THIRTEENTH KERALA LEGISLATIVE ASSEMBLY

COMMITTEE ON PUBLIC ACCOUNTS (2014-2016)

FIFTY SIXTH REPORT

(Presented on 9th July, 2014)

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SECRETARIAT OF THE KERALA LEGISLATURE
THIRUVANANTHAPURAM
2014

THIRTEENTH KERALA LEGISLATIVE ASSEMBLY

COMMITTEE
ON
PUBLIC ACCOUNTS
(2014-2016)

FIFTY SIXTH REPORT

On

Paragraphs relating to Health and Family Welfare Department contained in the Report of the Comptroller and Auditor General of India for the year ended 31 March, 2009 (Civil)

1097/2014.

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INTRODUCTION

I, the Chairman, Committee on Public Accounts, having been authorised by the Committee to present this Report, on their behalf present the 56th Report on paragraphs relating Health and Family Welfare Department contained in the Report of the Comptroller and Auditor General of India for the year ended 31 March 2009 (Civil).

The Report of the Comptroller and Auditor General of India for the year ended 31 March, 2009 (Civil) was laid on the Table of the House on 25th March, 2010.

The Committee considered and finalised this Report at the meeting held on 30th June, 2014.

The Committee place on record their appreciation of the assistance rendered to them by the Accountant General in the Examination of the Audit Report.

DR. T. M. THOMAS ISAAC,
Chairman,
Committee on Public Accounts.

Thiruvananthapuram,
9th July, 2014.

REPORT

HEALTH AND FAMILY WELFARE DEPARTMENT

AUDIT PARAGRAPH

National Rural Health Mission

The National Rural Health Mission was launched by the Government of India in April 2005. It aimed at strengthening rural health care institutions by provision of infrastructure facilities and funds. A review of the implementation of the National Rural Health Mission in the State revealed improvement in the flow of funds of rural health institutions, upgrade infrastructure in some of the institutions and better health awareness among the rural population. However, deficiencies like absence of a Perspective Plan, accumulation of huge unspent funds in banks, slow pace of upgradation work in some institutions, lack of medical and paramedical staff, etc., were noticed.

Although only sample household surveys were carried in three test-checked districts, facility surveys required for identifying the health care needs of rural areas were conducted only in Community Health Centres through the guidelines stipulated that these were also to be carried-out in Primary Health Centres and Sub Centres.

No Perspective Plan for the Mission period was prepared by the State Health and Family Welfare Society to ensure execution of projects along a critical path.

National Rural Health Mission funds of ₹ 1.48 crore were spent during 2007-08 and 2008-09 for activities not approved by Government of India in the annual programme Implementation Plans and ₹ 51.86 lakh was diverted without their approval.

Management expenditure during 2007-08 and 2008-09 exceeded the prescribed limit of six per cent.

Construction of buildings for only 70 out of 115 Community Health Centres had been completed. Construction of buildings for 50 Sub Centres had not been started as of September 2009.

Accredited Social Health Activists selected during 2007-08 and 2008-09, were not imparted training in three out of five prescribed modules.

Manpower, infrastructure and equipment in Community Health Centres and Primary Health Centres did not meet the Indian Public Health Standards despite upgradation through National Rural Health Mission funds.

Guidelines and the Purchase Preference Policy prescribed by Government of India for procurement of medicines were not followed. No pre-despatch or postdespatch inspections of drug kits, surgical kits and Accredited Social Health Activists' drug kits were conducted. Non-levy of penalty for delayed supplies of medicines amounted to ₹ 3.18 crore.

Supply of surgical kits and Accredited Social Health Activists' drug kits was made by M/s Karnataka Antibiotics and Pharmaceuticals Limited after purchasing them from private firms at lesser prices. As a result, the supplier earned undue benefit of ₹ 3.78 crore and the State Health and Family Welfare Society incurred extra expenditure of an equivalent amount.

An effective Health Management Information System was not set-up though hardware and software for ₹ 4.70 crore were procured for the purpose.

Under the 'Integrated Disease Surveillance Project', hardware and accessories procured for video-conferencing units at the district level at a cost of ₹ 54.82 lakh were lying idle as of March 2009 as the State level video-conferencing unit had not been set-up due to non-provision of space by the Director of Health Services.

Introduction

The National Rural Health Mission (NRHM) was launched by Government of India (GOI) in April 2005 throughout the country with special focus on 18 States. The Mission aimed at providing accessible, affordable, accountable, effective and reliable health care facilities in the rural areas by reducing the infant and maternal mortality rates, stabilising the total fertility rate of the population as well as preventing and controlling communicable and non-communicable diseases, including locally endemic diseases by involving the community in

planning and monitoring. The key strategy of the Mission was to bridge gaps in health care facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II and various disease control programmes. It sought to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. In Kerala, the State Health Mission (SHM) for implementation of various interventions under NRHM was set-up in September 2006 and the State Programme Management Support Unit* was institutionalised in December 2006. The State Health and Family Welfare Society (SHS) and the District Health and Family Welfare Societies (DHS) were formed in April 2007. Prior to this, the activities under NRHM were being implemented by the Director of Health Services.

Organisational Set-up

At the State level, NRHM functions under the overall guidance of the SHM under the Chairmanship of the Chief Minister. The activities of the SHM are carried-out through the SHS headed by the Health Minister. The Executive Committee of the SHS is headed by the Secretary, Health and Family Welfare Department.

At the district level, there are District Health Missions and DHSs headed by the Chairpersons of the District Panchayats. Their Executive Committees are headed by the District Collectors. The implementation of various disease control programmes is supervised by the respective heads of the Disease Control Programmes.

Audit Objectives

The objectives of the performance audit were to assess whether:

- the planning process at the village, block, district and State levels were adequate;
- the assessment, release and utilisation of funds were efficient and effective;

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* Secretariat to the SHM as well as the SHS. It provides technical support on logistics, financial management, tracking of funds, etc.

- capacity building and strengthening of physical and human infrastructure were as per the Indian Public Health Standards (IPHS)* norms;
- the systems and procedures of procurement and distribution of drugs and services were cost-effective and efficient and ensured improved availability of drugs and services;
- the performance indicators and targets fixed, especially in respect of reproductive and child health care, immunisation and disease control programmes were achieved; and
- the level of community participation was as per the guidelines.

Audit Criteria

The audit criteria adopted for arriving at the audit conclusions were the following:

- The GOI framework on implementation of NRHM,
- Guidelines issued by GOI for various components, disease control programmes, financial aspects etc.,
- Circulars issued by GOI, containing directions for NRHM activities,
- Orders and instructions issued by the State Government, and
- IPHS for upgradation of health centres.

Scope and Methodology of Audit

The performance audit was conducted from April 2008 to June 2009, covering the period from 2005-06 to 2008-09 by test check of records in the Department of Health and Family Welfare, the Directorate of Health Services, the SHS and Disease Control Societies. In addition, three† out of 14 DHSs were selected for detailed review. In the above three districts, three Taluk Headquarters Hospitals, three District Hospitals, six Community Health Centres (CHCs),

* A set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

† Palakkad, Thiruvananthapuram and Wayanad.

12 Primary Health Centres (PHCs) and 24 Sub Centres (SCs) were also selected using the Simple Random Sampling Method. Besides, data relating to 71 CHCs and 83 PHCs from all the districts were collected and analysed.

An entry conference was held with the Secretary to Government, Health and Family Welfare Department in April 2008, during which the audit objectives and criteria were discussed. Another meeting was held with the Secretary in February 2009, wherein certain State specific issues were discussed.

An exit conference with the Secretary was conducted on 10th August, 2009 during which the audit findings were discussed.

Audit Findings

Planning

NRHM envisaged a decentralised and participatory planning process with a bottom-up approach from village level to the State level. The State and districts were, thus, required to prepare Perspective Plans for the Mission period (2005-2012). Action plans for each year were to be prepared by the SHS by consolidating all the districts level plans to enable interventions in the health sector. Household surveys at the levels of CHC, PHC and SC were to be conducted for preparing comprehensive District Action Plans. Audit scrutiny revealed that only a sample household survey was conducted by the Department of Community Medicine of the Medical College, Kozhikode in selected panchayaths and municipalities of three* out of 14 districts during February-March 2007. Consequently, the Annual Action Plan were prepared without adequate field data, rendering the planning process defective.

AS per NRHM guidelines, facility surveys to ascertain the facilities available at the CHC/PHC/SC level were to be carried-out in all the districts by 2008. It was seen in audit that facility surveys were conducted in all the 115 CHCs during

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* Kannur, Malappuram and Wayanad.

September-December 2006. However, no facility survey had been carried-out in any of the PHCs and SCs as of May 2009.

Government stated (September 2009) that as the State Programme Management Support Unit was institutionalised only in December 2006 and SHS started functioning from April 2007, there were delays in conducting necessary field surveys to collect essential data for preparing the Annual Plans. As regards the facility survey, the Government states (September 2009) that such surveys had been conducted in all the CHCs in the first stage, Facility surveys in PHCs would be taken up in phases in due course and the entire exercise would be completed in stages.

However, the fact remains that the State Government took two years, since the launch of NRHM to establish the set-up for NRHM and even after these two years, all the required household surveys and facility surveys, had not been conducted (September 2009). Thus, the formulation of the Annual Action Plans was deficient to this extent.

Action Plans at Village, Block and District levels

Due to delays in setting-up of the SHS and DHSs, no Action Plans were prepared for NRHM during 2005-06 and 2006-07. Only proposals for Reproductive and Child Health II(RCH II) were sent to GOI for these years and funds were released by GOI on the basis of these proposals. In 2007-08, Plans at the Sub Centre, block, district and in 2008-09, Action Plan below the State level were not prepared, instead State level were prepared as per the NRHM guidelines. However, fund requirements under various heads were collected from all the institutions and furnished to the SHS for preparation of a detailed State Level Action Plan. Consequently, prioritization of issues at the district level and below the district level could not be done in the State Action Plan for 2008-09.

Government stated (September 2009) that institution-based Action Plans were the basis for 2008-09. During 2010-11, ward would be the basis for preparation of Action Plans.

Perspective Plan

The SHS did not submit a Perspective Plan, as envisaged in the NRHM guidelines to GOI for the Mission period. No Perspective Plans had been prepared by the DHSs in the three test-checked districts of Palakkad, Thiruvananthapuram and Wayanad. Government stated (September 2009) that the SHS had a clear Perspective Plan in terms of clearly laid down technical targets for the Mission period and for each year. Action Plans were prepared by the State with reference to these targets and goals. It was, however, found that the SHS had only fixed targets to be achieved in the Annual Action Plans, but had not prepared a comprehensive Perspective Plan for the entire Mission period. In the absence of such a plan, the convergence of vertical health programmes, monitoring with reference to performance indicators; rationalization of manpower and resources available, etc., was not possible. Thus, the SHS had not evolved a systematic Perspective Plan based on reliable inputs for scheduling each and every activity in a critical path to execute the same within the time frame to ensure economy efficiency and effectiveness in the implementation of NRHM.

Financial Management

Fund Management

GOI provided 100 per cent grant-in-aid to the State Government for the years 2005-06 and 2006-07. During the Eleventh Plan (2007-2012), the contribution was to be in the ratio of 85 : 15 between the Centre and the State. Funds released by GOI for the components* were credited to one single bank account while funds for the National Disease Control Programmes were credited to the bank accounts of the respective societies responsible for these programmes.

* RCH-II: Maternal health, child health, family planning, tribal health, etc., Additionalities: Hospital Management Committee, untied grant, maintenance grant, etc., and Immunisation: Pulse Polio immunisation and routine immunisation.

The funds released by GOI to the SHS during 2005-2009 *vis-à-vis* the expenditure incurred were as follows:

TABLE 1.8: AVAILABILITY OF FUNDS AND EXPENDITURE *(Rupees in crore)*

Year	Opening balance	Funds received from GOI	State share received	Total funds available	Expenditure	Closing balance	Percentage of savings
2005-06	7.70*	44.90	Nil	52.60	11.14	41.46	79
2006-07	41.46	88.29	Nil	129.75	33.36	96.39	74
2007-08	96.39	229.95	Nil	326.34	154.52	171.82	53
2008-09†	171.82	151.29	53.25	376.36	290.54	85.82	23
Total		514.43	53.25		489.56		

Source: Annual accounts certified by Chartered Accountants.

In the first three years, i.e., 2005-2008, utilisation of funds was less than 50 per cent , mainly due to delalys in setting-up the SHS and the DHSs. During 2008-09, expenditure was 77 per cent of the available funds. The major items of expenditure were on Janani Suraksha Yojana‡ (₹ 12.84 crore) appointment of contractual staff (₹ 34.50 crore), procurement of drug kits (₹ 27.38 crore), grant-in-aid to SC, PHC,CHC and other hospitals (₹ 38 crore) and strengthening/ upgradation of health centres (₹ 62.03 crore).

It was seen in audit that during 2007-2009, the State Government contributed ₹ 53.25 crore against its committed share of ₹ 55.02 crore, resulting in short contribution of ₹ 1.77 crore. There were unspent balances ranging from ₹ 41.46 crore to ₹ 171.82 crore at the close of each financial year during 2005-2009.

Government stated (September 2009) that the State Programme Management Support Unit was institutionalised only in December 2006 and that

* Opening balance of National Disease Control Programme and Information, Education and Communication activities.

† Financial Management Report (not certified by Chartered Accounts).

‡ A scheme to promote safe delivery at health centres by providing cash incentives to pregnant women and Auxiliary Nurses or Accredited Social Health Activists.

the District Programme Managers were put in place only at the beginning of 2007. Also, the gestation period would be high since NRHM activities involved upgradation of facilities, etc. However, the fact remains that Government could utilise only 21 to 26 per cent of the funds during the first two years (2005-2007) due to delay in establishing the set-up for implementing NRHM in the state.

Low utilisation of funds

Government of India, Ministry of Health and Family Welfare, released funds to the State based on the progress of expenditure. Due to low utilisation of funds during the initial years of implementation of NRHM, ₹ 5.51 crore and ₹ 1.95 crore sanctioned for the National Immunisation Day, RCH II Flexible Pool*, Mission Flexible Pool† and strengthening of immunisation were not released by the Ministry during 2006-07 and 2007-08 respectively. Government stated (September 2009) that the low utilisation of funds was due to delays in formation of the State Programme Management Support Unit and SHS.

Out of ₹ 154.21 crore released to the 14 DHSs during 2005-06 to 2007-08, the actual expenditure was only ₹ 86.13 crore while the balance of ₹ 68.08 crore remained unutilised with them.The expenditure for 2005-06 and 2006-07 was below 20 per cent of the funds released. Government stated (September 2009) that there were delays in generating consensus on the action to be taken for utilising the funds released to the hospitals as well as in accounting of the expenditure as the hospital management committees were headed by elected members. Government also added that necessary orders had been issued to organise regional level workshops to collect statements of expenditure and utilisation certificates from the institutions concerned.

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* RCH II Flexible Pool: Discretionery resources made available to the States with the flexibility to make plans and for utilisation for maternal health, child health, family planning, tribal health, etc. according to their needs.

† Mission Flexible Pool: Discretionary resources made available to the States with the flexibility to make plans and for utilisation for Hospital Management Committee, untied grant, annual maintenance grant, etc.

Release of corpus grant, untied grant and annual maintenance grant

Each CHC was entitled to receive Rupees one lakh, as a corpus and a maintenance grant and an untied grant totalling ₹ 50,000. Each PHC was entitled to receive ₹ 50,000, as a corpus and a maintenance grant and an untied grant ₹ 25,000. During 2006-07 to 2008-09, ₹ 81.12 crore* was sanctioned by GOI towards corpus grant (₹ 25.98 crore), maintenance grant (₹ 24.27 crore) and untied grant (₹ 30.87 crore).

Information collected from 71 out of 115 CHCs and 83 out of 929 PHCs through questionnaire revealed that one to 46 CHCs and four to 66 PHCs received the entitled grants during 2006-09 as detailed below:

TABLE 1.9 NUMBER OF CHCS/PHCS WHO RECEIVED ENTITLED GRANTS

Year	Corpus grant		Maintenance grant		Untied grant	
	Number of CHCs	Number of PHCs	Number of CHCs	Number of PHCs	Number of CHCs	Number of PHCs
2006-07	1	4	9	17	13	26
2007-08	32	48	35	65	41	66
2008-09	40	45	44	52	46	57

Source: Details collected through pro forma from CHCs and PHCs.

It may thus be seen that the additional resources provided by GOI for the CHCs and PHCs did not reach a large number of these institutions, despite the availability of funds. Government stated (September 2009) that during 2006-07 and 2007-08 the entire amount approved by GOI for payment of grant was released to the CHCs/PHCs through the District Health Societies. But during 2008-09 grants were released only to those CHCs/PHCs which utilised 80 per cent of the funds released earlier. However, the information received by Audit from the CHCs/PHCs revealed that the grants were received by a few institutions as shown in the table above.

* Figures adopted from the proceedings of meetings of National Programme Co-ordination Committee of GOI, Ministry of Health and Family Welfare during 2006-07 to 2008-09.

Lapses in budgetary control

GOI approved ₹ 80 lakh towards selection and training of Accredited Social Health Activists (ASHA*) during 2006-2008 and Rupees five crore for procurement of ASHA drug kits during 2008-09. However, the SHS spent ₹ 6.81 crore and ₹ 16.69 crore respectively for the above purposes against the approved amounts which resulted in excess expenditure of ₹ 17.70 crore. Further, in the test-checked districts, it was noticed that NRHM funds were utilised for unapproved activities as described below:

- The SHS released ₹ 91.20 lakh (2007-08 and 2008-09) towards stipend for BSc(Nursing) Students, Rupees six lakh (2008-09) as maintenance grants to six CHCs where upgradation work was in progress and ₹ 16.20 lakh (2007-08 and 2008-09) to Hospital Management Committees (HMC) of the General Hospitals at Thiruvananthapuram and Wayanad. In response to Audit, the State Mission Director (SMD) stated (July 2009) that stipends had been given to nursing students to resolve the shortage of nurses. Maintenance grants to CHCs under upgradation and funds to the HMCs of the General Hospitals were provided because these units were running short of funds. The reply is not acceptable as it was the responsibility of the State Government to provide adequate funds for such activities which were not covered under NRHM.

- As per NRHM guidelines, SCs attached to CHCs/PHCs were not entitled for untied grants. Contrary to this, DHS provided untied grants of ₹ 14.50 lakh to SCs attached to CHCs/PHCs during 2007-08 and 2008-09. In response, the SMD stated (July 2009) that the districts concerned had been asked to explain the reasons for this action.

- A refundable loan of Rupees seven lakh was released (2007-08) to the Kerala State Institute to Virology and Infectious Diseases, Alappuzha. ₹ 13.30 lakh was released (2008-09) towards routine expenses (purchase of furniture, fuel charges, etc.,) of the Kerala Medical Service Corporation.

* A trained coimmunity health worker to be provided in each village for assisting in neonatal care, prevention and cure of common childhood diseases, immunisation and family planning activities and other activities for control of malaria, tuberculosis, leprosy, etc.

These activities were not covered under NRHM. The SMD stated (July 2009) that the institutions had been asked to refund the amounts.

- An amount of ₹ 51.86 lakh, approved for the constitution of 14 Mobile Outreach Units and payment of salaries to Junior Public Health Nurses in urban wards, was diverted (2007-08 and 2008-09) for meeting expenses relating to ward health sanitation activities. In response, the SMD justified the diversion and states (July 2009) that funds were released to selected urban wards in the State to enable them to initiate action for their designated activities, with a special focus on mothers. However, the diversion was made without the approval of GOI and hence was irregular.

Management expenditure

As per NRHM guidelines, management expenditure should not exceed six per cent of the approved amount under RCH-II. During 2005-06, the expenditure on management was below six per cent, whereas it exceeded the limit by ₹ 3.08 crore during 2007-08 and 2008-09. Audit scrutiny revealed that inadmissible expenditure unconnected with the activities of NRHM like Nurses/Doctors day celebration, wages to drivers attached to the Ministers Office, wages to staff of the Kerala Medical Service Corporation Limited, entertainment of visitors, etc., was incurred during the period, contribution to the excess.

Accounting System

The annual accounts for the years 2005-06, 2006-07 and 2007-08 were audited and certified in December 2006, February 2008 and May 2009 respectively while accounts for 2008-09 had not been prepared till June 2009. The SMD stated (July 2009) that the Audit Report for 2008-09 was expected to be ready by July 2009. However, the audited accounts for 2008-09 had not been finalised as of August 2009.

Upgradation of Health Care Infrastructure and Capacity Building

The core strategy of NRHM includes strengthening of health institutions through better human resource development and providing adequate infrastructure and equipment to raise them at par with Indian Public Health Standards. GOI approved upgradation of 174 health care institutions at a cost of ₹ 142.40 crore

during 2006-2009. The construction works were entrusted to five Government agencies* and ₹ 49.75 crore was released to them up to March 2009. Construction of buildings for only 34 institutions out of 174 had been completed as of March 2009.

GOI also released ₹ 20.18 crore during 2006-2009 for upgradation of the Institute of Maternal and Child Health, Kozhikode to a Centre of Excellence. Rupees 4.58 crore was released as advance to Hindustan Prefab Limited for installation of a sewage treatment plant for the institute during 2007-2009. Only the work of the sewage treatment plant was completed. The remaining work of laying of a pipeline within the premises and external pipelines to carry the treated effluents was still to be completed (September 2009).

Delay in completion of upgradation of CHCs

Hindustan Latex Limited (HLL) was appointed as the consultant for upgradation work of building infrastructure of CHCs in the State. As per the agreement signed for the purpose in February 2007, HLL was to prepare a detailed project report on the basis of a facility survey, get it approved by the hospital management committee of the CHCs and then prepare estimates for the works. Administrative sanction for the work was to be given by the SHS. During 2006-2009, upgradation of 115 CHCs had been entrusted to HLL at an estimated cost of ₹ 35.66 crore. ₹ 27.16 crore was paid as advance to HLL. It was observed that construction of only 22 CHCs had been completed as of March 2009. Work on 91 CHCs was in progress at various stages. Work was still to be started in the other two CHCs. None of the 22 CHCs which had been constructed had been upgraded as per the IPHS so far.

Government stated (September 2009) that the delay in upgradation of CHCs was due to various reasons such as delays in constitution of institutional level committees, revision of estimates to suit the budget, poor response of contractors to tender notifications, etc., which were beyond their control. The Government also stated that work had been completed in 70 out of 115 CHCs and work in the other CHCs was in progress. Government added that tendering procedures had almost been completed for procurement of equipment for a few CHCs and equipment for the remaining CHCs would be given according to availability of funds.

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* Hindustan Prefab Limited, Hindustan Latex Limited, Kerala Health Research and Welfare Society, Kerala Police Housing Construction Corporation and Kerala State Nirmithi Kendra.

Construction of buildings for Sub Centres

In order to provide their own buildings to 2020 SCs, which were functioning in rented buildings, GOI approved in the Programme Implementation Plan for 2007-08, construction of buildings for 50 SCs at an estimated cost of ₹ 3.30 crore (₹ 6.60 lakh per SC) and for the balance 1970 SCs during the subsequent years (2008-09: 700 and 2009-10: 1270). However, the construction of buildings was not taken up as of September 2009 as priority was given to CHC upgradation.

Government stated (September 2009) that the District Programme Managers had been instructed to submit proposals for upgradation of SCs under their jurisdiction and the work would be prioritised after the receipt of these proposals.

Deficiencies in the selected institutions

During field visits to the selected institutions in the sample districts, the following deficiencies were noticed:

- The blood storage centre at the Taluk Headquarters Hospital, Ottappalam, Palakkad, for which ₹ 1.55 lakh was spent during 2006-07, had not started functioning due to the absence of a trained blood bank technician. Government stated (September 2009) that the technician would be given training shortly.

- An outpatient block completed in March 2009 at a cost of ₹ 25.26 lakh for CHC, Kadampazhipuram, Palakkad was not fully utilised due to shortage of specialist doctors and paramedical staff. Government stated (September 2009) that the outpatient wing was currently functional and an attempt was being made for getting the services of specialist doctors.

- Equipment viz., incubators, suction apparatus, etc., purchased in December 2008, at a cost of ₹ 10 lakh, for renovation of the children's ward at the Taluk Headquarters Hospital, Ottappalam, Palakkad was not utilised as of April 2009, due to lack of three-phase electrification. Purchases were made without ensuring availability of space and usability of the equipment. Government stated (September 2009) that action was under way for getting three-phase electrical connection to operate the equipment and that furniture and other items had been distributed.

- A hospital building for the Taluk Headquarters Hospital, Sulthan Bathery, Wayanad, constructed at a cost of ₹ 1.75 crore (₹ 50 lakh from NRHM

funds) had started functioning from June 2008. However, the operation theatre, laboratory and Intensive Care Unit set-up at a cost of ₹ 34 lakh in October 2008 could not be made functional as of May 2009 due to shortage of staff. Government stated (September 2009) that staff had been posted under NRHM and the facilities were currently functioning.

- Non-posting of specialist doctors resulted in decrease of outpatients and non-utilisation of facilities viz., a fully equipped mini operation theatre, a labour room and an inpatient ward in PHC, Panamaram, Wayanad. Similarly, the operation theatre and labour room in CHC, Porunnannur, Wayanad was idling due to shortage of doctors. Government stated (September 2009) that efforts were being made to address the problem of shortage of doctors.

Accredited Social Health Activist Scheme

One of the key components of NRHM is to provide every village in the country with a trained female Accredited Social Health Activist (ASHA), accountable to the village. According to the guidelines, 28757 ASHAs selected during 2007-08 and 2008-09, were to be imparted 23 days' training in five prescribed modules. However, training was imparted to 20680 ASHAs in the first module, 16180 ASHAs in the second module and 800 ASHAs in the third module during 2007-2009. It was noticed that in the three selected districts, the third to fifth module training was not given to any of the selected ASHAs as of March 2009. The SMD stated that as of July 2009, 27024 ASHAs were trained in the first module, 17817 ASHAs in the second module and 1720 ASHAs in the third module. As ASHAs were expected to create awareness on health and mobilise the community towards local health planning, it was necessary to give them training in all the five modules. Government stated (September 2009) that the training was in progress. Imparting training in five modules to a such a large number of ASHAs would take time. Lack of complete training could interfere with the purpose for which the ASHAs had been recruited.

Mobile Medical Units

Under NRHM, financial assistance* was to be provided for establishment of one Mobile Medical Unit† (MMU) for every district for improving health services in medically under-served remote areas. In the Programme Implementation Plan

* ₹ 25.25 lakh per MMU towards capital cost and ₹ 9.25 lakh per annum towards recurring charges.

† Two vehicles (a 10-seater passenger carrier to transport medical/paramedical personnel and the second vehicle for carrying equipment/accessories with basic laboratory facilities) with Medical Officer: 2; Nurse:1; Laboratory Technician:1; Pharmacist: 1; Helper:1 and Driver: 2.

for 2006-07, GOI approved ₹ 1.55 crore towards the capital cost of one MMU and recurring costs for 14 MMUs including the 13 MMUs already in use in seven districts. In the Programme Implementation Plan for 2007-08, GOI approved ₹ 5.12 crore for 13 MMUs. However, no allocation of funds was made to the DHSs for purchase of the vehicles and for meeting the recurring charges of the MMUs, which resulted in the amount remaining unutilised. Government stated (September 2009) that ₹ 5 crore had been released during 2008-09 to the Kerala Medical Services Corporation Limited for procurement of MMUs.

Deficiencies in upgradation of CHCs and PHCs compared to IPHS norms

NRHM envisages bringing of health institutions at par with IPHS to provide round-the-clock services. In order to ascertain the facilities available, Audit obtained relevant information through questionnaires from 71 CHCs and 83 PHCs from all the districts. Audit scrutiny revealed the following:

Manpower

As per IPHS norms, seven specialists* and nine staff nurses with supporting staff were required in each CHC. Forty nine CHCs did not have any specialists, while 21 CHCs had less than the prescribed number of specialists and only one CHC had the full complement of specialists. As regards staff nurses, nine CHCs had nine or more staff nurses, 57 had less than nine and four CHCs had no staff nurse.

According to IPHS norms, each PHC was required to have a Medical Officer, three staff nurses, one Pharmacist and one Laboratory Technician. Ten PHCs did not have a full time Medical Officer. Eleven PHCs had three or more staff nurses, while 42 had less than three and 30 did not have any staff nurse. It was also noticed that 79 PHCs did not have a Laboratory Technician, while 10 did not have a Pharmacist.

Government stated (September 2009) that every effort would be made to ensure adequate number of doctors in the institutions and to fill up regular vacancies.

* One post each of Anaesthetist, General Surgeon, Gynaecologist/Obstetrician, Ophthalmic Surgeon, Paediatrician, Physician and Public Health Programme Manager.

Infrastructure

NRHM envisages providing of 30 beds for inpatients in each CHC together with other facilities*. Information furnished by 71 out of 115 CHCs revealed that 22 CHCs had bed strength in excess of 30 and 35 CHCs had bed strength less than 30. Fourteen CHCs did not furnish the relevant information. The number of CHCs out of these 71 CHCs, where infrastructural facilities were not available, are given in the following table:

TABLE 1.10: NON-AVAILABILITY OF INFRASTRUCTURAL FACILITIES

Facilities not available	Number of CHCs
Blood Storage	70
ECG 60	60
Labour room	29
Operation theatre	39
X-ray	62
24 hour emergency services	30

Source: Details collected through questionnaires from 71 CHCs.

Equipment

According to IPHS norms, 10† major types of equipment are necessary to make an operation theatre (OT) operational. Out of 32 CHCs which had operation theatres, 27 did not have even 50 per cent‡ of equipment in the OTs.

Government stated (September 2009) that the deficiencies in infrastructural facilities and equipment pointed out by Audit were being addressed.

Procurement

A standardised procurement procedure was essential for the SHS to operationalise best practices to ensure transparency and public accountability and to facilitate a systematic approach in decision-making. During 2007-08 and

* Operation theatre, labour room, X-ray, blood storage facility, 24 hour emergency services, wards, telephone, etc.

† Air conditioner, Boyle's apparatus, cardiac monitor, defibrillator, emergency lamp, EMO machine, fumigation apparatus, generator, oxygen cylinder and ventilator.

‡ Boyle's apparatus, cardiac monitor, defibrillator, oxygen cylinder and ventilator.

2008-09, the SHS purchased surgical kits, ASHA drug kits and other drug kits from M/s Karnataka Antibiotics and Pharmaceuticals Limited (KAPL), a Central Public Sector Enterprise. Details are given in the table below:

TABLE 1.11: DETAILS OF PURCHASE OF KITS

Sl. No.	Details of items	Quantity supplied (numbers)	Period of supply	Date of agreement	Due Date of completion of supply as per agreement	Amount (₹ in crore)
1	Surgical kits	245[*]	August to September 2007	17th May, 2007	28th July, 2007	33.54
2	Surgical kits	245[†]	April 2008	24th November, 2007	12th March, 2008	
3	ASHA drug kits	8450	November 2008 to January 2009	29th September, 2008	30th November, 2008	6.69[†]
4	Drug kits	6218[‡]	April to May 2007 November and December 2007 August to November 2008	3rd February, 2007 (First supply order) 3rd August, 2007 (Second supply order) 17th June, 2008 (Third supply order)	31st March, 2007 31st October, 2007 31st July, 2008	26.14

Source: Records from the State Health and Family Welfare Society.

[*] One kit per CHC for 115 CHCs and two kits per First Referral Unit (FRU) for 65 FRUs.

[†] ₹ 7,923 per kit (Basic price: ₹ 7,370 plus Central Sales Tax of ₹ 295 plus administration charges of ₹ 258 at 3.5 per cent of basic price).

[‡] SCs: 5094 kits, PHCs: 829 Emergency Obstetric Care (EOC) kits, CHCs and Block PHCs: 230 RTI/STI drug kits and FRUs: 65 EOC kits.

Procedural irregularities

- The procurement guidelines issued by the Ministry of Health and Family Welfare in July 2006 for the RCH II project envisages different methods for procurement like open tenders, limited tenders, global tenders, etc. However, the single tender system was to be adopted only for drugs and equipment which were of proprietary nature or where only one particular firm was the manufacturer of the item demanded. Also, the Purchase Preference Policy approved by GOI in August 2006, envisaged procurement of 102 medicines manufactured by Pharma Central Public Sector Enterprises (CPSEs) and their subsidiaries, either by inviting limited tenders or by purchasing directly at rates certified by the National Pharmaceuticals Pricing Authority with discounts up to 35 per cent. However, for purchase of surgical kits and drug kits, the single tender system was adopted and for ASHA drug kits, the limited tender system was adopted, though various options were available as per the procurement policy. Moreover, the entire purchase was made from a single firm, viz., KAPL.

  Conditions of agreement for supply of surgical kits, ASHA drug kits and drug kits specify pre-despatch and/or post-despatch inspection by the purchaser. Final payments are to be made only after the receipt of final acceptance certificates from the district Stores-in-charges. Scrutiny of records in the Family Welfare Stores at the three districts test checked revealed that no pre-despatch or post-despatch inspections were conducted by the SHS or by the DHSs to ensure quality, quantity and workability of the supplied material. However, the final payments were released by the SHS/DHSs despite getting reports of short supply and damages. In reply, Government stated (September 2009) that the damaged items of the kits had been immediately replaced by KAPL.

- According to the agreement conditions, a penalty equivalent to one per cent of the price of the delayed goods for each week of delay in supply was leviable from the suppliers, subject to a maximum of

10 per cent of the cost of delayed goods. There were delays of three to eight weeks in supply of surgical kits, one to five weeks in the case of ASHA drug kits and one to fourteen weeks in the case of drug kits. The penalty, leviable from KAPL in the above cases was ₹ 3.18 crore*. Government stated (September 2009) the Governing Body of the SHS had resolved to exempt KAPL from the penalty clause as there were only minor delays in supplies for reasons like transport bottlenecks, strikes, lack of raw materials, etc. The reply cannot be accepted because the delay ranged from two to fourteen weeks (excluding the delay of one week) and Government should have invoked the penalty clause as per the agreement conditions.

Surgical kits and drug kits

- Though the supply order was placed with KAPL, it was seen that the actual supply was made by another firm, viz., M/s Plasti Surge Industries Private Limited, Amaravati, Maharashtra, on behalf of KAPL though there was no provision in the contract for subletting the contract. KAPL was allowed 6.8 per cent discount as per the invoice of M/s Plasti Surge Industries kept in the records of three test checked District Family Welfare Stores. However, KAPL had not passed on this discount to the SHS. The indirect purchase resulted in extra expenditure of ₹ 1.99 crore[†] to the SHS and undue benefit of an equivalent amount to KAPL. Government stated (September 2009) that the in-house purchase policy of KAPL was not enquired into and the SHS had no knowledge of any private company through which KAPL had procured surgical kits and drugs kits. However, the fact remains that Government had incurred extra expenditure of ₹ 1.99 crore.

- The SHS did not assess the actual requirement based on the sample survey conducted in September 2006 in all the CHCs before placing the order. In the Family Welfare Stores of the three districts test checked, 26 out of 102 surgical kits had not been distributed to CHCs/First Referral Units as of

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* ASHA drug kits: ₹ 0.13 crore, surgical kits: ₹ 1.75 crore and drug kits: ₹ 1.30 crore.

† 6.8 per cent of ₹ 29.29 crore= ₹ 1.99 crore.

March 2009. Physical verification done by Audit in two First Referral Units and three CHCs also revealed idling of seven surgical kits costing ₹ 31 lakh.

