the two test-checked districts, showed acute shortages of equipment, as detailed in ***Appendix 4.12***.

  Out of the 21 test-checked types of equipment, essential to run an SNCU, Jalpaiguri DH and Basirhat DH did not have 16 and 11 types of equipment, respectively.

  Important instruments, like Resuscitation Kits, Portable X-ray machines, Suction Machines, Infantometers, Multi-Channel Monitors, Digital Thermometers, CFL Phototherapy, Horizontal Laminar Flow *etc*., were either scarce and/ or absent, across Jalpaiguri DH (JDH) and Bashirhat DH (BDH).

Further, it was noticed in audit that out of two Foetal Dopplers in Ghatal SDH, one had remained non-functional for 18 months, during the audit period.

In reply, the Department stated (February 2024) that six of the major equipment for running SNCU were supplied centrally which are available at all functional SNCUs. The Department, however, did not comment on the shortages found in availability of those equipment in audit. In respect of availability/ shortage of the other 15 types of equipment, the Department stated that funds are disbursed to the facilities enabling local procurement.

- ***Non-availability of OT equipment:*** Status of availability of the equipment (as of January-March 2023) , in the OTs of the selected DHs and SDHs, was found grossly deficient, as below:

Table 4.10: Requirement and availability of equipment for OT, in selected DHs

Equipment Type	Requirement of equipment		Absence of equipment		Shortage of equipment	
			JDH	BDH	JDH	BDH
OT:	***Essential***	**19**	7	13	1	2
	Desirable	**3**	3	3	--	--
Anesthesia	***Essential***	**15**	2	5	3	9

Source: Test-checked DHs

Table 4.11: Requirement and availability of equipment for OT, in SDHs

Equipment Type	Requirement of equipment		Absence of equipment			Shortage of equipment		
			Paschim Medinipur	Purulia	Uttar Dinajpur	Paschim Medinipur	Purulia	Uttar Dinajpur
OT	***Essential***	**17**	9	Not made available	7	2	Not made available	1
Anaesthesia	***Essential***	**15**	4		3	4		1

Source: Test-checked SDHs & DHs

It may be seen from the above table that, out of 17 essential OT equipment, the SDHs in Paschim Medinipur and Uttar Dinajpur, did not have nine and seven types of equipment, while four and three types of Anaesthesia equipment were found absent in these two SDHs, respectively. Out of the available types of OT equipment, the SDHs in Paschim Medinipur and Uttar Dinajpur, had shortage in two and four types of equipment whereas the shortages in respect of Anaesthesia equipment were four and one in these two SDHs, respectively.

- ***Equipment/ instruments required in Emergency not available:*** Status of availability (as on January-March 2023) of essential emergency equipment, as prescribed in Assessors Guidebook, under the National Quality Assurance Scheme, showed that:
  - Bashirhat DH did not have basic equipment, like ECG, Defibrillator and Laryngoscope in its Emergency ward.
  - Ghatal SDH, in Paschim Medinipur, did not have Spotlights, in its Emergency ward and
  - Islampur SDH, in Uttar Dinajpur, did not have seven types of equipment, *viz.* Spotlight, ECG, Ambu bag, Defibrillator, Laryngoscope, Suction Apparatus, Crash cart/ drug trolley, in its Emergency ward.
- ***Shortage/ non-ustilisation of essential major equipment in CCU:*** Operational Guidelines of the Government of West Bengal, for CCU and HDU, laid down the standard lists of equipment. The status of availability, when checked in audit, revealed considerable shortages and/ or non-functioning of equipment, in CCUs, as below:
  - The Jalpaiguri District Hospital did not have an adequate number of nebulisers (two, against stipulated eight).
  - Although the Jalpaiguri District Hospital had an adequate number (20) of Standard Ventilators, seven were non-functional.
  - The Bashirhat District Hospital did not have an adequate number of Ripple Mattress as (nil, against the stipulated 12), nebulisers (nil, against the stipulated eight), Syringe Infusion Pumps (six, against the stipulated 12) and Overbed Table (nil, against the stipulated 12).
  - ***Non-availability/ Shortage of equipment:*** The lists of equipment prescribed in IPHS (for a 500-bedded DH), for some of the remaining departments/ services, obtained from the respective departments, revealed shortages and anomalies in stock, as detailed in ***Appendix 4.13 to Appendix 4.18***.
- **ENT equipment** ***(Appendices 4.13 & 4.14)*****:** Out of 20 essential ENT equipment, all the test-checked DHs, SDHs did not have/ had a shortage of 19 types of equipment. Out of three desirable equipment, Jalpaiguri DH and Ghatal SDH did not have two and Basirhat DH did not have one equipment.

  In reply, the Department stated (February 2024) that desirable equipment are subject to demand of the hospitals and availability of fund. However, the

Department did not comment on non-availability of essential equipment as observed in audit.

- **Eye equipment** ***(Appendices 4.15 & 4.16)*****:** Review of 20 types of essential and two types of desirable Eye equipment, in the test-checked DHs, showed that while in Jalpaiguri DH, there were no equipment or inadequate equipment in respect of 16 types, Bashirhat DH had 11 types of equipment which were absent or inadequate in number. Islampur SDH suffered a shortage in respect of two types of eye equipment, against the essential nine types.

  The Department, in reply, claimed (February 2024) that necessary equipment have already been supplied subsequently in the year 2022-23 and 2023-24.

- **Cardiopulmonary equipment** ***(Appendices 4.17 & 4.18)*****:** Out of sixteen essential Cardiopulmonary Equipment, five equipment were not available, across both-the two selected DHs.

It is evident from the above that all the selected DHs/ SDHs were operating in the absence of and/ or with serious shortages of essential equipment.

- ***Radiology Equipment:*** Most of essential equipment, as stipulated in IPHS, which was required to ensure delivery of desired radiology services in a district hospital, as well as in a sub-divisional hospital, was not available in the DHs/ SDHs, as below:

Table 4.12: Dearth of equipment *vis-à-vis* IPHS requirements, in DHs

Sl. No.	Equipment	Number required	Nos. available		Remarks
			JDH	BDH	
1.	500 M.A. x-ray machine	1	1	0	**JDH:** More than 22 years old and is partly functional
2.	300 M.A. x-ray machine	1	0	0	--
3.	100 M.A. x-ray machine	1	3	1	**JDH:** 2 Non-Functional
4.	60 M.A. x-ray machine (Mobile)	1	0	0	--
5.	C arm with accessories	1/ desirable	0	0	--
6.	Dental x-ray machine	1	1	0	**JDH:** Non-Functional
7.	Colour Doppler Ultrasound machine with 4 probes.	4	6	1	**JDH:** 3 Non-Functional
8.	Portable ultrasound	1/ desirable	0	0	--
9.	C.T. Scan Multi slice (64 slice)	1/ desirable	0	0	--
10.	Mammography Unit	1	1	0	--
11.	Echocardiogram	1/ desirable	1	0	--
12.	MRI 1.5 Tesla	1/ desirable	0	0	--

Source: Test-checked DHs

Table 4.13: Dearth of equipment *vis-à-vis* IPHS requirements in SDHs

Sl. No.	Name of Equipment	Number required	Nos. available			Remarks
			Ghatal SDH	Raghunathpur SDH	Islampur SDH	
1.	300 M.A. x-ray machine	1	0	**Not furnished to Audit**	0	Non-functional in Ghatal for past four year and declared condemned in Islampur on 07.01.21
2.	100 M.A. x-ray machine	1	0		1	Non-functional in Ghatal for past one year
3.	60 M.A. x-ray machine (Mobile)	1	1		1	--
4.	C arm with accessories	1/ desirable	1		1	--

Sl. No.	Name of Equipment	Number required	Nos. available			Remarks
			Ghatal SDH	Raghunathpur SDH	Islampur SDH	
5.	Dental x-ray machine	1	1		1	--
6.	Ultra Sonogram (Obs & Gyne. department should be having a separate ultra-sound machine of its own)	1 + 1	2		1	1 Non-functional in Ghatal for past three years
7.	Mammography Unit	1/ desirable	0		0	--
8.	Echocardiogram	1/ desirable	0		1	--

Source: Test-checked SDHs and IPHS norms

- **Lack of essential Laboratory equipment:** The 58 essential types of laboratory equipment, as stipulated by IPHS, to ensure delivery of desired diagnostic services in a district hospital, were not available with the DHs, as below:
  - 24 and 38 types of laboratory equipment were not available with Jalpaiguri DH and Bashirhat DH, respectively.
  - 34 and 46 types of equipment showed gross shortages, in Jalpaiguri DH and Bashirhat DH, respectively.
  - In Ghatal SDH, Binocular Microscope, Semiauto analyser and Electric Centrifuge tabletop, had remained non-functional, for two to three years, during the audit period, from 2016-17 to 2021-22.

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

4.5.2 Ventilators supplied from PMCARES

- Five ventilators[116] were received by the Critical Care Medicine Department of SSKM MCH, under PMCARES, and installed on 23.9.2020. They were also recorded in the stock register on the same date and had been lying in stock, (as of March 2022).
- These ventilators had not been made operational, due to lack of consumables[117]. After repeated pursuance by the Department with suppliers who supplied ventilators to the SSKM earlier, 10 flow sensors[118] could be arranged, but the ventilators could not be made functional.
- The ventilators, in their basic form, as supplied, were fit for short period use. For continued use, supply of consumables was necessary. Without the back-up supply of consumables, the ventilators were not fit for functioning for a longer period, at a stretch. Use these of machines in the 'Assist control' mode[119] or 'Pressure Controlled' modes[120], was still not possible, as of March 2022.

[116] *Sl. No.-BVACV 24799, BVACV 24422, BVACV 24571, BVACV 11417 and BVACV 247*
[117] *Bacteria Filter, Bains Circuit etc.*
[118] *Flow sensor is one of the components of ventilators. They are required to make the ventilators functional.*
[119] *Assist Control Mode (AC) is one of the most common methods of mechanical ventilation in the ICU. It works by setting a fixed tidal volume that the ventilator will deliver at set interval of time or when patient initiates a breath.*
[120] *Pressure Controlled mode is a modality utilized in patients with an indwelling endotracheal tube or tracheostomy tube that affords the practitioner the ability to ventilate a patient with a maximal peak pressure.*

- Another three (3) ventilators (Model: CV 200), received (dates of receipts not available) under PMCARES, were found lying packed in the store room of the Hospital, during physical verification (March 2022). No handing over note, challans of items received, warranty papers *etc*., in their regard, were made available to Audit.

Picture 4.1: Three ventilators (Model: CV 200) received under PMCARES, lying packed in the store room of SSKM (March 2022)

- Seventeen (17) ICU Ventilators, received by RMC&H, under PMCARES, during 2020-22 were found to have remained non-functional (as of March 2022), due to non-operation of the HDU. Some of them were lying in store room of the hospital. Five (5) Oxygen Concentrators, also received under PMCARES, were lying in the store.

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

4.5.3 PSA plants supplied from PMCARES

Government of India, between October 2020 and June 2021, supplied[121] 46 Pressure Swing Adsorption (PSA) oxygen generating plants to the State under PMCARES. The State also received 29 more PSA plants donated under Corporate Social Responsibility (CSR) scheme. Audit, however, observed that 57.33 *per cent* of the PSAs were either not commissioned and/or not functioning as shown in **Table 4.14**:

Table 4.14: Functional status of PSA plants as of December 2023

Sources	PSAs received	Commissioned	Functional	Not commissioned and/or not functional
PMCARES	46	43	23	23
CSR	29	18	9	20
Total:	**75**	**61**	**32**	**43 (57.33 *per cent*)**

Source: Records of the H&FW Department

In reply, West Bengal Medical Services Corporation Limited (WBMSCL), stated (February 2024) that the activity of installation of PSA plants/ making non-functional commissioned PSA plants, functional, was within the scope of the GoI/ donating Corporate Concerns. No documents, in this regard, though were made available. The reply further showed that, as per H&FW Department's directive (July 2023), the WBMSCL had invited tenders for making non-functioning PSA plants, functional, and after their finalisation, with approval of the H&FW Department, agencies would be selected for making non-functioning PSA plants, functional. The reply was to an extent dichotomous as on one hand it says that it was beyond the scope of work and on the other hand it says that it had since invited tenders for selection of agencies for making

[121] *Excluding three PSAs supplied to AIIMS-Kalyani, ESI Baltikuri and ESI Joka.*

non-functional commissioned PSA plants, functional. Further, there was also no clarity in respect of these issues from the H&FW Department, though called for.

Thus, there was no assurance available to indicate as to when commissioning of yet to be installed PSA plants would be done/non-functional PSA plants, would be actually put to use.

Recommendations:

9. ***Appropriate steps may be taken to make all essential equipment available in health facilities, to ensure proper diagnosis and treatment.***
10. ***Maintenance of bio-medical equipment may be ensured, to avoid instances of the equipment going out of order and lying non-functional, hindering services.***
11. ***Centralised monitoring may be carried out, to ensure that the bio-medical equipment undergoes periodic calibration, ensuring error-free diagnosis and treatment.***

CHAPTER 5

Healthcare Infrastructure

5 Chapter Healthcare Infrastructure

Audit Objective: Whether the health sector had adequate infrastructure as per prescribed norms and whether these were utilised efficiently and effectively.

There were inadequate Primary Healthcare facilities (including Primary Health Centres), to serve the rural population throughout the State. Absence of requisite physical infrastructure was noticed in the existing primary healthcare facilities. Community Health Centres were running with less than the number of prescribed beds. Most of the Super Speciality Hospitals (SSHs) had failed to deliver super-speciality services. Intensive Care Units and Cardiac Care Units in SSHs were also found non-functional. Further, equipment, acquired at significant expenses, could not be traced during the tagging exercise and many items of equipment were found lying idle in SSHs. The newly set up Integrated AYUSH Hospital in Paschim Medinipur, had remained un-utilised.

Infrastructure

5.1 Inadequate Primary Healthcare facilities to serve rural population

As prescribed in the Indian Public Health Standards (IPHSs), there should be one Sub-Centre for every 5,000 population, one Primary Health Centre (PHC) for every 30,000 population and one Community Health Centre for every 1.20 lakh population for plain areas[122].

An assessment (based on the population figure of the 2011 census and conservatively considering the population criteria for plain areas only) of availability of the existing primary health facilities in the State, showed the following status:

Table 5.1: Availability of the existing primary health facilities in the State

Type of health facility	Population norm (in plain areas) for Healthcare facilities	Rural population of West Bengal as per 2011 census	Ideal number of facilities	Total number of facilities available	Shortage of health facilities	Shortage Percentage
Sub-Centre (SC)	1 SC per 5,000 population	6,21,83,113	12,437	10,368	2,069	16.64
PHC	1 PHC per 30,000 population		2,073	916	1,157	55.81
CHC	1 CHC per 1,20,000 population		518	348	170	32.84
Total:			**15,028**	**11,632**	**3,396**	**22.60**

Source: HMIS data and IPHS norms and data furnished by H&FW Department

It could be seen that there was considerable shortage of PHC facilities in the State, as against the norms laid down by the IPHS. Non-availability of PHCs in the State, (as high as 56 *per cent*) was alarming.

In reply, Department stated (February 2024) that 3,187 new Sub-centres had been sanctioned and made functional. However, scrutiny of HMIS data showed that only 2,305 SCs were added in HMIS as of April 2024. The reply remained silent about shortages in PHCs and CHCs in the State.

[122] *3,000 for SCs, 20,000 for PHCs and 80,000 for CHCs in hilly/ tribal/ desert areas*

A district and facility-wise shortage analysis ***(Appendix 5.1, Appendix 5.2 and Appendix 5.3)*** of healthcare facilities, showed the following position of shortages in Primary Healthcare facilities, across districts:

Table 5.2: Percentage of shortages in Healthcare facilities in the State

Shortage in Sub-Centres		Shortage in PHCs		Shortage in CHCs	
Districts	**Shortage *(percentage)***	**Districts**	**Shortage *(percentage)***	**Districts**	**Shortage *(percentage)***
Nadia	37.11	**Uttar Dinajpur**	79.58	**Uttar Dinajpur**	59.09
Uttar Dinajpur	34.97	**South 24 Pgs. & Diamond Harbour HD**	70.86	**Nadia**	45.16
Murshidabad	27.06	**Malda**	70.41	**Malda**	44.83
Malda	25.88	**Purba Medinipur & Nandigram HD**	66.02	**Murshidabad**	43.75
Purba Medinipur & Nandigram HD	21.61	**North 24-Parganas & Bashirhat HD**	64.93	**Coochbehar**	42.86
Birbhum & Rampurhat HD	20.73	**Murshidabad**	63.18	**South 24 Parganas & Diamond Harbour HD**	41.18
Coochbehar	19.75	**Nadia**	62.19	**Jalpaiguri & Alipurduar**	39.13
Purba & Paschim Bardhman	17.55	**Dakshin Dinajpur**	60.42	**North 24 Parganas & Bashirhat HD**	38.89
Paschim Medinipur & Jhargram	17.35	**Jalpaiguri & Alipurduar**	59.47	**Purba Medinipur & Nandigram HD**	36.84
Bankura & Bishnupur HD	14.47	**Coochbehar**	57.31	**Hooghly**	35.71
North 24 Parganas & Bashirhat HD	13.27	**Paschim Medinipur & Jhargram**	52.61	**Dakshin Dinajpur**	33.33
South 24 Parganas. & Diamond Harbour HD	12.09	**Hooghly**	46.91	**Paschim Medinipur & Jhargram**	32.56
Dakshin Dinajpur	11.11	**Birbhum & Rampurhat HD**	43.01	**Birbhum & Rampurhat HD**	24.00
Purulia	5.15	**Darjeeling & Kalimpong**	41.01	**Bankura & Bishnupur HD**	18.52
Jalpaiguri & Alipurduar	4.53	**Bankura & Bishnupur HD**	37.21	**Purba & Paschim Bardhman**	12.82
Hooghly	2.67	**Purulia**	36.64	**Purulia**	4.76
Darjeeling & Kalimpong	-4.02	**Purba & Paschim Bardhman**	31.45	**Howrah**	0.00
Howrah	-26.13	**Howrah**	27.36	**Darjeeling & Kalimpong**	-33.33

Source: HMIS data and IPHS norms and data furnished by H&FW Department
As figures of population are not available separately, all newly formed districts and/ or health districts[123] (HDs) have been included in the original district

It could be seen that individually, nine districts, in respect of SCs; 10 districts, in respect of PHCs; and 12 districts, in respect of CHCs; had shortages higher than the State average in that category, ranging up to 37 *per cent*, 80 *per cent* and 59 *per cent*, respectively. It is pertinent to mention that three districts *viz.* Uttar Dinajpur, Malda and Murshidabad, commonly featured among the top six deficient districts, in regard to all the three categories of facilities (SC/ PHC/ CHC).

[123] *A district which is not administratively created but created on the basis of health services only, with posting of a Chief Medical Officer, Health, in each such district, are known as Health District.*

No recorded reasons in this regard, nor any evidence of having carried out a gap analysis exercise, or formulation of a time-bound plan to address such shortages, was furnished to Audit, though asked for. Thus, the existing SCs/ PHCs/ CHCs of the State were serving populations beyond their prescribed capacities. Around 89 *per cent* of the Sub-Centres (8,533), whose data was available (9,587), were serving more than the prescribed 5,000 (3,000 in Hilly areas) population per SC, while the number was as high as 98 *per cent* (796) in the tribal areas of the State (812). The Department in its reply (February 2024) offered no response in this regard.

This apart, the existing health facilities lacked the essential infrastructure and resources necessary to render services as per IPHS, as discussed in the following paragraphs:

5.2 Absence of requisite physical infrastructure in the existing primary and secondary healthcare facilities

5.2.1 Physical Infrastructure of Sub-Centers

(i) Own building & location: As per IPHS, a Sub-Centre should have its own building. If that is not possible immediately, premises with adequate space should be rented, in a central location, with easy access. The norms specified that, as far as possible, no person must travel more than three kms. to reach a Sub-Centre.

Analysis of the Health Management Information System (HMIS) data revealed that 2,084 SCs of the State (20 *per cent*) were not operating from government buildings. Moreover, 5,893 SCs (56.84 *per cent*) were located more than three kms. from the furthest village, in coverage area of those SCs.

Of the 38 test-checked SCs, in the five selected districts, seven SCs (18 *per cent*) did not have their own buildings ***(Appendix 5.4)***.

In reply, Department stated (February 2024) that presently there are 1,208 rented SCs in the State. Further, GPS based exercise and notification of new SCs has been done to reduce distance gap.

(ii) Building & layout: The building and layout norms of IPHS prescribed that SCs should have a boundary wall/ fencing with gate, for safety and security; a waiting room; one room for store; one room for clinic/ office; and one toilet facility, each in the wardroom and in the waiting area. Further, the building should have provisions for easy access, like ramp with railing, for the disabled and elderly. It should also have one Labour Room (with one labour table and newborn care corner) for Type-B SCs[124], with toilet facility.

The buildings were supposed to have a prominent board, displaying the name of the Centre in the local language, at the gate and on the building. Display boards, providing information regarding the services available, and the timings of the SCs, were to be displayed at a prominent place. Suggestion/ complaint box, for the patients/ visitors and information regarding the person responsible for redressal of complaints, were also to be displayed.

[124] *Type B Sub-Centre-SCs provide facilities for conducting deliveries, apart from other basic primary healthcare facilities, to the community.*

Review of the infrastructure module of 10,368 SCs, in HMIS, showed significant deficiencies in the availability of physical infrastructure, in the SCs of the State, as shown below:

Table 5.3: Deficiencies in the availability of physical infrastructure in the SCs of the State

Sl. No.	Infrastructure	Number of deficient SCs	Percentage
1	Labour Room not available	9,625	92.83%
2	No boundary wall and/ or gate	7,535	72.67%
3	No provision for separate public utility (toilet)	5,814	56.08%
4	Complaint box not installed	3,494	33.70%
5	Examination Room not available	1,561	15.06%
6	Prominent display board/ patient charter not available	1,119	10.79%
7	Clinic Room not available	862	8.31%

Source: HMIS data

Non-availability of labour room in SCs is corroborative of the audit observation *(paragraph 3.1.1(ii) (A))* that all SCs were Type-A.

Thus, the availability of essential healthcare services, security, patient/ public utilities *etc.*, could not be ensured. The scenario in the 38 test-checked SCs, of the five selected districts, was similar to that of the State ***(Appendix 5.4)***.

Table 5.4: Deficiencies in the availability of physical infrastructure in the selected SCs

Sl. No.	Infrastructure	No. of deficient SCs	Percentage
1	Labour Room not available	38	100
2	No boundary wall and/ or gate	26	68.42
3	No provisions for separate public utility (Toilet)	38	100
4	Complaint box not installed	10	26.32
5	Examination room not available	38	100
6	Prominent display boards and Patient Charter not available	10	26.32
7	Clinic room not available	38	100

Source: Data provided by test-checked districts

Picture 5.1: No boundary wall at Aturia SC, Bashirhat (February 2022)

Non-availability of examination rooms and clinic rooms, in the test-checked SCs, was found to be higher than the position depicted in the HMIS.

In respect of non-availability of Labour Rooms, the Department stated in its reply (February 2024) that it is not promoting deliveries at SCs. The Department also claimed that except SCs under construction, display/ patient charters were available in all SCs. In respect of non-availability of separate toilets and examination rooms, the Department while accepting the facts, assured about gradual reduction in number. No comments in respect of non-availability of boundary walls and/ or complaint boxes were made.

Picture 5.2: No concrete building of Nimki Mohar SC of West Medinipur (April 2022)

Picture 5.3: Kachcha approach road of Nimki Mohar SC, which gets flooded with water from the side canals/ drains (April 2022)

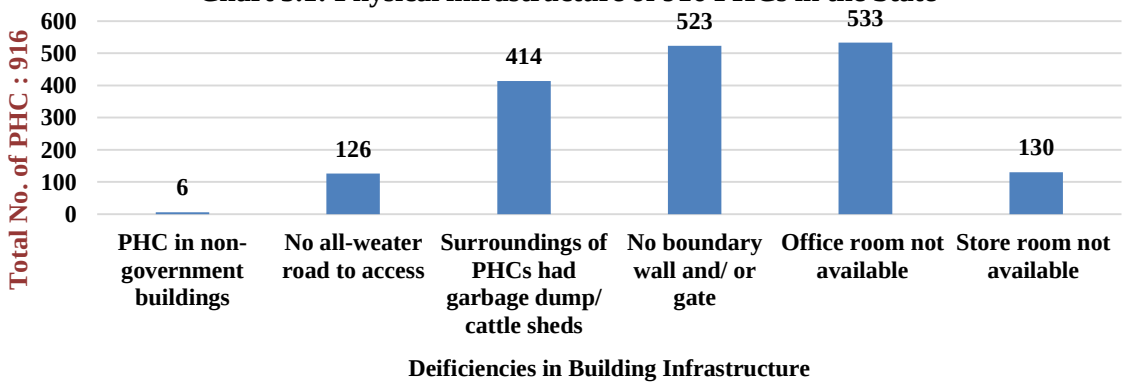
(iii) Water & Electricity: 43.39 *per cent* of the SCs in the State (4,499) did not have overhead tanks and/ or pumps, for ensuring water supply to the SCs. Moreover, out of the SCs where overhead tanks and/ or pumps were available (5,006)[125], in 568 SCs, either the tank was of insufficient capacity and/ or the pumps were non-functional. Uninterrupted power supply could not be ensured in 403 SCs.

In reply, the Department stated (February 2024) that overhead tanks and facility of uninterrupted power supply are mostly not available in rented/ rent free sub-centres the number of which is reducing gradually.

5.2.2 Physical Infrastructure of Primary Health Centres

(i) Building: As per IPHS, a PHC should have a building of its own. The surroundings should be clean with all-weather road communication and adequate water supply. Further, the PHC should be away from garbage collection, cattle shed, water logging area *etc.* A PHC should also have a proper boundary wall and gate.

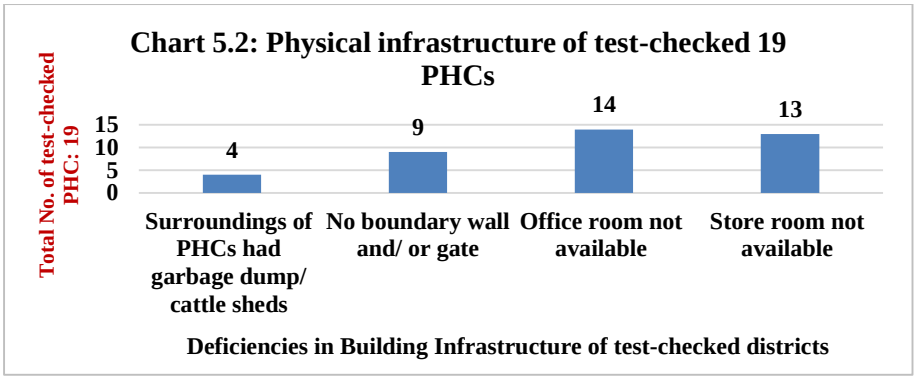
Chart 5.1: Physical infrastructure of 916 PHCs in the State



Source: HMIS data

Review of the HMIS data showed that, though only 6 of the 916 PHCs were not housed in government buildings, accessibility to 126 PHCs was not supported with all-weather roads. The surroundings of 414 PHCs had garbage dump and/ or cattle sheds. The premises of 523 PHCs were not secured by boundary wall and/ or gate. Office room and storeroom were not available in 533 and 130 PHCs, respectively.

[125] *Information in respect of 863 SCs was not available in HMIS.*



Source: Data furnished by test-checked PHCs

In the test-checked 19 PHCs ***(Appendix 5.5)*** in the surroundings of four PHCs had garbage dumps and/ or cattle sheds. The premises of nine PHCs were not secured by boundary walls and/ or gates. Office room and storeroom were not available in 14 and 13 PHCs, respectively.

(ii) Signage: As per IPHS, a PHC building should have a prominent board, displaying the name of the Centre in the local language at the gate and on the building. Further, PHCs should have pictorial, bilingual directional and layout signage of all the departments and public utilities (toilets, drinking water). Prominent display boards, in the local language, providing information regarding the services available/ user charges/ fee[126] and the timings of the Centre, should be available. The Citizen's Charter, including patient rights and responsibilities, is to be displayed at the OPD and entrance, in local language.

Review of records revealed that 84 PHCs in the State did not have display boards of the names, services and charter of patient rights in the State. In the test-checked PHCs, eight PHCs did not have display boards of the names, services and charter of patient rights.

In reply, Department stated (February 2024) that all PHCs are now functioning with proper citizen charter. The Department, however, remained silent about non-availability of display boards of names and/ or services in the PHCs.

(iii) Barrier-free access and disaster management measures: IPHS envisaged that a barrier-free access environment (ramp, hand railing *etc.*) was to be ensured in the PHCs, for easy access to non-ambulant (wheelchair, stretcher), semi-ambulant, visually disabled, and elderly persons. All PHCs were to have a Disaster Management Plan, in line with the District Disaster management Plan. All health staff were to be trained and well conversant with disaster prevention and management aspects. Further, surprise mock drills were to be conducted at regular intervals.

A review of the 19 test-checked PHCs showed that 14 PHCs had no arrangements for a barrier-free access environment (ramp, hand railing *etc.*). None of the PHCs had a Disaster Management Plan[127], in line with the District Disaster management Plan and/ or had conducted surprise mock drills, at regular intervals**.**

[126] *Cost of services, like OPD registration charges, diagnostic charges of units set up for X-ray, CT, MRI, pathology etc., in PPP mode.*

[127] *Apart from the building and the internal structure being earthquake proof, flood proof and equipped with fire protection measures, all health staff was to be trained and well conversant with disaster prevention and management aspects. Surprise mock drills were to be conducted at regular intervals.*

In reply, Department stated (February 2024) that provisions for barrier free environment has now been incorporated in designs for new buildings of PHCs.

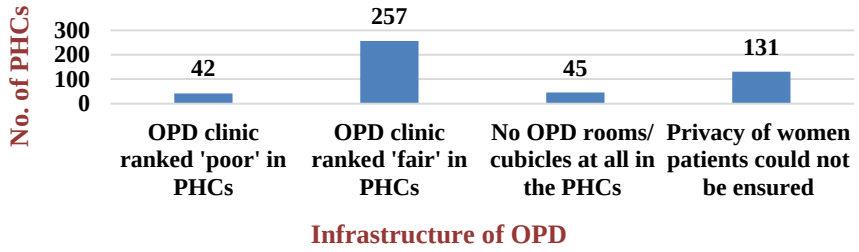
(iv) Waiting area: A waiting area, as per IPHS, was supposed to have adequate space and seating arrangements for waiting clients/ patients, as per the patient load. A locked complaint/ suggestion box was to be provided, and it was to be ensured that the complaints/ suggestions were looked into at regular intervals and addressed.

However, out of the 916 PHCs in the State, waiting areas for patients were not available in 258 PHCs (28 *per cent*), while complaint/ suggestion boxes had not been provided in 208 PHCs (23 *per cent*) in the State. In the test-checked PHCs, waiting areas for patients were not available in six PHCs, while complaint/ suggestion boxes had not been provided in 12 PHCs.

The Department replied (February 2024) that waiting area are now been constructed in all upgraded PHCs.

(v) Infrastructure for OPD and IPD: IPHS prescribes that outpatient rooms should have separate areas for consultation and examination, with provision for ample natural light and air. The area for examination should have sufficient privacy. There should be four to six beds in IPD of a Primary Health Centre. Separate wards/ areas should be earmarked for males and females, with the necessary furniture. Facilities for drinking water and separate clean toilets for men and women were also to be ensured. An Operation Theatre (optional) was to be in place, to facilitate conducting selected surgical procedures (*e.g.* vasectomy, tubectomy, hydrocelectomy *etc.*). It was to have a changing room, sterilization area, operating area and washing area. Each PHC was supposed to have a Labour Room, with provision for a Newborn Care Corner. There were to be separate areas, for septic and aseptic deliveries.

Chart 5.3: Physical Infrastructure of OPD clinics of 916 PHCs in the State



Source: HMIS data

HMIS data showed status of OPD clinics were poor[128] in 42 PHCs. However, the criteria standards for earmarking a PHC as poor was not on record. There were no OPD rooms/ cubicles in 45 PHCs. Privacy of women patients could not be ensured in 131 PHCs. Outpatient rooms, with separate areas for consultation, were not available in 8 of the 19 test-checked PHCs.

IPD: Analysis of HMIS data showed:

- There was no provision of beds in 34 *per cent* of the PHCs (316), while in 35 *per cent* of the PHCs (324), though bedded, IPDs were non-functional.

[128] *As ranked by the hospitals themselves in HMIS information*

- In PHCs with functional Beds (276), the status of IPDs was poor in 23 PHCs.
- There were no separate wards for males and females, in 86 PHCs.
- Separate public utilities, for males and females, were not available in 231 PHCs.
- The condition of toilets was poor in 101 PHCs.

Picture 5.4: IPD beds lying idle at Bajitpur PHC, Bashirhat (March 2022)

There was no Operation Theatre (OT) in 699 PHCs, while 18 of the existing OTs did not have power supply. Labour Rooms (LR) were not available in 473 PHCs, while 73 LRs suffered from problems of water seepage and 46 did not have power supply.

The status, as found in the test-checked 19 PHCs, showed that:

Table 5.5: Non-availability of IPD facilities in the test-checked PHCs

Sl. No.	Facilities not available	Deficient PHCs
1.	Provision of beds	13
2.	Separate wards for male and female patients	13
3.	Separate public utilities (toilets) for males and females	12
4.	Operation Theatre	17
5.	Operation Theatre (OT) for C-section deliveries	19
6.	Labour room with Labour table	10
7.	Labour room and OT of PHCs having Newborn Care Corner	13
8.	Labour room and Newborn Care Corner within LR, fitted with Radiant Warmer	12
9.	Arrangement for separate delivery areas, for septic and aseptic deliveries	19

Source: Data of the test-checked PHCs

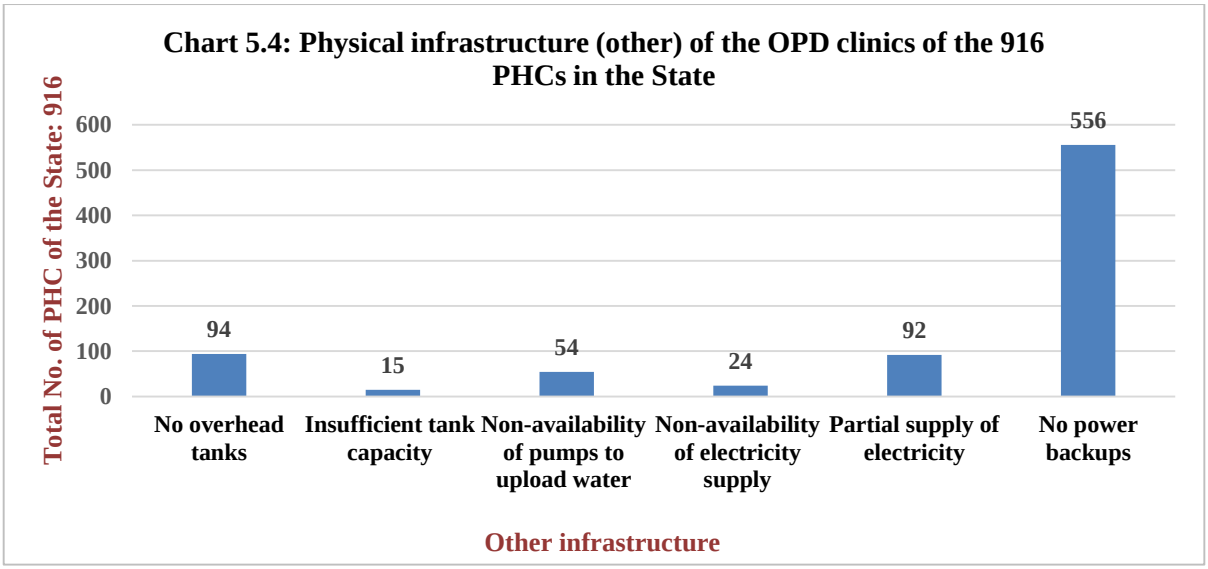
Thus, the test-checked PHCs were lacking in regard to providing privacy for women patients, conducting selected surgical procedures (*e.g.* vasectomy, tubectomy, hydrocelectomy *etc.*) and availability of resuscitation facilities for newborns.

(vi) Other infrastructure: Decent accommodation, with all amenities, such as 24-hrs water supply, electricity *etc.*, were to be ensured for Medical Officer, Nursing staff, Pharmacist, laboratory technician and other staff.

The PHCs were to be, as far as possible, environment friendly and energy efficient. Rainwater harvesting, solar energy use and use of energy-efficient bulbs/ equipment, were to be encouraged.

Adequate water supply and water storage facility (overhead tank), with piped water, was to be made available. Regular electricity supply, in all parts of the PHCs, with power backup facilities, was to be ensured.

Records of HMIS, however, showed that provisions for overhead tanks had not been made in 94 PHCs in the State and, of the PHCs where tanks were available, 15 were not of sufficient capacity and 54 PHCs did not have pumps to upload water into the tank. Electricity supply was not available in 24 PHCs and was only partially available in 92 PHCs. There were no provisions for power backup in 556 PHCs.



Source: HMIS data

Picture 5.5: Non-functional generator at Hingalganj PHC, Bashirhat (April 2022)

In the 19 test-checked PHCs, it was found that, in eight PHCs, accommodation with amenities like 24-hrs water supply, electricity *etc.*, were not available, for Medical Officers, nursing staff pharmacists, laboratory technicians and other staff. In 17 PHCs, there was no arrangement for rainwater harvesting and use of solar energy. Further, no provisions for power backup, were found in the Operation Theatres in 15 PHCs ***(Appendix 5.5)***.

The Department, in respect of non-availability of power supply in PHCs, stated (February 2024) that initiative to resolve this issue has been taken up utilising 15th FC funds.

5.2.3 Physical Infrastructure of Community Health Centres

(i) Location: The area chosen for a CHC, as per IPHS, should have facility for all-weather road communication. Further, CHC should be away from garbage dumps, cattle sheds, water logging areas *etc.*

Records revealed that seven of the 348 CHCs in the State did not have all-weather roads, to make them accessible in all-weather conditions. There were garbage dumps in the vicinity of 172 CHCs, while 47 CHCs had cattle sheds in their vicinity.

(ii) Building: As per IPHS, CHCs should not be in a low-lying area, to prevent flooding. CHCs should have a dedicated, intact boundary wall, with a gate. The name of the CHC, in the local language, should be prominently displayed at the entrance. Further, all CHCs should have a Disaster Management Plan[129], in line with the District Disaster Management Plan. All health staff should be trained and well conversant with disaster prevention and management aspects. Surprise mock drills should be conducted at regular intervals.

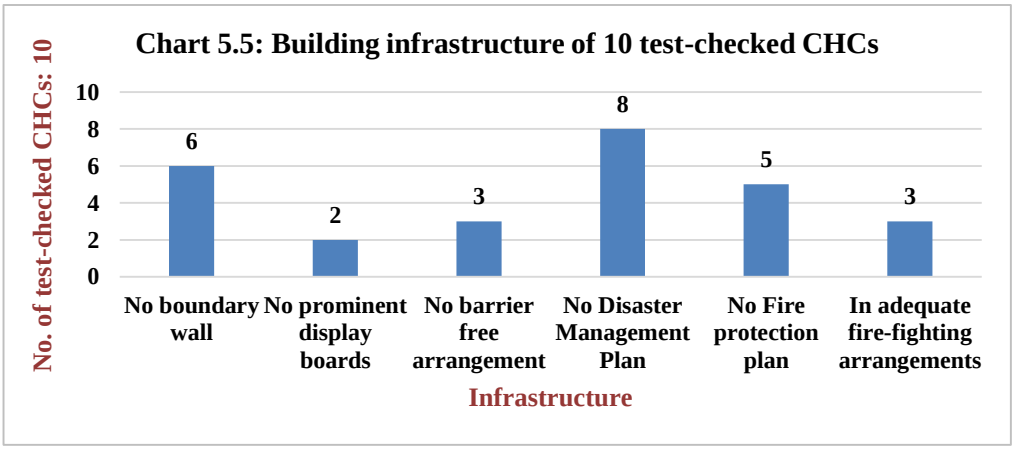
[129] *Apart from the building and the internal structure being earthquake proof, flood proof and equipped with fire protection measures, all health staff was to be trained and well conversant with disaster prevention and management aspects. Surprise mock drills were to be conducted at regular intervals.*

The CHC should be, as far as possible, environment friendly and energy efficient. Rainwater harvesting, solar energy use and use of energy efficient CFL bulbs/ equipment, were to be adopted.

Records showed that 66 CHCs in the State did not have boundary walls, while boundary walls were partially available[130] in 102 CHCs. Prominent display boards, in the local language, as also the charter of patients, had not been provided in 24 CHCs.

Picture 5.6: No boundary wall of Sandelerbill RH, Bashirhat (April 2022)

In the 10 test-checked CHCs ***(Appendix 5.6)***, there were no boundary walls in six CHCs. Prominent display boards, in the local language, were not available in two CHCs. Three CHCs had no arrangements of a barrier-free environment (ramp, hand railing *etc.*) for easy access. Eight CHCs had no Disaster Management Plans, while there were no Fire prevention Plans in five CHCs. Moreover, fire-fighting arrangements were not adequate, in three CHCs.



Source: data provided by test-checked CHCs

(iii) Entrance Zone: IPHS stipulated that prominent display boards, in the local language, providing information regarding the services available and the timings of the hospital, were to be installed. Directional and layout signages for all the departments and utilities (toilets, drinking water *etc.*) were to be appropriately displayed for easy access. All the signages were to be bilingual and pictorial. Citizen charter's were to be displayed at the OPD and Entrance, in the local language, including patient's rights and responsibility. Clean Public utilities, separate for males and females, Suggestion/ complaint boxes for the patients/ visitors and information regarding the person responsible for redressal of complaints, were to be provisioned for, in the CHCs.

Review of HMIS records showed that, out of 348 CHCs in the State, 24 CHCs had not displayed the charter of patient rights. Separate public utilities, for males

[130] *Boundary walls were not available all round the campus.*

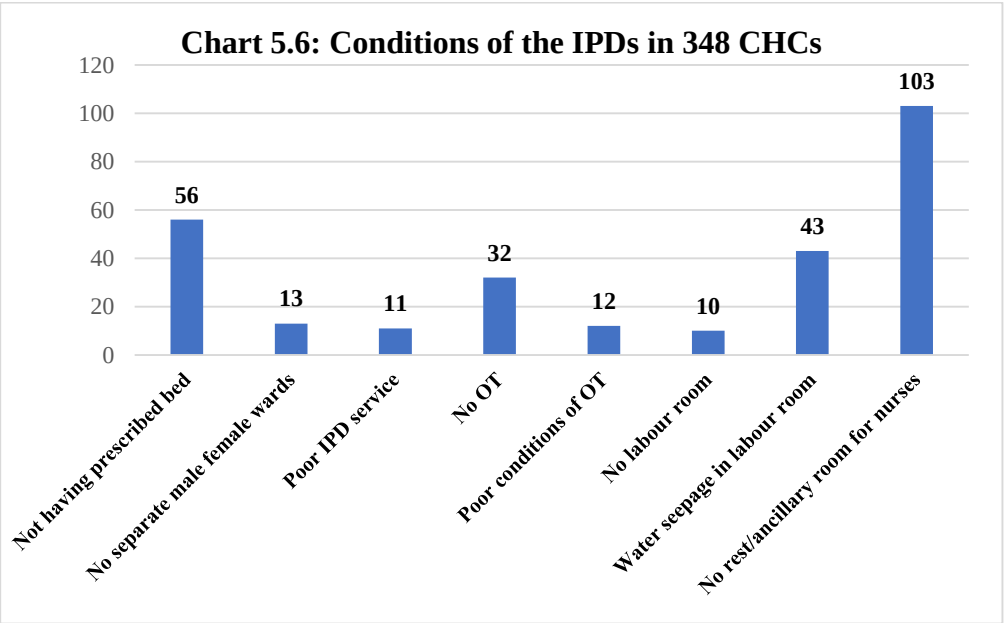
and females were not available in 16 CHCs. Where toilets were available, HMIS showed conditions as 'poor' in 25 CHCs. Complaint and/ or suggestion boxes had not been installed in 11 CHCs, for the purpose of grievance redressal.

