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FIFTEENTH KERALA LEGISLATIVE ASSEMBLY

COMMITTEE ON PUBLIC ACCOUNTS (2021-2023)

SIXTH REPORT

(Presented on 16th March, 2022)

SECRETARIAT OF THE KERALA LEGISLATURE
THIRUVANANTHAPURAM
2022

FIFTEENTH KERALA LEGISLATIVE ASSEMBLY

COMMITTEE
ON
PUBLIC ACCOUNTS
(2021-2023)

SIXTH REPORT

On

Paragraphs relating to Health and Family Welfare Department contained in the Report of the Comptroller and Auditor General of India for the year ended 31st March, 2017 (General and Social Sector)

291/2022.

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INTRODUCTION

I, the Chairman, Committee on Public Accounts, having been authorised by the Committee to present this Report, on their behalf present the Sixth Report on paragraphs relating to Health and Family Welfare Department contained in the Report of the Comptroller and Auditor General of India for the year ended 31st March, 2017 (General and Social Sector).

The Report of the Comptroller and Auditor General of India for the year ended 31st March, 2017 (General and Social Sector) was laid on the Table of the House on 18th June, 2018.

The Committee considered and finalised this Report at the meeting held on 11th March 2022.

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

SUNNY JOSEPH,
Chairman,
Committee on Public Accounts.

Thiruvananthapuram,
16th March, 2022.

REPORT

HEALTH AND FAMILY WELFARE DEPARTMENT

National Health Mission Reproductive and Child Health (RCH) and Immunisation

[Audit paragraphs 2.1 to 2.6 contained in the Report of the C & AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.1 Introduction

Government of India launched (April 2005) the National Rural Health Mission (NRHM), renamed (2013) as National Health Mission (NHM) to provide equitable, affordable and quality healthcare services in rural areas through strengthening of health systems, institutions and capabilities. It was envisaged that the NHM would facilitate universal access to quality healthcare services through partnership between the Centre, State, Local Self - Governments and community in the management of primary health programmes and infrastructure. There were 18 General Hospitals, 99 hospitals at District/Taluk level[1], 22 Speciality hospitals, 14 District Tuberculosis Centres (DTBCs), 232 Community Health Centres (CHCs), 848 Primary Health Centres (PHCs), 5,408 Sub-Centres and 47 other health facilities functioning in Kerala as on 31 March 2017.

The Reproductive and Child Health (RCH) programme under NHM provided for healthcare to women and children with a view to reducing maternal and infant mortality and total fertility rates as well as social and geographical disparities in access to and utilisation of quality reproductive and child health services. The immunisation programme in India has undergone significant changes in recent years, which included a new policy environment through the NHM, new vaccines and new procedures/technologies for vaccine delivery.

2.2 Organisational Setup

At State level, the Mission functioned under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister. The Mission carried out its activities through the State Health Society headed by the Principal Secretary,

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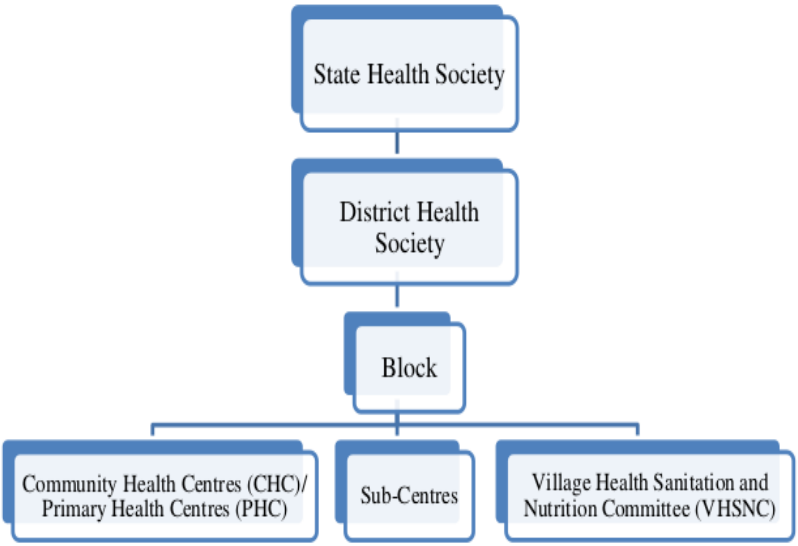
1 18 District Hospitals, 41 Taluk Headquarters Hospitals and 40 Taluk Hospitals.

Health and Family Welfare Department. At the District level, the District Health Mission was headed by the head of the Local Self- Government viz., President, Chairperson/Mayor as decided by the State Government depending upon whether the district was predominantly rural or urban. The District Collectors headed the respective District Health Societies in each district.

A chart showing the Programme implementation structure of NHM in the State is shown below:

Chart 2.1: Programme implementation structure of NHM



2.3 Audit scope and methodology

The Performance audit covering the period 2012-17 was conducted between May 2017 and September 2017 by test-check of relevant records in the Government Secretariat, State Health Society, Directorate of Health Services (DHS), four District Health and Welfare Societies in Alappuzha, Thrissur, Malappuram and Wayanad districts and 65 health institutions[2] in the selected districts. Besides, Audit also covered 32 Sub-Centres. The districts were selected using Simple Random Sampling without Replacement (SRSWOR) technique.

2 32 PHCs, 16 CHCs, 8 Taluk/Taluk Headquarters Hospitals, 4 District Hospitals, 4 General Hospitals and 1 Women and Child Hospital.

The Audit Report of the Comptroller and Auditor General of India (Civil) for the year ended March 2009 discussed the implementation of NRHM in the State. The Public Accounts Committee (PAC) in its 56th report made recommendations on the report and Audit also examined the follow–up action of the Department on the recommendations of the PAC.

Audit methodology included scrutiny of records and gathering of evidence by issue of audit enquiries and conduct of joint inspections along with Departmental officials. The Performance Audit commenced with an Entry Conference with the Additional Chief Secretary, Health and Family Welfare Department, Government of Kerala on 11 May 2017 wherein the audit objectives, scope and methodology of audit were discussed in detail. An Exit Conference was held with the Additional Chief Secretary to Government on 21 November 2017 wherein the audit findings were discussed and responses of Government obtained.

2.4 Audit Objectives

The Performance Audit was conducted to assess whether:

- The interventions of National Health Mission (NHM) in the areas of Maternal health, Child health, Family planning and Immunisation were effective in improving health standards of women and children in the State and were targeted to achieve UN Sustainable Development Goal of 'Good Health and Well-being' as adopted by the Government of India;
- The physical and human resources were adequate and procurement of equipment and drugs were efficient and economical in providing improved health care service; and
- The overall financial management including release and utilisation of funds earmarked under various schemes was efficient and effective.

2.5 Audit criteria

Audit findings were benchmarked against the criteria derived from the following documents:

- NRHM Framework for Implementation, 2005-2012 and 2012-2017;
- Operational Guidelines for Financial Management;

- Indian Public Health Standards, 2012 for Sub-Centres, Primary Health Centres, Community Health Centres, Sub-Divisional Hospitals and District Hospitals;
- Operational Guidelines for Quality Assurance in Public Health Facilities, 2013;
- Audited Annual Financial Statements of State Health Society;
- Guidelines of various GoI schemes under NHM;
- World Health Organisation (WHO) standards; and
- State/Central Public Works Department Manuals.

Audit Findings

2.6 Attainment of demographic goals

Improving maternal and child health and their survival are central to the achievement of national health goals. NHM aimed to reduce Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR). In this process, NHM was expected to help achieve related goals set under the UN Sustainable Development Goals by 2030. The performance of the State was impressive and exceeded the targets set under the UN Sustainable Development Goals as indicated in Table below.

Status of target and achievement of IMR, MMR and TFR

Performance indicators	NHM framework for implementation (2012-2017)		UN Sustainable Development Goals (2030)	
	Target	Achievement as on 31-3-2017	Target	Achievement as on 31-3-2017
1	2	3	4	5
IMR (Infant Mortality Rate)	25 per 1000 live births	6	12 per 1000 live births	6

1	2	3	4	5
MMR (Maternal Mortality Rate)	100 per 100000 live births	29	70 per 100000 live births	29
TFR (Total Fertility Rate)	Reduce to 2.1	1.6 [3]	No target	

(Source: Directorate of Health Services)

Notes received from the Government based on the above audit paragraph is included as Appendix - II.

Excerpts from the discussion of Committee with department officials is given below:

1. Considering the paragraph based on, 'Attainment of demographic goals', the Committee remarked that the State had already exceeded the targets set under the UN sustainable development goals. The Principal Secretary, Health & Family Welfare Department informed that the State had surpassed the goals for 2030 for Infant Mortality Rate, Maternal Mortality rate and Total Fertility Rate set under UN sustainable Development Goals by 2017 itself.

Conclusion/Recommendation

No remarks.

[Audit paragraph 2.7 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.7 Non-allotment of State share of funds

The State NHM received funds directly from the Ministry of Health and Family Welfare, Government of India (GoI) upto the year 2013-14. From the year 2014-15 onwards, GoI released funds to Government of Kerala (GoK), which, in turn released the same to State Health Society through the DHS. The funding pattern from 2012-13 to 2014-15 between GoI and State was in the ratio 75:25 which shifted to 60:40 from 2015-16.

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3 Data as per National Family Health Survey-04/2015-16.

Year-wise details of receipt of funds and expenditure of SHM, Kerala during 2012-2017 were as shown in Table below:

Grants received and expended under NHM during 2012-2017 (in crore)

Period	Opening Balance	Central Grant received	State share released	Interest earned during the year	Total fund available	Total fund expended by NHM	Closing Balance
1	2	3	4	5	6= 2+3+4+5	7	8=6-7
2012-13	46.56	490.55	30.00	5.14	572.25	626.98	-54.73
2013-14	-54.73	360.98	76.94	5.08	388.27	632.30	-244.03
2014-15	-244.03	521.99	112.24	5.89	396.09	628.71	-232.62
2015-16	-232.62	315.35	70.00	4.62	157.35	682.64	-525.29
2016-17	-525.29	455.25	302.80	1.15	233.91	744.78	-510.87
TOTAL		2144.12	591.98	21.88	1747.87	3315.41	

(Source: GoI correspondence and data obtained from NHM/Directorate of Health Services)

The NHM Framework for Implementation, 2005-2012 (Guidelines), while referring to the finances of the Mission specifically stated that the aim of NHM was to increase the share of Central and State Governments on health care. The Guidelines stipulated that it must be ensured that the State expenditure on health increased in real terms and there was no substitution of the State expenditure by Central expenditure.

Audit observed that as per letter forwarded (April 2017) from GOI to NHM, against the release of ₹ 2144.12 crore by GoI during 2012-17, GoK should have contributed ₹ 915.20 crore. However, the actual release was only ₹ 591.98 crore resulting in a short release of ₹ 323.22 crore. It was noticed that even though

GoK contribution was less to the extent of ₹ 323.22 crore during 2012-2017, GoK reported its contribution to GoI as ₹ 901.74 crore. Audit scrutinised the accounts of GOK/NHM for the period 2012-17, which revealed that GoK released from the State Plan fund, ₹249.01 crore in 2012-13 and ₹ 60.73 crore in 2014-15 to NHM, for execution of various plan schemes. Thus, ₹ 309.74 crore, which was released from the State Plan Fund was intimated to GoI as State share of contribution to NHM. The booking of State plan funds as State share of funds under various heads of account, which were not related to NHM activities, was contrary to the guidelines, which required the State expenditure on health to increase in real terms. The statement of the Government during the Exit Conference (November 2017) that the matter was discussed with GoI and settled was not accepted by Audit in the absence of records to substantiate the claim.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

Excerpts from the discussion of Committee with department officials is given below

2. To a query of the Committee about non-allotment of state share of funds, the witness Principal Secretary, Health & Family Welfare Department informed that as per the Government order, certain plan funds released by State Government were treated as State share till 2012-13, but later from 2013-14 as per the instructions from Government of India, plan funds were not treated as State share and State share is to be released separately to check how much of the State share is increasing every year. He added that from the financial year 2013-14, State Government is releasing corresponding State share in line with share of Government of India.

3. The Accountant General reiterated his view that the State achieved the ratio 60:40 by booking State plan funds as State share of funds under various heads of account and insisted that the State share from plan fund expended for NHM is against guidelines and the plan fund in various heads of accounts allocated for other purposes is seen utilised for NHM.

4. The Committee asked whether the plan allocation is still shown as State share. The witness, Principal Secretary, Health & Family Welfare Department informed that now a days the earmarked amount is shown in the budget as State share. He added that in order to increase the central share in NHM, maximum amount is being expended which is higher than the budgeted amount for NHM and the additional fund is being compensated from State plan fund and then the additional amount expended over the budgeted State amount is fully recouped from GoI. In order to leverage maximum resources from Government of India, this matter was discussed with Planning Board and Finance Department. He informed that even though treating of plan funds as State share was contrary to guidelines, central ministry had accepted the same till 2012-13 .

5. The Committee then enquired the reasons for decrease in the amount of Central Share during 2013-14 & 2015-16. The witness Principal Secretary, Health & Family Welfare Department apprised that the ratio of Central and State share changed from 75:25 to 60:40 from 2015-16. He again informed that the Central share is released only after the State share is released. He further added that the next instalment of Central share is allowed only after spending 60% of the first instalment and it depends on the expenditure capability in that particular year and the amount that has been released by the State Government. He added that the department always tries its best to increase the implementation efficiency by investing more amount and achieving the best result and implementation is monitored regularly.

Conclusion/Recommendation

No remarks.

[Audit paragraph 2.8 & 2.8.1 contained in the Report of C & AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.8 Health care for Women

The maternal health care package with its focus on the health of women during pregnancy, childbirth and post-partum period was a vital component of NHM due to its profound effects on the health of women, immediate survival of the newborn and long-term well-being of children. Key strategies to improve

maternal health included improved access to skilled obstetric care through facility development, increased coverage and quality of antenatal and postnatal care, increased access to skilled birth attendance, institutional delivery, etc. The important services for ensuring maternal health care included antenatal care, delivery care and postnatal care. As per Indian Public Health Standards (IPHS) 2012, health institutions of the status of PHCs and above shall be equipped with the Minimum Assured Services of Ante Natal Care (ANC), Intra Natal Care (INC) and Post Natal Care (PNC). Audit examined whether there were adequate institutions for providing services to pregnant women and whether these institutions were equipped in terms of skilled manpower and equipment for providing delivery services to expectant mothers. Deficiencies noticed are discussed in the succeeding paragraphs.

2.8.1 Ante Natal Care (ANC)

Government of India, recognising that reproductive, maternal and child health cannot be addressed in isolation and that the health of adolescent girls and pregnant women impacted on the health of the newborn and the child, adopted (January 2013) a strategy of expanding the scope of Reproductive and Child Health (RCH) to Reproductive, Maternal, Newborn, Child plus Adolescent Health (RMNCH+A). The guidelines provided for interventions to be made at various stages of life cycle, which should be mutually linked.

The RMNCH+A guidelines identified delivery of antenatal care package and tracking of high-risk pregnancies as a priority intervention to monitor the progress of foetal growth and to ascertain the well-being of the mother. The women who reach the Health Centre for the first time only during labour carry more risk of complications during childbirth. The NRHM Framework for Implementation issued by GoI as well as the IPHS stipulated the first antenatal checkup within the first 12 weeks of pregnancy and three check ups thereafter. The Guidelines also prescribed Iron and Folic Acid (IFA) supplementation of 100 milligram of elemental iron and 500 microgram of folic acid daily for 100 days during pregnancy, followed by same dose for 100 days in post-partum period. The position of ANC registration and services provided in the State during 2012-2017 are as detailed in Table below.

ANC registration and services provided

Year	Total pregnant women registered for ANC	Registered within first trimester (12 weeks)	Received three ANC checkups during pregnancy	Not received three ANC checkups	Pregnant women who received TT1	Pregnant women who received TT2	Pregnant women who received 100 IFA tablets
2012-13	515226	396933	461253	53973	438339	415089	441235
2013-14	518811	412737	486203	32608	452769	435913	511134
2014-15	495640	401565	456179	39461	417985	399293	497822
2015-16	477820	385274	434759	43061	411064	388412	404900
2016-17	488095	403137	440375	47720	415964	388420	326231
TOTAL	2495592	1999646	2278769	216823	2136121	2027127	2181322
Percentage		80.13	91.31		85.60	81.23	87.41

(Source: Health Management Information System (HMIS) data)

Thus, during 2012-17, 80 per cent of 24.95 lakh pregnant women registered for ANC within the first trimester of pregnancy. Further, 2.17 lakh (nine per cent) did not receive three ANC checkups during the pregnancy period. There was also shortfall in the percentage of women who received Tetanus Toxoid (TT) shots. Against 85.60 per cent of women who received first dose of TT, 81.23 per cent received the second dose.

Audit observed that Government was not able to keep track of all pregnant women who were registered for ANC and ensure whether all of them received the stipulated quantum of ANC checkups, TT and IFA tablets at timely intervals. Government stated in the Exit Conference (November 2017) that due to ineffective data capturing, the sizeable share of pregnant women moving to private sector went unrecorded which was devoid of follow-up. Audit observed that unless those registered for ANC were tracked and followed up, the very purpose of registration was defeated.

Audit further noticed that over 12 per cent of 24.95 lakh pregnant women who had registered for ANC during 2012-2017 did not receive 100 IFA tablets. Anaemia is a major cause of maternal mortality. Treatment against anaemia required[5] administration of a daily dose of IFA tablets for a period of 100 days to a pregnant woman. In the selected districts of Malappuram, Wayanad, Alappuzha and Thrissur, 44 out of 65 institutions test-checked reported stock out of IFA tablets during various periods in 2012-2017 . These districts also reported 3,774, 1,215, 363 and 1,104 instances respectively of severe anaemic[6] cases during 2012-2017. In the 65 test-checked institutions, it was seen that 45678 out of 231587 pregnant women (19.72 per cent) who were registered for ANCs were not given the stipulated 100 IFA tablets. Besides, 1,931 pregnant women in the test-checked institutions were detected with severe anaemia.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

Excerpts from the discussion of Committee with department officials is given below:

6. To a query about Ante Natal Care, the witness Principal Secretary, Health & Family Welfare Department replied that the Ante Natal Care program is being done effectively. As per District household data, out of 5,00,000 pregnancy cases, only 2.8 lakh cases had reached Government hospitals and the rest of the cases are gone to private hospitals. Approximately 1.3-1.5 lakh deliveries are taken place in Government hospitals which accounts to 30% of total cases. Even though more than 70% of expectant mothers approach private sector for delivery services, all efforts are being taken to register all the pregnant woman in the MCTS during the first trimester of pregnancy itself.

7. The Committee directed the department to take necessary steps to provide better delivery services in Government hospitals so that in comparison with private institutions total percentage of delivery cases attended in Government hospitals would increase.

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5 Paragraph 4.1 (Supplementation Interventions by Ministry of Health and Family Welfare) of Guidelines for Control of Iron Deficiency Anaemia specified a requirement of 100mg of elemental iron and 500 mcg of folic acid daily for 100 days for pregnant women.

6 Severe anaemic cases –Cases where the haemoglobin level is below seven.

8. The Principal Secretary, Health & Family Welfare Department said that the department has taken many steps to increase the number of delivery cases in Government hospitals. He added that all ANC services are provided through ante-natal clinics including registration of ante natal women, ante natal check up, distribution of Iron and Folic Acid tablets and T.T. injection. He further added that Folic acid tablets are distributed among pregnant women to reduce anaemia and distribution of Iron and Folic acid has helped to reduce the infant mortality rate. He pointed out that in order to strengthen the ante natal care programme, immunisation programmes are also conducted.

9. Regarding the reason for non supply of IFA tablets, the witness, the Principal Secretary, Health & Family Welfare Department submitted that IFA tablets had been issued from GoI directly till 2008 and at the time of audit observation there was delay in supply of IFA tablets from GoI and later sanction for procuring the tablets had been obtained when the proposal was sent through NHM. NHM started procuring the IFA tablets from 2016-17 when there was shortage in the supply of tablets.

10. The witness, Principal Secretary, Health & Family Welfare Department informed that total number of IFA tablets distributed was 2.625 crore in 2016-17, 5.25 crore in 2017-18 and 7.45 crore in 2018-19. Besides, steps had already been taken as part of the 'Ardram Mission' to provide healthy food to pregnant women and infants. A new project "Anaemia free Kerala" linked with Nutrition Mission which would focus on the health of mother and baby was launched in 2019 to find and focus on the group having stunted growth.

The Committee directed to furnish a detailed report on the steps taken to ensure sufficient supply of IFA tablets.

Conclusions/Recommendations

11. The Committee directs the department to take necessary steps to provide better care and service to expectant mothers in Government hospitals so that in comparison with private institutions total percentage of delivery cases attended in Government hospitals would increase.

12. Committee noticed that 20% of pregnant women were seen anaemic in test checked ANC institutions and pointed out that they were not given IFA tablets after they have shifted voluntarily to private hospitals.

13. The Committee recommends that Government should ensure registration of all pregnant women in an area for Ante Natal Care (ANC) services and to closely monitor whether all of them are getting the required IFA and other services even if they were shifted to private hospitals.

14. The Committee also directs the department to furnish a detailed report on the steps taken to ensure sufficient supply of IFA tablets to pregnant women.

[Audit paragraph 2.8.2 contained in the Report of C & AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.8.2 Testing of pregnant women for HIV and STI infections

The RMNCH+A Guidelines issued by GoI (January 2013) identified parent-to-child transmission of Human Immunodeficiency Virus (HIV) as a major route of new and emerging HIV infections in children and suggested universal confidential HIV screening of pregnant women to be included as an integral component of routine ANC checkup. Diagnostic and laboratory services for management of Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI) were to be provided at all CHCs, First Referral Units and at 24x7 PHCs. Further, special focus was to be given to linking up with Integrated Counselling and Testing Centres (ICTCs) and establishing appropriate referrals for HIV testing and RTI/STI management.

Audit noticed that out of 24.95 lakh pregnant women who registered for ANC checkups during 2012-13 to 2016-17, 36.88 per cent and 55.86 per cent were not tested for HIV and STI respectively during 2012-2017 as shown in Table below.

Status of conduct of HIV/STI tests in pregnant women

Year	Total pregnant women registered for ANC	No. of pregnant women tested for HIV	No. of pregnant women not tested for HIV	Per cent not tested	No. of positive cases in HIV tested cases	No. of pregnant women tested for STI	No. of pregnant women not tested for STI	Per cent not tested
2012-13	515226	260027	255199	49.53	413	182058	333168	64.66
2013-14	518811	303909	214902	41.42	60	214545	304266	58.65
2014-15	495640	318140	177500	35.81	94	223502	272138	54.91
2015-16	477820	329310	148510	31.08	67	223242	254578	53.28
2016-17	488095	363758	124337	25.47	376	258118	229977	47.12
TOTAL	2495592	1575144	920448		1010	1101465	1394127	
percentage				36.88				55.86

(Source: HMIS data)

Data obtained from the four test-checked districts revealed that during 2012-2017, 1.53 lakh cases of suspected RTI/STI were identified during testing. In addition, 69 instances of pregnant mothers afflicted with HIV were also detected during the period in the test-checked districts. The possibility of more such cases escaping detection due to non-testing of pregnant women could not be ruled out.