- GOI instructed (December 2006) the State Government to procure the drugs from primary manufacturers following the Purchase Preference Policy for 102 medicines. The kits were to be formed by the State after procuring the drugs separately and this process was to be completed by 15th February, 2007. However, the State Government purchased (January 2007) drug kits from KAPL directly instead of purchasing the drugs separately from primary manufacturers and making their own kits. In response, Government stated (September 2009) that kitting required a long process i.e., procuring the stores, assembling them in godowns and kitting using semi-skilled and unskilled labourers. This would involve huge investment and therefore readymade kits were purchased. The reply of the Government is not acceptable because the purchase of readymade kits was against the instructions of GOI.

ASHA drug kits

Limited tenders were invited from Pharma CPSEs* in April 2008 by the SHS. After opening the technical bids, the Technical Committee rejected the bids of three Pharma CPSEs because a criminal case was pending against HAL and the required documents had not been submitted by IDPL and BCPL. However, the technical bid of KAPL was accepted as it had furnished product permits for two tablets (Albendazole and Paracetamol) and had agreed to supply the other items from reputed Good Manufacturing Practice (GMP) Companies. It was seen that the financial bid of KAPL was accepted without any negotiations to reduce the rates as envisaged in the Purchase Preference Policy because it was the only firm which qualified for the financial bid. Moreover, the need for going in for the two-bid system of selection of vendor in the purchase of common medicines for ASHA kits

* Bengal Chemicals and Pharmaceuticals Ltd. (BCPL), Hindustan Antibiotic Ltd. (HAL), IndianDrugs and Pharmaceuticals Ltd. (IDPL) and Karnataka Antibiotics and Pharmaceuticals Ltd.

was not justifiable. This clearly indicated that KAPL was favoured by the SHS. Government stated (September 2009) that all the three CPSEs whose bids were examined did not submit product permits for all the products. The Technical Committee decided to open the financial bid of KAPL based on an undertaking given by it that it would procure the drugs from reputed GMP companies. Though negotiations were held with KAPL, it did not agree to reduce the rates. The procurement order was issued to KAPL based on the decision of the Governing Body of SHS.

- Though the supply order was placed with KAPL, it was seen that the actual supply was made by M/s Vimal Labs Private Limited, Indore on behalf of KAPL. As per the invoices of the Indore based firm kept in the stores of the three test checked District Family Welfare Stores, the rate quoted for each ASHA drug kits was ₹ 5,250 and this amount was entered as the cost in the stock register. However, the basic price quoted by KAPL and paid by the SHS was ₹ 7,370. Thus, the SHS incurred extra expenditure of ₹ 1.79 crore* and provided undue benefit of an equal amount to KAPL. Government stated (September 2009) that the in-house purchase of KAPL had not been enquired into by them.

The SHS did not apply the principles of financial propriety in the selection of KAPL for the supply of surgical kits and ASHA kits as procedures were violated, quality of materials were not assessed and finally the procured surgical and drug kits were not utilised in full.

Performance Indicators

NRHM prescribes national targets for reducing the Infant Mortality Rate (IMR), the Maternal Mortality Rate (MMR) and the Total Fertility Rate (TFR), as well as reducing the morbidity and mortality rate and increasing the cure rate of different endemic diseases covered under various national programmes.

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* ₹ 2,120 x 8450 kits = ₹1.79 crore.

State-specific targets were not prescribed by GOI, as different States were at different levels of achievement/performance at the beginning of the Mission period. The targets fixed by the SHS for 2007-08 to 2011-12 were as below:

TABLE 1.12: PERFORMANCE INDICATORS

Indicator	2006-07 Current level (actual figures)	2007-08	2008-09	2009-10	2010-11	2011-12
Infant Mortality Rate (per 1000 live births)	12	12	12	11	10	9
Maternal Mortality Rate (per 100000 live births)	110	75	65	50	40	30
Total Fertility Rate (per woman)	1.9	1.8	1.8	1.7	1.7	1.6

Source: Reproductive and Child Health Project Implementation Plan of SHS for the year 2007-08.

As the SHS had not evolved a mechanism to ascertain whether the targets fixed were achieved at the close of the respective years, audit could not ascertain the extent of achievement against the targets fixed.

Maternal health

The important services which ensure maternal health are antenatal care, institutional delivery, post-natal care and referral services. It is essential to register all the pregnant women before they attain 12 weeks of pregnancy and provide them with three antenatal check-ups, 90 or more iron-folic acid (IFA) tablets, two doses of Tetanus Toxoid (TT) and advice on correct diet and vitamin supplements. It is mandatory for a Junior Public Health Nurse to prepare a micro-birth plan at the SC

level for each beneficiary of the Janani Suraksha Yojana (JSY), containing dates of antenatal check-ups and TT injections, identification of the health centre for referral services, the place of delivery, expected date of delivery, etc. Audit scrutiny revealed that micro-birth plans were not drawn up in any of the selected 24 SCs.

- In the selected districts (Palakkad, Thiruvananthapuram and Wayanad), out of 514139 pregnant women registered, only 430156 received three antenatal check-ups during 2005-06 to 2008-09. In these districts, there were no significant variations over the years in the number of pregnant women receiving three antenatal check-ups.
- Although all the pregnant women registered were required to be provided with IFA tablets for 100 days, shortfalls ranging from 16 to 44 per cent were noticed during 2005-06 to 2007-08.
- During 2007-08 and 2008-09, ₹ 23.95 lakh was disbursed to 7985 beneficiaries in three Taluk Hospitals and two District Hospitals towards transportation cost under JSY, which was inadmissible.
- The percentage of institutional deliveries of pregnant women registered at the hospitals in the selected districts ranged from 77 to 96 in Palakkad, 61 to 104 in Thiruvananthapuram and 85 to 89 in Wayanad.

Immunisation

Routine immunisation

The immunisation of a child against six preventable diseases, namely, tuberculosis, diphtheria, pertussis, tetanus, polio and measles has been the cornerstone of routine immunisation in the State. During 2005-06 to 2007-08, the State had achieved 95 to 99 per cent success in pulse polio immunisation. However, immunisation in respect of other diseases showed wide variations ranging from 53 to 85 per cent in the test checked districts during 2007-09. The targets and achievements of Diphtheria (DT) and TT immunisation carried out during 2005-09 are given in Appendix III.

As per information furnished by the Director of Health Services, during 2005-06 to 2008-09, 1930592 out of 2213479 children between the 0-1 age group were administered full vaccines *viz.*, BCG, Measles, Diphtheria, Pertussis and Tetanus (DPT) and Oral Polio Vaccine (OPV), leaving 282887 children uncovered. The percentage of fully immunised children was in the range of 85 to 88 per cent during the period and did not show significant variations.

It was seen that DT coverage of children above five years declined steadily during 2005-06 to 2008-09 from 94 to 60 per cent. TT to children of 10 years and 16 years also declined during 2005-06 to 2007-08, but showed an increase during 2008-09.

Government stated (September 2009) that long periods of vaccine shortage occurred in 2007-08 and 2008-09 due to inadequate supply from GOI.

Shortfall in administering Vitamin A Solution

The RCH-II programme emphasizes administering of Vitamin A solution to all children below three years of age. Prophylaxis against blindness amongst children due to deficiency of Vitamin A requires the first dose at nine months of age along with the measles vaccine, the second dose along with DPT/OPV and the subsequent three doses at six-monthly intervals.

Scrutiny of records in the three test checked districts revealed a steady decline in the percentage of children supplied with all five doses during 2005-06 to 2008-09, the details of which are given in Appendix IIIa. The main reason for the steady decline was the short supply of Vitamin A at health centres.

Government stated (September 2009) that the shortfall in administering Vitamin A solution was due to stoppage of supply by GOI from 2007-08.

Health Management Information System

As per NRHM guidelines a health information system is to be in place for facilitating the smooth flow of information and for effective decision-making. The SHS purchased 1033 computers along with printers and UPS at a cost of ₹ 3.64 crore for this purpose and supplied them to CHCs and PHCs in February 2008.

The application software (MS Office 2007) was procured at a cost of ₹ 1.06 crore during July 2008.

The SHS adopted the following multiple software applications:

- Health Management Information System (HMIS) viz., DHIS 2 developed by M/s HISP India Limited, a Non-Government Organisation working in collaboration with the University of Oslo, Norway.
- A dynamic web-based surveillance system for monitoring disease incidence for the Integrated Disease Surveillance Project on a weekly basis.
- A Geospatial Kerala Health Information System developed by the Kerala State Remote Sensing and Environment Centre for tracking the spread and frequency of diseases and
- An MS-excel based format for data collection on diseases on daily basis by the State Disease Control and Monitoring Cell.

All these applications were independently operated by various users despite requiring common data sets relating to health parameters for their operation.

Instead of integrating various vertically driven information systems to create a single window system for data entry and report generation, the SHS developed multiple applications with common modules that resulted in data redundancy, duplication in data entry and increase in the workload at all levels. The State Data Officer stated (July 2009) that action was under way to integrate the systems of the Integrated Disease Surveillance Project and the State Disease Control and Monitoring Cell with the SHS.

Integrated Disease Surveillance Project

The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect early warning signals of impending outbreaks and to help initiate an effective response in a timely manner. Surveillance units were set-up at the Central, State and District levels with linkages with all State headquarters,

District headquarters and all Government medical colleges on a Satellite Broadband Hybrid Network. Data is collected on a weekly (Monday–Sunday) basis. Whenever there is a rising trend of illness in any area, it is investigated by the Medical Officers/Rapid Response Teams to diagnose and control the outbreak. Data analysis and action are to be undertaken by the respective districts. The total cost of the project was ₹ 9 crore, of which GOI released ₹ 4.82 crore up to 2008-09. The expenditure incurred on the project was ₹ 2.74 crore.

All the 14 District Surveillance Units (DSU) were supplied with hardware accessories costing a total of ₹ 21.06 lakh. Civil works for videoconferencing units were also completed in the districts at a cost of ₹ 19.60 lakh. Accessories were also supplied to State Surveillance Units (SSU) and seven* medical colleges at a cost of ₹ 33.76 lakh. Necessary manpower was also provided to all DSUs and SSU. However, the video conferencing unit at the State level had not been set-up as of March 2009 as the Director of Health Services had not provided space for this. Consequently, hardware and accessories procured for ₹ 54.82 lakh and the civil works executed at an expenditure of ₹ 19.60 lakh, besides the manpower, remained idle. Moreover, the intention of the Government of detecting impending outbreaks and initiating an effective response could not be achieved. Government stated (September 2009) that the videoconferencing unit would be set-up as soon as the civil works were completed within two months' time.

Information, Education and Communication Activities

'Radio Health' launched by DHS, Thiruvananthapuram in September 2008 aimed to create positive changes in the health habits and behaviour of people by ensuring wider community participation through interactive and innovative radio programmes. It mainly focussed on primary health care and preventive aspects of health by giving importance to all medical systems and alternative health practices. Up to 31st March, 2009, 108 programmes of 30 minutes duration had been broadcasted. Ten Radio Health Clubs were also established in schools, colleges, residential associations, etc., in different locations and 31 meetings were also conducted. This model could be adopted in other districts also to propagate health care programmes. Other activities under the Information, Education and

* Co-operative Medical Colleges at Ernakulam and Pariyaram, Medical College Hospital at Alappuzha, Kottayam, Kozhikode, Thiruvananthapuram and Thrissur.

Communication like Health Melas in Assembly constituencies, school health camps, street plays, cultural programmes, etc., were also conducted by the SHS. Government stated (September 2009) that the Radio Health Programme had been well received by the community and had been appreciated at various fora of the Ministry of Health and Family Welfare as a true innovation.

Community participation

NRHM envisages involving communities in planning, implementation and monitoring through representatives of Panchayati Raj Institutions and community based organisations at each level. It also envisages formation of Village Health and Sanitation Committees in each village within the overall framework of the Grama Sabhas. However, the State Government decided (February 2007) to constitute Ward Health and Sanitation Committees (WHSC) at the ward level instead of at the village level. In all the 24 SCs under the three test checked districts, WHSCs, had been constituted. However, no revolving funds for providing referral and transport facilities on emergency deliveries had been set-up in any of the WHSCs though envisaged under the scheme. Government stated (September 2009) that it was a conscious decision to constitute Ward Level Committees within the overall framework of the local bodies in lieu of Village Level Committees as improved community participation was the key to success of the scheme.

Conclusion

Introduction of NRHM in Kerala has improved the fund flow to health institutions at various levels, upgraded infrastructure in health institutions and helped in facilitating their routine management. It has led to the creation of Ward Health and Sanitation Committees and Hospital Management Committees and innovations like 'Radio Health' in Thiruvananthapuram district to create health awareness.

Decentralised planning was crucial for implementation of the scheme but the planning process was flawed as Annual Action Plans were prepared without preparing the State Perspective Plan and without using field level data, obtained through household and facility surveys. The execution of projects by the SHS

without the Perspective Plan by specifying the project activities in a critical path resulted in the projects being implemented without adhering to the time schedule. Thus, the SHS could not spend the funds released by GOI, huge amounts were kept in bank deposits and the accounts were not finalised in time. Though funds were available, the entitled grants were not released to all the CHCs and PHCs. Release of funds to activities not approved by GOI was also noticed. Upgradation work of CHCs and SCs were proceeding at a slow pace and even the facilities created were not fully utilised. There were deficiencies in medical and paramedical manpower, infrastructure facilities and equipment in CHCs and PHCs in the State. Procurement of drugs, surgical equipment and computers for ₹ 70.01 crore was made without observing the principles of financial propriety and distributed without assessing the requirements of institutions.

Recommendations

- The Perspective Plan should be prepared for the remaining Mission period by incorporating all the required strategies to achieve the objective of convergence of all health initiatives under one umbrella. Each activity should be executed along a critical path to achieve the desired result within the Mission period.
- The SHS and DHS should synchronise all their activities and integrate structurally to ensure sustainability of NRHM initiatives even after the Mission period.
- The State level Action Plan should be a part of the Perspective Plan and prepared only on the basis of consolidated Action Plans at the village, block and district levels so that actual requirements are projected.
- Proposals in the Action Plan should be made on the basis of the absorption capacity of the Mission and the funds released should be utilised without undue delays to avoid retention of huge balances in bank deposits.
- Corpus grants, maintenance grants and untied grants should be released annually to all the entitled health care institutions.

- Priority should be accorded to complete all the upgradation works for which GOI approvals have been received.
- Steps should be taken to fill up the regular vacancies of medical and paramedical staff in the CHCs and PHCs and post contractual staff under NRHM as per requirements to achieve Indian Public Health Standards.
- The principles of financial propriety should be observed in all the procurement processes to avoid undue favour to the suppliers.
- The SHS should integrate various vertically driven information systems to create a one-point system for data entry and report generation that covers all its activities like accounting, manpower, health profile, stores, disease surveillance, etc., to provide online information for planning, execution and monitoring of the Mission.

[Audit Paragraph 1.2 contained in the Report of the Comptroller and Auditor General of India for the Year ended 31 March 2009.]

Notes received on the above audit paragraph is included as Appendix II.

The Committee considered the audit paragraph and desired to know the details and objectives of National Rural Health Mission in the State. The witness, State Mission Director, National Rural Health Mission informed that in the year 2012-13 a comprehensive health plan for five years had been charted out by the Health and Family Welfare Department in which a perspective plan for each individual institution was prepared separately considering the prospect of the stakeholders of that institution and based on that, annual plan for local bodies was prepared. She also deposed that Local Self Government Department had issued a circular instructing to take the said comprehensive health plan as a template for the annual action plan of local bodies for the current financial year. National Rural Health Mission took up this proposal with the Panchayath and about 2379 projects for ₹ 107 crore has been earmarked in the annual action plan under Local Self Government Department.

2. The Committee remarked that even though Government of India launched NRHM during the year 2005, the State Government had commenced to utilise the fund only after a gap of two years and enquired whether the quality of health service in the state had improved with the induction of NRHM and desired to know its impact in the health sector of the state.

3. The State Mission Director, NRHM detailed that NRHM is visualised differently in different States of India. In Northern States of India, where health service system was not in existence at the grass root level, health services began to roll under the NRHM scheme. But in Kerala, NRHM was aimed to strengthen and supplement the health service of the state and for the last two years NRHM was focussed to improve the quality of health system. But the lack of personnel is a serious problem faced by the department over the years and it could not be completely solved out. At present the fund from NRHM is being utilised for the appointment of required staff on contract basis and also for building up infrastructure facilities in the existing hospitals. The Principal Secretary, Health and Family Welfare Department supplemented that at present, around 540 doctors are working under NRHM on contract basis. As a result of the developmental activities initiated by NRHM, three hospitals in public sector viz., General Hospital, Ernakulam, Government Hospital for women and Children, Thycaud and Taluk Hospital, Cherthala were privileged with the accreditation of NABH (National Accreditation Board for Hospitals). Also the blood bank and laboratory at Aluva were accredited by NABH.

4. The Committee remarked that the health standards of Kerala is far better than other states and asked what hindrance or negative factors prevents the state from becoming a role model in the health service in the country.

5. The State Mission Director, NRHM informed that the state of Kerala, had launched a project called Kerala Accreditation Standard for Hospitals (KASH) of its own capacity and its accreditation was given to six institutions in the state so far. She also stated that, Kerala and Tamil Nadu were the only states in India having accredited medical institutions at the Government level. Likewise so many decisive steps were being taken by NRHM for quality improvement in health service.

6. Admitting the administrative apathy in this regard, the witness, Principal Secretary, Health and Family Welfare Department informed that, more time would be necessary to reach up to the level of international standard even after the strenuous effort on the part of Health and Family Welfare Department.

7. He continued that the present rate of maternal mortality in Kerala is 80-100 per 100000 live births and the department is aimed to lower the rate below 40 mark during the 12th Five year plan. The Committee was also informed that a Memorandum of Understanding (MoU) had been signed between Health and Family Welfare Department and National Institute of Health and Clinical Excellence, the quality consultant of the department, for the betterment of quality in health service .

8. The Committee sought the details regarding the Public Health Centre level oriented five year plan. The State Mission Director of NRHM informed that ward based five year action plan was prepared incorporating the requirements of Primary Health Centre.

9. The Committee also inquired whether any survey had been conducted to assess the changes occurred in the field of health service sector after the induction of NRHM. The Principal Secretary, Health and Family Welfare Department informed that it could not be assessed because NRHM is implemented with the technical and financial support of Health Service and it is not a standalone project. He added that with the implementation of NRHM, infrastructure facilities had been improved and treatment facilities were provided in a better way.

10. The Committee appreciated the planning process initiated by the department and directed to submit a detailed note regarding the action plan of the centrally sponsored scheme to integrate it with the local plan at the earliest.

11. When the witness, Principal Secretary, Health and Family Welfare Department put forth the practical difficulties in integrating the ward level plan to PHC plan, the Committee remarked that using Information Kerala Mission state level visual priority could be developed by analysing the health programmes taken by panchayath for the last ten years. It suggested that the district plan should be

developed in accordance with the vision and perspective so arrived at and it should be done after evaluating what had been done so far to avoid duplication and repetition. If such interventions are carried-out, more interesting projects could have been formulated in the next local action plan.

12. The Committee remarked that the project was implemented, even before formulating perspective plan and the National Rural Health Mission had a clear perspective plan in terms of clearly laid down technical targets for the mission period i.e., 2005-2012. But the planning process done by the Health and Family Welfare Department was totally an independent one without any perspective plan. Then the witness apprised that the objective of the mission is to achieve the goals as envisaged by Government of India. But the prevailing scenario in our state is better than the set standards and based on the health indices to be achieved, the Department had set-up a different target. When the Committee sardonically asked whether the perspective plan intends merely fixing the target or the activities to achieve the target, the witness informed that fixing a target for health indices was done first and plans were prepared to achieve those health indices. NRHM develops action plan for every next year as per the guidelines of Government of India. The Committee decided to recommend that instead of focussing on annual plans, perspective plan should be prepared with a long-term vision and strategies to reach these targets should also be laid down by considering decentralized planning.

13. To a query of the Committee regarding the low utilisation of allotment up to the year 2008-2009, the witness informed that the present scenario is entirely different. During the entire mission period i.e., from 2005-2006 to 2011-2012, NRHM had received ₹ 1218 crore. i.e., ₹ 1090 crore as central share and ₹ 127.51 crore as state share. Out of which ₹ 1112 crore had been expended. The Committee appreciated NRHM State Mission for its notable performance.

14. Regarding the audit objection on release of corpus grant, untied grant and annual maintenance grant, the Principal Secretary, Health and Family Welfare Department stated that the fund was released to the Hospitals through Hospital Development Committee, RSBY (Rashtriy Swasth Bhima Yojana) and Karunya Benevolent fund, but lack of adequate planning support for effective utilisation

was a major problem. Hence the department is planning to consult the World Bank for fixing this issue.

15. The Committee remarked that medical personnel could give useful advices to the Hospital Development Committee for planning the projects. But the Principal Secretary, Health and Family Welfare Department pointed out that very few medical personnels have a clear vision about planning. The Committee opined that Hospital Development Committee bridges the institution and local bodies and the result is obvious in the hospitals having well managed Hospital Development Committees.

16. Regarding the releasing and utilisation of corpus fund and untied grant, the State Mission Director, NRHM replied that 86% of the untied fund and 94% of the annual maintenance grant had already been expended as on January 31, 2013 and the department is expecting hundred per cent expenditure in next year. To a query of the Committee the Principal Secretary, Health and Family Welfare Department apprised that the fund utilisation of NRHM was not monitored at any level and it was the weakest part of the project. At present the fund was being transferred to the joint account of the Superintendent of Hospital and Chairman of the Hospital Development Committee. Also there was no clear guidelines regarding fund allocation, as per demand, fund get allotted.

17. The Committee pointed out another aspect that the ambulances were allotted to all Hospitals but it is unoperational due to the absence of drivers. So it urged the Health and Family Welfare Department that necessary direction may be issued to utilise the fund of NRHM for such essential services.

18. The Committee noticed that maintenance grant issued to CHCs undergoing upgradation was against the guidelines of NRHM. Also the minimum posts required for the functioning of CHCs were not created and fund allotment from NRHM for Human Resources is decreasing annually. In this regard the witness from Health and Family Welfare Department informed that proposal for post creation was under consideration. As per the NRHM guidelines, the expenditure towards Human Resources should be met by the State Government. The Committee decided to recommend that Health and Family Welfare Department

should take necessary steps to create adequate number of posts of doctors and nurses for the effective functioning of Community Health Centres and Primary Health Centres in the state.

19. Regarding the audit reference, that the expenditure on Management during 2007-2009 exceeded the prescribed limit of six per cent of the approved amount under Reproductive and Child Health II, the Committee sought the reason for this kind of misappropriation.

20. The State Mission Director, NRHM, replied that such an increase was incurred at the initial stage, after that it had been maintained below six per cent. In addition, the witness, Principal Secretary, Health and Family Welfare Department informed that Management expenditure was very low and hence did not spend enough money on Programme Management.

21. As the Committee wanted the details regarding the upgradation of Health Care Infrastructure and Capacity Building, the witness, Principal Secretary, Health and Family Welfare Department informed that decision was taken to discharge the treated effluent from sewage treatment plant of IMCH, Kozhikode to their own land where it was envisaged to set-up a garden. He assured that the effluent would be devoid of bioorganisms due to ultra-violet treatment and it would not be harmful even if seeped into ground water. He informed that the sewage plants are under construction at Alapuzha and Kottayam.

22. An official from Health and Family Welfare Department supplemented that upgradation of all 174 buildings were completed. The Committee sought a detailed statement indicating the number of buildings allotted each year from 2005-06 onwards, amount allotted per building, number of buildings completed up to 2011-12, and the amount expended in this regard to the Committee at the earliest.

23. The Committee also enquired the reason for the delay in completion of upgradation of CHC's, Principal Secretary, Health and Family Welfare Department replied that the guidelines issued by the Government of India envisaged the strengthening of both PHC's and CHC's. But the State Government is of the opinion that the hospitals attending the most number of delivery cases should be given special attention.

24. The Committee pointed out that even though infrastructure facilities like ambulance, laboratories etc. were allotted from MLAs SDF, they could not be utilised due to lack of personnel to operate them. The witness, Principal Secretary, Health and Family Welfare Department informed that the department had taken up this matter with the NRHM, for creating necessary posts. He also informed that Government of India had intimated the Department that only ₹ 620 crore would be allotted as against the department's demand for ₹ 1800 crore. The Committee suggested to appoint sufficient doctors and other staff for the effective functioning of PHC's and CHC's.

25. The Committee was informed that in our state there is one sub centre for every 2.1 square.km. and for 5000 persons with one JPHN in each centre. Then the Committee suggested that while constructing building for sub centre, upgradation of it into CHC in future should be kept in mind and also to examine the possibility of utilising the service of ASHA workers in the sub centres.

26. The Committee emphasized the need for filling up the regular vacancies of medical and paramedical staff in CHC's and PHC's as per IPHS norms.

27. The Committee pointed out the audit reference regarding the non- availability of infrastructural facility at the CHC's and desired to know the percentage of delivery cases attended by the medical institutions in the private sector. The witness, Principal Secretary, Health and Family Welfare Department apprised that about sixty per cent of delivery cases was being reported from private hospitals in Kerala and expressed his apprehension over this matter. He also informed that the primary health centres of Tamil Nadu is well equipped with infrastructural facility to attend the delivery cases. But in Kerala, people normally relying upon higher centres rather than going to PHCs & CHCs for the medical attention for cases like delivery etc.

28. In this regard Committee decided to recommend the Health and Family Welfare Department to take necessary steps for providing adequate manpower, infrastructure facilities , blood storage centre etc. to PHCs & CHCs.

29. The Committee remarked that the guidelines prescribed by Government of India for procurement of medicines were not followed in our state and that resulted in incurring of extra expenditure for the Department and the Committee desired to know the present status of this case.

30. The Principal Secretary, Health and Family Welfare Department informed that Government of Kerala decided to procure the requirement of NRHM either through DGS&D or from Central/State PSU. Hence they purchased the required medicines from Karnataka Antibiotics and Pharmaceutical Ltd. (KAPL), a Public Sector Enterprise. But since KAPL did not have all the required medicines, they had given sub contract and supply was delayed. Now the mistake had been rectified and the public sector fixation in order to adhere the rules envisaged by Government of India had been changed. He informed that necessary steps had been taken to avoid such mistakes in future.

31. Discussing the matter in detail, the Committee reminded the authorities that, Government of Kerala has invested about ₹ 50 crore during the last four years in Kerala Drugs and pharmaceutical Ltd., Alappuzha, a public sector undertaking and developed a capacity to produce drugs cost ₹ 100 crore. But the capacity utilisation was merely five per cent.

32. The Principal Secretary, Health and Family Welfare Department apprised that, the Department had asked Kerala State Drugs and Pharmaceuticals Ltd. authorities to chalk out a drugs plan regarding the production of drugs according to the requirement of the department. As the cost of chemicals could not be compromised, the Committee suggested that the price could not be negotiated beyond certain extent. So it urged the Health Department that tender procedures should be diluted and cost of chemicals and its labour charges should be taken into account while assessing the out turn cost of medicines. It urged Health and Family Welfare Department that it should be more cautious in avoiding such abrasions in future.

33. When the Committee asked whether Infant Morality Rate (IMR) of our state could be reached the expected level of 9, the witness, Principal Secretary, Health and Family Welfare Department was optimistic.

34. By appreciating NRHM for giving special attention in reducing the Maternal Mortality Rate the Committee strongly advocated the importance of lowering of Infant Morality Rate (IMR) in Kerala and suggested that earnest effort should be made by the Department in this regard.

35. The Committee asked the reason for the decline in immunisation rates in Kerala. The State Programme Manager of NRHM informed that shortage of vaccines was the main reason behind it, but The Principal Secretary, Health and Family Welfare Department added that the immunisation rate in Kerala was eighty two per cent (82%) as against the rate of ninety eight (98%) per cent in Tamil Nadu.

36. At this juncture, the Committee observed that the main reason for decline in immunisation was the laxity on the part of department in the effective implementation of the programme and expressed its serious concern over the matter.

37. Regarding the audit reference of non-setting-up of an Effective Integrated Health Management Information System as envisaged in the NRHM guideline, the Committee enquired why the department did not adopt scientific methods like National Sample Survey. The Principal Secretary, Health and Family Welfare Department informed that the department was proposed to design a new system in the name of Kerala State Health Surveillance Survey shortly, under which JPHN would collect universal data rather than depending upon sample data.

38. When the Committee was told that Health Campaign through Doordarshan is too expensive, the Committee remarked that either making programmes worth to be shown as news or conducting health oriented reality shows in this regard would be a better option rather than resorting to advertisements.

Conclusion/Recommendation

39. The Committee remarks that the health standard of Kerala is far better when compared to other States and at the same time it is far behind the international health standard. It urges the Health and Family Welfare Department to furnish detailed report regarding the steps taken to improve the quality of health service in Kerala at par with international health standard.

40. The Committee lauds the planning process commenced by the Health and Family Welfare Department and directs the department to submit a note in detail regarding the integration of the action plan of the Centrally Sponsored Schemes with the local plan, to the Committee at the earliest.

41. The Committee was informed of the difficulties faced by the department in integrating ward level plan with PHC plan and total decentralized plan could not be practised. It opines that health programmes implemented by the panchayat for the last ten years should be analysed using Information Kerala Mission so that state level priority could be sorted out.

42. The Committee suggests that the action plan should be developed in accordance with the vision and perspective so arrived at and it should be done after evaluating what had been done so far to avoid duplication and repetition.

43. The Committee recommends the Health and Family Welfare Department that a comprehensive perspective plan should be prepared with a long-term vision and strategy to achieve the target considering decentralized planning.

44. The Committee observes that fund utilisation of NRHM is not monitored at any level and it is the weakest part of the project. So the Committee urges the Health and Family Welfare Department to constitute specific guidelines regarding utilisation of fund provided by NRHM.

45. The Committee expresses its displeasure over the lack of drivers to operate ambulance service though ambulances are alloted to all hospitals. The Committee urges the Health and Family Welfare Department to issue necessary directions to utilise the fund of NRHM for such essential services.

46. The Committee recommends that Health and Family Welfare Department should take urgent steps to create requisite number of posts of doctors and staff nurses for the effective functioning of Community Health Centres and Primary Health Centres in the State. It also emphasized the need for filling up the vacancies of medical and paramedical staff in CHCs and PHCs as per IPHS norms.

47. The Committee urges the Health and Family Welfare Department to furnish a detailed statement indicating the number of buildings allotted each year from 2005-2006 onwards for the upgradation of health care institutions with break up details of the amount allotted per building, number of buildings completed up to the year 2011-12 and also the total amount expended in this regard.

48. It suggests that designs of buildings for sub centre would be in such a manner that it could get upgraded into CHC in future and also to check the feasibility of utilising the service of ASHA workers in sub centres.

49. The Committee recommends that Health and Family Welfare Department should take necessary steps for providing requisite manpower, infrastructure facility such as blood storage centre, ECG unit, Operation Theatre, X-ray unit, Labour room etc. according to IPHS norms to provide round the clock services in CHCs and PHCs.

50. The Committee opines that a standardised procurement procedure should be formulated in the Department to ensure transparency and public accountability during the purchase of medicine/drugs and other surgical/medical kits without further delay. The Committee also urges that tender procedures should be diluted and factors like cost of chemicals and labour charges should be taken into account while assessing the out turn cost of medicines.

51. The Committee appreciates NRHM authorities for giving special attention, in reducing maternal mortality rate in the State, but advocates the importance of reducing the Infant Morality Rate (IMR) in the state and directs that earnest effort should be exercised by the authorities in this regard.

52. The Committee expresses its grave concern over the decline of immunisation rate in Kerala and observes that administrative laxity is the main reason behind this and the Committee directs to implement immunisation programme in the state effectively by rectifying the shortage of vaccines.

53. The Committee moots the setting-up of an Effective Integrated Health Management System as envisaged in the NRHM guidelines. The Committee was informed that the department is proposed to design a new system viz, Kerala State Health Surveillance Survey to collect data. So it urges the department to furnish a detailed report regarding it and also the methods adopted to collect universal data.

54.The Committee opines that innovative health awareness programmes should be conducted to propagate health care programmes as part of Information, Education and Communication activities in future instead of resorting to advertisements through the visual media.

DR. T. M. THOMAS ISAAC,
Chairman,
Committee on Public Accounts.

Thiruvananthapuram,
9th July, 2014.

1097/2014.

APPENDIX I

SUMMARY OF MAIN CONCLUSION/RECOMMENDATION

Sl. No.	*Para No.*	*Department concerned*	*Conclusion/ Recommendation*
(1)	(2)	(3)	(4)
1	39	Health and Family Welfare	The Committee remarks that the health standard of Kerala is far better when compared to other States and at the same time it is far behind the international health standard. It urges the Health and Family Welfare Department to furnish detailed report regarding the steps taken to improve the quality of health service in Kerala at par with international health standard.
2	40	Health and Family Welfare/Local Self Government	The Committee lauds the planning process commenced by the Health and Family Welfare Department and directs the department to submit a note in detail regarding the integration of the action plan of the Centrally Sponsored Schemes with the local plan, to the Committee at the earliest.
3	41	Health and Family Welfare	The Committee was informed of the difficulties faced by the department in integrating ward level plan with PHC plan and total decentralized plan could not be practised. It opines that health programmes implemented by the panchayat for the last ten years should be analysed using Information Kerala Mission so that state level priority could be sorted out.

(1)	(2)	(3)	(4)
4	42	Health and Family Welfare	The Committee suggests that the action plan should be developed in accordance with the vision and perspective so arrived at and it should be done after evaluating what had been done so far to avoid duplication and repetition.
5	43	"	The Committee recommends the Health and Family Welfare Department that a comprehensive perspective plan should be prepared with a long-term vision and strategy to achieve the target considering decentralized planning.
6	44	"	The Committee observes that fund utilisation of NRHM is not monitored at any level and it is the weakest part of the project. So the Committee urges the Health and Family Welfare Department to constitute specific guidelines regarding utilisation of fund provided by NRHM.
7	45	"	The Committee expresses its displeasure over the lack of drivers to operate ambulance service though ambulances are allotted to all hospitals. The Committee urges the Health and Family Welfare Department to issue necessary directions to utilise the fund of NRHM for such essential services.
8	46	"	The Committee recommends that Health and Family Welfare Department should take urgent steps to create requisite number of posts of doctors and staff nurses for the effective functioning of Community Health Centres and Primary Health Centres in the state. It also emphasized the need for filling up the vacancies of medical and paramedical staff in CHCs and PHCs as per IPHS norms.

(1)	(2)	(3)	(4)
9	47	Health and Family Welfare	The Committee urges the Health and Family Welfare Department to furnish a detailed statement indicating the number of building allotted each year from 2005-2006 onwards for the upgradation of health care institutions with break up details of the amout allotted per building, number of buildings completed up to the year 2011-12 and also the total amount expended in this regard.
10	48	"	It suggests that designs of buildings for sub centre would be in such a manner that it could get upgraded into CHC in future and also to check the feasibility of utilising the service of ASHA workers in sub centres.
11	49	"	The Committee recommends that Health and Family Welfare Department should take necessary steps for providing requisite manpower, infrastructure facility such as blood storage centre, ECG unit, Operation Theatre, X-ray unit, Labour room etc. according to IPHS norms to provide round the clock services in CHCs and PHCs.
12	50	"	The Committee opines that a standardised procurement procedure should be formulated in the Department to ensure transparency and public accountability during the purchase of medicines/drugs and other surgical/medical kits wtthout further delay. The Committee also urges that tender procedures should be diluted and factors like cost of chemicals and labour chargs should be taken into account while assessing the out turn cost of medicines.

