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NATIONAL RURAL HEALTH MISSION

[Action Taken by the Government on the Observations/Recommendations of the Committee contained in their Thirty-second Report (15th Lok Sabha)]

MINISTRY OF HEALTH AND FAMILY WELFARE

PUBLIC ACCOUNTS COMMITTEE 2012-2013

SEVENTY-FIRST REPORT

FIFTEENTH LOK SABHA

LOK SABHA SECRETARIAT
NEW DELHI

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PUBLIC ACCOUNTS COMMITTEE
(2012-2013)

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Presented to Lok Sabha on 21.03.2013
Laid in Rajya Sabha on 21.03.2013

LOK SABHA SECRETARIAT
NEW DELHI
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(2012-2013)

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* Elected *w.e.f.* 6th December, 2012 *vice* Shri Sarvey Sathyanarayana appointed as Minister on 28th October, 2012.

† Elected *w.e.f.* 6th December, 2012 *vice* Dr. Shashi Tharoor appointed as Minister on 28th October, 2012.

INTRODUCTION

I, the Chairman, Public Accounts Committee (2012-13), having been authorised by the Committee, do present this Seventy-first Report (Fifteenth Lok Sabha) on Action Taken by the Government on the Observations/Recommendations of the Committee contained in their Thirty-second Report (Fifteenth Lok Sabha) on 'National Rural Health Mission'.

2. The Thirty-second Report was presented to Lok Sabha/laid in Rajya Sabha on 23rd March, 2011. Replies of the Government to the Observations/Recommendations contained in the Report were received from the Department of Health & Family Welfare and Department of AYUSH on 29th September, 2011 and 27th September, 2011, respectively. The Public Accounts Committee considered and adopted this Report at their sitting held on 19th March, 2013. Minutes of the sitting are given at *Appendix-I.*

3. 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.

4. 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.

5. An analysis of the Action Taken by the Government on the Observations/ Recommendations contained in the Thirty-second Report (Fifteenth Lok Sabha) is given at *Appendix-II.*

NEW DELHI;
19 *March*, 2013
28 *Phalguna*, 1934 (*Saka*)

DR. MURLI MANOHAR JOSHI
Chairman,
Public Accounts Committee.

CHAPTER I

REPORT

This Report of the Public Accounts Committee deals with the Action Taken by the Government on the Observations and Recommendations of the Committee contained in their 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.

2. The Thirty-second Report (Fifteenth Lok Sabha), which was presented to Lok Sabha on 23rd March, 2011, contained 32 Observations and Recommendations. Action Taken Notes in respect of all the Observations and Recommendations have been received from the Ministry of Health and Family Welfare and are broadly categorized as under:—

(i) Observations/Recommendations which have been accepted by the Government:

Para Nos. 1-4, 6, 8, 9, 11, 13-32

Total: 28
Chapter -II

(ii) Observations/Recommendations which the Committee do not desire to pursue in view of the replies received from the Government:

Para Nos. 5 and 10

Total: 2
Chapter - III

(iii) Observations/Recommendations in respect of which replies of Government have not been accepted by the Committee and which require reiteration:

Para Nos. 7 and 12

Total: 2
Chapter - IV

(iv) Observations/Recommendations in respect of which Government have furnished interim replies:

-Nil-

Total: Nil
Chapter - V

3. The National Rural Health Mission (NRHM) was launched on 12 April 2005 with a view to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas especially to the poor and vulnerable sections of the population. The scheme was launched 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 implementation of NRHM covering the period 2005-06 to 2007-08 was examined by the Public Accounts Committee (15th Lok Sabha) and their findings reported in the Thirty-second Report (2010-11). In the said report, the Committee had highlighted various shortcomings or lapses in implementation of the National Rural Health Mission. Accordingly the Committee had made their Observations and suggested remedial action by way of Recommendations in their Thirty-second Report presented to Parliament on 23.3.2011.

4. The Action Taken Notes furnished by the Ministry of Health and Family Welfare in respect of all Observations and Recommendations of the Committee contained in their Thirty-second Report have been reproduced in the relevant Chapters of this Report. *In the following paragraphs, the Committee have dealt with the Action Taken by the Government on the Observations and Recommendations made in the Original Report which need reiteration or merit comments.*

A. Constitution of District Health Society (DHS), District Health Mission (DHM) and District and Vigilance Monitoring Committee

Recommendations (Sl. No. 2 and 5)

5. While scrutinizing the subject in detail, the Committee had *inter-alia* noted inordinate delays in constitution of DHS and DHMs and in holding the prescribed meetings, laxity in conducting vital household surveys and in preparation of annual district plans. The Committee's examination had 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 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. In this context, it was, therefore, recommended that a comprehensive central electronic database may be prepared for all districts State-wise and uploaded on the SHS's website for easy access by district planning teams. The Committee also desired that the reasons for delay in constitution of DHS and DHM and laxity in holding the meetings of these bodies where constituted may be obtained from each defaulter State.

The Committee had desired that the District and Vigilance Monitoring Committee constituted under the Chairmanship 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 and the Committee so constituted start functioning expeditiously.

6. In this regard, the Ministry stated its position as under:—

"The recommendations of the PAC on DHMs and DHSs have been shared with Mission Directors of States and it was informed by the States that they are in the process of constituting, the DHM where it is not done. Further, as per the recommendations of the PAC, communication has been sent to the Mission Directors of all States/UTs requesting them to prepare a comprehensive central electronic database of vital household surveys and district health action plans, facility survey and district plans and upload the same on SHS's website for eacy access by district planning teams. The States have also been advised to ensure that the State Health Society strictly adhere to the framework of decentralized planning to ensure that the State PIP reflect the requirements based on actual felt needs. State Governments have also been advised to hold meetings of DHM/DHS on regular intervals.

The States were asked to explain the reasons for delay in the constitution of DHS and DHM. Jharkhand and Puducherry have informed that DHS have been constituted in all the districts. In Bihar DHM has been formed in 25 out of 38 districts and the remaining districts are being followed up regularly. Andhra Pradesh, Jharkhand and Uttar Pradesh are in the process of constitution of DHM.

Government of NCT of Delhi has informed that District Health Mission has not been constituted as Delhi being primarily an urban State does not have the structures intrinsic to the District Health Mission as prescribed under NRHM Framework and the existing structures have already been incorporated in the DHSs. As regards reasons for delay in the constitution of the District Mission, the States have not reported any specific reason.

The Ministry had launched a web based Health Management Information System (HMIS) portal in October 2008 and the districts are reporting their performance by uploading data on the portal on a monthly basis. States have also been asked to upload facility level data. Continued efforts are made for improving the quality of information reported on the HMIS portal. Further, reports/factsheets of district level household survey (DLHS) conducted during 2007-08 and Concurrent Evaluation of NHRM are also available on the HMIS portal. The Programme Implementation Plans (PIPs) for 2011-12 have been prepared by most of the States/UTs using the information available on the HMIS portal including national level survey data and have targeted their interventions accordingly. Further, under DLHS to be conducted during 2011-12 it is planned to conduct the facility survey and make this information available on the Ministry's website".

7. Further, the Department of Health and Family Welfare also submitted as under:—

"In this connection, a letter dated 3rd May, 2011 was written to all Principal Secretaries (Health & Family Welfare) with copy to all Mission Directors in

NRHM including household facility surveys for all the districts of the States/ UTs and for uploading the same on the website for use and for facilitating need based district planning.

(i) The framework of implementation as approved by the Cabinet and disseminated to all the States/UTs already contain necessary instructions in regard to the decentralised planning. Instructions were also issued to the States in this regard at the time of preparation of State Programme Implementation Plans (PIPs).

(ii) Further, as regards holding the meeting of DHM/DHS, the same is being monitored quarterly by collecting the required data from the States. Based on the report, the States are advised to hold regular meetings of DHM.

As reported by the States, the District Health Mission was not constituted in the State of Jharkhand as Panchayati Raj Institutions (PRIs) were not in place. The State is now in the process of formation of DHMs since PRIs have now been formed. The State of Andhra Pradesh had reported that District Health Missions were constituted in their State and the previously reported information was due to oversight.

The States of Bihar and U.P. are in the process of constitution of DHMs in remaining districts wherever DHM is not constituted."

In respect of District level Vigilance Monitoring Committee, the Ministry has submitted that 18 States have completed the Constitution of the Committee in all districts and reply from rest of the States was awaited.

8. **In pursuance of the recommendations of the Committee, the Ministry has taken steps by way of issuing circulars to the States to have decentralized planning, timely preparation of State Programme Implementation Plans (PIPs) and holding of regular meetings of DHM/DHS which was to be monitored quarterly by the Centre. However, as seen in many cases, such initiatives remain on paper for want of effective monitoring and follow up.** ***The Committee urge the Ministry to ensure that these measures do not merely remain on paper but on the other hand they are implemented both in letter and spirit.***

The Committee note that in many States, DHMs are still in the stage of formation which clearly reflects non-serious attitude of the States towards such an important issue as health. ***The Committee would like the Ministry to pursue the matter vigorously with the States so that the DHMs are constituted expeditiously in the States and the objectives of NRHM achieved to a large extent.***

The Committee note that District level Vigilance Monitoring Committees have been constituted in 18 States. ***The Committee would like to be apprised about the command structure of these Committees that have been constituted, the precise functions assigned to them, the periodicity of the meetings and the steps taken to implement their decisions.***

B. Monitoring of Village Health and Sanitation Committee (VHSC) Funds

Recommendation (Sl. No. 7)

9. In their Thirty-second Report, the Committee had noted 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 State Health Societies (SHSs) for the VHSCs. It was also found that 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 had expressed concern about the fact that disbursal of funds to the VHSCs by the States was not reported and only the actual expenditure incurred by the VHSCs was 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. Noting these lacunae the Committee had recommended that the Ministry had to streamline its monitoring system urgently in order to ensure that untied grants released to States were actually passed on to and spent by the VHSCs and reflected in the FMRs. The Committee had also insisted that the Ministry should release funds to SHS only after receipt of Utilisation Certificate (UC) for the previous year and on the assurance from the SHS that the untied funds were utilized in compliance with the guidelines. Regarding compilation of accounts, the Committee had desired that interest earned on the unspent balances by the SHS and its utilization be reflected in the audited accounts.

10. While submitting the Action Taken in this regard, the Ministry has stated as under:—

> "At the initial phase of NRHM, emphasis was laid on the constitution of the VHSCs at every village as per the NRHM Framework for Implementation. The functioning of the VHSCs has been reviewed in depth by the Ministry and in order to streamline the monitoring system for release and utilization of funds by the VHSCs in the States, draft guidelines on the utilization and maintenance of funds given for VHSCs have been issued to all the States in December. As a further step in this direction, a Model Accounting Handbook for Village Health and Sanitation Committees has also been issued to the States for proper utilization of funds for specified activities of the VHSCs, proper accounting and reporting of funds including interest earned by the VHSCs. The guidelines for constitution of the VHSCs and the formats of account books and the Utilization Certificates have also been incorporated in the Handbook.
>
> Funds are released to the States under the Mission Flexible Pool in a consolidated manner and not against specific activities such as VHSCs etc. The States have the flexibility to further release the funds to the Districts including the block and the village level units depending upon the actual availability of funds. The funds at the district and the sub-district levels including VHSCs are, therefore, utilized depending upon priorities and the availability of funds. Nevertheless, the emphasis under NRHM is to ensure

that untied funds are released to VHSCs in time annually. Therefore, only the expenditure is reported from the sub-district levels to the district and State level.

The release of funds to the States is made only after the receipt of UCs for the previous years and after adjustment of the unspent balances available with the States. The guidelines for utilization of funds are also specifically communicated along with approvals accorded to the States Programme Implementation Plans. The interest earned and utilized is reflected in the audited accounts of the State and District Health Societies received by way of Statutory Audit Reports of the State Health Societies every year."

11. The Ministry has assured that the release of funds to the States is made only after the receipt of Utilisation Certificates (UCs) for the previous years and adjustment of the unspent balances available with the States and the guidelines for utilization of funds are also specifically communicated alongwith approvals accorded to the States Programme Implementation Plans. It has also submitted that the interest earned and utilized is reflected in the audited accounts of the State and District Health Societies received by way of Statutory Audit Reports of the State Health Societies every year. However, the Committee are not happy with the Ministry's submission that only the expenditure incurred by the VHSCs is reported from the sub-district levels to the district and State level and not the disbursal of funds to the VHSCs by the States. Clearly, the emphasis under NRHM is to ensure timely release of untied funds to the VHSCs. Being the funding agency, the Ministry ought to have details regarding disbursal of funds in a consolidated manner as well as for specific activities such as VHSCs etc. ***The Committee, therefore, reiterate their earlier recommendation that the Ministry has to streamline its 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.*** **The Committee note that in the instructions issued by the Ministry of Health and Family Welfare (NRHM Finance Division), lack of proper coordination between the Sarpanch and ANM of the village, who are the joint signatories for operating the funds of VHSC maintained in a bank account, is cited as one of the reasons for these funds remaining unspent at VHSC level**. ***In this regard, the Committee would call upon the Ministry to work out an alternative to overcome this problem and apprise them on this issue at the earliest.***

C. Scaling up of Budgetary Allocation to NRHM

Recommendation (Sl. No. 8)

12. The Committee, in their Thirty-second Report had noted 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 were amazed to note that the proportion of the public expenditure on Health was merely 1.1% of GDP which

was less than 50 per cent of the target of 2-3% set under the Mission. Given this scenario, the Committee had wondered whether the laudable targets set under the Mission could be achieved considering the half-hearted and grossly inadequate allocations for the purpose.

13. The Ministry *vide* its ATNs has submitted as under:—

> "The original Eleventh Plan (2007-12) allocation for National Rural Health Mission (NRHM) was fixed at Rs. 90558 crore. However, the combined annual allocation (BE) for NRHM during the last five years from 2007-08 to 2011-12 was Rs. 70030 crore indicating a shortfall of Rs. 20528 crore. Department of Health and Family Welfare have been requesting Planning Commission over the years for greater allocation of plan resources to meet its requirements. During the last two years (2010-11 & 2011-12), Ministry had requested for an allocation of Rs. 19989 crore and Rs. 24807 crore respectively for NRHM, against which an allocation of Rs. 15440 and Rs. 17840 crore was provided. It may be noted that allocation of Plan funds is the prerogative of Planning Commission, based on the overall priorities of the Plan. The Ministry will strive for a better allocation of funds from Planning Commission in the coming years. With regard to utilization of funds, the Department agrees that there has been a slight shortfall in utilization of allotted funds. An analysis of expenditure of Health and Family Welfare Programmes of the Department over the last three years (2008-09 to 2010-11) indicate that the utilization under NRHM programme was in the range of 95-96%. However, the utilization by the States in the year 2009-10 was higher than in 2008-09. As against the allocation of ₹ 10192.23 crore, the expenditure was 10565.1 crore in 2008-09. In 2009-10, against the allocation of Rs. 11601.67 crore, the expenditure is provisionally placed at Rs. 13225.91 crore. The constraints on the absorptive capacity with regard to physical infrastructure development in different States are being addressed through regular interaction with State Governments."

14. The Committee note that since the inception of NRHM, inadequate allocation of funds has been a persisting problem in achieving the targets of this mission, though, paradoxically, by their own admission, the Ministry has conceded that allotted funds have been underutilized. It has also been submitted that regular interactions with State Governments are being held to address the problem of absorptive capacity of the States due to lack of physical infrastructure development. ***The Committee, while emphasizing the need for total utilization of funds released for NRHM for tangible and speedy development of infrastructure in different States, urge the Ministry of Health and Family Welfare to vigorously pursue with the Planning Commission for stipulated allocation of funds for expenditure on health of citizens of this country while ensuring that the allocated funds are utilized for intended objectives within the given timeline.***

D. Contribution of States to NRHM Funds

Recommendation (Sl. No. 10)

15. 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 had

noted 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 Programme Implementation Plan (PIP) from their own budget despite the Ministry's directive that the States had to transfer 15 per cent of their share to the State Health Societies from the State funds from 2008-09. In this regard, the Ministry had 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. Observing such gross violation in earmarking requisite funds by the concerned States which displayed lack of regard for the laudable objectives of the Mission, the Committee had recommended that the release of future instalments to the defaulter States be made contingent upon their making the stipulated contribution and recouping the accumulated short contribution to the State Mission budget.

16. The Ministry in its Action Taken Note has stated as under:—

"Necessary guidelines have been issued to all the States *vide* D.O. letter No. G27034/19/2008-NRHM finance dated 26th April, 2011 with greater emphasis on contribution of 15% State share as a necessary condition prior to release of funds. In the absence of specific guidelines during the initial phase of NRHM in 2007-08, many States made their contribution through the treasury route and, therefore this amount of State contribution was not necessarily reflected in their NRHM balance sheet. The Ministry has asked the States to provide the details of such contribution. During the year 2009-10 and 2010-11 there has been a marked increase in the State contribution made by the States in 2009-10, Out of 35 States, 34 States have contributed for State share. The years-wise details of State share contribution made by the States are given below:

(Rs. in crore)

Year	Releases	State Share contribution to be contributed by the States	Amount credited by the States	% of amount credited against required contribution
2007-08	8508.87	1501.56	338.22	22.53%
2008-09	9628.44	1699.14	1316.16	77.46%
2009-10	11224.62	1980.82	1618.76	81.72%
2010-11	12871.23	2271.39	2144.53	94.41%

Note: Figures for 2010-11 are provisional.

The Ministry is vigorously pursuing with the States to deposit the outstanding State share for the previous years. The release of further funds to the States has been made contingent to deposit of State share by the States/UTs and the same has been incorporated as a condition in the PIP approvals sent to States in 1011-12."

17. The Committee note that in pursuance of their recommendation, the release of further funds to the States has been made contingent to deposit of State

share by the States/UTs and the same has been made a condition in the Programme Implementation Plan (PIP) approvals sent to the States in 2011-12. ***The Committee would like to be apprised of the outcome of the efforts of the Ministry in persuading the States to deposit the outstanding State share of the previous years. The Committee also call upon the Ministry to have an effective monitoring mechanism and keep a constant vigil over the States which have been defaulting over the years to contribute to the State Mission Budget as a State's health system suffers due to non-contribution of 15% State share to NRHM funds.***

E. Maintenance of Requisite Infrastructure Facilities and Standard Hygiene Levels at all Health Centres

Recommendation (Sl. No. 12)

18. Taking note of the unhygienic conditions, sub-standard environment and lack of essential infrastructure in a large number of Health Centers at various levels, the Committee had desired that the Empowered Progamme 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 Committee had also urged that the data regarding the conditions of hygiene at all the Health Centres should be maintained centrally and monitored regularly through quarterly/monthly reporting system.

19. In this regard, the Ministry in its Note has submitted the following as action taken at its end:—

> "Health being a State subject, day to day functioning of health centres is handled by respective State Governments. For improvement in the hygienic conditions of the health facilities, the States specific proposals, of outsourcing the sanitation services in health facilities have been supported under NRHM. Assistance is also provided to States for installing biomedical waste disposal. The funds provided to the health facilities like untied funds, Rogi Kalyan Samiti grants and annual maintenance grants can also be used to improve the conditions of hygiene and infrastructure in the health facilities. Regarding the recommendation for maintaining data of condition of hygiene in the health centres centrally, it may not be feasible to maintain such data centrally. The matter will be placed before the Empowered Programme Committee (EPC) of NRHM in its next meeting for suggesting appropriate steps to maintain requisite infrastructure facilities and standard hygiene levels."

20. Further, the Department of Health and Family Welfare has also added as under:—

> "In pursuance of the observations of PAC, the States were asked to issue necessary instructions to all concerned to comply with the guidelines of Government of India in this regard *vide* D.O. letter dated 28th January, 2012. The matter was also placed before Empowered Programme Committee in its

meeting held on 08.02.2012. The EPC directed that the matter be pursued with the States from time to time."

21. Mindful of the fact that health is a State subject, the Committee reiterate the need for providing healthy and pollution-free ambience in Health Centres across the country with a view to providing accessible, affordable and effective healthcare facilities especially in rural India. ***Emphasizing the role of Empowered Programme Committee (EPC) of NRHM in this regard, the Committee would like to be apprised of the follow up action taken by it for improvement in the hygienic conditions of the health facilities as directed by EPC at their meeting held on 8.2.2012.***

F. Time-bound Training Programme for Accredited Social Health Activists (ASHAs)

Recommendation (Sl. No. 14)

22. The Committee had noted that ASHA had been engaged in all high-focus States, except Himachal Pradesh. However, 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. The Committee were 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. Expeditious implementation of a time bound training programme for the ASHAs was recommended by the Committee so that they become fully trained and well-equipped with necessary drug kits to take up the multifarious healthcare activities assigned to them under the Mission. It was also recommended that the Government need to provide suitable incentives to them so as to reduce the rate of attrition amongst ASHAs.

23. The Ministry in its Action Taken Note has *inter-alia* stated:—

"..... States do not provide data on payments made to ASHA under different schemes. ....."

24. The Department of Health and Family Welfare, has further submitted as under:—

"Annexure A provides information on the State-wise numbers of ASHAs trained upto Module 5 and respective %. In Bihar, Module 5 is being clubbed with Modules 6 & 7 and the training of ASHAs is expected to start by mid December. The State has taken necessary steps to ensure time bound training.

The summary of incentives proposed by the States for FY 2011-12 in their respective PIPs is placed as Annexure B.

Attached at Annexure A is a status update on training of ASHAs and drug kit distribution, as on March 31, 2012.

The term "trained: is meant to include all ASHAs trained upto Module 3 or a State specific induction training, which is indicative of a basic level of training.

For the high focus States, the number of untrained ASHAs is highest in Bihar. The State estimates that it will complete training of all ASHAs by

December, 2013. In the remaining States, the untrained ASHAs are mostly represented by those newly selected into the programme.

In the non high states, Tamil Nadu has recently recruited 1011 ASHAs into the programme and is making arrangements to train them. The State of Delhi also has a similar case. Both States will ensure training of newly selected ASHAs within this fiscal year."

25. The Committee have been informed that as on 31st March, 2012, 91.59% ASHAs have been trained and 92.43% ASHAs have been provided drug kits. The Committee emphasise that the Ministry make concerted efforts to implement a comprehensive, pragmatic and time bound action plan wherein ASHAs would be adequately trained and well equipped with required drug kits. In their Thirty-second Report, the Committee had recommended that suitable incentives be provided to ASHAs so as to reduce the rate of attrition amongst them. The Ministry has submitted a summary of incentives proposed by the States for Financial Year 2011-12 in their respective PIPs. However, the Committee desire assurance as regards the adequacy of incentives so proposed to contain attrition. ***The Committee would therefore like to be apprised of the details of new incentives and the result thereof on the rate of attrition within six months of the presentation of this Report.***

G. Conversion of Department of Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH) into a full-fledged Ministry

Recommendation (Sl. No. 23)

26. While examining the Subject, the Committee had noted with concern that despite increase in the budget allocation of the Department of AYUSH from Rs. 775.00 crore in the 10th Plan to Rs. 3988.00 crore in the 11th Plan, it had not been able to meet the 10% overall allocation of the health budget. The Secretary (AYUSH), during evidence had deposed 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 Committee expressed serious concern over the fact that despite the stipulation of increase in the share of plan outlay for the Department of AYUSH in total health budget by 10 per cent in the National Policy on Indian Systems of Medicine and Homoeopathy-2002, the same had not been achieved even after lapse of 8 years. It was a disturbing fact that inspite of the Committee's recommendation in 38th Report (14th Lok Sabha) for stepping up of allocation to AYUSH and the Government's own stated resolve in this regard, no tangible progress had been made to increase the allocation to Department of AYUSH. Taking this scenario into account, the Committee had recommended that the budgetary outlay for the Department of AYUSH be suitably enhanced during 12th Plan to fulfil the avowed objective of mainstreaming of AYUSH in national healthcare as enunciated in the National Policy 2002. They had also recommended the Planning Commission had to step up the allocation during the 12th Plan by 25 per cent for achieving the targets set under the Mission. The Committee had also laid stress on mainstreaming AYUSH with NRHM and the National Healthcare System. 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 were of the considered view that the Department of AYUSH may be converted into a full-fledged Ministry and rechristened as the Ministry of Indigenous Systems of Medicine or AYUSH Ministry.

27. Elaborating on the action taken in this regard, the Department of AYUSH has stated as under:—

> "The Programme Implementation Plan (PIP) of NRHM provides for mainstreaming of AYUSH through co-location of AYUSH facilities at Primary Health Centres (PHCs) and Community Health Centres (CHCs). The Department of AYUSH has observed that inspite of concerted and sincere efforts of Ministry of Health and Family Welfare, Government of India for mainstreaming of AYUSH systems by way of co-locating the AYUSH units at PHCs, CHCs and district hospitals all over the country, out of 28,605 number of total such facilities only 11,575 number of AYUSH doctors have been reported to be engaged by the States as on 31.03.2011. In many cases, the money has remained unspent in the States for the reason of not having dedicated AYUSH administrative setup under NRHM to monitor the programme. The Department of AYUSH has observed that Mission Directors in the States have found to be mainly focusing the activities under Directorate of Health Services which is manned by allopathic doctors and the AYUSH services in the States are being managed by a separate directorate administered by Indian System of Medicines and Homoeopathy technical personnels or commissioners from central or state administrative services. It is found that they have not any role in co-locating tasks of NRHM Mission Director in the State. Similarly, the state level implementation committees/district level implementation committees/block level implementation committees or rogi kalyan samities etc. which have been formed as a part of NRHM have also been found to be mainly allopathic system oriented and the concerns of AYUSH systems have been observed to have been neglected. As a result, mainstreaming of AYUSH could not make significant headway under NRHM except for few co-location in primary health network.
>
> Administrative setup for mainstreaming of AYUSH under NRHM needs to be revamped in the State with necessary infrastructure and required manpower during 12th Plan provided that sufficient funds are made available to the Department of AYUSH. The Department of AYUSH in the 12th Plan will seek to take over from Department of Health and Family Welfare, the entire responsibility including financial provision for hiring or AYUSH manpower, training etc. It is also proposed that the State Directorates of AYUSH systems shall also be involved in the mainstreaming of AYUSH systems.
>
> D/o AYUSH is aware that for meaningful mainstreaming of AYUSH, adequate funds are required. Accordingly, Department of AYUSH has projected the

following requirements of the funds for implementation of the various projects during the 12th Plan.

1. Centrally Sponsored Scheme for Development of AYUSH Hospitals and Dispensaries: Rs. 11633.00 crore.

2. Transfer from NRHM flexipool for Manpower, training etc.: Rs. 10,000.00 crore."

28. The Department of Health and Family Welfare has also submitted the following:—

* "The 11th Plan document stated 'the existing level of Government expenditure on Health in India is about 1%, which is unacceptably low. Effort will be made to increase the total expenditure by the Centre and the States to at least 2% of GDP by the end of the 11th Five Year Plan'.

* The plan allocation for the Deptt. of AYUSH has been increasing over the successive Five Year Plans. Details of allocation (BE), actual expenditure for 9th & 10th Plan and year wise allocation (BE) and actual expenditure for the 11th Plan is as under:

(Rs. in crore)

Sl.No.	Plan/Year	Allocation	Expenditure	% Utilization
1.	9th Plan	266.00	293.72	110.42
2.	10th Plan	775.00	1029.56	132.85
3.	11th Plan	3988.00	—	—
4.	2007-08	488.00	382.54	78.39
5.	2008-09	534.00	471.12	88.22
6.	2009-10	734.00	680.00	92.64
7.	2010-11	800.00	844.53 (provisional)	105.57
	Total (2007-08 to 2010-11)	2556.00	2378.19	93.04
8.	2011-12	900.00	—	—

* Actual expenditure from 2007-08 to 2010-11 is 93% of the total approved outlay (BE) for 2007-08 to 2010-11. The actual expenditure during first four years of the 11th Plan is only 59.63% of the approved outlay for the 11th Plan.

* The resource envelope of the 12th Plan is not known. However, the Mid-Term Appraisal of the 11th Plan states, "the total allocation of plan and non-plan resources for health for the Centre and States combined remains low compared to the target of taking it to 2-3 per cent of GDP. A very strong effort will be needed in the last year of the 11th Plan and mainly in the 12th Plan to achieve this goal."

29. Subsequently Department of AYUSH also added:—

> ".....the Department of AYUSH in its working group on AYUSH for 12th Five Year Plan made proposal for the consideration of Planning Commission duly ascertaining the needs, gaps and challenges AYUSH systems are faced with. Accordingly, the working group on AYUSH for 12th Five Year Plan constituted by the Department of AYUSH has recommended total projected outlay of Rs. 47535.55 crore in the 12th Plan against the Outlay of Rs. 3988.00 crore during the 11th Plan.
>
> Regarding converting Department of AYUSH into a separate Ministry, it is felt that this could be taken up in line with the increasing budget and activities of the Department."

30. Taking note of the various initiatives for mainstreaming of AYUSH healthcare, the Committee find that the working group on AYUSH for 12th Five Year Plan constituted by the Department of AYUSH has recommended a total outlay of Rs. 47535.55 crore in the 12th Plan as against the outlay of Rs. 3988.00 crore during the 11th Plan. ***Considering that the Department of AYUSH continues facing constraints such as insufficient budgetary allocation, lack of dedicated AYUSH administrative set up and manpower, the Committee reiterate that the Department of AYUSH be converted into a full-fledged Ministry with the nomenclature Ministry of Indigenous System of Medicines or AYUSH Ministry so that the time-tested traditional healthcare systems such as Ayurveda, Sidha, Unani, Yoga, Naturopaghy and Homoeopathy are encouraged and popularized.***

H. Patenting the AYUSH medicines

Recommendation (Sl. No. 26)

31. In their Thirty-second Report, the Committee had noted that notwithstanding the steps taken by the Department of AYUSH for ensuring procurement and supply of quality AYUSH medicines, the medicines were not available in the AYUSH Dispensaries/ Hospitals across the Country. The Committee therefore had recommended that alongwith securing cooperation of the States for ensuring availability of AYUSH medicines in all the health facilities, the Department of AYUSH should take measures for standardizing the AYUSH medicines. They had also recommended that financial assistance should be given to the drug manufacturers of AYUSH medicines to enable them to undertake Research and Development and also to patent the medicines. Formulation of a five year special plan for AYUSH to encourage cultivation of herbal medicines in the States having congenial climatic condition for growth of such plants both for domestic consumption and export was also recommended.

32. Elaborating on the action taken in this regard, the Department of AYUSH has stated as under:—

> *"(a) Availability of AYUSH medicines in the State dispensaries/hospitals:* Department of AYUSH advised the State Governments to expedite the utilization of Grant-in-Aid and to submit the Utilization Certificates for the Grant-in-Aid provided under Centrally Sponsored Scheme for Development of AYUSH Hospitals' and Dispensaries for procurement of AYUSH medicines. The States were also requested to ensure the availability of AYUSH medicines

from out of the funds released by Government of India, wherever co-location has been made.

(b) Certification of AYUSH Products: Department of AYUSH has taken a major initiative to improve quality standards in the AYUSH sector by partnering with Quality Council of India (QCI) for Voluntary certificate scheme for AYUSH Products. The scheme has been started since Oct., 2009, which has two levels of certification—For domestic market and international market, AYUSH standard and AYUSH premium marks are available respectively. The Voluntary certification scheme for product certification of AYUSH product would result in Quality seal being awarded to those who opt for third party evaluation. Till now 125 Premium marks and 95 standard marks has been awarded to Ayurveda Siddha Unani (ASU) products.

(c) Timely and adequate Supply of AYUSH medicines in CGHS dispensaries: Ayurveda Medical Store Depot (AMSD), Under the CGHS (Department of Health and Family Welfare) looks after procurement of Ayurvedic medicines related to Delhi region. Outside Delhi concerned CGHS head of the city looks after the procurements on the basis of the Rate Contract and formularly prepared by the AMSD after following the codal procedures. The procurements are made on the basis as per the annual estimates called "provisioning". Throughout the year around 92 to 95% of medicines out of 345 formulary medicines are made available to the dispensaries.

All the medicines that the procured by AMSD are from GMP complied firms and the supplies are accepted in the AMSD only when batch wise analytical reports are enclosed along with supply.

(d) Plan for encouraging cultivation of herbal medicines in the States: Government has been implementing a Centrally Sponsored Scheme of "National Mission of Medicinal Plants" with a total outlay of Rs. 630.00 crore during the 11th Plan. The scheme aims at supporting market driven cultivation of medicinal plants, prioritized by Department of AYUSH and implemented in a mission mode for cultivation through growers, farmers, cultivators, Growers Associations, Federations, Self Help Groups, Corporate, Growers Co-operatives etc. with backward and forward linkages. The Scheme is primarily supporting cultivation on private lands with backward linkages by establishment of nurseries for supply of quality planting material and forward linkages for Post-harvest management, Processing, Marketing infrastructure, Certification and crop insurance in project mode.

The scheme is being implemented since 2008-09. 26 States *viz.* Andhra Pradesh, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Himachal Pradesh, Haryana, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Tamil Nadu, Uttar Pradesh, Uttarakhand, West Bengal are already implementing the scheme. Assistance amounting to Rs. 146 crores has been provided to the aforesaid states for establishing 642 nurseries of

medicinal plants, undertaking cultivation of identified medicinal plants on additional 52,367 ha., setting up of Post Harvest Management (PHM) units and Management Support till 31.03.2011."

33. The Department of AYUSH has further submitted as under:—

"63 Ayurveda, Siddha, Unani and Homoeopathy drugs manufacturers have been assisted financially under Centrally Sponsored Scheme for Quality Control of Ayurveda Siddha, Unani and Homoeopathy drugs for the establishment of in-house laboratory. However, no other scheme for financial assistance to manufacturers for undertaking research and development exists in Department of AYUSH. Patenting however is to be taken up by the entrepreneurs/manufacturers themselves."

34. Apart from financial assistance to 63 AYUSH drug manufacturers under Centrally Sponsored Scheme for quality control of AYUSH drugs for establishment of in-house laboratory, the Committee find that there is no other scheme in place in the Department of AYUSH for financial assistance to manufacturers for undertaking research and development. The Committee deplore the fact that research and development which is critical for the growth and enrichment of AYUSH medicines remains neglected by the Department of AYUSH. The contention of the Department the patenting of AYUSH medicines is to be taken up by the entrepreneurs/manufacturers themselves is, therefore, not acceptable. ***The Committee wish to remind the Department that AYUSH drugs/ medicines are repositories of our rich and glorious traditional knowledge and civilisational heritage and the nation can ill-afford their neglect. The Committee, therefore, reiterate their earlier recommendation regarding extending financial assistance to the drug manufacturers of AYUSH medicines.***

I. Need for Earmarking 25% Funds for Utilization of AYUSH Medicines and Therapies for National Health Programme

Recommendation (Sl. No. 27)

35. Taking cognizance of allopathy-centric and western oriented healthcare system in India and effectiveness of AYUSH drugs/medicines in combating various diseases, the Committee had recommended that the Government should earmark 25 per cent funds out of the total funds for National Health Programmes for utilization of AYUSH medicines, therapies and Research and Development.

36. Submitting the Action taken in this regard, the Department of AYUSH stated as under:—

"In the 9th Plan on an experimental basis, 7 Ayurveda and 5 Unani medicines were included in the Reproductive and Child Health (RCH) Kit for trial in 9 States and 4 Cities. However, this experiment was not continued by Department of Health and Family Welfare. Apart from this experiment, Department of Health and Family Welfare has not associated the Department of AYUSH and AYUSH systems in framing up various National Health Programmes. Therefore, in view of this background, now Department of AYUSH is proposing to launch during 12th Plan several national AYUSH programmes

with mandate and objective of promoting AYUSH practices of maternal and child health care, geriatric care, mental health, nutritional care and health promotion for the benefit of masses subject to the availability of funds during forthcoming 12th Five Year Plan."