(iv) OPD & Emergency: Provisions for clinics, as per IPHS, for general medicine, general surgery, dental, Obstetrics and Gynaecology, Paediatrics and family welfare, were essential in CHCs. Separate cubicles for general medicine and surgery, with separate areas for internal examination (privacy), were to be provided, if there were no separate rooms for each. A separate earmarked emergency area was to be located near the entrance of hospital, preferably having four rooms, one each for doctor, minor OT, plaster/ dressing and patient observation (at least four beds). In a CHC, there was to be a waiting room for patients and a pharmacy for drug dispensing.

Review of records showed that there were no rooms or cubicles for OPD clinics, in 15 CHCs. The condition of OPD clinics, in 10 CHCs, was 'poor' as shown in HMIS. Provisions for ensuring the privacy and dignity of women patients had not been ensured in 23 CHCs. Family welfare clinics were non-existent in 60 CHCs. Further, there were no provisions for emergency and/ or casualty areas in 48 CHCs. Waiting rooms for patients had not been provided in 51 CHCs.

(v) IPD: IPHS prescribed that a CHC should be a 30-bedded hospital. Separate toilets for males and females in IPD and separate space/ room, for patients needing isolation, were to be provisioned. CHCs were to have a nurse's rest room/ ancillary room. Operation theatre/ Labour rooms were required to have a Patient waiting Area, Pre-operative and Post-operative (recovery) rooms and Newborn care Corner. Review of records showed the following:

Chart 5.6: Conditions of the IPDs in 348 CHCs



Source: HMIS data

Out of the 348 CHCs in the State, 56 CHCs had less than the prescribed number of 30 beds. While 13 CHCs did not have separate male or female wards, the condition of IPDs, in 11 CHCs, was 'poor'. Similarly, while 32 CHCs did not have any OT, conditions of the OTs in 12 other CHCs were 'poor'. Labour Room (LR) was not available in 10 CHCs, while 43 LRs suffered from water seepage. There were no provisions for nurse's rest room or ancillary rooms, in 103 CHCs.

In 10 test-checked CHCs, it was observed that, in two CHCs, there was no patient waiting area. While pre-operative and post-operative (recovery) rooms were not available in six CHCs, Newborn Care Corner was also not available in one CHC ***(Appendix 5.6)***. At the Kunor BPHC, in the Uttar Dinajpur district, only one third of its sanctioned beds (30) were functional.

(vi) Water Supply & Power backup: Arrangements were to be made for supply of 10,000 litres of potable water per day, to meet all requirements (including laundry) except firefighting. Storage capacity, for two day's requirements, was to be based on the above consumption. Round-the-clock water supply was to be made available to all wards and departments of the hospital. Separate reserve emergency overhead tank was to be provided for the OT. Necessary water storage overhead tanks, with pumping/ boosting arrangements, were to be made available. Further, generator back-up was to be ensured in all healthcare facilities (hospitals). Generator of 5 KVA with POL[131], was necessary for Immunisation Cold Chain maintenance.

Review, however, showed that, out of 348 CHCs in the State, 10 CHCs did not have any overhead tank and/ or pump. Of the CHCs where overhead tanks were present, those were not of sufficient capacity in 26 CHCs. Scrutiny of HMIS data showed that 59 CHCs suffered regular to frequent power cuts. Standby generator facility was not available in 61 CHCs (apart from the 21 CHCs in respect of which no data was available); while, separate power-backup, in 63 CHCs had not been provisioned.

In the 10 test-checked CHCs, it was observed that Generator back-up was not available in the Labour Rooms and OTs of four CHCs. Moreover, 5 KVA generator sets, for maintenance of Immunisation Cold Chain, were not available in three CHCs. Adequate water supply was not available in Sandelerbil BPHC, in Bashirhat HD ***(Appendix 5.6)***.

The Department in reply stated (February 2024) about availability of 7.5 KVA generators at district level. However, the Department did not respond in regard to non-availability of 5 KVA generator at defaulting CHCs.

(vii) Administrative Zone: As per IPHS, separate rooms were essential for Office and Stores; CHCs needed to have a minimum of eight quarters for doctors and eight for staff nurses/ paramedical staff, two quarters for ward-boys and one quarter for driver, so that they remained available round the clock, in case of need.

HMIS records, however, showed that 13 CHCs (3.73 *per cent*) did not have provision for an office room, while nine CHCs (2.58 *per cent*) did not have storerooms. Kitchen rooms were not available in 40 CHCs (11.49 *per cent*).

Out of the 10 test-checked CHCs, three CHCs (30 *per cent*) did not have the requisite quarters for doctors, staff nurses/ paramedical staff ***(Appendix 5.6)***. Quarters for ward-boys and drivers were not available in eight CHCs (80 *per cent*).

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

[131] *Petrol Oil Lubricant*

5.2.4 Physical Infrastructure of District/ Sub-District Hospitals

(i) Building Infrastructure and location of Hospitals

As per the IPHS, the Hospital Management Policy was to emphasize on quake proof, fireproof, protected, flood proof buildings and be away from high tension wires. The infrastructure was to be eco-friendly and disabled friendly. Provision was to be made for water harvesting, solar energy/ power back-up, and horticulture services, including herbal garden. The hospital was to have a high boundary wall, with at least two exit gates.

Further, the following factors were to be considered in locating a Sub-district Hospital and District Hospital:

- The location was to be near the residential areas. If the buildings were too old, they could be demolished and new construction was to be done in its place.
- It was to be free from the danger of flooding; it was, therefore, not to be sited at the lowest point of the district.
- Necessary environment clearance was to be taken by the hospital authorities.

Analysis of information, against 18 District Hospitals and 36 SDHs of the State, in the HMIS data, revealed the following ***(Appendices 5.7 & 5.8)***:

- Hospital buildings were not free from danger of flooding, in case of five SDHs and one DH.
- Disabled friendly provisions, in terms of the Disabilities Act, were not available in 11 SDHs.
- Two SDHs were operating without having obtained the necessary environment clearances.
- Compound walls/ fencings were partial for protecting the premises of 11 SDHs and eight DHs.

Of the three test-checked SDHs, the buildings of two[132] test-check SDHs were not earthquake proof and located in flood prone areas. Environment-friendly measures, like Rainwater harvesting, had not been adopted by any of the three test-checked SDHs.

(ii) Waiting spaces and other facilities at hospitals

Registration, assistance and enquiry counter facilities were to be made available in all the clinics, along with proper sitting arrangement, drinking water, ceiling fans and toilet facilities (separate for males and females). The main entrance, general waiting and subsidiary waiting spaces, were required to be adjacent to each consultation and treatment room, in all the clinics.

Analysis of the State data of HMIS showed that:

- Registration counters were not available in two SDHs.
- Waiting spaces, adjacent to the consultation and treatment rooms, were not available in one SDH.
- Assistance and enquiry counter was not available in one SDH.
- Non-availability of separate toilet facility, for males and females, was noticed in eight SDHs and five DHs.

[132] *Ghatal and Raghunathpur SDH*

(iii) Residential Quarters

All the essential medical and para-medical staff were supposed to be provided with residential accommodation, to ensure availability of essential staff 24 x 7, in cases of need.

Analysis of HMIS data revealed that residential quarters, for all medical and para medical staff, were not available, in nine SDHs and seven DHs ***(Appendices 5.9 & 5.10)***.

(iv) Clinics

The clinics, in a secondary level hospital, were supposed to include general, medical, surgical, ophthalmic, ENT, dental, obstetrics and gynaecology, Post Partum Unit, paediatrics, dermatology and venereology (Desirable in SDH), psychiatry (Desirable in SDH), neonatology, orthopaedic and social service departments. Clinics for infectious and communicable diseases were to be located in isolation, preferably, in a remote corner, provided with independent access.

Analysis of State data, as available in HMIS, however, showed that the following clinical services were not available in different SDHs in the State ***(Appendices 5.7 & 5.8)***.

Table 5.6: Non-availability of services in different SDHs in the State

Sl. No.	Name of the Clinic	No. of SDHs not having services	No. of DHs not having services
1	Neonatology	16	3
2	Orthopaedics	3	-
3	ENT	1	-
4	Dental	1	-
5	Dermatology	8	1
6	Psychiatry	15	-

Source: HMIS data

Further analysis showed that infectious and communicable disease clinics were not located in remote corners with independent access, in 10 SDHs and 2 DHs, although this was prescribed in the IPHS.

(v) Operation Theatres

An Operation Theatre was supposed to have a Preparation Room, Pre-operative room and Post-Operative Resting Room. Operating rooms were to be made dust-proof and moisture-proof. There was also to be a scrub-up room, where the operating team could wash and scrub their hands and arms, put on their sterile gowns, gloves and other covers, before entering the operation theatre. The theatre was to have sinks/ photo sensors, for water facility. Laminar flow of air was to be maintained in the operation theatres.

Analysis of HMIS data, however, revealed that pre-operative rooms were not available in nine SDHs & two DHs and Post-operative rooms were not available in 10 SDHs and 2 DHs.

Further, scrub-up rooms were not available for washing and scrubbing, in two SDHs ***(Appendices 5.9 & 5.10)***.

Delivery Suite Units: The delivery suit units were to be located near operation theatre. The delivery Suit Unit was to include facilities of accommodation for various facilities, such as:

(i) Reception and admission
(ii) Examination and Preparation Room
(iii) Labour Room (clean and a septic room)
(iv) Neo-natal Room
(v) Sterilizing Room
(vi) Sterile storeroom
(vii) Scrubbing Room

Review of records showed the following ***(Appendices 5.9 & 5.10)***:

- Fully equipped delivery units, located near OTs, were not available in seven SDHs and two DHs
- Examination and preparation rooms were not available in two SDHs.
- Neo-natal rooms were not available in seven SDHs and one DH.
- Sterilization rooms were not available in three SDHs[133] and one DH[134].

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

5.2.5 Findings of the beneficiary survey

Survey of patients, randomly selected in the test-checked PHCs and CHCs, showed the following scenario, in respect of the quality of infrastructure of the healthcare facilities:

A. OPD infrastructure

Table 5.7: Beneficiary survey report in regard to the OPD infrastructure of the test-checked PHCs and CHCs

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue	Percentage
1	Non-availability of Enquiry/ 'May I Help' desk, with competent staff	179	128	71.51
2	Inadequate/ not good seating arrangement at the registration/ OPD counter of the facility	366	138	37.70
3	Non-availability/ not good condition of drinking water facility for the patients at the healthcare facilities	366	149	40.71
4	Non-Availability/ not good status of neat and clean toilet facility	366	161	43.99
5	Inadequate number of registration counters	179	94	52.51
6	Time taken for registration more than 10 minutes	179	43	24.02
7	Time taken for registration more than 30 minutes	179	20	11.17
8	OPD area not clean	179	37	20.67
9	Non-satisfactory patient calling system at the facility	179	116	64.80
10	Non-availability of complaint box in OPD	179	131	73.18
11	Sufficient information (regarding direction & location signages, Registration counter, Laboratory, Radiology dept., dispensary *etc.*) not available in Hospital	187	21	11.23
12	Promptness at Medicine distribution counter ranked below "good"	187	40	21.39

Source: beneficiary survey of test-checked PHCs/ CHCs

[133] *Mathabanga SDH, Coochbehar; Gangarampur SDH & SSH, D. Dinajpur & Ghatal SDH & SSH, Paschim Medinipur*
[134] *Alipurduar DH, Alipurduar*

An analysis of the average patient load on registration counters of the test-checked CHCs showed 6 of the 10 CHCs had patient load of more than 100 ranging up to 177 (Itahar RH) during 2016-22 ***(Appendix 5.11)***.

B. IPD infrastructure

Table 5.8: Beneficiary survey report in regard to the IPD infrastructure of the test-checked PHCs and CHCs

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue	Percentage
1	Clean and adequate toilet facility not available for male and female patients	96	35	36.46
2	Cleanliness of the wards was ranked below 'good'	86	15	17.44
3	Cleanliness of surroundings and campus drain was ranked below 'good'	86	19	22.09

Source: beneficiary survey of test-checked PHCs/ CHCs

It could be seen that patients were largely dissatisfied with the facilities and amenities which should have been provided in the OPDs of the test-checked hospitals. Moreover, almost 73 *per cent* of the patients said that there were no provisions (complaint boxes) to register a complaint in the OPD areas. Though complaints for inadequate and unclean IPD toilets had emerged from the survey, the overall opinion about IPD infrastructure was better than it was in regard to the OPD infrastructure.

Results of a survey of 38 doctors, of these test-checked health facilities, showed that more than one third (37 *per cent*) of the doctors believed that requisite infrastructure for proper examination of patients, was lacking in the hospitals.

- Survey of patients randomly selected in the test-checked DH/ SDHs, showed the following scenario in regard to the quality of infrastructure of the healthcare facilities:

Table 5.9: Survey of randomly selected patient in test-checked DH/ SDH

Sl. No.	Issues raised through surveys	No. of patients surveyed	No. of patient confirming the issue in PSS[135]	Percentage
OPD				
1	Enquiry/ 'May I Help' desk not available with competent staff	81	42	51.85
2	Seating arrangement not adequate at registration/ OPD counters	81	34	41.98
3	Drinking water facility not available for patients	81	28	34.57
4	Rate list not displayed in the reception area	81	20	24.69
5	Facilities for differently abled persons not available	81	20	24.69
IPD				
1	Clean and adequate toilet facility not available for male and female patients	79	42	53.16

Source: patient satisfaction survey of test-checked DHs/ SDHs

[135] *Patient Satisfaction Survey*

It could be seen that 25 *per cent* to 53 *per cent* of the patients were not happy with the OPD and IPD facilities like 'May I help' Desk, drinking water, rate chart, clean toilets *etc.* The Department in its reply (February 2024) offered no response in this regard.

5.2.6 Lack of action to plug gaps

The State Health & Family Welfare Department had failed to provide any document, which could suggest that an action plan had been prepared to identify and plug gaps, against a specific time frame, in the infrastructure position relating to the primary health sector of the State. No plan and/ or effort, to bridge the shortage in number of available primary health facilities, was evident from records. The number of available health facilities, at present, in the State, when compared to the position prevailing in 2016, showed the following:

Table 5.10: Comparison of availability of Primary healthcare facilities

Type of Facility	Number of health facilities		Creation of new facility
	As on 31.12.16	As on 31.03.22	
Sub-Centre	10,357	10,368	11
Primary Health Centre	913	916	3
Community Health Centre	348	348	0

Source: HMIS data State level

It may be seen from **Table 5.10** that only 11 new sub-centres and three new Primary Health Centres had been set up in the State, in the last six years.

In the test-checked Jalpaiguri District, it was observed that the Chief Medical Officer of Health (CMOH), Jalpaiguri, had sent a proposal (April 2015) to the Health Department, GoWB, for setting up a new PHC at the Samsing Tea Garden in Matiali Block (hilly area) of Jalpaiguri, as there was no nearby health facility. Due to the unavailability of nearby health services, home deliveries (20 *per cent*) and transit deliveries (average five per year) were also very high in the area. Review revealed that Administrative Approval from the Health Department had been accorded in March 2017, with financial sanction of ₹ 388.07 lakh. In the same order, a meagre amount of ₹ 5,000 only had been allotted to the Chief Engineer, Headquarters, PWD, as the first instalment.

Subsequently, when the CMOH asked (April 2017) the Executive Engineer, PWD, Jalpaiguri, to prepare the detailed estimate of the proposed construction work, the estimated value was derived at ₹ 656.40 lakh (Civil: ₹ 581.05 lakh; Electrical: ₹ 75.35 lakh). The revised estimate was sent (September 2017) to the Department for administrative approval and fresh Financial Sanction. It was sent back to the CMOH (December 2018), with queries and observations regarding the huge cost escalation, as well as non-commencement of work after passing of one and a half years of Administrative Approval. The CMOH, in his clarification, mentioned revision in the schedule of rates of PWD, as well as some modifications/ changes in the plan, among the reasons for the escalation. The Department finally approved (November 2021) the escalated cost of the project.

Up to June 2022 the Health Department had only released the first instalment of ₹ 5,000 (March 2017). Thus, delay in approvals and release of a meagre amount for the work, were the main reasons for delay in the progress of the work.

Resultantly, after a lapse of seven years, the work was still lying (June 2022) incomplete, with only 12 *per cent* of the work having been executed so far (June 2022), thereby depriving the people of the Matiali Block of primary healthcare services.

The case was corroborative of the absence of a comprehensive plan and action on part of the State department, in a case where deficiencies in coverage, due to inadequate primary health facilities, had been noticed.

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

5.3 Lack of physical Infrastructure at Medical College and Hospitals (MCHs)

The following observations emerged from a review of available infrastructure in the four test-checked MCHs, out of the 18 MCHs of the State:

- As per provision contained in clause A.1.5 for the National Medical Commission (NMC) standard for 200 admissions, lecture halls should have a provision for 'E-class'. There were five lecture halls at the IPGME&R, Kolkata, having a capacity of 730 students. However, these halls had no provision for conversion to e-class/ virtual class, for teaching.
- In the Raiganj Medical College & Hospital (RMC&H), an auditorium-*cum*-examination hall, having an area of 800 sq.m, had been constructed without seating facilities, as of March 2022.
- As per provision contained in A.1.7 of the NMC standard for 200 admissions, facilities for microphotography[136] and mounting should be provided at the central photographic section of the medical college. However, no such facility was available, either at the IPGME&R or at the RMC&H.
- As per provision contained in A.1.8 of the NMC standard for 200 admissions, there should be a central workshop, having facilities for repair of mechanical, electrical, air conditioners and refrigeration equipment of the college and the hospital, manned by qualified personnel. However, no such facility was available, either at the IPGME&R or at the RMC&H.
- As per provision contained in A.1.19 (b) of the NMC standard for 100 admissions, there should be one well-equipped Central Research Laboratory in the Medical College, which could be under the control of the Dean of the college. However, no such laboratory was available at the RMC&H.
- As per provision contained in A.1.21 of the NMC standard for 100 admissions, every Medical College was to have one Rural Health Training Centre, under the administrative control of the Dean of the College, for training of students in community-oriented primary healthcare and rural-based health education for the rural community,

[136] *Microphotography: This is a process where photography can be undertaken while viewing the sample under a microscope.*

attached to it. Separate residential arrangements for boys, girls and interns, with mess facilities, was also to be provided. The Raiganj Medical College & Hospital did not have any such rural health training centre, affiliated to any Govt. owned health centre for training of students and interns, while residential arrangements were under construction, at the rural health training centre owned by the IPGME&R, as of March 2022.

- As per provision contained in A.1.19 (b) of the NMC standard for 200 admissions, every Medical College was to have Close-Circuit Television (CCTV) system in the Medical College and shall provide live streaming of both classroom teaching and patient care in the teaching hospital, to maintain a constant vigil on the standard of medical education/ training being imparted. Both were to be integrated as a part of the "Digital Mission Mode Project" of the College Council. However, RMC&H and IPGME&R did not provide such live streaming of classroom teaching and patient care, in the teaching hospital.

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

5.4 Infrastructure of newly created Multi/ Super Specialty Hospitals (SSHs)

5.4.1 Idle infrastructure of the SSHs

With the aim of decongesting teaching hospitals in and around Kolkata and discouraging patients being referred from far away districts, and for providing Speciality and Super-specialty healthcare services at the district/ sub-district level, the H&FW Department, decided (September 2011) to set up 34 Multi/ Super Speciality Hospitals (SSHs), by utilizing Special Central Assistance, under the BRGF[137] (State Component) fund, in 11 BRGF districts[138]. Setting up of eight more SSHs were also decided (January 2014) from State funds in non-BRGF districts, as Tertiary Healthcare Facilities. In the meeting (23 December 2011) of the Empowered Committee, under the Planning Commission, GoI, it was decided that the WBMSCL would implement the project and funds for the purpose would be routed through the "Deposit Account" of the WBMSCL.

Based on presumptive demand, two types of SSHs were planned, *viz.* 10 storied 500-bedded SSHs and five storied 300-bedded SSHs, for construction at different places across the State ***(Appendix 5.12)***. The works of 29 SSHs (BRGF: 21 & non-BRGF: eight), at a total estimated cost of ₹ 1,858.30 crore, and other 13 SSHs (BRGF), at an estimated cost of ₹ 683.97 crore, were awarded to different executing agencies, selected through the tender process, on Turnkey and non-Turnkey basis, respectively. In the Turnkey basis contract, apart from construction of the buildings, the agencies were to supply the agreed quantity/ number of equipment and furniture to the SSHs, as a package.

[137] *Backward Regions Grant Fund (BRGF), launched in February 2007, funded by GoI, for solving the problems of poverty, low-growth and poor governance in the backward districts.*

[138] *Bankura, Birbhum, Dakshin Dinajpur, Jalpaiguri (Jalpaiguri & Alipurduar), Malda, Murshidabad, , Paschim Medinipur (Paschim Medinipur & Jhargram), Purba Medinipur, Purulia, South 24 Parganas and Uttar Dinajpur,*

In case of the 28 SSHs (except for the SSH at Uluberia, Howrah), taken up on turnkey basis, details of planning, design and construction, along with supply of specified medical equipment and furniture, was part of, NITs. However, no Detailed Project Reports (DPRs), detailing the specifications, quantities and costs (as per the PWD Schedule) of the material to be used for construction, were annexed, as part of the tender documents.

The works of 41 SSHs (except SSH at Belda, Paschim Medinipur[139]) were completed and these SSHs were made functional between January 2016 and March 2019. The Corporation, however, could not provide SSH-wise expenditure, though sought for.

Review of records, however, showed that, out of 41 newly constructed SSHs, 30 SSHs had to be merged (January 2018) with the attached District Hospital/ Sub-Divisional Hospital/ State General Hospital and could not render the intended services due to acute shortage of manpower as shown in subsequent paragraphs.

(i) Non-posting of Manpower in SSHs against posts sanctioned

The H&FW Department created and sanctioned (27 November 2014) 13,701 posts, of different categories, for 40 SSHs[140].

While analyzing records relating to that manpower in 40 SSHs, Audit observed that the manpower position of 30 SSHs had been shown by merging the Men-in-Position of attached DHs/ SDHs/ SGHs. Hence, the status of postings against the Sanctioned Strength of these SSHs, could not be determined. MIP, in respect of the remaining 10 SSHs[141], as of March 2022, was as below:

Table 5.11: Shortage of Manpower in SSHs

Sl. No.	Manpower Category	Manpower in 10 SSHs			
		Sanctioned Strength	Men in position	Shortage	Shortage (Percentage)
1	Medical Officer	360	122	238	66
2	Nursing Staff	1,090	675	415	38
3	Technical Staff	170	119	51	30
4	Others*	1,430	344	1,086	76

*Source: WBMSCL data; * Medical Technologists, sweeper, GDA, official staff, etc.*

Posting of Medical Officer, Nurses, Technical staff and others, was highly inadequate in the SSHs, leading to shortage, of 66, 38, 30 and 76 *per cent*, against the sanctioned strength. Consequently, the SSHs could not use the created infrastructure and render desired services as discussed in succeeding paragraphs.

(ii) Beds of SSHs not made functional, as sanctioned

Out of 40 SSHs, six SSHs were planned as 500-bedded and 34 SSHs as 300-bedded. However, review of 15 SSHs showed that 13 *per cent* to 52 *per cent* of the sanctioned beds had not been made operational, till the date of audit (June 2022) ***(Appendix 5.13)***, despite the passage of almost four years of their becoming operational. IPD beds, had, however, been supplied, as planned in respect of the Turnkey projects, by the executing agencies.

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[139] *The works could not be completed due to failure of contractors, execution of re-tenders etc.*

[140] *SSH Hatuara, Purulia, was converted as an attached hospital to the Deben Mahato Government Medical College and Hospital.*

[141] *Bolpur, Domkal, Diamond Harbour, Kalna, Rampurhat, Nayagram, Gopiballavpur, Sreerampore, Bongaon and Islampur.*

(iii) Absence of Super Specialty Services

SSHs were set up at district/ sub-district levels, to provide specialty/ super-specialty (tertiary) healthcare services. Accordingly, the H&FW Department had specified SSH-wise super-specialty services (ranging between one and four) for each SSH, like ENT, Eye, Orthopaedics, Trauma Care, Skin, Dialysis *etc.*

Review, however, showed that 26 of the 40 SSHs ***(Appendix 5.14)*** had failed to deliver any kind of super-specialty services. Super-specialty services, only for Eye and/ or ENT, were available in 10 SSHs. As such, the intended objective of providing super speciality healthcare services at the district/ sub-district levels, had not been fulfilled.

In reply (February 2024), the Department remained silent about non-availability of super-speciality services in the SSHs as pointed out in audit. The Department has, however, claimed that SSHs of Jangipur, Domkal and Raghunathpur are having functional SNCU super speciality services.

(iv) Non-Functioning of Intensive Care Units (ICUs) and Cardiac Care Units (CCUs)

The Intensive Care Units (ICUs), which had been established in 12 of the 41 SSHs, had not been made functional in six[142] SSHs, as of March 2022.

Similarly, the Cardiac Care Units (CCUs), in seven[143] SSHs, had not been made functional (out of the 19 SSHs where those they had been setup, with sophisticated equipment).

Non-delivery of super-specialty services, even after creation of physical infrastructure with significant expenditure, not only frustrated the project objectives, but, the built-up infrastructure, along with the costly equipment installed therein, remained idle, suffering wear and tear.

(v) Equipment lying Idle and equipment not found in place

For providing super specialty services through SSHs, 5,230 items of bio-medical equipment[144] (4,764, for 28 SSHs, on turnkey basis and 466, for 12SSHs, on non-turnkey basis), costing ₹ 363.15 crore (Turnkey: ₹ 356.17 crore and Non-turnkey: ₹ 6.98 crore), had been procured and installed in 40 SSHs.

Scrutiny of records relating to tagging of assets[145] for maintenance and the replies furnished to Audit, revealed that 290 items of equipment, valuing ₹ 1.50 crore, were lying in the stores of 16 SSHs (as of June 2022), even after a lapse of six to seven years, from initiation of their operations.

Moreover, 1,633 items of equipment, valuing ₹ 72.80 crore (Turnkey: ₹ 71.12 crore and Non-turnkey: ₹ 1.68 crore), in 39 SSHs, could not be traced in the SSHs, as of June 2022, during the tagging exercise, for repair and maintenance of the equipment.

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

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[142] *Panskura SSH, Sagardighi SSH, Basirhat SSH, Metiabruz SSH, Bangaon SSH and Uluberia SSH.*
[143] *Falakata SSH, Domkal SSH, Suri SSH, Uluberia SSH, Basirhat SSH, Metiabruz SSH and Bangaon SSH.*
[144] *Biomedical/medical devices are instruments, machines, implants, in vitro reagents, software, materials, or other related articles, that are purposed for the safe and effective prevention, diagnosis, treatment, and rehabilitation of illness and disease for human beings.*
[145] *Assets tagged with bar-codes for tracking and maintenance*

5.4.2 Absence of General Compliance in SSHs

Apart from the above, the following general facilities, which should have been available in a hospital, were absent in the SSHs:

(i) Accessibility for Persons with Disabilities

Rights of Persons with Disabilities Act, 2016, under Section 45, mandates that all public buildings shall be made accessible to Persons with Disabilities (PwD), with physical infrastructure, like ramps with handrail, toilets suitable for PwDs *etc*.

It was, however, observed that there were no ramps in 12 SSHs, to provide accessibility to the PwDs. No barrier-free toilets, for persons with disabilities, were available in five SSHs.

(ii) Handling and Management of BMWs without valid Authorization from WBPCB

Every Healthcare Facility handling bio-medical waste (BMW) is required to obtain authorization from the West Bengal Pollution Control Board (WBPCB) under Rule 10 of the Bio-Medical Waste Management Rules, 2016. Four SSHs, were, however, handling bio-medical waste, without obtaining BMW authorization from WBPCB, in violation of the provisions of the BMWM Rules. Thus, compliances required for BMW management had not been assessed and/ or monitored by the Department.

(iii) SSHs functioning without Fire Safety Certificate

Fire Safety Certificates, given under the WB Fire Service Act, 1950, indicate conformity with the requirements of fire safety. They are given to building structures such as hospitals, educational institutions, government offices, and private offices. Audit, however, observed that 13 of the 40 SSHs were running without obtaining fire safety certificates, keeping their patients and staff exposed to the risk of fire hazards. It was also noted that, though there had not been any casualties, there had been fire incidences in five[146] SSHs, during the period covered under audit.

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

5.5 Non-availability of facilities for Trauma Care & Burn Injuries

With the objective of bringing down preventable deaths due to road accidents, to 10 *per cent*, by developing a Pan-India trauma care network, in which no trauma victim is to be transported for more than 50 kilometers and a designated trauma centre is available at every 100 km, GoI initiated a pilot project during the 9th Five Year Plan (FYP), which, during the 11th FYP period, was re-modified as a 100 *per cent* Centrally Assisted scheme[147]. The scheme was further extended to the 12th FYP, to set up new Trauma Care Facilities (TCFs), with 60:40 Central and State fund sharing. The unit costs, as fixed for Levels I, II and III TCFs[148], under the 11th FYP and 12th FYP, are detailed in ***Appendix 5.15***.

[146] *Asansol SSH, Basirhat SSH, Diamondharour SSH, Egra SSH and Sreerampore SSH.*

[147] *Assistance for Capacity Building for Developing Trauma Care Facilities (TFCs) in Government Hospitals on National Highways*

[148] *Level III TCF was to provide initial evaluation and stabilization (surgically, if appropriate) to the trauma patient; Level II TCF was to provide definitive care for severe trauma victims with in-house Emergency physicians, surgeons, Orthopaedic and Anesthetists; Level I TCF was to provide the highest level of definitive and comprehensive care, for patient with complex injuries.*

In view of increasing burnt cases every year coupled with absence of organized burn care at primary and secondary healthcare level, Ministry of Health & Family Welfare introduced the programme named 'National Programme for Prevention and Management of Burn Injuries' (NPPMBI) during the 12th FYP. Under the scheme GoI grants were to be provided (60: 40 ratio) to identified Medical Colleges of the State Government for developing a 12-bedded Burn Unit including four ICU beds, one OT and procurement of some essential equipment at total project cost of ₹ 6.58 crore per unit.

In West Bengal, five hospitals ***(Appendix 5.16)*** during 11th FYP and another five hospitals[149] in 12th FYP ***(Appendix 5.21)*** were identified for setting up the Trauma Care Facilities. Six hospitals[150] of the State were selected for setting up Burn Injury Units (BIUs) during 12th FYP. A review of implementation of the scheme revealed the following:

5.5.1 TCFs of the 11th Five Year Plan

Though the TCFs approved under 11 FYP were shown to have been completed and become functional, scrutiny of the utilisation of funds received for procurement of equipment ***(Appendix 5.16)*** for the TCFs, revealed gross irregularities, as discussed below:

(i) Doubtful Expenditure and submission of false utilisation certificates- funds remaining un-utilised:

Out of ₹ 17.76 crore of the grants received for procurement of equipment, a total amount of ₹ 15.92 crore was shown to have been utilised by the State, as detailed in **Table 5.12**.

Table 5.12: Receipt and utilization of funds for procurement of equipment in TCFs

Sl. No.	Name of hospital	Funds received for procurement of Equipment *(₹ in crore)*		Utilisation *(₹ in crore)*		
				By the Hospital	By WBMSCL[151]	Total
1	Burdwan MCH	2011-12	3.83	2.50	11.50	
2	North Bengal MCH	2015-16	4.99	0.00		
3	Asansol DH	2015-16	5.00	0.00		
4	Islampur SDH	2015-16	1.98	0.00		
5	Kharagpur SDH	2006-07 & 12-13	1.96	1.90		
	Total		**17.76**	**4.40**	**11.50**	**15.90**

Source: data received from H&FW Department, Govt. of West Bengal

Review, however, revealed that:

- Though utilisation of an amount of ₹ 11.50 crore (November 2019) had been shown by WBMSCL, a list of procured equipment, valuing only ₹ 8.64 crore, could be produced to Audit, when called for. A further scrutiny of the list revealed that procurement of equipment, valuing ₹ 0.85 crore, was not admissible under the scheme for TCFs and the equipment was not even in possession of the TCFs for which it was shown to have been procured ***(Appendix 5.17)***. The list also contained lumpsum entries of procurement,

[149] *Murshidabad MCH, Diamond Harbour MCH, Ranaghat SDH, Alipurduar SDH, Raiganj DH*
[150] *SSKM, Burwan MCH, NBMCH, Murshidabad MCH, Malda MCH and Bankura MCH*
[151] *Responsible for efficient execution of construction works of TCFs and procurement of trauma care equipment.*

valuing ₹ 1.62 crore, without any description of equipment and against which no bills could be produced before Audit ***(Appendix 5.18)***. This indicated submission of doubtful utilisation certificates of ₹ 2.86 crore[152], coupled with incurring of doubtful expenditure of ₹ 2.47 crore[153].

- Utilisation Statements against spending of ₹ 2.51 crore, by the Burdwan Medical College & Hospital (BMC&H), revealed that ₹ 2.42 crore had been spent by BMC&H, for procurement of equipment for different departments of BMC&H and/ or for its super specialty block, other than the TCF. Thus, not only was there a diversion of GoI funds of ₹ 2.42 crore, but also the requirements of the TCF had remained unfulfilled.

The actual position of the unspent grants could not be furnished to Audit, though called for.

(ii) Non-availability of trauma equipment

In the above backdrop, the actual status of availability of trauma equipment, in five TCFs, when checked by Audit, revealed that a considerable number of items of equipment were not available in the TCFs, as shown below:

Table 5.13: Non-availability of TCF equipment

Name of the TCF	Level	Types of Equipment required as per norms	Types of Equipment not available	Total No. of equipment comprising all types required for the facility	Total no. of equipment actually available
North Bengal MCH	II	33	11 (33.33%)	73	46
Burdwan MCH			11 (33.33%)		61
Asansol DH			29 (87.87%)		06
Islampur SDH	III	20	09 (45%)	41	19
Kharagpur SDH			04 (20%)		47

Source: data received from H&FW Department, Govt. of West Bengal

From the Statement of non-availability, as detailed in ***Appendix 5.19*** & ***Appendix 5.20***, it may be seen that the shortages in equipment relating to Radiology, Anaesthesia, OT, Orthopaedic *etc.*, ranged between 20 *per cent* and 45 *per cent*, in four TCFs, whereas Asansol DH did not have 88 *per cent* of the different types of equipment. Further, Asansol DH had only six types of equipment, against the normative requirement of 73. On the other hand, it was observed that excess numbers of equipment had been supplied to Kharagpur SDH.

(iii) Non-availability of Human Resources

The operational guidelines for Capacity Building for Trauma Care Facilities prescribed the Human Resource requirements in a TCF, for its operation. A scrutiny of the availability of manpower, in the TCFs constructed under 11th FYP, showed that there was almost no manpower posted in the facilities to run the TCFs. The table below depicts the status of manpower in the TCFs:

[152] *₹ 11.50 crore minus ₹ 8.64 crore*
[153] *₹ 0.85 crore plus ₹ 1.62 crore*

Table 5.14: Availability of manpower in TCFs

Sl. No.	Human Resource		Requirement as per scheme guideline	Men in position as on (1st April of every year)		
				NBMCH*	BMC**	Asansol
Availability in Level II TCFs:						
1	Specialist	General Surgeon	2	0	0	0
2		Radiologist	2	0	0	0
3		Orthopaedic Surgeon	3	0	0	01
4		Anaesthetist	3	0	0	0
5		Neurosurgeon	1	0	0	0
6		Casualty Medical Officer	8	0	8	0
7	Nursing Staff	Staff Nurse	40	0	16	28
8		Nursing attendant	16	0	0	0
9	Para Medics	OT Technician	5	0	4	0
10		Radiographer	4	0	4	0
11		Lab Technician	2	0	2	01
12	MTS	Multitask worker	15	0	0	0
	Total:		**101**	**0**	**34**	**30**
Level III TCFs						
Sl. No.	**Human Resource**		**Requirement as per scheme guideline**	**Islampur**		**Kharagpur**
1	Specialist	General Surgeon	2	0		01
2		Orthopaedic Surgeon	2	0		0
3		Anaesthetists	2	0		0
4		Casualty Medical Officer	6	0		0
5	Nursing Staff	Staff Nurse	25	06		01
6		Nursing attendant	13	07		0
7	Para Medics	OT Technician	5	0		0
8		Radiographer	4	0		0
9		Lab Technician	2	02		0
10	MTS	Multitask worker	12	05		0
	Total		**73**	**20**		**02**

Source: Data received from H&FW Department, Govt. of West Bengal;
** No MIP from FY 2016-17; ** From FY 2021-22*

It may be seen that no manpower had been posted in the TCF in North Bengal Medical College. Specialist doctors, like General Surgeons, Radiologists, Anaesthetist and Neurosurgeons, were not available in any of the Level II TCFs. In Level III, Islampur also had no Specialist doctors posted. Asansol (Level II) and Kharagpur (Level III) had one Orthopaedic surgeon and one General Surgeon, respectively. Moreover, posting of nurses, with no doctors and/ or paramedics in the centres, raised questions about the utilisation of the services of these nurses.

Evidently, with absolutely no or miniscule posting of doctors, paramedics and nurse in the Level II and Level III TCFs, none of the Trauma Care Facilities could be made optimally functional, even after the passage of almost 15 years of their approval, rendering the expenditure incurred towards the construction and equipment unfruitful. The Department in its reply (February 2024) offered no response in this regard.

5.5.2 Trauma Care Facilities and Burn Care Facilities under the 12th FYP

GoI had released ₹ 21.09 crores for construction of five TCFs (₹ 8.41 crore) and six Burn units (₹ 12.68 crore) in the State, between 2014 and 2017, under the 12th FYP ***(Appendix 5.21)***. Scrutiny of records, however, showed that the State had not been able to initiate any of the projects, as on the date of audit (June 2022), for reasons not found available on records and the entire funds had remained unutilised, for periods ranging from five to eight years.

The grants in aid, received from GoI under the 12th FYP, were to be deposited in an interest-bearing account and the interest accrued on the grant was to be deposited in the Government account, as revenue of GoI. The sanction of ₹ 11.98 crore, released (2015-16) by GoI, in favour of WBMSCL, for procurement of equipment under the 11th FYP projects, was also governed by the same criteria.

Review, however, showed that, instead of keeping the GoI grants in interest--bearing accounts, the grants had either been kept with the State exchequer or in Deposit Accounts maintained with the treasuries. This action had resulted in loss of GoI revenue of at-least ₹ 3.95 crore arrived by a conservative calculation as shown in table below (detailed in ***Appendix 5.22***).

Table 5.15: Calculation of bank interest *(₹ in crore)*

GoI Grants	Grants received	Total amount of interest	Kept in State Exchequer/ Deposit A/ c
12th FYP TCF grants kept in state exchequer	**14.95**	**2.01**	Out of total 21.09 core released (2014-17) by GoI under 12th FYP, ₹ 14.95 crore were not drawn and kept in state exchequer ***(Appendix 5.22)***.
12th FYP Burn Unit grants kept in state exchequer	**6.14**	**1.22**	The remaining 6.14 crore of grants under 12 FYP was drawn and kept in bank account. However, the earned interests were not deposited to GoI ***(Appendix 5.22)***.
11th FYP TCF grants kept in non-interest-bearing Deposit Account of WBMSCL	**11.98**	**0.72**	₹ 11.98 crore of GoI grants released (2015-16) to WBMSCL for procurement of equipment under 11th FYP, was kept in non-interest bearing Deposit Account of WBMSCL ***(Appendix 5.22)***.
Total:	**33.07**	**3.95**	

Source: Data received from H&FW Department, Govt. of West Bengal

As such, failure of the State government, in operationalising the TCFs approved by GoI in the 11th FYP and non-utilisation of grants given to the State for setting up another five TCFs and six Burn Care Units in the State, during the 12th FYP, resulted in non-availability of the intended facilities for patients encountering Trauma and Burn injuries, in the last 15 years.

Evidently, the objective of bringing down preventable deaths due to road accidents, by setting up Trauma Care Facilities, remained unfulfilled. It was noted that, although SDG Goal 3.6 set the target of reducing deaths and injuries from road traffic accidents by half by 2020, in West Bengal, deaths due to road traffic accidents had increased by 58.69 *per cent* (from 627 in 2016-17 to 995 in 2018-2019), up to 2019. However, deaths reduced to 569 in 2020.

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

5.6 Non-utilisation of newly set up Integrated AYUSH Hospital, Paschim Medinipur involving a cost of ₹ 8.78 crore

A 50-bedded integrated AYUSH Hospital was proposed (June 2016) to be set up in the Paschim Medinipur district. WBMSCL acted as the executing agency for the project. Administrative and financial sanction of ₹ 8.79 crore was accorded (November 2017) in favour of WBMSCL.

Though the said construction was completed by November 2019, CMOH, Paschim Medinipur, took over this building only in April 2021. In between, the hospital was used as a Covid hospital.

Records, however, revealed that the proposals for creation of 26 regular posts[154] under different categories and 45 posts on contractual/ outsourcing basis, as well as engagement of Specialist Doctors on call, for six disciplines, was deferred (December 2019) in the Cabinet meeting and no further action was found in this respect till June 2022.

The IPD services of the hospital could not start functioning, due to lack of manpower and only OPD services were rendered, from March 2022 onwards, with one Senior Ayurvedic Medical Officer (SMAO) and One Homoeopathy Medical Officer (HMO) attending each day.

As such, even after completion of almost three years of the construction of the Integrated AYUSH hospital, having financial involvement of ₹ 8.79 crore, it had not been operationalised, due to delay in deployment of manpower.

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

5.7 Release of Central grants to non-entitled Nursing Schools

Ministry of Health & Family Welfare, GoI, released (May and July 2017) ₹ 20.06 crore, under a centrally sponsored scheme for Upgradation/ Strengthening of Nursing Services, as the second and final instalment, towards the cost of civil works, transport, laboratory equipment/ furniture, AV aids and books, for the ongoing project of setting up of eight General Nursing and Midwifery (GNM) schools[155], at different districts of the State.

Review of records revealed that, instead of spending the fund towards the specified GNM schools, ₹ 2.40 crore had been spent (during FYs 2020-21 and 2021-22) for procurement of projectors and other accessories *etc.*, for making smart classrooms in 31 other GNM Nursing Training Schools, under the head of AV aids, by diverting the funds of the centrally sponsored scheme. Similarly, release and expenditure of ₹ 1.17 crore was noticed (FY 2021-22) for procurement of furniture for eight GNM Nursing Training Schools[156] (NTS), other than the specified for procurement of furniture.

Thus, there was diversion of GoI grants, amounting to ₹ 3.57 crore, for procurement of AV aids and furniture for non-entitled Nursing Training Schools. The Department in its reply (February 2024) offered no response in this regard.

5.8 Facilitating health service availability through Health Insurance Schemes

With a view to providing health insurance cover to Below Poverty Line (BPL) families, Government of India (GoI) had introduced a health insurance scheme titled 'Rashtriya Swasthya Bima Yojana (RSBY)[157]' from 2008-09. In West Bengal, the Health & Family Welfare Department (H&FW Department) was responsible for implementing the scheme since September 2013.

