THIRTY-SECOND REPORT

PUBLIC ACCOUNTS COMMITTEE
(2010-11)

FIFTEENTH LOK SABHA

NATIONAL RURAL HEALTH MISSION

MINISTRY OF HEALTH AND FAMILY WELFARE
(DEPARTMENT OF ECONOMIC AFFAIRS)

Presented to Lok Sabha on 23.3.2011

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LOK SABHA SECRETARIAT
NEW DELHI

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INTRODUCTION

I, the Chairman, Public Accounts Committee (2010-11), having been authorized by the Committee, of present this Thirty Second Report (Fifteenth Lok Sabha) on 'National Rural Health Mission' based on C&AG Report No. 8 of 2009-10 (Performance Audit), Union Government (Civil) for the year ending March, 2008 relating to the Ministry of Health and Family Welfare (Department of Health and Family Welfare).

2. The Report of Comptroller and Auditor General of India for the year ended March, 2008 was laid on the Table of the House on 18th December, 2009.

3. The Committee took evidence of the representatives of the Ministry of Health and Family Welfare (Department of Health and Family Welfare) on the subject at their sittings held on 15th July, 13th September and 27th October, 2010 and that of the Department of Ayush on 27th October, 2010. The Committee considered and adopted this Report at their sitting held on 18th March, 2011. Minutes of the sittings form Appendices to the Report.

4. For facility of reference and convenience, the Observations and Recommendations of the Committee have been printed in thick type in the body of the Report.

5. The Committee would like to express their thanks to the representatives of the Ministry of Health and Family Welfare (Departments of Health and Family Welfare and AYUSH) for tendering evidence before them and furnishing the requisite information to the Committee in connection with the examination of the subject.

6. The Committee place on record their appreciation of the assistance rendered to them in the matter by the office of the Comptroller and Auditor General of India.

NEW DELHI;
18 *March,* 2011
29 *Phalguna,* 1932 *(Saka)*

DR. MURLI MANOHAR JOSHI
Chairman,
Public Accounts Committee.

REPORT

PART I

I. INTRODUCTORY

With a view to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas of the entire country, especially to the poor and vulnerable sections of the population, the National Rural Health Mission (NRHM) was launched on 12 April, 2005 throughout the country with special focus on 18 States, *viz.* eight Empowered Action Group (EAG) States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand), eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices. The key strategy of the NRHM is to bridge gaps in healthcare 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, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programmes and Integrated Disease Surveillance Project. It also addresses the issue of health in the context of a sector wide approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health and advocates convergence with related social sector departments such as Women and Child Development, AYUSH and Panchayati Raj.

2. The mandate of NRHM is to provide health to all in an equitable manner through increase outlays, horizontal integration of existing schemes, capacity building and human resource management. The Mission envisages increasing expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2-3% of GDP over the mission period 2005—2010).

3. The main objectives of the NRHM are:

- Reduction in Maternal Mortality Rate (MMR) from 407 to 100 per 1,00,000 live births;
- Reduction in Infant Mortality Rate (IMR) from 60 to 30 per 1000 live births;
- Reduction in Total Fertility Rate (TFR) from 3.0 to 2.1 within 7 years period (2005—12);
- Universal accesss to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis;
- On services addressing women's and children's health and universal immunization;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;

- Access to integrated comprehensive primary health care;
- Population stabilization, gender and demographic balance;
- Revitalize local health traditions and mainstream AYUSH; and
- Promotion of healthy life styles.

Organisational Structure

(a) Central level

4. At the national level, NRHM, is led by a Mission Steering Group (MSG) headed by the Union Minister of Health and Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health and Family Welfare. The MSG was empowered to approve financial norms in respect of all schemes and components which were part of NRHM. The EPC had the flexibility to change financial norms approved by the MSG within a range of (+) 25 *per cent.* The MSG and the EPC were required to periodically monitor progress of the Mission. Besides, a Mission Directorate has been set up at the Central level for planning, implementation and monitoring of the mission activities and day-to-day administration. The directorate is headed by a Mission Director at the level of Additional Secretary to the Government of India.

5. Besides, the programmes of family welfare amalgamated into the NRHM such as the Reproductive and Child Health-II (RCH-II) and Immunisation—Routine and Pulse Polio are headed by the respective Joint Secretaries under the overall control of the Secretary, Health and Family Welfare. The various Programmes for disease control such as National Vector Borne Disease Control Programme, Revised National Tuberculosis Control Programme, National Programme for Control of Blindness, National Leprosy Eradication Programme, National Iodine Deficiency Disorder Control Programme and Integrated Disease Surveillance Project are administered through respective Programme Divisions headed by Director/Deputy Director General and function under the overall control of the Director General of Health Services. The disease control programme divisions were reporting to the Mission Director through their respective Joint Secretaries.

(b) State level

6. At the State level, the NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. The Activities under the Mission are carried out through the State Health Society (SHS), which was formed by integrated all the societies set up for the implementation of various disease control programmes. The Governing Body of the Society, headed by Chief Secretary/Development Commissioner of the State, meets at least once in every six months. The Executive Committee of the SHS, headed by Principal Secretary/Secretary, H&FW meets at least once in every month. For administrative convenience, the States may constitute Programme Committees for various National Programmes for more focussed planning and review of each activity. The State Programme Management Support Unit (SPMSU) acts as the Secretariat to the State Health Mission as well as the State Society and is headed by an Executive Director/Mission Director. The SPMSU has experts in technical areas like CAs, MBAs and MIS Specialists etc.

(c) Financing pattern

7.Funds are released by the Central Government to the States through two separate channels, *i.e.* through State Finance Departments and directly to the different Societies/ State Health Society (SHS). The funds routed through the State Finance Departments are released quarterly depending on the norms prescribed for various activities under these schemes, based on infrastructure available in the States.

8. The funds are provided to SHSs on the basis of approval of State Programme Implementation Plans (PIPs) by the Government of India. The States/UTs are required to reflect their requirements in a consolidated Programme Implementation Plan (PIP) having various sections for individual programmes under parts (a) RCH, (b) Additionalities under NRHM, (c) Immunisation, (d) Revised National Tuberculosis Control Programme (RNTCP), (e) National Vector Borne Disease Control Programme (NVBDCP), (f) Other National Disease Control Programmes (NDCPs), and (g) Intersectoral issues. During 2005-06 and 2006-07, hundred percent grants were provided to States. From the Eleventh Plan Period (2007-12) States are to contribute 15 *per cent* of the funds required. At the State and District levels, Financial Management Group (FMG) under respective Programme Management Support Unit (PMSU) is responsible for centralised processing of funds releases, accounting for the expenditure reported from the subordinate units, monitoring of Utilisation Certificates and audit arrangements. They are also responsible for collecting, compiling and submitting Statements of Expenditure (SOEs), Financial Management Reports (FMRs), UCs and audit reports from District Health Societies to SHS and from SHSs to GOI.

II. AUDIT REVIEW

9. The performance Review of implementation of the NRHM was conducted by the Audit during April-December 2008 in the Ministry of Health and Family Welfare, State health Societies (SHSs) of 33 States/UTs, District Health Societies (DHSs) of 129 districts and 2369 health centres at block and village levels covering the period from 2005-06 to 2007-08. The Audit Report [Report No. 8 of 2009-10 Union Government (Civil)] was tabled in the Parliament on 18th December, 2009. The purpose of undertaking the performance audit of the implementation of activities under the Mission is to highlight the positive trends and developments, while simultaneously pointing out possible areas of weakness or shortcomings in field-level operations that could hinder progress towards achivement of the Mission's overall goals.

10. The main objectives of Performance audit were to verify whether:

(i) The planning of the implementation of the Mission as well as monitoring and evaluation procedures at the level of Village, Block, District, State and Centre were oriented towards its principal objective of ensuring accessible, effective and reliable healthcare to the rural population;

(ii) There was adequate community participation in planning, implementation and monitoring of the Mission;

(iii) Convergence and regulation of the Mission activities with other departments, programmes and non-governmental stakeholders was ensured for achieving the broad objectives of the programme;

(iv) The public spending on healthcare increased to the desired level as envisaged in the Mission objective/vision. Also to acertain the assessment and release of funds in the decentralized set up and their utilization and accounting was prompt and adequate;

(v) Capacity building and strenthening of physical and human infrastructure at different levels took place as planned and targeted;

(vi) The procedure and system of procurement of equipment, drugs and services, supplies and logistics management were cost effective, effecient and ensured improved avialability of drugs, medicine and services.

III. PLANNING AND MONITORING OF THE MISSION

11. One of the major objectives of NRHM is decentralized planning. Under the Mission the District Health Societies (DHSs) were required to prepare perspective plans for the entire Mission period as well as annual plans consisting of all the components of the Mission. These were to be integrated into the State Perspective Plan and annual State Programme Implementation Plan (PIP) respectively. The NRHM focused on the village as an important unit for planning. However, realising the requirement of extensive capacity building to make villages capable of taking up a planning exercise, the Mission did not insist on village level plans for the first two years of its existence. Thus, Block Health Action Plans were to form the basis of the District Health Action Plan. Simultaneously, the Mission envisaged an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring.

(a) District Health Society (DHS) and District Health Mission (DHM)

12. The NRHM aimed to ensure that need based and community owned District Health Action Plans (DHAP) become the basis for further interventions. The DHAP was to be prepared by the DHS and approved by the DHM. A DHS was to be constituted in each district by amalgamating all existing district level societies engaged in implementing national level health and family welfare programmes. The governing and executive bodies of the DHS were to meet at least twice a year and once a month respectively.

13. Audit exmination has revealed that a DHM had been constituted in all districts of 18 States/UTs and a DHS had been formed in districts of all States/UTs other than Jharkhand, Orissa and Puducherry and uni-district UTs. The DHM had not been constituted in any of the districts of Andhra Pradesh, Bihar, Delhi, Jharkhand, Madhya Pradesh, Mizoram and Uttar Pradesh. This meant that decentralised planning, as envisaged in the Mission, was yet to be achieved in these States.

14. According to Audit the two bodies of the DHS met at the presecribed frequency only in Andhra Pradesh. The meetings of the DHS's governing and executive bodies were never held in any district of Himachal Pradesh and Puducherry. In Bihar, Manipur and Punjab the governing body had never met. In the remaining States, the meetings of these two bodies did take place intermittently and frequency was much less than

prescribed. In Jammu & Kashmir, the governing and executive bodies of the DHS were not constituted separately.

(b) Baseline surveys

15. Under the Mission, annual DHAP were to be prepared on the basis of preparatory studies, mapping of services and household and facility surveys conducted at village, block and district level, which would act as the baseline for the Mission against which progress would be measured. The Mission targeted to complete 50 *per cent* of household and facility surveys by 2007 and 100 *per cent* by 2008.

16. Audit review revealed that while household surveys were conducted in all villages of eight States/UTs (Chandigarh, Chhattisgarh, Dadra & Nagar Haveli, Daman and Diu, Manipur, Punjab, Sikkim and Tamil Nadu), these surveys were not conducted in 20 States/UTs, *viz.* Andaman & Nicobar Islands, Bihar, Delhi, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Karnataka, Lakshadweep, Madhya Pradesh, Meghalaya , Mizoram, Orissa, Puducherry, Rajasthan, Tripura, Uttarakhand, Uttar Pradesh and West Bengal as of October 2008. In the remaining States (Assam, Arunachal Pradesh, Andhra Pradesh, Gujarat and Maharashtra) surveys were conducted, but the coverage was incomplete/partial. Facility surveys at all levels of health centres were completed only in eight States/UTs (Chhattisgarh, Dadra and Nagar Haveli, Daman and Diu, Himachal Pradesh, Jammu and Kashmir, Manipur, Puducherry and Sikkim). Facility surveys were completed at the CHC and the PHC levels in Assam; at the CHC level in Kerala and Orissa; at the PHC level in Jharkhand and at the Sub Centre level in Tamil Nadu. In seven States/UTs (Andhra Pradesh, Bihar, Lakshadweep, Madhya Pradesh, Tripura, West Bengal and Chandigarh) facility survey had not been conducted for any health centre. In the remaining 12 States/UTs, the facility surveys were only partially complete. Further, data on conduct of facility surveys provided by the SHS could not be verified during audit in four States.

(c) Annual Plans

State and District Annual Plans

17. The NRHM framework stipulated that the Project Implementation Plan (PIP) for the State be prepared annually by the SHS by aggregating the DHAPs of each district. The National Programme Coordination Committee (NPCC) of the Ministry under the Chairmanship of the National Mission Director was to appraise the PIP and the representatives of the State and National Health Missions were to appraise district annual plans. The guidelines issued by the Ministry prescribed a time schedule for all the activities under the planning process.

18. However, Audit examination revealed that during 2005-08, the DHAP was prepared by all districts only in three States/UTs (Chhattisgarh, Chandigarh and Puducherry) while the annual district plan was not prepared by any district in nine States/UTs (Bihar, Daman and Diu, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Punjab, Tamil Nadu, Uttar Pradesh and Uttarakhand). In the remaining States/UTs, the district plan was not prepared by the most districts in 2005-06, but the situation improved by 2007-08.

19. When asked whether the Ministry has assessed the reasons for non-setting up of the DHMs and the DHSs in some of the districts even after a lapse of the three years of the Mission and how they propose to address this issue, the Ministry in a written note stated that they have been regularly monitoring the setting up of the District Health Societies and District Health Missions. They have also been monitoring the meetings held by the District Health Mission and the State Health Mission. The available data from the States indicate that constant monitoring of these key elements of the programme has helped in speeding up the progress. It is also a fact that in many States the District Health Societies *i.e.* the Executive Body meet regularly but the meetings of District Health Mission are not held regularly. The same had been brought out by the first Common Review Mission team and States were asked to take corrective action.

20. In their post-evidence reply, the Ministry have informed the Committee that as per the information available as on 30.06.2010, District Health Society has been formed in 634 districts out of total 642 districts. In the remaining 8 districts formation of the District Health Societies are not necessary as per the explanation provided by the State. At the commencement of implementation of the NRHM, the Ministry directed States/UTs to set up District Health Societies and the District Health Missions immediately.

21. To a specific query as to how does the Ministry monitor the preparation of District Health Action Plan (DHAP) & Block and Village annual Plan and whether these have been prepared for 2008-09 and 2009-10, the Ministry in a written reply stated as under:

> "The Ministry of Health and Family Welfare sends a communication to State Health Secretaries in the month of September-October each year to initiate the planning process in the States. The communication outlines the likely resource envelope for the State and the process to be followed in the preparation of District Health Action Plans. The process of Village and Block Health Plans has taken a little longer as the institutional arrangement of Village Health and Sanitation Committees had to be formulated within the framework of Panchayati Raj Institutions.
>
> All districts of the country have been preparing their District Health Action Plans regularly and the State Programme Implementation Plan draws upon the specific interventions suggested in the District Health Action Plans. States like Rajasthan and a large number of North East States formulated Village Health Action Plans in 2009-10. The process has been encouraged in other States as well. Once the resource envelope is indicated to the State Government, they are advised to indicate the district resource envelope for the coming year to enable prioritization in the preparation of District Health Action Plans. The State are now preparing District Health Action Plans on their own without dependence on external consulting agencies. State and District Level Programme Management units have developed capacity to prepare the District Health Action Plans. Detailed guidelines for planning for District Health Action Plans were issued in 2006. Revised planning

guidelines were issued again for the plan year 2010-11 to create a focus on identified 235 backward districts. Besides guidelines, training and capacity development for decentralized planning has been a priority capacity under the NRHM. The National Health System Resource Centre has facilitated training of district teams in decentralized planning. Thirteen modules developed by the Public Health Resource Network in this regard have been used in such programmes."

IV. MONITORING OF ACTIVITIES UNDER THE MISSION

Meetings of Mission Steering Group

22. The NRHM framework was approved by the Cabinet in July 2006, i.e. a year after the formal launch of the Mission. The Cabinet empowered the Mission Steering Group (MSG) to approve financial norms in respect of all schemes and components which were part of NRHM and allowed the Empowered Programme Committee (EPC) the flexibility to change financial norms approved by the MSG within a range of (+) 25 per cent. The MSG was required to periodically monitor progress of the mission and to meet twice a year. To review the progress, Secretaries (Health & Family Welfare) of four high focus States were to be nominated by the Ministry as members of the MSG for a period of one year each by rotation.

23. Audit scrutiny revealed that MSG, met only four times in four years, during 2005-09, instead of eight times as envisaged. The delegation of powers to the MSG and EPC was subject to the condition that a progress report regarding NRHM, also indicating deviation from the financial norms and modifications in ongoing schemes would be placed before the Cabinet on an annual basis. However, during the past four years, the Mission had submitted a progress report to the Cabinet only once in August 2008.

24. In their response, the Ministry stated that the empowerment of the MSG was received from the Cabinet in July, 2006 and since then the MSG had held four meetings till May 2009.

25. However, Audit contended that the order of 4 May 2005 establishing the MSG had stipulated that it would meet at least twice a year. The first meeting of the MSG was held on 30 August 2005 and only three meetings (in September 2006, July 2007 and August 2008) of the Group had been held since then, against the requirement of seven meetings up to May 2009.

26. Enquired about the reasons for not conducting required number of meetings of the MSG during 2005-09 and not placing the annual reports on progress under the NRHM before the Cabinet regularly, the Ministry in a written note submitted that the NRHM framework for implementation was approved in July 2006. The MSG had met as and when necessary to decide on issues placed before it and for taking stock on the progress under the mission. The decisions of the Mission Steering Group were earlier placed before the Union Cabinet in December 2008. Though Cabinet had mandated placing of the decisions of MSG every year it was felt that only after a substantive number of decisions have been taken by the Mission Steering Group, the matter can be placed before the Cabinet for its information. Since December 2008 two meetings of the

MSG have been held and a further cabinet note is in the process of finalization for placing the same for information of the Union Cabinet.

27. The Committee desired to know how did the Ministry could monitor the progress of Mission in the absence of holding requisite number of meetings of MSG. In response, the Ministry in a written reply stated that the progress is monitored through reports submitted by the State on regular basis as well State visits undertaken by Ministry officials. Besides the Mission Steering Group the Ministry annually conducts the Common Review Mission which visits 13-17 States every year for two weeks. The CRM review mission teams draw on members of MSG, Public Health experts, Civil Society experts etc. to visit two districts in each State and to give a feed back on identified 23-27 parameters of NRHM. Besides this, a regular physical and financial monitoring, through HMIS and through surveys like DLHS-3 etc. are undertaken.

28. The Committee enquired whether Central team of officials periodically undertake visits/inspections to the Village/Blocks and districts for evaluating the functioning of the mission at the gross root level; the number of inspections/tours conducted during the last 3 years alongwith the deficiencies that were noticed and the remedial/corrective action taken. In response, the Ministry in a written note stated as under:

"(a) Regional Evaluation Teams (RETs) located in the offices of Regional Directors, Ministry of Health and Family Welfare, Government of India at Lucknow, Patna, Kolkata, Chennai, Bangaluru, Bhopal evaluate the implementation of Health and Family Welfare Services provided in the States/ UTs under NRHM and also check the reliability of information relating to the performance of various health programmes. Field Survey Units (FSUs) of Central Bureau of Health Intelligence (CBHI) attached with the Regional Offices of Health and Family Welfare at Patna, Jaipur, Bhubaneswar, Lucknow, Bhopal and Bangaluru have also been partly associated along with RETs from 2009-10.

Each RET undertakes tour to districts allocated to them by the Ministry every month. During the evaluation work, the teams visit district head quarters and various health facilities like Community Health Centres (CHCs), Primary Health Centres (PHCs), Sub-Centres (SCs) and Urban Family Welfare Centres etc. The teams also cover acceptors of Family Planning (FP) beneficiary of Maternal and Child Health (MCH) Servies, Janani Suraksha Yojana (JSY) and also interact with ASHAs and Village Health and Sanitation Committee (VHSC) Members and community Members. A sample of beneficiaries is selected from the records/registers maintained by the Health Centres. The teams undertake both qualitative and quantitative assessment of beneficiaries.

Apart from above, review missions such as Joint Review Missions and Common Review Missions are undertaken to States/districts as a collaborative effort by multi-disciplinary teams of Government functionaries, public health experts, civil society members, and Development Partners to see the achievements made under the NRHM/RCH programme. The review missions provide inputs on several areas of progress such as infrastructure, human resources, institutional strengthening, programme management and community processes and these are used for planning and taking corrective action.

(b) The number of districts covered by the RETs during different years was as under:

Table 1

Year	No. of Districts
2007-08	82
2008-09	88
2009-10	116

(c) The reports of the RETs provide information on the functioning of various aspects of NRHM programme components like, functioning of ASHAs, Rogi Kalyan Samities, Village Health and Sanitation Committees, utilization of United Funds, Implementation of Janani Suraksha Yojana etc. The reports also provide information about the level of services rendered to the community and the utilization of facilities. The district-wise reports are prepared and circulated to the concerned State Government and the Programme Divisions for taking appropriate action. For wider availability of these reports to the stakeholders, the same are now uploaded on the NRHM website viz. *http://mohfw.nic.in/NRHM.htm.* The reports of the review missions are also available on the above mentioned Website.

The field visits and programme reviews over the last four years have highlighted the following major deficiencies in the States:

- **Human resources for health:** There is a huge shortfall in the number of human resources required and currently in position.
- **Governance:** Tenure of key officers, including Principal Secretaries, State NRHM Mission Directors, Directorate officials at the State levels, Chief District Medical Officers and Block Medical Officers, is not assured. This affects programme ownership and continuity of interventions.
- **Infrastructure:** The public health infrastructure needs strengthening in several States especially in the high load facilities in terms of patient friendly buildings, drugs, equipments and human resources.
- **Referral Transport:** Referral Transport services especially for mother and child need to be strengthened.
- **Tracking of Mother and Child:** Tracking of mother and child for RCH services is inadequate especially reasons for mother and infant deaths have not been recorded properly.
- **Monitoring and supervision:** Supervisory structures at the State and district level are weak. At many places, there is no mechanism for monitoring and supervision.

- **Public Private Partnerships (PPP):** Public Private Partnerships in RCH services is not up to the expected levels.
- **Decentralized Planning:** Decentralised planning capacities are inadequate, including capacity to utilise locally available data for district planning. Facility surveys have been carried out by most States; however these have not been systematically analysed to map out the resources and gaps, and prepare facility-wise micro plans for strengthening these facilities.

Remedial/corrective action taken:

Besides bringing the deficiencies gaps to the notice of the State Governments for remedial action the Ministry of Health and Family Welfare has initiated several new strategies to accelerate the pace of decline in MMR, IMR and TFR. These are the following:

- **Maternal and Child Health (MCH) Centres:** Ministry of Health and Family Welfare has identified 264 districts as backward districts which account for 32% of the country's population but nearly 60% of the IMR and 70% of MMR. Govt. of India is supporting these districts in identifying the delivery points/MCH centres (for basic and emergency obstetric management) for quality care during pregnancy, child birth and in post natal period and commensurate Family Planning Services, operationalization of these facilities alongwith rational deployment of existing manpower, training of doctors and specialists in these identified MCH centres/delivery points and providing funds for strengthening and upgradation of these centres.
- **Name Based Tracking of Pregnant Women:** Government of India has taken a policy decision to track every pregnant woman by name for provision of timely ANC, Institutional Delivery, and PNC alongwith immunization of the new born.
- **Maternal Death Review (MDR):** A decision has been taken to review every maternal death both at the health facilities and in the community through formation of MDR Committees at district level headed by the District Collector and a task force at State Level. The purpose of the review is to find the gaps in the service delivery which leads to maternal deaths and take corrective action to improve the quality of service provision.
- **Infrastructure strengthening:** Funds are being provided to the States for strengthening of public health facilities including renovations and new constructions, for drugs, equipments, and also for local action in the form of untied funds and Annual Maintenance Grants at each facility level.
- **Meeting the Human Resource shortfall:** Under the Mission, funds have been provided to the States to hire medical staff on contractual basis to bridge the shortfall in human resources. Apart from this, funds are also provided to the States for capacity building of the Medical officers and other staff in technical and programmatic areas.
- **Referral Transport:** In order to strengthen the referral transport services especially for the mother and child, funds have been provided to the States to

run various referral transport models as per their needs including Mobile Medical Units, Ambulance services, boat services and Emergency Transport System.