GoK stated (November 2017) that the reports received on HIV testing of pregnant women were low since the data captured was mainly the reports from Facility Integrated Counselling and Testing Centres (FICTC). GoK also stated that 60 per cent of the population accessed private hospitals for their medical care and that, only 50 per cent of FICTCs established in CHCs and PHCs were functional. The reply was not justifiable since the data on such pregnant women who were registered for ANC and not screened for HIV/RTI/STI was derived from the HMIS, which was a fully functional health information system and included data from multiple information systems in various health programmes.

Recommendation: Government may ensure that pregnant women who register for ANC are tested for HIV/STI and administered with the required doses of IFA tablets/TT vaccine.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

Excerpts from the discussion of Committee with department officials is given below

15. While considering the audit para, the Committee enquired whether all pregnant women who register for ANC are being tested for HIV/STI infections. The witness, Principal Secretary, Health & Family Welfare Department answered that various successful measures had been taken to prevent HIV infection. He added that HIV data are collected only from ICTCs (Integrated Counselling and Testing Centres) and data from PPTCT (Preventation of Parent to Child Transmission) programme are not included which accounted for low figures in HIV testing. As per NACO & RMNCHA guidelines, women who access ante natal services at health facilities should receive a routine offer to test for HIV infection. He further added that for those pregnant women who refuses to undertake HIV testing, counselling is given to understand the merits of HIV testing and injections are given in HIV positive cases to prevent the spread of HIV infection to the infant. He informed that the HIV test is conducted at the first stage of the pregnancy and after delivery the infant is given treatment after checking the blood samples.

16. The Committee enquired whether the HIV test have been done only in Government Hospitals. The witness, Principal Secretary, Health & Family Welfare Department apprised that to scale up the Public Private Partnership for PPTCT services, NACO introduced a project "Svetana" which was rolled out from 1st October 2015 in Kerala for establishment of ICTCs in private hospitals and registering private hospitals for data sharing. He further added that initially the centres were started in 10 districts and they would be covering all districts this year and now there are 120 PPP sites in the state.

17. The Committee directed the department to provide a detailed reply whether all pregnant women who register to ANC are tested for HIV/STI infection and measures taken to ensure that nobody gets missed out of the list.

Conclusion/Recommendation

18. The committee directs the department to take effective measures to ensure that all pregnant women who register for ANC are tested for HIV/STI such that no one gets missed out and to forward a detailed report about the measures taken for such a drive.

[Audit paragraph 2.8.3 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.8.3 Adequacy of health centres and manpower

The NHM, in its Framework for Implementation 2005-2012, stipulated the norms for setting up of Sub-Centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs) on the basis of population. It was envisaged therein that one Sub-Centre was to be set up for a population of 5000 (3000 in hilly and tribal areas), one PHC for 30,000 population (20,000 in hilly and tribal areas) and one CHC for 1,20,000 population (80,000 in hilly and tribal areas).

Audit noticed shortfall in setting up of Sub -Centres, PHCs and CHCs as per population norms (2011 census) in the State and selected districts. Under NHM, the CHCs were conceived as health service providers, capable of addressing 80 per cent of all ailments requiring out-patient services or hospitalisation. Considering their importance in delivery of health care services, the NHM attached great significance to strengthening existing CHCs and setting up new ones to bring them in conformity to the ratio of one per population of 1,20,000. The shortfall in setting up of CHCs was acute in Malappuram (54 per cent) and Thrissur (62 per cent), as shown in Table below.

Shortfall in setting up of Sub-Centres, PHCs and CHCs

State/ District	Availability of								
	Sub-Centres			PHCs			CHCs		
	Required as per norms	Actual	Shortfall (per cent)	Required as per norms	Actual	Shortfall (per cent)	Required as per norms	Actual	Shortfall (per cent)
Kerala	9263	5408	3855 (42)	1293	848	445 (34)	366	232	134 (37)
Wayanad	278	204	74 (27)	32	23	9 (28)	9	9	0 (00)
Mala ppuram	959	589	370 (39)	160	84	76 (48)	48	22	26 (54)
Thrissur	636	472	164 (26)	106	79	27 (25)	63	24	39 (62)
Alappuzha	467	366	101 (22)	78	59	19 (24)	16	16	0 (00)

(Source: Data from DHS and DPMs)

Audit observed that GoK did not set up stipulated number of CHCs and also did not fill up vacancies of doctors and para medical staff to the extent of 48 per cent and 35 per cent, respectively in test-checked institutions. This resulted in patients not receiving envisaged benefits.

The need for filling up the vacancies in the cadre of doctors and para medical staff in CHCs and PHCs, as per IPHS norms, was also emphasised by the Public Accounts Committee (PAC) in its 56th report. Though, in the Action Taken Report, GoK stated (October 2015) that 564 posts were created in PHCs and CHCs, the problem of shortage of doctors and para medical staff in CHCs persisted.

Recommendation 2.2: Government may address the shortfall in health centres also, after the shortfall in availability of doctors, nurses and para medical staff is effectively addressed.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

Excerpts from the discussion of Committee with department officials is given below:

19. Considering the audit reference on short fall in setting up of Sub centres, PHCs and CHCs as per population norms, the Principal Secretary, Health & Family Affairs Department informed that the department taking note of the short fall was trying to create such centres and new posts to resolve the problems.

20. To a query on whether any post creations were done for PHC &CHC recently, the witness Principal Secretary, Health & Family welfare Department replied that post creation was done by DHS and steps have been taken to provide better treatment facilities, services of doctors and other staff in all Government Hospitals and improvement in the basic infrastructure of hospitals.

21. The Committee queried whether any arrangement is being done to relocate the doctors and other staff from PHCs to hospitals where large number of patients come to OP for treatment. The Committee also enquired whether steps had been taken to fill up the vacancies created under Aardram Mission. The witness the Additional Chief Secretary, Health & Family welfare Department informed that around thousand doctors were appointed in most needed hospitals and the procedure is going on and those doctors had been appointed in the hospitals where the services of the doctors are most needed instead of appointing two or more doctors at one place. He added that under Aardram Mission initially 170 PHCs were selected for up-gradation as Family Health Centres in the year 2017-18 and 503 PHCs in 2018-19 and the remaining PHCs were upgraded in 2019-20. He also informed that post creation will be done in the second stage after examining the number of posts needed.

22. The Committee enquired whether the posts created for hospitals which has been converted to Family Health Centres has been filled. The Principal Secretary informed that vacancies are filled considering the OP inflow and the disease burden. The department is trying to understand the needs of each hospital and is trying to provide better service for the public. The Committee pointed out

that even though the working hours of FHCs were extended till evening there are many Family Health Centres in which the service of the doctors were not available. So the Committee decided to recommend that the department should examine in detail about such Family Health Centres where there is scarcity of doctors. The Principal Secretary, Health and Family Welfare Department agreed to do so.

23. The Committee pointed out that though in many hospitals there is scarcity of doctors to attend to large number of patients, in some hospitals there is a surplus number of doctors with few patients to attend to. The Committee directed the Department to conduct a study on patient inflow, O.P./I.P. data in each hospital and availability of medical staff in each of these institutions.

24. The Committee decided to recommend that based on the study of patient inflow, doctors from the hospitals with the less number of patients in O.P./I.P. should be redeployed to hospitals with more patients. Rearrangement of medical staff should not be limited to one particular region or district but should be done throughout the State. While redeploying, special consideration/exemption must be granted in the case of hospitals in coastal areas and hilly areas. The posts of doctors and paramedical staff under Aardram Project are to be filled on need basis.

Conclusions/Recommendations

25. The Committee points out that there are many Family Health Centres in which the service of the doctors was not available. The Committee recommends that the department should examine in detail about Family Health Centres where there is scarcity of doctors and take necessary steps to appoint the doctors in such Family Health Centres.

26. The Committee directs the department to conduct a study on patient inflow, OP/IP data in each hospital and availability of medical staff in each of these institutions. The Committee recommends that the doctors from the hospitals with less number of patients in OP/IP should be redeployed to the hospitals with more patients. The re-deployment of the doctors and medical staff should be done State wide and should not be limited to one particular region or district.

[Audit paragraph 2.8.4 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.8.4 Availability of delivery facility

The Janani Suraksha Yojana (JSY) implemented by GoI since April 2005 as a 100 per cent Centrally Sponsored Scheme (CSS) under the overall umbrella[7] of NHM, targeted to reduce overall maternal and infant mortality ratios, besides aiming to increase institutional deliveries in Below Poverty Line (BPL) families. The strategy involved operationalisation of 24x7 delivery services to provide basic obstetric care at PHC level and First Referral Units (FRU) to provide emergency obstetric care, etc. Similarly, the Janani Shishu Suraksha Karyakram (JSSK) under NHM launched by GoI (June 2011), stressed upon entitlements and elimination of out of pocket expenses for pregnant women and sick neonates, promotion of institutional deliveries and proper care of newborn in all health institutions across the State. Audit noticed that out of the test-checked 65 health institutions in the selected districts of Wayanad, Malappuram, Thrissur and Alappuzha, delivery facility was not available in 50 institutions. These included 32 PHCs and 15 CHCs wherein the post of Gynaecologist was not created. Of the remaining three institutions, delivery service was not provided in General Hospital (GH), Alappuzha since the District already have a Women and Children hospital. Delivery was not conducted in Taluk Hospital (TH), Thuravoor due to lack of infrastructure and manpower. In TH Pudukkad delivery facility was not provided inspite of the availability of Gynaecologists, citing the reason of poor infrastructure. Government (November 2017) replied that specialist posts as per IPHS were not available in CHCs and PHCs. The Additional Chief Secretary, Health and Family Welfare Department also admitted in the Exit Conference (November 2017) that some THs were not having satisfactory facilities.

The IPHS also envisaged PHCs and CHCs to provide delivery services such as Ante Natal Care, Intra Natal Care[8], Post Natal Care, Newborn Care, etc. as part of Maternal and Child Health care. Audit observed that none of the 245 PHCs in the test-checked districts provided delivery services. In fact, even the CHCs were not equipped to handle delivery services in the four test-checked districts with only two[9] out of the 71 CHCs providing delivery services. Out of the 20 TH/Taluk Headquarters Hospitals (THQHs) in the test-checked four districts, delivery facility

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7 The assistance under JSY would form part of the overall release under NHM. The implementation of JSY would be as per the parameters indicated in the JSY guidelines.

8 24-hour delivery services, both normal and assisted.

9 CHC Meenangadi in Wayanad district, CHC Edappal in Malappuram district.

was being provided in 16 hospitals. The district wise details are shown in Table below:

Shortfall in PHC/CHC/THQH/TH providing delivery facility

Name of district	Total no. of PHCs	No. of PHCs where delivery facility is provided	Total no.of CHCs	No. of CHCs where delivery facility is provided	Total no. of TH/ THQHs	No. of TH/THQHs where delivery facility is provided
Alappuzha	59	0	16	0	6	3
Thrissur	79	0	24	0	6	5
Malappuram	84	0	22	1	6	6
Wayanad	23	0	9	1	2	2
Total	245	0	71	2	20	16

(Source: Data received from DHS)

Audit observed that despite GoK sanctioning posts of Gynaecologists in four out of 16 test-checked CHCs, a Gynaecologist was posted only in CHC Meenangadi in Wayanad district. In respect of another hospital viz., CHC Pulpally in Wayanad district, even though the hospital had a six-bedded maternity ward, a well-equipped operation theatre and labour room with adequate facility, there was no Gynaecologist and the hospital generally provided only ANC. However, the hospital provided delivery services in instances where patients were not in a position to be transferred to other hospitals. Significantly, while it is to be appreciated that the CHC, Pulpally provided normal delivery services to 35 pregnant women during 2012-2017 even without the services of a Gynaecologist, Anaesthetist and Paediatrician and without essential facilities like Blood storage unit and Newborn care corner, it needed to be emphasised that both mothers and babies were exposed to avoidable risks.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

Excerpts from the discussion of Committee with department officials is given below:

27. While considering the paragraph on availability of delivery facility, the Committee asked what action was being taken to make the availability of the specialist posts and infrastructure for conducting delivery services in THs/CHCs. The witness Principal Secretary, Health & Family Welfare Department answered that delivery facilities were already available in Taluk Hospitals, District Hospitals, General Hospitals, Women & Children Hospitals and Medical Colleges.

28. The Principal Secretary, Health & Family Welfare Department informed that there were 82 Taluk hospitals in our State and 46 are having delivery facilities. Out of 82 Taluk hospitals, 40 has been upgraded as Taluk head quarters hospitals. The Committee expressed its displeasure over the fact that only 50% hospitals which were upgraded to Taluk hospitals have delivery facilities. The Committee criticised that the department neither provided the basic facilities nor appointed sufficient doctors and medical staff even though the hospitals were upgraded to Taluk hospitals. The Principal Secretary, Health & Family Welfare Department informed the Committee that at present the number of deliveries in Government hospitals has increased by improving the basic facilities and by ensuring the service of doctors. The Deputy Director informed that major Taluk Hospitals has been converted to District General Hospitals. The Principal Secretary, Health and Family Welfare Department added that the department had taken necessary steps with an intention to improve the facilities in Taluk hospitals by providing better delivery facilities in them. Delivery facilities were also available in CHCs like CHC in Meenangadi and CHC in coastal areas.

29. The Committee opined that the department should take necessary steps to start IP and delivery units in all Taluk hospitals and priority should be given to Taluk Head quarters hospitals. The Committee emphasised that more attention should be given to upgrade the hospitals in rural areas to Taluk hospitals in order to avoid the difficulty of the people in rural areas to access and avail the facilities of Taluk Head Quarters Hospitals. The Committee pointed out that lack of sufficient doctors and lack of delivery facilities were the major drawbacks in many of the Taluk Head Quarters Hospitals.

30.The witness, Principal Secretary, Health & Family Welfare Department replied that they had given special attention to hospitals in remote areas. In addition to Janani Suraksha Programme which provide the transportation cost, nutrition cost etc. to patients, priority was given to remote areas.

31. To a query of the Committee, the Principal Secretary, Health and Family Welfare replied that since service of single gynaecologist is not enough and creation of adequate number of specialist's post is required and gynaecologist has not been posted in CHC, Pulpally eventhough maternity ward, operation theater and labour room was available there.

32. The Principal Secretary, Health & Family Welfare Department detailed that even though CHCs had basic infrastructure, people are reluctant to go there for delivery and so it is better to give good delivery facilities in Taluk hospitals. He added that the only effective method to improve the delivery unit in Taluk hospitals is by providing good and sufficient facilities with adequate staff.

33. To a query regarding the policy and priority of the department, the Principal Secretary, Health & Family Welfare Department explained that some maternal/infant deaths had occurred due to the delay in reaching the hospital in time. He added that the efforts had been taken to solve this for setting state of the art medical services to the newborn and mother problem in those places and steps had been taken to implement a programme for providing modern delivery centre in ANC clinics.

34. The Principal Secretary, Health & Family Welfare Department informed that according to Sustainable Development Goal (SDG) to attain infant and maternal mortality target rate by 2030, the doctors are appointed in the hospitals on working arrangement where the service of doctors is not available. The Committee directed the department to take necessary action to provide delivery facilities in CHCs in remote areas.

Conclusions/Recommendations

35. The Committee expresses its displeasure over the fact that only 50% hospitals which were upgraded to Taluk hospitals have delivery facilities. The Committee criticises the department for neither providing the basic facilities nor appointing sufficient doctors and medical staff even though the hospitals were upgraded to Taluk hospitals. The Committee recommends the department that necessary steps should be taken with an intention to improve the infrastructure facilities and also providing adequate medical personnel and other staff for setting state of the art medical services to the new borns and mothers in Taluk hospitals.

36. The Committee opines that the department should take necessary steps to start IP and delivery units in all Taluk hospitals and priority should be given to Taluk Head Quarters Hospitals. The Committee emphasis that more attention should be given to upgrade the hospitals in rural areas to Taluk hospitals in order to alleviate the difficulty of the people in rural areas to access and avail the facilities of Taluk Head Quarters Hospitals.

37. The Committee directs the department to take necessary action to provide delivery facilities in CHCs in remote areas.

[Audit paragraph 2.8.5 contained in the Report of C&AG of India for the year ended 31st March 2017(General & Social Sector)]

2.8.5 Impact of inadequate manpower and infrastructure on maternal care

The IPHS guidelines recognised that Sub-divisional hospitals (Taluk Hospitals in Kerala) were below the district level and above the block level (CHC) hospitals and acted as First Referral Units (FRU) for the Tehsil/Taluk/Block population in which they were geographically located. These guidelines also recognised that THs had an important role to play as FRUs in providing emergency

obstetric and neonatal care and helped in bringing down MMR and IMR. As per IPHS, TH/THQHs were classified as those with bed strength from 31 to 100. Audit test-checked the availability of Gynaecologists in eight out of 20 THs/THQHs in the selected districts. It was noticed that Gynaecologists were not available in one out of the eight test-checked THs/THQHs. There was shortage of one Gynaecologist in one hospital as detailed in Table below:

Shortage of Gynaecologists

Name of hospital	Bed strength	Sanctioned strength	Men in position	Requirement as per IPHS	Shortage
THQH Kayamkulam	125	2	2	2	Nil
THQH Kodungallur	176	2	2	2	Nil
TH Pudukkad	75	2	2	1	Nil
THQH Ponnani	125	2	2	2	Nil
THQH Tirurangadi	157	3	2	2	Nil
THQH Sulthan Bathery	127	2	1	2	1
THQH Vythiri	129	3	3	2	Nil
TH Thuravoor	24	1	0	1	1

(Source: Details collected from health institutions)

Audit noticed number of deliveries in 10[10] out of 15 hospitals coming down during the last three years due to shortage of Gynaecologists. Due to this the possibility of these hospitals turning away patients cannot be ruled out. In THQH Tirurangadi, Audit noticed that the number of deliveries was steadily declining over the years from 574 during 2012-13 to 284 during 2016-17. Analysis of the confinement register maintained by the Hospital revealed that the number of

10 GH Thrissur, DH Mananthavady, THQH Vythiri, CHC Meenangadi, DH Tirur, THQH Tirurangadi, THQH Kodungallur, W&C Alappuzha, DH Mavelikkara and THQH Kayamkulam 291/2022.

primipara[11] cases attended to by the hospital during 2015-2017 was only seven out of 635 deliveries. The Hospital stated (August 2017) that patients were aware of risk factors like there being no Paediatrician on call and no facility for emergency intervention and therefore requested for reference to higher centres during the course of antenatal checkup. Similarly, in THQH Vythiri, delivery facilities were not made available to the patients from August 2015 to June 2017 due to the transfer of the lone Gynaecologist to another hospital. GoK stated (November 2017) that measures were being taken to fill all the sanctioned posts of Gynaecologists in different hospitals in the State. However, the fact remains that the risk factors been minimised, these ANC patients could have claimed delivery service from PHCs/CHCs and not sought reference to higher centres as stated above. Thus, the objective of NHM to provide health to all in an equitable manner was not achieved.

Audit noticed in District Hospital (DH), Mananthavady that GoK accorded sanction (November 2005) to increase the bed strength from 274 to 500 since the average number of inpatients was between 475 and 500 per day. Similarly, in respect of GH, Kalpetta GoK accorded sanction (November 2005) to increase the bed strength from 43 to 250. However, neither the number of beds was increased nor the infrastructure developed to cater to the demand, citing paucity of funds. Audit observed that the constraints in space and bed strength led to situations like patients sharing beds and even resting on floors as shown in Picture below:

Picture 2.1: Patients sharing beds at DH Mananthavady in Wayanad District (28 June 2017)

11 Primipara cases relate to women who are pregnant for the first time.

Picture 2.2: Delivery patients resting in corridors and floors at GH Manjeri in Malappuram District (24 May 2017)

GoK attached (January 2014) General Hospital (GH) Manjeri, including its staff and equipment to Government Medical (GM) College, Manjeri for the purpose of medical education. GoK also renamed (June 2014) the GH Manjeri as GM College, Manjeri. While the Superintendent, GH was designated as Superintendent (Administration), the Principal, GM College Manjeri was given overall control of the hospital for the purpose of running the Medical College.

Joint physical verification (24 May 2017) of the antenatal and postnatal wards in the GM College, Manjeri, revealed that 88 patients were allowed to be admitted though the sanctioned bed strength was 78. Patients were lying on the floor or sharing beds with other patients. The normal delivery patients along with the newborn were accommodated on the floor in the corridor, as seen in Picture. Two instances of pregnant women giving birth to children in the toilet at ANC ward occurred in 2016 and 2017. The Hospital stated (August 2017) that lack of vacant beds in the labour room forced the patients to be retained in ANC wards. In these circumstances, it is felt that there was need for increasing the bed strength to accommodate the increasing number of patients.

The Superintendent (Administration) of the GM College, Manjeri stated (November 2017) that the existing hospital buildings were converted into Medical College Education Unit for housing the academic blocks and Clinical Academic areas. He also confirmed that a building originally constructed for the Women and Child (W&C) block was converted into an academic block for the GM College, Manjeri. Audit was further informed by the Government in its reply that despite the need for more beds, no proposal seeking increase of bed strength was forwarded by GM College, Manjeri due to lack of space for constructing new buildings.

The reply of the Superintendent (Administration) was not justifiable as GM College, Manjeri despite facing shortage of beds converted the building constructed for accommodating women and children into an academic block. The upgradation of the GH Manjeri into the GM College, Manjeri without enhancing the existing limited facilities adversely impacted on the delivery of services for maternal care.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

Excerpts from the discussion of Committee with department officials is given below:

38. The Committee accepted the notes furnished by the Government on this audit paragraph.

Conclusion/Recommendation

No remarks.

[Audit paragraph 2.8.6 & 2.8.7 contained in the Report of C & AG of India for the year ended 31st March 2017(General & Social Sector)]

2.8.6 Shortage of drugs and consumables in Post-Partum Units

All services relating to Reproductive and Child health programme, immunisation sessions, monthly clinics, etc., are conducted through Post-Partum Unit (PPU). The Guidelines for Control of Iron Deficiency Anaemia issued by the GoI emphasises IFA supplementation among pregnant women and lactating mothers. Stock-out of drugs and consumables was noticed in 47 of the 65 test-checked institutions with period of stock-outs ranging from two to 74 months as detailed in Appendix III. The stipulations contained in the National Health Mission Framework for Implementation 2012-2017 requiring hospitals to provide for appropriate increase in drugs and supplies commensurate with caseloads was not achieved.