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[154] *Medical superintendent, Special Medical Officer (AYUSH), General Duty Medical Officer (AYUSH), RMO (AYUSH), Accounts Officer, Staff Nurse etc.*

[155] *NTS Ghatal, NTS Barasat, NTS Tamluk, NTS Jangipur, NTS Jhargram, NTS Uluberia, NTS Kolkata Uttar (Sagar Dutta), NTS Bashirhat*

[156] *NTS Bolpur, NTS Rampurhat, NTS Kalimpong, NTS Shrirampur, NTS Howrah DH, NTS Kharagpur, NTS Berhampur MCH, NTS Purulia MCH*

[157] *.Beneficiaries under RSBY were entitled to a hospitalisation coverage of up to ₹30,000 and the premium was to be shared between the GoI and the State in the ratio 60:40.*

However, in December 2016, the Government of West Bengal introduced "Swasthya Sathi", a Group Health Insurance Scheme with an aim to cover initially the lowly paid contractual workers/ volunteers associated with various schemes/ projects/ programmes administered by different Departments of the State Government who were not covered under any health scheme. In October 2018, the Swasthya Sathi Samity decided to subsume RSBY beneficiaries into Swasthya Sathi Scheme. At present, the scheme covers all permanent resident of the State except those covered by any health insurance/ assurance scheme/ coverage by any Government/ Government organisations/ Parastatals/ Public Sector Undertakings, *etc*. The Government did not implement Centrally Sponsored Scheme of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY)[158] launched by the GoI in September 2018.

Initially the Swasthya Sathi scheme was implimented by engaging Insurance Companies, where secondary and tertiary care upto ₹ 1.5 lakh per annum was covered by Insurance Companies and coverage above ₹ 1.5 lakh and upto ₹ 5.00 lakh was provided by the Department itself. Entire premium paid to the Insurance Companies was borne by the State Government (Hybrid mode). It was later decided that services (*i.e.* enrolment and claim management) to those beneficiaries would be provided without engaging insurance companies (Assurance mode). Hybrid mode and Assurance mode were operated simultaneously upto July 2022 and from July 2022 entire scheme was shifted to Assurance mode.

As of March 2023, 2.43 crore families were enrolled under the Scheme and 2,605 Hospitals were empaneled under the Scheme. Detailed implementation statistics in respect of Swasthya Sathi is depicted in ***Appendix 5.23***.

Implementation of Swasthya Sathi was subjected to compliance audit and mention was made in the Report of the Comptroller & Auditor General of India on Government of West Bengal for the year ended March 2020 (Report No. 5 of 2021) in respect of

- Avoidable payment of health insurance premium of ₹ 10.20 crore towards premium of Rashtriya Swasthya Bima Yojana (RSBY) due to overlapping with that of Swasthya Sathi (***vide para 3.9 of that Report***).
- Non-recovery of` ₹ 6.11 crore as penal amount from Swasthya Sathi Insurance Companies by the State Nodal Agency, from Insurance Companies for their under-performance, in spite of having enabling provisions in the agreement (***vide para 3.10 of that Report)***.

The report was tabled in the Legislative in March 2022; however, the same has not yet been discussed in the Public Accounts Committee. The Department in its reply (February 2024) offered no response in this regard.

5.9 Infrastructure for Emergency Response & Health System Preparedness (ER&HSP)

Government of India sanctioned (2021-22) India COVID 19 Emergency Response and Health Systems Preparedness Package (ER&HSP) - Phase II as a

[158] *The scheme aimed to cover poor and vulnerable families providing coverage upto five lakh rupees per family per year for secondary and tertiary care hospitalization. The scheme subsumed the then existing health insurance schemes like 'Rashtriya Swasthya Bima Yojana and Senior Citizen Health Insurance Scheme.*

Central Sector Scheme (60:40) to support preparedness and prevention related functions, that would address not only the COVID-19 outbreak, but also such outbreaks, in future. States were to prepare Emergency COVID Response Plans (ECRPs) for obtaining and utilising funds under these packages.

Slow progress in works relating to upgradation of health facilities (COVID units):

Out of the funds under ER&HSP Package- Phase II against Emergency COVID Response Plan (ECRP-II), the Department of Health and Family Welfare (Department) decided (FY 2021-22) to construct Covid units, at various existing health care facilities of the State. It was also decided to set up 435 new Paediatric Intensive Care Units (PICUs), in addition to the already sanctioned 244 such PICU beds. The expenditure was to be met from ECRP-II funds. The present status of construction was as follows:

- **Construction of PICUs**: The Department issued (September 2021) Administrative Approval & Financial Sanction (AA&FS) for setting up of 435 PICU beds and released ₹ 1.35 crore to different hospitals for minor electrical, civil and Medical Gas Pipeline System works to prepare and ready the sites. Its further sanctioned (December 2021 and March 2022) ₹ 15.18 crore, for procurement of 41 Catalogue items [159] for setting up these PICU beds, at different hospitals. However, as per the reports made available to Audit, 356 beds (82 *per cent*) were functional while the rest remained non-functional (as of February 2023).
- **Construction of permanent Covid units in existing health facilities:** The Department decided (April 2022) to construct permanent Covid units, at different health facilities of the State, and issued (April 2022) AA&FS, amounting to ₹ 307.77 crore, against an estimate of the same amount, prepared by the PWD. The status of construction, as furnished (as of February 2023) by the Department, was as follows:

Table 5.16: Position of construction of permanent Covid units in the existing health facilities

Sl. No.	Type of construction	Number of projects sanctioned	Status of Completion	Percentage of incomplete works
1.	Covid units with 100 beds	25	Not completed	10% to 30% - 20 units 31% to 50% - 05 units
2.	Covid units with 50 beds	5		30% to 90%
3.	Covid units with 20 beds	119	Completed : 52 units Incomplete : 67 units	10% to 30% - 09 units 31% to 50% - 20 units 51% to 70% - 38 units

Source: Covid Funds under NHM (State level)

As may be seen from **Table 5.16** in regard to construction of 119 permanent Covid units with 20 beds, only 52 (44 *per cent*) had been completed and the rest were incomplete, with the progress of work ranging between 10 *per cent* and 70 *per cent*. However, none of the Covid units with 50 and 100 beds, were complete, and the percentage of incomplete work ranged between 10 *per cent* and 90 *per cent*.

[159] *Infusion Pump, Multichannel monitor, Crash Cart Trolley, Suction Machine, Laryngoscope with curved and straight blade etc.*

Non-completion of the Covid units and non-functioning of a number of PICU Beds, pointed towards deficiencies in providing quality healthcare services, as per the targets fixed by the Department.

- **Setting up of Hybrid Critical Care Units:** The Department decided (September 2021) to establish 24-bedded Hybrid Critical Care Units[160] (8 CCU beds and 16 HDU beds), at 79 MCHs/ DHs/ SDHs/ SSHs across the State, under the ECRP-II package. Accordingly, AA&FSs were issued, on different occasions, for 73 units, having 1,682 beds. The Department released funds, from time to time, to different CMOsH/ Medical Superintendent-*cum*-Vice-Principals (MSVPs) and PWD, for civil and electrical works relating to repair and renovation, at earmarked hospitals. Funds were also released to the West Bengal Medical Service Corporation Limited, either for purchase of different equipment for use in the CCUs, or in the hospital, to make the Medical Gas Pipeline System (MGPS) operational. As per records made available to Audit, during 2021-23, ₹ 29.76 crore (₹ 27.52 crore in FY 2021-22 and ₹ 2.24 crore in FY 2022-23) was released to different hospitals, for the said purpose.

As per the completion report furnished by the department (February 2023), out of 73 Hybrid CCU units being established, 26 units (36 *per cent*) were not ready for use (as of March 2023), resulting in 614 beds remaining non-functional.

Recommendation:

12. The H&FW Department may ensure setting up of the required new health facilities, throughout the State to reduce the shortages of health facilities in the State. Infrastructure deficiencies, in the existing healthcare facilities, may also be plugged.

[160] *Hybrid Critical Care Unit is a care unit where all beds are not CCU beds. It has High Dependence Unit (HDU) bed (which is essentially a step lower than CCU bed) along-with some CCU beds.*

CHAPTER 6

Financial Management

6 Chapter

Financial Management

Audit Objective: Whether comprehensive strategies and plans had been developed and adequate funding in the health sector had been made available, for ensuring accessible, affordable, and quality health services.

There was a decreasing trend in capital expenditure over the years and inadequate budgetary spending on the health sector, in respect of the State Gross Domestic Product (SGDP), as well as the overall State Budget for the covered audit period. Instances of parking of funds, along with short release of State share, also come to notice.

6.1 Departmental financial management

State Government made budgetary provisions for the Health & Family Welfare Department, against the following heads, under Demand No.24:

Table 6.1: Major Head-wise total expenditure of the H&FW Department

Sl. No.	Major head	Description of major head	Total expenditure during 2016-17 to 2021-22 *(₹ in crore)*
1	2210	Medical and public health	54,701.43
2	4210	Capital outlay on Medical and public health	6,214.27
3	2211	Family Welfare	5,553.68
4	2235	Social security and Welfare	169.91
5	2236	Nutrition	0.31
6	2049	Interest Payment	1.80
7	2051	Public Service Commission	17.28
8	2251	Secretariat – Social Services	94.33
9	2551	Hill Areas	0.66
10	2250	Other Social Services	0.15
11	2515	Other Rural Development Programmes	19.22
12	6210	Loans and Advances	97.34
	Total		**66,870.38**

Source: Budget documents of H&FW, Govt. Of W.B., FYs 2016-17 to 2021-22

6.1.1 Budgetary Savings and decrease in capital expenditure

On comparing the departmental expenditure against the revised estimates in the State Budget, by the department, as detailed below, it was noticed that there had been savings, in all years, including considerable savings of 23.32 *per cent* in FY 2021-22, as below:

Table 6.2: Budgetary Expenditure of the H&FW Department for the audited period

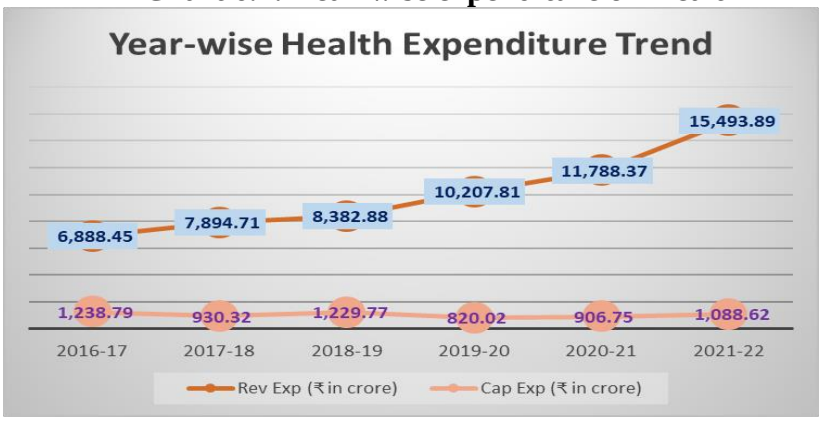
Financial Year	Revised Estimate (₹ in crore)	Released by the Department (₹ in crore)	Gross Expenditure (₹ in crore)	Savings (₹ in crore)	Savings (Percentage) over RE
	A	B	C	(A-C)	(A-C)/ A*100
2016-17	8,713.07	8,047.99	8,127.24	585.83	6.73
2017-18	9,820.60	8,836.47	8,825.03	995.57	10.14
2018-19	10,342.63	9,645.63	9,612.65	729.98	7.05
2019-20	11,938.55	10,461.31	11,027.83	910.72	7.63

Financial Year	Revised Estimate (₹ in crore)	Released by the Department (₹ in crore)	Gross Expenditure (₹ in crore)	Savings (₹ in crore)	Savings (Percentage) over RE
	A	B	C	(A-C)	(A-C)/ A*100
2020-21	14,162.89	12,143.92	12,695.12	1,467.77	10.3
2021-22	21,624.61	16,821.98	16,582.51	5042.10	23.32
Total	**76,602.35**	**65,957.30**	**66,870.38**	**9,731.97**	**12.70**

Source: Budget documents of H&FW, Govt. of W.B., FYs 2016-17 to 2021-22

A detailed analysis of departmental spending ***(Appendices 6.1 & 6.2)*** showed that, while the revenue expenditure of the department had gradually increased (125 *per cent*) over 2017-22, capital expenditure in the health sector had experienced a consistent decrease (12 *per cent*) over the same period, as shown in ***Chart 6.1***.

Chart 6.1: Year-wise expenditure on Health



Source: Budget documents of H&FW, Govt. of W.B., FYs 2016-17 to 2021-22

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

6.1.2 Inadequate funding in the Health Sector

The National Health Policy, 2017, outlined the indicative quantitative goals, and objectives, under three broad components, *viz.:* (a) health status and programme impact (b) health systems performance and (c) health system strengthening. These goals and objectives are aligned to achieve sustainable development in the health sector, keeping in view the policy thrust. Strengthening of the health system is directly associated with health finance, which targeted for goals such as:

- increase in the health expenditure by Government, as a percentage of GDP[161], from the existing 1.15 *per cent*, to 2.5 *per cent*, by 2025.
- increase in the State sector health spending, to more than eight *per cent* of its budget, by 2020.

The status of State spending in health sector, however, as may be seen from the following table, was below the national level of 1.15 *per cent*, in all the years except FY 2021-22. The target of 2.5 *per cent* by 2025, had remained unachieved, up to 2021-22.

- Further, the health sector expenditure ranged between 4.24 *per cent* and 6.37 *per cent* of the overall budgetary expenditure of the State, against the target of more than eight *per cent* by 2020.

[161] *Gross Domestic Product*

Table 6.3: Health sector expenditure *vis-à-vis* GSDP and State expenditure

(₹ in crore)

Financial Year	GSDP of the State	Total Budgetary Spending of the State	Health sector spending	Percentage against GSDP	Percentage against total Budgetary spending
	A	B	C	C/ A*100	C/ B*100
2016-17	8,72,527.23	1,58,755.22	8,127.24	0.93	5.11
2017-18	9,74,700.05	1,85,425.81	8,825.03	0.91	4.75
2018-19	11,02,053.65	2,26,742.74	9,612.65	0.87	4.24
2019-20	11,79,097.14	2,20,224.97	11,027.83	0.94	5.00
2020-21	11,55,820.61	2,20,121.09	12,695.12	1.09	5.77
2021-22	13,63,925.86	2,60,285.69	16,582.51	1.22	6.37

Source: Finance & Appropriation Accounts; GSDP- Directorate of Economics and Statistics; MoSPI

The Department did not have any mechanism to capture private investments made in the health sector.

6.1.3 Short release of State Share

The State was supposed to release its share of funds against GoI funds released to implement the National Health Programmes, under the 'National Health Mission', in the ratio of 60:40. A review and analysis of records showed that the State had not released ₹ 500.81 crore of the State share, against the GoI releases, under NHM, as detailed below:

Table 6.4: Short/ Excess release of State Share under NHM *(₹ in crore)*

Year	GoI grants received	Commodity grant* received	Total GoI grants received	State Share	Actually released	Short(+)/ excess(-) release
2016-17	735.41	77.16	812.57	541.71	393.42	148.29
2017-18	1,086.19	217.16	1,303.35	868.90	642.98	225.92
2018-19	1,005.83	110.01	1,115.84	743.89	719.96	23.93
2019-20	1,617.72	132.03	1,749.75	1,166.50	1,185.62	-19.12
2020-21	17,52.55**	150.47	1,903.02	1,268.68	968.63	300.05
2021-22	1,169.43	136.26	1,305.69	870.46	1,048.73	-178.27
Total:	**7,367.13**	**823.09**	**8,190.22**	**5,460.14**	**4,959.34**	**500.81**

*Source: WB Finance Accounts; **excluding ₹ 295 crore of Covid-19*
** Commodity Grant denotes cash equivalent of vaccines*

In reply (February 2024), the Department furnished different set of data weherein the short release of State share has been depicted as ₹ 344.25 crore[162]. The Department, however, did not clarify/ provide source of figures and claimed that the amount of short release has been made good subsequently in 2022-23. However, no documentary evidence was furnished.

It is pertinent to mention that the figures in audit as depicted in **Table 6.4** were sourced from West Bengal Finance Accounts which also tallied with the actual figures of expenditure of State budget documents.

6.1.4 Parking of funds

(i) Parking of GoI grants in the State Exchequer

Scrutiny of records (State Finance Accounts) revealed that the Health Department had not drawn GoI grants, credited to the State exchequer towards NHM, as shown below:

[162] *State share due: ₹5,540.99 crore; State share released ₹5,147.97 crore;* ***Short release of State share = ₹344.25 crore*** *{₹5,540.99 crore minus ₹5,147.97 crore (after adjusting excess release of ₹48.77 crore upto FY 2015-16)}.*

Table 6.5: Release of GoI Grants under NHM *(₹ in crore)*

Year	GoI grants received by State for NHM*	GoI grants drawn and deposited to the Deposit/ Bank Account of NHM	Difference of grants received but not drawn
	A	B	A-B
2016-17	584.58	602.45	(-) 17.87
2017-18	955.61	709.48	246.13
2018-19	804.72	826.19	(-) 21.47
2019-20	888.93	841.27	47.66
2020-21	1,331.3	1,186.49	144.81
Total	**4,565.14**	**4,165.88**	**399.26**

*Source: Annual Accounts of NHM from 2016-17 to 2020-21; Annuual Accounts for FY 2021-22 had not been finalised; * This grant is exclusive of grants received under the 'Infrastructure Maintenance (IM)' component of NHM, which is spent through the treasuries and not through bank accounts.*

It may be seen from **Table 6.5** that, though GoI grants, amounting to ₹4,565.14 crore (excluding grants meant to be spent through treasury), were credited between FYs 2016-17 and 2020-21, under the National Health Mission (NHM), to the State exchequer, around ₹ 399 crore of GoI grants had remained parked in the State exchequer and had not been drawn and deposited to the bank account/ Deposit account of NHM, for running the National Health Programmes in the State.

In its reply (February 2024), the Department has furnished a different set of figures wherein the amounts not drawn was shown as ₹ 235.02 crore[163]. Though neither the source nor the supporting documents in favour of the above figures were provided by the Department, even with these figures, a short release of GoI grants from the State exchequer was evident.

(ii) Parking in bank/ deposit accounts of various authorities

The closing balances of budgetary drawals, remaining parked in the bank accounts of different Societies/ Corporations under the department, are shown below:

Table 6.6: Parking of funds of various authorities, in bank/ deposit accounts *(₹ in crore)*

Name of the Society/ company	Closing Balances at the end of the financial years				
	2016-17	2017-18	2018-19	2019-20	2020-21
West Bengal State Health and Family Welfare Samity[164]	1,580.39	956.71	802.21	1,072.78	1,546.81
WB Medical Services Corporation[165]	653.05	523.64	726.31	269.28	350.09
WB State AYUSH Samity[166]	48.29	59.07	74.46	82.16	56.75
Society for Health & Demography[167]	3.94	2.99	2.88	0.60	0.63
Total: **(Percentage to health sector spending)**	**2,285.67** ***(28.12%)***	**1,542.41** ***(17.48%)***	**1,605.86** ***(16.71%)***	**1,424.82** ***(12.92%)***	**1,954.28** ***(15.39%)***

Source: Annual Accounts of the respective Samity/ Corporation/ Mission/ Society; Annual Accounts of NHM for 2021-22 not finalised

[163] *GoI grants received but not drawn: ₹ 235.02 crore (GoI grants received by State: ₹ 4,024.14 crore minus grants drawn and deposited in NHM account: ₹3,789.12)*

[164] *West Bengal State Health & Family Welfare Samity is the society created under the department of H&FW for execution of the National Health Programmes specially under National Health Mission.*

[165] *West Bengal Medical Services Corporation (WBMSCL) is a corporation under the H&FW Department, created primarily to bring efficiency in construction of health facilities, procurement of drugs and equipment and maintenance thereof.*

[166] *A society created under H&FWD to govern and execute the AYUSH Mission and for programme implementation in the State.*

[167] *A society created under the H&FWD for maintaining a dynamic data warehouse on various social, demographic and health characteristics to understand the health and demographic changes in the rural community over time.*

It could be seen that funds ranging between ₹ 1,424.82 crore and ₹ 2,285.67 crore, had remained parked in the bank accounts of various Societies and Companies/ Corporations under the H&FW department. These funds constituted 12.92 *per cent* to 28.12 *per cent* of the health sector spending incurred during the concerned years.

West Bengal Health & Family Welfare Samity did not maintain age-wise analysis of the closing balances. Age analysis of closing balances could also not be made available by WBMSCL.

In West Bengal State AYUSH Samity, as of 2022-23, 8 *per cent* and 32 *per cent* of the closing balances (₹ 29.95 crore) were lying unspent from 2018-19 and 2019-20 respectively which mainly included funds for Public Health Outreach activities, training, construction of AYUSH hospital (Institute of Post Graduate Ayurvedic Education & Research, Kolkata), Project Management Cost *etc*.

Of the closing balance of ₹ 62.71 lakh lying with the Society for Health & Demographic Surveillance as of 2020-21, ₹ 69,415 meant for the head 'health care' had been lying from 2015-16, while 54 *per cent* of the closing balance were lying from 2019-20 meant for execution of Anganwadi and Iron Folic Acid projects.

Further scrutiny of WBMSCL[168] records showed that funds amounting to ₹ 285.30 lakh, received for procurement of different bio-medical equipment, had remained parked in the bank account of the Corporation, for periods ranging between one to seven years ***(Appendix 6.3)***. Moreover, excepting for FY 2021-22, 49 *per cent* to 94 *per cent* of the funds had been withdrawn and deposited to the Deposit Account of WBMSCL, in the 4th quarters of the respective years[169]. This indicated unnecessary drawal of funds, to avoid lapse of budget allotment, in contravention of Rule 389A of the West Bengal Financial Rules.

The Department, in its reply (February 2024) has offered its comments only for balances in respect of West Bengal State Health and Family Welfare Samity. In reply it was stated that the closing balances of the Samity includes remittances in transit and also the balances at district and block levels which were mostly committed for expenditure in next year. The Department, also stated that no age-wise analysis of closing balances were done.

6.2 COVID fund management

Government of India, with financial supports from the World Bank and other Financial Institutions, sanctioned (April 2020) India COVID-19 Emergency Response and Health Systems Preparedness Package (ER&HSP)-Phase I, as a Central Sector Scheme. The scheme, fully funded by the GoI with no State

[168] *West Bengal Medical Services Corporation (WBMSCL) is a corporation under the H&FW Department, created primarily to bring efficiency in construction of health facilities, procurement of drugs and equipment and maintenance thereof.*

[169]

(₹ in crore)

Financial Year	Opening Balance	Total funds received	Fund received in 4th Qtr. of FY	Percentage
2017-18	*₹ 653.05*	*₹ 373.51*	*₹ 183.02*	*49*
2018-19	*₹ 523.64*	*₹ 782.35*	*₹ 735.41*	*94*
2019-20	*₹ 726.31*	*₹ 556.44*	*₹ 283.79*	*51*
2020-21	*₹ 269.28*	*₹ 610.32*	*₹ 329.57*	*54*
2021-22	*₹ 350.09*	*₹ 638.29*	*₹ 217.02*	*34*

share, intended to build resilient health systems to support preparedness and prevention related functions, that would address not only the COVID-19 outbreak, but also such outbreaks, in future.

In the FY 2021-22, Phase II of the package (ER&HSP) was introduced by GoI as a Centrally Sponsored Scheme, with some Central Sector components. The aim of Phase II was to strengthen the health systems further and support States in managing the second wave and any future upsurges. This phase was to be shared by the GoI and State on a 60:40 basis.

As per the Guidance Notes issued vide MoHFW (in April 2020, August 2020 and June 2021) the States were to prepare Emergency COVID Response Plans (ECRPs), in the prescribed format ***(Appendix 6.4 to 6.6)***, for obtaining and utilising funds under these packages. The response plans (ECRPs) were to include details of activities necessary for effective response.

However, even before introduction of the above packages (ER&HSP) and preparation of ECRP, GoI had released, in the financial year 2019-20, funds for supplementing the resources out of NHM funds (under the component Mission Flexi-pool for Health Systems Strengthening).

Details of funds received (along with the State share) against the ECRPs and allotment of funds from State budget (COVID untied fund- State), for COVID-19, for the period from FY 2019-20 to FY 2021-22, was as below:

Table 6.7: Fund Position of Covid – 19 (ECRPs) ***(₹ in Crore)***

Year	State funds from Budget	ER&HSP against ECRPs			Grand Total	Remarks
		GoI Share	State Share	Total		
2019-20	100.00	44.53	29.69	74.22	174.22	State had to release its share in NHM pattern (60:40) against funds released prior to introduction of ER&HSP Phase I
2020-21	910.00	295.28	0.00	295.28	1205.28	No state share involved in ER&HSP Phase-I (Central Sector scheme)
2021-22	835.16	604.76	403.17	1007.93	1843.09	ER&HSP-Phase-II was shared at 60:40 basis
Total:	**1,845.16**	**944.57**	**432.86**	**1,377.43**	**3,222.59**	

Source: Covid Fund as furnished by H&FW Department

All funds were drawn and placed in the West Bengal State Health & Family Welfare Samity accounts for utilization.

As regards ₹ 1,845.16 crore of State Funds released from Budget, the Government did not attach any specific purpose to these funds; instead, the same was to be spent based on locally felt needs. Utilisation of various types of funds are discussed below:

Utilisation of COVID untied State funds: Out of total ₹ 1,845.16 crore placed with West Bengal State H&FW Samity, an expenditure of ₹ 1,742.11 crore was incurred during FYs 2019-20 to 2021-22. However, it was observed that out of the same, an expenditure of ₹ 364.60 crore was adjusted against funds received against ECRPs. The position is tabulated below:

Table 6.8: Utilisation of COVID untied State funds *(₹ in crore)*

Year	Opening balance	Funds received by WB H&FW Samity	Total funds available during the years	Funds released to various lower level functionaries[170]	Total Expenditure booked	Expenditure adjusted against ECRP heads	Adjusted Expenditure	Closing balance
2019-20	0.00	100.00	100.00	52.96	5.60	5.60	0.00	94.40
2020-21	94.4	910.00	1004.4	**1,101.61**	**1,101.61**	318.20	783.41	220.99
2021-22	220.99	835.16	1,056.15	773.22	634.90	40.80	594.10	462.05
Total:		**1,845.16**		**1,927.79**	**1,742.11**	**364.6**	**1,377.51**	**462.05**

Source: Covid Fund under NHM (State level)

Utilisation of funds under ER&HSP –I & II against ECRPs: A summary position of receipt, availability and utilization of funds received under ER&HSP Phase I and Phase II against Emergency COVID Response Plans is discussed in **Table 6.9** below:

Table 6.9: Utilisation of funds under ECRP *(₹ in crore)*

Particulars	2019-20	2020-21	2021-22
	ECRP-I (NHM)	ECRP-I	ECRP-II
Opening Balance	0.00	68.62 *(unspent fund of ECRP)*	Nil
Central share	44.53	295.28	604.76
State share	29.69	0.00	403.17
Total funds received	74.22	295.28	1,007.93
Total available funds	74.22	363.90	1,007.93
Funds released	0.00	63.02	663.12 *(as per ledger updated up to 09.06.2022)*
Expenditure ***(As UC furnished)***	5.60* (7.54%)	363.90** (100%)	348.65 (34.59%) *(as per ledger updated up to 09.06.2022)*
Closing Balance	68.62	0.00	659.28

*Source: Covid Fund (ECRP-I) under the NHM (State level)*Expenditure incurred from State untied funds was adjusted against ECRP; ** ₹ 363.90 cr. = ₹ 45.70 cr. + ₹ 318.20 cr. (Spent ₹ 45.70 crore from ECRP-I and adjusted expenditure of ₹ 318.20 crore from the State untied fund)*

Thus, substantial quantum of funds had been lying un-utilised with West Bengal State H&FW Samity and its subordinate functionaries as per available records. While, State COVID Untied Funds of ₹ 462.06 crore (25 *per cent*) were lying unutilized (as of March 2022), 65 *per cent* of ECRP-II funds (₹ 659.28 crore) were also lying unspent as of last available ledger entries. Specific reasons if any, for non-utilisation of these funds, were not stated to Audit, though asked for. However, it shows lack of preparedness of the State to utilize available funds.

Non-production of records: In spite of several pursuance, the following records/ information was not produced/ furnished to Audit by the H&FW Department/ State H&FW Samity.

i. ECRPs prepared by the State Health Samity and sent to MoHFW, in the prescribed format.

ii. Financial and physical progress reports, which States were to submit by the 7th of every month, against all the ECRPs.

iii. Up-to-date status of implementation of the activities approved in the ECRPs.

[170] *District and Block Health & Family Welfare Societies, Rogi Kalyan Samities*

The following information, in regard to Untied State funds, drawn for COVID-19 purposes, for the period from FY 2019-20 to FY 2021-22, was also not furnished:

i. Year-wise plans, if any, for the FYs 2019-20, 2020-21 and 2021-22, for utilization of State funds received for COVID-19 purpose

ii. Year-wise physical and financial progress reports, if any, as on date, regarding utilization of State funds received for COVID-19 purpose, for the FYs 2019-20, 2020-21 and 2021-22.

iii. Sources of excess release and expenditure, by ₹ 97.21 crore (₹ 1,101.61 crore – ₹ 1,004.40 crore) under the COVID untied State funds, against the available funds in FY 2020-21.

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

Recommendation:

13. Department may ensure that adequate funds are allotted in Health Sector and are utilized in a more efficient manner, as envisaged in the National Health Policy and other relevant guidelines.

CHAPTER 7

Implementation of Centrally Sponsored Schemes

7 Chapter Implementation of Centrally Sponsored Schemes

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

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

National Health Mission (NHM)

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

Scrutiny of records revealed the following:

(ii) Vision Centres not set up

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

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

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

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

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

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

(iii) Acute shortage of Para Medical Optometrists

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

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

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

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

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

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

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

(iv) Cataract surgeries conducted were inadequate

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

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

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

Table 7.2: Cataract surgeries- Target and Achievement

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

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

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

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

(v) Corneal transplantations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendation:

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

7.2 National Leprosy Eradication Programme (NLEP)

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

(i) Adequate screening of population not done as prescribed

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

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

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

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

(ii) Suspected positive cases remaining unexamined for confirmation

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

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

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

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

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

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

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

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

(iii) High incidence of Grade-II deformity

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

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

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

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

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

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

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

[177] *Visible deformity or damage*

(iv) Rate of prevalence of leprosy more than prescribed

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

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

Table 7.7: Prevalence Rate in six districts of the State

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

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

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

Recommendation:

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

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

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

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

(i) Inadequate screening and treatment

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

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

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

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

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

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

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

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

(ii) Shortage of Human Resource

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

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

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

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

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

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

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

Source: NPCDCS under NHM (State level)

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

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

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

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

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

(iii) Inadequate capacity building through training

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

Table 7.10: Status of training programmes under NPCDCS

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

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

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

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

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

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

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

(iv) Lack of investigation facilities

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

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

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

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

(v) Absence of Day Care and Palliative Care Units

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

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

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

[180] *Bleeding Time & Clotting Time*

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

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

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

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

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

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

(vii) Lax monitoring and review

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

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

Table 7.11: Periodic review meetings of the State NCD Cell

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

Source: NPCDCS under NHM (State level)

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

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

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

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

(viii) No database of NCDs developed for the State

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

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

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

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

Recommendations:

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

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

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

7.4 National Programme for Healthcare of the Elderly (NPHCE)

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

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

(i) Non-execution of MoU

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

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

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

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

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

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

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

(iii) Programme benefits not extended by Sub-Centres

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

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

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

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

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

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

(iv) Geriatric Clinics not held in PHCs

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

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

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

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

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

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

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

(vi) Shortage of human resources

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

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

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

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

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

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

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

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

Recommendation:

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

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

CHAPTER 8

Adequacy and effectiveness of Regulatory Mechanisms

8 Chapter *Adequacy and effectiveness of Regulatory Mechanisms*

Audit Objective: Whether adequate monitoring and regulatory systems had been put in place and had been effectively followed, for ensuring delivery of quality healthcare to the public.

Under the National Quality Assurance Scheme, there was no roadmap for attaining national standards, within any measurable timeframe. Due to inadequate numbers of meetings having been held, as well as and non-discussion of quality scores by the State and the district level committees, corrective actions had not been planned. A considerable number of health facilities had not furnished 'Key Performance Indicator' (KPI) information. The KPI dataset, reported by the health facilities, were also not discussed.

Maternal deaths had remained unreviewed, contradicting the facts claimed by the State. The State level Task Force had not followed the prescribed mechanism of centrally reviewing maternal deaths. Child deaths were not been reviewed in the State, at any level.

8.1 National Quality Assurance Scheme (NQAS)

The Ministry of Health & Family Welfare, GoI, in order to support and facilitate a sustainable quality assurance programme for the public health system in the country, framed (2013) guidelines under NHM, for Quality Assurance, which were adopted by the State in 2014. The guidelines introduced a scoring system, against a set of standards, indicators and other measurable elements, for continuous internal assessment, to be carried out by the facility itself at least once in a quarter, followed by preparation and implementation of an action plan, for bridging the observed gaps.

A State Level Quality Assurance Committee (SQAC) was to be formed, to oversee quality assurance activities across the State and ensure regular and accurate reporting of various Key Performance Indicators (KPIs). The SQAC was to develop a roadmap for achieving the national standards; ensure orientation and training; conduct six-monthly review meetings; and define targets/ road maps, for corrective actions, on review of the quality scores of the public health facilities of the State. The Committee's review reports were to be uploaded onto the State's website.

A State Quality Assurance Unit (SQAU) was to act as a working arm of the SQAC. With the same terms of reference as the SQAC, the SQAU was to develop a plan for quality assurance, at each level of health institution, in a phased manner; develop a field travel plan for visits to districts; and compile and collate the monthly data received from the districts in regard to the KPIs.

At the district level, District Quality Assurance Committee (DQAC) and District Quality Assessment Unit (DQAU), were to carry out similar functions.

District Quality Assessment Teams (DQTs) were to be formed, at each District Hospital (DH), for carrying out internal assessment of the DH and the health institution below the DH level, under the scheme. Once the DQT had completed these assessments, the DQAC and SQAC were to ensure external assessments

of all facilities, were carried out, on a quarterly and bi-annual basis, by the District and State assessors. This process was to continue, till the SQAC assessors had certified the attainment of quality standards at the hospital. Thereafter, the DQTs were to maintain the standards.

Review of records and replies showed that no comprehensive road map had been devised by the SQAC, for attaining the national standards, within any measurable timeframe.

In regard to the trainings conducted by the SQAC, no details of the year-wise trainings conducted and the number of participants, had been provided by the Health & Family Welfare Department, GoWB, though sought for. An analysis of the funds approved by GoI, for the purpose of imparting Quality Assurance trainings, during the audited period, and the utilisation of the same, revealed significant non-utilisation of the funds, as shown below:

Table 8.1: Utilisation of GoI funds for training on Quality Assurance

(₹ in lakh)

Financial Year	OB	Budget Allotted, as per Record Of Proceedings	Expenditure	CB
2016-17	**--**	479.98	103.04	**376.94**
2017-18	**376.94**	0.00	19.52	**357.42**
2018-19	**357.42**	83.53	12.49	**428.46**
2019-20	**428.46**	70.73	17.83	**481.36**
2020-21	**481.36**	4.19	6.80	**478.75**
2021-22	**478.75**	56.80	18.48	**517.07**
Total		**695.23**	**178.16**	

*Source: Records furnished by H&FW Department; *Financial Management Report*
Note: OB as of April 2016, if any, has been ignored, for the purpose of this analysis

Non-utilisation of 74.37 *per cent* of the GoI grants, by the SQAC, was indicative of the fact that the targets for training of staff, had remained grossly unachieved, under the scheme.

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

8.1.1 Lack of review through SQAC meetings

The Committee had to conduct review meetings at six-monthly intervals. However, against the normative 12 meetings, which had fallen due in the period audited, minutes of only four State level SQAC/ SQAU meetings could be produced before Audit, as detailed below:

Table 8.2: Minutes of SQAC/ SQAU meetings

Committee	Date of meeting	Issues discussed in the meeting
State Quality Assurance Committee (SQAC) (formed on 14.01.2014)	08.07.2015	The importance and strengthening of the fumigation procedure, planned training programme for infection control measures, implementation of uniform signage system across all hospitals, quality of diet supply to indoor patients with proper dress code, training on hygiene, antibiotic policy to be implemented at the State level *etc.*
	22.06.2017	Removal of solid waste by rubberised mops, nursing personnel to be properly trained about dismantling the laparoscopes, removing blood clots meticulously and proper sterilisations. One team at each DH/ SDH/ SGH was to monitor for quality of diet supplied and one dietician was to be engaged, for different medical colleges, One internal quality assurance was to be developed in respect of the Medical College Pathology or Bio-chemistry Department and Mercury spill, management kits to be maintained at Hospitals, in all wards and user areas *etc.*

Committee	Date of meeting	Issues discussed in the meeting
	27.07.2021	Implementation of LaQshya in all the Medical College and Hospitals, building an IT-based patient information system, where all details of mothers be generated from a single portal, for the reduction of referral rate and implementation of referral audit, to assess the cause of all referrals and take preventive measures from all types of hospital.
State Quality Assurance Unit (SQAU) (formed on 28.04.2015)	05.04.2016	Developing a field visit plans to the districts, by the members of the SQAU, Meetings at the district level (DQAC and DQAU) being more regular and timely, lists of non-functioning equipment of hospitals undergoing quality assurance to be collected in a format that would be finalised by the Ophthalmology Dept., State officers nominating experts, specifically for training programmes organized at district hospitals in the evening slots, Orientation of DQAC and DQAU, sharing field visit reports on quality assessment and discussing the way forward for improving services.

Source: SQAC/ SQAU meetings State level

It may be seen from **Table 8.2** that, not only had very few SQAC/ SQAU meetings been held, but also, in none of the meetings had the assessed scores of the public health facilities been reviewed by SQAC. Thus, defining of targets/ road maps for taking corrective action, on review of quality scores, had not been done at the State level.

In reply, the Department stated (February 2024) that two SQAC meetings had been conducted in the year 2023 and regular SQAC meetings are being conducted now. No details/ documents in support, however, have been provided.

As per norms, DQAC meetings were to be conducted on a quarterly basis. It was, however, observed that only 28 DQAC meetings had been conducted, instead of 116, in the selected districts, with a shortfall of 75.86 *per cent* in conducting DQAC meetings.

Table 8.3: Conduct of DQAC meetings in the selected districts

District	DQAC meetings to be conducted as per norms (2016-22)	Target for conducting DQAC meeting (2016-22)	No. of meetings conducted	Shortfall percentage
Bashirhat Health District	20 (As the health district was formed in F/Y 2017-18)	20	7	65
Jalpaiguri	24	12	8	66.66
Paschim Medinipur	24	0	2	91.66
Purulia	24	24	3	87.5
Uttar Dinajpur	24	24	8	66.66
Total	**116**	**80**	**28**	**75.86**

Source: DQAC/ DQAU meetings of test-checked District

In reply, Department while acknowledging (February 2024) the fact regarding inadequate DQAC meetings, stated that in the year 2023, 60 DQAC meetings had been conducted across districts. No documentary evidence, however, was provided.

8.1.2 State level Assessments not done

As per the records provided by the State Department, State level assessments had been carried out (under NQAS) for only 20 health facilities[183] (15 in 2019

[183] *Jalpaiguri DH, Kalimpong DH, Siliguri DH, Rajgunj RH, Mirik BPHC, Jashodanga RH, MR Bangur DH, Vidyasagar SGH, Katwa SDH, Durgapur SDH, Bolpur SDH, Suri DH, Balurghat DH, Gangarampur SDH, Tarakeswar RH, Silbarihat PHC, Oodlbari RH, Kalna SDH, Jangipara RH, Joypur BPHC*

and 5 in 2021), against the 1,382 health facilities[184] in the State (from the PHC level, up to the DH level), during the period checked by audit. Out of these, 12 health facilities had obtained National Certification.

The Department eventually accepted the shortfall by stating (February 2024) that it has conducted 1,053 State level Assessments of MCHs to Sub-centres under NQAS including assessments under LaQshya & MusQan scheme in 2023. However, no document in support was provided.

8.1.3 Monitoring of Key Performance Indicators (KPI)

The State Department issued an order, in March 2015, that, as part of the Quality Assurance programme under NHM, all hospital authorities of the State were to collect and collate critical data from their various departments, calculate certain performance indicators and monitor them on a monthly basis. These identified Key Performance Indicators (KPIs), were to be reported to the DQAC and SQAC, for monitoring, on a monthly basis and addressing the gaps in performance.

Review of the records however, revealed that none of the 916 PHCs, only 329 out of 348 BPHCs/ RHs, one of the 40 other decentralised/ teaching hospitals, 10 of the 42 Super Speciality Hospitals and none of the Medical College Hospitals of the State, has reported the KPI data, during the test-checked year 2021.

Moreover, the SQAC, as discussed above, had not met, to review the dataset reported by the health facilities and nor had it discussed the KPIs in its meetings. Thus, the purpose of the scheme had remained unfulfilled.

In the test-checked districts/ units, it was observed that internal assessment had not been carried out at 37 of the 38 test-checked SCs. It had not been done in 14 PHCs (out of 19 PHCs), in five CHCs (out of the seven CHCs whose data was available) and one SDH (Islampur), out of five test-checked DH/ SDHs. External assessments had been carried out in only seven PHCs and one CHC, out of the eight health facilities whose internal assessments had done ***(Appendix 8.1 to 8.3)***.

The State Government, in its reply, stated (December 2023) that all the facilities have been requested to conduct internal assessments after forming facility level Quality Improvement/ Assurance Teams. Shortage of manpower has been sited as one of the reasons for not conducting the assessments. After completion of internal assessments, external assessments of the eligible facilities would be carried out.

The Department subsequently stated (February 2024) that Quality Assurance Teams have now been constituted and internal assessments are carried out in every tier of facility. It was also stated that all facilities except 718 PHCs are now reporting in KPI portal. No documentary evidence, however, has been furnished by the Department.

8.1.4 Patient Satisfaction Surveys and Medical & Death Audits

The Health Department stated that: (i) Patient Satisfaction Surveys (PSSs), of OPD and IPD patients, are conducted across all facilities and (ii) medical and death audits are also conducted for all deaths across the State.

[184] *DH: 18 + SDH: 36+ SGH:24 + Other Hosp.: 40 + RH/ BPHC: 348 + PHCs: 916 = 1382 Health facilities*

In the 19 test-checked PHCs, Patient Satisfaction Surveys had not been conducted at 16 PHCs. While none of the test-checked PHCs had carried out death audits, medical audits had also not been conducted in 18 of the test-checked PHCs ***(Appendix 8.2)***. Patient Satisfaction Surveys had not been conducted in five of the 10 test-checked CHCs. Neither Medical Audits, nor Death Audits, had been conducted in any of the test-checked CHCs ***(Appendix 8.3)***. Medical audits had never been conducted in Islampur SDH and Raghunathpur SDH.

In reply, State Government stated (December 2023) that communications will be made to conduct PSS in the bedded PHCs. Medical audit is only conducted in PHCs undergoing State Certification under NQAS. No comments in respect of non-conduct of such audits in other facilities were made.

The Department in its further reply (February 2024) stated that Patient Satisfaction Survey, medical audits and death audits have been rolled out in all tiers of facilities from 2023 onwards. This, however, was not mentioned by the Department in its reply in December 2023. No documentary evidence was also furnished in support by the Department.