- **Differential planning and supportive supervision:** In order to accelerate the achievement of the UN Million Development Goals (MDG) goals, 264 backwards districts have been identified with special focus to reduce regional disparities and to fast track improvements in RCH outcomes by extensive district planning and ensuring supportive supervision through dedicated teams comprising officials of the Ministry of Health, development partners and professionals.
- **Annual Health Survey:** The Government of India has approved the annual health survey to study the impact of the schemes under NRHM in reduction of Total Fertility Rate (TFR), Infant Mortality Rate (IMR) at the district level and the Maternal Mortality Ratio (MMR) at the regional level and to prepare District Health profile of 284 districts in the erstwhile EAG States (States with poor RCH indicators) and Assam to assess progress of health indicators on an annual basis."

V. CONSTITUTION OF THE DISTRICT VIGILANCE AND MONITORING COMMITTEE FOR OVERSEEING THE FUNCTIONING OF THE MISSION

29. During the course of examination of the subject, the Committee desired that there is a need for a Vigilance and Monitoring Committee at the district level to be chaired by local Members of Parliament (MP) on the lines of District Vigilance and Monitoring Committee under the Ministry of Rural Development.

30. In response, the Secretary (Health) during evidence deposed as under:

> "I personally would feel that we find it very useful if such a Committee as in the Rural Development is constituted at the District level. We would take action straightaway in constituting a similar Vigilance Committee under the Chairmanship of the Members of Parliament. I think, it would strengthen our programme greatly because the more the Members of Parliament and the local representatives are engaged with health, it is only then we will be able to achieve our goals. There is no doubt or no dispute on that I would like to thank the Hon'ble Members for having brought this to our attention. It is an oversight that we have not adequately involved the Members of Parliament and we will do so straightaway. We will write to the Chief Secretaries and mark a copy of my letters to all the Members for their information."

31. The Ministry in a written note informed the Committee that the order constituting a separate District Vigilance and Monitoring Committee at district level to monitor the progress of implementation of NRHM have been issued on 15th Septemeber, 2010.

32. Taking cognizance of the order issued by the Ministry of Health and Family Welfare (Department of Health), the Committee, however, expressed the apprehension that unless the Ministry notifies that who are the Chairman of respective districts, the Vigilance Committee cannot come into existence.

33. In response, the Secretary (Health) during evidence stated as under:

"Sir, you said that you wanted us to follow the Rural Development example of naming. We have no problem, we will do it."

VI. COMMUNITY PARTICIPATION

(a) Community involvement under the Mission

34. NRHM envisaged involving Panchayati Raj Institutions and the community in the management of primary health programmes and infrastructure, empowering the community to take leadership in health matters, put in place a pool of community workers and establishing institutional arrangement for community involvement in planning, management and monitoring of the Mission through setting up community based Planning and Monitoring Committees at State, district, block, PHC and village levels.

(b) Village Health and Sanitation Committee

35. A Village Health and Sanitation Committee (VHSC) was to be formed in each village within the overall framework of the Gram Sabha. The VHSC was to be responsible for village level planning and monitoring. The Ministry had set the goal of constituting VHSC in 30 *per cent* of six lakh villages by 2007 and 100 *per cent* by 2008. Every village with a population of up to 1500 was to receive an annual untied grant of up to Rs. 10,000, after constitution and orientation of the VHSC. The untied grant was to be used for household surveys, health camps, sanitation drives, revolving fund etc. The Mission envisaged setting up of a revolving fund at village level by the VHSC for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization.

36. Audit review revealed that the progress towards formation of the VHSC showed the scope of improvement in the Special Focus States. In nine States/UTs, the VHSC had not been formed in any village. In Rajasthan and Uttar Pradesh the Committee was formed in less than 30 per cent of the villages. In 14 States/UTs, VHSCs were formed in 30 to 96 per cent of the villages.

37. Further Audit examination revealed that during 2006-07, untied grants of Rs. 123.62 crore was approved/released to 19 States whereas VHSCs were formed only in two States resulting in non-utilisation of Rs. 119.28 crore released to the SHSs for the VHSCs. Similarly, during 2007-08, Rs. 282.52 crore was approved/released as untied grants to the health societies of 28 States/UTs. However, no VHSCs were formed in eight States/UTs. The revolving fund was not created with VHSCs in any State, (except Sikkim and Manipur) due to delayed setting up of VHSCs and consequent delays in release of grants to them.

38. In their response, the Ministry have stated that they had issued detailed guidelines for VHSCs approximately two years back. However, the percolation of information and its implementation had taken time.

39. However, Audit contended that delay in percolation of information to the grass roots, indicated that the goal of improving the healthcare delivery by setting up

health societies at the State and district levels and orienting them to work in Mission mode met with limited success.

40. When asked whether the Ministry monitors constitution and functioning of VHSCs and disbursement of untied grants to them, the Ministry in their reply stated as under:—

> "The Ministry of Health and Family Welfare laid down the broad framework for constitution of Village Health and Sanitation Committees in the Framework for Implementation. They have been constituted by the States within the framework of Panchayati Raj Institutions. The untied grants to Village Health and Sanitation Committees are released to the State Societies which in turn provide the resources to Village Health and Sanitation Committees after their joint accounts are established. The setting up of joint accounts at Sub Centre and Village Health and Sanitation Committee level are monitored in the regular monitoring format of NRHM".

41. The Committee enquired about the number of VHSCs set up State-wise and the total amount disbursed by the States to them and also the current status with regard to release of untied grants to VHSCs by the respective States. In response, the Ministry in their written note stated as under:—

> "Each VHSC is provided an untied grant of Rs. 10,000/- per year. During 2010-11 an amount of Rs. 539.27 crore has been allocated to the States/UTs as untied grant to the VHSCs. The information about disbursal of funds to the VHSCs by the States is not reported. Only the actual expenditure incurred by the VHSCs is reported on quarterly basis through FMRs. During the first quarter of 2010-11 the expenditure reported by the VHSCs is Rs. 68.48 crore. 415213 VHSCs were constituted during 2008-09. The number increased to 494085 VHSCs in March 2010 which has further increased to 495653 as on 30.06.2010. Consequently there has been a corresponding increase in allocation of funds for the VHSCs."

42. When asked whether the Ministry have ever asked the State Health Missions to monitor and appraise the functioning of VHSCs, the Ministry in their note stated as under:—

> "It is submitted that the VHSCs exist under the District Health Mission. Accordingly there is a specific provision (Point IV) in the accountability clause of VHSCs which reads as under:
>
> > The District Mission in its meeting also through its members/block facilitators supporting ASHA [wherever ASHA's are in position] would periodically elicit information on the functioning of the VHSC, and issue the appropriate guidelines to improve their functioning.
> >
> > In the initial stage the emphasis was on ensuring constitution of the VHSCs and make them functional. The State Health Societies are duty-bound to ensure that District Missions ensure that VHSCs function in a manner that is best suited to the interests of the Mission. Keeping in view the interested elicited by the Honourable Committee in the matter the State Health Societies are having advised to develop more sohpisticated monitoring tools so that the performance of VHSCs could be more closely appraised."

43. Enumerating the findings of the joint mission which had conducted inspection regarding functioning of village health and sanitation Committees, the Ministry in their reply stated as under:—

"Functioning of Village Health and Sanitation Committees has been a focus area under the Common Review Mission of NRHM. The three Common Review Missions (CRM) conducted in 2007, 2008 and 2009 respectively under NRHM have observed that strengthening of Village Health & Sanitation Committee (VHSC) requires sustained effort. In the first CRM the progress on VHSCs had been reported as slow. In 2nd CRM it was observed that the constitution and the facilitation process need to be strengthened. In the 3rd CRM, it was observed that there is better utilization of VHSCs in many States. However improving the functionality of the Committees is now the central challenge in most States.

The mid-term review of Reproductive and Child Health programme held between September and December, 2008 had observed that the VHSC members are not fully aware of their roles and responsibilities and hence are hesitant to fully utilize the flexibility provided to them. They recommended for training/sensitization of the VHSC members and to establish procedures to periodically monitor their performance."

44. The Committee enquired whether the guidelines regarding composition and functioning of VHSC are followed by the Ministry both in letter and spirit. In response the Secretary (Health) during evidence stated as under:—

"To be very honest with you, we have got a survey done recently by the Institute of Population Sciences and yesterday they gave us a presentation. It is not a very happy picture on the village health societies. In many of them, people did not know it existed; they did not know who the members are; they did not know whether they are functioning; that was the finding of the Planning Commission's Mid-term review also, when they had gone round the country and seen..... That is VHND. There is certainly a vision in the NRHM when it was designed. That has not been fructified. We need to strengthen the community in taking responsibility for health. The vision is very good; we should continue to strive for it."

The witness further added:

"Our experience with Panchayat Raj is not good. They also complained about it. Half the fund is not spent because he is the co-signatory— either he is not living in the village or if he is, he harasses her and why should she sign? The entire panchayat raj system, with due respect, has not really worked; the ideal is one thing, but practically it is not; those who take interest, have got excellent experience; but those who are not interested, it is not good. It is very difficult for these people; it has not worked out well."

45. Enquired about the orientation training to the VHSCs the Secretary (Health) during evidence stated as under:—

"That is right. It is extremely weak; it is a fact that we have not done enough and we have to do more."

46. As regards release of funds to VHSCs against the receipt of Utilisation Certificates (UCs) for the previous year the Secretary (Health) during evidence stated as under:—

> "But the point that the hon. Member said that we should release against the UC of the previous year, that was for some reason, not done, in the belief that it is a small amount of money and we should continue to give; but we need to re-review our guidelines and insist on UC and much stricter guidelines should be given and we must invest money on training the community. There is this money and this money can be utilised for these purposes. So, I admit there has to be some social audit."

47. The Committee enquired as to how the Ministry ensure that the disbursal of funds by the States Health Societies to VHSCs is monitored. In response the Secretary (Health) during evidence stated as under:—

> "This is a huge task for the States. They are finding it very difficult to keep a track of so many small accounts. But we have given them an accountant at every block level. In a block there will be some 100 VHSCs. He should have been able to get these accounts and see what they have spent it on and do the auditing. We will have to streamline it further and get them to do the auditing. But we suspect about almost Rs. 100-200 crore lying unspent. That is our present assessment."

VII. EXPENDITURE ON HEALTH CARE

(a) Public spending on healthcare

48. The Mission aimed to annually increase allocation by the Central Government for the health sector by 30 per cent up to 2007-08 and by 40 per cent from 2009-10. State Governments were also required to increase their allocation on health by 10 per cent annually during the Mission period. The NRHM also aimed at strengthening the financial management structure and accounting systems so as to conform to best practices and meet accounting and auditing standards, at all levels.

49. Details of increase in expenditure/allocation on healthcare by the Ministry and the States was as under:

Table 2

Year	Union Government*		State Government#		Total Union and State Government	
	Expenditure	Per cent increase over previous year	Expenditure	Per cent increase over previous year	Expenditure	Per cent increase over previous year
2004-05	8086.46		18771.00		26857.46	
2005-06	9650.24	19.34	22031.00	17.37	31681.24	17.96
2006-07	10948.24	13.45	25375.00	15.18	36323.24	14.65
2007-08	14410.37	31.62	31567.00(RE)	24.40	45977.37	26.58
2008-09	18476.00(RE)	28.21	36961.00(BE)	17.09	55437.00	20.57

**Source*: Government of India Budget Documents

#Source: State Finances: A Study of Budgets of 2008-09 (Reserve Bank of India)

50. As per the information furnished by the Ministry, the proposed outlay, budgetary allocation made and the actual amount spent under the National Rural Health Mission since the inception of the Scheme till 30.06.2010 is as under:

Table 3

Statement showing the fund availability under National Rural Health Mission

(Rs. in crores)

Sl. No.	Financial Year	Proposed Outlay	B.E.	R.E.	Release	Expenditure
1.	2005-06	7284.85	7189.20	6637.82	6286.48	4873.12
2.	2006-07	9122.50	9000.00	7951.08	7486.59	6146.68
3.	2007-08	12866.62	10890.00	10668.61	10380.25	8655.43
4.	2008-09	15448.56	11930.00	11930.00	11200.52	11839.49
5.	2009-10	17654.86	13930.00	13377.75	13261.90	14263.89
6.	2010-11	19989.00	15440.00	14960.45	12357.89	7832.96*
		82366.39	68379.20	50565.26	52823.06	

Note: The release figures for 2010-11 are up to 28.02.2011 and the expenditure figures are up to 31.12.2010. Expenditure given for 2010-11 is provision and does not include kind grant.

51. The revised figures with regard to budget estimates/revised estimates in respect of NRHM for the financial year 2010-11 (upto 31st October 2010) is given as under:—

Table 4

(Rs. In crores)

Sector	2010-11	
	Budgetary Estimates	Releases as on 31st October 2010 (Prov.)
National Rural Health Mission (NRHM)	15440.00	7451.64

52. In a written note furnished to the Committee the Ministry have explained that the budget estimate figure in respect of NRHM programmes for the year 2010-11 is Rs. 15440 crore. The Revised Estimates proposed is Rs. 17151.92 crore but the same not been agreed to as yet. The release of funds made upto 31st October, 2010 is Rs. 7451.64 crore. As the expenditure reports are received on a quarterly basis, the expenditure figures are available up to the end of second quarter ending 30th September, 2010. Accordingly, the expenditure reported by the States as per quarterly Financial Management Reports (FMRs) upto 30th September, 2010 is Rs. 4854.54 crore.

53. The Committee desired to know about the estimated/projected expenditure for meeting the targets in respect of various components under NRHM *viz*. Infrastructure, Human Resources and Research etc. for the next 5 years. In response the Ministry in a written note have furnished the following information:—

"For working out the future requirement, *i.e.* the last year of the Eleventh Five Year Plan and the Twelfth Five Plan, two alternate scenarios have been attempted. These are briefly described in the following paragraphs.

Scenario I:

The percapita expenditure/allocation by the Central Government under NRHM has increased by an average of nearly 15 percent per annum in nominal terms since its inception. The per-capita allocation for the year 2010-11 works out to around Rs. 186 which is close to about Rs. 15.5 per month. Keeping in view the requirements of NRHM, as projected in Eleventh Five Year Plan and relatively much lower allocations, as well as keeping in view the overall budgetary constraints, it is assumed that an overall increase of 30% (nearly double the trend) would not be too unrealistic for the terminal year of the Eleventh Plan, though the requirement could be much larger. This implies that the per-capita allocation of Rs. 240 per annum or Rs. 20 per month. Multiplying this by the projected rural population of the country, it is estimated that around Rs. 20150 crore would be required in the terminal year of the Eleventh Five Year Plan *i.e.* 2011-12, as against allocation of Rs. 15440 crore in 2010-11. It may be mentioned that this is the minimum requirement of funds for the year 2011-12. Keeping in view the backlog of infrastructure facilities and manpower requirements, as well as insufficient funds provided in the previous years, greater amount of funds could be required.

For the Twelfth Plan, the following assumptions are made to estimate the requirement of funds for NRHM;

(i) It is assumed that the economy will grow at 9% per annum, as in the absence of firm projection of growth rate for Twelfth Five Year Plan, it is assumed that targeted growth rate for Eleventh Plan would continue to remain the same in the Twelfth Plan,

(ii) With an assumption of inflation of 6 percent per annum, and

(iii) Elasticity of 1.3 of health expenditure with respect to income.

Given these assumptions, the nominal percapita allocation would need to increase by around 20 per cent per annum in the Twelfth Five Year Plan. This would imply that the per capita allocation on NRHM will have to increase from Rs. 240 in 2011-12 to around Rs. 600 in 2016-17. Given this, and the projected rural population of around 88 crore, the fund requirement of NRHM would have to increase from around 20150 crore in 2011-12 to Rs. 52500 crore in 2016-17. The total requirement for Central sector allocation for NRHM for the Twelfth Plan in nominal terms in thus estimated to be around Rs. 186,000 crore.

Scenario II:

As per the estimates available from World Health Statistics, brought out by the World Health Organization (WHO), the percapita public expenditure on health in India was estimated to be $7 for the year 2006. In the absence of information of its rural/urban break up, it is assumed that this expenditure is same for rural and urban areas. This expenditure is one of the lowest in the world and requires significant step up. However, it would be difficult to achieve a step up to the level of China (US $38 percapita) in the near future. Other countries like Malaysia, Thailand, etc. have higher percapita public expenditure. Even to achieve Sri Lanka's level of US $30 may be difficult. However, the percapita expenditure of Philippines was $17 which could be feasible to achieve by 2016-17, *i.e.* by the end of Twelfth Plan. Assuming an exchange rate of Rs. 46.5 per US $, the percapita requirement of public allocation by the Central Government for NRHM works out to around Rs. 792 in 2016-17. The requirement for the remaining years of the Twelfth Plan is interpolated. Given the projected rural population, the fund requirement for the Twelfth Plan is worked out. It may be mentioned that the requirement for Central sector allocation for Twelfth Plan works out around Rs. 2,25,000 crore for NRHM. The requirement for terminal year of the Twelfth Plan *i.e.* 2016-17 works out around Rs. 70,000 crore."

54. According to the Ministry the requirement of funds for NRHM, thus estimated in both the aforesaid scenarios on an annual basis which are necessarily indicative is as under:—

Table 5

Allocation Required for Brhm in 2011-12 and Twelfth plan (2012-17) - *The Two Scenarios*

(Rs. in crore)

Sl.No.	Year	Scenario I	Scenario II
A.	2011-12	20150.00	20150.00
B.	Twelfth Plan (2012-17)	185700.00	224930.00
1.	2012-13	24410.00	25850.00
2.	2013-14	29600.00	33110.00
3.	2014-15	35820.00	42090.00
4.	2015-16	43360.00	5433.00
5.	2016-17	52510.00	69550.00

55. However, the Ministry have clarified that actual utilization of the funds allocated shall depend upon a number of factors in particular the absorptive capacity of the system. In fact, one of the arguments put forward by many is that while the actual

allocation in the Eleventh Plan was lower than the original plan allocation, the actual expenditure has still been lower, *i.e.* the system has not even been able to utilize the curtailed outlay. The question of absorptive capacity could be crucial even in the Twelfth Plan though the level of utilization has gone up considerably over the last five years.

56. The per capita expenditure on National Rural Health Mission (NRHM) from 2005-06 onwards as furnished by the Ministry if shown as under:—

Table 6

(Rs. in crore)

Year	Allocation	Expenditure	Rural Population (in crore)	Per Capita Expenditure (in Rs.)
2005-06	7189.20	6286.48	78.15	80.44
2006-07	9000.00	7486.59	79.08	94.67
2007-08	10890.00	10380.40	79.99	129.77
2008-09	11930.00	11260.18	80.88	139.22
2009-10	13930.00	13377.75	81.76	163.62
2010-11	15440.00		82.62	186.88

57. During the evidence held on 13th September, 2010, Secretary (Health) deposed that presently the Public Expenditure on health is 1.1 percent of GDP. The Secretary further stated that as per World Health Organisation (WHO) norm everyone (country) should spent atleast 5-6 percent of GDP on health, out of which three-fourths should be Public Expenditure.

(b) Absorptive Capacity of the NRHM

58. The Committee desired to know the efforts made by the Ministry to increase the absorptive capacity of the NRHM given the fact that while the actual allocation in the Eleventh Plan was lower than the original plan allocation, the actual expenditure has still been lower. In response, the Ministry in the written reply have stated as under:—

> "Over the years the absorptive capacity of the States have increased as would be evident from the increasing level of utilisation of funds under National Rural Health Mission. Programme management structures have been considerably strengthened with setting up of programme management units at State, district and block levels. These units provide managerial support to the health personnel in planning and execution of health and family welfare programmes.
>
> The annual planning process at district and State levels is also facilitated by issuing detailed guidelines. Support of the National Health Systems Resource Centre and State Health Systems Resource Centres are provided for facilitating

the decentralized planning. During the planning and monitoring process, resource persons also visit the States and districts to facilitate analysis of the current situation, expenditure levels, implementation of programme activities etc. for identifying gaps and initiate appropriate remedial measures.

The finance and management structure have also been strengthened. The Financial Management Group of the Ministry has been regularly interacting with the State finance and accounts personnel to build their capacity for improved financial management. The flow of funds has also been streamlined through electronic transfer to avert delays. Strengthening the monitoring process the regular financial management reports and regular review with State officials have facilitated in expediting utilization of funds and increasing the absorting capacity of the States.

In the case of programmes relating to communicable diseases constant dialogue with states to fill up vacant posts, sanction of additional posts to strengthen the disease control and surveillance set up also helps to implement the programmes more effectively as they absorb more financial assistance from the Central Government."

59. When asked whether the Union Minister of Health and Family Welfare have held any meetings with the State Health Ministers to impress upon the States the need to increase their spending, the Ministry in the written reply have stated as under:—

"Yes, Conference of Central Council of Health and Family Welfare (CCH&FW) was held under the chairmanship of HFM on 30th August, 2010. It stressed the need for increased fund allocation by both Centre and State to accelerate the improvement in the health status of the population."

60. While expressing concern over the poor budgetary allocation to the health sector by the Government the Committee enquired whether the Ministry have taken up the matter with Planning Commission and Finance Ministry. In response the Secretary (health) during evidence stated as under:—

"Every year we go back and when the NRHM was made, we projected more than Rs.one lakh crore as the requirement to implement the NRHM vision. So far, in the last four years that we have been implementing, we have got less than Rs. 50,000 crore. So, we have not got the money that we have been asking from the Planning Commission. That is one problem and we have been assured that next year the deficit would be made up and they would given us a higher allocation of money."

The witness added:

"From the Health Ministry side, we have done our maximum best to try and convince the Planning Commission that we need more resources. I think the Planning Commission is also convinced and said that next year they will give us 37 per cent more than what we are getting this year."

(c) States' contribution to NRHM from their own resources/budget

61. As per NRHM framework, during the 11th Five Year Plan (2007-12), States were to contribute 15 per cent of the funds requirement of the Mission.

62. Audit review revealed that during 2007-08 only 4 States/UTs (Andhra Pradesh, Bihar, Gujarat and West Bengal) made the desired contribution of 15 per cent of State PIP from their own budget. Six States/UTs (Assam, Chhattisgarh, Haryana, Rajasthan, Sikkim and Chandigarh) also contributed to the NRHM from the State/UT budget, but their contribution remained between 0.54 to 13.59 per cent. The remaining 18 States/ UTs (Arunachal Pradesh, Jharkhand, Himachal Pradesh, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Punjab, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand, A&N Islands, D&N Haveli, Lakshadweep and Puducherry) did not contribute at all the NRHM from their own budget during 2007-08. The Ministry too did not insist on the States/UTs contribution during 2007-08.

63. The Ministry in their response to Audit observation stated that since 2008-09, the States were directed to transfer the 15 per cent State share to the State Health Societies from the State funds.

64. However, Audit contented that the reply of the Ministry should be viewed in the context that the direction for States to contribute their share for funds for the Mission was already a part of the NRHM framework for implementation. Even in 2008-09, State/UT Governments of Manipur and Lakshadweep did not make any contribution while the contribution made by Arunachal Pradesh, Assam, Bihar, Chandigarh, Dadra and Nagar Haveli, Daman and Diu, Delhi, Goa, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Maharashtra, Meghalaya, Orissa, Puducherry, Punjab, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand and West Bengal (24 States/ UTs) was less than 15 per cent.