(1)	(2)	(3)	(4)
13	51	Health and Family Welfare	The Committee appreciates NRHM authorities for giving special attention, in reducing maternal mortality rate in the State, but advocates the importance of reducing the Infant Morality Rate (IMR) in the State and directs that earnest effort should be exercised by the authorities in this regard.
14	52	"	The Committee expresses its grave concern the decline of immunisation rate in Kerala and observes that administrative laxity is the main reason behind this and the Committee directs to implement immunisation programme in the state effectively by rectifying the shortage of vaccines.
15	53	"	The Committee moots the setting-up of an Effective Integrated Health Management System as envisaged in the NRHM guidelines. The Committee was informed that the department is proposed to design a new system viz., Kerala State Health Surveillance Survey to collect data. So it urges the department to furnish a detailed report regarding it and also the methods adopted to collect universal data.
16	54	"	The Committee opines that innovative health awareness programmes should be conducted to propagate health care programmes as part of Information, Education and Communication activities in future instead of resorting to advertisements through the visual media.

APPENDIX II

NOTES FURNISHED BY GOVERNMENT

REPORT OF THE COMPTROLLER AND AUDITOR GENERAL OF INDIA FOR THE YEAR 2008 - 09 (CIVIL) -

PARAGRAPH No. 1.2 -

ADDITIONAL INFORMATION

Details of funds and actual expenditure from 2006-2007 & Expenditure trends up to 2011-12:

Year	Release (Rs in crores)			Expenditure (Rs in crores)		
	Central share	State share	Total	Central share	State share	Total
2005-06	33.92	0	33.92	3.19	0	3.19
2006-07	79.11	0	79.11	17.65	0	17.65
2007-08	210.45	0	210.45	108.75	0	108.75
2008-09	142.02	53.25	195.27	225.76	40.18	265.94
2009-10	215.90	9.41	225.31	249.17	12.18	261.35
2010-11	184.48	35.92	220.40	227.83	25.61	253.44
2011-12	236.10	28.93	265.03	194.81	7.16	201.97
TOTAL	1101.98	127.51	1229.49	1027.15	85.13	1112.29

ACTION TAKEN REPORT ON AUDIT OBSERVATIONS OF THE CAG ON NRHM FOR 2008-09

Para No	Audit Report	Factual Position / Action taken Report	Current Status
1.2.6	**Planning** NRHM envisaged a decentralized and participatory planning process with a bottom up approach from village level to the State level. The State and districts were, thus, required to prepare Perspective Plans for the Mission period (2005-12). Action Plans for each year were to be prepared by the SHS by consolidating all the district level plans to enable interventions in the health sector. Household surveys at the levels of CHC, PHC and SC were to be conducted for preparing comprehensive District Action Plans. Audit scrutiny revealed that only a sample household survey was conducted by the Department of Community Medicine of the Medical College, Kozhikode in selected panchayats and municipalities of three out of 14 districts during February - March 2007. Consequently, the Annual Action Plans were prepared without adequate field data, rendering the planning process defective.	**Factual Position:** Perspective plan is contained in the technical targets for the Mission period (2005-12) as laid down in Chapter III of the Annual PIPs, and each year the action plans are prepared by the State with reference to these targets and goals to enable interventions in the health sector, and the construction of the Project Implementation Plan (PIP) every year is on the basis of these perceptions. The annual Program Implementation Plan (PIP) of the state for NRHM has been prepared through a participatory and consultative process with the District Health and Family Welfare Societies (14 Districts), headed by the District Panchayat President. The District NRHM Plan is put up to the State Society by these District Societies. Being a decentralized structure, the District Society follows a planning process that takes care of the requirements of the grass root level institutions in each of the WARD of the District. It is on this basis that NRHM interventions are planned out and implemented. Participatory approach is in built in the present system, because feed back from the grass root level workers such as JPHN/ASHA/Ward Members etc on the various needs and necessities of each ward is taken into account by the District Society in the formulation of the District Action Plans. While facility survey was conducted in the CHC's the same was not done in the PHC/ Subcentres. This was because deliveries are not taking place at these levels. Hence priority is for CHC level services. Audit may also kindly note that in addition to the needs at the grass root levels, some of the interventions under NRHM are generally technical in nature. ACTION TAKEN: In order to strengthen the process, State Health	The NRHM PIP for the year 2012-13 was prepared by the process of decentralized planning. Program Implementation Plan (PIP) for National Rural Health Mission (2012-13) for the state is an initiative to support the State Governments vision on establishing a proper healthcare system for the people of the State so as to craft a society that is healthy, active and vibrant to meet the twin challenges of re-emerging and emerging diseases. A 5 year Comprehensive Health Plan (CHP) , first-of-its-kind initiative in the country, has been formulated, as an attempt to look at all the health and health related issues in a holistic perspective. The key principle behind the

	As per NRHM guidelines, facility surveys to ascertain the facilities available at the CHC/PHC/SC level were to be carried out in all the districts by 2008. It was seen in audit that facility surveys were conducted in all the 115 CHCs during September-December 2006. However, no facility survey had been carried out in any of the PHCs and SCs as of May 2009. Government stated (September 2009) that as the State Programme Management Support Unit was institutionalized only in December 2006 and SHS started functioning from April 2007, there were delays in conducting necessary field surveys to collect essential data for preparing the Annual Plans. As regards the facility survey, the Government stated (September 2009) that such surveys had been in all the CHCs in the first stage. Facility surveys in PHCs would be taken up in phases in due course and the entire exercise would be completed in stages. However, the fact remains that the State Government took two years, since the launch of NRHM to establish the set up for NRHM and even after these two years, all the required household surveys and facility surveys,	Systems Resource Centre (SHSRC) has been established which will function as a 'think-tank' for NRHM. One Senior Consultant (Public Health Planning) has been appointed in SHSRC which will assist NRHM in preparation of Action Plans and monitor the programme. A decentralised planning process will be piloted in Alappuzha this year and extended to the entire state.	preparation of this Decentralized Plan for the State's health sector is the realization that people's participation, local relevance and convergence of functioning of various departments are very crucial for developing region-specific and creative health plans for all the 14 Districts, taking into account the requirements of each ward, panchayath and block till the district-level. The solutions to most of the health problems in a locality are often beyond the capacity of the Health Department alone. There are several departments- Social Welfare, LSG, and Water Authority, etc- whose activities are so interlinked to health and whose schemes need to be integrated into the plan. As per Govt Letter No 43725/DA112/LSGD dated 17/7/12 of Secretary, LSGD has directed the Heads of Departments- Director of Panchayath, Director of Urban

	had not been conducted (September 2009). Thus, the formulation of the Annual Action Plans was deficient to this extent.		Affairs and Commissioner of Rural Development to include all Health and Health related projects taken up in the CHP duly approved by District Planning Committee (DPC) in the XIIth five year plan. The most important thing to highlight is that, from the Comprehensive Health Plan, around 2379 projects for a budgeted amount of Rs 107 crores are included so far in the Annual Action Plan (2012-13) of other Departments and PRIs. Many PRI's have not yet completed the process of project formulation and hence the included number of projects in the annual Action Plan and the budgeted amount will increase.
1.2. 6.1	**Action Plan at Village, Block and District Levels** Due to delays in setting up of the SHS and DHSs, no Action Plans were prepared for NRHM during 2005-06 and 2006-07. Only proposals for Reproductive and Child Health II (RCH II) were sent to GOI for these years and funds were released by GOI on the basis of these proposals. In 2007-08,Plans at	**Factual Position:** During 2005-06 and 2006-07 the Ministry of Health and Family Welfare, Government of India had instructed the state to furnish proposals only for the RCH-II Programme. Accordingly the proposals for these two years in respect of RCH-II were furnished and the same was approved by the Ministry. The Ministry did not instruct that Action Plan for NRHM on the basis of village/block/district be furnished. While so, funds for Additionalities under NRHM were released to the state even though no Action Plan under NRHM was instructed to be furnished. In the circumstances that funds were released to the state, block/district	

	the Sub Centre, block, district and State level were prepared as per the NRHM guidelines. However, in 2008-09, Action Plans below the State level were not prepared. Instead, fund requirements under various heads were collected from all the institutions and furnished to the SFIS for preparation of a detailed State level Action Plan. Consequently, prioritization of issues at the district level and below the district level could not be done in the State Action Plan for 2008-09. Government stated (September 2009) that institution-based Action Plans were the basis for 2008-09. During 2010-11, ward would be the basis for preparation of Action Plans.	action plan were drafted and taken as the basis for executing the works under NRHM for these two years. It was subsequently that instructions were received that the State Action Plan was required to be furnished. Audit may also note that the State and District Societies were put in place only in 2007. It may be noted that ward-wise action plans were prepared, consolidated, the block & district complied and the State Health action Plan finalized. It may be noted that the Action Plans prepared are consolidated from Sub Centre action Plans / Ward Health and sanitation plans. Block Level Action plan has been a little weak as institutional mechanism yet to gear up. However the District Level is fully functional. For 2008-09 the Institution based Action Plans were the basis. **Action Taken:** For 2010-11, Action Plans have been prepared with Ward Committees as the basis for preparation of the Action Plans. Similarly, for the preparation of District Health Action Plans for 2011-12, a detailed exercise was carried out in districts. Institutional level and ward level requirements were taken and the same was consolidated in the District Health Action Plan. The District Health Action Plans were consolidated into the State level Action Plans.	 State PIP was prepared based on the district PIPs and district PIP for the year 2012-13 was developed by decentralized health planning.
1.2.6.2	**Perspective Plan** The SHS did not submit a Perspective Plan, as envisaged in the NRHM guidelines, to GOI for the Mission period. No Perspective Plans had been prepared by the DHSs in the three test-checked districts of Palakkad, Thiruvananthapuram and Wayanad. Government stated	**Factual Position:** The Mission has a clear perspective plan in terms of clearly laid down technical targets for the Mission period (2005-12) as laid down in Chapter III of the Annual PIPs, and each year the action plans are prepared by the State with reference to these targets and goals to enable interventions in the health sector. This is the perception of the goals and targets of the state and the construction of the Project Implementation Plan (PIP) every year is on the basis of these perceptions. However as a means of improvement it is aimed that in 2010-11, the gains and experiences so far made in the state will be measured once again, and wherever required fresh perceptive targets laid down for the year ending 31st	The annual targets for next 5 years for various output as well as outcome indicators were included in the PIP 2012-13. The details are given as **Annexure-1**

	(September 2009) that the SHS had a clear Perspective Plan in terms of clearly laid down technical targets for the Mission period and for targets for the Mission period and for each year. Action Plans were prepared by the State with reference to these targets and goals. It was, however, found that the SHS had only fixed targets to be achieved in the Annual Action Plans, but had not prepared a comprehensive Perspective Plan for the entire Mission period. In the absence of such a Plan, the convergence of Vertical health programmes, monitoring with reference to performance indicators, rationalization of manpower and resources available, etc., was not possible. Thus, the SHS had not evolved a systematic Perspective Plan based on reliable inputs for scheduling each and every activity in a critical path to execute the same within the time frame to ensure economy, efficiency and effectiveness in the Implementation of NRHM.	March 2012. It may be noted that the essence of NRHM is envisaged in a decentralized and participatory planning process with a bottom up approach. Accordingly, the annual Program Implementation Plan (PIP) of the state for NRHM has been prepared through a participatory and consultative process with the designated nodal agency being responsible at the District Levels for planning and implementation of the NRHM. In each of the Districts (14 Districts), there is in place a decentralized structure in terms of District Health and Family Welfare Society. This society is headed by the District Panchayat President and the District NRHM Plan is put up to the State Society by these District Societies. Being a decentralized structure, the District Society has a process of planning that takes care of the requirements of the grass root level institutions in each of the WARD of the District. It is on this basis that NRHM interventions are planned out and implemented. Participatory approach is in built in the present system, because feed back from the grass root level workers such as JPHN/ASHA/Ward Members etc on the various needs and necessities of each ward is taken into account by the District Society in the formulation of the District Action Plans. It may also kindly note that in addition to the needs at the grass root levels, some of the interventions under NRHM are generally technical in nature. ACTION TAKEN: In order to strengthen the process, State Health Systems Resource Centre (SHSRC) has been established which will function as a 'think-tank' for NRHM. One Senior Consultant (Public Health Planning) has been appointed in SHSRC which will assist NRHM in preparation of Action Plans and monitor the programme.	
1.2.7	**Financial Management**	**Factual Position:** Funds for implementation of NRHM flows from Government of India directly through e-banking to the authorized bank account of the Society. The Ministry of Health and Family Welfare, Government of India specifies that RCH-II/Additionalities	
1.2.	**Fund Management** GOI provided 100 per cent grant-in-aid to		

7.1

the State Government for the years 2005- 06 and 2006-07. During the Eleventh Plan (2007-12), the contribution was to be in the ratio of 85: 15 between the Centre and the State. Funds released by GOI for the components were credited to one single bank account while funds for the National Disease Control Programmes were credited to the bank accounts of the respective societies responsible for these programmes. The funds released by GOI to the SHS during 2005-09 vis-à-vis the expenditure incurred were as follows.

TABLE 1.8: Availability of funds and expenditure

Rs in crores

Year	OB	Funds received from GOI	State share	Total funds available	Expenditure	Closing balance	% of [illegible]
2005-06	7.70	44.90	0	52.60	11.14	41.46	79
2006-07	41.46	88.29	0	129.75	33.36	96.39	74
2007-08	96.39	229.95	0	326.34	154.52	171.82	53
2008-09	171.82	151.29	55.25	376.36	290.54	85.82	23
Total		514.43	55.25		489.56		

Source: Annual accounts certified by

and Immunization should have a single Bank Account at the State level as well at the District Levels. These bank accounts are operated under e-Banking mode and all transactions are carried out 100 % electronically to the designated bank accounts of the recipients. In the case of the electronic banking funds are received and released to districts by using the software 'i-check' developed by the Ministry in association with the authorized bank. Fund release to the districts is on the request received from districts for the approved activities, and the districts in turn releases electronically funds to the vendors/implementing units as the case may be. For Disease Control Programs, each of them has separate bank accounts in the designated bank account at both the state as well district level. State share for NRHM is released by the State Government and is credited to the Bank Account of the Society.

The quantum of funds sanctioned and released by the Ministry to these accounts is on a yearly basis, on the basis of the component-wise requirement under each of the program contained in the Programme Implementation Plan (PIP). This would include activities under various components such as RCH – II, Additionalities under NRHM, Immunisation and National Disease Control Programmes. Each of the components has several activities and these are reflected in the approved head of accounts laid down by the Ministry of Health and Family, Government of India.

It is pertinent to note that in respect of the RCH-II/Additionalities/Immunization, during 2005-06 the value of expenditure was 3.90 Crores, which rose to Rs17.64 crores by 2006-07 and still higher to Rs.112.49 crores by 2007-08 (as per audit reports of the society). It may be noted that this was a big achievement, considering the fact that there were some bottlenecks in the initial days. Under any program, especially of the size and magnitude of NRHM, it would take some time for the funds to be utilized. This is so because there are many technical factors involved. With concentrated efforts, the state is now in the stage

	Chartered Accountants		
	In the first three years, in, 2005-08, utilisation of funds was less than 50 percent, mainly due to delays in setting up the SHS and the DHSs. During 2008- 09, expenditure was 77 per cent of the available funds. The major items of expenditure were on Janani Suraksha Yojana (Rs 12.84 crore), appointment of contractual staff (Rs 34.50 crore), procurement of drug kits (Rs27.38 crore), grant-in-aid to SC, PHC,CHC and other hospitals (Rs38crore) and strengthening/upgradation of health centres (Rs 62.03 crore). It was seen in audit that during 2007-09, the State Government contributed Rs 53.25 crore against its committed share of Rs 55.02 crore, resulting in short contribution of Rs 1.77 crore. There were unspent balances ranging from Rs 41.46 crore to Rs 171.82 crore at the close of each financial year during 2005-09. Government stated (September 2009) that the State Programme Management Support Unit was institutionalised only in December 2006 and that the District Programme Managers were put in place only at the beginning of 2007. Also, the gestation period would be high since NRHM activities involved upgradation of facilities, etc. However, the fact remains	where the absorption capacity has increased. In this connection it is pertinent to note that the entire NRHM Scheme was not launched in Kerala during 2005-06. The Ministry of Health & Family Welfare, Government of India envisaged only RCH-II and funds were sanctioned for Kerala in 2005-06. While so when the state was primed to implement the technical strategies under the RCH –II, additional funds were also released to the state by the Ministry under Part 2 Additionilities. At that time, there was no mechanism in place to implement the Additionilities portion, since Kerala was not in the NRHM focus. While the situation was that in other states of the country was that NRHM was initiated in 2005-06 itself, in Kerala only RCH – 2 was initiated in Kerala in 2005-06. The State and District Societies to implement NRHM were not in place. The organizational set up in terms of the State Health Mission, State Health & Family Welfare Society, District Health Mission, District Health & Family Welfare Society was initiated and issued as an order on 31st December 2005. However, in the said order, District Collectors were designated as the Chairperson of the District Societies. This contradicted the Government of India instructions that District Societies are to be headed by the District Panchayat Presidents. Hence the final orders for formation of these bodies were issued only on 22-09-2006, and registration commenced thereafter. State Mission Director (Arogya Keralam) for NRHM was appointed only in August 2006. The order constituting various bodies in State and District was issued in September 2006 and several orders for proper implementation of the program were issued only subsequently. The State Program Support Unit was institutionalized only in December 2006. In order to properly implement the program, the district delivery system had to be streamlined properly. Necessary actions in this regard were taken and the District Program Managers for NRHM joined during the 1st week of April 2007. In the circumstance, that the District Program	

that Government could utilise only 21 to 26 per cent of the funds during the first two years (2005-07) due to delay in establishing the set up for implementing NRHM in the State.

Low utilisation of funds

Government of India, Ministry of Health and Family Welfare, released funds to the State based on the progress of expenditure. Due to low utilisation of funds during the initial years of implementation of NRHM, Rs 5.51 crore and Rs 1.95 crore sanctioned for the National Immunisation Day, RCH II Flexible Pool2413, Mission Flexible Pool26 and strengthening of immunisation were not released by the Ministry during 2006- 07 and 2007-08 respectively. Government stated (September 2009) that the low utilisation of funds was due to delays in formation of the State Programme Management Support Unit and SHS.

Out of Rs 154.21 crore released to the 14 DHSs during 2005-06 to 2007-08,the actual expenditure was only Rs 86.13 crore while the balance of Rs 68.08 crore remained unutilised with them. The expenditure for 2005-06 and 2006-07 was below 20 per cent of the funds released. Government stated (September 2009) that there

Managers were put in place only at the beginning of 2007-08, the organizational set up as indicated above which is the basic and essential unit for implementing the scheme at the Districts and below was effectively in place in 2007-08 and not 2005-06. In the circumstance, that the District Program Managers were put in place only at the beginning of 2007, the achievement of expenditure as indicated above for 2005-06, 2006-07 were in fact a big achievement. It may also be noted that the gestation period is high in the case of the activities under the Mission Flexible Pool, since it involves upgradation of facilities etc.

In this connection it may be noted that under RCH – II, there are around 14 main and 49 sub activities under RCH-II. Each of them is distinct and a number of technical factors involved. Similarly under Mission Flexible Pool, there are 26 heads. To implement all these activities, considering that NRHM is part of decentralization of health actions, thrust of the actions under NRHM in 2007-08 was on establishing fully functional, community owned, decentralized health delivery system to ensure simultaneous action on a wide range of determinants of health. Priority actions were therefore initiated to ensure availability of health functionaries at all levels such as Doctors and Nurses. Strengthening public health delivery was taken on the agenda, as otherwise with shortage of doctors and nursing staff, no meaningful actions could be implemented. Similarly simultaneous action on many fronts, creating institutional set ups like Ward Health and Sanitation Committees etc was initiated. An army of locally resident Accredited Social health Activists with strong referral links was also initiated to strengthen health system. Success of NRHM is linked to these factors.

As far as the project expenditure pattern is concerned, that the value of expenditure has steadily increased over the years reflecting in increased levels of spending for the activities. The task of putting in place Doctors and Nurses in the public health institutions was also a

	were delays in generating consensus on the action to be taken for utilising the funds released to the hospitals as well as in accounting of the expenditure as the hospital management committees were headed by elected members. Government also added that necessary orders had been issued to organise regional level workshops to collect statements of expenditure and Utilization certificates from the institutions concerned.	key factor addressed to ensure that the technical strategies under NRHM flow smoothly. Now that these issues have been addressed, these activities are proceeding smoothly. The cash flow cycle from the state to the districts has been improved, and nowadays it just takes around 4-5 days for the State Health and Family Welfare Society to release funds to the districts. Thus as far as Government of India as well as the State Health and Family Welfare Society is concerned, substantial amounts have been pumped into the public health system. It may be noted that there are more than 1400 health institutions across the State. One Block Coordinator who is supposed to collect the SOEs from the Blocks has nearly 8-10 institutions spread over an area of 25 sq.kms. Moreover, HMCs of these institutions are headed by elective members and at times, there is delay in generating consensus regarding the actions to be taken for utilizing these funds. These are the prime reasons for delay in utilizing the expenditure as well as accounting the expenditure. Government of Kerala has issued orders in GO(Rt) No: 2043/2007/H&FWD dated 8th June 2007, wherein decision has been taken that the districts organize regional level workshops, to collect Statement of Expenditure/Utilization Certificate from institutions down the line. The districts have initiated this process and workshops are being organized at different regions. Block level Coordinators have also been placed in 234 blocks in the state to strengthen the process. Audit may note that the unspent amounts as at the end of the financial year does not lapse and is carried forward to the next financial year. As far as performance of the districts is concerned, during the last week of every month, Senior Officers Meetings are held at the State Headquarters. These meetings are attended by the Minister of Health, Secretary, Health Government of Kerala, Director of Health Services, State Mission Director (NRHM), all	

		Additional Directors of Health Services, All District Medical Officers of Health, District Programme Managers of NRHM and other senior officers. At these meetings, district wise detailed analysis of expenditure is done and physical performance reviewed. Technical and operational issues are discussed and bottlenecks resolved, as a means of improving the performance and utilization of funds. As already stated, many of the activities would because of its own technical reasons have a longer gestation period. Further, in the districts, on the 5th working day of the month, the District Medical Officer who is also the Chief Executive Officer of NRHM conducts review of activities of NRHM in the Medical Officer's Monthly Conference. Likewise, during the 1st week of every month, block level review is conducted in all the 234 Health Blocks in the State. The district will be represented by a District Programme Officer who will review the activities of NRHM. It may be noted that the District Programme Officers have been trained on the activities of NRHM. Finally, audit may note that NRHM devolves majority of the funds to Government Institutions such as PHCs/CHCs/Sub-Centres etc. Utilization of funds is the responsibility of these institutions, and NRHM acts as a facilitator to devolve funds and has taken efforts as indicated above to increase the pace of utilization. ACTION TAKEN: As a result of instructions and follow up with the Districts, during 2009-10 the expenditure increased to 77%. The District Societies are utilizing the services of Block Co-ordinators and other staff to collect the expenditure statements from implementing PHCs/CHCs/Sub-Centres etc. All the District Societies have been repeatedly instructed to increase utilization of funds and to pass similar instructions to the peripheral institutions on similar lines. As majority of the expenditure takes place at various public health institutions below the District Level, instructions are issued from time to time to ensure that the activities are expedited and funds are utilized by the institutions. This is also	During 2010-11 Fund utilized against grant received from GOI is 82%. And during 2011-12, 68% of the amount allocated has been utilized. Now action such as monthly block review and district review etc. arranged to increase the % utilization.

		being monitored closely at the monthly district conference at DMOH.	

1.2.7.3

Release of Corpus Grant, untied grant and annual maintenance grant

Each CHC was entitled to receive Rupees one lakh, as a corpus and a maintenance grant and an untied grant totalling Rs 50,000. Each PHC was entitled to receive Rs 50,000, as a corpus and a maintenance grant and an untied grant Rs 25,000. During 2006-07 to 2008-09, Rs 81.12 crore, was sanctioned by GOI towards corpus grant (Rs 25.98 crore), maintenance grant (Rs 24.27 crore) and untied grant (Rs 30.87 crore). Information collected from 71 out of 115 CHCs and 83 out of 929 PHCs through questionnaires revealed that one to 46 CHCs and four to 66 PHCs received the entitled grants during 2006-09 as detailed below:

Table 1.9: Number of CHCs/PHCs who received entitled grants

	Corpus Grant		AMG		UF	
	No. of CHCs	No. of PHCs	No. of CHCs	No. of PHCs	No. of CHCs	No. of PHCs
2006-07	1	4	9	17	13	26
2007-08	32	48	35	65	41	66

Factual Position: During 2006-07 to 2008-09, an amount of Rs.80.11 crores was approved by Government of India towards Corpus grant, Maintenance grant and Untied Grant. The details of approval and release of funds to the institutions are shown in the table below.

	2006-07		2007-08		2008-09		TOTAL	
	App	Release	App	Release	App	Release	App	Release
HMC	-	-	13.84	13.84	12.14	11.54	25.98	25.38
AMG	4.55	4.55	9.77	9.77	9.94	4.28	24.26	18.6
UF	7.37	7.37	8.76	8.76	14.74	5.85	30.87	21.98
Total	11.92	11.92	32.37	32.37	36.82	21.67	81.11	65.96

It may be noted that during the year 2006-07 and 2007-08, the entire amounts approved for the above activities by Government of India, were released to the public health institutions through the District Health and Family Welfare Societies functioning in the 14 Districts of the State. During 2008-09, the Executive Committee and Governing Body of the State society took a conscious decision, in order to set an internal control of fostering better funds utilization and preventing idling of funds due to non-utilization, that Grants need to be released only those institutions which utilize more than 80% of the funds released to the institutions earlier. As a result out of the approved amount of Rs.36.82 crores during 2008-09, only an amount of Rs.21.67 crores were released to the institutions.

ACTION TAKEN:- During 2010-11, an amount of Rs.50.12crores

As per Annexure 2 during 10-11 85% of fund received under Corpus grant, Maintenance grant and Untied Grant had been disbursed to institutions. But as a control measure of utilization only those institution which utilized 85% of funds received are given fresh funds for the next year. As a result during 11-12 only 74% of institutions received fresh funds. During 12-13 FY GOI approved only balance amount after deducting grant in hand and the entire amount sanctioned has been released to the institutions.

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<td><table><tr><td>2008-09</td><td>40</td><td>45</td><td>44</td><td>52</td><td>46</td><td>57</td></tr></table>
Source: Details collected through proforma from CHCs and PHCs

It may thus be seen that the additional resources provided by GOI for the CHCs and PHCs did not reach a large number of these institutions, despite the availability of funds. Government stated (September 2009) that during 2006-07 and 2007-08, the entire amount approved by GOI for payment of grant was released to the CHCs/PHCs through the District Health Societies. But during 2008-09, grants were released only to those CHCs/PHCs which utilised 80 per cent of the funds released earlier. However, the information received by Audit from the CHCs/PHCs revealed that the grants were received by a few institutions as shown in the table above.</td>
<td>was approved by Government of India towards Corpus grant, Maintenance grant and Untied Grant and the entire amount is released to the institutions. Guidelines have been issued from time to time to ensure that the expenses are made at the institutions.</td>
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<td>1.2.7.4</td>
<td>Lapses in Budgetary Control
GOI approved Rs 80 lakh towards selection and training of Accredited Social Health Activists (ASHA31) during 2006-08 and Rupees five crore for procurement of ASHA drug kits during 2008-09. However, the SHS spent Rs 6.81 crore and Rs 16.69 crore respectively for the above purposes against the approved amounts which resulted in</td>
<td>ASHA
Factual Position: The scheme of "Trained female community health activist – 'ASHA' or Accredited Social Health Activist" is an activity envisaged to provide services to the community. The scheme has been put in place in Kerala on a strong basis and the state Government in G.O. (Rt.)No.649/07/H&FWD dated 24.02.2007 issued detailed guidelines for implementation of ASHA scheme in the state. According to the above order, one ASHA should be selected for every 1000 population in tribal areas, coastal areas and urban slums. Training in 5 Modules is also provided to</td>
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	excess expenditure of Rs 17.70 crore. Further, in the test-checked districts, it was noticed that NRHM funds were utilised for unapproved activities as described below: • The SHS released Rs 91.20 Lakh (2007-08 and 2008-09) towards stipend for BSc (Nursing) students, Rupees six lakh (2008-09) as maintenance grants to six CHCs where upgradation work was in progress and Rs 16.20 lakh (2007- 08 and 2008-09) to Hospital Management Committees (HMC) of the General Hospitals at Thiruvananthapuram and Wayanad. In response to Audit, the State Mission Director (SMD) stated in July 2009) that stipends had been given to nursing students to resolve the shortage of nurses. Maintenance grants to CHCs under upgradation and funds to the HMCs of the General Hospitals were provided because these units were running short of funds. The reply is not acceptable as it was the responsibility of the state Government to provide adequate funds for such activities which were not covered under NRHM. As per NRHM guidelines, SCs attached to CHCs/PHCs were not entitled for untied grants. Contrary to this, DHS provided untied grants of Rs 14.50 lakh to SCs attached to CHCs/PHCs during 2007-08 and 2008-09. In response, the SMD stated (July 2009) that the districts concerned	them. Therefore more than 32000 ASHAs have to be selected and trained for the entire state of Kerala. Naturally this cannot be done with a limited budget. In view of the Government Order the scheme was put in place on a large scale. These health activists have been selected from the villages itself and act as an interface between the community and the public health system. The scheme is well received by the community and is now a major activity under NRHM. Had the selection and training of ASHAs in 2006-07 and 2007-08 been delayed due to paucity of funds, the technical strategies under NRHM itself would have been adversely affected and its impact would have been felt over a long period, and ASHA services to the community would have been affected. **Stipend to B.Sc. Nursing students** Factual Position: An amount of Rs.91.20 lakh was released towards payment of stipend B.Sc internship students of three Government Nursing Colleges as per the directions of the Government of Kerala in G.O (Rt.) No.2455/2007/H& FWD, Trivandrum dated 5.7.2007. These are students who have passed out of the Government Nursing Schools, and during the period of one year during which they are paid stipend by NRHM, they will be working at the Government Medical Colleges, providing nursing services to the patient. This scheme is beneficial to the public health institutions since services of qualified nursing personnel will be augmented, and also beneficial to the nursing profession which is one of the core competency areas of the state. The essence of NRHM is increase services to the community, and hence the scheme was beneficial to the community. Action Taken: During 2010-11 the scheme of paying stipend from NRHM has been stopped. **Maintenance grant to CHCs where upgradation work was undergoing**	The scheme of paying stipend from NRHM has been stopped.

	had been asked to explain the reasons for this action.	Factual Position: All the CHCs are in the Government Buildings, and needed immediate maintenance including repair of taps, electricity points, painting etc. These are basically minor in nature. Up-gradation is a wider concept involving construction, manpower, infrastructure etc. Construction is generally new or putting up an additional floor. Maintenance is done in other areas of the CHC Complex, not covered under the process of up-gradation. Holistic view has been taken on strengthening CHC from the perspective of the community and it was not desirable to leave out one area of the CHC out of modernization. The concept and spirit of NRHM is that funds should flow to the needed areas so that the community is benefited. Action Taken: Government is being requested to provide funds for the purpose mentioned by Audit.	GOI has approved maintenance Grant for all CHCs and the amounts released to the institutions concerned.
	A refundable loan of Rupees seven lakh was released (2007-08) to the Kerala State Institute of Virology and Infectious Diseases, Alappuzha. Rs.13.30 lakh was released (2008-09) towards routine expenses (purchase of furniture, fuel charges, etc.) of the Kerala Medical Service Corporation.These activities were not covered under NRHM. The SMD stated (July 2009) that the institutions had been asked to refund the amounts.	**Untied funds to Sub Centres attached to CHCs/PHCs** Factual Position: Sub Centres caters to a population of 2.50 sq km, and is the key to better health services at the local level. Some of them even when attached to another main centre, would need independent actions and funds for key actions such as source reduction, minor modifications, cleaning, provision of bleaching powder/disinfectants, clearing of larvicidal measures for stagnant water, repair of soak pits etc.	GOI has approved untied funds for all subcentres
	An amount of Rs.51.86 lakh, approved for the constitution of 14 Mobile Outreach Units and payment of salaries to Junior Public Health Nurses in urban wards, was diverted (2007-08 and 2008-09) for meeting expenses relating to ward health sanitation activities. In response, the SMD justified the diversion and stated (July 2009) that funds were released to selected urban wards in the State to enable them to initiate action for their designated activities, with a special focus on mothers. However, the diversion was made without the approval of GOI and hence was irregular.	**Refundable loan to Kerala State Institute of Virology and Infectious Diseases, Alappuzha** Factual Position:A sum of Rs 5 lakhs was given on 14/06/2007 and Rs 2 lakhs given on 12/12/2007 is yet to be refunded by KSIVD, Allepey. The institute has been reminded on the matter to refund the same. Action Taken: Notice has been issued. The Government has also been addressed in this regard. **Routine Expenses of KMSCL** Action Taken: NRHM has asked KMSCL to reimburse the same and the same is under process **JPHN in Urban Health**	Loan not settled Yet to reimburse the amount

		Factual Position: Ward level Health and Sanitation actions in the Urban area was an area of concern, since the Rural Wards were covered under the actions, leaving insufficient actions at the Ward level in urban areas. As in Kerala there in real urban-rural divide, the entire state being almost an extended village, lack of actions in the Urban Wards may not be desirable. Thus during 2007-08 and 2008-09 Rs.51.86 lakhs was utilized for Ward Health and Sanitation activities in urban wards. In this connection it may be noted that urban RCH has an approved component for 2007-08 and 2008-09. The concept and spirit of NRHM is that funds should flow to the needed areas so that the community is benefited. Action Taken: Accounts have been furnished to GoI.	Urban RCH is an approved component under NRHM and for the programme , Medical Officers, JPHNs and Health Supervisors are appointed in Urban areas with the approval of GOI.
1.2.7.5	**Management Expenditure** As per NRHM guidelines, management expenditure should not exceed six per cent of the approved amount under RCHII. During 2005-06 and 2006-07, the expenditure on management was below six per cent, whereas it exceeded the limit, by Rs.3.08 crores during 2007-08 and 2008-09. Audit scrutiny revealed that inadmissible expenditure unconnected with the activities of NRHM like Nurses'/Doctors' day celebration, wages to drivers attached to the Minister's Office, wages to staff of the Kerala Medical Service Corporation Limited, entertainment of visitors, etc., was incurred during the period, contributing to the excess.	**Factual Position**: During the year 2007-08 and 2008-09, Programme Management Expenditure incurred was above the permissible limit of 6 % of RCH-II Cost alone, but did not exceed 6 % of total cost of NRHM. However, this does not also mean that the routine administrative expenditure increased beyond the permissible levels. The reason for the increase was technical in nature because during the year 2007-08, Block Coordinators numbering more than 200 and also a number of Doctors and Nurses were appointed throughout the state, and the salary cost was booked under Programme Management Expenditure. The appointment of Block Co-ordinators was done to co-ordinate block level activities and Doctors and Nurses were appointed to augument the public health services. For any project of the scale of NRHM during the initial days the cost of management would be on the higher side, especially in the NRHM context where large number of Block Coordinators/ Doctors/Nurses appointed, and the salry cost was booked under Programme Management Cost. Audit may note that in terms of percentage the Programme Management Cost was less than 2.20 %, of the total cost of NRHM, while it exceeded 6 % of RCH Cost. **Action Taken**: During 2009-10 the management cost was 5.05% of	During 2010-11 and 2011-12 the management expenditure was within the budget approved. During 2010-11, the amount approved for programme management by GOI is Rs.4.50 crores and the expenditure is Rs.4.40 crores. During 2011-12, the amount approved for programme management by GOI is Rs.17.28 crores and the expenditure was Rs.14.04 crores.