Recommendation:

19. The H&FW Department may ensure conduct of regular meetings, by the State Level and District Level Committees, for discussion on the information received as Key Performance Indicators (KPIs), from the health facilities, for identifying and plugging gaps, for maintaining the healthcare services at an optimal level.

8.2 Maternal and Child Death Reviews

8.2.1 Maternal Death Review (MDR)

Maternal Death Review (MDR) is an important strategy for improving the quality of obstetric care and reducing maternal mortality and morbidity. The importance of MDR lies in the fact that it provides detailed information on various factors relating to the health care facilities at the district, community, regional and national levels, that need to be addressed, to reduce maternal deaths. GoI had requested the State (2010) for issuing a GO, making MDR mandatory, by involving District Collectors in the maternal death review process and making the CMOH responsible for reviewing all maternal deaths.

The State Government, in line with the central norms, had issued guidelines in this regard, in July 2010. Two methods of investigation were adopted for every maternal death, *viz.* Community-Based Maternal Death Review (CBMDR) and Facility-Based Maternal Death Review (FBMDR). CBMDR is a technique, wherein the family members, relatives, neighbours or other informants and care providers are interviewed and asked for a narrative, to elicit information on the events leading to the death of the mother during pregnancy (in their own words), to identify the medical and non-medical (including socio-economic) factors responsible for the death of the mother. FBMDR, on the other hand, aims to identify various delays causing maternal deaths in the health facilities and to enable the health system to take corrective measures, at various levels.

Every district was supposed to have a committee for maternal death reviews. The District MDR Committee had to review all the maternal deaths in the district, once every month, on a pre-fixed date. The MDR committee under the

CMOsH, was to receive two types of MDR reports. One was the CBMDR, from the block medical officers, based on the verbal autopsy[185] conducted by the ANM in regard to the area of residence of the deceased mother. The other was the FBMDR, from the Nodal Officer/ ACMOH, for MCHs/ DHs/ SGHs/ SDHs/ RHs/ BPHCs/ PHCs/ Sub-Centres and other private and decentralised Hospitals. However, CBMDR was to be taken up mandatorily for all deaths that had occurred in the specified geographical area of the deceased's residence, irrespective of the place of death, be it at home, facility or in transit.

The District MDR Committee was to prepare reports, in the form of Case Summaries, of all the maternal deaths reviewed by the Committee and share the findings with the DM. The DM would then have the option of reviewing, in detail, a sample of these deaths, in the quarterly meetings (DQAC meetings). The minutes of the meetings were to record the corrective measures discussed by the Committee, for being taken in at the community level, and at the facility level, as also the issues needing intervention at the State level, with timelines.

A State level Task Force (SLTF), headed by Principal Secretary H&FW Department, also was to be constituted. It was to meet once in six months, to review the analyzed data at the State level. This was to be followed by feedback to the districts and action at the State level, if any. SLTC was also to discuss the actions taken on the minutes of the last meeting and make recommendations to Government, for policy and strategy formulation. Every year, an annual maternal death review report for the State was to be prepared and a dissemination meeting was to be organized, to sensitize the various service providers and managers.

The list of districts, having MDR Committees, under the chairmanship of the CMOHs and the District Maternal Child Health Officers (DMCHOs), as the nodal officers, were not furnished to Audit, though asked for.

Further, the number of monthly meetings conducted by the District MDR Committees, as furnished in the reply given by H& FW Department, was unrealistic, as shown below:

Table 8.4: Number of meetings conducted by the District MDR Committee

Financial Year	Number of meetings conducted	Remarks
2016-17	1,240	Had all 27 districts (including the health districts) of the State conducted the monthly review meetings regularly, the maximum number of meetings would have been 324 (27 x12) in a given year. Therefore, these number of meetings, as furnished in the reply, seems unrealistic.
2017-18	1,126	
2018-19	786	
2019-20	756	
2020-21	967	
2021-22 *(Upto January)*	773	

Source: Reply of West Bengal State Health Samity

The Department in its reply accepted (February 2024) the fact of erroneous supply of information and stated that the number shown against the column of meetings were actually the number of maternal deaths reviewed by the District MDR Committee. Number of monthly meetings conducted by District MDR Committees, however, was not provided.

[185] *The verbal Autopsy technique involves interviews of family members, relatives, neighbours or other informants and care providers, for eliciting information on the events leading to the death of the mother during pregnancy/ abortion/ delivery/ after delivery and recording/documenting, in their own words, the medical and non-medical (including socio-economic) factors involved in the death of the mother.*

As per norms, each maternal death, in the State, was to be reviewed, by following the CBMDR and FBMDR mechanism. However, records showed that a considerable number of maternal deaths had remained unreviewed, as shown below:

Table 8.5: Review of maternal deaths

Financial Year	Maternal Deaths occurred at				Maternal Deaths Reviewed	
	Home	Health care Facilities	In transit	Total Maternal Deaths	CBMDR	FBMDR
2016-17	90	1,121	97	1,308	818	779
2017-18	64	1,170	91	1,325	667	790
2018-19	44	1,038	86	1,168	734	673
2019-20	28	898	100	1,026	689	625
2020-21	58	1,040	108	1,206	785	746
2021-22	37	918	82	1,037	654	761
Total:	**321**	**6,185**	**564**	**7,070**	**4,347**	**4,374**

Source: NHM data (State level)

As evident from **Table 8.5**, there was a shortfall of almost 39 *per cent* (only 4,347 deaths had been reviewed, against the total of 7,070 deaths) in respect of CBMDR whereas in respect of FBMDR a shortfall of 29 *per cent* (only 4,374 deaths were reviewed against 6,185 deaths at health care facilities) was noticed.

In reply, the Department stated (February 2024) that in 2022-23, 87 *per cent* of FBMDR and 73 *per cent* of CBMDR were conducted and thrust is given to achieve 100 *per cent* FBMDR and CBMDR.

However, FBMDR in respect of 13 *per cent* maternal deaths and CBMDR in respect of 27 *per cent* of maternal death still remained unreviewed.

The status of review, in the five (5) selected districts showed that a considerable number of maternal deaths had remained unreviewed, as below:

Table 8.6: Review of maternal deaths in the test-checked districts

Financial Year	Maternal Deaths occurred at				Maternal Deaths Reviewed	
	Home	Health care Facilities	In transit	Total Maternal Deaths	CBMDR	FBMDR
2016-17	23	150	13	186	168	63
2017-18	18	121	20	159	131	50
2018-19	14	139	14	167	109	38
2019-20	7	135	21	163	114	63
2020-21	13	167	27	207	154	99
2021-22	11	170	31	212	182	117
Total:	**86**	**882**	**126**	**1,094**	**858**	**430**

Source: NHM data (State level)

Thus, though the State level figures showed almost equal figures for CBMDR and FBMDR, figures of the test-checked districts showed that only 430 (48.75 *per cent*) of the 882 institutional deliveries had been reviewed by the facilities where the deaths had taken place. A considerable number of deaths had remained unreviewed for CBMDR also.

Further, in the nine test-checked DHs/ SDHs/ MCHs, out of 495 deaths, only 242 deaths had been reviewed by these health care facilities, leaving 51.11 *per cent* deaths unreviewed.

In regard to the formation of the State Level Task Force (SLTF) and convening of six-monthly review meetings, with the aim of reducing maternal mortality, it

was observed that, though the SLTF had been formed (2014), the data of only two meetings (one in August 2014 and one in April 2022) could be produced to Audit. However no minutes, of these meetings, were produced. Further, some documents (pertaining to 2019-2022) were produced before Audit, showing intermittent action having been taken, in regard to the increasing trend of maternal deaths in some districts/ health institutions, including field visits and issue of directions. However, the prescribed mechanism of centrally reviewing the CBMDR and/ or FBMDR, at the State level, to identify gaps, prepare of action plans and execute them, had not been followed.

In reply (February 2024), while admitting the fact, the Department did not furnish any reason for not holding the meeting at prescribed interval. It was further claimed that weekly review of maternal deaths has been undertaken for last two years.

No annual MDR report had been prepared, at the State level, for any of the years covered under audit. Further, no dissemination meetings had been organised, in any year, to sensitize the various service providers and managers.

In regard to the selected health facilities, in the test-checked districts, it was observed that, as per the information furnished by the facilities, CBMDR of all the Maternal Deaths Reported in the Blocks and FBMDR, in regard to two deaths that had occurred in the health care facilities, had been conducted. However, it was observed that Rudrapur RH, and Sandelerbil RH of North 24 Parganas, had not formed any facility-based MDR Committee, till FY 2021-2022. Thus, deaths had remained unreviewed/ had been improperly reviewed.

Moreover, in respect of Sabang RH, Paschim Medinipur district, two deaths were reported in the block during FY 2016-17 and one death in 2018-19. The hospital authorities admitted that these deaths had occurred on account of lapses in the Government mechanism[186] ***(Appendix 8.3)***.

8.2.2 Child Death Review

Improving child survival and development is one of the key goals of the National Health Mission. Child Death Review (CDR) is a step in this direction. The purpose of this review is to establish a mechanism, through which all child deaths are reported, investigated and accounted for. At the same time, it enables the concerned authorities at the block and district level to take corrective measures for averting such deaths in future.

The H&FW Department had issued guidelines[187] in April 2015, for conducing CDR of children, in the age group of 0 to 5 years. CDR, like MDR, was of two types for every child death, *viz.* Community-Based Child Death Review (CBCDR) and Facility-Based Child Death Review (FBCDR). The mechanism of the review was similar to that of the MDR. In CDR also, the same State Level Task Force was the apex monitoring and reviewing authority.

Scrutiny of records, however, showed that, in disregard of its own formulated guidelines, no child deaths had been reviewed in the State, at any level. There was no documentary evidence of the functioning of the State Level Task Force for child death reviews. Records showed that the State Department had

[186] *Delay in getting transport, sub-standard care in hospital, dearth of blood/ equipment/ drugs, etc.*
[187] *H/ SFWB/ 9D-01-2013/ 4413 dated 02.04.2015*

circulated an order, along with the CDR guidelines, in April 2022, for commencing the review process, from April 2022 only.

In reply, the Department claimed (February 2024) that CDR has been started at the State level as well as facility level since April 2022.

8.3 Other controls

A survey of 38 doctors, conducted by Audit, across the test-checked CHCs, SDHs and DHs, brought out the following facts, which were indicative of the absence of some common regulatory mechanisms:

Table 8.7: Survey of doctors on common regulatory protocols

Issues raised in the Survey	No. of Doctors confirming the issue	Percentage
Registration number of the doctor not being displayed in the clinic, prescription, and receipts	19	50
Manuals on Standard Treatment Guidelines not being available in the doctors' chambers	18	35
Doctors not creating awareness among the patients regarding usage of prohibited drugs and educating them on their side-effects	16	37
Doctor opining that the applicable rules and regulations were not sufficient for regulating the Government health sector	21	49
No monthly meeting held among doctors, to discuss or address the issues faced by the hospital	16	37

Source: Doctor's Survey in the test-checked PHCs & CHCs

Further, another survey of 20 doctors, of the test-checked DHs and SDHs showed the following:

Table 8.8: Survey of 20 doctors of test-checked DHs and SDHs

Sl. No.	Issues raised through surveys	No. of Doctors Surveyed	No. of Doctors confirming the issue	Percentage
1	Doctor was not provided with all required infrastructure in the hospital to examine the patient	20	7	35
2	Doctor had to attend more than 50 patients (OPD/ IPD) on an average in a day	20	5	25
3	Doctor had to attend more than 100 patients (OPD/ IPD) on an average in a day	20	14	70
4	Patient influx was heavy	20	9	45
5	Registration number of the doctor was not displayed in the clinic, prescription and receipts	20	10	50

Source: Doctor's Survey in the test-checked DHs & SDHs

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

8.4 Quality Assurance at Medical College and Hospitals

- As per provisions contained in the National Quality Assurance Standards, 2013, and State Govt. order[188] issued in January 2015, a five-member 'Family Planning Indemnity Sub-Committee', is to be formed, from within the District Quality Assurance Committee, to process claims, received from clients, as well as complaints/ claims lodged against surgeons and accredited facilities, as per the manual on the 'Family Planning Indemnity Scheme, 2013'. It was, however observed that no such sub-committee had been formed in RMC&H, during 2016-22. No information in this regard was furnished by the SSKM Hospital authorities.

[188] *Order No. NHM/ 1H-162-2013/ 06 dated 06.01.2015*

- The Quality Assurance Committee (QAC)[189], formed at RMC&H, had not conducted any quarterly review meetings, to take corrective measures and define targets and roadmaps, during the period covered under Audit. Quality Assurance Units[190], working arms of the QAC, had also not been formed.
- No Quality Team, with the Superintendent of the hospital as the head, had been formed of the RMC&H.
- Social Audit, through Rogi Kalyan Samity[191], had not been conducted, during the entire period of Audit.

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

8.5 IT System at the SSKM Hospital

(i) Patients were being registered at emergency and OPD ticket counter, based on HMIS online software module after coming to the hospital. Though an online registration system was in operation, it is again to be validated at the hospital counter.

(ii) A system-developed registration number (**RG number**) was being generated against each registered patient. This number also served as the unique identity code for that particular patient.

(iii) Though it was possible to obtain the status of vacant beds online, at any point of time, in the HMIS system, this practice was not followed. In the absence of real-time vacancy position of beds, patient service was suffering.

(iv) The Store Management Information System (SMIS)[192] was being used to manage the stock position of various medicines and consumables, at the medicine and surgical store of the hospital. However, this system was not followed at different wards and OPD *etc.*, where the records of consumption of medicines and consumables were maintained manually. As a result, obtaining the status of availability of medicines and consumables, in the hospital as a whole, on a real-time basis was not possible.

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

8.6 Maintenance of Medical Records at SSKM Hospital

(i) Preservation of medical records is required for future case reference, in connection with various court cases, processing insurance claims *etc.* It is used for research purposes also.

(ii) The process of keeping medical records of the Hospital, in a digitized form, had started since 2011, for the period 2009 onwards. Digitized records pertaining to 2017 were not available, due to reason(s) not stated on records.

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[189] *Quality Assurance Committee is responsible for monitoring the quality assurance efforts*

[190] *Quality Assurance Unit is to act as working arm of the Quality Assurance Committee to implement the directions of the QAC.*

[191] *RKS or Rogi Kalyan Samity is a registered society which acts as a group of trustees for the hospitals to manage the affairs of the hospital.*

[192] *SMIS stands for Store Management Information System. It is an online inventory management system of drugs, equipment and consumables in all secondary and tertiary tier hospitals in West Bengal. District Reserve Store at the district handles SMIS operation for all primary tier hospitals in a district.*

(iii) Medical reports of patients, including clinical test reports, BHTs[193], doctors' advice *etc.* were available in digitized form however, no case notes/ case narration were maintained.

(iv) As per provision of Order no. SBHI/ 2D-4/ 2016/ 259/ 1(33) dated 31.08.2016, OPD records, like case sheets and registration books, were to be disposed of after a period of five years. However, no OPD records either in hard copy or in soft copy were being preserved in the hospital.

(v) In case of requirement, records were retrieved on the basis of the discharge dates or expiry dates or Patient Admission numbers printed on the BHT. However, no unique identity (AADHAAR or any such number developed by the IT system) was attached with each individual patient.

(vi) Copies of medical records were not available in the Hospital's portal. There was no system of records which could make available online, to the patient or his/ her relatives after ensuring the patients' identity, through due technical process.

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

Recommendation:

20. The H&FW Department may ensure that all maternal deaths are reviewed, for detection of the underlying causes and take remedial measures for minimising maternal mortality in the State. The H&FW Department may also ensure immediate commencement of reviews of the child deaths in the State.

[193] *'BHT' stands for Bed Head Ticket. It contains all the relevant data relating to the treatment of patient such as advice/test prescribed, findings etc. in a chronological order.*

CHAPTER 9

Sustainable Development Goals

9 Chapter Sustainable Development Goals

Audit Objective: Whether comprehensive strategies and plans had been developed to achieve the Sustainable Development Goals.

9.1 Sustainable Development Goals (SDGs): Absence of road map

There was neither any Health Policy/ Standard at the State level, nor any District Health Action Plan at the district level, to cover the broad aspects of health, for attaining SDG Goals, as well as to follow the Indian Public Health Standard guidelines for the health facilities throughout the State.

In 2015, the member countries of the United Nations (UN) agreed to adopt the 2030 Agenda for Sustainable Development. The historic agenda lays out 17 Sustainable Development Goals (SDGs) and targets for dignity, peace, and prosperity for the planet and humankind, to be completed by the year 2030. Out of the 17 SDGs, Goal 3 aimed to "Ensure healthy lives and promote wellbeing for all at all ages", having the following targets:

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
2. By 2030, to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing.
5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
6. By 2020, halve the number of global deaths and injuries from road traffic accidents.
7. By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into strategies and programmes.
8. Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.
10. Implement the WHO framework convention on tobacco control.
11. Support research, development and universal access to affordable vaccines and medicines.
12. Increase health financing and support health workforce in developing countries.
13. Improve early warning systems for global health risks.

NITI Aayog, in India, had the twin mandate to oversee the adoption and monitoring of the SDGs in the country and promote competitive and cooperative federalism among States and UTs.

In terms of the requirement of the NITI Ayog, the Chief Secretary, Government of West Bengal, had issued directions in August 2016, for preparation of a vision document up to 2030, a long-term perspective plan/ Mission/ Strategy document till the year 2025 and a short-term Perspective/ Action plan till the year 2020, to achieve SDG goal No. 3 relating to 'Good Health and Well Being'.

The existing schemes/ programmes were to be reviewed, with reference to the 2030 Agenda, to identify gaps. Indicators against all the targets mentioned in the SDG-3 had to be fixed and the progress periodically monitored, for achieving the goals under SDG-3.

No documents, however, could be provided to Audit in this regard, though requisitioned for. Further, during an audit carried out on 'Preparedness for implementation of SDGs- Goal: 3- 'Good Health and Well Being' for CAG's Audit Report for the year ended March 2018 (Report no. 8 of 2019), it had been noted that a Draft Sector Paper on Health and Welfare, to integrate the 2030 agenda of SDG, was under finalization and awaiting approval of cabinet. No approved sector paper, however, could be produced to Audit, even after a lapse of four years.

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

9.2 Absence of health policy or attainable standards

Further, delivery of qualitative and efficient healthcare services, in public health facilities, plays a significant role in improving the health indicators of the public at large. Thus, it was incumbent upon the H&FW Department, GoWB, to carry out comprehensive and outcome-based planning, so that essential resources could be provided to the public hospitals and the available resources could be utilised optimally, in the short, medium, and long-terms.

Audit observed that neither had the GoWB framed any Health Policy and/ or Standards excepting a 'State Drug Policy and standards for CCU[194]/ NICU[195]', and Essential Drug Lists, nor had it expressly followed the Indian Public Health Standards (IPHS)[196] for the State. Though a Health Sector Strategy, for 2004 to 2013, had been framed by the H&FW Department, with objectives like improving accessibility, reducing maternal and child mortality, reducing communicable/ non-communicable diseases, ensuring quality of medical care services, *etc.*, no short-term plans were, however, framed for implementation of these strategic goals or for collating the Department's budgeting process to achieve these objectives.

Further, in the absence of any set of standards for achievement, no efforts had been made to identify the gaps in various facets of healthcare services expected from a public health system and to devise plans to plug the deficiencies. As a result, the budget estimates also were not need-based.

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

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[194] *CCU- Critical Care Unit*

[195] *NICU- Neonatal Intensive Care Unit*

[196] *There was no annual plan/ strategic plan/ gap analysis document or any other document, wherefrom it could be stated that the State Government had adopted the standards prescribed in the IPHS, as performance goals/ parameters.*

9.3 Absence of District Health Action Plans

As per the NHM framework, the State Programme Implementation Plan (PIP) is to be an aggregate of the District Health Action Plans (DHAPs), which include the facility strengthening plans. DHAPs are required to specify the current (baseline) package of services available in each facility; as well as the inputs, activities and budget required to expand this package, improve the quality of care, expand access and enable positive outcomes in service delivery.

However, no DHAPs had been prepared and aggregated, to arrive at the State PIPs, during the period covered under audit. PIPs had been prepared without taking inputs of the requirements of the districts/ facilities.

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

Recommendations:

21. ***The Health & Family Welfare (H&FW) Department, Govt. of West Bengal (the nodal department) may either expressly follow the Indian Public Health Standards or set its own standards.***
22. ***The H&FW Department may conduct a 'Gap Analysis' exercise to arrive at the shortages in infrastructure, man-power and services, against the set standards and prepare long and short-term health action plans, based on the gap analysis exercise. The H&FW Department may ensure that the annual budgeting process is driven by long and short-term plans.***
23. ***The H&FW Department may ensure integration of SDG goals with the health action plans and setting of intermediate targets, ensuring achievement of SDG goals by 2030.***

9.4 Adverse impacts on health & wellbeing of people

Absence of any long-term/ short-term plans, neglect of SDG goals, and an unguided budgeting methodology, led to non-achievement of the Indian Public Health Standards. Healthcare funding remained grossly inadequate in the State. Shortages were conspicuous in regard to existing resources, like physical infrastructure, human resources, drugs, and equipment. Further, there had been inadequate action by the department, in bridging the gaps in such resources, over the years. Essential drugs, equipment, diagnostic services remained inadequate/ absent in the healthcare facilities.

Lack or absence of resources adversely affected the delivery of healthcare services, in the public health facilities in rural Bengal. Essential OPD, IPD and other support services were absent in many hospitals.

Moreover, improper enforcement of schemes, regulations and provisions, including the National Quality Assurance Scheme; Clinical Establishment Act/ Rules; provisions for medical and death audits, including Maternal and Child Death Reviews *etc.*, rendered the delivery of healthcare services ineffective, to a large extent.

Resultantly, it was noticed from the fifth National Family Health Survey (NFHS) that, in regard to some major health indicators, the State had declined from its earlier standards/ levels, potentially causing a negative impact on the related SDG goal as mentioned against each indicator in the **Table 9.1**.

Table 9.1: Deterioration of Key Health Indicators of the State

Key Health Indicators	West Bengal		National	Impacted SDG Goals
	2017-19	2018-20	2018-20	
	(per 1,000)			
Sex Ratio	944	936	907	--
Crude Death Rate	5.3	5.5	6.0	--
Key Health Indicators	**West Bengal**		**National**	**Impacted SDG Goals**
	2015-16	**2019-20**	**2019-21**	
	(in *per cent*)			
Mothers who had at least 4 antenatal care visits	76.4	75.8	58.1	3.1 Reduce MMR
Mothers whose last birth had been protected against neonatal tetanus	95.4	94.6	92	
Home births that had been conducted by skilled health personnel	6.8	2.6	3.2	
Pregnant women aged 15-49 years who are anaemic (<11.0 g/ dl)	53.6	62.3	52.2	
All women aged 15-49 years who are anaemic	62.5	71.4	57	
All women aged 15-19 years who are anaemic	62.2	70.8	59.1	
Children aged 12-23 months fully vaccinated, based on information from vaccination card only	92.5	90.8	83.8	3.3 & 3.4 Reduce death from NCD and CDs.
Children aged 9-35 months who had received a Vitamin-A dose in the last 6 months	75	68.4	71.2	
Men who have comprehensive knowledge of HIV/ AIDS	25.9	15.5	30.7	3.3 Reduce death from CDs.
Men who know that consistent condom use can reduce the chance of getting HIV/ AIDS	82.6	72.7	82	
Non-breastfeeding children aged 6-23 months who had received an adequate diet	25.7	17	12.7	--
Children aged 6-59 months who are anaemic (<11.0 g/ dl)	54.2	69	67.1	--
Non-pregnant women aged 15-49 years who are anaemic (<12.0 g/ dl)	62.8	71.7	57.2	--
Men aged 15-49 years who are anaemic (<13.0 g/ dl)	30.3	38.9	25	--
Men aged 15-19 years who are anaemic (<13.0 g/ dl)	31.7	38.7	31.1	--

Source: 4th and 5th National Family Health Survey

A list of health indicators, where the performance of the State of West Bengal was below the National level, are given below:

Table 9.2: Comparison of Key Health Indicators with the National Level

Key Health Indicators (SRS)	West Bengal		National	Impacted SDG Goals
	2016-18	2018-20	2018-20	
	(per 1,00,000 live births)			
Maternal Mortality Ratio (MMR)	98	103	97	3.1 Reduce MMR
Key Health Indicators (NFHS)	**West Bengal**		**National**	**Impacted SDG Goals**
	2015-16	**2019-20**	**2019-21**	
	(in *per cent*)			
Mothers who received postnatal care from a doctor/ nurse/ LHV/ ANM/ midwife/ other health personnel within 2 days of delivery	61.1	68	78	3.1 Reduce MMR
Pregnant women, age 15-49 years, who are anaemic (<11.0 g/ dl)	53.6	62.3	52.2	
All women age 15-49 years who are anaemic	62.5	71.4	57	
All women age 15-19 years who are anaemic	62.2	70.8	59.1	
Children who received postnatal care from a doctor/ nurse/ LHV/ ANM/ midwife/ other health personnel within 2 days of delivery	NA	76.8	79.1	3.2 Reduce NMR
Children age 6-59 months who are anaemic (<11.0 g/ dl)	54.2	69	67.1	
Home births that were conducted by skilled health personnel	6.8	2.6	3.2	3.1 Reduce MMR & 3.2 Reduce NMR
Female sterilization	29.3	29.4	37.9	3.7 Universal access to sexual and reproductive healthcare services including family planning.
Male sterilization	0.1	0.1	0.3	
Condom	5.9	7	9.5	
Health worker ever talked to female non-users about family planning	12.3	17.5	23.9	
Current users ever told about side effects of current family planning method	49.6	53.6	62.4	
For Women: Blood sugar level - high or very high (>140 mg/ dl) or taking medicine to control blood sugar level	NA	17.5	13.5	3.3 Reduce death from NCD
For Men: Blood sugar level - high or very high (>140 mg/ dl) or taking medicine to control blood sugar level	NA	21.3	15.6	
Moderately or severely elevated blood pressure (Systolic =160 mm of Hg and/ or Diastolic =100 mm of Hg)	NA	5.3	5.2	
Ever undergone a screening test for cervical cancer	NA	0.2	1.9	
Ever undergone a breast examination for breast cancer	NA	0.2	0.9	
Women: Ever undergone an oral cavity examination for oral cancer	NA	0.2	0.9	
Men: Ever undergone an oral cavity examination for oral cancer	NA	0.7	1.2	

Key Health Indicators (NFHS)	West Bengal		National	Impacted SDG Goals
	2015-16	2019-20	2019-21	
	(in *per cent*)			
Women who have comprehensive knowledge of HIV/ AIDS	18.6	18.5	21.6	3.4 Reduce death from CDs.
Men who have comprehensive knowledge of HIV/ AIDS	25.9	15.5	30.7	
Women who know that consistent condom use can reduce the chance of getting HIV/ AIDS	53.9	60.4	68.4	
Men who know that consistent condom use can reduce the chance of getting HIV/ AIDS	82.6	72.7	82	
Children aged 12-23 months who have received 3 doses of rotavirus vaccine	NA	1.8	36.4	3.3 & 3.4 Reduce death from NCD and CDs.
Children aged 9-35 months who received a Vitamin-A dose in the last 6 months	75	68.4	71.2	
Children under 6 months exclusively breastfed	52.3	53.3	63.7	--
Children under 5 years who are underweight (weight-for-age)	31.6	32.2	32.1	--
Women who have high risk waist-to-hip ratio (=0.85)	NA	74.7	56.7	--
Non-pregnant women, age 15-49 years, who are anaemic (<12.0 g/ dl)	62.8	71.7	57.2	--
Men age 15-49 years who are anaemic (<13.0 g/ dl)	30.3	38.9	25	--
Men age 15-19 years who are anaemic (<13.0 g/ dl)	31.7	38.7	31.1	--

Source: 4th and 5th National Family Health Survey

The above areas need to be addressed, on priority, in order to ensure the effectiveness of the healthcare interventions by the State.

Kolkata
The 28 OCT 2024

(BIBHUDUTTA BASANTIA)
Principal Accountant General (Audit-I)
West Bengal

Countersigned

New Delhi
The 30 OCT 2024

(GIRISH CHANDRA MURMU)
Comptroller and Auditor General of India

APPENDICES

Appendix 1.1

(Refer Paragraph 1.7)

List of selected Sub-Centres

District	Block	PHC	Name of test-checked Sub-Centre
Paschim Medinipur	Salboni	Godapiasal	Bhadutala
	Salboni	Godapiasal	Arabari
	Salboni	Pirakata	Garhmal
	Salboni	Pirakata	Satpati
	Sabang	Mohar	Lokepith
	Sabang	Mohar	Nimki Mohar
	Sabang	Kharika	Adasimla
	Sabang	Kharika	Kharika PHC attached
Bashirhat Health District (HD)	Rudrapur	Bajitpur	Aturia
	Rudrapur	Bajitpur	Paschim Joynagar
	Rudrapur	Masia	Kankrasuti
	Rudrapur	Masia	Buruj
	Sanderbill	Jogeshganj	Jogeshganj South
	Sanderbill	Jogeshganj	Sridharkati
	Sanderbill	Hingalganj	Boltala
	Sanderbill	Hingalganj	Bishpur
Uttar Dinajpur	Itahar	Surun	Surun
	Itahar	Surun	Indran
	Itahar	Marnai	Marnai
	Itahar	Marnai	Borote
	Kunor	Majhiar	Majhiar
	Kunor	Majhiar	Dilwarpur
Jalpaiguri	Mal (Odlabari BPHC)	Moulani	Chakmoulani
	Mal (Odlabari BPHC)	Moulani	Jharmatiali
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Anandpur Tea Estate
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Karaibari
	Nagrakata (Suklapara RH)	Dhumpara	Kalabari
	Nagrakata (Suklapara RH)	Dhumpara	Suklapara
	Nagrakata (Suklapara RH)	Looksan	Looksan
	Nagrakata (Suklapara RH)	Looksan	Hilla Tea Estate
Purulia	Purulia-II (Kustaur RH)	Chayanpur	Golamara
	Purulia-II (Kustaur RH)	Chayanpur	Chayanpur SSK
	Purulia-II (Kustaur RH)	Hutmura	Dhansura SSK
	Purulia-II (Kustaur RH)	Hutmura	Hutmura SSK
	Santuri (Muradih RH)	Santuri	Santuri
	Santuri (Muradih RH)	Santuri	Pirorgoria
	Santuri (Muradih RH)	Balitora	Balitora
	Santuri (Muradih RH)	Balitora	Dandahit

Appendix 2.1

(Refer Paragraph 2.3)

HR position of ANMs & Male Health Workers at test-checked PHCs and SCs ***(MIP as of March 2022)***

District(s)	Block	PHC	SC	Category of the SC (A/ B)	ANM/ Health Worker (Female) (MIP)	Health Worker (Male) (MIP)
Paschim Medinipur	Salboni	Godapiasal	Bhadutala	A	1	0
	Salboni	Godapiasal	Arabari	A	1	0
	Salboni	Pirakata	Garhmal	A	2	0
	Salboni	Pirakata	Satpati	A	2	0
	Sabang	Mohar	Lokepith	A	2	0
	Sabang	Mohar	Nimki Mohar	A	2	0
	Sabang	Kharika	Adasimla	A	2	0
	Sabang	Kharika	Kharika PHC attached	A	1	0
Bashirhat	Rudrapur	Bajitpur	Aturia	A	2	0
	Rudrapur	Bajitpur	Paschim Joynagar	A	2	0
	Rudrapur	Masia	Kankrasuti	A	2	0
	Rudrapur	Masia	Buruj	A	2	0
	Sanderbill	Jogeshganj	Jogeshganj South	A	2	0
	Sanderbill	Jogeshganj	Sridharkati	A	1	0
	Sanderbill	Hingalganj	Boltala	A	2	0
	Sanderbill	Hingalganj	Bishpur	A	1	0
Uttar Dinajpur	Itahar	Surun	Surun	A	2	0
	Itahar	Surun	Indran	A	2	0
	Itahar	Marnai	Marnai	A	2	0
	Itahar	Marnai	Borote	A	2	0
	Kunor	Majhiar	Majhiar	A	2	0
	Kunor	Majhiar	Dilwarpur	A	2	0
Jalpaiguri	Mal (Odlabari BPHC)	Moulani	Chakmoulani	A	2	0
	Mal (Odlabari BPHC)	Moulani	Jharmatiali	A	1	1
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Anandpur Tea Estate	A	1	1
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Karaibari	A	2	0
	Nagrakata (Suklapara RH)	Dhumpara	Kalabari	A	1	0
	Nagrakata (Suklapara RH)	Dhumpara	Suklapara	A	2	0
	Nagrakata (Suklapara RH)	Looksan	Looksan	A	1	0
	Nagrakata (Suklapara RH)	Looksan	Hilla Tea Estate	A	1	1

District(s)	Block	PHC	SC	Category of the SC (A/ B)	ANM/ Health Worker (Female) (MIP)	Health Worker (Male) (MIP)
Purulia	Purulia-II (Kustaur RH)	Chayanpur	Golamara	A	2	0
	Purulia-II (Kustaur RH)	Chayanpur	Chayanpur SSK	A	2	0
	Purulia-II (Kustaur RH)	Hutmura	Dhansura SSK	A	2	0
	Purulia-II (Kustaur RH)	Hutmura	Hutmura SSK	A	2	0
	Santuri (Muradih RH)	Santuri	Santuri	A	2	0
	Santuri (Muradih RH)	Santuri	Pirorgoria	A	1	0
	Santuri (Muradih RH)	Balitora	Balitora	A	1	0
	Santuri (Muradih RH)	Balitora	Dandahit	A	2	0

Source: Replies furnished by test-checked districts

Appendix 2.2

(Refer Paragraph 2.4)

HR position of MOs & Staff Nurses in test-checked PHCs

(MIP as of March 2022)

District(s)	Block	PHC	Category of the PHC (A/B)	Average deliveries per month	Medical Officer MBBS (MIP)	Nurse-midwife (Staff-Nurse) (MIP)
Paschim Medinipur	Salboni	Godapiasal	A	5	1	4
	Salboni	Pirakata	A	0	1	2
	Sabang	Mohar	A	0	1	3
	Sabang	Kharika	A	0	1	2
Bashirhat	Rudrapur	Bajitpur	A	0	1	1
	Rudrapur	Masia	A	0	1	1
	Sanderbill	Jogeshganj	A	18	2	5
	Sanderbill	Hingalganj	A	0	2	2
Uttar Dinajpur	Kunor	Majhiar	Non-bedded (A)	NA	0	1
	Itahar	Surun	Non-bedded (A)	NA	0	1
	Itahar	Marnai	A	4	2	3
Jalpaiguri	Mal (Odlabari BPHC)	Moulani	A	0	1	1
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	A	0	2	2
	Nagrakata (Suklapara RH)	Dhumpara	A	7	2	4
	Nagrakata (Suklapara RH)	Looksan	A	0	0	2
Purulia	Purulia-II (Kustaur RH)	Chayanpur	Non-bedded (A)	NA	0	2
	Purulia-II (Kustaur RH)	Hutmura	B	NA	0	2
	Santuri (Muradih RH)	Santuri	A	NA	0	3
	Santuri (Muradih RH)	Balitora	Non-bedded (A)	NA	0	1

Source: Replies furnished by test-checked districts

Appendix 2.3

(Refer Paragraph 2.4)

HR position of Pharmacists, Health Workers (Male/ Female), Health Assistants, Health Educators & Laboratory Technicians in test-checked PHCs ***(MIP as of March 2022)***

District(s)	Block	PHC	Pharmacist	Health Worker (F)	Health Assistant (M)	Health Assistant (F)/ Lady Health Visitor	Health Educator	Laboratory Technician
Paschim Medinipur	Salboni	Godapiasal	0	0	1	0	0	0
	Salboni	Pirakata	1	0	0	0	0	1 (Contractual)
	Sabang	Mohar	1	0	0	0	0	0
	Sabang	Kharika	1	0	0	0	0	1 (Contractual)
Bashirhat	Rudrapur	Bajitpur	0	0	0	0	0	1
	Rudrapur	Masia	1	0	0	0	0	0
	Sanderbill	Jogeshganj	1	0	0	0	0	1
	Sanderbill	Hingalganj	1	0	0	0	0	0
Uttar Dinajpur	Kunor	Majhiar	0	0	0	0	0	0
	Itahar	Surun	1	0	0	0	0	0
	Itahar	Marnai	0	0	0	0	0	1
Jalpaiguri	Mal (Odlabari BPHC)	Moulani	1	0	0	0	0	0
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	1	0	0	0	0	1
	Nagrakata (Suklapara RH)	Dhumpara	1	0	0	0	0	2
	Nagrakata (Suklapara RH)	Looksan	0	0	0	0	0	2
Purulia	Purulia-II (Kustaur RH)	Chayanpur	1	0	0	0	0	0
	Purulia-II (Kustaur RH)	Hutmura	1	0	0	0	0	0
	Santuri (Muradih RH)	Santuri	1	0	0	1	0	0
	Santuri (Muradih RH)	Balitora	0	0	0	0	0	0

Source: Replies furnished by test-checked districts;
Note: F-Female and M-Male

Appendix 2.4

(Refer Paragraph 2.5)

HR position of specialists and GDMOs in the test-checked CHCs

(MIP as of March 2022)

District(s)/ Health District(s)	BPHC/ RH	General Surgeon	Physician	Obstetrician & Gynaecologist	Paediatrician	Anaesthetist	General Duty Medical Officer
Sanctioned Strength		**1**	**1**	**1**	**1**	**1**	**2**
Jalpaiguri	Sulkapara RH (Nagrakata)	0	0	0	0	0	5
	Odlabari BPHC (Mal)	0	0	0	0	0	6
Uttar Dinajpur	Itahar RH	0	0	0	1	0	10
	Kunor BPHC (Kaliaganj)	0	0	0	0	0	3
Bashirhat Health District (HD)	Rudrapur RH (Baduria)	0	0	3	0	0	5
	Sandelerbil RH (Hingalganj)	0	0	0	0	0	3
Paschim Medinipur	Salboni RH	0	0	1	0	1	8
	Sabang RH	0	0	0	0	0	6
Purulia	Kushtor RH (Purulia II)	0	0	0	0	0	3
	Muradih RH (Santuri)	0	0	0	0	0	3

Source: Replies furnished by test-checked districts

Appendix 2.5

(Refer Paragraph 2.5)

HR position of Nursing and Paramedical staff in the test-checked CHCs

(MIP as on April 2022)

District(s)/ Health District(s)	BPHC/ RH	Staff Nurse	Pharmacist	Lab. Technician	Radiographer	Ophthalmic Assistant	OT Technician
Sanctioned Strength		**10**	**1**	**2**	**1**	**1**	**1**
Jalpaiguri	Sulkapara RH (Nagrakata)	15	3	3	0	0	0
	Odlabari BPHC (Mal)	19	1	2	1	1	0
Uttar Dinajpur	Itahar RH	16	6	2	1	1	0
	Kunor BPHC (Kaliaganj)	8	1	0	0	0	0
Bashirhat HD	Rudrapur RH (Baduria)	17	2	2	1	1	0
	Sandelerbil RH (Hingalganj)	9	2	2	0	1	0
Paschim Medinipur	Salboni RH	102	6	7	4	1	0
	Sabang RH	27	2	3	1	1	0
Purulia	Kushtor RH (Purulia II)	12	3	3	0	0	0
	Muradih RH (Santuri)	25	2	3	0	0	0

Source: Replies furnished by test-checked districts

Appendix 2.6

(Refer Paragraph 2.5)

HR position of Administrative and Support Staff in the test-checked CHCs ***(MIP as on April 2022)***

District(s)/ Health District(s)	BPHC/RH	Registration Clerk	Statistical Assistant/ Data Entry Operator	Accounts Assistant	Dresser (certified by Red Cross/ Johns Ambulance)	Ward Boys/ Nursing Orderly
Sanctioned Strength		**2**	**2**	**1**	**1**	**5**
Jalpaiguri	Sulkapara RH (Nagrakata)	1	3	0	0	0
	Odlabari BPHC (Mal)	0	0	0	0	0
Uttar Dinajpur	Itahar RH	0	2	1	0	0
	Kunor BPHC (Kaliaganj)	0	0	0	0	0
Bashirhat HD	Rudrapur RH (Baduria)	0	0	0	0	0
	Sandelerbil RH (Hingalganj)	0	0	0	0	0
Paschim Medinipur	Salboni RH	2	0	0	0	0
	Sabang RH	0	2	0	0	17
Purulia	Kushtor RH (Purulia II)	1	1	0	0	0
	Muradih RH (Santuri)	0	1	0	0	0

Source: Replies furnished by test-checked districts

Appendix 2.7

(Refer Paragraph 2.5)

HR position of Block Level Medical Personnel in BPHU

District(s)/ Health District(s)	BPHC/ RH	Block Health Officer/ Medical Superintendent	Public Health Specialist/ Manager	Public Health Nurse (PHN)
Sanctioned Strength		**1**	**1**	**1**
Jalpaiguri	Sulkapara RH (Nagrakata)	1	0	2
	Odlabari BPHC (Mal)	1	0	2
Uttar Dinajpur	Itahar RH	1	0	3
	Kunor BPHC (Kaliaganj)	1	0	1
Bashirhat HD	Rudrapur RH (Baduria)	1	0	1
	Sandelerbil RH (Hingalganj)	1	0	1
Paschim Medinipur	Salboni RH	1	0	2
	Sabang RH	0	0	1
Purulia	Kushtor RH (Purulia II)	1	0	1
	Muradih RH (Santuri)	1	0	1

Source: Replies furnished by test-checked districts

Appendix 2.8

(Refer Paragraph 2.6.1)

Speciality-wise HR position of MOs in District Hospitals

Facility Name	Medicine			Surgery			Obstetrics & Gynaecology			Dermatology/ Venerology			Paediatric			Anesthethesiology			ENT			Opthalmology		
	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage
Barasat DH	4	4	0	5	5	0	7	7	0	2	2	0	5	5	0	5	5	0	3	3	0	3	4	-1
Basirhat DH	7	7	0	3	4	-1	8	6	2	2	2	0	4	5	-1	8	4	4	2	6	-4	2	4	-2
M. R. Bangur DH	9	3	6	9	1	8	11	7	4	1	1	0	10	3	7	7	5	2	2	2	0	2	3	-1
Alipurduar DH	6	5	1	4	2	2	6	3	3	2	0	2	4	3	1	5	3	2	2	2	0	2	0	2
Bishnupur DH	5	4	1	5	3	2	6	5	1	2	0	2	4	3	1	7	2	5	3	2	1	3	2	1
Suri DH	6	3	3	6	6	0	8	6	2	1	1	0	6	6	0	8	5	3	4	3	1	4	2	2
Darjeeling DH	4	3	1	4	2	2	5	3	2	1	2	-1	4	3	1	3	1	2	3	2	1	3	2	1
Siliguri DH	4	3	1	4	2	2	9	4	5	2	1	1	4	5	-1	8	4	4	2	2	0	2	2	0
Balurghat DH	6	3	3	5	4	1	12	6	6	3	2	1	5	4	1	10	3	7	4	2	2	4	3	1
Imambara DH	5	3	2	4	4	0	6	5	1	2	1	1	4	9	-5	4	7	-3	2	3	-1	2	2	0
Howrah DH	7	6	1	5	4	1	7	7	0	2	1	1	6	6	0	9	5	4	4	3	1	2	1	1
Jalpaiguri DH	8	3	5	8	6	2	8	3	5	4	1	3	8	6	2	6	5	1	4	3	1	4	3	1
Jhargram DH	6	3	3	6	6	0	8	7	1	2	1	1	6	6	0	8	4	4	3	3	0	2	2	0
Kalimpong DH	4	2	2	4	1	3	4	4	0	2	1	1	3	2	1	4	2	2	2	1	1	2	2	0
Tamluk DH	4	4	0	4	3	1	4	8	-4	1	2	-1	1	6	-5	4	4	0	1	2	-1	2	3	-1
Nadia DH	4	4	0	4	4	0	6	9	-3	1	1	0	3	7	-4	4	5	-1	2	2	0	2	3	-1

