THIRTEENTH KERALA LEGISLATIVE ASSEMBLY

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COMMITTEE ON PUBLIC ACCOUNTS (2014-2016)

FIFTY SIXTH REPORT

(Presented on 9th July, 2014)



SECRETARIAT OF THE KERALA LEGISLATURE THIRUVANANTHAPURAM 2014

THIRTEENTH KERALA LEGISLATIVE ASSEMBLY

COMMITTEE ON PUBLIC ACCOUNTS (2014-2016)

FIFTY SIXTH REPORT

On

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

1097/2014.

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INTRODUCTION

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

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

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

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

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

Thiruvananthapuram, 9th July, 2014.

REPORT

HEALTH AND FAMILY WELFARE DEPARTMENT

Audit Paragraph

National Rural Health Mission

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

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

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

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

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

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

1097/2014.

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

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

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

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

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

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

Introduction

The National Rural Health Mission (NRHM) was launched by Government of India (GOI) in April 2005 throughout the country with special focus on 18 States. The Mission aimed at providing accessible, affordable, accountable, effective and reliable health care facilities in the rural areas by reducing the infant and maternal mortality rates, stabilising the total fertility rate of the population as well as preventing and controlling communicable and non-communicable diseases, including locally endemic diseases by involving the community in planning and monitoring. The key strategy of the Mission was to bridge gaps in health care facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II and various disease control programmes. It sought to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. In Kerala, the State Health Mission (SHM) for implementation of various interventions under NRHM was set-up in September 2006 and the State Programme Management Support Unit* was institutionalised in December 2006. The State Health and Family Welfare Society (SHS) and the District Health and Family Welfare Societies (DHS) were formed in April 2007. Prior to this, the activities under NRHM were being implemented by the Director of Health Services.

Organisational Set-up

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

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

Audit Objectives

The objectives of the performance audit were to assess whether:

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

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

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

Audit Criteria

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

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

Scope and Methodology of Audit

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

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

[†] Palakkad, Thiruvananthapuram and Wayanad.

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

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

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

Audit Findings

Planning

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

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

Kannur, Malappuram and Wayanad.

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

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

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

Action Plans at Village, Block and District levels

Due to delays in setting-up of the SHS and DHSs, no Action Plans were prepared for NRHM during 2005-06 and 2006-07. Only proposals for Reproductive and Child Health II(RCH II) were sent to GOI for these years and funds were released by GOI on the basis of these proposals. In 2007-08, Plans at the Sub Centre, block, district and in 2008-09, Action Plan below the State level were not prepared, instead State level were prepared as per the NRHM guidelines. However, fund requirements under various heads were collected from all the institutions and furnished to the SHS for preparation of a detailed State Level Action Plan. Consequently, prioritization of issues at the district level and below the district level could not be done in the State Action Plan for 2008-09. Government stated (September 2009) that institution-based Action Plans were the basis for 2008-09. During 2010-11, ward would be the basis for preparation of Action Plans.

Perspective Plan

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

Financial Management

Fund Management

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

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

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

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

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

Source: Annual accounts certified by Chartered Accountants.

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

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

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

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[•] Opening balance of National Disease Control Programme and Information, Education and Communication activities.

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

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

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

Low utilisation of funds

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

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

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

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

Release of corpus grant, untied grant and annual maintenance grant

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

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

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

TABLE 1.9	NUMBER OF	CHCS/PHCS	WHO RECEIVED	ENTITLED GRANTS
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Source: Details collected through pro forma from CHCs and PHCs.

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

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

Lapses in budgetary control

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

- The SHS released ₹ 91.20 lakh (2007-08 and 2008-09) towards stipend for BSc(Nursing) Students, Rupees six lakh (2008-09) as maintenance grants to six CHCs where upgradation work was in progress and ₹ 16.20 lakh (2007-08 and 2008-09) to Hospital Management Committees (HMC) of the General Hospitals at Thiruvananthapuram and Wayanad. In response to Audit, the State Mission Director (SMD) stated (July 2009) that stipends had been given to nursing students to resolve the shortage of nurses. Maintenance grants to CHCs under upgradation and funds to the HMCs of the General Hospitals were provided because these units were running short of funds. The reply is not acceptable as it was the responsibility of the State Government to provide adequate funds for such activities which were not covered under NRHM.
- As per NRHM guidelines, SCs attached to CHCs/PHCs were not entitled for untied grants. Contrary to this, DHS provided untied grants of ₹ 14.50 lakh to SCs attached to CHCs/PHCs during 2007-08 and 2008-09. In response, the SMD stated (July 2009) that the districts concerned had been asked to explain the reasons for this action.
- A refundable loan of Rupees seven lakh was released (2007-08) to the Kerala State Institute to Virology and Infectious Diseases, Alappuzha.
 ₹ 13.30 lakh was released (2008-09) towards routine expenses (purchase of furniture, fuel charges, etc.,) of the Kerala Medical Service Corporation.

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

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

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

Management expenditure

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

Accounting System

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

Upgradation of Health Care Infrastructure and Capacity Building

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

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

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

Delay in completion of upgradation of CHCs

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

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

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

Construction of buildings for Sub Centres

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

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

Deficiencies in the selected institutions

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

- The blood storage centre at the Taluk Headquarters Hospital, Ottappalam, Palakkad, for which ₹ 1.55 lakh was spent during 2006-07, had not started functioning due to the absence of a trained blood bank technician. Government stated (September 2009) that the technician would be given training shortly.
- An outpatient block completed in March 2009 at a cost of ₹ 25.26 lakh for CHC, Kadampazhipuram, Palakkad was not fully utilised due to shortage of specialist doctors and paramedical staff. Government stated (September 2009) that the outpatient wing was currently functional and an attempt was being made for getting the services of specialist doctors.
- Equipment viz., incubators, suction apparatus, etc., purchased in December 2008, at a cost of ₹ 10 lakh, for renovation of the children's ward at the Taluk Headquarters Hospital, Ottappalam, Palakkad was not utilised as of April 2009, due to lack of three-phase electrification. Purchases were made without ensuring availability of space and usability of the equipment. Government stated (September 2009) that action was under way for getting three-phase electrical connection to operate the equipment and that furniture and other items had been distributed.
- A hospital building for the Taluk Headquarters Hospital, Sulthan Bathery, Wayanad, constructed at a cost of ₹ 1.75 crore (₹ 50 lakh from NRHM

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

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

Accredited Social Health Activist Scheme

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

Mobile Medical Units

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

 ^{₹ 25.25} lakh per MMU towards capital cost and ₹ 9.25 lakh per annum towards recurring charges.

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

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

Deficiencies in upgradation of CHCs and PHCs compared to IPHS norms

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

Manpower

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

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

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

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

Infrastructure

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

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

TABLE 1.10: NON-AVAILABILITY OF INFRASTRUCTURAL FACILITIES

Source: Details collected through questionnaires from 71 CHCs.

Equipment

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

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

Procurement

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

1097/2014.

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

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

^{*} Boyle's apparatus, cardiac monitor, defibrillater, oxygen cylinder and ventilator.

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

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

TABLE 1.11: DETAILS OF PURCHASE OF KITS

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

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

^{* ₹ 7,923} per kit (Basic price: ₹ 7,370 plus Central Sales Tax of ₹ 295 plus administration charges of ₹ 258 at 3.5 per cent of basic price).

^{*} SCs: 5094 kits, PHCs: 829 Emergency Obstetric Care (EOC) kits, CHCs and Block PHCs: 230 RTUSTI drug kits and FRUs: 65 EOC kits.

Procedural irregularities

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

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

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

Surgical kits and drug kits

- Though the supply order was placed with KAPL, it was seen that the actual supply was made by another firm, viz., M/s Plasti Surge Industries Private Limited, Amaravati, Maharashtra, on behalf of KAPL though there was no provision in the contract for subletting the contract. KAPL was allowed 6.8 per cent discount as per the invoice of M/s Plasti Surge Industries kept in the records of three test checked District Family Welfare Stores. However, KAPL had not passed on this discount to the SHS. The indirect purchase resulted in extra expenditure of ₹ 1.99 crore[†] to the SHS and undue benefit of an equivalent amount to KAPL. Government stated (September 2009) that the in-house purchase policy of KAPL was not enquired into and the SHS had no knowledge of any private company through which KAPL had procured surgical kits and drugs kits. However, the fact remains that Government had incurred extra expenditure of ₹ 1.99 crore.
- The SHS did not assess the actual requirement based on the sample survey conducted in September 2006 in all the CHCs before placing the order. In the Family Welfare Stores of the three districts test checked, 26 out of 102 surgical kits had not been distributed to CHCs/First Referral Units as of

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

^{* 6.8} per cent of ₹ 29.29 crore= ₹ 1.99 crore.

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

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

ASHA drug kits

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

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

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

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

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

Performance Indicators

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

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

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

TABLE 1.12: PERFORMANCE INDICATORS

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

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

Maternal health

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

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

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

Immunisation

Routine immunisation

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

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

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

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

Shortfall in administering Vitamin A Solution

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

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

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

Health Management Information System

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

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

The SHS adopted the following multiple software applications:

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

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

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

Integrated Disease Surveillance Project

The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect early warning signals of impending outbreaks and to help initiate an effective response in a timely manner. Surveillance units were set-up at the Central, State and District levels with linkages with all State headquarters, District headquarters and all Government medical colleges on a Satellite Broadband Hybrid Network. Data is collected on a weekly (Monday–Sunday) basis. Whenever there is a rising trend of illness in any area, it is investigated by the Medical Officers/Rapid Response Teams to diagnose and control the outbreak. Data analysis and action are to be undertaken by the respective districts. The total cost of the project was ₹ 9 crore, of which GOI released ₹ 4.82 crore up to 2008-09. The expenditure incurred on the project was ₹ 2.74 crore.

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

Information, Education and Communication Activities

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

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

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

Community participation

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

Conclusion

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

Decentralised planning was crucial for implementation of the scheme but the planning process was flawed as Annual Action Plans were prepared without preparing the State Perspective Plan and without using field level data, obtained through household and facility surveys. The execution of projects by the SHS without the Perspective Plan by specifying the project activities in a critical path resulted in the projects being implemented without adhering to the time schedule. Thus, the SHS could not spend the funds released by GOI, huge amounts were kept in bank deposits and the accounts were not finalised in time. Though funds were available, the entitled grants were not released to all the CHCs and PHCs. Release of funds to activities not approved by GOI was also noticed. Upgradation work of CHCs and SCs were proceeding at a slow pace and even the facilities created were not fully utilised. There were deficiencies in medical and paramedical manpower, infrastructure facilities and equipment in CHCs and PHCs in the State. Procurement of drugs, surgical equipment and computers for ₹ 70.01 crore was made without observing the principles of financial propriety and distributed without assessing the requirements of institutions.

Recommendations

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

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

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

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

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

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

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

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

5. The State Mission Director, NRHM informed that the state of Kerala, had launched a project called Kerala Accreditation Standard for Hospitals (KASH) of its own capacity and its accreditation was given to six institutions in the state so far. She also stated that, Kerala and Tamil Nadu were the only states in India having accredited medical institutions at the Government level. Likewise so many decisive steps were being taken by NRHM for quality improvement in health service. 6. Admitting the administrative apathy in this regard, the witness, Principal Secretary, Health and Family Welfare Department informed that, more time would be necessary to reach up to the level of international standard even after the strenuous effort on the part of Health and Family Welfare Department:

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

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

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

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

11. When the witness, Principal Secretary, Health and Family Welfare Department put forth the practical difficulties in integrating the ward level plan to PHC plan, the Committee remarked that using Information Kerala Mission state level visual priority could be developed by analysing the health programmes taken by panchayath for the last ten years. It suggested that the district plan should be developed in accordance with the vision and perspective so arrived at and it should be done after evaluating what had been done so far to avoid duplication and repetition. If such interventions are carried-out, more interesting projects could have been formulated in the next local action plan.

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

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

14. Regarding the audit objection on release of corpus grant, untied grant and annual maintenance grant, the Principal Secretary, Health and Family Welfare Department stated that the fund was released to the Hospitals through Hospital Development Committee, RSBY (Rashtriy Swasth Bhima Yojana) and Karunya Benevolent fund, but lack of adequate planning support for effective utilisation 1097/2014. was a major problem. Hence the department is planning to consult the World Bank for fixing this issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32. The Principal Secretary, Health and Family Welfare Department apprised that, the Department had asked Kerala State Drugs and Pharmaceuticals Ltd. authorities to chalk out a drugs plan regarding the production of drugs according to the requirement of the department. As the cost of chemicals could not be compromised, the Committee suggested that the price could not be negotiated beyond certain extent. So it urged the Health Department that tender procedures should be diluted and cost of chemicals and its labour charges should be taken into account while assessing the out turn cost of medicines. It urged Health and Family Welfare Department that it should be more cautious in avoiding such abrasions in future. 33. When the Committee asked whether Infant Morality Rate (IMR) of our state could be reached the expected level of 9, the witness, Principal Secretary, Health and Family Welfare Department was optimistic.

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

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

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

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

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

Conclusion/Recommendation

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

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

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

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

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

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

45. The Committee expresses its displeasure over the lack of drivers to operate ambulance service though ambulances are alloted to all hospitals. The Committee urges the Health and Family Welfare Department to issue necessary directions to utilise the fund of NRHM for such essential services. 46. The Committee recommends that Health and Family Welfare Department should take urgent steps to create requisite number of posts of doctors and staff nurses for the effective functioning of Community Health Centres and Primary Health Centres in the State. It also emphasized the need for filling up the vacancies of medical and paramedical staff in CHCs and PHCs as per IPHS norms.

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

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

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

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

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

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

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

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

Thiruvananthapuram, 9th July, 2014.

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

1097/2014.

APPENDIX I

SUMMARY OF MAIN CONCLUSION/RECOMMENDATION

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

(1)	(2)	(3)	(4)
4	42	Health and Family Welfare	The Committee suggests that the action plan should be developed in accordance with the vision and perspective so arrived at and it should be done after evaluating what had been done so far to avoid duplication and repetition.
5	43	39	The Committee recommends the Health and Family Welfare Department that a comprehensive perspective plan should be prepared with a long-term vision and strategy to achieve the target considering decentralized planning.
6	44	"	The Committee observes that fund utilisation of NRHM is not monitored at any level and it is the weakest part of the project. So the Committee urges the Health and Family Welfare Department to constitute specific guidelines regarding utilisation of fund provided by NRHM.
7	45	39	The Committee expresses its displeasure over the lack of drivers to operate ambulance service though ambulances are allotted to all hospitals. The Committee urges the Health and Family Welfare Department to issue necessary directions to utilise the fund of NRHM for such essential services.
8	46	7	The Committee recommends that Health and Family Welfare Department should take urgent steps to create requisite number of posts of doctors and staff nurses for the effective functioning of Community Health Centres and Primary Health Centres in the state. It also emphasized the need for filling up the vacancies of medical and paramedical staff in CHCs and PHCs as per IPHS norms.

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(1)	(2)	(3)	(4)
9	47	Health and Family Welfare	The Committee urges the Health and Family Welfare Department to furnish a detailed statement indicating the number of building allotted each year from 2005-2006 onwards for the upgradation of health care institutions with break up details of the amout allotted per building, number of buildings completed up to the year 2011-12 and also the total amount expended in this regard.
10	48	n	It suggests that designs of buildings for sub centre would be in such a manner that it could get upgraded into CHC in future and also to check the feasibility of utilising the service of ASHA workers in sub centres.
11	49	17	The Committee recommends that Health and Family Welfare Department should take necessary steps for providing requisite manpower, infrastructure facility such as blood storage centre, ECG unit, Operation Theatre, X-ray unit, Labour room etc. according to IPHS norms to provide round the clock services in CHCs and PHCs.
12	50	u	The Committee opines that a standardised procurement procedure should be formulated in the Department to ensure transparency and public accountability during the purchase of medicines/drugs and other surgical/medical kits without further delay. The Committee also urges that tender procedures should be diluted and factors like cost of chemicals and labour chargs should be taken into account while assessing the out turn cost of medicines.