37. In its further submissions, the Department stated:—

"In order to improve the access to and outreach of AYUSH system of Medicine for the benefit of rural masses, particularly in the area of health promotion, disease prevention and management of non-communicable, a new initiative in the name of 'National AYUSH Health Programme' has been proposed for implementation during the 12th Plan period (2012-17). An allocation of Rs. 1,000 crores has been sought for this purpose.

For 12th Five Year Plan, a significantly scaled up allocation of Rs. 2,649.50 crores has been proposed for Research and Development in AYUSH against the 11th Plan outlay of Rs. 359.50 crores for the purpose.

The Centrally Sponsored Scheme for Development AYUSH Hospitals and Dispensaries, through which financial assistance is also provided to States for supply of medicines, is intended to be implemented in the 12th Plan period as 'National Mission on AYUSH'. The 12th Plan allocation for this initiative has been projected to the tune of Rs. 11,633 crores against the outlay of Rs. 625 crores in the 11th Five Year Plan. The Scheme is proposed to be implemented to cover all PHCs, CHCs, District Hospitals, stand alone AYUSH facilities and all districts of North Eastern States and Other Hilly States.

In order to bring about more effective delivery of Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) systems of medicines to the entire rural population, the Department proposed to operate three scheme under mission mode to be called the 'National Mission on AYUSH'. The three schemes would be existing schemes for Development of AYUSH Hospitals and Dispensaries and two new items *i.e.* NRHM flexipool and National AYUSH programme on the lines of such programme being taken up by the Department of Health.

Department of AYUSH has projected Rs. 22.63 crore to the Planning Commission for 12th Five year Plan for these three items.

Further, the working group of AYUSH for 12th Five Year Plan (2012-17) proposed for Research and Development in AYUSH a scaled up allocation of Rs. 2,649.50 crore against the 11th Plan outlay of Rs. 359.50 crore."

38. The Committee observe that in the 9th Plan, on an experimental basis, Ayurvedic and Unani medicines were used for trial in some States. However, the practice was discontinued by the Ministry for some unknown reasons. ***Further, the Ministry owes explanation as to why the Department of AYUSH was not being associated with the formulation of various National Health Programmes.*** **However, the Committee have been apprised that to improve the outreach of AYUSH system of Medicine for the benefit of rural masses, particularly in the area of health promotion,**

disease prevention and management of non-communicable diseases, a new initiative in the name of 'National AYUSH Health Programme' has been proposed for implementation during the 12th Plan period (2012-17) and allocation of Rs. 1,000 crore has been sought for the same. ***The Committee call upon the Ministry to pursue the matter vigorously with the Planning Commission and also to ensure effective monitoring of utilization of funds so that the intended objectives are attained.***

ANNEXURE A

Status of ASHA Training and Drug Kit Distribution—as on 31 March, 2012

Sl.No.	Name of State	No. of ASHAs Selected	No. of ASHAs Trained	% of ASHAs Trained	No. of ASHAs given drug kit	% of ASHAs given drug kit
1	2	3	4	5	6	7
High Focus States	Bihar	83301	52859	63.46	83301	100.00
	Chhattisgarh	60092	60092	100.00	60092	100.00
	Jharkhand	40964	39214	95.73	35000	85.44
	Madhya Pradesh	52393	47022	89.75	52393	100.00
	Orissa	42597	40948	96.13	40948	96.13
	Rajasthan	50287	45000	89.49	38044	75.65
	Uttar Pradesh	136094	129150	94.90	128434	94.37
	Uttarakhand	11086	11086	100.00	9983	90.05
	Total	476814	425371	89.21	448195	94.00
North Eastern States	Assam	29172	27499	94.27	27855	95.49
	Arunachal Pradesh	3740	3559	95.16	3740	100.00
	Manipur	3878	3878	100.00	3878	100.00
	Meghalaya	6258	6250	99.87	6250	99.87
	Mizoram	987	987	100.00	987	100.00
	Nagaland	1700	1700	100.00	1700	100.00
	Sikkim	666	666	100.00	641	96.25
	Tripura	7367	7367	100.00	7367	100.00
	Total	53768	51906	96.54	52418	97.49
Non-High Focus States	Andhra Pradesh	70700	70700	100.00	70700	100.00
	Delhi	4121	2372	57.56	3435	83.35
	Gujarat	29508	26429	89.57	29508	100.00
	Haryana	13683	13683	100.00	5000	36.54
	Jammu & Kashmir	9700	9500	97.94	9500	97.94
	Karnataka	33750	33750	100.00	33750	100.00
	Kerala	31868	28205	88.51	23350	73.27
	Maharashtra	59316	56027	94.46	58394	98.45
	Punjab	16800	16214	96.51	16463	97.99
	Tamil Nadu	2650	1639	61.85	1639	61.85
	West Bengal	45564	41548	91.19	32123	70.50
	Total	317660	300067	94.46	283862	89.36
Union Territories	Andman & Nicobar Island	407	407	100.00	407	100.00
	Dadra & Nagar Haveli	208	85	40.87	85	40.87
	Lakshadweep	83	83	100.00	83	100.00
	Chandigarh	423	30	7.09	0	0.00
	Total	1121	605	53.97	575	51.29
Grand Total for All States and Union Territories:		849363	777949	91.59	785.050	92.43

ANNEXURE B

Table 1—PIP Incentives for ASHAs High Focus States—INCENTIVE IN INR/CASE-2011

Sl. No.	Activity Name	Bihar	Chhattisgarh	Jharkhand	Madhya Pradesh	Odisha	Rajasthan	Uttar Pradesh	Uttarakhand
1	2	3	4	5	6	7	8	9	10
	Pregnancy/ANC								
1.	Pregnant women tracking								
2.	Child Tracking								
3.	Registration during the first trimester of pregnancy		200		150(50/case additional for every anaemic pregnant woman consuming 200 IFA tablets)			MCH card=30	40
4.	Completion of 3/4 antenatal checkups, 2 IT immunization and 120 days of IFA tablets to pregnant woman				150		100	100/case	310
5.	For motivating deliveries in tribal areas								
	Birth/delivery								
6.	Pregnant woman having institutional delivery in government health institution-JSY; inclusive of transport	600(R)—(inclusive of 3, 4 & 6); 200 for U	200/case for(R): & 150/case for transport	600	350	600	500	600	600(R) 200(U)
7.	Pregnant woman having institutional delivery private health institution								
8.	Referral of Post-Partum complication to a CEMONC Centre and escort							200 each for 3 cases in an year in	

9.	Postnatal Care and New born Care for mother and neonate	200 on completion of 6 home visits under HBNC, IMNCI	200 only in 18 selected blocks		200 in NIPI districts; 100 in other districts	100/case if baby is alive for a month in high focus district	100/case for 5 PNC visits—institutional delivery Home delivery= 200/case	emergency 50	100/case for completion of 6 new born visits
10.	Referral of Sick New Born baby to a SNCU		100	100					
	Nutrition and related								
11.	Referral of severe Malnutrition cases/SAM, to Malnutrition rehabilitation Centres		200	100	100 per malnourished child	200			
12.	Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi workers and ensuring the child completes 12 months of age in a health state/exclusive breastfeeding to neonates								
13.	No. of Children weighed every month								
14.	Referring New born with birth weight less than 2000 grams and follow up on progress								
15.	Weekly follow up of low birth weight new borns								

1	2	3	4	5	6	7	8	9	10
	Immunisation								
16.	Complete Immunisation—All doses of immunization for BCG, DPT, OPV, Measles, and Hepatitis-B and Vitamin A Supplementation	5-10 children= 50, 11-15 children= 100, 16-20 children =150 20 & above=200	100	For 75% of children covered =150 on VHND		150		100 each for minimum 30 children with complete immunization in one year	
17.	Pulse polio atleast three times a year					75/ programme		75	
	Reporting								
18.	Maternal Death Reporting to Sub-centre and PHC		50			50		5	
19.	Infant Death Reporting to Sub-centre and PHC		50					5	
20.	Birth registration/Birth certificate					20/case		5 each for minimum 30 birth registration	50
	Family Planning								
21.	Counselling and motivation of women for Tubectomy/DPL surgery and follow up visit of the cases	150	150	150		150	150	150	
22.	Counselling and motivation of men for Vasectomy/NSV operation and follow up visit	200	200	200		200	200	200	
23.	Motivation and Counselling for successful IUCD insertion and retention for atleast one year and intake of contraceptive Pills for one year		300			100	200		
24.	Motivation for taking OCPs for 1 year								

	Abortion Services								
25.	Incentive for post abortion services–escort and promoting					100			
	Organizing								
26.	VHND		50/session		150/VHND	100/session for high focus non high=50	150		150
27.	ASHA/Diwas/Review meetings					150/meet	100/meet	50/ASHA for conveyance	
28.	VHSC meetings and ensuring other facilities					50/meet	100/meet		
	Disease Control Programmes								
29.	Identification of Malaria cases—RD/Treatment and follow up		Slide-na/ only for referral of positive cases=200	5/slides; positive slide=5; positive RDK slide-5 complete treatment-max. 200/month	200/month	FTD referral=20/case	50 for radical treatment. And 25 for making slide		5/slide. 50/Pv case 25/Pf case
30.	Identification of Leprosy/treatment Plausi/Multi-bacillary cases, follow up	100/300/500	Na/300/500	Na/300/500	100/200/400	Na/300/500	100/200/400	Na/300/500	Na/300/500
31.	Identification of TB cases, and successful completion of DOTS	250	250	250	50 for detection, 50 additional if report is positive; for DOTS=250	250	250	250	250

1	2	3	4	5	6	7	8	9	10
32.	Identification and referral of cataract cases	175/case	175/case	175		150/case	175/case	50 for post operation follow up	175
33.	Kala Azar	100 for detection and completion of treatment							
34.	Outbreak Reporting					20/instance/ case informing PHC/CHC on emg. health situation/ dehydration			
	Miscellaneous								
35.	Adolescent Anaemia control								
36.	Eye testing and helping in provision of glasses for 15 years children							25	
37.	Counselling session for adolescent girls/women						100/ session	100 for one meeting each, with women and ado. girls separately. 02 such meetings are organized in a month	

38.	Screening Camps for school health programme			50/school
39.	Mobile Health Unit visits			50/MHU point
40.	Accompanying freedom fighters for treatment			100/case
41.	Deworming			
42.	Calcium Compliance			
43.	Vitamin A			
44.	RTI/STI to PHC and CHC		100	
	Reporting HIV+/AIDS cases			
45.	Material care on HIV	500 for HIV+ women for ANC, PNC & safe delivery	ANC for HIV testing=300	100 in selected districts for HIV testing; 500 for such women for institutional delivery
46.	Child care on HIV			
47.	Referral of mentally and physically handicapped			100/child for disability in children
48.	RSBY			30 in V3 & V4 sub-centres for RSBY
	Other Incentives			
49.	Sarees			

1	2	3	4	5	6	7	8	9	10
50.	Best ASHA Awards PHC/Cluster/District/ State level			5000 for 1000 best performing sahiyas					
51.	ASHA Gruhas Corpus fund for supporting sahiyas in death and accident cases			10/sahiya					
52.	MIS								
53.	Ensuring safe drinking water and other sanitation facilities								
54.	TA/DA during training	100/days				100/day	100/day		
55.	Maintaining accounts for documents/annual expenditure/ maintenance of daily expenditure of the untied fund for village								
56.	Maintaining village health register							500	
57.	Monthly honorarium (only in specific States)						500/month-by ICDS		
	ITDA Areas								
58.	Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas								
59.	Referral of pregnant mother to Birth Waiting Homes a week before EDD; and ensuring safe institutional delivery in ITDA areas								
60.	Referral and admission of severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow up								

1. For New born 6 visits 3rd, 4th, 7th, 14th, 21st and 28th day.
2. R=Rural; U=Urban

Table 1—PIP Incentives for ASHAs Non High Focus States-2011

Sl. No.	Activity Name	Incentives in INR/case										
		Andhra Pradesh	Delhi	Gujarat	Haryana	Jammu & Kashmir	Karnataka	Kerala	Maharashtra	Punjab	Tamil Nadu	West Bengal
1	2	3	4	5	6	7	8	9	10	11	12	13
	Pregnancy/ANC											
1.	Pregnant women tracking							20/case				
2.	Child Tracking							50/case				
3.	Registration during the first trimester of pregnancy	30			50	200				100/case		10/case; for JSY= 5/-
4.	Completion of 3/4 antenatal checkups, 2 TT immunization and 120 days of IFA tablets to pregnant woman	120		150	25 for 3 ANC visits/ case	400	Ensuring consumption 100 IFA during ANC=200			100/case and 50/case in giving IFA*		150/case
5.	For motivating deliveries in tribal areas			NA								
	Birth/delivery											
6.	Pregnant women having institutional delivery in government health institution-JSY	150/case		100	200	600	200 for all & 600 for tribal	600-tribal areas, 200 non-tribal	600/ case for tribal; 200/case for non-tribal	200/case	200/case	200/case for escort & admiss-ion, if stays=120 case

1	2	3	4	5	6	7	8	9	10	11	12	13
7.	Pregnant woman having institutional delivery in private health institution	75/case										
8.	Referral of Post-Partum Complication to a CEMONC Centre	50/case									300/case	
9.	Postnatal Care and Newborn Care for mother and neonate	150@ 25/visit			200 for 1+6 home visits		50 for six visits		100/new-born for all visits	for three visits 50/case		440/new-born for 6 visits upto 42nd day
10.	Referral of Sick New born baby to a SNCU	50/case							50/child		300	
	Nutrition and related											
11.	Referral of severe Malnutrition cases/SAM to Malnutrition rehabilitation Centres	50/case										
12.	Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi worker and ensuring the child completes 12 months of age in a health state/exclusive breastfeeding to neonates	50/case		100/case	25/case		50 (Only in cases of home deliveries)			25/case for breastfeeding		
13.	No. of children weighed every month			2/child								

14. Referring Newborn with birthweight less than 2000grams and follow up on progress	100/case				50 on follow up for three months (only in cases of home deliveries)			200		
15. Weekly follow up of low birthweight newborns		50/case								
Immunization										
16. Complete Immunisation— All doses of immunization for BCG, DPT, OPV, Measles, and Hepatitis-B and Vitamin A Supplementation	150/case	50 per case for 6th, 10th and 14th week infants	100/case	400/case for mobilizing dropout children- 150/month if all children- immunized	100/case (for reporting side effects of immunization AEFI=100/case)	750/ case for complete & 500/case if 90% immuniz-ation	150/ case	100/ case	150/ child	
17. Pulse polio at least three times a year		75/day		75/day	75/day					
Reporting										
18. Maternal Death Reporting to Sub-centre and PHC	50/case	50/case	100/case	for any event= 100/case	500/case within the first 24 hours to RCH officers and otherwise 50	500/case	100/case		20/case	
19. Infant Death Reporting to Sub-centre and PHC	50/case	50/case	100/case		100/case within first 24 hours & others 50	50/infant	100/case	25/case	20/case	

1	2	3	4	5	6	7	8	9	10	11	12	13
20.	Birth Report/Registration			100/reg.	50/case				10/case	100/ trimest	25/case	20/case
	Family Planning											
21.	Counselling and motivation of women for Tubectomy/ DPL surgery and follow up visit of the cases	50		150/case	100/case	150/case	100/case		150/case	150/case	100/case	150/case
22.	Counselling and motivation of men for Vasectomy/ NSV operation and follow up visit	100		200/case	100/case	200/case	200/case		200/case	200/case	250/case	200/case
23.	Motivation and Counselling for successful IUCD insertion and retention for at least one year and intake of contraceptive Pills for one year	100		125/case	100/case		50/case					150/case; only for IUD motivation 10/case
24.	Motivation for taking OCPs for 1 year											
	Abortion Services						100/case					
25.	Incentive for post abortion services			25/case 50/day	100/case for MTP		100case					

Organizing											
26. VHND			50/day		100/day		75/day	100/case	100		
27. ASHA/Diwas/Review meetings		50/session	100/meet		100/day		50/quarterly meeting	100/ month	200		
28. VHSC meetings and ensuring other facilities		200/meet			25/meet			100/3 months			
Disease Control Programmes											
29. Identification of Malaria cases-RD/Treatment and follow up	10/case 3 months follow up in ITDA	5/slide	20/case till treatment		5/slide and identifying 100/case (also for any other NVBD Programme=100		5/slide, 20/Pf case; 50/Pv case & 50/case for admission of critical cases.			5/slide, treatment 2 O/Pf case, Pf/Pv detection & complete treatment-50/case	
30. Referral of Dengue/Chikunguniya etc.							25/case				
31. Identification of Leprosy/treatment Plausi/Multi bacillary cases, follow up	Na/300/ 500		300/case	100/200/ 400	100/200/ 400	5.6 lakhs lumpsum	200/200/ 400	100/200/ 400	100/200/ 400	100/200/ 400	
32. Identification of TB cases, and successful completion of DOTS	300/case	250/case	250/case	250/case-RNTCP	250/case		250/case	250/case	100/case	MDR cases-2500/ case	

1	2	3	4	5	6	7	8	9	10	11	12	13
33.	Identification and referral of cataract cases			Rs. 175/ case					100/case for transport. 75/ case for IEC	175/case for ensuring surgery		
34.	Identifying any other infectious diseases						100					
35.	Outbreak Reporting/ Surveillance			Rs. 100/ case					100/infor-mation	100/infor-mation	100 per month	50/case
36.	Adolescent/others anaemia control			50/30 tablets							100/case in two years	
37.	Deworming										200/case in two years	
38.	Calcium Compliance											
39.	Vitamin A										200/case in two years	
40.	Identifying STI/RTI infec-ted case and referral						10-100/ case (maximum)					

	Reporting HIV+/AIDS cases	Rs. 50/ case		10/pregnant mother 500/case for delivery at PPTCT. & 300/ case for follow up
41.	Maternal care on HIV		100/case detection for up to delivery 1000/case.*	
42.	Child care on HIV		Each non + case 100/ visit. HIV + case-200/visit	
43.	Referral of mentally and phycially handicaped	As per 100/case disability	100	
44.	RSBY	Rs. 50/case		20/case
	Other Incentives			
45.	Sarees			
46.	Best ASHA Awards PHC/Cluster/District/ State level			
47.	ASHA Gruhas			

		Incentive in INR/Case										
1	2	3	4	5	6	7	8	9	10	11	12	13
48.	MIS			50/episode								
49.	Ensuring safe drinking water and other sanitation facilities				50/sample of water for testing				75/toilet construction	Toilet construc-tion on 50/ case		
50	TA/DA during training				125/ASHA							
51.	Maintaining accounts for documents/annual expenditure/maintenance of daily expenditure of the united fund for village						1000/year-two times in an year					
52.	To do household survey For ITDA Areas only in Andhra Pradesh						500 in one year					
53.	Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas	100										
54.	Referral of pregnant mother to Birth waiting homes a week before EDD and ensuring safe Institutional delivery in ITDA areas											

55.	Referral and admission of Severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow-up	50 for admission in NRC; and 25/ month for follow-up

1. For Newborn 6 visits 3rd, 4th, 7th, 14th, 21st and 28th day.
2. In Tamil Nadu 6 visits for 28 days ASHAs get incentive
3. In Kerala ASHA incentive=40,000/district lumpsum
4. *In Karnataka for HIV + postnatal mothers and exposed infant upto 18 months = 1200/case; for bringing HIV + mothers for ART Centre = 400/case

Table 3—North East States: PIP Incentives for Asha—Incentive in INR/Case-2011

S. No.	Activity Name	Assam	Arunachal Pradesh	Manipur	Meghalaya	Mizoram	Nagaland	Sikkim	Tripura
1	2	3	4	5	6	7	8	9	10
	Pregnancy/ANC								
1.	Pregnant women tracking								
2.	Child Tracking								
3.	Registration during the first trimester of pregnancy								
4.	Completion of 3/4 antenatal checkups, 2TT immunization and 120 days of IFA tablets to pregnant women								
5.	For motivating deliveries in tribal areas								
	Birth/delivery								
6.	Pregnant woman having institutional delivery in Government health institution-JSY	600	600	600	600	600	600	600	600(R): 200(U)-institutional delivery in non JSY-50/case
7.	Pregnant woman having institutional delivery private health institution								

8. Referral of Post-Partum Complication to a CEMONC Centre
9. Postnantal Care and Newborn Care for mother and neonate
10. Referral of Sick New Born baby to a SNCU

Nutrition and related

11. Referral of severe by acute Malnutrition cases/SAM to Malnutrition rehabilitation Centres
12. Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi worker and ensuring the child completes 12 months of age in a health state/exclusive breastfeeding to neonates
13. No. of Children weighed every month
14. Referring Newborn with birthweight less than 2000 grams and follow up on progress

1	2	3	4	5	6	7	8	9	10	
15.	Weekly follow up of low birth weight new borns									
	Immunization									
16.	Complete Immunization All doses of immunization for BCG, DPT, OPV, Measles, and Hepatitis-B and Vitamin A supplementation	250/case	150/case	150/case	150/case	150/case	150/case	150/case		
17.	Pulse polio at least three times a year									
	Reporting									
18.	Maternal Death Reporting to Sub-centre and PHC									
19.	Infant Death Reporting to Sub-centre and PHC									
20.	Birth Report/Registration									
	Family Planning									
21.	Counselling and motivation of women for Tubectomy/DPL surgery and follow up visit of the cases	150	150	150	150	150	150	150	150	150
22.	Counselling and motivation of men for Vasectomy/NSV operation and follow up visit	200	200	200	200	200	200	200	200	

23.	Motivation and Counselling for successful IUCD insertion and retention for at least one year and intake of contraceptive Pills for one year		20/case							
24.	Motivation for taking OCPs for 1 year									
	Abortion Services									
25.	Incentive for post abortion services									
	Organizing									
26.	VHND	100	100	100	100	100	100	100	100	
27.	ASHA/Diwas/Review meetings									
28.	VHSC meetings and ensuring other facilities									
	Disease Control Programmes									
29	Identification of Malaria cases-RD/Treatment and follow up		55/case		50/case			50/smear collection 20/RDK slide		
30.	Identification of leprosy/treatment Plausi/ Multi bacillary cases, follow up					100				

1	2	3	4	5	6	7	8	9	10
31.	Identification of TB cases, and successful completion of DOTS	250	250	250	250		250	250	250
32.	Identification and referral of cataract cases			175	175		100	175	
	Outbreak Reporting								
	Miscellaneous								
33.	Adolescent anaemia control								
34.	Deworming								
35.	Calcium Compliance								
36.	Vitamin A								
	Reporting HIV+/AIDS cases								
37.	Maternal care on HIV Child care on HIV								
38.	Referral of mentally and physically handicapped								
39.	RSBY								
	Other Incentives								
40.	Sarees								
41.	Best ASHA Awards PHC/Cluster/District/State level								

42. ASHA Gruhas
43. MIS
44. Ensuring safe drinking water and other sanitation facilities
45. TA/DA during training
46. Maintaining accounts for documents/annual expenditure/maintenance of daily expenditure, of the untied fund for village

ITDA Areas

47. Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas
48. Referral of pregnant mother to Birth Waiting Homes a week before EDD; and ensuring safe institutional delivery in ITDA areas
49. Referral and admission of Severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow-up

Annexure to Action Taken Report on 32nd Report on PAC (15th Lok Sabha) 2011-12

Sl.No.	State/UT	No. of Trainings already given	No. of Participants already trained
1.	Andhra Pradesh	1	26
2.	Arunachal Pradesh	2	61
3.	Assam	2	37
4.	Bihar	2	67
5.	Chhattisgarh	1	1
6.	Gujarat	1	41
7.	Haryana	1	7
8.	Himachal Pradesh	1	3
9.	Jammu and Kashmir	1	1
10.	Jharkhand	2	52
11.	Karnataka	1	33
12.	Madhya Pradesh	3	64
13.	Maharashtra	4	128
14.	Manipur	2	17
15.	Meghalaya	2	98
16.	Mizoram	1	4
17.	Nagaland	1	3
18.	Odisha	2	130
19.	Punjab	1	38
20.	Rajasthan	2	115
21.	Sikkim	2	37
22.	Tamil Nadu	1	3
23.	Tripura	2	57
24.	Uttarakhand	2	122
25.	Uttar Pradesh	1	4
26.	Chandigarh	1	5
27.	The Govt. of NCT of Delhi	1	5
28.	Puducherry	1	3
	Total	44	1162

CHAPTER II

OBSERVATIONS/RECOMMEND ATIONS WHICH HAVE BEEN ACCEPTED BY THE GOVERNMENT

Observations/Recommendations

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, Odisha, 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 pogrammes 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.

[Recommendation No. 1, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

I. Achievements under NRHM:

* The IMR has decreased from 58 in 2005 to 50 in 2009, MMR has reduced from 254 in 2005 to 212 in 2009. TFR has seen a reduction from 2.9 in 2005 to 2.6 in 2009.

* 55% mortality reduction in malaria in 2010 as against 2006 and 44% mortality reduction in Kala Azar in 2010 as against 2006 and Elimination to be achieved by 2015.

* 26% mortality reduction in dengue in 2010 as against 2006.
* The target of less than 1 for Leprosy Prevalence Rate was achieved in December 2005 and maintained same as thereafter.
* 72% case detection rate and 87% cure rate has been achieved for Tuberculosis.
* Presently, 8.05 lakh ASHAs have been engaged in the villages across the country.
* NRCs address severe acute malnutrition/wasting in children < 5 years age 492 Nutritional Rehabilitation Centres are operational across 13 States.
* 6403 New Born Care Corners at delivery points, 1102 New Born Stabilization Units at FRUs and 263 Sick Newborn Care Units have been set up at District Hospitals.

Village Health and Sanitation Committee (VHSC) has been renamed as Village Health Sanitation & Nutrition Committee (VHSNC) to include the mandate of Nutrition. Currently out of 638588 villages, 4.83 lakhs villages constituted VHSCs. Social marketing of contraceptives through ASHAs and Menstrual Hygiene project for adolescent girls has also been promoted under NRHM for promotion of healthy lifestyle.

II. As regards expenditure in respect of NRHM from 2005-2012, it is proposed to be increased from the existing 1.1% of the GDP to 2-3% of the GDP over the Mission period. The Planning Commission and the Ministry of Finance are being requested to provide enhanced allocation of funds for NRHM.

III. The Status of achievement of targets under the universal Immunization programme for TT (P/W), DPT, OPV, BCG, and Measles during NRHM period 2005-06 to 2010-11 is shown in **Annexure-I.**

IV. Non-Communicable Diseases (NCD)

National Programme for Health Care of the Elderly (NPHCE) is a new initiative in the 11th Five Year Plan to address various health related problems of elderly people. The NPHCE has been approved by the Hon'ble Minister of Finance on 10th June, 2010 at an expenditure of Rs. 288.00 crore for the remaining period of the 11th Five Year Plan. This includes 20% share of State Governments (excluding the expenditure on Regional Medical Institutes) amounting to Rs. 48.00 crore. The Government of India's share would be Rs. 240.00 crore. Operational and Financial Guidelines for implementation of the programme has been finalised and put on the website of the Ministry of H&FW.

Physical targets (till 31st March, 2012):—

* Regional Geriatric Centres (8):—
    - Establishment of Geriatric Department at the 8 Regional Geriatric Centres.
    1. Construction/Renovation/extension of the existing building and furniture of department of Geriatric with 30 beds and OPD facilities including academic and research wing.
    2. Procurement of Machinery and Equipment.
    3. Establishment of Video Conferencing Unit.

* Districts and below (100 Districts in 21 States):

Establishment of Geriatric unit at the district hospitals.

1. Construction/Renovation/extension of the existing building and furniture of Geriatric Unit with 10 beds and OPD facilities.
2. Procurement of Machinery and Equipment.

- Establishment of Rehabilitation Units at CHCs.

1. Procurement of Machinery and Equipment.

- Establishment of Weekly Geriatric Clinic at PHCs.

1. Procurement of Machinery and Equipment.

Achievements:

It has been decided to take up the programme activity in those districts selected under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS). Accordingly, the programme has been initiated in 30 districts of 21 States during 2010-11. Funds to the tune of Rs. 32.61 crore for the year 2010-11 have been released to 19 States (covering 27 districts).

Funds sanctioned for Jharkhand and Uttar Pradesh could not be released due to non-recepit of Bank Accounts details. Funds to the tune of Rs. 8.59 crore have also been released to four Regional Geriatric Centres.

For the year 2011-12, fund is being released to the remaining four Institutes. Action has also been taken for release of funds for the year 2011-12 to take up new districts in 7 States *viz.* Bihar, Himachal Pradesh, Karnataka, Rajasthan, Sikkim, Kerala and Punjab.

A WHO workshop was organized in July, 2011 in NIHFW for developing 6 month course in Geriatric medicine and a 6 hour training module for training of Medical Officers.

The NCD cells proposed to be constituted at the Centre, State and district under the National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke will implement and monitor the NPHCE. The National NCD Cell has been established at the Centre.

National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) is a new initiative in the 11th Five Year Plan. The NPCDCS aims at reducing the burden of Non-Communicable Diseases (NCDs) such as cancer, diabetes, cardiovascular diseases and stroke and which are major factors reducing potentially productive years of human life, resulting in huge economic loss.

Progress of National Programme on Control of Cancer, Diabets Cardiovascular Diseases (NPCDCS):

(i) The NPCDCS has been approved by the CCEA at a total outlay of Rs. 1230.90 crore in July, 2010. This includes Rs. 499.39 crore for NPDCS and Rs. 731.51

crore for Cancer Control Programme. The expenditure will be met on cost sharing basis with the participating States at ratio of 80:20. The programme has been initiated in 30 districts of 21 States during 2010-11.

(ii) Earlier, the EFC proposals for the programme have been approved by the Expenditure Finance Committee in its meeting held on 8th March, 2010. The proposal was finalised after extensive consultation with the States/UTs, concerned Department, experts etc.

(iii) Operational Guidelines for the implementation of the programme has been finalised and put on the website of this Ministry for the information of all stakeholders as well as general public.

(iv) MoUs from 11 States (*viz.* Bihar, Karnataka, Madhya Pradesh, Maharashtra, Sikkim, Kerala, Punjab, West Bengal, Himachal Pradesh, Rajasthan and Haryana) have been received.

(v) Funds to the tune of Rs. 2867.46 lakhs have been released to 19 States on receipt of Bank Account details.

(vi) National NCD Cell has been constituted.

Future Plan and targets till March, 2012:—

* Setting up of 21 States NCD Cells and 100 District NCD cells.
* Strengthening of 100 District Hospitals by establishing NCD Clinic, District Cancer Facility and Cardiac Care Unit.
* Screening of common non-communicable disease upto sub-centre level in 100 districts.

V. Control of Communicable Diseases (CCD) Achievements under National Vector Borne Disease Control Programme:

Malaria:

* The reported cases in country have been reduced from 1.79 million in 2006 to 1.5 million in 2010.
* Human resource such as multi-purpose workers (Male), State and District Consultant, Malaria Technical Supervisors etc. provided by GoI as additional assistance to high malaria endemic States.
* External assistance of US$ 250 million under World Bank support and 101.87 million US$ under GFATM project for a period of 5 years have been approved.
* Diagnosis of malaria strengthened through Rapid test.
* Artemisinine based combination therapy to P. falciparum cases introduced.
* Distribution of Long Lasting Insecticidal Nets (LLINs) in remote and inaccessible areas.
* Achieved reduction by 15.73% in reported malaria cases in 2010 as against 2006.

Japanese Encephalitis:

* Surveillance strengthened through 51 Sentinel laboratories.
* "Vector Borne Disease Surveillance Unit" and NIV (ICMR) Unit established at BRD Medical College, Gorakhpur in Uttar Pradesh.
* JE vaccination for children between 1-15 years was launched in 2006 and 111 districts have been covered till 2010.
* The case fatality rate has reduced from 23% in 2006 to 13% in 2010.

Dengue and Chikungunya:

* Upscaled the diagnostic facilities from 137 to 311 sentinel surveillance hospitals which are linked to 14 Apex Referral Laboratories.
* Strengthened management of Dengue cases which brought down case fatality rate from 1.49% in 2006 to 0.39% in 2010.
* About 13.90 lakhs suspected cases of Chikungunya were reported in 2006 first time in country after 30 years, however, only 48176 cases have been reported in 2010.

Kala Azar:

* Rapid Diagnostic tests and for better treatment compliance, oral drug Miltefosine introduced, upscaled and extended in all districts.
* Free Diet and financial support to patients for loss of wages during the hospital admission.
* Incentives to ASHAs for improvement in treatment compliance.
* Case detection has increased but mortality has reduced to 0.36% in 2010 against 0.48% in 2006.

Lymphatic Filariasis:

* Revised Strategy of Mass Drug Administration with annual single dose of anti-filarial tablets towards Elimination of Lymphatic Filariasis was scaled up from 202 districts in 2004 to 250 districts in 2007 onwards and the coverage of targeted population has been above 80%.
* Efforts towards Elimination of Lymphatic Filariasis has brought down microfilaria rate in the community of endemic districts from 1.24% in 2004 to 0.65% in 2010.

VI. Revised National Tuberculosis Control Programme (RNTCP):

The goal of TB control Programme is to decrease mortality and morbidity due to TB and cut transmission of infection until TB cases to be a major public health problem in India. The Objectives are:

(a) To achieve and maintain cure rate of at least 85% among New Sputum Positive patients.

(b) To achieve and maintan case detection of at least 70% of the estimated New Sputum Positive (NSP) cases in the community.

The current focus of the programme is on ensuring universal access to quality TB diagnosis and treatment services to all TB patients in the community.

* Since 2007 RNTCP is achieving treatment success of >85% and has consistently maintained the NSP (New Sputum Positive) case detection of >70%. In 2010, RNTCP has achieved the NSP case detection rate of 72% and treatment success rate of 87% which is in line of global targets for TB control.

* According to WHO Global TB Report, TB mortality has reduced from over 42/100,000 population in 1990 to 23/100,000 population in 2010 and TB prevalence has reduced from 568/100,000 population in 1990 to 249/100,000 population by the year 2009.

* From inception in 2007 till March, 2011, the Multi Drug Resistant (MDR) TB services has been scaled up in 150 districts across 15 States. In 2010, 2150 MDR TB cases have been registered for DOTS Plus treatment. So far, a total of 22695 MDR TB suspects have been examined for diagnosis; 6069 cases have been confirmed and 4217 MDR TB cases have been initiated on Category IV treatment.

* The programme is in the process of establishing a network of 43 accredited Culture and Drug Susceptibility (DST) laboratories across the country in a phased manner for diagnosis and follow up of TB patients. In 2010, 13 laboratories have been accredited. Till May, 1127 labs have been accredited (4 National Reference Laboratories, 15 Intermediate Reference Laboratories and 8 laboratories in private sector).

* Intensified TB/HIV package has been rolled out in 29 States of the country and the rest of the country will be covered under this package by 2012. In 2010, 393110 TB suspects (7.4% of all clients counselled) were referred from Integrated Counselling and Testing Centres (ICTC) to RNTCP and of them about 35547 were diagnosed as having TB and provided TB treatment. In the same period 480,752 TB patients (59% of total TB patients registered in states implementing intensified TB/HIV package) were tested for HIV and of them about 41476 were diagnosed as HIV-infected and linked to HIV care services. The proportion of HIV-positive TB patients put on Cotrimoxazone Prophylactic Treatment (CPT) has improved to 93% but linkages to Anti-Retroviral Treatment (ART) through improved (53%) but still remains the biggest challenge.

* RNTCP has involved more than 1900 NGOs and more than 10000 private practitioners. 150 corporate hospitals and 282 medical colleges are implementing RNTCP.