Facility Name	Medicine			Surgery			Obstetrics & Gynaecology			Dermatology/ Venerology			Paediatric			Anesthethesiology			ENT			Opthalmology		
	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage
Asansol DH	5	5	0	5	6	-1	6	6	0	2	3	-1	5	9	-4	7	5	2	3	3	0	5	3	2
Nandigram DH	3	0	3	4	1	3	3	3	0	1	1	0	4	4	0	3	2	1	2	2	0	4	2	2
Total	**97**	**65**	**32**	**89**	**64**	**25**	**124**	**99**	**25**	**33**	**23**	**10**	**86**	**92**	**-6**	**110**	**71**	**39**	**48**	**46**	**2**	**50**	**43**	**7**

Facility Name	Orthopaedic			Radiology			Pathology			General Duty MO			Dental			Forensic			Microbiology			Ayush			Psychiatry		
	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage
Barasat DH	3	3	0	2	3	-1	1	1	0	18	10	8	2	2	0	1	1	0	1	1	0	0	0	0	2	2	0
Basirhat DH	2	3	-1	5	1	4	4	0	4	23	2	21	4	4	0	2	1	1	1	0	1	4	0	4	2	2	0
M. R. Bangur DH	8	2	6	7	1	6	7	3	4	30	9	21	5	3	2	0	0	0	6	2	4	2	1	1	1	1	0
Alipurduar DH	2	2	0	2	0	2	2	2	0	15	5	10	2	1	1	2	0	2	1	1	0	3	3	0	2	2	0
Bishnupur DH	3	1	2	3	0	3	3	2	1	19	6	13	0	0	0	0	0	0	2	0	2	0	0	0	2	2	0
Suri DH	6	4	2	5	1	4	3	1	2	15	8	7	3	3	0	2	1	1	1	1	0	1	1	0	2	2	0
Darjeeling DH	3	1	2	2	1	1	3	1	2	13	8	5	2	2	0	1	0	1	1	0	1	2	1	1	1	1	0
Siliguri DH	2	1	1	2	2	0	1	1	0	25	6	19	2	2	0	0	0	0	1	1	0	1	1	0	1	0	1

Facility Name	Orthopaedic			Radiology			Pathology			General Duty MO			Dental			Forensic			Microbiology			Ayush			Psychiatry		
	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage	SS	MIP	Shortage
Balurghat DH	5	4	1	4	2	2	2	2	0	14	6	8	3	3	0	1	1	0	2	1	1	4	1	3	3	2	1
Imambara DH	2	2	0	2	2	0	2	2	0	15	8	7	0	2	-2	0	1	-1	1	1	0	0	1	-1	2	2	0
Howrah DH	3	2	1	2	2	0	3	2	1	17	17	0	2	2	0	2	2	0	1	0	1	0	0	0	3	3	0
Jalpaiguri DH	4	2	2	4	1	3	8	5	3	24	14	10	6	4	2	2	0	2	2	1	1	2	1	1	4	2	2
Jhargram DH	2	0	2	5	2	3	4	4	0	24	9	15	4	4	0	1	1	0	1	1	0	4	1	3	1	1	0
Kalimpong DH	2	1	1	2	1	1	2	0	2	17	11	6	3	3	0	1	1	0	1	0	1	2	2	0	2	0	2
Tamluk DH	2	3	-1	1	1	0	3	6	-3	15	8	7	2	1	1	1	1	0	1	1	0	1	1	0	1	1	0
Nadia DH	2	5	-3	2	2	0	3	3	0	8	8	0	1	2	-1	1	0	1	1	1	0	1	1	0	2	2	0
Asansol DH	5	3	2	3	3	0	3	7	-4	25	6	19	0	3	-3	0	1	-1	2	1	1	0	4	-4	2	2	0
Nandigram DH	2	1	1	2	1	1	1	0	1	12	4	8	3	3	0	2	0	2	1	1	0	2	0	2	1	1	0
Barasat DH	58	40	18	55	26	29	55	42	13	329	145	184	44	44	0	19	11	8	27	14	13	29	19	10	34	28	6

Source: HMIS data

Appendix 2.9

(Refer Paragraph 2.6.1)

Average Surgery per Surgeon in FY 2021-22 in District Hospitals

Facility Name	Total Surgeries					Total number of Surgery	Average Number of Surgeon	Average Surgery per Surgeon
	General Surgery Department	Gynaecology & Obstetrics	Ophthalmology	ENT	Orthopaedics			
Barasat DH	356	278	1,477	31	78	2,220	28	79
Basirhat DH	147	270	290	147	54	908	24	38
M. R. Bangur DH	00	12	00	00	00	12	2	6
Alipurduar DH	273	175	316	154	65	983	16	61
Bishnupur DH	2181	661	2,074	154	176	5,246	17	308
Suri DH	219	195	581	224	554	1,773	20	89
Darjeeling DH	52	48	117	32	34	283	13	22
Siliguri DH	116	48	554	215	19	952	16	60
Balurghat DH	397	510	755	156	426	2,244	17	132
Imambara DH	980	1,752	467	93	112	3,404	16	213
Howrah DH	471	149	550	43	514	1,727	20	86
Jalpaiguri DH	1,483	331	1,855	83	227	3,979	21	189
Jhargram DH	154	40	470	5	47	716	16	45
Kalimpong DH	NA	NA	NA	NA	NA	NA	NA	NA
Tamluk DH	92	236	562	10	85	985	17	58
Nadia DH	3,197	1,296	1,664	238	1,321	7,716	26	297
Asansol DH	1,477	484	1,530	696	863	5,050	23	220
Nandigram DH	438	149	52	3	1,020	1,662	10	166

Source: Key Performance Indicator data as furnished by H&FW Department

Appendix 3.1

{Refer Paragraph 3.1.1 (i)}

Inadequate Monthly Meetings

Sl. No.	District	Block	PHC	SC	No. of monthly meetings held by ANM, with ASHA, from FY 2016-17 to FY 2021-22 (at least 72 meetings in six years)
1.	**Paschim Medinipur**	Salboni	Godapiasal	Bhadutala	60
2.		Salboni	Godapiasal	Arabari	48
3.		Salboni	Pirakata	Garhmal	60
4.		Salboni	Pirakata	Satpati	60
5.		Sabang	Kharika	Kharika PHC attached	68
6.	**Bashirhat HD**	Rudrapur	Bajitpur	Paschim Joynagar	71
7.		Rudrapur	Masia	Kankrasuti	71
8.		Rudrapur	Masia	Buruj	68
9.	**Uttar Dinajpur**	Itahar	Surun	Indran	71
10.		Itahar	Marnai	Marnai	58
11.		Itahar	Marnai	Borote	58
12.	**Jalpaiguri**	Nagrakata (Sulkapara RH)	Dhumpara	Sulkapara	61
13.	**Purulia**	Santuri (Muradih RH)	Santuri	Santuri	24

Source: Replies furnished by test-checked districts

Appendix 3.2

{Refer Paragraph 3.1.1 (i)}

Inadequate Weekly Meetings

Sl. No.	District	Block	PHC	SC	No. of weekly meetings held by ANM, with ASHA, from FY 2016-17 to FY 2021-22 (at least 312 meetings in six years)
1.	**Paschim Medinipur**	Salboni	Godapiasal	Bhadutala	251
2.		Salboni	Godapiasal	Arabari	297
3.		Salboni	Pirakata	Garhmal	260
4.		Salboni	Pirakata	Satpati	260
5.		Sabang	Mohar	Lokepith	288
6.		Sabang	Mohar	Nimki Mohar	288
7.		Sabang	Kharika	Adasimla	288
8.		Sabang	Kharika	Kharika PHC attached	285
9.	**Bashirhat HD**	Rudrapur	Bajitpur	Aturia	288
10.		Rudrapur	Bajitpur	Paschim Joynagar	284
11.		Rudrapur	Masia	Kankrasuti	288
12.		Rudrapur	Masia	Buruj	396[197]
13.		Sanderbill	Jogeshganj	Jogeshganj South	96
14.		Sanderbill	Jogeshganj	Sridharkati	0
15.		Sanderbill	Hingalganj	Boltala	288
16.		Sanderbill	Hingalganj	Bishpur	144
17.	**Uttar Dinajpur**	Itahar	Surun	Indran	296
18.		Itahar	Marnai	Marnai	244
19.		Itahar	Marnai	Borote	244
20.		Kunor	Majhiar	Dilwarpur	275
21.	**Jalpaiguri**	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Anandpur Tea Estate	0
22.		Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Karaibari	288
23.		Nagrakata (Suklapara RH)	Dhumpara	Kalabari	288
24.		Nagrakata (Sulkapara RH)	Dhumpara	Sulkapara	280
25.		Nagrakata (Sulkapara RH)	Looksan	Looksan	288
26.		Nagrakata (Suklapara RH)	Looksan	Hilla Tea Estate	96
27.	**Purulia**	Santuri (Muradih RH)	Santuri	Pirorgoria	288
28.		Santuri (Muradih RH)	Balitora	Dandahit	288

Source: Replies furnished by test-checked districts

[197] *In 2020-21 only 36 meetings were held*

Appendix 3.3

{Refer Paragraph 3.1.1 (ii) B}

ANC Check-ups in SCs

Sl. No.	District	Block	PHC	SC	No. of mothers registered during 2016-17 to 2021-22	No. of mothers registered within first Trimester	No. of registered mothers who received 4 ANC check-ups during 2016-17 to 2021-22	No. of pregnant mothers whose BP was monitored	No. of pregnant mothers whose Hb was monitored	No. of pregnant mothers whose urine was examined for sugar and protein	No. of pregnant mothers given 2nd dose of TT
1.	**Paschim Medinipur**	Salboni	Godapiasal	Bhadutala	615	607	443	575	575	575	581
2.		Salboni	Godapiasal	Arabari	464	463	418	457	457	457	7
3.		Salboni	Pirakata	Garhmal	392	384	348	392	392	392	372
4.		Salboni	Pirakata	Satpati	575	578	477	575	575	575	46
5.		Sabang	Mohar	Lokepith	586	569	533	586	586	586	530
6.		Sabang	Mohar	Nimki Mohar	868	826	751	868	868	868	812
7.		Sabang	Kharika	Adasimla	509	472	436	436	436	436	470
8.		Sabang	Kharika	Kharika PHC attached	543	524	416	543	509	495	453
9.	**Bashirhat HD**	Rudrapur	Bajitpur	Aturia	627	610	571	627	627	628	609
10.		Rudrapur	Bajitpur	Paschim Joynagar	786	757	709	781	781	771	781
11.		Rudrapur	Masia	Kankrasuti	730	720	711	729	729	729	730
12.		Rudrapur	Masia	Buruj	840	811	709	830	692	796	786
13.		Sanderbill	Jogeshganj	Jogeshganj South	311	303	274	311	311	311	23
14.		Sanderbill	Jogeshganj	Sridharkati	537	502	478	537	537	537	27
15.		Sanderbill	Hingalganj	Boltala	469	432	361	469	469	469	459
16.		Sanderbill	Hingalganj	Bishpur	550	525	506	550	550	550	513
17.	**Uttar Dinajpur**	Itahar	Surun	Surun	870	815	807	870	870	870	199
18.		Itahar	Surun	Indran	810	761	702	810	810	810	254

Sl. No.	District	Block	PHC	SC	No. of mothers registered during 2016-17 to 2021-22	No. of mothers registered within first Trimester	No. of registered mothers who received 4 ANC check-ups during 2016-17 to 2021-22	No. of pregnant mothers whose BP was monitored	No. of pregnant mothers whose Hb was monitored	No. of pregnant mothers whose urine was examined for sugar and protein	No. of pregnant mothers given 2nd dose of TT
19.		Itahar	Marnai	Marnai	923	891	763	923	923	923	242
20.		Itahar	Marnai	Borote	1,227	1,142	1,081	1,227	1,227	1,227	242
21.		Kunor	Majhiar	Majhiar	565	537	502	565	565	565	67
22.		Kunor	Majhiar	Dilwarpur	782	717	713	746	746	746	119
23.	**Jalpaiguri**	Mal (Odlabari BPHC)	Moulani	Chakmoulani	668	632	600	596	596	596	629
24.		Mal (Odlabari BPHC)	Moulani	Jharmatiali	441	388	300	426	426	426	398
25.		Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Anandpur Tea Estate	473	381	304	468	468	468	443
26.		Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Karaibari	773	719	687	773	776	470	655
27.		Nagrakata (Suklapara RH)	Dhumpara	Kalabari	591	544	520	591	591	514	481
28.		Nagrakata (Sulkapara RH)	Dhumpara	Sulkapara	622	567	566	619	619	619	558
29.		Nagrakata (Sulkapara RH)	Looksan	Looksan	689	645	641	620	620	620	92
30.		Nagrakata (Suklapara RH)	Looksan	Hilla Tea Estate	188	180	155	188	188	177	9
31.	**Purulia**	Purulia-II (Kustaur RH)	Chayanpur	Golamara	763	641	596	663	663	663	663

Sl. No.	District	Block	PHC	SC	No. of mothers registered during 2016-17 to 2021-22	No. of mothers registered within first Trimester	No. of registered mothers who received 4 ANC check-ups during 2016-17 to 2021-22	No. of pregnant mothers whose BP was monitored	No. of pregnant mothers whose Hb was monitored	No. of pregnant mothers whose urine was examined for sugar and protein	No. of pregnant mothers given 2nd dose of TT
32.		Purulia-II (Kustaur RH)	Chayanpur	Chayanpur SSK	650	587	606	654	654	654	654
33.		Purulia-II (Kustaur RH)	Hutmura	Dhansura SSK	800	777	707	800	800	800	800
34.		Purulia-II (Kustaur RH)	Hutmura	Hutmura SSK	1,409	1,318	1,206	1,409	1,409	1,409	1,409
35.		Santuri (Muradih RH)	Santuri	Santuri	537	523	474	529	529	529	496
36.		Santuri (Muradih RH)	Santuri	Pirorgoria	441	422	371	441	441	441	413
37.		Santuri (Muradih RH)	Balitora	Balitora	666	642	539	539	862	539	564
38.		Santuri (Muradih RH)	Balitora	Dandahit	444	428	369	433	433	433	400
				Total	**24,734**	**23,340**	**21,350**	**24,156**	**24,310**	**23,674**	**16,986**

Source: Replies furnished by test-checked districts

Appendix 3.4

{Refer Paragraphs 3.1.1 (ii) C & 3.1.1 (ii) E}

Home Deliveries and PNC visits

Sl. No.	District	Block	PHC	SC	Total No. of Home Deliveries	No. of Home deliveries by ANMs	Total No. of deliveries in Sub-centre areas[198]	No. of post-natal visits (within 7-10 days) paid	Total No. of post-natal visits paid on the 42nd day
1.	**Paschim Medinipur**	Salboni	Godapiasal	Bhadutala	0	0	524	475	455
2.		Salboni	Godapiasal	Arabari	0	0	432	247	249
3.		Salboni	Pirakata	Garhmal	0	0	292	243	198
4.		Salboni	Pirakata	Satpati	0	0	515	367	381
5.		Sabang	Mohar	Lokepith	10	10	532	562	436
6.		Sabang	Mohar	Nimki Mohar	0	0	773	811	811
7.		Sabang	Kharika	Adasimla	9	9	456	342	340
8.		Sabang	Kharika	Kharika PHC attached	27	27	460	308	291
9.	**Bashirhat HD**	Rudrapur	Bajitpur	Aturia	5	0	586	0	294
10.		Rudrapur	Bajitpur	Paschim Joynagar	9	0	731	562	562
11.		Rudrapur	Masia	Kankrasuti	1	0	663	435	408
12.		Rudrapur	Masia	Buruj	6	0	745	520	633
13.		Sanderbill	Jogeshganj	Jogeshganj South	3	0	273	273	253
14.		Sanderbill	Jogeshganj	Sridharkati	7	0	502	417	446
15.		Sanderbill	Hingalganj	Boltala	6	0	446	373	357
16.		Sanderbill	Hingalganj	Bishpur	7	0	532	416	427
17.		Itahar	Surun	Surun	104	0	995	0	124

[198] *Sub-centre area is the area under the jurisdiction of the SC. The data in regard to number of deliveries within the area under the jurisdiction of the Sub-centres has been obtained from the records of the SCs. Total deliveries includes home deliveries*

Sl. No.	District	Block	PHC	SC	Total No. of Home Deliveries	No. of Home deliveries by ANMs	Total No. of deliveries in Sub-centre areas[198]	No. of post-natal visits (within 7-10 days) paid	Total No. of post-natal visits paid on the 42nd day
18.	**Uttar Dinajpur**	Itahar	Surun	Indran	59	0	735	279	230
19.		Itahar	Marnai	Marnai	19	0	896	0	105
20.		Itahar	Marnai	Borote	116	0	1,140	0	814
21.		Kunor	Majhiar	Majhiar	14	0	622	0	536
22.		Kunor	Majhiar	Dilwarpur	23	0	720	0	338
23.	**Jalpaiguri**	Mal (Odlabari BPHC)	Moulani	Chakmoulani	1	0	589	489	591
24.		Mal (Odlabari BPHC)	Moulani	Jharmatiali	2	0	387	387	368
25.		Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Anandpur Tea Estate	15	0	455	445	441
26.		Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	Karaibari	8	0	653	563	653
27.		Nagrakata (Suklapara RH)	Dhumpara	Kalabari	0	0	680	560	512
28.		Nagrakata (Sulkapara RH)	Dhumpara	Sulkapara	2	2	596	592	592
29.		Nagrakata (Sulkapara RH)	Looksan	Looksan	1	1	310	291	291
30.		Nagrakata (Suklapara RH)	Looksan	Hilla Tea Estate	0	0	428	424	424
31.	**Purulia**	Purulia-II (Kustaur RH)	Chayanpur	Golamara	0	0	Not Furnished	Not Furnished	Not Furnished

Sl. No.	District	Block	PHC	SC	Total No. of Home Deliveries	No. of Home deliveries by ANMs	Total No. of deliveries in Sub-centre areas[198]	No. of post-natal visits (within 7-10 days) paid	Total No. of post-natal visits paid on the 42nd day
32.		Purulia-II (Kustaur RH)	Chayanpur	Chayanpur SSK	0	0	Not Furnished	Not Furnished	Not Furnished
33.		Purulia-II (Kustaur RH)	Hutmura	Dhansura SSK	0	0	Not Furnished	Not Furnished	Not Furnished
34.		Purulia-II (Kustaur RH)	Hutmura	Hutmura SSK	0	0	Not Furnished	Not Furnished	Not Furnished
35.		Santuri (Muradih RH)	Santuri	Santuri	0	0	551	451	478
36.		Santuri (Muradih RH)	Balitora	Balitora	0	0	674	436	447
37.		Santuri (Muradih RH)	Balitora	Dandahit	0	0	457	377	353
38.		Santuri (Muradih RH)	Santuri	Pirorgoria	0	0	504	328	329
				Total	**454**	**49**	**19,854**	**11,973**	**14,167**

Source: Replies furnished by test-checked districts

Appendix 3.5

{Refer Paragraph 3.1.2 (i) B}

Sanctioned and Functional Beds in the test-checked PHCs

Sl. No.	District	Block	PHC	No. of sanctioned beds	No. of functional beds
1.	**Paschim Medinipur**	Salboni	Godapiasal	10	10
2.		Salboni	Pirakata	0	0
3.		Sabang	Mohar	10	10
4.		Sabang	Kharika	0	0
5.	**Bashirhat HD**	Rudrapur	Bajitpur	6	0
6.		Rudrapur	Masia	6	0
7.		Sanderbill	Jogeshganj	10	10
8.		Sanderbill	Hingalganj	10	10
9.	**Uttar Dinajpur**	Kunor	Majhiar	0	0
10.		Itahar	Marnai	10	10
11.		Itahar	Surun	0	0
12.	**Jalpaiguri**	Mal (Odlabari BPHC)	Moulani	0	0
13.		Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	6	6
14.		Nagrakata (Suklapara RH)	Dhumpara	10	10
15.		Nagrakata (Suklapara RH)	Looksan	10	0
16.	**Purulia**	Purulia-II (Kustaur RH)	Chayanpur	0	0
17.		Purulia-II (Kustaur RH)	Hutmura	10	0
18.		Santuri (Muradih RH)	Santuri	10	0
19.		Santuri (Muradih RH)	Balitora	0	0
	Total			**108**	**66**

Source: Replies furnished by test-checked districts

Appendix 3.6

{Refer Paragraph 3.1.2 (i) C 1}

ANC check-ups in the test-checked PHCs

Sl. No.	District	Block	PHC	Total no. of mothers registered during FYs 2016-17 to 2021-22	Total no. of mothers registered during the first trimester, during FYs 2016-17 to 2021-22	No. of mothers who received 4 ANC check-ups	No. of mothers checked by MO, PHC, at least once, on 3rd ANC	No. of pregnant mothers whose BP was monitored	No. of pregnant mothers whose Hb was monitored	No. of pregnant mothers whose urine was examined for sugar and protein	No. of pregnant mothers who were given 2nd dose of TT
1.	Paschim Medinipur	Salboni	Godapiasal	4,338	4,297	1,888	3,549	4,297	4,297	4,297	4,297
2.		Salboni	Pirakata	4,705	4,628	3,798	3,352	4,612	4,612	4,612	3,683
3.		Sabang	Mohar	6,361	6,092	5,616	Not Furnished	6,361	6,361	6,361	5,776
4.		Sabang	Kharika	4,974	4,700	4,001	2,591	4,974	4,974	4,974	4,527
5.	Bashirhat HD	Rudrapur	Bajitpur	7,607	7,244	6,993	Not Furnished	7,386	7,386	7,386	7,240
6.		Rudrapur	Masia	3,539	3,462	3,275	Not Furnished	3,525	3,442	3,501	3,497
7.		Sanderbill	Jogeshganj	4,256	4,102	3,882	Not Furnished	4,071	4,068	4,341	3,061
8.		Sanderbill	Hingalganj	2,423	2,337	2,195	1,045	2,443	2,441	2,451	2,302
9.	Uttar Dinajpur	Kunor	Majhiar	2,265	1,997	1,877	1,927	2,265	1,928	2,265	Not Furnished
10.		Itahar	Marnai	8,003	7,504	6,662	6,419	8,245	7,894	7,092	4,841
11.		Itahar	Surun	6,377	5,987	5,467	2,579	6,141	6,112	6,112	1,462
12.	Purulia	Purulia-II (Kustaur RH)	Chayanpur	7,919	7,502	7,031	Not Furnished	127	6,474	Not Furnished	3,217
13.		Purulia-II (Kustaur RH)	Hutmura	6,931	6,601	5,882	Not Furnished	44	5,458	Not Furnished	2,987
14.		Santuri (Muradih RH)	Santuri	3,120	2,929	2,552	Not Furnished	1	2,651	Not Furnished	2,987
15.		Santuri (Muradih RH)	Balitora	1,831	1,730	1,490	Not Furnished	12	1,510	Not Furnished	489
	Total			**74,649**	**71,112**	**62,609**	**21,462**	**54,504**	**69,608**	**53,392**	**50,366**

Source: Replies furnished by test-checked districts

Appendix 3.7

{Refer Paragraph 3.1.3 (ii)}

Intra-Natal Care (RHs & BPHCs)

District	BPHC/ RH	Financial Year	Deliveries conducted (including C-Sections)	Women discharged within 48 hours of delivery	Percentage of mothers discharged within 48 hours
Jalpaiguri	Sulkapara RH (Nagrakata)	2016-17	1,502	1,502	100
	Sulkapara RH (Nagrakata)	2017-18	1,392	1,392	100
	Sulkapara RH (Nagrakata)	2018-19	1,212	1,212	100
	Sulkapara RH (Nagrakata)	2019-20	1,166	1,166	100
	Sulkapara RH (Nagrakata)	2020-21	1,033	1,033	100
	Sulkapara RH (Nagrakata)	2021-22	782	782	100
	Odlabari BPHC (Mal)	2016-17	0	0	100
	Odlabari BPHC (Mal)	2017-18	122	122	100
	Odlabari BPHC (Mal)	2018-19	464	31	6.68
	Odlabari BPHC (Mal)	2019-20	588	144	24.49
	Odlabari BPHC (Mal)	2020-21	518	44	8.49
	Odlabari BPHC (Mal)	2021-22	488	33	6.76
Uttar Dinajpur	Itahar RH	2016-17	1,305	38	2.91
	Itahar RH	2017-18	1,694	0	0
	Itahar RH	2018-19	1,787	30	1.68
	Itahar RH	2019-20	1,587	1	0.06
	Itahar RH	2020-21	1,755	8	0.46
	Itahar RH	2021-22	1,234	0	0
	Kunor BPHC (Kaliaganj)	2016-17	148	0	0
	Kunor BPHC (Kaliaganj)	2017-18	314	0	0
	Kunor BPHC (Kaliaganj)	2018-19	560	0	0

District	BPHC/ RH	Financial Year	Deliveries conducted (including C-Sections)	Women discharged within 48 hours of delivery	Percentage of mothers discharged within 48 hours
	Kunor BPHC (Kaliaganj)	2019-20	540	0	0
	Kunor BPHC (Kaliaganj)	2020-21	3,993	0	0
	Kunor BPHC (Kaliaganj)	2021-22	3,471	15	0.43
Bashirhat HD	Rudrapur RH (Baduria)	2019-20	378	3	0.8
	Rudrapur RH (Baduria)	2020-21	453	0	0
Paschim Medinipur	Salboni RH	2016-17	972	25	2.57
	Salboni RH	2017-18	1,005	28	2.78
	Salboni RH	2018-19	1,427	32	2.24
	Salboni RH	2019-20	1,170	23	1.96
	Salboni RH	2020-21	896	28	2.2
	Salboni RH	2021-22	921	22	2.3
	Sabang RH	2016-17	283	0	0
	Sabang RH	2017-18	563	0	0
	Sabang RH	2018-19	762	0	0
	Sabang RH	2019-20	618	0	0
	Sabang RH	2020-21	345	0	0
	Sabang RH	2021-22	443	0	0

Source: Replies furnished by test-checked districts

Appendix 3.8

{Refer Paragraph-3.1.4 (ii)}

Availability of Services in District Hospitals

Facility Name	Medicine	Surgery	O&G	Paediatrics	Emergency	ICU	Anaesthesia	Ophthalmology	ENT	Orthopaedics	Dental	Public Health Management	Radiology	Psychiatry
Barasat DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Basirhat DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
M. R. Bangur DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Alipurduar DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bishnupur DH*	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Suri DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Darjeeling DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Siliguri DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Balurghat DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Imambara DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Howrah DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Jalpaiguri DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Jhargram DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kalimpong DH	Yes	Yes	Yes	**NA**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**NA**	Yes	**NA**
Tamluk DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nadia DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes
Asansol DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nandigram DH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes

Source: HMIS data

**Note: Data not available in HMIS pertaining to Bishnupur DH*

Appendix 3.9

{Refer Paragraph-3.1.4 (ii)}

Availability of Services in Sub-Divisional Hospitals

Facility Name	Medicine	Surgery	O&G	Paediatrics	Anaesthesia	Orthopaedics	ENT	Radiology	Ophthalmology	Community Health	Dental	Emergency	AYUSH
DR BN BOSE (Barrackpore) SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	**No**
Bongaon SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Salt Lake SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Baruipur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Canning SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Kakdwip SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	**No**	Yes	Yes	Yes
Khatra SDH	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	**No**	Yes	Yes	**No**
Bolpur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Dinhata SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mathabhanga SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes
Mekhliganj SDH	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tufanganj SDH	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**	Yes	Yes	Yes
Kurseong SDH	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gangarampur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Islampur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Arambagh SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Serampore SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Chandannagore SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Uluberia SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Mal SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	**No**	Yes	Yes	Yes
Chanchal SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes
Contai SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Egra SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Haldia SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Ghatal SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Kharagpur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Domkol SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**
Kandi SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lalbagh SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**
Jangipur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**
Ranaghat SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	**No**
Tehatta SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Durgapur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kalna SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Katwa SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Raghunathpur SDH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes

Source: HMIS data

Appendix 3.10

{Refer Paragraph 3.1.4 (iii)}

Availability of Maternal and Child Care Services and bed strengths in the DHs

Name of the DHs	Availability of Maternity & Child Care Services	Functional Bed Strength						
		Maternity Ward	Labour Room	OT	Post-Operative Ward	Neonatal Ward	SNCU	Child Ward
Barasat DH	Yes	128	5	10	100	NA	37	56
Basirhat DH & SSH	Yes	40	6	3	1	0	25	50
M. R. Bangur DH & SSH	Yes	71	5	4	2	15	33	31
Alipurduar DH	Yes	161	6	4	4	0	30	50
Bishnupur DH & SSH	Yes	97	3	4	2	0	20	40
Suri DH & SSH	Yes	183	7	11	22	0	42	51
Darjeeling DH	Yes	49	4	7	10	5	13	30
Siliguri DH	Yes	27	3	9	45	0	26	43
Balurghat DH & SSH	Yes	120	7	9	40	10	20	60
Imambara DH	Yes	141	6	7	5	0	29	48
Howrah DH	Yes	62	5	6	2	8	21	46
Jalpaiguri DH	Yes	330	4	16	20	10	26	70
Jhargram DH	Yes	104	3	3	170	0	21	49
Kalimpong DH	Yes	51	2	5	6	0	5	30
Tamluk DH	Yes	128	3	4	40	0	20	24
Nadia DH	Yes	112	5	7	188	16	18	56
Asansol DH & SSH	Yes	129	6	7	8	0	52	42

Source: Reply furnished by H&FW Department; Note: Though Maternity & Child services were available in Nandigram DH. Bed Strength was not available. Hence excluded from Appendix

Appendix 3.11

(Refers Paragraph 3.2.1)

Non-availability of Diagnostic Tests at CHCs

Sl. No.	Districts	BPHCs/ RHs	Haematology		Urine & stool analysis		Pathology & Microbiology		Serology & Cardiology		Biochemistry		Opthalmology & Radiology		Total essential variety of tests	Total of varieties not available	Percentage of test facility not available	Records/register related to Down time of critical lab equipment mainteind?	Turn Around Time (TAT) Calculated	TAT for emergency investigations calculated?
			Essential variety of tests	Varieties not available	Essential variety of tests	Varieties not available	Essential variety of tests	Varieties not available	Essential variety of tests	Varieties not available	Essential variety of tests	Varieties not available	Essential variety of tests	Varieties not available						
1.	**Jalpaiguri**	Sulkapara RH (Nagrakata)	14	9	3	3	4	3	4	3	5	4	6	5	36	27	75.00	N	N	N
2.		Odlabari BPHC (Mal)	14	4	3	2	4	3	4	2	5	0	6	4	36	15	41.67	N	N	N
3.	**Uttar**	Itahar RH	14	10	3	2	4	3	4	4	5	4	6	2	36	25	69.44	N	N	N
4.	**Dinajpur**	Kunor BPHC (Kaliaganj)	14	13	3	3	4	2	4	3	5	4	6	6	36	31	86.11	N	N	N
5.	**Bashirhat HD**	Rudrapur RH (Baduria)	14	6	3	3	4	3	4	1	5	4	6	4	36	21	58.33	N	N	N
6.		Sandelerbil RH (Hingalganj)	14	4	3	3	4	3	4	3	5	5	6	5	36	23	63.89	N	N	N
7.	**Paschim**	Salboni RH	14	4	3	3	4	3	4	4	5	5	6	5	36	24	66.67	N	N	N
8.	**Medinipur**	Sabang RH	14	9	3	2	4	3	4	0	5	3	6	3	36	20	55.56	N	N	N
9.	**Purulia**	Kushtor RH (Purulia II)	14	NA	3	NA	4	NA	4	NA	5	NA	6	NA	36	NA		N	N	N
10.		Muradih RH (Santuri)	14	11	3	2	4	3	4	1	5	3	6	6	36	26	72.22	N	Y	Y

Source: Replies furnished by test-checked districts

Appendix 3.12

(Refer Paragraph 3.2.1)

Availability of diagnostic services at the test-checked SDHs

Sl. No.	Speciality	Diagnostic Services/Test	Ghatal SDH (Yes/ No)	Raghunathpur SDH (Yes/ No)	Islampur SDH (Yes/ No)
I Clinical Pathology					
1	**a. Haematology**	Haemoglobin estimation	Yes	Yes	Yes
2		Total Leucocyte count	Yes	Yes	Yes
3		Differential Leucocyte count	Yes	Yes	Yes
4		Absolute Eosinophil count	No	No	Yes
5		Reticulocyte count	No	No	No
6		Total RBC count	Yes	Yes	Yes
7		E.S.R.	Yes	Yes	Yes
8		Bleeding time	Yes	Yes	Yes
9		Clotting time	Yes	Yes	Yes
10		Prothrombin time	No	No	NA
11		Peripheral Blood Smear	Yes	Yes	Yes
12		Malaria/Filaria Parasite	Yes	Yes	Yes
13		Platelet count	Yes	Yes	Yes
14		Packed Cell volume	Yes	Yes	Yes
15		Blood grouping	Yes	Yes	Yes
16		Rh typing	Yes	Yes	Yes
17		Blood Cross matching	Yes	Yes	No
18	**b. Urine Analysis**	Urine for Albumin, Sugar, Deposits, bile salts, bile pigments, acetone, specific gravity, Reaction (pH)	Yes	Yes	Yes
19	**c. Stool Analysis**	Stool for Ova and Cysts	Yes	Yes	Yes
20		Hanging drop for V. Cholera	No	No	No
21		occult blood	No	No	NA
22	**d. Semen Analysis**	Morphology, count, Motility *etc.*	Yes	No Info	Yes
23	**e. CSF Analysis**	Analysis, Cell count *etc*.	No	No Info	No
24	**f. Aspirated fluids**	Cell count, cytology	No	No Info	Yes
II Pathology					
25	**a. Sputum**	Sputum cytology	Yes	Yes	Yes
III Microbiology					
26		Smear for AFB (Acid Fast Bacilli), KLB (Diphtheria Bacilli)	Yes	No Info	AFB-YES, DIPTH-No
27		Grams stain for Meningococci	No	No Info	No
28		KOH study for fungus	No	No Info	No
29		Grams Stain for Throat swab, sputum *etc*.	No	No Info	No
IV Serology					
30		RPR Card Test for Syphilis	Yes	-	Yes
31		Pregnancy test (Urine gravindex)	Yes	Yes	Yes
V Biochemistry					
32		Blood Sugar	Yes	Yes	Yes
33		Blood urea, blood cholesterol, Lipid Profile	Yes	Yes	Yes
34		Liver function tests	Yes	Yes	Yes
35		Kidney function tests	Yes	Yes	Yes
36		stocking of OT test for residual chlorine in water	No	No	NA
37		CSF for protein, sugar	No	No	No

Sl. No.	Speciality	Diagnostic Services/Test	Ghatal SDH (Yes/ No)	Raghunathpur SDH (Yes/ No)	Islampur SDH (Yes/ No)
VI Cardiac Investigation					
38		ECG	Yes	Yes	Yes
VII Ophthalmology					
39		Refraction by using Snellen's chart	Yes	No Info	No
40		Retinoscopy	Yes	No Info	No
41		Tonometry	NA	No Info	No
42		Biometry	NA	No Info	No
43		Ophthalmoscopy	NA	No Info	No
VIII ENT					
44		Audiometry	Yes	Yes	No
IX Radiology					
45		X-ray for Chest, Skull, Spine, Abdomen, bones	Yes	Yes	Yes
46		Dental X-ray	Yes	Yes	No
47		Ultrasonography with colour doppler	Yes	Yes	Yes
X Endoscopy					
48		Laparoscopy (Diagnostic)	No	No	No
XI Respiratory					
49		Pulmonary function tests	No	No	Yes

Source: Replies furnished by test-checked districts

Appendix 3.13

(Refer Paragraph 3.2.1)

Availability of diagnostic services at the test-checked DHs

Sl. No.	Speciality	Diagnostic Services/Tests	Jalpaiguri DH & SSH (Yes/ No)	Bashirhat DH & SSH (Yes/ No)
I	**Clinical Pathology**			
	a. Hematology	Haemoglobin estimation	Yes	Yes
		Total Leukocytes count	Yes	Yes
		Differential Leucocytes count	Yes	Yes
		Absolute Eosinophil count	Yes	Yes
		Reticulocyte count	No	Yes
		Total RBC count	Yes	Yes
		E. S. R.	Yes	Yes
	Immunoglobin Profile (IGM, IGG, IGE, IGA)	Bleeding time	Yes	Yes
	Fibrinogen Degradation Product	Clotting time	Yes	Yes
		Prothrombin time	Yes	No
		Peripheral Blood Smear	Yes	Yes
		Malaria/Filaria Parasite	Yes	Yes
		Platelet count	Yes	Yes
		Packed Cell volume	Yes	Yes
		Blood grouping	Yes	Yes
		Rh typing	Yes	Yes
		Blood Cross matching	Yes	Yes
		ELISA for HIV, HCV, HBs Ag	Yes	Yes
		ELISA for TB	No	Yes
		APTT	No	No
		ANA/ANF, Rhemmatoid Factor	No	Yes
	b. Urine Analysis	Urine for Albumin, Sugar, Deposits, bile salts, bile pigments, acetone, specific gravity, Reaction (pH)	Yes	Yes
	c. Stool Analysis	Stool for Ova and cysts	Yes	Yes
		Hanging drop for V. Cholera	Yes	No
		Occult blood	Yes	No
		Bacterial culture and sensitivity	No	No
	d. Semen Analysis	Morphology, count	Yes	No
	e. CSF Analysis	Analysis, Cell count *etc*.	Yes	No
	f. Aspirated fluids	Cell count cytology	Yes	No
II	**Pathology**	Cytology		
	a. PAP smear		Yes	No
	b. Sputum	Sputum cytology	Yes	No
	c. Haematology	Bone Marrow Aspiration	Yes	No
		Immuno haematology	No	No
		Coagulation disorders	No	No
		Sickle cell anaemia	Yes	No
		Thalassemia	Yes	Yes
	d. Histopathology	All types of specimens, Biopsies	No	No
III	Microbiology			
		KOH study for fungus	No	No

Sl. No.	Speciality	Diagnostic Services/Tests	Jalpaiguri DH & SSH (Yes/ No)	Bashirhat DH & SSH (Yes/ No)
		Smear for AFB, KLB (Diphtheria)	Yes	Yes
		Culture and sensitivity for blood, sputum, pus, urine *etc*.	No	No
		Bactriological analysis of water by H_2S based test	No	No
		Stool culture for Vibrio Cholera and other bacterial enteropathogene	No	No
		Supply of different media* for peripheral Laboratories	No	No
		Grams Stain for Throat swab, sputum *etc*.	No	No
IV	Serology	RPR Card test for syphillis	Yes	Yes
		Pregnancy test (Urine gravindex) ELISA for Beta HCG	No	No
		Leptospirosis, Brucellosis	No	No
		WIDAL test	Yes	Yes
		Elisa test for HIV, HBsAg, HCV	Yes	Yes
		DCT/ ICT with Titre	No	No
		RA factor	No	Yes
V	Blood Bank	Services as per norms for the blood bank including services for self component separation	Yes	Yes
VI	Biochemistry	Blood Sugar	Yes	Yes
		Glucose tolerance test	Yes	No
		Glycosylated Hemoglobin	Yes	No
		Blood urea, blood cholesterol	Yes	Yes
		serum bilirubin	Yes	Yes
		Icteric index	Yes	No
		Liver function tests	Yes	Yes
		Kidney function tests	Yes	Yes
		Lipid Profile	Yes	Yes
		Blood uric acid	Yes	Yes
		Serum calcium	Yes	Yes
		Serum Phosphorous	No	Yes
		Serum Magnesium	No	Yes
		CSF for protein, sugar	Yes	No
		Blood gas analysis	No	No
		Estimation of residual chlorine in water	No	No
		Thyroid T3 T4 TSH	Yes	Yes
		CPK	Yes	No
		Chloride (Desirable)	Yes	No
		Salt and Urine for Iodine (Desirable)	No	No
		Iodometry Titration	No	No
VII	**Cardiac Investigations**	a) ECG	Yes	Yes
		b) Stress tests	No	No
		c) ECHO	No	No

Sl. No.	Speciality	Diagnostic Services/Tests	Jalpaiguri DH & SSH (Yes/ No)	Bashirhat DH & SSH (Yes/ No)
VIII	**Ophthalmology**	a) Refraction by using Snellen's chart	Yes	Yes
		Retinoscopy	Yes	Yes
		Ophthalmoscopy	Yes	Yes
IX	**ENT**	Audiometry	Yes	Yes
		Endoscopy for ENT	Yes	No
X	**Radiology**	a) x-ray for Chest, Skull, Spine, Abdomen, bones	Yes	Yes
		b) Barium swallow, Barium meal, Barium enema, IVP	No	No
		c) MMR (chest)	Yes	No
		d) HSG	No	No
		e) Dental xray	Yes	Yes
		f) Ultrasonography	Yes	Yes
		g) CT scan	Yes	Yes
XI	**Endoscopy**	Oesophagus	No	No
		Stomach	No	No
		Colonoscopy	No	No
		Bronchuscopy	No	No
		Arthros copy	Yes	No
		Laparoscopy (Diagnostic)	Yes	No
		Colposcopy	No	No
		Hysteroscopy	No	No
XII	**Respiratory**	Pulmonary function tests	No	No

Source: Replies furnished by test-checked districts

Appendix 3.14

(Refer Paragraph 3.2.2)

Dietary Services in test-checked CHCs

District	BPHC/ RH	Outsourced agencies not having statutory licence (No licence: N)	Having policy and procedure for regular quality checking of raw material, equipment, kitchen sanitation, cooked food *etc.* (No policy: N)	Having grievance redressal cell (No grievance redressal: N)	Whether the complaints lodged by the patients were recorded and addressed quickly (Not recorded: N; Not addressed: NA)	Whether inspections in the hospital kitchen has been conducted by the Food Safety Officer?
Jalpaiguri	Sulkapara RH	N	Y	Y	Y	N
	Odlabari BPHC	N	Y	Y	Y	N
Uttar Dinajpur	Kunor BPHC	N	Y	N	NA	N
Bashirhat HD	Rudrapur RH	Y	N	N	NA	N
	Sandelerbil RH	Y	N	N	NA	N
Paschim Medinipur	Salboni RH	N	Y	Y	N	Y
	Sabang RH	Y	N	Y	N	Y
Purulia	Kushtor RH (Purulia II)	N	N	Y	NA	N
	Muradih RH	N	N	Y	NA	N
Uttar Dinajpur	Itahar RH	No dietary services provided				
Total		**6 (N)**	**5 (N)**	**3 (N)**	**2 (N); 5 (NA)**	**7 (N)**

Source: Replies furnished by test-checked districts

Appendix 3.15

(Refer Paragraph 3.2.2)