65. The Committee enquired whether the Ministry link the release of Central grants to the SHSs with the actual contribution by the State/UT Governments. In response the Ministry in the written reply as stated as under:—

> "In 2007-08 of NRHM many of the States were not having a separate budget line for NRHM and therefore, States contributed funds directly through the treasury route. The Ministry has been regularly following up with the all States for their 15% contribution of the State share and States have begun contributing their share. During the year 2008-09, 25 out of 35 States contributed 68.75% of the total State share requirements and in FY 2009-10, 34 out 35 States had contributed 79.28% of funds due towards State contribution. Linking the Central release to release of State share was not done earlier to ensure that the health system does not suffer a setback on account of non-availability of funds. All States have been requested to meet the shortfall in their contribution on earlier years and release State share for the current year."

66. Elaborating further on the issue of States contribution to NRHM, the representative of the Department of Health during their evidence held on 13-09-2010 has stated as under:—

> "One point was mentioned about the State's contribution. In fact, we had mentioned in the presentation also that there are deficiencies in some of the States because from 2005-06 to 2006-07, there was no State contribution involved. In 2007-08, the State contribution started. In 2007-08 it was said that there was no separate budget

to contribute to the society. So, they made a provision in the budget for that. But from 2008-09 to 2009-10, each State is releasing money to the State societies. Sir, there have been deficiencies.

In fact, we had pointed this to all the State Governments and this year we have clearly indicated that further release of instalment will be dependent upon meeting the full contribution. There are deficiencies ranging from five per cent to more than 50 per cent among the State Governments. We have very categorically indicated that this year they must fulfil the backlog and then only we will release the second instalment of funds for that."

(d) Out of Pocket Expenditure on Health by the Households

67. Noting that out of pocket expenditure on health incurred by the households constituted around three-fourths of the total expenditure in the health sector, the Committee desired to know the impact NRHM made in reducing the same particularly with reference to expenditure incurred on medicines and doctors consultation etc. In response, the Ministry in a written reply stated as under:—

"As per the National Health Accounts India 2004-05 (with Provisional Estimates from 2005-06 to 2008-09), the Total Out of Pocket Expenditure (TOPE) constitutes the expenditure incurred by the households, social insurance funds, firms and NGO. Out of pocket expenditure accounted for 78.05% of the total expenditure in health sector in the year 2004-05 and 71.62% in the year 2008-09 there by showing a slight decline. The break-up of TOPE in terms of rural and urban is not available. However, the break-up of household expenditure in terms of rural and urban is available in the report which is estimated from the information contained in the report entitled "Morbidity, Health Care and the Condition of the Aged" [NSSO 60th Round (January-June 2004)] and excludes the expenditure on insurance premium paid to the public and private insurance companies. The expenditure by households on health has been estimated for the time period 2004-05 to 2008-09, separately for the rural and urban areas. These are reported in the table below:

Table 7

Share of Rural and Urban Household Expenditure as a % of Total Out of Pocket Expenditure

(Rs. in crores)

Year	Total Out of Pocket Expenditure	Household Expenditure			Household Expenditure (%)		
		Rural	Urban	Total	Rural	Urban	Total
2004-05	104413.59	57898.89	35101.43	93000.32	55.45	33.62	89.07
2005-06	115000.52	63768.24	38659.75	102427.99	55.45	33.62	89.07
2006-07	127840.57	70232.58	42578.86	112811.44	54.94	33.31	88.24
2007-08	142690.24	77352.23	46895.10	124247.33	54.21	32.86	87.07
2008-09	157393.54	85193.62	51648.97	136842.59	54.13	32.82	86.94

It may be observed that rural households account for around 55% of the total out of pocket expenditure within the country.

(i) The increase in the coverage of pregnant women from backward classes and low income groups for institutional delivery, as delineated below, had the connotation of reduction of out of pocket expenditure;

Table 8

Category of Women	Percentage in 2005-06 (as per NFHS-III)	Percentage in 2007-08 (as per DLHS-III)
Scheduled Castes	32.9	41.9
Scheduled Tribes	17.7	32.5
Other backward Classes	37.7	47.8
Lowest Wealth Index	12.7	19.1

(ii) In addition drugs and medicines provided free at the CHCs, PHCs and Sub-centres under the NRHM also helped to reduce the out of pocket expenditure of rural households."

VIII. CAPACITY BUILDING OF PHYSICAL AND HUMAN INFRA-STRUCTURE

68. The NRHM aimed to bridge gaps in the existing capacity of rural health infrastructure through revitalization of existing physical and human infrastructures. The mission also aimed to generate management capacity at entry level of implementation of the mission by creating a large pool of community health workers to act as an interface between the health centre and the rural population.

(i) Hygiene and Sanitation at Health Centres

69. Audit examination revealed that a large number of health centres were functioning in unhygienic conditions due to various infrastructural deficiencies. In many cases, the centres were functioning in an unhygienic environment since they were located in the close vicinity of garbage dumps, cattle sheds, stagnant water bodies or polluting industries. Audit checks also revealed that many health centres lacked essential infrastructure *viz.,* water supply and storage tanks; sewage disposal facilities; disposal facilities for bio-medical waste and separate utilities for men and women. The details are given as under:

Table 9

Status of hygiene and sanitation at sample health centres

Infrastructural attributes	Sub Centres			PHCs			CHCs		
	Number	Per cent	State/ Uts involved	Number	Per cent	States/ Uts involved	Number	Per cent	States/ Uts involved
Substandard environment	159	12	21	69	10	16	24	7	10
Poor cleanliness	322	24	22	91	13	15	25	8	10
Lack of separate utilities for men and women	1108	81	28	431	63	26	102	32	22
No arrangement for water supply	529	39	27	120	17	18	14	4	6
No infrastructure for water storage	1008	74	28	287	42	24	60	19	15
No sewage disposal facility	668	49	18	241	35	23	58	18	13
No facility for disposal of bio-medical waste	1000	73	28	332	48	21	142	42	20

(*Source*: Information collected from health centres)

70. Audit scrutiny also revealed that there was a wide inter-State as well as inter-level variation in hygiene awareness and facilities. While, health centres at Sikkim, Daman and Diu, Uttarakhand, Tamil Nadu, Puducherry, Manipur, Lakshadweep, D & N Haveli, Andhra Pradesh and A & N Islands maintained a relatively acceptable level of hygiene with deficiency in only a few determinants of sanitation; hygiene at many of the health centres of Bihar, Karnataka, Madhya Pradesh and Orissa was poor. Further, while CHCs in almost every State had maintained a certain minimum level of sanitation, the condition at Sub Centres was not up to a minimum standard.

(ii) Staff Availability and Depolyment

(a) Sub Centres

71. Under the NRHM each Sub Centre was to be run by two Auxiliary Nursing Midwives (ANM, female) and a Multipurpose Worker (MPW, male). The Mission aimed to ensure two ANMs at 30 per cent Sub Centres by 2007 and 60 per cent by 2008 with the second ANM being appointed on a contract basis. While the ANMs were to be paid out of central grants, the MPWs were to be paid by the State Government.

72. Audit review revealed that 116 Sub Centres (9 per cent) in 20 States/UTs were functioning without an ANM. At 992 Sub Centres (77 per cent) of 29 States/UTs two ANMs were not posted and in Himachal Pradesh, Karnataka, Madhya Pradesh, Manipur, Meghalaya, Sikkim, Tamil Nadu, Uttar Pradesh, West Bengal and Lakshadweep none of Sub Centres had two ANMs. The deployment of MPWs was inadequate and 775 Sub Centres (60 per cent) of 27 States/UTs had no MPW. In Bihar, Uttar Pradesh,

Lakshadweep, Chandigarh and Puducherry none of the test checked Sub Centres had an MPW. In contrast, in Meghalaya, Mizoram, Sikkim and Daman and Diu all the tested Sub Centres had an MPW.

(b) Primary Health Centres (PHCs)

73. The PHC was the first point of interaction of the rural population with a doctor and was to be manned by a medical officer. Besides, the Mission aimed to provide an AYUSH doctor at each PHC on contract basis. Since the NRHM aimed to run the PHCs on 24x7 basis, three staff nurses were to be appointed at each PHC (at 30 per cent PHCs by 2007 and 60 per cent by 2008). Support para medical staff such as Nursing Mid-wife, Pharmacist, Lab Technician and Lady Health Visitor were also to be appointed at the PHCs.

74. Audit examination revealed that 71 PHCs (11 per cent) in 15 States were functioning without an allopathic doctor. In 518 PHCs (86 per cent) of 28 States/UTs an AYUSH doctor had never been appointed. 69 test-checked PHCs were functioning without an allopathic doctor or an AYUSH doctor. This meant that population residing in their sphere of coverage had no doctor available at all in the public domain. In Andhra Pradesh, Haryana, Himachal Pradesh, Kerala, Madhya Pradesh, Mizoram, Punjab, Sikkim, Tripura and Lakshadweep none of the test checked centres had an AYUSH doctor.

(c) Community Health Centres (CHCs)

75. The NRHM aimed to develop the Community Health Centres as the First Referral Unit for the rural population by providing seven specialist doctors and nine staff nurses under the IPHS (30 *per cent* by 2007 and 50 per cent by 2009). Support staff such as pharmacist and lab technicians were also to be provided at the CHCs.

76. According to Audit availability of specialist doctors at the CHCs was very low at the test-checked CHCs. As regards availability of nine staff nurses (two of whom might be ANMs), 245 CHCs (81 per cent) of 25 States/UTs did not have the full strength of nurses, out of which 145 CHCs (48 per cent) of 23 States/UTs did not have even five staff nurses. Further, 14 CHCs (5 *per cent)* of 11 States were functioning without a nurse. All the test checked CHCs of Bihar and Lakshadweep had less than five nurses and all the test checked CHCs of Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Mizoram, Orissa, Tamil Nadu, Tripura and Uttar Pradesh had less than nine staff nurses.

(d) Appointment of contractual staff

77. With a view to fill the gaps and provide additional manpower for the delivery of healthcare services, NRHM provides for engagement of medical and support manpower on contractual basis. However, Audit review revealed shortfall in the appointment of the contractural staff *vis-a-vis* targets set under the PIPs in respect of 19 States/UTs. While the shortfall was high in engagement of contractual manpower at medical levels of doctors and nurses and support staff at block level, it was relatively less with regard to engaging support staff at district level. According to Audit, the reasons for this divergent trend may be lack of qualified people to serve in the rural areas and delayed/non-initiation of the process of recruitment of contractual staff by the SHS and the DHS. Further, in five States/UTs (Chhattisgarh, D & N Haveli, Gujarat, Madhya Pradesh and Puducherry) 29 to 57 *per cent* of contractual staff left before completion of their contract period.

78. When asked whether the Ministry has analyzed the reasons for shortage of staff and the steps taken by to improve the availability of medical care providers in the rural areas, the Ministry in a written reply stated as under:

"This Ministry is aware of the problem of shortage of medical and para-medical staff in rural areas. Steps have been taken to bridge the gap by making contractual appointments of staff. The contractual appointment of staff made under NRHM as on March, 2010 is as under:

Specialists at CHC:	2434
Specialists at levels other than CHCs:	4596
GDMOs:	8771
Staff Nurses:	26197
Paramedics:	17471

Besides this, Ministry has already initiated action on identification of PHC, CHC and DH falling under the categories of difficult, most difficult and inaccessible specially in hilly and north east states, tribal areas and desert areas etc. so that the health personnel could be provided financial and HR incentives to work in these difficult facilities."

79. The Ministry have informed the Committee that State Governments have taken the following initiatives to ensure presence of doctors in rural areas:

- "Compulsory rural/difficult area posting for admission to post-graduate courses and as a pre-requisite for promotion, foreign assignment or training abroad;
- Compulsory rotation of doctors on completion of prescribed tenure as per classification of locations;
- Option to forgo non-practicing allowance and undertake practice without compromising on assigned, as per the service rules; offering incentive in form of allowance etc.
- Manning of PHCs by NGOs/Non Government Stakeholders.

To increase the availability of doctors and specialists, Government of India has also taken a number of initiatives to reform medical education. This includes rationalization of norms, to facilitate setting up of medical colleges, changing the teacher-student ratio, to increase PG seats, providing assistance to medical colleges to improve infrastructure for increasing PG seats and start new PG courses, setting up ANM/Nursing schools in different districts and centre of excellence for paramedics etc. ..."

80. When asked about the measures taken for posting requisite number of specialists at the CHCs/PHCs in the country, the Ministry in a written note state as under:

"As per the norms, specialists are appointed only at CHCs level and not at PHCs level. As per the data available in Bulletin on Rural Health Statistics in India (updated upto March 09), a total of 5789 specialists are in position at CHCs across the country, as against the sanctioned posts of 9028 specialists. Besides as per

data available in State Data Sheet, updated upto June 2010, a total of 1589 specialists have been appointed on contractual basis at various CHCs across the country.

Human resource engagement is a major thrust area under NRHM and is a priority being pursued with the States/UT Government. This include multiskilling of doctors and para-medics, provision of incentives, to serve in rural areas like blended payments, difficult areas allowances, PG allowance, case based payments, improved accommodation arrangements, provision of AYUSH doctors and para-medics in PHCs and CHCs as additional doctors in rural areas, block pooling of doctors in under served areas, engaging with the non government sector for under served areas provisioning of untied and flexible funds etc."

81. A statement showing the number of Specialists required as per norm, sanctioned and in-position of specialists at the existing CHCs as on March, 2009 is given in Annexure-I

(iii) Accredited Social Health Activists (ASHA)

82. NRHM envisaged that a trained female community health worker called Accredited Social Health Activist (ASHA) be placed in each village in the ratio of one per 1000 population (or less for large isolated habitations) in the 18 high focus. States using the Mission Flexible Pool funds. States were given the freedom to relax the population norm prescribed for ASHA so as to suit their local conditions. The ASHA was expected to act as an interface between the community and the public health system. About 6.16 lakh ASHA have been engaged under the Mission in the States/ UTs.

83. Audit review revealed that the ASHA had been engaged in all high-focus States, except Himachal Pradesh. In six high focus States Shortfall in the selection of ASHA ranged between 4 to 24 *per cent,* when compared with the requirements as per population norms. In five high focus States a larger number of ASHAs were engaged when compared with the requirements as per population norms, but as long as this had been in response to a felt need this was a proactive development. Further, among non-high focus States, Andhra Pradesh had engaed 28 *per cent* more ASHAs than required as per population norm. Maharashtra had engaged ASHAs only for the tribal areas.

Training of ASHAs

84. Under the NRHM guidelines trainings was to be provided to ASHAs to equip them with necessary knowledge and skills. The guidelines provided for five modules of induction training, as well as periodic trainings for skill enhancement, ASHAs were to be provided with drug kit containing medicines for minor ailments, ORS, contraceptives etc.

85. Audit examination revealed that in none of the States/UTs had all the five modules of induction training been given to all the selected ASHAs . Besides incomplete training was a major problem in mainstreaming the workers. Moreover, inconsistencies in district-wise data provided by the SHS regarding training and selection of ASHAs and data provided by the DHSs of the audited districts were observed in some States/ UTs. Further, ASHAs were not provided with a drug kit in Bihar, Gujarat, Haryana,

Jharkhand, Kerala, Meghalaya, Mizoram, Sikkim, Tripura, Uttar Pradesh, West Bengal, A & N Islands and D & N Haveli. According to Audit Non-completion of induction training of the ASHA was the main reason behind this, making their full utilisation difficult.

86. The Ministry in their response to aforesaid Audit observation stated that all high focus States except Bihar had since distributed drug kits. They have also stated that there were delays in commencing training in many States because different State had to adopt the ASHA scheme after an internal process of discussions and consultations. As regards the discrepancies between DHS and SHS figures; the Ministry stated that the difference was less than five per cent, as a rule. This may occur since these health workers were volunteers and, at any time, there were changes with some ASHAs ceasing to function, new recruitments taking place. Discrepancies may also merely reflect the time period to which the data relates.

87. When asked to state the reasons for not ensuring completion of the process of selection and training of ASHAs in the States in a time-bound manner, the Ministry in their written note stated as under:

"ASHA is one of the key strategies in NRHM. In initial years of NRHM, ASHA program was launched in high focus states only. Later on, based on the success in ASHA program in High focus states and approval of Mission Steering Group, this scheme was expanded to other States. Selection of ASHAs was done in all the states (except Himachal Pradesh, Chandigarh, Goa, Daman and Diu and Puducherry). Reasons for delay in the selection process includes:

I. The number of ASHAs initially proposed were as per the number of Anganwari Centre in country. Later few states have revisited ASHA targets based on their regional needs.

II. Selection process of ASHA was done through community participation and involvement of PRI according to Guidelines. Process was time consuming and at some places, the selection was delayed.

III. There was attrition of ASHA from the program on account of,

a. Poor performing ASHAs droped out of the program voluntarily,

b. Highly educated ASHA moved to other jobs like AWW, ANM etc.

Training to ASHA

Initial seven days induction training is completed in all the States.

Bihar, Rajasthan, Madhya Pradesh and Jharkhand are lagging behind in completion of training beyond the induction training. Officials from MOHFW and NHSRC are repeatedly visiting these States and the issues followed up at the highest level in the States. NHSRC has deployed ASHA facilitator in these States to strengthen the ASHA program. These facilitators are working with State NRHM team to support ASHA selection and trainings.

In North Eastern States and UTs ASHA training were completed as per norms.

In non-high focus States, trainings are lagging behind in majority of States. ASHA program started in these States in later half of year 2008. Training was initiated later on and still ongoing in these States. MOHFW-GOI is regularly following up with States to complete the training at earliest."

88. When asked about the remedial/corrective steps to reduce the attrition rate of ASHAs in NRHM the Ministry informed the Committee that ASHA receives only performance based incentives for various activities performed by them. Hence the amount received by ASHAs varies. Workers not performing statisfactorily receive low amount as incentive and they tend to drop out. In order to reduce attrition rates for ASHA, the center provides funding to the states to expand the facilitation and support structures and ensure prompt and timely payment. A turnover rate of approximately 5% per year could be considered acceptable.

IX. PROCUREMENT AND SUPPLY OF MEDICINES

89. In any health system timely supply of drugs of good quality, which involves procurement as well as logistics management, assumes critical importance. To decentralize the procurement activities and build capacity for this purpose, NRHM emphasized setting up State Procurement Systems and Distribution Networks for improved supplies and distribution.

(a) Procurement manual/policy

90. NRHM stipulated that all organizations should prepare codified purchase manuals, containing detailed purchase procedures, guidelines and also proper delegation of powers, so as to ensure systematic and uniform approach in decision-making relating to procurements.

91. Audit examination revealed that in 26 States/UTs, SHSs had no documented written procedures and practices on procurement. In the absence of a uniform and well documented procurement policy, the system of procurement was quite often *ad-hoc* and there was no uniformity in the procedures followed by the various procurement wings under SHS/DHS.

(b) Empowered Procurement Wing

92. The Ministry had set up an Empowered Procurement Wing (EPW) in October 2005 to consolidate, streamline, strengthen and professionalize the procurement of health sector goods under the NRHM, which were made by the various programme divisions in a fragmented and disjointed manner. There were to be three functional units of EPW, *viz*. Health, Family Welfare and Universal Immunisation Programme, under three Directors headed by a Joint Secretary. Seven Deputy Directors oversee procurement activities under the disease control programmes (DCPs) and IDSP.

93. Audit scrutiny revealed that the desired structure did not physically exist under one wing *i.e*. EPW. The EPW had been only directly handling the procurement of vaccines and contraceptives and supervising the procurement undertaken by RNTCP and was not overseeing the procurements made by various programme divisions by monitoring their procurement plan. Thus, the intended purpose of having a centralised

procurement unit so as to generate cohesiveness and efficiency remained unfulfilled. Further, an integrated procurement plan and fixed time schedule for completion of procurement activities had not been prepared by the EPW as envisaged. Though the EPW was also required to maintain computerized databases on requirement of goods and services; firms holding the Good Manufacturing Practices (GMP) certificate; market surveys/market intelligence; complaints received and services etc., however, the Wing did not maintain any such databases. Besides no market survey of goods and services etc. had been carried out so far.

94. According to Audit another objective of the EPW was to build capacities of State and dependent agencies and monitor them for improving procurement of health sector goods and services etc. However, audit examination revealed that no progress in this regard had been made. In the absence of computerized database and integrated procurement plan, the EPW failed to monitor the procurement activities in the various divisions under the Ministry and in the States.

95. In their response to the Audit observation the Ministry stated that in January 2009 a section has been set up for the EPW and it is in the process of setting up a Centralized Procurement Agency (CPA). However, establishment and operationalisation of the CPA needs to be expedited, since the Mission has entered its fifth year of operation.

(c) Procurement Process Management

Formulary list of drugs

96. A health care system can ill-afford to purchase drugs mentioned under different proprietary brands at widely varying prices. A limited list of essential drugs, also referred to as a drug formulary, defines which drugs would be regularly purchased for stock. Audit review of the procedures followed revealed that a common formulary or essential drugs list was available only in 14 States/UTs *viz.* Bihar, Chandigarh, Dadra and Nagar Haveli, Himachal Pradesh, Madhya Pradesh, Maharashtra, Orissa, West Bengal, Uttarakhand, Uttar Pradesh, Sikkim, Rajasthan, Gujarat and Chhattisgarh but had not been developed in 13 States/UTs namely Assam, Delhi, Haryana, Jammu & Kashmir, Jharkhand, Lakshadweep, Manipur, Meghalaya, Mizoram, Punjab, Puducherry, Tripura and Arunachal Pradesh. Besides there were wide variations between the number and type of drugs included in the essential drugs list adopted by the districts/SHSs.

97. The Committee enquired about the method of procurement, the time taken to deliver the medicines and whether these are purchased through bidding or through outsourcing. In response the Secretary (Health) during evidence deposed as under:

> "Sir, under the World Bank Project for the Reproductive Child Health, we procure through our procurement agent and supply to the States. Then again, for vaccine, we procure centrally under the Universal Immunisation Programme. Then, as my colleague has mentioned, for each facility, what drug should be put in place is what the States are supposed to be making available. Basically, this should be coming from their own State Budget but if they did not have, some NRHM could also be used if required. But they have to guarantee that these drugs are being made available.

I would like to state that Haryana has done some exceedingly good work. They not only took a policy decision to develop the Essential Drug List and make it available in every hospital; whether it is a rich man or poor should get these drugs free of cost. All doctors were ordered only to prescribe from this Essential Drug List, which is a generic drug; and they found that all it required was Rs.10 per capita investment. They were able to give free drugs to anyone who came."

The witness further added:

"These giving of free drugs has really helped a lot of poor people. In Rajasthan, in some districts they have also done it. Sir, we are trying to make this model available to all States and asking them to replicate it."

98. When asked about the steps taken by the Ministry to ensure adoption of a common formulary list of drugs and standard bid document for procurements under the NRHM by the SHS and the DHSs, the Ministry in a written reply stated as under:

"Common formulary list of essential drugs for facilities under NRHM has been prepared conforming to IPHS. This is available on the website of MoHFW. Empowered Procurement Wing has helped Andhra Pradesh to develop their Essential Drug List (EDL). Regarding variations in EDL, it is on account of variance in disease burden from state to state. Procurement Manual containing templates for Standard Bidding Documents has been developed by the Ministry and shared with the States/UTs."

(d) Non-availability of essential drugs in health centre

99. Availability of drugs, which involves procurement, as well as logistics management, is of critical importance in any health system. Under NRHM, it was provided that two months stock for essential medicines/drugs was to be maintained in the health centres. Audit review revealed that the stock of essential drugs, contraceptives and vaccines adequate for two months consumption were not available in any of the test checked PHCs and CHCs in nine States/UT (Assam, Bihar, D&N Haveli, Jharkhand, Manipur, Mizoram, Orissa, West Bengal and Sikkim). In six States, two months' stock was available partially at sample health centres.