2.8.7 Deliveries through Caesarean sections

Government of Kerala recognising that the percentage of Caesarean section (C-section) among the total number of deliveries was on the increase, issued guidelines (May 2011) for reduction of C-sections and promotion of safe vaginal delivery. GoK, while emphasising the WHO recommendation that C-section among the Primipara should be limited to less than 15 per cent, observed that the average proportion of C-sections in Kerala was higher than the national average and that high risk of complications in second C-section warranted reduction of primary C-section to as minimum as possible. Against the national average of 17.20 per cent[12] C-sections, data obtained from the Directorate of Health Services (DHS), Kerala indicated that 40 to 42 per cent of the deliveries in the State during 2012-2017 were C-sections. Audit noticed an increase in percentage of C-section deliveries in 2016-17 over 2012-13, in respect of nine out of 15 institutions test-checked as detailed in Appendix III. Though the remaining six institutions did not show a similar increase in 2016-17, it was observed that the percentage of C-section deliveries was still high and ranged between 20.58 and 49.01 per cent. During the Exit Conference (November 2017), Government accepted that the State average of C-section deliveries was high as compared to the national average and admitted that it was a shameful situation. Government also admitted its failure to bring down the percentage of C-section inspite of concerted efforts.

Notes received from the Government based on the above audit paragraph is included as Appendix – II.

39. The Committee accepted the notes furnished by Government regarding the audit paragraphs 2.8.6, 2.8.7.

Conclusion/Recommendation

No remarks.

[Audit paragraph 2.8.8, 2.8.8.1 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

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12 Data obtained from National Family Health Survey–4 as average of last five years before 2015-16.

2.8.8 Janani Shishu Suraksha Karyakram (JSSK)

Janani Shishu Suraksha Karyakram (JSSK) launched on 1st June 2011, was an initiative to assure cashless services to all pregnant women including normal deliveries, C-sections, and treatment of sick newborn (upto 30 days after birth) in all Government health institutions across the State. In order to reduce MMR and IMR, JSSK under NHM stressed upon promotion of institutional deliveries and proper care of newborn. The entitlements for pregnant women under JSSK included free and zero expense delivery and C-section, free Drugs and Consumables, free Diagnostics (Blood, Urine tests, Ultrasonography, etc.), free diet during stay in the health institutions (upto three days for normal deliveries and upto seven days for caesarean deliveries), free provision of blood, free transport from home to health institutions, between facilities in case of referrals and drop back from institution to home.

2.8.8.1 Deficiencies in providing free diet and other facilities to pregnant women under Janani Shishu Suraksha Karyakram (JSSK)

Supply of diet

JSSK guidelines envisaged that extra calorific diet was to be provided to mothers upto three days for normal deliveries and upto seven days for caesarean deliveries. Further, GoI while launching the scheme stated that non-availability of diet at the health facilities demotivates the delivered mothers from staying at the health facilities and consequently, most of the mothers prefer returning home after delivery, at the earliest.

The JSSK guidelines envisaged to provide cooked food, local seasonal fruits, vegetables, milk and eggs. The NHM, in its Circular (August 2012) suggested supply of bed coffee, breakfast, seasonal fruits, lunch, tea and snacks and dinner to the beneficiaries under the scheme. Audit observed that only six[13] of the 15 delivery points test-checked, which 15 included one Women and Children (W&C) hospital, three GHs, four DHs, six THs and one CHC provided diet as specified in JSSK guidelines. The details of two institutions, which failed to provide any diet

13 CHC Meenangadi, W&C Alappuzha, GH Manjeri, General Hospital Thrissur, District Hospital Wadakkancherry and TH Kodungallur.

to the mothers and that of the remaining seven institutions where diet as supplied did not conform to the Guidelines, are given in Appendix III. It was also observed that in four[14] institutions, the mothers were discharged from the institutions prior to the days prescribed (three days for normal and seven days for LSCS[15]) in the Guidelines resulting in mothers not receiving the stipulated diet.

Lack of sufficient intake of calorific food by mothers in post-partum period could hamper adequate care of the mothers and neonates. GoK stated (November 2017) that strict instructions were issued to the districts to ensure free diet for pregnant women in all institutions. GoK further stated that though Post-Partum duration of hospital stay varied from individual to individual and was the choice of the patient as well, institutions were since instructed not to discharge mothers prior to acquiring fitness.

Non-implementation of patient transport ambulance under JSSK and resultant parking of ₹11.88 crore with KMSCL

The JSSK launched by GoI (June 2011) provided for free and cashless services to pregnant women including normal deliveries and caesarean section deliveries and also treatment of sick newborn (upto 30 days after birth) in all Government health institutions across State/UT. As per the initiative, all pregnant women shall be provided with free transportation from residence to the health centre, from there to the referral points, if needed and back to residence. Patient Transport Ambulance (102) services essentially consisted of basic patient transport aimed to cater to the needs of pregnant women and sick infants under JSSK. It was observed that the patient transport ambulance system was not set up (November 2017) and instead the State Mission Director, NHM accorded sanction (August 2012) to disburse cash assistance of ₹500 each to the mothers until GoK established transport system for the pregnant women under JSSK.

Audit examined the reasons for not setting up the patient transport ambulance system as envisaged under the JSSK guidelines. It was observed that an amount of ₹27.45 crore (₹15.57 crore for purchase of 283 Patient transport ambulances, ₹5.09 crore for setting up a control room and ₹6.79 crore for its operational cost)

14 TH Sultan Bathery, DH Tirur, TH Ponnani and THQH Tirurangadi.

15 Lower Segment Caesarean Section.

was earmarked in the approved Programme Implementation Plan (PIP) for 2012-13 for the purchase and operation of patient transport ambulance. NHM transferred (March 2013) ₹11.88 crore to M/s. Kerala Medical Services Corporation Ltd. (KMSCL), which included ₹5.09 crore for setting up of a control room and ₹ 6.79 crore to meet operational costs. However, the cost of purchase of ambulances (₹15.57 crore) was not transferred to KMSCL. Audit noticed that KMSCL neither set up the call centre nor purchased ambulances as the cost of ambulances (₹15.57 crore) was not transferred to them. Thus, ₹11.88 crore was retained by KMSCL since March 2013. It was also noticed that NHM submitted Utilisation Certificate (UC) for 2012-13 to GoI certifying that all amount received during 2012-13 was utilised.

Audit observed that besides parking ₹11.88 crore with the KMSCL since March 2013, an amount of ₹3.23 crore[16] was paid as cash assistance to the beneficiaries in test-checked institutions thereby violating the scheme guidelines.

GoK stated (November 2017) that though ₹11.88 crore was released to KMSCL for patient transport ambulance, formal directions for purchase of vehicles and implementation of the project were yet to be issued resulting in the idling of funds. The reply was not acceptable since NHM and GoK were bound to utilise the funds approved by GOI for setting up of patient transport ambulance system under JSSK. The reply also failed to explain why NHM misled GoI by forwarding UC certifying that all amounts received during 2012-13 were expended, when ₹11.88 crore was parked unspent with KMSCL. Government stated in the Exit Conference (November 2017) that the matter would be looked into. Failure to utilise funds for the intended purpose and submission of wrong UCs calls for fixation of responsibility.

Free Drugs and Consumables/Diagnostics/Blood

The scheme envisages cashless service to women on account of free supply of drugs and consumables, diagnostic services and blood transfusion. Visits to hospitals during the course of Audit revealed that in three out of 15 delivery points, pregnant women were compelled to purchase medicines and blood from outside

16 At the rate of ₹500 per beneficiary.

sources (Appendix III). GOK stated (November 2017) that consequent to observations of Audit steps were taken to ensure that the entitlements envisaged under the scheme would be made available to all mothers. However, the steps taken were not intimated to Audit, despite being asked.

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

Excerpts from the discussion of Committee with department officials is given below:

40. While examining the audit para 2.8.8.1 the Committee enquired the status of ₹11.88 crore kept with KMSCL since 2013. The witness, Principal Secretary, Health & Family Welfare Department replied that the amount had been ear marked and released to KMSCL from the head of refferal transport patient-transport ambulance. The Committee enquired whether the amount has been regularised. The Principal Secretary, Health and Family Welfare Department answered that the amount which had been allotted to implement the scheme was resumed by Finance Department at the end of March 2013 as it was not utilised. He conceded that the fund was not utilised fruitfully at the initial stage. He added that steps were taken to introduce the ambulance service in aggregate model in 2017 (108 ambulance) and measures are ongoing to establish the aggregate model ambulance service throughout the State by identifying 315 spots.

41. The Committee queried why the department had furnished incorrect Utilisation Certificate (UC) for 2012-13 to Government of India without spending the amount. The witness explained that the fund allotted to NHM to implement the project was transferred to KMSCL on their books of accounts and non-issual of the formal orders of Government for implementation of the scheme led to idling of funds. The Principal Secretary was of opinion that it occurred generally for all centrally sponsored programmes in all departments and that projects usually do not get completed within a year because all the process required for implementing the programme need more time to complete. He added that the Central Government was informed of the fact at the time of presentation of Programme Implementation plan and there was no lapsing of fund according to NHM guidelines.

42. The Principal Secretary, Health & Family Welfare Department explained that as per the direction of the Government, KMSCL accepted the bid submitted by M/s. GVKEMRI for engaging Ambulance Services in the aggregated model in all districts of Kerala. Later as per the direction from the Government an aggregated model ambulance service was implemented from September, 2019.

43. Considering the Para, free drugs and consumables, the Principal Secretary, Health & Family Welfare Department informed that there exists very well structured mechanism for drug measurement especially in the context of mother and child health and for the last three years there was no shortage for drugs. He added that the department had conducted a study about diseases and the quantity of medicine consumed and after examining the expiry date steps were taken to procure 10% more medicines than that purchased last year keeping in mind to avoid over procurement. Medicines are procured in tranches and the work order for whole quantity of medicine is not given at a time. He further added that sometimes alternative medicines are suggested so that there was no shortage of medicines. The Principal Secretary, Health & Family Welfare Department supplemented that they had plans to procure the generic molecule instead of branded ones. He informed that department also tries to find out the medicines which are more purchased locally in medical colleges or CHCs and to include the generic molecules of that medicine to the Drugs supply formula of Government.

44. The witness pointed out that generally the department was procuring medicines on the indent prepared on the basis of consumption. He added that the responsibility would be fixed if outdated medicines or over stock of medicines were kept in the hospital. Therefore the department had oriented all drugs by inventory management to check whether there was any kind of over stocking and if it happened in any of the area, the last supply order was adjusted accordingly so that there was no over procurement. He stated that now they had decided to procure the cancer care drugs collectively in all five medical colleges and in all cancer care centres of Malabar, Kochi and Thiruvananthapuram.

45. The Committee pointed out that there was complaint among the patients that the medicines of fatal diseases are not available in Karunya Pharmacies. The witness, Principal Secretary, Health & Family Welfare Department replied in

negative and added that all kinds of medicines are available in Karunya Pharmacies. He informed that certain doctors prescribed the medicines of branded companies and though such branded medicines may not be available in Karunya Pharmacies, related generic molecule medicines are available there. He further added that department continuously gives awareness to the people to buy the medicines from Karunya Pharmacies and strict instructions have been given to ensure the quality of medicines made available in Karunya Pharmacies. To the query of Committee regarding the cost of medicines, the witness replied that there occurred a price stabilisation in connection with medicines after the establishment of Karunya Pharmacies and now there are 72 Karunya Community Pharmacies in Kerala.

46. The Committee suggested that either the department or KMSCL had to directly negotiate with the pharmaceutical companies so that the department would get the medicines directly from the companies at a lower cost.

47. The witness State Mission Director, National Health Mission informed that they had purchased the medicines on demand basis and had directly negotiated with the pharmaceutical companies and the companies would supply the medicines any time they demand for it. She also informed the Committee that they had a plan to establish Karunya Pharmacy in each constituency with an aim to spread the activities of pharmacy all over the State and decided to set up pharmacies in the hospital premises based on the availability of land.

Conclusion/Recommendation

48. The Committee directs the department to take effective measures to ensure the quality and availability of medicines especially medicines for critical care and fatal diseases, in Karunya Pharmacies. The Committee recommends to increase the number of Karunya Pharmacies in the State and to establish it in the premises of all Government Hospitals so that it is easily accessible to the public.

[Audit paragraph 2.9.1 contained in the Report of C & AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.9 Health care of children

2.9.1 Setting up of facilities for newborn at delivery points

The IPHS 2012 and the Operational guidelines for Facility Based Newborn Care mandated all facilities where deliveries were conducted, to set up Newborn Care Corner (NBCC)[17]. Similarly, all FRUs/CHCs needed to have a Newborn Stabilisation Unit (NBSU)[18], in addition to NBCC, with a Paediatrician in charge. It was also stipulated that any facility with more than 3,000 deliveries per year should have a Special Newborn Care Unit (SNCU), which would provide special care (all care except assisted ventilation and major surgery) for the sick newborn.

Data obtained from the DHS revealed that there were 107 delivery points in the State (March 2017). Though the DHS stated (October 2017) that NBCC was available at all delivery points, test-check revealed that three[19] out of 15 delivery points did not have the facility. There was shortfall in setting up NBSUs also. Across the State, NBSUs were not available in 41 out of 107 delivery points. NBSUs were not available in five[20] out of 15 delivery points test-checked. Two delivery points viz., DH, Wadakkancherry and DH, Mananthavady neither had NBCC nor NBSU facilities. Thus, 10 delivery points out of 15 test-checked, failed to set up stipulated facilities for the newborn.

Audit also noticed in the 10 delivery points which were lacking either in NBCCs/NBSUs or both, shortfall in filling up of sanctioned posts of Paediatricians in four delivery points. While shortfall of one Paediatrician against two sanctioned posts was noticed in THQH, Kodungallur and TH, Kayamkulam, there was shortfall of one Paediatrician against three sanctioned posts in GH, Thrissur. In DH, Mananthavady, shortfall of two Paediatricians against the sanctioned four posts was observed.

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17 Newborn Care Corner (NBCC)–a space within the delivery room in any health facility, where immediate care is provided to all newborns at birth. This is mandatory for all health facilities where deliveries are conducted.

18 Newborn Stabilization Unit (NBSU) –a facility within or in close proximity of the maternity ward where sick and low birth weight newborns can be cared for during short periods. All FRUs/CHCs need to have a Neonatal Stabilization Unit, in addition to the Newborn Care Corner.

19 THQH Kodungallur, TH Kayamkulam and THQH Ponnani.

20 THQH Vythiri, GH Kalpetta, W&C Hospital Alappuzha, GH Thrissur and CHC Meenangadi.

As GOK neither set up the required number of NBCCs and NBSUs nor effectively addressed the problem of shortages of Paediatricians, the newborns were denied the envisaged special care. Government agreed in the Exit Conference (November 2017) that the non-availability of NBCC was a very serious issue. Government further stated that NBSUs were provided in 66 institutions and that NBSUs in remaining institutions would be proposed in the next programme implementation plan of NHM.

Notes received from the Government based on the above audit paragraph is included as Appendix-II.

Excerpts from the discussion of Committee with department officials is given below:

49. To the Committee's query about the audit para, the witness Principal Secretary, Health & Family Welfare Department detailed that in the case of maternal and child health, the department had build a very good partnership with private sector. He added that for example, in the case of maternal health, Kerala Federation of Obstetrics and Gyneacology are partners and it helps in the inclusion of many doctors from private sector. The department called for the meeting every month for analysing the situation. If any maternal mortality occurred, they examined the circumstances in detail and take steps to maintain the state level capacity if necessary. At present the State's maternal mortality rate is 42 per 100000 live births and the department plans to reduce it to 30 by next year and to 20 by the year 2030.

50. The witness, Principal Secretary, Health & Family Welfare Department explained that as per national survey, infant mortality rate in the Kerala is 10 per 1000 live births but as per the data base in Kerala the rate is less than 8. The department want to get it validated as the department follow very excellent model now and the Indian Paediatric Association is the partner of Government. All paediatricians in the private sector are also joining hands with the State Government to achieve the SDG targets. All programmes like RNTCP, HIV programme, maternal/infant mortality programme etc. are operated with the co-operation of private sector. Now the government had developed a partnership in other area such as 'HRIDYAM' programme as the department understand that

congenital heart diseases and congenital anomalies are the main causes of infant mortality and as per the scheme, arrangements are made for heart surgery in 5 hospitals in the State.

Conclusions/Recommendations

51. No comments.

[Audit paragraph 2.9.2 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.9.2 Low birth weight (LBW) babies

World Health Organisation (WHO) defined Low Birth Weight (LBW) babies as such infants with a birth weight of 2,499 grams or less. It estimated that LBW contributed to 60 to 80 per cent of all neonatal deaths. Audit observed that the percentage of LBW babies increased in 2016-17 compared to 2012-13 for the State as well as selected districts as detailed in Table below.

Percentage of LBW babies in the State and selected districts

State/District	2012-13	2013-14	2014-15	2015-16	2016-17
Kerala	10.90	11.21	10.83	11.72	12.36
Alappuzha	9.57	9.80	10.81	12.24	12.15
Thrissur	8.01	8.10	8.20	10.38	9.39
Malappuram	11.71	11.82	12.23	10.99	14.31
Wayanad	15.04	14.75	15.41	15.38	16.39

(Source: HMIS data)

The percentage of LBW babies in the test-checked 15 delivery points ranged from 2.60 to 30.61 during 2012-2017 as detailed in Appendix III. Operational Guidelines for Facility Based Newborn Care, 2011, stipulated setting up of NBSUs in every FRU and CHC. The expected services to be provided at NBSUs included management of LBW infants less than 1.8 kg[21] with no other complication. Only 10 of the 15 institutions test-checked offered records showing details of children

21 Infants with birth weight more than 1.2 kg and less than 1.8 kg have significant problems in neonatal period.

weighing less than 1.8 kg at birth. Audit noticed that almost 7.82 per cent of the underweight children recorded weight of less than 1.8 kg. Audit observed that eight,38 and 10 per cent of underweight children delivered in DH Mananthavady, W&C Alappuzha and GH Kalpetta respectively during 2012-2017 were less than 1.8 kg in birth weight. Even though the percentage of LBW babies was increasing in the State, NBSUs and NBCCs which were required for stabilisation of such babies were not setup in the delivery points.

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

Excerpts from the discussion of Committee with department officials is given below:

52. To the Committee's query about Low Birth Weight Babies, the witness Principal Secretary, Health & Family Welfare Department apprised that the majority of cases of high prevalence of Low Birth Weight babies are reported mainly from places in Wayanad (Attappady) and Idukki districts. He added that this situation has improved by ensuring testing for anemia and treatment through supply of IFA tablets through community level intervention by Health department. Moreover the medical facilities are equipped to manage cases requiring medical attention due to LBW or premature babies by establishing facility centres like SNCU, NBSU and NBCC across the state at relevant levels of institutions and such measures help to control infant mortality.

Conclusions/Recommendations

53. No comments.

[Audit paragraph 2.9.3.1 contained in the Report of C&AG of India for the year ended 31st March 2017(General & Social Sector)]

2.9.3 Child Health Screening and Early Intervention Services under NHM

2.9.3.1 District Early Intervention Centres (DEIC)

Government of India launched (February 2013) the Rashtriya Bal Swasthya Karyakram (RBSK) targeted to deliver Child Health Screening and Early Intervention Services under NHM. The scheme envisaged to cover 30 identified

health conditions for early detection, free treatment and management through dedicated mobile health teams placed in every block in the country. The operational guidelines of the scheme envisaged first level of screening[22] to be done at all delivery points through existing Medical Officers, Staff Nurses and Auxiliary Nurse Midwives (ANM). After 48 hours till six weeks, the screening of new borns were to be done by ASHA[23] at home as a part of Home Based Newborn Care (HBNC) package.

Dedicated Mobile Health Teams (MHT) were to be constituted to conduct outreach screening to children between six weeks and six years at Anganwadi Centres and to children aged between six and 18 years at schools. The scheme envisaged engagement of at least three MHTs in each block to conduct screening of children. Each MHT was to consist of four members viz., two Doctors (AYUSH), one male and one female, one ANM/Staff nurse and one pharmacist. The screening of children in the Anganwadi Centres was to be conducted at least twice a year and at least once a year for school children to begin with.

The RBSK also envisaged setting up of District Early Intervention Centres (DEIC) at the District Hospital level across the country. The DEICs were to be the first referral points for further investigation, treatment and management of children detected with health conditions during health screening. A team consisting of one Paediatrician, one Medical officer, one Dentist, two Staff Nurses, Paramedics and visiting specialists will be engaged to provide services.

Audit observed laxity in implementation of the scheme, as discussed below:

- Even though the State constituted DEICs, which were functional from 2013-14 onwards, it neither constituted dedicated MHTs nor proposed capital cost for setting up the same as required under the guidelines. The screening activities to be undertaken by the MHT were being done by Junior Public Health Nurses (JPHN) who were trained and posted for the purpose. The District Programme Managers (DPM) and the State Health Society confirmed that these nurses were being deployed for screening in Anganwadis and schools for which proposals were

22 Screening of visible defects like cleft lip, clubfoot, etc.

23 Accredited Social Health Activist (ASHA).

made and funds allotted. Thus, the action of NHM of deploying JPHNs instead of Doctors was not in order. The probability of JPHN failing to detect children with health condition cannot be ruled out.

- Audit observed that the scheme guidelines provided for doctors to be part of the MHT and that a JPHN, however well trained, would still not be able to identify health conditions like Neural Tube defects, Down's Syndrome, Congenital cataract, Congenital deafness, Congenital Heart diseases, Thalassemia, etc. Thus, the screening activities done by JPHN were not in compliance with RBSK guidelines which clearly stipulated that there should be two doctors in each team to screen the children with the help of an ANM/Staff nurse.

- Audit observed that even though DEICs were formed in all the selected districts, they were working without the service of Paediatrician in Wayanad and Malappuram districts. DPMs of both districts replied that interviews were being arranged to fill the post.

- Scrutiny of records maintained at DEICs Alappuzha, Malappuram, Wayanad and Thrissur districts for the year 2016-17 revealed that out of 9588 children referred to DEICs under the School Health programme, only 1616 children reached DEICs for further treatment. Thus, almost 83 per cent of the children did not report for further treatment. There was no mechanism at the DEICs to ensure that all cases referred from various periphery level institutions reached DEICs for further investigation and treatment.

Thus, the objective of DEIC to intervene in the early stages of child health could not be achieved in the test-checked districts. Government stated in the Exit Conference (November 2017) that the issue of these children not being followed up was serious and directed NHM and DHS to initiate immediate action to track every child referred to DEIC.

Recommendation: GOK may direct DEICs to maintain database of children referred to them including follow-up activities to ensure that all cases referred from various periphery level institutions reached DEICs.

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

Excerpts from the discussion of Committee with department officials is given below:

54. The Committee enquired whether the App for Birth Defect Screening, Reporting and Documenting had become functional. The Principal Secretary, Health & Family Welfare Department informed that the Android App is a new technological service which helps to record and monitor any defect in new born babies and it is user friendly. The preliminary details as well as the photograph of new born along with disease condition, if any, would be entered using the Android App installed in the Tab. Further health condition of the child is updated in the App and nurses can see the check list of the condition listed in the App with photographs and description. Concerned DEIC will be able to see the case and verify the condition. The information is then passed over automatically by the system to RSBK MHT of concerned field area for ensuring follow up services. Innovation Awards were granted to Android App programme and HRIDYAM Project in national level.