Sd/-
(P.K. Pradhan)
Special Secretary and Mission Director (NRHM)

ANNEXURE I

UNIVERSAL IMMUNIZATION PROGRAMME COVERAGE IN FIGURE 2010-11 (April-2010 to March-2011)

Sl. No.	State/UT	TT (PW)			DPT			OPV		BCG		Measles	
		Target (in 000's)	Achieve-ment	%	Target (in 00's)	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1.	Arunachal Pradesh	30000	10438	34.8	26000	15177	58.4	15207	58.5	19547	76.2	15579	59.9
2.	Assam	800000	564777	70.6	680000	567468	83.5	560005	82.4	618,648	91.0	551,696	81.1
3.	Manipur	42000	34884	82.1	382000	45154	118.8	44881	118.1	52026	136.9	42035	110.6
4.	Meghalaya	72000	59217	82.2	62000	68653	110.7	68485	110.5	82017	132.3	64479	104.0
5.	Mizoram	20000	21358	106.8	17000	22821	134.2	22751	133.8	22803	134.1	21817	128.3
6.	Nagaland	43000	12694	29.5	38000	18854	49.6	19030	50.1	20295	53.4	17673	46.5
7.	Sikkim	12000	8173	68.1	11000	8921	81.1	9031	82.1	8899	80.9	8814	80.1
8.	Tripura	61000	45130	74.0	54000	49943	92.5	49667	92.0	55186	102.2	48301	89.4
9.	Bihar	3090000	1793998	58.1	2652000	1930107	72.8	1833470	69.1	2,247,028	84.7	1,919,254	72.4
10.	Chhattisgarh	693000	590156	85.2	594000	572290	96.3	570423	96.0	585,098	98.5	565,338	95.2
11.	Himachal Pradesh	132000	117241	88.88	115000	121582	105.7	121330	105.5	128,046	111.3	116,789	101.6
12.	Jammu & Kashmir	241000	191594	79.5	208000	215061	103.4	215734	103.7	217,078	104.4	210,706	101.3
13.	Jharkhand	888000	555387	62.5	770000	628488	81.6	592065	76.9	696,929	90.5	711,458	92.4
14.	Madhya Pradesh	2209000	1689911	76.5	1868000	1632431	87.4	1635305	87.5	1,615,511	86.5	1,619,381	86.7
15.	Odisha	956000	734305	76.8	809000	692434	85.6	919604	113.7	737,600	91.2	663,216	82.0
16.	Rajasthan	2039000	1561038	76.6	1737000	1560414	89.8	1557224	89.7	1,502,775	86.5	1,507,359	86.8
17.	Uttar Pradesh	6381000	4988285	78.2	5412000	4771222	88.2	4746738	87.7	5,158,554	95.3	4,542,351	83.9
18.	Uttarakhand	219000	178103	81.3	190000	178085	93.7	171998	90.5	181,822	95.7	167,817	88.3
19.	Andhra Pradesh	1709000	1641207	96.0	1473000	1476573	100.2	1472844	100.0	1,486,717	100.9	1,456,038	98.8
20.	Goa	26000	21302	81.9	24000	23008	95.9	22912	95.5	23965	99.9	22169	92.4
21.	Gujarat	1459000	1237438	84.8	1260000	1192082	94.6	1194093	94.8	1,239,731	98.4	1,153,782	91.6
22.	Haryana	639000	536226	83.9	550000	542941	98.7	543859	98.9	587,361	106.8	542,894	98.7
23.	Karnataka	1289000	1180178	91.6	1119000	1098221	98.1	1092524	97.6	1,115,862	99.7	1,038,278	92.8
24.	Kerala	554000	352493	63.6	497000	380065	76.5	378635	76.2	385,295	77.5	365,085	73.5
25.	Maharashtra	2206000	1540506	69.8	1939000	1559825	80.4	1558369	80.4	1,585,439	81.8	1,489,753	76,8

1	2	3	4	5	6	7	8	9	10	11	12	13	14
26.	Punjab	524000	428337	01.7	457000	439541	96.2	438994	96.1	468,442	102.5	420,244	92.0
27.	Tamil Nadu	1184000	1165865	98.5	1043000	1057917	101.4	1058054	101.4	1,048,218	100.5	1,035,521	99.3
28.	West Bengal	1716000	1470756	85.7	1506000	1405166	93.3	1400949	93.0	1,598,792	106.2	1,371,691	91.1
29.	A & N Islands	9000	2356	26.2	8000	2452	30.7	2510	31.4	3093	38.7	2694	33.7
30.	Chandigarh	25000	18203	72.8	23000	15541	67.6	15521	67.5	23852	103.7	16109	70.0
31.	Dadra & Nagar Haveli	10000	8486	84.9	9000	7095	78.8	7054	78.4	7670	85.2	6700	74.4
32.	Daman & Diu	5000	1864	–	4000	2799	–	2799	–	2715	–	3068	–
33.	Delhi	369000	212692	57.6	324000	229545	70.8	231639	71.5	260,851	80.5	215,804	66.6
34.	Lakshadweep	1000	1121	112.1	1000	678	67.8	754	75.4	583	58.3	751	75.1
35.	Puducherry	25000	17530	70.1	22000	16152	73.4	16608	75.5	37760	171.6	15165	68.9
	M/o Defence	–	20940	–	–	43084	–	60443	–	33087	–	25894	–
	M/o Railways	–	7726	–	–	21025	–	11685	–	7851	–	7364	–
	TOTAL	29678000	23021915	77.6	25540000	22612815	88.5	2263194	88.5	23867146	93.5	21983067	86.1

Note: Provisional Figures (States as on 11th April, 2011)
Data source HMIS Reports

UNIVERSAL IMMUNIZATION PROGRAMME COVERAGE IN FIGURE 2009-10 (April 2009 to March 2010)

Sl. No.	State/UT	TT (PW)			DPT			OPV		BCG		Measles	
		Target (in 000's)	Achieve-ment	%	Target (in 000's)	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%
1.	Arunachal Pradesh	29000	9971	34.4	26000	14189	54.6	14178	54.5	17725	68.2	13635	52.4
2.	Assam	790000	593124	75.1	672000	614128	91.4	612491	91.1	676534	100.7	593493	88.3
3.	Manipur	42000	35147	83.7	38000	45713	120.3	45599	120.0	50460	132.8	41319	108.7
4.	Meghalaya	71000	54033	76.1	61000	61899	101.5	61604	101.0	76241	125.0	54405	89.2
5.	Mizoram	19000	22626	119.1	17000	23732	139.6	23256	136.8	23687	139.3	21833	128.4
6.	Nagaland	43000	13385	31.1	38000	24882	65.5	25359	66.7	24299	63.9	24211	63.7
7.	Sikkim	12000	7260	60.5	11000	8811	80.1	8105	73.7	8045	73.1	8590	78.1
8.	Tripura	60000	44191	73.7	53000	46395	87.5	45968	86.7	51083	96.4	43672	82.4
9.	Bihar	3047000	1716653	56.3	2615000	2235000	85.5	2115854	80.9	2255972	86.3	1946179	74.4
10.	Chhattisgarh	683000	610202	89.3	586000	581457	99.2	582235	99.4	598499	102.1	573198	97.8
11.	Himachal Pradesh	130000	128807	99.1	113000	127350	112.7	127358	112.7	131262	116.2	123899	109.6
12.	Jammu & Kashmir	238000	194076	81.5	206000	247944	120.4	247850	120.3	231739	112.5	251454	122.1
13.	Jharkhand	876000	532193	60.8	760000	685534	90.2	685488	90.2	680808	89.6	639780	84.2
14.	Madhya Pradesh	2174000	1710211	78.7	1838000	1695047	92.2	1684256	91.6	1646367	89.6	1719386	93.5
15.	Odisha	947000	819032	86.5	802000	795590	99.2	782012	97.5	784011	97.8	772899	96.4
16.	Rajasthan	2006000	1817647	90.6	1709000	1655099	96.8	1649084	96.5	1755677	102.7	1612166	94.3
17.	Uttar Pradesh	6269000	5707229	91.0	5317000	5500429	103.4	5560695	104.6	5719622	107.6	5344922	100.5
18.	Uttarakhand	215000	194789	90.6	187000	201066	107.5	194584	104.1	198703	106.3	181577	97.1
19.	Andhra Pradesh	1693000	1700671	100.5	1459000	1507164	103.3	1508254	103.4	1539151	105.5	1498743	102.7
20.	Goa	25000	20200	80.8	23000	19046	82.8	22983	99.9	24332	105.8	22303	97.0
21.	Gujarat	1440000	1217471	84.5	1243000	1172382	94.3	1164703	93.7	1187795	95.6	1130074	90.9
22.	Haryana	629000	568028	90.3	541000	572865	105.9	571999	105.7	609555	112.7	565094	104.5
23.	Karnataka	1275000	1152762	90.4	1107000	1032024	93.2	1125957	101.7	1057304	95.5	976021	88.2
24.	Kerala	550000	510281	92.8	494000	535871	108.5	536963	108.7	522419	105.8	508182	102.9
25.	Maharashtra	2175000	1857635	85.4	1912000	2049613	107.2	2045714	107.0	2186125	114.3	1941634	101.5
26.	Punjab	518000	427044	82.4	452000	451964	100.0	452033	100.0	462491	102.3	430814	95.3
27.	Tamil Nadu	1176000	1156404	98.3	1036000	1097820	106.0	1087746	105.0	1091645	105.4	1075399	103.8
28.	West Bengal	1700000	1502713	88.4	1492000	1678522	112.5	1600142	107.2	1719572	115.3	1552782	104.1
29.	A & N Islands	9000	4097	45.5	8000	4792	59.9	4845	60.6	5195	64.9	4732	59.2
30.	Chandigarh	24000	18042	75.2	21000	16290	77.6	16369	77.9	24401	116.2	17589	83.8
31.	Dadra & Nagar Haveli	10000	9300	93.0	9000	8031	89.2	8047	89.4	8057	89.5	7725	85.8
32.	Daman & Diu	5000	—	—	4000	—	—	—	—	—	—	—	—
33.	Delhi	359000	204679	57.0	315000	226366	71.9	227857	72.3	267904	85.0	219370	69.6
34.	Lakshadweep	1000	786	78.6	1000	767	76.7	774	77.4	644	64.4	689	68.9
35.	Puducherry	24000	20117	83.8	21000	15367	73.2	16716	79.6	36179	172.3	15368	73.2
	M/o Defence	—	16740	—	—	54319	—	55406	—	33485	—	28415	—
	M/o Railways	—	18660	—	—	35344	—	21236	—	16290	—	15630	—
	TOTAL	29264000	24616206	84.1	25187000	25042812	99.4	24933720	99.0	25723278	102.1	23977182	95.2

Note: Provisional Figures (Status as on: 11th April, 2011)
Data source HMIS Reports

UNIVERSAL IMMUNIZATION PROGRAMME COVERAGE IN FIGURE 2008-09 (April 2008 to March 2009)

Sl. No.	State/UT	TT (PW)			DPT			OPV		BCG		Measles	
		Target (in 000's)	Achieve-ment	%	Target (in 000's)	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%
1.	A & N Islands	8,000	3,645	45.6	7,000	4,254	60.8	4,254	60.8	3,593	51.3	3,688	52.7
2.	Andhra Pradesh	1,704,000	1,703,550	100.0	1,466,000	1,515,175	103.4	1,518,572	103.6	1,544,541	105.4	1,492,304	101.8
3.	Arunachal Pradesh	29,000	10,402	35.9	26,000	16,370	63.0	16,649	64.0	19,566	75.3	17,851	68.7
4.	Assam	793,000	600,122	75.7	673,000	617,095	91.7	618,530	91.9	692,433	102.9	560,569	83.3
5.	Bihar	3,055,000	1,137,521	37.2	2,616,000	1,784,762	68.2	1,895,519	72.5	2,423,801	92.7	2,012,318	76.9
6.	Chandigarh	22,000	17,170	78.0	19,000	13,418	70.6	14,186	74.7	21,226	111.7	14,199	74.7
7.	Chhattisgarh	684,000	634,757	92.8	585,000	556,311	95.1	571,622	97.7	592,964	101.4	564,085	96.4
8.	D&N Haveli	9,000	9,374	104.2	8,000	7,425	92.8	7,430	92.9	7,918	99.0	7,543	94.3
9.	Daman & Diu	5,000	1,428	28.6	4,000	1,293	32.3	1,293	32.3	1,417	35.4	1,534	38.4
10.	Delhi	343,000	115,263	33.6	301,000	131,829	43.8	130,238	43.3	156,814	52.1	116,922	38.8
11.	Goa	26,000	22,679	87.2	24,000	24,552	102.3	24,599	102.5	27,813	115.9	22,423	93.4
12.	Gujarat	1,445,000	1,199,510	83.0	1,245,000	1,063,496	85.4	1,051,716	84.5	1,140,740	91.6	1,024,029	82.3
13.	Haryana	629,000	511,565	81.3	540,000	496,494	91.9	506,630	93.8	558,428	103.4	527,163	97.6
14.	Himachal Pradesh	127,000	125,667	99.0	110,000	130,842	118.9	130,840	118.9	134,314	122.1	122,201	111.1
15.	Jammu & Kashmir	237,000	170,856	72.1	205,000	215,761	105.2	212,959	103.9	201,891	98.5	215,770	105.3
16.	Jharkhand	874,000	492,178	56.3	756,000	568,010	75.1	582,124	77.0	683,922	90.5	534,755	70.7
17.	Karnataka	1,268,000	1,111,544	87.7	1,099,000	1,026,567	93.4	1,043,284	94.9	1,073,672	97.7	1,008,460	91.8
18.	Kerala	549,000	472,296	86.0	493,000	491,454	99.7	498,149	101.0	508,871	103.2	494,112	100.2
19.	Lakshadweep	2,000	119	6.0	1,000	136	13.6	136	13.6	133	13.3	129	12.9
20.	Madhya Pradesh	2,177,000	1,275,804	58.6	1,836,000	1,506,989	82.1	1,530,754	83.4	1,864,885	101.6	2,248,975	122.5
21.	Maharashtra	2,168,000	2,031,853	93.7	1,904,000	1,855,253	97.4	1,890,234	99.3	2,004,914	105.3	1,730,804	90.9
22.	Manipur	38,000	35,764	94.1	34.000	42,679	125.5	42,697	125.6	46,753	137.5	36,990	108.8
23.	Meghalaya	68,000	44,337	65.2	59,000	52,374	88.8	52,155	88.4	64,262	108.9	45,182	76.6
24.	Mizoram	20,000	18,372	91.9	17,000	10,488	61.7	10,501	61.8	10,374	61.0	10,775	63.4
25.	Nagaland	42,000	8,655	20.6	37,000	14,131	38.2	15,439	11.7	15,202	41.1	12,133	32.8
26.	Odisha	943,000	653,392	69.3	796,000	549,270	69.0	596,980	75.0	639,446	80.3	512,497	64.4
27.	Puducherry	21,000	19,649	93.6	18,000	14,391	80.0	15,204	84.5	40,238	223.5	14,149	78.6
28.	Punjab	521,000	428,486	82.2	453,000	404,750	89.3	420,544	92.8	459,812	101.5	427,046	94.3
29.	Rajasthan	2,001,000	1,910,849	95.5	1,701,000	1,714,928	100.8	1,705,050	100.2	1,832,836	107.8	1,647,520	96.9
30.	Sikkim	12,000	11,593	96.6	10,000	10,106	101.1	10,836	108.4	8,246	82.5	9,799	98.0
31.	Tamil Nadu	1,154,000	1,214,531	105.2	1,012,000	1,090,287	107.7	1,091,244	107.8	1,088,081	107.5	1,043,372	103.1
32.	Tripura	66,000	45,999	69.7	58,000	52,200	90.0	52,081	89.8	55,466	95.6	50,977	87.9
33.	Uttar Pradesh	6,241,000	6,500,567	104.2	5,282,000	6,262,130	118.6	6,567,475	124.3	6,991,573	132.4	6,288,413	119.1
34.	Uttarakhand	215,000	209,578	97.5	186,000	190,376	102.4	192,661	103.6	201,903	108.6	171,828	92.4
35.	West Bengal	1,723,000.0	1,545,057	89.7	1,508,000	1,091,479	72.4	1,306,733	86.7	1,566,125	103.9	1,308,934	86.8
	M/O Defence		27,063	*DIV/01		37,529	#DIV/01	38,316	#DIV/01	27,736	#DIV/01	21,648	#DIV/01
	M/O Railways		11,269	#DIV/01		17,164	#DIV/01	15,839	#DIV/01	13,251	#DIV/01	11,228	#DIV/01
	TOTAL	29,219,000	24,332,464	83.3	25,089,000	23,581,768	94.0	24,383,473	97.2	26,725,140	106.5	24,332,325	97.0

Note : Provisional Figures (Status as on: 4th August, 2009)
Data Source HMIS Reports

UNIVERSAL IMMUNIZATION PROGRAMME COVERAGE IN FIGURE 2007-08

Sl. No.	State/UT	TT (PW)			DPT			OPV		BCG		Measles	
		Target (in 000's)	Achieve-ment	%	Target (in 000's)	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%
1.	A & N islands	7.5	6,014	79.7	6.7	6,117	90.9	6,117	90.9	5,505	81.8	5,557	82.6
2.	Andhra Pradesh	1,709.6	1,736,326	101.6	1,462.5	1,564,191	107.0	1,565,217	107.0	1,577,729	107.9	1,506,146	103.0
3.	Arunachal Pradesh*	27.9	8,826	31.7	24.4	13,193	54.1	13,389	54.9	15,045	61.7	11,731	48.1
4.	Assam	820.3	629,651	76.8	696.5	637,580	91.5	622,463	89.4	695,196	99.8	572,546	82.2
5.	Bihar	3,101.3	865,093	27.9	2,647.3	1,277,302	48.2	1,144,965	43.3	1,502,118	56.7	1,171,508	44.3
6.	Chandigarh	18.5	18,506	100.1	16.5	16,383	99.6	16,383	99.6	24,067	146.3	16,859	102.5
7.	Chhattisgarh*	707.8	632,910	89.4	604.9	587,434	97.1	587,165	97.1	601,299	99.4	588,513	97.3
8.	D&N Haveli	8.2	8,033	98.3	7.1	7,277	102.9	7,277	102.9	7,928	112.1	7,153	101.1
9.	Daman & Diu	4.0	2,786	68.8	3.5	3,356	94.7	3,356	94.7	3,564	100.6	2,955	83.4
10.	Delhi	337.5	231,867	68.7	297.0	237,988	80.1	241,809	81.4	302,969	102.0	225,722	76.0
11.	Goa	24.1	24,323	101.0	21.5	23,768	110.5	23,799	110.6	27,549	128.0	23,355	108.6
12.	Gujarat*	1,499.5	1,181,466	78.8	1,291.0	1,211,932	93.9	1,207,836	93.6	1,258,339	97.5	1,170,354	90.7
13.	Haryana	652.3	590,234	90.5	556.8	559,352	100.5	558,569	100.3	595,719	107.0	552,045	99.1
14.	Himachal Pradesh	137.9	132,223	95.9	118.9	127,471	107.2	127,475	107.2	129,882	109.2	125,056	105.1
15.	Jammu & Kashmir	247.9	247,043	99.7	214.3	299,246	139.6	299,246	139.6	309,796	144.5	275,979	128.8
16.	Jharkhand	858.5	501,990	58.5	742.2	682,444	91.9	653,559	88.1	725,198	97.7	653,839	88.1
17.	Karnataka	1,314.4	1,144,299	87.1	1,136.3	1,082,879	95.3	1,083,219	95.3	1,097,468	96.6	1,040,265	91.5
18.	Kerala	569.4	527,949	92.7	511.4	504,352	98.6	503,655	98.5	539,523	105.5	476,608	93.2
19.	Lakshadweep*	1.4	932	65.9	1.2	1,033	82.8	1,033	82.8	977	78.4	1,092	87.6
20.	Madhya Pradesh	2,253.4	1,938,376	86.0	1,886.7	1,849,200	98.0	1,852,682	98.2	1,995,229	105.8	1,835,597	97.3
21.	Maharashtra	2,230.9	1,952,056	87.5	1,955.1	1,983,696	101.5	1,971,814	100.9	2,054,591	105.1	1,873,507	95.8
22.	Manipur	39.8	18,546	46.5	35.7	21,436	60.0	21,710	60.8	27,228	76.2	25,510	71.4
23.	Meghalaya*	70.0	64,037	91.5	60.2	70,565	117.2	57,564	95.6	68,154	113.2	50,988	84.7
24.	Mizoram*	20.5	18,973	92.6	18.3	18,963	103.8	18,612	101.9	19,962	109.3	17,970	98.4
25.	Nagaland*	33.2	23,430	70.6	29.7	26,917	90.7	28,235	95.2	28,180	95.0	24,153	81.4
26.	Odisha	992.3	819,920	82.6	832.7	799,418	96.0	799,322	96.0	847,802	101.8	781,868	93.9
27.	Puducherry	19.9	20,274	102.0	17.6	16,459	93.9	16,459	93.3	44,134	250.2	16,209	91.9
28.	Punjab	544.0	463,267	85.2	472.3	498,503	105.5	498,503	105.5	514,843	109.0	4,63,316	98.1
29.	Rajashtan	2,049.4	1,915,998	93.5	1,738.3	1,711,203	98.4	1,707,738	98.2	1,798,416	103.5	1,665,288	95.8
30.	Sikkim	12.7	9,657	76.2	11.2	10,735	96.2	10,734	96.2	11,133	99.8	10,917	97.9
31.	Tamil Nadu	1,244.3	1,231,593	99.0	1,084.8	1,140,122	105.1	1,139,616	105.0	1,136,573	104.8	1,132,719	104.4
32.	Tripura	57.5	46,259	80.5	50.6	51,336	101.5	50,308	99.5	58,276	115.3	51,292	101.4
33.	Uttar Pradesh	6,417.9	5,150,016	80.2	5,414.3	5,317,827	98.2	5,238,429	96.8	5,641,889	104.2	5,243,913	96.9
34.	Uttarakhand	212.4	221,910	104.5	185.0	218,270	118.0	216,559	117.1	228,027	123.3	201,757	109.1
35.	West Bengal	1,855.5	1,516,417	81.7	1,619.4	1,525,676	94.2	1,454,860	89.8	1,768,910	109.2	1,505,096	92.9
	M/O Defence	$$	43,622		$$	56,979		50,712		38,231		28,749	
	M/O Railways	$$	14,294		$$	30,916		33,644		17,961		16,198	
	TOTAL	30,101.8	23,959,116	79.6	25,772.1	24,191,519	93.9	23,834,033	92.5	25,719,410	99.8	23,372,330	90.7

$ = Provisional ; * = Estimated ; $$= No separate targets allocated

UNIVERSAL IMMUNIZATION PROGRAMME COVERAGE IN FIGURE 2006-07

Sl. No.	State/UT	TT (PW)			DPT			OPV		BCG		Measles	
		Target (in 000's)	Achieve-ment	%	Target (in 000's)	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%
1.	Andhra Pradesh	1,816.1	1,724,913	95.0	1,553.6	1,505,259	96.2	1,508,070	97.1	1,525,449	98.2	1,471,194	94.7
2.	A & N Islands	7.4	6,413	86.1	6.7	5,745	86.4	5,745	86.4	6,071	91.3	5,968	89.7
3.	Arunachal Pradesh	24.5	13,477	55.0	21.5	20,778	96.6	21,187	98.5	21,428	99.6	19,373	90.1
4.	Assam	846.4	652,089	77.0	717.9	621,956	86.6	637,402	88.8	702,868	97.9	612,258	85.3
5.	Bihar	3,102.1	1,063,128	34.3	2,650.9	2,028,358	76.5	1,972,246	74.4	2,329,813	87.9	1,817,749	68,6
6.	Chandigarh	16.6	17,405	104.9	14.8	15,858	107.2	15,858	107.2	23,819	161.0	15,618	105.6
7.	Chhattisgarh	638.9	667,678	104.5	540.2	605,886	112.2	607,775	112.5	619,464	114.7	601,794	111.4
8.	D & N Haveli	8.4	8,352	99.8	7.2	7,778	108.1	7,778	108.1	8,640	120.1	7,099	98.7
9.	Daman & Diu	4.4	3,324	75.4	3.9	3,589	93.1	3,589	93.1	3,851	99.9	3,391	88.0
10.	Delhi	307.6	212,637	69.1	271.8	261,358	96.2	267,716	98.5	319,495	117.5	239,676	88.2
11.	Goa	23.6	23,697	100.6	21.1	24,238	115.0	24,253	115.1	28,536	135.4	23,018	109.2
12.	Gujarat	1,495.8	1,305,912	87.3	1,282.3	1,211,932	94.5	1,207,836	94.2	1,258,339	98.1	1,170,354	91.3
13.	Haryana	672.9	580,326	86.2	575.7	570,643	99.1	570,092	99.0	597,600	103.8	543,969	94.5
14.	Himachal Pradesh	146.6	135,639	92.5	126.7	129,173	101.9	129,140	101.9	133,212	105.1	126,284	99.7
15.	Jammu & Kashmir	238.9	269,468	112.8	207.7	296,255	142.7	296,255	142.7	315,771	152.1	285,987	137.7
16.	Jharkhand	851.7	443,818	52.1	734.8	733,827	99.9	732,937	99.8	744,553	101.3	695,677	94.7
17.	Karnataka	1,355.9	1,150,649	84.9	1,168.6	1,092,494	93.5	1,092,942	93.5	1,126,149	96.4	1,035,473	88.6
18.	Kerala	619.8	545,094	87.9	557.3	526,300	94.4	522,688	93.8	536,925	96.3	500,046	89.7
19.	Lakshadweep	1.4	932	66.5	1.2	1,033	83.2	1,033	83.2	977	78.8	1,092	88.0
20.	Madhya Pradesh	2,241.8	1,962,553	87.5	1,870.8	1,897,493	101.4	1,897,914	101.4	1,972,593	105.4	1,878,896	100.4
21.	Maharashtra	2,293.2	2,007,729	87.6	1,997.1	1,984,169	99.4	1,985,957	99.4	2,033,616	101.8	1,891,520	94.7
22.	Manipur	43.9	39,917	90.9	39.3	48,064	122.4	48,064	122.4	55,225	140.6	47,360	120.6
23.	Meghalaya	67.7	43,214	63.8	58.1	65,886	113.5	65,185	112.3	77,715	133.8	58,883	101.4
24.	Mizoram	16.9	20,095	118.9	15.1	21,897	144.9	21,802	144.3	22,079	146.1	18,813	124.5
25.	Nagaland	58.7	28,614	48.8	50.1	24,615	49.1	24,611	49.1	25,513	50.9	22,377	44.6
26.	Odisha	994.6	832,062	83.7	829.1	817,910	98.6	819,920	98.9	869,547	104.9	788,074	95.0
27.	Pondicherry	20.2	18,186	90.1	17.9	16,352	91.4	16,352	91.4	42,101	235.2	16,328	91.2
28.	Punjab	592.6	537,810	90.8	512.3	536,117	104.6	537,564	104.9	548,285	107.0	503,062	98.2
29.	Rajasthan	2,104.3	1,832,974	87.1	1,769.5	1,685,976	95.3	1,687,852	95.4	1,745,015	98.6	1,650,528	93.3
30.	Sikkim	14.1	9,927	70.6	12.4	11,427	92.4	11,454	92.6	11,708	94.7	10,496	84.9
31.	Tamil Nadu	1,320.7	1,229,479	93.1	1,149.0	1,130,245	98.4	1,130,483	98.4	1,130,783	98.4	1,120,967	97.6
32.	Tripura	54.8	45,929	83.8	48.2	59,216	122.8	59,541	123.5	69,047	143.2	59,841	124.1
33.	Uttar Pradesh	6,398.5	5,174,507	80.9	5,374.7	5,457,184	101.5	5,457,890	101.5	5,646,385	105.1	5,103,901	95.0
34.	Uttaranchal	175.3	226,848	129.4	152.8	222,690	145.7	222,690	145.7	229,759	150.3	211,311	138.3
35.	West Bengal	1,928.4	1,572,581	81.5	1,672.5	1,588,878	95.0	1,600,286	95.7	1,859,365	111.2	1,522,628	91.0
	M/O Defence	$$	19,367		$$	25,318		33,297		15,586		14,615	
	M/O Railways	$$	14,347		$$	22,903		24,341		18,966		16,895	
	TOTAL	30,504.7	24,441,090	80.1	26,032.8	25,278,800	97.1	25,269,745	97.1	26,676,248	102.5	24,112,515	92.6

$ = Provisional ; * = Estimated ; $$ = No separate targets allocated

UNIVERSAL IMMUNIZATION PROGRAMME COVERAGE IN FIGURE 2005-06

Sl. No.	State/UT	TT (PW)			DPT			OPV		BCG		Measles	
		Target (in 000's)	Achieve-ment	%	Target (in 000's)	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%	Achieve-ment	%
1.	Andhra Pradesh	1,821.6	1,763,052	96.8	1,553.3	1,543,966	99.4	1543,859	99.4	1,560,537	100.5	1,524,712	98.2
2.	A & N Islands	7.2	6,771	94.7	6.4	6,705	104.7	6,705	104.7	5,787	90.4	5,555	86.7
3.	Arunachal Pradesh	25.9	10,335	40.0	22.6	12,676	56.0	12,797	56.5	18,136	80.1	22,247	98.3
4.	Assam	842.2	599,344	71.2	712.0	581,214	81.6	579,718	81.4	672,731	94.5	570,715	80.2
5.	Bihar	3,070.7	845,737	27.5	2,621.2	1446,056	55.2	1,356,485	51.8	2,163,026	82.5	1329,340	50.7
6.	Chandigarh	16.0	18,046	112.8	14.2	15,987	112.3	15,960	112.4	23,461	164.8	16,731	117.5
7.	Chhattisgarh	622.2	660,073	106.1	524.4	626,905	119.6	626,835	119.5	639,191	121.9	616,913	117.7
8.	D & N Haveli	8.2	8,502	103.8	7.0	7,625	108.4	7,625	108.4	8,154	116.0	6,950	98.8
9.	Daman & Diu	4.3	3,321	77.0	3.8	2,878	76.6	2,878	76.6	3,788	100.9	3,351	89.2
10.	Delhi	296.7	228,763	77.1	261.6	251,804	96.3	262,795	100.5	320,531	122.5	232,772	89.0
11.	Goa	23.1	25,826	112.0	20.6	25,821	125.3	25,903	125.7	28,221	137.0	23,543	114.3
12.	Gujarat	1,479.8	1,323,995	89.5	1,264.5	1,213,337	96.0	1,210,065	95.7	1,262,294	99.8	1,169,733	92.5
13.	Haryana	669.7	577,986	86.3	571.1	548,404	96.0	548,346	96.0	583,438	102.2	529,636	92.7
14.	Himachal Pradesh	145.8	136,762	93.8	125.6	131,548	104.7	131,288	104.5	134,050	106.7	128,308	102.1
15.	Jammu & Kashmir	239.4	240,410	100.4	207.8	284,000	136.7	283,980	136.7	311,729	150.0	277,982	133.8
16.	Jharkhand	842.4	465,840	55.3	726.7	677,576	93.2	704,047	96.9	812,534	111.8	734,159	101.0
17.	Karnataka	1,358.9	1,151,078	84.7	1,167.4	1,094,827	93.8	1,095,865	93.9	1,109,145	95.0	1,036,885	88.8
18.	Kerala	620.9	589,527	95.0	558.8	536,424	96.0	554,579	99.3	565,879	101.3	542,018	97.0
19.	Lakshadweep	1.4	993	72.0	1.2	1,622	132.6	915	74.8	880	72.0	910	74.4
20.	Madhya Pradesh	2,213.8	1,986,616	89.7	1841.5	1,950,408	105.9	1,951,965	106.0	2,013,196	109.3	1,942,122	105.5
21.	Maharashtra	2,308.0	2,061,763	89.3	2,003.7	2,079,367	103.8	2,072,128	103.4	2,139,148	106.8	1,984,167	99.0
22.	Manipur	47.0	28,320	60.2	42.1	35,599	84.6	35,606	84.5	39,999	94.9	36,436	86.5
23.	Meghalaya	69.9	46,399	66.4	59.7	48,640	81.5	49,175	82.4	69,796	116.9	46,991	78.7
24.	Mizoram	17.6	25,223	143.0	15.8	19,104	120.8	19,151	121.1	20,115	127.2	18,087	114.4
25.	Nagaland	44.3	41,095	92.8	39.5	22,384	56.7	23,164	58.7	26,036	66.0	20,291	51.4
26.	Odisha	991.8	813,897	82.1	823.2	850,624	103.3	853,224	103.7	925,816	112.5	840,283	102.1
27.	Pondicherry	20.3	17,610	86.6	18.1	16,185	89.5	16,185	89.5	36,182	200.1	15,934	88.1
28.	Punjab	591.1	534,156	90.4	509.9	531,806	104.3	531,803	104.3	561,406	110.1	510,755	100.2
29.	Rajasthan	2,086.5	1,927,188	92.4	1,748.9	1,752,430	100.2	1,746,871	99.9	1,759,153	100.6	1,693,619	96.8
30.	Sikkim	13.9	9,927	71.4	12.2	11,427	93.6	11,454	93.8	11,708	95.9	10,496	86.0
31.	Tamil Nadu	1,322.8	1,208,276	91.3	1,149.6	1,129,310	98.2	1,129,729	98.3	1,135,831	98.8	1,131,304	98.4
32.	Tripura	55.6	47,114	84.8	48.8	62,168	127.4	61,731	126.5	64,956	133.1	58,500	119.9
33.	Uttar Pradesh	6,336.1	5,222,940	82.4	5,299.3	5,320,615	100.4	5,342,965	100.8	5,610,855	105.9	5,180,650	97.8
34.	Uttaranchal	170.5	233,208	136.8	148.7	231,430	155.7	231,430	155.7	220,150	148.1	218,428	146.9
35.	West Bengal	1,923.0	1,512,125	78.6	1,662.5	1,621,658	97.5	1,605,785	96.6	1,855,722	111.6	1,520,463	91.5
	M/O Defence		22,690			24,680		24,895		37,827		23,828	
	M/O Railways		16,791			24,268		24,437		20,726		18,257	
	TOTAL	30,308.2	24,411,699	80.5	25,793.9	24,741,478	95.9	24,702,346	95.8	26,772,135	103.8	24,043,072	93.2

$ = Provisional ; * = Estimated ; $$ = No separate targets allocated

Audit Vetted Comments

The Ministry has proposed to increase the expenditure in respect of NRHM up to 2-3% of the GDP over the Mission period of 2005-2012. As the Mission period is going to end shortly, the percentage expenditure on NRHM to the GDP achieved till now be mentioned. It may also be mentioned whether the Ministry would be able to meet the proposed percentage of expenditure. The Ministry may also mention as to when the target of expenditure of 2-3% of GDP would be achieved.

Further Reply by Department of Health and Family Welfare

The NRHM framework for implementation (2005-2012), aimed at raising public spending on health from 0.9% of GDP to 2-3% of GDP with improved arrangements for community financing and risk pooling. The outlay under NRHM is a component of public spending on health and is a flagship programme of the Ministry of Health & Family Welfare. The Eleventh Five Year Plan had targeted for increasing the public spending on health to atleast 2 percent of GDP by the end of the Plan. As regards, NRHM, the original Eleventh Plan (2007-12) allocation was fixed at Rs. 90558 crore. However, the combined annual allocation (BE) for NRHM during five years from 2007-08 to 2011-12 was Rs. 70030 crore, indicating a shortfall of Rs. 20528 crore.

As per Revised Estimates 2010-11, the total expenditure for NRHM under central sector (including both plan and non-plan) was Rs. 15037.04 crore, which accounted for 0.19% of GDP. As regards Budget Estimates for 2011-12, the total allocation for NRHM is Rs. 17924.76 crore, which is 0.2% of GDP. As per Indian Public Finance Statistics (2010-11), published by Ministry of Finance, Government of India, the allocation of Centre and the States under Medical and Public Health, Water Supply, Sanitation and Family Welfare during 2010-11 (BE) was Rs. 96672.79, which is 1.22% of GDP. It may be noted that allocation of plan funds is the prerogative of Planning Commission based on the availability of financial resources and overall priorities of the Plan. As per the Planning Commission draft approach Paper to the 12th Five Year Plan, the aim is to raise total public health expenditure to 2.5% of GDP by the end of Twelfth Plan. The department will strive for greater allocation of resources in the Twelfth Plan. The department has worked and is continuing to work with the States/UTs to enhance the absorption capacity for increased public health spending.