(1)	(2)	(3)	(4)
13	51	Health and Family Welfare	The Committee appreciates NRHM authorities for giving special attention, in reducing maternal mortality rate in the State, but advocates the importance of reducing the Infant Morality Rate (IMR) in the State and directs that earnest effort should be exercised by the authorities in this regard.
14	52		The Committee expresses its grave concern the decline of immunisation rate in Kerala and observes that administrative laxity is the main reason behind this and the Committee directs to implement immunisation programme in the state effectively by rectifying the shortage of vaccines.
15	53	u	The Committee moots the setting-up of an Effective Integrated Health Managemen System as envisaged in the NRHM guidelines. The Committee was informed that the department is proposed to design a new system viz., Kerala State Health Surveillance Survey to collect data. So is urges the department to furnish a detailed report regarding it and also the method adopted to collect universal data.
16	54	11	The Committee opines that innovative healt awareness programmes should be conducted to propagate health care programmes as par of Information, Education and Communicatio activities in future instead of resorting t advertisements through the visual media.

APPENDIX II

NOTES FURNISHED BY GOVERNMENT REPORT OF THE COMPTROLLER AND AUDITOR

GENERAL OF INDIA FOR THE YEAR 2008 - 09 (CIVIL) -

PARAGRAPH No. 1.2 -

ADDITIONAL INFORMATION

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

	Rela	nte (Re in a	rores)	Equ	ullture (ils in a	rores)
Year	Control share	State share	Total	Central share	State share	Total
2005-06	33.92	0	33.92	3.19	0	3.19
2006-07	79.11	0	79.11	17.65	0	17.65
2007-08	210.45	0	210.45	108.75	0	108.75
2008-09	142.02	53.25	195.27	225.76	40.18	265.94
2009-10	215.90	9.41	225.31	249.17	12.18	261.35
2010-11	184.48	35.92	220.40	227.83	25.61	253.44
2011-12	236.10	28.93	265.08	194.81	7.16	201.97
TOTAL	1101.96	127.51	1229.49	1627.15	45.13	1112.29

ACTION TAKEN REPORT ON AUDIT OBSERVATIONS OF THE CAG ON NRHM FOR 2001-09

ľ		The state of a select defense to second	Commit States
.	Part Auron Koport B No		
1	Planing	Factual Perition: Perspective plan is contained in the technical	The NRHM PIP for the year 2012-13 use memoral by the
0	NRHM envienced a decentralized and		process of decentralized
	perticipatory planning process with a		plenning. Program
	bottom up approach from village level	interventions in the health sector, and the construction of the Project Involvementation Plan (PTP) every year is on the basis of these	for National Rural Houlth
	were thus required to prepare		Mission
	Perspective Plans for the Mission period		_
	(2005-12). Action Plans for each year		
	were to be prepared by the SHS by		
	consolidating all the district level plans		computering a proper-
	10 GIADOR IBARYKRANOUS IN LOC INCLUD	PUBLICA OUTINGS, DOUG & UCCULIANZOU BUILOURY AND DEPARTS	people of the State
	of CHC. PHC and SC ware to be		
	conducted for preparing comprehensive		active and vibrant to meet the
	District Action Plans. Audit scrutiny		allenges
	revealed that only a sample household	_	emerging and emerging
	survey was conducted by the		diseases. A 5 year
	Department of Community Medicine of	-	-
	the Medical College, Kozhikode in		
	selected panchayats and municipalities	While facility survey was conducted in the UHU's the same was not	Introductive in the country, these
	DI ULICE OUL UP 14 UNITARE UNITARE Estimates - Manch 2007 Controllinerity		attempt to look at
	the Annual Action Plans were propared		bealth and health
	without adequate field data, rendering		issues in a holistic
	the planning process defective.		perspective.
		ACTION TAKEN: In order to strengthen the process, State Health principle	principle benind we

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Plan for the sector is the that people's local relevance rgence of	various various region- boalth Districtu		tevet. The solutions to most bould problems in a are often bevond the	the Health ne. There are neuts- Social	Water whose the to schemos	Letter No dather y, LSGE	영역
	of sing creative vary	account of each d block ti	hutions proble fen ber		LSG, and atc- are so interti d whose a	Govr I /LSGD	the Head Director
State's health sector is the realization that poople's participation, local relevance and convergence of	functioning of various departments are very crucial for developing region- specific and creative bealth obser for all the 1.4 Districts	taking into account the requirements of each ward, puncheyath and block till the	district-lovet. The solutions to most of the besidth problems in a locality are often beyond the	capacity of the Health Department alone. There are evveral departments- Social	Welfare, LSG, and Water Authority, etc. whose activities are so intertimized to braith and whose schemes	pood to be mitogramod unto une pism. As per Govt Lotter No 43725/DA112/LSGD damod 13/7/12 of Socretary, LSGD	has directed the Hends of Departments- Director of Panchayath, Director of Urban
		taking requires panchey		Cepacity Depertune several	Auth Volt		
(Public Health Planning) has been appointed in SHSRC which will assist NRHM in preparation of Action Plans and monitor the programme. A decentralised planning process will be piloted in Alappuzha this							
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assist NRH programme. A decentrali	year and extended to the entire state.				۰.		
10 00 10 10 10 10 10 10 10 10 10 10 10 10 1	2006. SCan 1000.	2009) amme was			surveys the first would be and the	e State Ice the set up	these ischold c y s ,
at the CHCPHCSC level were to be carried out in all the districts by 2008. It was seen in sudit that facility surveys were conducted in all the 115 CHCs during	Ce and a	Progr Unit	n condo	the training	e HC E	that the Bry, sit th	after ed hou
diatric facility 115 (the Pills	(Sept. State port	d days days in D	data for proj s regards th Government	e 12 € ° e 13 € ° e 13 € °	id be munims two years certable	even requir
ment of the distribution o	September-December 2006. However, no facility survey had been carried out in any of the PHCs and SCs as of May 2009.	Government stated (September 2009) that as the State Programme Management Support Unit was	institutionalized only in December 2006 and SHS started functioning from April 2007, there were delays in conducting necessary field surveys to	colloct essential data for proparing the Annual Plans. As regards the facility survey, the Government stated	(September 2009) that such surveys had been in all the CHCs in the first stage. Facility surveys in FHCs would be about up in phases in due course and the	entire exercise would be completed in sugges. However, the fact remains that the State Government took two years, since the launch of NRHM to establish the set up	for NRHM and even after these two years, all the required household surveys and facility surveys.
	September-D However, n cerried out in of May 2009.		Hornalization His adm there arry		The set of	cultre exorcise wor completed in stages. However, the fact Government took launch of NRHM (RHM
	opter Intio	No a la l	nditu od Sj 1007,	colloci Annual survey,		A contraction of the second of	lor l
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attroys to sectam the sectament sectance symmotic at the CHC/PHC/SC level were to be carried out in all the districts by 2008. It was seen in audit that finally surveys were conducted in all the 115 CHCs during	<u> </u>						

	the most supprised in the second seco	from the Comprehensive Health Plan, around 2379 projects for a budgeted amount of Rs 107 crows are included so far in the Amount Actor Plan (2012-13) of	Amery PRI's have not yet completed the process of 66 projects in the annual Action Plan and the budgeted amount will increase.	Pactnal Position: During 2005-06 and 2006-07 the Ministry of Health and Family Welfhre, Government of India had instructed the state to furnish proposals only for the RCH-II Programme. Accordingly the proposals for these two years in respect of RCH-II were furnished and the same was approved by the Ministry. The Ministry did not instruct that Action Plan for NRHM on the basis of village/blook/district be furnished. While so, funds for Additionalities under NRHM ware released to the state even though the Action Plan under NRHM ware released to the state of chromatences that funds were released to the state block/district chroumstances that funds were released to the state, block/district
Action Fiam at Action Fiam at District Levels District Levels and DHS4, no program and Chily, no program and (I) where sent to GO IIII were sent to GO III were sent to GO IIII were sent to GO III were sent to GO IIII	•			The at Village, Block and advys in setting up of the SHS is slays in setting up of the SHS is Sa, no Action Plants were for NRHM during 2005-06 and Only proposals for Only proposals for the and Child Health II (RCH of these years and e released by GOI on the basis is proposals. In 2007-08, Plants at a

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Remote 2012. It may be noted that the casence of NRHM is enviraged in a decentralized and participatory planning process with a bottom up anorescale. Accordinaly, the annual Program Innelementation Plan	PIP) of the same for NRHM has been prepared through a anticipatory and consultative process with the designment modul gency being responsible at the Diantic Lovels for planning and	Districts), there is in place a docentralized at ucture in terms of Districts Health and Family Welfnes Society. This society is headed by the District Pranchayat President and the District NRHM Plan is put up to the State Society by these District Societies. Being a docentralized structure the District Societies. Being a	planning that takes care of the requirements of the grass root level institutions in sech of the WARD of the District. It is on this basis that NRHM instructions: are planned out and implemented. Participatory approach is in built in the present system, because feed back from the grass root level workers and as JPHNVASHA/Ward Members etc on the various needs and necessities of each ward is alson into account by the District Society is the formulation of the	District Action Plans. It may also kindly note that in addition to the moods at the grass root levels, scane of the interventions under NRHM are generally technical in nature. ACTYON TAKEN: In order to strengthen the process. State Health Systems Resource Centre (SHSRC) has been established which will function as a 'think-tent' for NRHM. One Senior Committent function as a 'think-tent' for NRHM. The senior for fourthic Health Planning has been appointed in SHSRC which will an an Article the senior of Action Plans and monitor the programme'.	Pactual Puddion: Punds for implementation of NRHM flows from Government of India directly through e-banking to the authorhood bank account of the Society. The Ministry of Health and Pamily Welfare, Government of India specifies that RCH-II/Additionalities
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level as well at the District Levels. These bank accounts are operated under e-Banking mode and all transactions are carried out 100 % determinally to the designated bank accounts of the	woipients. In the case of the electronic banking funds are roceived of measured to districts by neise the solverse "London developed	by the Ministry in association with the authorized bank. Fund	release to the districts is on the request received from districts for	Ŧ	lectronically finds to the vendors/implementing units as the case		Mank accounts in the contignated basik account at both the state at well Alertic Found State share for NRFRM is released by the State		The quentum of finds senctioned and released by the Ministry to	ġ	when requirement under each of the program contained in the	include	Ħ	į	1	and upped are releated in the approved near of accounts that cover by the Ministry of Health and Pamily. Government of India.	RCH-	during 2005-06 the value of	췷	츃:	2		1	5	
arei as well at the District Lords. These bank accounts operated under e-Banking mode and all transactions are carried 100 % electronically to the designated hank accounts of	2 I	L.	ŝ	the districts in turn release	8			È	i i i	Ĕ.	R.	Ë.	-	Ä				-	Ā	Į.	4 : 9 :	<u>ĝ</u> :		4	With concentrated efforts, the state is now in the stage
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and 2006-07. During the Ellowards Plan (2007- 12), the contribution was to be in the ratio of 85: 15 between the Centre and the	State. Funds released by GOI for the components were credited to one	single bank account while funds for the	National Disease Control Programmes	were coolified to the bank accounts of the	reportive societies responsible for these	indications, the number reaction of GOI	au are and uning zuut-19 vis-e-vis me smerifikas incimel ven at fallmas		-		Rolin creme		J	đ		3		9		E.		į	╋		ļ
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and 2006-07. During the Howath Plan (2007- 12), the contribution was to be in the radio of \$5: 15 between the Centre and the		'≩ :18	3	2	<u>ן</u>				3				44 ا د	i				F	•	R .			╡	-	
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In this connection it is pertinent to note that the entire NRHBA at in other states of the country was that NRHM was initiated RCH-II and finds were senctioned for Kerala in 2005-06. While by the Ministry under Part 2 Additionilities. At thet time, there v nce Korala was not in the NRHM foom. While the situation mued in September 2006 inder the RCH -II, additional funds were also released to the s mizational act up in terms of the State Hk 2005-06 iuolf, in Kernin only RCH - 2 was initiated in Karn ued as an order on 31st December 2005. However, in the 73 4 (Arogya Karakan) for NRHM State Health & Pumily Welthre Society, District H on the state was primed to implement the technical atrait a 2005-06. The M at 2006. The order committation no mechanism in place to implement the Additionilitie of Houlth & Fendly Welflers, Government of India envi 200 200 200 200 at Presidents. Hence the final orders for 1 a 2-0-206 2005-06. The State and Diatrict Societies to imple indian of issios, District Hashie & Panily Welfs ar 200 bes incr . This contradicts y in Decemb madad in Kan istrict Collectors were d case that District Sociati on capacity orders for proper BOX H Î ē. Amil 2007. hot in place. The org ititi Pasa Scheme was not in brope 1 ist Societie f anced (h where the abi ۲ 7 of 2007. Also, the uppointment of contractual staff (Rs Ĭ ch since Į from Rs 41.46 olved upgradiation of store to Rs 171.52 crore at the close of the District ц. З Surataha Yojana (Ra 12.84 crore), tember 2009) 2006-09, expenditure was 77 per cent of the available funds. The major items ţ ł otting up the SES and the DESa. Durine within of Ris 1.77 artics. Theirs war nere pet in 1 a seen in multi that during 2007-09. han 50 percent, mainly due to del molet year during 2005-09. Ы ould be hi 8 h combres (R.s. 62.03 cross). li i i kite (A27.34 cros) 34.50 crore), promont to SC, PHC,CHC and other Rs 55.02 arore, resulti **ANDIA** Chartered Account went stated (Se Sale Postan 2005-08, utiliantion of and Solutions (199 December 2006 أعدثاراته Ï, expenditure para Na O SLUX area at thick 8 a A Ē Ъ e.

increased levels of speeding for the activities. The task of putting in place Doctors and Nurses in the public health institutions was also a in the case of the activities under the Mianion Flexible Pool, since it weith actions, thrust of the actions under NRHM in 2007-08 was on stablishing fully functional, community owned, decentralizad of expenditure has steadily increased over the years reflecting in In this connection it may be noted that under RCH - II, there are delivery system to ensue sinnifumeous action on a wide essential unit for implementing the acheme at the Districts and below was effectively in place in 2007-06 and not 2005-06. In the round 14 main and 49 mb activities under RCH-II. Each of them is otivities, considering that NRHM is part of decentralization of nursing staff, no meaningful actions could be implemented. Similarly simultaneous action on many fronts, creating institutional set ups like Ward Health and Sanitation Committees etc was initiated. An army of locally resident Accredited Social health As far as the project expenditure pattern is concerned, that the value indicated above for 2005-06, 2006-07 were in flact a big ach as Doctors and Nurses. Strongthening public health delivery ns taken on the agenda, as otherwise with shortage of dootors and Activists with strong referral links was also initiated to strongther se of determinants of health. Priority actions were therefor schievement. It may also be noted that the gentation period is high only at the beginning of 2007, the achievement of expenditure : distinct and a number of technical factors involved. Similarly unde Mission Floxible Pool, there are 26 beads. To implement all the organizational set up as indicated above which is the basic a Managers were put in place only at the beginning of 2007-08, circumstance, that the District Program Managers were put in p ated to ensure availability of health functionaries at all) health system. Success of NRHM is linked to these flucture. involves upgradation of facilities etc. in it i a State the funds released. Government 26 per cent of the funds during the first Ì 06 and 2006-07 was below 20 per cent that Government could utiline only 21 to two years (2005-07) due to delay in atablishing the set up for implementing and Pamily Welfare, released finds to the utilization of funds during the initial years of implementation of NRHM, Rs 5.51 crore and Rs 1.95 crore National immunisation Day, RCH II Pleuble Support Out of Rs 154.21 errore released to the 14 DHSs during 2005-06 to 2007-Rs 86.13 crore while the belance of Rs with them. The arpenditure for 2005-Government of India, Ministry of Health Pop12413, Mission Florable Pop26 and trengthening of immunication were not aleased by the Ministry during 2006- 07 inted (September 2009) that the low stilisation of funds was due to delays in 08, the actual expenditure was only State based on the progress Сонализи unutilised 8 the Management 200 đ (September 2009) 2007-06 respectively. 68.08 crore remained Bucken of June expenditure. ð NUTEM IN the State. ä formation . Programme Unit and SHS. motioned 1 stated 7 ٦ و Ъ

concerned, substantial amounts have been pumped into the public It may be noted that there are more than 1400 health institutions cross the State. One Block Coordinator who is supposed to collect of India as well as the State Health and Family Welfare Society i he Blocks has nearly 8-10 institutious spread over h flow cycle fl and nowedays it d Panely We TALE IN COCKET) Nor 20(3/2007/HAPTWID ipe au alay in utility ure. Covers and is cerried forward to 1 intricte is con to the proo rea of 25 sq.kms. Moreover, HMCs of these instit 2 collect reut regions. Block lovel Coordin 異义 these activities are proceeding amonthly. The ca our placed in 234 blocks in the state to strength to resons for d is ections to i Next amounts perved 8 Society to release funds to the districts. The ž 8 (RHM flow smoothly. Now that there is) Solution a mombars and a ed this proce N SHO cretery, H No. a second 4-5 days for the S Ì ek of every r ization Certific Audit may note that the u Service 89 Tenncial year does not | nditure as well as a The districts have into bus instead and anized at differ me 2007, w porte de po the SOEs from a inditure/Util fictor add e funds. 71 salth system. Dimeter ĩ 8 wurlahope expenditure 4 consensus on the action to be taken for WOLO orders had been issued to organise utilising the funds released to of the expenditure as the hospital elected members. Government also indied that necessary the hospitals as well as in accounting committees g . Utilization certificate institutions concerner to collect statements headed by regional mangenent Į ĕ