Status of availability of Support Services in the District Hospitals

Facility Name	Emergency Services	Blood Bank	Ambulance services	Dietary services	Laundry Services	BMW Management
Barasat DH	Yes	Yes	Yes	Yes	Yes	Yes
Basirhat DH	Yes	Yes	Yes	Yes	Yes	Yes
M. R. Bangur DH	Yes	Yes	Yes	Yes	Yes	Yes
Alipurduar DH	Yes	Yes	No	Yes	Yes	Yes
Bishnupur DH	Information not available					
Suri DH & SSH	Yes	Yes	Yes	Yes	Yes	Yes
Darjeeling DH	Yes	Yes	Yes	Yes	Yes	Yes
Siliguri DH	Yes	Yes	Yes	Yes	Yes	Yes
Balurghat DH	Yes	Yes	Yes	Yes	Yes	Yes
Imambara DH	Yes	Yes	Yes	Yes	Yes	Yes
Howrah DH	Yes	Yes	Yes	Yes	Yes	Yes
Jalpaiguri DH	Yes	Yes	Yes	Yes	Yes	Yes
Jhargram DH	Yes	Yes	Yes	Yes	Yes	Yes
Kalimpong DH	Yes	NA	Yes	Yes	Yes	Yes
Tamluk DH	Yes	Yes	Yes	Yes	Yes	Yes
Nadia DH	Yes	Yes	Yes	Yes	Yes	Yes
Asansol DH	Yes	Yes	Yes	Yes	Yes	Yes
Nandigram DH	Yes	Yes	Yes	Yes	Yes	Yes

Source: HMIS data

Appendix 3.16

(Refer Paragraph 3.2.5)

Blood Storage Units in the test-checked CHCs

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
Blood Storage Unit							
1	CHCs having Blood Storage Unit (BSU)	1	0	0	0	0	**1**
2	CHC having no Medical Officer at the BSU	1	NA	NA	NA	NA	**1**
3	CHC having no Technician at the BSU	0	NA	NA	NA	NA	**0**
4	CHC having no Reagents at the BSU	0	NA	NA	NA	NA	**0**
5	CHC with no genrator backup for the BSU	0	NA	NA	NA	NA	**0**

Source: Replies furnished by test-checked districts; NA: Not Applicable

Appendix 4.1

(Refer Paragraph 4.3.4)

Delays in uploading test results of drugs

Financial Year	Test-checked unit whose samples were found non-standard	Samples declared non-standard	Batch numbers of those samples	Dates when the samples Sent from CMS to laboratory (received by the laboratory)	Dates when the report were uploaded to the portal	Difference (F-E) (in days)	Delay (G-14) (in days)
(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
2016-17 -	DRS-Uttar Dinajpur	Calcium Carbonate Equivalent to Elemental Calcium 500mg and Vitamin D3 250 I.U. Tab	CD026	22.06.2016	19.08.2016	58	44
			CD024	22.06.2016	19.08.2016	58	44
			CD025	22.06.2016	19.08.2016	58	44
			CD-116	06.09.2016	25.11.2016	80	66
			CD023	22.06.2016	19.08.2016	58	44
			CD-118	06.09.2016	25.11.2016	80	66
			CD-117	16.09.2016	27.12.2016	102	88
			CD-259	02.12.2016	20.04.2017	139	125
		Diclofenac Sod. 50 mg Tab	DFS-04	01.08.2016	03.09.2016	33	19
	DRS-Paschim Medinipore	Diclofenac Sod. 50 mg Tab	DFS-05	24.08.2016	12.09.2016	19	5
			DFS-08	10.02.2017	02.03.2017	20	6
		Benzyl Benzoate Application I.P 25% w/w	41734	12.05.2017	31.05.2017	19	5
	SSKM Medical College & Hospital	Atorvastatin 10 mg Tab	AVT-06	01.08.2016	17.05.2017	289	275
	DRS-Jalpaiguri	Amoxicillin 500 mg + Clavulanic Acid 125 mg Tab	CLMD-859	09.06.2017	01.07.2017	22	8
2017-18	DRS-Uttar Dinajpur	Amoxicillin 250 mg with Clavulanic Acid 125 mg Tab.	CLM-297	20.06.2017	13.07.2017	23	9
	DRS-Uttar Dinajpur	Amoxicillin 500mg + Clavulanic Acid 125 mg Tab	CLMD-953	20.06.2017	13.07.2017	23	9
	DRS-Uttar Dinajpur	Amoxicillin 500mg + Clavulanic Acid 12 5mg Tab	CLMD-954	19.06.2017	21.07.2017	32	18
2017-18	DRS-Jalpaiguri	Amoxicillin 500mg + Clavulanic Acid 125 mg Tab	CLMD-986	29.06.2017	21.07.2017	22	8
	DRS-Jalpaiguri	Amoxicillin 500mg + Clavulanic Acid 125 mg Tab	CLMD-987	10.08.2017	15.09.2017	36	22
	DRS-Paschim Medinipur	Amoxicillin 250 mg with Clavulanic Acid 125 mg Tab.	CLM-302	24.08.2017	16.10.2017	53	39
	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 125 mg Tab	CLMD-1006	24.08.2017	16.10.2017	53	39
	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 125 mg Tab	CLMD-1008	24.08.2017	16.10.2017	53	39
	DRS-Paschim Medinipur	Amoxicillin 500mg + Clavulanic Acid 125 mg Tab	CLMD-1007	24.08.2017	16.10.2017	53	39
	DRS-Basirhat	Rabeprazole 20 mg tablets	17065	04.08.2017	20.12.2017	138	124

Financial Year	Test-checked unit whose samples were found non-standard	Samples declared non-standard	Batch numbers of those samples	Dates when the samples Sent from CMS to laboratory (received by the laboratory)	Dates when the report were uploaded to the portal	Difference (F-E) (in days)	Delay (G-14) (in days)
	DRS-Basirhat	Rabeprazole 20 mg tablets	17066	04.08.2017	20.12.2017	138	124
	DRS-Basirhat	Rabeprazole 20 mg tablets	17067	04.08.2017	20.12.2017	138	124
	DRS-Uttar Dinajpur	Amoxicillin 250 mg with Clavulanic Acid 125 mg Tab.	CLM-304	07.08.2017	11.09.2017	35	21
	DRS-Uttar Dinajpur	Amoxicillin 250mg with Clavulanic Acid 125 mg Tab.	CLM-303	07.08.2017	11.09.2017	35	21
	DRS-Uttar Dinajpur	Amoxicillin 500 mg + Clavulanic Acid 125mg Tab	CLMD-1015	07.08.2017	11.09.2017	35	21
	DRS-Paschim Medinipur	Amoxicillin 250 mg with Clavulanic Acid 125 mg Tab.	CLM-305	21.08.2017	15.09.2017	25	11
2017-18	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 125mg Tab	CLMD-1027	21.08.2017	15.09.2017	25	11
2017-18	DRS-Jalpaiguri	Amoxicillin 500 mg + Clavulanic Acid 125mg Tab	CLMD-1034	14.09.2017	29.09.2017	15	1
	DRS-Purulia	Cetrizine I.P. 10 mg Tabs.	CTH-43	16.11.2017	21.12.2017	35	21
	DRS-Uttar Dinajpur	Ciprofloxacin 250 mg Tab	CPR185	28.12.2017	10.01.2018	13	--
	DRS-Uttar Dinajpur	Ciprofloxacin 250 mg Tab	CPR184	28.12.2017	01.02.2018	35	21
	DRS-Uttar Dinajpur	Ciprofloxacin 250 mg Tab	CPR186	28.12.2017	10.01.2018	13	--
	DRS-Uttar Dinajpur	Ciprofloxacin 250 mg Tab	CPR200	28.12.2017	10.01.2018	13	--
	DRS-Uttar Dinajpur	Ciprofloxacin 250 mg Tab	CPR197	28.12.2017	10.01.2018	13	--
	DRS-Uttar Dinajpur	Ciprofloxacin 250 mg Tab	CPR198	28.12.2017	10.01.2018	13	--
	SSKM Medical College & Hospital	Ciprofloxacin HCl Tab. I.P. 500 mg (scored)	CPL-122	28.12.2017	10.01.2018	23	9
	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 125 mg Tab	CLMD-940	20.06.2017	13.07.2017	23	9
	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 125 mg Tab	CLMD-939	20.06.2017	13.07.2017	23	9
	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 12 5mg Tab	CLMD-937	20.06.2017	13.07.2017	23	9
	DRS-Paschim Medinipur	Amoxicillin 500 mg + Clavulanic Acid 125mg Tab	CLMD-938	20.06.2017	13.07.2017	23	9
2018-19	DRS-Paschim Medinipur	Paracetamol Infusion 1000 mg/100 ml	18PPC005	03.10.2018	30.11.2018	58	44
	DRS-Uttar Dinajpur	Rabeprazole 20 mg tablets	RBT 82028	09.04.2019	25.04.2019	16	2
	DRS-Purulia	Rabeprazole 20 mg tablets	RBT 82031	07.05.2019	31.05.2019	24	10
2019-20	DH-Jalpaiguri	ParacetamolSusp. I.P. 125 mg/5ml.	L27623	02.03.2020	21.03.2020	19	5
	DH-Jalpaiguri	Betamethasone Oint.I.P. 0.1%	BV-083	12.02.2021	15.06.2021	123	109
	DRS-Jalpaiguri	Povidone Iodine Solution I.P 5% w/v	61981	13.02.2020	28.02.2020	15	1
	DRS-Paschim Medinipur	Ibuprofen Oral Suspension 100 mg / 5 ml	IBS1901	11.12.2019	08.01.2020	28	14
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental	CLF-19131	11.12.2019	20.02.2020	71	57

Financial Year	Test-checked unit whose samples were found non-standard	Samples declared non-standard	Batch numbers of those samples	Dates when the samples Sent from CMS to laboratory (received by the laboratory)	Dates when the report were uploaded to the portal	Difference (F-E) (in days)	Delay (G-14) (in days)
		Calcium 500 mg and Vitamin D3 250 I.U. Tab.					
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19129	11.12.2019	20.02.2020	71	57
2019-20	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19136	11.12.2019	20.02.2020	71	57
2019-20	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19137	11.12.2019	20.02.2020	71	57
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19134	11.12.2019	20.02.2020	71	57
	DRS-Paschim Medinipur	Amoxicillin 200mg with Clavulanic Acid 28.5 mg / 5 ml Syrup I.P	YAP06006	12.02.2021	24.06.2021	132	118
	DRS-Purulia	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19152	24.02.2020	14.07.2020	141	127
	DRS-Purulia	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19156	02.03.2020	14.07.2020	141	127
	DRS-Purulia	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19149	24.02.2020	14.07.2020	79	65
	DRS-Purulia	Calcium Carbonate Equivalent to Elemental	CLF-19151	24.02.2020	14.07.2020	79	65
2019-20	DRS-Purulia	Calcium Carbonate Equivalent to Elemental Calcium 500mg and Vitamin D3 250 I.U. Tab.	CLF-19150	24.02.2020	14.07.2020	26	12
2019-20	DRS-Purulia	Metronidazole Benzoate Oral Suspension I.P. 100 mg / 5 ml.	L08314	07.10.2020	25.12.2020	79	65
	DRS-Purulia	Metronidazole Benzoate Oral Suspension I.P. 100 mg / 5 ml.	L08315	07.10.2020	25.12.2020	79	65
	DRS-Purulia	Paracetamol Suspension I.P. 125 mg/ 5ml.	L27635	24.02.2020	21.03.2020	26	12
	DRS-Purulia	Paracetamol Suspension I.P. 125 mg/ 5ml.	L27633	24.02.2020	21.03.2020	26	12
	DRS-Purulia	ParacetamolSusp.I.P. 125 mg/ 5 ml.	L27634	24.02.2020	21.03.2020	26	12
	DRS-Uttar Dinajpur	Calcium Carbonate Equivalent to Elemental Calcium 500mg and Vitamin D3 250 I.U. Tab.	CLF-19144	30.12.2019	22.01.2020	23	9
2020-21	DRS-Jalpaiguri	Enalapril Maleate Tablet I.P. 5mg.(scored)	GA20009	25.08.2020	11.11.2020	78	64
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium500 mg and Vitamin D3 250 I.U.Tab.	CLF-19261	29.12.2020	09.03.2021	70	56

Financial Year	Test-checked unit whose samples were found non-standard	Samples declared non-standard	Batch numbers of those samples	Dates when the samples Sent from CMS to laboratory (received by the laboratory)	Dates when the report were uploaded to the portal	Difference (F-E) (in days)	Delay (G-14) (in days)
	DRS-Paschm Medinipur	Calcium Carbonate Equivalent to Elemental Calcium500 mg and Vitamin D3 250 I.U.Tab.	CLF-19255	29.12.2020	09.03.2021	70	56
2020-21	DRS-Paschm Medinipur	Calcium Carbonate Equivalent to Elemental Calcium500 mg and Vitamin D3 250 I.U.Tab.	CLF-19262	29.12.2020	9.03.2021	70	56
	DRS-Paschm Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg and Vitamin D3 250 I.U. Tab.	CLF-19263	29.12.2020	09.03.2021	70	56
	DRS-Paschim Medinipur	Misoprostol Tab.200 mcg	ATH-244	20.01.2021	16.06.2021	147	133
	DRS-Uttar Dinajpur	Paracetamol I.P. 125 mg. Tab.	J2909	21.05.2021	03.12.2021	196	182
	DRS-Basirhat	Paracetamol I.P. 125 mg. Tab.	J2906	20.04.2021	03.12.2021	227	213
	DRS-Paschim Medinipur	Betamethasone Oint.I.P. 0.1%	BV-094	05.05.2021	13.07.2021	69	55
	DRS-Paschim Medinipur	Metronidazole Tab. I.P. 400 mg (Film coated)	AT28116	04.06.2021	03.12.2021	182	168
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg	CLF-19257	29.12.2020	09.03.2021	70	56
	DRS-Paschim Medinipur	Metronidazole Tab. I.P. 400 mg (Film coated)	AT28116	04.06.2021	03.12.2021	70	56
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg	CLF-19257	29.12.2020	09.03.2021	70	56
	DRS-Paschim Medinipur	Metronidazole Tab. I.P. 400 mg (Film coated)	AT28116	04.06.2021	03.12.2021	70	56
2020-21	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg	CLF-19257	29.12.2020	09.03.2021	70	56
	DRS-Paschim Medinipur	Metronidazole Tab. I.P. 400 mg (Film coated)	AT28116	04.06.2021	03.12.2021	70	56
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg	CLF-19257	29.12.2020	09.03.2021	70	56
	DRS-Paschim Medinipur	Metronidazole Tab. I.P. 400 mg (Film coated)	AT28116	04.06.2021	03.12.2021	70	56
	DRS-Paschim Medinipur	Calcium Carbonate Equivalent to Elemental Calcium 500 mg	CLF-19257	29.12.2020	09.03.2021	73	59
2021-22	**NIL**						

Source: Information provided by Cental Medical Store

Appendix 4.2

(Refer Paragraph 4.3.4)

Instances of administration of NSQ drugs in the DRS of Jalpaiguri

Sl. No.	Name of drug	Financial Year	Batch No.	Quantity. distributed	Name of the HCF where distributed
1	Amoxicillin 500mg + Clavulanic Acid 125mg Tab	2016-17	CLMD-859	3,000	Mainaguri BPHC
				5,000	Dhupguri BPHC
				2,455	Belakoba BPHC
				500	Randhamali PHC
				715	Shikarpur PHC
				1,000	Sakoajhar PHC
				1,000	Dhuramari PHC
				1,000	Jharaltagram PHC
				3,000	Kalinagar PHC
				500	Looksan PHC
				500	Nandanpur Boalmari PHC
				825	DH Jalpaiguri
2	Amoxicillin 500mg + Clavulanic Acid 125mg Tab	2017-18	CLMD-986	8,215	DH Jalpaiguri
				10	ACMOH Sadar
				1,000	Dhupguri BPHC
				2,125	Rajganj BPHC
				1,765	Mainaguri BPHC
				5,000	SDH Malbazar
3	Amoxicillin 500mg + Clavulanic Acid 125mg Tab	2017-18	CLMD-987	1,875	Rajganj BPHC
4	Amoxicillin 500mg + Clavulanic Acid 125mg Tab	2017-18	CLMD-1034	6,555	DH Jalpaiguri
				5,000	Jalpaiguri SSH
				1,500	Odlabari RH
				300	Sulkapara BPHC
				500	South Berubari PHC
				3,000	Belakoba BPHC
				2,000	Mangalbari BPHC
				950	Dakshin Hanskhali PHC
5	Povidone Iodine Solution I.P 5% w/v	2019-20	61981	2,000	DH Jalpaiguri
				500	SDH Malbazar
				100	Sulkapara BPHC
				200	Belakoba BPHC
				50	Randhamali PHC
				100	Ramshai PHC
				10	Jharaltagram PHC
				100	Odlabari RH
				20	Mathaculka PHC
				1,000	SDH Malbazar
				50	South Berubari PHC
				200	Churabander PHC
				20	Nandanpur Boalmari PHC
				50	Kalinagar PHC
				100	Bahadur PHC
				30	Kharija Berubari PHC
				600	Dhupguri BPHC
				20	Moulani PHC
				30	Saptibari PHC
				32	A.C.M.O.H. Sadar
				1,000	SDH Malbazar
				50	Dhuramari PHC
				1,000	DH Jalpaiguri
				300	Mangalbari BPHC
				1,428	SDH Malbazar

Sl. No.	Name of drug	Financial Year	Batch No.	Quantity. distributed	Name of the HCF where distributed
				100	Bernish PHC
				10	UPHC-I NUHM
				200	SDH Malbazar
				95	Belakoba BPHC
6	Enalapril Maleate Tablet I.P. 5mg.	2020-21	GA20009	200	SDH Malbazar
				500	UPHC-II NUHM
				20	DH Jalpaiguri
				300	Nandanpur Boalmari PHC
				500	Bahadur PHC
				1	Mangalbari BPHC
				400	Mangalbari BPHC
				50	DH Jalpaiguri

Source: Replies furnished by test-checked districts

Appendix 4.3

(Refer Paragraph 4.3.6)

Non-availability of Essential Drugs in the test-checked SCs

District(s)	Test-checked SC	No. of drugs as per EDL (applicable for SC)	Percentage of drugs never procured	No. of drugs out of stock >300 days	No. of drugs out of stock >100 days
Paschim Medinipur.	Bhadutala	53	45.28	0	1
	Arabari	53	52.83	1	1
	Garhmal	53	60.38	3	2
	Satpati	53	49.06	9	4
	Lokepith	53	56.60	3	6
	Nimki Mohar	53	56.60	5	2
	Adasimla	53	50.94	5	5
	Kharika PHC attached	53	60.38	0	2
Bashirhat HD	Aturia	53	75.47	Data NA	Data NA
	Paschim Joynagar	53	84.91	Data NA	Data NA
	Kankrasuti	53	67.92	Data NA	Data NA
	Buruj	53	67.92	Data NA	Data NA
	Jogeshganj South	53	73.58	Data NA	Data NA
	Sridharkati	53	62.26	1	0
	Boltala	53	58.49	Data NA	Data NA
	Bishpur	53	75.47	Data NA	Data NA
Uttar Dinajpur	Surun	53	52.83	2	1
	Indran	53	56.60	1	1
	Marnai	53	54.72	1	5
	Borote	53	54.72	1	4
	Majhiar	53	43.40	1	0
	Dilwarpur	53	52.83	5	0
Jalpaiguri	Chakmoulani	53	41.51	6	8
	Jharmatiali	53	45.28	10	10
	Anandpur Tea Estate	53	69.81	0	1
	Karaibari	53	56.60	5	2
	Kalabari	53	43.40	3	1
	Suklapara	53	43.40	4	0
	Looksan	53	62.26	1	1
	Hilla Tea Estate	53	45.28	4	0
Purulia	Golamara	53	Data NA	Data NA	Data NA
	Chayanpur SSK	53	Data NA	Data NA	Data NA
	Dhansura SSK	53	Data NA	Data NA	Data NA
	Hutmura SSK	53	Data NA	Data NA	Data NA
	Santuri	53	56.60	10	10
	Pirorgoria	53	52.83	3	5
	Balitora	53	64.15	6	7
	Dandahit	53	52.83	0	1

Source: Replies furnished by test-checked districts

Appendix 4.4

(Refer Paragraph 4.3.6)

Non-availability of Drugs in the test-checked PHCs

District(s)	Block	PHC	No. of drugs as per EDL (applicable for PHC)	Period checked (in days)	No. of drug never procured	Percentage of drugs never procured	No. of drugs out of stock >300 days	Percentage of drugs out of stock>300 days	No. of drugs out of stock >100 days	Percentage of drugs out of stock>100 days
Paschim Medinipur	Salboni	Godapiasal	229	731	118	51.53	23	10.04	24	10.48
	Salboni	Pirakata	229	731	163	71.18	14	6.11	27	11.79
	Sabang	Mohar	229	731	153	66.81	1	0.44	17	7.42
	Sabang	Kharika	229	731	174	75.98	5	2.18	21	9.17
Bashirhat HD	Rudrapur	Bajitpur	229	731	180	78.6	15	6.55	8	3.49
	Rudrapur	Masia	229	731	155	67.69	31	13.54	11	4.80
	Sanderbill	Jogeshganj	229	731	143	62.44	26	11.35	2	0.87
	Sanderbill	Hingalganj	229	731	162	70.74	8	3.49	12	5.24
Uttar Dinajpur	Kunor	Majhiar	229	731	178	77.73	3	1.31	17	7.42
	Itahar	Surun	229	731	169	73.8	4	1.75	61	26.64
	Itahar	Marnai	229	731	160	69.87	6	2.62	58	25.33
Jalpaiguri	Mal (Odlabari PHC)	Moulani	229	731	161	70.3	1	0.44	2	0.87
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	229	731	174	75.98	26	11.35	37	16.16
	Nagrakata (Suklapara RH)	Dhumpara	229	731	157	68.56	9	3.93	17	7.42
	Nagrakata (Suklapara RH)	Looksan	229	731	163	71.18	3	1.31	3	1.31
Purulia	Purulia-II (Kustaur RH)	Chayanpur	229	1,096	183	79.91	12	5.24	15	6.55

District(s)	Block	PHC	No. of drugs as per EDL (applicable for PHC)	Period checked (in days)	No. of drug never procured	Percentage of drugs never procured	No. of drugs out of stock >300 days	Percentage of drugs out of stock>300 days	No. of drugs out of stock >100 days	Percentage of drugs out of stock>100 days
	Purulia-II (Kustaur RH)	Hutmura	229	1,096	180	78.6	9	3.93	14	6.11
	Santuri (Muradih RH)	Santuri	229	2,191	133	58.08	13	5.68	15	6.55
	Santuri (Muradih RH)	Balitora	229	1,096	178	77.73	12	5.24	16	6.99

Source: Replies furnished by test-checked districts

Appendix 4.5

(Refer Paragraph 4.3.6)

Non-availability of Drugs in the test-checked CHCs

District(s)/ Health District(s)	BPHCs/ RHs	No. of drugs as per EDL (applicable for CHC)	Period checked (in days)	No. of drug never procured	Percentage of drugs never procured	No. of drugs out of stock >300 days	No. of drugs out of stock >100 days	No of available drugs at least 100 days	Percentage of non-available drugs at least 100 days	Whether drugs are prescribed in generic name only? (Y/ N)	Whether drugs were prescribed in Capital letters? (Y/ N)
		(1)	(2)	(3)	(4)	(5)	(6)	(7 = 1-3-6)	(8 = 3+6)	(9)	(10)
Jalpaiguri	Sulkapara RH (Nagrakata)	271	731	140	51.66	11	18	113	58.30	Y	N
	Odlabari BPHC (Mal)	271	731	156	57.56	15	37	78	71.22	Y	N
Uttar Dinajpur	Itahar RH	271	731	146	53.87	18	54	71	73.80	N	N
	Kunor BPHC (Kaliaganj)	271	731	153	56.46	24	54	64	76.38	N	N
Bashirhat HD	Rudrapur RH (Baduria)	271	731	150	55.55	4	4	117	56.83	Y	N
	Sandelerbil RH (Hingalganj)	271	1,096	188	69.37	11	8	75	72.32	N	N
Paschim Medinipur	Salboni RH	271	731	124	45.76	36	6	141	47.97	N	N
	Sabang RH	271	731	118	43.54	23	22	131	51.66	N	N
Purulia	Kushtor RH (Purulia II)	271	2174	144	53.14	70	83	44	83.76	Y	N
	Muradih RH (Santuri)	271	2174	160	59.04	53	76	35	87.08	Y	N

Source: Replies furnished by test-checked districts

Appendix 4.6

(Refer Paragraph 4.4.4)

District-wise numbers of equipment for which calibration, under the comprehensive maintenance was not done

Sl. No.	District(s)	Number of equipment (except SSHs)	Value (₹ in crore)	Equipment (five lakh & above), except SSHs	Value (₹ in crore)	Calibration not done as of March 2022		
						Equipment (five lakh & above) except SSHs	Value (₹ in crore)	Percentage
1	Bashirhat HD	727	7.59	32	3.41	7	0.93	21.88
2	Jalpaiguri	1,770	22.20	102	10.87	16	1.84	15.69
3	Paschim Medinipur	2,996	34.13	180	17.68	50	5.72	27.78
4	Purulia	1,236	13.17	70	6.15	15	1.58	21.43
5	Uttar Dinajpur	1,422	18.47	120	9.82	28	3.25	23.33
6	Kalimpong	446	5.84	35	3.07	20	1.63	57.14
7	Malda	2,151	29.54	154	17.28	77	9.36	50.00
8	Murshidabad	3,347	39.13	170	18.26	51	5.89	30.00
9	Nadia	3,343	55.43	212	31.03	55	6.13	25.94
10	Nandigram HD	831	9.15	57	4.46	12	1.15	21.05
11	North 24 Parganas	3,899	55.13	249	27.22	67	8.69	26.91
12	Paschim Bardhaman	1,102	11.37	49	4.66	13	1.18	26.53
13	PurbaBurdhaman	3,787	69.91	295	46.81	113	13.02	38.31
14	Purba Medinipur	1,422	16.25	79	8.06	29	3.29	36.71
15	Rampurhat HD	652	6.91	31	3.12	8	1.19	25.81
16	South 24 Parganas	2,576	33.91	155	16.83	18	2.58	11.61
17	Alipurduar	1,255	14.46	69	6.76	30	3.62	43.48
18	Bankura	2,205	45.75	208	31.84	96	19.04	46.15
19	Birbhum	1,288	17.42	97	9.81	42	5.34	43.30
20	Bishanpur HD	610	6.82	35	3.37	22	2.31	62.86
21	Coochbehar	1,801	22.06	126	11.02	12	1.08	9.52
22	Dakshin Dinajpur	1,331	220.59	104	12.28	51	7.08	49.04
23	Diamond Harbour HD	1,282	13.70	58	6.06	10	1.11	17.24

Sl. No.	District(s)	Number of equipment (except SSHs)	Value (₹ in crore)	Equipment (five lakh & above), except SSHs	Value (₹ in crore)	Calibration not done as of March 2022		
						Equipment (five lakh & above) except SSHs	Value (₹ in crore)	Percentage
24	**Hooghly**	2,802	39.60	228	21.56	110	11.11	48.25
25	**Howrah**	1,735	25.18	118	12.49	46	5.49	38.98
26	**Jhargram**	825	9.83	51	5.02	31	3.56	60.78
27	**Darjeeling**	3,831	67.51	309	43.22	37	9.54	11.97
28	**Kolkata**	21,292	596.10	2,417	438.13	264	61.26	10.92
Total:		**71,964**	**1507.15**	**5,810**	**830.29**	**1,330**	**197.96**	**22.89**

Source: Information provided by WBMSCL

Appendix 4.7

(Refer Paragraph 4.5)

Non-availability of equipment in the test-checked SCs

District(s)	Test-checked SC	Types of equipments test-checked (essential equipment)	Types of equipments not available (percentage)	Types of equipments non-functional since long (percentage)	Types of equipments not functional for> 1month (percentage)	Types of equipments not functional equipments for < 1 month (percentage)	Total types non-functional (percentage)	Total types of unavailable and non-functional equipments	Percentage of unavailable and non-functional equipments (Types)
		(1)	(2)	(3)	(4)	(5)	(6)=(3+4+5)	(7)=(2+6)	(8)
Paschim Medinipur	Bhadutala	43	9 (21)	11 (26)	0 (0)	11 (26)	22 (51)	31	72
	Arabari	43	11 (26)	0 (0)	0 (0)	0 (0)	0 (0)	11	26
	Garhmal	43	12 (2)	8 (19)	0 (0)	3 (7)	11 (26)	23	53
	Satpati	43	9 (21)	4 (9)	1 (2)	3 (7)	8 (19)	17	40
	Lokepith	43	10 (23)	9 (21)	0 (0)	9 (21)	18 (42)	28	65
	Nimki Mohar	43	23 (53)	7 (16)	0 (0)	3 (7)	10 (23)	33	77
	Adasimla	43	4 (9)	3 (7)	0 (0)	3 (7)	6 (14)	10	23
	Kharika PHC attached	43	21 (49)	1 (2)	0 (0)	1 (2)	2 (5)	23	53
Bashirhat HD	Aturia	43	19 (44)	0 (0)	0 (0)	0 (0)	0 (0)	19	44
	Paschim Joynagar	43	16 (37)	6 (14)	6 (14)	0 (0)	12 (28)	28	65
	Kankrasuti	43	21 (49)	0 (0)	0 (0)	0 (0)	0 (0)	21	49
	Buruj	43	22 (51)	2 (5)	2 (5)	0 (0)	4 (9)	26	60
	Jogeshganj South	43	15 (35)	1 (2)	1 (2)	0 (0)	2 (5)	17	40
	Sridharkati	43	18 (42)	10 (23)	10 (23)	0 (0)	20 (47)	38	88
	Boltala	43	15 (35)	8 (19)	8 (19)	0 (0)	16 (37)	31	72
	Bishpur	43	29 (67)	1 (2)	1 (2)	0 (0)	2 (5)	31	72
Uttar Dinajpur	Surun	43	22 (51)	5 (12)	0 (0)	0 (0)	5 (12)	27	63
	Indran	43	23 (53)	2 (5)	2 (5)	0 (0)	4 (9)	27	63
	Marnai	43	22 (51)	2 (5)	0 (0)	0 (0)	2 (5)	24	56

District(s)	Test-checked SC	Types of equipments test-checked (essential equipment)	Types of equipments not available (percentage)	Types of equipments non-functional since long (percentage)	Types of equipments not functional for> 1month (percentage)	Types of equipments not functional equipments for < 1 month (percentage)	Total types non-functional (percentage)	Total types of unavailable and non-functional equipments	Percentage of unavailable and non-functional equipments (Types)
		(1)	(2)	(3)	(4)	(5)	(6)=(3+4+5)	(7)=(2+6)	(8)
	Borote	43	16 (37)	1 (2)	0 (0)	0 (0)	1 (2)	17	40
	Majhiar	43	26 (60)	1 (2)	0 (0)	0 (0)	1 (2)	27	63
	Dilwarpur	43	22 (51)	2 (5)	0 (0)	0 (0)	2 (5)	24	56
Jalpaiguri	Chakmoulani	43	16 (37)	0 (0)	0 (0)	0 (0)	0 (0)	16	37
	Jharmatiali	43	28 (65)	0 (0)	0 (0)	0 (0)	0 (0)	28	65
	Anandpur Tea Estate	43	16 (37)	1 (2)	0 (0)	0 (0)	1 (2)	17	40
	Karaibari	43	14 (33)	0 (0)	3 (7)	1 (2)	4 (9)	18	42
	Kalabari	43	21 (49)	0 (0)	0 (0)	0 (0)	0 (0)	21	49
	Suklapara	43	21 (49)	0 (0)	2 (5)	2 (5)	4 (9)	25	58
	Looksan	43	18 (42)	0 (0)	0 (0)	0 (0)	0 (0)	18	42
	Hilla Tea Estate	43	20 (47)	0 (0)	3 (7)	1 (2)	4 (9)	24	56
Purulia	Golamara	43	Data not available						
	Chayanpur SSK	43	Data not available						
	Dhansura SSK	43	Data not available						
	Hutmura SSK	43	Data not available						
	Santuri	43	23 (53)	5 (12)	5 (12)	0 (0)	10 (23)	33	77
	Pirorgoria	43	16 (37)	1 (2)	1 (2)	0 (0)	2 (5)	18	42
	Balitora	43	17 (40)	0 (0)	1 (2)	0 (0)	1 (2)	18	42
	Dandahit	43	16 (37)	4 (9)	2 (5)	0 (0)	6 (14)	22	51

Source: Replies furnished by test-checked districts

Appendix 4.8

(Refer Paragraph 4.5)

Non-availability of equipment in the test-checked PHCs

District(s)	Block	PHC Type	General Equipment			Equipment for Pap smear		
			No of equipment test-checked (essential equipments)	Type of equipment not available	Percentage of equipment not available (Types)	Type of equipment test-checked	Type of equipment not available	Percentage of equipment not available (Types)
Paschim Medinipur	Salboni	Godapiasal	36	18	50.00	7	2	28.57
	Salboni	Pirakata	36	29	80.56	7	7	100.00
	Sabang	Mohar	36	23	63.89	7	2	28.57
	Sabang	Kharika	36	27	75.00	7	4	57.14
Bashirhat HD	Rudrapur	Bajitpur	36	32	88.89	7	7	100.00
	Rudrapur	Masia	36	26	72.22	7	3	42.86
	Sanderbill	Jogeshganj	36	19	52.78	7	1	14.29
	Sanderbill	Hingalganj	36	23	63.89	7	7	100.00
Uttar Dinajpur	Kunor	Majhiar	36	32	88.89	7	6	85.71
	Itahar	Surun	36	31	86.11	7	6	85.71
	Itahar	Marnai	36	21	58.33	7	7	100.00
Jalpaiguri	Mal (Odlabari BPHC)	Moulani	36	20	55.56	7	1	14.29
	Mal (Odlabari BPHC)	Rajdanga Dakshin Hanskhali	36	19	52.78	7	1	14.29
	Nagrakata (Suklapara RH)	Dhumpara	36	13	36.11	7	2	28.57
	Nagrakata (Suklapara RH)	Looksan	36	28	77.78	7	4	57.14
Purulia	Purulia-II (Kustaur RH)	Chayanpur	36	0		7	5	71.43
	Purulia-II (Kustaur RH)	Hutmura	36	15	41.67	7	7	100.00
	Santuri (Muradih RH)	Santuri	36	30	83.33	7	7	100.00
	Santuri (Muradih RH)	Balitora	36	33	91.67	7	4	57.14

Source: Replies furnished by test-checked districts

Appendix 4.9

(Refer Paragraph 4.5)

Non-availability of equipment in the test-checked CHCs (Part-I)

District(s)/ Health District(s)	BPHC/RH	Equipment related to Maternity services															
		Standard Surgical Set- I to VI			IUD Insertion Kit			Normal Delivery Kit			Anaesthesia		Neo-natal Resuscitation			Equipment for OT	
		No. of essential equipment test-checked (Types)	No. (Types) Of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	Percentage (Type) of equipment not available
Jalpaiguri	Sulkapara RH (Nagrakata)	130	97	74.62	19	8	42.11	12	5	41.67	17	17	25	16	64	13	0
	Odlabari BPHC (Mal)	130	127	97.69	19	4	21.05	12	2	16.67	17	17	25	5	20	13	46
Uttar Dinajpur	Itahar RH	130	81	62.31	19	7	36.84	12	1	8.33	17	17	25	11	44	13	31
	Kunor BPHC (Kaliaganj)	130	130	100.00	19	19	100.00	12	3	25.00	17	17	25	12	48	13	100
Bashirhat HD	Rudrapur RH (Baduria)	130	112	86.15	19	8	42.11	12	10	83.33	17	15	25	12	48	13	31
	Sandelerbil RH (Hingalganj)	130	116	89.23	19	12	63.16	12	3	25.00	17	0	25	15	60	13	31
Paschim	Salboni RH	130	82	63.08	19	15	78.95	12	5	41.67	17	14	25	17	68	13	62
Medinipur	Sabang RH	130	85	65.38	19	9	47.37	12	5	41.67	17	11	25	12	48	13	8
Purulia	Kushtor RH (Purulia II)	130	107	82.31	19	9	47.37	12	4	33.33	17	17	25	16	64	13	54
	Muradih RH (Santuri)	130	119	91.54	19	14	73.68	12	10	83.33	17	17	25	15	60	13	46

Source: Replies furnished by test-checked districts

Appendix 4.10

(Refer Paragraph 4.5)

Non-availability of equipment in the test-checked CHCs (Part-II)

District	BPHC/RH	Radiology		Immunization equipment			New-born Corner			Stabilization Unit			Laboratory equipment		
		No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available
Jalpaiguri	Sulkapara RH (Nagrakata)	10	10	6	1	16.67	7	3	42.86	8	2	25.00	10	1	10
	Odlabari BPHC (Mal)	10	5	6	2	33.33	7	1	14.29	8	1	12.50	10	3	30
Uttar Dinajpur	Itahar RH	10	6	6	2	33.33	7	2	28.57	8	2	25.00	10	2	20
	Kunor BPHC (Kaliaganj)	10	10	6	2	33.33	7	1	14.29	8	7	87.50	10	5	50
Bashirhat HD	Rudrapur RH (Baduria)	10	10	6	2	33.33	7	3	42.86	8	2	25.00	10	4	40
	Sandelerbil RH (Hingalganj)	10	10	6	2	33.33	7	1	14.29	8	1	12.50	10	8	80
Paschim Medinipur	Salboni RH	10	10	6	6	100.00	7	5	71.43	8	8	100.00	10	0	0
	Sabang RH	10	10	6	5	83.33	7	3	42.86	8	2	25.00	10	3	30
Purulia	Kushtor RH (Purulia II)	10	10	6	1	16.67	7	1	14.29	8	8	100.00	10	4	40
	Muradih RH (Santuri)	10	10	6	3	50.00	7	1	14.29	8	5	62.50	10	0	0

Source: Replies furnished by test-checked districts

Appendix 4.11

(Refer Paragraph 4.5)

Non-availability of equipment in the test-checked CHCs (Part-III)

District	BPHC/ RH	NPPCD[1]		NPCDCS[2]			Physical Medicine & Rehabilitation		NVBDCP[3]			Whether Downtime Register for critical equipment maintained (Y/ N)
		No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	No. of essential equipment test-checked (Types)	No. (Types) of equipment not available	Percentage (Types) of equipment not available	
Jalpaiguri	Sulkapara RH (Nagrakata)	7	7	11	8	72.73	18	18	9	0		N
	Odlabari BPHC (Mal)	7	7	11	9	81.82	18	9	9	1	11	Y
Uttar Dinajpur	Itahar RH	7	7	11	11	100.00	18	18	9	4	44	N
	Kunor BPHC (Kaliaganj)	7	7	11	8	72.73	18	18	9	6	67	N
Bashirhat HD	Rudrapur RH (Baduria)	7	7	11	11	100.00	18	18	9	0		N
	Sandelerbil RH (Hingalganj)	7	7	11	8	72.73	18	18	9	9	100	N
Paschim Medinipur	Salboni RH	7	7	11	6	54.55	18	18	9	4	44	N
	Sabang RH	7	7	11	11	100.00	18	18	9	9	100	N
Purulia	Kushtor RH (Purulia II)	7	7	11	11	100.00	18	18	9	6	67	N
	Muradih RH (Santuri)	7	7	11	9	81.82	18	18	9	1	11	N

Source: Replies furnished by test-checked districts; [1] National Programme for Prevention and control of Deafness [2:] National Programme for Cancer, Diabetes, Cardio Vascular Diseases and Stroke [3:]National Vector Borne Diseases Control Programme

Appendix 4.12

(Refer Paragraph 4.5.1)

Availability of SNCU Equipment – District Hospitals

Sl. No.	Essential Equipment	Requirement, as per IPHS	Quantities available		Shortage	
			Jalpaiguri (26-bedded)	Basirhat (12-bedded)	Jalpaiguri (26-bedded)	Basirhat (12-bedded)
SNCU General Equipment:						
1.	Electronic weighing scale	5	2	5	3	0
2.	Infantometer	5	1	1	4	4
3.	Procedure trolley	5	0	3	5	2
4.	Spot lamp	5	0	2	5	3
5.	Portable x-ray machine	1 for the unit	0	0	1	1
6.	Basic surgical instruments *e.g.* fine scissors, scalpel with blades, fine artery forceps, suture material & needles, towel, clips *etc.*	1 set	1	0	0	1
7.	Nebulizer	1 for the unit	4	2	0	0
8.	Multichannel monitor with non-invasive BP monitor (3 size: 0, 1, 2-disposable in plenty-reusable neonatal probe, at least 4)	4 (desirable)	3	2	1	2
Individual Care Equipment:						
9.	Servo-controlled Radiant Warmer	1 for each bed + 2	26	22	2	0
10.	Low-Reading Digital Thermometer (centigrade scale)	1 for each bed	2	3	24	9
11.	Neonatal Stethoscope	1 for each bed + 2	4	21	24	0
12.	Neonatal Resuscitation Kit (Laerdal type, Silicone, Autoclavable 240 ml, 450 ml resuscitation bag with valves-including pressure release valve), oxygen reservoir & silicone round cushion masks – sizes 0 & 00), Neonatal laryngoscope with straight blade and spare bulbs)	1 set for each bed + 2	6	0	22	14
13.	Suction Machine (80% should be electrically operated & 20% foot operated)	1 for each beds	20	9	6	3
14.	Oxygen Hood (unbreakable-neonatal/infant size)	1 for each bed 20% extra (in case of repair/ disinfection)	16	29	15	0
15.	Non-stretchable measuring tape (mm scale)	1 for each bed	9	8	17	4
16.	Infusion pump or syringe pump	1 for every 2 beds	28	30	0	0
17.	Pulse Oxymeter	1 for every 2 beds	17	21	0	0
18.	Double Outlet Oxygen Concentrator	1 for every 3 beds	0	10	8	0
19.	Flux meter	1 (Desirable)	NA	0	NA	0
20.	CFL Phototherapy	1 for every 3 beds	NA	NA	NA	NA
21.	Horizontal Laminar Flow	1	NA	NA	NA	NA

Source: Replies furnished by test-checked districts

Appendix 4.13

(Refer Paragraph 4.5.1)

Non-availability/ Shortage of ENT equipment in DHs

Sl. No.	Equipment, as per IPHS (For up to 500-Bedded hospital)	Number required, as per IPHS	Available equipment		Shortage, as compared to IPHS norms		Remarks
			Jalpaiguri	Basirhat	Jalpaiguri	Basirhat	
1.	Audiometer	2	0	2	2	0	--
2.	Impedance Audiometer	1	0	1	1	0	--
3.	Operating Microscope (ENT)	2	1	1	1	1	--
4.	Head light (ordinary) (Boyle Davis)	3	1	0	2	3	--
5.	ENT Operation set, including headlight, for Tonsils	2	1	1	1	1	1 non-functional in JDH
6.	Ear Surgery Instruments set	2	1	0	1	2	--
7.	Mastoid Set	2	1	1	1	1	--
8.	Micro Ear Set Myringoplasty	2	1	0	1	2	--
9.	Stapedotomy set	1	0	0	1	1	--
10.	Micro drill system set	2	1	1	1	1	--
11.	ENT Nasal Set (SMR, Septoplasty, Nasal Endoscopic Set (0 & 30 degree) Polypetcomy, DNS, Rhinoplastly)	1	1	2	0	0	--
12.	Laryngoscope fibreoptic ENT	1	0	0	1	1	--
13.	Laryngoscope Indirect	4	1	0	3	4	--
14.	Otoscope	4	0	2	4	2	--
15.	Oesophagoscope Adult	1 (Desirable)	0	0	1	1	--
16.	Oesophagoscope Child	1 (Desirable)	0	0	1	1	--
17.	Head Light (cold light)	2	1	1	1	1	1 non-functional in JDH
18.	Tracheostomy set	2	0	0	2	2	--
19.	Tuning fork	4	0	0	4	4	--
20.	Bronchoscope Adult & Child	1 (Desirable)	1	0	0	1	1 non-functional in JDH
21.	Examination instruments set (speculums, tongue dipressors, mirrors, Bull's lamp)	4	4	0	0	4	--
22.	Oto Acoustic Emission (OAE) analyzer	1 (Desirable)	0	1	1	0	--
23.	Sound Proof room	1 (Desirable)	0	1	1	0	--

Source: Replies furnished by test-checked districts

Appendix 4.14

(Refer Paragraph 4.5.1)

ENT Equipment – Sub-Divisional Hospitals

Sl. No.	Equipment, as per IPHS (For up to 500-Bedded hospital)	Number required, as per IPHS	Available equipment			Shortage from IPHS norm		
			Ghatal SDH	Islampur SDH	Raghunath pur SDH	Ghatal SDH	Islampur SDH	Raghunath pur SDH
1.	Audiometer	1	1	0	**Not made available**	**0**	**1**	**Not made available**
2.	Impedance Audiometer	1	0	0		**1**	**1**	
3.	Head light (ordinary) (Boyle Davis)	1	1	3		**0**	**0**	
4.	ENT Operation set including headlight, Tonsils	1	0	0		**1**	**1**	
5.	Ear Surgery Instruments set	2	2	1		**0**	**1**	
6.	Mastoid Set	1	1	0		**0**	**1**	
7.	Micro drill system set	2	0	0		**2**	**2**	
8.	Laryngoscope Indirect	1	0	0		**1**	**1**	
9.	Otoscope	1	0	1		**1**	**0**	
10.	Head Light (cold light)	1	1	0		**0**	**1**	
11.	Tracheostomy set	1	1	1		**0**	**0**	
12.	Tuning fork	1	1	1		**0**	**0**	
13.	Oto Acoustic Emission (OAE) analyzer	1	0	0		**1**	**1**	
14.	Sound Proof room	1	1	0		**0**	**1**	

Source: Replies furnished by test-checked districts
Note: Ghatal SDH, in Paschim Medinipur, and Islampur SDH, in Uttar Dinajpur, had non-availability of six types and ten types of equipment, respectively.