The year-wise approved outlay (BE), RE and actual expenditure during Eleventh Plan in respect of NRHM is given below:

(Rs. in crores)

Year	BE	RE	Actual Expenditure
2007-08	10890.00	10668.61	10380.40
2008-09	11930.00	11930.00	11239.33
2009-10	13930.00	13377.75	13305.75
2010-11	15440.00	14960.45	14696.42
2011-12	17840.00	17127.00	16490.14 (prov.)
Total-11th Plan	70030.00	68063.81	66112.04

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Audit Vetted Comments

The Ministry has proposed to increase the expenditure in respect of NRHM up to 2-3% of the GDP over the Mission period of 2005-2012. Now, as per Planning Commission approach paper, the aim is to raise total public Health expenditure to 2.5% of GDP by the end of Twelfth Five Year Plan. The Ministry has stated that it would strive for greater allocation of resources. The PAC may be informed about the percentage of expenditure achieved on health care to the GDP by the end of the Mission period (2012) and the steps proposed to be taken to ensure the achievement of total expenditure on health care of 2.5% of the GDP at the end of 12th Plan.

Further Reply by Department of Health and Family Welfare

As per Economic Survey 2011-12, the percentage of expenditure on health (Centre and State Government combined) for the year 2011-12 (BE) was 1.30% of the GDP.

The Ministry had proposed an allocation of Rs. 4,04,490.69 crore to the Planning Commission in the 12th Plan. However, the 11th Plan document as approved by the NDC indicates that the aim is to raise the total public health expenditure to 1.86% of GDP.

Planning Commission has communicated that Gross budgetary support for Department of Health & Family Welfare for the 12th Five Year Plan would be Rs. 2,68,551 crore.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

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 and 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.

[Recommendation No. 2, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

The recommendations of the PAC on DHMs and DHSs has been shared with Mission Directors of States and it was informed by the States that they are in the process of constituting the DHM where it is not done. Further, as per the recommendations of the PAC, communication has been sent to the Mission Directors of all States/UTs requesting them to prepare a comprehensive central electronic database of vital household surveys and district health action plans, facility survey and district plans and upload the same on SHS's website for easy access by district planning teams. The States have also been advised to ensure that the State Health Society strictly adhere to the framework of decentralized planning to ensure that the State PIP reflect the requirements based on actual felt needs. State Governments have also been advised to hold meetings of DHM/DHS on regular intervals.

The States were asked to explain the reasons for delay in the constitution of DHS and DHM. Jharkhand and Puducherry have informed that DHS have been constituted in all the districts. In Bihar DHM has been formed in 25 out of 38 districts and the remaining districts are being followed up regularly. Andhra Pradesh, Jharkhand and Uttar Pradesh are in the process of constitution of DHM.

Government of NCT of Delhi has informed that District Health Mission has not been constituted as Delhi being primarily an urban State does not have the structures intrinsic to the District Health Mission as prescribed under NRHM Framework and the existing structures have already been incorporated in the DHSs. As regards reasons for delay in the constitution of the District Mission, the States have not reported any specific reason.

The Ministry had launched a web based Health Management Information System (HMIS) portal in October 2008 and the districts are reporting their performance by uploading data on the portal on a monthly basis. States have also been asked to upload facility level data. Continued efforts are made for improving the quality of information reported on the HMIS portal. Further, reports/factsheets of District Level Household Survey (DLHS) conducted during 2007-08 and Concurrent Evaluation of NRHM are also available on the HMIS portal. The Programme Implementation Plans (PIPs) for 2011-12 have been prepared by most of the States/UTs using the information available on the HMIS portal including national level survey data and have targeted

their interventions accordingly. Further, under DLHS-4 to be conducted during 2011-12 it is planned to conduct the facility survey and make this information available on the Ministry's website.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

(i) Ministry may provide a copy of the letter through which instructions regarding preparation of comprehensive central electronic data base of vital household surveys and District Health Action Plans etc. which were stated to be issued to State Mission Directors.

(ii) Please furnish copies of the communication advising States to (a) adhere to the framework of decentralised planning and (b) holding the meeting of DHM/DHS.

(iii) Ministry may also mention about the constitution of DHM in remaining 13 Districts out of 38 Distts. in Bihar. Ministry may also explain the delay in constitution on DHM in Andhra Pradesh, Jharkhand, and Uttar Pradesh States.

Further reply by Department of Health and Family Welfare

In this connection, a letter dated 3rd May, 2011 was written to all Principal Secretaries (Health and Family Welfare) with copy to all Mission Directors in the States/UTs for preparation of a comprehensive electronic data base on NRHM including house hold facility surveys for all the districts of the States/UTs and for uploading the same on the website for use and for facilitating need base district planning. Copy of the same is enclosed as **Annexure I.**

(i) A copy of the DO letter no. G. 25014/1/2008/NRHM-II dated 20.07.2011 written to States by Secretary (H&FW) in this year is attached at **Annexure II.**

(ii) The framework of implementation as approved by the Cabinet and disseminated to all the States/UTs already contain necessary instructions in regard to the decentralised planning. Instructions were also issued to the States in this regard at the time of preparation of State Programme Implementation Plans (PIPs), a copy of which is placed at **Annexure III.**

(iii) Further, as regards holding the meeting of DHM/DHS, the same is being monitored quarterly by collecting the required data from the States. Based on the report, the States are advised to hold regular meetings of DHM. A copy of the specimen letter issued to States is attached as **Annexure IV.**

As reported by the States, the District Health Mission was not constituted in the State of Jharkhand as Panchayati Raj Institution (PRI's) were not in place. The State is now in the process of formation of DHMs since PRIs have now been formed. The State of Andhra Pradesh had reported that District Health Missions were constituted in their State and the previously reported information was due to oversight.

The States of Bihar and U.P. are in the process of constitution of DHMs in remaining districts where ever DHM is not constituted. Copies of the letters written to the States are attached as **Annexure V.**

Sd/-

(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE I

P.K. PRADHAN, I.A.S.
Special Secretary &
Mission Director (NRHM)
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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110 108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi-110 108
D.O. No. G-25012/1/2008-State
Date: 03/05/2011

Dear,

The Public Accounts Committee in its 32nd report on performance audit of NRHM has recommend that a comprehensive central electronic database may be prepared for all districts State-wise and uploaded on the SHS's website for easy access by district planning teams. The PAC has also asked for adherence to the framework of decentralized planning to ensure that the State PIPs reflect the requirements based on actual demand. The exact observations and recommendations of PAC is annexed.

2. I would, request you to take early action for preparation of a comprehensive electronic database on NRHM including household and facility surveys for all the districts of your State and upload the same on the website for use and for facilitating need based district planning. Since district-wise data from other sources like DLHS is also available on the HMIS portal of the Ministry of Health & Family Welfare, link could be provided to the same and also the NRHM Website of the Ministry of Health & Family Welfare.

With regards,

Yours sincerely,

Sd/-

(P.K. Pradhan)

To

All Principal Secretaries (Health & FW)

Copy to: All Mission Directors

ANNEXURE II

P.K. PRADHAN, I.A.S.
Special Secretary &
Mission Director (NRHM)
Tele: 23061451 Fax: 23061975
E-Mail: md-nrhm@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110 108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi-110 108
D.O. No. G-25014/1/2008-NRHM-II
Dated: 20th July, 2011

Dear,

As you are aware, District Health Societies have been entrusted with the preparation of District Health Action Plan which are then amalgamated into State PIP. For better planning the district planning teams should utilize the information collected through household survey as well as date available under the HMIS.

The Public Accounts Committee in its 32nd Report has indicated laxity in conducting vital household surveys and preparation of annual district health action plans. The Committee has recommended that States and UTs should prepare a comprehensive Central electronic database of vital household surveys, district health action plans and facility survey and upload the same on SHS's website for easy access by district planning teams. The Committee has further advised to ensure that the State Health Societies strictly adhere to the framework of decentralized planning to ensure that the State PIP reflects the requirements based on actual demand. I am enclosing a copy of the relevant paragraph of the report.

You are requested to take immediate steps to ensure compliance of the recommendations of Public Accounts Committee and intimate the progress made in the matter to the Ministry regularly.

With warm regards,

Yours sincerely,

Sd/-

(P.K. Pradhan)

Sh. Rajeev Sadanandan
Principal Secretary (Health & Family Welfare),
Department of Health & Family Welfare,
Government of Kerala,
Secretariat Building,
Thiruvananthapuram-695001
KERALA

Copy to: Sh. Biju Prabhakar, Mission Director (NRHM), Directorate of Health Services, Govt. of Kerala, General Hospital Jn., Thiruvananthapuram-695 035, Kerala.

Sd/-

(P.K. Pradhan)

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 targetted 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 and 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 shield 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 monitored 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.

ANNEXURE III

AS&MD

D.O. NO. 10(37)/2010 NRHM-I
Dated: the 2nd December, 2010

Subject: NRHM—Planning Process for 2011-2012

Dear,

Preparation of the annual Programme Implementation Plan (PIP) is an integral part of National Rural Health Mission (NRHM). The time has now come for preparation of the PIP for the year 2011-12. In PIPs for 2011-12, States should clearly articulate the vision for health sector and reflect on the core goals of NRHM *viz.* reduction of MMR, IMR, stabilization of TFR and disease control. It should be ensured that the proposed strategies/interventions are completely aligned with the key goals of NRHM.

2. Substantial investments have been made by Government of India and the States under the National Rural Health Mission (NRHM) in the past five years. States have embraced the challenge for health system strengthening and used the flexibility under the mission to address the service delivery gaps. However, several of the systems strengthening initiatives have been unevenly implemented across States, resulting in outcomes that could have been better. In order to ensure the necessary thrust on such "Management Imperatives" for systems strengthening to enable better outcomes, States need to relook and provide details on the initiatives taken/lack thereof, and clear steps with timelines to address them in the newly introduced chapter "Policy and Systemic Reforms in Strategic Areas".

3. NRHM framework envisages a "bottom up" planning process from the Village to the Block, Block to the District and finally to the State, involving the stakeholders. To enable preparation of District Plans, the State Government should communicate the resource allocation to the Districts for the financial year 2011-12 based on current year's allocation. For this, the district resource envelope should be determined based on population of the district, giving a weightage of 1.3 to the high focus districts and 1.0 to the other districts. District Health Action Plan (DHAP) budgets should not exceed the resource envelope indicated. DHAPs should be a miniature of the State PIPs and should be organized in the same broad framework. The budget heads should also be in the same order. The State PIP should incorporate the gist of DHAP in the relevant chapter as provided in the enclosed framework. Once the DHAP is approved as part of the State PIP, re-appropriation between districts will not be allowed without approval from the Central Government.

4. It is necessary to review the progress of implementation of the PIP of current year. For this a chapter on "Outcome analysis of PIP 2010-11" has been introduced. An analysis of physical and financial outcomes in respect of various parameters of the PIP of 2010-11 should be given in this chapter. In order to get a complete picture of the resources available for the health sector, the State should clearly indicate the resources available from the State Government and from other sources and the details of the activities for which these funds would be utilized. A separate chapter on "State Resources and other Sources of Funds for Health Sector" should be there in the State PIP as mentioned in the enclosed framework.

5. States may also give a prioritized list of projects based on felt needs that should be given top priority if additional resources are available. Certain conditions have been introduced for release of funds to the States/UTs for the year 2011-12 for implementation of approved PIPs. States must ensure strict compliance to these conditionalities.

6. It is also proposed to set up an incentive pool for rewarding robust performance under NRHM. For this the guidelines are being issued separately. Apart from high performance, cost effective innovations with potential for large impact and models of good governance and system reforms would also attract bonus/incentive by ways of enhanced resource allocation.

7. The following key areas have been identified for priority action in 2011-12:

- **Action Plan for Maternal Child Health Centres:** The State must map out MCH centres and ensure that a complete action plan for operationalization of the same (as per standards) is detailed in the PIP for each activity.
- **Action Plan for Operationalising HMIS up to facility level:** The States must endeavour to have a road map for web enabled facility based reporting from facility level.
- **Capacity Development for all Institutions crafted under NRHM:** Plan for capacity building of ASHA, VHSC, RKS, PRIs, Programme Management Units, should be given. Regular meetings of RKS/District Health Mission (DHM)/State Health Mission (SHM) should be ensured.
- **Human resource for health:** This should include the steps undertaken by the States for filling up the vacant posts.
- **Action Plan on Training and Skill Development:** States should aim at a comprehensive and integrated training and skill development, training plan and include a calendar for the same in the PIP.
- **Action Plan for tackling High Burden of Communicable Diseases:** States should analyze and identify areas/Districts that have a high burden of communicable diseases. The additional funds required to tackle the same should be budgeted for in the NRHM Mission Flexipool.
- **Name Based Tracking:** State must put in place tracking of information on pregnant mothers and children's immunization.
- **Robust Action Plan for Monitoring:** Monitoring especially field supervision has undoubtedly been identified as one of the weakest components in the current programme implementation process, the lack of which is leading to unsuccessful implementation of various activities. States are thus urged to strengthen their monitoring components and ensure that a clear, detailed action plan for effective monitoring of the programmes is chalked out.
- **Action Plan for Difficult/Most Difficult/Backward/LWE effected Districts as part of the PIP:** The State must identify backward areas for greater attention (inaccessible, difficult, left wing affected, minority, tribal, SC/ST gender etc.)

Special incentive to medicos and paramedics for performing duties in these hard to reach and difficult areas should be reflected in the PIP in the form of comprehensive HR Policy.

- **Plan for streamlining of procurement and logistics:** Supply Chain Management System, Procurement Management Information System (ProMIS) and Rational Drug Use plan should be given in detail. To ensure sustainable drug supply at all levels and its replenishment, logistic and information systems arrangement need to be strengthened on a priority.

8. The Planning process for 2011-12 may be initiated immediately and should be completed as per the following schedule:

- Communication of Resource envelope to Districts by the State —10th December, 2010.
- District Plans based on Village/Gram Panchayats/Block Panchayat Samiti Plans— 31st December 2010.
- First Draft PIP before State Health Mission—15th January 2011.
- Receiving of PIP 2011-12 in MOH&FW, GOI—Third week of January 2011.
- Pre-appraisal/sub-group meetings from last week of January up to 15th February, 2011.
- Final NPCC meetings from 15th February, 2011 to 15th March, 2011.

I am confident that your personal oversight of the planning process would go a long way in enriching the quality of the plan in 2011-12.

With regards.

Yours sincerely,

Sd/-

(P.K. PRADHAN)

To,

All Principle Secretaries/Health Secretaries of the States
Mission Directors, NRHM of all the States
(As per list attached)

ANNEXURE IV

AMIT MOHAN PRASAD, IAS
Joint Secretary
Tele : 23061195
Telefax : 23061842
e-mail : am.prasad@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110 108

Government of India
Ministry of Health & Family Welfare
Nirmam Bhavan, New Delhi-110 108
D.o. No. N.37032/1/2010-NRHM-II
Dated: 18th February, 2011

Dear Ms. Garg,

Please refer to the periodic statement of progress of NRHM of your State. May I draw your attention to the status sheet as on 30th September, 2010 and highlight some critical issues for your attention.

1. **ASHAs**

   The Report of your state shows that 40597 ASHAs have been selected, 34232 trained up to 5th Module and 34214 are provided with Drug Kits. Emphasis may be given on the training of all ASHAs upto 5th Module. Drug Kit should be provided to all ASHAs and should be replenished regularly.

2. **Village Health and Sanitation Committee (VHSCs)**

   As per mandate of NRHM, all VHSCs were to be constituted by 2008. However in your State, out of 51349 villages, VHSCs have been constituted only in 44929 villages. Remaining 6420 villages should constitute CHSC on top priority. Regular orientation of all VHSCs members may be done to enable them to discharge the functions of CHSCs effectively. Opening their own joint accounts should also be ensured of all VHSCs and Sub-Centres.

3. **Appointment of ANM at Sub-Centres as per IPHS**

   As per the mandate of NRHM 100% of Sub-Centres are to be strengthened with 2nd ANM by 2013. As per your report, out of 6688 Sub-Centres, only 869 (12.99%) have 2nd ANMs. This needs your immediate attention to ensure service guarantee as per IPHS.

4. **Appointment of 3 Staff Nurse at PHCs as per IPHS**

   As per the mandate of NRHM, 15CS of PHCs are to be strengthened with 3 Staff Nurse by 2010. Out of 1273 PHCs in the State, only 48 PHCs have 3 Staff Nurses. The appointment of Staff Nurse may be taken on top priority for strengthening the PHC to provide service guarantee as per IPHS.

5. **Specialist and Staff Nurses at CHC as per IPHS**

   As per the mandate of NRHM, 100% of CHCs are to be strengthened with 7 Specialists and 9 Staff Nurses by 2010. As reported during the second quarter of

2010-11, there are no specialists and 177 Staff Nurses has been appointed on contractual basis under NRHM. The appointment of Specialists and Staff Nurses needs to be taken on top priority for strengthening the CHCs to provide service guarantee as per IPHS.

6. **Doctors and Paramedics**

As reported by State during second quarter of 2010-11, 17 Doctors and 123 Paramedics have been appointed on contractual basis at various levels. The appointment of the doctors and paramedics should be taken on top priority.

7. **Strengthening of District and Sub-Divisional Hospitals**

Two Districts does not have a District Hospital. 20 Sub-Divisional Hospital has been strengthened to work as FRU. 30 out of 32 District Hospitals are working FRUs. Strengthening of the remaining Sub-Divisional and District Hospitals as FRUs needs to be prioritised.

8. **24x7 PHCs**

As per the mandate of NRHM, 100% of PHC should be strengthened by 2010 to work on 24x7 basis. Out of 1279 PHCs in the State, only 64 (5.0%) PHCs are functioning as 24x7 basis. Emphasis must be given to operationalize remaining PHCs as 24x7.

9. **Rogi Kalyan Samiti in all CHCs/SDH and District Hospital**

As per the mandate of NRHM, Rogi Kalyan Samiti needs to be registered in all PHCs/CHCs/SDH & District Hospital by 2009. RKS is registered at all facilities. The State may ensure regular meetings of the RKS.

10. **FRUs**

As reported during the last quarter of 2010-11, there are 62 health Centres/ hospitals (30 DHs, 20 SDHs and 12 CHC) operating as FRU. The emphasis must be given on strengthening of these Centres.

11. **VHNDs**

As per the mandate, VHNDs is to be organised once every month in every village. During the last two quarters of 2010-11, only 163532 VHNDs were held in the State, which is low. Steps must be taken to organise VHNDs every month.

12. **Meeting of State and District Health Societies**

In first 6 months of 2010-11, 1 meeting of State Health Society held and 12 Meetings of District Health Societies were held. In next two quarters of 2010-11, the State must call for regular meetings of District Health Mission for further improvement.

I request you to direct the concerned officials to undertake a comprehensive review of the progress of the Mission and take corrective steps as indicated above. Your personal attention to these issues will expedite corrective action on the same. Please

convey the specific actions taken by the State to address these issues and also to achieve NRHM timelines.

With regards.

Yours faithfully,

Sd/-

(Amit Mohan Prasad)

Ms. Anu Garg,
Commissioner-cum-Secretary (Health and Family Welfare)
Department of Health and Family Welfare,
Government of Odisha, Secretariat Building,
Bhubaneshwar-751 001, Odisha.

ANNEXURE V

G-25014/1/2008-HPM(Vol. 4)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NATIONAL RURAL HEALTH MISSION

Nirman Bhawan, New Delhi-110 108
Dated the 20th December, 2011

To,

Sh. Sudhir Kumar Srivastava
Mission Director (NRHM)
Department of Health & Family Welfare,
Government of Uttar Pradesh,
19-A, Om Kailash Tower, Janpath Market,
Vidhan Sabha Marg, Hazrat Ganj,
Lucknow-226 001, UP

Subject: 32nd Report of Public Accounts Committee (PAC)

Sir,

Please refer to this Ministry's letter of even number dated 25th November, 2011 on the subject cited above, the requisite information asked therein has not yet been received from your State. It is, therefore requested to kindly furnish the same at the earliest.

Yours faithfully,

Sd/-
(Mrs. P. Padmavati)
Assistant Director (NRHM)
Telefax: 011-2306 2430
Email: p.padmaravi@gmail.com

G-25014/1/2008-NRHM-II (Vol. II)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NATIONAL RURAL HEALTH MISSION

Nirman Bhawan, New Delhi-110 001
Dated the 20th December, 2011

To,

Ms. Aradhana Patnaik
Mission Director (NRHM)
Department of Health and Family Welfare
Government of Jharkhand State, RCH office
G.V.I. Campus, Namkum
Ranchi-834 010, Jharkhand

Subject: 32nd Report of Public Accounts Committee (PAC)

Madam,

Please refer to this Ministry's letter of even number dated 25th November 2011 on the subject cited above, the requisite information asked therein has not yet been received from your State. It is, therefore requested to kindly furnish the same at the earliest.

Yours faithfully,

Sd/-
(Mrs. P. Padmavati)
Assistant Director (NRHM)
Telefax: 011-2306 2430
Email: p.padmaravi@gmail.com

G-25014/1/2008-NRHM-II (Vol. II)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NATIONAL RURAL HEALTH MISSION

Nirman Bhawan, New Delhi-110 001
Dated the 20th December, 2011

To,

Sh. D.S. Lokesh Kumar (IAS)
Mission Director (NRHM)
Health Medical & Family Welfare Deptt.
Government of Andhra Pradesh
Deptt. DM HS Campus, Sultan Bazar,
Hyderabad-500 095, Andhra Pradesh

Subject: 32nd Report of Public Accounts Committee (PAC)

Sir,

Please refer to this Ministry's letter of even number dated 25th November, 2011 on the subject cited above, the requisite information asked therein has not yet been received from your State. It is, therefore requested to kindly furnish the same at the earliest.

Yours faithfully,

Sd/-
(Mrs. P. Padmavati)
Assistant Director (NRHM)
Telefax: 011-2306 2430
Email: p.padmaravi@gmail.com

G-25014/1/2008-NRHM-II (Pt.)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NATIONAL RURAL HEALTH MISSION

Nirman Bhawan, New Delhi-110 001
Dated the 25th November, 2011

To,

Sh. Sanjay Kumar,
Mission Director (NRHM)
State Health Society, Bihar
Pariwar Kalyan Bhawan,
Sheikhpura,
Patna-800 014, Bihar

Sir,

Reference is invited to the 32nd Report of Public Accounts Committee (PAC) and the reply submitted by State *vide* email dated 13th May, 2011, wherein it was mentioned that District Health Mission (DHM) has been constituted in 25 districts out of 38 districts.

It is requested to kindly provide us:

(i) status of constitution of District Health Mission (DHM) in remaining 13 districts.

(ii) the reasons for delay in constitution.

Yours sincerely,

Sd/-
(Ajith Kumar N.)
Deputy Director (NRHM)
Telefax: 011-23062998
Email: dd-nrhm@nic.in

Audit Vetted Comments

Ministry may inform the PAC after constitution of DHMs in remaining Districts of Bihar & Uttar Pradesh

Further reply by Department of Health & Family Welfare as reported by the States, the State of Bihar has constituted District Health Mission in all 38 Districts. The State of UP has constituted DHMs in 72 districts and they are in the process of constitution of DHM in remaining 3 districts which have been created recently.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

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 shield 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.

[Recommendation No. 3, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

The NRHM Framework for Implementation which provides for MSG was approved in July 2006. Till now 7 Meetings of the Mission Steering Group have been convened and the progress report to the Cabinet has been submitted four times so far.

There exists sound quarterly monitoring system through which the physical as well as financial progress under NRHM are being reported by the States. These State-wise

reports are compiled and a consolidated final progress is submitted to the Mission Steering Group in its meetings as a separate agenda item.

Regular monitoring and impact assessment of the activities of NRHM is done through web based Health Management Information System (HMIS), quarterly MIS report and monthly Financial Monitoring Reports (FMRs). The deficiencies observed are regularly communicated to the States by the Ministry to undertake timely corrective actions.

In the guidelines for preparation of the State Annual Programme Implementation Plan of NRHM for 2011-12, States were also asked to make provision for impact assessment and evaluation studies. Regional Evaluation Team (RET) of the Ministry also regularly visit the States to evaluate various components of NRHM. Ministry has also recently constituted 14 Joint Monitoring Teams to visit 264 High Focus Districts to monitor implementation of NRHM.

Besides these, Common Review Mission (CRM) is also conducted every year to monitor various activities under the mission. The CRM teams under the mission comprise of GoI officials, development partners, Public Health Experts and Civil Society Representatives.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry has not mentioned action taken on the PAC recommendation regarding prescribing suitable format for quarterly and annual reporting by DHSs and SHSs to the Mission Group (MSG) to make monitoring more effective and meaningful.

Further reply by Department of Health and Family Welfare

There exist Quarterly monitoring systems through which the physical as well as financial progress under NRHM is being reported by States. These State-wise reports are compiled and consolidated physical and financial progress report is submitted to the MSG as a separate agenda item. It may not be practicable to institutionalise a quarterly reporting mechanism and reporting by DHS and SHS to the MSG for monitoring as MSG is an apex body of NRHM consisting of Cabinet Ministers and other higher level functionaries and does not meet every quarter.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

The Committee note that besides the Mission Streering 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 Experts etc. The CRM visits 13—17 States every year for 2 weeks and give feedback on identified parameters of NRHM. In addition, 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 and 86 districts were covered by the RETs during 2007-08 and 2008-09 respectively. Though the number of Districts 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.

[Recommendation No. 4, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

In addition to Regional Evaluation Teams (RETs), the Ministry has constituted 14 Joint Monitoring Teams comprising of Regional Directors, Consultants from the Ministry, National Health Systems Resources Centre (NHSRC) and National Institute of Health and Family Welfare (NIHFW) to visit 264 High Focus Districts. Tangible impacts made by various measures initiated by the Ministry for fulfilling the objectives of the Mission include reduction in IMR from 58 in 2005 to 50 per thousand live births in 2009 and reduction in MMR from 254 in 2004-06 to 212 in 2007-09.

Each RET is required to undertake a tour to districts of the States allocated to them by the Ministry for evaluation every month. Each RET consists of one Evaluation Officer and four Evaluation Assistants. However, due to large number of vacancies, RETs could undertake evaluation of health facilities in 80-90 districts in the country in a year. As against the sanctioned strength of 42, only 16 members are in position in RETs. Efforts are being made to increase the scope and coverage of evaluation work. Findings of the evaluation teams are circulated to the key stakeholders for taking appropriate action. The recommendation of PAC regarding undertaking more visits to more States by CRM and RETs, is noted for future compliance.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry may mention the numbers of Districts covered by RET in 2010-11. Ministry may also mention the numbers of visits of States made by CRM during 2010-11.

Further reply by Department of Health and Family Welfare

It may be mentioned that the Regional Evaluation Teams (RETs) had covered 133 districts during 2010-11.

The Fourth CRM was held in December, 2010 and the States/UTs covered were: Arunachal Pradesh, Assam, Chandigarh, Chhattisgarh, Jharkhand, Kerala,

Madhya Pradesh, Maharashtra, Nagaland, Odisha, Rajasthan, Punjab, Tamil Nadu, Uttarakhand and Uttar Pradesh. Each of these States was visited by CRM teams during 16th December —22nd December, 2010.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

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 villages 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 VHSC 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.

[Recommendation No. 6, Part II of 32nd PAC Report, 15th Lok Sabha]

ANNEXURE

Village Health and Nutrition day and Village Health Sanitation Committee (as on 31st March, 2011)

Sl. No.	States/UTs	Villages	VHSC constituted
1.	Bihar	45098	7906
2.	Chhattisgarh	20308	19088
3.	Himachal Pradesh	20118	3243
4.	Jammu & Kashmir	6652	6788
5.	Jharkhand	32615	30011
6.	Madhya Pradesh	55393	44438
7.	Orissa	51349	46928
8.	Rajasthan	41353	43437
9.	Uttar Pradesh	107452	51943
10.	Uttarakhand	16826	15431
11.	Arunachal Pradesh	4065	3012
12.	Assam	26312	26816
13.	Manipur	2391	3470
14.	Meghalaya	6026	5568
15.	Mizoram	817	815
16.	Nagaland	1317	1278
17.	Sikkim	452	641
18.	Tripura	870	1040
19.	Andhra Pradesh	28123	21916
20.	Goa	359	308
21.	Gujarat	18539	17751
22.	Haryana	6955	6280
23.	Karnataka	29406	24513
24.	Kerala	1364	18369
25.	Maharashtra	43711	39980
26.	Punjab	12673	13104
27.	Tamil Nadu	16317	15158
28.	West Bengal	40782	13312
29.	A&N Islands	547	275
30.	Chandigarh	24	22
31.	D&N Haveli	70	70
32.	Daman & Diu	23	28
33.	Delhi	165	456
34.	Lakshadweep	24	9
35.	Puducherry	92	92
	TOTAL	638588	483496

Action Taken (Department of Health and Family Welfare)

The scope and mandate of VHSC has been expanded to include engagement with and monitoring of nutrition related issues at the village level. Accordingly, the Committee has been rechristened as Village Health, Sanitation and Nutrition Committee (VHSNC), Out of, approximately 6 lakh villages in the country, so far 4.80 lakh villages have functional VHSNCs. Some States like Bihar, Himachal Pradesh etc. have constituted one VHSNC per Gram Panchayat instead of one VHSNC per revenue village, and therefore, the number of VHSNCs is less than the number of villages. VHSNC united funds are provided as per number of VHSNCs constituted. In Himachal Pradesh (3243), Bihar (7906), Chandigarh (22), Dadra and Nagar Haveli (70), Assam (26816), Orissa (46928), Tripura (1040), Uttarakhand (15431) and Daman and Diu (28) VHSNCs have been constituted. The number of VHSNCs formed in the remaining States is given in **Annexure II.**

All States/UTs are advised from time to time through D.O. Letters and at various forums *i.e*. CRM, periodic review meetings etc. to constitute VHSNCs.

Funds are also provided to States for capacity building of VHSNC members and to make them aware and capable for effective participation in VHSNC.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

(i) Ministry may mention the timeframe for constitution of remaining VHSNCs in 155092 Villages of various States.

(ii) The Ministry has not mentioned the action taken on the PAC recommendation that the funds are released to States after the VHSNCs are formed and start monitoring the health delivery services.

Further reply by Department of Health and Family Welfare

Ministry has repeatedly asked the States to constitute Village Health, Sanitation and Nutrition Committees (VHSNCs) on top priority although no time-frame was indicated to constitute remaining VHSNCs. A copy of the specimen letter is placed at **Annexure VII**. Over the last three years period of NRHM, the number of VHSNCs constituted has increased from 2.28 lakhs in 2008 to 5.00 lakhs in 2011. It may be mentioned that the VHSNCs have been constituted at villages as per needs of the States keeping in view their local administrative structure. Therefore, setting a conditionality of the constitution of remaining VHSNCs for release of funds to States may not be practicable in a federal structure. However, funds to VHSNC by State Health society are keeping released only after they are formed.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

AMIT MOHAN PRASAD, IAS
Joint Secretary
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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110 108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi-110 108

D.O. No. N 37032/1/2010-NRHM-II
Dated 20th May, 2011

Dear Madam,

Please refer to the periodic statement of progress of NRHM of your State. May I draw your attention to the status sheet as on 31 December, 2010 and progress shown during the last quarter for 2010-11. In this regard, I take this opportunity to bring some critical issues for your attention.

1. **ASHAs**

   Report of your State shows that 136182 ASHAs have been selected, none of them has been trained up to 5th Module and 128434 are provided with Drug Kits. Emphasis may be given on training of all ASHAs up to 5th module. Drug Kits should be provided to all ASHAs and should be replenished regularly.

2. **Village Health and Sanitation Committees (VHSCs)**

   As per mandate of NRHM, all VHSCs were to be constituted by 2008. However, in your State, out of 107452 villages, VHSCs have been constituted only in 51943 villages. Remaining 51494 villages should constitute VHSC on top priority. Further opening of joint account at remaining 6314 VSHC constituted should be taken on top priority.

3. **Appointment of ANM at Sub Centres as per IPHS**

   As per the mandate of NRHM, 100% of Sub Centre is to be strengthened with 2nd ANM by 2010. As per your report, Out of 20521 Sub Centres, only 1158 (5.64%) have 2nd ANM. This needs your immediate attention to ensure service guarantee as per IPHS.

4. **Appointment of 3 Staff Nurses at PHCs as per IPHS**

   As per the mandate of NRHM, 100% of PHC strengthened with 3 Staff Nurses by 2010. Out of 3690 PHCs in the State only 252 PHCs (6.8%) have 3 staff nurses. The appointment of Staff Nurse may be taken on top priority for strengthening the PHC to provide service guarantee as per IPHS.

5. Specialist and Staff Nurses at CHC level as per IPHS

As per the mandate of NRHM, 100% of CHCs are to be strengthened with 7 Specialists and 9 Staff Nurses by 2010. As reported during the third quarter of 2010-11, there are 189 specialists and 687 Staff Nurses appointed on contractual basis under NRHM. The appointment of Specialist and Staff Nurses may be taken on top priority for strengthening the CHC to provide service guarantee as per IPHS.

6. Doctors and Paramedics

As reported by State during third quarter of 2010-11, 523 Doctors and 239 Paramedics have been appointed on contractual basis at various levels. The appointment of the doctors and paramedics should be taken on top priority.

7. Strengthening of District and Sub-Divisional Hospitals

18 Districts do not have District Hospitals. 6 Sub-Divisional Hospitals have been strengthened to work as FRU. 54 out of 72 District Hospitals are working as FRU. Strengthening of Sub-Divisional and District Hospitals should be taken up as a priority.

8. 24 x 7 PHCs

As per the mandate of NRHM, 100% PHC should be strengthened by 2010 to work on 24x7 basis. Out of 3690 PHCs, only 668 (18%) PHCs are functioning as 24x7 basis. Emphasis must be given to operationalize remaining PHCs as 24x7.

9. Rogi Kalyan Samiti in all CHCs/SDHs and District Hospitals

As per the mandate of NRHM, Rogi Kalyan Samiti needs to be registered at all PHCs/CHCs/SDHs and District Hospitals by 2009. Out of 4277 facilities, only 980 facilities (72 DHs, 438 CHCs and 470 PHCs) have been registered with RKS. The RKS in remaining facilities may be constituted and registered without further delay.

10. FRUs

As reported during the third quarter of 2010-11, there are 158 Health Centres/ Hospitals (54 DHs, 6 SDHs and 98 CHCs) operationalized as FRU. The emphasis must be given on strengthening of the Centres.

11. Mobile Medical Units provided to each district

As per the mandate of NRHM, 100% of Districts need to be provided Mobile Medical Unit by 2009. 15 out of 71 Districts have Mobile Medical Unit.

12. Meeting of State and District Health Societies

In first 9 months of 2010-11, no meetings of State Health Society and of District Health Societies has been held. The State must call for regular meeting of State Health Mission and District Health Mission for further improvement.

I request you to direct the concerned officials to undertake a comprehensive review of the progress of the Mission and take corrective steps as indicated above. Your personal attention to these issues will expedite corrective action on the same. Please convey the specific actions taken by the State to address these issues and also to achieve NRHM timelines.

With Regards,

Your sincerely,
Sd/-
(Amit Mohan Prasad)

Ms. Nita Chaudhary,
Principal Secretary (Health & Family Welfare)
Department of Health & Family Welfare,
Government of Uttar Pradesh,
5th Floor, Room No. 516, Vikas Bhawan,
Janpath Market, Vidhan Sabha Road, Hazaratganj
Lucknow-226 001, Uttar Pradesh.

Observation/Recommendation

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 the GDP which is less than 50 percent 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 annum in nominal terms since its inception as against the targeted increase upto 30 percent by 2007-08 and by 40 percent 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.