Additional Directors of Health, District Programme Managers of NRHM and Officers of Health, District Programme Managers of NRHM and other sealor of expendione's done and physical performance reviewed. Technical and operational insure are distanted and building to find, An already stated, many of the activities would because of its own technical researces have a longer gentations period. Further, in Modical Officer, on the 5 ⁻⁴ working day of the month. The District Modical Officer who is also the Ohief Excoutive Officer of NRHM book tervel review of activities of NRHM in the Madical Officer's Monthly Conference. Likewise, during the 1 ⁻⁴ week of every month, book tervel review is conduced in all the 234 Handh Buokh in the State. The district Programme Officers have been tended on the extivities of NEHM. Finally, and the 234 Handh Monthus District Programme Officers have been tended on the state the District Programme Officers have been tended on the extivities of NEHM. Finally, and the y a District Programme Officer who will brinew the activities of NRHM as a parti- tion of the control of the optimum of the first of the district Programme Officers have been tended on the extivities of NEHM. Finally, and tany use the Madical Officer's District Societies are utilization, and NRHM acts as a facilitator to derove funds and has taken efforts as indicated above to increase the proce of utilization. ACTION TAXEN: As a meent of instructions and follow up with the District Auring 2004-10 the copacitiume increased to 07%. The District Societies are utilizing the services of Block Co-ordinators and other staff to orollocal and frants as a facilitation to derove funds and has taken efforts as indicated above to interven- ted to pass statilize instructions to the periohemel softwated and the principal during 2004-10 the copacitiume increased to 07%. The District Societies are utilizing the services of Block Co-ordinators are appedied and front time to time to state the productine and the princing societies are utilizing t	•			During 2010-11 Fund utilized	against grant received from GOI is 82%. And during 2011-12, 68% of the amount allocated has been utilized. Now action auch as menthy block review and diatrict review on: arranged to increase the % utilization.
	If Hashin, District Programme Managers of NRHM and for officers. At these motings, district who detailed for officers. At these motings, district who detailed f expenditure is done and physical performance reviewed. and operational issues are discussed and bothenedes as a means of improving the performance and utilization as a means of improving the performance and utilization	A As around shown, using on use survivous worse, or a positional forefuer, in tricts, on the 5° working day of the month, the District in Cofficient who is also the Chief Excentive Officer of NRHM in the Medical Officer's or Correspondence.	level review is conducted in all the 224 Health Blocks in the The district will be represented by a District Programme a who will review the activities of NRHM. It may be noted be District Programme Officers have been trained on the first of NRHM. Finally, andit may note that NRHM devolves ity of the hands to Government institutions and an	Art. 2020. Control on Unitation of Market as a facilitator ability of these institutions, and NRHM acts as a facilitator of utilization. IN TAKEN: As a result of instructions and follow up with tricts, during 2009-10 the expenditure increased to 77%. The 1 Societies are utilizing the services of Block Co-ordinators	other staff to collect the expenditure statements from menting PHCs/CHCs/Sub-Centres etc. All the District less have been repeatedly instructed to increase utilization of and to peas similar instructions to the peripheral institutions mine lines. An mejority of the expanditure halos place at a public health institutions below the District Lewel, dions are issued from time to time to ensure that the activities pedieot and funds are utilized by the institutions. This is also
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	Officers (Officers (officer see analysis o Technical reactived,	the dial Medical Medical	(Hook State. Coffice that 1 activities	response to derror the pact ACTIG the District District	and . Societ Societ fands vertice instru-
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	As per Amexure 2 during	10-11 \$5% of fund received	under Corpus grant,	Maintenance grant	Untied Grant had been	disbursed to institutions. But	as a control monsure of	utilization only those	institution which utilized	85% of funds received are	given fresh funds for the next		certy /47% of instantations	12-13 FY GOI approved only	belence amount after	deducting grant in hand and	innount sin	has been released to the institution	"Showing there				-					•	
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being monitored closely at the monthly district conference DMOH.	Factual Position: During 2006-07 to 2008-09, an amount of	Ra.80.11 crores was approved by Government of India towards	Corpus grant, Maintenance grant and Untied Grant. The details of	approval and release of funds to the institutions are shown in the	table below.		ц		MH	с С	W	5	l	╈	Teta T	-	It may be noted that during the year 2006-07 and 2007-05, the artice	amounts approved for the above activities by Government of India	were released to the public health institutions through the District	Health and Family Welfare Societies functioning in the 14 Districts	of the State. During 2008-09, the Executive Committee and	Governing Body of the State society took a conscious decision, in	order to set an internal control of fostering better funds utilization	and preventing idling of funds due to non-utilization, that Grants	need to be released only those institutions which utilize more than	80% of the funds released to the institutions earlier. As a result out	of the approved amount of Ra.36.82 crores during 2008-09, only an amount of Ps 21 K7 crores used and an above historication		ACTION TAKTN During 2010.11 and after 50 12-
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	Release	grat and annual maintenance grant	Each CHC was entitled to receive Rupces	one laids, as a corpus and a maintenance	grant and an untied grant totalling Rs	50,000. Each PHC was entitled to receive	Rs 50,000, as a corpus and a	multitemence grant and an untied grant Rs	25,000. During 2006-07 to 2008-09, Rs 81.12	crore, was sunctioned by GOI towards			untrea grant (14,5 30.6/ Group). Information collected from 71 out of 115	CHCs and \$3 out of 929 PHCs through	questionnaires revealed that one to 46	CHCs and four to 66 PHCs received the	entitled grants during 2006-09 as detailed	onom: Table 19: Namber of CHCARHC arts	a contract and the factor	0	3	Ļ	:	2 %	Ö	8	1	13 19 19	-
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200 40 45 44 32 45 57 Source: Details collected farough proforms from CFK2 and FFK3 Source: Details collected farough proformer provided by GOI for the CFK3 and PFK3 did not reach a large number of these institutions, despite the availability of finada. Government approved? and 2007/08, the earlier amount approved? and 2008-09, grants were released only to those CFK2FHC3 through which utilised 80 per cent of the finads which utilised 80 per cent of ASHA311 Social Health Activista (ASHA311 Social Health Activista (ASHA311 Social Health Activista (ASHA311 Social Health Activista (ASHA310 Social Health Activi
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	The acheme of paying stipend from NRHM has been stopped.	
them. Insertiore more than 32000 ASHAs have to be seconds and trained for the catine state of Karla. Naturally this cannot be done with a limited budget. In view of the Government Order the advance was put in place on a large scale. These health activists have been redected from the villages itself and act as an interface between the community and the public health system. The acharas is well received by the community and is now a major activity under NRHM. Had the selection and training of ASHAs in 2006-07 and 2007-08 been delayed due to paucity of funds, the technical attrategies under NRHM itself would have been advected, and ASHA and its impact would have been after over a king period, and ASHA	Stipeed to B.S.e. Nursing students Fectual Position: An amount of Ra.91.20 lakit was released towards pryment of stipend B.S.e internabip students of three Government Nursing Colloges as per the directions of the Government of Keenia in G.O (Rt.) No.2455/2007/Hdk FWD, Trivendrum dated 5.7.2007. These are students who have passed out of the Government Narsing Schools, and during the period of one year during which they are paid ational by NRHM, they will be working at the Government Medical Colleges, providing marking services to the patient. This externe is bondicial to the public health institutions since services of qualified mursing personnel will be augmented, and also beneficial to the nursing personnel will be augmented, and also competency areas of the state. The cesence of NRHM is increase services to the community, and hence the scheme was beneficial to the commutiv.	
Author, in the teached of MS 17.70 or one Further, in the teached of fairlos, it was noticed that NRHM funds were utilised for mapproved activities at dearthed below. • The SHS released Rs 91.20 Lathr (2007-05 and 2008-09) towards signed for BSe (Numing) students, Rupces six lathr (2008-09) as maintenance grants to six CHCs where upgradation work was in progress and Ra 16.20 lath (2007-08 and 2008-09) to Hospital Management Carmities (HMC) of the G eneral H ospitals at Thinwarefueatment	Waymaid in response to Audit, the State Minimum Director (SMD) stated in July 2009) that stipents had been given to numbing students to reactive the shortage of numera. Maintenance greats to CHCs inder upgendation and funds to the HMCs of the General Houpitals were provided because these units were normalized to funds. The repty is not accept to ble as it was it he responsibility of the state Government to provide adequate finds for auch activities which were not covered under NRHM.	grants. Contrary to this, DHS provided untited grants of Ra 14.50 lishts to SCs attached to CHORPHC during 2007.08 and 2008-09. In response, the SMD stand (July 2009) that the districts concerned

ps, cc, GOI has approved an maintenance Grant for all fC CHCs and the amounts tic released to the institutions of concerned.	or n, GOI has approved untied funds for all subcentres as	1d D. Lown not settled	Yet to reimburse the amount
had been asked to explain the reasons Frachual Position: All the CHCs are in the Government Building, for this action. Artifundable here of Rupten severu lab. A refundable here of Rupten severu lab. was released (2007-08) to the Kerala Stute Ibstitute of Visology and infertureture etc. Construction is generally new or putting up an Ibstitute of Visology and infervious lifetional floor. Maintenance is done in other areas of the CHC beares. Alapteria. Re 13:30 kith wes infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up an infrastructure etc. Construction is generally new or putting up infrastructure etc. Constructure etc. Construction is generally new or putting up infrastructure etc. Constructure etc. Constructure etc. Constructure infrastructure etc. Constructure etc. Constructure etc. Constructure infrastructure etc. Constructure etc. Constructure	Action Taken: Government is being requested to provide funds for the purpose mentioned by Audit. Unstead frands to Sub Centres attached to CHCa/PHICs Factual Position: Sub Centres caters to a population of 2.50 aq km, and is the key to better health services at the local level. Some of them even when attached to another main centre, would need independent actions and funds for key actions such as non- reduction, minor modifications, cleaning, provision of bleaching provder/disinflecturt, cleaning of larvicidal measures for stagment water, repair of soak pris edu.	Referedable loue to Karula State Institute of Virology and Infectious Diseases, Alappenda Factual Position: A sum of Re 5 laids was given on 14/06/2007 and Rs 2 laids given on 12/12/2007 is yet to be refunded by KSIVD, Allepey. The institute has been reminded on the matter to refund the same. Action Takan: Notice has been issued. The Government has also been addressed in this regard. Routhe Expenses of KMSCCL.	Action Taken: NRHM has asked KMSCL to reimburse the same and the same is under process JPHN in Urban Health
had been asked to cuplent the reasons for this action. A refundable lown of Rupeen seven labri was released (2007-08) to the Kerala State Institute of Virology and Inferious Discesse, Alaptura. Re 1330 kith was reference, Alaptura. Re 1330 kith was reference. Alaptura. Re 1330 kith was reference. Alaptura eventor and reference covered under NRHM. The SMD stated	(July 2009) that the institutions had been asked to reflued the amounts. An amount of R.a.51.36 labh approved for the constitution of 14 Mobile Outerech Unitent primers of satings to Junior Public Health Nurues in urban wards, was diverted (2007-08 and 2008-09) for meeting expenses relating to ward health sanitation activities. In response, the SMD justified the diversion and	stated (Jaly 2009) that funds were released to selected urban wards in the State to emble from to initial articular for their designated activities, with a special focus on mothers. However, the diversion was made without the approval of GOI and hence was	lirogular.

Restand Position: Ward lovel Haulth and Sanitacion actions in the Urban area was an ense of concerns. And wards were are the overal under Restan being allored or litega, lack of existina in the units wards. Urban RCH is an approved concerned work in the outcome the concerns. And wards were in urban area. An in Karah dawa in real urban stands. Wards were are component and schraudo. Production is an approved to the program in the posting in the units were in a spectra of concerns. And the technic field in the outcome area. An in Karah dawa in real urban schraub for the posting in the units were. An in Karah dawa in real urban schraub for the outcome area. An in Karah dawa in the outcome the real schraudo. Urban RCH has an spectra of existing in the posting in the units work. In this connection if may be noted the urban RCH has an approved component for 2007-06 and 2008-09. 13. As prowed for the opproved dama provided on the posting in the units of the community is beneficit. Action Taken: Account have been funciled to Gol. During 2010-11 and 2011-12. 13. As provided for us to activate area work in the concern of the approved for use activation of the approved for the management were approved for the another on management were approved for the management for posting the function were approved for the and the outform the abolt on any to the another of the abolt on activities of the abolt on any to the ability of the abolt for the function were approved for the abolt for the function were abound in about on the ability of the abolt for the function were abound in about on the ability of the about the about of the ability of the about on the ability of the ability of the function, were about an out the ability ability ab	Uthen RCH is an approved component under NRHM and for the programme . Medical Officers, JPHNs and Health Supervisors are appointed in Uthen areas with the approval of GOI.	During 2010-11 and 2011-12 the management exponditure was within the budget approved. During 2010-11, the amount approved for programme management by GOI is A4.50 corose and the expenditure is 8.4.40 corose approved for programme management by GOI is Ra.17.28 corose and the expenditure was Ra.14.04 corose.
Management Expenditure A per NRHM guidelines, manage expenditure should not exceed six cont of the sporved amount u RCHI. During 2005-06 and 2006 the exponditure on management below six per cent, whereas it acro the similar of the sporved amount u RCHI. Invite a sporved amount u below six per cent whereas it acro the formation of the socretain the Kernia Medical Service Corpor Limited, outertainment of visitors, was incurred during to the occess.	Factual Position: Ward level Health and Sanitation actions in the Urban area was an area of concern, since the Rural Wards were covered under the actions, leaving insufficient actions at the Ward level in urban areas. As in Korala there in real urban-rural divide, the entire state being almost an extended village, lack of actions in the Urban Wards may not be desirable. Thus during 2007-08 and 2008-09 Ra.51.86 lakhs was utilized for Ward Health and Samination activities in urban wards. In this connection it may be noted that urban RCH has an approved component for 2007-08 and 2008-09. The concept and spirit of NRHM is that funds should flow to the noted areas to that the community is benefited. Action Taken: Accurate here fundabed to Gol.	Factural Fonktion: During the year 2007-06 and 2008-09, Frogramme Management Expenditure incurred was above the permissible limit of 6 % of RCH-II Cost alone, but did not encoord 6 % of total cost of NRHM. However, this does not also mean that the routine administrative expenditure increased beyond the permissible levels. The reason for the increase was technical in nature because during the year 2007-08, Block Coordinators numbering more than 200 and also a number of Dootors and Nurnes were appointed throughout the same, and the aslary cost was booland under Programme Management Expenditure. The appointment of Block Co-ordinators was done to co-ordinate block level activities and Doctors and Nurnes were appointed to augument the public health aervices. For any project of the scale of NRHM during the initial days the cost of management would be on the higher aids, especially in the NRHM contact where large number of Block coordinatora? Doctors/Nurses appointed to augument for public health aervices. For any project of the scale of NRHM during the initial days the cost of management where large number of Block coordinatora? Doctors/Nurses appointed, while it exceeded 6 % of RCH Coordinatora? Doctors/Nurses appointed to angement Cost was less than thems of percentage the Programme Management Cost. Audit may note that in thems of percentage the Programme Management cost was 5.05% of Action Taleas: During 2009-10 the management cost was 5.05% of
		Management Kapemolitarie As per NRHM guidelines, management expanditure should not exceed six per cost of the approved amount under RCHII. During 2005-06 and 2006-07, the expanditure on management was below six per cost, whences it exceeded the limit, by Re.3.06 corers during 2007- 06 and 2006-09. Audit scrutiny revealed that inadmisatible cargembling the limit, by Re.3.06 dorors dury the limit of the activities of NRHM like Nurnes/Doctors' day celebration, wages to drivers stached to the Karala Medical Service Corporation Limited, extertainment of visitors, etc., was incourded during the period, contributing to the excees.