100. When asked the reasons for non-availability of essential medicines, contraceptives etc. at health centres in many States and the action taken to improve stock position the same, the Ministry in a written note stated as under:—

"During April to October, 2008, there was some shortage of Diptheria-Pertussis-Tetanus (DPT), Tetanus Toxoid (TT) and Diptheria Tetanus (DT) in some States. However, there was no shortage of Bacillus Calmette Guerin (BCG), Measles and Polio (OPV) vaccines. Vaccine manufacturing takes a lead time of 3-6 months and another 21 days is required for laboratory testing. The supply orders were placed in July, 2008. Manufacturers were pressurised by the Government to curtail the lead time and deliver the vaccines to the States. Therefore, the dislocation was only temporary and the programme as such was not hampered.

There is no shortage of vaccines at present under Universal Immunization Programme (UIP) in the country.

Similarly due to court cases involving procurement of condoms and OCPs during 2008-09 and 2009-10 fewer supplies could be procured than the requirement. However, the court cases have now been decided and procurement for full quantity is in progress.

Monitoring of stocks of the healthcare stores in the States/UTs is being regularly done by the programme divisions. Procurement division will also monitor the stock through ProMIS software, once it is implemented in all the states and the states enter data regularly in the system."

101. Enquired about the steps taken to ensure timely supply of medicines and equipment at health centres, the Ministry in a written note stated as under:—

"MoHFW has taken following initiatives during 2010-11 for timely supplies of medicines and equipment—

1. Hitherto procurement was being done in fragmented manner by various Programme Divisions. From this year all procurements done by the Ministry have been centralized in Empowered Procurement Wing. The procurement of kits, drugs, vaccines etc. under RCH, RNTCP, NVBDCP, UIP, Pulse Polio Immunization, Family Welfare and IDSP are done by EPW only.

2. Procurement Plan has been prepared in respect of all programme divisions. This contains the date line for the various activities starting from bid preparation and ending with completion of contract.

3. Indents for the year 2010-11 are sought by EPW from the Programme Division in the month of February, 2010 so that procurement action can be initiated in time. Normal procurement cycle is 6 to 9 months. Regular monitoring of the status of procurement is being done at the level of Secretary (HFW) and JS (Procurement).

4. In case of shortage and stock outs, emergency procurement has been resorted to.

5. MoHFW has decided to create Central Procurement Agency (CPA) for handling all procurement and supply chain management issues. Matter is being pursued with Planning Commission before EFC appraisal.

6. Issues concerning procurement of CSS stores are discussed in the meeting with State Health Secretries /MD (NRHM).

7. Procurement Management Information System (ProMIS) software has been developed for procurement and inventory management. All States and UTs have been asked to put in place the system during the current year."

(e) Quality assurance of drugs

102. The pre and post-shipment quality tests are required, especially in the case of purchase of medicines. However, audit scrutiny revealed that in three States *viz.* Orissa, Jharkhand and West Bengal cases of procurement of sub-standard drugs or procurement of drugs without assuring quality was noticed. In orissa, sub-standard

drugs were administered to patients in Koraput district due to belated receipt of test reports from lab and late communication from the State Drug Management Unit (SDMU). Similarly, in Sundergarh and Bolangir districts, in 14 cases, time expired medicines of Rs. 3.02 lakh were administered to patients due to late receipt of communication from SDMU declaring the drugs as 'not of standard quality.' In Bihar, quality test mechanism of drugs was non-existent and medicines were used without ensuring quality. In Assam 58.13 lakh condoms of 10 different batch numbers were supplied, of which sample from five batches were sent to laboratory for testing. The entire sample was tested as sub-standard and subsequently was replaced by the supplier. However, 43 lakh condoms of remaining five batches were supplied to districts without conducting laboratory tests.

103. Expressing concern over the purchase of sub-standard drugs in certain States the Committee enquired whether there is any mechanism to penalize the persons responsible for dereliction of duty. In response the Secretary (Health) during evidence stated as under:—

> "To be very honest with you, in terms of purchasing sub-standard drugs or the governance part of it, it squarely rests with the State Government. There is a limitation. In fact, we can only say that please take action. If the State Government does not want to take action, there is nothing that we can do. Secondly, the licensing of these generic producers is done by the state Drug Controller and our Drug Controller has absolutely, by law, no way in which he can say that you have given a licence to a sub-standard manufacturer. So, there are some limitations to the extent to which the Central Government can intervene in the Government structures of the State Government. That is why, we have said that health being a State subject, there is a limitation on us to enforce our standards or our programmes."

104. Expressing serious concern over the circulation of spurious drugs and sub-standard drugs in the market the Committee enquired about the steps taken by the Government to ensure supply of quality medicines to the people. In response the Secretary (Health) during evidence deposed as under:—

> "We have a very stringent procedure on whatever drugs we supply from the Central Government on ensuring the quality. What is happening at the State level is where the concern is. For that reason, we had tried to amend the Drug act centralizing the entire thing into the Central Government to give powers the DCI to be able to conduct raid or take action against any manufacturer manufacturing spurious drugs. But the State Governments simply did not accept. So, we have try and see how to centralize it. Right now, we do not have any powers. The licensing authority is the State Drug Controller. Having said that, we did conduct a evaluation and according to our reports, the spurious drugs are not more than 5 per cent. This is our report. But the counterfeit argument that you get from the European press is completely about corporate wars. We have taken up in the WHO very strongly and we have fought a bitter battle with them with the result today, there is a Committee in which India is a member. This is deliberate fighting against the generic drugs because we are really the world's best. In fact, we are better than

China in terms of the USFD approval that we have. These are because of corporate wars mainly because of western multinationals losing their market share as against the Indian companies. That is why, they are also coming and purchasing many of our companies which is again causing us concern as to what will happen if MNCs took over the entire drug industry in India, the prices will definitely will go on increasing. These are some of the issues which are being discussed in the Committee of Secretaries because in the next two to three years, almost 41 billion dollars worth of drugs will be off patent and will be available for generic. So, there is much more to the whole story than what meets the eye when they try to ban Indian production."

The Witness added:

"As I said, we are constrained in the legal provisions. But we have taken a decision recently that our DCI is going to conduct a few raids in some States and pick up those drugs and get them tested in our laboratories and be able to tell openly giving a press statement that these are spurious and put pressure on the State Governments to tighten their own laws. The point is there are not enough drug inspectors. Drug Inspectors are not appointed. Though we have written several times but control is with them. By law, the Drug Controller of the State Government has to do the inspections and surveillance. We are trying to build up pressure but till we amend the Drug Act and bring in some concurrent power with the Central Government, this will constantly be a problem."

105. While expressing concern that the prices of generic drugs are going up the Committee enquired whether there could be a scheme differential pricing for poor people. In response the Secretary (Health) during evidence deposed as under:—

".....On the issue of whether generic drugs are getting more expensive, there are two aspects. One is that the drugs that are required by the rural people for minor ailments and common diseases are totally generic drugs and are low priced. They are affordable and are low priced. The prices of drugs which are really increasing are those related to non-communicable diseases like hypertension, diabetes, cancer, etc. For TB, malaria, etc. prices of common drugs are not increasing."

106. To a concern of the Committee that the affordability of drugs should be commensurate with the level of the person's income, the Secretary (Health) deposed:—

"We do not have any user fees, if they come to Government Hospitals. We provide it free of cost."

107. When asked about the measures taken to ensure that only generic drugs are made available at the CHCs, PHCs under NRHM and also that the doctors at PHCs/ CHCs and district hospitals prescribe only generic drugs, the Ministry in their written reply stated as under:—

"Under the National Rural Health Mission, emphasis has been placed on promotion of rational drug use. The need for promoting rational drug use and the series of steps required to be taken to ensure this, was also shared with the Health Secretaries and the Mission Directors in a workshop held in Orissa in August, 2009.

The Union Government encourages use of generic drugs in the maximum possible extent. The Central Government procures and supplies certain quantities of drugs under the National Rural Health Mission in the form of RCH kits, drug for Malaria, TB and other diseases and in all such cases generic drugs are procured and supplied.

The Government is also making continuous efforts for use of generic drugs to the maximum extent possible in the CGHS Dispensaries and discourages use of branded drugs.

Instructions have been issued at various level to the States including a communication from Hon'ble Minister for Health & FW to Health Ministers of all States to ensure the rational drug use and provisioning of quality generic drugs at Central Government Institutions and Hospitals. The specifications of all generic drugs have been finalised."

X. PERFORMANCE INDICATORS

108. The NRHM prescribed national targets for reducing infant mortality rate (IMR), maternal mortality rate (MMR), total fertility rate (TFR) and morbidity and mortality rates and increasing the cure rate of different endemic diseases covered under various NDCPs. The State specific targets were not prescribed under the Mission. States had to fix their own targets keeping in view the overall national targets.

Reproductive and Child Health (RCH)

(a) Maternal Health

109. Under maternal health, the RCH II aimed to reduce maternal and infant mortality rates to 100 per one lakh and 30 per thousand respectively by 2010. The important services for ensuring maternal health and care included antenatal care, institutional delivery care, post natal care and referral services.

(b) Institutional delivery care and Janani Suraksha Yojana

110. The Janani Suraksha Yojana (JSY) scheme was introduced in April 2005 replacing the earlier National Maternal Benefit Scheme (NMBS). JSY had the twin objectives of reducing maternal and infant mortality by providing cash incentive to pregnant women of BPL/SC/ST families in all States and all pregnant women in ten low performing States (eight EAG States, Assam and Jammu and Kashmir).

(c) Targets and Achievement

111. The primary objective of the scheme was to increase institutional deliveries and achieve the target of 100 per cent institutional deliveries by the end of 2010. However, Audit review revealed that in 12 States/UTs *viz.* Andaman & Nicobar, Arunachal Pradesh, Bihar, Chandigarh, Dadra & Nagar Haveli, Himachal Pradesh, Karnataka, Kerala, Manipur, Mizoram, West Bengal and Orissa, the SHS did not prescribe year-wise targets for institutional deliveries. Shortfall in target achievement was noticed in 11 States which ranged between 25 to 81 per cent in six States and maximum in Jharkhand (60 per cent*),* Uttarakhand (78 per cent) and Punjab (81 per cent*)*. Further,

even in 47 audited districts of low performing States, a shortfall was noticed in 19 districts (40 per cent) and shortfall was not measured in 16 districts due to non-fixation of targets.

112. The Ministry in their response to the aforesaid Audit findings states that for the year 2007-08 more than 540 districts had made their health action plans fixing physical and financial targets. Substantial progress had been made in this regard. Overall figures of JSY beneficiaries had risen 11 times (approx.) between 2005-06 (7.39 lakh) and 2008-09 (84.5 lakh). However, the States were being advised to fix their targets keeping in mind the available resources both in terms of infrastructure and manpower.

(d) Implementation of the scheme

113. The scheme envisaged that all registered pregnant women would be provided with JSY and Mother and Child Health (MCH) cards and ASHAs would keep track of them for ante-natal care (ANC), delivery and post delivery care. The ANM would prepare Micro Birth Plan for effective monitoring of the antenatal and post delivery care.

114. Audit scrutiny revealed that the Micro Birth Plan had not been prepared in the audited districts at the PHC and Sub Centre levels in Arunachal Pradesh, Andhra Pradesh, Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Madhya Pradesh, Orissa, Rajasthan, Sikkim, Tripura, Tamil Nadu, Uttar Pradesh, Uttarakhand and West Bengal (17 States). In the absence of any Micro Birth Plan, JSY and MCH cards, all the registered pregnant women could not be tracked for checkups, institutional delivery and post natal care. Further, in 13 out of 20 States, less than 50 per cent of total registered pregnant women preferred institutional delivery at health centres. In 19 out of 23 sample districts of Chhattisgarh, Himachal Pradesh, Jharkhand, Orissa, Uttar Pradesh and Uttarakhand (6 States) domicilliary deliveries were more than institutional deliveries. Besides, women were discharged after delivery and without the minimum recommended stay, and consequently the proper delivery and post natal care required to be provided under the scheme was not availed of. Lack of infrastructure, supporting staff and doctors at health centres, further affected the extent and quality of institutional delivery care.

115. The Ministry in their response stated that the issue pointed out by Audit was well taken. They have stated that it has been their constant endeavour to ensure that after registration of the pregnant women in the first trimester, a Micro Birth Plan was made. The Micro Birth Plan captures all essential data required. States were constantly striving towards preparations of the Micro Birth Plan for each pregnant woman. The Ministry states that while audit had pointed out domiciliary deliveries were more than institutional deliveries, however, institutional deliveries as percentage of total deliveries rose from 42 per cent (2005-06) to 84 per cent (2006-07) among the below poverty line JSY beneficiaries. The Ministry had been advising States to ensure that the women staying at the facility for two days after delivery for proper post-natal care (PNC). The Ministry felt that recent trends were encouraging. The States were being advised to ensure quality of care for the pregnant women both in terms of PNC and ANC.

116. When asked about the steps taken to increase the coverage of pregnant women under Janani Suraksha Yojana (JSY) the Secretary (Health) during evidence deposed as under:—

".....the main problem that we are facing for escalating or expanding the coverage and institutional deliveries is the infrastructure and availability of adequate human resources in terms of particularly doctors. So, we are now training our nurses as you say. We have been employing many more nurses and we have also asked them to take on contract.

Now, we are also training ANM to do home deliveries, if required but in regard to institutional deliveries, there will be some amount of problem till we are able to strengthen our own infrastructure but we are also now trying to see and map where the private nursing homes are and getting into some contract with them. For example, for child, we have a huge infrastructure of nursing homes throughout, almost 5,000 facilities. It would be useful for us and we are encouraging the States to contract on reasonable rates so that they can get institutional delivery in private facilities, which are small medium sized facilities."

117. As regards the steps taken to achieve the goals in respect of reduction in IMR and MMR, the Secretary during evidence stated that:—

"The goal is 2015 MDG goal, and we are very conscious of it but we are very confident that we will be able to achieve the target largely because we have been able to identify where exactly the IMR and MMR taking place and once you are able to focus on these 235 districts and in the 235 districts also the poorer segment of people, and provide them this facility, I am quite confident that we will be able to reduce the mortality rate".

118. When asked whether any special attention is paid to achieve population stabilization in backward States like UP, Jharkhand, Bihar, Rajasthan and Madhya Pradesh where the TFR is very high, the Secretary (Health) during evidence deposed as under:—

"Now we have taken up these nine States as the focus area. We are not going to bother about Tamil Nadu and Kerala. So, in these nine States, there are two things that we are doing. One is, since due to the JSY lot of women are coming for deliveries to our public health facilities. So, we want to set up there the postpartum centres. We are exploring whether through private participation it can be done or not. We had a meeting with the private sector. We are going to intensify our meetings further whether they can also be in partnership with us. We provide the drugs and other facilities but through the mobile vans and through doctor support, and management support we will try and establish postpartum centres and make access available to these services.

The second which we are seriously considering is the injectables. This has till now not been introduced in our package of contraceptives. There has to be one final meeting held. We had lot of discussions with the NGOs and others who had objected to using of injectables. Now, we are having one final meeting in two months' time. If that comes, it makes it much easier to give.

Then, the invasive procedures are not there. One injection means at least protection for 3-4 months. In the private sector, lot of poor people are accessing these but we want to introduce it in our country".

The witness added:

"They are doing it informally but it is not in our national programme. It does have side effects like everything has. Even oral pills or anything that distrubs hormonal cycle or menstrual cycle is going to have side effects but the real point here is that we have done the research in regard to injectables. We have done the literature study. We have got our recommendations from all the doctors Committee. We have sat with the NGOs. We have told them that we are going to ensure that every woman will be tracked to see that the side effects are addressed. So, I am confident that we will be able to introduce injectables also. Otherwise, we do not have much of a choice, except sterilization, IUD and condoms".

119. When asked about the targets fixed State-wise for reducing the Total Fertility Rate (TFR), Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) under the NRHM each year during the last 4 years *vis-a vis* the achievements made there against, the Ministry in a written note furnished the information as under:—

"The targets for TFR, IMR and MMR are not fixed State-wise. However, through implementation of strategies and interventions for accelerating the pace of reduction in Maternal Mortality, Infant Mortality and Total fertility, the States are striving towards the National goal of reduction of MMR to 100 per 1,00,000 live births, IMR to 30 per thousand and TFR to 2.1 by 2012 in the country as per the NRHM goals. The details of Maternal Health, Child Health and Family Planning strategies are as under:

Maternal Health Interventions

The key Maternal Health interventions being carried out include:

1. Demand Promotion

Janani Suraksha Yojana (JSY): It is a national conditional cash transfer scheme to incentivise women of low socio-economic status to give birth in a health facility. The JSY has seen a phenomenal growth since its inception in 2005 as per the following details:

Table 10

Year	No. of beneficiaries (in lakhs)	Expenditure (in crores)
2005-06	7.39	38.29
2006-07	31.58	258.22
2007-08	73.29	880.17
2008-09	90.37	1241.33
2009-10	100.78	1476.03

2. Services

(a) Ensuring early registration of pregnancy, Ante Natal Care and Post Natal Care services.

(b) Essential and Emergency Obstetric Care, including:

- Skilled Attendance at birth (domicilliary & health facilities). **43,577 ANMs** have been trained in SBA till June 2010.
- Operationalizing facilities—First Referral Units (FRUs), and 24x7 Primary Health Centres (PHCs). **2072 FRUs** and **9454 24x7 health facilities** have been established till August 2010.
- Multi-skilling of doctors to overcome shortage of critical specialities—training on Life Saving Anaesthesia Skills (LSAS) and Emergency Obstetric Care (EmOC). **1091** Medical Officers have been trained in LSAS and **599** Medical Officers have been trained in EmOC till June 2010.
- Appointing additional Auxiliary Nurse Midwives (ANMs) and staff nurses on contract; engaging laboratory technicians on contract; and hiring medical officers and specialists.

(c) Strengthening Referral Systems through Public Private Partnership (PPP), voucher schemes, referral funds at all levels.

(d) Safe Abortion Services.

(e) Village Health & Nutrition Days (providing community level comprehensive Maternal and Child Health and family planning, including immunization).

(f) Maternal Death Review—both facility based and community based, has been rolled out in the States.

Child Health Interventions

1. Key child health interventions being carried out include:

(i) **Integrated Management of Neonatal & Childhood Illnesses (IMNCI)** which includes Pre-service and In-service training of providers, improving health systems (*e.g.* facility up-gradation, availability of logistics, referral systems), Community and Family level care. IMNCI is being implemented in **356 districts** across the country and **266947 health personnel** have been trained in IMNCI till August 2010.

(ii) Home Based New born and Child Care (HBNCC).

(iii) Facility Based New born and Child Care:

- **198** Sick New Born Care Units (SNCUs) have been established till August 2010;
- **722** New Born Stabilisation Units (NBSUs) have been established till August 2010;
- **4204** New Born Care Corners (NBCCs) have been established till 2009-10.

(iv) Navjat Shishu Suraksha Karyakram (NSSK) is a programme aimed to train health personnel in basic newborn care and resuscitation. **7262 medical personnel** have been trained in NSSK till date.

(v) Infant and Young Child Feeding.

(vi) Nutritional Rehabilitation Centres (NRC) to treat severe acute malnutrition amongst children. **758 NRCs** have been established across the country till August 2010.

(vii) Reduction in morbidity and mortality due to Acute Respiratory Infections (ARI) and Diarrhoeal Diseases.

(viii) Supplementation with micronutrients: Vitamin A & iron.

(ix) School Health Program for screening, health care and referrall for school going children.

Family Planning Interventions

(i) **Addressing the unmet need** in contraception through

a. Assured delivery of family planning services

b. Capacity building of service providers

(ii) Increasing **male participation** through No Scalpel Vasectomy (NSV)

(iii) Promotion of **Intra Uterine Contraceptive Device (IUCDs)** as a short & long term spacing method

(iv) **Family planning insurance scheme**

(v) Promoting **Public Private Partnerships**

(vi) Ensuring **quality care in family planning services** by establishing Quality Assurance Committees at Central, State and District levels and regular monitoring

(vii) Increasing **basket of choices** in contraception."

120. The statement showing the achievements made in reducing the TFR, IMR and MMR, State-wise during the last 4 years is given at Annexures II to IV.

121. Elaborating further on the steps taken to reduce the TFR in the country, the Secretary (Health) during the further evidence held on 27/10/10 stated as under:—

"It is admitted that we did lose sight of family planning programme in the initial years. But now our Minister has really positioned it as priority no. 1. Recently, after a gap of five years, the meeting of the National Commission of Population chaired by the Prime Minister, was held. The States like Madhya Pradesh has taken extraordinary steps to flag it as a priority State and the Chief Minister himself is driving the family planning programme. We are getting huge political support in States like Madhya Pradesh. Now, a decision has been taken that we are going to create a division in the Ministry led by the Joint Secretary level officer right down to the State and district level we will fund posts to focus on the high prevalence States. It is only to focus on family planning. In most of these States, like Bihar there are two important issues. One is there is huge unmet need. That means there are eligible couples who want contraceptive services and family planning services, but the facilities are not there. So, that is what we are going to address. The other issue is that almost fifty-five per cent of the marriages in Bihar are teenage girls below 18 years old. Now, that is a social issue. There was a big discussion in the Parliament also where we looked for political support to bring in this social change in this social behaviour. Early marriage contributes to high maternal mortality and higher number of children born because of child mortality being very high. These are all linked issues. Now, we are seized of this matter. We are going to give high priority to family planning".

122. The Committee desired to know as to whether any close watch has been kept on the problem of gender disparity which has been widening in certain States. In response, the Secretary (Health) during evidence stated as under:—

"Yes, Sir. The population demographic impact is quite severe in some of these States like Punjab and Haryana and in U.P. where the sex ratio is very adverse. But now we are giving a very high priority to the family planning programme."

XI. ROLE OF AYUSH IN HEALTH CARE

(a) Budgetary Allocation to Department of AYUSH

123. The National Policy on Indian Systems of Medicine & Homoeopathy-2002 stipulated that the share of plan outlay for Department of AYUSH in the total Health budget be increased to 10% with designed growth of 5% in every Five Year Plan.

When asked whether the budgetary outlay for the Department for AYUSH had met the above stipulation the Ministry in a written note stated as under:—

"There has been quantum increase in the budget allocation of the Department of AYUSH from 775.00 crore in the 10th Plan to 3988.00 crore in the 11th Plan, despite this fact, it has not been able to meet the 10% overall allocation of the health budget."

124. The budgetary outlay for various Department under Ministry of Health and Family Welfare for the years 2002-03 to 2010-11 and AYUSH budget as percentage of total health budget is furnished in following table:

Table 11

Budgetary Outlay of Ministry of Health and Family Welfare

(Rs. in crore)

Year	B E					
	Department of Health	Department of Family Welfare	Health Research	ISM&H (AYUSH)	Total Health Budget	AYUSH Budget as % of Total Health Budget
2002-03	1550.00	4930.00	—	150.00	6630.00	2.26
2003-04	1550.00	4930.00	—	150.00	6630.00	2.26
2004-05	2208.00	5780.00	—	181.00	8169.00	2.21
2005-06	9332.00		—	345.00*	9667.00	3.57
2006-07	11305.00		—	381.60#	11686.60	3.27
2007-08	13875.00		—	488.00	14363.00	3.39
2008-09	15580.00		420.00	534.00	16534.00	3.23
2009-10	18380.00		420.00	734.00	19534.00	3.76
2010-11	21000.00		500.00	800.00	22300.00	3.59

*Total Plan allocation of Department of AYUSH is '350 crore out of which' 5.00 crore is in the Demand Book of Ministry of Urban Development for "Strengthening of PLIM/HPL".