[Recommendation No. 8, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

The original Eleventh Plan (2007-12) allocation for National Rural Health Mission (NRHM) was fixed at Rs. 90558 crore. However, the combined annual allocation (BE) for NRHM during the last five years from 2007-08 to 2011-12 was Rs. 70030 crore,

indicating a shortfall of Rs. 20528 crore. Department of Health & Family Welfare have been requesting Planning Commission over the years for greater allocation of plan resources to meet its requirements. During the last two years (2010-11 & 2011-12), Ministry had requested for an allocation of Rs. 19989 crore and Rs. 24807 crore respectively for NRHM, against which an allocation of Rs. 15440 and Rs. 17840 crore was provided. It may be noted that allocation of Plan funds is the prerogative of Planning Commission, based on the overall priorities of the Plan. The Ministry will strive for a better allocation of funds from Planning Commission in the coming years. With regard to utilization of funds, the Department agrees that there has been a slight shortfall in utilization of allotted funds. An analysis of expenditure of Health & Family Programmes of the Department over the last three years (2008-09 to 2010-11) indicate that the utilization under NRHM programme was in the range of 95-96%. However, the utilization by the States in the year 2009-10 was higher than in 2008-09. As against the allocation of Rs. 10192.23 crore, the expenditure was 10565.1 crore in 2008-09. In 2009-10, against the allocation of Rs. 11601.67 crore, the expenditure is provisionally placed at 13225.91 crore. The constraints on the absorptive capacity with regard to physical infrastructure development in different States are being addressed through regular interaction with State Governments.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Observation/Recommendation

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. 20150 crore would be required in the terminal year of the Eleventh Five Year Plan (2011-12), as against the allocation of Rs. 15440 crore in 2010-11. Assuming that the nominal per-capita allocation would need increase by around 20 percent per 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. 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 is thus estimated to be aruond 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 healthcare 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 healthcare, the Committee fear that the goal of universal healthcare 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 healthcare 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.

[Recommendation No. 9, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

As indicated in the response given for Para 8, the Department will strive for better allocation of resources with Planning Commission for Health and Family Welfare sector in the coming years. In a presentation made in the meeting of full Planning Commission on 'Issues for Approach to Twelfth Five Year Plan' held on 21st April, 2011 (available in the website of Planning Commission), it has been indicated that the expenditure on health by Centre and States needs to be increased from 1.3% of GDP at present to 2.0 per cent and perhaps even 2.5 per cent by the end of 12th Plan.

The overall absorption capacity of the States *vis-a-vis* utilisation of NRHM funds had increased progressively over the years. To build capacity of the States to speed up pace of infrastructure projects, assistance is provided to the States for setting up civil construction wings under NRHM. Regarding improving utilization of availability of infrastructure, two pronged strategy of increasing demand and augmenting the supply has been adopted. Demand side intervention includes cash benefits under JSY and new initiative of Janani Shishu Suraksha Karyakaram which provides for free and cashless treatment to pregnant women and sick neonates. On the supply side, public health facilities have been strengthened by improving manpower and infrastructure, drugs and equipment.

Other steps undertaken to enhance the absorption capacity under the NRHM programmes include periodical training of programme management as well as financial management personnel through National Health Systems Resource Centre (NHSRC) and National Institute of Health & Family Welfare (NIHFW) at the Central level and SHSRCs and SIHFWs at the State level. The central teams also conduct training of

NRHM personnel in the states from time to time. Programme wise guidelines have also been issued for the guidance of State, district and sub-district level personnel.

Recently, Accounting Handbooks for Sub-District level finance personnel, e-training modules on finance and accounts have been rolled out in the States to bring about an effective financial management system at all levels. Detailed Operational Guidelines on Financial Management under NRHM are under finalization and will be issued shortly.

In order to strengthen the programme implementation, a firm commitment is taken from the States for filling up the vacant posts by a definite time line, for release funds to the States.

The timely and proactive action on above lines by the States will further improve the absorption capacity of the States which will not only be useful towards proper utilisation of funds but also shall be beneficial for speeding up the process of programme implementation.

Sd/-
(P. K. Pradhan)
Special Secretary & Mission Director (NRHM)

Observation/Recommendation

The Committee are concerned to note that out of the pocket expenditure on health incurred by the households constituted around three-fourths of the total expenditure in the health sector. The Ministry conceded that as per the National Health Accounts India 2004-2005 (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 percent of the total expenditure in health sector in the year 2004-05 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 shortages 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 households on their health.

[Recommendation No. 11, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Efforts are being intensified to secure still higher allocations of resources for the Health sector in the coming years. The report of the PAC will be a very useful tool in bringing home the need to significantly step up outlays for Health during the Twelfth Plan for which initial preparatory steps have already been set in motion. Simultaneously, the Ministry is fully conscious of the fact that higher allocations and better utilization of funds must be in tandem.

The pattern of expenditure on the NRHM during 2008-09 and 2009-10 demonstrate a steady improvement in utilization of funds as will be evident from the following:—

Year	Grant Releases (Rs. in crore)	Actual Expenditure
2008-09	9625.09	10565.10
2009-10	11230.72	13225.91*

*Provisional figures

The excess of expenditure over release during the particular year indicates clearly that the absorptive capacity has improved and this will strengthen the case for much higher allocations for Health and make a clear impact on out of pocket expenditure.

Further to reduce out of pocket expenses on delivery and newborn care, Janani Shishu Suraksha Karykram (JSSK) was launched on 1.06.11 for providing free delivery and neonatal care in public health facilities. It includes free transport to health facility and back, free drugs, diagnostics, blood, consumables and diet which will reduce out of pocket expenditure for pregnant women and sick women.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Direct (NRHM)

Observation/Recommendation

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 per cent 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 Health Public 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 startled 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/UT 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.

[Recommendation No. 13, Part II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Augmentation of human resources is one of the thrust area under the National Rural Health Mission (NRHM). As on 31st March, 2011 under NRHM, the following staff has been engaged by States on contractual basis:—

Sl. No.	Designation and Place of Posting	No. of staff added
1.	Specialists at CHCs	7063
2.	General Duty Medical Officers	9432
3.	AYUSH Doctors	11575
4.	Staff Nurses	33667
5.	ANM	60268
6.	Para Medics	21740
7.	AYUSH Para Medics	4616

During meetings and review, State Governments have been impressed upon to make efforts to fill up the vacant posts on priority. As per the data available in Rural Health Statistics (RHS) in India, updated upto March, 2010, a table showing the increase in regular staff at various Health Centres from 2005 to 2010 is as under:—

Particulars of staff	RHS 2005	RHS 2010	Increase
ANMs at Sub-Centre/PHC	133194	191457	58263
Nurse Midwife at PHC/CHC	28930	58450	29520
MBBS Doctors at PHCs	20308	25870	5562
Specialists at CHCs	3550	6781	3231
GDMOs at CHCs	NA	9933	9933
Pharmacists at PHC/CHC	17708	21688	3980
Lab. Technicians at PHC/CHC	12284	15094	2810
Radiographers at CHCs	1337	1817	480

Multi-skilling of doctors to overcome the shortage of specialists, provision of incentives to serve in rural areas, improved accommodation arrangements, measures to set up more medical colleges, GNM Schools, ANM Schools to produce more doctors and paramedics are some of the measures taken to bridge the gap in human resources.

States are advised to ensure better attendance during review meetings for better service delivery. Financial assistance for installation of bio-metric attendance system in health facilities has also been provided.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry may mention the latest status of vacant posts *i.e.* sanctioned posts, men-in position in all the cadres. The Ministry may also mention the Schedule, if any, fixed to fill up all the vacancies.

Further reply by Department of Health and Family Welfare

i. The sanctioned strength of post of Female Health Worker/ANM at Sub Centre & PHCs is 161794 and 10214 posts are vacant across the country. There are 191457 Health Workers/ANMs in position which include contractual ANMs also.

ii. The sanctioned strength of post of Health Worker (Male) at Sub Centres is 76074 and 25853 posts are vacant across the country. There are 52774 Health Worker (Male) in position including the surplus Health Worker (Male) in some States.

iii. The sanctioned strength of post of Doctors/General Duty Medical Officers (GDMOs)(Allopathic) at Primary Health Centre/Community Health Centre is 39539 and 6148 posts are vacant across the country. There are 35883 Doctors/ General Duty Medical Officers (GDMOs)(Allopathic) in position which include Doctors engaged on contractual basis.

iv. The sanctioned strength of post of Total Specialists at CHCs (Surgeons, OB&GY, Physicians & Pediatricians) at CHCs is 9825 and 4156 posts are vacant across the country. There are 6781 total specialists in position which include Specialists engaged on contractual basis.

v. The sanctioned strength of post of Radiographers at CHCs is 2907 and 1260 posts are vacant across the country. There are 1817 Radiographers are in position which include Radiographers engaged on contractual basis.

vi. The sanctioned strength of post of Pharmacists at PHCs & CHCs is 23376 and 4653 posts are vacant across the country. There are 21688 Pharmacists are in position which include Pharmacists engaged on contractual basis.

vii. The sanctioned strength of post of Laboratory Technicians at PHCs & CHCs is 17858 and 5183 posts are vacant across the country. There are 15094 Laboratory Technicians are in position which include Laboratory Technicians engaged on contractual basis.

viii. The sanctioned strength of post of Nursing Staff at PHCs & CHCs is 56805 and 10289 posts are vacant across the country. there are 58450 Nursing Staff is in position which include Nursing Staff engaged on contractual basis.

Nearly 144129 Health Personnel are appointed on contractual basis across the country under NRHM which include Doctors/Specialists, Staff Nurses, Paramedics, ANM etc. All the vacancies are required to be filled by the State/UT Governments. GoI has repeatedly impressed upon them to fill up the vacant posts at the earliest. However, to timeline can be fixed.

The posts in the health facilities are filled up by respective State/UT Governments. They are impressed upon from time to time to fill up the vacant posts at the earliest. The GoI has further stipulated that vacancies in delivery points particularly in High Focus districts should be filled up on priority basis. However, no time limit can be fixed by the Union Government for filling up all the vacant posts.

Sd/-

(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Audit Vetted Comments

(i) In view of the Ministry's statement that no time limit can be fixed by the Union Govt., PAC may be informed of the impact on NRHM, due to continuation of non-filling of vacant posts of doctors, specialist staff nurses etc.

(ii) Ministry may also inform the PAC about the details of efforts made by the States for filling up the vacancies in all cadres.

Further Reply by Department of Health and Family Welfare

(i) Non-filling of vacant posts of specialists, doctors and staff nurses adversely affects public healthcare delivery. The States are regularly requested to fill up the vacant posts.

(ii) Health being a state subject, filling of vacant posts based on identified gaps in health human resources falls under the purview of State Governments. NRHM strengthen the hands of State Governments by providing funds for contractual appointments based on the requirement projected by the State in their Annual Programme Implementation Plans (PIP) which is appraised and approved by Government of India based on the recommendation of National Programme Coordination Committee (NPCC). The position of contractual staff under NRHM as on 30.06.2012 is annexed as **Annexure B**. A letter has been sent to the States seeking information on the efforts made by them for filling up vacancies of Doctors, Specialists, Staff Nurses etc. Replies have been received only from Puducherry, Dadar & Nagar Haveli and Chandigarh. Puducherry has replied that vacancies are being filled up immediately on contract basis, Chandigarh has replied that recruitment is being made on contract basis as per ROP 2012-13 and Dadra & Nagar Haveli has replied that all vacant posts of Paramedical had been filled up and though they are facing shortage of specialists, they are taking effective measures to address the same.

Sd/-

(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

Human Resource augmented under NRHM*

Sl. No.	State/UT	GDMOs	Paramedics	Specialists	ANMs	Staff Nurse	AYUSH Doctors	AYUSH Paramedics
1.	Bihar	1664	414	119	8109	1619	1386	0
2.	Chhattisgarh	0	0	0	281	338	80	0
3.	Himachal Pradesh	0	0	0	0	0	140	0
4.	Jammu & Kashmir	266	696	43	1966	543	439	362
5.	Jharkhand	21	317	192	4461	862	0	0
6.	Madhya Pradesh	232	103	82	4102	301	465	161
7.	Odisha	0	112	0	1186	881	1250	0
8.	Rajasthan	1	420	31	4471	7203	1009	401
9.	Uttar Pradesh	395	260	82	1528	1037	710	0
10.	Uttarakhand	0	0	2	237	189	210	413
11.	Arunachal Pradesh	85	82	1	158	196	32	0
12.	Assam	626	1566	90	4921	3141	405	0
13.	Manipur	10	122	1	463	136	88	25
14.	Meghalaya	26	14	2	266	110	73	0
15.	Mizoram	24	66	1	419	53	19	0
16.	Nagaland	49	69	12	310	234	29	0
17.	Sikkim	27	43	5	88	55	8	6
18.	Tripura	0	139	0	80	0	135	33
19.	Andhra Pradesh	17	1538	18	10650	276	373	1625
20.	Goa	0	24	4	43	35	11	26
21.	Gujarat	0	1461	978	764	542	788	0
22.	Haryana	124	304	26	2613	1631	169	188
23.	Karnataka	85	149	52	909	4110	625	68
24.	Kerala	756	242	495	842	932	597	238
25.	Maharashtra	1036	5226	714	6617	877	880	78
26.	Punjab	79	47	43	1530	1146	205	182
27.	Tamil Nadu	756	89	0	83	5887	403	273
28.	West Bengal	478	530	37	7284	83	19	18
29.	A&N Islands	30	135	6	81	38	19	13
30.	Chandigarh	28	30	7	98	31	8	8
31.	D&N Haveli	4	62	1	30	27	5	0
32.	Daman & Diu	1	11	5	11	24	1	0
33.	Delhi	366	479	33	778	276	0	0
34.	Lakshadweep	14	87	3	34	28	8	10
35.	Puducherry	19	47	2	80	37	39	57
	TOTAL	7219	14884	3087	65493	32878	10628	4185

*Status as on 30.06.2012 (As per the data provided by the States)

Human Resource augmented under NRHM*

Sl. No.	State/UT	Programme Management Staff					
		District Programme Manager	District Accounts Manager	District Data Manager	Accountants at Block level	Accountants at PHC level	Total
1.	Bihar	35	38	36	472	472	14364
2.	Chhattisgarh	27	12	15	84	598	1435
3.	Himachal Pradesh	0	0	0	69	0	209
4.	Jammu & Kashmir	19	21	20			4375
5.	Jharkhand	20	23	22	168		6086
6.	Madhya Pradesh	43	26	26	255	208	6004
7.	Odisha	29	29	30	292	0	3809
8.	Rajasthan	25	32	33	237	493	14356
9.	Uttar Pradesh	53	43	48	745	NA	4901
10.	Uttarakhand	13	13	13	95	0	1185
11.	Arunachal Pradesh	16	16	16	84	0	685
12.	Assam	27	27	27	149		10979
13.	Manipur	9	9	9	35	73	980
14.	Meghalaya	7	7	7	39	108	659
15.	Mizoram	9	9	9	0	57	666
16.	Nagaland	11	11	11	0	0	736
17.	Sikkim	4	4	4	0	0	244
18.	Tripura	4	4	4	17	78	494
19.	Andhra Pradesh	22	23	22	0	0	14564
20.	Goa	0	0	1	0	0	144
21.	Gujarat	24	26	26	164	1080	5853
22.	Haryana	19	18	19	105	0	5216
23.	Karnataka	27	28	0	176	0	6229
24.	Kerala	14	14	12	22		4164
25.	Maharashtra	32	31	32	351	659	16533
26.	Punjab	19	16	15	111		3393
27.	Tamil Nadu	30	34	42	0	0	7597
28.	West Bengal	18	18	16	332	0	8833
29.	A&N Islands	3	3	0	0	0	328
30.	Chandigarh	1	1	1	0	0	213
31.	D&N Haveli	1	1	1	1	6	139
32.	Daman & Diu	2	1	1	1	0	58
33.	Delhi	7	8	8	0	0	1955
34.	Lakshadweep	0	0	0	0	0	184
35.	Puducherry	4	4	1	2	8	300
	TOTAL:	574	550	527	4006	3840	147871

*Status as on 30.06.2012 (As per the data provided by the States)

Observation/Recommendation

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 timebound 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 Committee 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.

[Recommendation No. 14, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

The State-wise numbers of ASHA and those trained are shown **(Annexure IV).** States do not provide data on payments made to ASHA under different schemes. A consolidated summary of incentives proposed by the States in the Programme Implementation Plan (PIP) for the year 2011-2012 is shown in **Annexure V.**

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

ANNEXURE

Sl. No.	Name of State	No. of ASHAs in place	No. of ASHAs trained up to Module 4	Mudule 5
1	2	3	4	5
EAG States (as on 30 April, 2011)				
1.	Bihar	79808	52859	0
2.	Chhattisgarh*	60092	60092	60092
3.	Jharkhand##	40964	35675	40964
4.	Madhya Pradesh	50113	45777	29114
5.	Odisha	40942	40814	40246
6.	Rajasthan	47209	34776	12116
7.	Uttar Pradesh	136182	128434	115661
8.	Uttarakhand	11086	11086	8978
North-Eastern States (as on 30 April, 2011)				
9.	Assam	29114	26980	26590
10.	Arunachal Pradesh	3649	3556	3557
11.	Manipur	3878	3878	3878
12.	Meghalaya	6258	6175	3589
13.	Mizoram	987	987	987
14.	Nagaland	1700	1700	1700
15.	Sikkim	666	666	666
16.	Tripura	7367	7367	7367
Non-High Focus States (as on 31 March, 2011)				
17.	Andhra Pradesh**	70700	70700	70700
18.	Delhi	3622	1386	1112
19.	Gujarat	29552	24728	20404
20.	Haryana	12857	12169	5097
21.	Himachal Pradesh	16888	0	0
22.	Jammu & Kashmir	9500	9000	5711
23.	Karnataka	33105	32939	32939
24.	Kerala	31868	21063	1112
25.	Maharashtra	59151	8354	7646
26.	Punjab	16597	16191	13476
27.	Tamil Nadu	2650	1639	1639
28.	West Bengal	42003	22264	20379
Union Territories (as on 31 March, 2011)				
29.	Andaman & Nicobar Islands	407	188	188
30.	Dadra Nagar Haveli (UT)	107	91	91

1	2	3	4	5
31.	Lakshadweep	83	83	83
32.	Chandigarh***	423	30	30
	TOTAL	849528	681647	536112

*Chhattisgarh had a set of Training Modules different from Govt. of India's 4 Modules.

**Andhra Pradesh had a 30 days combined training module.

***Chandigarh gave a 3 day combined orientation of Module 1 to 4.

For Module 4 training the State had engaged NGOs to undertake the training. However there were problems with training quality so the NGOs were terminated. Module 5 training was undertaken directly by the VSRC: (Sahiyya Resource Center) through independent block training teams and they were able to complete this. Thus more numbers have been trained in Module 5 than in Module 4. The State is now working on completing Module 4 training.

ANNEXURE

Table: 3 Incentives for ASHAs as Proposed in State's Project Implementation Plan (PIP) for Financial Year 2011-12—North-Eastern States

Sl. No.	Activity Name	Assam	Arunachal Pradesh	Manipur	Meghalaya	Mizoram	Nagaland	Sikkim	Tripura
1	2	3	4	5	6	7	8	9	10
	Pregnancy/ANC								
1.	Pregnant women tracking								
2.	Child Tracking								
3.	Registration during the first trimester of pregnancy								
4.	Completion of 3/4 antenatal checkups, 2TT immunization and 120 days of IFA tablets to pregnant women								
5.	For motivating deliveries in tribal areas								
	Birth/delivery								
6.	Pregnant woman having institutional delivery in government health instituion—JSY	600	600	600	600	600	600	600	600(R): 200(U)—institutional delivery in non-JSY—50/case
7.	Pregnant woman having institutional delivery private health institution								

8. Referral of Post-Partum Complication to a CEMONC Centre

9. Postnatal Care and New Born Care for mother and neonate

10. Referral of Sick New Born baby to a SNCU

Nutrition and related

11. Referral of severe Malnutrition cases/SAM to Malnutrition rehabilitation Centres

12. Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi worker and ensuring the child completes 12 months of age in a health state/ exclusive breastfeeding to neonates

13. No. of Children weighed every month

14. Referring New Born with birth weight less than 2000 grams and follow up on progress

1	2	3	4	5	6	7	8	9	10
15.	Weekly follow up of low birth weight New Borns								
	Immunization								
16.	Complete Immunization—All doses of immunization for BCG, DPT, OPV, Measles, and Hepatitis-B and Vitamin A supplementation	250/case	150/case	150/case	150/case	150/case	150/case	150/case	
17.	Pulse polio at least three times a year								
	Reporting								
18.	Maternal Death Reporting to Sub-centre and PHC								
19.	Infant Death Reporting to Sub-centre and PHC								
20.	Birth Report/Registration								
	Family Planning								
21.	Counselling and motivation of women for Tubectomy/DPL surgery and follow up visit of the cases	150	150	150	150	150	150	150	150

22.	Counselling and motivation of men for Vasectomy/NSV operation and follow up visit	200	200	200	200	200	200	200	200
23.	Motivation and Counselling for successful IUCD insertion and retention for at least one year and intake of contraceptive pills for one year				20/case				
24.	Motivation for taking OCPs for 1 year								
	Abortion Services								
25.	Incentive for post abortion services								
	Organizing								
26.	VHND	100	100	100	100	100	100	100	100
27.	ASHA/Diwas/Review meetings								
28.	VHSC meetings and ensuring other facilities								
	Disease Control Programmes								
29	Identification of Malaria cases-RD/Treatment and follow up				55/case		50/case		50/smear collection 20/RDK slide

1	2	3	4	5	6	7	8	9	10
30.	Identification of Leprosy/ treatment Plausi Multi bacilliary cases follow up					100			
31.	Identification of TB cases, and successful completion of DOTS Identification and referral of cataract cases	250	250	250 175	250 175	 100	250	250 175	250
32.	Outbreak Reporting								
	Miscellaneous								
33.	Adolescent anaemia control								
34.	Deworming								
35.	Calcium Compliance								
36.	Vitamin A								
	Reporting HIV+/AIDS cases								
37.	Maternal care on HIV Child care on HIV								
38.	Referral of mentally and physically handicapped								

39. RSBY

Other Incentives

40. Sarees

41. Best ASHA Awards PHC/ Cluster/District/State level

42. ASHA Gruhas

43. MIS

44. Ensuring safe drinking water and other sanitation facilities

45. TA/DA during training

46. Maintaining accounts for documents/annual expenditure/maintenance of daily expenditure, of the untied fund for village

ITDA Areas

47. Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas

1	2	3	4	5	6	7	8	9	10
48.	Referral of pregnant mother to Birth Waiting Homes a week before EDD; and ensuring safe institutional delivery in ITDA areas								
49.	Referral and admission of Severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow-up								

Audit Vetted Comments

Ministry may mention about the steps taken or proposed to be taken for time bound training programme of remaining untrained ASHAs. Ministry has not mentioned that necessary drug kits are provided to all ASHAs, as recommended by the PAC, the Ministry has mentioned details of incentives to ASHAs, proposed or the year 2011-12 for only 8 States. The status of remaining States may also be mentioned

Further reply by Department of Health & Family Welfare

The information in respect of point No. 14 of Comments on 32nd Report of PAC (15th Lok Sabha) 2011-12 regarding Peformance Audit of "NRHM" is as below:

Annexure-X provides information on the State-wise numbers of ASHAs trained upto Module 5 and respective %. In Bihar, Module 5 is being clubbed with Module 6 & 7 and the training of ASHAs is expected to start by mid December. The State has taken necessary steps to ensure time bound training.

The summary of incentives proposed by the States for FY 2011-12 in their respective PIPs is placed as **Annexure-XI.**

Attached at **Annexure-X** is a status update on training of ASHAs and drug kit distribution, as of March 31, 2012.

The term "trained: is meant to include all ASHAs trained upto Module 3 or a State specific induction training, which is indicative of a basic level of training.

For the high focus States, the number of untrained ASHAs is highest in Bihar. The State estimates that it will complete training of all ASHAs by December 2013. In the remaining States, the untrained ASHAs are mostly represented by those newly selected into the programme.

In the non-high focus States, Tamil Nadu has recently recruited 1011 ASHAs into the programme and is making arrangements to train them. The State of Delhi also has a similar case. Both States will ensure training of newly selected ASHAs within this fiscal year.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

Status of ASHA Training and Drug Kit Distribution—as on 31 March 2012

	Name of State	No. of ASHAs Selected	No. of ASHAs Trained	%of ASHAs Trained	No. of ASHAs given Drug Kit	% of ASHAs given Drug Kit
1	2	3	4	5	6	7
High Focus States	Bihar	83,301	52859	63.46	83,301	100.00
	Chhattisgarh	60,092	60092	100.00	60092	100.00
	Jharkhand	40,964	39214	95.73	35000	85.44
	Madhya Pradesh	52,393	47022	89.75	52393	100.00
	Odisha	42,597	40948	96.13	40948	96.13
	Rajasthan	50,287	45000	89.49	38044	75.65
	Uttar Pradesh	136094	129150	94.90	128434	94.37
	Uttarakhand	11,086	11086	100.00	9983	90.05
	Total	**476,814**	**425371**	**89.21**	**448,195**	**94.00**
North-Eastern States	Assam	29,172	27499	94.27	27855	95.49
	Arunachal Pradesh	3740	3559	95.16	3740	100.00
	Manipur	3,878	3878	100.00	3878	100.00
	Meghalaya	6,258	6250	99.87	6250	99.87
	Mizoram	987	987	100.00	987	100.00
	Nagaland	1,700	1700	100.00	1700	100.00
	Sikkim	666	666	100.00	641	96.25
	Tripura	7,367	7367	100.00	7367	100.00
	Total	**53,768**	**51906**	**96.54**	**52418**	**97.49**
Non-High Focus States	Andhra Pradesh	70,700	70700	100.00	70700	100.00
	Delhi	4,121	2372	57.56	3435	83.35
	Gujarat	29,508	26429	89.57	29508	100.00
	Haryana	13,683	13683	100.00	5000	36.54
	Jammu & Kashmir	9,700	9500	97.94	9500	97.94
	Karnataka	33,750	33750	100.00	33750	100.00
	Kerala	31,868	28205	88.51	23350	73.27
	Maharashtra	59,316	56027	94.46	58394	98.45
	Punjab	16,800	16214	96.51	16463	97.99
	Tamil Nadu	2,650	1639	61.85	1639	61.85
	West Bengal	45,564	41548	91.19	32123	70.50
	Total	**317,660**	**300067**	**94.46**	**283862**	**89.36**

1	2	3	4	5	6	7
Union Territories	Andaman & Nicobar Island	407	407	100.00	407	100.00
	Dadra & Nagar Haveli	208	85	40.87	85	40.87
	Lakshadweep	83	83	100.00	83.00	100.00
	Chandigarh	423	30	7.09	0	0.00
	Total	**1,121**	**605**	**53.97**	**575**	**51.29**
Grand total for All States and Union Territories		**849,363**	**777,949**	**91.59**	**785,050**	**92.43**

ANNEXURE

Table 1—PIP Incentives for ASHAs High Focus States—INCENTIVE IN INR/CASE—2011

Sl. No.	Activity Name	Bihar	Chhattisgarh	Jharkhand	Madhya Pradesh	Odisha	Rajasthan	Uttar Pradesh	Uttarakhand
1	2	3	4	5	6	7	8	9	10
	Pregnancy/ANC								
1.	Pregnant women tracking								
2.	Child Tracking								
3.	Registration during the first trimester of pregnancy		200		150(50/case additional for every anaemic pregnant woman consuming 200 IFA tablets)			MCH card=30	40
4.	Completion of 3/4 antenatal checkups, 2 TT immunization and 120 days of IFA tablets to pregnant women				150		100	100/case	310
5.	For motivating deliveries in tribal areas								
	Birth/Delivery								
6.	Pregnant woman having institutional delivery in government health institution—JSY; inclusive of transport	600(R)-(inclusive of 3, 4 & 6) 200 for U	200/case for(R): & 150/case for transport	600	350	600	500	600	600(R) 200(U)
7.	Pregnant woman having institutional delivery in private health institution								
8.	Referral of Post-Partum complication to a CEMONC Centre and escort							200 each for 3 cases in a year in emergency	

9.	Postnatal Care and New Born Care for mother and neonate	200 on completion of 6 home visits under HBNC, IMNCI	200 only in 18 selected blocks		200 in NIPI districts; 100 in other districts	100/case if baby is alive for a month in high focus district	100/case for 5 PNC visits- institutional delivery Home delivery= 200/case	50	100/case for completion of 6 new born visits
10.	Referral of Sick New Born baby to a SNCU		100	100					
	Nutrition and related								
11.	Referral of severe Malnutrition cases/SAM, to Malnutrition rehabilitation Centres		200	100	100 per malnourished child	200			
12.	Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi worker and ensuring the child completes 12 months of age in a healthy state/exclusive breastfeeding to neonates								
13.	No. of Children weighed every month								
14.	Referring Newborn with birth weight less than 2000 grams and follow up on progress								
15.	Weekly follow up of low birth weight new borns								
	Immunization								
16.	Complete Immunization-All doses of immunization for BCG, DPT,	5-10 children=	100	For 75% of children		150		100 each for minimum 30	

1	2	3	4	5	6	7	8	9	10
	OPV, Measles, and Hepatitis-B and Vitamin-A Supplementation	50, 11-15 children= 100, 16-20 children= 150, 20 & above children= 200		covered =150 on VHND				children with complete immunization in one year	
17.	Pulse polio at least three times a year					75/ programme		75	
	Reporting								
18.	Maternal Death Reporting to Sub-centre and PHC		50			50		5	
19.	Infant Death Reporting to Sub-centre and PHC		50					5	
20.	Birth registration/Birth certificate					20/case		5 each for minimum 30 birth registration	50
	Family Planning								
21.	Counselling and motivation of women for Tubectomy/DPL surgery and follow up visit of the cases	150	150	150		150	150	150	
22.	Counselling and motivation of men for Vasectomy/NSV operation and follow up visit	200	200	200		200	200	200	
23.	Motivation and Counselling for successful IUCD insertion and retention for at least one year and intake of contraceptive Pills for one year		300			100	200		
24.	Motivation for taking OCPs for 1 year								

	Abortion Services								
25.	Incentive for post abortion services—escort and promoting					100			
	Organizing								
26.	VHND		50/session		150/VHND	100/session for high focus non-high=50	150		150/day
27.	ASHAS/Diwas/Review meetings					150/meet	100/meet	50/ASHAs for conveyance	
28.	VHSC meetings and ensuring other facilities					50/meet	100/meet		
	Disease Control Programmes								
29.	Identification of Malaria cases-RD/Treatment and follow up		Slide-na/ only for referral of positive cases=200	5/slide; positive slide=5; positive RDK slide-5 complete treatment -max 200/month	200/month	FTD referral=20 /case	50 for radical treatment and 25 for making slide		5/slide 50/Pv case 25/Pf case
30.	Identification of Leprosy/treatment Plausi/Multi bacillary cases, follow up	100/300/ 500	Na/300/ 500	Na/300/ 500	100/200/ 400	Na/300/ 500	100/200/ 400	Na/300/ 500	Na/300/500
31.	Identification of TB cases, and successful completion of DOTS	250	250	250	50 for detection, 50 additional if report is positive; for DOTS=250	250	250	250	250

1	2	3	4	5	6	7	8	9	10
32.	Identification and referral of cataract cases	175/case	175/case	175		150/case	175/case	50 for post operation follow up	175
33.	Kala Azar	100 for detection and completion of treatment							
34.	**Outbreak Reporting**					20/instance /case informing PHC/CHC on emg. health situation/ dehydration			
	Miscellaneous								
35.	Adolescent Anaemia control								
36.	Eye testing and helping in provision of glasses for 15 years children							25	
37.	Counselling session for adolescent girls/women						100/ session	100 for one meeting each, with women and ado. girls separately. 02 such meetings are organized in a month	

38.	Screening Camps for school health programme			50/school
39.	Mobile Health Unit visits			50/MHU point
40.	Accompanying freedom fighters for treatment			100/case
41.	Deworming			
42.	Calcium Compliance			
43.	Vitamin-A		100	
44.	RTI/STI to PHC and CHC			
	Reporting HIV+/AIDS cases			
45.	Maternal care on HIV	500 for HIV+ women for ANC, PNC & safe delivery	ANC for HIV testing=300	100 in selected districts for HIV testing; 500 for such women for institutional delivery
46.	Child care on HIV			
47.	Referral of mentally and physically handicapped			100/child for disability in children
48.	RSBY			30 in V3 & V4 sub centres for RSBY
	Other Incentives			
49.	Sarees			

1	2	3	4	5	6	7	8	9	10
50.	Best ASHAs Awards PHC/Cluster/District/ State level			5000 for 1000 best performing sahiyas					
51.	ASHAs Gruhas Corpus fund for supporting sahiyas in death and accident cases			10/sahiya					
52.	MIS								
53.	Ensuring safe drinking water and other sanitation facilities								
54.	TA/DA during training	100/days				100/day	100/day		
55.	Maintaining accounts for documents/annual expenditure/ maintenance of daily expenditure of the untied fund for village								
56.	Maintaining village health register							500	
57.	Monthly honorarium (only in specific States)						500/month-by ICDS		
	ITDA Areas								
58.	Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas								
59.	Referral of pregnant mother to Birth Waiting Homes a week before EDD; and ensuring safe institutional delivery in ITDA areas								

60.	Referral and admission of severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow-up

1. For New born 6 visits 3rd, 4th, 7th, 14th, 21st and 28th day
2. R=Rural; U=Urban

Table 1—PIP Incentives for ASHAs Non-High Focus States-2011—INCENTIVES IN INR/CASE

Sl. No.	Activity Name	Andhra Pradesh	Delhi	Gujarat	Haryana	Jammu & Kashmir	Karnataka	Kerala	Maharashtra	Punjab	Tamil Nadu	West Bengal
1	2	3	4	5	6	7	8	9	10	11	12	13
	Pregnancy/ANC											
1.	Pregnant women tracking							20/case				
2.	Child Tracking							50/case				
3.	Registration during the first trimester of pregnancy	30			50	200				100/case		10/case; for JSY=5/-
4.	Completion of 3/4 antenatal checkups, 2 TT immunization and 120 days of IFA tablets to pregnant woman	120		150	25 for 3 ANC visits/ case	400	Ensuring consumption 100 IFA during ANC=200			100/case & 50/case giving IFA*		150/case
5.	For motivating deliveries in tribal areas			NA								
	Birth/Delivery											
6.	Pregnant women having institutional delivery in government health institution—JSY	150/case		100	200	600	200 for all & 600 for tribal	600-tribal areas, 200 non tribal	600/ case for tribal; 200/case for non-tribal	200/case	200/case	200/case for escort & admis-sion, if stays=120 case
7.	Pregnant women having institutional delivery in private health institution	75/case										

8.	Referral of Post-Partum Complication to a CEMONC Centre	50/case					300/case	
9.	Post-natal Care and New Born Care for mother and neonatal	150@ 25/visit		200 for 1+6 home visits	50 for six visits	100/new born for all visits	for three visits 50/case	440/new born for 6 visits upto 42nd day
10.	Referral of Sick New Born baby to a SNCU	50/case				50/child	300	
	Nutrition and related							
11.	Referral of severe Malnutrition cases/SAM to Malnutrition rehabilitation Centres	50/case						
12.	Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi worker and ensuring the child completes 12 months of age in a health state/exclusive breastfeeding to neonates	50/case	100/case	25/case	50 (Only in cases of home deliveries)		25/case for breastfeeding	
13.	No. of Children weighed every month		2/child					
14.	Referring New born with birthweight less than 2000 grams and follow up on progress	100/case			50 on follow up for three months (only in cases of home deliveries)		200	

1	2	3	4	5	6	7	8	9	10	11	12	13
15.	Weekly follow up of low birth weight new borns			50/case								
	Immunization											
16.	Complete Immunization—All doses of immunization for BCG, DPT, OPV, Measles, and Hepatitis-B and Vitamin-A Supplementation	150/case		50 per case for 6th, 10th and 14th weeks infants	100/case	400/case. for mobilizing dropout children= 150/month if all children are immunized	100/case (for reporting side effects of immunization AEFI=100/case		750/case for complete & 500/case if 90% immuniz-ation	150/ case	100/ case	150/ child
17.	Pulse polio at least three times a year			75/day		75/day	75/day					
	Reporting											
18.	Maternal Death Reporting to Sub-centre and PHC	50/case		50/case	100/case	for any event= 100/case	500/case within the first 24 hours to RCH officers and otherwise 50		500/case	100/case		20/case
19.	Infant Death Reporting to Sub-centre and PHC	50/case		50/case	100/case		100/case within first 24 hours & others 50		50/infant	100/case	25/case	20/case

20. Birth Report/Registration		100/reg.	50/case			10/case	100/ trimester	25/case	20/case	
Family Planning										
21. Counselling and motivation of women for Tubectomy/DPL surgery and follow-up visit of the cases	50	150/case	100/case	150/case	100/case	150/case	150/case	100/case	150/case	
22. Counselling and motivation of men for Vascectomy/NSV operation and follow-up visit	100	200/case	100/case	200/case	200/case	200/case	200/case	250/case	200/case	
23. Motivation and Counselling for successful IUCD insertion and retention for at least one year and intake of contraceptive pills for one year	100/case	125/case	100/case		50/case				150/case; only for IUD motivation 10/case	
24. Motivation for taking OCPs for 1 year										
Abortion Services					100/case					
25. Incentive for post abortion services		25/case	100/case for MTP		100/case					

1	2	3	4	5	6	7	8	9	10	11	12	13
	Organizing			50/day								
26.	VHND				50/day		100/day		75/day	100/case	100	
27.	ASHAs Diwas/Review meetings			50/session	100/meet		100/day		50/quarterly meeting	100/month	200	
28.	VHSC meetings and ensuring other facilities			200/meet			25/meet			100/3 months		
	Disease Control Programmes											
29.	Identification of Malaria cases-RD/Treatment and follow-up	10/case 3 months follow-up in ITDA		5/slide	20/case till treatment		5/slide and identifying 100/case (also for any other NVBD programme = 100)		5/slide, 20/Pf case; 50/Pv case & 50/case for admission of critical cases			5/slide, treatment 20/Pf case, Pf/Pv detection & complete treatment-50/case
30.	Referral of Dengue/Chikunguniya etc.								25/case			
	Incentives in INR											
31.	Identification of Leprosy/treatment Plausi/Multi bacillary cases, follow up	Na/300/500			300/case	100/200/400	100/200/400	5.6 lakhs lumpsum	200/200/400	100/200/400	100/200/400	100/200/400

32. Identification of TB cases, and successful completion of DOTS	300/case	250/case	250/case	250/case-RNTCP	250/case		250/case	250/case	100/case	MDR cases-2500/case
33. Identification and referral of cataract cases		175/case					100/case for transport. 75/case for IEC	175/case for ensuring surgery		
34. Identifying any other infectious diseases					100					
35. Outbreak Reporting/ Surveillance		100/case					100/information	100/information	100 per month	50/case
Miscellaneous										
36. Adolescent/others anaemia control		50/30 tabs							100/case in two years	
37. Deworming									200/case in two year	
38. Calcium Compliance										
39. Vitamin-A									200/case in two years	
40. Identifying STI/RTI infected case and referral					10-100/case (maximum)					

1	2	3	4	5	6	7	8	9	10	11	12	13
	Reporting HIV+/AIDS cases			Rs. 50/ case					10/pregnant mother 500/case for delivery at PPTCT & 300/ case for follow up			
41.	Maternal care on HIV						100/case detection for up to delivery 1000/case.*					
42.	Child care on HIV						Each non + case 100/ visit. HIV + case-200/visit					
	Incentives in INR											
43.	Referral of mentally and physically handicapped			As per disability	100/case		100					
44.	RSBY			Rs. 50/case							20/case	
	Other incentives											
45.	Sarees											
46.	Best ASHAs Awards PHC/Cluster/District/ State level											

47. ASHAs Gruhas						
48. MIS		50/episode				
49. Ensuring safe drinking water and other sanitation facilities			50/sample of water for testing		75/toilet construction	Toilet construc-tion on 50/ case
50. TA/DA during training			125/ASHAs			
51. Maintaining accounts for documents/annual expenditure/maintenance of daily expenditure of the untied fund for village				1000/year-two times in an year		
52. To do household survey				500 in one year		
For ITDA Areas only in Andhra Pradesh						
53. Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas	100					
54. Referral of pregnant mother to Birth waiting homes a week before EDD and ensuring safe Institutional delivery in ITDA areas						

1	2	3	4	5	6	7	8	9	10	11	12	13
55.	Referral and admission of Severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow-up	50 for admission in NRC ; and 25/ month for follow-up										

1. For New born 6 visits 3rd, 4th, 7th, 14th, 21st and 28th days.
2. In Tamil Nadu 6 visits for 28 days ASHAs get incentive.
3. In Kerala ASHAs incentive-40,000/district lumpsum.
4. *In Karnataka for HIV + postnatal mothers and exposed infant upto 18 months = 1200/case; for bringing HIV + mothers for ART Centre = 400/case.