55. The Committee enquired about the functioning pattern of DEIC regarding data base and newborn children. The Principal Secretary, Health & Family Welfare Department apprised that DEICs were established in all districts as first referral point for further investigation, treatment, management of cases and follow up services. He added that DEICs are working as per the guidelines of RBSK and they took assessment of birth defects and also provided referral support for children requiring surgery. DEICs verifies the investigation report of children having congenital Heart Disease and sent it online to the hospitals which are included in HRIDYAM scheme. These reports are then examined by expert doctors to determine the order of priority, based on the complexity of the disease. He added that the cases requiring emergency surgery were conducted by empanelled private hospitals in addition to Government Medical Colleges. Cardiac operations are performed even in children of one or two days of age. He informed that more than hundred operations had been performed during the last one year and now a days the congenital anomaly can be detected within the first sixteen weeks of pregnancy through genetic study.

56. The Committee questioned whether the department of Paediatric Cardiology are fewer in government hospitals. The Principal Secretary, Health & Family Welfare Department answered that at present there are 5 such centres and department is planning to start a new centre at Kozhikode.

57. The Committee asked whether the data of children having congenital defects are being collected and saved. The witness Deputy Director, Health & Family Welfare Department informed that the data had already been collected and DEIC were functioning in every districts. In Thiruvananthapuram, functioning of DEIC is attached to the General Hospital. In DEIC, physiotherapy and speech therapy were given to persons having learning disability and autism in addition to those having congenital diseases. He further added that counselling was also given to the families about congenital diseases from this year onwards. To a query of the Committee about availability of paediatricians in Wayanad and Malappuram, he replied that paediatricians were appointed at DEIC there.

Conclusions/Recommendations

58. No comments.

[Audit paragraph 2.10.1 contained in the Report of C&AG of India for the year ended 31st March 2017(General & Social Sector)]

2.10 Family planning

2.10.1 Non-availability of Family planning activities

As per IPHS, 2012, all PHCs shall provide Education, Motivation and Counselling to adopt appropriate family planning methods and to provide for contraceptives such as condoms, oral pills, emergency contraceptives and Intra Uterine Contraceptive Device (IUCD) insertions. The standards also envisaged that CHCs would provide full range of family planning services including Information, Education and Communication (IEC), counselling, provision of Contraceptives, Non-Scalpel Vasectomy (NSV), Laparoscopic Sterilisation Services and their follow-up.

It was observed that all the 32 PHCs test-checked provided all the family planning activities as envisaged in IPHS, except IUCD insertion. Of the test-checked 16 CHCs, only three CHCs[24] provided all the stipulated family planning activities. None of the remaining 13 test-checked CHCs provided Tubectomy, Vasectomy and Laparoscopy services. All family planning activities were being provided in all the TH/THQHs except TH Thuravoor[25]. The details are as shown inTable below:

Details of institutions providing family planning activities

Family Planning Activities	Alappuzha		Thrissur		Malappuram		Wayanad	
	PHC	CHC	PHC	CHC	PHC	CHC	PHC	CHC
Vasectomy	Not required	1	Not required	Nil	Not required	Nil	Not required	2
Tubectomy	Not required	1	Not required	Nil	Not required	Nil	Not required	2
Laparoscopy	Not required	1	Not required	Nil	Not required	Nil	Not required	2
IUCD insertion	Nil	4	Nil	4	Nil	4	Nil	4
Oral pills/ Mini lap sterilisation/ Condom distribution	8	4	8	4	8	4	8	4

(Source: Data collected from test-checked institutions)

Government stated (November 2017) that since most of the sterilisation procedures were performed by Gynaecologists or Surgeons, family planning measures were provided through Taluk/District/ General/W&C hospitals. The reply was not acceptable in view of the fact that the State was to equip CHCs with full range of family planning activities as per IPHS norm.

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

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24 CHCs Meenangadi, Pulpally and Ambalappuzha.

25 Vasectomy and Tubectomy not available.

Excerpts from the discussion of Committee with department officials is given below:

59. The witness Principal Secretary, Health & Family Welfare Department apprised that family planning measures are full fledged in Kerala. He added that the department has taken necessary steps to create awareness among the tribals in our State. He stated that in Kerala most of the sterilization procedures were done by Gynaecologist or Surgeons and hence family planning services like Laparoscopy, PPS and NSV are provided through Taluk, District, General and Women & Children Hospitals. The Committee directed the department to start providing family planning services in CHCs too.

Conclusions/Recommendations

60. The Committee recommends to equip CHC's with full range of family planning services.

[Audit paragraph 2.11.1 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.11 Immunisation

2.11.1 Poor progress in Immunisation

The NHM Immunisation Hand book for Medical Officers recognises a child as fully immunised with all basic vaccinations, if the child has received Bacille Calmette-Guerin (BCG) vaccine against tuberculosis at birth; three doses each of polio and pentavalent [diphtheria, tetanus, pertussis, Hepatitis B(Hep) and Haemophilus influenza type B (Hib)] vaccines at 6, 10 and 14 weeks of age; and a vaccination against measles at nine months of age. Timely administration of vaccines has implications for the success of childhood immunisation programmes.

The details of immunisation in the selected districts from 2012-13 to 2016-17 are as shown in Table below:

Details of immunisation

District	Target	Fully immunised	Fully immunised (in per cent)	Partially immunised	Unimmunised
Wayanad[26]	72635	67669	93.16	5839	316
Malappuram	1275326	1148923	90.09	113604	12799
Thrissur	458992	454829	99.09	3908	255
Alappuzha	113745	112212	98.65	1440	93

(Source: Data from DPMs)

The reasons for the slow progress in immunisation in the districts of Malappuram and Wayanad as stated by the DPMs included reckoning of vaccination by some communities as anti-religious, impact of anti-vaccination lobby such as Naturopathy, propaganda against immunisation through social media and fear of immunisation. Audit observed that the failure of GOK to successfully overcome public resistance to vaccination resulted in a setback to the success of childhood immunisation programmes as envisaged under NHM.

Recommendation: GOK must strengthen dissemination activities to spread awareness of the necessity of immunisation amongst such communities.

Notes furnished from the Government based on the above audit paragraph is included as Appendix – II.

61. The Committee approved the reply furnished by the Government.

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26 In respect of Wayanad, the District Medical Officer, Wayanad while confirming the figures stated that achievement exceeded target since children from neighbouring two States and districts availed immunisation service from that district.

Conclusions/Recommendations

62. No Comments.

[Audit paragraph 2.12 & 2.12.1 contained in the Report of C&AG of India for the year ended 31st March 2017(General & Social Sector)]

2.12 Infrastructure and manpower

As per the Indian Public Health Standards, 2012 (IPHS) certain essential/desirable services at Sub-Centres/PHCs/CHCs/THs/ THQHs and DHs are to be provided so as to ensure availability of uniform standards of services and infrastructure to the public. Deficiencies in manpower have been pointed out in paragraph 2.8.3 of this report. Audit also noticed deficiencies in service delivery by Accredited Social Health Activists (ASHA), as discussed below:

2.12.1 Functioning of Accredited Social Health Activist

The NHM framework required Accredited Social Health Activists (ASHAs) to reinforce community action for universal immunisation, safe delivery, newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. Each ASHA was to be equipped with a kit to provide the rural population with immediate and easy access to essential health supplies like Oral Rehydration Salts (ORS), contraceptives and a set of 10 basic drugs, besides a health communication kit and other IEC materials.

As per approved norms, one ASHA was to be provided for every 1000 population at village level and all ASHAs were to undergo series of training sessions to acquire the necessary knowledge, skills and confidence for performing their spelt out roles.

- Audit observed that against the requirement of 32854 ASHAs in the State, only 25680 were available resulting in shortage of 7174 ASHAs. In the test-checked districts, against the target of 9924 ASHAs, there was shortage of 1683 ASHAs. The shortfall against target was highest in Thrissur (24 per cent) while in Wayanad, Malappuram and Alappuzha, it was 20, 17 and 7 per cent respectively.

Availability of ASHAs and details of training imparted in selected districts:

District	No. of ASHA			Training imparted		
	Target	Available	Shortage	Available	Trained	Shortage
Wayanad	835	669	166	669	666	3
Malappuram	3900	3228	672	3228	2478	750
Thrissur	2889	2209	680	2209	1800	409
Alappuzha	2300	2135	165	2135	2035	100

(Source: Data from State Health Society)

• NHM replied (September 2017) that revamping of the programme was going on with ward based redistribution of ASHAs and that new ASHAs would be nominated once the process was completed. The reply was not acceptable as the department was well aware of the shortage of ASHAs and as such, the process to nominate new ASHAs could have been initiated well in advance, to avoid further delay.

• Audit observed that the project for supply of ASHA kits was implemented by NHM in 2008-09 and in 2013-14 only. ASHA kits comprising of essential drugs and consumables, meant to be distributed free of cost to the beneficiaries in the field were not replenished from time to time. In the 32 test-checked Sub-Centres in four districts, no ASHA kits were replenished since 2013-14.

• On enquiry it was stated (September 2017) by SHS that approval from GOI was not received to replenish ASHA kits since 2013 and that GOI directed in the Record of Proceedings (ROP) of 2016-17 to replenish them from existing health facilities.

Notes furnished from the Government based on the above audit paragraph is included as Appendix – II.

63. The Committee approved the reply furnished by the government regrading the audit paragraph 2.12.1.

Conclusions/Recommendations

64. No Comments.

[Audit paragraph 2.12.2 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.12.2 Deficiencies in infrastructure in health centres

2.12.2.1 Non-conducting of baseline survey

As per paragraph 81 of the NHM Frame work, in order to enable the District Health Mission to take up the exercise of comprehensive district planning, a house hold and facility survey of Sub-Centre /PHC/CHC/Sub-Divisional/DHs was to be conducted, which would act as the base line for the Mission. This exercise was to be taken up at regular intervals to assess the progress under the Mission. Mention was also made in the C&AG's Audit Report, 2009 that though facility survey was conducted in all CHCs during September to December 2006, no such survey was conducted in any of the PHCs and Sub-Centres in the State.

NHM confirmed (October 2017) that it did not conduct any baseline survey after 2006. Audit observed that in the absence of baseline survey, NHM neither possessed inputs to monitor the progress in imparting health care nor placed itself in a position to access details of improvement, which came about due to the investments made under the scheme.

2.12.2.2 Status of Civil works

The physical status as on 31st March 2017, of 212 works relating to construction of health institutions, training centres and staff quarters sanctioned during 2012-2015 is given in Table below:

Status of Civil Works

Year	No. of works sanctioned	No. of works completed	No. of works in progress	No. of works not started due to non-availability of land	No. of works not started due to other reasons
2012	84	83	Nil	Nil	1
2013	117	106	Nil	7	4
2014	4	Nil	3	Nil	1
2015	7	4	1	Nil	2
Total	**212**	**193**	**4**	**7**	**8**

(Source: Data from SHS)

Audit observed that 15 works could not be taken up for construction, out of which, seven works could not be taken up due to non-availability of land and eight due to other reasons.

Shortfall in setting up of Sub-Centres, PHCs and CHCs have been mentioned in paragraph 2.8.3 of this report. Many of the test-checked institutions lacked in essential facilities like electricity, drinking water facility, toilet, road accessibility, equipment like Cardiogram, X-Ray, Lab service, etc. (Appendix III).

Details of buildings idling after completion/incomplete works are indicated below:

- **Training Centre in the premises of TB Hospital, Manjeri**

  Even after the lapse of 48 months since handing over of the building (August 2013) to NHM, the building was idling due to lack of manpower and infrastructure. Training activities were being conducted in rented buildings and an amount of ₹1.86 lakh was incurred towards rent from 2013-14 to 2016-17 alone. Proposal submitted by District Medical Officer, Malappuram in April 2017 was for an additional post of a watchman, with no requisition for administrative staff. The proposal was not approved by GOK (September 2017).

- **Maternity Block at CHC, Edappal**

The Maternity Block building was idling for more than two years for want of sufficient equipment and furniture and posting of electrical and cleaning staff. GoK stated (November 2017) that proposal for supply of equipment would be included in the supplementary PIP for 2017-18.

- **Maternal and Child Health (MCH) Block in CHC Fort, Thiruvananthapuram**

The building could not be put to use due to objection raised (June 2016) by the Chief Town Planner, Thiruvananthapuram that the elevation of the building was not as per the norms prescribed under heritage zone. Besides, the building plan was not approved before commencement of work.

- **W&C Block at District Hospital, Tirur**

Deviation on civil works necessitated due to site condition. Lack of proper planning as per CPWD specifications and preparation of project estimate without studying the site condition resulted in the increase of project cost by more than 20 per cent. The work, which was scheduled for completion by November 2016 with a project cost of ₹ 5 crore, could not be completed till September 2017.

- **Construction of MCH Block at THQ Hospital, Chengannur**

As the progress of work was very slow, the consultant terminated the contract on 27 May 2015 after forfeiting the Performance Guarantee of ₹40.42 lakh. Work was re-tendered and the lowest amount quoted by another contractor for an amount of ₹1,030.52 lakh was accepted by the Technical Committee in January 2016 with a time of completion of one year. The additional liability consequent on revision of estimate due to termination of work by the first contractor was avoidable, had the agreement included a conditional risk and cost clause to make good any loss, in case of termination of work.

- **Construction of Staff Quarters at DH Mananthavady**

  During the course of execution of work, the Kerala Police raised objection stating that a part of the land belonged to their department. The dispute was yet to be resolved (September 2017). Failure of SHM in proper planning and ensuring hindrance free land led to inability to complete the staff quarters and infructuous payment of ₹ 36.89 lakh to the consultant.

Notes furnished from the Government based on the above audit paragraph is included as Appendix – II.

65. The Committee approved the reply furnished by the Government regrading the above audit paragraph.

Conclusions/Recommendations

66. No Comments

[Audit paragraph 2.12.3 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.12.3 Shortage in blood bank/blood storage

As per IPHS and report on Standardisation of Medical Institutions in Kerala, blood storage is an essential requirement in CHCs/TH/THQHs and blood banks, in District hospitals. Audit noticed 11 out of 33 medical institutions (CHC/TH/ DH/GH/W&C) functioning without blood storage/blood bank, available blood storage facilities remaining non-functional due to failure to obtain licence, blood banks functioning without licence from the Drugs Controller and Licensing Authority and institutions offering blood storage facilities instead of the stipulated full-fledged blood bank (Appendix III). GoK stated (November 2017) that blood storage units were made available at THQHs Kodungallur and Vythiri. Audit was also informed that action was initiated in four hospitals[27] to obtain licence. In two hospitals[28] it was stated that Blood storage units were functioning in place of Blood banks. In respect of GH, Alappuzha, it was stated that the nearby MCH had

27 THQHs Tirurangadi and Sulthan Bathery, W&C Alappuzha and CHC Meenangadi.

28 GH Kalpetta and DH Mavelikkara.

the facility of blood bank. The reply was not acceptable as IPHS stipulate that hospitals falling under the category DH and above, should invariably be equipped with blood banks. In respect of other two hospitals[29] it was stated that they did not have delivery facility and hence blood storage units were not provided. The reply was not acceptable as the provision of blood storage was not based solely on the availability of delivery facilities in the institution.

Notes furnished from the Government based on the above audit paragraph is included as Appendix- II.

67. The Committee approved the reply furnished by the Government based on the above audit paragraph.

Conclusions/Recommendations

68. No Comments

[Audit paragraph 2.12.4 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.12.4 Ambulance service

As per IPHS guidelines, referral transport facility was to be made available at each PHC. However, ambulances were available only in 54 out of 848 PHCs and 58 out of 232 CHCs across the State. Thus, 94 per cent of PHCs and 75 per cent of CHCs did not possess ambulances. Status of availability of ambulances in the four test-checked districts to transport patients to referral centres is presented in Table below.:

Availability of ambulances

Name of the district	Total number of PHCs	Number of PHCs provided with ambulances	Total number of CHCs	Number of CHCs provided with ambulances
1	2	3	4	5
Alappuzha	59	1	16	2

29 THs Pudukkad and Thuravoor.

1	2	3	4	5
Malappuram	84	0	22	1
Wayanad	23	3	9	5
Thrissur	79	3	24	5

(Source: Data from DHS)

Government replied (November 2017) that 50 ambulances were procured for functioning as '108 Ambulances'. The reply was not acceptable as '108 Ambulances' were utilised for management of emergencies of serious concern like road accidents, health related problems etc., and not to cater to the needs of PHCs/CHCs.

Notes furnished from Government based on the above audit paragraph is included as Appendix- II.

69. The Committee approved the reply furnished by the Government based on the above audit paragraph.

Conclusions/Recommendations

70. No Comments

[Audit paragraph 2.12.5 & 2.12.6 contained in the Report of C&AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.12.5 Idling of equipment

Audit observed that in 19 institutions in the test-checked districts, equipment worth ₹ 0.98 crore were idling for various reasons such as non-availability of infrastructure/space/manpower, non-requirement of equipment, etc., as shown in Appendix III.

Government stated (November 2017) that action will be taken to utilise the equipment.

2.12.6 Non-availability of laboratory services

As per IPHS, the status (March 2017) of availability of laboratories in the test-checked health institutions and the services rendered by them are shown in Table below:

Availability of Laboratories

Health institution	Test-checked number of institutions	Non-availability of laboratory	Required number of laboratory tests	Non-availability of tests
PHC	32	17	11	2-9
CHC	16	Nil	36	9-27
TH/THQH	8	Nil	51	11-34
DH	4	Nil	97	51-66

(Source: Data collected from test-checked institutions)

Audit observed severe shortfall in laboratory services provided by TH/THQHs/CHCs/DHs in the test-checked four districts (Appendix III).

The institutions cited inadequate infrastructure and shortage in space, manpower, reagents, etc., as reasons for the non-availability of laboratory and laboratory services. The reply was not acceptable as laboratory services were essential in the process of diagnosis and hence, adequate proposals were to be projected in the Programme Implementation Plans to overcome shortage of space, infrastructure and equipment.

Notes received from Government based on the above audit paragraphs are included as Appendix -II.

71. The Committee approved the reply furnished by the government based on the above audit paragraph.

Conclusions/Recommendations

72. No Comments

[Audit paragraph 2.12.7 contained in the Report of C&AG of India for the year ended 31st March 2017(General & Social Sector)]

2.12.7 Safety measures in X-ray centres

Atomic Energy Regulatory Board (AERB) guidelines (August 2004) on licensing of X–ray units provided for issuing licence for operating radiation installations after inspecting the working practices being followed, to ensure adherence to prescribed safety standards, availability of appropriate radiation monitors and dosimetry devices for purposes of radiation surveillance, etc. In Kerala, the Director of Radiation Safety (DRS) is the authorised agency to issue licences on behalf of AERB.

Audit noticed that 15 out of 32 hospitals test-checked offered X–ray services. However, in 10[30] out of 15 hospitals, X–ray machines were operated without obtaining Certificate of Safety from DRS and 10 equipment in seven[31] hospitals were being utilised without conducting the quality tests as shown in Appendix III.

Audit noticed that the technicians manning the X–ray units in five[32] hospitals were not provided with Thermoluminescent Dosimeter (TLD) badges to indicate levels of exposure to radiation. In the absence of TLD badges and safety certification from the DRS, Audit could not obtain reasonable assurance that patients and technicians were not being exposed to more than permissible radiation levels.

DPMs, Thrissur, Malappuram and Wayanad replied (August 2017) that action was being taken to obtain AERB licences and necessary arrangements were made for conducting quality assurance test. District Medical Officer (DMO), Thrissur replied (August 2017) that necessary directions for obtaining AERB registration were forwarded to peripheral institutions.

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30 GH Kalpetta, DH Mavelikkara, DH Wadakkancherry, DH Tirur, DH Mananthavady, THQH Kayamkulam, THQH Ponnani, THQH Tirurangadi, THQH Sulthan Bathery and CHC Muthukulam.

31 DH Mavelikkara, DH Wadakkancherry, THQH Kayamkulam, THQH Kodungallur, THQH Tirurangadi, THQH Sulthan Bathery and CHC Muthukulam.

32 DH Mavelikkara, THQH Kayamkulam, THQH Kodungallur, CHC Muthukulam and THQH Tirurangadi.

NHM stated (September 2017) that AERB registration and purchase of TLD badges was to be done by the hospital authorities concerned and quality assurance tests of radiological equipment were being conducted by NHM as per request of hospitals. Unrestrained exposure of patients and technicians to more than permissible levels of radiation would pose serious health risks. GoK stated that NHM was preparing a proposal in supplementary PIP 2017-18 for obtaining funds for taking AERB licence for all radiological equipment at all the Government hospitals.

Notes received from the Government based on the above audit paragraphs are included as Appendix- II.

Excerpts from the discussion of Committee with department officials is given below:

73. The Committee enquired whether all radiological equipments have since got AERB licence. The Principal Secretary, Health & Family Welfare Department stated that license will be granted to MRI scan and X-ray unit only after quality checking and strict inspection is being done in connection with AERB license. He added that about 55% of equipment of our state had got the quality certificate as part of national quality certification programme and the score of the state is the best. He informed that the best Taluk Hospital, Family Health Centre and District Hospitals are in Kerala. The Bio Medical waste disposal, disposal of wastes and medicine dispensing are also examined.

74. The Committee recommend that the department should give awareness to the Hospital Management Committee to upgrade the standard of the hospitals and prepare a guideline about waste disposal and bio medical waste disposal. The Committee directed that such awareness to improve the standard should be given to Taluk Hospitals also. The Committee pointed out that the Government could not allow funds for all purposes, so the Hospital Management Committee should try to find out the fund for providing hospital facilities.

75. The Principal Secretary, Health and Family Welfare Department agreed to prepare the guideline about it. The Committee directed the department to ensure the proper execution of the guidelines and to take necessary steps to provide

training to the superintendent of Health Institutions. The Principal Secretary further informed that about 600 health institutions are keeping their best standards and state will be the top most in the country in Health sector in one or two years.

Conclusions/Recommendations

76. The Committee recommends that steps should be taken to ensure that all medical institutions, in the State Government as well as private, which offers X-ray services and uses radiation equipments are properly registered. All institutions using radiological equipments without maintaining prescribed safety standards as prescribed by AERB must be listed out and should be directed to follow the safety standards as per the AERB guidelines within fixed timeframe. The licenses of the institutions who fail to maintain the safety standards should be cancelled. The steps taken in this regard should be furnished to the Committee.

77. The Committee recommends the department to prepare a guideline on waste disposal and bio medical waste disposal in hospitals.

78. The Committee pointed out that it is impossible for the Government to cater all needs of a hospital and allow funds for all the purposes. Therefore Hospital Management Committee should work effectively to look into all matters of the hospital and find out alternative methods apart from Government assistance to improve/upgrade the physical as well as medical standards of a hospital with special emphasis on Taluk Hospitals.