		RCH – II Cost and during 2010-11, the management cost would be within the ceiling limit. Salary of doctors and Block Co-ordination are now booked under the new heads.	
1.2.7.6	**Accounting System** The annual accounts for the years 2005-06, 2006-07 and 2007-08 were audited and certified in December 2006, February 2008 and May 2009 respectively while accounts for 2008-09 had not been prepared till June 2009. The SMD stated (July 2009) that the Audit Report for 2008-09 was expected to be ready by July 2009. However, the audited accounts for 2008-09 had not been finalized as of August 2009.	Action Taken: Audit for all the years up to 2009-10 is over and Audit Reports have been submitted to Government of India.	Audit report for 2010-11 had been submitted to GOI and statutory audit for 2011-12 is going on and will be completed by November 2012.
1.2.8	**Upgradation of Health Care Infrastructure and Capacity Building** The core strategy of NRHM includes strengthening of health institutions through better human resource development and providing adequate infrastructure and equipment to raise them at par with Indian Public Health Standards. GOI approved upgradation of 174 health care institutions at a cost of Rs 142.40 crore during 2006-09. The construction works were entrusted to five Government agencies and Rs 49.75 crore was released to them up to March 2009. Construction of buildings for only 34 institutions out of 174 had been	Factual Position: Upgradation works have been entrusted to five Government Agencies viz. Hindustan Prefab Limited (HPL), Hindustan Latex Limited (HLL), Kerala Health Research Welfare Society (KHRWS), Kerala Police Housing Construction Corporation (KPHCC) & Kerala State Nirmithi Kendra. Audit may note that upgradation work has a long gestation period and would take more than 2 years. Further, procedures such as concurrence at various levels etc also take time. Audit may note that large projects involving construction and civil works are generally delayed in India due to several factors such as availability of raw materials, labor supply, procedural delays, technical reasons, and these are beyond the direct control of the organization. This is true in every state and Kerala is no exception. It is true that the Government of India sanctioned the project for Upgradation of IMCH, Kozhikode into 'Centre of Excellence'. Out of this Rs.5.18 crore was allotted during 2006-07 and Rs.5 crore during 2007-08. An agreement was made on 3rd May 2007 between NRHM and M/s Hindustan Prefab Limited with a total consultancy	

	completed as of March 2009. GOI also released Rs 20.18 crore during 2006-09 for upgradation of the Institute of Maternal and Child Health, Kozhikode to a Centre of Excellence. Rupees 4.58 crore was released as advance to Hindustan Prefab Limited for installation of a sewage treatment plant for the institute during 2007-09. Only the work of the sewage treatment plant was completed. The remaining work of laying of a pipeline within the premises and external pipelines to carry the treated effluents was still to be completed (September 2009).	period of 30 months from the date of placement of work order. In view of the Hon'ble High Court of Kerala directions, it was decided to give first preference for the installation of Sewage Treatment Plant (STP). The estimate submitted by HPL on 24-08-07 for the 'Treatment of Sewage' was Rs.3.30 crore. The Kerala State Pollution Control Board (KSPCB) issued 'in principle clearance' vide order No.WPCB/T/2445/78 dated 14.02.2008 subject to its 20 point conditions. Important condition was that the sewage and sullage shall be separately collected and treated. Treated effluent shall be discharged to soak pit and the remaining disinfected water with a maximum BOD of 3mg/l shall be released to the maximum extent possible for gardening, flushing etc. The disposal of treated effluent was initially intended to be made to Canoly canal. However when HPL had submitted proposal to Pollution Control Board which suggested limiting standards to let out the effluent to the canal, the Board authorities insisted for a revised proposal for discharge into a soak pit after maximum recycling within the premises itself. The treatment had to be more sophisticated for achieving such stringent standards. Cost of additional pipelines for separation of sullage and sewage and also the risk of recycling treated hospital effluent was pointed out to the Board and finally in a meeting convened by the Hon'ble Minister it was again decided to discharge the treated effluent to Canoly canal. The decision to combine the sullage and sewage was also taken by the Board. The construction of the STP is now complete and only pipe laying work within the premises remains. The work for internal pipe laying has started as the question of separation of sullage and sewage has been sorted out. The treated effluent can be carried out to Canoly canal only through pipelines to be laid by KWA as this has to go along the sides of the neighboring roads. It is now understood that the KWA has prepared estimates for the pipeline to the tune of Rs.2.5 crores. As a goodwill gesture Kerala State	

		Pollution Control Board has sanctioned Rs. 1 crore initially to KWA for executing the work. Once pipe tying is completed by KWA treated effluent can be conveyed to Canoly canal. **Action Taken:** The STP has been completed and trial runs have started. However the laying of pipeline to Canoly canal is not progressing as the local public has objected to this. Hence treated effluent is now discharge into own land. The funds for the laying of pipeline to Canoly Canal are from the Kerala State Pollution Control Board and NRHM has no role in this work. The construction of the new building and the renovation of the old structure have reached the final stages and is almost complete. Installation of lift air conditioning, laying of medical gas line and firefighting is progressing and all works are expected to be completed by March 2011.	Many rounds of discussions have been completed the latest at Chief Minister's level to find out routes for laying pipe line, but decision is yet to be taken
1.2.8.1	**Delay in completion of upgradation of CHCs** Hindustan Latex Limited (HLL) Was appointed as the consultant for upgradation work of building infrastructure of CHCs in the State. As per the agreement signed for the purpose in February 2007, HLL was to prepare a detailed project report on the basis of a facility survey, get it approved by the hospital management committee of the CHCs and then prepare estimates for the works. Administrative sanction for the work was to be given by the SHS. During 2006-09, upgradation of 115 CHCs had been entrusted to HLL at an estimated cost of Rs 35.66 crore. Rupees 27.16 crore was paid as advance	**Factual Position:** Large projects involving construction and civil works are generally delayed in India due to several factors such as availability of raw materials, labor supply, procedural delays, technical reasons, and these are beyond the direct control of the organization. This is true in every state and Kerala is no exception. In this case, delay had also occurred owing to various reasons such as delay in constitutional of Institutional Level Committee (ILC) in each cases, difference of opinion in the ILC's and hence delay in their approval, revision of estimates to suit the budget, poor response of contractors to tender notifications, delay in demolition of existing structures constructed by PWD/ other agencies, cutting of trees etc, which require lot of paper and file work. Delay in execution of the project in some areas, especially in the district of Alappuzha is owing to not getting any willing contractor to take up the work in spite of repeated tendering. Now the possibility of executing the work through the LSGI with the plans and drawings prepared by HLL is being explored. These delays are beyond our control and may be condoned. Audit may note that upgradation work has a long gestation period and would take more than 2 years.	

	to HLL. It was observed that construction of only 22 CHCs had been completed as of March 2009. Work on 91 CHCs was in progress at various stages. Work was still to be started in the other two CHCs. None of the 22 CHCs which had been constructed had been upgraded as per the IPHS so far. Government stated (September 2009) that the delay in upgradation of CHCs was due to various reasons such as delays in constitution of institutional level committees, revision of estimates to suit the budget, poor response of contractors to tender notifications, etc., which were beyond their control. The Government also stated that work had been completed in 70 out of 115 CHCs and work in the other CHCs was in progress. Government added that tendering procedures had almost been completed for Procurement of equipment for a few CHCs and equipment for the remaining CHCs would be given according to availability of funds.	Further, procedures such as concurrence at various levels etc also take time. Procurement for the equipments at few CHCs has started and the tendering procedures are almost completed. Equipments for the remaining CHCs will be given accordingly with the availability of funds. **Action Taken: The upgradation of CHC's have been completed in the case of all works that have been initiated except for CHC Pazhanji and Ranni Perinad. The works in these institutions are progressing and is expected to be completed shortly.**	**The upgradation of CHC Pazhanji and Ranni Perinnad had been completed**
1.2.8.2.	**Construction of buildings for sub centres** In order to provide their own buildings to 2020 SCs, which were	**Factual Position**: In Kerala there is 1 Sub-Centre for every 2.1 Square Kilometers, as against the national average of 3.50 Square Kilometres. Due to better availability of public transport and road connectivity in the state, service demand from the CHC level institutions is much on the higher side. As evidenced by the remarks	Subcentres are given priority in the next PIP (2013-14). Based on this construction of subcentres shall be taken up.

	functioning in rented buildings, GOI approved in the Programme Implementation Plan for 2007-08, construction of buildings for 50 SCs at an estimated cost of Rs 3.30 crore (Rs 6.60 lakh per SC) and for the balance 1970 SCs during the subsequent years (2008-09: 700 and 2009-10: 1270). However, the construction of buildings was not taken up as of September 2009 as priority was given to CHC upgradation. Government stated (September 2009) that the District Programme Managers had been instructed to submit proposals for upgradation of SCs under their jurisdiction and the work would be prioritised after the receipt of these proposals.	of the Joint Review Mission (JRM), JPHNs are residing at the Sub-Centres and hence adequacy of services of Sub-Centres was felt. Moreover demand from PHC/Sub-centre level is also low for up-gradation which again is linked to the health seeking pattern of the society. Therefore up-gradation of PHC and Sub-Centres was not in the vicinity of the visualization of the mission during the times of acute demand for immediate up-gradation of the CHCs. In Kerala, health seeking behaviour is for specialists.	
1.2.8.3	**Deficiencies in the selected institutions** During field visits to the selected institutions in the sample districts, the following deficiencies were noticed: • The blood storage centre at theTaluk Headquarters Hospital, Ottappalam, Palakkad, for which Rs 1.55 lakh was spent during 2006- 07, had not started functioning due to the absence of a trained blood bank technician. Government stated (September 2009) that the technician would be given	Both the Medical Officer as well as Blood Bank Technicians has since been trained.	

	training shortly. • An outpatient block completed in March 2009 at a cost of Rs 25.26 lakh for CHC, Kadampazhipuram, Palakkad was not fully utilized due to shortage of specialist doctors and paramedical staff. Government stated (September 2009) that the outpatient wing was currently functional and an attempt was being made for getting the services of specialist doctors.	Doctors and para medical staff have been provided	
	• Equipment viz., incubators, suction apparatus, etc., purchased in December 2008, at a cost of Rs 10 lakh for renovation of the children's ward at the Taluk Headquarters Hospital, Ottappalam, Palakkad was not utilised as of April 2009, due to lack of three-phase electrification. Purchases were made without ensuring availability of space and usability of the equipment. Government stated (September 2009) that action was under way for getting three-phase electrical connection to operate the equipment and that furniture and other items had been distributed.	Action Taken: Request givn to KSEB authorities for getting 3 phase connection through Nirmithi Kendra. Beds have already been purchased and cots are put in to use. All other furniture have been utilized for patient benefits in OP, Casuality, Wards, waiting area etc..	All equipment are working in the operation theatre of M C H block from August 25th 2012. All cots are being used and new bed purchased in May 2012 are being used in the newly constructed M C H block from August 25th 2012.
	• A hospital building for the Taluk		

	Headquarters Hospital, Sulthan Bathery, Wayanad, constructed at a cost of Rs 1.75 crore (Rs 50 lakh from NRHM funds) had started functioning from June 2008. However, fxoperation theatre laboratory and Intensive Care Unit set up at a cost of Rs 34 lakh in October 2008 could not be made functional as of May 2009 due to shortage of staff. Government stated (September 2009) that staff had been posted under NRHM and the facilities were currently functioning.	Staff has been posted under NRHM and the facilities are functional. The Hospital is also trying for NABH accreditation.	
	• Non-posting of specialist doctors resulted in decrease of outpatients and non-utilisation of facilities viz., a fully equipped mini-operation theatre, labour room and an in- patient ward in PHC, Panamaram, Wayanad. Similarly, the operation theatre and labour room in CHC, Porunnannur, Wayanad was idling due to shortage of doctors. Government stated (September 2009) that efforts were being made to address the problem of shortage of doctors.	This is not a specialty hospital. One Pedatrician is now posted on working arrangement basis.	
1.2.8.4	***Accredited Social Health Activist scheme*** One of the key components of NRHM is to provide every village in the	Factual Position:The scheme of "Trained female community health activist – 'ASHA' or Accredited Social Health Activist" has put in place in Kerala on a strong basis. These health activists have been selected from the villages itself and act as an interface between the	The details of training conducted till date is shown as Annexure-3

country with a trained female Accredited Social Health Activist (ASHA), accountable to the village. According to the guidelines, 28,757 ASHAs selected during 2007-08 and 2008-09, were to be imparted 23 days' training in five prescribed modules. However, training was imparted to20,680 ASHAs in the first module, 16,180ASHAs in the second module and 800ASHAs in the third module during 2007-09. It was noticed that in the three selected districts, the third to fifth module training was not given to any of the selected ASHAs as of March 2009.

The SMD stated that as of July 2009, 27,024 ASHAs were trained in the first module, 17,817 ASHAs in the second module and 1,720 ASHAs in the third module. As ASHAs were expected to create awareness on health and mobilize the community towards local health planning, it was necessary to give them training in all the five modules.

community and the public health system. The scheme is well received by the community. The State Government in G.O. (Rt.)No.649/07/H&FWD dated 24.02.2007 issued detailed guidelines for implementation of ASHA scheme in the state. According to the above order, one ASHA should be selected for every 1000 population in tribal areas, coastal areas and urban slums. Training is in progress, and it would take time to impart 5 modules of training to such a large number. In any case work by ASHAs in service of the community is well received and appreciated by the community as well as the Government.

Action Taken: The details of training conducted till December 2010 is shown below:-

Districts	Total target	Total Selected	Mod I	Mod II	Mod III	Mod IV	Mod 5
KSGD	1100	1100	1045	789	232	0	0
KNR	2350	2354	2332	2280	2277	2257	0
WYD	835	835	835	835	835	830	0
KKD	2943	2777	2469	2349	2188	2158	0
MLPM	3900	3872	3740	3620	2976	0	0
PLKD	2650	2686	2680	2584	2550	2506	0
TCR	2889	2940	2623	2263	320	0	0
EKM	3090	2178	2078	1946	1832	712	0
IDK	1272	1220	1188	1116	1116	1116	0
KTYM	1965	1965	1965	1965	1930	1900	0
ALP	2300	2375	2375	2300	2225	2205	0
PTA	1340	1345	1340	1232	1200	1200	0
KLM	2750	2729	2729	2624	2533	2360	512
TVM	3470	3470	3320	3320	3320	3300	185
TOTAL	32854	31846	30719	29223	25534	20544	697

1.2.8.5	***Mobile medical units*** Under NRHM, financial assistance was to be provided for establishment of one Mobile Medical Unit34 (MMU) for every district for improving health services in medically under-served remote areas. In the Programme Implementation Plan for 2006-07, GOI approved Rs 1.55 crore towards the capital cost of one MMU and recurring costs for 14 MMUs including the 13 MMUs already in use in seven districts. In the Programme Implementation Plan for 2007-08, GOI approved Rs 5.12 crore for 13 MMUs. However, no allocation of funds was made to the DHSs for purchase of the vehicles and for meeting the recurring charges of the MMUs, which resulted in the amount remaining unutilised. Government stated (September 2009) that Rs five crore had been released during 2008-09 to the Kerala Medical Services Corporation Limited for procurement of MMUs.	**Factual Position:** Government of India has approved an amount of Rs. 512.33 lakhs during 2007-08 for Mobile Medical Unit. But no works could be initiated during 2007-08. During 2008-09 an amount of Rs. 500.00 Lakhs was released to M/s KMSCL for the procurement of 25 numbers of Mobile medical units. **Action Taken:** The Mobile Medical Units were not procured. As the Emergency Medical Services were launched in between, it was expected that funds would be required for the procurement of more ambulances for the service.	The Mobile Medical Units were not procured. As the Emergency Medical Services were launched in between, it was expected that funds would be required for the procurement of more ambulances for the service.

1.2. 8.6	***Deficiencies in upgradation of CHCs and PHCs compared to IPHS norms*** NRHM envisages bringing of health institutions at par with IPHS to provide round-the-clock services. In order to ascertain the facilities available, Audit obtained relevant information through questionnaires from 71 CHCs and 83PHCs from all the districts. Audit scrutiny revealed the following: • ***Manpower*** As per IPHS norms, seven specialists and nine staff nurses with supporting staff were required in each CHC. Forty nine CHCs did not have any specialists, while 21 CHCs had less than the prescribed Number of specialists and only one CHC had the full complement of specialists. As regards staff nurses, nine CHCs had nine or more staff nurses, 57 had less than nine and four CHCs had no staff nurse. According to IPHS norms, each PHC was required to have a Medical Officer, three staff nurses, one Pharmacist and one Laboratory Technician. Ten PHCs did not have a full time Medical Officer. Eleven PHCs had three or more staff nurses, while 42 had less than three and 30 did not have any staff nurse. It was also decades ago, but against our goal of	**Factual Position:** The institutional surveys of 2008-09 in the public health institutions pointed out inadequacy of equipments, infrastructure and manpower as the critical factors preventing better health services from the hospitals. This is because the health care delivery system has remained fragmented and uncontrolled for decades, and the growing demand of the community for better hospital services makes it necessary that quality assurance mechanism is put in place in the State by all means. It is with end in view that the exercise of making corrections in the health sector is under the purview of the Mission, and in fact our focus is not just on merely assuring compliance with minimum acceptable standards, but to set forth a system of constant improvements in the hospitals so that commitment of the Government to improve the quality of patient care is translated into reality and create greater efficiency, accountable & responsible governance in hospitals. With this in view, the deficiencies in facilities and equipments mentioned in the audit report is being addressed. Only 115 CHCs were taken up for up-gradation and PHCs were not envisaged. Efforts under the Mission would take time, and overnight deficiencies cannot be removed. While it is able for the Mission to correct the imbalances in equipments and infrastructure, it would require some time horizon to set right the manpower gaps, because of scarcity of Doctors in the market. However every effort will be made to see adequacy of Doctors at the institutions. Similarly, excess staff nurses in some of the institutions may be viewed not against the ratio fixed decades ago, but against our goal of attaining a ratio of 1:4 (bed: nurses). Accordingly more than 1000 Nurses have been inducted in the public health system to improve maternal, newborn and child health and nutrition, combat infectious diseases including TB and HIV/AIDS and provide physical and mental health care in emergencies. **Action Taken:** Action is continuing to equip the institutions. The	Action is continuing to

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<td>attaining a ratio of 1:4 noticed that 79 PHCs did not have a (bed: nurses). Accordingly more than 1000 Nurses have Laboratory Technician, while 10 did not been inducted in the public health system to improve have a Pharmacist. Government stated maternal, newborn and child health and nutrition, combat. (September 2009) that every effort would infectious diseases including TB and 111V/AIDS and provide be made to ensure adequate number of physical and mental health care in emergencies doctors in the institutions and to fill up regular vacancies.
Infrastructure
NRHM envisages providing of 30 beds for in-patients in each CHC together with other facilities. Information furnished by 71 out of 115 CHCs revealed that 22 CHCs had bed strength in excess of 30 and 35 CHCs had bed strength less than 30. Fourteen CHCs did not furnish the relevant information. The number of CHCs out of these 71 CHCs, where infrastructural facilities were not available, are given in the following table:

Table 1.10: Non-availability of infrastructural facilities

<table>
<tr><th>Facilities not available</th><th>No of CHCs</th></tr>
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<td>speciality cadre inducted in the health service system has changed the existing scenario and hence the supply of equipments and other items is now being revised based on the actual physical requirement. Regarding the manpower the Director of Health Services is being addressed to fill up the unfilled regular vacancies.</td>
<td>upgrade the CHCs and PHCs. But due to non availability of sufficient manpower, the institutions were not fully equipped with equipments as per IPHS standards to avoid idling of equipments due to the lack of manpower</td>
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<tr><td></td><td><table><tr><td>Blood storage</td><td>70</td></tr><tr><td>ECG</td><td>60</td></tr><tr><td>Labour room</td><td>29</td></tr><tr><td>Operation Theatre</td><td>39</td></tr><tr><td>X-ray</td><td>62</td></tr><tr><td>24 hour emergency services</td><td>30</td></tr></table>Source: Details collected through questionnaires from 71 CHCs

Equipment
According to IPHS norms, 1037 major types of equipment are necessary to make an operation theatre (0T) operational. Out of 32 CHCs which had operation theatres, 27 did not have even 50 per cent of equipment in the Ots.

Government stated (September 2009) that the deficiencies in infrastructural facilities and equipment pointed out by Audit were being addressed.</td><td></td><td></td></tr>
<tr><td>1.2.9</td><td>Procurement</td><td></td><td></td></tr>
<tr><td></td><td>A standardized procurement procedure was essential for the SHS to operationalise best practices to ensure transparency and public accountability and to facilitate a systematic approach in decision-making. During 2007-08 and 2008-09, the SHS purchased surgical kits, ASHA drug kits and other drugkits from M/s. Karnataka</td><td>The State Government had disbanded CPC in 2006-07 in order to establish a new Corporation based on the TNMSC model. However, Kerala Medical Services Corporation could be established only in 2008-09 and hence during the intervening period it was decided by the Government of Kerala to do procurement in respect of the requirements under NRHM as per the State Government policy of procuring through DGS&D rates or from Central / State Public Sector Undertakings. All the procurements under NRHM were thus</td><td></td></tr>
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Antibiotics and Pharmaceuticals Limited (KAPL), a Central Public Sector Enterprise. Details are given in the table below:

Table 1.11: Details of purchase of kits

Sl No	Details of Item	Qty supplied (Numbers)	Period of supply	Date of agreement	Due date of completion of supplies per agreement	Amt (Rs in crores)
1	Surgical Kits	265	Aug to Sep 2007	17 May 2007	28 July 2007	33.54
2	Surgical Kits	265	April 2008	24 Nov 2007	12 Mar 2008	
3	ASHA drug kits	8650	Nov 08 to Jan 2009	29 Sept 2008	30 Nov 2008	6.69
4	Drug Kits	6218	April to May 2007 Nov and Dec 2007 Aug to Nov 2008	30.02.2007 (first supply order) 05.02.07 (second supply order) 17.06.08 (Third supply order)	31 Mar 2007 31st Oct 2007 31 July 2008	26.14

Source: Records from the State health and Family Welfare Society

carried out based on orders issued by the Government of Kerala. It may be noted that the Governing Body of State Health & Family Welfare Society which is the apex body of the society has approved the process as well as the procedures involved in the items. As far as credibility of Karnataka Antibiotics & Pharmaceuticals Ltd (KAPL) is concerned, it may kindly be noted that the company is a Government of India Navratna company set up in the year 1981, and they are an ISO 9001-2000 accredited company and recipient of several awards, national and international, and more specifically prestigious awards for excellence in performance received from the Hon'ble. Prime Minister Dr. Manmohan Singh and former President Dr. Abdul Kalam. It was based on the credibility that Government of Kerala selected the company with due consideration of their financial soundness, record of quality supplies to various states under similar programs and administrative capabilities to execute such large and critical orders.

1.2. 9.1	**Procedural Irregularities** • The procurement guidelines issued by the Ministry of Health and Family Welfare in July 2006 for the RCH II project envisages different methods for procurement like open tenders, limited tenders, global tenders, etc. However, the single tender –system was to be adopted only for drugs and equipment which were of proprietary nature or where only one particular firm was the manufacturer of the item demanded. Also, the Purchase Preference Policy approved by GOI in August 2006,envisaged procurement of 102 medicines manufactured by Pharma Central Public Sector Enterprises (CPSEs) and their subsidiaries, eitherby inviting limited tenders or by purchasing directly at rates certified by the National Pharmaceuticals Pricing Authority with discounts up to 35per cent. However, for purchase of surgical kits and drug kits, thesingle tender system was adopted and for ASHA drug kits, the limitedtender system was adopted, though various options were available asper the procurement policy. Moreover, the entire purchase was made from a single firm, viz. KAPL. • Conditions of agreement for supply of	Procurement of surgical kits, drug kits, computers etc were done as per the State Government policy, under NRHM Mission Flexible Pool and not under the RCH II Project. The State Government had disbanded CPC in 2006-07 in order to establish a new Corporation based on the TNMSC model. However, Kerala Medical Services Corporation could be established only in 2008-09 and hence during the intervening period it was decided by the Government of Kerala to do procurement in respect of the requirements under NRHM as per the State Government policy of procuring through DGS&D rates or from Central / State Public Sector Undertakings. All the procurements under NRHM were thus carried out based on orders issued by the Government of Kerala. It may be noted that the Governing Body of State Health & Family Welfare Society which is the apex body of the society has approved the process as well as the procedures involved in the items. Audit may note that large amounts were lying unutilized under various heads under NRHM. Delay in funds utilization could have led to cutting down of allocation from subsequent allocations from Government of India. To avoid cuts during 2007-08, it was decided to expedite utilization of funds. During 2007-08, a budget of atleast 15 crores for procurement of drugs was indicated in the State Action Plan for NRHM, but it required that the funds already released be utilized first. In line with the Government of India's Purchase Preference Policy (PPP) for purchase of medicines manufactured by Pharma Central Public Sector Enterprises, and considering that No-Objection had been issued by Ministry of Health and Family Welfare, Government of India to effect procurement from Karnataka Antibiotics & Pharmaceuticals Limited, Government had sanctioned procurement of drug kits from M/s. Karnataka Antibiotics & Pharmaceuticals Limited, a Government of India enterprise. Further, the Government Order stated that during NRHM discussions with Health Ministers of other states, procurements were being done through Central	

	surgical kits, ASHA drug kits and drug kits specify pre-despatch and/or post-despatch inspection by the purchaser.. Final payments are to be made only after the receipt of final acceptance certificates from the district Stores-in-charges. Scrutiny of records in the Family Welfare Stores at the three districts test-checked revealed that no pre-despatch or post-despatch inspections were conducted by the SHS or by the DHSs to ensure quality, quantity and workability of the supplied material. However, the final payments were released by the SHS/DHSs despite getting reports of short supply and damages. In reply, Government stated (September 2009) that the damaged items of the kits had been immediately replaced by KAPL. • According to the agreement conditions, a penalty equivalent to one per cent of the price of the delayed goods for each week of delay in supply was leviable from the suppliers, subject to a maximum of 10 per cent of the cost of delayed goods. There were delays of three to eight weeks in supply of surgical kits, one to five weeks in the case of ASHA drug kits and one to fourteen weeks in the case of drug kits. The penalty,	Public Sector Undertakings by direct purchase. There were instances where direct purchases from Pharma CPSUs have been done in Kerala. NRHM started late in Kerala and from 2005-06 and 2006-07 and therefore Government decided to follow direct purchase through Central Public Sector Undertakings based on the lines of Drug Kits to avoid delay especially when kitting is required. State Mission in its letter No.NRHM/915/2007/SPMSU dated 28.03.2007 had proposed purchase of surgical kits to the Government, as per the requirement of Surgical Kits as decided by the Committee through limited tenders. The Government of Kerala has a policy to purchase directly from PSUs like M/s. KSDP (for medicines), M/s.SILK (for beds), M/s. Hanveev (for bedsheets), M/s. HLL for Civil Works etc. The procurement was done under NRHM – Mission Flexible Pool as per the State Government Policy. Government after examining the matter in detail had issued orders for procurement of surgicals for a total value of Rs 14.65 crores plus 2% Administrative expenses, out of the funds released by Government of India under Funds under NRHM. Based on the Government Order, procurement order was issued by the State Mission to M/s. KAPL vide order No.NRHM/682/2007SPMSU dated 21.11.2007. The expenditure was met from Mission Flexible Pool under NRHM for Upgradation of CHCs to IPHS. The Governing Body deliberated in detail and approved the procurement and process involved in the procurement of surgical kits. It may be kindly noted that the Standard surgical sets of various types comprises of different types of surgical equipments/instruments intended for different type of surgeries. Blood transfusion kits are comprises of items like centrifuges, water bath, test tubes, blood bags, microscopes, glass slides, BP apparatus, etc., intended to meet bear minimum requirements to set up any blood transfusion center. As per the above parameters, none of the above all items are available with any single manufacturer. For	

	leviable from KAPL in the above cases was Rs 3.18 crore. Government stated (September 2009) the Governing Body of the SHS had resolved to exempt KAPL from the penalty clause as there were only minor delays in supplies for reasons like transport, bottlenecks, strikes, lack of raw materials, etc. The reply cannot be accepted because the delay ranged from two to fourteen weeks (excluding the delay of one week) and Government should have invoked the penalty clause as per the agreement conditions	kitting, the items need to be sourced from several manufacturers. KAPL is the only pharma CPSE in health care sector having experience backed by performance of over two decades in this area. Supplies of these kinds of kits can be done only by a professional company like KAPL unlike other models of procurement for effective time bound implementation of NRHM/RCH health programmes. In addition to 102 lists of medicines, KAPL is the preferred supplier for these different kits for procurement by various state governments on case to case basis. As per the agreement, the purchaser shall under pre or post dispatch inspection on random basis as deemed fit. Also, Pre-dispatch and post-dispatch inspection condition was included in the agreement as a safeguard against any issue that could arise during supply. The condition is not a regulatory one to be enforced. However, M/s.KAPL was asked to give an undertaking that they will be liable for making of any discrepancy in the stock or functioning of the machine. M/s.KAPL had given an undertaking that they will fully comply with the agreement signed for supply of surgical kits and there shall not be any lapse in their part in implementing the works assigned to them. They also assured that the best quality of service would be provided for all works executed by them on the direction of State Mission. Certain complaints were received regarding the non-functioning of suction apparatus, pulse oximeter and some other apparatus were not functioning properly in certain districts. The State Mission did not release the payments and asked SPM (RCH) to get all the defects rectified in his regard. SPM(RCH) coordinated and informed M/s.KAPL who in turn deployed technical experts to all the districts in Kerala meeting the DMOs, DPMs, Superintendent of hospitals etc to rectify the defective / replace the non functioning and provide technical expertise for installation and proper working of equipments. All damaged items of the kits were immediately replaced by KAPL as and when demanded. KAPL has also deputed	

		their representatives to look into any problem as and when informed. Components of the kits were guaranteed and replacements were made in time. All ok reports were obtained and the supplier gave an undertaking that they will rectify any problems faced by the user. In many cases the users have directly contacted the suppliers and the same was attended to immediately. It was further informed by SPM (RCH) that they have submitted reports with certification from concerned authorities and only under these circumstances, the remaining payment was released. Since many of the items were delicate equipments, once they are being used, the items can be tested and replaced by M/s.KAPL, if not working. It may also be noted that the warranty clause has already been included in the agreement. The State Mission had issued a show cause notice to invoke penalty clause for invoking fine for the delay in supply. However, M/s. KAPL had requested not to invoke genuine difficulty in logistics in supplying kits to different hospitals. KAPL had written to NRHM explaining difficulties resulting in minor delays in supplies which included transport bottlenecks, strikes, raw material problems etc. The Governing Body in its meeting held on 12th June 2007 resolved to exempt M/s. KAPL from penalty clause. Audit observation in respect of the paragraph may therefore be dropped. **Action Taken:** Drugs purchased has been utilized by the institutions. The para may be dropped.	
1.2. 9.2	**Surgical Kits and drug kits** • Though the supply order was placed with KAPL, it was seen that the actual supply was made by another firm, viz. M/s.Plasti Surge IndustriesPrivate Limited, Amaravati, Maharashtra, on behalf of KAPL though there was no provision in the	Procurement order was issued to M/s.KAPL being a Central PSU. The in-house purchase policy of M/sKAPL was not enquired into. Procurement has been done by M/s.KAPL and the State Mission has no knowledge of any private company through which M/s.KAPL has procured. As far as the Mission is concerned, supply orders are for kits and not individual drugs. In any business the components within the product supplied would be procured by the supplier from different sources. Audit may note that in any business the supplier	

	contract for subletting the contract. KAPL was allowed 6.8 per cent discount as per the invoice of M/s.Plasti Surge Industries kept in the records of three test checked District Family Welfare Stores. However, KAPL had not passed on this discount to the SHS. The indirect purchase resulted in extra expenditure of Rs 1.99crores to the SHS and undue benefit of an equivalent amount to. KAPL. Government stated (September 2009) that the in-house purchase policy of KAPL was not enquired into and the SHS had no knowledge of any private company through which KAPL had Procured surgical kits and drugs kits However, the fact remains that Government had incurred extra expenditure of Rs1.99crore. • The SHS did not assess the actual requirement based on the sample survey conducted in September 2006 in all the CHCs before placing the order. In the Family Welfare Stores of the three districts test checked, 26 out of 102 surgical kits had not been distributed to CHCs/First Referral Units as of March 2009. Physical verification done by Audit in two First Referral Units and three CHCs also revealed idling of seven surgical kits costing Rs 31 lakh.	would try to condense their cost, so that enough profit is generated to sustain their business. The difference between the sale value and cost of goods sold is the profit margin of any concern. In this connection, it may be noted that Government of India has released funds for upgradation of Community Health Centres in Kerala. The main components for upgradation are broadly classified as follows. infrastructure manpower equipments drugs Investigative facilities etc. Under NRHM, it was proposed to upgrade all Community Health Centre to Indian Public Health Standards (IPHS). Government of India had initially allotted Rs.20 lakhs as the 1st installment for Civil Works, drugs, surgicals, infrastructure etc. Through NRHM, over 1200 doctors have been appointed on contract basis in the State as Contract Doctors / Compulsory Rural posting for doctors including 400 specialists. Further, over 1000 nurses, called *"Service Nurses"* have been appointed on contract basis. During several meetings held with doctors, it was reported that there is a shortage of drugs and surgicals in the health institutions. In order to overcome the shortage of drugs, as per G.O.(Rt).No.231/2007/H&FWD dated 19.1.2007, orders were given to M/s. Karnataka Antibiotics & Pharmaceuticals Limited to supply drug kits for health institutions in the State. The shortage of surgicals was still prevalent in the State. As per the Framework for Implementation of NRHM approved by the Union Cabinet, the Mission aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs will be operationalised as FRUs with all the facilities for Emergency Obstetric Care. IPHS is a concept to fix benchmarks of	