#Total Plan allocation of Department of AYUSH is '383.00 crores out which 1.40 crore is in the Demand Book of Ministry of Urban Development of "Strengthening of PLIM/HPL".

125. The proposed outlay, budgetary allocation made and the actual amount released for the department of AYUSH during the last 5 Years is as under:—

Table 12

(Rs. in crore)

Year	Proposed Outlay	Budgetary Allocation	Revised Estimate	Actual Release
2005-06	514.00	345.00*	305.00	290.96
2006-07	430.91	381.60#	320.00	316.69
2007-08	597.03	488.00	390.00	383.36
2008-09	759.59	534.00	475.00	471.13
2009-10	896.95	734.00	680.00	678.97

*Total Plan allocation of Department of AYUSH is '350 crore out of which' 5.00 crore is in the Demand Book of Ministry of Urban Development for "Strengthening of PLIM/HP".

#Total Plan allocation of Department of AYUSH is '383.00 crore out which' 1.40 crore is in the Demand Book of Ministry of Urban Development of "Strengthening of PLIM/HP".

126. Asked about the budget component of AYUSH in the NRHM, the Secretary (AYUSH) during evidence deposed that for NRHM, in the 11th plan they have Rs. 625 crore. Out of it we have exhausted Rs. 500 crore for the entire plan period.

127. A statement showing Budget Estimates, Revised Estimates and Acutal Estimates for the Centrally Sponsored Scheme for Development of AYUSH Hospitals and Dispensaries under NRHM is given below:

Table 13

(Rs. in crore)

YEAR	BE	RE	AE
2005-06	90.00	100.83	119.3
2006-07	110.02	99.67	135.76
2007-08	120.00	107.9	128.78
2008-09	120.00	140.00	130.52
2009.10	197.00	224.05	223.05
2010-11	232.00	244.00	165.70

128. The Committee enquired as to what would be the total budgetary requirement for AYUSH. In response, the Secretary (Health) during evidence stated as under:—

"In addition to that Rs. 800 crore, Rs. 300 crore is given from the NRHM. We have been submitting to you that the NRHM is a very decentralized model. Whatever the States have asked for in the PIP, we have approved it. So, they had asked for about, I think, Rs. 400 crore for AYUSH and, I think, Rs. 320 or Rs. 330 crore were approved. That is in addition to her Budget. This is AYUSH Budget. Then, the NRHM amount of Rs. 300 crore. So, it comes to about Rs. 1,000 crore."

129. In this regard the Secretary (AYUSH) supplemented as under:—

"I want to make a submission to you. The total NRHM allocation to the Health Department is about Rs. 15,000 to Rs. 20,000 crore per year. Look at AYUSH. For the entire plan you are giving only Rs. 625 crore. It is not one system. It consists of many systems, like Ayurveda, Siddha, etc. these have been traditionally practiced."

The witness further added:

"We have been told that we would be getting Rs. 4,000 under the 11th Plan.....Even then, in the first two years we have got about Rs. 490 and Rs. 425 crore. This year, we are getting Rs. 800 crore after making much noise. We are not getting the entire Rs. 4,000 crore, which are meant for us. The Planning Commission and the Department of Expenditure are supposed to give us these funds. We would request the Committee to kindly make suitable recommendations so that AYUSH system is promoted well in this country."

130. The Committee desired to know whether lack of absorption capacity and not the budget support has been the reason for not achieving the envisaged target of

10 per cent increase in the outlay for Department of AYUSH in the total Health Budget. In response, the Secretary (AYUSH) during evidence stated as under:—

> "Under the Eleventh Plan, if you carefully look at the first three years' figures, you will find that the allocation was about Rs. 425 crore to Rs. 450 crore in the first two years; it was Rs. 680 crore in the third year. In the fourth year, the allocation is Rs. 800 crore. Last year, Rs. 680 crore was given and we spent the full money. Now the capacity has increased in the AYUSH sector. We are in a position to absorb the entire Rs. 4000 crore but we are not being given the money saying that we do not have the capacity. This becomes a vicious circle. After this plan, the Planning Commission will tell us 'Oh, you have been able to utilize only Rs. 3000 crore out of Rs. 4000 crore.' Forgetting that, they allocated us Rs. 3000 crore out of Rs. 4000 crore. This the vicious cycle which we want to correct. We would request the Committee to make suitable recommendations."

131. The Department of AYUSH informed the Committee that Estimated budgetary outlay allocation/allocation and expenditure for Department of AYUSH could be Rs. 8000.00 crore as brought out in the Strategic plan for RFD.

(b) Mainstreaming of AYUSH Under NRHM

132. When asked about the steps taken by the Department of AYUSH to ensure that the defaulting States mandatorily include AYUSH component in their PIPs, the Ministry in a written note stated as under:—

> "Department of AYUSH sensitized the States for incorporating the AYUSH component in their PIPs. A Joint letter of Secretary, Health & Family Welfare and Secretary, AYUSH dated 12th August, 2005 has been forwarded to the States regarding Roadmap for Mainstreaming of AYUSH under NRHM. The need for specific action under strategies for mainstreaming of AYUSH was again reiterated under the Joint Letter of Secretary (Health) and Secretary (AYUSH) dated August 2006 and 15th May, 2009.
>
> The Department of AYUSH organized meeting with State Health Secretaries/ Directors of AYUSH on 12th December 2007, 16th to 17th and 22 December, 2008, 21st to 22nd May, 2009, 25th to 27th May, 2009, 13th August, 2009, 17th December, 2009 for NE States, and 5th to 16th March, 2010 highlighting these issues.
>
> Further, Department of AYUSH also organised Regional Meetings in State Head Quarters along with the State representatives, Programme Officers and Nodal Officers in the Department for review of progress of implementation of programmes including liquidation of UCs. The States were also advised to include the requirement of financial assistance for the contractual hiring of AYUSH Doctors. Pharmacists and their training in Programme Implementation Plan (PIP) under NRHM.
>
> Through the above, the States were asked to expedite the creation of AYUSH facilities in PHCs, CHCs and District Hospitals with support from Department of AYUSH."

133. Elaborating about the steps taken by the Department of AYUSH for mainstreaming AYUSH under NRHM, the Secretary (AYUSH) during evidence stated as under:—

> "The mainstreaming of AYUSH is one of the goals of NRHM. How mainstreaming is happening? It can happen in two different ways. One is by providing facilities, co-locating the facilities in all PHCs in the country at PHC level and at the district hospital level. That was one of the strategies. That was adopted by the Health Ministry in promoting NRHM, in mainstreaming it. About 25-30 per cent of PHCs today have something like AYUSH service system available. What we have done at that time was a model which has been followed in Tamil Nadu. If you walk into a PHC in Tamil Nadu, you can see all the systems together. It is on the customer; the client can choose what he wants. That was the idea behind this. We have been able to achieve collectively; both the departments together have 25-30 per cent of AYUSH facility."

The witness added:

> "We have posted a doctor; we are providing medicines. We have provided equipments.....Health Department provides the AYUSH practitioners; they select them and recruit them; we provide the funds for the medicines."

134. In a post evidence reply, the Department of AYUSH have stated that the following steps are being taken for mainstreaming the AYUSH under NRHM:—

> "With a view to extend the benefits of AYUSH health care facilities, Department of AYUSH is making efforts for Mainstreaming of AYUSH . This is sought to be achieved by two fold strategy firstly by Provision of AYUSH facilities in the Primary Health Centre (PHC), Community Health Centre (CHC) and District Hospital (DH) and secondly through Strengthening the existing stand alone AYUSH Hospitals & Dispensaries.
>
> Ongoing Centrally Sponsored Scheme for Development of AYUSH Hospitals & Dispensaries under NRHM which makes provision for support to infrastructure, supply of essential drugs, contingencies etc. to PHCs, CHCs and DHs were revised on 03.09.2009. New components such as upgradation of AYUSH hospitals (other than PHCs, CHCs, DHs) at the District/Sub-District levels, upgradation of AYUSH dispensaries, setting up of Programme Management Units etc. were added to the existing scheme provisions.
>
> States were requested for taking action on following points:—
>
> a. Proposals may be sent for assistance in prescribed format as per the revised scheme for hospitals & dispensaries.
>
> b. Submission of pending UCs.
>
> c. Preparation of State Programme Implementation Plan (PIP) with inclusion of AYUSH components."

(c) Co-location of Ayush facilities

135. The State wise details of Co-located AYUSH facilities at PHCs, CHC and District Hospitals is given as under:—

Table-14

Status of Co-location as on 30.6.2010

Sl. No.	State/UTs	DHs	CHCs	Other than CHCs	PHCs	Other health facilities above SC
1.	Bihar	-	-	429	-	127
2.	Chhattisgarh	15	92	-	353	-
3.	Himachal Pradesh	-	-	-	-	-
4.	Jammu and Kashmir	-	-	-	375	-
5.	Jharkhand	24	97	-	-	170
6.	Madhya Pradesh	-	-	-	-	-
7.	Orissa	-	231	59	1116	-
8.	Rajasthan	67	205	-	1036	31
9.	Uttar Pradesh	-	-	-	428	-
10.	Uttarakhand	18	20	-	10	-
11.	Andhra Pradesh	43	141	53	1071	233
12.	Goa	2	4	-	10	-
13.	Gujarat	-	127	-	792	-
14.	Haryana	21	86	-	-	0
15.	Karnataka	19	58	26	-	726
16.	Kerala	-	-	-	-	-
17.	Maharashtra	23	135	-	-	805
18.	Punjab	15	99	-	102	-
19.	Tamil Nadu	29	131	232	779	-
20.	West Bengal	-	178	67	368	223
21.	Arunachal Pradesh	12	15	0	15	7
22.	Assam	-	-	-	-	-
23.	Manipur	-	14	-	60	-
24.	Meghalaya	1	12	-	35	-
25.	Mizoram	8	8	-	-	-
26.	Nagaland	0	21	-	-	-
27.	Sikkim	4	-	-	-	-
28.	Tripura	2	7	10	53	121
29.	A and N Islands	3	4	-	19	0
30.	Chandigarh	-	2	-	-	7
31.	D and N Haveli	-	1	2	1	-
32.	Damand and Diu	1	1	-	2	-
33.	Delhi	-	-	18	-	118
34.	Lakshadweep	1	2	-	-	-
35.	Puducherry	4	4	-	38	-
	Total	312	1695	896	6663	2568

(d) Availability and Deplopyment of AYUSH staff/personnel

136. Enquired about the number of AYUSH practitioners available in the country. The Secretary (AYUSH) during evidence stated as under:—

"We have seven lakh AYUSH practitioners in the country. Every year we produce 25,000 AYUSH practitioners... Under the NRHM, 12,000 to 15,000 AYUSH practitioners have already been inducted and they are manning many of the PHCs..... Our Minister went to the interior areas of Jammu and Kashmir. He was very happy to find that in an interior area of Kashmir, a Primary Health Centre was manned by an AYUSH practitioner. I went to Himachal Pradesh. In an interior area of Kinnaur, I found an AYUSH practitioner."

The witness added:

"My humble submission is that the NRHM has actually made an impact as far as recruitment of AYUSH doctors are concerned. Even in States like Bihar and Uttar Pradesh, they have been recruited. I am happy to tell you that in Bihar ... for 26 AYUSH district hospitals, we have given money for upgradation. In U.P. we did not get much response."

137. The Department of AYUSH have informed the Committee that the Ministry of Health and Family Welfare (Department of Health and Family Welfare) is providing financial assistance for contructual appointment of AYUSH Doctors and Paramedics in PHCs/CHSs under Mission flexi pool component of NRHM. The State-wise details regarding number of AYUSH Doctors and paramedics appointed till 30.6.2010 in PHCs/CHCs is furnished below:—

Table 15

Status of AYUSH Doctors and Paramedics working in PHCs/CHCs/DHs as on 30.6.2010

S. No.	State/UTs	Doctors	Paramedical Staff
1.	Bihar	-	-
2.	Chhattisgarh	325	-
3.	Himachal Pradesh	-	-
4.	Jammu and Kashmir	398	331
5.	Jharkhand	50	-
6.	Madhya Pradesh	-	-
7.	Orissa	1286	-
8.	Rajasthan	1034	435
9.	Uttar Pradesh	428	-
10.	Uttarakhand	140	140
11.	Andhra Pradesh	670	1789
12.	Goa	11	25
13.	Gujarat	919	-
14.	Haryana	137	63
15.	Karnataka	723	-

S. No.	State/UTs	Doctors	Paramedical Staff
16.	Kerala	403	28
17.	Maharashtra	426	138
18.	Punjab	202	0
19.	Tamil Nadu	299	150
20.	West Bengal	-	-
21.	Arunachal Pradesh	31	11
22.	Assam	232	-
23.	Manipur	73	23
24.	Meghalaya	48	50
25.	Mizoram	10	-
26.	Nagaland	22	-
27.	Sikkim	2	4
28.	Tripura	69	23
29.	A and A Island	19	18
30.	Chandigarh	4	4
31.	D and N Haveli	7	-
32.	Daman and Diu	1	-
33.	Delhi	-	-
34.	Lakshadweep	-	-
35.	Puducherry	24	-
	Total	7993	3232

138. When asked whether there is shortage of AYUSH doctors and paramedics in various PHCs/CHCs and if so the steps taken to address the issue, the Department of AYUSH in their note stated as under:—

"As per information made available by the Department of Health and Family Welfare, out of total number of 23474 PHCs, 4276 CHCs, 571 District Hospitals till now 7993 number of AYUSH Doctor and 3232 Paramedic Staff have been appointed on contractual basis under Mission Flexi pool of NRHM at Co-located AYUSH units in 6633 PHCs, 2568 Other health facilities of above Sub Centres, 1695 CHCs, 896 Other than CHCs and 312 District Hospitals. States have not brought to the notice of the Department of AYUSH about the shortage of AYUSH doctors and paramedics in PHCs/CHCs etc."

(e) Procurement and Availability of AYUSH Medicines

139. When asked whether any procurement policy/manual for purchase of AYUSH drugs for distribution undr NRHM has been formulated, the Department of AYUSH in a written reply stated:—

"The Department of AYUSH has circulated the guidelines *vide* Department letter on 09/06/2010, regarding procurement of essential drugs for the Centrally

Sponsored Scheme namely Hospitals and Dispensaries scheme under NRHM. The highlights of these guidelines are as follows:

(a) The essential drugs and medicine required for implementation of the Centrally Sponsored Scheme for Hospital and Dispensary Scheme under NRHM are to be procured from M/s. Indian Medicine Pharmaceutical Corporation Ltd. (a Central Public Sector Undertakings) or from Public Sector undertakings, Pharmacies under State Govt. and Co-operatives, who are GMP complaint, keeping in view the need for ensuring quality of AYUSH drugs and medicines.

(b) Drugs other than under NRHM or under any other scheme of the State/UT administration may be procured from any GMP complaint organization and in accordance with the norms prevalent in the respective State/UTs."

140. To a specific query as to whether the essential list of AYUSH drugs has been made available to all the States and whether the Department monitor that the States adhere to the list while procuring the medicines, the Ministry in written reply stated that the Department of AYUSH has prepared suggestive list of essential AYUSH drugs and given to all the States. The Department of AYUSH has published a Manual for Doctors on Mainstreaming of AYUSH under NRHM. The suggestive list of essential medicine of AYUSH Stream is printed in this manual, which was circulated to State Government. This was also distributed among the doctors in 2009-10 during the training programme organized by Department of AYUSH on Mainstreaming of AYUSH under NRHM. Earlier Similar suggestive list of essentials ayurvedic drugs for Dispensaries and Hospitals was published by the Department in 2001.

141. To a specific query regarding measures taken for incorporation of AYUSH system under NRHM, the Secretary (AYUSH) during evidence deposed as under:—

"We have the scheme called Hospitals and Dispensaries which we are implementing from 10th Plan under which we have been supporting the State Governments for purchase of AYUSH medicines... as far as AYUSH is concerned, the State Governments are purchasing the medicines. Rs. 647 crore has been spent under the 10th Plan. That support is given to them for purchase of medicines in the State Governments."

142. As regards quality of AYUSH medicines, the Secretary (AYUSH) during evidence stated that they have a partnership with the Quality Council of India, started certifying AYUSH drugs and that five pharmaceutical companies have already got the AYUSH mark on them.

143. Enquired about the steps taken for implementation of the best manufacturing practices for Ayurvedic medicines, the representatives of Department of AYUSH during evidence stated as under:—

"Good Manufacturing Practices (GMP) has been published in 2005. Subsequently they were made for metallic medicines 2 years back and we are constantly improving upon the GMPs. Even the WHO GMP has now been introduced. Two companies, Charag Pharmacy of Bombay and Himalaya have not got the WHO GMP also and we are supporting the industry in this endeavour with some financial assistance."

144. Responding to the query of the Committee whether any study has been conducted to show how yoga helps in safe delivery without caesarean, the representative of Department of AYUSH testified:—

"Morarji Desai National Institute of Yoga (MDNY) have published a book on the effect of yogic asanas for facilitating normal delivery."

The witness added:

"Recently as a pilot project the ICMR and the CCRS have launched a project in Himachal Pradesh where 1,000 women will be recruited for this purpose and they will take care of period of pregnancy and afterwards the child will be taken care of by the ayurvedic intervention for two years. This project was launched in August, 2010."

(f) Promotion of Traditional Systems of Medicine

145. The Committee enquired whether the Department of AYUSH have any information about the medical systems by those who live in the jungles *i.e*. vanvasis. In response the Secretary (AYUSH) during the evidence deposed as under:—

"Actually, Ayurveda is not a single system. A lot of contributions had come. Charakha Samyuta is actually a codified form of all the systems prevalent at that time. We know that in different areas, different systems are being practiced. We are trying to find out. Sowa-ripa is the first step. Sub-Himalayan regions practice their own systems, which is called the Tibetan system. but in India, it is called Sowa-Ripas and we have given recognition. Other systems would follow. This is the background of it."

146. When asked whether any new database is being created on the traditional knowledge system relating to AYUSH, the Department of AYUSH stated that they have established Traditional Knowledge Digital Library (TKDL) of Ayurveda, Siddha, Unani and Yoga respectively. Till October 2010, 28,320 formulations have been transcribed, 1,25,580 Unani formulations, 14,300 Siddha formulations have been transcribed. 1195 Yoga postures have also been transcribed.

147. In a post-evidence reply, the Department of AYUSH have forwarded the following points/suggestions for augmenting the role of Ayush in the implementation of NRHM:—

"Current status

- In 11th Plan so far, Rs. 55,000 crores have been spent under NRHM programme. Out of this, a meagre Rs. 350 crores only has been provided to the States for hiring of AYUSH manpower and their capacity building. This amounts to merely 0.63 percent of entire NRHM budget. While the entire financial burden for the running of entire sub-centres in the country, (including staff salary, rent, contingency and untied funds) infrastructure upgradation, additional staff deployment, Untied funds, Annual Maintenance Grants of entire PHCs and CHCs are also taken by the NRHM, the Financial assistance provided to the AYUSH stream is considerably low.

- During the past 4 years only 9500 AYUSH doctors has been deployed under the Mainstreaming strategy, while there are 23,458 PHCs, 4,276 CHCs and approximately 600 DHs in the country. There is an actual requirement of 34,410 AYUSH doctors in these facilities, while the deployment so far remained to 28 percent approximately. The remaining 72 percent of co-location has yet to be done. Similarly, the gap in AYUSH pharmacist (one for PHC, two for CHCs, and DHs) and Para medical Staff including Panchkarma, Ksharsutra therapists (3 for each CHCs and 6 for each DHs) deployment is evident. Similarly, Yoga therapist at each CHCs and DHs are also required.

The following intervention/corrective measures are needed in the implementation of NRHM:—

1. Mainstream of AYUSH under NRHM should be implemented in the true spirit wherein at least 25 percent budget under NRHM should be earmarked for AYUSH sector, manpower, medicines, therapies and for infrastructure development relating to AYUSH sector.

2. As was explained under NRHM that AYUSH doctor, pharmacists, paramedical and multi purpose workers are required at all levels of healthcare delivery system *i.e.* at Sub Centre, (one AYUSH doctor for 2 sub centres), one doctor for PHCs, 2 for CHCs and four for district AYUSH centre are required. At all levels double the number of pharmacists and paramedical is required for supporting the AYUSH doctors.

(a) In the last 6 years only 28 percent PHCs/CHCs are covered with AYUSH doctor. We should aim to cover 100 percent institutions in the coming 5 years. Extension of co location to all PHCs, CHCs and DHs in the country. For hiring AYUSH doctors Rs. 1209 crores per annum is required. For hiring AYUSH Pharmacists, and other Para medics Rs. 523 crores are required.

(b) At present the available 1, 48,036 Sub-centres in the country have been left to the service of ANM and MPW (Male). The services offered in the Sub-centres are preventive, therapies, management of diarrhea, immunization, and provision of RCH services. These services can be much better provided and supervised by institutionally qualified AYUSH doctors, if one AYUSH doctor is given the charge of 2 sub-centres instead of LHV. From the current pool of 8 lakhs AYUSH doctors, we can ensure adequate supply of AYUSH doctors in the rural area. For this purpose Rs. 220.00 crores per annum is required.

3. The AYUSH doctors and therapies requires dedicated space at PHCs, CHCS and district level. So far even 5 percent institutions have not created sitting and therapy arrangemetns for AYUSH doctors. Therefore, in every PHC @ 25 Lakh (Rs. 5864.5 crores), CHC @ 50 lakh (Rs. 2138.00 crores) and district hospital @ 1.5 crore (Rs. 900.00 crores) is required to create AYUSH infrastructure. The residential accommodation for AYUSH doctor is equally important at PHC/CHC and district hospital level.

4. The pay scales and remuneration to AYUSH doctor should be equal to the MBBS doctors. There is lot of variation in the remunerations given by various States

to AYUSH doctors. There is lot of variation in the remunerations given by various States to AYUSH doctors. As a Government of India programme equality of pay scales of AYUSH doctors and paramedical staff is policy agreement which should be implemented.

5. It is equally important that AYUSH medicines and therapy related equipment like Panchkarma and Ksharsurtra etc. is provided under NRHM. AYUSH doctors appointed under NRHM are not provided with AYUSH medicines. Therefore, they are practicing allopathic medicines, which is not the object of mainstreaming of AYUSH.

AYUSH medicines for ASHA kit @ 2000 per annum, for ANM kit @ 3000 p.a. for PHC @ 1.00 lakh per annum for CHC @ 3.00 lakh p.a. and for district hospital @ 10 lakh p.a. for medicines and material should be provided under the flexipool of NRHM. Considering a total number of 8.25 lakhs of ASHAs are deployed in the country, the total financial implication would be Rs. 160.00 crores p.a. for AYUSH medicines.

6. For implementation of various activities, contingency funds are required. Therefore, under the flexi pool wherever AYUSH manpower is posted 25 percent money of contingency should be earmarked for AYUSH.

7. Supervisory, Monitoring and Administration of AYUSH manpower by senior AYUSH officers.

So far only AYUSH doctors are working in PHC and CHCs 28 percent PHCs/ CHCs. There is nothierarchy of AYUSH doctors at block level or district level AYUSH officers are not available to monitor and implement AYUSH components under NRHM. Therefore, at block level, at district level and State level dedicated AYUSH doctors should be posted at senior level who can contribute in the policy formulation and implementation of the Programme.

8. *Training Institutions of AYUSH*

Under NRHM periodic trainng, CME/ROTP programmes are required for paramedical staff and doctors. There is no dedicated institute for this purpose. For every State there is one or more dedciated centre for allopathic doctors and paramedical staff. They are not accommodation AYUSH training programme in these institutions. Therefore, in every state training institute of HFW should have a dedicated wing, manpower and other related infrastructure for training the AYUSH manpower for which Rs. 50 crore may be earmarked.