[Audit paragraph 2.12.8 contained in the Report of C&AG of India for the year ended 31st March 2017(General & Social Sector)]

2.12.8 Compliance to Quality Assurance Guidelines

The Public Health Operational Guidelines for Quality Assurance, 2013 (Quality Assurance guidelines) envisaged that the health facilities were not only to provide full range of services which are committed in the National Health Programmes but also to ensure that the services meet verifiable and objective quality standards. The Quality Assurance guidelines recommended to create State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC), District Quality Assurance Teams (DQAT) at District Hospitals and Facility Level Quality teams for strengthening quality assurance activities at various levels.

Audit noticed that though SQAC and DQACs were formed, DQAT and Facility Level Quality teams were not constituted in all institutions. In the test-checked eight General/District Hospitals and eight Taluk Hospitals, QAT was not formed in three General/District Hospitals and four Taluk Hospitals. Further, Facility Level QATs were not formed in 11 CHCs and 24 PHCs. In the absence of such QATs, internal assessment of quality activities, preparation of key performance indicators, patient satisfaction surveys, identification of gaps and improvement, follow-up actions etc., were not being done.

Notes received from the Government based on the above audit paragraph is included as Appendix -II.

79. The Committee approved the reply furnished by the government based on the above audit paragraph.

Conclusions/Recommendations

80. No Comments

[Audit paragraph 2.13.1 to 2.13.4 contained in the Report of C & AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.13 Financial Management

2.13.1 Short release of funds to High Priority Districts

To ensure equitable health care and to bring about sharper improvements in health outcomes, the bottom 25 per cent of the districts in every State, on the basis of outcome indicators covering the three areas of Maternal health, Child health and family planning were identified as High Priority Districts (HPD). GoI identified (July 2013) three districts viz., Kasaragod, Malappuram and Palakkad as HPDs in the State. It was also conveyed to the States that HPDs must, within the overall State Resource Envelope[33] under NHM, receive at least 30 per cent more budget per capita as compared to the other districts. It was emphasised that diversion of this envelope to other districts would not be permitted.

33 Financial resources that are expected to be made available under various components.

Audit analysed the average annual assistance received by 11 non-HPDs during 2013-17. Audit noticed that there was short release of ₹ 86.40 crore to the three HPDs during 2013-2017 as detailed in Table below:

Shortage of funds allotted to High Priority Districts (₹ in crore)

Year	2013-14	2014-15	2015-16	2016-17	Total
Total allotment to 11 non-high priority districts	181.59	181.53	305.50	209.59	
Average of 11 such districts	16.51	16.50	27.77	19.05	
Amount due adding 30 percent of average to each HPD	21.46	21.45	36.10	24.77	
Amount allotted to Kasaragod	16.39	12.22	12.19	10.72	
Amount allotted to Malappuram	24.44	20.98	21.99	25.77	
Amount allotted to Palakkad	20.06	19.92	18.34	21.92	
Shortage of funds to Kasaragod	5.07	9.23	23.91	14.05	52.26
Shortage of funds to Malappuram	-2.98	0.47	14.11	-1.00	10.60
Shortage of funds to Palakkad	1.40	1.53	17.76	2.85	23.54
Total short release of funds					86.40

(Source: State Health Society data)

NHM stated (October 2017) that the activities approved in the ROP were those based on proposals forwarded by the districts and that the districts implemented the approved proposals. It was stated that since the demand from the districts were usually provided, the question of additional funds over and above their usual necessity did not arise. The reply was not correct since GoI during the years 2012-17 accorded approval to only 67 per cent of the PIPs forwarded by GoK. Thus, against the PIP of ₹ 4014.75 crore[34], approval was accorded by GoI for only ₹ 2673.07 crore. It was, therefore, clear that the districts did not obtain the amount sought for in their plan proposals. It was also mandatory for the GoK to comply with the GoI instructions and to allot additional resources to the three HPDs.

2.13.2 Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the NHM being implemented (since 2005) with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the pregnant women below poverty line. This scheme integrated cash assistance with delivery and post-delivery care. As per guidelines, the cash assistance of ₹700 under JSY was admissible only to mothers belonging to BPL families who hailed from rural areas and ₹600 to those from urban areas in Kerala, being a High Performing State. JSY guidelines required all payments including compensation amount for sterilisation wherever applicable, to be made in one instalment at the time of discharge from the hospital/health centre. The Auxiliary Nurse Midwives (ANM) and ASHA workers were to ensure disbursal of JSY cash assistance in time. The Guidelines recognised the district level Nodal Officer as the officer responsible for proper implementation of the JSY scheme.

- Audit observed that during 2012-2017, 11.44 lakh beneficiaries across the State (47 per cent) and 33782 (33 per cent) out of 1.01 lakh beneficiaries in the 15 selected institutions of the four selected districts were not paid the stipulated cash assistance as shown in Table below:

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34 Including Supplementary proposal of 646.94 crore.

Details of payment of cash assistance

Year	State			Selected institutions		
	Total number of institutional deliveries	Number of beneficiaries to whom cash assistance not paid	Percentage of non-disbursement	Total number of institutional deliveries	Number of beneficiaries to whom cash assistance not paid	Percentage of non-disbursement
2012-13	494504	236541	47.83	20601	11111	53.93
2013-14	496257	229922	46.33	23445	8572	36.56
2014-15	493636	231071	46.81	21959	4106	18.70
2015-16	480656	245295	51.03	18973	4696	24.75
2016-17	446123	201654	45.20	15937	5297	33.24
TOTAL	2411176	1144483	47.46	100915	33782	33.47

(Source: Data from State Health Society)

The reasons stated for non-disbursement of JSY assistance were patients not collecting money on discharge and non-furnishing of proper documents like JSY card, copy of bank pass book, ID proof, copy of discharge summary, etc. The reply was not acceptable since incentives were being paid to ASHA for assisting the beneficiaries. As such, availability of documents should have been ensured through ASHA.

• Government of India instructed (May 2013) that in Low Performing States (LPS), the financial assistance under JSY was to be made available to all women regardless of age and number of children, for delivery in Government/private accredited health facilities. Even though Kerala fell under the category of High Performing States where the facility could be extended only to BPL/SC/ST women, the State Mission Director (NHM) Kerala wrongly extended the facility (September 2013) to all women irrespective of age and number of

children. Audit observed in the test-checked districts that the institutions were not maintaining separate records for APL and BPL women and JSY assistance was paid irrespective of the income factor.

- Government (November 2017) replied that on the basis of the observation in C&AG's All India Review Report, 2016 on NHM regarding ratification of grant of JSY assistance to all women irrespective of being BPL/SC/ST, directions were issued (May 2017) by GoK to continue with the payment of JSY assistance to all women who deliver in Government hospitals except those availing payward facilities. The reply was not acceptable as the C&AG's report brought to light the irregularity in deviating from the guidelines of JSY, a 100 per cent Centrally Sponsored Scheme, without ratification from the State and Central Government. Government admitted the facts in the Exit Conference (November 2017). Thus, laxity of ASHA workers resulted in failure to ensure that eligible beneficiaries obtained stipulated financial assistance. Orders of GoI were also violated, resulting in JSY cash assistance meant for BPL/SC/ST being wrongly extended to APL women as well.

2.13.3 Non-maintenance of records at PHC, Chethalayam

The Operational Guidelines for Financial Management of the National Health Mission (NHM) stipulated[35] that records like Cash book, Cheque Issue Register, Allotment/fund register, Bank Pass book, reconciliation statement vouchers, etc., should be maintained. The cash book should be updated on daily basis in case of PHC/CHC etc., and authenticated by the drawing/disbursing officer or any responsible officer authorised for the purpose. It was also stipulated that cash transactions should be made only for petty expenses.

All receipts, payments/disbursements should be entered in the cash book on the day of the payment itself. Cheque Issue Register should be maintained properly in respect of issue of every cheque. Audit noticed violation of these guidelines in PHC, Chethalayam situated in Wayanad district.

35 Chapter 6 (Internal Controls) of the Operational Guidelines for Financial Management of the National Health Mission (NHM).

Audit observed that the PHC maintained two accounts in State Bank of India, Sulthan Bathery branch to effect transactions of NHM. While one account was in the joint name of the Medical officer and the Block Panchayat President for transactions like Untied fund, Maintenance grant, Ward Health Sanitation Fund, etc., the second account was maintained in the name of Medical officer for all other schemes of NHM.

An amount of ₹19.59 lakh was transferred by the District Project Manager (DPM) to the PHC for the period from 1st April 2012 to 29th November 2014. However, Cash Book was available in the PHC only from 30 November 2014 with an opening balance of ₹ 37,685. Other essential registers like Fund register, Cheque Issue register, Statements of Expenditure, supporting vouchers, etc., were also not maintained by the PHC. Audit noticed that contrary to guidelines, the Medical Officer of PHC issued Cash cheques[36] for large amounts. All these cheques were drawn on the account, operated by the Medical Officer solely in his name.

As the Cash book and connected records were not maintained and since the Medical Officer drew sizeable amounts by way of cash cheques, the possibility of misappropriation of Government funds could not be ruled out.

NHM stated (October 2017) that consequent to audit findings, the PHC was directed (September 2017) to prepare the books of accounts and produce the supporting documents. As these directions were not complied with, the matter was reported by the NHM to the DMO and the District Collector who was the Chairman of the Executive Committee of the District Health and Welfare Society. GoK stated (November 2017) that DHS was directed to take necessary action in this regard.

2.13.4 Advances pending settlement

As per Chapter 6.9.1 of Operational guidelines for Financial Management, all advances should be settled within a maximum period of 90 days. Audit observed that contrary to the above guidelines, ₹ 83.74 lakh released during the period from 2010-11 to 2016-17 to various organisations/individuals involving nine cases were

36 Cash cheque No. 578486 dated 4-10-2013 for ₹ 87,040, Cash cheque No. 350698 dated 3-3-2015 for ₹ 29,100 and Cash cheque No.350699 dated 10-3-2015 for ₹ 25,000.

still pending settlement. The advances were pending since 2010. Details of advances pending settlement are shown in Appendix III. The SHM needs to take action to adjust these advances without further delays and fix responsibility for lack of action in this regard.

Notes received from the Government based on the above audit paragraphs are included as Appendix -II.

81.The Committee approved the reply furnished by the government based on the above audit paragraph.

Conclusions/Recommendations

82. No Comments

[Audit paragraph 2.14 & 2.15 contained in the Report of C & AG of India for the year ended 31st March 2017 (General & Social Sector)]

2.14 Non-compliance to mandatory disclosures

The yearly approval to the State's PIP, accorded by GoI contained certain conditionalities to be adhered to by the States and which were to be treated as non-negotiable. Audit observed that the State NHM did not make disclosures of four of the nine mandatory stipulations required by GoI (7th October 2017) in its website www.arogyakeralam.gov.in as shown in Table below.

Mandatory Disclosures

Sl. No.	Mandatory requirement as per ROP	Status as on 7th October 2017
1	2	3
1	Facility wise service delivery data particularly on Outpatient Department (OPD), Inpatient Department(IPD), Institutional delivery, C-section, Major and minor surgeries etc., on Health Management Information System (HMIS).	While the OPD data upto November 2015 only, was available on the website the HMIS data was protected by user name and password. Thus, the information was not generally available.

1	2	3
2	Patient transport ambulance and emergency response ambulances–total number of vehicles, types of vehicle, registration number of vehicles, service delivery data including clients served and kilometre logged on a monthly basis.	A copy of the list of vehicles with registration number and category was available. However, the data does not contain service delivery data including clients served and kilometre logged on monthly basis.
3	All procurements including details of equipment in specified format.	The website exhibited the details of availability of equipment only without giving the procurement details.
4	Supportive supervision plan and reports shall be part of mandatory disclosures. Block wise supervisory plan and reports should be uploaded on the website.	Available for only 12 institutions.

(Source: Website of NHM)

The NHM stated (October 2017) that the data till 2016 was uploaded and that they were in the process of updating the data and making it live in the portal. Audit examined the webpage on 17th October 2017 and observed that data with respect to Sl.No.1 only was updated upto November 2016, while the other requirements were yet to be complied with by NHM. Government stated (November 2017) that facility-wise service delivery data on OPD, IPD, Institutional delivery, C-section, major/minor surgeries etc., was updated upto March 2017 and that the remaining data would be updated shortly.

2.15 Conclusion

The performance audit brought out deficiencies in providing Ante Natal Care, failure to test all pregnant women for HIV, inadequate health centres, delivery facilities not available at all institutions and inadequacies in infrastructure. There was also shortage of manpower and a rising trend in Caesarean sections

in the State, which was a matter of concern. Deficiencies in delivery services under the Janani Shishu Suraksha Karyakram and Janani Suraksha Yojana were also noticed. Facilities for newborns were not available in many test-checked institutions. Deficiencies in Child Health Screening and Early Intervention Services were also observed. The State did not release stipulated additional financial assistance of ₹ 86.40 crore to identified High Priority Districts of Kasaragod, Malappuram and Palakkad during 2013-2017. Despite these identified deficiencies, the performance of the State was impressive in terms of exceeding the targets set under the UN Sustainable Development Goals of reduction in Infant Mortality Rate and Maternal Mortality Rate.

Notes received from the Government based on the above audit paragraphs is included as Appendix- II.

83. The Committee approved the reply furnished by the Goverment based on the above audit paragraph.

Conclusions/Recommendations

84. No Comments.

SUNNY JOSEPH,
Chairman,
Committee on Public Accounts.

Thiruvananthapuram,
16th March, 2022.

APPENDIX I

SUMMARY OF MAIN CONCLUSION/RECOMMENDATION

Sl. No.	Para No.	Department concerned	Conclusion/Recommendation
1	11	Health and Family Welfare	The Committee directs the department to take necessary steps to provide better care and service to expectant mothers in Government hospitals so that in comparison with private institutions total percentage of delivery cases attended in Government hospitals would increase.
2	12	Health and Family Welfare	Committee noticed that 20% of pregnant women were seen anaemic in test checked ANC institutions and pointed out that they were not given IFA tablets after they have shifted voluntarily to private hospitals.
3	13	Health and Family Welfare	The Committee recommends that Government should ensure registration of all pregnant women in an area for Ante Natal Care (ANC) services and to closely monitor whether all of them are getting the required IFA and other services even if they were shifted to private hospitals.
4	14	Health and Family Welfare	The Committee also directs the department to furnish a detailed report on the steps taken to ensure sufficient supply of IFA tablets to pregnant women.
5	18	Health and Family Welfare	The committee directs the department to take effective measures to ensure that all pregnant women who register for ANC are tested for HIV/STI such that no one gets missed out and to forward a detailed report about the measures taken for such a drive.
6	25	Health and Family Welfare	The Committee points out that there are many Family Health Centres in which the service of the

			doctors was not available. The Committee recommends that the department should examine in detail about Family Health Centres where there is scarcity of doctors and take necessary steps to appoint the doctors in such Family Health Centres.
7	26	Health and Family Welfare	The Committee directs the department to conduct a study on patient inflow, OP/IP data in each hospital and availability of medical staff in each of these institutions. The Committee recommends that the doctors from the hospitals with less number of patients in OP/IP should be redeployed to the hospitals with more patients. The re-deployment of the doctors and medical staff should be done State wide and should not be limited to one particular region or district.
8	35	Health and Family Welfare	The Committee expresses its displeasure over the fact that only 50% hospitals which were upgraded to Taluk hospitals have delivery facilities. The Committee criticises the department for neither providing the basic facilities nor appointing sufficient doctors and medical staff even though the hospitals were upgraded to Taluk hospitals. The Committee recommends the department that necessary steps should be taken with an intention to improve the infrastructure facilities and also providing adequate medical personnel and other staff for setting state of the art medical services to the new borns and mothers in Taluk hospitals.
9	36	Health and Family Welfare	The Committee opines that the department should take necessary steps to start IP and delivery units in all Taluk hospitals and priority should be given to Taluk Head quarters hospitals. The Committee emphasis that more attention should be given to upgrade the hospitals in rural areas to Taluk hospitals in order to alleviate the difficulty of the

			people in rural areas to access and avail the facilities of Taluk Head Quarters Hospitals.
10	37	Health and Family Welfare	The Committee directs the department to take necessary action to provide delivery facilities in CHC s in remote areas.
11	48	Health and Family Welfare	The Committee directs the department to take effective measures to ensure the quality and availability of medicines especially medicines for critical care and fatal diseases, in Karunya Pharmacies. The Committee recommends to increase the number of Karunya Pharmacies in the State and to establish it in the premises of all Government Hospitals so that it is easily accessible to the public.
12	60	Health and Family Welfare	The Committee recommends to equip CHCs with full range of family planning services.
13	76	Health and Family Welfare	The Committee recommends that steps should be taken to ensure that all medical institutions, in the State Government as well as private, which offers X-ray services and uses radiation equipments are properly registered. All institutions using radiological equipments without maintaining prescribed safety standards as prescribed by AERB must be listed out and should be directed to follow the safety standards as per the AERB guidelines within fixed timeframe. The licenses of the institutions who fail to maintain the safety standards should be cancelled. The steps taken in this regard should be furnished to the Committee.
14	77	Health and Family Welfare	The Committee recommends the department to prepare a guideline on waste disposal and bio medical waste disposal in hospitals.
15	78	Health and Family Welfare	The Committee pointed out that it is impossible for the Government to cater all needs of a hospital and allow funds for all the purposes. Therefore

Hospital Management Committee should work effectively to look into all matters of the hospital and find out alternative methods apart from Government assistance to improve/upgrade the physical as well as medical standards of a hospital with special emphasis on Taluk Hospitals.

APPENDIX II
Notes Furnished By Government

REPLY ON THE DRAFT PERFORMANCE AUDIT PARAGRAPH OF THE PRINCIPAL ACCOUNTANT GENERAL (GENERAL AND SOCIAL SECTOR AUDIT) ON THE PERFORMANCE AUDIT ON NATIONAL HEALTH MISSION-RCH AND IMMUNISATION FOR THE PERIOD 2012-17

AUDIT FINDINGS	REMARKS
2.6. Attainment of demographic goals NHM aimed to reduce Infant mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility rate (TFR). In this process, NHM was expected to help achieve related goals set under the Millennium Development Goals (MDG) 2015 and UN Sustainable Development goals (2030). The performance of the State was impressive and exceeded the targets set under the UN Sustainable Development Goals	No comments
2.7. Non-allotment of State share of funds Audit noticed that against the receipt of Rs.2144.12 crores by GOI during 2012-17, the State contributed only Rs.591.98 crores as its share of contribution. There was thus a short release of funds by GOK to the extent of Rs.323.22 crores. It is also noticed that Rs.309.74 crores which was released from State Plan fund was intimated to GOI as State share which is contrary to the guidelines.	As per the Government orders received from State Government till 2012-13, certain plan funds released by State Government were treated as state share, but later as per the instructions from Government of India, no plan funds were treated as state share. From the financial year 2013-14, State Government is releasing corresponding state share in line with GOI releases. However, GOI accepted the treatment of plan funds as state share till 2012-13, and further State Society not received any letter rejecting the plan funds treated as state share from GOI. It is also informing that even though treating of plan funds as state share was contrary to the guidelines, till 2012-13 Ministry had accepted the same and it is evident in further letters from GOI. Letter received from GOI regarding state share pendency as on 31.03.2017 is enclosed to substantiate the claim. As per the letter an amount of Rs.84.26 crores was the pendency which was released by State Government during 2017-18.
2.8. Health care for Women **2.8.1 Ante Natal Care (ANC)**	As per DLHS 4 (District Level Household survey) data, the Antenatal Care in Government Health institutions is 54.4% only. Rest of the care is given

During 2012 17 only 80.13% of 24 95 lakh pregnant women registered for ANC within the first trimester for pregnancy Further, 9% (216823) could not receive three ANC checkups during the pregnancy period. There was also shortfall in the percentage of woman who received first dose of TT Against 85 6% women who received first dose of TT, only 81 23% received the second dose	by private institutions. This is attributed to the high level of health seeking behavior (that too a specialist oriented) of people against what is observed in other parts of the country During 2016-17, a new programme called PMSMA (Pradhan Mantri Surakshit Mathritva Abhiyan) has been launched for strengthening ANC for identifying high risk pregnancies and the care during second and third trimester All antenatal care services are provided through PHCs and CHCs including registration of antenatal women, Injection TT, antenatal checkup, Iron and Folic acid tablets Even though more than 70% of patients approach private sector for delivery services, all efforts are being taken to register all the pregnant women in the MCTS during the first trimester itself. However in the corporation/Municipal area, the data capturing is very poor as there are deficiencies in HR under health department and the available field staff are under the direct control of the Local Self Government. From 2014-15, Urban Health Centers have been started in the urban areas with the contract staff appointed by NHM. Now the data collection and services in the urban areas have improved to a large extent. With regard to the point raised for TT Immunisation, the current protocol for TT administration as provided in the "Immunisation Handbook for Medical Officers reprint 2017" page No. 17 there can be a single 'Booster Dose' for the Pregnant women who had two doses of TT in their last pregnancy within previous three years. This could be the reason for the slight difference of 4%.
Audit noticed that over 12% of 24 95 lakhs pregnant women who had registered for ANC during 2012-17 did not receive IFA tablets. Records revealed that the test checked districts of Malappuram, Wayanad, Alappuzha and Thrissur reported 3774, 1205, 363 and 1104 instances of severe anaemic cases during 2012-17	Till 2008, IFA tablets were issued as a part of RCH Kit from GOI directly. When the ASHA Kit was introduced, the IFA tablets were included in the ASHA kit also. Due to abrupt programmatic changes within the system, responsibility for procurement and supply of IFA was shifted from GoI to state under NHM, but without any hike in Resource Envelope for the state. For the last two years ASHA Kits were not supplied due to lack of funds and request was placed before GOI for supply of IFA tablets. Meanwhile steps were taken not to compromise the care to pregnant and lactating women in the state by providing Ferrous sulphate tablets through general supply intend by all the health institutions in the state through KMSCL in their annual intend. However, NHM got approval for the procurement of IFA tablets during 2016-17 (supplementary PIP) and procured the same through KMSCL. For the year 2017-18 also, GOI has approved the procurement of IFA Tablets and procured through KMSCL. So the point raised may be changed to "over 12% of 24.95 lakhs pregnant women who had registered for ANC during 2012-17 did not found receive IFA tablets