	• GOI instructed (December 2006) the State Government to procure the drugs from primary manufacturers following the Purchase Preference Policy for 102 medicines. The kits were to be formed by the State after procuring the drugs separately and this process was to be completed by 15 February 2007. However, the State Government purchased (January 2007) drug kits from KAPL directly instead of purchasing the drugs separately from primary manufacturers and making their own kits. In response, Government stated (September 2009) that kitting required a long process i.e. procuring the stores, assembling them in godowns, and kitting using semi-skilled and unskilled labourers. This would involve huge investment and therefore readymade kits were purchased. The reply of the Government is not acceptable because the purchase of readymade kits was against the instructions of GOI.	infrastructure including building, manpower, equipments, drugs, quality assurance through introduction of treatment protocols. IPHS defines the level of services that a CHC would be expected to provide. It also mentioned that centre would support the entire capital expenses of construction / renovation of CHCs including manpower and equipment. As per the fund allotment for CHC Upgradation, equipment kit worth Rs.22.19 lakhs can be allotted per CHC for fully functional Community Health Centre as per IPHS standard. The State Mission conducted facility survey on all the CHCs in the State regarding the service delivery, clinical manpower, support manpower, investigative facilities, physical infrastructure, Operation Theatre, Operation Theatre Equipment, Labour room, Labour room equipment, Blood Storage units, Water Supply, Sewage, Waste Disposal, other equipments in general, quality assurance programme etc. Institution Level Committees were formed in each of the CHCs to collect the facility survey details and upgradation to FRU levels. M/s HLL conducted the facility survey in association and consultation with Institution Level Committees and proposed the following equipments required at the CHC level. Standard Surgical Set – I (Instruments) FRU Standard Surgical Set – II CHC Standard Surgical Set – III Standard Surgical Set – IV Standard Surgical Set – V Standard Surgical Set – VI IUD Insertion Kit Normal Delivery Kit Equipments for Anesthesia Equipment for Neo-natal Resuscitation Materials Kit for Blood Transfusion M/s.Hindustan Latex Limited, who are the consultative agency for implementing the activity "Upgradation of CHC to IPHS" in their	

		proposal for model CHC had suggested list of items in the Surgical kits to be procured for CHCs (copy annexed). Government of India as per their letter No.D.O.No.P.17108/17/2006-RHS dated 5-3-2007 approved the proposal of the State to provide manpower, infrastructure, equipments, drugs, investigative facilities etc. in CHCs. Government of India commented that they have received the IPHS facility survey of the CHCs. Government of India further stated that the requirement in terms of infrastructure, manpower, equipments, drugs and investigative facilities listed along with the general designs for CHC building and residential building in the IPHS guidelines for CHCs. It was also advised that Blood Storage unit should be included in the proposed model CHCs. Under these circumstances, it was planned to procure surgicals for the state as per requirement. In order to scrutinize the upgradation of CHCs, several meetings were held with specialist doctors and PRI members, the 1st being at Kozhikode on 21st February 2007. The meeting discussed in detail the requirements of surgicals as suggested by Government of India and Hindustan Latex Limited in CHCs and FRUs and drafted the same. During the 2nd meeting at Trivandrum held on 24th February 2007, the opinions of specialists were again taken wherein the necessity of surgicals was spelt out by the specialists based on the requirements. In both the meetings, recommendations of specialists were obtained and the list of surgicals to be procured for the State finalized based on the plan proposed by M/s. HLL. The doctors were of the opinion that at least 3 CHC kits and 6 FRU kits should be procured for each CHC/FRU. In order to finalise the list of surgicals as proposed by M/s.HLL, a core committee consisting of senior officers of NRHM, Pediatrician, Gynaecologist, Surgeon, Anesthetist, Preventive and Social Medicine specialist etc was formed as detailed below. Dr.K.P.Pradeepkumar, State Program Manager (NRHM)	

		Dr.Rajamohanan, Pediatrician and Superintendent, SAT Hospital, Trivandrum Dr.Ayesha Beegum, Gynaecologist, Civil Surgeon, W & C Hospital, Trivandrum Dr.Thomas Mathew, Preventive & Social Medicine Specialist & Technical Consultant (NRHM) Dr.K.Sandeep, Anaesthetist, NRHM Consultant (M&E) Dr.R.Suresh, Surgeon, ARMO, General Hospital, Trivandrum The committee took into consideration the recommendations of the meetings held Kozhikode and Trivandrum and finalized the list of surgicals to be procured for the State. The Committee was of the view that 3 CHC kits and 6 FRU kits should be procured for each CHC/FRU. However, since the budget outlay for the procurement for 3 CHC kits and 6 FRU kits will be too high, it is suggested that initially one CHC kit and 2 FRU kits may be procured in this financial year 2007-08. It can be clearly inferred from the above paras that the State Mission had worked out the actual composition and requirement of Surgical Kits with proper care. All those CHCs (including Block PHCs) which could be immediately upgraded into FRUs and the existing FRUs were selected for providing Surgical kits. This included 5 block PHCs from Malappuram, CHC Attapady and Tribal Hospital Nallornadu. Thus, the requirement of kits was done with proper planning and care taking into confidence all the stake-holders involved. Similarly, the 2nd order was also issued by Government of Kerala based on the previous facility survey, manpower deployment and minutes of the Senior Medical Officers meeting held on 6th September 2007 chaired by Director of Health Services. It may be kindly noted that in 2006, there were only 39 functional FRUs though Government had proclaimed 65 FRUs which were conducting deliveries. In March 2009, 136 institutions which were supplied surgical kits are conducting deliveries (list annexed). Not only this, this has also	

		helped in starting many peripheral centres conducting deliveries thereby easing crowds as well as better quality health services in tertiary level institutions. This also corroborated by the fact that JSY beneficiaries have increased from 2006 to 2009 especially from peripheral institutions. Government of Kerala decided to upgrade all the CHCs into FRUs during the Mission period upto 2012. Kerala has 234 medical blocks and 231 CHCs (including 115 Block PHCs). Government of Kerala decided to upgrade 115 CHCs in the 1st phase to the level of FRUs. Government of Kerala as per GO.(Rt).No.3685/2007/H&FWD dated 29.10.2007 approved procurement of surgicals worth Rs.14.65 crores plus 2% administrative expenses from M/s. Karnataka AntiBiotics and Pharmaceuticals Limited (KAPL). Even though NRHM was initiated in 2005-06, surgicals had not yet been procured although funds were made available by Government of India. In this context it is important to note that several doctors had been posted on contract basis. *Service Nurses* were also been appointed on contract basis. These measures should be supplemented with timely supply of surgical and other supplies to public health institutions in the state. During several meetings held with doctors, it had been reported that there is a shortage of drugs and surgicals in the health institutions. In order to overcome the shortage of drugs, Gvernment, as per G.O.(Rt).No.231/2007/H&FWD dated 19.1.2007, ordered supply of drug kits for health institutions in the State from M/s. Karnataka Antibiotics & Pharmaceuticals Limited. However the shortage of surgicals were still prevalent in the State. Under these circumstances, procurement of surgicals for the state had to be carried out on an urgency basis. Large amounts were lying unutilized under various heads under NRHM. Delay in funds utilization could have led to cutting down of allocation from subsequent allocations from Government of India. To avoid cuts during 2007-08, it was decided to expedite utilization	

		of funds. During 2007-08, a budget of atleast 15 crores for procurement of drugs was indicated in the State Action Plan for NRHM, but it required that the funds already released be utilized first. In line with the Government of India's Purchase Preference Policy (PPP) for purchase of medicines manufactured by Pharma Central Public Sector Enterprises, and considering that No-Objection had been issued by Ministry of Health and Family Welfare, Government of India to effect procurement from Karnataka AntiBiotics & Pharmaceuticals Limited, Government had sanctioned procurement of drug kits from M/s. Karnataka AntiBiotics & Pharmaceuticals Limited, a Government of India enterprise. Further, the Government Order stated that during NRHM discussions with Health Ministers of other states, procurements were being done through Central Public Sector Undertakings by direct purchase. There were instances where direct purchase from Pharma CPSUs have been done in Kerala. NRHM started late in Kerala and from 2005-06 and 2006-07 and therefore Government decided to follow direct purchase through Central Public Sector Undertakings based on the lines of Drug Kits to avoid delay especially when kitting is required. State Mission in its letter No.NRHM/915/2007/SPMSU dated 28.03.2007 had proposed purchase of surgical kits to the Government for as per the requirement of Surgical Kits decided by the Committee through limited tenders. The Government of Kerala has a policy to purchase directly from PSUs like M/s. KSDP (for medicines), M/s.SILK (for beds), M/s. Hanveev (for bedsheets), M/s. HLL for Civil Works etc. The procurement was done under NRHM – Mission Flexible Pool as per the State Government Policy. Government after examining the matter in detail had issued orders for procurement of surgicals for a total value of Rs 14.65 crores plus 2% Administrative expenses, out of the funds released by Government of India under Funds under NRHM. Based on the Government Order, procurement	

order was issued by the State Mission to M/s. KAPL vide order No.NRHM/682/2007SPMSU dated 21.11.2007. The expenditure was met from Mission Flexible Pool under NRHM for Upgradation of CHCs to IPHS. The Governing Body deliberated in detail and approved the procurement and process involved in the procurement of surgical kits.

It may be kindly noted that the Standard surgical sets of various types comprises of different types of surgical equipments/instruments intended for different type of surgeries. Blood transfusion kits are comprises of items like centrifuges, water bath, test tubes, blood bags, microscopes, glass slides, BP apparatus, etc., intended to meet bear minimum requirements to set up any blood transfusion center. As per the above parameters, none of the above all items are available with any single manufacturer. For kitting, the items need to be sourced from several manufacturers. KAPL is the only pharma CPSE in health care sector having experience backed by performance of over two decades in this area. Supplies of these kinds of kits can be done only by a professional company like KAPL unlike other models of procurement for effective time bound implementation of NRHM/RCH health programmes.

In addition to 102 lists of medicines, KAPL is the preferred supplier for these different kits for procurement by various state governments on case to case basis.

It may kindly be noted that KAPL is a Govt of India Navratna company set up in the year 1981 and they are an ISO 9001-2000 accredited company and recipient of several awards, National and International, more specifically the prestigious award for excellence in performance from the Hon'ble. Prime Minister Dr. Manmohan Singh and former President Dr. Abdul Kalam. Government of Kerala selected KAPL due to their financial soundness, record of quality supplies to various states under similar programs and administrative capabilities to execute such large and critical orders.

The procurement order was issued to M/s.KAPL by the Government, M/s. KAPL being a Central PSU. The in-house purchases of M/s.KAPL was not enquired into. Procurement has been done by M/s. KAPL and the State Mission has no knowledge of any private company through which M/s. KAPL has procured.

The State Mission had issued a show cause notice to invoke penalty clause for invoking fine for the delay in supply. However, M/s. KAPL had requested not to invoke genuine difficulty in logistics in supplying kits to different hospitals. KAPL had written to NRHM explaining difficulties resulting in minor delays in supplies which included transport bottlenecks, strikes, raw material problems etc. The Governing Body in its meeting held on 12th June 2007 resolved to exempt M/s. KAPL from penalty clause. As per the agreement, the purchaser shall under pre or post dispatch inspection on random basis as deemed fit. Also, Pre-dispatch and post-dispatch inspection condition was included in the agreement as a safeguard against any issue that could arise during supply. The condition is not a regulatory one to be enforced. However, M/s.KAPL was asked to give an undertaking that they will be liable for making of any discrepancy in the stock or functioning of the machine. M/s.KAPL had given an undertaking that they will fully comply with the agreement signed for supply of surgical kits and there shall not be any lapse in their part in implementing the works assigned to them. They also assured that the best quality of service would be provided for all works executed by them on the direction of State Mission.

Certain complaints were received regarding the non-functioning of suction apparatus, pulse oximeter and some other apparatus were not functioning properly in certain districts. The State Mission did not release the payments and asked SPM (RCH) to get all the defects rectified in his regard. SPM(RCH) coordinated and informed M/s.KAPL who in turn deployed technical experts to all the districts in Kerala meeting the DMOs, DPMs, Superintendent of hospitals etc to rectify the defective / replace the non functioning

and provide technical expertise for installation and proper working of equipments. All damaged items of the kits were immediately replaced by KAPL as and when demanded. KAPL has also deputed their representatives to look into any problem as and when informed. Components of the kits were Guaranteed and replacements were made in time. All ok reports were obtained and the supplier gave an undertaking that they will rectify any problems faced by the user. In many cases the users have directly contacted the suppliers and the same was attended to immediately. It was further informed by SPM (RCH) that they have submitted reports with certification from concerned authorities and only under these circumstances, the remaining payment was released. Since many of the items were delicate equipments, once they are being used, the items can be tested and replaced by M/s.KAPL, if not working. It may also be noted that the warranty clause has already been included in the agreement.

Out of the 490 kits ordered, at present, over 400 kits have already been distributed and put to use in various institutions. The remaining 90 kits could not be used since the upgradation work of CHCs and certain FRUs could not take place at the pace intended either due to indecision by the Institution Level Committees or Non-clearance of land from encumbrances (for eg. demolition of old building, tree cutting, encroachment etc.). In fact, with the Comprehensive Health Insurance Scheme being implemented, there is a huge demand from other FRUs and the Governing Body resolved to transfer only those number of kits which are essentially required in the tertiary hospitals and the remaining kits to be issued to CHCs as and when they are upgraded (minutes annexed). As mentioned above, at present, 136 institutions in Kerala are working as FRUs as compared to 39 institutions in 2007. 21 CHCs were upgraded as Taluk Hospitals who were supplied surgical kits. It may kindly be noted that the target for 2010 is to have 165 FRUs and the remaining kits have been earmarked for the institutions being

		upgraded. It is the commitment of the Government to make a fully functional referral chain with CHCs working as 2nd tier of treatment and as First Referral Units. It may be acknowledged that because of infrastructure upgradation, posting of doctors, equipments, surgicals etc, nearly 63 CHCs are functioning as FRUs. The target for 2010 is for making all the 115 CHCs as FRUs. In order to evaluate the Surgical Kits procured, a Technical Committee was formed with Pediatrician, Gynaecologist, Anaesthesiologist, etc. The technical committee was formed to find the usability and they have opined that the kits are highly useful. The Committee observed that *"the surgical kits supplied were extensively used in the State and has helped the institutions improve the quality of service rendered through Govt hospitals. The IUD kit and the Normal delivery kit and infant resuscitation kit are very useful and more numbers may be supplied"*. Report of the technical committee dated 20th August 2008 is annexed. After the operationalisation of Kerala Medical Services Corporation (KMSCL), the State Mission has taken a policy decision that all procurements for NRHM shall be done through KMSCL on e-tendering and e-procurement basis. **Action Taken:** At present, all equipments are being purchased through KMSCL. Further, the equipments purchased are being utilized in the institutions. NRHM acts as a facilitator for up-grading the public health institutions and proper utilization is the responsibility of the respective public health institution under the Government.	
1.2.9.3	• Limited tenders were invited from Pharma CPSEs in April 2008 by the SHS. After opening the technical bids, the Technical Committee rejected the bids of three Pharma CPSEs because a criminal case was pending against	The 3rd Governing Body in its meeting held on 3rd March 2008 had resolved to procure ASHA drug kits by inviting limited tenderes from Pharmac CPSUs subject to qualifications of the following conditions. 1.CPSUs should have experience to supply drugs for more than 3 years. 2.Non-conviction certificate.	

	HAL and the required documents had not, been submitted by MPL and BCPL. However, the technical bid of KAPL was accepted as it had furnished product permits -for two tablets(Albendazole and Paracetamol) and had agreed to supply the other items from reputed Good Manufacturing Practice (GMP) Companies. It was seen that the financial bid of KAPL was accepted without any negotiations to reduce the rates as envisaged in the Purchase Preference Policy because it was the only firm which qualified for the financial bid. Moreover, the need for going in for the two -bid system of Selection of vendor in the purchase of common medicines for ASHA kits was not justifiable. This clearly indicated that KAPL was favored by the SHS. Government Stated (September 2009) that all the three CPSEs whose bids were examined did not submit product permits for all the products. The Technical Committee decided to open the financial bid of KAPl based on an undertaking given by it that it would procure the drugs from	3.CPSUs should have minimum turnover of drugs worth at least Rs.10 crores in the last 3 financial years. 4. CPSUs should have obtained quality certificate like ISO 9001:2000 from reputed organizations. They should have valid GMP certificates and revised Schedule M. 5. They should have a valid Drug Manufacturing license. 6. They should submit Performa statement and Client satisfactory certificate from various State Governments. 7. CPSUs should have satisfactorily executed at least one single order of quantity of 20% of the present requirement of the item offered during any one of the last 3 years anywhere in the country. While submitting the tender, M/s.IDPL had not submitted product permit to manufacture certain items as well as ISO-9001-2000 certificate. M/s.BCPL had not submitted product permit to manufacture certain items as well as Performance Statement and client satisfactory certificate. M/s.KAPL had not submitted product permit to manufacture certain items while they had submitted all the other documents like Non-conviction certificate, minimum turnover statement, ISO Certificate, Performance certificate etc. Hence these documents were called for from other companies by the technical committee vide their minutes dated 17.06.2008. Based on this office letter, the three companies submitted a few of the requisite papers. M/s.BCPL failed to submit documents to prove that they have executed one single order quantity for 20% of the present requirement of the offered items. M/s.IDPL failed to submit the required ISO 9001-2000 Certification. All the three companies did not submit product permit for all the products. M/s.KAPL had given an undertaking to the effect that they will procure the other items from reputed GMP companies. As per the Purchase Preference Policy of Government of India, companies will be able to supply drugs as approved by Government of India. However, M/s.BCPL and M/s.IDPL were not able to produce some documents other than product permit. The technical committee, therefore in its meeting	

	reputed GMP companies. Though negotiations were held with KAPL, it did not agree to reduce the rates. The procurement order was issued to KAPL based on the decision of the Governing Body of SHS	held on 21/06/2009 decided the following. *All the participants are not holding the product permit for all the products tendered and they intend to supply these items by procuring it from other manufacturers. The same procedure is following during the previous years and also in other states. The Committee recommended to open the financial bid for M/s.KAPL.*	
	• Though the supply order was placed with KAPL, it was seen that the actual supply was made by M/s.Vimal Labs Private Limited, Indore on behalf of KAPL. As per the invoices of the Indore based firm, kept in the stores of the three test-checked District Family Welfare Stores, the rate quoted for each ASHA drug kit was Rs 5250 and this amount was entered as the cost in the stock register. However, the basic price quoted by KAPL and Paid by the SHS was Rs 7370. Thus, the SHS incurred extra expenditure of Rs 1.79 crore and provided undue benefit of an equal amount to KAPL. Government stated (September 2009) that the in-house purchase of KAPL had not been enquired into by them	Procurement of ASHA drug kits were utmost essential in the districts. Delay in this regard would have hampered the procurement process wherein there would have been a delay of atleast 6 months for purchase through tender. Moreover, Government of India had very clearly spelt out that purchase can be effected from Central Pharma Public Sector Undertakings. Under these circumstances, the State Mission's policy of adopting two bid system of selection of vendor is fully justified. KAPL was the only company qualified in the technical bid vis-à-vis other companies and hence its price bid was opened. Based on the acceptance of Technical Committee and after opening the financial bid, M/s.KAPL were requested to negotiate the rates quoted by them. However, M/s.KAPL vide their letter dated 10th July 2008 had offered to reduce the rates of Digital BP Apparatus, Glucometer and Glucometer test strips. However, while finalizing the agreement, orders were given only for the medicines and digital thermometer. The items of Digital BP Apparatus, Glucometer and Glucometer test strips were proposed to be procured on a later stage. Negotiation was done and KAPL did not agree to reduce the rates due to steep escalation in raw materials, packing materials cost, etc., However, they had agreed to supply ASHA kit in a compact bag/case made from rexin material for easy carrying by ASHAs, instead of general shipper carton, without additional cost.	
	The SHS did not apply the principles of financial propriety in the selection of KAPL for the supply of surgical kits and ASHA kits as procedures were violated,	Audit has pointed out that two bid system of selection of vendor in the purchase of common medicines for ASHA kits was not justifiable. It may be noted that the State Mission had favoured the two bid system to ensure that the best prices are obtained subject to	

	quality of materials were not assessed and finally the procured surgical and drug kits were not utilised in full.	the condition that the firm qualified in all other aspects. It may be noted that the product is a kit and not individual medicines. M/s.KAPL had informed vide their letter dated 10th July 2008 that they will be able to reduce the rates only for Digital BP Apparatus, Glucometer and Glucometer test strips. Percentage of administrative charges is fixed by M/s.KAPL for each tender in which the State Mission does not play any role. M/s.KAPL in their financial tender had quoted 3.5% as administrative charges. M/s.KAPL had vide their letter dated 10th July 2008 had offered to reduce the rates only for Digital BP Apparatus, Glucometer and Glucometer test strips but not on administrative charges. Hence administrative charges was 3.5% as proposed by M/S. KAPL, a central PSU. Procurement order was issued to M/s.KAPL being a Central PSU. This was based on decision of the Governing Body in its meeting held on 3rd March 2008. The in-house purchase of M/sKAPL was not enquired into. Procurement has been done by M/s.KAPL and the State Mission has no knowledge of any private company through which M/s.KAPL has procured. As far as the Mission is concerned, supply orders are for kits and not individual drugs. In any business the components within the product supplied would be procured by the supplier from different sources. Further, as per Office Memorandum No.50013/1/2006-SO(PI-IV) dated 7th August 2006, the Ministry of Chemicals & Fertilisers had decided to grant purchase Preference Policy for a period of FIVE years. **Background:** ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. In following pages, the role, responsibilities, profile, selection procedure, training modality and compensation package for ASHA has been explained. ASHA acts as a health activist in the community who will create awareness on health and its social	

determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. In the NRHM PIP for 2007-08, it was envisaged to appoint 8469 ASHAs in the State during 1st year. Based on this, it was proposed to procure 8469 ASHA drug kits in the State.

In order to decide upon the items to be in the drug kit, a committee as detailed below was formed to finalise the items in the drug kit.

1. State Mission Director (Arogyakeralam)
2. Dr. P.K. Jameela, Addl.DHS (FW)
3. Dr. Pisharady, Superintendent, Medical College, Trivandrum
4. Dr. Jagadeesh, ORT Officer, and Nodal officer for ASHA
5. Dr.K.P.Pradeepkumar, State Program Manager (RCH)
6. Dr. Suresh Kumar, Institute of Palliative Medicine
7. Dr. Mathew, Institute of Palliative Medicine
8. Ms.Seena K.M., Consultant (SD)

Based on discussions, the following items were suggested by the Committee.

Name of the Item	Number
Tab Paracetamol 500 mg	1000 tab
Paracetamol Syrup 60 ml	25 Bottle
Tab Albendazole 400 mg	500 Tab
Tab Ironfolic	1000 tab
ORS Packet	500 Packets
Povdine Iodine Ointment 100 gms	5 Tube
Povdine Iodine Lotion 100 ml	3 bottle
Band Aid	100 Nos
Cotton Absorbent Roll	10 Packets
Condoms –	to be supplied from Subcentre

Oral Pills	to be supplied from Subcentre	
Weighing Scale	1	
Height Measuring tape	1	
Uristix	1000 strips	
Digital BP Apparatus	1	
Digital Thermometer	1	

Further, during the Senior Officer's conference held on 17th & 18th December 2007, the list of drugs in the drug kit was circulated to all District Medical Officers and District Program Managers (NRHM). After discussions, it was decided to delete certain items. The final list was as below.

Name of the Item	Number
Tab Paracetamol 500 mg	1000 tab
Paracetamol Syrup 60 ml (125 mg/5 ml)	25 Bottle
Tab Albendazole 400 mg	500 Tab
Tab Ironfolic (Adult)	1000 tab
ORS Packet	500 Packets
Povdine Iodine Ointment 100 gms (5%)	5 Tube
Povdine Iodine Lotion 100 ml (5%)	3 bottles
Band Aid	100 Numbers
Cotton Absorbent Roll (400 gms)	10 Packets
Condoms –	to be supplied fro Subcentre
Oral Pills	to be supplied fro Sub centre
Uristix	1000 strips
Digital Thermometer	1

Procurement of ASHA drug kits were utmost essential in the districts. Delay in this regard would have hampered the procurement process wherein there would have been a delay of atleast 6 months for purchase through tender. Moreover, Government of India had

very clearly spelt out that purchase can be effected from Central Pharma Public Sector Undertakings. Under these circumstances, the State Mission's policy of adopting two bid system of selection of vendor is fully justified. KAPL was the only company qualified in the technical bid vis-à-vis other companies and hence its price bid was opened.

Based on the acceptance of Technical Committee and after opening the financial bid, M/s.KAPL were requested to negotiate the rates quoted by them. However, M/s.KAPL vide their letter dated 10th July 2008 had offered to reduce the rates of Digital BP Apparatus, Glucometer and Glucometer test strips. However, while finalizing the agreement, orders were given only for the medicines and digital thermometer. The items of Digital BP Apparatus, Glucometer and Glucometer test strips were proposed to be procured on a later stage. Negotiation was done in the office of the SPM. KAPL did not agree to reduce the rates due to steep escalation in raw materials, packing materials cost, etc., However, they had agreed to supply ASHA kit in a compact bag/case made from rexin material for easy carrying by ASHAs, instead of general shipper carton, without additional cost. This was approved by the State Mission.

Audit has pointed out that two bid system of selection of vendor in the purchase of common medicines for ASHA kits was not justifiable. It may be noted that the State Mission had favored the two bid system to ensure that the best prices are obtained subject to the condition that the firm qualified in all other aspects. M/s.KAPL had informed vide their letter dated 10th July 2008 that they will be able to reduce the rates only for Digital BP Apparatus, Glucometer and Glucometer test strips. The terms and conditions for the purchase of ASHA is fixed in the State Mission itself. It will not be possible to take all the points in other purchase orders. Moreover, during the submission of the financial bid, M/s.KAPL had stated their terms as 50% advance payment. During the signing of the agreement, it was mutually agreed that advance will be limited to

		50%. The State Mission has followed the agreement conditions only in this regard. Moreover, it may be noted that advance was given to a Central Pharma Public Sector Undertaking. Even KAPL too, had received and executed similar kits to Director General (Family Welfare), Lucknow. The payments terms indicated above are the prerogative of the UP government not the health authorities of the Kerala government. The certificate under reference has no relevance as we have procured kits, wherein some items are not under DPCO. Hence insisting KAPL for a certificate doesn't arise. M/s. KAPL had requested not to invoke genuine difficulty in logistics in supplying kits to different hospitals. KAPL had written to NRHM explaining difficulties resulting in minor delays in supplies which included transport bottlenecks, strikes, raw material problems etc. Moreover, since ASHA training had not been completed and M/s.KAPL had started the supply within the time frame and there was a delay of only few days in completion of the supply, no penalty clause was invoked.	
1.2.10	**Performance Indicators** NRHM prescribes national targets for reducing the Infant Mortality Rate(IMR) the Maternal Mortality Rate (MMR) and the Total Fertility Rate (TFR), as well as reducing the morbidity and mortality rate and increasing the cure rate of different endemic diseases covered under various national programmes. State-specific targets were not prescribed by GOI, as different States were at different levels of achievement/performance at the beginning of the Mission period. The targets fixed by the SHS for 2007-08 to 2011-12 were as below:	National targets for reducing Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), reducing morbidity & mortality rate and increasing cure rate of different endemic diseases are covered under various national programmes, and the aim of the state is to attain these targets over the Mission Period. However in certain cases given that the State has already reached high levels of achievement, the task of the state is to maintain these levels. Audit may note that it is difficult to sustain the achievements and hence concerted efforts are made to sustain these levels. The state specific targets for the period 2005-12 are contained in Chapter III of the PIP of the state in the yearly State PIP submitted by the State. It is the endeavour of NRHM to improve the levels of institutional delivery for increasing maternal mortality focuses on safe/institutional deliveries at functional health facilities in the	

<table>
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Table 1.12: Performance indicators
<table>
<tr><th>Indicator</th><th>2006-07 Current level actual figures</th><th>2007-08</th><th>2008-09</th><th>2009-10</th><th>2010-11</th><th>2011-12</th></tr>
<tr><td>IMR (per 1000 live births)</td><td>12</td><td>12</td><td>12</td><td>11</td><td>10</td><td>9</td></tr>
<tr><td>MMR (per 100000 live births)</td><td>110</td><td>75</td><td>65</td><td>50</td><td>40</td><td>30</td></tr>
<tr><td>TFR (per women)</td><td>1.9</td><td>1.8</td><td>1.7</td><td>1.7</td><td>1.7</td><td>1.6</td></tr>
</table>
As the SHS had not evolved a mechanism to ascertain whether the targets fixed, were achieved at the close of the respective years, audit could not ascertain the extent of achievement against the targets fixed.
</td>
<td>governmental and non-governmental sectors status of immunisation, reduction of child and maternal mortality, reducing the fertility rates, prevalence of contraceptives - both termination and spacing, number of patients reaching to out-patient (OPD) and in-patient department (IPD) and these are contained in the activities under the PIP of the State.
Audit may note that on behalf of the Government the State Society is the implementing the activities under NRHM. Investments are made by the Government, and mechanisms such as NFHS Survey etc are in place to monitor the attainment of the indicator. Audit may also note that in addition to the NRHM, there are many factors such as health services provided by private sector hospitals, in attainment of the targets. Hence the Government of India mechanisms would be more appropriate as full fledged survey is essential. However, the Society is implementing Health Information System in the State so as to capture levels of IMR/MMR etc along with other parameters. The Directorate of Health Services has a mechanism of reporting on these parameters.</td>
<td></td>
</tr>
<tr>
<td>1.2.10.1</td>
<td>Maternal Health
The important services which ensure maternal health are antenatal care, institutional delivery, post-natal care and referral services. It is essential to register all the pregnant women before they attain 12 weeks of pregnancy and provide</td>
<td>To reduce maternal and infant mortality rates to 100 per lakh and 30 per thousand respectively by 2010, important services which ensure maternal health such as antenatal care, institutional delivery, post natal care and referral services are in place in the state. Registration of pregnant women before they attain 12 weeks of pregnancy is done and three antenatal check-ups are done. Iron Folic Acid tablets, two doses of Tetanus Toxoid (TT) and advice on the correct</td>
<td>The current status is shown as Annexure-4</td>
</tr>
</table>

	them with three antenatal check-ups, 90 or more iron-folic acid (IFA) tablets, two doses of Tetanus Toxoid (TT) and advice on correct diet and vitamin supplements. It is mandatory for a junior Public Health Nurse to prepare a micro-birth plan at the SC level for each beneficiary of the Janani Suraksha Yojana (JSY), containing dates of antenatal checkups and TT injections, identification of the health centre for referral services, the place of delivery, expected date of delivery, etc. Audit scrutiny revealed that micro birth plans were not drawn up in any of the selected 24 Scs. •In the selected districts (Palakkad, Thiruvananthapuram and Wayanad), out of 5,14,139 pregnant women registered, only 4,30,156 received three antenatal check ups during 2005-06 to 2008-09. In these districts, there were no significant variations over the years in the number of pregnant women receiving three antenatal check ups. • Although all the pregnant women registered were required to be provided with IFA tablets for 100 days, shortfalls ranging from 16 to 44 per cent were noticed during 2005-	diet and vitamin supplements are given and in case of complications, they are referred for specialized gynecological care. The Junior Public Health Nurse prepares a micro birth plan at the sub-centre level. The plan also includes collecting BPL or necessary proofs/certificates, and timely submission of the completed JSY formats in the health centre, arranging transport for the beneficiary to the nearest health care facility in case of any complication and ensuring availability of fund etc. Maternal Mortality Ratio in Kerala has been reduced to 95 from 110 as per Special Bulletin on Maternal Mortality in India (2004-06), published by Sample Registration System. Kerala has the lowest MMR compared with other states of India and for India it is 254.	

	06 to 2007-08. • During 2007-08 and 2008-09, Rs 23.95 lakh was disbursed to 7,985 beneficiaries in three Taluk Hospitals and two District Hospitals towards transportation cost under JSY, which was inadmissible. • The percentage of institutional deliveries of pregnant women registered at the hospitals in the selected districts ranged from 77 to 96 in Palakkad, 61 to 104 in Thiruvananthapuram and 85 to 89 in Wayanad.		
1.2. 10.2	**Immunization** **Routine immunization** The immunisation of a child against six preventable diseases, namely tuberculosis, diphtheria, pertussis, tetanus, polio and measles has been the cornerstone of routine immunisation in the State. During 2005-06 to 2007-08, the State had achieved 95 to 99 per cent success in pulse polio immunisation. However, immunisation in respect of other diseases showed wide variations ranging from 53 to 85 per cent in the test-checked districts during 2007-09. The targets and achievements of Diphtheria (DT)	Long periods of vaccine shortage occurred in 2007-08 and 2008-09 due to inadequate supply from Government of India. As far as shortfall in administering Vitamin A Solution is concerned, there was no Vitamin A solution supply from Government of India since 2007-08.	

	and TT immunisation carried out during 2005-09 are given in Appendix L. As per information furnished by the Director of Health Services, during 2005-06 to 2008-09, 19,30,592 out of 22,13,479 children between the 0-1 age group were administered full vaccines viz. BCG, Measles, Diphtheria, Pertussis and Tetanus (DPT) and Oral Polio Vaccine (OPV), leaving 2,82,887 children uncovered. The percentage of fully. immunised children was in the range of 85 to 88 per cent during the period and did not show significant variations. It was seen that DT coverage of children, above five years declined steadily during 2005-06 to 2008-09 from 94 to 60 per cent. TT to children of 10 years and 16 years also declined during 2005-06 to 2007-08, but showed an increase during 2008-09. Government stated (September 2009) that long periods of vaccine shortage occurred in 2007-08 and 2008-09 due to inadequate supply from GOI.		
	Shortfall in administering Vitamin A solution The RCH-II programme emphasizes administering of Vitamin A solution to all children below three years of age.		