9. *AYUSH components in National Health Programmes*

As indicated earlier all the national health programmes are allopathy and western oriented. There is no component of AYUSH in these programmes. There are many strong areas of Ayurveda, Yoga, Homoeopathy and other AYUSH systems which can contribute significantly in the various national health programmes.

Conditions like malaria, recent outbreak of infectious diseases like Chickungunya, Dengue resistant tuberculosis and non-communicable diseases like diabetes and cardio-vascular disorders and other national health programmes like RCH, Geriatric care and Mental Health Programmes etc. should dedicate 25 percent funds for untilisation of AYUSH medicines, therapies and other interventions. The required R and D and

documentation required to support the intervention should also be undertaken with the funds dedicated for national health programmes.

10. *Training of AYUSH for ANM and ASHA*

Presently, the existing components of AYUSH concepts and practices, use of medicinal plants for common ailments, simple AYUSH medicine for common ailments in the training programmes of ASHA and ANM are not adequate and these components should be augmented. Training incentives to undertake AYUSH components should be specifically earmarked under the flexi pool. For this purpose Rs. 288.00 crores be earmarked @ Rs. 300 p.m. per ASHA.

11. The mobility support for various functionaries of AYUSH under NRHM should be explicitly indicated in the various sanction. Rs. 30,000 p.a. per person, total implication would be Rs. 1.8 crores.

12. The project management unit (PMU) only focus for allopathy segment only in couple of States there are PM at State level. The proper plan formulation, implementation and for reporting system of a dedicated PMU for AYUSH at district level is required. Similarly, the health management information system has been implemented upto the block level with modern medicine inputs, however, AYUSH has been grossly neglected from the database. Hence, dedicated HMIS system is to be implemented at State District and Block level for AYUSH data inflow and outflow from the States.

13. Lack of directives and guidance to AYUSH doctors working in the PHCs/CHCs.

It has come to the notice that AYUSH doctors posted in the PHCs/CHCs are not getting any directions about theirs duties and responsibilities. The absence of AYUSH medicines in PHCs/CHCs is compounding their problems. Therefore, their presence in the PHCs/CHCs is not yielding the results of mainstreaming of AYUSH. Therefore, proper guidance monitoring systems is required for their optimal utilization.

We feel that although the programme is to cater to the health services to rural India but the programme has totally ignored the involvement of AYUSH sector which is of indigenous nature and very compatible to the rural settings of India. Therefore, under NRHM there is a need of indicating vertically at every level the role of AYUSH, the budget for AYUSH, manpower for AYUSH and specific infrastructure for AYUSH. This is only possible if 25 percent NRHM funds are specifically earmarked for AYUSH sector and programme is recast by giving prominence to AYUSH sector for the coming five years of 12th Plan.

PART II

Observations and Recommendations

1. The National Rural Health Mission (NRHM) was launched in April 2005 to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas of the country especially to the poor and vulnerable sections within the Mission period upto 2012. The special focus of the Mission was on 18 States consisting of eight Empowered Action Group (EAG) States Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand, eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices. The key strategy of the NRHM was to bridge the gaps in healthcare facilities, provide health to all in an equitable manner through increased outlays, facilitate decentralized planning in the health sector, and provide an overarching umbrella to the existing disease control programmes run by the Ministry of Health and Family Welfare. The Mission sought to initiate key changes in the health sector, varying from the encouragement and development of planning capacity and community participation to an emphasis on convergence with other indicators of a 'good' life. The Mission envisages increasing expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2.3% of GDP over the Mission period (2005-2012). Other objectives of the NRHM include reduction in Maternal Mortality Rate (MMR) from 407 to 100 per 1,00,000 live births, reduction in Infant Mortality Rate (IMR) from 60 to 30 per 10,000 live births and reduction in Total Fertility Rate (TFR) from 3.0 to 2.1 within 7 years period (2005-12); universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization; prevention and control of communicable and non-communicable diseases access to integrated comprehensive primary health care; population stabilization; revitalizing local health traditions and mainstreaming of AYUSH health care etc.

2. The Committee note that under the Mission framework, the District Health Societies (DHSs) were required to prepare perspective plan for the entire Mission period as well as annual plans consisting of all the components of the Mission. These were to be integrated into the State Perspective Plan and annual State Programme Implementation Plan (PIP) respectively. The NRHM aimed to ensure that need based and community owned District Health Action Plans (DHAP) become the basis for further interventions. The DHAP was to be prepared by the DHS and approved by the District Health Mission (DHM). A DHS was to be constituted in each district by amalgamating all the existing district level societies engaged in implementing the national level health and family welfare programmes. The governing and executive bodies of the DHS were to meet at least twice a year and once a month respectively. The Committee's examination has revealed that DHM had been constituted in all districts of the 18 States/UTs and DHS formed in all States/UTs other than Jharkhand,

Orissa and Puducherry and uni-district UTs. Further, the DHM had not been constituted in any of the districts of Andhra Pradesh, Bihar, Delhi, Jharkhand, Madhya Pradesh, Mizoram and Uttar Pradesh. The Committee also find that the two bodies met at the prescribed frequency only in Andhra Pradesh. The meetings of the DHS's governing and executive bodies were never held in any district of Himachal Pradesh and Puducherry and in the remaining States, they met intermittently but at a frequency much less than the prescribed one. The Mission targeted to complete 50 per cent of household and facility surveys by 2007 and 100 per cent by 2008, which would act as the baseline for the Mission against which progress would be measured. However, the Committee's scrutiny revealed glaring lapses like delays in constitution of DHS & DHMs and in holding the prescribed meetings, laxity in conducting vital household surveys and in preparation of annual district plans. The Committee, therefore, recommend that a comprehensive central electronic database may be prepared for all districts State-wise an uploaded on the SHS's website for easy access by district planning teams. SHSs may be asked to adhere to the framework of decentralized planning to ensure that the State PIPs reflect the requirements based on actual demand. The reasons for delay in constitution of DHS and DHM may be obtained from each defaulter State and also for the laxity in holding the meetings of these bodies where constituted.

3. Under the NRHM framework the Mission Steering Group (MSG) was required to periodically monitor the progress of the Mission and also to meet twice a year. However, the Committee's examination revealed that MSG, met only four times in four years during 2005-09 instead of eight times as stipulated. Further, the delegation of powers to the MSG and Empowered Programme Committee (EPC) was subject to the condition that a progress report regarding NRHM, would be placed before the Cabinet on an annual basis. However, the Committee are concerned to note that during the past four years, the Mission had submitted a progress report to the Cabinet only once in August 2008. The Committee do not accept the plea of the Ministry that they could not apprise the Cabinet according to the prescribed periodicity for want of substantive decisions in the MSG. The admission by the Ministry that the MSG did not take any substantive decision is an eloquent comment on their poor performance which shied them away from apprising the Cabinet. The Committee hardly need to emphasise that the MSG should invariably meet twice in a year and the progress report on the functioning of the Mission must be placed before the Cabinet once a year as stipulated. The Committee are of the considered view that in the absence of a sound and strong monitoring mechanism, the planning process did not receive regular inputs and feedback and required interventions. The Committee recommend that the Monitoring framework needs further strengthening so as to ensure periodic impact assessment of the activities for timely interventions and necessary course correction by the MSG. Further, a suitable format may be prescribed for quarterly and annual reporting by DHSs and SHSs to the MSG so as to make monitoring more effective and meaningful.

4. The Committee note that besides the Mission Steering Group (MSG), the functioning of the NRHM is also monitoring by the Common Review Mission (CRM) comprising members of MSG, Public health experts, Civil Society expert etc. The

CRM visits 13-17 States every year for 2 weeks and give feed back on identified parameters of NRHM. In addtion, the Regional Evaluation Teams (RETs) located in the Offices of Regional Director, at Lucknow, Patna, Kolkata, Chennai, Bengaluru and Bhopal undertake tours to the districts every month to evaluate the implementation of health and family services provided in the States under NRHM. Out of 626 districts in the country, only 82 & 86 districts were covered by the RETs during 2007-08 & 2008-09 respectively. Though the number of District covered by RETs increased to 116 during 2009-10 nevertheless, the performance is far from satisfactory. They therefore, recommend that CRM and RETs should undertake visits to more States and also make the inspections positively impactful. The Committee would like to be apprised of the tangible impact made by the various measures initiated by the Ministry fulfilling the objectives of the Mission within six months from the presentation of this Report.

5. The Committee are happy to note that as desired by the Committee, the Ministry have issued an order dated 15th September, 2010 constituting a District and Vigilance Monitoring Committee under the Chairmanship of the Local Member of Parliament. The Committee desire that the Monitoring Committee so constituted under the Charimanship of the local MP should be broadbased to include local MLAs, Chairman Zila Panchayat, District Health Officer/Chief Medical Officer and senior AYUSH doctor as members. The Committee trust that the Ministry would take necessary action for notifying the names of the Members of Parliament who would be heading the respective District and Vigilance Monitoring Committees, on the lines done by the Ministry of Rural Development, so that the Vigilance and Monitoring Committees come into effect expeditiously and start functioning.

6. With a view to ensure community involvement in planning, management and monitoring of the Mission at the grass root level, the NRHM framework envisages that a Village Health and Sanitation Committee (VHSC) may be formed in each village within the overall framework of the Gram Sabha. The Ministry had set the goal of constituting VHSC in 30 per cent of six lakh villages by 2007 and 100 per cent by 2008. Surprisingly, in nine States/UTs (namely Himachal Pradesh, Bihar, Chandigarh, Dadra and Nagar Haveli, Assam, Orissa, Tripura, Uttarakhand and Daman and Diu) the VHSC had not been formed in any village, whereas in Rajasthan and Uttar Pradesh, the Committee was formed in less than 30 per cent of the village and in rest of the 14 States/UTs, VHSCs were formed in a widely varying percentage falling far short of the fixed goal. To a pointed question, the Ministry conceded that the CHSC members were not fully aware of their roles and responsibilities and hence were hesitant to fully utilize the flexibility provided to them. The Committee, while emphasizing the need for launching a publicity campaign to sensitize the villagers for their effective participation in VHSCs, recommend that the VHSCs be formed in every village as per the guidelines and the funds released to the SHS only after the VHSCs are formed and start monitoring the Health delivery services.

7. The Committee note that every village with a population of up to 1500 was to receive an annual untied grant of up to Rs. 10,000 after constitution and orientation of the VHSC. The untied grant was to be used for household surveys, health camps,

sanitation drives, revolving fund etc. The Committee find that during 2006-07, untied grants of Rs. 123.62 crore was approved/released to 19 States whereas VHSCs were formed only in two States resulting in non-utilisation of Rs. 119.28 crore and of Rs. 123.62 crore released to the SHSs for the VHSCs. Similarly, during 2007-08, Rs. 282.52 crore was approved/released as untied grants to the health societies of 28 States/UTs including the eight States where no VHSCs were formed. The Committee are concerned to note that disbursal of funds to the VHSCs by the States is not reported and only the actual expenditure incurred by the VHSCs is reported on quarterly basis through Financial Management Reports (FMRs). During the first quarter of 2010-11, the expenditure reported by the VHSCs was Rs. 68.48 crore and the Ministry suspected that about Rs. 100 to 200 crore was lying unspent. The Committee, therefore, recommend that the Ministry need to streamline their monitoring system urgently so as to ensure that untied grants released to States are actually passed on to and spent by the VHSCs and reflected in the FMRs. They also recommend that the Ministry should release funds to SHS only after receipt of UC for the previous year and on the assurance from the SHS that the untied funds are utilised in consonance with the guidelines so as to prevent diversion/misuse of the funds. The interest earned on the unspent balance by the SHS and its utilization must also be reflected in the audited accounts.

8. The NRHM contemplated increase in expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2-3% of GDP over the Mission period (2005-2012). The Mission also aimed to annually increase the allocation by the Central Government for the health sector by 30 per cent up to 2007-08 and by 40 per cent from 2009-10. The Committee note that during 2005-06, *i.e.* the year of commencement of the NRHM, the revised estimates regarding budgetary allocation for the NRHM was pegged at Rs. 6637.82 crore, whereas the amount released was Rs. 6286.48 crore and the expenditure actually incurred was Rs. 4873.12 crore. Though the budgetary allocation to the Mission was increased to Rs. 15,440 crore (Budget estimates) during 2010-11, however, the funds released to the Mission upto 31st October, 2010 were merely Rs. 7451.64 crore. The Committee are perplexed to note that the proportion of the public expenditure on Health is currently 1.1% of GDP which is less than 50 per cent of the target of 2-3% set under the Mission. Still worse, the per-capita expenditure/allocation by the Central Government under NRHM has increased by an average of merely 15 per cent per annuam in nominal terms since its inception as against the targeted increase upto 30 per cent by 2007-08 and by 40 per cent from 2009-10. The Committee wonder whether the laudable targets set under the Mission would be achieved considering the half-hearted and grossly inadequate allocations for the purpose.

9. As regards the allocation required for the terminal year of the 11th Plan (2011-12) and for the 12th Plan period (2012-13 to 2016-17), the Ministry have worked out two alternative scenarios. In scenario I, the Ministry have estimated that around Rs. 20,150 crore would be required in the terminal year of the Eleventh Five Year Plan (2011-12), as against the allocation of Rs. 15,440 crore in 2010-11. Assuming that the nominal per-capita allocation would need increase by around 20 per cent annum in the Twelfth Five Year Plan, the Ministry estimated that the

per-capita allocation on NRHM will have to increase from Rs. 240 in 2011-12 to around Rs. 600 in 2016-17 at current prices. Taking into account the projected per capita allocation needed at the end of 12th Plan period (2016-17) and the projected rural population of 88 crore, the Ministry estimated that the fund requirement of NRHM would have to increase from around Rs. 20,150 crore in 2011-11 to Rs. 52,500 crore in 2016-17. The total requirement for Central sector allocation for NRHM for the Twelfth Plan in nominal terms is thus estimated to be around Rs. 186,000 crore. In scenario II, the Ministry worked out the projected expenditure, based on the estimates available from the World Health Statistics, brought out by the World Health Organization (WHO), according to which the per-capita public expenditure on health in India was estimated at $7 for the year 2006. Assuming an exchange rate of Rs. 46.5 per US $, the Ministry estimated that the per-capita requirement of public allocation by the Central Government for NRHM works out to around Rs. 792 in 2016-17. The Ministry stated that the requirement for Central sector allocation for Twelfth Plan works out to around Rs. 2,25,000 crore for NRHM and around Rs. 70,000 crore for the terminal year of the Twelfth Plan. The Committee are perturbed to note the abysmal low per capita public expenditure on the health care in India which was estimated to be US $ 7 during 2006 as against a per capita public expenditure of US $ 30 of a neighbouring countries like Sri Lanka. At such a paltry rate of public expenditure on health care, the Committee fear that the goal of universal health care to all the citizens as envisaged in the Mission may remain a pious platitude and a distant dream. The Committee are of the considered view that of all the charges on the resources of the State, the expenditure on public health must receive earnest consideration and priority. The Committee, therefore, recommend that Government must scale up the budgetary outlays for the NRHM for both the terminal year of 11th Plan and for the 12th Plan period so that the laudable objective of providing universal health care to the rural population is attained. At the same time, the Ministry need to take all possible measures to ensure that the absorption capacity of the health infrastructure—both at the central level and that of the States is commensurately increased.

10. During the 11th Five Year Plan (2007-12), the States were to contribute 15 per cent of the funds requirement of the Mission. However, the Committee note that during 2007-08, only 4 States/UTs *viz.* Andhra Pradesh, Bihar, Gujarat and West Bengal made the desired contribution of 15 per cent of the State PIP from their own budget. Though Six States/UTs (Assam, Chhattisgarh, Haryana, Rajasthan, Sikkim and Chandigarh) also contributed to the NRHM from the State/UT budget, but their contribution ranged between 0.54 to 13.59 per cent. The remaining 18 States/UTs (referred to in Paras 82 and 84 of the Reports) did not contribute at all to the NRHM from their own budget during 2007-2008. The Committee are surprised to note that despite the Ministry's directive that the States have to transfer 15 per cent of their share to the State Health Societies from the State funds from 2008-09, some State Governments like Manipur and Lakshadweep did not make any contribution in 2008-09, while the contribution made by 24 States/UTs was less than 15 per cent. The Ministry clarified that in 2007-08 many of the States were not having a separate budget line for NRHM and therefore States contributed funds directly through the

treasury route. The Ministry further stated that linking the Central release to release of State share was not done earlier to ensure that the health system does not suffer a setback on account of non-availability of funds. Obviously, such a gross violation in earmarking requisite funds by the concerned States shows lack of regard for the laudable objectives of the Mission. The Committee, therefore, recommend that the release of future instalment to the defaulter States may be made contingent upon their making the stipulated contribution and recouping the accumulated short contribution to the State Mission budget.

11. The Committee are concerned to note that out of the pocket expenditure on health incurred by the households contituted around three fourths of the total expenditure in the health sector. The Ministry conceded that as per the National Health Accounts India 2004-05 (with Provisional Estimates from 2005-06 to 2008-09), the Total Out of Pocket Expenditure (TOPE) constituting the expenditure incurred by the households, social insurance funds, firms and the NGOs accounted for 78.05 per cent of the total expenditure in health sector in the year 2004-2005 which fell to 71.62 percent in the year 2008-09, showing a slight decline. Explaining the impact the NRHM had in reducing out of pocket expenditure by the Rural House Holds, the Ministry stated that the increase in the coverage of pregnant women from backward classes and low income groups for institutional delivery had the connotation of reduction of out of pocket expenditure. In addition, drugs and medicines provided free at the CHCs, PHCs and Sub-centres under the NRHM also helped reduce the out of pocket expenditure of rural households. The Committee find the contention of the Ministry quite untenable as the Mission had made no significant impact on reduction of the out of the pocket expenditure. The Committee are of the view that given the huge shortage of funds and manpower and backlog in creation of assets, it would take several long years for the Mission to reduce significantly the out of pocket expenditure of the rural households on health. No wonder, unless there is adequate increase in budgetary outlays the Mission would not be able to achieve the intended objective in this behalf. They, therefore, recommend commensurate increase in budgetary outlays and concomitant increase in absorption capacity of the health delivery system under the NRHM so as to bring down significantly the total out of pocket expenditure of rural house holds on their health.

12. The Committee are distressed to note that a large number of Health Centres at various levels *viz*. sub-centres, PHCs and CHCs are located in sub-standard environment such as garbage dumps, cattle sheds, stagnant water bodies, pulluting industries etc. and functioning in unhygienic conditions. Besides, these health centres lacked essential infrastructure *viz.*, water supply and storage tanks, facilities for disposal of sewage and biomedical waste and separate utilities for men and women. The Committee wonder how these health centres would be able to attract patients given their pathetic and shabby conditions. It is therefore, not surprising that rather than curing diseases such health centres will not only breed and spread diseases to otherwise healthy patients and their attendants but also drive away the patients to private health facilities thereby unwittingly defeating the very purpose of setting up these health centres. The Committee desire that the Empowered Programme Committee (EPC), being the apex body for supervision and monitoring of the

functioning of the Mission, should pay full attention to this important aspect so as to ensure that the State Governments take immediate corrective steps to maintain requisite infrastructure facilities and standard hygiene levels in all the health centres. The data regarding the conditions of hygiene at all the Health Centres should be maintained centrally and monitored regularly through quarterly/monthly reporting system.

13. The Committee note that NRHM aimed to ensure two ANMs at 30 per cent Sub Centres by 2007 and 60 per cent by 2008 with the second ANM being appointed on a contract basis. The Mission also envisaged that PHC was to be manned by a medical officer besides an AYUSH doctor on contract basis and three staff nurses were also to be appointed at each PHC (at 30 percent PHCs by 2007 and 60 per cent by 2008). Further, the CHC under the Mission is to be provided by seven specialist doctors and nine staff nurses under the Indian Public Health Standards (IPHS) (30 per cent by 2007 and 50 per cent by 2009). However, the Committee's scrutiny revealed that 116 Sub Centres (9 per cent) in 20 States/UTs were functioning without an ANM. At 992 Sub Centres (77 per cent) of 29 States/UTs two ANMs were not posted and in 10 States/UTs none of Sub Centres had two ANMs. The deployment of MPWs was inadequate in as many as 775 Sub Centres (60 per cent) in 27 States/UTs. In 5 States/UTs none of the test checked Sub Centres had an MPW. The Committee are started to find that 71 PHCs (11 per cent) in 15 States were functioning without an allopathic doctor, in 518 PHCs (86 per cent) of 28 States/UTs an AYUSH doctor had never been appointed and the 69 PHCs test-checked in Audit were functioning without an allopathic doctor or an AYUSH doctor. With respect to CHCs, the Committee note that the availability of specialist doctors was equally worse and disappointing. Undoubtedly, the availability of skilled human resources and their proper deployment at all levels under the NRHM, being the critical variables for effective provision of health care, assume critical importance in the delivery of healthcare to the rural populace. The Committee, therefore, recommend that immediate steps must be taken for recruitment/deployment of adequate and skilled human resources in the health centres in the rural areas as also to check absenteeism in order to make the NRHM a success story.

14. A trained female community health worker, namely Accredited Social Health Activist (ASHA), was to be placed in each village in the ratio of one per 1000 population (or less for large isolated habitations) as a part of NRHM framework in the 18 high focus States using the Mission Flexible Pool funds. The ASHA was expected to act as an interface between the community and the public health system. The Committee note that ASHA had been engaged in all high-focus States, except Himachal Pradesh but in six high focus States namely Arunachal Pradesh, Bihar, Madhya Pradesh, Rajasthan, Tripura and Uttar Pradesh the shortfall in the selection of ASHA ranged between 4 to 24 per cent. Among non-high focus States, while Andhra Pradesh had engaged 28 per cent more ASHAs than required as per population norm, Maharashtra had engaged ASHAs only for the tribal areas. The Committee are dismayed to note that none of the States/UTs had imparted all the five normative modules of induction training to all the selected ASHAs nor were they provided with a drug kit in the 13 States/UTs. The Committee recommend that a time bound training programme may be drawn by the Ministry expeditiously for the ASHAs so that they are fully trained

and well-equipped with necessary drug kits to take up the multifarious healthcare activities assigned to them under the Mission. Further, the Government need to provide suitable incentives to them so as to reduce the rate of attrition amongst ASHAs. The Committe would like to be apprised of the number of Accredited Social Health Activists imparted training so far and the numbers yet to be trained and the incentives being provided to them.

15. The Committee are greatly concerned that there is a general tendency amongst doctors and paramedical staff not to work in Sub Centres/Primary Health Centres/ Community Health Centres for different reasons. the doctors/paramedical staff posted to work in the rural areas either do not join or proceed on leave or quit the job, obviously for lack of proper facilities and other standard living conditions at the Health centres. The Committee, recommend that the Government should take necessary steps to provide necessary infrastructure and standard living facilities at all the Sub Centres/Primary Health Centres/Community Health Centres so that the doctors and other medical staff are encouraged to stay there. They may also consider giving monetary and other incentives to doctors/staff so as to make rural posting attractive enough.