	through the usual program." As Iron tablets were available throughout the year in the general supply through institution pharmacy. As per the Government of India guidelines, 100 tablets of Iron and Folic acids are provided to all pregnant mothers for prevention of Anemia. As per the latest guidelines, the number of IFA to be provided to pregnant mothers is 180 during pregnancy and 180 during lactation. Innovative IEC/BCC activities for awareness creation will be done this year as part of the campaign 'Anemia free Kerala'which will the Kerala model of 'Anemia Mukth Bharath'. Different steps are being taken up by Department of Health in the state to tackle the issue of anemia even though the prevalence of Anemia is less in Kerala comparing the National figures as observed in NFHS-4. The prevalence of anemia in the state is high in the adolescent population, the reason for the same is unknown. In all schools, weekly Iron and Folic acids tablets are given to the children for the prevention of anemia. The health facilities where delivery takes place are being equipped with facilities for the management of severe anemia. This includes the test and treat strategy adopted under 'Anemia Mukth Bharath' campaign and for this testing device and strips are being provided to all Subcenters for point of care testing even during field visits. There is a provision given to capture data online in a real time basis and with a provision for tracking all those found anemic. The measures are already taken to establish High Dependency Unit in one hospital per district for management of obstetrics complications including severe anemia.
2.8.2 Testing of pregnant women for HIV and STI infections Audit noticed that out of 24.95 lakhs pregnant women who registered for ANC during 2012-17, almost 36.88% and 55.86% were not tested for HIV and VDRL respectively. Since pregnant mothers with HIV/VDRL were identified during during testing, the possibility of more such cases escaping detection due to failure	As per NACO & RMNCH+A guidelines, Women who access antenatal services at health facilities should receive a routine offer to test for HIV infection. The Prevention of Parent To Child Transmission (PPTCT) programme involves counseling and testing of pregnant women in the first trimester, detection of positive pregnant women and early initiation of ART to HIV positive pregnant women and Antiretroviral (ARV) prophylaxis to their infants, to prevent mother to child transmission of HIV. In Kerala, 60% of the population access private hospitals for their medical care and only 50% of FICTCs established in CHCs and PHCs are functional. The data captured is mainly the reports from Stand Alone ICTCs. Hence reports received on HIV testing of pregnant women are low. But over the years ANC coverage has increased from 260027 in 2012-13 to 363758 in 2016-17. Various measures were taken up by NHM, KSACS and development partner UNICEF together to improve the coverage and

to conduct the tests cannot be ruled out	capture information on testing for HIV including that from the private sector too Training offered to all category of staff under the program from each district in Kerala in the year 2016-17 and the improvement in coverage reflects the effectiveness of the intervention. In order to achieve universal screening/testing of pregnant women for HIV & syphilis, as a part of the essential antenatal care package, scale up is to be planned up to the level of Community Health Centre and Primary Health Centre through NHM integration, as well as private sector by developing public- private partnerships Kerala State AIDS Control Society has asked Director of Health Services (DHS) to give proper directions to DMOs and Superintendents/Medical Officers i/c of the ICTCs to improve referrals to ICTCs, and action in this regard has happened To scale up Public Private Partnerships for PPTCT services NACO introduced a project "Svetana" which was rolled out from October 1st 2015 in Kerala for establishment of ICTCs in private hospitals and registering private hospitals for data sharing. The NGO SAATHII (Solidarity and Action Against the HIV Infection in India) has been selected under new funding model as Principal Recipient (PR) to implement this intervention. Initially started with 10 districts, this year they are covering all 14 districts in Kerala By March 2018, they targeted to achieve 120 PPP sites in the state thereby improving the coverage of PPP sites and work towards elimination of pediatric HIV. Now we have 92 PPP sites reporting in SIMS and 353 hospitals who are sharing data through SAATHI's HIV Pulse, an online reporting system.
2.8.3 Adequacy of Health Centers manpower Audit noticed shortfall in setting up of Sub Centres, PHCs and CHCs as per population norms (2011 census). The shortage of CHCs was acute in the districts of Malappuram (54%) and Thrissur (62%). Audit observed that the GOK did not set up stipulated number of CHCs and also did not fill up vacancies of doctors and para medical staff to the extent of 48% and 35% respectively in test checked institutions.	The shortfall in setting up of Sub Centres, PHCs and CHCs were noted. The matter will be taken up with the Health Department. As per the present pattern at least one Health Care Institution is established in all Panchayats. The National perspective providing specialty care through CHCs (under IPHS) was not taken up in the state and the services were provided through Taluk level Hospitals. All specialty services are available in TH in the state including the provisions for LSCS, Blood and Blood products through BSU. Being a state with specialty oriented mindset for public the availability of Obstetricians and Anesthetists is the key limiting factor for providing such services in CHCs and it is the reason for not establishing new CHCs in the state. In Kerala, the antenatal care is providing through PHCs. However patients always prefer to go to the Gynecologists for the antenatal care. Delivery

	services are available in Thaluk hospitals, District Hospitals, General Hospitals and W & C Hospitals only. Moreover the OP services, field activities, National Health Programmes and other preventive services are provided through PHCs. The PHCs and CHCs were handed over to the Local Self Government Institutions during the decentralization process. Health programmes of the LSGI department are also implemented through PHCs and CHCs. During 2017-18, State Government has started a new programme *viz* Aardram Mission. Under this mission, initially 170 PHCs are selected for upgradation as family health centres in the year 2017-18 and 503 PHCs in 2018-19 and remaining PHCs are proposed in 2019-20. Through these PHCs, the state is ensuring extended OP services from 9am to 6pm. Stae has been creating new posts in Health institutions through Aardram project.
2.8.4 Availability of delivery facility Audit noticed that out of test checked 65 health institutions in the selected districts, delivery facility was available only in 15 institutions. None of the 245 PHCs in the test checked districts provided delivery services. Even the CHCs not equipped to handle delivery services in the four test checked districts. Audit observed that despite GOK sanctioning posts of Gynecologists in 4 out of 16 test checked CHCs, a Gynecologist was posted only in CHC Meenangandi in Wayanad. In the case of CHC Pulpally, even though the hospital has a six bedded maternity wards, a well-equipped OT and labor room with adequate facility, there was no Gynecologist and the hospital generally provided only ANC.	In Kerala, delivery services are available in Thaluk hospitals, District Hospitals, General Hospitals and W and C Hospitals only. Due to the typical health seeking behavior of the public, they always prefer to see Gynecologists for antenatal and deliver services and prefer to go to major hospitals for delivery than to CHCs and PHCs. There are no provision of providing an obstetrician in a PHC as per the existing guidelines. And as per the existing practice in the state it is preferred not to do any delivery in PHCs considering the availability of facilities in the nearby itself. Also it may be considered that there are no accessibility issues (except in tribal areas) other than the financing in Kerala if the facility for healthcare is considered in Kerala. Moreover with regard to having new posts created in CHCs is not enough to have delivery services there, rather the posts of anesthetists and more than that the position getting filled up is very much essential. More over the specialist posts as per Indian Public Health Standards, like Gynecologists, Pediatrician, Physician, Surgeon and Anesthesiologist are not available in the CHCs in the state. If adequate numbers of specialist posts are not available in PHCs and CHCs, providing more facilities and equipments may go unutilized. At present, the facilities like Operation theatre, Blood bank, ambulance services and other infrastructure facilities for the management of Obstetric emergencies are either not available or inadequate in the CHCs and PHCs. Creation of the adequate number of Specialist posts in CHC Pulpally is required for providing delivery services.

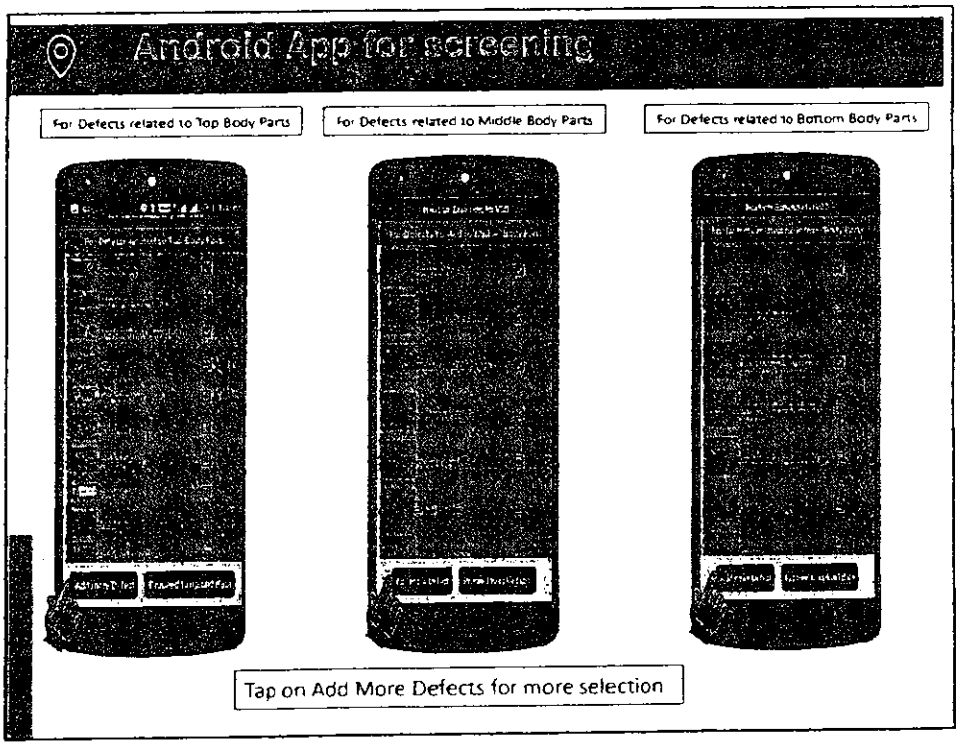
	One Gynecologist is not able to provide 24 hour delivery services in 365 days in the CHC Feasibility of converting this centre as an active delivery point will be ascertained and necessary proposal will be submitted to Government in this regard. Not satisfied with this.
2.8.5 Impact of inadequacy of manpower and infrastructure on maternal care Shortage of Gynecologists noted in THQH Sulthan Bathery (1) and TH Thuravoor (2) as per IPHS. Audit noticed instances of number of deliveries in hospitals coming down during the years due to availability of lesser number of doctors leading to the suspicion that the hospitals might be turning away patients on some pretext or the other. In the THQH Thirurangadi, it is noticed that the number of deliveries was steadily declining over the years from 574 during 2012-136 to 284 during 2016-17. Similarly in THQH vythiri, delivery facilities were not made available to the patients from August 2015 to June 2017 due to the transfer of the lone Gynecologist to another hospital. In THQH Thirurangadi, men in position were short of posts sanctioned by GOK (1). In DH Mananthawady and in GH Kalpetta, GOK accorded sanction to increase the bed strength. However, neither the number of beds was increased nor the infrastructure developed to cater	Measures are being taken to fill all the sanctioned posts of Gynecologists in different hospitals the state. Moreover various steps are being taken to improve the quality of care provided to the pregnant women, like implementing LaQshya program, setting up new HDU and ICU to manage complications of delivery at least one facility in each district, BSU in all FRUs, NBSU for taking care of Newborn babies which is often a reason for referral, etc. Extensive creation of floor area to bring down the congestion is happening across all delivery points in the state considering the people's feeling that adequate privacy with regard to providing rooms and private area in hospitals. Hopefully all these efforts will improve the numbers and will be able to reduce the out of pocket expenditure. Decision may be taken up in the Government level for the creation of more specialist's posts in selected institutions as per the delivery load

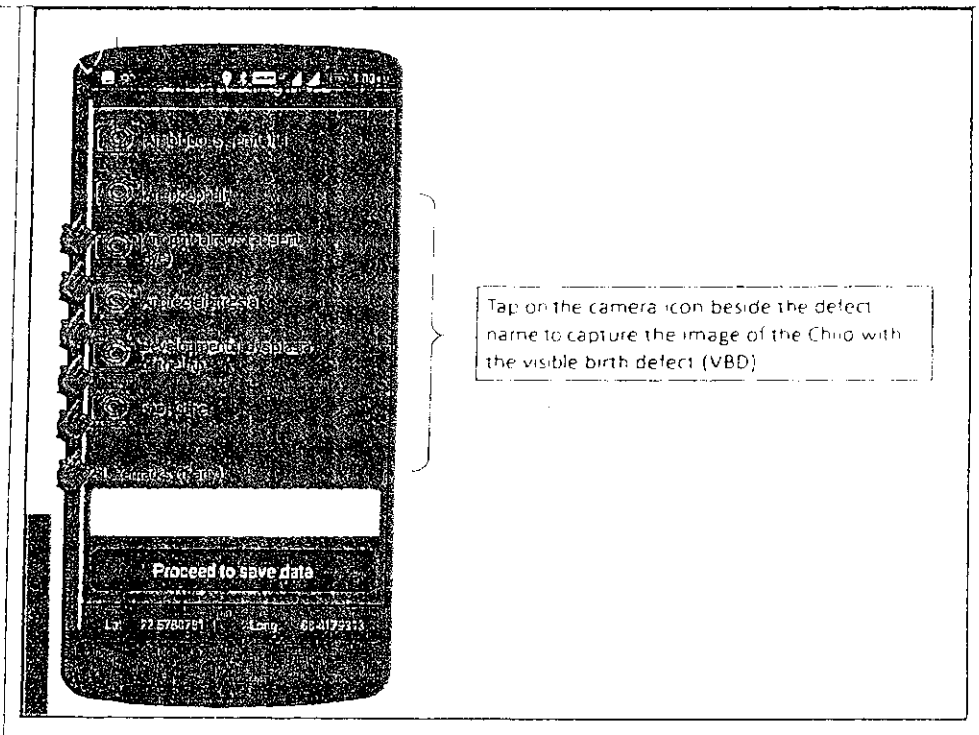
to the demand. The resultant shortage of space and beds led to situations like patients having to share beds and even sleep on floors. In DH Manjery, 36 delivery patients were admitted against the sanctioned strength of 25. Audit observed two instances of pregnant women delivering children in the toilet at ANC ward in GH Manjeri due to delay in shifting them to the labour room	
2.8.6 Shortage of drugs and consumables in PP Units Shortage of drugs and consumables noticed in the 65 test checked institutions IFA- Intermittent shortage from 2012-17, IFA small from 2014 onwards, Vitamin A, Contraceptive pills/condom/EC pills-from 2016 onwards, ORS-Intermittent shortage from 01/09/2015, Nishchay from Nov 2016 onwards	Measures were taken to supply the IFA and Vitamin A through KMSCL. Contraceptive pills/condom/EC pills are supplied by the Government of India. The policy changes and changes in program implementation and the hurdles in the initial phase of rolling out results in the intermittent shortage as pointed out. This has been corrected in due course and was possible only because of the strong monitoring system Kerala Health system is having and the commitment of state to provide primary and preventive care services through these units. Earlier all these commodities were directly supplied under RCH Program as RCH Kit to these units and now it is brought under different vertical program components and the procurement happens locally in state. The process of procurement, supply chain and logistics makes it cumpursome when it is done based on intend and allocation. The programmatic change of supply through ASHA as mandated by GOI and as a paid service through selling these commodities to beneficiaries made these items excess stock in some areas and stock out in few other areas.
2.8.7 Deliveries through Caesarian sections It is observed that the average proportion of C-sections in Kerala was higher than the national average and that high risk of complications in the second C-section warranted reduction of primary C-section to as minimum as possible. Against the national average of 17.2% C-	The Health Department has taken steps to reduce the Caesarian section by issuing guidelines. GO (Rt) No 1791/2011/H&FWD dated 07-05-2011. Training was provided to the Doctors, Nurses and other staff working in the labor room with the support from KFOG. At the end it is the clinical judgment and decision making of the treating physician is the final with regard to whether go for LSCS or normal delivery. Moreover there is no difference between government and private sector in this regard, in fact the LSCS figures are more in private sector.

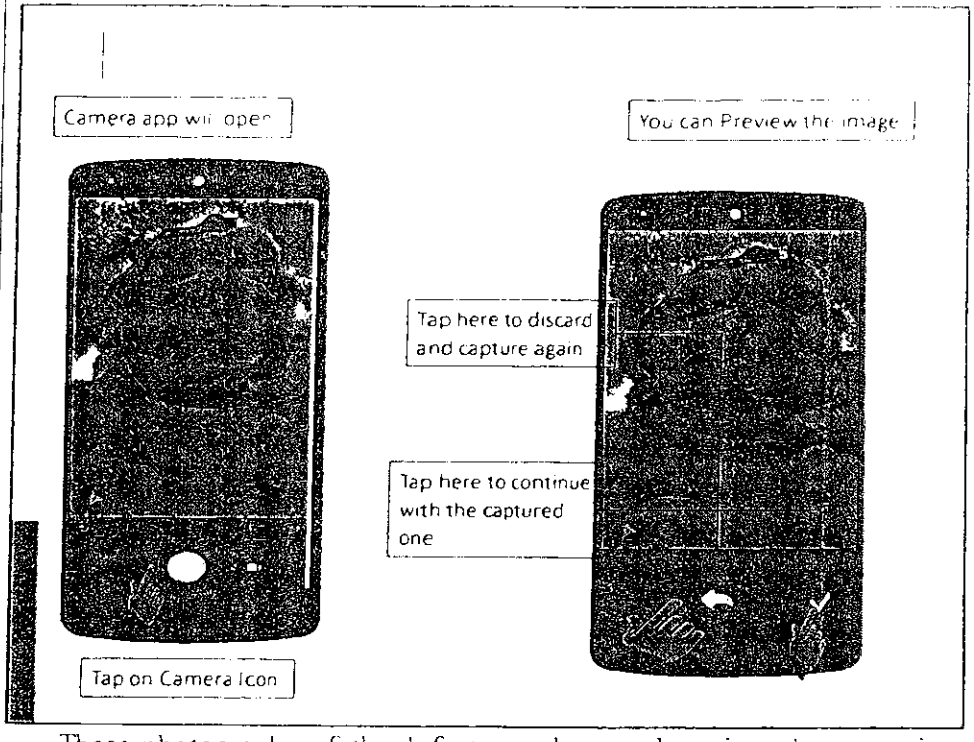
sections in 2015-16, data obtained from DHS indicates that 40-42% of the deliveries in the state during 2012-17 were through C-section	
2.8.8 JSSK **2.8.8.1 Deficiencies in providing free diet and other facilities to pregnant women under JSSK**	
Supply of diet Audit observed that 6 out of 15 test checked institutions provided diet as per JSSK guidelines 7 institution provided diet but not conforming to guidelines and two (THQH Kayamkulam, THQH Vythiri) did not provide any diet In 4 institutions mothers were discharged prior to the days mentioned in the guidelines resulting in mothers not receiving the stipulated diet	JSSK being an entitlement to mothers and Children's Health, Instructions have been given by NHM to all Districts to ensure that free diet for all pregnant women may be ensured at all institutions. This will be complied. Post Partum duration of hospital stay varies from individual to individual and is the choice of the patient as well, as the national guidelines says only about monitoring for first 48 hours post partum in the facility. Instructions have been given that no mother will be discharged prior to fitness to leave the hospital. Guidelines formulated by GOI are broad ones meant for the entire country. Kerala's health picture is vastly different from National Mother and Child health picture and Kerala often modifies them to suit our Health scenario
Non implementation of patient transport ambulance under JSSK and resultant parking of Rs.11.88 crores with KMSCL The transport system is yet to be set up. It was noticed that no further action has been initiated by NHM to implement the project after transfer of funds to KMSCL The failure of NHM to effectively utilize the assistance received by it for implementation of the transportation project led to an avoidable expenditure of Rs.3.23 crore by way of disbursement of cash assistance, in the test	As per the request from KMSCL Rs. 11.88 Crores released to KMSCL from the head of referral transport – Patient transport ambulance. Though the funds have been transferred to KMSCL, formal directions are awaited from the Government for the purchase of the vehicles and implementation of the project, which in turn has resulted in the idling of the funds. Since the ambulances are not purchased, as per GOI instructions free referral transport support is being providing from the state by way of cash assistance @ Rs.500/- each to the mothers until Government established transport system for the pregnant women under JSSK. But as a new initiative a prepaid model where the cost is born by NHM an arrangement is being done by most of the districts since January 2019 called 'Mathru yaanam'. Here a counter is provided in the office of PRO of the hospital and all those getting discharged will be arranged a vehicle at a fixed cost per kilometers. One other factor also was considered when the program is initiated that the poor acceptance of an ambulance by the family for return from hospital due to socio cultural reasons.