Table 3—North-East States: PIP Incentives for ASHAs—INCENTIVE IN INR/CASE—2011

Sl. No.	Activity Name	Assam	Arunachal Pradesh	Manipur	Meghalaya	Mizoram	Nagaland	Sikkim	Tripura
1	2	3	4	5	6	7	8	9	10
	Pregnancy/ANC								
1.	Pregnant women tracking								
2.	Child Tracking								
3.	Registration during the first trimester of pregnancy								
4.	Completion of 3/4 ante-natal checkups, 2TT immunization and 120 days of IFA tablets to pregnant women								
5.	For motivating deliveries in tribal areas								
	Birth/Delivery								
6.	Pregnant woman having institutional delivery in Government health institution—JSY	600	600	600	600	600	600	600	600(R): 200(U)-institutional delivery in non JSY-50/case
7.	Pregnant woman having institutional delivery in private health institution								

1	2	3	4	5	6	7	8	9	10
8.	Referral of Post-Partum Complication to a CEMONC Centre								
9.	Post-natal Care and New Born Care for mother and neonate								
10.	Referral of Sick New Born baby to a SNCU								
	Nutrition and related								
11.	Referral of severe Malnutrition cases to Malnutrition rehabilitation Centres								
12.	Providing health and nutrition counselling to the parents and family members in close coordination with the Anganwadi worker and ensuring the child completes 12 months of age in a healthy state/exclusive breastfeeding to neonates								
13.	No. of Children weighed every month								

14.	Referring Newborn with birthweight less than 2000 grams and follow-up on progress								
15.	Weekly follow-up of low birth weight new borns								
	Immunization								
16.	Complete Immunisation All doses of immunization for BCG, DPT, OPV, Measles, and Hepatitis-B and Vitamin-A supplementation	250/case	150/case		150/case	150/case	150/case	150/case	150/case
17.	Pulse polio at least three times a year								
	Reporting								
18.	Maternal Death Reporting to Sub-centre and PHC								
19.	Infant Death Reporting to Sub-centre and PHC								
20.	Birth Report/Registration								
	Family Planning								
21.	Counselling and motivation of women for Tubectomy/DPL surgery and follow up visit of the cases	150	150	150	150	150	150	150	150

1	2	3	4	5	6	7	8	9	10
22.	Counselling and motivation of men for Vasectomy/NSV operation and follow-up visit	200	200	200	200	200	200	200	200
23.	Motivation and Counselling for successful IUCD insertion and retention for at least one year and intake of contraceptive pills for one year				20/case				
24.	Motivation for taking OCPs for 1 year								
	Abortion Services								
25.	Incentive for post abortion services								
	Organizing								
26.	VHND	100	100	100	100	100	100	100	100
27.	ASHAs/Diwas/Review meetings								
28.	VHSC meetings and ensuring other facilities								

	Disease Control Programmes									
29.	Identification of Malaria cases—RD/Treatment and follow up				55/case		50/case			50/smear collection 20/RDK slide
30.	Identification of Leprosy/treatment Plausi Multi baciliary cases follow up					100				
31.	Identification of TB cases, and successful completion of DOTS Identification and referral of cataract cases	250	250	250	250		250	250	250	
32.	Outbreak Reporting			175	175	100		175		
	Miscelleneous									
33.	Adolescent anaemia control									
34.	Deworming									
35.	Calcium Compliance									
36.	Vitamin-A									
	Reporting HIV+/AIDS cases									
37.	Maternal care on HIV Child care on HIV									
38.	Referral of mentally and physically handicapped									

1	2	3	4	5	6	7	8	9	10
39.	RSBY								
	Other Incentives								
40.	Sarees								
41.	Best ASHAs Awards PHC/Cluster/District/State level								
42.	ASHAs Grihas								
43.	MIS								
44.	Ensuring safe drinking water and other sanitation facilities								
45.	TA/DA during training								
46.	Maintaining accounts for documents/annual expenditure/maintenance of daily expenditure of the united fund for village								
	ITDA Areas								
47.	Ensuring Skilled Birth Attendance at delivery and for 48 hours after delivery in ITDA areas								

48.	Referral of pregnant mother to Birth Waiting Homes a week before EDD; and ensuring safe institutional delivery in ITDA areas
49.	Referral and admission of Severely Acute Malnourished (SAM) Child in Nutrition Rehabilitation Centre (NRC) and monthly follow-up

Observation/Recommendation

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/para-medical 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.

[Recommendation No. 15, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Infrastructure improvement including staff quarters is one of the thrust areas of National Rural Health Mission. 17,388 new construction works at Sub-centres (SCs), Public Health Centres (PHCs), Community Health Centres (CHCs) and District Hospitals (DHs) have been taken up under NRHM so far and 22,731 upgradation work, have been sanctioned for SCs, PHCs, CHCs and DHs.

Besides proposals for providing monetary incentives to medical and para medical staff hostel in hard/difficult rural areas are also supported under NRHM. Some States are also providing non-monetary incentives including reservation of seats and extra marks for PG admission.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry may mention about the details of standard living facilities proposed to make available in all Sub Centres/PHCs/CHCs for doctors and other medical staff. Ministry may mention the time frame, if any, fixed for construction/ development of infrastructure in all centres. Ministry may also mention the details of monetary and other incentives to doctors/staff to make rural posting attractive.

Further reply by Department of Health and Family Welfare

Health being a State subject all the SC, PHC and CHCs are maintained and upgraded by respective State/UT Governments.

As the State/UT Governments incorporate their requirements for funds for construction/development of infrastructure, living facilities (for doctors & medical staff) etc. in their Annual PIPs, the Ministry of Health & Family Welfare approves such works within the norms and framework of NRHM.

The SC/PHC/CHC to be upgraded and constructions to be done for living facilities are decided by State/UT Governments. The target/time frame for development of infrastructure in all centres is fixed by respective State/UT Governments.

Augmentation of human resources is one of the thrust areas under the National Rural Health Mission (NRHM). Public Health is a state subject. Monitoring and other incentives to staff/doctors to make rural posting attractive are decided by respective State Governments. Approvals under NRHM are accorded to monetary and other incentives proposed in the State PIPs for making rural postings more attractive to doctors/staff to ensure availability of doctors and staff in remote rural areas. Financial support is being provided under NRHM for engagement of staff on contractual basis. Approvals are accorded to the States.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

The Committee deplore that in 26 States/UTs (except Goa, Gujarat, Maharashtra, Nagaland, Odisha, 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 had set up an Empowered Procurement Wing (EPW) in October, 2005 to consolidate, streamline, strengthen and professionalise 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 data base 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 interal 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.

[Recommendation No. 16, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Procurement Manual has been prepared and circulated to all States, which contains standard procurement procedures and practices so as to streamline and professionalise the procurement of health sector goods. The States have been advised to adopt and follow Procurement Manual developed by the Ministry for all procurement activities so as to ensure uniformity and standardization countrywide. The other steps undertaken in this direction are as below:—

(1) Capacity Building has been carried out for five states (M.P., A.P., Odisha, West Bengal, Bihar) by organizing workshop on "Best Practices on Quality assurance and Quality Control Procedures" in September, 2010. The workshop included sensitization of different issues including "GMP certification as tool of vendor certification"; Pre-dispatch inspection and sampling, Quality Assurance through defined drug specifications, Quality Assurance through independent quality control laboratory, quality assurance through post-delivery audit and significance of Standard Operating Procedures for ensuring quality assurance for drug procurement agencies. Capacity building programme would be taken up for all States/ UTs.

(2) The proposal to set up Central Procurement Agency has been approved by Expenditure Finance Committee on 11th May, 2011 and Note for the Cabinet has been submitted by the Ministry. After the approval of the Cabinet, Central Procurement Agency will be operationalized.

(3) ProMIS (Procurement MIS) has been fully developed. Initially Familiarization Training was conducted for all States/UTs except, eight States/UTs such as Kerala, Goa, Daman & Diu, Tripura, Andaman & Nicobar, Dadar & Nagar Haveli, Lakshadweep and Punjab. Hands-on training programme was conducted for Assam, Rajasthan, Madhya Pradesh, Maharashtra, Odisha, Karnataka, Bihar, Gujarat, Uttarakhand, Punjab and all North-East States except Nagaland and Mizoram. Similarly ProMIS training was also organized for Central Programmes, Government Medical Stores Depots (GMSDs) and Procurement Agents like RIES and UNOPS. Data entry by Maharashtra,

Odisha, Madhya Pradesh, Rajasthan, Meghalaya, Sikkim, Tripura, Arunachal Pradesh, all GMSDs and central programmes is being carried out. Increase in usage of ProMIS by different stakeholders will help in building up of computerized data base and IT-enabled supply chain management system.

(4) Data base of World Health Organization — Good Manufacturing Practices (WHO-GMP) certified firms is available on Central Drugs Standard Control Organization (CDSCO) website.

Sd/-

(P.K. Pradhan)

Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry has not replied to the PAC recommendation relating to the data sharing by Ministry and States regarding blacklisted firms on their websites.

Further reply by Department of Health and Family Welfare

All the States have been requested to upload the relevant data on their websites. DO letters dated 30.12.11 to 35 States/UTs were sent by JS (R), none except Tripura State responded so far. In case of Tripura, they have informed that there was no occasion to blacklist any firm. Similarly all purchase organizations of MoHFW have been requested to provide data in respect of blacklisted firms along with the reasons of blacklisting them and the period of blacklisting. The data, after receipt from the various organizations, is planned to be uploaded on the website.

Sd/-

(Anuradha Gupta)

Additional Secretary & Mission Director (NRHM)

Audit Vetted Comments

In view of the non-receipt of response of D.O. letter date 30.12.11 from all the states except one, Tripura regarding uploading the data of black listed firms on their websites, the Ministry may propose some other effective measures to comply the recommendations of the PAC at the earliest.

Further reply by Department of Health and Family Welfare

A reminder was sent to all States to upload data relating to blacklisting of firms on their websites. States of Gujarat and Bihar have informed that the requisite data has been uploaded whereas States of Tamil Nadu and Assam have issued instructions to the concerned departments to upload relevant data. State of Tripura and UTs Daman & Diu and Lakshadweep have informed that no firm has been blacklisted by them. The Secretary, DHFW has now written to all the

Chief Secretaries to comply with the recommendations of PAC *vide* letter No. Z.-21015/02/2011-EPW. (Annexure-C)

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE C

P.K. PRADHAN
Secretary
Department of Health & FW
Tel: 23061863 Fax: 23061252
E-mail:Secyhfw@Nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110001
Government of India
Ministry of Health &
Family Welfare
Nirman Bhavan, New Delhi-110001

DO. No. Z-21015/02/2011-EPW
3rd January, 2013

Dear Shri Chaudhary,

The Public Accounts Committee (15th Lok Sabha) in its 32nd Report on National Rural Health Mission (NRHM) has made recommendations that Ministry of Health & Family Welfare and all States/UTs should share the data regarding blacklisted firms on their websites. In this connection, Dr. Arun K. Panda, Joint Secretary had sent a D.O. No. Z-21015/02/2011-EPW dated 30.12.2011 to you requesting to upload data on your website about blacklisted firms, if any, giving full particulars, reasons of blacklisting and the period for which a firm has been blacklisted under intimation to the Ministry. A reminder was also sent through a D.O. of even No. dated 19th June, 2012.

The PAC has sought 'Action Taken Report' on this issue. Accordingly, it is requested that the necessary information may please the provided on TOP PRIORITY.

With regards,

Yours sincerely,

Sd/-
(P.K. Pradhan)

Shri S.K. Chaudhary,
Chief Secretary,
Government of Jharkhand,
Secretariat, AE-I,
Deen Dual, Booty Road,
Ranchi-834008.

Observation/Recommendation

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, can 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 States/UT so that poor patients are not fleeced and they are supplied standard quality drugs on time.

[Recommendation No. 17, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

1. MoHFW has notified National List of Essential Medicines 2011. It is available in CDSCO's website. Essential Generic Drugs specific to different National Programmes (RCH, TB, VBD, Immunization) have been worked out based on Standard treatment Guidelines by involving specialists and experts, including those from WHO and other International agencies, in the relevant fields. Respective Programmes Divisions are sharing the lists of essential drugs with States/UTs so that common practices are followed throughout the country.

2. MoHFW has issued instructions to doctors of Government Hospitals to prescribe generic drugs.

Health and Family Welfare Minister has written to the Health Ministers of All States/UT Governments that generic drugs should be prescribed by the doctors in health centres/health dispensaries under the control of the Government. It was also emphasized that the availability of generic drugs should be ensured at those health centres/health dispensaries.

Sd/-

(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Observation/Recommendation

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. Notwithstanding the measures belatedly initiated by the Government, the Committee note that non-availability of essential medicines, vaccines etc. at various levels *viz.* sub centers, 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.

[Recommendation No. 18, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

All Vaccines under Universal Immunization Programme and Pulse Polio Campaigns are being supplied in time. Steps are also being taken to steamline supplies of drugs under various National Health Programmes. M/s. RITES, a Government of India Undertaking under Ministry of Railways has been selected as Procurement Agent of the MoHFW. Third Party sampling, inspection and quality control tests have been made an integral part of the procurement system to ensure the quality for the end-users.

After introduction of Procurement Management Information System (ProMIS) in April, 2009, the stock position has improved in respect to drugs procured centrally. However, more efforts are required by States/UTs to utilize ProMIS fully so as to ensure the availability of drugs, contraceptives and vaccines till the end user. Also it is expected that after establishment of Central Procurement Agency (CPA), there would be a further improvement in regard to availability of essential drugs, contraceptives and vaccines.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

(i) Ministry has not mentioned the action taken on the PAC recommendation regarding monitoring of timely availability of adequate quantity of standard medicines, vaccines etc.

(ii) The Ministry may mention whether availability of adequate quantity of qualitative essential medicine in PHC, CHC & Distt. Hospitals are being ensured as envisaged in NRHM programme.

(iii) Ministry has stated that more efforts were required by States/UTs to utilise ProMIS fully and establishment of CPA. Ministry may mention its own action taken in this regard.

Further reply by Department of Health and Family Welfare

(i) In case of Centrally Sponsored Schemes in order to ensure availability of medicines, vaccines, diagnostics and other items, Procurement Plans are prepared, taking into account the lead time involved at various stages of procurement and subsequently monitoring of the supply chain is carried out by the Procurement Agent and the concerned Programme Divisions. For procurement made by States/UTs out of NRHM funds, ensuring timely availability is primarily the responsibility of State/UTs.

(ii) MoHFW is supplying Medicines, Vaccines, Kits, contraceptives etc. for UIP, RCH, RNTCP, NVBDCP and Family Welfare Programmes at State Headquarter levels for onward despatch to District Hospitals, CHCs & PHCs. Approvals for procuring essential medicine are being given under NRHM as per the need reflected by the States in their PIPs. Ensuring adequate quantity of essential medicines in PHCs, CHCs and District Hospitals comes under the domain of States.

(iii) Training programmes as detailed in the **Annexure-XII** have been conducted to build up capacity for States/UTs for effective implementation of ProMIS. The Union Cabinet has accorded approval for setting up of CPA on 30th September, 2011 and Ministry is taking necessary action to establish it.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

Annexure to Action Taken Report on 32nd Report on PAC (15th Lok Sabha) 2011-12

Sl. No.	State/UT	No. of Trainings already given	No. of Participants already trained
1.	Andhra Pradesh	1	26
2.	Arunachal Pradesh	2	61
3.	Assam	2	37
4.	Bihar	2	67
5.	Chhattisgarh	1	1
6.	Gujarat	1	41
7.	Haryana	1	7
8.	Himachal Pradesh	1	3
9.	Jammu and Kashmir	1	1
10.	Jharkhand	2	52
11.	Karnataka	1	33
12.	Madhya Pradesh	3	64
13.	Maharashtra	4	128
14.	Manipur	2	17
15.	Meghalaya	2	98
16.	Mizoram	1	4
17.	Nagaland	1	3
18.	Odisha	2	130
19.	Punjab	1	38
20.	Rajasthan	2	115
21.	Sikkim	2	37
22.	Tamil Nadu	1	3
23.	Tripura	2	57
24.	Uttarakhand	2	122
25.	Uttar Pradesh	1	4
26.	Chandigarh	1	5
27.	NCT of Delhi	1	5
28.	Puducherry	1	3
	TOTAL	44	1162

Audit Vetted Comments

Though ensuring timely availability of medicines is primarily the responsibility of States/UTs, the Ministry may inform the PAC as to how it monitors the availability of adequate quantity of standard medicines as recommended by PAC.

Further reply by Department of Health and Family Welfare

The Ministry monitors the physical and financial progress against the approved Programme Implementation Plans (PIP). Further, the Ministry has been supporting the States to put in place robust procurement systems, supply chain management, IT systems including ProMIS etc. so that the State can effectively monitor the availability of essential medicines in public health facilities.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

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 Odisha, Jharkhand and West Bengal cases of procurement of substandard drugs or procurement of drugs without assuring quality was noticed. In Odisha, 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 centers 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.

[Recommendation No. 19, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Pre-shipment quality control is mandatory part of procurement process. However, post shipment quality checks are made only when complaints regarding quality are received. However, establishment of Institutional mechanism for post delivery quality check is being explored.

As far as the suggested legislation to amend the Drugs and Cosmetics Act is concerned, it would be pertinent to point out the said Bill is in Rajya Sabha. The advice of the Hon'ble Committee would be considered while finalizing the amendments in the Drugs and Cosmetics Act.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Observation/Recommendation

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 Yojana (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 the 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.

[Recommendation No. 20, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

JSY has seen a phenomenal growth since its inception and institutional deliveries beneficiaries has been increasing every year under the scheme.

With regard to the Committee's observation on fixation of district specific targets for institutional delivery, it is submitted that the States/UTs submit physical

and financial progress report for JSY to the Ministry every quarter. However, these reports do not have district specific details. The States/UTs are responsible for ensuring that the States and districts achieve the targets for institutional delivery.

The Ministry of Health and Family Welfare has initiated several new strategies to accelerate the pace of decline in MMR and IMR. These are the following:—

Ministry of Health & Family Welfare has identifies 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.

Some of the new initiatives that have been taking up are:—

* Name Based Tracking of Pregnant Women: Government of India has introduced name based tracking of pregnant woman to ensure timely provision of ANC, Institutional Delivery, and PNC along with immunization of the new born. So far, data in respect of 86 lakh mothers and 36 lakhs children have been entered.

* 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 Committee 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.

Janani Shishu Suraksha Karyakram (JSSK)

A new initiative has been launched to provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (upto 30 days after birth) in Government health institutions in both rural and urban areas.

The following are the Free Entitlements for pregnant women:—

* Free and cashless delivery

* Free C-section

* Free drugs and consumables

* Free diagnostics

* Free diet during stay in the health institutions

* Free provision of blood
* Exemption from user charges
* Free transport from home to health institutions
* Free transport between facilities in case of referral
* Free drop back from institutions to home after 48 hrs. stay

The following are the Free Entitlements for Sick new borns till 30 days after birth:—

* Free treatment
* Free drugs and consumables
* Free diagnostics
* Free provision of blood
* Exemption from user charges
* Free Transport from Home to Health Institutions
* Free Transport between facilities in case of referral
* Free drop Back from Institutions to home.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Observation/Recommendation

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 percent of total registered pregnant women preferred institutional delivery at health centres. In 19 out of 23 sample districts of 6 States, domiciliary deliveries were more than institutional deliveries as highlited 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 Meternal 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 compenstion 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.

[Recommendation No. 21, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

It is Government of India's policy to have birth preparedness and complication readiness, so far this various tools have been developed, these include Mother and Child Protection Card developed in collaboration with WCD. This card is to be filled in for every pregnant woman. Secondly a safe motherhood booklet is being distributed to every pregnant woman at the time of registration so that she is aware of her entitlements and her micro birth plan is made. Name based tracking is also being done to track all pregnant women for provision of timely ANC, Institutional Delivery, and PNC along with immunization of the new born.

According to the Coverage evaluation survey by UNICEF in 2009, there has been a substantial increase in the institutional deliveries *i.e.* from 47% in 2007-08 (DLHS-3) to 72.9% CES (2009). The %age of Safe Deliveries (Institutional + Home delivery conducted by SBA) has also increased to 76.2% (CES-2009).

* However there are still some pockets where home deliveries are being conducted, for those a number of initiatives have been undertaken to bring such deliveries into the institutional fold.

* Out of the 642 districts in the country, 264 high focus districts have been identified in the country for special attention including enhanced budget provision and intensive monitoring.

* States have been given flexibility to provide special incentives to attract and retain health professionals in government health facilities located in remote, inaccessible and difficult areas of the country which face considerable shortage of ANMs, health workers, doctors, specialists and other health professionals. This includes performance based incentive.

* States have been requested to give special focus for placing assured referral linkages in such areas.

* Many States have either hired or created birth waiting homes for such people who are residing in hilly and remote areas so that they can come atleast a week before the due date of delivery for a skilled care during child birth at the health facilities.

* Emphasis is also placed on creating awareness to encourage women to access institutions for delivery.

Sd/-
(P.K. Pradhan)
Special Secretary and Mission Director (NRHM)

Audit Vetted Comments

(i) The Ministry has not mentioned regarding action taken to make available of laproscopy in tubectomy, new spacing methods at all the prescribed centres as recommended by the PAC.

(ii) The Ministry may also mention whether training in IUD insertions have been provided to Doctors, Nurses of ANMs as recommended by PAC.

Further reply by Department of Health and Family Welfare:—

(a) Laproscopy tubectomy is already available at appropriate facilities in the States; funds are provided to states for training surgeons/doctors in laproscopic tubectomy as well as procurement of laproscopes through annual PIPs.

(b) Ministry has introduced new IUD-380A in 2002 under the Family Planning Programme, which is available at all health facilities. CuIUCD 375 is also being introduced at all the prescribed centres and doctors and nurses are also being trained in Post-partum IUCD insertion.

(c) Training of personnel in IUD insertion is an ongoing activity in States; under Alternate Training Methodology (ATM) in IUCD, since 2007 around 50,000 service providers have been trained which includes doctors, nurses, LHVs and ANMs.

Sd/-
(Anuradha Gupta)
Additional Secretary and Mission Director (NRHM)

Observation/Recommendation

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 prenatal care and weak adolescenthood. What could be the fate of the weak mother with high degree of anaemia 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 Women 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.

[Recommendation No. 22, Part-II of 32nd PAC Report, 15th Lok Sabha)]

Action Taken (Department of Health and Family Welfare)

To address maternal deaths due to Malnutrition various measures for integrating nutrition with obstetric care include:—

* Nutritional counselling and provision of IFA tablets at the time of Antenatal care.

* Hb testing and 100 IFA tablets given during ante-natal period and additional 100 IFA tablets to be given during PNC. Additional 100 IFA tablets are given to all the pregnant women who have been diagnosed anaemic.

* IV iron sucrose for treatment of severe anaemia (being implemented on pilot basis in various States).

Iron Deficiency is an important cause of anaemia in woman. Intra uterine iron deficiency is known to cause irreversible alteration in brain development. Nutritional anaemia is one of the most important causes of maternal mortality and foetal loss. The important contributing factors for anaemia among the population in our country are: (i) inadequate intake of dietary iron, (ii) inadequate absorption of iron from cereal based diets, (iii) Frequent pregnancies with shorter intervals, (iv) high prevalence of infections and infestations, (v) faulty feeding practices, (vi) lack of dietary diversification, (vii) illiteracy, (viii) poverty, (ix) socio-economic conditions, (x) poor hygienic economic conditions etc.

Control Measures

I. In order to improve Health and Nutrition status of population with emphasis on women and children, the Government has taken various measures as mentioned in **Annexure VI.**

II. Specific measures are being taken to prevent and combat anaemia by supplementation of iron and folic acid to infants above 6 months to

adolescence, Pregnant and Lactating women. Iron and folic acid tablets are being distributed through Sub-centres and Primary Health Centres to targeted population *viz.* pregnant women, lactating women, family planning acceptors and infants above 6 months to 5 years are provided iron and folic acid syrup. Children 6 years to 10 years are provided iron and folic tablets (small). Under this programme, every pregnant woman is given 100 mg of elemental iron and 0.5 mg of Folic Acid for at least 100 days. Pregnant women who are anemic are given an additional 100 tablets. Adolescents 11-18 years are provided with adult dose for 100 days.

III. Accredited Social Health Activist (ASHA) a honorary village link worker who will orient the community on the importance of Nutrition and shall be provider of IFA tablets, Vitamin A supplementation and testing of salt through salt testing kits besides orienting the community on other health relates issues. ASHA observes one day of every month as "Village Health and Nutrition Day" (VHND) for creating awareness about various programme related to improve health and nutritional status of the community.

Continuous decline in child sex ratio since 1961 Census is a matter of concern for the country (**Table I, Annexure VII**). Beginning from 976 in 1961 Census, it declined to 927 in 2001. As per Census 2011 (provisional) the Child Sex Ratio (0-6 years) has dipped further to 914 against 927 girls per thousand boys recorded in 2001 Census. Except for the States of Himachal Pradesh (906), Punjab (846), Chandigarh (867), Haryana (830), Mizoram (971), Tamil Nadu (946), Andaman & Nicobar Islands (966) showing marginal improvement, rest of the 27 States/ UTs have shown decline. **(Table II, Annexure VII)**

This negative trend establishes the fact that the girl child is more at risk than ever before and the efforts till date have not been completely effective. The issue of survival of girl child is critical and needs systematic efforts to build a positive environment for the girl child through gender sensitive policies, provision and legislation to protect women against any gender based violence.

While changing the mind set and creating a favourable environment for girl child is the mandate of Ministry of Women and Child Development, Ministry of Health and Family Welfare is concerned with regulating and prohibiting the use of medical technology for selective elimination of the girl child.

Towards this end, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act was enacted on September 20, 1994 and the Act was further amended in 2003. While the regulatory framework has been in place for implementation by States, enforcement of the Pre-conception and

Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 has been lackadaisical in most States.

Following the publication of the 2011 Census figures, Ministry of Health and Family Welfare has initiated the following steps for effective implementation of PC & PNDT Act:—

1. Central Supervisory Board (CSB) under the Act has been reconstituted. The new Central Supervisory Board met on 4th June, 2011. The Board reviewed the progress made by the States in respect of the implementation of the Act and stressed the need to follow up on medical audit and on line record of the form Fs in all the States, etc.

2. 17 States with the most skewed child sex ratio have been identified for concerted attention. A meeting of Health Secretaries of these States was convened on 20th April, 2011. The efforts on their part to implement PC & PNDT Act were reviewed in depth and following action points highlighted:—

    * Constitute/reconstitute State supervisory board and conduct regular meetings.

    * Constitute/reconstitute appropriate authorities and advisory committees at State/district and sub-district levels.

    * Constitute State Inspection and Monitoring Committees (SIMC) for checking the activities of ultrasound facilities indulging in advertisement and/or determination/revealing of the sex of the foetus.

    * Identify districts and map reasons for skewed Child Sex Ratio.

    * Conduct regular surveys, update registrations and renewals to avoid multiple registrations and irregularities including on call registrations and unrestrained use of portable machines.

    * Analysis and scrutiny of Form-F for effective monitoring and tracking of the Ultrasound clinics.

    * Take immediate action against any breach of the provisions of the Act and Rules.

    * Make ultrasound manufacturers accountable and get regular details of the sale of machines.

    * Submit regular quarterly progress report to the Central Supervisory Board.

    * Sensitize and Conduct training programme for law enforcers, medical practitioners, judiciary etc. for effective implementation of the Act.

    * Enhance in-house capacities for building strong cases against offenders that can successfully withstand the legal scrutiny.

    * Devise inter-State coordination mechanism for regulating activities of USG clinics across borders.

3. National Inspection Monitoring Committees have been reconstituted for regular State monitoring and surprise inspection of the clinics on the ground Random inspections of ultrasound facilities were undertaken in the States of Uttar Pradesh and Rajasthan in January-February, 2011.

4. States have been asked during appraisal of the annual Programme Implementation Plan (PIP) to take advantage of funding available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the PC &PNDT Act.

5. Operational guidelines for PNDT-NGO Grant-in-Aid Scheme have been revised to ensure targeted use of resources for effective implementation of the Act.

6. Chief Secretaries in the States/UTs are being addressed to take effective measures and regularly monitor implementation of the PNDT Act.

7. Letters have been addressed by Hon. Prime Minister to Chief Ministers of all States to provide personal leadership to address the declining trends in child sex ratio.

8. HFM has addressed the Chief Ministers of all States/UT administration, exhorting them to ensure effective implementation of the PC & PNDT Act and community mobilization in the matter of declining sex ratio in the 0-6 year age group.

9. It is proposed to carry forward regular appraisal of effective implementation of the Act through zonal and State specific reviews.

10. Review of implementation of PC & PNDT Act has been made part of all RCH programme review meetings.

Sd/-
(P.K. Pradhan)
Special Secretary and Mission Director (NRHM)

Annexure VI to Recommendation No. 22

Government has taken various measures to improve the health and nutrition status of vulnerable population of the country, which are as follows:—

1. A National Nutrition Policy has been adopted in 1993 and a National Plan of Action for Nutrition (1995) is being implemented though various Departments of Government. The National Nutrition Mission has been set up.
2. Reproductive Child Health Programme under National Rural Health Mission (NRHM) includes:
   - Emphasis on appropriate infant and Young Child Feeding.
   - Janani Suraksha Yojana (JSY) to promote institutional deliveries for better birth outcomes.
   - Focus on Maternal Health by promoting institutional deliveries improved coverage and quality of ANC skilled care to pregnant women, Post-partum care at community level.
   - Immunization level.
   - Integrated Management of Neonatal and Childhood Illness and malnutrition.
   - Treatment of severe acute malnutrition though Nutrition Rehabilitation Centres (NRCs) set up at public health facilities.
   - Specific Programme to prevent and combat micronutrient deficiencies of Vitamin A and Iron & Folic Acid. Vitamin A supplementation for children till the age of 5 years.
   - Iron and Folic Acid syrup to children from the age of 6 months to 5 years. Iron and Folic Acid supplementation to pregnant and lactating mothers.
3. National lodine Deficiency Disorders Control Programme (NIDDCP) is being run under the NRHM umbrella.
4. Nutrition Education to increase the awareness and bring about desired changes in the dietary practices including the promotion of breast feedings and dietary diversification is being encouraged under both Integrated Child Development Services Scheme (ICDS) and National Rural Health Mission (NRHM).
5. Other schemes targeting improvement of nutritional status are as under:
   (a) Integrated Child Development Services Schemes (ICDS).

(b) Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)-(SABLA).

(c) Indira Gandhi Matritva Sahyog Yojana (IGMSY).

(d) National Programme of Nutritional Support to Primary Education (Mid Day Meal Programme).