	Audit report for 2010-11 had been submitted to GOI and statutory audit for 2011-12 is going on and will be completed by November 2012.	
RCH - II Cost and during 2010-11, the management cost would be within the coiling limit. Salary of doctors and Block Co-ordination are now booked under the new heads. Action Taken: Audit for all the years up to 2009-10 is over and	Audit Reports have been submitted to Government of India.	Factual Poettion: Upgradation worts have been entrusted to five Government Agencies viz. Hindustan Prefab Limited (HPL), Hindustan Latax Limited (HLJ), Kerala Haulth Research Welfare Society (KHRWS), Kerala Saate Nirmithi Research Welfare society (KHRWS), Kerala Saate Nirmithi Kendra. Andit may note that upgradation works has a long greatation period and would take more than 2 years. Further, procedures stach as concurrence at various levels etc also take time. Audit may note that large projects involving construction and civil works are generally delayed in India due to several factors such as availability of raw materials, labor supply, procedural delaya, technical reasons, and these are beyond the direct control of the organization. This is true in every state and Kerala is no excoption. It is true that the Government of India sanctioned the project for Upgendesion of the Overnment of India sanctioned the project for Upgendesion of the Government of and a sanctioned the project for of this R.2.2007-08. An agreement was made on 3 rd May 2007 between NRHM and M/s Hindustan Prefab Limited with a total consultancy
Accounting System	and 2007-05 were and 2007-05 were a Docember 2005, FJ 2008-09 had no me 2009. The SMC net the Audit Rep proted to be ready proted to be ready finalized not been finalized	Upgradation of Health Care Infrastructure and Capacity Building The core strategy of NRHM includes strongthening of health institutions through bettor hum an resource development and providing adequate infrastructure and equipment to raise them at par with Indian Public Health Standards. GOI approved upgradation of 1/3 bealth care institutions at a cost of Rs 142.40 crore during 2006-09. The construction works works and Rs 0.00 for oney 34 institutions and to them up to March 2009. Construction of 1/3 had been
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period of 30 months from the date of placement of work order. In view of the Hourbie High Court of Karala directions, it was deaded to give first prederence for the installation of Sewage Treatment Plant (STP).	The estimate submitted by HPL on 24-08-07 for the 'Treatment of Severge' was R.a.3.0 ators. The Karaka State Pollution Control Board (KSPCB) issued 'in principle clearance' vide order	No.WPCB/T/2445/75 dated 14.02.2006 subject to its 20 point conditions. Important condition was that the severe and sullage shall be apparately collected and treated. Treated effluent shall be	discharged to soak pit and the remaining disinfected water with a maximum BOD of 3mg/l shall be released to the maximum extent possible for gardening. flushing etc.	The disposal of treated effluent was initially intended to be made to Canoly canal. However when HPL, had automitted proposal to Pollution Control Board which suggested limiting standards to let	out use outpett to use carant, use notes manutures under a revised proposal for discharge into a soak pit after maximum recording within the promises itself. The treatment had to be more soohisticased for actieving such stringent standards. Cost of	additional province, for apparation of sulfage and aswage and also the risk of recycling treated hospital efficient was pointed out to the Board and finally in a mosting convened by the Hon'ble Minister it	was again occase to cancer by uncered surger and severe surger was also taken by The decision to combine the sullage and severes was also taken by the Board. The construction of the STP is now complete and only pipe laying work within the premises remains. The work for internal	pipe laying has started as the question of separation of sullage and sowage has been sorted out. The treated effluent can be carried out to Caroly canal only through pipelines to be haid by KWA as this has to go along the sides of the neighboring reach. It is now understood that the KWA has propured estimates for the pipeline to
completed as of March 2009. OOI also released Rs 20.18 croce during 2006-09 for upgradation of the Institute	of Maternal and Child Haulth, Kozhilkode to a Cantre of Excellence. Rupees 4.58 crore was released as	advance to Hindustan Prefab Limited for installation of a severge treatment plant for the institute during 2007-09.	Only the work of the sovinge treatment plant was completed. The remaining work of laying of a pipeline within the	promises and extramal pipelines to carry the treated effluents was still to be completed (September 2009).				

Pollution Control Board has senctioned R.a. I crore initially to KWA treated affluent can be conveyed to Canoly canal is not treated affluent can be conveyed to Canoly canal. Action Takes: The STP has been completed to this. Hance treated progressing as the local public has objected to this. Hance treated progressing as the local public has objected to this. Hance treated offluent is nov discharge into own land. The finads for the piying of progressing as the local public has objected to this. Hance treated offluent is nov discharge into own land. The finads for the piying of progressing as the local public has objected to this. Hance treated offluent is nov discharge into own land. The finad for the piying of progressing and all works are exported to be attracture have reached the final steps and is almost completed to the final steps and and the final steps and and works are exported to be used by Mach 2011. Delay is completed or an approach and the final steps and the propose in final steps and is almost completed to building infrastructure of CHCs in the propose in final steps and is almost completed to building aurvey, get it approved, revision al Lond the proving to various research the propose in final steps and is no counted of the organization. This is tree in every state and Kranis are and the propose in final steps and frames to suith the pinas and the organization. This is tree in every state and Kranis are and the propose in final steps or construction of the cases, difference of opinion in the ILC's and hence delay in the propose in final steps or construction of the section station of the CHCs and hence proved is of restation structures of the propose of the work, was to be given by the SHS the work through the pixel with the pixes and frames are dimension of the CHCs and hence proved is the project in approved the work was to be given by the SHS the work in apite of repeated tradefining. Now the possibility of the work was to be given by the SHS the work in a sing structures to reported the hold	Many rounds of discussions have been completed the latest at Chief Minister's level to find out routes for bying pipe line, but decision is yet to be taken	
Delay is completion of apgradation of CHCs CHCs Hindusten Latas Limited (HLL) Was appointed as the consultant for up grad at i on work of building infrastructure of CHCs in the State. As per the agreement signed for the purpose in February 2007, HLL was to propere a forsielity survey, get it approved by the hospital management committee of the CHCs and then proper estimates for the work. Administrative samction for build 2006-09, upgradation of 115 CHCs had been entrusod to HLL at an estimated cost of Rs 33.66 crote. Rupecs 27.16 orcre was paid as advance	Pollution Control Board has anotioned R4. I crore initially to KWA for executing the work. Once pipe lying is completed by KWA treated effluent can be conveyed to Canoly canal. Action Takes: The STP has been completed and trial runs have started. However the laying of pipeline to Canoly canal is not progressing as the local public has objected to this. Hence treated effluent is now discharge into own land. The funds for the laying of pipeline to Canoly Canal are from the Kerala State Polihtion Control Board and NRHM has no role in this work. The control Board and NRHM has no role in this work. The control Board and NRHM has no role in this work. The construction of the new building and the removation of the old intuities in progressing and all works are expected to be completed kits reconditioning laying of medical gas line and firefighting is progressing and all works are expected to be completed kits in the final stages and all works are expected to be	Pactual Position: Large projects involving construction and civil works are generally delayed in india due to several factors such as availability of raw materials, labor supply, procedural delays, technical reasons, and these are beyond the direct countrol of the organization. This is true in every state and Korala is no excoption. In this case, delay had also occurred owing to various reasons ach as delay in constitutional of institutional Level Committee (ILC) in each cases, difference of opinion in the ILC's and hence delay in their approval, revision of estimates to suit the budget, poor response of contractors to tender notifications, dolay in demolition of stating structures constructed by PWIV other agencies, cutting of trees etc, which require lot of paper and file work. Delay in eacoution of the project in some areas, especially in the district of Alspurzha is owing to not getting any willing constractor to take up the work in spite of repeated tradering. Now the possibility of executing the work through the LSGI with the plans and drawings prepared by HLL is being explored. These delays are beyond our control and may be condoned. Audit may note that upgradation work has a long gestation period and would take more than 2 years.

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stioning in rented build approved in the Progra lementation Plan for 20 SC motion of buildings for 50 SC medicost of Rs 3.30 crore (R per SC) and for the balance during the subsequent 8-09: 700 and 2009-10: ever, the construction of buil not taken up as of September priority was given cupgradation. Cupgradation of the priority was given of the District Progra agers had been instructed to a part of these proposals. Di that the District Progra agers had been instructed to a part of these proposals. District following deficiencie of: the blood storage cent a luk Headquarters Hoa present daring 2006-07, h d functioning due to the absen mined blood bank not be a blood bank not be a blood bank of the rented blood bank beat a fanctioning due to the absen mined blood bank beat a spent her instructed bale a fanctioning due to the absent a blood balood bank beat a spent her the bood bank beat a spent her and bood bank beat a spent beat and bood bank beat a spent beat and beat and beat a spent beat and balance absent a spent beat and bood bank beat a spent beat and bood bank beat a spent beat and beat and beat a spent bala bood bank beat a spent beat and balance absent a spent bala bood bank balance absent a spent bala bood bank balance absent a spent bala bala bala balance absent a spent bala bala bala bala bala bala bala bal	g at the Sub- trea was fait. I low for up- patien of the es was not in the times of a. In Korala,			thuicians has
ing in rented buildings, proved in the Programme entation Plan for 2007-08, cost of Rs 3.30 crore (Rs 6.60 cost of Rs 3.30 crore (Rs 6.60 SC) and for the balance 1970 ing the subsequent years ing the construction of buildings alten up as of September alten up as of September alter up as of September for upgradation of SCs for upgradation of SCs heir jurisdiction and the uild be prioritised after the institutions in the sample the following deficiencies were blood atorage centre at de blood bank bedmician. and blood bank bedmician.	If the Joint Review Mission (JRM), JPHNs are residis Cantres and hence adequacy of services of Sub-Can Moreover domand from PHC/Sub-centre level is als pradation which again is linked to the health seeking pradation of PHC and Sub-Centra ociety. Therefore up-gradation of the mission during cute domand for immediate up-gradation of the CHK ealth seeking behaviour is for specialists.			both the Medical Officer as well as Blood Bank Te ince boon trained.
	rented buildings, n the Programme Plan for 2007-08, inger for 50 SCs at an 3 3.30 crore (R.s. 6.60 for the balance 1970 subsequent years of 2009-10: 1270). truction of buildings s of September 2009 was given to	2009) that the District Programme Managers had been instructed to automic proposals for upgradation of SCs under their jurisdiction and the work would be prioritised after the receipt of these proposals.	Deficiencies in the selected institutions During field visits to the selected institutions in the sample districts, the following deficiencies were noticed: • The blood storage centre at the Taluk Headquarters Hospital,	

•	 An outpatient block completed in March 2009 at a cost of Rs 25.26 takh for CHC, Kadampazhipuram, Palakinad was not fully utilized due to shortage of specialist doctors and 	Doctors and para medical staff have been provided	· · ·
	paramodical staff. Government stated (September 2009) that the outpatient wing was currently functional and an attempt was being made for getting the services of specialist doctors.		
	viz, incu etc., pi 006, at a 006, at a 006, at a vard at vard at vard at vitieed at vitieed at vitie	Action Takon: Request give to KSEB authorities for getting 3 phase to connection through Numithi Kendra. Beds have already been purchased and cots are put in to use. All other fumiture have been utilized for patient benefits in OP, Casuality, Wards, waiting area etc	All equipment are working in the operation theatre of M C H block from August 25th 2012. All cots are being used and new bed purchased in May 2012 are being used in the newly constructed M C H block from August 25th
	availability of space and usability of the equipment. Government stated (September 2009) that action was under way for getting three-phase electrical connection to operate the equipment and that furniture-and other itoms had heard distributed.		2012.

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Staff has been posted under NRHM and the facilities are functional. The Hospital is also trying for NABH accreditation.	This is not a speciality hospital. One Pedatrician is now posted on working arrangement basis.	Factual Position: The scheme of "Trained female community health activist - 'ASHA' or Accredited Social Health Activist" has put in place in Keralt on a strong basis. These health activists have been selected from the villages itself and act as an interface between the
Bathery, Waywarad, constructed at a cost of Rs 1.75 crore (Rs 50 lakh from NRHM funds) had started functioning from June 2008. However, funperation theatre laboratory and Intensive Care Unit set up at a cost of Rs 34 lakh in October 2006 ould not be made functional as of May 2009 due to shortage of staff. 2009 due to shortage of staff.	 Non-posting of specialist doctors resulted in decrease of outpatients and non-utilisation of facilities viz., a fully equipped mini-operation theatre, labour room and an in-perient ward in PHC, Panamaram, Wayanad, Similarly, the operation theatre and labour room in CHC, Porumamur, Wayanad was idling due to shortage of doctors. Soptember 2009) that efforts were being made to address the problem of abortage of doctors. 	lited Social Health Activist the key components of NRHM provide every village in the
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well G.O. tailed state. dules dules y the y the y the	3	5	0	•	0	0	•	0	0	•	0	0	0	•	512	185	697
The scheme is well Government in G.O. 207 issued detailed scheme in the same. scheme in the same. areas and urben shume. In to impart 5 modules are work by ASHAs in and appreciated by the and appreciated by the ted till December 2010	M	2	0	2257	830	2158	0	2506	0	712 .	1116	1900	2205	1200	2360	3300	20544
The achies of the achies by the achies in the achies in the	Mad		232	2277	835	2188	2976	2550	320	1832	1116	1930	2225	1200	2533	3320	25534
system. The scheme is state Government in 24.02.2007 issued de ASHA scheme in the ASHA scheme in the ASHA scheme in the ASHA scheme is a constal areas and urban a t constal areas and urban a in any case work by ASH escived and appreciated b art. g conducted till December g conducted till December	2		789	2280	35	2349	3620	2584	2263	1946	1116	1965	2300	1232	2624	3320	29223
o health g ifty. The dated 24 dated 24 dated 24 date of A bal arcest of heal arce		IboM	1045	2332	835	2469	3740	2680	2623	2078	1188	5961	2375	1340	2729	3320	30719
public manuality of du emeanation ove order ove order ove order ove order and it large nu unity is the Gov s the Gov	Total	od bo	1100	2354	835	2777	3872	2686	2940	2178	1220	1965	2375	1345	2729	3470	31846
and the control of the control of the control of the control of the second in program in program is well at as well at the communication of the communicatio	I TA		1100	2350	835	2943	3900	2650	2889	0606	1272	1965	2300	1340	2750	3470	32854
community and the public health system. The scheme is well received by the community. The State Government in G.O. (RL)No.64907/HAETWD dated 24.02.2007 issued detailed guidelines for implementation of ASHA scheme in the state. According to the above order, one ASHA should be selected for every 1000 population in tribal areas, constal areas and urban shume. Training is in progress, and it would take time to impart 5 modules of training to such a large number. In any case work by ASHAs in service of the community is well received and appreciated by the community as well as the Government. Action Taken: The details of training conducted till December 2010 is shown below:-		Districts	KSCD	KNR	QYYD	KKD	MILPM	PLKD	TCR	EKM	IDK	KTYM	ALP	PTA	KLM	TVM	TOTAL
formation Activist Activist 28,757 28,757 06 lead and modules modules modules modules ceed that tots, the gues not	IAs as	200	k fig	becond		pected .		towards	Decementy	I the							
a trained formale il Health Activist able to the village. paring 2007-06 "and be imparted 23 days preactibed modules. ing was imparted in the first modules. in the first modules, in the second module that the second module that fit was noticed that bottle training was not	ed ASH	of July	ed 11 4	in the s	4) (1) (1)	ixo ele	8	ity to		in all				•			
a trained i Health able to the being 2000 be imparte preached in the fir the secon n the thir in the thir in the thir in the thir in the thir in the thir in the thir	select		e treja	SHAs	VHSV	2.8	8	un acu		ning				•			
country with a trained formale Accredited Social Health Activist (ASHA), accountable to the village. According to the guidelines, 23,757 ASHAs selected during 2007-06 and 2008-09, were to be imparted 23 days training in five preactified modules. However, training was imparted to 20,860 ASHAs in the first modules. 16,180ASHAs in the second modules 16,180ASHAs in the second modules if \$180ASHAs in the second modules in the three selected districts, the third to fifth module training was not	given to any of the selected ASHAs as	The SMD stated that as of July 2009,	27,024 ASHAs were trained in the first	module, 17,817 ASHAs in the second	module and 1,720 ASHAs in the third	module. As ASHAs were expected	create awareneds	the community	local health planning, it was	to give them training in	lules.	÷					
country with Accredited Social (ASHA), account Accorting to the ASHA's selected ASHA's selected thinking in five training in five to 2008 ASHAs in and 800ASHAs in and 800ASHAs in the three seli-	von to at	e SMD	,024 AS	odule, 1	odulo an	odule.		mobilize	cal heal	give th	five modules.						
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The Mobile Medical Units were not procured. As the Emergency Medical Services were launched in between, it was expected that funds would be required for the procurement of more ambulances for the service.	
	· · ·
Factual Positions: Government of India has approved an amount of The Mobile Medical Units Rt. 512.33 lakin during 2007-08 for Mobile Medical Unit. But no works could be initiated during 2007-08. During 2008-09 an amount works could be initiated during 2007-08. During 2008-09 an amount of Rt. 500.00 Lakins was released to M/s KMSCL, for the was capected that funds Action Taken: The Mobile Medical Units. Action Taken: The Mobile Medical Units Action Taken: The Mobile Medical Units acceled that funds would be required for the procurement of more capected that funds would be required for the procurement of more ambulances for the service.	
	In seven the time the takion Plan of R. 1/2 owevel, no of the the amount mont stand the amount mont stand the amount of the severes and for the amount of the severes the amount of the severes the amount of the severes the amount of the severes the amount of the severes the amount of the severes the severes the severe
1.2. Models medical units 8.5 Under NRHM, financial assistance was to be provided for establishment of one Mobile Medical Unit34 (MMU) for every district for improving health services in medically under-served remote areas. In the Programme Implementation Plan for 2006-07, GOI approved Rs 1.55 crore towards the capital cost of one MMU and nourring costs for 14 MMU and nourring models. 1.4 MMU and nourring costs for 14 MMU including the 13 models.	Markurus aureacy in use in seven districts. In the Programme Implementation Plan for 2007-08, GOI approved Rs 5.12 crore for 13, MMUs. However, no allocation of finds was made to the DFRS for purchase of the vehicles and for moeting the recurring charges of the MMUs, which resulted in the amount remaining unutilised. Government shared (September 2009) that Ra fire, crore had been released during 2008-09 to the Kerala Medical Services Corporation Limited for procurement of MMUs.