checked 4 districts during 2012-17	
Free Drugs and Consumables/Diagnostics/Blood In three institutions (DH Wadakancherry, THQH Sulthan Bathery, THQH Vythiri), pregnant women were compelled to purchase medicines and blood from outside sources	The steps have been taken to ensure that the entitlements envisaged under the scheme will be made available to all mothers. As part of FRU operationalization minimum BSU is ensured in all delivery points across Kerala and measures are taken to provide equipment and HR in these facilities.
2.9. Health care of Children **2.9.1 Setting up of facilities for newborns at delivery points** Even though DHS stated that NBCC was available at all delivery points, test check revealed that 5/15 of these delivery points did not have the facility. There was shortfall in setting up of NBSUs also. NBSUs were not available in 41 DPs across the state. In the test checked districts, NBSUs were not available in 7 DPs	SNCUs and NBSUs had set up based on the IPHS/UNICEF Guideline. As per UNICEF and FBNC (Facility Based Newborn Care) Guideline, any facility with more than 3000 year per delivery should have an SNCU and SNCUs are provided accordingly. NBSUs are provided having delivery less than 3000 delivery per year as per the guideline. Based on delivery load, availability of infrastructure, NBSUs are provided at 68 institutions. NHM is providing equipments to strengthen NBCC as per the requirement. Currently there are 97 Delivery points in the state and all are having NBCCs. There are 21SNCU (17 functional, 4 under construction) in the state, 68 NBSUs attached delivery points with adequate delivery load and all delivery points have NBCC.
2.9.2 Low Birth Weight babies Audit observed an increasing trend of LBW babies. The percentage of LBW babies in the test checked 15 DPs ranged from 2.61%-30.61% (30.61% in DH Mananthawady, 27.33 in TH Sulthan Bathery, 21.79 in CHC Meenangadi, 20.30 in GH Kalpetta). Audit noticed that almost 7.82% of the underweight children recorded weight of less than 1.8 kg.(W&C Alappuzha - 38% of 1.8kg) Audit noticed that even though the percentage of LBW babies was increasing in	Measures will be taken to find out the cause of LBW and measures will be taken to reduce the number of LBW. Currently there are 97 Delivery points in the state and all are having NBCCs. NBSUs are provided with institutions having delivery less than 3000 delivery per year as per the guideline. Based on delivery load, availability of infrastructure, NBSUs are provided at 68 institutions. The institution wise in the parameter of LBW can not be considered for an argument or analysis as this has lot of implications. The prevalence of LBW in the state as per national surveys is less than 11% in the state. But there are pockets and vulnerable groups among which the prevalence is noticed high and community level interventions by health department like testing for anemia and treatment through supply of IFA is ensured. Similarly other line departments are also contributing to improve the situation. Moreover the facilities are equipped to manage cases requiring medical

the State, NBSUs an NBCCs which were required for stabilization of such babies were not set up in the delivery points	attention due to LBW or prematurity by establishing 21 SNCU, 68 NBSU and 100 NBCC across the state at relevant levels of institutions. All the LBWs need not be stabilized or admitted in the unit, but based on the clinical need they will have to be admitted in the units.
2.9.3 Child Health Screening and Early Intervention Services under NHM 2.9.3.1 District Early Intervention Centers (DEIC) Even though the State had constituted DEIC which were functional from 2014-15 onwards, it neither constituted dedicated Mobile Health Teams nor proposed capital cost for setting up the same as required under the guidelines. The screening activities to be undertaken by MHT were being done by JPHN who were trained and posted for the purpose. Audit observed that screening activities done by JPHN was not in compliance with RBSK guidelines which clearly stipulate that here should be of two doctors in each team to screen the children with the help of an ANM/SN. Audit observed that even though DEIC was formed in all the selected districts, it is working	• Justification for non formation of MHT under RBSK Rashtriya Bal Swasthya Karyakram(RBSK) is an initiative under the project National Health Mission by Government of India is a Child Health Screening and Early Intervention Services programme to provide comprehensive care to all the children in the community. Child Health Screening and Early Intervention Services envisage to cover 30 identified health conditions under birth Defects, Diseases, Deficiencies, Development Delays and Disability for early detection, free treatment and management through dedicated RBSK nurses and the large network of health personnel of the Government health services in the state. As per the National RBSK guideline, a dedicated RBSK Mobile Health Team (MHT) is responsible for the primary RBSK screening, but in Kerala, we have dedicated RBSK Nurses instead of MHT. The RBSK program is implemented in the state as a modified version of existing School Health Programme in the FY 2013-14, and as per the GO(Rt) No 3320/2013/H&FWD-dtd 28.09.2013, the RBSK program is being operational in the state. In the above said GO it is clearly mentioned that, the RBSK screening has to done by School Health Nurses/ RBSK Nurse. The RBSK Nurses will carry out screening (as per the RBSK Job Aid) of all children in the pre-school age enrolled at Anganwadi centers at least twice a year besides screening of all children studying in Government and Government aided schools, whereas the newborns are screened for visible and functional birth defects in all delivery points by trained staff nurses/RBSK Nurses. Now Shalabham-Comprehensive New Born Screening programme is strengthened with the availability of digital platform for the screening, referrals and service access. As part of Shalabham-Comprehensive New Born Screening programme consists of comprehensive clinical examination of a full physical assessment from head to toe to be performed on all Newborn babies, usually within the first 48 hours of life at each delivery point. This needs to be performed by the trained delivery point Staff Nurse/ RBSK Nurses (Post Natal Ward or anyone designated), under the guidance of the Pediatrician/ or medical officer. **Android App for Visible Birth Defect Screening reporting and documenting** This is planned in such a way that each child will be linked to the corresponding sub center and AWC using GIS technology. For this mapping of all health institutions including sub centers and AWCs is completed. The details along with photographs of new born screened will be entered using the Android app installed in the Tab. The preliminary

without the service of Pediatrician in Wayanad and Malappuram districts. Scrutiny of record maintained at DEICs Alappuzha, Malappuram, Wayanad and Thrissur districts for the year 2016-17 revealed that out of 9588 children referred to DEIC under SHP only 1616 children reached DEIC for further treatment. There is no mechanism at the DEICs to endure that all cases referred from various periphery level institutions reached the DEIC for further investigation and treatment.	details like name, contact number, residing local body (drop box provided), date of birth, no. of live births, time of delivery, APGAR score, new born reflexes, anthropometric measures, breast feeding etc will be documented through this app. After that, if the child does not have any defects it will be saved as normal baby, if not, the app will be moving to the disease condition part and the nurses can see the check list of the condition listed in the app with photographs and description.  As per the above picture all condition with photographs and description is added in the android app itself, so that the RBSK Nurses can add the presenting condition of the child after comparing with photo and description, and they can take photograph of the presenting defects of the child as seen below





These photographs of the defects can be saved against the screening details of the child. The Program is designed in such a way that while entering the screening details on visible birth defect result for any new born screened at delivery point into the Android app including the photographs, concerned DEIC will be able to see the case and verify the condition. Before verifying the case DEIC should see the image, interact

with concerned staff uploaded the same or even the Pediatrician/ MO i/c to confirm the case. Then information will be passed to RBSK MHT of concerned field area for ensuring follow up services automatically by the system. It is also planned to provide instant alerts to all relevant stakeholders through text messages and consolidated reports on screening and follow up on a designated frequency for program monitoring at district and state level

VBD ID- after screening(either normal or defect identified) one ID will be generated against the data of the child, this id will be base for the further screening of the child including pulse oximery screening for congenital heart diseases, OAE screening for hearing and IEM screening for inborn errors of metabolism. These programmes also digitalized now, the same VBD-ID is adding in the initial part of documentation, so that all screening details will be added to the same child profile.

The identified cases are conformed by Pediatricians and referrals and service access through DEICs. The children from the age group of 6weeks to 6 yrs are screened during the regular immunization sessions with the help of android app. Now the RBSK nurses are using their personal phone for screening, and ROP of NHM 2019-20 approved for procuring tablet computer with internet connection for all RBSK Nurses. So that all components of screening will be converted to digital data. The District Early Intervention Centers (DEICs) are established in all districts as first referral point for further investigation, treatment, management of cases and follow up services.

In the ROP 2018-19, we got approval for mobility support for RBSK screening at difficult-rural, tribal, vulnerable areas. There are 19 such areas were identified across the state, doctors are being the part of this team along with 3 skilled RBSK nurses. A MUV is allotted for visiting these vulnerable areas, they are planned to visit all AWCs and Schools as per the micro plan, which is being prepared with the guidance of Block MO and ICDS-CDPO/Supervisor.

Our RBSK Nurses are dedicated and trained for screening of 4Ds, repeated capacity building sessions and close monitoring is being done by the block/district/state teams. They have the enough capacity to screen NTD, Down's syndrome, cataract, deafness, CHD etc.

Pediatricians service at DEIC Wayanad and Malappuram

DEIC Wayanad- Now pediatrician is appointed at DEIC Wayanad

DEIC Malappuram- Now pediatrician is appointed at DEIC Malappuram

Service access at DEIC

Audit report states that the major numbers of screened positive referred cases are not attending DEIC for further investigation and management of diseases

The RBSK nurses are screening on the basis of RBSK Job Aids, they are identifying/suspecting the conditions under 4 Ds. The major portion of the screened conditions by the RBSK nurses will be under child hood diseases

	and deficiencies, which does not require any DEIC service unless the same child has some issues in developmental delay or disability. Under RBSK Scheme, state has following state specific protocols for referring the children to DEIC. The DEIC is the specialized unit for the early intervention & management of developmental delays and disabilities especially for under 6 yrs children. The Childhood Deficiency and diseases are the major health issues among under 18 yrs children especially in rural areas in the state. In Kerala scenario the Childhood Deficiency and Diseases can be managed at SDH level itself. The RBSK Nurses screening all children under 18 yrs as per their micro plan, identifying the 4Ds and referring the child according the actual needs. The childhood deficiency and diseases are referring to nearby institutions where the treatment facility is available and the child with Developmental Delay and Disabilities are referring directly to DEICs Under this circumstances, we proposed one tablet computer for all RBSK Nurses and 10 tablet computer for each DEIC in order to digitalize the documentation from screening to service access. Now we got approval, the procurement process already going on at state level. For this, sofiware is establishing with the help of NHM It wing, so that the screened/referred children to DEIC will be identified and the follow up can be done easily for missing child. The DEICs are established in the district level hospitals, the accessibility of children from rural areas is very poor, this will be influencing in children referred to DEIC for its services. For this reason NHM is established Mobile Intervention Unit (MIUs) as part of Anuyathara campagn of social justice dept of Kerala. The financial support for MIUs is from SID-KSSM, Dept of Social Justice. One MIU will cover 6 CD blocks (6 institutions in a week), 23 MIU is operational and one special unit is operational at Attapadi area. The staff pattern for MIUs consists of 1 Developmental therapist, 1 Physiotherapist, 1 Clinical Psychologist, 1 Early Interventionist cum Special educator and 1 Audiologist cum speech therapist. One vehicle and set of equipments is provided for the intervention services. The developmental delay, disability children can attend the MIU clinic as per the plan and avail the early intervention services.
2.10. Family Planning **2.10.1 Non availability of Family Planning activities** It is observed that all the 32 PHCs test checked provide all the FP activities as envisaged in IPHS, except IUCD insertion. Out of the test checked 16 CHCs, only one CHC (Meenangadi) provide for all the stipulated FP	In Kerala most of the Sterilization procedures were done by Gynecologists or Surgeons. Hence Laproscopy, PPS and NSV are provided through Thaluk, District, General and W and C Hospitals.

activities. Out of the remaining 15 CHCs, none of them provide for Tubectomy, Vasectomy, Laparoscopy while IUCD insertion is not provided in CHC Vengara and CHC Muhamma. All the FP activities were being provided in all the TH/THQHs except TH Thuravoor	
2.11. Immunisation **2.11.1 Poor Progress in Immunisation** The details of Immunisation in the selected districts from 2012-13 to 2016-17 are % of fully immunized Wayanad - 93.16, Malappuram 90.09, Thrissur 99.09, Alappuzha 98.65.	The reason for not completing immunization is as follows:- 1. False belief against fear of immunization 2. Negative propaganda against immunization and 3. The decision makers abroad in some of the families especially in Malappuram districts. However the immunization status of Kerala is improving since 2011. The State has taken various measures to improve the immunization status like Special Immunisation Programme, Total Immunization Programme, Mission Indradhanush Programme, Mission Mukthi Programme (Malappuram only) and awareness regarding immunization has been strengthened. It may be noted that there is no act in India for compulsory immunization. Hence if the parents are not willing for immunization even after the health education by health staff, it is not possible to provide immunization against their will.
2.12. Infrastructure **2.12.1 Functioning of ASHA** Audit observed shortage of 7058 ASHAs in the state (Required 32584, existing 25796) and 3143 ASHAs were not trained in all the seven stipulated modules. Audit observed that the project for supply of ASHA kits was implemented by NHM in 2008-09 and in 2013-14 only. ASHA kits comprising of essential drugs and	At present 26314 ASHAs are working in fourteen districts. We have completed the training of all ASHA on module 7. We have started a state specific module called ASHA Module VIII in 2018-19. The module has two parts; the first part is a revision of previous seven modules and the introduction of Aardhram. The second part is AYUSH which is an introduction to all the systems under AYUSH for ASHA workers. It is first time ASHA workers are trained on AYUSH. We have completed around 9500 ASHA training on Module 8. In the ROP 2019-20 we have got approval for remaining batches. As per ROP 2016-17, we have not got approval for ASHA drug kit. GoI has directed to replenish it at the existing health facility.

consumables meant to be distributed free of cost to the beneficiaries in the field are not replenished from time to time In the test checked 32 SC, no ASHA kits have been replenished since 2013-14 Audit observed that 1939 ASHAs are not bringing any case to health Centre	As per the recommendations of the Governing Body of the State Health & Family Welfare Society, NHM has expelled 1939 non performing ASHAs
2.12.2 Deficiencies in infrastructure in health centres 2.12.2.1 Non conducting of baseline survey NHM had not conducted any baseline survey after 2006. Audit observed that in the absence of baseline survey, NHM did not possess inputs to monitor the progress and was not in a position to access details of improvement which came about due to the investments made under NHM	State has not conducted Baseline survey The State has 5403 Subcentres and each centre have 10000-15000 population and 10-15 ASHAs are working the area @ 1000 per population ASHA workers have all the details regarding total population, total number of houses, eligible couples, under five ratio, antenatal cases etc and the data are being updated regularly every year and entered in the family health register Even though no baseline surveys were conducted, every year, Programme Implementation Plans are being prepared based Comprehensive Health Action Plans submitted by the institutions A bottom up process is done for consolidating these Action Plans These plans are prepared from ward level then consolidated at SC level, PHC level Block level and then district level These plans are giving required inputs for further improvement of the facilities
2.12.2.2 Status of Civil Works 1.Training Centre in the premises of TB Hospital, Manjeri-HLL life care ltd-even after the lapse of 48 months since handing over the building to NHM, the building is idling due to lack of manpower and infrastructure. Training activities are being conducted in rented building. 2.Maternity Block at CHC Edappal-HLL-the maternity block building is idling for more than two years for want of sufficient equipment and	1.Manjeri- NHM has constructed the training centre and handed over to the hospital authorities. The district is conducting the internal trainings of all the programmes at the training centre. 2.Edappal- NHM has entrusted the maternity block and handed over to the hospital authorities. There was a delay in getting the electric connection and the connection obtained on 16.05.2017. Equipments are supplied by NHM in 2018. 3.Fort - Request to review the stand of the town planning department was sent to Chief Town Planner. The issue is in the consideration of Heritage Commission. However the building is put to use by the hospital authorities.

furniture, posting of electrical and cleaning staff. 3.**MCH Block in CHC Fort-**HLL- the building could not be put to use due to the objection raised by the Chief Town Planner, Trivandrum that the elevation of the building was not as per the norms prescribed under heritage zone. 4 **W&C Block at DH Tirur-**BSNL- deviation on civil works necessitated die to the site condition. Lack of proper planning and preparation of project estimate without studying the site condition resulted in the increase of project cost by more than 20%. The work which should have been completed by November 2016 with a project cost of Rs. 5crores could not be completed till date. 5. **Construction of MCH Block at THQH Chengannur-**M/s HSCC (India)- as the progress of the work was very slow, the consultant terminated the contract on 27/05/2015 after forfeiting the Performance Guarantee. Work was retendered and the lowest amount quoted was accepted by the technical Committee in January 2016 with a time of completion of one year. The additional liability consequent on revision of the estimate due to termination of the work by the first contractor was avoidable if the agreement included a	4.**Tirur-** Initially the building was proposed on the rear side of the compound after dismantling some existing structures. There was a delay in getting clearance from Health department. So the building was shifted to the parking area. A basement floor to accommodate the vehicle parking was necessary. Above this basement parking area the three storied building was built with the facilities as per the proposal. As a result heavier foundation was needed. The construction of an extra basement floor resulted in excess cost. Also there were changes in electrical installations such as A/C, power wiring etc. based on the requirement of the hospital authorities. More over 4 Nos of toilets has been provided in addition to the earlier provision. It was necessary to construct RCC staining to well, RCC wall for Ramp, dadoing with wall tiles for the entire building, additional wall construction for the parapet wall, providing plastic emulsion paint instead of distemper etc. Also it was necessary to provide wet riser for firefighting as per the latest revision of fire rules. Changes were effected in the Operation Theatre such as Vinyl flooring was done as per the requirement of the hospital authorities. There was poor response for the tender calls for the laminar flow A/C in the Operation theatre. Response was obtained only on the 4th call which was received on 27/09/2017. Approval for the same is since communicated to BSNL on 31/10/2017. With the completion of this work, the building will be ready for occupation. The actual escalation will be known after the settlement of final bill. **Chengannur-** NHM follows the CPWD rules in our works. As per the CPWD rules, there is no clause for risk and cost. So risk and cost clause has not been included in the agreement condition. The re arrangement of the work through a new contractor based on DSR 2014 resulted in excess amount. The original estimate was based on DSR 2012. Following the views of Audit party, the risk and cost conditions have now been included in the recent contracts. Hence the loss due to rearrangement of works through other agencies can be minimized.

conditional risk and cost clause to make good any loss in case of termination of work 6 Construction of Staff Quarters at DH Mananthawady H.I.L- during the execution of work the Kerala police raised an objection stating that a part of the land belonged to their department and the dispute is yet to be resolved. Failure of the SHM in planning and failure to ensure hindrance free land led to inability to complete the Staff quarters and infructuous payment of Rs.36.89 lakh to the consultant	Mananthavady- Within the land assigned to the hospital authorities, there are three pockets occupied by Pazhashi Memorial Police Department and Water Authority. As per the survey map, an extent of 27 cents belongs to police department. Now the police department has claimed ownership of 63 cents. The absence of any clear cut boundary has paved the way for dispute. The issue was raised before the DDC that met on 28/05/2016 and they have resolved to handover the land of police department to District hospital Mananthavady. A proposal to rehabilitate the police office to some other revenue land has been referred to the Government. The decision is awaited.
2.12.3 Shortages in blood bank/blood storage Audit noticed instances of medical institutions functioning without blood storage/blood bank, available blood storage facilities remaining non functional due to failure to obtain license, blood banks functioning without license, blood banks functioning without license and institutions offering Blood storage facilities instead of the stipulated full-fledged blood bank No blood bank at GH Kalpetta, GH Alappuzha, DH Mavelikkara, and BSU not available in THQH Pudukkad, THQH Kodungallur, THQH Thuravoor. Blood Storage available but not functioning in THQH Thirurangadi, THQH Vythiri and	Among the various CHCs/Thaluk Hospital/Thaluk Head Quarters Hospital,Blood bank/Blood Storage Centres are set up based on the requirement of blood units in the hospital where there are surgery/delivery points which requires blood transfusion as part of the treatment.42 permitted BSC are there in Kerala State of which 16 are non functional because of nil requirement of blood in the institution. The blood banks are given license and renewal by Drugs Control Department. There are three proposed Blood banks where equipments were given in the year 2013, still they are functioning as BSC at DH Neyyattinkara, DH Mavelikara and DH Vadakara. 1.GH Kalpetta- Though Blood bank is not available, Blood Storage unit is functioning 2.GH Alappuzha- The Medical College Hospital has the facility of Blood bank which is nearby the GH Alappuzha. 3.DH Mavelikkara- Though Blood bank is not available, Blood Storage unit is functioning 4.THQH Pudukkad- The institution is recently upgraded as THQH and there is no delivery services are provided. 5. THQH Kodungallur- Blood Storage Unit is now functioning in the hospital 6. THQH Thuravoor- The institution is recently upgraded as THQH and there is no delivery services are provided. 7.THQH Thirurangadi, - license obtained and Blood Storage unit is now

CHC Meenangadi, Blood bank functioning without license in W&C Alappuzha and THQH Sulthan Bathery	functioning. 8.THQH Vythiri - Blood Storage unit is now functioning. 9.CHC Meenangadi- Blood Storage Unit is now functioning in the hospital 10.W&C Alappuzha –License obtained in 2018. 11. THQH Sulthan Bathery- the hospital applied for renewal of the license and approval is awaiting.
2.12.4 Ambulance Service As per IPHS guidelines, referral transport facility was to be made available in each PHC. It was seen that ambulances were available only in 50out of 850 PHCs and 58 out of 232 CHCs. Out of the 32 PHCs and 16 CHCs test checked ambulance facility was available in two CHCs and one PHC (Pulpally, Meenangadi and Noolpuzha)	Under NHM 50 Ambulances are procured for running 108 ambulances. As per the request from KMSCL Rs. 11.88 Crores released to KMSCL from the head of referral transport for the procurement of Patient Transport Ambulance. Though the funds have been transferred to KMSCL, formal directions are awaited from the Government for the purchase of the vehicles and implementation of the project.
2.12.5 Idling of equipments worth Rs.98 lakhs Audit observed in 17 institutions in the test checked districts equipments worth Rs.98 lakhs were idling for various reasons such as non availability of infrastructure/space/man power and its non-requirement.	Equipments idling as unserviceable – In the case of unserviceable idling, action has to be taken to declare the items condemned and to dispose as per the GO Ms:63/2013/H& FWD dated 23.02.2013.Process for the same will be initiated. Equipments idling for want of repair – In the case of items to be repaired, action has to be taken at the institution level.NHM had already initiated a programme " Biomedical Equipment Maintenance Programme" to get the equipment repaired within the shortest possible time under an agreement with M/s Kirloskar Technologies Pvt Ltd. Action intimated to repair the same. Equipment idling for want of Manpower – The equipments can be managed by the staff in the institution. Hence direction in this regard is being given.
2.12.6 Non Availability of Laboratory services Audit noticed non availability of laboratory in 18 out of 32 test checked PHCs. Severe shortfall in the laboratory services provided by the DH, TH/THQHs, CHCs and PHCs in the test	Presently laboratories are available in all THQH, DH, GH and W and C Hospitals. Public Health laboratory, Regional Public Health Laboratories many CHCs have Laboratories and regular post of laboratory Technicians. Through NHM, sanction has accorded to start 205 Laboratories (5 labs are sanctioned in 2017-18). KMSCL has supplied equipments for 185 labs and for 15 labs all other equipments supplied except micropipette. Local Self Government also started laboratories which are functioning under Hospital

checked four districts.	Management Committees
2.12.7 Safety measures in X-ray Centres Audit noticed that 16 out of 32 hospitals test checked offered X-ray services However in 11 out of 16 hospitals, X-ray machines were operated without obtaining Certification of Safety from DRS (Director of Radiation Safety) and ten equipments in seven hospitals are being used without conducting the quality tests. Audit noticed that the technicians manning the X-ray units in four hospitals were not provided with TLD film badges to indicate levels of exposure to radiation	AERB Registration of Radiological Equipments & the purchase of TLD Badges should be done by the concerned hospital authority by registering the details through e - LORA Software. QA test of Radiological Equipments is included in Biomedical Equipment Maintenance Programme of NHM and as per the request from hospital, QA Test is being conducted NHM got approval in PIP 2018-19 for taking AERB License for all Radiological equipments at all the government hospitals and AS issued to KMSCL
2.12.8 Compliance to Quality Assurance Guidelines Audit noticed that though the SQAC and DQACs were formed, DQAT and facility level Quality teams were not constituted in all institutions In the test checked 8DH/GH, QAT was not formed in 3GH/DH and four Thaluk hospitals. Further facility level quality teams were not formed in 11 CHCs and 24PHCs. In the absence of such QAT, internal assessment of quality activities, preparation of key performance indicators, patient satisfaction surveys, identification of gaps and improvement, follow up actions etc were not done.	As per the operational guidelines for Quality Assurance 2013, the organizational structure shows that the quality team should be formed only till District Hospital level In all other institutions which are not taken for NQAS accreditation. Infection Control Committee is formed and they serve the functions of quality control team. In the case of patient satisfaction survey a new android application for conducting online patient satisfaction survey is being developed with of C-DAC and will be implemented soon Now instructions are given to all districts to form quality teams in all institutions.
2.13. Financial Management	

13.1 Short release of funds to High priority Districts

Audit noticed short release of Rs.86.40 crores to the three HPDs during 2013-17

Usually NHM budget division is mainly based on population, but in these districts some additional proposal as requested by districts and as GOI approvals were given as additional approvals such as additional incentive to Medical Officers, Endosulphan rehabilitation programmes, Nutritional development programme, etc. In addition to this there were no additional requests by these districts. Thus state is providing additional funds in order to get required doctors and other services. These are the figures of fund allotted to these districts, fund allotment to districts are as per the requirements of districts.

	2013-14		2014-15		2015-16		2016-17	
	Budget allotted	Fund Allotted	Budget allotted	Fund Allotted	Budget allotted	Fund Allotted	Budget allotted	Fund Allotted
PLKD	1592 00	2006 00	1908 00	1991 85	2201 0	1834 69	2411 0	2191 97
MLPM	2104 48	2443 79	2551 8	2099 49	2507 0	2199 02	3137 0	2576 74
KSD	1203 73	1639 5	1242 8	1222 66	1433 0	1219 06	1504 0	1071 52
Total	4900.21	6089.29	5702.6	5314.0	6141.0	5252.77	7052.0	5840.23

Except 2013-14 it can be seen that budget allotted was more compared to fund allotted. It shows that even though we allotted more budget in HPDs the absorption capacity of these districts are comparatively low.