(e) Improving the purchasing power of the people through various income generating scheme including Mahatma Gandhi National Rural Employment Guarantee Scheme.

(f) Availability of essential food items at subsidized cost through Targeted Public Distribution System, Antodaya Anna Yojana.

ANNEXURE

Table I

Sex Ratio of Child Population in the Age Group 0-6: 1961-2011

Census Year	Child Sex Ratio	Absolute Change
1961	976	-12
1971	964	-2
1981	962	-17
1991	945	-18
2001	927	-13
2011	914	—

Table II

State-wise Child (Age Group 0-6 Years)

Sex Ratio in India

(1991, 2001 & 2011)

State	2001	2011	Absolute Change
India	927	914	-13
Haryana	819	830	11
Punjab	798	846	48
Jammu and Kashmir	941	859	-82
Delhi	868	866	-2
Chandigarh	845	867	22
Rajasthan	909	883	-26
Maharashtra	913	883	-30
Gujarat	883	886	3
Uttaranchal	908	886	-22
Uttar Pradesh	916	899	-17
Himachal Pradesh	896	906	10
Lakshadweep	959	908	-51
Daman and Diu	926	909	-17
Madhya Pradesh	932	912	-20
Goa	938	920	-18
Dadra and Nagar Haveli	979	924	-55

State	2001	2011	Absolute Change
Bihar	942	933	-9
Odisha	953	934	-19
Manipur	957	934	-23
Karnataka	946	943	-3
Andhra Pradesh	961	943	-18
Arunachal Pradesh	964	943	-21
Jharkhand	965	943	-22
Sikkim	963	944	-19
Nagaland	964	944	-20
Tamil Nadu	942	946	4
West Bengal	960	950	-10
Tripura	966	953	-13
Assam	965	957	-8
Kerala	960	958	-2
Chhattisgarh	975	964	-11
Puducherry	967	965	-2
Andaman and Nicobar Islands	957	966	9
Meghalaya	973	970	-3
Mizoram	964	971	7

Observation/Recommendation

The National Policy on Indian Systems of Medicine and 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. 8,000 crore during 12th Plan. The Committee express serious concern over the fact that despite the stipulation in the National Policy on Indian systems of Medicine and 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 of the recommendation made by PAC in their 38th Report (14th Lok Sabha) for stepping up allocation to 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 outlay for the Department of AYUSH be suitably 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 per cent for achieving the targets set under the Mission. There is also an overriding need for mainstreaming 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 healthcare systems like Ayurveda, Sidha, 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.

[Recommendation No. 23, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

- The 11th Plan document stated "the existing level of Government expenditure on Health in India is about 1%, which is unacceptably low. Effort will be made to increase the total expenditure by the Centre and the States to at least 2% of GDP by the end of the 11th Five Year Plan".
- The plan allocation for the Deptt. of AYUSH has been increasing over the successive Five Year Plans. Details of allocation (BE), actual expenditure for 9th & 10th Plan and year-wise allocation (BE) and actual expenditure for the 11th Plan is as under:—

(Rs. in crore)

Sl. No.	Plan/Year	Allocation	Expenditure	% Utilization
1.	9th Plan	266.00	293.72	110.42
2.	10th Plan	775.00	1029.56	132.85
3.	11th Plan	3988.00		
4.	2007-08	488.00	382.54	78.39
5.	2008-09	534.00	471.12	88.22
6.	2009-10	734.00	680.00	92.64
7.	2010-11	800.00	844.53 (provisional)	105.57
	Total (2007-08 to 2010-11)	2556.00	2378.19	93.04
8.	2011-12	900.00	—	

- Actual expenditure from 2007-08 to 2010-11 is 93% of the total approved outlay (BE) for 2007-08 to 2010-11. The actual expenditure during first four years of the 11th Plan is only 59.63% of the approved outlay for the 11th Plan.
- The resource envelope of the 12th Plan is not known. However, the Mid-Term Appraisal of the 11th Plan states, "the total allocation of plan and non-plan resources for health for the Centre and the States combined remains low compared to the target of taking it to 2-3 per cent of GDP. A very strong effort will be needed in the last year of the 11th Plan and mainly in the 12th Plan to achieve this goal".

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

(i) Ministry may mention the details of the steps taken to step up the allocation of funds during the 12th Plan with the Planning Commission as recommended by the PAC.

(ii) Whether the Ministry has taken any move to convert the department of AYUSH into a full-fledged Ministry of Indigenous System of Medicines or AYUSH Ministry.

Further reply of Department of Health and Family Welfare

(i) A working group was constituted for working out the modalities of continuation of NRHM in the Twelfth Plan. The recommendations of the working group have been sent to the Planning Commission which *inter-alia* propose for higher allocation of funds.

(ii) Under NRHM, no such plans exist. However, a reply in this regard may be obtained from AYUSH department.

(The AYUSH Department has directly submitted the reply to DGACE).

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Action Taken (Department of AYUSH)

The Programme Implementation Plan (PIP) of NRHM provides for mainstreaming of AYUSH through co-location of AYUSH facilities at Primary Health Centres (PHCs) and Community Health Centres (CHCs). The Department of AYUSH has observed that inspite of concerted and sincere efforts of Ministry of Health & Family Welfare. Government of India for mainstreaming of AYUSH systems by way of co-locating the AYUSH units at PHCs, CHCs and district hospitals all over the country, out of 28,605 number of total such facilities only 11,575 number of AYUSH doctors have been reported to be engaged by the States as on 31.03.2011. In many cases, the money has remained

unspent in the States for the reason of not having dedicated AYUSH administrative setup under NRHM to monitor the programme. The Department of AYUSH has observed that Mission Directors in the states have found to be mainly focussing the activities under Directorate of Health Services which is manned by allopathic doctors and the AYUSH services in the states are being managed by a separate directorate administered by Indian System of Medicines and Homoeopathy technical personnels or commissioners from central or state administrative services. It is found that they have not any role in co-locating tasks of NRHM Mission Director in the state. Similarly, the State level implementation committees/district level implementation committees/block level implementation committees or Rogi Kalyan Samities etc. which have been formed as a part of NRHM have also been found to be mainly allopathic system oriented and the concerns of AYUSH systems have been observed to have been neglected. As result, Mainstreaming of AYUSH could not make significant headway under NRHM except for few co-location in primary health network.

Administrative setup for mainstreaming of AYUSH under NRHM needs to be revamped in the State with necessary infrastructure and required manpower during 12th Plan provided the sufficient funds are made available to the Department of AYUSH. The Department of AYUSH in the 12th Plan will seek to take over from Department of Health and Family Welfare, the entire responsibility including financial provision for hiring of AYUSH manpower, training etc. It is also proposed that the State Directorates of AYUSH systems shall also be involved in the mainstreaming of AYUSH systems.

D/o AYUSH is aware that for meaningful mainstreaming of AYUSH, adequate funds are required. Accordingly, Department of AYUSH has projected the following requirements of the funds for implementation of the various projects during the 12th Plan.

1. Centrally Sponsored Scheme for Development of AYUSH Hospitals and Dispensaries: Rs. 11633.00 crore.
2. Transfer from NRHM flexipool for Manpower, training etc.: Rs. 10,000.00 crore.

Audit Vetted Comments

i. Ministry may mention the details of the steps taken to step up the allocation of funds during the 12th Plan with the Planning commission as recommended by the PAC.

ii. Whether the ministry has taken any move to convert the department of AYUSH into a full-fledged ministry of indigenous system of medicines or AYUSH ministry.

Further reply by Department of AYUSH

The 32nd report of the PAC on Performance Audit of NRHM *vide* recommendation no. 23 (i) recommended that the budgetary outlay of department of AYUSH be suitably enhanced during the 12th Plan to fulfil the avowed objective of Mainstreaming of AYUSH in National Health Care as enunciated in the National Policy, 2002. They also recommended that the Planning commission need to step up the allocation during the 12th Plan by 25 per cent for achieving the targets set under the Mission.

In this regard, the Department of AYUSH in its working group on AYUSH for 12th Five Year Plan made proposal for the consideration of Planning Commission duly ascertaining the needs, gaps and challenges AYUSH systems are faced with. Accordingly, the working group on AYUSH for 12th Five Year Plan constituted by the Department of AYUSH has recommended total projected outlay of Rs. 47535.55 crores in the 12th Plan against the Outlay of Rs. 3988.00 crores during the 11th Plan.

Regarding converting Department of AYUSH into a separate Ministry. It is felt that this could be taken up in line with the increasing budget and activities of the Department.

Observation/Recommendation

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 and 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 Governments to ensure that there is no disparity in the pay scales and remunerations given to AYUSH doctors and the MBBS doctors.

[Recommendation No. 24, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

The following steps have been taken for Mainstreaming of AYUSH healthcare:

NRHM provides for AYUSH Wings in PHCs in CHCs *i.e.* co-location of AYUSH wings at PHCs and CHCs.

Financial assistance is provided for appointment of AYUSH doctors/paramedics on contractual basis on the basis of the requirements projected by various States/UTs in

the annual PIP under NRHM. The number of AYUSH doctors under this initiative has increased substantially. As on 31st March, 2011 11575 AYUSH Doctors and 4616 AYUSH Paramedics have been appointment by All States/UTs on contractual basis under NRHM. The remuneration package for various contractual staff including AYUSH doctors is decided by the States and projected in the State Programme Implementation Plans which are considered by the National Programme Coordination Committee of the Ministry in consultation with the State Mission directors. The Department of AYUSH shall be submitting its reply separately on the remaining issues.

The pace of training of ASHAs has been stepped up. As on 31st March, 2011— 3.47 lakhs ASHAs have been trained upto 5th Module. All the States have been asked to complete the training of all ASHAs upto 5th Module expeditiously. 6,90,221 ASHAs have been provided drug kits. To increase the amount of incentives to ASHAs, the Ministry has decided to engage ASHAs in more activities including home based new born care, supply of contraceptives and menstrual hygiene among adolescent girls. ASHAs will get incentives for each of these activities.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

The Ministry may mention whether it has ascertained the shortage of AYUSH doctors in PHCs and CHCs from the States as recommended by the PAC. If yes, the details thereof be mentioned. The steps taken to fill up the vacancies so ascertained may also be mentioned as recommended by the PAC.

Further reply by Department of Health and Family Welfare

A reply in this regard may be obtained from AYUSH department.

(The AYUSH Department has directly submitted the reply to DGACE).

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Observation/Recommendation

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 and 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 para-medical 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 Governments to ensure that there is no disparity in the pay scales and remunerations given to AYUSH doctors and the MBBS doctors.

[Sl. No. 24, of Para-II of the 32nd Report of Public Accounts Committee (15th Lok Sabha) on National Rural Health Mission]

Action Taken (Department of AYUSH)

Out of a total number of 28,605 PHCs, CHCs and DHs, only 11,575 number of AYUSH doctors have been reported to be engaged by the States as on 31.03.2011. Remaining facilities for co-location are proposed to be covered in 12th Five Year Plan, subject to budget allocation.

Department of AYUSH has projected the following requirements of the funds for implementation of the various projects during the 12th Plan.

1. Centrally Sponsored Scheme for Development of AYUSH Hospitals and Dispensaries: Rs. 11633.00 crore. Department of AYUSH proposed to make adequate allocation for infrastructures, equipments and furniture and essential medicines during 12th Five Year Plan for covering entire PHCs/CHCs/DHs with AYUSH facilities.

2. Transfer from NRHM flexipool for Manpower, training etc.: Rs. 10,000.00 crore. The transfer of Rs. 10,000 crore from NRHM flexible pool resource to Department of AYUSH would facilitate proper coordination of various aspect of mainstreaming of AYUSH including adequate and reasonable payment support for AYUSH manpower and their training. This would also address unavailability of AYUSH doctors in total health facilities and disparity in the remuneration given to AYUSH doctors and MBBS doctors.

Audit Vetted Comments

The ministry may mention whether it has ascertained the shortage of AYUSH doctors in PHCs and CHCs from the States as recommended by the PAC. If yes, the

details thereof be mentioned. The steps taken to fill up vacancies so ascertained may also be mentioned as recommended by the PAC.

Further reply of Department of AYUSH

Out of a total number of 28,605 CHCs, PHCs and DHs, only 11,575 number of AYUSH doctors have been reported to be engaged by the States as on 31.03.2011. It indicate that 17,030 facilities are without AYUSH doctors. Remaining facilities for co-location are proposed to be covered in 12th five year plan, subject to budget allocation. At present, financial assistance for AYUSH manpower at co-located facilities at PHCs/CHCs are provided by the Department of Health under NRHM flexipool, and only financial assistance for medicines and infrastructure development of AYUSH co-located facilities are provided by the Department of AYUSH. However, it is observed that during the prioritisation of other major health programmes, the AYUSH manpower and their training requirement at co-located facilities get neglected resulting in non-achievement of goals under Mainstreaming of AYUSH. This also create operational difficulties in implementing the Mainstreaming of AYUSH programme. Further more, in most of the States, institutional mechanism available for under taking mainstreaming of AYUSH activities are weak and there is no synergy between AYUSH directorate/ commissionerate/department with NRHM and Department of Health. There is dichotomy of implementation strategy of co-location at one place and functioning of exclusive AYUSH facilities. It was also observed that the services of AYUSH manpower at co-located facilities are not accounted or monitored in the project implementation. This shows that there is need for better plan, coordination, implementation and monitoring of mainstreaming of AYUSH activities, by creating a dedicated institutional structure at State level with the leading role of AYUSH technical person, empowered with financial power to implement the programme of mainstreaming of AYUSH.

In order to bring about more effective delivery of Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) systems of medicine to the entire rural population, the Department in the report of its 12th Plan working group to the Planning Commission has proposed to operate three schemes under mission mode to be called the 'National Mission on AYUSH'. The three schemes would be existing schemes for Development of AYUSH Hospitals and Dispensaries, and two new items *i.e.* NRHM flexipool and National AYUSH programme on the lines of such programme being taken up by the Department of Health.

Department of AYUSH has also projected in the Working Group Report Rs. 22,633 crores to the Planning Commission for 12th Five Year Plan for these three items.

Observation/Recommendation

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 suburban 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 and hygiene related issues as well as all the components of Ayurveda, Unani, Siddha dealing with medicines, surgery, gynae, obstetrics and pediatric related practices of AYUSH. These doctors if utilized in the healthcare 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 per cent 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 deployment of AYUSH pharmacist and Para-medical Staff including Panchkarma and Ksharsutra therapists is also quite evident. The Committee further note 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.

[Recommendation No. 25, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

NRHM provides for co-location at PHC and CHC only. Augmentation of AYUSH manpower under co-location initiative has already been explained in reply to recommendation No. 24. Regarding this recommendation, AYUSH department may take a view. This will have to be done departmentally. A reply is being given by Department of AYUSH separately.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry may mention about the steps taken or proposed to be taken to achieve the posting of Yoga therapist in the ratio of 1:4 *i.e.,* 1 Yoga therapist for 4 PHCs or one for each cluster of PHCs. The latest status of vacancy in each category and steps taken to fill up those vacancies may also be mentioned.

Further reply by Department of Health and Family Welfare

A reply in this regard may be obtained from AYUSH department.

(The AYUSH Department has directly submitted the reply to DGACE).

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Action Taken (Department of AYUSH)

With regard to gap in the deployment of AYUSH doctors in PHCs/CHCs etc. has already been commented in response to recommendation No. 24.

Out of a total requirement of 32000 AYUSH doctors for the co-location at PHCs, CHCs, DHs, so far only 11575 AYUSH doctors have been engaged. This shows that remaining facilities are also required to be covered in 12th Five Year Plan. As far as sub-centres are concerned, in these facilities medical doctors are not available. Since AYUSH doctors are available at rural area, they are culturally-oriented towards the basic health needs of rural population. The AYUSH pharmacist and Para-medical Staff including Panchkarma, Ksharsutra, Yoga therapist also could be posted to the PHCs/CHCs provided they are adequately available in the States.

Audit Vetted Comments

Ministry may mention about the steps taken or proposed to be taken to achieve the posting of Yoga therapist in the ratio of 1:4 *i.e.*, 1 yoga therapist for 4 PHCs or one for each cluster of PHCs. The latest status of vacancy in each category and steps taken to fill up those vacancies may also be mentioned.

Further reply by Department of AYUSH

Department of AYUSH proposed the transfer of Rs. 10,000 crores for AYUSH manpower and training component of NRHM flexipool from Department of Health to be administered by Department of AYUSH. This would also facilitate the States to engage AYUSH doctors including Yoga therapist in the ratio of 1:4 *i.e.* 1 yoga therapist for 4 PHCs or one for each cluster of PHCs as per the availability. However, the hiring of contractual or regular staff is the responsibility of States.

Observation/Recommendation

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 and 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 year special plan for AYUSH should be formulated to encourage cultivation of herbal medicines in the States where climatic conditions 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 ample employment opportunities to the youth as the nascent AYUSH industry has tremendous potential considering its growing popularity world-wide.

[Recommendation No. 26, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Reply to be furnished by AYUSH directly to the PAC.

As regards measures required to be taken to ensure timely and adequate supply of standard AYUSH medicines in all the CGHS run AYUSH dispensaries, the following procedure is adopted by the CGHS regarding the supply of medicines to AYUSH CGHS dispensaries. A Committee of experts draws up a formulary list of AYUSH medicines to be procured by the CGHS during the course of next 12—18 months. Out of the formulary, whichever medicines are produced by the Indian Medicine Pharmaceutical Company Ltd. (a Govt. of India undertaking set up for the supply of AYUSH medicines to the CGHS and Government agencies) are procured by the CGHS through this undertaking. Only in respect of those medicines which are not manufactured by this undertaking, action is taken for procurement through open tender system. The tender contains stringent conditions for the firms to fulfil before they become eligible for supply of medicines to the CGHS. Despite getting medicines from the two sources, situations do occur at times that some medicines are not available in stock. For this purpose CGHS has appointed local authorised chemists for supply of medicines out of stock. These local authorised chemists are also appointed through an open tender system. The action on the other points is to be taken by the Department of AYUSH.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Action Taken (Department of AYUSH)

(a) Availability of AYUSH medicines in the State dispensaries/hospitals: Department of AYUSH advised the State Governments to expedite the utilization of Grant in Aid and to submit the Utilization Certificates for the

Grant in Aid provided under Centrally Sponsored Scheme for Development of AYUSH Hospitals and Dispensaries for procurement of AYUSH medicines. The States were also requested to ensure the availability of AYUSH medicines from out of the funds released by Government of India, wherever co-location has been made.

(b) Certification of AYUSH Products: Department of AYUSH has taken a major initiative to improve quality standards in the AYUSH sector by partnering with Quality Council of India (QCI) for Voluntary certificate scheme for AYUSH Products. The scheme has been started since Oct., 2009, which has two levels of certification — For domestic market and international market, AYUSH standard and AYUSH premium marks are available respectively. The Voluntary certification scheme for product certification of AYUSH product would result in Quality seal being awarded to those who opt for third party evaluation. Till now **125 Premium marks and 95 standard marks has been awarded to Ayurveda, Siddha, Unani (ASU) products.**

(c) Timely and adequate Supply of AYUSH medicines in CGHS dispensaries: Ayurveda Medical Store Depot (AMSD), under the CGHS (Department of Health and Family Welfare) looks after procurement of Ayurvedic medcines related to Delhi region. Outside Delhi concerned CGHS head of the city looks after the procurement on the basis of the Rate Contract and formulary prepared by the AMSD after following the codal procedures. The procurements are made on the basis as per the annual estimates called "provisioning". Throughout the year around 92 to 95% of medicines out of 345 formulary medicines are made available to the dispensaries.

All the medicines that are procured by AMSD are from GMP complied firms and the supplies are accepted in the AMSD only when batch-wise analytical reports are enclosed along with supply.

(d) Plan for encouraging cultivation of herbal medicines in the States: Government has been implementing a Centrally Sponsored Scheme of "National Mission on Medicinal Plants" with a total outlay of Rs. 630.00 crore during the 11th Plan. The scheme aims at supporting market driven cultivation of medicinal plants, prioritized by Department of AYUSH and implemented in a mission mode for cultivation through growers, farmers, cultivators, Growers Associations, Federations, Self Help Groups, Corporate, Growers Co-operatives etc. with backward and forward linkages. The Scheme is primarily supporting cultivation on private lands with backward linkages by establishment of nurseries for supply of quality planting material and forward linkages for Post-harvest management, Processing, Marketing infrastrucutre, Certification and crop insurance in project mode.

The scheme is being implemented since 2008-09. 26 States *viz.* Andhar Pradesh, Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Himachal Pradesh, Haryana, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Tamil Nadu, Uttar Pradesh, Uttarakhand, West Bengal are already implementing the

scheme. Assistance amounting to Rs. 146 crores has been provided to the aforesaid States for establishing 642 nurseries of medicinal plants, undertaking cultivation of identified medicinal plants on additional 52,367 ha., setting up of Post Harvest Management (PHM) units and Management Support till 31.03.2011.

Audit Vetted Comments

The ministry may mention the steps taken or proposed to be taken to give financial assistance to drug manufactures of AYUSH medicines for undertaking research and development and to patent the medicines.

Further reply of Department of AYUSH

63 Ayurveda, Siddha, Unani and Homoeopathy drugs manufacturers have been assisted financially under Centrally Sponsored Scheme for Quality Control of Ayurveda, Siddha, Unani and Homoeopathy drugs for the establishment of in-house laboratory. However, no other scheme for financial assistance to manufacturers for undertaking research and development exists in Department of AYUSH. Patenting however is to be taken up by the entrepreneurs/manufacturers themselves.

Recommendation/Observation

The Committee are disheartened to note that the healthcare 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 diseases 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 interventions should also be undertaken with the funds dedicated for the National Health Programmes.

[Sr. No. 27 of Part-II of the 32nd Report of Public Accounts Committee (15th Lok Sabha) on National Rural Health Mission]

Action Taken (Department of AYUSH)

In the 9th Plan on an experimental basis, 7 Ayurveda and 5 Unani medicines were included in the Reproductive and Child Health (RCH) Kit for trial in 9 States and 4 Cities. However, this experiment was not continued by Department of Health and Family Welfare. Apart from this experiment, Department of Health and Family Welfare has not associated the Department of AYUSH and AYUSH systems in framing up various National Health Programmes. Therefore, in view of this background, now Department of AYUSH is proposing to launch during 12th Plan several National AYUSH Programmes with mandate and objective of promoting AYUSH practices of maternal and child healthcare, geriatric care, mental health, nutritional care and health promotion for the benefit of masses subject to the availability of funds during forthcoming 12th Five Year Plan.

Audit Vetted Comments

The PAC has recommended that out of total funds for National Health Programmes the Govt. should earmark 25 per cent funds for utilization of AYUSH medicines, Research and Development (R&D) etc. The action taken in this regard may be mentioned.

Further reply of Department of AYUSH

In order to improve the access to and outreach of AYUSH system of Medicine for the benefit of rural masses, particularly in the area of health promotion, disease prevention and management of non-communicable, a new initiative in the name of "National AYUSH Health Programme" has been proposed for implementation during the 12th Plan period (2012-2017). An allocation of Rs. 1,000 crores has been sought for this purpose.

For 12th Five Year Plan, a significantly scaled up allocation of Rs. 2,649.50 crores has been proposed for Reseach and Development in AYUSH against the 11th Plan outlay of Rs. 359.50 crores for the purpose.

The Centrally Sponsored Scheme for Development of AYUSH Hospitals and Dispensaries, through which financial assistance is also provided to States for supply of medicines, is intended to be implemented in the 12th Plan period as 'National Mission on AYUSH'. The 12th Plan allocation for this initiative has been projected to the tune of Rs. 11,633 crores against the outlay of Rs. 625 crores in the 11th Five Year Plan. The Scheme is proposed to be implemented to cover PHCs, District Hospitals, stand alone AYUSH facilities and all districts of North Eastern States and Other Hilly States.

In order to bring about more effective delivery of Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) system of medicines to the entire rural population, the Department proposed to operate three schemes under mission mode to be called the 'National Mission on AYUSH'. The three schemes would be existing schemes for Development of AYUSH Hospitals and Dispensaries, and two new items *i.e*. NRHM flexipool and National AYUSH Programme on the lines of such programme being taken up by the Department of Health.

Department of AYUSH has projected Rs. 22,633 crores to the Planning Commission for 12th Five Year Plan for these three items.

Further, the working group of AYUSH for 12th Five Year Plan (2012-17) proposed for Research and Development in AYUSH a scaled up allocation of Rs. 2,649.50 crores against the 11th Plan outlay of Rs. 359.50 crores.

Recommendation/Observation

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 resource to painful caesarian deliveries often at prohibitive cost. They also recommend that such Yoga Asanas/practices need to be standardized and widely popuarlized as an effective system of safe and healthy delivery.

[Sl. No. 28 of Part-II of the 32nd Report of Public Accounts Committee (15th Lok Sabha) on National Rural Health Mission]

Action Taken (Department of AYUSH)

The Central Council for Research in Yoga and Naturopathy (CCRYN) is running a collaborative research project titled "The effect of Yoga in prevention of pregnancy complications in high risk pregnancies—a randomized controlled trial" at Swami Vivekananda Yoga Anusandhana Sansthan (SVYASA), Bengaluru.

The Morarji Desai National Institue of Yoga (MDNIY) proposes to conduct multicentric study on the subject of — Efficacy of Yoga on pregnancy and safe delivery. Based on the results of such studies, the practices will be standardized and the same will be widely publicized through different media for the use of general public and the professionals.

Audit Vetted Comments

No comments.

Observation/Recommendation

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 along with 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 of 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 civilization heritage is not patented or arrogated by unscrupulous elements/countries.

[Sl. No.29 of Part-II of the 32nd Report of Public Accounts Committee (15th Lok Sabha) on National Rural Health Mission]

Action taken (Department of AYUSH)

The Department of AYUSH in collaboration with the Council for Scientific and Industrial Research has taken up a project entitled 'Traditional Knowledge Digital Library' (TKDL) to forestall the wrongful grant of patents by International Patent Offices on Indian Traditional Medicinal Knowledge including 'Yoga'. A total number of 1,346 Yoga postures have been transcribed in patent compatible format in the TKDL data has upto 31st May, 2011.

Audit Vetted Comments

i. Ministry has not mentioned the action taken on the specific PAC recommendation for creating the data base of reputed practitioners in field of all branches of AYUSH, the villages and the regions.

ii. The measures to popularise the 1346 yoga asanas/postures may also be mentioned .

Further Reply by Department of AYUSH

Department of AYUSH brings out the publication. "AYUSH in India" every year containing information about State-wise registered practitioners in respect of Ayurveda, Unani, Siddha, Naturopathy and Homoeopathy based on the information received from State Boards of Indian Systems of Medicine and Homoeopathy.

The latest publication "AYUSH in India—2010" is available on the website (w.w.w. indianmedicines.nic.in) of the Department of AYUSH.

Further, 1346 Yoga Asanas/Postures are mentioned in the context of digitalisation. However, Department has taken initiative to standardize yoga asanas/postures during last few years. Morarji Desai National Institute for Yoga (MDNIY) has prepared the atlas of 100 yoga postures popularly used by the public under the WHO project 2009-2010. Further, the initiative will be taken by (MDNIY) to standardize yoga postures/ practices which are in the public domain during the 12th Plan.

Traditional Knowledge Digital Library (TKEL) is a collaborative project between Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH), Ministry of Health and Family Welfare and Council of Scientific and Industrial Research (CSIR), IT was established in 2001 with a view to prevent patenting of knowledge and avoiding misinterpretation of publically available information as being an invention or a discovery with the approval of Cabinet Committee of Economic Affairs (CCEA). The digitization in TKDL covers the knowledge available in public domain of Ayurveda, Unani, Siddha and Yoga into patent compatible format into five international languages, namely, English, French, German, Spanish and Japanese. The primary users of the TKDL database are the Patent Examiners in national and international Patent Offices. So far, the TKDL Access Agreements, have been done with 6 International Search Authorities *viz*.

European Patent Office (EPO), United States Patent and Trademark Office (USPTO), Canadian Intellectual Property Office (CIPO), Intellectual Australia (IP Australia), Japan Patent Office (JPO) and Controller General of Patents, Designs and Trade Marks (Indian Patent Office) and 2 International Patent Officers *viz*. German Patent Office (GPO) and Intellectual Office United Kingom (IPO-UK).

As per presentation made in TKDL Task Force meeting held on 13.01.2012, the following number of formulations has been transcribed from 292 books:

Sl.No.	Systems	Number of Books	Number of formulations
1.	Aurveda	112	93,500
2.	Unani	54	1,37,731,
3.	Siddha	98	17,700
4.	Yoga	28	916
5.	Total	292	2,49,847

[Ministry of Health and Family Welfare, Department of AYUSH O.M. No. G-25015/ 01/2011-12/H&D Cell, dated 6.2.2012]

Observation/Recommendation

The Committee note that the oft-invoked plea that health is a State subject didn't deter the Ministry of Health and Family Welfare to launch the NRHM to create the intended healthcare 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 to provide accessible, affordable and reliable healthcare 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 as also its wealth multiplier. Considering the mutually invigorating relationship between health and wealth, the Committee firmly believe that in such a critical area like healthcare, 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.

[Recommendation No. 30, Part-II of 32nd PAC Report (15th Lok Sabha)]

Action Taken (Department of Health and Family Welfare)

The Ministry of Health and Family Welfare has made concerted efforts to improve availability and quality of healthcare services and to achieve the goals of NRHM over the last six years. Apart from providing funds under NRHM the Ministry has encouraged innovations, guided the States and closely monitored the implementation. This has lead to significant achievements which inlcude:

- The IMR has decreased from 58 in 2005 to 50 in 2009, MMR has reduced from 254 in 2005 to 212 in 2009. And TFR has seen a reduction from 2.9 in 2005 to 2.6 in 2009.
- 55% mortality reduction in malaria in 2010 as against 2006 and 44% Kala Azar Mortality reduction in 2010 as against 2006.
- 26% mortality reduction in dengue in 2010 as against 2006.
- The target of less than 1 for Leprosy Prevalence Rate was achieved in December 2005 and maintained same as thereafter.
- 72% case detection rate and 87% cure rate has been achieved for Tuberculosis.
- Presently, 8.49 lakh ASHAs have been engaged in the villages across the country to provide the link between community and healthcare facilities in the country.
- Funds are provided to the States for engaging contractual health human resources under NRHM. As a result, the health human resources have been augmented by engaging nearly 1.45 lakh health professionals including doctors and specialists.

- NRCs address severe acute malnutrition/wasting in children <5 years age 492 Nutritional Rehabilitation Centres (NRCs) are operational across 13 States.
- 6403 New Born Care Corners, 1102 New Born Stabilization Units at FRUs and 263 SNCUs have been set up at District Hospitals.
- The no. of institutional deliveries has increased from 108.4 lakhs in 2005-06 to 168.05 lakhs million in 2010-11.
- The no. of JSY beneficiaries has increased from 7.34 lakhs in 2005-06 to 113.39 lakhs in 2010-11.
- Other recent advances includes — VHSC renamed to VHSNC to include the mandate of Nutrition and currently out of 638588 villages, 4.83 lakhs villages constituted VHSCs. Social marketing of contraceptives through ASHAs and Menstrual Hygiene project for adolescent girls has also been promoted under NRHM.
- A new initiative, Janani Shishu Suraksha Karyakram (JSSK) recently under the National Rural Health Mission (NRHM) which entitles all pregnant women accessing public health institutions completely free and cashless deliveries including free medicine with zero out of pocket expenses.
- Mother and Child Tracking System has been operationalised to ensure registration of all pregnant mothers and children and to monitor the ante-natal and post-natal check up of mothers and immunization of children.
- Annual Health Survey has been introduced to provide feedback on the impact of the schemes under NRHM particularly 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 by estimating these rates on an annual basis in selected States.

From the above-mentioned achievements and initiative under the Mission, it is clear that although Health is a State subject, Ministry has been striving hard to provide accessible, affordable and reliable healthcare facilities to all citizens of the country especially for expecting mothers and new borns. With increased availability of resources, the strengthening of public health system to provide quality healthcare to the rural population could be possible.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Observation/Recommendation

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 healthcare systems and models obtaining in different countries—both developed and developing countries and also evaluate thoroughly the implementation 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 healthcare systems in the World.

[Recommendation No. 31, Part-II of 32nd PAC Report (15th Lok Sabha)]

Action Taken (Department of Health and Family Welfare)

The best practices followed by various States are shared with all States/UT Governments at Common Review Missions (CRMs) dissemination workshops and in periodic review meetings. The State/UT Government can adopt those models as per their requirement. The recommendation regarding studying the Cuba model has been noted.

Sd/-
(P.K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

As per PAC recommendation, the Ministry is to conduct a study of the best healthcare systems and models of different countries. The Action Taken in this regard may be mentioned.

Further reply by Department of Health and Family Welfare

No such study has been conducted so far by the Department of AYUSH.

NHSRC has been asked to conduct a desk review of healthcare models of Thailand, Sri Lanka, Canada, UK and Brazil *vide* this Department's letter of even number dated 13th February, 2012.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

G-25014/1/2008-NRHM-II (Vol. II)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NATIONAL RURAL HEALTH MISSION

Nirman Bhawan, New Delhi
Dated the 13th February, 2012

To

Dr. T. Sundararaman
Executive Director,
NHSRC, NIHFW Campus,
Baba Gang Nath Marg,
Munirka, New Delhi-110 067

Subject: Conduct Desk Review of healthcare models of Thailand, Sri Lanka, Canada, UK and Brazil—regarding.

Sir,

On the above-mentioned subject, it is stated the following observations have been made in the 32nd Report of the Public Accounts Committee (PAC):

"Para 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 healthcare systems and models obtaining in different countries — both developed and developing countries and also evaluate thoroughly the implementation 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 healthcare systems in the World."

In this reference it is requested that NHSRC to conduct desk review of healthcare models of Thailand, Sri Lanka, Canada, UK and Brazil and send report at the earliest.

This issues with the approval of JS(P).

Yours faithfully,
Sd/-
(Ajith Kumar N.)
Deputy Director (NRHM)
Telefax: 011-23062998
E-mail: *dd-nrhm@nic.in*

Copy to: Director (NRHM-Finance) with reference to OM No. 25020/12/2008/ NRHM(F) dated 2nd January, 2012 for information.

ANNEXURE

G-25014/1/2008-NRHM-II (Vol. II)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NATIONAL RURAL HEALTH MISSION

Nirman Bhawan, New Delhi

Dated the 12th December, 2012

To

DR. T. SUNDARARAMAN,
Executive Director,
NHSRC, NIHFW Campus,
Baba Gang Nath Marg,
Munirka, New Delhi-110 067

Subject: Conduct Desk Review of healthcare models of both developed and developing countries particularly the Cuban model — regarding.

Sir,

This is in continuation of this Ministry's letter of even number dated 13.02.2012 in pursuance of the following observation/recommendation made in the 32nd Report of the Public Accounts Committee (PAC) in connection with Para 31 which is reproduced below:

"Para 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 healthcare systems and models obtaining in different countries — both developed and developing countries and also evaluate thoroughly the implementation 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 healthcare systems in the World."

In this connection, NHSRC is requested to do the needful as per the PAC's specific recommendation. A report in this regard may be submitted to this Ministry at the earliest.

Yours faithfully,

Sd/-

(Suresh K. Mohammed)
Director (NRHM)
Telefax: 011-23061333
E-mail: *suresh mohammed@nic.in*

Copy to: Director (NRHM-Finance) with reference to OM No. 25020/12/2008/ NRHM(F) dated 7th December, 2012 for information.

Observation/Recommendation

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 until 2008 was stated to be only 2.6. Similarly against the target for reduction of IMR from 60 to 30 per thousand live births, the achievement until 2008 was merely 53. As regards the MMR the achievement until 2006, was stated to be 254 as against the target of 100 per 100,000 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.