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

PRICE did not have a (ped: nurses), speciality cadre involute PRICE did not have a (ped: nurses), the extaing scenario an Accordingly more than 1000 Nurses (items is now being bave Laboratory Technician, while 10 requirement. Regarding did not been inducted in the public Services is being addres befun ayatem to improve have a Pharmetiat. Government stated maternal, howborn and child hands and matrixen	combat. (September 2009) that every effort would infoctions discesses including TB and 111V/AIDS and provide be made to ensure adoquate number of physical and markin health care in emergencies doctors in the inathutions and to fill up require varancia.	Information and the second sec	Table 1.10: Non-evallability of lafrastractaral facilities	No of CHC
speciality cache inducted in the heatth acrite system that changed the extaining scenario and hence the supply of equipments and other items is now being revised based on the actual physical requirement. Regarding the manpower the Director of Health Services is being addressed to fill up the unfilled regular vacancies.		•		
upgrade the CH/Cs and PH/Cs. But due to non availability of sufficient menpower, the institutions were not fully equipped with equipments as per IPHS standards to avoid idling of equipments due to the k-d of meancure				

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			The State Government had dishanded CPC in 2006-07 in order to embletish a new Corporation based on the TNMSC model However, Karala Medical Services Corporation could be established only in 2008-09 and hence during the intravvasing period it was decided by the Government of Karala to do procurement in respect of the requirements under NRHM as per the State Government policy of spoouring through DG84D, rates or from Central / State Public a Sector Undertakings. All the procurements under NRHM vere duts
and through 71 CHCs	4, 1037 major mary to make operational. and operation even 50 per	mber 2009) Mastrochura Dinted out addressed.	ment procodure is to operationation is transparency and and to facilitate a decision-making, 2008-09, the SHS A ASHA drug kits a M/A. Kamataka
Blood storage 70 ECG: 60 ECG: 60 Labour room 29 Operation Theatre 39 Arany 62 24 hour 26 62 27 10 28 curregency 29 curregency 20 curregency Source: Details collected through questionnaires from 71 CHCs	Equipment Equipment According to IPHS norms, 1037 major types of equipment are nonsenary to make the operation theatre (0T) operational. Out of 32 CHCs which had operation theatres, 27 did not have even 50 per cost of equipment in the On.	Government stated (September 2009) that the deficiencies in infragroctural facilities and equipment pointed out by Audit were being addressed. Progressed	d procu br the SH molity a molity a sub- the from

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We not come the the Governing Body of Same Hauffa 4 may be noted that the Governing Body of Same Hauffa 4 the process a vali at the procedures involved in the heart the process a vali at the procedures involved in the heart coefficility of Karnataka Antibiotics & Pharmacounticals Law coefficility of Karnataka Antibiotics & Pharmacounticals Law coefficility of Karnataka Antibiotics & Pharmacounticals Law coefficility of Karnataka Antibiotics & Pharmacounticals at concerned, it may kindly be noted that the comp Government of ladia Navratas company set up in the y and they are at ISO 9001-2000 accordined company and re- server a severts, mational and intermeticand, and more ap provedipous areards for excellence in performance restrict Hon 'bh. Prime Minister Dr. Marmotan Singh and former Dr. Abdal Kalam. It was based on the contibility that Gorder formedial soundbess, record of quality but consideration under similar programs and administrative capabilities to under similar programs and administrative capabilities to under similar programs and administrative capabilities to under similar programs and administrative capabilities to the continue of the sound of the former.	(KAPPU), a Canti Padio Sector Manufactor (KAPPU), a Canti Padio Sector Manufactor Details are given in the table balanc Table 1.11: Details of patchase of hits	4~4 1~1 1~1	1		- 1A / IA	大人員	-28 928 2849 2		854 8 6 7 8 8 8 8 8	 €s€]-{	Source: Records from the State health and Family Welfare Society
		121 171			「「」」	<u>.</u>	9 R 1 1	「「「「「「」」	1. #R	 		itate ociety
				Hourigious awards for excellence in performance received from the Hourible, Prime Minister Dr. Mannohan Singh and former President			1					

Governing Body of State Health & Family Welfare Society which is the apex body of the society has approved the process as well as the Audit may note that large amounts were lying unufilized under on for NRHM, but it required that the funds already released be In line with the Government of India's Purchase Preference Policy of drug kits from M/s. Kamataka Antibiotics & Pharmacouticals Order stated that during NRHM discussions with Health Ministers of other states, procurements were being done through Central per the State Government policy of procuring through DG841D usued by the Government of Kerala. It may be noted that the distributed CPC in 2006-07 in order to establish a new Corporation the intervening period it was decided by the Government of Kertala to do procurement in respect of the requirements under NRHM as rates or from Central / State Public Sector Undertakings. All the procurements under NRHM were thus carried out based on orders various honds under NREM. Delay in funde utilization could have led to cutting down of allocation from subsequent allocations from Government of India. To avoid cuts during 2007-08, it was decided 15 crores for procurement of drags was indicated in the State Action Limited, a Coverment of India entryprise. Further, the Governmen per the State Government policy, under NRHM Minston Flerible Pool and not under the RCH II Project. The State Government had Corporation could be estublished only in 2008-09 and hence during (PPP) for purchase of medicines manufactured by Pharma Centra been issued by Ministry of Health and Pamily Welfare, Governmen to expedite utilization of finds. During 2007-06, a budget of atlen In No-Objection is based on the TNMSC model. However, Kerala Medical Service Pharmacouticals Limited, Government had anotioned producine Procurement of surgical kits, drug kits, computers etc were done of India to effect procurement from Karnstalia Antibiotics Public Sector Enterprises, and considering 4 procedures involved in the items. utilized first. Ē. te made from a single Conditions of agreement for supply of nd Family project envisages different methods for te single tender --system was to be dopted only for drugs and equipment were of proprietury nature or Also, the Purchase Preference Policy August of 102 Phenne iscounts up to 35per cent. However, for or ASHA drug kits, the limitedhander though various options were available asper he procurement policy. Moreover, the Weiflare in July 2006 for the RCH II procurement like open tenders, limited anders, global tenders, etc. However, . Enterprises absidiaries, eitherby inviting limited directly at the National Authority with han was adopted and munificatures of the item demanded. The procurement guidelines issued by where only one particular firm was the xurchase of surgical kits and drug I 2006, envisaged procurement adopted. GOI H the Ministry of Health nedicines manifactured Sector enders or by puthing Thermaceuticals Pricing Procedural Irregulariti ð oringle trader Syl to purchase wi (CPSEs) and their , TRA certified à im viz. KAPI pevoide Cittered

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augetal kita, ASHA dang kita and drug kita Public Sector Undertakings by direct purchase. There were specify pre-despetch and/or post-despetch instances where direct purchases from Pharma CPSUs have been inspection by the parchase. Final done in Karala.				or surgcau area. It may be kindly noted that the Standard surgical sets of various types comprises of different types of surgcal equipmentAratuments intended for different type of surgcal Blood transflueion kits are comprises of items like centrifages, where beth, test tubes, blood bags, microscopes, glass slides, BP appendan, etc., intended to meet beer minimum requirements to set up any blood transflueion center. As per the above parameters, none of the above all items are svaliable with any single manufacturer. For
surgical kith, ASHA drug kith and drug kith specify pre-despetch and/or post-despetch inspection by the purchaser. Final	prevents are to be made only after the receipt of final acceptance cartificates from the district Stores-in-charges. Scrutiny of records in the Family Welfare Stores at the three districts test-checked	revenued that no pre-despatch or post-despatch impositions were conducted by the SHS or by the DHSs to ensure quelly, quantity and workshifty of the supplied material. However, the final programma were released by the provincema	 antrutures comprise genting reports of short supply and damages. In reply, Government stated (September 2003) that the damaged items of the kits had been immediately replaced by KAPL. According to the agreement conditions, a penalty equivalent to one per cond the penalty one penalty one per cond the penalty one penalty one per conditions. 	was not not not not not up in appropriate subject to a maximum of 10 per cent of the cost of delayed goods. There were delays of three to eight words in supply of surgical kins, one to five words in the case of ASHA drug kits and one to fourteen words in the case of drug kins. The penalty,

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n hevin His nov Resion	여러 날 다 나 나 나 나 나 나 나 다 다 다 다 다 다 다 다 다 다 다	diepete stath en	R-dispetch inspection condition was included in the agreement as aftegment against any issue that could arise during supply. The diffion is not a requisitory one to be enforced. However, c.K.A.P.L. was asted to give an undertaking that they will be liable	r making of any discrepancy in the stock or functioning of the auchine. M/s.K.A.F.L had given as undertaking that they will fully omply with the agreement signed for supply of arrejont kits and over shall not be any lapse in their part in implementing the works assumed to them. They also assured that the best quality of service asimol to them.	directio ioning the we	t all d the state arts to y articles	worki
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kitting, the fra KAPL is the arperience bed Supplies of the	company like KAPL unlike other models of procurement for effective time bound implementation of NRHM/RCH health programmes. In addition to 102 lists of medicines, KAPL is the oreferred surplier for these different kits for procurement by various	tatic governments on case to case busit. As per the agreement, the purchaser shall under pre or post dispatch inspection on random basis as doemed fit. Also, Pre-dispatch and	post-disputch inspection condition was metuoded in the agreement as a suffegrand against any issue that could arise during supply. The condition is not a regulatory one to be enforced. However, M/r,KAPL was asked to give an undertaking that they will be liable	for making of any discrepancy in the stock or functioning of the machine. M/s.K.A.P.L had given as undertaking that they will fully comply with the agreement signed for anyphy of aurgical kits and there shall not be any lapse in their part in implementing the works usianed to them. They also assured that the best quality of service	would be provided for all works executed by them on the direction of State Mission. Certain complaints were received regarding the non-functioning of auction appendua, pulse oximeter and some other apparatus were not functioning properly in cartain districts. The State Mission did	not release the payments and saided SPM (RCH) to get all the deflects rectified in his regard. SPM(RCH) coordinated and informed M/s.K.A.F.L who in turn deployed tochnical experts to all the districts in Kernala meeting the DMOs, DPMs, Superintendent of kernetist. An anxiety the Addressian / survey the new functionity	and provide technical expertise for installation and proper working of equipments. All damaged items of the kits were immediately
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Barryleast for the action of the bit were generated and reprised to the supply orders for supply the use. In many cases the user is the action is many cases the user is and the user is the user is and the user is the user is and the user is an ison case. The course is a later is the user is the user is an ison case to the user is an ison case. The course is a later is the user is an ison case to the user is the user is the user is an ison case. The course is a later is the user is an ison case to the user is an ison case. The course is a new case is and the user is a many case the user is a many case.	· · · · · · · · · · · · · · · · · · ·		<u> </u>	
	their representatives to look into any problem as and when informed. Components of the kits were guaranteed and replacements were made in time. All ok reports were obtained and the supplier gave an undertaking that they will readily any problems the supplier gave an undertaking the they will readily any problems	he suppliers and the same was attended to immediately. It was incluse informed by SPM (RCH) that they have submitted reports with certification from concorned authorities and only under these incumstances, the remaining perment was released. Since many of he items were dedicate equipment, once they are being used, the terms can be tested and replaced by MA.KAPI., if not working, it terms can be tested and replaced by MA.KAPI., if not working.	ray also be noted that the warranty clause has already been included in the agreement. The State Mission had issued a show cause notice to invoke penaity clause for invoking time for the delay in apply. However, Mis. (APL had requested not to involte genuine difficulty in logistics in mpplying kits to different hospitals. KAPL had written to NRHM applaining difficulties resulting in minor delays in supplies which included transport bottlenedia, striker, raw material problems etc. The Governing Body in its meeting held on 12 th Jane 2007 resolved	Audit observation in respect of the paragraph may therefore be dropped. Action Takes: Drugs purchased has been utilized by the institutions. The para may be dropped. Procurement order was issued to M/s.KAPL was not conquired into. The in-inouse purchase policy of M/s.KAPL was not conquired into. Procurement has been done by M/s.KAPL and the Same Minsion has no knowledge of any private company through which M/s.KAPL has procured. As far as the Minsion is concorred, supply ordens are for kits and not individual drugs. In any business the supplier from different serveces. Anoth may note that in any business the supplier from different serveces.

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would try to condense their cost, so that enough profit is generated to sustain their business. The difference between the sale value and cost of goods sold is the profit margin of any concern. In this connection, it may be noted that (Jovernment of india has released finads for upgradation of Community Health Centres in Kerala. The main components for upgradation are broadly classified	as follows. infrastructure manpower equipments drugs investigative facilities etc. Under NRHM, it was proposed to upgrade all Community Health Centre to Indian Public Health Sandards (IPHS). Government of Centre to Indian Public Health Sandards (IPHS). Government of	Works, drugs, surgicids, infinaturations as up 1 unsurgets for CVI. Works, drugs, surgicids, infinaturations each Through NRHM, over 1200 doctors have been spointed on contrast basis in the State as Contract Doctors / Compularry Runal porting for doctors including 400 specialists. Ferther, over 1000 numes, called "Service Nemes" have been appointed on contract basis.	is a shortage of drugs and sargicals in the health institutions. In order to overcome the shortage of drugs, as per G.O.(Rt).No.231/2007/H.ArTWD dated 19.1.2007, orders were given to M/a. Karnatala Antibiotics & Pharmacouticals Limited to supply drug kits for health institutions in the State. The shortage of surgicial was still prevalent in the State.	As per the Framework for implementation of Nichim approved by the Union Cabiner, the Mitselon abus at bringing all the GHCs on a per with the IPTS in a gradual messer. In the process, all the GHCs will be operationalized as PRUs with all the facilities for Emergency Objectic Gare. IPHS is a concept to fix benchmarks of
contract for subliciting the contract. KAPL was allowed 6.8 per cent discount as per the involue of M/s.Plasti Surge industries keept in the records of three test checked District Panily Welfare Stores. However,	KAPL had not passed on this discount to the SHS. The indirect purchase retuiled in extra expenditure of Rs 1.99ences to the SHS and under benefit of an equivalent amount to KAPL. Government stated (September 2009) that the in-bouss purchase policy of KAPL was not equived into and the SHS had no honduched into and the SHS had no honduched into and the	 Company through which KAPL had company through which KAPL had procured angical liberadrugs his However, the fact remains that Government had incarned extra expenditure of Ra1.99crore. The SHS did not assess the actual 	requirement based on the sample survey conducted in September 2006 in all the CHCs before placing the order. In the Family Welfare Surves of the three districts test checked, 26 out of 102 surged it is had not been distributed to	CRUSTER REPORTS UNDER OF MARCH 2009. Physical verification done by Audit in two First Referral Units and three CFICs also revealed idling of seven surgical kits conting Rs 31 lath.