2.13.2 Janani Suraksha Yojana (JSY)

Audit observed that during 2012-17, 11.44 lakh beneficiaries across the state and 33782 (33%) beneficiaries in the 15 selected institutions of the four selected districts were not paid the stipulated cash assistance.

Even though it was clearly stipulated that for High Performing States the facility would be available only to BPL/SC/ST, audit noticed that the State extended the JSY benefits to APL beneficiaries.

Nonpayment of JSY incentives was mostly due to the introduction of DBT. The software was not working properly and the technical support was also not in a proper way. That all affected the payment delay to the beneficiaries. Corrective measures have been taken for clearing the pending incentives.

As per the JSY guideline of Ministry of Health and Family Welfare the cash assistance for High Prevalent States is Rs.700 for Rural areas and Rs.600 for urban areas. In Kerala, it was decided that the cash assistance should be extended to all the women who are delivering in government hospitals from March 2012. However, CAG, in the All India Performance Audit in the State for 2011-16 has mentioned that Kerala had extended (March 2012) the benefit of JSY to all women who are delivering in government hospitals irrespective of their BPL/APL status. It was pointed out that this was done without obtaining State/Central Government approval. As per the direction from the Governing Body of NHM, a proposal in this regard has been submitted to Government of Kerala for further approval. Based on this, Government of Kerala has given direction to continue the same as per the letter no Health – FW1/191/2017 /Health

dated 2/5/2017

2.13.3 Non availability of records at PHC Chethalayam Audit observed that the PHC maintained two accounts in SBI Sulthan Bathery to effect transactions of NHM. While one account was in the joint name of MO and Block Panchayath President for transactions like untied fund, maintenance grant, WHSC etc and the second account was maintained in the name of MO for all other schemes of NHM. Cash book was available only from November 2014. Other registers like fund register, Cheque issue register, SOE, supporting vouchers etc also not maintained by the PHC. MO of the PHC issued cash cheques for large amounts. Hence the possibility of misappropriation of Government funds cannot be ruled out.	The matter has been informed to Director of Health Services, as these funds are handled by regular staff of health services, for taking necessary actions in this regard.
2.13.4 Advance pending statement Audit observed that an amount of Rs.83.74 lakhs released during the period from 2010-11 to 2016-17 to various organisations/ individuals (total 9 cases) are still pending settlement.	All the advances are settled. Details are shown below.-

Sl.No	To whom paid	Amount of Advance (In Rs.)	Date	Status
1	SPM(Admn &Trg)	5,000.00	6.3.2010	Settled
2	Dr.Rathan Khelkar	39,000.00	11/2010	Settled
3	IDSP	50,00,000.00	11/12/2012	Settled
4	Dr.Sunil	20,000.00	2013-14	Settled
5	State Health Resource Centre	787722	2013-14	Settled
6	State Health Resource Centre	425000	2015-16	Settled
7	NMHP	10,00,000.00	2016-17	Settled

6	State Health Resource Centre	425000	2015 16	Settled
7	NMHP	10,00,000 00	2016 17	settled
8	Quiz Kerala	3,20,000 00	2016 17	settled
9	SHSRC	7,77,728 00	2016 17	Settled

2 14 Non Compliance to mandatory Disclosures It is observed that NHM did not make disclosures of four of the nine mandatory stipulations required by GOI in its website	The facility wise service delivery data particularly on OPD, IPD, Institutional Delivery, C section, major and minor surgeries etc on HMIS has been updated up to MARCH 2017 The data regarding the service delivery data including clients served and kilometer logged on monthly basis of PTA and emergency ambulances, all procurement details and supportive supervision plan and reports will be updated shortly

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സെക്രട്ടേറിയറ്റ്,തിരുവനന്തപുരം.
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APPENDIX III

Appendix From Audit Report

Appendix 2.1

Shortage of drugs in post-partum units

(Reference: Paragraph 2.8.6; Page: 23)

Sl. No.	Name of drug/ vaccine	Purpose	Period of stock-out in the test-checked institutions during the period 04/2012 to 05/2017
1.	Iron folic Acid	Essential during ANC, INC and PNC (upto six weeks).	Intermittent shortage ranging from six to 70 months in 44 institutions
2.	IFA small	Required to be administered to children between the age group three to 12	From 2014, ranging from 17 to 74 months in 45 institutions
3.	Vitamin A	Required to be administered to the children between the age of nine months to five years	Intermittent shortage ranging from four to 15 months in five institutions
4.	Oral Rehydration Solution (ORS)	Essential during Diarrhoea infection	Intermittent shortage ranging from two to 21 months in four institutions
5.	Nishchay	Used for pregnancy test which is essential in the ASHA kits for Sub-Centres to be distributed among beneficiaries in the field	From November 2016 ranging from one to 22 months in 21 institutions
6.	Contraceptive pills/condom	Essential for family planning	Intermittent shortage ranging from nine to 60 months in eight institutions
7.	EC Pills	Essential for family planning	Intermittent shortage ranging from nine to 60 months in 11 institutions

Appendix 2.2

Caesarean Sections performed in test-checked delivery points

(Reference: Paragraph 2.8.7; Page: 24)

Sl. No.	Name of institution	2012-13			2013-14			2014-15			2015-16			2016-17		
		Total Delivery	LSCS	Percentage of LSCS	Total Delivery	LSCS	Percentage of LSCS	Total Delivery	LSCS	Percentage of LSCS	Total Delivery	LSCS	Percentage of LSCS	Total Delivery	LSCS	Percentage of LSCS
1.	GH Kalpetta	833	152	18.25	619	102	16.48	774	154	19.90	808	144	17.82	429	86	20.05
2.	GH Manjeri	3935	754	19.16	4553	879	19.31	4138	750	18.12	3763	692	18.39	3969	859	21.64
3.	GH Thrissur	1271	435	34.23	2435	724	29.73	2980	979	32.85	2804	704	25.11	2478	890	35.92
4.	W&C Alappuzha	3168	1536	48.48	2694	1373	50.97	2129	1148	53.92	1798	963	53.56	1251	602	48.12
5.	DH Mananthavady	2766	649	23.46	2544	471	18.51	1966	394	20.04	1757	426	24.25	1489	371	24.92
6.	DH Tirur	1796	836	46.55	2869	1212	42.24	2324	972	41.82	777	261	33.59	458	152	33.19
7.	DH Wadakkancherry	362	119	32.87	427	164	38.41	518	195	37.64	679	241	35.49	570	187	32.81
8.	DH Mavelikkara	492	328	66.67	679	388	57.14	498	200	40.16	341	190	55.72	137	104	75.91
9.	THQH Vythiri	454	104	22.91	801	157	19.60	672	142	21.13	204	44	21.57	2	1	50.00
10.	THQH Sulthan Bathery	1309	360	27.50	1145	266	23.23	808	217	26.86	1296	292	22.53	1074	221	20.58
11.	THQH Tirurangadi	574	150	26.13	461	110	23.86	363	54	14.88	351	53	15.10	284	62	21.83
12.	THQH Ponnani	1925	562	29.19	1373	484	35.25	1594	671	42.10	1780	755	42.42	1824	703	38.54
13.	THQH Kodungallur	908	467	51.43	1138	532	46.75	1221	615	50.37	1188	573	48.23	806	395	49.01
14.	THQH Kayamkulam	75	36	48.00	514	264	51.36	590	323	54.75	470	293	62.34	317	181	57.10
15.	CHC Meenangadi	733	202	27.56	1193	348	29.17	1384	449	32.44	1000	379	37.90	854	317	37.12

** LSCS - Lower Segment Caesarean Section*

Appendix 2.3

Provision for free diet

(Reference: Paragraph 2.8.8.1; Page: 25)

Sl. No.	Name of the hospital	Audit observation
1.	DH Mananthavady	General diet of Raw egg and milk was provided
2.	GH Kalpetta	Only breakfast was provided to the mothers
3.	THQH Sulthan Bathery	Early discharge/three times diet
4.	THQH Vythiri	No Diet
5.	DH Tirur	Early Discharge/Diet provided for only three to four days
6.	TH Ponnani	Early discharge/Diet provided for only three to four days
7.	THQH Tirurangadi	Early Discharge/Diet provided for four to six days
8.	THQH Kayamkulam	No Diet
9.	DH Mavelikkara	Only breakfast and dinner were served to the mothers and there was no food on Sundays

Appendix 2.4

Free drugs and consumables

(Reference: Paragraph 2.8.8.1; Page: 26)

Sl. No.	Name of the hospital	Items on which expenditure incurred	Audit observation
1.	DH Wadakkancherry	Medicines, Lab investigation Blood, etc.	Shortage of drugs and consumables necessitated patients to purchase drugs and consumables from outside agencies. The hospital had a blood storage unit but instance of patients buying blood from outside noticed.
2.	THQH Sulthan Bathery	Caesarean, medicine, etc.	Patient survey report maintained by the hospital revealed instances of expenses incurred by them.
3.	THQH Vythiri	Blood	An ST patient requesting financial assistance to the Superintendent for procuring blood from THQH Sulthan Bathery for Caesarean. Instance of incurring expenditure to purchase medicine and to conduct test was noticed.

Appendix 2.5

Low Birth Weight babies

(Reference: Paragraph 2.9.2; Page: 27)

Sl. No.	Institution	Total cases of delivery during 2012-17	No. of babies with birth weight upto 1.8 kg	No. of babies with birth weight between 1.8 kg and less than 2.5 kg	Total no. of LBW babies	Percentage of LBW babies with birthweight upto 1.8 kg	Percentage of LBW babies out of total deliveries
1	2	3	4	5	6 = 4+5	7 = (4/6)*100	8
1.	GH Kalpetta	3463	68	635	703	9.67	20.30
2.	GH Manjeri	20358	-	2215	2215	-	10.88
3.	GH Thrissur	11968	-	311	311	-	2.60
4.	W&C Alappuzha	11040	166	271	437	37.99	3.96
5.	DH Mananthavady	10522	257	2964	3221	7.98	30.61
6.	DH Tirur	8224	58	447	505	11.49	6.14
7.	DH Wadakkancherry	2556	10	280	290	3.45	11.35
8.	DH Mavelikkara	2147	-	142	142	-	6.61
9.	TH Vythiri	2133	22	332	354	6.21	16.60
10.	TH Sulthan Bathery	5632	255	1284	1539	16.57	27.33
11.	TH Tirurangadi	2033	2	187	189	1.06	9.30
12.	TH Ponnani	8496	-	524	524	-	6.17
13.	TH Kodungallur	5261	-	500	500	-	9.50
14.	TH Kayamkulam	1966	19	253	272	6.99	13.84
15.	CHC Meenangadi	5164	107	1018	1125	9.51	21.79
TOTAL		100963	964	11363	12327	7.82	12.21

Appendix 2.6

Shortage of essential facilities in test-checked institutions

(Reference: Paragraph 2.12.2.2; Page: 33)

Shortage of essential facilities in test-checked CHCs

Infrastructure facility		Test-checked CHCs	ECG	X ray	Generator	USS	IUD kit	Ambulance	Blood storage
No. of CHCs which do not have the facility	Alappuzha	4	3	3	3	4	1	4	4
	Thrissur	4	3	4	3	4	0	3	4
	Malappuram	4	2	4	0	4	1	3	4
	Wayanad	4	4	3	1	4	0	2	4
Total		16	12	14	7	16	2	12	16

Shortage of essential facilities in test-checked PHCs

Infrastructure facility		Test-checked PHCs	Own building	IP facility	Lab services	Generator	Separate toilet for M/F	IUD kit	Management of RTI/STI
No. of PHCs which do not have the facility	Alappuzha	8	0	8	6	8	6	0	3
	Thrissur	8	0	8	5	7	2	1	1
	Malappuram	8	0	8	4	4	3	2	3
	Wayanad	8	1	7	4	7	5	1	2
Total		32	1	31[180]	19	26	16	4	9[181]

Sub-Centre data for the selected districts

Infrastructure facility		Total no. of Sub-Centres	Quarters for ANM	Electricity	Drinking water	Road access	Toilet	Telephone	Computer and internet
No. of Sub-Centres which do not have the facility	Alappuzha	366	321	48	220	18	126	366	366
	Thrissur	472	253	23	0	0	0	NA[182]	472
	Malappuram	589	95	18	109	17	44	622	NA[182]
	Wayanad	204	12	12	47	0	4	140	194
Total		1631	681	101	376	35	174	1128	1032

[180] Three PHCs *viz.*, Pothukkal and Thirunavaya in Malappuram and Nattika in Thrissur have the facility but do not provide IP service.
[181] PHC Pothukkal in Malappuram provide partial services only.
[182] Data not available.

Appendix 2.8

Idling of equipment

(Reference: Paragraph 2.12.5; Page: 35)

District	Institution	Name of equipment	Numbers	Cost of equipment (in ₹)	Date from which idling	Remarks
Thrissur	GH Thrissur	Automatic film processor	Details not available	Details not available	01.04.2016	A/c not available
	THQH Kunnamkulam	Centrifuge	Details not available	15540.00	21.04.2017	Site not ready
		Vertical Autoclave	Details not available	108150.00	10.07.2017	Site not ready
Malappuram	TH Areacode	Neonatal Resuscitation unit	Details not available	125080.00	02.2016	No Delivery
		Electro Hydraulic OT Table	Details not available	895000.00	02.2016	No operation theatre
	GH Manjeri	Incubator	Details not available	47500.00	Details not available	SNCU was not in paediatric ward
		Generator	Details not available	Details not available	Details not available	Have another one
Wayanad	GH Kalpetta	X Ray Machine	Details not available	1597138.00	18.03.2016	High tension supply not available
		Deep Freezer (2 nos.)	Details not available	450000.00	02.04.2015	
	THQH Sulthan Bathery	Plasma Thawing Bath	Details not available	100000.00	18.06.2015	Space for Blood component separation unit not available in the present building
		Laminar Air Flow cabinet	Details not available	65374.00	07.07.2017	
		Platelet Agitator	Details not available	173949.49	07.07.2017	
		Cryo Centrifuge	Details not available	2900000.00	07.05.2015	
Alappuzha	DH Mavelikkara	Blood collection Monitor	3	271018.00		
		Blood donor couch	3	421024.00		
		VDRL Rotator	1	12781.00	10.2013	Infrastructure not ready
		Hot Air Oven	1	19223.00		
		Incubator	1	30819.00		
		Water Bath	1	141805.00		
	PHC Pathiyoor	Semi Auto Analyser	1	67998.00		
		Colorimeter	1	9823.30		
		Centrifuge	1	5722.50		
		Binocular Microscope	1	28825.40	08.2015	No lab technician
		Hot Air Oven	1	17685.50		
		Water Bath	1	8307.60		
		Needle Destroyer	1	5250.00		
		Micropipette	1	24496.50		
	CHC Muhamma	Generator	1	29500.00	06.03.2017	

Equipment idling for want of repair

Institutions	Equipment	Amount (in ₹)	Date from which Idling
GENERAL HOSPITAL			
GH Manjeri	Vacuum cleaner	4978	01.04.2017
	Nebulizing Machine	2507	01.02.2017
	Dental Lathe	8000	01.02.2017
	Dental Chair	100000	10.04.2014
	Gas stove	3000	18.01.2016

Institutions	Equipment	Amount (in ₹)	Date from which Idling
	ECG Machine (Magic R-2)	43000	20.03.2016
	C ARM	1145000	01.2016
	Pulse Oxymeter (2)	5277	23.05.2017
	Needle Burner	340	
	BP Apparatus	750	
	Phototherapy(4)	27532	05.06.2015
	Warmer	27500	10.10.2015
	C pap Ventilator	84040	
DISTRICT HOSPITALS			
Wadakkancherry	ECG	Details not available	Details not available
	Pulse Oxymeter	Details not available	Details not available
	Generator	Details not available	Details not available
Mananthavady	Foetal Doppler	7500	06.2017
	Steriliser	7000	01.2017
THQH			
Tirurangadi	C Pap	25000	01.01.2017
	Defibrillator	177000	01.01.2017
	Dermatology phototherapy	74500	10.03.2017
	Pulse Oxymeter	37225	01.2017
	BP apparatus	323	02.2017
	Operating Microscope	646000	12.2016
	Stimuplex nerve locator	Details not available	01.2017
	ENT microscope with endoscope	Details not available	01.12.2016
	BP apparatus	1502	05.04.2017
	Foetal Doppler	2500	16.05.2017
	Suction Apparatus	8726	03.04.2017
	Radiant warmer	23256	06.04.2017
Pudukkad	ECG Machine	Details not available	17.12.2016
CHC			
Purunannore, Wayanad	Pulse Oximeter	Details not available	Details not available
	Generator	Details not available	Details not available
Meppadi, Wayanad	ECG Machine	Details not available	03.10.2015
Vettom, Malappuram	Autoclave	Details not available	20.02.2017
	ECG Machine	Details not available	10.01.2017
Vengara, Malappuram	Radiant Heat Warmer 2	15000	01.2010
	Phototherapy	8000	01.2010
	ECG Machine	21814	01.2010
PHC			
Chethalayam, Wayanad	Fogging Machine	15000	30.03.2016

Equipment idling as unserviceable

Institutions	Equipment	Amount (in ₹)	Date from which idling
GENERAL HOSPITAL			
Manjeri	Dental Lathe	8000	06.2015
	ECG Machine Cardiart 108 (3 nos.)	27000	25.05.2012
	Medmarc CG42S	30000	10.11.2011
	Boyles Apparatus (3 nos.)	52990	01.2016
	Electronic Weighing Machine	4750	2016

Institutions	Equipment	Amount (in ₹)	Date from which idling
	Labour cot (2 nos.)	13250	20.04.2017
	Vacuum extractor (2 nos.)	4750	20.12.2014
	500MA X-Ray Machine	787500	20.10.2015
	BP Apparatus	750	15.05.2016
	Steriliser	1500	08.10.2010
	Refrigerator	12000	10.2014
	Deep Freezer	55244	06.2013
DISTRICT HOSPITAL			
	Suction apparatus	10500	Details not available
	O2 flow metre	1300	Details not available
	Stethoscope	700	Details not available
	BP apparatus	1800	Details not available
	Foetal Doppler	15000	Details not available
	Cryo cautery	Details not available	Details not available
	Spot light	30000	Details not available
	Ambu bag (Adult)	2250	Details not available
	Needle Cutter	6500	Details not available
Mananthavady	Weighing machine	1000	Details not available
	Artery forceps	150	Details not available
	Scissors	140	Details not available
	Electric steriliser	7000	Details not available
	Nebuliser	2300	Details not available
	Electronic weighing machine	2000	Details not available
	X Ray viewer	10000	Details not available
	Needle destroyer	6500	Details not available
	Wheel chair	6500	Details not available
	Stretcher trolley	4000	Details not available
	Examination table	4000	Details not available

Equipment idling for want of manpower

Institutions		Equipment	Amount (in ₹)	Date from which Idling
General Hospital	Manjeri	Spot Welder	8000	27.05.2016
		Infusion pump	2700	Details not available
District Hospital	Mananthavady	Foetal Doppler	15000	Details not available
		ECG Machine	2339	05.09.2013
CHC	Pulpally	ECG Machine	21814	23.08.2012
		Anaesthesia Kit	Details not available	29.10.2008
		Vacuum-Extractor	Details not available	23.10.2008
THQH	Pudukkad	Diathermy	Details not available	01.04.2013

Appendix 2.9

Non-availability of laboratory/diagnostic services

(Reference: Paragraph 2.12.6; Page: 35)

(i) PHCs- Number of tests required to be conducted - 11

District	Test-checked number of institutions	Non-availability of lab	Non-availability of tests
Wayanad	8	4	2 – 8
Malappuram	8	4	5 – 8
Thrissur	8	5	6 – 8
Alappuzha	8	6	6 – 9

(ii) CHCs- Number of tests required to be conducted - 36

District	Test-checked number of institutions	Non-availability of tests
Wayanad	4	9 – 21
Malappuram	4	18 – 25
Thrissur	4	15 – 27
Alappuzha	4	15 – 25

(iii) TH/THQHs - Number of tests required to be conducted - 51

District	Test-checked number of institutions	Non-availability of tests
Wayanad	2	11 and 15
Malappuram	2	11 and 23
Thrissur	2	22 and 36
Alappuzha	2	20 and 21

(iv) DH - Number of tests required to be conducted-97

District	Test-checked number of institutions	Non-availability of tests
Wayanad	1	51
Malappuram	1	59
Thrissur	1	63
Alappuzha	1	60

(v) GH - Number of tests required to be conducted - 97

District	Test-checked number of institutions	Non-availability of tests
Wayanad	1	60
Malappuram	1	32
Thrissur	1	63
Alappuzha	1	54

Appendix 2.10

Non-availability of radiation equipment

(Reference: Paragraph 2.12.7; Page: 36)

Sl. No.	Name of the institution	Total number of radioactive equipment	No. of radioactive equipment operated without AERB Licence/ Registration	No. of equipment for which QA test not conducted	Whether TLD badge given to workers
1.	DH Mavelikkara	2	2 (X ray and C Arm)	2	No
2.	CHC Muthukulam	1	1 (X ray)	1	No
3.	THQH Kayamkulam	1	1	1	No
4.	GH Alappuzha	8	0	0	Yes
5.	TH Thuravoor	1	0	0	Yes
6.	THQH Sultan Bathery	1	1	1	Yes
7.	THQH Vythiri	1	0	0	Yes
8.	DH Mananthavady	2	1	0	Yes
9.	GH Kalpetta	1	1	0	No (not installed)
10.	DH Tirur	3	2	0	Yes
11.	THQH Ponnani	3	3	0	Yes
12.	THQH Tirurangadi	3	3	3	No
13.	GH Thrissur	1	0	0	Yes
14.	DH Wadakkancherry	1	1	1	Yes
15.	THQH Kodungallur	1	0	1	No
Total		30	16	10	

Appendix 2.11

Advances pending adjustment

(Reference: Paragraph 2.13.4; Page: 41)

Sl. No.	To whom advance released	Date	Amount of advance (₹)
	2010 – 2011		
1.	State Programme Manager (Administration and Training)	06.03.2010	5,000
2.	Dr. Rathan Kelkar, Director	11.2010	39,000
Total			44,000
	2012 – 2013		
3.	Integrated Disease Surveillance Programme	11.12.2012	50,00,000
Total			50,00,000
	2013 – 2014		
4.	Dr. Sunil	19.03.2014	20,000
	2014 – 2015		
5.	State Health Resource Centre	30.01.2014	7,87,722
Total			8,07,722
	2015 – 2016		
6.	State Health Resource Centre	27.08.2015	4,25,000
Total			4,25,000
	2016 –2017		
7.	National Mental Health Programme	13.04.2016	10,00,000
8.	Quiz Kerala	15.10.2016	3,20,000
9.	State Health Resource Centre	19.11.2016	7,77,728
Total			20,97,728
GRAND TOTAL			83,74,450