	Prophylaxis against blindness amongst children due to deficiency of Vitamin A requires the first dose at nine months of age along with the measles vaccine, the second dose along with DPT/OPV and the subsequent three doses at six-monthly intervals. Scrutiny of records in the three test checked districts revealed a steady decline in the percentage of children supplied with all five doses during 2005-06 to 2008-09, the details of which are given in Appendix II. The main reason for the steady decline was the short supply of Vitamin A at health centres. Government stated (September 2009) that the shortfall in administering Vitamin A solution was due to stoppage of supply by GOI from 2007-08.		
1.2.10.3	**Health Management Information System** As per NRHM guidelines a health information system is to be in place for facilitating the smooth flow of information and for effective decision making. The SHS purchased 1033 computers along with printers and UPS at a cost of Rs 3.64 crore for this purpose and supplied them to CHCs and PHCs in February 2008. The application software (MS Office 2007) was	As per the essence of the NRHM Frame work, the state has made efforts in the right direction to put in a strong Health Management Information System (MIS) network in the state. Under IDSP monitoring for surveillance activities is in place. Further under the HMIS the Districts are being linked from the PHC level to the state level. Audit may note that the development of software for computer based HMIS to capture the health data from all the health institution is an exercise that involves development of application software and this has already been initiated. HMIS Software is not ready made software. The HMIS Implementation for State is taken up with specific objectives surrounding data reporting. The plan includes phasing	Using the computers purchased in CHCs & PHCs etc and using DHIS2 software, we are getting the data through online before 5th working day of every month. In DLHS2 the IDSP also have been Integrated with in this time. After proper scrutiny and verification, (updated HMIS data) are being forwarded to

	procured at a cost of Rs 1.06 crore during July 2008. The SHS adopted the following multiple software applications: • Health Management Information System (HMIS) viz., DHIS 2 developed by M/s HISP India Limited, organisation working in collaboration with the University of Oslo, Norway. • A dynamic web-based surveillance system for monitoring disease incidence for the Integrated Disease Surveillance Project on a weekly basis. • A Geospatial Kerala Health Information System developed by the Kerala State Remote Sensing and Environment Centre for tracking thespread and frequency of diseases and • An MS-excel based format fr data collection on diseases on daily basis by the State Disease Control and Monitoring Cell. All these applications were independently operated by various users despite requiring common data sets relating to health parameters for their operation. Instead of integrating various vertically driven information systems to create a single window system for data entry and	out paper reporting with real time data reporting using DHIS 2 web application having customized FW reporting formats which is in tune with requirements at national level. The Data reporting milestones Envisaged for State were- • Paper reporting to continue till Mar 09 • From April 09 only reporting through DHIS 2 software shall be done down from peripheral sub centres The HMIS Project implementation for Kerala State envisaged the following objectives: 1. Establishing State level server and Loading the HMIS (DHIS2) application on the server 2. Installing offline application in all reporting Health institutions 3. Setting up of district based systems for each of the 14 districts. 4. Training programs for State, district and block level Health staff Likewise, the project is implemented keeping above objectives in mind and all milestones including objectives 1, 2, 3 and 4 are achieved before April 09 to realize data reporting from field. As a result, the GOI web portal now carries data for April, May 09 generated through the DHIS2 software as envisaged for entire State. The data for June 09 is nearing completion. This effort is one of its kinds in the country and Gujarat is the only other State to take up Health facility level reporting also through the DHIS 2 software. As far as IDSP data is concerned, routine reports from State/ Districts are generated and being reported (weekly basis) to GOI from the State Surveillance Unit, IDSP, under the supervision of Addl Director & State Surveillance Officer (PH). It is envisaged to use DHIS 2 for reporting IDSP data from reporting institutions for better data quality taking advantage of	Government of India web portal positively by 5th working day of the following month. The quality of data is systematically reviewed in State as well as in Districts. In the State from Health Information Cell (HIC), functioning under Demographer, one officer has been given the charge of one district to verify the quality of the data. On every 9th working day the quality / timeliness of the data is reviewed by Demographer, on 10th working day by Additional DHS (FW) in DHS Office.On 12th working day it is also reviewed in State level in District Statisticians meeting and last Wednesday of the month the Quality as well as progress of data is reviewed in Senior Medical Officers conference, before the Principle Secretary (H). In Districts, HMIS data is reviewed by District Medical Officer (DMO), on 5th working day in their monthly

	report generation, the SHS developed multiple applications with common modules that resulted in data redundancy, duplication in data entry and increase in the workload at all levels. The State Data Officer stated (July 2009) that action was under way to integrate the systems of the Integrated Disease Surveillance Project and the State Disease Control and Monitoring Cell with the SHS.	internet connectivity in field and therefore the same is incorporated in the DHIS 2 software for reporting henceforth. Continuing training and handholding support is envisaged through programs in districts for 17 days every month till end of project in 2010. <u>Action Taken: From April 2011, Government of India is planning is launching DHIS 2 system, which is web-based system. Hardware and Software is being used. IDSP data will be integrated.</u>	meeting. In block level and PHC level also it is reviewed. The data in DHIS2 / HMIS is being utilised for all planning purposes in State /District/Central Level. As we have stopped paper reporting of forms 6 to 10, in DHS, there is no other source for the data. GIS: - An amount of Rs 40 lakhs is also utilized to set up GIS in the state. The software is developed by Kerala State Remote Sensing Centre. The scheme is to implement shortly after certain modifications.
1.2. 10.4	**Integrated Disease Surveillance Project** The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect early warning signals of impending outbreaks and to help initiate an effective response in a timely manner. surveillance units were set up at the Central, State and district levels with linkages with all State headquarters, district headquarters and all government medical colleges on a Satellite Broadband' Hybrid Network. Data is collected on a weekly (Monday-	Integrated Disease Surveillance Project (IDSP) is functioning, to detect early warning signals of impending outbreaks, and surveillance units have been set up, as planned. Necessary manpower as well hardware and accessories has been supplied to the units. However at the state level, there was some constraint of space in the Directorate to house the video conference unit, as there was no vacant space available in the Directorate or at the NRHM Office. After efforts some space was vacated and Video-Conferencing Unit has been set up. Audit may also note that the equipments such as Hardware and accessories were not lying idle as the same was used at the office of the Additional Director of Health Services (Public Health) for regular communication with the national level. **Action Taken: The unit is ready.**	

	Sunday) basis. Whenever there is a rising trend of illness, in any area, it is investigated by the Medical Officers/Rapid Response Teams to diagnose and control the outbreak. Data analysis actions are to be undertaken by the respective districts. The total cost of the project was Rupees nine crore, of which GOI released Rs 4.82 crore up to 2008-09. The expenditure incurred on the project was Rs 2.74 crore. All the 14 District Surveillance Units (DSU) were supplied with hardware accessories costing a total of Rs 21.06 lakh. Civil works for videoconferencing units were also completed in the districts at a cost of Rs 19.60 lakh. Accessories were also supplied to State Surveillance Units (SSU) and seven medical colleges at a cost of Rs 33.76 lakh. Necessary manpower was also provided to all DSUs and SSU However, the videoconferencing unit at the State level had not been set up as of March 2009 as the Director of Health Services had not provided space for this. Consequently, hardware and accessories procured for Rs 54.82 lakh and the civil works executed at an expenditure of Rs 19.60 lakh, besides the manpower, remained idle. Moreover, the		

	intention of the Government of detecting impending outbreaks and initiating an effective response could not be achieved. Government stated (September 2009) that the video-conferencing unit would be set up as soon as the civil works were completed within two months' time.		
1.2. 11	**Information, Education and Communication activities** 'Radio Health' launched by DHS, Thiruvananthapuram in September 2008 aimed to create positive changes in the health habits and behaviour of people by ensuring wider community participation through interactive and innovative radio programmes. It mainly focussed on primary health care and preventive aspects of health by giving importance to all medical systems and alternative health practices. Up to 31 March 2009, 108 programmes of 30 minutes duration had brwn brnarle'acf.nd. Ton PPrlin Clubs were also established in schools, colleges, residential associations, etc., in different locations and 31 meetings were also conducted. This model could be adopted in other districts also to propagate health care programmes. Other activities under the Information, Education and	The concept of FM Radio Health emerged as a pilot project on a real time basis to experiment with the use of mass media tool as a means of communication with the community. Such a concept is a valid tool in the social sector, and was experimented for the first time in the health sector in the state. The idea was to develop a community based model for communication. In fact the model emerged as a result of various discussions and reviews done at various forums and there was also a demand from the community itself for such a concept on a pilot basis. In these circumstances, radio FM health emerged as a national community demand and hence was approved on a pilot basis in the district of Trivandrum. This was a novel concept and has been well received by the community and has been appreciated at various forums of the Ministry of Health and family welfare, Government of India as a true innovation. The Impact Analysis of Radio Health is being conducted by Rajagiri College of Social Sciences, a reputed institution in the concerned area, and the final report of the study is expected soon. The audit may note that the FM Radio health is perceived by the community as a successful innovation and hence has proved beyond doubt that the pilot is a feasible one.	A study was conducted by The Research Institute, Rajagiri College of Social Science, Kalamassery, Kochi, Kerala to assess the Radio Health FM programme in Thiruvananthapuram on July 2009. *The Report says:-* "The responses showed that 85.5 % people have listened to the FM Radio Health programme either on a daily or frequently basis and rated its performance as either good or very good. The figures thus show that public has already accepted/embraced the programme with an open hand but the Radio Health should take maximum efforts to convey accurate and apt information to the public whereby they could frame a healthy life style for

	Communication like Health Melas in Assembly constituencies, school health camps, street plays, cultural programmes, etc., were also conducted by the SHS. Government stated (September 2009) that the Radio Health Programme had been well received by the community and had been appreciated at various forums of the Ministry of Health and Family Welfare as a true innovation.		themselves." "The review proved that Radio Health FM programme of NRHM is welcomed by the people in general. A good number of the people across the different panchayats of the district of Thiruvananthapuram have listened to the programme and had a fairly positive comment on the different aspects viz. content, presentation, duration, resource person, clarity of message, audibility and language of the programme. Most of them rated them as satisfactory, or good or very good. A good number of the respondents who have heard other health programmes in radio were of the suggestion that Radio Health FM had an outstanding quality in terms of its content, presentation and language." Radio Health has so far broadcasted 681 thirty minutes and 305 fifteen minutes programmes in Ananthapuri FM and 217 fifteen minutes programmes in All Kerala

			Network of All India Radio from 25, Sept 2008 to 31, October 2013. Earlier Radio Health was broadcasted only through Ananthapuri FM, 4 days/week only limiting its coverage in Thiruvananthapuram, part of Kollam and Pathanamthitta districts. Considering its increasing listenership and popular demand, the broadcast has been extended to the entire state from January 1, 2012 through various FM and AM stations of All India Radio; as 15 minutes programme on all days in Ananthapuri FM and 5days per week in All Kerala Network Stations of AIR. During the period of 2010 and 2012, Radio Health had broadcasted 209 programmes each. A new studio had been set up in NRHM directorate and the production was shifted to the new studio from Thiruvananthapuram District NRHM office in 2010. Out-reach activities and outdoor recordings started for involving community in radio programmes; a total number of

			70 such sessions were conducted. Same status maintained in 2011 with 67 sessions. Rs. 10 Lakhs and Rs. 15 Lakhs have spent in 2010 and 2011 respectively as broadcast fee, production charges and for salary. In 2012 the programme has been scaled up to all Kerala level. Radio Health has broadcasted 305 programmes in Ananthapuri FM and 217 programmes in All Kerala Stations from January 1 to October 31. Measures have been taken to expand the manpower and to make the programme more informative and entertaining. Linking Radio Health programme with Health Clubs of School Health programme, NRHM is one of innovative venture for this year. Also we are planning to start a live phone in programmes in association with AIR and to extend the activity to video production. The ongoing innovative activity now undergoing is a series quiz competition named AROGYA THARAKAM for school children which is scheduled as district as well as state level competitions.

1.2.12	**Community participation** NRHM envisages involving communities in planning, implementation and monitoring through representatives of Panchayati Raj Institutions and community based organisations at each level. It also envisages formation of Village Health and Sanitation Committees in each village within the overall framework of the Gramasabhas. However, the State Government Decided (February 2007) to constitute Ward Health and Sanitation Committees (WHSC) at the ward level instead of at the village level. In all the 24 Scs under the three test-checked districts, WHSCs, had been constituted. However, no revolving funds for providing referral and transport facilities on emergency deliveries had been set up in any of the WHSCs though envisaged under the scheme. Government stated (September 2009) that it was a conscious decision to constitute Ward Level Committees within overall framework of the local bodies in lieu of Village Level Committees as improved community participation was the key to success of the scheme.	As per the framework, NRHM envisages involving communities in planning, implementation and monitoring through participation of representatives of Panchayati Raj Institutions (PRIs), Non-Governmental Organizations (NGOs) and Community Based Organizations (CBOs) at each level, and this process has been by and large attained in Kerala. Ward Health and Sanitation Committee have been formed within the overall framework of the local bodies. Government has issued orders in this regard which may be seen. It is a conscious decision that improved community participation at the ward level is the key to success of the scheme, and accordingly ward level committees have been constituted in lieu of the village level committee. Under NRHM, a project for providing transport facilities on emergency deliveries has been worked out as "Kerala Emergency Medical Project (KEMP)". This initiative will take care of the requirements of providing transport facilities on emergency deliveries. In the circumstances, the revolving funds have not been set up. The launch of NRHM in Kerala has provided a unique opportunity for restructuring the health delivery system as well as for developing better health financing mechanism. Health institutions have been strengthened and will be further strengthened during the next few years. The core strategy of the Mission is to better human resources of these institutions and in providing adequate infrastructure and equipments to raise them on par with IPH standards. Further, Accredited Social Health Activists (ASHAs) numbering have been selected so far and have been trained and engaged on the basis of one per 1000 population in tribal areas, urban slum and coastal areas. Critical support infrastructure such as operation theatre, labour room, wards, OPD rooms, electricity, generator, telephone, ambulance, computer etc. are essential and have been provided to improve the health service. In addition the WHSC in Kerala are very active and does immunization, ante natal	At present, the Annual Action Plan is prepared from Ward level itself wherein community participation is ensured.

		check ups and village level activities. **Action Taken: At present, the Annual Action Plan is prepared from Ward level itself wherein community participation is ensured.**	
1.2.13	Conclusion Introduction of NRHM in Kerala has improved the fund flow to health institutions at various levels, upgraded infrastructure in health institutions and helped in facilitating their routine management. It has led to the creation of Ward Health and Sanitation Committees and Hospital Management Committees and innovations like 'Radio Health' in Thiruvananthapuram district to create health awareness. Decentralised planning was crucial for implementation of the scheme but the planning process was flawed as Annual Action Plans were prepared without preparing the State Perspective Plan and without using field level data, obtained through household and facility surveys. The execution of projects by the SHS without the Perspective Plan by specifying the project activities in a critical path resulted in the projects being implemented without adhering to the time schedule. Thus, the SHS could not spend the funds released by GOI, huge amounts were kept in bank deposits and the accounts were not finalised in time.	Village level health plans are being prepared this year in consultation with LSGD and experts on health related issues. These will be aggregated to form block and district level plans.	

	Though funds were available, the entitled grants were not released to all the CHCs and PHCs. Release of funds to activities not approved by GOI was also noticed. Upgradation work of CHCs and SCs were proceeding at a slow pace and even the facilities created were not fully utilised. There were deficiencies in medical and para-medical manpower, infrastructure facilities and equipment in CHCs and PHCs in the State. Procurement of drugs, surgical and equipment computers for Rs.70.01crore was made without observing the principles of financial propriety and distributed without assessing the requirements of institutions.		
1.2.14	**Recommendations** • The Perspective Plan should be prepared for the remaining Mission period by incorporating all the required strategies to achieve the objective of convergence of all health initiatives under one umbrella. Each activity should be executed along a critical path to achieve the desired result within the Mission period. • The SHS and the DHSs should synchronise all their activities and integrate structurally to ensure	This has been done in 2010-11. Committee would be formed to examine the subject and give its considered recommendations	This has been done in 2012-13.

	sustainability of NRHM initiatives even after the Mission period. •		
	The State level Action Plan should be a part of the Perspective Plan and prepared only on the basis of consolidated Action Plans at the village, block and district levels so that actual requirements are projected.	This has been done in 2010-11	This has been done in 2012-13.
	•Proposals in the Action Plan should be made on the basis of the absorption capacity of the Mission and the funds released should be utilised without undue delays to avoid retention of huge balances in bank deposits.	Noted	The entire amount has been released to the institutions during 2012-13 and the society has no bank fixed deposits.
	• Corpus grants, maintenance grants and untied grants should be released annually to all the entitled health care institutions.	The entire amount has been released to the institutions during 2010-11	
	• Priority should be accorded to complete all the upgradation works for which approvals have been received.	Actions initiated to complete all the pending works.	Out of the 54 spillover works during 2012-13, 32 works have already been completed as on 01.11.2012.
	• Steps should be taken to fill up the regular vacancies of medical and para-medical staff in the CHCs and PHCs and post contractual staff under NRHM as per requirements to achieve Indian Public Health Standards.	Director of Health Services has been addressed to fill up, the vacant positions. Contractual postings would be made on a need based manner.	Contractual postings would be made on a need based manner.
	• The principles of financial propriety should be observed in all the procurement processes to avoid undue favour to the suppliers.		

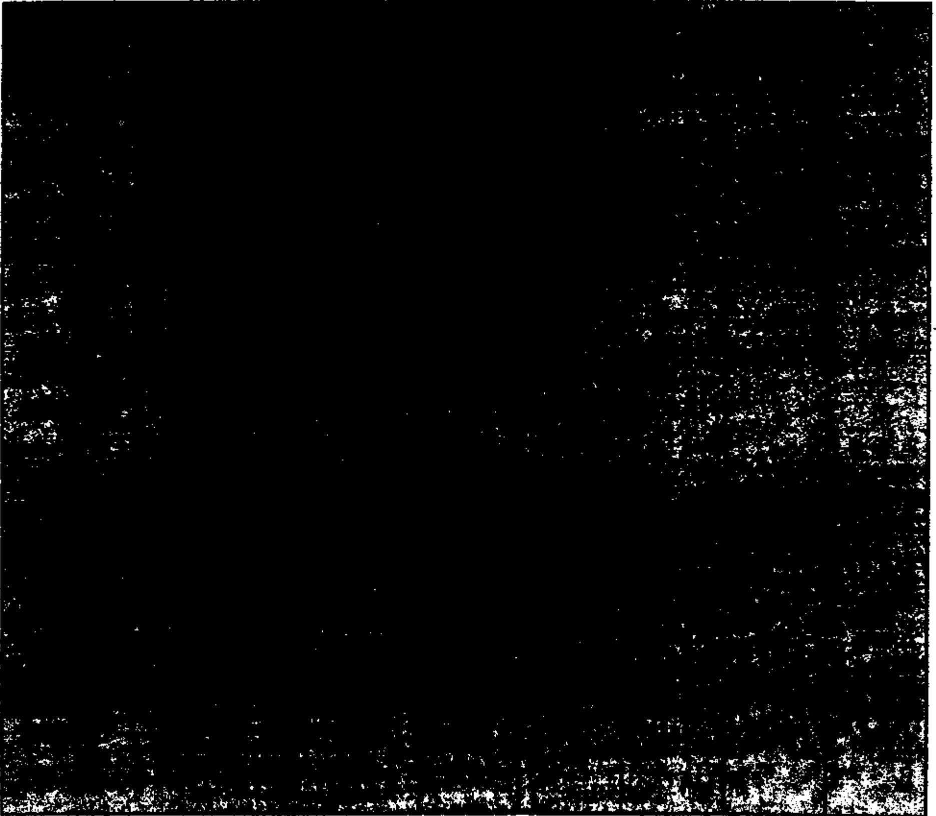
	• The SHS should integrate various vertically driven information systems to create a one-point system for data entry and report generation that covers all its activities like accounting, manpower, health profile, stores, disease surveillance, etc. to provide online information for planning, execution and monitoring of the Mission.	With effect from 2009-10 all major procurements is being done through Kerala Medical Services Corporation Ltd, a 100% Government owned company specialized in procurement on e-Tendering platform, modeled on thenTNMSC model. Further a procurement manual for in-house purchase has been developed. Noted for compliance.	

Annexure-1

1.2.6.2 Perspective Plan

The annual targets for next 5 years for various output as well as outcome indicators were included in the PIP 2012-13.

A. Outcome Indicators



Kerala State have achieved population stabilization as TFR is already 1.7. However as per the trend, the TFR may fall to 1.6 in the next 5 years.

B. Output Indicators

			2012-13	2013-14	2014-15	2015-16	2016-17
A	***Maternal Health***						
1	Institutional Deliveries (%)	99.8	99.9	99.9	100	100	100
2	24x7 Facilities (Sub-District)	175	175	180	180	185	185
3	Functional First Referral	65	75	80	95	100	113

	Units						
B	***Child health***						
4	Sick New Born Care Units	11	11	12	14	18	20
5	New Born Care Corners	91	95	100	120	125	130
6	Stabilization Units in FRUs	65	70	75	80	85	90
7	Full Immunization (%)	81.9	83	85	87	92	95
C	***Population Stabilization***						
8	Male Sterilization	3%	5	10	15	20	25
9	Female Sterilization	97%	95	90	85	80	75
10	No. of IUD Insertions	60000	60200	60450	60650	60875	61000
D	***Disease Control***						
11	Annualized New Smear Positive Detection Rate of TB (%)	73	90	86	88	90	90
12	Success Rate of New Smear Positive Treatment initiated on DOTS (%)	83 91	95 100	85 91	85 95	90 99	95 100
13	ABER for malaria (%)	6 %	8 %	9 %	10 %	10 %	10 %
14	API for malaria (per 1000 population)	0.06	0.06	0.06	0.06	0.06	0.06
15	Annual New Case Detection Rate for Leprosy (per 1,00,000 population)	0.28	0.28	0.28	0.27	0.26	0.25

16	Cataract Surgeries performed	626000	121000	123000	125000	127000	130000
E	Training						
19	Doctors trained on EmOC						
20	Doctors trained on LSAS	283	300	310	315	325	330
21	Doctors trained in NSV/ Conventional vasectomy	88	125	150	175	200	225
22	Doctors trained in Abdominal Tubectomy (Minilap)	293	310	315	325	350	360
23	Doctors trained in laparoscopic Tubectomy	176	200	225	250	275	300
24	Personnel trained in IMNCI		140 MOs 840 JPHN	280 MOs 1680	420 MOs 2520	560 MOs 3360	680 MOs 4200
F	Community Processes						
25	Functional VHSCs	19560	19560	19560	19560	19560	19560
26	ASHAs with Drug kits	23350	27741	31000	31000	31000	31000
27	ASHAs trained in 6th and 7th modules		10000	15000	20000	25000	30000
G	Improved Management						
28	Evaluation and Assessment of NRHM Activities	Continuous process	Continuous process	Continuous process	Continuous process	Continuous process	Continuous process
29	Cold Chain Management	1200	1420	1420	1420	1420	1420

	(number of functional ILR points)						
H	**Infrastructure**						
30	**Construction of sub-centre buildings**	**1**					
31	**Construction of PHC buildings**	**28**		**10**	**25**	**40**	**60**
32	**Construction of CHC buildings**	**87**	**8**	**16**	**24**	**32**	**40**
33	**Construction of District Hospital buildings**	**13**	**15**	**20**	**25**	**30**	**35**
34	**Construction of Other Hospital buildings**	**10**	**2**	**4**	**8**	**10**	**14**
I	**MMU and Referral Transport**						
35	**No. Of Functional Mobile Medical Units**	**16 5 Floating Dispensaries**	**16 5 Floating Dispensaries**	**20 7**	**24 8**	**26 8**	**32 8**
36	**No. Of Emergency and Referral Transport vehicles**	**Ambulances – 35 Due for condemnation-185 Condemned -36 KEMP - 50**	**KEMP will be up scaled to all Districts**	**KEMP will be functional in all Districts**	**KEMP will be functional in all Districts**	**KEMP will be functional in all Districts**	**KEMP will be functional in all Districts**

J	Operationalisation of MCTS						
37	% of registration of pregnant women in MCTS	60	100	100	100	100	100
38	% of registration of children in MCTS	15	100	100	100	100	100
39	% of facilities (SC, PHC, CHC, DH & others) uploading data	80	100	100	100	100	100
40	% of facilities having internet connectivity	90	100	100	100	100	100
41	% of data validated at State level		100	100	100	100	100
K	Operationalisation of HMIS						
42	% of facilities (SC, PHC, CHC, DH & others) uploading data	100 % reporting to state server. No facility wise reporting to central server.	100 % state server. 100 % to central server	100 % state server. 100 % to central server	100 % state server. 100 % to central server	100 % state server. 100 % to central server	100 % state server. 100 % to central server
43	% of districts uploading committing HMIS data within a week of reporting month/quarter	100 %. In 3 weeks time	100 %. In 2 weeks time	100 %. In 2 weeks time	100 %. In 1 weeks time	100 %. In 1 weeks time	100 %. In 1 weeks time
	Other Indicators						

44	Collocation of AYUSH at health facilities						

L	Human Resources				
L. 1	Category	Number of Sanctioned post	Number of vacant post against sanctioned	Target for Filling up of vacant posts	
				2012-13	2013-14
45	Gynecologists	283	45	90 %	
46	Pediatricians	203	24	90 %	
47	Anesthetists	136	39	80 % or on call	
48	Other Specialists	1062	287	80 %	
48	Doctors	2702	342	90 %	
49	Staff Nurses	7303	218	95 %	
50	LHV				
51	ANM / JPHN	5575	235	95 %	
45	MPW	397(field worker)	129	95 %	
46	Laboratory Technicians	776	178	90%	
47	Pharmacists	1514	51	90 %	
48	Others	27431	2820	90 %	

Annexure 2

		2010-11				2011-12			
		GOI Approved	Amount disbursed by district	Institutions received amount	Expenditure	GOI Approved	Amount disbursed by district	No. of institutions	Expenditure
Untied funds	Ward	1836.90	1602.20	16022	1325.57	1956.00	1929.30	19293	2009.05
	Subcentre	523.50	501.43	5014	396.96	540.30	473.63	4736	472.46
	PHC	165.25	177.99	711	120.17	208.50	180.42	721	178.71
	CHC	211.50	122.25	244	100.42	155.50	133.00	266	127.45
Annual maintenance grant	Subcentre	332.80	211.75	2117	133.70	370.90	110.30	1102	127.61
	PHC	330.50	328.48	656	196.79	834.00	165.47	330	177.40
	CHC	423.00	233.75	233	153.32	311.00	166.98	166	134.80
HMC	PHC	661.00	412.51	412	461.20	834.00	621.3061	621	479.99
	CHC	423.00	244.63	244	142.02	311.00	221.918	221	278.50
	Taluk/DH/W&C/others	105.00	428.96	85	391.34	245.00	239	47	247.37
Total		5012.45	4263.95	25738	3421.49	5766.20	4241.33	27503	4233.34

Annexure 3

ASHA - DISTRICT DETAILS

Districts	Total target	Total Selected	Currently working ASHAs	Total Trained - Module I	Total Trained - Module II	Total Trained - Module III	Total Trained - Module IV	Total Trained Module 5
KASARGOD	1377	1285	990	1056	1105	971	758	688
KANNUR	2500	2431	2185	2431	2374	2063	2057	2100
WAYANAD	839	839	776	928	825	908	816	681
KOZHIKODE	2800	2592	2048	2048	2048	2045	2041	2033
MALAPURAM	4000	3991	3626	3948	3774	3747	3585	3425
PALAKKAD	2800	3306	2701	3233	3097	3035	2933	2647
THRISSUR	3205	3205	2777	2983	2872	2800	2619	2144
ERNAKULAM	3100	2683	2413	2569	2452	2278	2025	1900
IDUKKI	1200	1188	1137	1188	1116	1065	1073	1137
KOTTAYAM	1965	2031	1732	2031	1965	1836	1685	1590
ALAPUZHA	2300	2375	2297	2375	2300	2225	2150	2054
PATHANAMTHITTA	1340	1340	1212	1340	1244	1189	1141	1086
KOLLAM	1729	1729	1618	1729	1641	1481	1320	1189
TVM	3600	3901	3399	3901	3419	3178	3006	2646
TOTAL	32755	32896	28911	31760	30232	28821	27209	25320

Annexure 4

1.2.10.1 Maternal Health.

As per SRS the M M Ratio between India and Kerala from 2005 is as shown below

Year	India	Kerala
2001-03	301	110
2004-06	254	95
2007-09	212	81

and as per Vital Statistics published by Economics & Statistics Department the Maternal Mortality rates in Kerala under Civil Registration System for these years is

Year	Kerala
2005	0.67
2006	0.67
2007	0.19
2008	0.21

All the maternal deaths in Kerala are strictly collected and audited under Directorate of Health Services. Maternal Mortality Ratio calculated for these years is given below.

Year	India
2005-06	30
2006-07	27
2007-08	32
2008-09	36
2009-10	36
2010-11	36

Maternal Death shows significant decrease after the implementation of NRHM.

Kerala	*DLHS-3 (2007-08)			*DLHS-2 (2002-04)		
Item details	Total	Rural	Urban	Total	Rural	Urban
Mother received any antenatal check-up %	99.8	99.8	100.0	99.7	99.6	99.8
Who had 3 or more ANC (%)	95.3	95.2	95.5	96.5	96.2	97.5
Mothers who consumed 100 IFA Tablets (%)	74.3	74.6	73.3	74.1	74.5	72.9
Mothers who had full antenatal checkup (%).	72.3	72.5	71.4	69.5	69.9	68.5
Institutional Delivery	99.4	99.3	99.9	97.6	97.1	99.0

*Latest District Level Household Survey (DLHS) reports

The data above shows that Kerala has any antenatal checkups during the period is above 99%, Mother who received 3 or more ANC is above 95% and Institutional Delivery is above 99%. The reason for poor achievement in mothers who consumed 100 IFA tablets is the shortage in IFA tablet during the period

Annexure 5

Budget approved for 2012-13 and Expenditure received till august 31st					
Rupees in Lakhs					
	Summary	Budget for 2012-13	Remarks	Expenditure as on 31.8.2012	% of exp
A	RCH II	16155.26		4563.57	28
B	Mission Flexi Pool	24669.37		4339.63	18
C	Immunisation	1088.95		367.54	34
	Sub Total	41913.57		9270.74	22
D	NDCP				
	NPCB	702.91		95.45	14
	RNTCP	1086.07		155.60	14
	IDSP	210.09		17.39	8
	NVBDCP	972.00		242.34	25
	NIDDCP	102.46		4.28	4
	NLEP	87.01		4.25	5
	Subtotal NDCP	3160.54		519.31	16
	Total	45074.11		9790.05	22
	RCH-II				
	Budget Head	Budget for 2012-13	Unit cost	Expenditure as on 30.09.2012	% of exp
A.1	Maternal Health (including JSY)	3875.86		609.18	16
A.1.1.4	RTI/STI services at health Services	68.00	through KSACS		0
A.1.3.1	RCH Outreach Camps	47.00	235 camps @20000/-	11.83	25
A.1.3.2	Monthly Village Health and Nutrition Day	232.40	19365VHND/month @ Rs.100/- for ASHA incentive	13.45	0
A.1.4	JSY	1212.66		401.66	33
A.1.4.1	Home deliveries	1.25	250 deliveries @Rs.500/-	0.04	3
A.1.4.2	Institution Deliveries	908.85	Rural-110403 deliveries @ Rs.700/-, Urban-22672@Rs 600/-	319.48	35
A.1.4.4	Incentive to ASHA for JSY	302.56	123971 rural and urban @Rs.200/- and 9104 tribal @Rs.600/-	82.14	27

A.1.5	Maternal Death Review	3.25	200 death investigation @ Rs.500/-, 50 deaths for incentive @ Rs.500/- and Rs.2 lakhs for printing of formats	0.00	0
A.1.6	Others (Blood transfusion and MCP card printing)	121.50	Screening of blood 12000units @Rs.500/-, MCP card 5.5 lakhs @Rs.5/-, 3 lakhs for 10 blood storage centre, 4 lakhs for training at state level	0.24	0
A.1.7	JSSK (for Pregnant Women)	2191.05		182.01	8
A.1.7.1	Drugs and consumables	781.22	Rs.350/normal delivery for 123541 cases and Rs.1600/cesarean for 21802 cases	64.30	8
A.1.7.2	Diagnostic	290.69	Rs.200/delivery for 145343 cases	21.85	8
A.1.7.3	Blood Transfusion	21.80	Rs.300/delivery for 7267 cases	18.36	84
A.1.7.4	Diet	370.63	100*3*72673 for normal delivery, 100*7*21802 for cesarean	33.37	9
A.1.7.5	Referral Transport	726.71	Rs.500/- for 145343 deliveries	44.13	6
A.2	Child Health	1231.82		13.24	1
A.2.2	Facility Based Newborn Care/FBNC	1006.87	operational cost for 65 NBSU @ Rs.1.75 lakhs p.a, 20 lkhs for NBCC, NBSU-142.36 lakhs for infrastructure, Rs.173.76 lks for equipment and operational cost of Rs.1 lakh for 49 units, SNCU-337lks for infrastructure, 145 lakhs for equipment and operational cost @ Rs.2 lkh for 13 units	0.00	0
A.2.5	Care of Sick Children and Severe Malnutrition	60.00	Screening tests for thyroid-PH lab	0.00	0
A.2.6	Management of Diarrohea, ARI and Micronutrient Malnutrition	7	setting up of 700 ORT corners @Rs.1000/-	0.00	0
A.2.7	Other CH activities (CDS project)	0.00		0.00	######

A.2.8	Infant Death Audit	5.33	650 deaths- Rs.200/- for POL, Rs.200/- for DA to doctors, Rs.100/- for contingency, Rs.2.08 lakhs for printing		0
A.2.10	JSSK (for sick neonates up to 30 days)	152.62		6.62	4
	Diagnostic	43.62	21802 neonates @Rs.200/-	2.29	5
	Referral Transport	109.00	21802 neonates @Rs.500/-	4.33	4
A.3	Family Planning	553.53		148.84	27
A.3.1.1	Dissemination of manuals	5.00	2 lkhs for printing, 1 lakh each for one state level and 2 regional level training	0.00	0
A.3.1.2	Female Sterilisation Camps	28.35	405 camps @7000/-	3.96	14
A.3.1.3	NSV Camps	21.70	62 camps @35000/-	1.85	9
A.3.1.4	Compensation for female sterilisation	388.50	6085 cases @Rs.1500/-	109.87	28
A.3.1.5	Compensation for male sterilisation	91.28	38850 cases @Rs.1000/-	32.48	36
A.3.2	IUD Services	13.70	68520@ Rs.20/-	0.68	5
	Repairs of Laproscopes	5.00	repair of 5 laproscopes @ Rs.1 lakh	0.00	0
A.4	ARSH	663.71		45.15	7
A.4.1	Adolescent services at health facilities.	71.22	11 new clinics at DH level @ Rs.1.26 lakhs, operating expense @Rs.3.6 lkhs for 14 existing clinics, sensitation workshop at AW and tribal 3 batch each for 14 districts @ Rs.8300/-per batch	2.24	3
A.4.2	School Health	577.49	printing of manuals, health club, jphn diary, school register, hiring of vehicles, website maintenance etc	28.73	5
A.4.3	Other activities	15.00	Strengthening of state ARSH team -Rs.5 lakhs, Assessment studies Rs.10 lakhs	14.18	95
A.5	Urban RCH	632.69	salary of 50 MO @ Rs.27000/-, 300 JPHN@11620/- and 9 health Supervisor@Rs.16180/-, Rs.34.90 lakhs for other urban RCH activities like review meeting, training, printing etc.	256.69	41

A.6	Tribal RCH	131.98	440 TMU camp @Rs.1000/- ,PHC/CHC camps 400 @Rs.3000/-, special medical camps 26@Rs.12000/-, Adolescent Health education class 24@Rs.1500/-, Rs.8.10 lakhs for Adolescent health club, Rs.9.90 lkhs for special education campaign, Rs.51.14 lakhs for sickle cell anemia, Rs.40 lkhs for tribal hospital, Kottathara	17.47	13
A.8	Infrastructure & HR	6495.51		2699.44	42
A.8.1.1	ANMs,Supervisory Nurses, LHVs	2630.35	738 ANM/JPHN @11620/- month, 960 SN @ Rs.13900/-	1174.20	45
A.8.1.2	Laboratory Technicians, ,MPWs	221.71	159 LT @11620/-	101.91	46
A.8.1.3	Specialists (Anesthetists, Pediatricians, Ob/Gyn, Surgeons, Physicians, Dental Surgeons, Radiologist, Sonologist, Pathologist,Specialist for CHC)	453.12	118 Specialists @32000/-	143.03	32
A.8.1.4	PHNs at CHC, PHC level			0.00	######
A.8.1.5	Medical Officers at CHCs / PHCs	2663.64	266 MBBS doctors @32000/-, 595 CRS @23000/-	914.57	34
A.8.1.6	Additional Allowances/ Incentives to M.O.s of PHCs and CHCs				######
A.8.1.7	Others - Computer Assistants/ BCC Co-ordinator etc	326.69	Pharmacists, physiotherapists, CSR/X-ray/BCG Technician/ Radiographer,Nutritionist etc	322.74	99
A.8.1.10	Other Incentives Schemes (Pl.Specify)	200.00	Call Allowance to doctors	43.00	21
A.9	Training	873.86		49.69	6