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infractructure including building, manpower, oquipments, drugs, quality assumes through introduction of treatment protocols. IPHIS defines the level of services that a CHC would be expected to provide. It also manismed that centre would support the entire central expenses of construction / removation of CHCs including	manpower and equipment. As per the final allotment for CHC Upgradation, equipment let worth Rs.22.19 lader can be allotted per CHC for fully functional Commanity Health Centre as per IPHS standard.	State regarding the service delivery, clinical manpower, algoot manpower, investigative facilities, physical infrastructure, Operation Theare, Operation Thearte Equipment, Labour room, Labour room equipment, Blood Storage units, Water Supply, Sevene Waren Disnoval, other conforments in several orality	 programme etc. Institution Lovel Committee teach of the CHCs to collect the facility survey date on to PRU lavela. M/s HLL conducted the facility ation and consultation with fractitution Lovel Con- mol the following equipment required at the CHC model the following equipment required at the CHC 	Sumdard Surgical Set - I (unavunenta) FAU Sumdard Surgical Set - II CHC Standard Surgical Set - III Standard Surgical Set - V Standard Surgical Set - VI (UD insertion Kit	Normal Delivery Kit Equipments for Anesthesia Equipment for Noo-natal Resuscitation Materials Kit for Blood Transfitsion M/a.Hindustan Latex Limited, who are the consultative agency for incolementing the activity "Upgradation of CHC to IPHS" in their
 GOI instructed (December 2006) the State Government to procure the drugs from primary manufacturers following the Purchase Preference Pollov for 102 	modicines. The kits were to be formed by the State after procuring the drugs appended by 15 February 2007.	고은장태리	tatted (September 2009) that citting required a long process i.e. accuring the strens, assembling them n godowns, and kitting using semi-stilled and unskilled labourers. This would	involve nuge investment and therefore readymade kits were purchared the reply of the Government is not coeptable because the purchare of readymade kits was against the instructions of GOI.	

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in the Surgical heir lotter approved the infrastructure, in CHCs. in CHCs.	the genera in the IPHIS Storage uni surgicals for surgicals for pgradation o	at Konthibode on 21 st February 2007. The fould the requirements of anglosts as t of India and Hindustan Laters Limited in affect the same. During the 2 st meeting at February 2007, the optimions of specialisti t the necessity of anglosuls was speci out by	d being opinio S'r ear	LHL Society
in the S approv approv infrast infrast in frast eved th etved th etved th	Stora the	de on 21 st Fobraary 2007, requirements of angloads and Hindustan Later Limite are. During the 2 st meetin 2007, the opinions of specia ity of angleads was sport ou	of the second	NA G
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d list nor of the start ficility of the start start of start	sted vised or vised		i e e e e e e e e e e e e e e e e e e e	Mark Mark Mark
C had suggested list of items CHCs (copy annexed). India as per /2006-RHS dated 5-3-2007 the to provide manpower, investigative facilities et onmented that they have rest onmented that they have rest investigative facilities at an of inflastucture. Interpower HCs. Government of inflasta	tion II resident and and addition		Martin RCU H	of surgicals as if senior office Anosthetist, formed as det
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proposal for model CHC had suggested list of items in the Surgical kits to be procured for CHCs (copy amercad). Government of India as per their letter No.D.O.No.P.17108/17/2006-RHS dated 5-3-2007 approved the proposal of the State to provide manpower, infrastructure, equipments, drugs, investigative facilities etc. in CHCs Government of India commented that they have received the DHS facility survey of the CHCs. Government of India further stated that the recultive survey of the CHCs.	drugs and investiguative facilities listed along with the general designs for CHC building and residential building in the IPHS guidelines for CHCa. It was also advised that Blood Storage unit should be included in the proposed model CHCa. Under these cirgametances, it was planned to procure surgiculs for the state as per requirement. In order to securitatize the upgradation of the state as per requirement. In order to securitatize the upgradation of the state as per requirement.	The members, the I [#] being at Kondnikode on 21 [#] February 2007. The members, the I [#] being at Kondnikode on 21 [#] February 2007. The meeting discussed in detail the requirements of surgicules as suggested by Government of India and Hinduatan Later Limited in CHCs and FRUs and drafted the same. During the 2 [#] meeting at Trivendrum held on 24 [#] February 2007, the optimions of specialists were again taken wherein the necessity of surgiculs was spech out by	the spectatists used on use requirements. In both the meetings, recommendations of specialists were obtained and the list of surgicials to be procured for the State finalized based on the plan proposed by M/s. HIL. The doctors were of the opinion that at least 3 CHC kits and 6 FRU kits should be procured for each CHVFRU.	In order to finalise the list of surgicals as proposed by M/s.H.L., a core committee consisting of senior officers of NRHM, Pediatriciae, Gynaecologist, Surgeon, Anesthetist, Preventive and Social Medicine specialist etc was formed as detailed below.
proposal for a kits to be proor Government No.D.O.No.P. proposal of equipments, Government of facility survey the requirement	daugs and i destigns for guidelines fo should be in Under these the state	normon and meeting of meeting of CHCs and Trivendrum were applin	in both the i and the list on the plan j that at least CHC/FRU	In order to core count Gynaecolo Medicine The K P Ph
proposal for model CHC had suggested list of items in the Surgies kits to be procured for CHCs (copy armozod). Government of India as per their latte No.D.O.No.P.17108/17/2006.RHS dated 5-3-2007 approved the proposal of the Sante to provide manpower, infrastructure equipments, drugs, investigative facilities etc. in CHCs Government of India commented that they have received the DHS facility survey of the CHCs. Government of ladia further stated the the requirement in herms of infrastructure, manpower, equipments	deviges and i deviges for guidelines fo though be in the state	noembers, di meenbers, di meenbers, di meenbers, CHCs and Trivendrum vere aprin	In both the I and the list (on the plan I that at least CH4/YRU	In order to core comm Gynaecolo Medicine
proposal for a kits to be proor Government No.D.0.No.P. proposal of equipments, Government of facility survey the recutivente	darugs and i designs for guidelines fo though be in the state as	noembora, d meenbora, d meenbora i anggeotod b CHCa and Trivendrum were again	In both the I and the list (on the plan I that at least CH47RRU	In order to core contra Gynaecolo Modicine (The F 2 bu
proposal for a kits to be proof kits to be proof Government No.D.O.No.P. proposal of equipments, Government of facility survey the requirement	dentigra for dentigra for guidelines fo Under these the state as p	normon, and member, d member, d suggented b CHCs and Trivendrum vere again	In both the I in both the I and the list on the pian I that at least CTACTRR I.	In order to core count Gynaecolo Medicine 1 Te Y D D
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Gynaecologist, Civil Surgeon, W & C Preventive & Social Modicine Specialist & NRHM) betist, NRHM Consultant (M&E) ARMO, General Hospital, Trivandrum at consideration the recommendations of the othe consideration the recommendations of the and 6 RU kits should be procured for each since the budget outlay for the procurement RU kits will be too high, it is asgessed that i and 2 RU kits any be procured for each since the budget outlay for the procurement RU kits will be too high, it is asgessed that i and 2 RU kits any be procured for each since the budget outlay for the procurement for the state. The and for and since the budget outlay for the procurement for the state. This and the eristing for providing Surgical kits. This included 5 distaby urgraded into FRUs and the eristing for providing Surgical kits. This included 5 appuram, CHC Attapady and Thial Hospital cold kits was done with proper planning and teno all the static-holders involved Similarly, mence all the static-holders involved Similarly, mence all the static-holders involved Similarly, teno all the static-holders involved Similarly and 30 Russ were conducting deliveries. In Auth were conducting deliveries. In Auth were a sub- ted and the state outh prove of the sector. It may be a the sector and the state outh and a sector sector and a sector	 Dr. Mondrum Dr. Mondrum Dr. Monas Mathew, Preventive & Social Moticine Specialist & Hospital, Trivandrum Dr. Monas Mathew, Preventive & Social Moticine Specialist & Technical Consultant (NRHM) Dr. Kandeen, Amasthetisk, NRHM Consultant (M&E) Dr. Sandeen, Amasthetisk, NRHM Consultant (MAE) It can be procured for the bolve percentent of the angested that intitually one CHC kits and 6 FRU kits will be too high, it is asgested that intitually one CHC kits and 5 FRU kits will be too high, it is asgested that intitually one CHC kits and 5 FRU kits and the cristing for ould be immediately upper planning and care taking into confidence all those CHC (Including Block PHCs) which ould be immediately upper planning and care taking into confidence all the static-holders involved. Similarly, the 2th order was also issued by Government of Kanla bead on the providing Block threak are only 30 functional FRUs though Government of there when 2007, there wave o	The requirements, reveal near organization with a second provided and the processing of the provident in the provident in the provident in the provident in the provident of the provident provident (NREM). Dr.R. Samdon, Amasthick, NREM Consultant (NREM) Dr.R. Samdon, Amasthick, NREM Consultant (MREM) Dr.R. Samdon, ARMO, General Hoopital, Trivandrum The committee took into consideration the recommendations of the programmer and fragment and fragment of the state of surgicials bie by Exc. The Committee was of the procured for each CHCFRU. Howeve, aince the budget outlay for the procured for each the risk of a state of a sta																	
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			Dr.Avandrum Dr.Avandrum Hoardreita Beegu	Dr.Thomas Math	Dr.K.Sundeop, A Dr.R.Surosh, Su	The committee meetings held	surgicals to b	CHC/PRU. 1	for 3 CHC k Initially one	financial year	kine with p	FRUs were	block PHCs Nallomadu.	Thus, the re- care taking i	the 2 ^{md} orde	Senior Med	chaired by]	had proclaim	March 2005
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			Lrt. Augamouanan, J Trivandrum Dr. Aveeda Beegu	Dr.Thomas Math	Dr.K.Sandcep, A Dr.R.Surveh, Su	The committee true true true true true true true	surgicals to b	CHC/FRU. 1	for 3 CHC k linitially one	finencial year	bad worked Kits with p	PRUS were	Diock PHUS Naliomadu.	Thus, the recent taking i	the 2 ^{md} orde	previous rac Servior Med	chaired by 1 in 2006. the	had proclaim	March 2005

thereby easing many perturbative control of the source of	oripheral institutions. Government of Karala decided to upgrade all the CHCs into FRUs	during the Massion period upto 2012. Kernas mis 224 threads no conce and 231 CHCs (including 115 Block PHCs). Government of Kerna and 242 threads the forth the set of the set	Decided to upgrade 113 Critics in use 1 planes to use sevel of revol- Government of Kerala as per GO.(Rt).No.3645/2007/H&PWD	isted 29.10.2007 spproved procurement of surgicals worth 18.14.65 crores plus 2% administrative expenses from M/s.	Kanataka AntiBiotics and Pharmaceuticals Limited (KAPL). Down dowed NUDUA and indicated in 2005.05 environts had not not	een proctred although funds were made available by Government	of India. In this context it is important to note that several doctors and been nosted on contract basis. Service Narses were also been	on contract basis. Those measures should be	uppremented with unterly supply of suggrau and outer supples to ublic health institutions in the state. During several meetings held	with doctors, it had been reported that there is a shortage of drugs	of drugs, Gvennent, as per	2	ard kus for negatin insumations in the class mount rate. Antibactics & Pharmaceuticals Limited. However the shortage of	aurgicals were still prevalent in the State. Under these	curcumanances, procurational of surgivisus for the sumption who control out on an unsonery basis.	Large amounts were lying unutilized under various heads under NBMA Theirwin funds utilization could have led to cutting down of
thereby eas tertiary leve beneficiarie	portpheral i Governmen	auraig the land 231 CF	Governmen	danted 29.1 Rs.14.65	Kamatala.	peer boog	of India. In I had been p	appointed on	public heat	with docto	shortage	G.O.(Rt).N	Antibiotics	surgicals	curulation curried out	Large and

totate 12 causes for the Action Plan for released to utilized	ee Preference Policy I by Pharma Central # No-Objection had Velfare, Government	taka Autustotice & ctioned procurement & Pharmacouticals her, the Government ith Health Ministers	ne through Central chase. There were I CPSUs have been	06 and 2006-07 and ct purchase through is lines of Drug Kits vd. State Mission in d 28.03.2007 had	mment for as per the Committee through a policy to purchase pee), M/s.SILK (for for Civil Works etc.	lission Flortible Pool met after examining urement of surgicals 25% Administrative ment of India under Order, arcounsment
of much. Luring 2007-09, a budget of attours in cures not procurement of drugs was indicated in the State Action Plan for procurement of drugs was indicated in the State Action Plan for first DRFHM, but it required that the finds already released be utilized first.	In line with the Government of India's Purchase Preference Policy (PPP) for purchase of medicines manufactured by Pharma Central Public Sector Enterprises, and considering that No-Objection had been issued by Ministry of Health and Family Welfare, Government	of India to effect procuroment from Karnataka Autibiothes & Pharmaceuticals Limited, Government had samotioned procarement of drug kits from M/s. Karnataka AutiBiothes & Pharmaceuticals Limited, a Government of India enterprise. Further, the Government Order stated that during NRHM discussions with Health Ministers	of other states, procurements were being done through Central Public Sector Undertakings by direct purchase. There were instances where direct purchases from Pharma CPSUs have been done in Kerala.	NRHM started late in Kernia and from 2005-06 and 2006-07 and therefore Government decided to follow direct purchase through Central Public Sector Undertairings based on the lines of Drug Kits to zvoid delay especially when kitting is required. State Mission in its letter No.NRHM/915/2007/SPMSU dated 28.03.2007 had	proposed purchase of surpical kits to the Government for as per the requirement of Surgical Kits decided by the Committee through limited tenders. The Government of Keenla has a policy to purchase directly from PSUs like M/s. KSDP (for medicines), M/s.SILK (for bods), M/s. Hanveev (for bedsheete), M/s. HLL, for Civil Works etc.	The procurement was done under NRHM Mission Flexible Pool as per the State Government Policy. Government after examining the matter in detail had issued orders for procurement of surgicals for a total value of Ra 14.65 errors plus 2% Administrative expenses, out of the funds released by Government of India under Funds under under URHM. Based on the Government Order, procurement
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programs and tigious award for excellence in addition to 102 lists of medicines, KAPL is the preferred supplier for procuroment by various state acial soundness, roomd of mary kindly be noted that KAPL is a Govt of India Navration company set up in the year 1961 and they are an ISO 9001-2000 tens are available with any single manufacturer. For tation of NRHM/RCH hoald and critical orders. es met from Mission Flexible Pool under NRHM for Upgradation pproved the procurement and process involved in the procurement surgion The expenditury ge Minister Dr. Manmols eccedited company and recipient of several awards, National a KAPL vide ord e, the items need to be sourced from several menufacture and former President Dr. Abdul Kalam. Government E of CHCs to IPHS. The Governing Body deliberated in detail a erience backed by performance of over two decades in this a her models of procuration care rector it may be kindly noted that the Sundard surgical acts of v ntended to meet beer minimum requirements to set a Supplies of these kinds of hits can be done only by a profit 1 20 H lood transfusion center. As per the above parameters, not intended for different type of a liteo centrifi 6 inite' types No.NRHM/682/2007SPMSU_dated_21.11.2007. order was issued by the State Mission to M/s. and CPSE in holds th, test tabes, blood bags, microscopes, gi Blood transfusion kits are comprises of its ected KAPL due to their fin international, more specifically the pres di Acrent a performance from the Hoa'ble. Pritive capabilities to execute upplies to various states company like KAPL unlike of prvermments on case to case basis these different kits đ neuto/instrumonts CAPL is the only phy time bound CONDITION of surgical kits. rogrammes. a E floctive ą danimi