[Recommendation No. 32, Part-II of 32nd PAC Report (15th Lok Sabha)]

Action Taken (Department of Health and Family Welfare)

A lot of progress has been made under NRHM in the last six years. IMR has been reduced further from 53 in 2008 to 50 in 2009 while MMR has declined from 254 in 2004-06 to 212 in 2007-09. It is expected that the vital health indicators will significantly improve further by 2012. However, the 12th Five Year Plan provides opportunity to work further for achievement of NRHM goals and Millennium Development Goals (MDGs) and improve the service quality further. Working group on NRHM for 12th FYP has been constituted under the Chairmanship of Secretary HFW. Two meetings of working group have been held wherein the progress of NRHM and strategies for next FYP were discussed in detail. Representatives of some states are part of the working group while some other states have also given suggestions on the TOR for working group and thrust areas for 12th Plan.

For effective implementation and independent monitoring following initiatives have been taken:

- Health Management Information System (HMIS): A web-based system has been established by the M&E Division of the Ministry for flow of information of both physical and financial progress from District to State and there in up to the National Level.
- Quality Assurance (QA) Cell: QA cells have been placed at district and at State level to monitor and evaluate the performance of various strategies including trainings under RCH-II/NRHM.
- Programme Management Units (PMUs): The State, District and block PMUs have been established at State/District/Block level to monitor the performance of the programme in their area through regular field visits, evaluation of data.

- Evaluation Surveys: M&E Division also organizes large scale surveys *e.g.* National Family Health Survey (NFHS) on the lines of Demographic and Health Surveys conducted in the other countries, District Level Household Surveys (DLHS) to assess and evaluate the outcome/impact of the programmes/interventions from time to time.
- Annual Health Survey is also being implemented for receiving better quality and regular data on safe motherhood indicators.
- Joint/Common Review Missions: Regular review missions in partnership with development partners and State representatives (JRM/CRM) are organized for review and concurrent evaluation of RCH-II and NRHM programme respectively to assess the progress/bottlenecks in implementation of the programme and thus suggest recommendations/further actions to be taken.
- Appraisal of State PIPs through sub-committees and committees before the release of funds for activities related to NRHM/RCH strategies and interventions, based on outcomes and targets achieved and funds utilized in the previous year.

Sd/-
(P.K. Pradhan)
Special Secretary and Mission Director, NRHM

Audit Vetted Comments

As per the PAC recommendations, the NRHM warrants a thorough restructuring so as to remedy the shortcomings and difficulties in its effective implementation. The Ministry has not replied to the issue of need for restructuring of NRHM. Action Taken on this recommendation may also be mentioned.

Further reply by Department of Health and Family Welfare

The working group which was set up by the Planning Commission for working out the modalities of continuation of NRHM *inter-alia* had a mandate to review the performance of NRHM including its restructuring keeping in view the shortcoming and difficulties observed in its First Phase. The recommendations of the working group have been sent to the Planning Commission.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry may inform PAC about the action taken by the Planning Commission on the recommendations of the working group.

Further reply by Department of Health and Family Welfare

The working group reports form part of the 12th Plan formulation process of the Planning Commission. Planning Commission has communicated that Gross budgetary

support for Department of Health and Family Welfare for the 12th Five Year Plan would be Rs. 2,68,551 crore.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

CHAPTER III

OBSERVATIONS/RECOMMENDATIONS WHICH THE COMMITTEE DO NOT DESIRE TO PURSUE IN VIEW OF THE REPLIES RECEIVED FROM THE GOVERNMENT

Observation/Recommendation

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 Chairmanship 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.

[Recommendation No. 5, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

The composition of the Committee includes local MLAs, Chairman, Zila Panchayat as members and Chief Medical Officer of Health as Member Secretary & Convener. The States are further advised *vide* DO letter No. D.O. No. Z-1815/6/2008-NRHM-II dated 4th Oct., 2010 to constitute the Committee immediately and nominate the names of MPs, who will chair this Committee.

Sd/-

(P.K. Pradhan)

Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

(i) A copy of D.O. letter No. Z-1815/6/2008-NRHM-II dated 04.10.2010 advising the States to constitute the Committee be provided.

(ii) The details of number of Distt. Level Vigilance Monitoring Committees constituted by the States in pursuance of Ministry's instruction quoted above may also be mentioned.

Further reply by Department of Health and Family Welfare

(i) A copy of the order is attached as **Annexure VI.**

(ii) As per the reports received from States, DLVMC has been constituted in 16 States and is awaited from rest of the States.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

K. SUJATHA RAO
HFW Secretary
Fax: 2306125
Secyhfw@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110 011
Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi-110 011
D.O. No. Z-1815/6/2008-NRHM-II

Dated the 4th October, 2010

Dear Sh. Gopal,

Under the National Rural Health Mission, community involvement and decentralized monitoring has become Institutionalized for achieving Mission goals. The Members of Parliament have also been associated at various levels like DHS, RKS concerned with planning, implementation, monitoring and evaluation of the programme. However, it is felt that the closer involvement of the Members of Parliament will help in greater community involvement and accountability.

On the lines of the Committee set-up by Minister of Rural Development for monitoring the implementation of NREGS, it has been decided to constitute District Level Vigilance and Monitoring Committee (DLVMC) under the chairmanship of one of the MPs of Lok Sabha in each District to monitor the progress of implementation of NRHM. The Committee shall review the intersect oral convergence, community monitoring mechanisms, management information system etc. order issue by Ministry consultating the DLVMC is enclosed for your information.

You may take necessary action to immediately constitute the Committee in each district so that it can start functioning immediately. In such districts where there are more than one elected member of the Lok Sabha the name can be recommended for deciding as to who will chair the Committee. You are also requested to advise all concerned officials to provide necessary support so that the Committee can undertake the functions underlined in the Terms of Reference effectively.

I would request an immediate response from your end.

With best wishes. Kind regards.

Yours sincerely,

Sd/-

(K. Sujatha Rao)

Encl: as above
Shri Satya Gopal
Administrator
Dadra & Nagar Haveli Administration
Collectorate
Silvasa-396 230
Dadra & Nagar Haveli

FILE No. Z-18015/6/2008-NRHM-II
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NRHM DIVISION

Nirman Bhawan, New Delhi
Dated the 15th September, 2010

ORDER

It has been decided to constitute a "District Level Vigilance and Monitoring Committee (DLVMC)" at district level to monitor the progress of implementation of National Rural Health Mission under the overall framework of implementation. The DLVMC shall review the intersectoral convergence, community monitoring mechanisms, management information system etc.

The composition of DLVMC shall be as follows:

i.	One of the MPs (Lok Sabha) of the District	Nominated by the Ministry of Health and Family Welfare as Chairman
ii.	All other MPs (Lok Sabha) of the District	Vice Chairman
iii.	All MLAs of the District	
iv.	Chairperson of Zila Panchayat	
v.	District Magistrate	
vi.	Chairperson of Panchayat Samities (Block Pramukh)	
vii.	Officer-in-charge of Women & Child Development, Water Supply & Sanitation, Education, Panchayati Raj and Social Welfare	
viii.	CEO, DRDA/Project Director, DRDA	
ix.	Chief Medical Officer of Health	Member Secretary and Convener

The Terms of Reference for the District Level Vigilance and Monitoring Committee (DLVMC) shall be as under:

i. To review the progress of implementation of the annual district health action plan under the NRHM and provide guidance.

ii. To review the release of funds by Centre and States, utilization thereof and unspent balance.

iii. To undertake regular monitoring visits to the field, visit to the peripheral health facilities and assess their performance including drug availability.

iv. To ensure that a fully functional management structure is in place and is properly utilized.

v. To ensure constructive engagement and participation of all concerned departments in the district for multi-sectoral intervention.

vi. To recommend corrective measure to ensure that the programme objectives are achieved and service delivered in an effective as well as efficient manner.

The Committee shall meet once every quarter.

Sd/-

(P.K. Pradhan)
Special Secy. & Mission Director (NRHM)

To,

1. Chief Secretary of all States/UTs.
2. Principal Secretary/Secretary (HFW) of all States/UTs.
3. Mission Director (NRHM) of all States/UTs. This should be brought to the notice of all Districts Health Societies and all the DLVMC be constituted accordingly.
4. All programme Divisions in the Ministry of Health and Family Welfare.

Audit Voted Comments

Ministry may inform PAC about the timeframe for constitution of District Level Vigilance Monitoring Committees (DLVMC) in remaining States.

Further Reply by Department of Health and Family Welfare

A.D.O. letter *vide* No. Z-18015/6/2008-NRHM-II dated 22.06.2012 from Secretary (H&FW) was issued to States requesting them to send the status of constitution of DLVMCs. As per the reports received, 18 States have completed the constitution of DLVMCs in all districts. Reply is awaited from rest of the States. The States have again been requested to constitute the DLVMC at the earliest in every district *vide* D.O. letter No. Z-18015/6/2008-NRHM-II (Vol. II) dated 17th and 18th December, 2012.

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

MANOJ JHALANI, IAS
Joint Secretary
Telefax: 23063687
E-mail:manoj.jhalani@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110001
Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi-110001

D.O. No. Z-18015/6/2008-NRHM-II (Vol. II)
Dated the 17th December, 2012

Dear,

Kindly refer to this Ministry's D.O. letter of even number dated 22nd June, 2012 from the Secretary (H&FW) and the subsequent reminder letter dated 27th November, 2012 regarding constitution of District Level Vigilance and Monitoring Committee (DLVMC) in all the districts of your State/UT. In this regard it is noted with regret that despite several reminders, the District Level Vigilance and Monitoring Committees have not been set up in all districts in your State.

You are once again requested to take immediate necessary action to set up DLVMCs in all districts of your State and send us a status note on the functioning of these committees as per format in Annexure.

With regards,

Yours sincerely,

Sd/-
(Manoj Jhalani)

The Principal Secretary

(Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Manipur, Odisha, Puducherry, Rajasthan, Tamil Nadu, Uttar Pradesh & West Bengal)

ANNEXURE

Sl. No.	Name of the District	Name of the Chairperson	Date of Meeting	Whether Quarterly field visit undertaken (Y/N)	Remarks/ Any special observation of DLVMC

MANOJ JHALANI, IAS
Joint Secretary
Telefax: 23063687
E-mail:manoj.jhalani@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110 001

Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi-110 001

D.O. No. Z-18015/6/2008-NRHM-II (Vol. II)

Dated the 18th December, 2012

Dear,

Kindly refer to this Ministry's D.O. letter of even number dated 22nd June, 2012 from the Secretary (H&FW) and the subsequent reminder letter dated 27th November, 2012 seeking information related to functioning of District Level Vigilance and Monitoring Committee (DLVMC) in all the districts of your State/UT.

In this regard, you are once again requested that information on functioning of the DLVMC in all districts of your State may be sent regularly on a quarterly basis to this Ministry as per format given in Annexure.

With regards,

Yours sincerely,

Sd/-
(Manoj Jhalani)

The Principal Secretary

(A&N Islands, Andhra Pradesh, Arunachal Pradesh, Assam, Chandigarh, Dadra & Nagar Haveli, Daman & Diu, Goa, J&K, Karnataka, Lakshadweep, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tripura & Uttarakhand)

ANNEXURE

Sl. No.	Name of the District	Name of the Chairperson	Date of Meeting	Whether Quarterly field visit undertaken (Y/N)	Remarks/ Any special observation of DLVMC

Observation/Recommendation

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 2007-08. 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.

[Recommendation No. 10, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Necessary guidelines have been issued to all the States *vide* D.O. letter No. G-27034/ 19/2008-NRHM finance dated 26th April, 2011 with greater emphasis on contribution of 15% State share as a necessary condition prior to release of funds. In the absence of specific guidelines during the initial phase of NRHM in 2007-08, many States made their contribution through the treasury route and, therefore this amount of State contribution was not necessarily reflected in their NRHM balance sheet. The Ministry has asked the States to provide the details of such contribution. During the years 2009-10 and 2010-11 there has been a marked increase in the State contribution made by the States in 2009-10. Out of 35 States, 34 States have contributed for State share. The year-wise details of State share contribution made by the States are given below:

(Rs. in crore)

Year	Releases	State Share contribution to be contributed by the States	Amount credited by the States	% of amount credited against required contribution
1	2	3	4	5
2007-08	8508.87	1501.56	338.22	22.53%
2008-09	9628.44	1699.14	1316.16	77.46%

1	2	3	4	5
2009-10	11224.62	1980.82	1618.76	81.72%
2010-11	12871.23	2271.39	2144.53	94.41%

Note: Figures for 2010-11 are provisional.

The Ministry is vigorously pursuing with the States to deposit the outstanding State share for the previous years. The release of further funds to the States has been made contingent to deposit of State share by the States/UTs and the same has been incorporated as a condition in the PIP approvals sent to States in 2011-12.

Sd/-
(P. K. Pradhan)
Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

Ministry may provide the copy of guidelines which have been issued to all the States *vide* D.O. letter No. G-27034/19/2008-NRHM Finance dated 26th April, 2011 emphasising the contribution of 15% State share as a necessary condition prior to release of funds.

Further reply by Department of Health and Family Welfare

The copy of the guidelines is given as **Annexure VIII.**

Sd/-
(Anuradha Gupta)
Additional Secretary & Mission Director (NRHM)

ANNEXURE

No. G-27034/19/2008-NRHM-Finance
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NRHM FINANCE DIVISION

210-D, Nirman Bhawan,
New Delhi-110001

Dated the 29th April, 2011

To

The Mission Directors (NRHM)

All States/UTs

Subject: Guidelines on Accounting of 15% State Share Contribution and issue of Utilisation Certificate

Sir/Madam,

The NRHM Framework for Implementation provides for a 85:15 ratio of fund sharing between the Centre and the States. Accordingly, the States/UTs contribute 15% towards all the programmes under NRHM including NDCPs, NCDs and Infrastructure Maintenance. At the end of each year, States/UTs have to issue sanction-wise Utilisation Certificates along with the Annual Audited Statements. It has been noted that the State share utilisation is not appropriately reflected in the FMRs, Statements of Funds Position (SFPs) and the UCs, leading to minus unspent balances being reported by many States and also delays in settlement of UCs with the PAO, MoHFW.

With a view to ensure greater clarity of reporting and fund management and to facilitate effective monitoring and issue of UCs, this Ministry has drafted the "**Guidelines on accounting treatment of 15% State Share Contribution towards State Health Society and issue of Utilisation Certificate under NRHM",** a copy of which is enclosed herewith. It is requested that appropriate directions may be issued to the State officers concerned for implementation of these guidelines with immediate effect. Comments if any, may also please be communicated at the earliest for further consideration.

This issues with the approval of Special Secretary & Mission Director (NRHM).

Yours faithfully,

Sd/-
(Jaya Bhagat)
Director (NRHM-Finance)
Ph: 23061360

Encl: As stated

NO. G-25020/30/2009/NRHM(F)
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NRHM FINANCE DIVISION

Guidelines on accounting treatment of 15% State Share Contribution towards State Health Society and issue of Utilization Certificate under NRHM.

As per NRHM Framework of Implementation, all States and UT Health Society receiving grants from the Central Government shall have to make contribution in the ratio of 85:15 based on the total funds released by the Government of India under all the programmes under NRHM including NDCPs, NCDs and Infrastructure Maintenance. It is however, observed that in many States, this contribution is being made only against the releases under the Programmes of RCH, Mission Flexible Pool and Routine Immunization. It is, therefore, clarified that required State contribution should be made taking into account the releases made under all NRHM programmes during a particular financial year.

2. The State share contribution made by the State Government is booked as expenditure in the State Budget at the time of its release to the State Health Society. As regards utilization of the State contribution under NRHM, as a general principal, the State contribution can be proportionately utilized among the different programmes or the same can be utilized on any or all programmes/activities considering their priorities and requirement of funds for such programmes under intimation to the Ministry. As regards reporting, it has been decided that the same may be reflected separately in the periodical FMRs and Statement of Funds Position (SFPs) and a separate Utilization Certificate of the total amount utilized along with unspent balance, if any would be required to be furnished at the end of the financial year. Henceforth, the States/UTs will also sent the proof *i.e.* the copy of the bank statement showing the credit of the State share into the State Health Society Account to FMG in the Ministry.

3. The Utilization Certificates for the grants received from GoI and the State contribution made during a financial year should be prepared separately and incorporated in the audited accounts of the State/UT. This would enable submission of UCs by the States for the exact amount of grants received from GoI and facilitate their correct settlement with the PAO, MoHFW. Secondly, the reflection of State contribution utilization separately in the quarterly FMRs and monthly Statements of Funds Position (SFPs) would obviate the problem of minus unspent balances being reported by many states. The consolidated unspent balances at the end of the month or quarter should, therefore, be worked out and reported after separately mentioning the amount of grant and the State contribution received and utilized.

4. A format of the Utilization Certificate for the State contribution is enclosed as **Annexure I.**

Sd/-
(R. K. Parmar)
Under Secretary to Govt. of India.

Place: New Delhi
Dated: 25th April, 2011

ANNEXURE

FORM GFR 19-A

UTILIZATION CERTIFICATION FOR----------PROGRAMME

For the Financial year----------

Sl.No.	Sanction No. and Date	Purpose	Amount in Rs.
	Total		

Certified that out of Rs. ———————— of grants-in-aid sanctioned during the year ———————— in favour of State Health Society ———————— (name of the State) *vide* Ministry of Health and Family Welfare Sanction Order number given above and Rs. ———————— on account of unspent grant of the previous year *i.e.* ———————— and Rs. ———————— **as State contribution OR other contribution received during the year (to be specified),** a total sum of Rs. ——— has been utilized for the programme/programmes mentioned below during the year ————————:

1.

2.

3. and so on

and that the balance of Rs. ———————— remaining unutilized at the end of the year will be carried forward to the next financial year ————————.

Further certified that I have satisfied myself that the conditions on which the grants-in-aid were sanctioned have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

Kinds of checks exercised: Examining of:

1. Vouchers,
2. Cash Book,
3. Ledgers,
4. Monthly & quarterly statements of expenditure,
5. Fund position report,
6. Audit Report.

Signature ————————
(Auditor's name and stamp)

Signature ————————
Mission Director

CHAPTER IV

OBSERVATIONS/RECOMMENDATIONS IN RESPECT OF WHICH REPLIES OF GOVERNMENT HAVE NOT BEEN ACCEPTED BY THE COMMITTEE AND WHICH REQUIRES REITERATION

Observation/Recommendation

The Committee note that every village with a population of upto 1500 was to receive an annual untied grant of upto 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 balances by the SHS and its utilization must also be reflected in the audited accounts.

[Recommendation No. 7, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

At the initial phase of NRHM, emphasis was laid on the constitution of the VHSCs at every village as per the NRHM Framework for Implementation. The functioning of the VHSCs has been reviewed in-depth by the Ministry and in order to streamline the monitoring system for release and utilization of funds by the VHSCs in the States, draft guidelines on the utilization and maintenance of funds given for VHSCs have been issued to all the States in December as per **Annexure III.** As a further step in this direction, a Model Accounting Handbook for Village Health and Sanitation Committees has also been issued to the States for proper utilization of funds for specified activities of the VHSCs, proper accounting and reporting of funds including interest earned by the VHSCs. The guidelines for constitution of the VHSCs and the formats of account books and the Utilization Certificates have also been incorporated in the Handbook.

Funds are released to the States under the Mission Flexible Pool in a consolidated manner and not against specific activities such as VHSCs, etc. the States have the flexibility to further release the funds to the Districts including the block and the

village level units depending upon the actual availability of funds. The funds at the district and the sub-district levels including VHSCs are, therefore, utilized depending upon priorities and the availability of funds. Nevertheless, the emphasis under NRHM is to ensure that untied funds are released to VHSCs in time annually. Therefore, only the expenditure is reported from the sub-district levels to the district and State level.

The release of funds to the States is made only after the receipt of UCs for the previous years and after adjustment of the unspent balances available with the States. The guidelines for utilization of funds are also specifically communicated along with approvals accorded to the States Programme Implementation Plans. The interest earned and utilized is reflected in the audited accounts of the State and District Health Societies received by way of Statutory Audit Reports of the State Health Societies every year.

Sd/-
(P.K. Pradhan)

Special Secretary & Mission Director (NRHM)

ANNEXURE

GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NRHM FINANCE DIVISION

Instructions for Utilisation and maintenance of funds given for VHSC

The NRHM seek to empower the Panchyati Raj Institutions (PRIs) at each level *i.e.* Gram Panchayat, Panchayat Samiti (Block) and Zila Parishad (district) to take the lead in controlling and managing the public infrastructure at district and sub-district levels. Accordingly, a Village Health and Sanitation Committee (VHSC) has to be formed (if not already there) in each village within the overall framework of the Gram Sabha in which proportionate representation of all the hamlets is to be ensured. Adequate representation to the disadvantaged categories such as women, SCs/STs/OBCs/ Minority. Communities is also be given in the VHSCs.

2. In order to assist VHSCs work towards their objectives, an untied fund of Rs. 10,000/- has been approved under NRHM to be given to each VHSC every year. These funds are to be maintained in a separate bank account under the joint signatures of the Sarpanch of the village and the ANM. There are more than 5,00,000 VHSCs in all the States/UTs and thus, the total funds involved are approximately Rs. 500 crore in a year.

3. Instances of differing treatment of these funds have arisen as under:—

(a) Some states booking the amount of releases to VHSCs as expenditure as and when the funds are given.

(b) These funds also remain unspent at VHSC level for varied reasons such lack of information about the manner of utilisation or absence of proper co-ordination between the sarpanch and the ANM of the village who are the joint signatories for operating the bank account.

(c) This leads to substantial unspent balances, and some States have retained untied funds at State level as there is a considerable unspent balance below.

Manner of treatment of untied funds given to VHSCs:

(a) It has therefore been decided that the actual expenditure incurred out of these funds shall be booked as expenditure and the balance outstanding shall be monitored on a regular basis by the block/district authorities.

(b) States must possess information on the balance funds maintained in VHSC relaled bank accounts and educate villages and ANMs and Gram Pradhans on their use.

(c) Utilization Certificates in a simplified format (as attached) should be furnished by ANM and gram-pradhan annually.

(d) States are encouraged to consider calling for quartely reports and undertaking IEC efforts to generate greater awareness about their utility.

4. For the proper understanding on the uses of these untied funds, following heads of indicative expenditure are suggested based on feedback from States:—

(i) To carry out cleanliness drives for health related activities, health awareness activities in schools and aganwadis and household/health survey of families at village level.

(ii) Printing and publicity of information for village health and sanitation activities, preparation of banners etc.

(iii) For the treatment of very poor women or any orphaned child in unusual circumstances.

(iv) To arrange transportation upto the hospitals of any child of below six months of age.

(v) To arrange transportation for carrying any patient in an emergent situation such as Road Accidents, Snake bite, electric shock, burn, or any other such incident-falling into a well, falling from a tree etc.

(vi) To arrange medicines, ORS and any other important items in case of any natural calamities (Flood, drought, and earthquake) and also to hold any health camps etc.

(vii) To announce a prize for any courageous act performed by any ASHA-Sahyogini, ANM, Aganwadi Worker, any member of Women Group, local self-help group worker etc. Who goes beyond the call of duty during the year.

(viii) To construct platforms for hand pumps, facilitating removal of water for plantations in the village.

(ix) To arrange for providing help for prevention mosquito breeding.

(x) Making arrangements for removal of dirty water, maintenance of cleanliness etc. To introduce sanitation related measures and spread information on simple but effective hygiene measures such as handwashing.

(xi) To arrange for tea etc. for the monthly meetings.

(xii) To buy stationery etc. for the maintenance of records.

(xiii) to prepare an annual budget for get approval.

The above list is illustrative and not exhaustive any other items can be added as per the need of the village. It can also be decided by the State that any amount (say Rs. 2,000/-) can spent independently by the ANM without the signature of sarpanch for the activities which have been approved for the year.

At the end of each month, each VHSC shall prepare and send a Statement of Expenditure incurred during the month to their block. The block in turn will consolidate its quarterly and submit to the district for onward submission to the Government of India. An example of the formal of such statement is enclosed.

The State Mission Directors are encouraged to review the utilization of funds by VHSCs. In case where utilization is poor and substantial balances already exist or the village population needs do not require these funds as their capacity to spend is exhausted, those VHSCs may be considered for one year freeze and not included in the PIP for that year. This should be clearly communicated to GOI and a review should be held in the following year to determine their utilization capacity and requirements again.

Sd/-

(R. K. Parmar)
Under Secretary to Government of India

Dated: 30th December, 2010

ANNEXURE

Format of UC Reporting for VHSC

Form No. GFR-19A

Name of village: Name of PHC:

Month & Year:

Utilization Certificate for the Year:..... Dated:

Sanction Letter No. and Date	Purpose	Amount
(Please give here details of Sanction Letters)	(As per details in SOE annexed)	(Amount of Sanctions)
1.		
2.		
3.		

Certified that out of Rs..... of grants-in-aids sanctioned during the Financial Year ..... in favour of the ..... VHC under Block ..... by the District Health Society..... *vide* letter nos. (given above) and Rs. ..... on account of unspent balance of the previous year(s), a sum of Rs. ..... has been utilized for the purpose for which it was sanctioned and that the balance of Rs. ..... remained as unutilized at the end of the year will be adjusted towards the grants-in-aids payable during the next financial year.

Further certified that I have satisfied myself that the conditions, on which the grants-in-aids was sanctioned, have been duly fulfilled and that I have exercised the following checks to see that the money was actually utilized for the purpose for which it was sanctioned.

Signature of the ANM Signature of the Gram Pradhan

Village and Health Sanitation Committee
Expenditure Statement

Name of village:

Month & Year:

Date of receipt of untied fund of Rs. 10,000/-

Amount available at the end of last month: .....

Sl.No.	Date	Amount of Expenditure (Rs.)	Details of Expenditure

Closing Balance of previous month	Rs. .....
Expenditure during the month	Rs. .....
Closing month at the end of current month	Rs. .....

Dated.....

Signature of the ANM

SCHEDULE

STATE HEALTH SOCIETY

Schedule of Interest Earned at State and Districts during the year ending 31.3.2009.

Sl.No.	Bank	Used for	Bank Balance as on 31st March, 2009 (as per Books)
	State Level:		
A	Bank-1	RCH/NRHM	
B	Bank-2	TB	
C	Bank-3	Blindness	
D	Bank-4	IDSP	
E	Bank-5	Leprosy	
F	Bank-6		
	District Level:		
G	Bank-1	as per List A	as per List A
	Grand Total		**Figure C**

State Finance Officer Mission Director

List A

Sl.No.	Name of the Districts	Bank Balance as on 31st March, 2009, (as per Books)
1.	A	
2.	B	
3.	C	
4.	D	
5.	E	
6.	F	
7.	G	
	Grant Total	

STATUS OF ADVANCES IN (NAME OF STATE)

		Rog. Kalyan Samitis						Village Health and Sanitation Committee						Grand Total					
Sl. No.	Name of the District	Open. Bal. 1st April, 2009	Release 2009-10	Refund 2009-10	Total funds available	Expr. upto 31st Mar. 2010	Closing Balance 2009-10	Open. Bal. 1st April, 2009	Release 2009-10	Refund 2009-10	Total funds available	Expr. upto 31st Mar. 2010	Closing Balance 2009-10	Open. Bal. 1st April, 2009	Release 2009-10	Refund 2009-10	Total funds available	Expr. upto 31st Mar. 2010	Closing Balance 2009-2010
1.																			
2.																			
3.																			
4.																			
5.																			
6.																			
7.																			
8.																			
9.																			
10.																			
	Total																		

Observation/Recommendation

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, polluting 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.

[Recommendation No. 12, Part-II of 32nd PAC Report, 15th Lok Sabha]

Action Taken (Department of Health and Family Welfare)

Health being a State subject, day-to-day functioning of health centres is handled by respective State Governments. For improvement in the hygienic conditions of the health facilities, the States specific proposals of outsourcing the sanitation services in health facilities have been supported under NRHM. Assistance is also provided to States for installing bio-medical waste disposal. The funds provided to the health facilities like untied funds, Rogi Kalyan Samiti Grants and annual maintenance grants can also be used to improve the conditions of hygiene and infrastrucutre in the health facilities. Regarding the recommendation for maintaining data of condition of hygiene in the health centres Centrally, it may not be feasible to maintain such data centrally. The matter will be placed before the Empowered Programme Committee (EPC) of NRHM in its next meeting for suggesting approriate steps to maintain requisite infrastructure facilities and standard hygiene levels.

Sd/-
(P.K. Pradhan)

Special Secretary & Mission Director (NRHM)

Audit Vetted Comments

When the Empowered Programme Committee (EPC) is proposed to be held? Ministry may mention the outcome of meeting of EPC regarding maintenance of the requisite infrastructure facilities and standard hygiene levels.

Further Reply by Department of Health and Family Welfare

In pursuance of the observations of PAC, the States were asked to issue necessary instructions to all concerned to comply with the guidelines of Government of India in this regard. A copy of the D.O. letter dated 28th January, 2012 issued to States is enclosed as **Annexure IX.** The matter was also placed before Empowered Programme Committee in its meeting held on 08.02.2012. The EPC directed that the matter be pursued with the States from time to time.

Sd/-
(Anuradha Gupta)

Additional Secretary & Mission Director (NRHM)

ANNEXURE

AMIT MOHAN PRASAD
Joint Secretary

Tele : 23061195
Telefax : 23061842
e-mail : am.prasad@nic.in

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली–110001

Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi-100 001

D.O. No. V-11011/6/2011-NRHM-II
Dated the 28th January, 2012

Dear Sir,

Reference is invited to the 32nd report of Public Accounts Committee wherein the committee in its Para 12 mentioned that SC's, PHC's and CHC's are located in sub-standard environment and functioning in unhygienic conditions which may drive away patients to private health facilities thereby defeating the very purpose of setting up these centres. The report also urges the State Governments to take immediate corrective steps to maintain requisite infrastructure facilities and standard hygiene levels in all the public health centres. A copy of the relevant extract is enclosed for reference.

The Ministry of Health and Family Welfare has already circulated the guidelines for maintenance of infrastructure and hygiene standards from time to time and Indian Public Health Standards (IPHS) has also prescribed norms for quality of care which helps to monitor and improve functioning of Health facilities, *viz,* Sub Centres, Primary Health Centres, Community Health Centres and District Hospitals. The Ministry has also developed a National Policy to address issues relating to infection control and waste management. It has defined a framework for implementation of an Infection Management and Environment Plan (IMEP) in healthcare facilities.

Under NRHM guidelines have been issued to States/UTs for maintenance of Infrastructure, upkeep of public health facilities, and standards of hygiene from time to time. In the light of the PAC report, there is a need to reiterate and re-emphasize the prescribed guidelines so that they are followed by all public health institutions in your State.

You are requested to issue necessary instructions to all concerned to comply with the guidelines and strictly ensure infrastructure maintenance, hygiene and safety standards in all public health institutions so as to ensure quality healthcare and public health standards at all levels.

With regards,

Yours sincerely,

Sd/-
(Amit Mohan Prasad)

Sh. D.P. Wahlang (IAS)
Commissioner-cum-Secretary (Health)
Department of Health and Family Welfare
R. No. 315, Additional Secretariat Building,
Shillong-793 001, Meghalaya.

Audit Related Comments

Ministry may inform PAC about the monitoring mechanism devised by it to ensure the compliance of instruction issued to States on 28.02.2012.

Further Reply by Department of Health and Family Welfare

Ministry has put in place monitoring mechanisms including Surveys, field visits by Common Review Mission, Integrated Monitoring Visits etc. to monitor the progress under the Mission including development of infrastructure facilities and maintaining hygiene and infection control. In pursuance of the recommendation by PAC, the Ministry gave specific emphasis to this aspect in the Terms of Reference (ToR) for 6th Common Review Mission which was held during 2nd—9th November, 2012.

Sd/-
(Anuradha Gupta)

Additional Secretary & Mission Director (NRHM).

CHAPTER V

OBSERVATIONS/RECOMMENDATIONS IN RESPECT OF WHICH THE GOVERNMENT HAVE FURNISHED INTERIM REPLIES

-NIL-

NEW DELHI;
19 *March,* 2013
28 *Phalguna,* 1935 *(Saka)*

DR. MURLI MANOHAR JOSHI
Chairman,
Public Accounts Committee.

APPENDIX I

MINUTES OF THE TWENTY-SEVENTH SITTING OF THE PUBLIC ACCOUNTS COMMITTEE (2012-13) HELD ON 19TH MARCH, 2013

The Committee sat onTuesday, the 19th March, 2013 from 1500 hrs. to 1615 hrs. in Room No. '62', Parliament House, New Delhi.

PRESENT

Dr. Murli Manohar Joshi — *Chairman*

MEMBERS

Lok Sabha

2. Shri Anandrao Vithoba Adsul
3. Shri Sandeep Dikshit
4. Shri Bhartruhari Mahtab
5. Shri Shripad Yesso Naik
6. Shri Abhijit Mukherjee
7. Shri Ashok Tanwar
8. Dr. Girija Vyas

Rajya Sabha

9. Shri Prasanta Chatterjee
10. Shri Prakash Javadekar
11. Shri J.D. Seelam
12. Shri N.K. Singh

SECRETARIAT

1.	Shri Devender Singh	—	*Joint Secretary*
2.	Shri Abhijit Kumar	—	*Director*
3.	Shri M.L.K. Raja	—	*Deputy Secretary*
4.	Shri D.R. Mohanty	—	*Deputy Secretary*
5.	Smt. A. Jyothirmayi	—	*Deputy Secretary*
6.	Shri S.L. Singh	—	*Under Secretary*
7.	Smt. Anju Kukreja	—	*Under Secretary*

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

1.	Ms. Shubha Kumar	—	Director General (Report Central)
2.	Shri Venkatesh Mohan	—	Director General of Audit
3.	Ms. Anim Cherian	—	Principal Director (ST)
4.	Shri Rajiv Kumar Pandey	—	Principal Director of Audit

2. At the outset, the Chairman welcomed the Members and the representatives of the Office of the C&AG of India to the sitting of the Committee.The Chairman, then, apprised that the meeting had been convened to consider the following Draft Reports of the Committee:

(i) *** *** ***

(ii) Action Taken by the Government on the Observations/Recommendations of the Committee contained in their Thirty-second Report (15th Lok Sabha) on 'National Rural Health Mission (NRHM)';

(iii) *** *** ***

(iv) *** *** ***

(v) *** *** ***

(vi) *** *** ***

(vii) *** *** ***

(viii) *** *** ***

(ix) *** *** ***

(x) *** *** ***

3. Giving an overview of the issues contained in the Draft Reports and the comments of the Committee thereupon, the Chairman solicited the views/suggestions of the Members.

4. After some discussions, the Committee adopted the above-mentioned Draft Reports. The Committee, then, authorized the Chairman to finalise the Reports in the light of the factual verifications, if any, made by the Audit and present them to Parliament on a convenient date.

5. The Chairman thanked the Members for their active participation in the consideration and adoption of the Reports.

The Committee, then, adjourned.

***Matter not related to this Report.

APPENDIX II

(*Vide* Para 5 of Introduction)

ANALYSIS OF THE ACTION TAKEN BY THE GOVERNMENT ON THE OBSERVATIONS/RECOMMENDATIONS OF THE PUBLIC ACCOUNTS COMMITTEE CONTAINED IN THEIR THIRTY-SECOND REPORT (FIFTEENTH LOK SABHA)

(i)	Total No. of Observations/Recommendations	32
(ii)	Observations/Recommendations of the Committee which have been accepted by the Government Para Nos. 1-4, 6, 8-9, 11 and 13-32	Total: 28 Percentage—87.5%
(iii)	Observations / Recommendations which the Committee do not desire to pursue in view of the replies received from the Government: Para Nos. 5 and 10	Total: 02 Percentage—6.25%
(iv)	Observations / Recommendations in respect of which replies of the Government have not been accepted by the Committee and which require reiteration: Para Nos. 7 and 12	Total: 02 Percentage—6.25%
(v)	Observations / Recommendations in respect of which Government have furnished interim replies: -NIL-	Total: 0 Percentage—0%

GMGIPMRND—18LS—13-07-2013.