A9.3	MH Training	159.21	Bemoc training 1 per district @ Rs.5 lakhs, training on safe abortion services to MO-3MO/district @ Rs.30230/MO, RTI/STI training- Rs.5.08 lakhs for TOT, LT training 14*Rs.51290, MO 14*Rs.84065, staff nurse 14*Rs.75440, Pre marital counselling training for JPHN Rs.50000/- for 14 batch, 100 batches of post marital counselling training @ Rs.35000/-	0.68	0
A9.4	IMEP training	9.20	15 batches @ Rs.61405/-		0
A9.5	CH Training	62.92	IMNCI -TOT Rs.2.52 lkhs, JPHNs 4 batch @ Rs.2.26 lkhs, F-IMNCI- TOT Rs.2.52 lkhs, MO 3*Rs.2.26 lkhs per batch, Staff Nurse 3 *Rs.2.26 lkhs per batch,training on lactation magt Rs.21.19 lkhs, NSSK Training-TOT Rs.94000/-, MO and SN 14 batches *Rs.94000/-	0.00	0
A9.6	FP Training	133.06	Laproscopic sterilisation-TOT Rs.71000/-, for MO, SN and OT assistants 14 batches @ Rs.71240, refresher training 14 batches @ Rs.71240, Minilap training-TOT-Rs.44000/-, for MO 14 batches *Rs.43900/-, refresher training 14 batches *Rs 43900/-, NSV-for MO 14 batches *Rs 26175/-, refresher training 14 batches *Rs.26175/-, IUD insertion-TOT-1.67 lkhs, MO -14.81 lkhs for 14 batch, SN-14.81 lkhs for 14 batch , ANM/LHV 14.81 lkhs for 14 batch, Contraseptive update seminars16*Rs.40000/-, PPIUD-TOT 1.67 lkhs , MO -14.81 lkhs for 14 batch, SN-14.81 lkh for 14 batch, refresher training 14.81 lkhs for 14 batch	3.85	3

A9.7	ARSH	38.58	TOT-Rs.2.21 lkhs, orientation training for state and district programe managers 4*1.47lkhs, for MO28*Rs.40000/-, SN 28*Rs.36000/-, JPHN 28*Rs.40000/-	0.00	0
A9.8	Other Training	470.89	programme management trining-7 lkhs, Blood storage unit training Rs.4.8 lkhs, counsellors28*Rs.18107-, ARSH cordinators 1batch @ Rs.57000/-, TOT for WIFS Rs.2.21lkhs, district TOT 4*Rs.1.47 lkhs, workshop for module translation- Rs.20000/-, for JPHN/AWW 14 batches *Rs.39000/-, teachers training 223 @ Rs.15000/-, ASHA/AWW training on MH Rs.3.12 lakhs, Training at Kozhikode institute 34.48 lkhs, BCC training Rs.78.90 lkhs, Induction training for New JPHN for SHP 37*Rs.61950/-, Training to teachers 416*Rs.29400/-, Training to HM/PTA president 416*Rs.25756/-, computer training for JPHN 52*Rs.42600/-, training on Child rights and abuse 52*Rs.32210/-, trg for district cordinators 1* Rs.60000/-	13.01	3
9.11.3	Other trng & capacity bldg			32.16	#### #
A.10	Programme Management	1691.30	HR cost at last years rates, other expenses , financial management training, Audit fees	723.87	43
A.11	Vulnerable group- Geriatric care	5.00	Approved an initial budget of Rs.5 lkhs for training		0
	Total -A	16155.2 6		4563.57	28
	Mission Flexi pool				#### #
B.1	ASHA	1426.64		404.58	28

B.1.1.1	Selection & Training	644.91	584.91lkhs for training 1-6 module, 20 lkhs for printing modules, Rs.40 lkhs for BCC kit for ASHA	145.07	22
B.1.1.2	Procurement of ASHA drug kit	113.11	7540 new kits @ Rs.350/-, replenishment of 23350kits @ Rs.350/-, Rs.5 lkhs for kitting charge		0
B.1.1.3	Incentive	630.97	Pregnant women tracking 15*31549 ASHA @ Rs.20/-, Child tracking 10*31549*Rs.50/-, monthly review meeting 31549 asha @ Rs.100/pm	259.51	41
B1.1.4	Awards to ASHA's/Link workers	8.67	Rs.1000/-PHC for 839 PHC, Rs.2000/- for 14 district		0
B1.1.5	ASHA Resource Centre/Mentoring Group	28.98	Lumpsum		0
B.2	**Untied funds**	**2789.13**		**1364.61**	49
	CHC/THQH	145.20	310*Rs.50000 (Approved 93.68%)	46.80	32
	PHC/24x7 PHC	187.39	835*Rs.25000 (Approved 89.77%)	47.96	26
	Subcentres	520.04	5407*Rs.10000 (Approved 96.18%)	110.84	21
	VHSC	1936.50	19365*Rs.10000	1159.01	60
B.3	**Annual Maintenance Grants**	**415.92**		**151.29**	36
	CHC/THQH	158.38	310*Rs.100000 (Approved 51.09%)	59.44	38
	PHC/24x7 PHC	112.30	835*Rs.50000 (Approved 26.90%)	58.20	52
	Subcentre	145.24	3709*Rs.10000 (Approved 39.16%)	33.65	23
B.4	**Hospital Strengthening**	**4255.06**		**154.01**	4
	District/General Hospitals	936.14	3 institutions-DH Palakkad - 172.50 lkhs, Kannur - 311.48 lkhs and Kanhangad-100 lkhs, 352.16 lakhs for spillover works	8.85	1

	Others-W&C	1221.59	Renovation of W&C Kottayam-31.20 lkhs, Alappuzha-42 lkhs, Palakkad-56.70 lkhs, Mangattuparambu -242.78 lkhs and new work at Idukki-67.50 lkhs, Kollam -700 lakhs, Rs.81.41 lakhs for spill over works	21.37	2
	Thaluk/Government	1788.23	Rs.1713.23 lkhs spill over wrks, Rs.75 lkhs for THQH Sulthan Bathery	68.36	4
	SC rent and Contingencies	53.10	885*Rs.500/- pm	4.18	8
	Logistic Management	256.00	For vehicles at Block, district and Urban activity	51.26	20
B.5	**New Constructions/ Renovation and Setting up (CHC,PHC,SC)**	**2511.66**		**213.30**	**8**
B5.1	CHC	245.83	5 institution- Nedumangad Rs.46.80lakhs, Pathanapuram Rs.34.65 lkhs, Kumarakam Rs.75 lkhs, Pazhayangadi Rs.37.50 lakhs, Kannapuram Rs.15 lkhs, Rs.36.88 lakhs for spill over works	0.15	0
B5.2	PHC	81.65	Rs.31.65 lkhs for spill over works, Rs.50 lakhs for PHC Kurumbalangode	0.00	0
B5.4	Setting up of infra wing for civil works	63.38	salary of engineers	23.11	36
B5.5	Other renovations-Quarters	300.00	4 institution-construction of new Quarters in THQH Nedumkandam-90 lkhs, Vythiri-67.50lkhs, CHC vathikudi-67.50lks, GH Kalpeta-75 lkhs	0.00	0
B5.7	Major Civil works for Opr of FRU	1019.00	Rs.447.7 lakhs for spill over works, Rs.90 lks for THQH Punalur, Rs.50 lks for THQH Kadakkal, Rs.31.3 lakhs for THQH Kodungalloor, Rs.400 lkhs for THQH Thirurangadi	165.00	16

B5.9	Civil Works for Operationalising Infection Management & Environment Plan at health facilities	326.00	Lumpsum		0
B5.10.1	Strengthening of Existing Training Institutions	200.40	5 institution -Training institute Malaparamba-46.80lks, Thumpamon-25.20, Thrissur-41.40, Kottayam-37.80, Idukki-49.20	25.03	12
B5.10.2	New Training Institutions/School	275.40	6 institution -Training institute at Trivandrum-45lkhs, Kannur-45lkhs, Mlpm-46.80lks, Alappuzha-45 lks, plkd-48.60lkhs, Kargd-45lkhs		0
B.6	Corpus Grants to HMS/RKS	1026.73		234.68	23
	District/General Hospitals	130.00	26*5 lkhs	39.35	30
	CHC	310.00	310*Rs.100000	67.51	22
	PHC	542.33	835*Rs.100000 (Approved 64.95%)	116.25	21
	Others-Speciality and MCs	44.40	19*Rs.500000 (Approved 46.74%)	11.57	26
B.7	District Action Plans (Including Block, Village)	296.89	DHAP Rs.1 lakh per district, CHP-20lkhs per district, Rs.2 lkhs for state level	5.20	2
B.8	Panchayath Raj Initiative	0.00		0.00	
B.9	Mainstreaming of AYUSH	1943.23	salary of 750 MO @ Rs.20740/-, Vehicle Rs.52 lkhs, Rs.24.63 lkhs for 19 other category of staff for EKM	622.42	32
B.10	BCC / IEC	708.83		106.31	15
	Strengthening and development of BCC Strategy	26.80		1.35	5
	For MH	160.16		64.22	40
	For CH	156.72		2.12	1
	For FP	145.06		10.47	7
	For ARSH	135.59	Lumpsum	1.42	1

	Health Mela	0.00		0.00	
	Others	84.50		26.72	32
B.11	MMU-Referral Transport	409.12	16 MMU @ Rs.19.87 lkhs/year, 5 floating dispensary @ 18.24 lkhs/year	73.93	18
B.12	Referral Transport -KEMP	3441.38	Rs.70.20 lkhs for operational expenses GOI share of 20% of Rs.1.7 lks for 25 ambulances at TVM, Rs.400 lkhs for cost for purchase of 20 ALS ambulance @ Rs.20 lks, Rs.42.12 lkhs for Opex @ Rs.1.2lks for 3 months-60% for first year, 151.63 lkhs for Operational cost for 18 ambulance running at Alpy, Rs.32.7lkhs for special strategy for inaccessible areas 109*Rs.5000*6 months, Rs.1556.50 lkhs for cost of 283 patient transport ambulance @ Rs.5.5 lkh, Rs.509.03 lakhs for capex for control room at TVM, Rs.679.2 laks for opex for patient transport ambulance for 3 months @ Rs.1.2 lks	137.22	4
B.13	PPP/NGOs	34.00		0.00	0
	MNGO	34.00	Baseline survey in four districts @ Rs.1 lakh each at Idukki, Malappuram, Wayd and kargd, and first phase intervention for 6 month @ Rs.125000/-pm	0.00	0
B.14	Innovations-	227.05		0.00	0
	Setting up of Dialysis Unit	210.00	Rs.15 lkhs for 14 institution(DH/GH)	0.00	0
	Total station survey	17.05		0.00	0
B.15	Community Monitoring	665.07		188.31	28
B.15.2	Quality Assurance	543.28	NABH, NABL, KASH, Printing of manuals, training, Blood bank accreditation for Aluva	123.82	23
B.15.3	HMIS/GIS	66.65	printing of new registers, review of existing registers, training etc	59.38	89

B.15.4	e-governanace	25.25	HW/SW procurement-3.50lkhs, Geo Spatial pending payment 16 lkhs, M&E for ARSH 5.75 lkhs	0.00	0
B.15.5	Other M&E	29.89	Salaries of M&E consultant, MCTS, GIS, SDO, DEO etc - Rs.20.64 lkhs, mobility for M&E officers-3 lkhs, Workshop and training for M&E-3 lkhs, publication of reports-3.25 lks	5.11	17
B.16	**Procurement**	**868.25**		**0.00**	0
	Equipment	90.00	18 laproscopes @ Rs.5 lkhs	0.00	0
	Drugs	778.25	Iron syrup for children Rs.15/100ml/2700000 childredn-405 lkhs, Vitamin A 1.1lkh bottles @ Rs.50/- 55 lkhs, IFA and Albendazole tablets-318.25 lkhs	0.00	0
B.18	**New Initiatives/ Strategic Interventions**	**3447.20**		**610.28**	18
	Pain and Palliative care	435.51		111.95	26
	ICCONS	400.00		400.00	100
	Mental Health	435.95	Ongoing CMHP in Kozhikode Mlpm and Kasargod @ Rs.31.15 lkhs each, Scaled up project for 5 Districts Kollam, Pathanamthitta, Alappuzha, Kottayam and Palakkad @39.56 lakhs each, Epidemiological Survey to Identify the Mentally ill Persons in Kerala at a total cost of Rs.105.13 lkhs	47.98	11
	NCD	0.00		27.54	
	Radio Health	72.91		2.64	4
	Menstrual Hygiene Project			0.61	
	Gender Based Violence	50.00		0.7525	2
	Nutritional Supplement programme	70.00	in Wayanad district		0
	Rehabilitation Endosulfan patients	560.10	in Kasaragod district	18.80	3

	Sabarimala	1422.73			0
B.19	Research, Studies, Analysis	0.00		0.50	
B.21	State level health resources center (SHSRC)	100.00		71.26	71
B.22	Support Service	103.21		1.74	2
	RNTCP	71.68		0.99	1
	IDSP	29.85		0.75	3
	NLEP	1.68		0.00	0
	Total-B	24669.37		4339.63	18
	Immunization				
C.1	RI strengthening project (Review meeting, Mobility support, Outreach services etc)	141.39	Mobility support Rs.1 lkh for state, 50000/- each for districts, review meeting, printing of cards/focus on slum and underserved areas, AVD, salary of contractual staff, ASHA incentive etc.	28.34	20
C.2	Salary of Contractual Staffs	18.12	Rs.500/PHC/CHC, Rs.1000/- for district per year	5.29	29
C.3	Training under Immunisation	45.56		7.10	16
C.4	Cold chain maintenance	6.72		1.69	25
C.5	ASHA Incentive	483.72		115.44	24
C.6	Pulse Polio operating costs	393.44		209.68	53
	Total-C	1088.95		367.54	34
	TOTAL (A+B+C)	41913.57		9270.74	22
	GRAND TOTAL (A+B+C+D)	40074.11		9790.05	22

Sl. No.	DISTRICT	NAME OF INSTITUTION	AS Amount	DATE OF COMMENCEMENT	DATE OF COMPLETION	TOTAL EXPENDITURE
1	TRIVANDRUM	W&C Thycaud	Rs. 14,956,557	01.04.2008	30.12.2009	Rs. 12,341,693
2	TRIVANDRUM	Repair work at GH Thiruvananthapuram	Rs. 882,000	09.04.2009	08.04.2010	Rs. 817,012
3	TRIVANDRUM	Telimedicine centre GH	Rs. 339,946	12.01.2010	25.01.2010	Rs. 327,316
4	TRIVANDRUM	DPM office, at W&C Thycaud	Rs. 2,526,082	06.09.2009	31.03.2010	Rs. 2,753,965
5	TRIVANDRUM	Cold chain work at GH TVM	Rs. 362,768	29.11.2010	18.11.2010	Rs. 362,768
6	TRIVANDRUM	CHC KANYAKULANGARA	Rs:10,78,075	19.02.2008	17.10.2008	Rs. 1,079,074
7	TRIVANDRUM	CHC VELLARADA	Rs:70,93,531	26.03.2008	15.02.2009	Rs. 7,017,396
8	TRIVANDRUM	CHC NEDUMANGAD	Rs:31,89,975	13.04.2008	10.01.2009	Rs. 3,175,682
9	TRIVANDRUM	CHC VITHURA	Rs. 3,958,095	21.04.2009	20.11.2009	Rs. 4,153,889
10	TRIVANDRUM	CHC VELLANADU	Rs:33,89,251	26.02.2009	23.12.2009	Rs. 3,526,883
11	TRIVANDRUM	CHC KESAVAPURAM	Rs:35,54,322	01.09.2008	30.07.2009	Rs. 3,878,632
12	TRIVANDRUM	CHC MANAMBUR	Rs:30,31,437	10.02.2009	31.07.2009	Rs. 2,949,710
13	TRIVANDRUM	Kanliramkulam	Rs. 3,801,466	27.03.2008	15.01.2009	Rs. 4,589,895
14	TRIVANDRUM	R.I.O. TVPM	Rs. 1,104,051	20.04.2008	08.08.2008	Rs. 894,092
15	TRIVANDRUM	JPHN-Peroorkada	Rs. 2,901,111	04.06.2008	15.11.2008	Rs. 2,728,044
16	TRIVANDRUM	DHS Office	Rs. 1,072,810	25.06.2009	22.09.2009	Rs. 1,078,089
17	TRIVANDRUM	NRHM Car Parking	Rs. 2,878,237	06.07.2009	05.10.2009	Rs. 3,501,739
18	TRIVANDRUM	Chirayinkeezhu THQH (Additional Works)	Rs. 2,194,165	22.04.2009	23.02.2010	Rs. 2,284,433
19	TRIVANDRUM	Chirayinkeezhu THQH (Lift)	Rs. 1,438,000	17.04.2009	23.02.2010	Rs. 1,438,000
20	TRIVANDRUM	Chirayinkeezhu THQH (DG Set)	Rs. 1,082,362	24.02.2010	30.04.2010	Rs. 1,043,912
21	TRIVANDRUM	PHC Vattiyoorkavu	Rs. 7,732,589	20.04.2009	09.04.2010	Rs. 7,732,589
22	TRIVANDRUM	Nature Cure Hospital, Varkala	Rs. 5,746,553	18.01.2010	25.09.2010	Rs. 5,510,926
23	TRIVANDRUM	GH Varkala	Rs. 2,086,000	21.09.2010	20.12.2010	Rs. 1,865,228
24	TRIVANDRUM	OT Nedumangad	Rs. 1,255,837	17.10.2011	13.01.2012	Rs. 899,108
25	TRIVANDRUM	Renovation of Gynaec ward Nedumangad	Rs. 975,000	17.10.2011	13.01.2012	Rs. 972,000
26	TRIVANDRUM	OT Chirayinkeezhu	Rs. 6,497,338	12.12.2011	18.01.2012	Rs. 3,863,000
27	KOLLAM	CHC KADAKKAL	Rs:14,63,884	06.03.2008	29.04.2009	Rs. 1,280,843
28	KOLLAM	CHC PATHANAPURAM	Rs:17,67,601	06.03.2008	28.02.2009	Rs. 1,646,702
29	KOLLAM	CHC ANCHAL	Rs:27,35,582	17.02.2008	31.12.2008	Rs. 2,916,440
30	KOLLAM	CHC OACHIRA	Rs:14,75,233	25.02.2008	25.11.2008	Rs. 1,239,382
31	KOLLAM	CHC MAYYANADU	Rs:23,72,917	24.03.2008	05.02.2009	Rs. 2,265,810
32	KOLLAM	CHC THRIKKADAVOOR	Rs:33,48,205	12.04.2008	28.02.2009	Rs. 4,223,867
33	KOLLAM	Kundara Govt Hospital	Rs. 24,874,281	12.05.2009	31.07.2010	Rs. 20,176,926
34	KOLLAM	PHC Thekkumbhagam	Rs. 2,442,765	17.09.2010	30.04.2011	Rs. 1,581,619
35	PATHANAMTHITTA	CHC KANJEETTUKARA	Rs:47,02,738	22.02.2008	08.05.2009	Rs. 5,121,173
36	PATHANAMTHITTA	CHC ENADHIMANGALAM	Rs:31,01,765	17.04.2008	25.07.2009	Rs. 2,488,710
37	PATHANAMTHITTA	CHC RANNI PERINADU	Rs:58,89,646	23.06.2010	07.11.2011	Rs. 5,518,011
38	PATHANAMTHITTA	DH Kozhencherry	Rs. 22,391,566	14.01.2010	31.05.2011	Rs. 19,235,856
39	PATHANAMTHITTA	CCU Pathanamthitta	Rs. 1,890,371	22.09.2011	11.11.2011	Rs. 1,772,317
40	PATHANAMTHITTA	OT at TH Thiruvalla	Rs. 2,062,743	18.08.2011	21.01.2012	Rs. 1,869,000
41	PATHANAMTHITTA	OT & Trauma care at GH pathanamthitta-Civil & Electrical	Rs. 1,200,000	10.01.2012	01.02.2012	Rs. 653,000
42	PATHANAMTHITTA	OT & Trauma care at GH pathanamthitta-Laminar flow		17.02.2011	03.03.2012	Rs. 400,000
43	PATHANAMTHITTA	OT at GH Adoor	Rs. 4,509,000	18.08.2011	17.03.2012	Rs. 3,077,000
44	ALAPUZHA	IDRV Clinic at TDMC Vandanam	Rs. 165,392	04.11.2008	30.09.2009	Rs. 153,537
45	ALAPUZHA	Ayurveda Hospital Mavelikkara	Rs. 2,910,441		15.12.2010	Rs. 4,144,775
46	ALAPUZHA	THQH Cherthala	Rs. 10,276,356	06.11.2009	31.12.2009	Rs. 9,178,005
47	ALAPUZHA	THQH Pulinkunnu	Rs. 19,230,856	30.01.2010	21.02.2011	Rs. 20,755,274
48	ALAPUZHA	THQH Cherthala A/C work	Rs. 2,500,000	25.09.2010	25.11.2010	Rs. 1,860,257
49	ALAPUZHA	THQH Cherthala (CSSD)	Rs. 755,710	19.06.2010	19.09.2010	Rs. 755,710
50	ALAPUZHA	CHC CHENGANOOR	Rs. 2,462,441	17.11.2009	16.07.2010	Rs. 2,698,685

Sl. No.	DISTRICT	NAME OF INSTITUTION	AS Amount	DATE OF COMMENCEMENT	DATE OF COMPLETION	TOTAL EXPENDITURE
51	ALAPUZHA	CHC MUHAMMA	Rs 37,46,545	10.09.2009	18.06.2010	Rs. 3,620,981
52	KOTTAYAM	DH Kottayam	Rs. 194,865	28.12.2008	17.01.2009	Rs. 194,865
53	KOTTAYAM	CHC EDAYARIKKAPUZHA	Rs:27,83,761	30.12.2008	28.10.2009	Rs. 2,187,824
54	KOTTAYAM	CHC KARUKACHAL	Rs:24,63,654	18.01.2009	30.12.2009	Rs. 2,022,224
55	KOTTAYAM	CHC KOODALLOOR	Rs:40,33,468	01.04.2008	31.01.2009	Rs. 988,965
56	KOTTAYAM	CHC PAIKA	Rs:27,67,990	17.11.2008	15.06.2009	Rs. 2,481,729
57	KOTTAYAM	CHC ERUMELI	Rs:31,96,762	11.06.2008	11.11.2009	Rs. 2,861,429
58	KOTTAYAM	CHC ULLANADU	Rs:32,13,201	26.04.2008	30.06.2009	Rs. 2,867,794
59	KOTTAYAM	CHC VAIKOM	Rs. 3,182,684	25.07.2008	30.04.2009	Rs. 3,158,386
60	KOTTAYAM	CHC ARUNOOTIMANGALAM	Rs. 2,468,320	22.09.2008	31.07.2009	Rs. 2,058,542
61	KOTTAYAM	CHC MUNDANKUNNU	Rs:15,57,322	26.05.2008	08.10.2008	Rs. 1,056,192
62	KOTTAYAM	IPHN Thalayolaparambu	Rs. 2,544,484	01.06.2008	22.10.2008	Rs. 2,409,006
63	KOTTAYAM	DH Kottayam	Rs. 19,616,527	13.10.2010	13.07.2012	Rs. 21,100,090
64	IDUKKI	CHC UPPUTHURA	Rs: 28,87,461	25.09.2009	15.04.2010	Rs. 2,420,580
65	IDUKKI	CHC VANDIPERIYAR	Rs: 21,72,097	25.05.2009	21.01.2010	Rs. 1,871,479
66	IDUKKI	CHC PURAPUZHA	Rs: 25,87,986	16.05.2009	14.12.2009	Rs. 2,188,656
67	IDUKKI	CHC NEDUMKANDOM	Rs: 26,36,140	29.04.2009	19.12.2009	Rs. 1,984,752
68	IDUKKI	CHC RAJAKKAD	Rs: 26,09,310	21.11.2008	09.12.2009	Rs. 2,415,301
69	IDUKKI	CHC ADIMALI	Rs: 26,25,764	20.11.2008	18.06.2009	Rs. 2,215,548
70	IDUKKI	TH Thodupuzha	Rs. 9,424,731	20.04.2011	09.09.2011	
71	ERNAKULAM	MGH Karuvelippady	Rs. 30,712,621	27.12.2008	07.12.2010	Rs. 32,259,640
72	ERNAKULAM	Repair & maint. Of PCU GH Ernakulam	Rs. 482,877	27.12.2008	20.02.2009	Rs. 451,287
73	ERNAKULAM	Rennovation of GH Ernakulam	Rs. 3,344,207	28.02.2009	30.06.2009	Rs. 3,265,050
74	ERNAKULAM	GH Ernakulam(NABH)	Rs. 23,317,370	28.02.2009	11.10.2010	Rs. 17,429,139
75	ERNAKULAM	Renovation of W & C Mattancherry	Rs. 23,503,079	09.02.2009	18.09.2009	Rs. 6,458,362
76	ERNAKULAM	THQ Thripunithara	Rs. 6,971,001	08.02.2009	29.10.2009	Rs. 7,901,897
77	ERNAKULAM	Nursing school Ernakulam	Rs. 15,031,443	30.09.2009	15.09.2010	Rs. 18,928,363
78	ERNAKULAM	Training Centre Thrippunithara	Rs. 5,991,500	27.02.2009	31.08.2009	Rs. 6,778,080
79	ERNAKULAM	THQH Aluva	Rs. 16,210,108	27.04.2009	31.12.2009	Rs. 14,907,649
80	ERNAKULAM	PHC, Angamaly, Ernakulam	Rs. 6,397,235	17.07.2009	06.09.2010	Rs. 5,182,250
81	ERNAKULAM	Staff, Qtrs, GH Ernakulam	Rs. 3,220,329	15.10.2009	05.09.2010	Rs. 3,453,670
82	ERNAKULAM	THQH, Muvattupuzha, Ernakulam	Rs. 13,949,699	27.11.2009	20.08.2010	Rs. 10,679,930
83	ERNAKULAM	PHC Neriyamangalam	Rs. 1,990,584	10.09.2010	26.08.2011	Rs. 1,864,547
84	ERNAKULAM	PHC Kuttampuzha	Rs. 1,010,300	10.09.2010	08.02.2011	Rs. 1,010,300
85	ERNAKULAM	GH Ernakulam(Dialysis Unit)	Rs. 1,971,200	16.04.2011	10.10.2011	Rs. 1,485,920
86	ERNAKULAM	CHC CHENGAMANAD	Rs:71,46,565	16.02.2008	31.01.2009	Rs. 6,826,796
87	ERNAKULAM	CHC VENGOLA	Rs:24,17,115	16.02.2008	15.11.2008	Rs. 2,682,891
88	ERNAKULAM	CHC PIRAVAM	Rs:70,15,432	16.02.2008	07.12.2008	Rs. 8,569,585
89	ERNAKULAM	CHC KUMBALANGI	Rs. 3,618,594	25.05.2009	20.01.2010	Rs. 4,080,257
90	ERNAKULAM	CHC KEECHERI	Rs. 3,742,051	29.10.2008	28.04.2009	Rs. 3,971,212
91	ERNAKULAM	CHC KALADY	Rs. 2,889,780	20.03.2009	08.02.2010	Rs. 3,751,015
92	ERNAKULAM	CHC EZHIKKARA	Rs. 2,813,070	21.08.2009	15.05.2010	Rs. 3,224,375
93	ERNAKULAM	CHC VADAVUKODE	Rs. 3,167,140	21.10.2008	20.04.2009	Rs. 3,080,806
94	THRISSUR	CHC ALAPPAD	Rs:49,50,880	22.12.2008	14.06.2010	Rs. 4,950,880
95	THRISSUR	CHC PUTHENCHIRA	Rs:37,48,956	23.11.2007	31.07.2008	Rs. 3,723,038
96	THRISSUR	CHC MULLASSERY	Rs:43,12,812	03.04.2008	11.03.2009	Rs. 3,321,409
97	THRISSUR	CHC CHELAKKARA	Rs:26,83,595	12.01.2009	11.07.2009	Rs. 2,550,288
98	THRISSUR	CHC THIRUVILWAMALA	Rs:26,53,694	09.09.2009	31.07.2010	Rs. 2,628,083
99	THRISSUR	CHC PAZHANJI	Rs. 2,616,689	25.11.2010	24.04.2011	Rs. 3,347,707
100	THRISSUR	CHC CHERPU	Rs:63,67,752	01.06.2008	20.07.2011	Rs. 5,625,905
101	THRISSUR	Anthikad PHC	Rs. 2,461,247	04.01.2010	03.08.2010	Rs. 2,315,580
102	THRISSUR	OT Vadakanchery	Rs. 2,063,030	05.08.2011	12.11.2011	Rs. 1,772,000
103	PALAKKAD	CHC NENMARA	Rs:24,87,648	25.03.2008	24.01.2009	Rs. 2,272,275
104	PALAKKAD	CHC KUZHALMANNAM	Rs:31,15,405	25.01.2008	24.11.2009	Rs. 3,086,374
105	PALAKKAD	CHC ELAPULLY	Rs:34,48,169	06.02.2009	31.10.2009	Rs. 2,923,984
106	PALAKKAD	CHC KODUVAYOOR	Rs:24,25,924	19.12.2008	18.09.2009	Rs. 2,074,348

Sl. No.	DISTRICT	NAME OF INSTITUTION	AS Amount	DATE OF COMMENCEMENT	DATE OF COMPLETION	TOTAL EXPENDITURE
107	PALAKKAD	CHC NANNIYODE	Rs:27,83,389	18.06.2008	31.03.2009	Rs. 2,741,880
108	PALAKKAD	CHC ALATHOOR	Rs:19,59,583	30.05.2008	31.03.2009	Rs. 1,902,812
109	PALAKKAD	CHC VADAKKANCHERY	Rs:11,40,690	19-04-2008	18.07.2009	Rs. 742,746
110	PALAKKAD	CHC AMBALAPPARA	Rs:26,75,208	06.05.2008	05.03.2009	Rs. 2,461,063
111	PALAKKAD	CHC CHERPULASSERY	Rs:29,16,585	05.03.2009	20.10.2009	Rs. 2,719,210
112	PALAKKAD	CHC KADAMPAZHIPURAM	Rs:25,26,072	25.04.2008	24.02.2009	Rs. 2,071,215
113	PALAKKAD	CHC AGALI	Rs:13,65,186	25.11.2008	24.06.2009	Rs. 1,183,623
114	PALAKKAD	CHC ALANALLOOR	Rs. 2,633,267	21.04.2009	10.11.2009	Rs. 2,595,328
115	PALAKKAD	DH Palakkad(OLD Work)	Rs. 23,000,000		02.11.2010	Rs. 15,207,189
116	PALAKKAD	TH Chittur	Rs. 4,231,906	01.03.2010	15.12.2010	Rs. 4,265,472
117	PALAKKAD	OT at TH Ottapalam	Rs. 1,553,594	02.07.2011	20.09.2011	Rs. 1,379,000
118	PALAKKAD	OT at TH Chittur	Rs. 1,627,776	23.06.2011	20.09.2011	Rs. 1,594,000
119	PALAKKAD	OT at TH Alathur	Rs. 1,772,637	30.06.2011	20.09.2011	Rs. 1,725,000
120	PALAKKAD	OT at TH Mannarkad	Rs. 1,615,291	3.01.2012	15.05.2012	Rs. 1,443,000
121	MALAPURAM	CHC KUTTIPPURAM	Rs. 2,939,440	27.05.2009	25.01.2010	Rs. 2,937,840
122	MALAPURAM	CHC VENGARA	Rs:32,69,411	12.08.2008	23.09.2009	Rs. 2,798,490
123	MALAPURAM	CHC NEDUVA	Rs:31,26,920	19.06.2008	03.08.2009	Rs. 3,050,177
124	MALAPURAM	CHC MALAPPURAM	Rs:25,01,497	15.01.2009	10.09.2009	Rs. 2,707,506
125	MALAPURAM	CHC KONDOTTY	Rs. 5,383,823	28.10.2009	27.07.2010	Rs. 5,596,910
126	MALAPURAM	CHC EDAVANA	Rs:17,26,282	27.05.2008	15.01.2009	Rs. 1,625,114
127	MALAPURAM	CHC AREAKODE	Rs:34,41,854	29.12.2008	20.07.2009	Rs. 3,289,598
128	MALAPURAM	CHC WANDOOR	Rs. 2,494,470	21.10.2009	20.04.2010	Rs. 2,374,374
129	MALAPURAM	CHC CHUNGATHARA	Rs:22,64,249	13.05.2008	30.11.2009	Rs. 2,099,715
130	MALAPURAM	CHC PURATHOOR	Rs:25,83,092	21.05.2008	02.04..2009	Rs. 2,470,281
131	MALAPURAM	TH Nilambur	Rs. 5,166,399	15.05.2010	14.01.2011	Rs. 5,118,785
132	MALAPURAM	Traumacare at GH Kuttippuram	Rs. 950,000	15.10.2011	15.12.2011	Rs. 800,286
133	MALAPURAM	OT at TH Tirur	Rs. 1,082,000	12.07.2011	12.09.2011	Rs. 869,000
134	MALAPURAM	OT at TH Nilambur	Rs. 890,870	06.07.2011	28.08.2011	Rs. 774,000
135	MALAPURAM	OT at TH Perinthalmanna	Rs. 1,512,611	01.07.2011	29.08.2011	Rs. 1,294,000
136	KOZHIKODE	STP Kozhikode		08.01.2008	23.03.2009	Rs. 43,121,439
137	KOZHIKODE	Extra Work STP Kozhikode			31.07.2010	Rs. 21,653,675
138	KOZHIKODE	New Building, IMCH, Kozhikode	Rs. 477,700,000	7.4.2009	31.03.2011	Rs. 245,243,713
139	KOZHIKODE	Renovation IMCH, K.Kode		30.3.2009	31.12.2010	Rs. 109,404,513
140	KOZHIKODE	IMCH K.Kode(A/C Work)			26.03.2011	Rs. 2,085,000
141	KOZHIKODE	IMCH K.Kode(Fire Fighting)		28.01.2011	31.01.2012	Rs. 8,494,915
142	KOZHIKODE	IMCH K.Kode(Lift)			27.06.2011	Rs. 5,952,750
143	KOZHIKODE	W & C Kozhikkode PH-I	Rs. 15,863,909	14.08.2008	31.03.2009	Rs. 12,736,978
144	KOZHIKODE	W & C Kozhikode PH-II(NABH)	Rs. 11,978,308		30.04.2010	Rs. 7,533,087
145	KOZHIKODE	GH Nadapuram	Rs. 12,467,983	04.01.2009	15.01.2011	Rs. 12,994,668
146	KOZHIKODE	Dental College, Kozhikode	Rs. 2,118,600		31.01.2011	Rs. 2,080,800
147	KOZHIKODE	THQH Vadakara	Rs. 1,190,000	07.0.2012	31.01.2012	Rs. 2,113,777
148	KOZHIKODE	CHC THAMARASSERY	Rs:32,79,346	08.06.2008	14.02.2009	Rs. 2,978,478
149	KOZHIKODE	CHC NARIKUNI	Rs. 2,962,722	17.04.2009	30.04.2010	Rs. 2,794,923
150	KOZHIKODE	CHC MUKKOM	Rs:29,20,109	11.06.2008	20.03.2009	Rs. 2,768,204
151	KOZHIKODE	CHC THALAKULATHUR	Rs:54,39,353	24.06.2009	02.05.2010	Rs. 5,352,107
152	KOZHIKODE	CHC KODUVALLY	Rs. 3,309,656	26.02.2009	02.11.2009	Rs. 3,295,959
153	KOZHIKODE	CHC PERAMBRA	Rs:5,12,112	21.05.2008	29.08.2008	Rs. 512,112
154	KOZHIKODE	CHC BALUSSERY	Rs: 27,15,572	07.01.2009	31.03.2010	Rs. 2,559,802
155	KOZHIKODE	CHC ULLIYERI	Rs: 27,48,968	12.12.2008	12.11.2009	Rs. 2,536,908
156	KOZHIKODE	CHC KUTTIYADI	Rs:4,23,522	21.05.2008	05.07.2008	Rs. 367,219
157	KOZHIKODE	CHC ORKATTARY	Rs:22,77,752	05.12.2008	08.09.2009	Rs. 1,965,883
158	KOZHIKODE	CHC THIRUVALLOOR	Rs: 32,24,877	13.01.2009	15.10.2009	Rs. 3,009,977
159	WAYANAD	CHC VYTHIRI	Rs:23,28,004	06.12.2008	31.12.2009	Rs. 2,387,920
160	WAYANAD	CHC THARIODE	Rs:15,22,185	09.06.2008	15.12.2009	Rs. 866,380
161	WAYANAD	CHC KALPETA	Rs:1609582	03.05.2008	04.08.2008	Rs. 1,485,901
162	WAYANAD	CHC MEENANGADY	Rs 26,47,537	15.04.2008	10.01.2009	Rs. 2,647,537
163	WAYANAD	CHC PULPALLY	Rs 30,79,182	12.04.2008	24.06.2009	Rs. 3,026,987
164	WAYANAD	CHC PERIYA	Rs: 13,89,375	26.05.2009	15.03.2010	Rs. 868,904
165	WAYANAD	PHC Pozhuthana	Rs. 2,767,014	22.10.2010	21.07.2011	