Appendix 4.15

(Refer Paragraph 4.5.1)

Eye Equipment – District Hospitals

Sl. No.	Equipment, as per IPHS (For up to 500-Bedded hospital)	Number required, as per IPHS	Available equipment		Shortages as compared to IPHS norms		Remarks
			Jalpaiguri	Basirhat	Jalpaiguri	Basirhat	
1.	Cryo Surgery Unit with retina probe	2	1	0	**1**	**2**	
2.	Opthalmoscope - Direct + indirect	2 + 1	1+1	2	**1+0**	**0**	1 non-functional in JDH
3.	Slit lamp	2	2	1	**0**	**1**	
4.	Retino scope	2	0	2	**2**	**0**	
5.	Perimeter	2	0	0	**2**	**2**	
6.	Binomags	2	0	0	**2**	**2**	
7.	Distant Vision Charts	2	0	2	**2**	**0**	
8.	Near Vision Chart	2	0	1	**2**	**1**	
9.	Colour Vision Chart	2	0	1	**2**	**1**	
10.	Foreign Body spud and needle	2	6	0	**0**	**2**	2 non-functional in JDH
11.	Rotating Visual acuity drum	2	0	1	**2**	**1**	
12.	Trial Frame Adult/ Children	2	0	1	**2**	**1**	
13.	Trial lens set	2	0	2	**2**	**0**	
14.	YAG Laser	1	0	1	**1**	**0**	
15.	Operating Microscope	1	2	2	**0**	**0**	
16.	A-Scan Biometer	1	1	2	**0**	**0**	
17.	Keratometer	1	1	2	**0**	**0**	
18.	Auto Refractometer	1	0	1	**1**	**0**	
19.	Flash Autoclave	1	0	0	**1**	**1**	
20.	Applanation Tonometer	1 (Desirable)	0	1	**1**	**0**	
21.	Phacomachine	1	1	1	**0**	**0**	
22.	Laser Photocoagulator	1 (Desirable)	0	0	**1**	**1**	

Source: Replies furnished by test-checked districts

Appendix 4.16

(Refer Paragraph 4.5.1)

Eye Equipment – Sub-Divisional Hospitals

Sl. No.	Equipment, as per IPHS (For up to 500-Bedded hospital)	Number required, as per IPHS	Available equipment			Shortage, as compared to IPHS norms			Remarks
			Paschim Medinipur	Uttar Dinajpur	Purulia	Paschim Medinipur	Uttar Dinajpur	Purulia	
1.	Opthalmoscope - Direct	1	1	1	**Not made available**	**0**	**0**	**Not made available**	
2.	Slit lamp	1	2	1		**0**	**0**		1 equipment in Paschim Medinipur non-functional for last two years of audit period
3.	Perimeter	1	1	0		**0**	**1**		1 equipment in Paschim Medinipur non-functional for last three years of audit period
4.	IOL Operation Set	2	4	4		**0**	**0**		
5.	Operating Microscope	1	2	1		**0**	**0**		
6.	A-Scan Biometer	1	1	1		**0**	**0**		
7.	Keratometer	1	1	1		**0**	**0**		
8.	Auto Refractometer	1	2	1		**0**	**0**		1 equipment in Paschim Medinipur non-functional for one and a half year of audit period
9.	Flash Autoclave	1	1	0		**0**	**1**		

Source: Replies furnished by test-checked districts

Appendix 4.17

(Refer Paragraph 4.5.1)

Cardiopulmonary Equipment – District Hospitals

Sl. No.	Equipment, as per IPHS (For up to 500 Bedded hospital)	Number required, as per IPHS	Available equipment		Shortage, as compared to IPHS norms		Remarks
			Jalpaiguri	Basirhat	Jalpaiguri	Basirhat	
1.	ECG machine computerized	1	3	3	0	0	--
2.	ECG machine ordinary	2	0	0	2	2	--
3.	12 Channel stress ECG test equipment Tread Mill	1	0	0	1	1	--
4.	Echocardiography Machine	1	0	0	1	1	--
5.	Cardiac Monitor	10	33	0	0	10	4 non-functional in JDH
6.	Cardiac Monitor with defibrillator	2	0	0	2	2	--
7.	Ventilators (Adult)	5	16	0	0	5	--
8.	Ventilators (Paediatrics)	2	0	0	2	2	--
9.	Pulse Oximeter	8	51	0	0	8	22 non-functional in JDH
10.	Pulse Oximeter with NIB.P	1	10	0	0	1	2 non-functional in JDH
11.	Infusion pump	2	11	0	0	2	8 non-functional in JDH
12.	B.P.apparatus table model	25	14	0	11	25	1 non-functional in JDH
13.	B.P.apparatus stand model	25	12	0	13	25	1 non-functional in JDH
14.	Stethoscope	40	64	0	0	40	24 non-functional in JDH
15.	Nebuliser	2	47	0	0	2	15 non-functional in JDH
16.	Peak Expiratory Flow Rate (PEFR) Meter	2	2	0	0	2	--

Source: Replies furnished by test-checked districts

Appendix 4.18

(Refer Paragraph 4.5.1)

Cardiopulmonary Equipment – Sub-Divisional Hospitals

Sl. No.	Equipment, as per IPHS (For up to 500-Bedded hospital)	Number required, as per IPHS	Available equipment			Shortage, as compared to IPHS norms			Remarks
			Paschim Medinipur	Uttar Dinajpur	Purulia	Paschim Medinipur	Uttar Dinajpur	Purulia	
1.	ECG machine ordinary	1	2	4	**Not made available**	0	0	**Not made available**	In Purulia on was out of order for 1 year of audit period and 1 lying is store at Uttar Dinajpur since 31.03.22
2.	Cardiac Monitor	3	0	6		3	0		--
3.	Cardiac Monitor with defibrillator	2	0	1		0	1		--
4.	Ventilators (Adult)	1	12	8		0	0		--
5.	Ventilators (Paediatrics)	1	0	0		1	1		--
6.	Pulse Oximeter	3	6	2		0	1		--
7.	Infusion pump	1	4	2		0	0		--
8.	B.P.apparatus table model	12	0	9		12	3		7 equipment non-functional in Uttar Dinajpur
9.	B.P.apparatus stand model	5	2	0		3	5		--
10.	Stethoscope	15	15	36		0	0		--
11.	Nebuliser	1	5	13		0	0		--

Source: Replies furnished by test-checked district

Appendix 5.1

(Refer Paragraph 5.1)

District-wise availability analysis of primary health facilities in the State
District-wise availability of Sub-Centres

Sl. No.	District(s)	Rural Population, as per Census 2011	Ideal no. of health facilities @ one SC/ 5,000 population	Actually available	Shortage	Percentage of shortage
1	**Nadia**	37,28,727	746	469	277	37.11
2	**Uttar Dinajpur**	26,44,906	529	344	185	34.97
3	**Murshidabad**	57,03,115	1,141	832	309	27.06
4	**Malda**	34,47,185	689	511	178	25.88
5	**Purba Medinipur & Nandigram**	45,03,161	901	706	195	21.61
6	**Birbhum & Rampurhat**	30,52,956	611	484	127	20.73
7	**Coochbehar**	25,29,652	506	406	100	19.75
8	**Purba & Paschim Bardhman**	46,39,264	928	765	163	17.55
9	**Paschim Medinipur & Jhargram**	51,90,771	1,038	858	180	17.35
10	**Bankura & Bishnupur**	32,96,901	659	564	95	14.47
11	**North 24-Parganas & Bashirhat**	42,77,619	856	742	114	13.27
12	**South 24 Parganas & Diamond Harbour**	60,74,188	1,215	1,068	147	12.09
13	**Dakshin Dinajpur**	14,39,981	288	256	32	11.11
14	**Purulia**	25,56,801	511	485	26	5.15
15	**Jalpaiguri & Alipurduar**	28,12,495	562	537	25	4.53
16	**Hooghly**	33,90,646	678	660	18	2.67
17	**Darjeeling & Kalimpong**	11,18,860	224	233	-9	-4.02
19	**Howrah**	17,75,885	355	448	-93	-26.13
	Total:	**6,21,83,113**	**12,437**	**10,368**	**2,069**	**16.64**

Source: Data furnished by H& FW Department, Govt. of West Bengal

Appendix 5.2

(Refer Paragraph 5.1)

District-wise availability of Primary Health Centres

Sl. No.	District(s)	Rural Population, as per Census 2011	Ideal no. of health facilities @ 1 PHC/ 30,000 population	Actually available	Shortage	Percentage of shortage
1	**Nadia**	37,28,727	124	47	77	62.19
2	**Uttar Dinajpur**	26,44,906	88	18	70	79.58
3	**Murshidabad**	57,03,115	190	70	120	63.18
4	**Malda**	34,47,185	115	34	81	70.41
5	**Purba Medinipur & Nandigram**	45,03,161	150	51	99	66.02
6	**Birbhum & Rampurhat**	30,52,956	102	58	44	43.01
7	**Coochbehar**	25,29,652	84	36	48	57.31
8	**Purba & Paschim Bardhman**	46,39,264	155	106	49	31.45
9	**Paschim Medinipur & Jhargram**	51,90,771	173	82	91	52.61
10	**Bankura & Bishnupur**	32,96,901	110	69	41	37.21
11	**Dakshin Dinajpur**	14,39,981	48	19	29	60.42
12	**North 24-Parganas & Bashirhat**	42,77,619	143	50	93	64.93
13	**South 24 Parganas & Diamond Harbour**	60,74,188	202	59	143	70.86
14	**Purulia**	25,56,801	85	54	31	36.64
15	**Jalpaiguri & Alipurduar**	28,12,495	94	38	56	59.47
16	**Hooghly**	33,90,646	113	60	53	46.91
17	**Darjeeling & Kalimpong**	11,18,860	37	22	15	41.01
19	**Howrah**	17,75,885	59	43	16	27.36
	Total:	**6,21,83,113**	**2,073**	**916**	**1,157**	**55.81**

Source: Data furnished by H& FW Department, Govt. of West Bengal

Appendix 5.3

(Refer Paragraph 5.1)

District-wise availability of Community Health Centres (BPHCs/ RHs)

Sl. No.	District(s)	Rural Population, as per Census 2011	Ideal no. of health facilities @ 1 CHC/ 1,20,000 population	Actually available	Shortage	Percentage of shortage
1	**Uttar Dinajpur**	26,44,906	22	9	13	59.09
2	**Nadia**	37,28,727	31	17	14	45.16
3	**Malda**	34,47,185	29	16	13	44.83
4	**Murshidabad**	57,03,115	48	27	21	43.75
5	**Coochbehar**	25,29,652	21	12	9	42.86
6	**South 24 Paraganas & Diamond Harbour**	60,74,188	51	30	21	41.18
7	**Jalpaiguri & Alipurduar**	28,12,495	23	14	9	39.13
8	**North 24-Parganas & Bashirhat HD**	42,77,619	36	22	14	38.89
9	**Purba Medinipur & Nandigram HD**	45,03,161	38	24	14	36.84
10	**Hooghly**	33,90,646	28	18	10	35.71
11	**Dakshin Dinajpur**	14,39,981	12	8	4	33.33
12	**Paschim Medinipur & Jhargram**	51,90,771	43	29	14	32.56
13	**Birbhum & Rampurhat HD**	30,52,956	25	19	6	24.00
14	**Bankura & Bishnupur HD**	32,96,901	27	22	5	18.52
15	**Purba & Paschim Bardhman**	46,39,264	39	34	5	12.82
16	**Purulia**	25,56,801	21	20	1	4.76
17	**Howrah**	17,75,885	15	15	0	0.00
19	**Darjeeling & Kalimpong**	11,18,860	9	12	-3	-33.33
	Total:	**6,21,83,113**	**518**	**348**	**170**	**32.82**

Source: Data furnished by H& FW Department, Govt. of West Bengal

Appendix 5.4

{Refer Paragraphs 5.2.1 (i) & 5.2.1 (ii)}

Physical Infrastructure of the test-checked Sub-Centres

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
Physical Infrastructure							
1	Not having own building	3	1	0	1	2	7
Gross deficiency in availability of physical infrastructure							
2	Labour Room not available	8	8	8	6	8	38
3	No boundary wall and/ or gate	8	2	5	5	6	26
4	No provisions for separate public utility	8	8	8	6	8	38
5	Complaint box not installed	3	6	0	1	0	10
6	Examination room not available	8	8	8	6	8	38
7	Prominent display boards and Patient Charter not available	5	4	0	1	0	10
8	Clinic Room Not Available	8	8	8	6	8	38

Source: Replies furnished by test-checked districts

Appendix 5.5

{Refer Paragraphs 5.2.2 (i) & 5.2.2 (vi)}

Infrastructure of the test-checked Primary Health Centres

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
Building							
1	PHC having own building	4	4	4	3	4	**19**
2	PHC connected by Road	4	4	4	3	4	**19**
3	Garbage collection site/ cattle sheds in the vicinity of the PHC	0	0	1	2	1	**4**
4	PHC having no Boundary wall with gate	3	0	3	2	1	**9**
5	PHC having no Office Room	4	2	3	2	3	**14**
6	PHC having no Store Room	2	4	4	1	2	**13**
7	PHC not displaying available services and timings at a prominent place	2	4	1	0	1	**8**
Barrier-free access and disaster management measures							
8	PHC having no Barrier free access (ramp, hand rail *etc.*) for disabled and elderly	4	4	2	2	2	**14**
9	PHC having no Disaster Management Plan	4	4	4	3	4	**19**
10	PHC staff having no training in disaster management	4	4	4	3	4	**19**
11	No mock drills conducted	4	4	4	3	4	**19**
12	No Waiting area	3	1	0	2	0	**6**
13	Complaint box not installed	1	4	1	3	3	**12**
14	No OPD Room with separate area	3	2	1	2	0	**8**
15	Non-functional beds	2	4	3	2	2	**13**
16	No separate ward for male and female patients	2	3	3	2	3	**13**

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
17	No Separate Public utility (toilet facility in LR room/ ward/ room and at waiting area)	2	3	2	2	3	**12**
18	No Separate Public utility (toilet facility in LR room/ ward/ room and at waiting area)	4	4	2	3	4	**17**
19	No OT (optional) to conduct selected surgical procedures (*e.g.* vasectomy, tubectomy, hydrocelectomy *etc.*)	4	3	2	3	3	**15**
20	No separate area for changing room/sterilisation area/ operating area/ washing area	4	4	4	3	4	**19**
21	PHC having no OT for c-section deliveries	1	3	2	2	2	**10**
22	No Labour room with Labour table	2	3	3	2	3	**13**
23	No Newborn Care Corner with resuscitation facility at LR and at OT	2	3	3	2	2	**12**
24	Labour Room and Newborn Care Corner within LR fitted without radiant warmer	4	4	4	3	4	**19**
25	No Separate area for septic and aseptic delivery	2	1	0	3	2	**8**
26	No residential facilities with 24 hours electricity and water supply	4	4	4	3	4	**19**
27	No Rainwater harvesting and	4	4	3	2	4	**17**
28	Non-adoption of solar energy	4	4	2	2	3	**15**

Source: Replies furnished by test-checked districts

Appendix 5.6

{Refer Paragraphs 5.2.3 (ii), 5.2.3 (v), 5.2.3 (vi) & 5.2.3 (vii)}

Infrastructure of the test-checked CHCs

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
Location							
1	Availability of All weather road	2	2	2	2	2	**10**
Building							
2	No Boundary Wall in the CHCs	1	2	1	2	0	**6**
3	No Display boards in local language on services available and the timings	0	0	1	1	0	**2**
4	No facility of ramps and hand railing	0	0	1	2	0	**3**
5	Ramps without hand railing	0	2	1	0	0	**3**
6	No Disaster Management Plan	1	2	2	2	1	**8**
7	No Fire prevention Plan	1	1	1	1	1	**5**
8	Inadequate fire fighting arrangement	0	1	1	0	1	**3**
Entrance Zone							
9	Charter of Patients' Rights not displayed in prominent places	0	2	0	1	0	**3**
OPD & Emergency							
10	No Minor OT	0	0	1	2	0	**3**
IPD							
11	No patient waiting area in Labour room OT area	0	0	1	0	1	**2**
12	No Pre-operative and Post-operative (recovery) room.	1	2	2	1	0	**6**
13	No Newborn care Corner	0	0	1	0	0	**1**

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
Water Supply & Power backup							
14	No Generator back up for hospital Labour Room and OT	0	2	0	1	1	**4**
15	Non-availability of 5 KVA for immunization cold chain maintenance	0	2	0	0	1	**3**
16	Adequate water supply	0	0	1	0	0	**1**
Administrative Zone							
17	No residential quarters	0	0	1	2	0	**3**
18	No residential quarters for Ward Boys	1	2	1	2	2	**8**
19	No residential quarters for Drivers	2	2	2	1	1	**8**

Source: Replies furnished by test-checked districts

Appendix 5.7

{Refer Paragraphs 5.2.4 (i) & 5.2.4 (iv)}

Physical infrastructure at Districts Hospitals of the State

Facility Name	Is the hospital located near residential area? (Y/ N)	Is the hospital building free from danger of flooding? (Y/ N)	Is the hospital located in an area free from pollution of any kind including air, noice, water and land pollution? (Y/ N)	Is necessary environmental clearance obtained? (Y/ N)	Whether hospital building is diabled friendly as per provisions of Disability Act? (Y/ N)	Compound Wall/ Fencing (All around/ Partial/ None)	ENT	Dental	Dermatology & Venereology	Psychiatry	Neonatology	Orthopaedic	Infectious & Communicable Diseases located in remote corner with independent access
Barasat DH	Y	Y	Y	Y	Y	All around (AR)[199]	Y	Y	Y	Y	Y	Y	Y
Basirhat DH & SSH	Y	Y	Y	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	Y
M. R. Bangur DH & SSH	Y	Y	**N**	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	Y
Alipurduar DH	Y	Y	Y	Y	Y	Partial	Y	Y	**N**	Y	Y	Y	Y
Bishnupur DH & SSH	Not available												
Suri DH & SSH	Y	Y	Y	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	Y
Darjeeling DH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y
Siliguri DH	Y	Y	Y	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	Y
Balurghat DH & SSH	Y	**N**	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y
Imambara DH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y
Howrah DH	Y	Y	Y	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	**N**
Jalpaiguri DH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	**N**	Y	Y
Jhargram DH	Y	Y	Y	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	Y
Kalimpong DH	**N**	Y	**N**	Y	Y	(AR)	Y	Y	Y	Y	**N**	Y	Y
Tamluk DH	Y	Y	Y	Y	Y	(AR)	Y	Y	Y	Y	Y	Y	Y
Nadia DH	Y	Y	**N**	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y
Asansol DH & SSH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y
Nandigram DH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	**N**	Y	**N**

Source: HMIS Data; Note: Y: Yes and N: No

[199] *AR-All around*

Appendix 5.8

{Refer Paragraphs 5.2.4 (i) & 5.2.4 (iv)}

Physical infrastructure at Sub-Divisional Hospitals

Facility Name	Is the hospital located near residential area? (Y/ N)	Free from danger of flooding? (Y/ N)	Located in an area free from pollution of any kind? (Y/ N)	Environmental clearance obtained? (Y/ N)	Building is diabled friendly as per provisions of Disability Act? (Y/ N)	Compound Wall/ Fencing (All around/ Partial/ None)	ENT (Y/N)	Dental (Y/N)	Obstetric & Gynaecologist (Y/N)	Paediatrics (Y/N)	Dermatology & Venereology (Y/N)	Psychiatry (Y/N)	Neonatology (Y/N)	Orthopaedic (Y/N)	Infectious & Communicable Diseases ward located in remote corner with independent access
DR BN BOSE (Barrackpore) SDH	Y	Y	**N**	**N**	Yes	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bongaon SDH & SSH	Not available														
Salt Lake SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	Y	Y	Y	N
Baruipur SDH & SSH	Y	Y	**N**	Y	**N**	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Canning SDH	Y	Y	Y	Y	**N**	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kakdwip SDH & SSH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	**N**	Y	Y
Khatra SDH		Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	**N**	**N**	**N**	Y
Bolpur SDH & SSH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dinhata SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	**N**	Y	**N**	Y
Mathabhanga SDH	Y	**N**	**N**	**N**	**N**	Partial	Y	Y	Y	Y	**N**	**N**	**N**	Y	**N**
Mekhliganj SDH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	**N**	**N**	**N**	Y	Y
Tufanganj SDH	Y	Y	Y	Y	Y	AR	**N**	Y	Y	**N**	**N**	Y	Y	Y	**N**
Kurseong SDH	Y	Y	**N**	Y	**N**	Partial	Y	**N**	Y	Y	**N**	**N**	**N**	**N**	**N**
Gangarampur SDH & SSH	Y	Y	**N**	Y	Y	AR	Y	Y	Y	Y	**N**	**N**	Y	Y	**N**
Islampur SDH & SSH	Y	**N**	**N**	Y	Y	AR	Y	Y	Y	Y	Y	**N**	Y	Y	Y
P C Sen (Arambagh) Govt. MCH	Y	Y	**N**	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y	Y	**N**
Serampore SDH & SSH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chandannagore SDH	Y	Y	**N**	Y	**N**	AR	Y	Y	Y	Y	Y	**N**	Y	Y	**N**

Facility Name	Is the hospital located near residential area? (Y/ N)	Free from danger of flooding? (Y/ N)	Located in an area free from pollution of any kind? (Y/ N)	Environmental clearance obtained? (Y/ N)	Building is diabled friendly as per provisions of Disability Act? (Y/ N)	Compound Wall/ Fencing (All around/ Partial/ None)	ENT (Y/N)	Dental (Y/N)	Obstetric & Gynaecologist (Y/N)	Paediatrics (Y/N)	Dermatology & Venereology (Y/N)	Psychiatry (Y/N)	Neonatology (Y/N)	Orthopaedic (Y/N)	Infectious & Communicable Diseases ward located in remote corner with independent access
Sarat Chandra Chattopadhyay Govt. MCH	Y	Y	Y	Y	**N**	AR	Y	Y	Y	Y	Y	Y	**N**	Y	Y
Mal SDH & SSH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	**N**	Y	**N**	Y	Y
Chanchal SDH & SSH	Y	**N**	Y	Y	Y	Partial	Y	Y	Y	Y	Y	**N**	**N**	Y	Y
Contai SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Egra SDH & SSH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Haldia SD Hospital	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ghatal SDH & SSH	Y	**N**	**N**	Y	**N**	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kharagpur SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Domkol SDH	Y	Y	**N**	Y	**N**	AR	Y	Y	Y	Y	Y	**N**	**N**	Y	Y
Kandi SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	**N**	**N**	Y	Y
Lalbagh SDH	Y	**N**	Y	Y	**N**	AR	Y	Y	Y	Y	Y	**N**	**N**	Y	Y
Jangipur SDH & SSH	Y	Y	Y	Y	Y	Partial	Y	Y	Y	Y	Y	**N**	**N**	Y	**N**
Ranaghat SDH	Y	Y	Y	Y	**N**	Partial	Y	Y	Y	Y	Y	Y	**N**	Y	**N**
Tehatta SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	**N**	**N**	Y	Y	**N**
Durgapur SDH	Y	Y	**N**	Y	Y	AR	Y	Y	Y	Y	Y	Y	**N**	Y	Y
Kalna SDH & SSH	Y	Y	Y	Y	**N**	AR	Y	Y	Y	Y	**N**	Y	**N**	Y	Y
Katwa SDH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	Y	Y	Y	Y
Raghunathpur SDH & SSH	Y	Y	Y	Y	Y	AR	Y	Y	Y	Y	Y	**N**	Y	Y	Y

Source: HMIS data; Note: Y: Yes and N: No

Appendix 5.9

{Refer Paragraph 5.2.4 (iii) & 5.2.4 (v)}

Availability of facilities at District Hospitals

Facility Name	Uninterrupted Electric Supply	Pre-operative Room	Post-operative Room	Scrub-up Room for washing and scrubbing	Examination and Preparation Room	Labour Room (clean and a septic room)	Delivery Room	Neo-natal Room	Sterilizing Rooms	Residential Quarters for all medical and para medical staff (Yes/ No)	Separate toilets for male and female	Fully Equipped delivery unit near OT
Barasat DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Basirhat DH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y
M. R. Bangur DH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Alipurduar DH	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y	Y	Y
Bishnupur DH & SSH	Not available											
Suri DH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y	**N**
Darjeeling DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y	Y
Siliguri DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	**N**
Balurghat DH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Imambara DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Howrah DH	Y	**N**	Y	Y	Y	Y	Y	**N**	Y	**N**	Y	Y
Jalpaiguri DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y	Y
Jhargram DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kalimpong DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y
Tamluk DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nadia DH	Y	Y	**N**	Y	Y	Y	Y	Y	Y	**N**	**N**	Y
Asansol DH & SSH	Y	**N**	**N**	Y	Y	Y	Y	Y	Y	**N**	**N**	Y
Nandigram DH	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y	Y

Source: HMIS data; Note: Y – Yes and N – No

Appendix 5.10

{Refer Paragraph 5.2.4 (iii) & 5.2.4 (v)}

Availability of services at Sub-Divisional Hospitals

Facility Name	Waiting Spaces adjacent to each consultation and treatment room	Registration Counter	Assistance and Enquiry Counter	Fully equipped Operation Theatre	Uninterrupted Electric Supply	Pre-operative Room	Post-operative Room	Scrub-up Room for washing and scrubbing	Examination and Preparation Room	Labour Room (clean and a septic room)	Delivery Room	Neo-natal Room	Separate toilets for male and female	Residential Quarters for all medical and para medical staff	Fully Equipped delivery unit near OT
Dr. B.N. Bose (Barrackpore) SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bongaon SDH & SSH	Not available														
Salt Lake SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Baruipur SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y
Canning SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y
Kakdwip SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Khatra SDH	Y	Y	Y	**N**	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y
Bolpur SDH & SSH	Y	Y	Y	Y	Y	**N**	**N**	Y	Y	Y	Y	Y	Y	Y	Y
Dinhata SDH	Y	Y	Y	Y	Y	**N**	**N**	Y	Y	Y	Y	Y	Y	Y	Y
Mathabhanga SDH	Y	Y	Y	**N**	Y	**N**	**N**	**N**	Y	Y	Y	**N**	**N**	**N**	Y
Mekhliganj SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Tufanganj SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kurseong SDH	Y	Y	Y	Y	Y	**N**	**N**	Y	Y	Y	Y	**N**	Y	Y	**N**
Gangarampur SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**N**	Y
Islampur SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Arambagh SDH **P. C. Sen MCH**	Y	**N**	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Serampore SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chandannagore SDH	Y	**N**	**N**	**N**	Y	**N**	**N**	Y	Y	Y	Y	Y	**N**	Y	Y

Facility Name	Waiting Spaces adjacent to each consultation and treatment room	Registration Counter	Assistance and Enquiry Counter	Fully equipped Operation Theatre	Uninterrupted Electric Supply	Pre-operative Room	Post-operative Room	Scrub-up Room for washing and scrubbing	Examination and Preparation Room	Labour Room (clean and a septic room)	Delivery Room	Neo-natal Room	Separate toilets for male and female	Residential Quarters for all medical and para medical staff	Fully Equipped delivery unit near OT
Uluberia SDH (S.C. Chattopadhyay MCH)	Y	Y	Y	N	Y	Y	Y	Y	N	Y	N	N	N	Y	N
Mal SDH & SSH	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	Y	N
Chanchal SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Contai SDH	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Egra SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Haldia SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ghatal SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Kharagpur SDH	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	N	Y
Domkol SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kandi SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Lalbagh SDH	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	N
Jangipur SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	Y
Ranaghat SDH	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	Y	Y	N	Y
Tehatta SDH	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N
Durgapur SDH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Kalna SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Katwa SDH	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N
Raghunathpur SDH & SSH	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N

Source: HMIS data; Note: Y – Yes and N – No

Appendix 5.11

(Refer Paragraph 5.2.5 A)

Average patient loads on doctors and patient registration counter in the test-checked CHCs

Sl. No.	Name of the CHCs	Years	Number of OPD cases attended	No. of IPD Admissions	Number of Doctor attended OPD	OPD cases per annum/ per doctor	No. of Patient Regiatration counter	Average daily patient load per counter	Average daily paitent load/ counter during 2016-22
1	**Sulkapara RH (Nagrakata)**	2016-17	70,042	0 (non-bedded PHC)*	2	35,021	2	112	129
		2017-18	78,019	0 (non-bedded PHC)*	2	39,010	2	125	
		2018-19	1,05,422	3,039	2	52,711	2	168	
		2019-20	1,10,243	3,491	3	36,748	2	176	
		2020-21	53,475	2,667	3	17,825	2	85	
		2021-22	66,050	2,571	3	22,017	2	106	
2	**Odlabari BPHC (Mal)**	2016-17	70,042	0 (non-bedded PHC)*	2	35,021	1	112	129
		2017-18	78,019	0 (non-bedded PHC)*	2	39,010	1	125	
		2018-19	1,05,422	3,039	2	52,711	1	168	
		2019-20	1,10,243	3,491	3	36,748	1	176	
		2020-21	53,475	2,667	3	17,825	1	85	
		2021-22	66,050	2,571	3	22,017	1	106	
3	**Itahar RH**	2016-17	1,14,470	5,246	1	1,14,470	2	183	177
		2017-18	1,71,881	5,763	1	1,71,881	2	275	
		2018-19	1,26,248	5,262	1	1,26,248	2	202	
		2019-20	1,26,629	5,021	1	1,26,629	2	202	
		2020-21	71,863	2,975	1	71,863	2	115	
		2021-22	53,367	2,763	2	26,684	2	85	
4	**Kunor BPHC (Kaliaganj)**	2016-17	54,000	5,63	1	54,000	1	86	99
		2017-18	37,390	1,387	1	37,390	1	60	
		2018-19	1,29,747	1,752	1	1,29,747	1	207	
		2019-20	45,170	1,809	1	45,170	1	72	
		2020-21	60,724	1,706	1	60,724	1	97	
		2021-22	44,887	1,971	2	22,444	1	72	

Sl. No.	Name of the CHCs	Years	Number of OPD cases attended	No. of IPD Admissions	Number of Doctor attended OPD	OPD cases per annum/ per doctor	No. of Patient Regiatration counter	Average daily patient load per counter	Average daily paitent load/ counter during 2016-22
5	**Rudrapur RH (Baduria)**	2016-17	1,26,382	10,054	9	14,042	1	202	175
		2017-18	1,32,423	95,37	9	14,714	1	212	
		2018-19	1,28,720	6,387	8	16,090	1	206	
		2019-20	1,19,258	6,538	8	14,907	1	191	
		2020-21	77,503	2,791	10	7,750	1	124	
		2021-22	73,505	3,142	10	7,351	1	117	
6	**Sandelerbil RH (Hingalganj)**	2016-17	31,992	1,911	2	15,996	1	51	54
		2017-18	32,643	1,949	2	16,322	1	52	
		2018-19	32,793	1,969	2	16,397	1	52	
		2019-20	34,579	2,177	2	17,290	1	55	
		2020-21	34,914	2,213	2	17,457	1	56	
		2021-22	35,873	2,296	2	17,937	1	57	
7	**Salboni RH**	2016-17	35,265	2,100	4	8,816	5	56	48
		2017-18	58,921	5,577	5	11,784	5	94	
		2018-19	38,270	3,126	5	7,654	5	61	
		2019-20	14,720	1,250	5	2,944	5	24	
		2020-21	13,390	2,315	5	2,678	5	21	
		2021-22	20,270	3,596	5	4,054	5	32	
8	**Sabang RH**	2016-17	86,334	7,364	6	14,389	1	138	130
		2017-18	91,606	8,189	6	15,268	1	146	
		2018-19	96,924	9,182	6	16,154	1	155	
		2019-20	98,975	10,112	6	16,496	1	158	
		2020-21	49,887	4,155	6	8,315	1	80	
		2021-22	65,887	6,775	6	10,981	1	105	
9	**Kushtor RH (Purulia II)**	2016-17	96,541	4,116	4	24,135	1	154	141
		2017-18	1,05,212	5,542	4	26,303	1	168	
		2018-19	1,05,167	5,579	4	26,292	1	168	
		2019-20	1,02,057	5,687	4	25,514	1	163	

Sl. No.	Name of the CHCs	Years	Number of OPD cases attended	No. of IPD Admissions	Number of Doctor attended OPD	OPD cases per annum/ per doctor	No. of Patient Regiatration counter	Average daily patient load per counter	Average daily paitent load/ counter during 2016-22
		2020-21	72,100	3,313	4	18,025	1	115	
		2021-22	46,782	4,036	4	11,696	1	75	
10	**Muradih RH (Santuri)**	2016-17	49,661	1,638	3	16,554	1	79	65
		2017-18	41,697	1,698	3	13,899	1	67	
		2018-19	44,602	2,042	3	14,867	1	71	
		2019-20	51,133	1,994	3	17,044	1	82	
		2020-21	23,383	1,405	3	7,794	1	37	
		2021-22	34,285	1,685	3	11,428	1	55	

Source: Reply furnished by H&FW Department and data furnished by test-checked CHCs
*Note: * During this period, CHCs had functioned as PHCs*

Appendix 5.12

(Refer Paragraph 5.4.1)

SSHs with 500 (10 storied) Beds and 300 Beds (5 Storied)

(as of March 2022)

Sl. No.	District(s)	Name of the SSH	Sanctioned Beds
1	**Dakshin Dinajpur**	Balurghat SSH	500
2	**Birbhum**	Suri SSH	500
3	**South 24 Parganas**	M R Bangur SSH	500
4	**Purulia**	Hatuara SSH	500
5	**Uttar Dinajpur**	Raigunj SSH	500
6	**Jalpaiguri**	Jalpaiguri SSH	500
7	**Alipurduar**	Falakata SSH	300
8	**Bankura**	Barjora SSH	300
9	**Bankura**	Chatna SSH	300
10	**Jhargram**	Gopiballavpur SSH	300
11	**Murshidabad**	Sagardighi SSH	300
12	**Hooghly**	Arambag SSH	300
13	**Uttar Dinajpur**	Islampur SSH	300
14	**Dakshin Dinajpur**	Gangarampur SSH	300
15	**Paschim Medinipur**	Salboni SSH	300
16	**Paschim Medinipur**	Debra SSH	300
17	**Purba Medinipur**	Nandigram SSH	300
18	**Paschim Medinipur**	Jhargram SSH	300
19	**Paschim Medinipur**	Nayagram SSH	300
20	**South 24 Parganas**	Baruipur SSH	300
21	**Malda**	Chanchol SSH	300
22	**Murshidabad**	Jangipur SSH	300
23	**Paschim Medinipur**	Ghatal SSH	300
24	**Paschim Medinipur**	Panskura SSH	300
25	**Purba Medinipur**	Egra SSH	300
26	**Bankura**	Onda SSH	300
27	**Birbhum**	Bolpur SSH	300
28	**South 24 Parganas**	Kakdwip SSH	300
29	**South 24 Parganas**	Metiaburuz SSH	300
30	**Bankura**	Bishnupur SSH	300
31	**Birbhum**	Rampurhat SSH	300
32	**Murshidabad**	Domkal SSH	300
33	**South 24 Parganas**	Diamond Harbour SSH	300
34	**Purulia**	Raghunathpur SSH	300
35	**Paschim Burdwan**	Asansol SSH	300
36	**Purba Burdwan**	Kalna SSH	300
37	**North 24 Parganas**	Basirhat SSH	300
38	**Hooghly**	Seerampure SSH	300
39	**North 24 Parganas**	Bangaon SSH	300
40	**Paschim Medinipur**	Belda SSH	300
41	**Paschim Medinipur**	Salboni SSH	300
42	**Howrah**	Uluberia SSH	300

Source: Data furnished by H&FW Department/ WBMSCL

Appendix 5.13

{Refer Paragraph 5.4.1 (ii)}

Number of functional beds against sanctioned beds in SSHs

(as of March 22)

Sl. No.	District	Name of the SSH	Sanctioned Beds	IPD Services Started	Functional Beds (*per cent*)
1	**Dakshin Dinajpur**	Balurghat SSH	500	01.03.2016	380 (76)
2	**Birbhum**	Suri SSH	500	19.04.2017	436 (87)
3	**South 24 Parganas**	M R Bangur SSH	500	01.02.2017	241 (48)
4	**Purulia**	Hatuara SSH	500	01.12.2020	320 (64)
5	**Alipurduar**	Falakata SSH	300	27.04.2017	180 (60)
6	**Bankura**	Barjora SSH	300	23.11.2015	240 (80)
7	**Bankura**	Chatna SSH	300	05.01.2016	205 (68)
8	**Jhargram**	Gopiballavpur SSH	300	29.06.2016	245 (82)
9	**Murshidabad**	Sagardighi SSH	300	08.02.2016	253 (84)
10	**Hooghly**	Arambag SSH	300	02.06.2017	232 (77)
11	**Uttar Dinajpur**	Islampur SSH	300	15.11.2017	179 (60)
12	**Dakshin Dinajpur**	Gangarampur SSH	300	31.08.2016	239 (80)
13	**Paschim Medinipur**	Salboni SSH	300	30.06.2017	200 (67)
14	**Paschim Medinipur**	Debra SSH	300	30.06.2017	200 (67)
15	**Purba Medinipur**	Nandigram SSH	300	01.01.2017	211 (70)

Source: Data furnished by H&FW Department/ WBMSCL

Appendix 5.14

{Refer Paragraph 5.4.1 (iii)}

Availability of Super Specialty Services in SSHs

(as of March 2022)

Sl. No.	District(s)/ Health District(s)	Name of SSHs	Sanctioned Super Specialty Services	Available Super Specialty Services
1	Bankura	Chatna	ENT	No
2	Bankura	Onda	EYE	EYE
3	Uttar Dinajpur	Islampur	Orthopaedic	No
4	Dakshin Dinajpur	Gangarampur	Trauma Care Unit, ENT and Dialysis	No
5	Alipurduar	Falakata	EYE	No
6	Purulia	Hatuara	ITU, Dialysis and EYE	EYE
7	Birbhum	Bolpur	ITU and EYE	NO
8	Murshidabad	Sagardighi	ENT	No
9	Diamond Harbour HD	Kakdwip	EYE	EYE
10	South 24 Parganas	Metiaburuz	EYE	No
11	Paschim Medinipur	Salboni	EYE	No
12	Paschim Medinipur	Debra	ENT	ENT
13	Nandigram HD	Nandigram	ITU, Dialysis, Burn Unit and Trauma Care	No
14	Bankura	Barjora	ENT	No
15	Jhargram HD	Jhargram	Pathology, ENT and Skin	No
16	Jhargram HD	Nayagram	ENT	No
17	Jhargram HD	Gopiballavpur	EYE	EYE
18	Purba Medinipur	Panskura	EYE and Orthopedics	No
19	Murshidabad	Jangipur	Dialysis and SNCU	No
20	South 24 Parganas	Baruipur	ENT	Audiometric & Thalasemia
21	Uttar Dinajpur	Raiganj	TRAUMA CARE UNIT	No
22	Dakshin Dinajpur	Balurghat	EYE and Orthopedics	No
23	Birbhum	Suri	ENT and Orthopedics	EYE & ENT
24	Paschim Medinipur	Ghatal	Dialysis	EYE & ENT
25	Jalpaiguri	Jalpaiguri	TRAUMA CARE UNIT	No
26	Purba Medinipur	Egra	ENT and Pathology	ENT and Pathology
27	Malda	Chanchol	Pathology and Biochemistry	No
28	Bishnupur HD	Bishnupur	Histopathology, Microbiology, Biochemistry and Orthopedics	No
29	Rampurhat HD	Rampurhat	Pathology, Biochemistry and EYE	No
30	Murshidabad	Domkal	SNCU and CCU	No
31	Purulia	Raghunathpur	ENT and SNCU	ENT
32	Jalpaiguri	Mal / Malbazar	Dialysis and EYE	No
33	South 24 Parganas	M R Bangur	Orthopaedics, Pathology and Biochemistry	No
34	Diamond Harbour HD	Diamond Harbour	ENT	No
35	North 24 Parganas	Bongaon	Ophthalmology and Orthopedics	EYE, ENT, Ortho and Burn
36	Paschim Bardhaman	Asansol	Ophthalmology and ENT	Oncology
37	Hooghly	Arambagh	ENT and Orthopedics	No
38	North 24 Parganas	Basirhat	ENT and TRAUMA CARE UNIT	No
39	Hooghly	Serampore	Ophthalmology and Dialysis	EYE
40	PurbaBardhaman	Kalna	ENT and Dialysis	EYE & ENT

Source: Data furnished by H&FW Department/ WBMSCL

Appendix 5.15

(Refer Paragraph 5.5)

TCFs under 11th FYP

Sl. No.	Type of Cost	Normative cost	11th FYP (₹ in crore)		
			Level-I TCF	Level-II TCF	Level-III TCF
1	Non-Recurring	Building	1.50	0.80	0.65
1		Equipment	10.00	5.00	2.00
3		Communication	0.02	0.02	0.02
4		Legal service & Data Entry	0.01	0.01	0.01
5		Training	0.10	-	-
		Non-recurring total	**11.63**	**5.83**	**2.68**
6	Recurring	Manpower (Max. 3 yrs)	4.30	3.80	2.10
		Total Cost:	**15.93**	**9.63**	**4.78**

TCFs under 12th FYP

Sl. No.	Type of Cost	Normative cost	12th FYP TCFs (₹ in crore)		
			Level-I	Level-II	Level-III
1	Non-Recurring	Building	2.00	1.50	1.00
1		Equipment	12.00	6.00	2.40
3		Communication	0.02	0.02	0.02
4		Legal service & Data Entry	0.01	0.01	0.00
		Non-recurring total	**14.03**	**7.53**	**3.42**
5	Recurring	Manpower (Max. 3 yrs)	3.09	2.73	1.51
		Total Cost:	**17.12**	**10.26**	**4.93**

Source: Data furnished by H&FW Department

Appendix 5.16

(Refer Paragraphs 5.5 & 5.5.1)