16. The Committee deplore that in 26 States/UTs (except Goa, Gujarat, Maharashtra, Nagaland, Orissa, Tamil Nadu, Uttarakhand, Daman and Diu and Puducherry) SHSs had no documented procedures and practices on procurement as required under the NRHM. The Committee note that the Ministry has set up an Empowered Procurement Wing (EPW) in October 2005 to consolidate, streamline, strengthen and professionalize the procurement of health sector goods under the NRHM. The EPW was to have three functional units, *viz.* Health, Family Welfare and Universal Immunisation Programme, under three Directors headed by one Joint Secretary. However, the Committee's scrutiny makes startling disclosures like inordinate delay in setting up a centralized, professional and efficient procurement agency and lack of effective oversight mechanism for monitoring the procurements, within the fixed time schedule, absence of the much needed computerized date base containing data of firms holding the Good Manufacturing Practices (GMP) certificate, market surveys/market intelligence, complaints received and services etc. Besides, no progress had been made by the EPW to build capacities of the States and the dependent agencies and monitor them for improving procurement of health sector goods and services. The Committee are saddened to observe note that in absence of computerized database and integrated procurement plan, the EPW failed to monitor the procurement activities in the various divisions under the Ministry and in the States. Post Audit, the Ministry did initiate some actions belatedly in January, 2009 for setting up a Centralized Procurement Agency (CPA). The Committee would like the establishment and operationalisation of the CPA to be expedited, since the Mission has entered its fifth year of operation. The Committee further recommend that the SHSs may be asked to adopt and follow the procurement manual developed by the Ministry for all subsequent procurement activities so as to ensure uniformity and standardization countrywide. EPW's functioning in terms of technical and professional expertise may be strengthened so as to infuse professionalism in the management of high value centralized procurement of medicines and equipment

under the NRHM. They further recommend that Department should strengthen internal controls to check delay in procurement process, avoid excess procurements and stockouts and ensure purchases of good quality medicines and equipment at the most competitive rates in accordance with the canons of financial propritely. The procurement procedures and bidding documents should be reviewed and a model manual prepared and adopted for setting out the standard procurement procedure. The Committee also recommend that the Ministry and the States should share the data regarding blacklisted firms on their websites.

17. The Committee note that the Ministry has prepared and placed on its website a common formulary containing the names of essential generic drugs conforming to the Indian Public Health Standards (IPHS) for facilities under NRHM. Each State is required to prepare such a standard formulary, allowing local variations from State to State contingent upon the nature and disease burden, for prescription by all hospitals/ doctors. The Committee are seriously concerned that such a common formulary was prepared in 14 States/UTs whereas 13 States/UTs grossly disregarded NRHM directive. While emulating the Haryana model, the representative of the Ministry assured the Committee to replicate the same in other States. The Committee hardly need to caution that a good health care system, considering the poor paying capacity and the awareness level of the rural people, call ill-afford to make available drugs of different proprietary brands of widely varying prices. The Committee would like each State/UT to prepare a common formulary of essential drugs for mandatory prescription of generic drugs therefrom by the hospitals/doctors in each State/UT so that poor patients are not fleeced and they are supplied standard quality drugs on time.

18. The Committee are perturbed to note that the stock of essential drugs, contraceptives and vaccines required to meet the consumption need of two months was not available in any of the test checked PHCs and CHCs in nine States/UTs whereas in six States, two months' stock was available partially at sample health centres (as referred to in para 124 of this Report). Of course, post Audit, the position has reportedly improved and Procurement Plan has been prepared in respect of all programme divisions of the Ministry, which contains the date line for the various activities starting from bid preparation and ending with completion of contract. To facilitate the States to have a proper procurement system, detailed guidelines on procurement were prepared and circulated to them. Nothwithstanding the measures belatedly initiated by the Government, the Committee note that non-availability of essential medicines, vaccines etc. at various levels *viz*. sub-centres, PHCs, CHCs and District Hospitals remains a chronic problem faced by the poor patients in the rural areas. The Committee, therefore, recommend that the Ministry take all possible steps including stringent periodic monitoring to ensure timely availability of adequate quantity of qualitative essential medicines, vaccines etc. in all the health facilities. The particulars of the States performing well and those lagging behind may be furnished to the Committee and also placed in the public domain periodically.

19. The Committee note that pre and post-shipment quality tests are essential, especially in the case of purchase of medicines. However, the Committee note that in three States namely Orissa, Jharkhand and West Bengal cases of procurement of sub-standard drugs or procurement of drugs without assuring quality was noticed.

In Orissa, in 14 cases, time expired medicines of Rs. 3.02 lakh were administered to patients due to late receipt of communication from State Drug Management Unit (SDMU) declaring the drugs as 'not of standard quality'. In Bihar, the mechanism for test check of drugs was non-existent and medicines were issued to poor patients without ensuring quality. The Secretary (Health) testified that purchasing of drugs or the governance part of it, squarely rests with the State Government and the Union Government can only ask the States to take corrective action. Further, the licensing of the generic drug producers is done by the State Drug Controller and the Drug Controller of India under the law has no say in the matter. The Committee find such a view of helplessness and despair rather self defeating when the Drug Controller of India is empowered to conduct raids across the States and pick up suspected drugs for lab tests. Further, NRHM being a Central Scheme, the Ministry should counsel and exhort the States and assert its financial authority to ensure that quality medicines are made available at all health centres by the respective State Governments. The Committee also recommend that Ministry should take immediate necessary steps to bring forward a legislation to amend the Drug Control Act bestowing powers on the Central Government to ensure supply and availability of quality medicines at affordable prices in the Country. More so, the need for a strong legislation assumes far greater importance in view of the veiled moves by many MNCs to take over Indian companies producing drugs with an eye to ban or restrict Indian production, create monopolies and soar up the prices of drugs.

20. The Committee note that Under Maternal health, the Reproductive and Child Health (RCH-II) aimed to reduce maternal and infant mortality rates to 100 per one lakh and 30 per thousand, respectively by 2010. The Committee also note that the Janani Suraksha Yojna (JSY) scheme had the twin objectives of reducing maternal and infant mortality by providing cash incentive to pregnant women of BPL/SC/ST families in all States and all pregnant women in ten low performing States (eight EAG States, Assam and Jammu and Kashmir). The primary objective of the scheme was to increase institutional deliveries and achieve the target of 100 per cent institutional deliveries by the end of 2010. However, the Committee's are unhappy to note that in 12 States/UTs the SHS did not prescribe year-wise targets for institutional deliveries. Shortfall in target achievement was noticed in 11 States which ranged between 25 to 81 per cent in six States. Further, even in 47 audited districts of low performing States, shortfall was noticed in 19 districts (40 per cent) and shortfall was not measured in 16 districts due to non-fixation of targets. The Ministry owes explanation for these alarming shortfalls and deficiencies in their implementation of JSY. The Committee would like to be apprised of the concrete measures taken to bring down drastically the maternal and infant mortality rates.

21. The Committee note with serious concern that the Micro Birth Plan had not been prepared in the audited districts at the PHC and Sub-Centre levels in 17 States. Further, in 13 out of 20 States, less than 50 per cent of total registered pregnant women preferred institutional delivery at health centres. In 19 out of 23 sample districts of 6 States, domicillary deliveries were more than institutional deliveries as highlighted in para 147 of this report. Besides, women were discharged after delivery but without the minimum prescribed stay. Obviously, want of prescribed post natal

care is fraught with serious health hazards. Similarly, as regards Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), there were large gaps between the targets and the actual achievements made. The Committee, therefore, recommend that the monitoring and reporting mechanism under Janani Suraksha Yojana be strengthened and streamlined so as to ensure availability of reliable information with the State and District Health Societies. Needless to say, this would also help mitigate the risk of fraud and irregularities in grant of cash compensation under the JSY. New technologies such as laparoscopy in tubectomy, new spacing methods etc. should be made available at prescribed levels of Health Centres. Usage of oral pill and Intra Uterine Device (IUD) may be encouraged among women. Further, training in IUD insertions needs to be provided to doctors, nurses and ANMs posted in PHCs and CHCs. The Committee are quite optimistic that full measure publicity campaigns across the country would go a long way to heighten public awareness, encourage safe institutional deliveries and bring down drastically the infant-maternal mortality rates.

22. Undoubtedly, maternal mortality and the health of the pregnant mother are closely inter-linked. The maternal deaths occur predominantly because of malnutrition to the pregnant mother and due to lack of pre-natal care and weak adolescenthood. What could be the fate of the weak mother with high degree of anemia is very well guessed. Obviously, merely by focusing on institutional delivery will not guarantee that there would be no maternal deaths. The Committee, are therefore, of the considered view that the Ministry needs to take a holistic view of the problem and take appropriate measures for integrating nutrition with obstetric care *i.e.*, pre and post natal care and also for convergence of various programmes run by the other Ministries such as Woman and Child Development with that of NRHM so that the problem of IMR/MMR can be effectively tackled. The Committee are perturbed to note the skewed sex ratio in some States especially in Punjab, Haryana and Uttar Pradesh. The Committee, therefore, recommend that Government should keep a close watch on the gender disparity in these States and take conscientious and stringent measures to prevent female foeticide.

23. The National Policy on Indian Systems of Medicine & Homoeopathy-2002 stipulated that the share of plan outlay for Department of AYUSH in the total Health budget be increased by 10% with a designed growth of 5% in every Five Year Plan. The Committee note with concern that despite increase in the budget allocation of the Department of AYUSH from 775.00 crore in the 10th plan to Rs. 3988.00 crore in the 11th Plan, it has not been able to meet the 10% overall allocation of the Health budget. The Secretary (Ayush), during evidence deposed that the budget component for Ayush in the NRHM for the 11th Plan was Rs. 625 crore, out of which they had exhausted nearly Rs. 500 crore. The representative (AYUSH) further testified that while the total allocation to the Department of Health and Family Welfare under NRHM was about Rs. 15,000 to Rs. 20,000 crore per year, the Department of AYUSH got only Rs.625 crore for the entire plan as against the assurance that they would get an allocation of Rs. 4,000 under the 11th Plan. The Department of AYUSH informed

the Committee that the estimated budgetary outlay/expenditure could be Rs. 8000 crore during 12th Plan. The Committee express serious concern over the fact that despite the stipulation in the National Policy on Indian Systems of Medicines & Homoeopathy-2002 that the share of plan outlay for Department of AYUSH in the total health budget be increased by 10 percent, the same has not been achieved even after lapse of 8 years. What disturbs the Committee most is the fact that despite the recommendation made by PAC in their 38th Report (14th Lok Sabha) for stepping up allocation of AYUSH and the Government's own stated resolve, no tangible progress has been made in increasing the allocation to Department of AYUSH. The Committee recommend that the budgetary outllay for the Department of AYUSH be suitable enhanced during 12th Plan to fulfil the avowed objective of mainstreaming of AYUSH in National Healthcare as enunciated in the National Policy 2002. They also recommend that the Planning Commission need to step up the allocation during the 12th Plan by 25 percent for achieving the target set under the Mission. There is also an overriding need for mainstreasming AYUSH with NRHM and the National Healthcare System, considering the long-established and wide spread reliance placed on the AYUSH system in the rural areas across the country. Taking note of the adverse side effects of many modern medicines, their prohibitive cost and the growing number of people looking east and preferring the time tested traditional health care systems like Ayurveda, Siddha, Unani, Yoga, Naturopathy and Homoeopathy, the Committee are of the considered view that it is opportune time to convert the Department of AYUSH into a full fledged Ministry which may be rechristened as the Ministry of Indigenous Systems of Medicine or AYUSH Ministry.

24. As regards mainstreaming of AYUSH under NRHM, the Department of AYUSH informed the Committee that they seek to achieve the objective by providing AYUSH facilities in the Primary Health Centre (PHC), Community Health Centre (CHC) and District Hospital (DH) and by strengthening the existing stand alone AYUSH Hospitals & Dispensaries. The Ministry further informed that AYUSH facilities have been co-located at 312 District Hospitals, 1695 Community Health Centres (CHCs), 896 Centres other than CHCs, 6663 Primary Health Centres and 2568 other facilities above Sub-Centres. It was also informed that as against total 23474 PHCs, 4276 CHCs and 571 District Hospitals spread across the country, 7993 AYUSH Doctors and 3232 Paramedic Staff had been appointed as on 30.6.2010, on contractual basis under Mission Flexi pool of NRHM at co-located AYUSH units in 6663 PHCs.

2568 other health facilities above-Sub Centres, 1695 CHCs, 896 other than CHCs and 312 District Hospitals. The Department of AYUSH further stated that the shortage of AYUSH doctors and paramedics in PHCs/CHCs was not brought to their notice by the States. Taking note of the serious shortages of AYUSH doctors and other paramedical staff at co-located AYUSH units in PHCs., CHCs and District

Hospitals etc. *vis-a-vis* the total health facilities established in the country, the Committee recommend that the human infrastructure in respect of AYUSH facilities under the NRHM should be increased suitably and integrated with the Healthcare System. They also recommend that the Department of AYUSH should ascertain the shortage of AYUSH Doctors in PHCs and CHCs from the respective States and provide financial assistance to enable the States to fill up all the vacancies. The Committee are perturbed to note the prevalent disparities in the remuneration given by various States to AYUSH doctors *vis-a-vis* allopathic doctors. The Committee recommend that Government should take necessary steps in consultation with State Government to ensure that there is no disparity in the pay scales and remunerations given to AYUSH doctors and the MBBS doctors.

25. The Committee are of the view that health system/services at the village level should be accessible and affordable. They should not only be self-reliant and sustainable but also use simple appropriate technology in diagnosis and treatment. The orientation of the AYUSH doctors as well as AYUSH paramedical staff is very much congenial to and compatible with the rural settings and sub-urban areas. Fortunately, the country has a huge pool of trained AYUSH doctors, numbering eight lakh out of which more than 5 lakh are institutionally trained degree holders. Their teaching and training contains the basic elements of modern medicines like anatomy, physiology, health & hygiene related issues as well as all the components of Ayurveda, Unani, Siddha dealing with medicines surgery, gynae, obstetrics and paediatric related practices of AYUSH. These doctors if utilized in the health care delivery system of India right from sub-centre, PHCs, CHCs, Sub-district and district hospitals can make a difference in implementing various programmes under NRHM. However, the Committee note that during the past 4 years, only 28 percent doctors have been deployed under the mainstreaming strategy, while there are 23458 PHCs, 4276 CHCs and approximately 600 DHs in the country. Similarly, the gap in development of AYUSH pharmacist and Paramedical Staff including Panchkarma and Ksharsutra therapists is also quite evident. The Committee further not that the sub-centres in the country have been left to the service of ANM and MPW (Male). As the services offered in the sub-centres are preventive therapies, immunization, and provision of RCH services, these can be provided and supervised much better by the institutionally qualified AYUSH doctors, if one AYUSH doctor is given the charge of 2 sub-centres. Similarly, there is also need for posting a Yoga therapist in the ratio of 1:4 *i.e.*, 1 yoga therapist for 4 PHCs or one for each cluster of PHCs.

26. The Committee note that the Department of AYUSH have prepared a suggestive list of AYUSH drugs and forwarded the same to the States and also circulated the guidelines regarding procurement of essential drugs for Hospitals and Dispensaries as per the scheme of NRHM. These drugs and medicines are to be procured from M/s Indian Medicine Pharmaceutical Corporation Ltd. (a Central Public Sector Undertaking) or from Public Sector Undertakings, Pharmacies under State

Governments and Co-operatives, who are GMP compliant, keeping in view the need for ensuring quality of AYUSH drugs and medicines. Rs. 647 crore were released to the State Governments for purchase of AYUSH medicines during the 10th Plan. In order to ensure supply of quality AYUSH medicines to the Hospitals and Dispensaries, the Secretary (AYUSH) stated that they have a partnership with the Quality Council of India and measures were underway for introduction of AYUSH mark on medicines, and for constantly improving the Good Manufacturing Practices (GMP) and even the WHO GMP. The Committee note that notwithstanding the steps taken by the Department of AYUSH for ensuring procurement and supply of quality Ayush medicines, the medicines are not available in the AYUSH dispensaries/hospitals across the country. The Department of AYUSH, therefore need to secure the co- operation of the States for ensuring availability of AYUSH medicines in all the health facilities. The Committee recommend that Department of AYUSH should take measures for standardizing the AYUSH drugs/medicines by way of ensuring that these products are certified with AYUSH mark. This will not only give assurance to the customers/patients about the quality of the medicines but also promote business of the companies producing 'AYUSH mark' medicines. They also recommend that financial assistance should be given to the drug manufacturers of AYUSH medicines to enable them to undertake Research & Development and also to patent the medicines. Measures also need to be taken to ensure timely and adequate supply of standard AYUSH medicines in all the CGHS run AYUSH dispensaries. The Committee also recommend that considering India's rich biodiversity, a 5 years special plan for AYUSH should be formulated to encourage cultivation of herbal medicines in the States where climatic condition are congenial for growth of such plants both for domestic consumption as well as export. This will not only lead to income generation for farmers but also provide Sample employment opportunities to the youth as the nascent AYUSH industry has tremendous potential considering its growing popularity world-wide.

27. The Committee are disheartened to note that the health care system in India in general, including all the national health programmes is allopathy centric and western oriented and there is no integrated component of AYUSH in these programmes in terms of medicaments, therapies and interventions. AYUSH medicines are reportedly quite effective in combating children diseases, besides contributing significantly in reducing ailments like malaria, Chickungunya, Dengue etc. The Committee recommend that for non-communicable disease like diabetes, cardio-vascular disorders and resistant tuberculosis and other national health programmes like RCH, Geriatric care and Mental Health Programmes etc., the Government should earmark 25 per cent funds for utilization of AYUSH medicines, therapies and other interventions. The required R&D and documentation required to support the inteventions should also be undertaken with the funds dedicated for the national health programmes.

28. The Committee note the widely held view that there are certain Yoga Asanas, which if done during pregnancy, help improve the muscular activity of the expectant mother and aid in safe delivery. The Committee, therefore, desire that the Department of Ayush undertake a comprehensive and empirical study to ascertain how Yoga can help in safe delivery and minimize or avoid recourse to painful caesarian deliveries often at prohibitive cost. They also recommend that such Yoga Asanas/practices need to be standardized and widely popularized as an effective system of safe and healthy delivery.

29. The Committee recommend that an all India database of reputed practitioners in the fields of all branches of AYUSH, the villages and the regions where it is practiced alongwith the places where traditional AYUSH medicines are available should be created and widely disseminated so as to extend the outreach of AYUSH to the people. The Committee also recommend that the data on the traditional knowledge systems of medicines should be collected, collated, tested and codified and certified of their authenticity. The database so compiled should be digitalized and constantly updated. Further, there is an imperative need to standardise yoga asanas/postures and maintain a strong database so that India's great civilisational heritage is not patented or arrogated by unscrupulous elements/countries.

30. The Committee note that the oft-invoked plea that health is a State object didn't deter the Ministry of Health and Family Welfare to launch the NRHM to create the intended health care facilities across the country. They are of the considered view that the primary responsibility for attaining the Mission objective in an efficacious manner within the given timeframe lies with the Government of India. The Committee believe that children have an inalienable right to life with dignity and therefore, it is incumbent upon the Union of provide accessible, affordable and reliable health care facilities to its citizens especially the expectant mothers, the new borns and the children. The Committee hardly need to emphasise that a healthy citizenry is the real wealth of a nation and also its wealth-multiplier. Considering the mutually invigorating relationship between health and wealth, the Committee firmly believe that in such a critical area like health care, time is of the essence. They are therefore optimistic that with constant interaction, persuasion, sustained monitoring and guidance with a right mix of financial support to the States, the Government can certainly achieve the laudable goals of the Mission and make the NRHM a resounding success.

31. The Committee recommend that the Good Governance and Best Management Practices that have been noticed with respect to certain aspects of the functioning of NRHM in the States like Haryana, Madhya Pradesh and Rajasthan should be flagged, studied in depth by the Ministry and wherever feasible, replicated in the States. The Committee also recommend that the Ministry of Health should also conduct a study of the best health care systems and models obtaining in different countries-both developed and developing countries and also evaluate thoroughly the implementational bottlenecks so that the Mission is restructured suitably during the 12th Plan period to make it really a grand success. The Committee in particular would like the Ministry to study the Cuba model, which is considered to be one of the best health care systems in the World.

32. The Committee are perturbed to note that despite allocation of huge funds under NRHM, glaring deficiencies/shortcomings have been noticed in its implementation. The performance in respect of key indicators *viz.* Total Fertility Rate (TFR), Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) is far from satisfactory and abysmally fall short of the stipulated targets. As against the set target of reduction of TFR from 3.0 to 2.1 within the Mission period (2005-12), the achievement uptil 2008 was stated to be only 2.6. Similarly against the target for reduction of IMR from 60 to 30 per thousand live beths, the achievement uptil 2008 was merely 53. As regards the MMR the achievement uptil 2006, was stated to be 254 as against the target of 100 per 1,00,000 live births. Surprisingly, no study has been conducted either before the launch of the Mission or after so as to take necessary course correction in the implementation of the Mission, keeping in view the aggregate expenditure of Rs. 45,776 crore on NRHM since its launch in 2005 till 2009-10. Given the glaring deficiencies, loopholes, infirmities and want of effective monitoring mechanism, the NRHM warrants a thorough restructuring so as to remedy the shortcomings and difficulties in its effective implementation so that the laudable goals of providing accessible, affordable effective and reliable health care to the rural people especially the poor are attained.

NEW DELHI;
18 *March*, 2011
29 *Phalguna,* 1932 (*Saka*)

DR. MURLI MANOHAR JOSHI
Chairman,
Public Accounts Committee.

ANNEXURE I

TOTAL SPECIALISTS AT CHCs

Total Specialists [Surgeons, OB&GY, Physicians & Paediatricians]

Sl.No.	State/UT	(As on March, 2009) Required[1] [R]	Sanctioned [S]	In Position [P]	Vacant [S-P]	Shortfall [R-P]
1.	Andhra Pradesh	668	668	480	188	188
2.	Arunachal Pradesh	176	NA	9	NA	167
3.	Assam	432	NA	142	NA	290
4.	Bihar	280	280	104	176	176
5.	Chhattisgarh	576	576	145	431	431
6.	Goa	20	14	14	0	6
7.	Gujarat	1124	338	76	262	1048
8.	Haryana	372	173	79	94	293
9.	Himachal Pradesh	292	NA	0	NA	292
10.	Jammu & Kashmir	340	381	138	243	202
11.	Jharkhand	776	NA	341	NA	435
12.	Karnataka	1296	843	691	152	605
13	Kerala[3]	904	633	794	*	110
14.	Madhya Pradesh	1332	502	245	257	1087
15.	Maharashtra	1504	314	438	*	1066
16.	Manipur	64	40	2	38	62
17.	Meghalaya	112	3	4	*	108
18.	Mizoram	36	0	0	0	36
19.	Nagaland	84	4	2	2	82
20.	Orissa	924	563	371	192	553
21.	Punjab	516	448	254	194	262
22.	Rajasthan	1468	976	598	378	870
23.	Sikkim	0	16	7	9	*
24.	Tamil Nadu	1024	0	0	0	1024
25.	Tripura	44	NA	4	NA	40
26.	Uttarakhand	220	220	39	181	181
27.	Uttar Pradesh	2060	1460	618	842	1442
28.	West Bengal	1336	542	175	367	1161
29.	A&N Islands	16	16	0	16	16
30.	Chandigarh	8	11	13	*	*
31.	D & N Haveli	4	0	0	0	4
32.	Daman & Diu	8	0	1	*	7
33.	Delhi	0	0	0	0	0
34.	Lakshadweep	12	4	0	4	12
35.	Puducherry	12	3	5	*	7
	All India[2]	18040	9028	5789	4026	12263

Notes:

NA: Not Available

1. Four per each Community Health Centre.
2. Surplus All India figures for Vacancy and Shortfall are the totals of State-wise Vacancy and Sortfall ignoring surplus in some States/UTs.
3. For calculating the overall percentages of vacancy and shortfall, the States/UTs for which manpower position is not available, are excluded.

*Break up of Specialist Doctors not available.

Source: Rural Health Statistics in India 2009.