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	KAPI, being a Central PSU. The in-he	
	purchases of M/s.KAPL was not ensuited into. Procurement has	
	been done by M/s. KAPL and the State Mission has no knowledge	-
	of any private company through which M/s. KAPL has procared.	
	The State Mission had issued a show cause notice to involve penalty	
	clause for invoking fine for the delay in supply. However, M/s.	
	KAPL had requested not to invoke genuine difficulty in logistics in	
	supplying kits to different hospitals. KAPL had written to NRHM	
•	explaining difficulties resulting in minor delays in supplies which	
•	included transport bottlenecks, strikes, raw material problems etc.	
,	The Governing Body in its meeting held on 12 th June 2007 resolved	
	to exempt M/s. KAPI. from penalty clause. As per the agreement,	
	the purchaser shall under pre or post dispetch inspection on random	
	-besis as deemed fit. Also, Pre-dispetch and post-dispetch inspection	
	condition was included in the agreement as a safeguard against any	
•	issue that could arise during supply. The condition is not a	
	regulatory one to be enforced. However, M/s.KAPL was asked to	
	give an undertaking that they will be liable for making of any	
•	discrepency in the stock or functioning of the machine. M/s.KAPL	<u>.</u>
	had given an undertaking that they will fully comply with the	
	agreement signed for supply of surgical kits and there shall not be	<u>.</u>
•	any lapse in their part in implementing the works assigned to them.	
	They also assured that the best quality of service would be provided	
	for all works executed by them on the direction of State Mission.	
	Certain complaints were received regarding the non-functioning of	
	suction apparatus, pulse oximeter and some other apparatus were	
	not functioning properly in certain districts. The State Mission did	
	not reference the payments and asked SPM (RCH) to get all the	
	deficits rectified in his regard. SPM(RCH) coordinated and	
	informed Mis.KAPL who in turn deployed technical experts to all	
	the districts in Kersia mosting the DMOs, DPMs, Superintendent of	
	booptials atc to rectify the defective / replace the non finactioning	•

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of equipments. All demaged items of the kits were immediately replaced by KAPL as and when demanded. KAPL has also deputed	their representatives to took mus any producin as and wi informed. Components of the kits were Guaranteed a meleorements were number in time. All ok reports were obtained a	the supplier gave an undertaking that they will redify any problems food by the new in more some that they dimetly controlor	the suppliers and the same was attended to immediately. It was	further informed by SPM (RCH) that they have submitted reports	with cartification from concerned authorities and only under these	circumstances, the remaining payment was released, but we inter of the items were delicate equipments, once they are being used, the	tens can be tested and replaced by M's.KAPI, if not working. It	may also be noted that the warranty clause has already been	-	Out of the 490 kits ordered, at present, over 400 kits have already	in various inditutions. The	commany yet has come not be used since up approximate were of CHCs and certain PRUs could not take these at the nace interned	bither due to indecision by the Institution Level Committees or Non-	clearance of land from enounbrances (for eg. demolition of old	etc.). In fact, with	Comprehensive Health Insurance Scheme being implemented, there	is a suge demand from other FRUs and the Governing Body	resolved to transfer only those number of kits which are essentially	required in the strugt hospitals and the required at the to be bester to CHCs as and when they are upgraded (minutes annexed). At	mentioned above, at present, 136 institutions in Kerala are working	as FRUs as compared to 39 institutions in 2007. 21 CHCs were	pgraded as Tahuk Hospitals who were supplied surgical kits. It may dealer he eased due the tweet for 2010 is to here 145 FDT hered due	
of equipments. All demanded itoms of the kits were immediated epideoci by KAPL as and when demanded. KAPL has also depute	their representatives to kook mito any problem as and informed. Components of the kits were Guaranteed melecometry were made in time. All ok reports were obtained	N N		lomitt.	분 / 같:		탱							<u>Cilon</u>	g.		LIONO			ala ar	21 C		subdry de noted unit the negat for 2010 is to parte 103 FK (75 a
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	their representatives to took informed. Components of redereneets were made in the	ddins -	ldas	Ę,		cuenta item		집	actuded in the agreement	t of t	een di		÷		puilding, tree cutting, encroachment	adu		bolved i		mtion	BE		
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 Limited tenders were invited from Pharma CPSEs in April 2006 by the SHS. After opening the technical bids, the Technical Committee rejected the bids of three Pharma CPSEs because a criminal case was pending against
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3.CPSUs should have minimum turnover of drugs worth at least 2 7. CPSUs should have antisfactorily executed at least one single 6. They should submit Performs statement and Client satisfactory order of quantity of 20% of the present requirement of the item While submitting the tender, M's.DPL had not submitted product ermit to manufacture certain items as well as ISO-9001-2000 bitent settisfactory certificate. M's.KAPI, had not submitted product tatement, ISO Certificate, Performence cartificate etc. Hence there Based on this office letter, the three companies submitted a few of the requisits equired ISO 9001-2000 Certification. All the three companies did not submit product permit for all the products. M/s.KAPL had given in undertaking to the effect that they will procure the other items rom reputed GMP companies. As per the Purchase Preference Policy of Government of India, companies will be able to supply ia. However, M/a.BCPL its meeting documents were called for from other companies by the technical spers. M/s.BCPL failed to submit documents to prove that they lave executed one single order quantity for 20% of the present requirement of the offered items. M/3.IDPI. failed to submit the other documents like Non-conviction certificate, minimum turnove nd M/s.IDPL were not able to produce some documents other that offered during any one of the last 3 years anywhere in the country ermit to merufacture certain items while they had submitted all (as Performance Statement **Here** <u>i</u>la 9001/2000 from reputed organizations. They should have M/n.BCPL had not submitted product CPSUs should have obtained quality certificate They should have a valid Drug Manufacturing license. therefore in committee vide their minutes dated 17.06.2008. certificate from various State Governments as approved by Government of Ind The technical committee, GMP certificates and revised Schedule M. Rs.10 crores in the last 3 financial years nanufacture certain items as well product permit. certificate. **MARK** à BCPL. However, the it had furnished Paracetamol) and had agreed to supply the other items from IAL and the required documents was seen that the financial bid of KAPL was accepted without my negotiations to reduce the rates the Purchase he financial bid. Moreover, the need for going in for the two -bid system of Selection of vendor in kits, was clearly tablets(Albendazole and would Good Manufacturing it was he only firm which qualified for COLUMNOR indicated that KAPE was favored the SHS. Government Stated (September 2009) that all the three CPSEs whose bids were examined did not submit product permits for open the financial bid of KAPI based on an indertaking given by it that the products. The Technical it would procure the drugs from Practice (GMP) Companies. **submitted** KAPL ļ Preference Policy because medicines for ASHA mmittee decided to justifiable. This 9 ğ ar maile purchase Deen R Бġ divine technical ocepted **Nodect** MPL 380 not ×

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nstifiable. It may be noted that the State Mission had favoured the Andit has pointed out that two bid system of selection of vendor in aubiect to State Mission's policy of adopting two bid system of selection of vendor is fully justified. KAPL was the only company qualified in he technical bid vis-à-vis other companies and hence its price bid However, they had agreed to supply ASHA kit in a compact ASHAs purchase of contraon medicines for ASHA kits was not All the participants are not holding the product permit for all the following during the previous years and also in other states. The process wherein there would have been a delay of atlaast 6 menth unpored the procurement very clearly spelt out that purchase can be effected from Centra uly 2006 had offered to reduce the rates of Digital BP Appendix thermometer. The items of Digital BP Appendus, Glucometer at Pharma Public Sector Undertakings. Under these chromatanees, t he agreement, orders were given only for the medicines and digi Committee recommended to apen the financial bid for Wir.KAPL. ther deted 1 Glucometer and Glucometer test strips. However, while finalizfor purchase through tender. Moreover, Government of India 1 due to steep escalation in raw materials, packing materials cost, a facturers. The same proceedian Procurement of ASHA drug kits were utmost essential in Negotiation was done and KAPL did not agree to reduce the n he financial bid, M/a.KAPL were requested to negotiate the r j agicase made from routin material for easy carrying by Based on the acceptance of Technical Committee and after Glucometer test strips were proposed to be procured on a la bid system to ensure that the best prices are obtained nteed of general shipper carton, without additional cost. moted by them. However, MarKAPL vide their I products tendered and they intend to 2 held on 21/06/2009 decided the following districts. Delay in this regard would h procuring it from other manu vas openod. not been The SHS did not apply the principles of KAPL for the supply of surgical kits and placed with KAPL, it was seen that the à indore on behalf of KAPL. As per the invoices of the indore based firm, tept in the stores of the three test-**Janpo** September 2009) that the in-house ction of oqL I · Though the supply order was M/s.Vimal Labs Private Limited. Wolffere Stores, the rate quoted for each ASHA mount was entered as the cost in the stock register. However, the basic price quoted by KAPL and Paid by the SHS was Ra G Though negotiations were held with KAPL, it did not agree to procurement order was issued to KAPL based on the decision of companios. ASHA kits as procedures were violate made. the SIIS incurred of Rs 1.79 crore provided undue benefit of an amount to KAPL. Government the Governing Body of SHS drug kit was Ra 5250 and this a financial propriety in the sel District Family Z enquired into by them WAS purchase of KAPL GMP actual supply 7370. Thus, reduce expenditure eputed checked

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f good health practices. F good health practices. Fe of curative care as the timely referrals. In segod to appoint \$469 on this, it was proposed	e drug kit, a committee bans in the drug kit. m) Medical College,	nd officer for ASHA 1 Memoger (RCH) ive Modicine citiene	were suggested by the	Number 1000 tab	25 Bottle 500 Tab Trimo rah	500 Packots 5 Tube	3 bottle 100 Nos	to be supplied from Subcentre
planning and increased utilization and accountability of the existing binkth services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely refarrals. In the NRHM PIP for 2007-08, it was envisaged to appoint 3469 ASHAs in the State during 1 st year. Based on this, it was proposed to procure 3469 ASHA drug kits in the State.	In order to decide upon the items to be in the drug kt, a committee as detailed below was formed to finalise the items in the drug kt. 1. State Mission Director (Arogyakoralam) 2. Dr. P.K. Jameela, Addi.DHS (FW) 3. Dr. Ptaharady, Superintendent, Madical Collega,		e. reactionst active, constraint (act) Based on discussions, the following items were angeated by the Committee.	Name of the from Tab Paracetamol 500 mg	Puracetamol Syrup 60 ml Tab Albendazole 400 mg Tah Invefalio	ORS Packet Providine Iodine Ointment 100 anns	Powdine Lotion 100 mi Band Aid	Condoms - Contractive room

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to be supplied from Subcentre		1	1000 stripe	1		oe held on 17th & 18th	it was circulated to all	n Managars (NRHM).	othein items. The final		INNUTION	1000 tab	25 Bottle	500 Tab	1000 tab	500 Peckets	5 Tube	3 bottles	100 Numbers	10 Paciets	to be supplied fro	Subcentre	to be supplied fro	Sub centre	1000 strips	1	most essential in the	spered the procurement	lay of atleast 6 mostlys
Oral Pills	Weighing Scale	Height Measuring tage		BP Appendus	Digital Thermomoter	Purther. during the Senior Officer's conference held on 17th & 18th	December 2007, the list of drugs in the drug kit was circulated to all	District Medical Officers and District Program Managers (NRHM).	After discussions, it was decided to delete contain items. The final	list was as below.	Name of the flom	Tab Paracetamol 500 mg	Paracetamol Syrup 60 mi (125 mg/5 ml)	Tab Albendazolo 400 mg	Tab Ironfolic (Adult)	et ORS Packet	Powdine Iodine Ointment 100 gms (5%)	Pavdine Lodine Lotion 100 ml (5%)	Bend Aid	Cotton Absorbent Roll (400 guns)	Condoms		Oral Pills		Uristix	Digital Thermometer	Procurement of ASHA drug kits were utmost estential in the	districts. Delay in this regard would have humpered the procurement	process wherein there would have been a delay of atleast 6 months
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ř						<u></u>			•		<u> </u>			<u> </u>						<u>.</u>					<u>.</u>				

Audit has pointed out that two bid system of selection of vendor in vendor is fully justified. KAPL was the only company qualified in the technical bid vis-à-vis other companies and hence its price bid the financial bid, M/s.KAPL were requested to negotiate the rates purchase of common medicines for ASHA kits was not wo bid system to ensure that the best prices are obtained subject to Pharma Public Sector Undertakings. Under these circumstances, the sed on the acceptance of Technical Committee and after opening quoted by them. However, M's.KAPI, vide their letter dated [0" astifiable. It may be noted that the State Mission had favored the he condition that the firm qualified in all other apports. M/s.KAPL c., However, they had agreed to supply ASHA ki on itself. It will not be gning of the advance will be limited to thermometer. The items of Digital BP Apparatus, Glucometer and is a compact bag/case made from ratin material for eary carryin re ordern. Moreover Glucometer and Glucometer test strips. However, while finalizis ts due to storp escalation in raw materials, packie to reduce the rates only far Digital BP Appendux, Glucomet the submission of the financial bid, M/s.KAPL had state the agreement, orders were given only for the medicines and digi m of selection Glucometer test strips were proposed to be procured on a latter sta Glucometer test strips. The terms and conditions for i can be effected from Cen buy 2008 had offered to reduce the rates of Digital BP Appers ASHAs, instead of general abipper carton, without addition gotistion was done in the office of the SPM. KAPL did not a inted 10 July 2008 ig two bid sym eir terms as 50% advance payment. During cost. This was approved by the State Mission. consible to take all the points in other purch uses of ASHA is fixed in the State Mit it was mutually agreed that State Minsion's policy of adouti informed vide their letter of very clearly spek out that metorials cost, of to reduce the re was opened. ĝ S R

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ven to sentity of the tig	as we have procured kits, wherein some items are not under DPCO. Hence insisting KAPL for a certificate doesn't arise. M/s. KAPL had requested not to involce genuine difficulty in logistics in supplying kits to difficulties resulting in minor delays in a NRHM explaining difficulties resulting in minor delays in supplies which included transport bottlenecks, strikes, raw material problems etc. Moreover, since ASHA training had not been problems etc. Moreover, since ASHA training had not been problems etc. Moreover, since ASHA training that not been completed and M/s.KAPL had started the supply within the time frame and there was a delay of only few days in completion of the	Repoyl, no penalty clause was involuted. National largets for reducting Inflat Mortality Rate (IMR), Matemal Mortality Rac (MMR), Total Ferdifity Rate (ITR), reducing morbidity & mortality rate and increasing cure tabe of different and the sim of the state is to attain these targets over the Mission Period. However in contain cases given that the State has a to maintain these levels. Andit may note that it is difficult to sustain the achievements and hence concerted efforts are made to sustain the achievements and hence concerted efforts are made to sustain the achievements and hence concerted efforts are made to sustain the achievements and hence concerted efforts are made to sustain the achievements and hence.
	thin the second se	Rupply, no penalty clause was invoted. National targets for reducing inflar Mortality Rate (BAR), Matema Mortality Rate (MAR), Total Fertility Rate (IFR), reducing morbidity & mortality rup and increasing cure rate of differen and the sim of the state is to attain these targets over the Missio ferenci. However in certain cases given that the State has alvest reacted thigh levels of achievennent, the task of the state is to maintain these levels. Audit may note that it is difficult to sustain the achievements and hence concerted efforts are made to sustain these levels. The state specific targets for the pariod 2005-12 and contained in Chapter III of the PIP of the state in the yearly State PIP athmitted by the State.
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k mey Sector Jayun Ventur ertific	when a contraction of the difficulation of the diff	Repoly, no penalty clause was invotod. National targets for reducing inflat M& Monthlipy Rate (AMMR). Total Fert morbidity & mortality rate and incre andemic diseases are covered under v and the sim of the state is to attain th reacted high levels of achievennut, maintain these levels. Audit may note the achievennets and hence concerts the achievennet in Chapter III of the PIP of PIP authmitted by the State.
	PL fue of the second of the adout of the over the over	Apply, no penalty clause we visional targets for reducing violatity. Rate (MMR), T norbidity & mortality rate and more discusses are cover- and the sim of the state is the discusses are cover- ted the sim of the state is maintain these levels. Audit maintain these levels, Audit maintain these levels. Audit the achievements and hence these levels. The state spec contained in Chapter III of PIP authmitted by the State. It is the endeavour of NRH delivery for increasing delivery for increasing
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in this regard. Moreover, it may be noted that advance was given to a Central Pharma Public Soctor Undertaking. Even KAPL too, had received and executed similar kits to Director General (Family Welfare), Lucknow. The payments tarms indicated above are the prerogative of the UP government not the health authorities of the Korala government. The certificate under reference has no relevance	as we have procured kits, wherein some items are not under DPCO. Hence insisting KAPL for a cortificate doesn't arise. M/s. KAPL had requested not to invoke genuine difficulty in logistics in supplying kits to different hospitals. KAPL had written to NRHM explaining difficulties resulting in minor delays in supplies which included transport bottlenecks, strikes, raw material problems etc. Moreover, since ASHA training had not been problems etc. Moreover, since ASHA training had not been completed and M/s.KAPL had started the supply within the time frame and there was a delay of only frw days in completion of the	
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in this real in this real a Central received Welfarro, prevogati Korala go	as we literate the second second literate the second literate the logistic completes any problem second literate the second literates t	