TCFs in selected Hospitals

Sl. No.	Name of hospital	Level	Unit cost (₹ in crore)	Funds released by GoI (₹ in crore)		
1	**Burdwan MCH**	II	9.63	2008-09	Construction	0.80
				2011-12	Equipment	3.83
				2020-21	Manpower	2.77
				Total:		**7.40**
2	**North Bengal MCH**	II	9.63	2009-10	Construction	0.80
				2015-16	Equipment	4.99
				2015-16	Communication and legal	0.03
				2020-21	Manpower	0.13
				Total:		**5.95**
3	**Asansol DH**	II	9.63	2008-09	Construction	0.80
				2015-16	Equipment	5.00
				2015-16	Communication and legal	0.03
				2020-21	Manpower	1.90
				Total:		**7.73**
4	**Islampur SDH**	III	4.77	2009-10	Construction	0.65
				2015-16	Equipment	1.98
				2015-16	Communication and legal	0.02
				2020-21	Manpower	1.88
				Total:		**4.53**
5	**Kharagpur SDH**	III	4.77	2006-07	Construction	0.65
				2006-07	Equipment	0.85
				2012-13	Equipment	1.11
				2020-21	Manpower	0.64
				Total:		**3.25**
	Approved cost:		**38.43**	**Grand Total:**		**28.86**

Source: Data furnished by H&FW Department

Appendix 5.17

{Refer Paragraph 5.5.1 (i)}

Non-admissible equipment that had been procured by WBMSCL but was not available with the TCFs

Name of Trauma Care unit	Level	Name of equipment shown as procured by WBMSCL	Admissible	Whether available with the Trauma care unit	Value (₹ in lakh)
			(Yes/ No)		
Islampur	III	3 D Ultrasound machine	No	No	9.93
Kharagpur	III	C-Arm	No	No	9.26
		3 D ultrasound machine	No	No	9.93
		Diathermy	No	No	8.11
		Invasive ventilator (Bi-pap)	No	No	1.75
		Vacuum suction machine	No	No	6.49
		Portable USG machine	No	No	7.16
Asansol	II	Portable USG machine	No	No	7.16
BMCH	II	Portable USG machine	No	No	7.16
		Blood Bank equipment	No	No	14.77
		Autoclave machine	No	No	3.16
Total:					**84.88**

Source: Data furnished by H&FW Department/ WBMSCL

Appendix 5.18

{Refer Paragraph 5.5.1 (i)}

Items shown in WBMSCL list in lumpsum, against which no bills could be produced

Lumpsum items as shown in the list of WBMSCL	Name of the TCFs shown as procured for	Value (₹ in lakh)
Trauma care equipment (craniotomy & Drills)	NBMCH, Burdwan & Kharagpur	69.74
Different instrument set	NBMCH, Islampur & Asansol	72.32
Different Trauma care equipment	Burdwan, Asansol, Kharagpur, Islampur & NBMCH	20.06
Total:		**162.12**

Source: Data furnished by H&FW Department/ WBMSCL

Appendix 5.19

{Refer Paragraph 5.5.1 (ii)}

Requirement *vis-à-vis* availability of equipment in TCFs (Level II)

Sl. No.	Name of Equipment	Requirement as per scheme guidelines	Status of availability of Equipment (as of April 2022)		
			NBMCH	BMC	Asansol
Radiology Equipment					
1	Image intensifier (C-Arm)- with CD Rom, Printer, 12" CCD, Double Monitor, Facilities for Electronic Transmission and Networking for Tele-Radiology with X-ray and DSA facilities for O.T.	1	1	1	0
2	3D Ultrasonography – Trolley based	1	1	1	0
3	500 mA X-ray machine with CR system and camera for both X-ray machine	1	1	1	0
4	100 mA Portable X-ray machine	1	1	0	0
5	CT scan 16 or more slices	1	0	1	0
Rehabilitation Equipment					
6	SW Diathermy	1	2	1	0
7	IFT machine	1	0	1	1
8	Cervical traction & Lumbar traction	1	1	0	0
9	Physiotherapy Equipment	1	0	2	0
Anaesthesia Equipment					
10	OT table- 4 segments, translucent top with orthopedics attachment	2	2	2	1
11	Cautery machine – mono & bipolar	2	2	0	0
12	O.T. ceiling light – shadow less	2	2	2	1
13	Central suction & central pipeline	1	1	2	0
14	High vacuum suction machine	2	2	2	0
15	Anesthesia machine with monitor 6-8 channel (Parameters: Agent monitoring, NIBP, SPO2, ET CO2, ECG, Temp., IBP)	2	2	2	0
16	Transport ventilator	1	1	2	0
17	Ventilator with high and end compressor	10	10	10	0
18	Defibrillator with monitor (Parameters: NIBP, ECG, SPO2 with AED)	10	2	10	0
19	Monitor (Large screen with ECG, SPO2, NIBP, ATCo2)	10	4	10	0
20	Operating head lights	2	0	0	0
21	Manifold system in ICU	1	0	0	0
22	Patient warming system	1	1	1	0
23	Syringe infusion pump	3	3	3	3
Orthopedic Equipment					
24	Pneumatic tourniquet	2	2	2	0
25	Powder drill & power saw	1	1	0	0
26	Splints & traction devices	2	0	0	0
27	General orthopedic instrument sets	2	2	2	0
OT Equipment					
28	General surgical instrument	2 sets	0	2	0
29	Thoracotomy instrument	1 set	0	0	0
30	Spinal surgery instrument	1 set	0	0	0
31	Craniotomy instrument	2 sets	2	1	0
32	Lab automatic blood gas analyzer	1	0	0	0
33	Humidity control meter	1	0	0	0

Source: Data furnished by H&FW Department

*Note: * Equipments at Sl. Nos. 5, 15, 16, 17, 18 and 32 were relocated from Asansol SDH to Singur RH; Equipment at Sl. No. 11 was non-functional*

Appendix 5.20

{Refer Paragraph 5.5.1 (ii)}

Requirement *vis-à-vis* availability of equipment in TCFs (Level III)

Sl. No.	Name of Equipment	Requirement as per scheme guidelines	Availability status of Equipment	
			Islampur	Kharagpur
Radiology Equipment				
1	Ultrasonography – Trolley based	1	1	1
2	500 mA X-ray machine with CR system and camera for both X-ray machine	1	0	1
3	100 mA Portable X-ray machine	1	0	0
Anaesthesia Equipment				
4	O.T. Table – 3 segments, translucent top with Orthopedics attachment	2	1	0
5	Cautery machine – mono & bipolar	2	0	1
6	O.T. ceiling light – shadow less	2	2	0
7	Suction machine	4	2	2
8	Anesthesia machine with monitor (Parameters: Agent monitoring, NIBP, SPO_2, ET CO_2, ECG, Temp., IBP)	2	2	1
9	Transport ventilator	1	2	4
10	Ventilator with high end compressor	5	4	7
11	ABG Machine-hand held analyzer	1	0	1
12	Defibrilator with monitor (Parameters : NIBP, ECG, SPO_2 with AED)	5	0	10
13	Monitor (Large screen with ECG, SPO_2, NIBP, $ATCo_2$)	5	0	7
14	Syringe infusion pump	1	0	1
Orthopedic Equipments				
15	Pneumatic tourniquet	2	1	2
16	Power drill & power saw	1	0	6
17	General orthopedic instrument sets	1 set	1	1
OT Equipments				
18	General surgical instrument	2 sets	2	1
19	Craniotomy instrument	1 set	1	1
20	Humidity control meter	1	0	0

Source: Data furnished by H&FW Department

Appendix 5.21

(Refer Paragraphs 5.5 & 5.5.2)

Details of TCFs and BUs under 12th FYP

Trauma Care Facility (TCF) *(₹ in crore)*

Sl. No.	TCF Unit	Level	Project cost	GoI share (60 *per cent*)	State share (40 *per cent*)	GoI release
1	Murshidabad MCH	II	10.27	6.16	4.10	2.70
2	Ranaghat SDH	III	4.94	2.96	1.97	1.22
3	Alipurduar SDH	III	4.94	2.96	1.97	1.22
4	Diamond Harbour MCH	III	4.94	2.96	1.97	1.22
5	Raiganj DH	III	4.94	2.96	1.97	2.04
	Total:		**30.03**	**18.00**	**11.98**	**8.41**

Burn Unit (BU) *(₹ in crore)*

Sl. No.	TCF Unit	Total cost of project	GoI share (60 *per cent*)	State share (40 *per cent*)	GoI release
1	SSKM	6.57	3.94	2.63	2.60
2	Burdwan MCH	6.57	3.94	2.63	2.60
3	North Bengal MCH	6.57	3.94	2.63	1.24
4	Murshidabad MCH	6.57	3.94	2.63	2.08
5	Malda MCH	6.57	3.94	2.63	2.08
6	Bankura MCH	6.57	3.94	2.63	2. 08
Total:		**39.42**	**23.64**	**15.78**	**12.68**

Source: Data furnished by WBMSCL

Appendix 5.22

(Refer Paragraph 5.5.2)

Calculation of loss of interest due to non-deposit of TCF and BU grants into Interest bearing account and non-remittance of earned interest

Sl. No.	TCF Unit	Allotment of GoI (in ₹)	Date of allotment of GoI	Period and calculation of Simple Interests				Total amount of interest	Cumulative Total
				From	To	Years	Rate of interest		
12th FYP TCFs: Amounts not drawn and kept in State Exchequer:									
1	Murshidabad MCH-II	2,70,00,000	17.11.16	01.04.17	31.03.22	5	3	40,50,000	
2	Ranaghat SDH-III	1,22,40,000	17.11.16	01.04.17	31.03.22	5	3	18,36,000	
3	Aliprduar SDH-III	1,22,40,000	17.11.16	01.04.17	31.03.22	5	3	18,36,000	
4	Diamond Harbour MCH-III	1,22,40,000	17.11.16	01.04.17	31.03.22	5	3	18,36,000	
5	Raiganj DH-II	2,04,00,000	28.09.17	01.04.18	31.03.22	4	3	24,48,000	
Total:		**8,41,20,000**						**1,20,06,000**	**1,20,06,000**
12th FYP Burn Units: Amounts not drawn and kept in state exchequer									
1	Murshidabad MCH	2,07,90,000	04.09.17	01.04.18	31.03.22	4	3	24,94,800	
2	Malda MCH	2,07,90,000	04.09.17	01.04.18	31.03.22	4	3	24,94,800	
3	Bankura MCH	2,07,90,000	04.09.17	01.04.18	31.03.22	4	3	24,94,800	
4	Burdwan MCH	30,10,000	31.12.14	01.04.15	31.03.22	7	3	6,32,100	
Total:		**6,53,80,000**						**81,16,500**	**2,01,22,500**
Total kept in State Exchequer:		**14,95,00,000**							
12 FYP Burn units: Amount drawn and kept in Bank account, but interests not deposited to GoI									
1	SSKM	2,59,90,000	31.12.14	01.04.15	31.03.22	7	3	54,57,900	
2	Burdwan MCH	2,29,80,000	31.12.14	01.04.15	31.03.22	7	3	48,25,800	
3	NBMCH	1,24,70,000	07.12.16	01.04.17	31.03.22	5	3	18,70,500	
Total :		**6,14,40,000**						**1,21,54,200**	**3,22,76,700**
Total 12 FYP:		**21,09,40,000**							
11 FYP TCFs: Amounts kept in Deposit Account (non-intestet bearing) of WBMSCL									
1	WBMSCL	11,97,92,140	22.01.16	01.04.16	31.03.18	2	3	71,87,528	
Total:		**11,97,92,140**						**71,87,528**	**3,94,64,228**
								Total Interest Earned:	**3,94,64,228**

Source: Data furnished by WBMSCL/ West Bengal Health and Family Samity

Appendix 5.23

(Refer Paragraph 5.8)

Salient features of Swasthya Sathi Scheme

- Basic health cover for secondary and tertiary care up to ₹ 5.00 lakh per annum per family.
- Paperless, Cashless, Smart Card based.
- All pre-existing diseases are covered.
- There is no cap on the family size and Parents from both the Spouse are included. All dependent physically challenged persons in the family are also covered.
- The entire premium is borne by the State Government and no contribution from the beneficiary.
- Swathya Sathi Smart card is provided to each family on the day of Enrolment. Smart Card captures the details of the family members, Photographs, biometric, address, Mobile Number, SECC ID.
- Management of the scheme is in paperless IT platform from day one.

(i) Number of families enrolled (year-wise since inception)

District(s)	Number of families enrolled as of					
	31.03.2018	31.03.2019	31.03.2020	31.03.2021	31.03.2022	31.03.2023
Alipurduar	89,998	98,606	2,15,034	3,13,196	3,91,660	4,05,239
Bankura	3,71,364	4,86,052	6,27,994	9,33,351	10,51,443	10,67,958
Birbhum	3,04,686	3,24,185	6,54,049	9,19,897	10,78,403	10,94,938
Coochbehar	2,45,046	2,78,321	3,90,344	5,42,163	7,20,141	7,62,842
Dakshin Dinajpur	1,05,460	1,16,120	2,17,138	3,03,327	4,40,893	4,56,078
Darjeeling	70,961	79,550	1,05,976	2,60,928	3,60,231	3,79,277
Hooghly	2,37,336	3,24,501	6,68,955	11,58,662	14,14,447	14,90,669
Howrah	1,27,011	1,54,051	3,67,119	8,97,408	11,33,954	11,81,612
Jalpaiguri	1,78,587	1,91,751	3,01,090	3,80,578	5,45,365	5,68,133
Jhargram	92,860	1,07,120	1,86,664	2,88,581	3,43,505	3,48,693
Kalimpong	7,656	9,463	21,375	38,237	53,774	55,720
Kolkata	17,325	22,676	92,833	7,07,832	8,24,666	8,73,499
Maldah	2,20,042	2,67,817	4,15,547	7,59,395	10,21,333	10,69,685
Murshidabad	3,37,562	3,91,180	7,93,462	16,84,151	20,73,174	21,04,093
Nadia	2,51,133	2,99,632	6,19,937	11,31,364	14,01,753	14,40,652
North 24 Parganas	3,36,264	3,81,839	6,71,018	16,88,327	22,48,421	23,64,030
Paschim Bardhaman	46,343	52,029	1,64,181	4,88,933	6,38,462	6,74,805
Paschim Medinipur	2,85,939	3,34,730	6,50,947	10,40,226	12,82,364	13,20,303
Purba Bardhaman	1,96,667	2,21,506	7,38,829	12,60,310	14,74,124	14,95,406
Purba Medinipur	3,18,928	3,29,655	5,99,859	11,31,190	14,65,748	14,88,229
Purulia	2,35,522	2,54,684	3,47,249	5,99,106	7,37,940	7,65,934
South 24 Parganas	3,63,783	4,61,263	9,35,568	16,51,110	21,09,302	21,94,728
Uttar Dinajpur	1,15,966	1,20,065	2,22,224	3,96,269	6,51,766	6,98,311
Total	**45,56,439**	**53,06,796**	**1,00,07,392**	**1,85,74,541**	**2,34,62,869**	**2,43,00,834**

Source: Reply furnished by the H&FW Department

(ii) Number of cases enrolled

Period	Number of cases enrolled
From February 2017 to July 2022	34,33,502
From August 2022 to March 2023	13,19,385

Source: Reply furnished by the H&FW Department

(iii) Number of hospitals enrolled (both Govt. & private) (year-wise since inception)

Particulars	Year						
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
No. of hospitals empanelled	635	896	1,307	1,537	2,082	2,395	2,605
a) Public/Govt.	333	434	482	495	508	520	520
b) Private	302	462	825	1,042	1,574	1,875	2,085

Source: Reply furnished by H&FW Department

(iv) Number of beneficiaries availing of benefit (year-wise since inception)

District (s)	Number of beneficiaries as on 31.05.2023
Alipurduar	14,71,887
Bankura	37,91,766
Birbhum	41,44,465
Coochbehar	24,34,527
Dakshin Dinajpur	14,92,596
Darjeeling	12,79,236
Hooghly	51,50,589
Howrah	40,47,072
Jalpaiguri	21,42,053
Jhargram	12,90,044
Kalimpong	1,99,135
Kolkata	27,70,905
Maldah	37,78,246
Murshidabad	75,71,593
Nadia	49,14,241
North 24 Parganas	82,50,708
Paschim Bardhaman	24,34,499
Paschim Medinipur	48,47,681
Purba Bardhaman	55,88,606
Purba Medinipur	52,22,867
Purulia	28,13,195
South 24 Parganas	81,09,326
Uttar Dinajpur	24,56,159
Total:	**8,62,01,396**

Source: Reply furnished by the H&FW Department

Appendix 6.1

(Refer Paragraph 6.1.1)

Budget Analysis of the Health & Family Welfare Department

Type of Expenditure		Financial Year	Central Share (₹ in crore)			State Share (₹ in crore)		
			RE	Release by Dept	Expenditure	RE	Release by Dept	Expenditure
Development Schemes	**Revenue**	2016-17	1,384.16	931.89	1,263.93	1,786.07	1,739.25	1,702.50
		2017-18	1,834.36	1,197.24	1,430.65	2,216.52	2,171.00	2,045.70
		2018-19	2,072.61	1,541.65	1,755.91	1,802.95	1,793.48	1,723.26
		2019-20	2,045.80	1,269.71	1,747.87	2,955.10	2,688.47	2,685.25
		2020-21	2,411.67	1,624.21	1,954.25	3,441.46	3,116.41	3,032.30
		2021-22	4,696.80	2,987.15	3,067.68	7,630.68	5,197.01	5,167.92
		Total	**14,445.40**	**9,551.85**	**11,220.29**	**19,832.78**	**16,705.62**	**16,356.93**
	Capital	2016-17	0.00	0.00	0.00	1,488.78	1,324.01	1,238.79
		2017-18	7.50	7.50	0.00	1,232.09	1,057.04	930.32
		2018-19	15.73	15.03	9.39	1,301.42	1,246.37	1,191.96
		2019-20	10.00	0.00	0.00	1,247.51	937.35	789.62
		2020-21	317.43	108.02	107.99	1,355.25	766.86	749.41
		2021-22	248.28	212.76	212.41	1,398.37	862.68	851.90
		Total	**598.94**	**343.31**	**329.79**	**8,023.42**	**6,194.31**	**5,752.00**
Administrative Expenditure	**Revenue & Loan**	2016-17	0	0	0	4,054.07	4,052.83	3,921.74
		2017-18	0	0	0	4,530.12	4,403.69	4,418.36
		2018-19	0	0	0	5,121.51	5,020.67	4,903.71
		2019-20	0	0	0	5,649.73	5,535.38	5,774.69
		2020-21	0	0	0	6,587.74	6,479.08	6,801.82
		2021-22	0	0	0	7,578.70	7,490.61	7,258.29
		Total	**0**	**0**	**0**	**33,521.87**	**32,982.26**	**33,078.61**
	Capital	2016-17	0	0	0	0	0	0
		2017-18	0	0	0	0	0	0
		2018-19	0	0	0	28.42	28.42	28.42
		2019-20	0	0	0	30.4	30.4	30.4
		2020-21	0	0	0	49.35	49.35	49.35
		2021-22	0	0	0	71.77	71.77	24.30
		Total	**0**	**0**	**0**	**179.94**	**179.94**	**132.47**
Total Admn. Expenditure			**0**	**0**	**0**	**33,701.82**	**33,162.2**	**33,211.08**
Grand Total:			**15,044.34**	**9,895.16**	**11,550.08**	**61,558.02**	**56,062.13**	**55,320.02**

Source: Finance Accounts, Budget Publication of Govt. of West Bengal and Integrated Financial Management Systme

Appendix 6.2

(Refer Parargraph 6.1.1)

Analysis of Revenue and Capital Expenditure

Financial Year	Revenue Expenditure (₹ in crore)	Increase over FY 2016-17 (₹ in crore)	Percentage increase over 2016-17	Capital Expenditure (₹ in crore)	Increase over 2016-17 (₹ in crore)	Percentage increase over FY 2016-17	Total expenditure (₹ in crore)
	A	B	C	D	E	F	G=A+D
2016-17	6,888.45	--	--	1,238.79	--	--	8,127.24
2017-18	7,894.71	1,006.26	14.61	930.32	-308.47	-24.90	8,825.03
2018-19	8,382.88	1,494.43	21.69	1,229.77	-9.02	-0.72	9,612.65
2019-20	10,207.81	3,319.36	48.18	820.02	-418.77	-33.79	11,027.83
2020-21	11,788.37	4,899.92	71.13	906.75	-332.05	-26.80	12,695.12
2021-22	15,493.89	8,605.44	124.92	1,088.62	-150.17	-12.12	16,582.51

Source: Budget Publications of Govt. of West Bengal

Appendix 6.3

{Refer Paragraph.6.1.4 (ii)}

Holding of received funds in bank account, by the WBMSCL, till March 2022

Sl. No.	Fund Received by WBMSCL from	Financial Year of Receipt	Purpose for which received by the WBMSCL	Lying at Bank Account of WBMSCL		
				Amount (in ₹)	From	Number of FY till FY 2021-22
1	DH&FWS, Burdwan	Prior to 2015-16	Procurement of Equipment	6,80,766.00	2016-17	6
2	Institute of PG Medical Education & Research	-Do-	-Do-	1,07,884.00	2017-18	5
3	Calcutta National Medical College	2017-18 & before	-Do-	1,12,774.00	2018-19	4
4	Murshidabad Medical College	2018-19	-Do-	16,87,603.00	2019-20	3
5	Bankura Sammilani Medical College	2019-20 & before	-Do-	9,31,057.00	2020-21	2
6	Calcutta Homoeopathic MCH	2018-19	-Do-	11,01,486.00	2019-20	3
7	M R Bangur Institute	2018-19	-Do-	37,953.00	2019-20	3
8	Kharagpur SD Hospital	2017-18	-Do-	82,43,227.00	2018-19	4
9	Nadia, DH	Prior to 2015-16	-Do-	9,70,676.00	2015-16	7
10	Barasat, DH	-Do-	-Do-	28,559.00	2018-19	4
11	CMOH, South 24 Parganas	2019-20	-Do-	2,09,645.00	2020-21	2
12	Diamondharbour District Hospital	2019-20	-Do-	2,09,272.00	2020-21	2
13	Asansol DH	2017-18	-Do-	2,71,310.00	2019-20	3
14	District Hospital, RKS	2016-17	NA	55,106.00	2017-18	5
15	WBSH & FWS - NVHCP	2020-21	Procurement of KITs	13,25,464.00	2021-22	1
16	Rogi Kalyan District Hospital	2015-16	Procurement of Equipment	26,,634.00	2016-17	6
17	RSBY	2018-19	-Do-	87,249.00	2019-20	3
19	Uttarbanga Unnayan Parishad	Prior to 2015-16	Procurement of Equipment	69,39,806.00	2019-20	3
20	DM, Burdwan	2020-21	NA	42,00,000.00	2021-22	1
21	Howrah Municipal Corporation	2019-20	Procurement of Equipment	6,02,932.00	2020-21	2
22	Kanchrapara Municipality	2018-19	-Do-	2,55,480.00	2019-20	3
23	Titagarh Municipality	2018-19	-Do-	4,45,410.00	2019-20	3
Total:				**2,85,30,293.00**		

Source: Data furnished by WBMSCL

Appendix 6.4

(Refer Paragraph 6.2)

ECRP-I in the financial year 2019-20, under NHM

FMR Code[200]	Particulars	Approved amount as per RoP (₹ in lakh)	Quantity to be purchased as per RoP[201]
B. 31.1	Equipment for molecular test	1,100.00	5
	Equipment for other diagnostics	250.00	5
	Reagent/ Diagnostic kits including provision for sero-surveillance	750.00	5
	VTMs	216.30	1,05,000
B. 31.2	PPE	3,500.00	5,00,000
	N 95 Masks	47.25	1,00,000
	Disposable masks	50.00	5,00,000
	Gloves	42.00	4,00,000
	Alcohol Rub	7.24	2,000 ltrs
B. 31.3	Bi-PAP	18.00	10
	Dialysis Machine (Hemodialysis and Portable dialysis machines)	121.20	10
	Defibrillator/ AED	50.00	10
	USG Portable	90.90	6
	Flash Sterilizers	70.00	10
	Flow meter	7.15	500
	ABG	15.50	5
	Creating adequate hand washing facilities at all facilities (Sub- centre upwards)	121.20	1,515
	Infrastructure including residential quarantine/ isolation facilities	300.00	10
	Ambulance parking and Decontamination area	1.60	100
B. 31.4	Epidemiological unit at district level- Epidemiologist, Microbiologist and Data Manager	2.00	5
	Support Staff	100.00	12,520
B. 31.5	Mobility support for monitoring and readiness	96.25	55
	Ambulance service	3.50	100
B. 31.6	Hardware	3.50	5
	Mobile and Tablet PC	4.80	32
	Telemedicine/ Tele-radiology facility	5.00	Not mentioned in RoP
B. 31.7	Print/ Mass Media/ Digital *etc.*	693.00	
	Social Media interventions	100.00	
B. 31.8	Field surveillance, Contact tracing, data management and reporting	1.00	
	Field surveillance, Contact tracing, data management and reporting	0.50	10
B. 31.9	Diet for quarantined people and patients and hospital staffs	360.00	2,000

Source: Reply furnished by H&FW Department

[200] *Code assigned for different activities for Financial Management under NHM*

[201] *RoP: Records of Proceeding (Approval of Health and Family Welfare Departmtent, Govt.of India for the proposals of State under NHM)*

Appendix 6.5

(Refer Paragraph 6.2)

ECRP-I in the financial year 2020-21

FMR Code	Particulars	Approved amount as per RoP (₹ in lakh)	Quantity to be purchased as per RoP
B. 31.1	Testing and Lab strengthening	2,000.00	Procurement of equipment for molecular test
	Value of Consumables and reagents	657.00	26,28,000
B. 31.2	Personal Protection Equipment	6,020.00	8,60,000
	N 95 mask	425.25	9,00,000
	Mask other than N 95	1,245.22	67,85,000
	Alcohol rub	1,013.60	2,80,000
	Gloves	378.00	36,00,000
	Hydroxy Chloroquine Tablets	974.40	2,10,00,000
	Disinfectant- Sodium Hypochlorite/ Hydrogen Peroxide/ Glutaraldehyde	760.15	Not mentioned in RoP
	Essential Drugs	497.00	
	PPE Kits		
	Masks		
B. 31.3	Procurement of Oxygen	432.00	
	Medical Gas Pipe-line	190.00	
	BiPAP Machines	180.00	100
	Portable RO Plant	210.00	70
	Multi para Monitor	875.00	250
	Defibrillator	300.00	60
	CT Scan Machines	2,200.00	4
	Flash Sterilizers	420.00	60
	Pulse Oxymeter	180.00	300
	Procurement of Flowmeter	45.00	Not mentioned in RoP
	BMW management	223.38	
	Hand washing facility	363.60	
	Ambulance parking	91.00	
	Mortuaries	360.00	45
	Dialysis Machine (Hemodialysis and Portable dialysis machines)	1,575.00	130
	Mobile X-Ray with CR system	1,000.00	100
	USG (Portable)	1,515.00	100
	ABG	201.50	65
	Negative pressure isolation rooms	432.00	5
	Operational/maintenance for equipment/facilities	8.56	Not mentioned in RoP
	Equipment for on-site disinfection	120	
B. 31.5	Monitoring and Facility Readiness visits	288.75	Deploy 55 vehicles
	Referral Transport	1,656.00	552
	Hiring of Hearse Van	200.00	100
B. 31.7	COVID/ Health helpline	1,490.40	Not mentioned in RoP
	Print/ Mass Media/ Digital *etc.* (Publicity)	1,000.00	
Total:		**29,527.81**	

Source: Reply furnished by H&FW Department

Appendix 6.6

(Refer Paragraph 6.2)

ECRP-I in the financial year 2021-22

FMR Code	Particulars	Quantity to be purchased/ setting up as per RoP	Approved amount as per ROP (in crore)
S.1.1	Provision for RAT and RT-PCR tests	--	85.24
	RTPCR test kits	71.03 lakh	
	Rapid Antigen test kits	71.03 lakh	
S.1.2	Lab strengthening of RT-PCR	3 new RTPCR labs & strengthening of 26 RTPCR labs in 20 districts	6.90
S.1.3	Essential drugs for COVID-19 management	Essential drugs for COVID-19 in 28 districts @Rs. 1 crore	28.00
S.2.1	Establishing dedicated Paediatric Care Units	--	60.83
	PICU beds at 21 facilities	319 beds total	
	Hybrid ICU Unit at 25 facilities	12 bedded each (8 HDU bed & 4 ICU bed)	
S.2.2	Establishing Paediatric CoEs at Govt. Hospital	3 at CNMC, BC Roy PGIPS and North Bengal MCH	7.57
S.2.3	Establishing additional beds by provision of Prefab Units closer to the Community	--	42.37
	Establishment of 6 bedded unit	At 75 functional PHCs	
	Establishment of 20 bedded unit	At 100 functional CHCs	
	Establishment of 20 bedded unit	10 additional (1st supplment)	3.50
		04 BPHC (2nd supplement)	1.40
S.2.4	ICU beds in public healthcare facilities including 20% Paediatric ICU beds (MCHs + DHs + SDHs/ CHCs *etc*.)	1847 (434 +305 + 1108) ICU beds in public healthcare facilities including 20% Paediatric ICU beds	311.22
S.2.5	*Field Hospitals*		
	Establishment of 100 bedded Field Hospitals with operational cost for 9 months	18 (1800 beds)	235.30
	Establishment of 100 bedded Field Hospitals	21	157.50
	Establishment of 50 bedded Field Hospitals with operational cost for 9 months	One at Kalimpong DH	6.28
	Establishment of 50 bedded Field Hospitals	04	14.00
S.2.6	Referral transport (for 9 months)	Services of 401 ALS Ambulances	72.18
S.2.7	Support for Liquid Medical Oxygen (LMO) plant (with MGPS) including site preparedness and installation cost	37 LMO and 43 MGPS in 22 districts	33.20
S.3.1	Medical PG Interns	--	13.01
S.3.2	Medical UG Interns	--	24.18
S.3.3	Final year MBBS Students	--	24.18
S.3.4	Final year GNM Nursing students	--	13.85
S.3.5	Final year B.Sc. Nursing students	--	4.43
S.4.1	Hospital Management Information System (HMIS)	At 18 MCHs, 18 DHs and 60 others	16.80

FMR Code	Particulars	Quantity to be purchased/ setting up as per RoP	Approved amount as per ROP (in crore)
S.4.2	Strengthening of Tele-medicine/ Tele consultation Hub	Establishment of 68 hubs with 5 doctors each; Strengthening of 18 hubs with 10 doctors	4.48
		Strengthening of existing 68 hubs plus hub at SSKM and strengthening of 30 COVID care centres	5.70
S.8	Capacity Building and Training for ECRP II components	--	1.87

Source: Reply furnished by H&FW Department

Appendix 7.1

(Refer Paragraph 7.2 (ii))

District-wise analysis of the percentage of suspected new cases not examined

District	No. of suspected new cases referred for confirmation	No. of suspected new cases examined	Suspected new cases not examined	Percentage of suspected new cases not examined
2019-20				
Jhargram	2,397	981	1,416	59.07
Darjeeling	1,562	734	828	53.01
Purba Medinipur	634	386	248	39.12
Birbhum	2,901	1,778	1,123	38.71
Malda	1,286	837	449	34.91
Dakshin Dinajpur	1,879	1,291	588	31.29
Nandigram HD	198	137	61	30.81
Jalpaigudi	8,861	6,167	2,694	30.40
Bashirhat HD	310	219	91	29.35
Nadia	2,480	1,824	656	26.45
South 24 Parganas	4,896	3,646	1,250	25.53
Paschim Burdwan	1,644	1,338	306	18.61
Howrah	3,606	2,989	617	17.11
Bishnupur HD	1,842	1,535	307	16.67
Purba Burdwan	2,433	2,091	342	14.06
Coochbehar	3,808	3,384	424	11.13
Uttar Dinajpur	3,333	3,030	303	9.09
Diamond Harbor HD	3,187	3,066	121	3.80
Paschim Medinipur	5,201	5,105	96	1.85
North 24 Parganas	1,569	1,553	16	1.02
Hooghly	4,385	4,370	15	0.34
Alipurduar	1,468	1,467	1	0.07
Bankura	4,578	4,578	0	0.00
Rampurhat HD	223	223	0	0.00
Kalimpong	0	0	0	0.00
Murshidabad	1,637	1,637	0	0.00
Purulia	16,050	16,050	0	0.00
Kolkata	0	0	0	0.00
Total	**82,368**	**70,416**	**11,952**	**14.51**
2020-21				
Uttar Dinajpur	8,970	6,019	2,951	32.90
Jhargram	1,658	1,192	466	28.11
Alipurduar	2,342	1,753	589	25.15
Paschim Burdwan	3,587	2,813	774	21.58
Nandigram HD	278	220	58	20.86
Nadia	5,826	4,805	1,021	17.52
Darjeeling	1,427	1,238	189	13.24
Purba Medinipur	868	778	90	10.37
Kolkata	5,409	4,870	539	9.96
Howrah	10,578	9,528	1,050	9.93
Rampurhat HD	894	812	82	9.17
Purulia	7,182	6,543	639	8.90
Basirhat HD	2,801	2,573	228	8.14
Malda	8,006	7,367	639	7.98
Birbhum	2,269	2,117	152	6.70
Kalimpong	294	275	19	6.46
Mushidabad	4,243	4,006	237	5.59
Hooghly	3,417	3,376	41	1.20
Diamond Harbour HD	4,663	4,623	40	0.86

District	No. of suspected new cases referred for confirmation	No. of suspected new cases examined	Suspected new cases not examined	Percentage of suspected new cases not examined
Paschim Medinipur	4,679	4,640.03	38.97	0.83
Purba Burdwan	2,182	2,167	15	0.69
North 24 Paraganas	4,240	4,211	29	0.68
Bishnupur HD	926	921	5	0.54
Jalpaigui	4,954	4,943	11	0.22
South 24 Paraganas	947	945	2	0.21
Dakshin Dinajpur	1,084	1,082	2	0.18
Bankura	4,160	4,160	0	0.00
Coochbehar	2,174	2,174	0	0.00
Total	**1,00,058**	**90,151.03**	**9,906.97**	**9.90**

Source: Information furnished by the H&FW Department

Appndix 8.1

(Refer Paragraph 8.1.3)

Status of NQAS in the 38 test-checked SCs

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
1	No quality control team under NQAS	7	8	8	6	8	37
2	Not carried out any internal assessments	7	8	8	6	8	37
3	Not carried out any external assessments	8	8	8	6	8	38

Source: Reply furnished by test-checked districts

Appendix 8.2

(Refer Paragraphs 8.1.3 & 8.1.4)

Status of NQAS in the 19 test-checked PHCs

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
1	No quality control team under NQAS	4	4	4	3	4	19
2	Not carried out any internal assessments	4	4	3	2	1	14
3	Not carried out any external assessments	2	4	2	2	2	12
4	Patient Satisfaction survey not carried out	4	4	2	2	4	16
5	Not conducted any medical audit	3	4	4	3	4	18
6	Not conducted any death audit	4	4	4	3	4	19

Source: Reply furnished by test-checked districts

Appendix 8.3

(Refer Paragraphs 8.1.3, 8.1.4 & 8.2.1)

Status of NQAS in the 10 test-checked BPHCs

Sl. No.	Comments	Paschim Medinipur	Purulia	Bashirhat	Uttar Dinajpur	Jalpaiguri	Total
1	No quality control team	1	2	2	0	1	6
2	No internal assessments carried out	0	2	2	0	1	5
3	No external assessments carried out	1	0	2	0	1	4
4	Patient Satisfaction Survey not conducted	2	2	0	1	0	5
5	Medical Audit not conducted	2	2	2	2	2	10
6	Death Audit not conducted	2	2	2	2	2	10
7	MDR Committee not formed	0	0	2	0	0	2
8	Deaths due to lapses in the Government mechanism	3	0	0	0	0	3

Source: Reply furnished by test-checked districts

ABBREVIATIONS USED IN THE REPORT

Abbreviation	Full Form
AA	Accounts Assistant
AA&FS	Administrative Approval & Financial Sanction
AEFI	Adverse Events Following Immunization
AFHC	Adolescent Friendly Health Clinic
ANC	Antenatal Care
ANM	Auxiliary Nurse and Midwife
AOC	Award of Contract
ASHA	Accredited Social Health Activist
AWW	Anganwadi workers
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BCC	Behaviour Change Communication
BCG	Bacillus Calmette Guerin
BHO	Block Health Officer
BHT	Bed Head Ticket
BLS	Basic Life Support
BMOH	Block Medical Officer of Health
BMW	Bio Medical Waste
BPHC	Block Public Health Centre
BPHU	Block Public Health Unit
BRGF	Border Region Grant Fund
BSU	Blood Separation Unit
BU	Burn Unit
CAG	Comptroller and Auditor General
CBMDR	Community Bases Maternal Death Review
CBMWTF	Common Biomedical Waste Treatment Facility
CCS	Common Collection Site
CCU	Critical Care Unit
CCU	Critical Care Unit
CDR	Child Death Review
CE	Clinical Establishment
CHC	Community Health Centre
CMOH	Chief Medical Officer of Health
CMS	Central Medical Store
CSF	Cerebrospinal Fluid
CSR	Corporate Social Responsibility
CVD	Cardio Vascular Disease
DALY	Disease Adjusted Life Year
DEO	Data Entry Operator
DG	Diesel Generator
DGU	District Geriatric Unit
DH	District Hospital

Abbreviation	Full Form
DHAP	District Health Action Plan
DHC	District Health Committee
DHS	Director of Health Service
DMCHO	District Maternal Child Health Officer
DME	Director of Medical Education
DMMC&H	Deben Mahato Medical College & Hospital
DQAC	District Quality Assurance Committee
DQAU	District Quality Assurance Unit
DQT	District Quality Assessment Team
DRS	District Reserve Store
ECG	Electrocardiography
ECHO	Echocardiogram
ECRP-I	Emergency Covid Response Plan-1
ECT	Electroconvulsive Therapy
EDL	Essential Drug List
EMIS	Equipment Management Information System
FBNC	Facilities Based Newborn Care
ENT	Ear Nose Throat
ER&HSP	Emergency Response & Health System Preparedness Package
FBMDR	Facility Bases Maternal Death Review
FDA	Food and Drug Administration
FLW	Front Line Worker
FPS	Fair Price Shop
FRU	First Referral Unit
FY	Financial Year
FYP	Five Year Plan
GDA	General Duty Assistant
GDMO	General Duty Medical Officer
GDP	Gross Domestic Product
GNM	General Nursing and Midwifery
GoI	Government of India
GoWB	Government of West Bengal
GSDP	Gross State Domestic Product
H&FW	Health & Family welfare
HA	Health Assistant
HA(F)	Health Assistant (Female)
HA(M)	Health Assistant (Male)
HCF	Health Care Facilities
HD	Health District
HDU	High Dependency Unit
HITES	HLL Infratech Services Ltd
HMIS	Health Information Management System

Abbreviation	Full Form
HMO	Homoeopathy Medical Officer
HR	Human Resource
HW(F)	Health Worker (Female)
HWC	Health and Wellness Centre
IBS	Ibuprofen Oral Suspension
ICU	Incentive Care Unit
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education & Communication
IMNCI	Integrated Management of Neonatal and Childhood Illness
IMR	Infant Mortality Rate
IPD	Inpatient Department
IPGMER&R	Institute of Post Graduate Medical Education & Research
IPHS	Indian Public Health Standards
IDSP	Integrated Disease control Programme
IT	Information Technology
JSSK	Janani Sishu Suraksha Karyakram
KFT	Kidney Function Test
KMC	Kangaroo Mother care
KMC	Kolkata Municipal Corporation
KPI	Key Performance Indicator
LFT	Liver Function Test
LHV	Lady Health visitor
LHV	Lady Health visitor
LR	Labour Room
LSS	Laparoscopic Sterilization Services
LT	Lab Technician
LT	Laboratory Technician
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and Child Health
MCH	Medical College & Hospital
MCI	Medical Council of India
MCP	Medical Care Plan
MDR	Maternal Death Review
MGPS	Medical Gas Pipeline System
MIP	Men in Position
MIS	Management Information System
MMC&H	Medinipur Medical college & Hospital
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MRI	Magnetic Resonance Imaging
MSVP	Medical Superintendent cum Vice Principal
MT	Medical Technologist

Abbreviation	Full Form
MTB	Maternity Benefit Programme
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
NABL	National Accreditation Board for Testing and Calibration Laboratories
NBCC	New Born Care Corner
NCD	Non-Communicable Disease
NFHS	National Family Health Survey
NHM	National Health Mission
NHP	National Health Programme
NICU	Neonatal Intensive care Unit
NLEP	National Leprosy Eradication Programme
NMC	National Medical Commission
NMHP	National Mental Health Programme
NMR	Neonatal Mortality Rate
NPCB&VI	National Programme for Control of Blindness & Visual Impairment
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
NPHCE	National Programme for Health Care of Elderly
NPPMBI	National Programme for Prevention and Management of Burn Injuries
NQAS	National Quality Assurance Standard
NRHM	National Rural Health Mission
NSQ	Non-Standard Quality
NSV	Non-Scalpel Vasectomy
NTCP	National Tobacco Control Programme
NTS	National Testing Service
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
OPV	Oral Polio Vaccine
OT	Operation Theatre
PBS	Population Based Screening
PG	Postgraduate
PHC	Public Health Centre
PHM	Public Health Manager
PHN	Public Health Nurse
PHT	Pharmacist
PICU	Paediatric Intensive Care Unit
PIP	Programme Implementation Plan
PMCARE	Prime Minister's Citizen Assistance & Relief in Emergency Situation
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMOA	Primary Medical Ophthalmic Assistant
PNC	Post Natal Care

Abbreviation	Full Form
POL	Petrol Oil & Lubricant
PPH	Post Partum Haemorrhage
PR	Prevalence Rate
PSA	Pressure Swing Adsorption
PW&LM	Pregnant Women and Lactating Mothers
PWD	Public works Department
RBC	Red Blood Cell
RDK	Rapid Diagnostic Kit
RH	Rural Hospital
RMC&H	Raiganj Medical College & Hospital
RMNCH+A	Reproductive, Maternal, Neonatal, Child Health and Adolescence Health
RNTCP	Revised National tuberculosis control Programme
RPR	Rapid Plasma Reagin
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Respiratory Tract Infection
SBA	Skill Birth Attendant
SC	Sub Centre
SDCRL	State Drug Control Research Laboratory
SDH	Sub Divisional Hospital
SGH	State General Hospital
SLTF	State Level Task Force
SMIS	Store Management Information system
SN	Staff Nurse
SNCU	Sick Neonatal Care Unit
SPMU	State Programme Management Unit
SQAC	State Quality Assurance committee
SQAC	State Quality Assurance committee
SQAU	State Quality Assurance Unit
SS	Sanctioned Strength
SSH	Super Speciality Hospital
SSKM	Seth Sukhlal Karnai Memorial Hospital
STD	Sexually Transmitted Diseases
TAT	Turn Around Time
TCF	Trauma Care Facility
TT	Tetanus Toxoid
ULB	Urban Local Body
USG	Ultrasonography
UT	Union Territory
VC	Vision Centre
VHND	Village Health and Nutrition Days
VIA	Visual Inspection of Cervix with Acetic Acid
WBC	White Blood Cell

Abbreviation	Full Form
WBMSCL	West Bengal Medical Service Corporation
WBPCB	West Bengal Pollution Control Board
WHO	World Health Organisation
WMWCD	Ministry of Women and Child Development

https://cag.gov.in/ag1/west-bengal/en