ANNEXURE II

TFR—India & States

State	Total Fertility Rate-Source : Sample Registration System Target is to achieve TFR 2.1 by 2012			
	TFR-2005	TFR-2006	TFR-2007	TFR-2008
All India	2.9	2.8	2.7	2.6
Andhra Pradesh	2	2	1.9	1.8
Assam	2.9	2.7	2.7	2.6
Bihar	4.3	4.2		
Chhattisgarh	3.4	3.3		
Gujarat	2.8	2.7	2.6	2.0
Haryana	2.8	2.7	2.6	2.5
Jharkhand	3.5	3.4		
Karnataka	2.2	2.1	2.1	2.0
Kerala	1.7	1.7	1.7	1.7
Madhya Pradesh	3.6	3.5		
Maharashtra	2.2	2.1	2	2.0
Orissa	2.6	2.5	2.4	2.4
Punjab	2.1	2.1	2	1.9
Rajasthan	3.7	3.5		
Tamil Nadu	1.7	1.7	1.6	1.7
Uttar Pradesh	4.2	4.2		
West Bengal	2.1	2	1.9	1.9
Arunachal Pradesh				
Delhi	2.1	2.1	2	2.0
Goa			1.79	
Himachal Pradesh	2.2	2	1.9	1.9
Jammu & Kashmir	2.4	2.3	2.3	2.2
Manipur			2.83	
Meghalaya				
Mizoram			2.86	
Nagaland				
Sikkim			2.02	
Tripura			2.22	
Uttarakhand			2.55	
A & N Islands			1.9	
Chandigarh			2.1	
D & N Haveli				
Daman & Diu			2.5	
Lakshadweep			2.8	
Puducherry			1.8	

ANNEXURE III

IMR-India and State

Source: Sample Registration System

Sl.No.	States	2003	2004	2005	2006	2007	2008
	ALL INDIA	60	58	58	57	55	53
1.	Andhra Pradesh	59	59	57	56	54	52
2.	Assam	67	66	68	67	66	64
3.	Bihar	60	61	61	60	58	56
4.	Chhattisgarh	70	60	63	61	59	57
5.	Gujarat	57	53	54	53	52	50
6.	Haryana	59	61	60	57	55	54
7.	Jharkhand	51	49	50	49	48	46
8.	Karnataka	52	49	50	48	47	45
9.	Kerala	11	12	14	15	13	12
10.	Madhya Pradesh	82	79	76	74	72	70
11.	Maharashtra	42	36	36	35	34	33
12.	Orissa	83	77	75	73	71	69
13.	Punjab	49	45	44	44	43	41
14.	Rajasthan	75	67	68	67	65	63
15.	Tamil Nadu	43	41	37	37	35	31
16.	Uttar Pradesh	76	72	73	71	69	67
17.	West Bengal	46	40	38	38	37	35
18.	Arunachal Pradesh	34	38	37	40	37	32
19.	Delhi	28	32	35	37	36	35
20.	Goa	16	17	16	15	13	10
21.	Himachal Pradesh	49	51	49	50	47	44
22.	Jammu & Kashmir	44	49	50	52	51	49
23.	Manipur	16	14	13	11	12	14
24.	Meghalaya	57	54	49	53	56	58
25.	Mizoram	16	19	20	25	23	37
26.	Nagaland	NA	17	18	20	21	26
27.	Sikkim	33	32	30	33	34	33
28.	Tripura	32	32	31	36	39	34
29.	Uttarakhand	41	42	42	43	48	44
30.	A & N Islands	18	19	27	31	34	31
31.	Chandigarh	19	21	19	23	27	28
32.	D & N Haveli	54	48	42	35	34	34
33.	Daman & Diu	39	37	28	28	27	31
34.	Lakshadweep	26	30	22	25	24	31
35.	Puducherry	24	24	28	28	25	25

ANNEXURE IV

Maternal Mortality Ratio
India and State-wise

Major States Source: Sample Registration System	MMR (2001—03)	MMR (2004—06)
India Total*	301	254
Assam	490	480
Bihar/Jharkhand	371	312
Madhya Pradesh/Chhattisgarh	379	335
Orissa	358	303
Rajasthan	445	388
Uttar Pradesh/Uttaranchal	517	440
Andhra Pradesh	195	154
Karnataka	228	213
Kerala	110	95
Tamil Nadu	134	111
Gujarat	172	160
Haryana	162	186
Maharashtra	149	130
Punjab	178	192
West Bengal	194	141
Others	235	206

*Includes Others

APPENDIX I

MINUTES OF THE FIFTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2010-11) HELD ON 15TH JULY, 2010

The Committee sat on 15th July, 2010 from 1530 hrs. to 1800 hrs. in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Dr. Murli Manohar Joshi—*Chairman*

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Shri Ramen Deka
4. Shri Naveen Jindal
5. Shri Satpal Maharaj
6. Shri Bhartruhari Mahtab
7. Dr. K. Sambasiva Rao
8. Shri Yashwant Sinha
9. Shri Jitendra Singh (Alwar)
10. Shri K. Sudhakaran
11. Shri Aruna Kumar Vundavalli

Rajya Sabha

12. Shri Ashwani Kumar
13. Shri N. Balaganga
14. Shri Prasanta Chatterjee
15. Shri Kalraj Mishra
16. Shri N.K. Singh
17. Shri Tiruchi Siva
18. Prof. Saif-ud-Din Soz

SECRETARIAT

1. Shri Raj Shekhar Sharma — *Director*
2. Shri M.K. Madhusudhan — *Addl. Director*
3. Shri Sanjeev Sharma — *Deputy Secretary*

Representatives of the Office of the Comptroller and Auditor General of India

1. Shri Vinod Rai	—	Comptroller & Auditor General of India
2. Ms. Rekha Gupta	—	Dy. CAG, (Report Central)
3. Ms. Shubha Kumar	—	Pr. Director (Report Central)
4. Shri A.K. Patnaik	—	Director General (Central Expenditure)
5. Ms. Ahladini Panda	—	Director (AMG-II)

Representatives of the Ministry of Health and Family Welfare (Department of Health)

1. Ms. Sujatha Rao	—	Secretary
2. Shri Naved Masood	—	Additional Secretary & Financial Advisor
3. Shri P.K. Pradhan	—	Additional Secretary & Mission Director (NRHM)
4. Shri Amarjeet Sinha	—	Joint Secretary (P)
5. Shri R.S. Shukla	—	Joint Secretary (PH)
6. Shri Amit Mohan Prasad	—	Joint Secretary (RCH)
7. Shri Praveen Shrivastava	—	DDG (Stats)
8. Dr. L.S. Chauhan	—	DDG (RNTCP)
9. Ms. Jaya Bhagat	—	Director
10. Shri Deep Shekhar	—	Director

2. At the outset, the Chairman welcomed the Members, the Comptroller and Auditor General of India, and other Audit Officers to the sitting of the Committee. Thereafter, the representatives of Ministry of Health and Family Welfare (Department of Health) were called in and the Committee commenced oral evidence on the subject 'National Rural Health Mission (NRHM)'. The representatives of the Ministry made a power point presentation highlighting the salient features of the NRHM and the constraints faced by them in its implementation. The Secretary and other representatives of the Ministry replied to the various queries of the Members. As some queries required detailed and statistical replies, the Chairman directed the Secretary, Ministry of Health & Family Welfare to furnish the written replies thereon expeditiously.

3. The Chairman thanked the representatives of the Ministry of Health and Family Welfare (Department of Health) for appearing before the Committee and for furnishing the available information, on the subject. The Chairman also thanked the C&AG of India for providing assistance to the Committee in the examination of the subject.

The witnesses, then, withdrew.

A copy of the verbatim proceedings of the sitting has been kept on record.

The Committee, then, adjourned.

APPENDIX II

MINUTES OF THE TENTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2010-11) HELD ON 13TH SEPTEMBER, 2010

The Committee sat on Monday, the 13th September, 2010 from 1430 hrs. to 1620 hrs. in Committee Room 'A', Parliament House Annexe, New Delhi.

PRESENT

Dr. Murli Manohar Joshi—*Chairman*

Lok Sabha

2. Dr. Baliram
3. Shri Ramen Deka
4. Shri Naveen Jindal
5. Shri Bhartruhari Mahtab
6. Shri Yashwant Sinha
7. Shri K. Sudhakaran
8. Dr. M. Thambidurai
9. Shri D. Venugopal
10. Shri Aruna Kumar Vundavalli

Rajya Sabha

11. Shri Ashwani Kumar
12. Shri N. Balaganga
13. Shri Kalraj Mishra
14. Shri N.K. Singh

SECRETARIAT

1. Shri Ashok Sarin	—	Joint Secretary
2. Shri Raj Shekhar Sharma	—	Director
3. Shri M.K. Madhusudhan	—	Addl. Director

Representatives of the Office of the Comptroller and Auditor General of India

1. Shri Vinod Rai	—	Comptroller & Auditor General of India
2. Ms. Rekha Gupta	—	Dy. CAG (Report Central)

3. Shri R.S. Mathrani	—	DGA, (Central Expenditure)
4. Ms. Subha Kumar	—	Pr. Director (Report Central)
5. Ms. Ahladini Panda	—	Director (AMG-II)

Representatives of the Ministry of Health and Family Welfare (Department of Health)

1. Ms. Sujatha Rao	—	Secretary, Health & Family Welfare
2. Shri Naved Masood	—	Additional Secretary & Financial Advisor
3. Shri P.K. Pradhan	—	Additional Secretary & Mission Director (NRHM)
4. Shri R.S. Shukla	—	Joint Secretary (PH)
5. Shri Amit Mohan Prasad	—	Joint Secretary (RCH)
6. Shri B.K. Prasad	—	Joint Secretary (Procurement)
7. Ms. Shalini Prasad	—	Joint Secretary (NCD)

2. At the outset, the Chairman welcomed the Members, the Comptroller and Auditor General of India and other Audit Officers to the sitting of the Committee. Thereafter, the representatives of the Ministry of Health and Family Welfare (Department of Health) were called in. The Chairman impressed upon the representatives of the Ministry of Health and Family Welfare and reminded the Members and all others present in the meeting not to disclose the contents of the deliberations of the sitting to any outsider, especially the Press. The Committee then commenced further evidence on the subject 'National Rural Health Mission (NRHM)'. The Secretary, Health and Family Welfare and other representatives of the Ministry of Health and Family Welfare replied to the various queries raised by the members. As some queries required detailed statistical information, the Chairman directed the Secretary, Health & Family Welfare to furnish the written replies thereon expeditiously.

3. The Chairman thanked the representatives of the Ministry of Health and Family Welfare (Department of Health) for appearing before the Committee and for furnishing the available information on the subject. The Chairman also thanked the C&AG of India and his team of officers for providing assistance to the Committee in the examination of the subject.

The witnesses, then, withdrew.

A Copy of the verbatim proceedings of the sitting has been kept on record.

The Committee, then, adjourned.

APPENDIX III

MINUTES OF THE THIRTEENTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2010-11) HELD ON 27TH OCTOBER, 2010

The Committee sat on Wednesday, the 27th October, 2010 from 1030 hrs. to 1350 hrs. in Committee Room 'C', Parliament House Annexe, New Delhi.

PRESENT

Dr. Murli Manohar Joshi—*Chairman*

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Shri Ramen Deka
4. Shri Bhartruhari Mahtab
5. Shri Jitendra Singh (Alwar)
6. Dr. M. Thambidurai
7. Shri Aruna Kumar Vundavalli

Rajya Sabha

8. Shri Ashwani Kumar
9. Shri Kalraj Mishra

SECRETARIAT

1. Shri Ashok Sarin — *Joint Secretary*
2. Shri Raj Shekhar Sharma — *Director*
3. Shri M.K. Madhusudhan — *Additional Director*

Representatives of the Office of the Comptroller and Auditor General of India

1. Ms. Rekha Gupta — Dy. CAG, (Report Central)
2. Shri R.S. Mathrani — Director General
3. Ms. Subha Kumar — Pr. Director
4. Ms. S. Ahladini Panda — Director

Representatives of the Ministry of Health and Family Welfare
(Department of Health)

1.	Ms. K. Sujatha Rao	—	Secretary
2.	Sh. Naved Masood	—	AS&FA
3.	Sh. R.S. Shukla	—	Joint Secretary (PH)
4.	Sh. Amit Mohan Prasad	—	Joint Secretary (P)
5.	Sh. Arun Kumar Panda	—	Joint Secretary (Procurement)
6.	Ms. Madhu Bala	—	Add. DG (Stats.)
7.	Sh. A.S. Sachdeva	—	Economic Adviser
8.	Dr. Rattan Chand	—	Chief Director (Stats.)
9.	Sh. Praveen Srivastava	—	Dy. Director General (Stats.)
10.	Dr. L.S. Chauhan	—	Dy. Director General (RNTCP)
11.	Ms. Jaya Bhagat	—	Director (NRHM—Finance)
12.	Sh. Deepa Shekhar	—	Director (EPW)
13.	Ms. Vandana Gurnani	—	Director (RCH-DC)
14.	Dr. A.C. Dhariwal	—	Director (NVBDCP)

Department of AYUSH

1.	Ms. S. Jalaja	—	Secretary
2.	Sh. D.D. Sharma	—	Joint Secretary, AYUSH
3.	Dr. S.K. Sharma	—	Advisor, AYUSH
4.	Sh. V.S. Gaur	—	Director

2. At the outset, the Chairman welcomed the Members, the Deputy C&AG and other Audit Officers to the sitting of the Committee. The Chairman, then, apprised the Members that the meeting has been convened to take further oral evidence of the representatives of the Ministry of Health and Family Welfare (Department of Health) as well as the Department of AYUSH, on the subject 'National Rural Health Mission' (NRHM).

3. Thereafter, the representatives of the Ministry of Health & Family Welfare (Department of Health) and Department of AYUSH were called in and the Chairman welcomed them to the sitting. The Chairman impressed upon the representatives of Ministry of Health and Family Welfare and reminded the Members and all others present in the meeting not to disclose the contents of the deliberations of the sitting to any outsider, especially the Press. The Committee, then commenced evidence of the representatives of Department of AYUSH on the subject. The Secretary (AYUSH) and other representatives of their Department of AYUSH explained in brief the measures taken by the Department in mainstreaming AYUSH under the NRHM and also replied to the various queries raised by the Members on the subject. As some queries required furnishing of detailed/statistical information, the Chairman directed the Secretary (AYUSH) to furnish requisite information to the Secretariat at the earliest.

The Committee then adjourned for tea.

4. After a short break the Committee reassembled and proceeded to take further evidence of the representatives of Ministry of Health and Family Welfare (Department of Health) on the subject. The Secretary, Health and Family Welfare and other representatives of the Department of Health replied to the various queries raised by the Members. As some queries required furnishing of detailed/statistical information, the Chairman directed the Secretary (Department of Health) to furnish requisite information to the Secretariat at the earliest.

5. The Chairman thanked the representatives of the Ministry of Health and Family Welfare (Department of Health) and Department of AYUSH for appearing before the Committee and furnishing the available information. He also thanked the Officers of the Office of C&AG of India for providing assistance to the Committee in the examination of the subject.

The witnesses, then, withdrew.

A copy of the verbatim proceedings of the sitting has been kept on record.

The Committee then, adjourned.

APPENDIX IV

MINUTES OF THE TWENTY-SEVENTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2010-11) HELD ON 18TH MARCH, 2011

The Committee sat on Friday, the 18th March, 2011 from 1000 hrs. to 1040 hrs. in Room No. '51', (Chairman's Chamber), First Floor, Parliament House, New Delhi.

PRESENT

Dr. Murli Manohar Joshi — *Chairman*

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Shri Naveen Jindal
4. Shri Satpal Maharaj
5. Dr. K. Sambasiva Rao
6. Shri Aruna Kumar Vundavalli

Rajya Sabha

7. Shri Kalraj Mishra
8. Shri N.K. Singh
9. Prof. Saif-ud-Din Soz

SECRETARIAT

1. Shri Devender Singh — *Joint Secretary*
2. Shri M.K. Madhusudhan — *Additional Director*
3. Smt. A. Jyothirmayi — *Under Secretary*

Representatives of the Office of the Comptroller and Auditor General of India

1. Shri R.S. Mathrani — Director General of Audit (Central Expenditure)
2. Shri Subir Mallick — Principal Director (Indirect Taxes)
3. Smt. A. Panda — Director of Audit (AMG-II)

2. At the Outset the Chairman welcomed the Members and the representatives of the Office of the C&AG of India to the sitting. The Chairman, then apprised the Members that the meeting has been convened to consider and adopt three Draft Reports *viz.* one Original Report and two Action Taken Reports.

3. The Committee, then took up the following Draft Reports for consideration:—

(i) Draft Report on **'National Rural Health Mission'** (Ministry of Health and Family Welfare) based on C&AG Report No. 8 of 2009-2010 (Performance Audit) Union Government (Civil);

(ii) Draft Report on Action Taken by the Government on the Observations/ Recommendations of the Committee contained in their Fifteenth Report (Fifteenth Lok Sabha) on '**Loss of Revenue due to Short Levy of Tax, Incorrect Classification of Excisable Goods and non-fulfilment of Export Obligation';** and

(iii) Draft Report on Action Taken by the Government on the Observations/ Recommendations of the Committee contained in their Seventeenth Report (Fifteenth Lok Sabha) on **'Conservation and Protection of Tigers inTiger Reserves'.**

4. After some deliberation, the Committee adopted the aforementioned Draft Reports with some modifications/amendments and authorized the Chairman to finalise the Reports, in the light of factual verification done by the Audit and present the same to both the Houses.

The Committee then adjourned.

LIST OF ABBREVIATIONS USED IN THE REPORT

A&N Islands	Andaman and Nicobar Islands
ABER	Annual Blood Examination Rate
ACMO	Additional Chief Medical Officer
AD	Automatic Disposable
AE	Actual Expenditure
AGCA	Advisory Group for Community Action
AMG	Annual Maintenance Grant
ANC	Ante Natal Checkup
ANM	Auxiliary Nursing Midwife
APHC	Additional Primary Health Centre
APHMHIDC	Andhra Pradesh Health Medical Housing and Infrastructure Development Corporation
API	Annual Parasitic Incidence
ARC	Apex Resource Centre
ASHA	Accredited Social Health Activist
ASTC	Assam State Transport Corporation
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga-Naturopathy Unani Sidha and Homoeopathy
BCC	Behavioural Change Communication
BCG	Bacillus Calmette-Guerin
BDA	Block Data Assistant
BDO	Block Development Officer
BE	Budget Estimates
BER	Bid Evaluation Report
BFA	Block Finance Assistant
BoB	Bank of Baroda
BPL	Below Poverty Line
BPM	Block Programme Manager
BSEB	Bihar School Examination Board
CA	Chartered Accountant
CAC	Chief Advisor Cost
CAN	Community Need Assessment
CBO	Community Based Organisation
CCA	Chief Controller of Accounts
CDMO	Chief District Medical Officer

CEMONC	Comprehensive Emergency Obstetric and Neonatal Care
CEO	Chief Executive Officer
CHC	Community Health Centre
CMHO	Chief Medical Officer of Health
CMO	Chief Medical Officer
CMSO	Central Medical Store Organisation
CPSE	Central Public Sector Enterprise
CSR	Cataract Surgery Rate
CVC	Central Vigilance Commission
D & N Haveli	Dadra and Nagar Haveli
DC	District Collector
DDM	District Data Manager
DDT	Dichloro Dimethyl Trichloro Ethane
DFM	District Finance Manager
DG	Diesel Generator
DGHS	Directorate General of Health Services
DH	District Hospital
DHAP	District Health Action Plan
DHM	District Health Mission
DHS	District Health Society
DPM	District Programme Manager
DPT	Diphtheria Pertusis Tetanus
DRDA	District Rural Development Authority
DSU	District Surveillance Unit
EAG	Empowered Action Group
E-banking	Electronic Banking
EC-SIP	European Commission-Sectoral Investment Programme
EPC	Empowered Programme Committee
EPW	Empowered Procurement Wing
E-transfer	Electronic Transfer
FI	Full Immunisation
FMG	Financial Management Group
FMR	Financial Management Report
FNGO	Field Non-Governmental Organisation
FRU	First Referral Unit
GDP	Gross Domestic Product
DFR	General Financial Rules
GIA	Grant-in-Aid
GMP	Good Manufacturing Practices

GMSD	Government Medical Store Depot
GOI	Government of India
GSDP	Gross State Domestic Product
GUS	Gram Unnayan Samiti
HDFC	Housing Development Finance Corporation
HMDI	Health Manpower Development Institute
HPS	High Performing States
HSCC	Hospital Services Consultancy Corporation
ICICI	Industrial Credit and Investment Corporation of India
IDSP	Integrated Disease Surveillance Project
IEC	Information Education and Communication
IFA	Iron Folic Acid
IMR	Infant Mortality Rate
IPC	Integrated Purchase Committee
IPD	Inpatient Department
IPHS	Indian Public Health Standards
ISRO	Indian Space Research Organisation
IT	Information Technology
IUD	Intra Uterine Device
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LPS	Low Performing States
MBA	Master of Business Administration
MCH	Mother and Child Health
MDA	Mass Drugs Administration
MIS	Management Information System
MLA	Member of Legislative Assembly
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MNGO	Mother Non-Governmental Organisation
MoU	Memorandum of Understanding
MP	Member of Parliament
MPW	Multipurpose Worker
MSG	Mission Steering Group
MTP	Medical Termination of Pregnancy
NBCC	National Building Construction Corporation
NDCP	National Disease Control Programmes
NE	North Eastern
NGO	Non-Governmental Organisation

NHSRC	National Health System Resource Centre
NIC	National Informatics Centre
NIDDCP	National Iodine Deficiency Disorder Control Programme
NIHFW	National Institute of Health and Family Welfare
NLEP	National Leprosy Elimination Programme
NMBS	National Maternal Benefit Scheme
NOC	No Objection Certificate
NPCB	National Programme for Control of Blindness
NPCC	National Programme Coordination Committee
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
OPHC	Orissa State Police Housing and Welfare Corporation
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
OSIC	Orissa Small Scale Industries Corporation
OT	Operation Theatre
PA	Performance Audit
PB Ratio	Patient Bed Ratio
PHC	Primary Health Centre
PHSC	Punjab Health Systems Corporation
PIP	Programme Implementation Plan
PMG	Programme Management Group
PMSU	Programme Management Support Unit
PPI	Pulse Polio Immunisation
PPSWR	Probability Proportion to Size With Replacement
PRI	Panchayati Raj Institutions
PS	Panchayat Samiti
PSU	Public Sector Undertaking
PWD	Public Works Department
RBI	Reserve Bank of India
RC	Rate Contract
RCH	Reproductive and Child Health
RH	Referral Hospital
RHS	Rural Health Survey
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
RRC	Regional Resource Centre
RTI	Reproductive Tract Infection

SBA	Skilled Birth Attendant
SBI	State Bank of India
SC	Scheduled Castes
SCOVA	Standing Committee on Voluntary Action
SDMU	State Drug Management Unit
SFU	State Facilitation Unit
SFWB	State Family Welfare Bureau
SHM	State Health Mission
SHS	State Health Society
SHSRC	State Health System Resource Centre
SIHFW	State Institute of Health and Family Welfare
SIT	Satellite Interactive Terminal
SNGO	Service Non-Governmental Organisation
SOE	Statement of Expenditure
SPMSU	State Programme Management Support Unit
SRSWOR	Simple Random Sampling Without Replacement
SSU	State Surveillance Unit
ST	Scheduled Tribes
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TNMSC	Tamil Nadu Medical Services Corporation
TOR	Terms of Reference
TT	Tetanus Toxoid
TTD	Thirumala Tirupati Devasthanam
UBI	Union Bank of India
UC	Utilisation Certificate
UHC	Urban Health Centre
UNICEF	United Nations' Children Fund
UNOPS	United Nations Operations
USAID	United States Assistance for International Development
UT	Union Territory
UTI	Unit Trust of India
VC	Video Conferencing
VDF	Vaccine Deep Freezer
VEN	Vital, essential and non-essential
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WCD	Women and Child Development
ZSS	Zilla Swasthya Samiti

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