Sl. No.	DISTRICT	NAME OF INSTITUTION	AS Amount	DATE OF COMMENCEMENT	DATE OF COMPLETION	TOTAL EXPENDITURE
166	KANNUR	JPHN, RPHL, Kannur	Rs. 270,000	30.08.2010	10.08.2010	Rs. 245,416
167	KANNUR	MMI DH Kannur(New York)	Rs. 8,225,031	9.01.2011	30.09.2011	Rs. 6,897,106
168	KANNUR	THQ Hospital Thaliparamba	Rs. 31,596,729	19.2.2009	23.08.2011	Rs. 15,296,156
169	KANNUR	Taluk Hospital Koothuparambu	Rs. 33,200,138	8.2.2009	25.08.2011	Rs. 12,808,231
170	KANNUR	CHC PERAVOOR	Rs 25,95,926	20.07.2008	15.04.2009	Rs. 1,763,884
171	KANNUR	CHC PANOOR	Rs:22,13,342	15.11.2008	30.12.2009	Rs. 2,047,920
172	KANNUR	CHC PINARAYI	Rs:27,54,787	18.08.2009	2/10/2010	Rs. 3,308,823
173	KANNUR	CHC IRIVERY	Rs:44,08,375	26.02.2008	3/5/2010	Rs. 3,356,438
174	KANNUR	CHC PAPPINISSERY	Rs:29,17,287	26.02.2008	15.02.2009	Rs. 2,886,685
175	KANNUR	CHC MAYYIL	Rs:45,38,564	26.02.2008	30.11.2009	Rs. 4,598,618
176	KANNUR	CHC IRITTY	Rs:15,46,237	09.06.2008	15.01.2009	Rs. 1,220,362
177	KASARGODE	DH Kanhangad	Rs. 2,350,000	27.10.2008	23.06.2009	Rs. 1,209,909
178	KASARGODE	PHC Anandasharam	Rs. 1,500,000	15.04.2011	15.07.2011	Rs. 1,271,148
179	KASARGODE	PHC Cheemeni	Rs. 2,500,000	15.04.2011	15.09.2011	Rs. 2,118,850
180	KASARGODE	PHC Panathoor	Rs. 3,500,000	15.04.2011	30.08.2011	Rs. 2,735,250
181	KASARGODE	PHC Badiaduka	Rs. 2,000,000	15.04.2011	15.08.2011	Rs. 1,501,355
182	KASARGODE	PHC Moodbar	Rs. 1,000,000	15.04.2011	30.06.2011	Rs. 677,487
183	KASARGODE	PHC Panathady	Rs. 4,500,000	15.04.2011	30.08.2011	Rs. 3,044,933
184	KASARGODE	Kanhangad Nursing School	Rs. 15,417,604	22.3.2009	31.3.2010	Rs. 11,422,686
185	KASARGODE	CHC THRIKARIPUR	Rs:29,58,586	01.01.2008	04.02.2009	Rs. 2,649,462
186	KASARGODE	CHC PANATHODY	Rs:18,79,084	23.12.2008	20.01.2010	Rs. 1,185,610
187	KASARGODE	CHC NILESWARAM	Rs: 2510399	20.12.2008	28.04.2009	Rs. 2,103,849
188	KASARGODE	CHC BEDIADUCCA	Rs: 22,40,360	20.12.2008	24.10.2009	Rs. 2,026,006
189	KASARGODE	JPHN Kasargode	Rs. 2,313,190	08.01.2009	31.08.2009	Rs. 2,270,008

Sl. No.	DISTRICT	NAME OF INSTITUTION	AGENCY	Amount	Status
1	TRIVANDRUM	CHC PALODE	KHRWS	2400000	Completed
2	TRIVANDRUM	PHC Chenkal	LSGI	2100000	Completed
3	KOLLAM	CHC Kulathupuzha	KHRWS	2000000	Completed
4	KOLLAM	THQH Punalur	KHRWS	10000000	Completed
5	KOLLAM	PHC Paravoor (Fisheries Disp)	LSGI	1500000	Completed
6	KOLLAM	CHC Nedumgolam	PWD	4000000	Completed
7	PATHANAMTHITTA	CHC ADOOR	KHRWS	2000000	Completed
8	PATHANAMTHITTA	DH Kozhencherry	KHRWS	2190000	Completed
9	KOTTAYAM	PHC Poonjar	KHRWS	2000000	Completed
10	ERNAKULAM	CHC Kothamangalam	PWD	6000000	Completed
11	THRISSUR	THQH Kunnamkulam	KHRWS	5000000	Completed
12	THRISSUR	THQH Irinjalakuda	KHRWS	10000000	Completed
13	THRISSUR	PHC Andathode	LSGI	2500000	Completed
14	MALAPPURAM	THQH Perinthalmanna	KHRWS	5200000	Completed
15	MALAPPURAM	THQH Nilambur	KHRWS	5000000	Completed
16	KOZHIKKODE	CHC Feroke	KHRWS	12500000	Nearing completion
17	WAYANAD	GH Kalpetta	KHRWS	27000000	Nearing completion
18	WAYANAD	THQH Vythiri	KHRWS	10000000	Completed
19	WAYANAD	CHC Meenangadi	KHRWS	5000000	Completed
20	WAYANAD	THQ Sulthanbathery	LSGI	5000000	Completed
21	KANNUR	PHC Irikkur	LSGI	4000000	Completed
22	KASARAGOD	THQH Kasaragod	PWD	17000000	Completed

NRHM NEW WORKS (2012-2013)					
Sl. No.	DISTRICT	NAME OF INSTITUTION	Project cost	Status	Date of start
	B.4.1.1 Strengthening of District Hospitals/General Hospitals				
1	Palakkad	DH Palakkad	17250000	Work in progress	
2	Kannur	DH Kannur	31147868	Work started	27.10.2012
3	Kasaragod	DH Kanhangad	10000000	Tender under finalisation	
	B.4.1.5 Strengthening of Other Institutions - Women & Children Hospitals				
4	Kollam	W & C Kollam	70000000	Tender finalised	
5	Alappuzha	W&C Alappuzha	4200000	Tender under finalisation	
6	Kottayam	W&C Kottayam	3120000	Work started	22.10.2012
7	Idukki	W&C Idukki	6750000	Work tendered	
8	Palakkad	W&C Palakkad	5670000	DPR under preparation.	
9	Kannur	W&C Mangattuparamba	24278000	Work started	25.10.2012
	B.4.2. Strengthening of SDH, CHCs, PHCs				
10	Kollam	THQH Karunagapally	48750000	Tender finalised	
11	Wayanad	THQH Sultan Bathery	7500000	AS to be issued	
	B.5.1 New Constructions / Renovation – CHCs				
12	Kollam	CHC Pathanapuram	3465000	Work re tendered	
13	Kottayam	CHC Kumarakom	7500000	Tender finalised	
14	Kannur	CHC Pazhayangadi	3750000	Work tendered	
15	Kannur	CHC Kannapuram	1500000	Work started	11.10.2012
	B.5.2 New Constructions / Renovation – PHCs				
16	Malappuram	PHC Kurumbalangode	5000000	Work tendered	
	B.5.3 New Construction/Renovation of Govt. Dispensaries/Others				
17	Idukki	THQH Nedumkandam	9000000	DPR under preparation	
18	Idukki	THQH Vathikkudi	6750000	Work tendered	
19	Wayanad	THQH Vythiri	6750000	Tender finalised	
20	Wayanad	GH Kalpetta	7500000	Tender finalised	
	B.5.10.1 Strengthening of Existing Training Institutions				
21	Pathanamthitta	Training Institute, Thumpamon	4004512	Work tendered	
22	Thrissur	Training Institute, Thrissur	4140000	Tender finalised	
23	Kottayam	Training Institute, Kottayam	3780000	Tender finalised	
24	Idukki	Training Institute, Idukki	3200000	Work tendered	
	B.5.10.2 New Training Institutions				
25	Trivandrum	Training Institute, Trivandrum	4500000	Work tendered	
26	Alappuzha	Training Institute, Alappuzha	4500000	Work tendered	
27	Palakkad	Training Institute, Palakkad	4860000	DPR under preparation	
28	Malappuram	Training Institute, Malappuram	4680000	Tender finalised	
29	Kannur	Training Institute, Kannur	4500000	Work tendered	
30	Kasaragod	Training Institute, Kasaragod	4500000	Tender finalised	
	B.5.7 Major Civil Works for Operationalisation of FRUs				
31	Kollam	THQH Punalur	9000000	Tender finalised	
32	Kollam	THQH Kadakkal	5000000	Work started	04.11.2012
33	Thrissur	THQH Kodungalloor	3130000	Work tendered	
34	Malappuram	THQH Thirurangadi	40000000	Tender finalised	

NRHM SPILL OVER WORKS (2012-2013)				
Sl. No.	DISTRICT	NAME OF INSTITUTION	Amount	Status
	B.4.1.1 Strengthening of District Hospitals/General Hospitals			
1	Kottayam	DH Kottayam	21100000	Completed
2	Trivandrum	GH Trivandrum	56700000	In Progress
3	Ernakulam	GH Ernakulam	1971200	Completed
	B.4.1.5 Strengthening of Other Institutions - Women & Children Hospitals			
4	Ernakulam	W&C Mattancherry	23503079	Nearing completion
5	Kozhikode	IMCH	12630579	Completed
	B.4.2. Strengthening of SDH, CHCs, PHCs			
6	Trivandrum	THQH Neyyatinkara	9230000	Nearing completion
7	Kottayam	THQH Vaikom	15700000	Tender finalised
8	Ernakulam	THQH N.Paravoor	22700000	In Progress
9	Ernakulam	THQH Muvattapuzha	19633000	In Progress
10	Thrissur	THQH Wadakanchery	7425400	DPR under revision
11	Thrissur	THQH Kunnamkulam	5000000	Completed
12	Palakkad	THQH Mannarkad	6979000	Nearing completion
13	Palakkad	THQH Ottapalam	8378000	Work started
14	Malappuram	THQH Perinthalmanna	5200000	Completed
15	Wayanad	THQH Vythiri	10000000	Completed
16	Wayanad	THQH Kalpetta	27000000	In Progress
17	Ernakulam	THQH Perumbavoor	20659000	In Progress
18	Thrissur	THQH Irinjalakuda	10000000	Completed
19	Malappuram	THQH Nilambur	5000000	Completed
20	Kozhikode	THQH Feroke	12500000	Nearing completion
21	Kollam	THQH Punaloor	10000000	Tender finalised
22	Kannur	THQH Payyanur	46609608	In Progress
	B.5.1 New Constructions / Renovation – CHCs			
23	Trivandrum	CHC Nedumangad	9750000	In Progress
24	Alappuzha	CHC Muthukulam	2460000	Civilwork completed, Electrical & Plumbing wo sanctioned
25	Alappuzha	CHC Edathua	2250000	Civilwork completed, Electrical & Plumbing wo sanctioned
26	Wayanad	CHC Meenangady	5000000	Completed

NRHM SPILL OVER WORKS (2012-2013)				
Sl. No.	DISTRICT	NAME OF INSTITUTION	Amount	Status
	B.5.2 New Constructions / Renovation – PHCs			
27	Kannur	PHC Eramam kuttur	5000000	Completed
28	Kannur	PHC Kadannapally	1400000	Completed
29	Kannur	PHC Cheruthazham	5000000	Completed
30	Kannur	PHC Perunthatta	700000	Completed
	B.5.7 Major Civil Works for Operationalisation of FRUs			
31	Trivandrum	THQH- Chirayankizhu	4000000	Work partially complete
32	Trivandrum	THQH Nedumangad	1355000	Completed
33	Trivandrum	THQH Neyyattinkara	5843000	In Progress
34	Pathanamthitta	THQH Thiruvalla	2670000	Completed
35	Pathanamthitta	GH Adoor	4509000	Completed
36	Kottaym	THQH Kanjirapally	1492000	Completed
37	Kottaym	THQH Pala	2400000	DPR under preparation
38	Idukki	THQH Adimali	4750000	Completed
39	Idukki	THQH Thodupuzha	3764193	In Progress
40	Alappuzha	THQH Kayamkulam	4993000	Completed
41	Alappuzha	THQH Haripad	4869000	Completed
42	Alappuzha	THQH Chengannoor	4940000	Completed
43	Alappuzha	THQH Mavelikkara	3373400	Completed
44	Ernakulam	THQH Muvattupuzha	3000000	Completed
45	Ernakulam	THQH Perumbavoor	2902000	Completed
46	Ernakulam	THQH Angamali	2000000	DPR under preparati
47	Thrissur	THQH Vadakkanchery	2621500	Completed
48	Palakkad	THQH Mannarkad	2097000	Completed
49	Palakkad	THQH Ottapalam	2226000	Completed
50	Palakkad	THQH Chittoor	2060000	Completed
51	Palakkad	THQH Alathoor	2489000	Eye OT in progress
52	Kozhikode	W&C Kozhikode	2219711	Nearing complet..
53	Kozhikode	THQH Vadakara	7074764	Completed

ACTION TAKEN REPORT ON AUDIT OBSERVATIONS OF THE CAG ON NRHM FOR 2008-09

Para No	Audit Report	Factual Position / Action taken Report	Current Status
1.2.8.3	**Deficiencies in the selected institutions** During field visits to the selected institutions in the sample districts, the following deficiencies were noticed:		
	• The blood storage centre at theTaluk Headquarters Hospital, Ottappalam, Palakkad, for which Rs 1.55 lakh was spent during 2006- 07, had not started functioning due to the absence of a trained blood bank technician. Government stated (September 2009) that the technician would be given training shortly.	Both the Medical Officer as well as Blood Bank Technicians has since been trained.	Blood Storage Unit is fully functioning now. Instruction has been given to District Hospital Palakkad to supply blood to the storage centre.
	• An outpatient block completed in March 2009 at a cost of Rs 25.26 lakh for CHC, Kadampazhipuram, Palakkad was not fully utilized due to shortage of specialist doctors and paramedical staff. Government stated (September 2009) that the outpatient wing was currently functional and an attempt was being made for getting the services of specialist doctors.	Doctors and para medical staff have been provided	Additional / Assistant Surgeons are posted.
	• Equipment viz., incubators, suction		

	apparatus, etc., purchased in December 2008, at a cost of Rs 10 lakh for renovation of the children's ward at the Taluk Headquarters Hospital, Ottappalam, Palakkad was not utilised as of April 2009, due to lack of three-phase electrification. Purchases were made without ensuring availability of space and usability of the equipment. Government stated (September 2009) that action was under way for getting three-phase electrical connection to operate the equipment and that furniture and other items had been distributed.	Action Taken: Request givn to KSEB authorities for getting 3 phase connection through Nirmithi Kendra. Beds have already been purchased and cots are put in to use. All other furniture have been utilized for patient benefits in OP, Casuality. Wards, waiting area etc..	All equipment are working in the operation theatre of M C H block from August 25th 2012. All cots are being used and new bed purchased in May 2012 are being used in the newly constructed M C H block from August 25th 2012. Three phase electrical connection is established.
	• A hospital building for the Taluk Headquarters Hospital, Sulthan Bathery, Wayanad, constructed at a cost of Rs 1.75 crore (Rs 50 lakh from NRHM funds) had started functioning from June 2008. However, the operation theatre laboratory and Intensive Care Unit set up at a cost of Rs 34 lakh in October 2008 could not be made functional as of May 2009 due to shortage of staff. Government stated (September 2009) that staff had been posted under NRHM and the facilities were currently functioning.	Staff has been posted under NRHM and the facilities are functional. The Hospital is also trying for NABH accreditation.	

	• Non-posting of specialist doctors resulted in decrease of outpatients and non-utilisation of facilities viz., a fully equipped mini-operation theatre, labour room and an in- patient ward in PHC, Panamaram, Wayanad. Similarly, the operation theatre and labour room in CHC, Porunnannur, Wayanad was idling due to shortage of doctors. Government stated (September 2009) that efforts were being made to address the problem of shortage of doctors.	This is not a specialty hospital. One Pedatrician is now posted on working arrangement basis.	Two Assistant Surgeons are posted under NRHM for the smooth functioning of the hospital. Specialty Cadre is not implemented in this hospital.

1.2.8.6	***Deficiencies in upgradation of CHCs and PHCs compared to IPHS norms*** NRHM envisages bringing of health institutions at par with IPHS to provide round-the-clock services. In order to ascertain the facilities available, Audit obtained relevant information through questionnaires from 71 CHCs and 83PHCs from all the districts. Audit scrutiny revealed the following: • ***Manpower*** As per IPHS norms, seven specialists and nine staff nurses with supporting staff were required in each CHC. Forty nine CHCs did not have any specialists, while 21 CHCs had less than the prescribed Number of speciaists and only one CHC had the full complement of specialists. As regards staff nurses, nine CHCs had nine or more staff nurses, 57 had less than nine and four CHCs had no staff nurse. According to IPHS norms, each PHC was required to have a Medical Officer, three staff nurses, one Pharmacist and one Laboratory Technician. Ten PHCs did not have a full time Medical Officer. Eleven PHCs had three or more staff nurses, while 42 had less than three and 30 did not have any staff nurse. It was also decades ago, but against our goal of	**Factual Position:** The institutional surveys of 2008-09 in the public health institutions pointed out inadequacy of equipments, infrastructure and manpower as the critical factors preventing better health services from the hospitals. This is because the health care delivery system has remained fragmented and uncontrolled for decades, and the growing demand of the community for better hospital services makes it necessary that quality assurance mechanism is put in place in the State by all means. It is with end in view that the exercise of making corrections in the health sector is under the purview of the Mission, and in fact our focus is not just on merely assuring compliance with minimum acceptable standards, but to set forth a system of constant improvements in the hospitals so that commitment of the Government to improve the quality of patient care is translated into reality and create greater efficiency, accountable & responsible governance in hospitals. With this in view, the deficiencies in facilities and equipments mentioned in the audit report is being addressed. Only 115 CHCs were taken up for up-gradation and PHCs were not envisaged. Efforts under the Mission would take time, and overnight deficiencies cannot be removed. While it is able for the Mission to correct the imbalances in equipments and infrastructure, it would require some time horizon to set right the manpower gaps, because of scarcity of Doctors in the market. However every effort will be made to see adequacy of Doctors at the institutions. Similarly, excess staff nurses in some of the institutions may be viewed not against the ratio fixed decades ago, but against our goal of attaining a ratio of 1:4 (bed: nurses), Accordingly more than 1000 Nurses have been inducted in the public health system to improve maternal, newborn and child health and nutrition, combat infectious diseases including TB and HIV/AIDS and provide physical and mental health care in emergencies. **Action Taken:** Action is continuing to equip the institutions. The	

	attaining a ratio of 1:4 noticed that 79 PHCs did not have a (bed: nurses). Accordingly more than 1000 Nurses have Laboratory Technician, while 10 did not been inducted in the public health system to improve have a Pharmacist. Government stated maternal, newborn and child health and nutrition, combat. (September 2009) that every effort would infectious diseases including TB and HIV/AIDS and provide be made to ensure adequate number of physical and mental health care in emergencies doctors in the institutions and to fill up regular vacancies. ***Infrastructure*** NRHM envisages providing of 30 beds for in-patients in each CHC together with other facilities. Information furnished by 71 out of 115 CHCs revealed that 22 CHCs had bed strength in excess of 30 and 35 CHCs had bed strength less than 30. Fourteen CHCs did not furnish the relevant information. The number of CHCs out of these 71 CHCs, where infrastructural facilities were not available, are given in the following table: **Table 1.10: Non-availability of infrastructural facilities**	specialty cadre inducted in the health service system has changed the existing scenario and hence the supply of equipments and other items is now being revised based on the actual physical requirement. Regarding the manpower the Director of Health Services is being addressed to fill up the unfilled regular vacancies.	IPHS norms are not implemented in all the institutions. Action is being taken for the upgradation of institutions to the IPHS norm. For increasing manpower steps are being taken. 200 posts of Assistant Surgeons and 570 posts of Staff Nurses are being newly created in the department. The proposals for New creation of post of Pharmacist and Lab Technicians are under processing. Steps are being taken to provide blood storage units in all the institutions with deliveries.

Facilities not available	No of CHCs

<table>
<tr>
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<tr><td>Blood storage</td><td>70</td></tr>
<tr><td>BCG</td><td>60</td></tr>
<tr><td>Labour room</td><td>29</td></tr>
<tr><td>Operation Theatre</td><td>39</td></tr>
<tr><td>X-ray</td><td>62</td></tr>
<tr><td>24 hour emergency services</td><td>30</td></tr>
</table>
Source: Details collected through questionnaires from 71 CHCs

Equipment
According to IPHS norms, 1037 major types of equipment are necessary to make an operation theatre (0T) operational. Out of 32 CHCs which had operation theatres, 27 did not have even 50 per cent of equipment in the Ots.

Government stated (September 2009) that the deficiencies in infrastructural facilities and equipment pointed out by Audit were being addressed.
</td>
<td></td>
<td>Facilities surveys are being done in almost all the institutions and the gaps are being filled by providing necessary equipments.</td>
</tr>
<tr>
<td>1.2.
10.1</td>
<td>Maternal Health
The important services which ensure maternal health are antenatal care, institutional delivery, post-natal care and referral services. It is essential to register all the pregnant women before they attain 12 weeks of pregnancy and provide them with three antenatal check-ups, 90 or more iron-folic acid (IFA) tablets, two doses of Tetanus Toxoid (TT) and advice</td>
<td>To reduce maternal and infant mortality rates to 100 per lakh and 30 per thousand respectively by 2010, important services which ensure maternal health such as antenatal care, institutional delivery, post natal care and referral services are in place in the state. Registration of pregnant women before they attain 12 weeks of pregnancy is done and three antenatal check-ups are done. Iron Folic Acid tablets, two doses of Tetanus Toxoid (TT) and advice on the correct diet and vitamin supplements are given and in case of complications, they are referred for specialized gynecological care. The Junior Public Health Nurse prepares a micro birth plan at the</td>
<td>The current status is shown as seperate Annexure</td>
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</table>

	on correct diet and vitamin supplements. It is mandatory for a junior Public Health Nurse to prepare a micro-birth plan at the SC level for each beneficiary of the Janani Suraksha Yojana (JSY), containing dates of antenatal checkups and TTinjections, identification of the health centre for referral services, the place of delivery, expected date of delivery, etc. Audit scrutiny revealed that micro birth plans were not drawn up in any of the selected 24 Scs. •In the selected districts (Palakkad, Thiruvananthapuram and Wayanad), out of 5,14.139 pregnant women registered, only 4,30,156 received three antenatal check ups during 2005-06 to 2008-09. In these districts, there were no significant variations over the years in the number of pregnant women receiving three antenatal check ups. • Although all the pregnant women registered were required to be provided with IFA tablets for 100 days, shortfalls ranging from 16 to 44 per cent were noticed during 2005-06 to 2007-08. • During 2007-08 and 2008-09,	sub-centre level. The plan also includes collecting BPL or necessary proofs/certificates, and timely submission of the completed JSY formats in the health centre, arranging transport for the beneficiary to the nearest health care facility in case of any complication and ensuring availability of fund etc. Maternal Mortality Ratio in Kerala has been reduced to 95 from 110 as per Special Bulletin on Maternal Mortality in India (2004-06), published by Sample Registration System. Kerala has the lowest MMR compared with other states of India and for India it is 254.	

	Rs 23.95 lakh was disbursed to 7,985 beneficiaries in three Taluk Hospitals and two District Hospitals towards transportation cost under JSY, which was inadmissible. • The percentage of institutional deliveries of pregnant women registered at the hospitals in the selected districts ranged from 77 to 96 in Palakkad, 61 to 104 in Thiruvananthapuram and 85 to 89 in Wayanad.		
1.2. 10.2	**Immunization** **Routine immunization** The immunisation of a child against six preventable diseases, namely tuberculosis, diphtheria, pertussis, tetanus, polio and measles has been the cornerstone of routine immunisation in the State. During 2005-06 to 2007-08, the State had achieved 95 to 99 per cent success in pulse polio immunisation. However, immunisation in respect of other diseases showed wide variations ranging from 53 to 85 per cent in the test-checked districts during 2007-09. The targets and achievements of Diphtheria (DT) and TT immunisation carried out during 2005-09 are given in Appendix I.	Long periods of vaccine shortage occurred in 2007-08 and 2008-09 due to inadequate supply from Government of India. As far as shortfall in administering Vitamin A Solution is concerned, there was no Vitamin A solution supply from Government of India since 2007-08.	[illegible] Steps are being taken to procure vitamin A solution and other items in the RCH kit by NRHM through KMCL. (Kerala Medical Services Corporation Limited).

	As per information furnished by the Director of Health Services, during 2005-06 to 2008-09, 19,30,592 out of 22,13,479 children between the 0-1 age group were administered full vaccines viz. BCG, Measles, Diphtheria, Pertussis and Tetanus (DPT) and Oral Polio Vaccine (OPV), leaving 2,82,887 children uncovered. The percentage of fully immunised children was in the range of 85 to 88 per cent during the period and did not show significant variations. It was seen that DT coverage of children, above five years declined steadily during 2005-06 to 2008-09 from 94 to 60 per cent. TT to children of 10 years and 16 years also declined during 2005-06 to 2007-08, but showed an increase during 2008-09. Government stated (September 2009) that long periods of vaccine shortage occurred in 2007-08 and 2008-09 due to inadequate supply from GOI.		The Second booster DT is replaced by DPT. DPT can be given up to 7 years as per the revised schedule recommended by Govt.of India. Because of this there was a steady decline in the percentage of DT in children with age above 5.
	Shortfall in administering Vitamin A solution The RCH-II programme emphasizes administering of Vitamin A solution to all children below three years of age. Prophylaxis against blindness amongst children due to deficiency of Vitamin A requires the first dose at nine months of		Steps are being taken to procure vitamin A solution and other items in the RCH kit by NRHM through KMCL. (Kerala Medical Services Corporation Limited).

	age along with the measles vaccine, the second dose along with DPT/OPV and the subsequent three doses at six-monthly intervals. Scrutiny of records in the three test checked districts revealed a steady decline in the percentage of children supplied with all five doses during 2005-06 to 2008-09, the details of which are given in Appendix II. The main reason for the steady decline was the short supply of Vitamin A at health centres. Government stated (September 2009) that the shortfall in administering Vitamin A solution was due to stoppage of supply by GOI from 2007-08.		
1.2. 10.3	**Health Management Information System** As per NRHM guidelines a health information system is to be in place for facilitating the smooth flow of information and for effective decision making. The SHS purchased 1033 computers along with printers and UPS at a cost of Rs 3.64 crore for this purpose and supplied them to CHCs and PHCs in February 2008. The application software (MS Office 2007) was procured at a cost of Rs 1.06 crore during July 2008. The SHS adopted the following multiple	As per the essence of the NRHM Frame work, the state has made efforts in the right direction to put in a strong Health Management Information System (MIS) network in the state. Under IDSP monitoring for surveillance activities is in place. Further under the HMIS the Districts are being linked from the PHC level to the state level. Audit may note that the development of software for computer based HMIS to capture the health data from all the health institution is an exercise that involves development of application software and this has already been initiated. HMIS Software is not ready made software. The HMIS Implementation for State is taken up with specific objectives surrounding data reporting. The plan includes phasing out paper reporting with real time data reporting using DHIS 2 web application having customized FW reporting formats which is in tune with requirements at national level.	Using the computers purchased in CHCs & PHCs etc and using DHIS2 software, we are getting the data through online before 5th working day of every month. In DLHS2 the IDSP also have been Integrated with in this time. After proper scrutiny and verification. (updated HMIS data) are being forwarded to Government of India web portal positively by 5th working day of the following

software applications:

- Health Management Information System (HMIS) viz., DHIS 2 developed by M/s HISP India Limited, organisation working in collaboration with the University of Oslo, Norway.
- A dynamic web-based surveillance system for monitoring disease incidence for the Integrated Disease Surveillance Project on a weekly basis.
- A Geospatial Kerala Health Information System developed by the Kerala State Remote Sensing and Environment Centre for tracking thespread and frequency of diseases and
- An MS-excel based format for data collection on diseases on daily basis by the State Disease Control and Monitoring Cell.

All these applications were independently operated by various users despite requiring common data sets relating to health parameters for their operation.

Instead of integrating various vertically driven information systems to create a single window system for data entry and report generation, the SHS developed multiple applications with common modules that resulted

The Data reporting milestones Envisaged for State were-

- Paper reporting to continue till Mar 09
- From April 09 only reporting through DHIS 2 software shall be done down from peripheral sub centres

The HMIS Project implementation for Kerala State envisaged the following objectives:

1. Establishing State level server and Loading the HMIS (DHIS2) application on the server
2. Installing offline application in all reporting Health institutions
3. Setting up of district based systems for each of the 14 districts.
4. Training programs for State. district and block level Health staff

Likewise, the project is implemented keeping above objectives in mind and all milestones including objectives 1, 2, 3 and 4 are achieved before April 09 to realize data reporting from field. As a result, the GOI web portal now carries data for April, May 09 generated through the DHIS2 software as envisaged for entire State. The data for June 09 is nearing completion.

This effort is one of its kinds in the country and Gujarat is the only other State to take up Health facility level reporting also through the DHIS 2 software.

As far as IDSP data is concerned, routine reports from State/ Districts are generated and being reported (weekly basis) to GOI from the State Surveillance Unit. IDSP, under the supervision of Addl Director & State Surveillance Officer (PH).

It is envisaged to use DHIS 2 for reporting IDSP data from reporting institutions for better data quality taking advantage of internet connectivity in field and therefore the same is incorporated in the DHIS 2 software for reporting henceforth.

Continuing training and handholding support is envisaged through

month.

The quality of data is systematically reviewed in State as well as in Districts.

In the State from Health Information Cell (HIC), functioning under Demographer, one officer has been given the charge of one district to verify the quality of the data. On every 9th working day the quality / timeliness of the data is reviewed by Demographer, on 10th working day by Additional DHS (FW) in DHS Office.On 12th working day it is also reviewed in State level in District Statisticians meeting and last Wednesday of the month the Quality as well as progress of data is reviewed in Senior Medical Officers conference, before the Principle Secretary (H).

In Districts, HMIS data is reviewed by District Medical Officer (DMO), on 5th working day in their monthly meeting. In block level and PHC level also it is reviewed.

	in data redundancy, duplication in data entry and increase in the workload at all levels. The State Data Officer stated (July 2009) that action was under way to integrate the systems of the Integrated Disease Surveillance Project and the State Disease Control and Monitoring Cell with the SHS.	programs in districts for 17 days every month till end of project in 2010. Action Taken: From April 2011, Government of India is planning is launching DHIS 2 system, which is web-based system. Hardware and Software is being used. IDSP data will be integrated.	The data in DHIS2 / HMIS is being utilised for all planning purposes in State /District/Central Level. As we have stopped paper reporting of forms 6 to 10, in DHS, there is no other source for the data. GIS: - An amount of Rs 40 lakhs is also utilized to set up GIS in the state. The software is developed by Kerala State Remote Sensing Centre. The scheme is to implement shortly after certain modifications.
1.2. 10.4	**Integrated Disease Surveillance Project** The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect early warning signals of impending outbreaks and to help initiate an effective response in a timely manner. surveillance units were set up at the Central, State and district levels with linkages with all State headquarters, district headquarters and all government medical colleges on a Satellite Broadband' Hybrid Network. Data is collected on a weekly (Monday-Sunday) basis. Whenever there is a rising trend of illness, in any area, it is investigated by the Medical	Integrated Disease Surveillance Project (IDSP) is functioning, to detect early warning signals of impending outbreaks, and surveillance units have been set up, as planned. Necessary manpower as well hardware and accessories has been supplied to the units. However at the state level, there was some constraint of space in the Directorate to house the video conference unit, as there was no vacant space available in the Directorate or at the NRHM Office. After efforts some space was vacated and Video-Conferencing Unit has been set up. Audit may also note that the equipments such as Hardware and accessories were not lying idle as the same was used at the office of the Additional Director of Health Services (Public Health) for regular communication with the national level. **Action Taken: The unit is ready.**	

	Officers/Rapid Response Teams to diagnose and control the outbreak. Data analysis actions are to be undertaken by the respective districts. The total cost of the project was Rupees nine crore, of which GOI released Rs 4.82 crore up to 2008-09. The expenditure incurred on the project was Rs 2.74 crore. All the 14 District Surveillance Units (DSU) were supplied with hardware accessories costing a total of Rs 21.06 lakh. Civil works for videoconferencing units were also completed in the districts at a cost of Rs 19.60 lakh. Accessories were also supplied to State Surveillance Units (SSU) and seven medical colleges at a cost of Rs 33.76 lakh. Necessary manpower was also provided to all DSUs and SSU However, the videoconferencing unit at the State level had not been set up as of March 2009 as the Director of Health Services had not provided space for this. Consequently, hardware and accessories procured for Rs 54.82 lakh and the civil works executed at an expenditure of Rs 19.60 lakh, besides the manpower, remained idle. Moreover, the intention of the Government of detecting impending outbreaks and initiating an effective response could not be		

	achieved. Government stated (September 2009) that the video-conferencing unit would be set up as soon as the civil works were completed within two months' time.		

APPENDIX III

STATUS OF IMMUNISATION OF CHILDREN ABOVE FIVE YEARS

(Reference: Paragraph 1.2.10.2; Page: 35)

2005-06	511619	481521	94	511619	510971	100	511619	499793	98
2006-07	529720	412516	78	540674	351349	65	534042	381515	71
2007-08	510667	379557	74	499154	318494	64	500816	263749	53
2008-09	531867	321659	60	462923	392050	85	462412	333149	72

Source: Health Statistics brought out by the Director of Health Services every year

APPENDIX III (a)

STATUS OF ADMINISTRATION OF VITAMIN A SOLUTION TO CHILDREN

(Reference: Paragraph 1.2.10.2, Page: 35)

Palakkad	2005-06	48900	39435	81	37999	78	41564	86
	2006-07	47475	12222	26	11802	25	11767	25
	2007-08	47095	21742	46	22344	47	17044	36
	2008-09	47430	21523	45	18442	39	13955	29
Thiruvananthapuram	2005-06	59900	50061	84	49090	82	48042	80
	2006-07	60485	20698	34	19985	33	23700	39
	2007-08	61920	28010	45	27187	44	21355	34
	2008-09	57630	21305	37	20628	36	19108	33
Wayanad	2005-06	75180	13542	18	12498	17	12733	20
	2006-07	77480	4518	6	4132	5	7430	9
	2007-08	65418	8712	13	8428	13	5845	[illegible]
	2008-09	78125	7622	11	9237	13	7446	10

Source: Records of District Medical Officer of Health