•		·			The current status is shown as Annexure-4
governmental and non-governmental sectors status of immunisation, reduction of child and maternal mortality, reducing the farelity rates, prevalence of contraceptives - both termination and gracing, number of patients reaching to out-patient (OPD) and in-patient dopartment (IPD) and these are contained in the activities under the PIP of the SNM.	Audit may note that on behalf of the Government the State Society is the implementing the activities under NRHM. Investments are made by the Government, and mechanisms such as NFHS Survey etc are in place to monitor the attainment of the indicator. Audit may also note that in addition to the NRHM, there are many factors	such as health services provided by private soctor hospitals, in attainment of the targets. Hence the Government of India mochanisms would be more appropriate as full fledged aurvey is essential. However, the Society is implementing Health Information	System in the Suite so as to capture levels of IMK/MMR etc along with other parameters. The Directorate of Health Services has a mechanism of reporting on these parameters.		To reduce maternal and infaut mortality rates to 100 per lakh and 30 per thousand respectively by 2010, important services which ensure maternal health auch as antenatal care, institutional delivery, post maternal rest and reformal services are in place in the state. Registration of pregnant woman before they statin 12 words of programory is done and three antenatal check-ups are done. Iron Folic Acid tablets, two dones of Tehmus Toxoid (TT) and advice on the correct
governmental and non-gover reduction of child and mar- rates; prevalence of contraso number of patients reaching department (IPU) and these PPP of the State.	Audit may note that on belo is the implementing the ac made by the Government, etc are in place to monitor may also note that in additic	such as health services pr ethimment of the target mechanisms would be mor essential. However, the Soc	System in the Name so as to capture levels , with other parameters. The Directorate of mechanism of reporting on these parameters		To reduce maternal and infu per thousand respectively by maternal health such as avio natal carto and reformal acrivic of pregnant women before done and three antennal tablets, two dones of Tehmu
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_ <u>1</u>	6 9 11 12 12 12 12 12 12 12 12 12 12 12 12	R . R . S . R . S .	1.2 1.3 1.5 1.6	SHS had not evolved a m to ascertain whether the fixed, were achieved at ose of the respective audit could not in the extent of	
		R	10 12 12 12 16	As the SHS had not evolved a mechanism to ascertain whether the targets fixed, were achieved at the close of the respective years, audit could not ascertain the extent of	active verment, against up cargets inco. Matternal Health The important services which ensure maternal health services which ensure maternal health such as and maternal health and maternal health such as and maternal health su

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diet and vitamin supplements are given and in case of complications, they are referred for specialized gynecological care. The Junior Public Health Nurse prepares a micro brith plan at the sub-contre level. The plan also includes collecting BPL or mocessary proofs/certificates, and timely adminission of the completed ISY formats in the health cente, arranging transport for the beneficiary to the nearest health care facility in case of any completed ISV Maternal gravitability of fund etc. Maternal Mortality Statio in Kerala has been reduced to 95 from 110 es per Special Buildein on Maternal Mortality in India (2004-06), published by Sample Registration System. Kerala has the lowest MMR compared with other states of India and for India it is 254.		
them with three arkinstal chock-ups, 90 or more iron-fiblic acid (IFA) tablets, two thoses of Tetarus Tomoid (TT) and advice on correct diet and visumin applements. It is mandacy for a junior Public Health Nume to prespare a micro-birth plan at the SC level for each beneficiary of the Janami Suraicha Yojama (JSY), containing dates of antenatal chockups and TT hipedones identification of the health contre for reformal services, the place of delivery, expected date of delivery, etc. Audit secutiny revealed that micro birth plans were not drawn up in any of the selected 24 Scs.	In the selected districts (Palaktad, Thiravenentheguram and Weyarad), out of 5,14,139 pregent worsen registered, only 4,30,156 mosted these antennaki check ups during 2005- 06 to 2006-09. In these districts, there were no significant variations over the years in the number of pregnant women receiving three antennatal check ups.	 Although all the pregnant women registered were required to be provided with IFA tablets for 100 days, shorthalls ranging from 16 to 44

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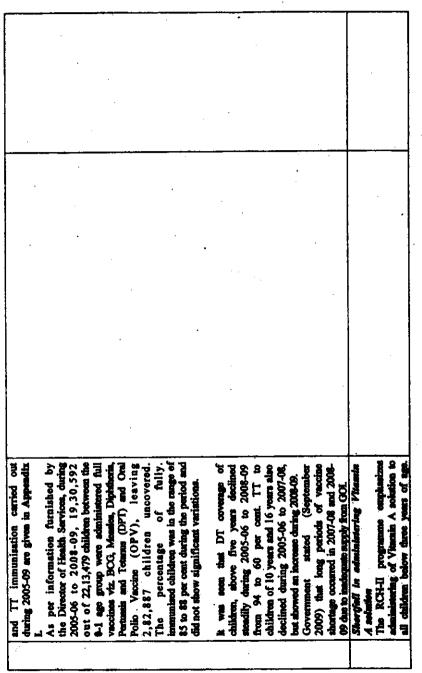
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	• During 2007-08 and 2008-09,									
	Rs 23.95 latch was disbursed to 7,985						-			
	beneficiaries in three Taluk	-								
	Hospitals and two District Hospitals									
	towards transportation cost under									
	JSY, which was inadmissible.			•						
	 The percentage of institutional 		•							
_	deliveries of pregnant women						• •			
	registered at the hospitals in the									
	selected districts ranged from 77 to 96									
	in Palakkad, 61 to 104 in									
	Thiruvananthapuram and 85 to 89 in									
	Wayanad.									
.2.	Incretation .	Long periods of vaccine shortage occurred in 2007-08 and 2008-09	scine shortage	occurred i	n 2007-0	\$ and 200	60-8			9
10.2	Routine immunization	due to imadequate supply from Government of India. As far as	supply from	Governme	ant of Ind	tia. As fi	3			8
	<u> </u>	shortfull in administering Vitamin A Solution is concerned, there	istoring Vitami	n A Solut	ion is co	ncerned,	there			
	six preventable discases, namely		solution supply	v from Go	vernment	of India	tince			
	ria, pertussis,	_			-					
	polio and measles has been the									
	concretone of routine immunisation in									
	the State. During 2005-06 to 2007-08, the									
	State had achieved 95 to 99 per cent									
	success in pulse polio immunisation.									
	However, immunisation in respect		•							
	of other diseases showed wide									
1	variations ranging from 53 to 85 per									
	cent in the test-checked districts	-							•	
-	during 2007-09. The targets and									
	achievements of Diphtheria (DT)									



As per the essence of the NRHM Frame work, the state has made for the right direction to put in a strong Health Management formation System (MIS) network in the state. Under DSP information System (MIS) network in the state. Information information is an exercise that the development of software is not network and software. The HMIS Implementation for Same is tatent up with specific (
dilidere due to deficiency of Vitarrin A age along with the meaker wereals of age along with the meaker wereals a standy becored does along with DPT/OPV and the subsequent three does at its memority interval. Servicity of records in the three test decine in Appendix II. The main service to 2008-09, the dentis of which service to 2008-09, the dentis of which memority interval. Servicity of Vitarrin A at health 2005-06 to 2008-09, the dentis of which memority interval. Servicity of Vitarrin A at health concrease. 2005-06 to 2008-09, the dentis of which memority interval. 2005-06 to 2008-09, the dentis of which memority of Vitarrin A at health contracting Vitarrin A at health data intracting for surveyord in the right direction the health Management of a force this office to a story and the device/opment of software for health Management of a force this office to a story and the device/opment of software for hills the health Management of a force the health Management of the NIMS the Districts are being linken from health heat health the a cont for 3.000, when a contract a heat involves development of software for health with primes and UPS compute a subord to be head to be able of the NIMS the Districts are being linken from the privit and the private subord head to CHCs and PHCs in Ference 2006. The application the a cont of the 3.000, when a private a software. The Site and the device a subord to a subord to a subord to the software.	Prophylaxis against blanchess amongst		
requires the first does stription months of see along with the meetice vaccine, the could distribut DPT/OPV and the subsequent three doess at sit- monthy intervals. Scruity of records in the three test decline in the precentage of alkitern supplied with all free doess during becarres in the precentage of alkitern supplied with all free doess during control for the about does during accords of a supply of Vitamin A at health about supply of Vitamin A at health control. Government attaid (September 2009) that the shortfall in administrering Vitamin A at health control. Government attaid (September 2009) that the shortfall in administrering Vitamin A at health control. Government attaid (September 2009) that the shortfall in administrering vitamin A at health control. Mither attain (September 2009) that the shortfall in administrering vitamin A at health control. Mither attain (Mither attain a strong Health Management Mither attain (Mither attain hear strong Health Management Mither attain a strong Health Mither attain hear attain Mither attain a strong Health Mither attain Mither attain a strong Health Mither attain hear attain Mither attain (Mither attain hear attain hear attain hear attain hear attain hear attain Mither attain attain attain hear attain he	A hildren due to definitence of Vitemin A	- -	
requires the first does at mine months of the standy does at size occord does along with the measure vaccine, the eccord does along with all free does at size work the standy intervals. Scattary of measure in the standy doctine in the percentage of children accord diarrhots arreaded a standy doctine was the does during 2005-06 to 2006-09, the densite of which are given in Appendix H. The main reason for the executive at a contract in the percentage of children was the doctine in Appendix H. The main reason for the executive at a doctine was the doctine to doctine was the doctine to doctine was the doctine to d	THINKING TO AND AND AND INTERING IN		-
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As per NRHM guidelines a health Information System (MIS) network in the state. Under IDSP is findination system is to be in place for monitoring for surveillance activities is in place. Further under the state information system is to be in place for monitoring for surveillance activities is in place. Further under the state information and for effective decision for or HMIS the Districts are being linked from the PHC level to the state driving a smooth flow of HMIS the Districts are being linked from the PHC level to the state driving information and for effective decision for or hilds the Districts are being linked from the PHC level to the state driving information and for effective decision for on Audit may note that the drivelopment of software for very making. The SHS purchased 1033 computer based HMIS to capture the health data from all the health is on extreme and this has atready been initiated. HMIS Software is not the purpose and anyplied them to CHCs and ready made software. The spheridon the PMCs in February 2008. The application the HMIS Implementation for Same is taken up with specific (1) and others and others around the data travely been initiated. HMIS Software is not a software the result at a cost of R 3.64 crone for this software.	ļ		
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level. Audit may note that the development of software for v computer based HMIS to capture the health data from all the health. It institution is an exarcise that involves development of application h software and this has already been initiated. HMIS Software is not tready made software. The HMIS Implementation for Shate is taken up with specific (objectives aurounding data reporting. The plan includes phasing b	\$		deta through online before 5th
computer based HMIS to capture the health data from all the health it institution is an exercise that involves development of application h software and this has already been initiated. HMIS Software is not trady made software. The HMIS Implementation for State is taken up with specific (objectives surrounding data reporting. The plan includes phaster b			_
institution is an exercise that involves development of application is achivate and this has already been initiated. HMIS Software is not tready made software. The HMIS Implementation for State is taken up with specific (objectives aurounding data reporting. The plan includes phasize (matino The SHS wombsond 1023		
institution is an exactive that involves development of application I software and this has already been initiated. HMIS Software is not the ready made software. The HMIS Implementation for Same is taken up with specific (objective surrounding data reporting. The plan inchales phasize fit			
software and this has already been initiated. HMIS Software is not to ready made software. The HMIS limplementation for Shate is taken up with specific (objectives surrounding data resorting. The plan includes phasing to	computers along with printers and UPS		have been integrated with in
ready made software. The FIMIS limplementation for State is taken up with specific (updated l objectives surrounding data reporting. The plan includes plasting being	at a cost of Rs 3.64 crore for this		this time. After proper
The HMIS Implementation for State is taken up with specific (updated) objectives surrounding data reporting. The plan includes plasing being	burrose and gunnlied them to CHCs and	-	and werifi
the invite any contractation for come is when up with specific (upuned) objectives surrounding data reporting. The plan includes phasing being	PLIC in Rebriev 2008 The surface		
(Mo Unice 200/) Wile (correctives surrounding data reporting. The plain includes phasing (being			
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Government of India web	portial positively by 5"	working day of the following		The quality of data is		-	in the State from Health	Information Cell (HIC),	functioning under	Demographer, one officer has		district to worlfy the quality	_	_	timeliness of the data is	reviewed by Domographer,		Additional DHS (FW) in	-	-			Wednesday of the month the	-	-	Medical Officers conference,	before the Principle Secretary					
-	application having customized FW reporting formets which is in	tune with requirements at mational lovel.	The Data reporting milestones Envisaged for State were-	 Paper reporting to continue till Mar 09 	From Anril 09 only reporting through DHIS 2 software shall	be done down from peripheral sub contros	The HMIS Project implementation for Karala State environed the	following objectives:	1. Establishing State level server and Loading the HMIS	(DHIS2) application on the server	2. Installing offine application in all reporting Health	institutions	3. Sotting up of district based systems for each of the 14	districts	4. Training programs for State, district and block level Health	staff		Likewise, the project is implemented knoping above objectives in	mind and all milestones including objectives 1, 2, 3 and 4 are	achieved before April 09 to realize data reporting from field. As a			The data for June 09 is noaring completion.	This effort is one of its kinds in the country and Gujarat is the only	other State to take up Health facility lovel reporting also through the	DHUS 2 software.	As far as IDSP data is concerned, routine reports from State/	Districts are generated and being reported (weekly basis) to GOI	from the State Surveillance Unit, IDSP, under the supervision of		_	reporting mathematicas for benet data quality taking advantage of
procured at a cost of Rs 1.06 crore	during July 2008.	The SHS adopted the following multiple	software applications:	· Houlds Management Information	System (HMIS) viz., DHIS 2 developed	by M/s HISP India Limited,	arrentiation working in colleboration	with the University of Oelo, Norway.	A dynamic web-based surveillance	system for	monitoring disease incidence for	the Integrated Discuss	Surveiliance Project on a wookly basia.	• A Geospatial Korala Health	Information System developed by the	Kerala State Remote Sensing and	Environment Centre for tracking	thespread and frequency of discusses	and the second se	· An MS-excel based format fir data	offication on discusses on daily basis by the	State Disease Control and Monitoring	Coll	•	Δ.	operated by various users	despite requiring common data sets	relating to health parameters for their	operation	Instead of integrating various vertically	drives information systems to create a	single window system for data entry and

PHC level also it is reviewed. PHC level also it is reviewed. The data in DHIS2 / HMIS is being utilised for all planning purposes in Sam (District/Contral Level. As we have stopped apper monting of forms 6 to 10, in DHIS, there is no other source for the data. GIS: - An amount of Rs 40 lakins is abo utilized to set up lakins is abo utilized to set up lakins is abo utilized to set up advente Sensing Centre. The scheine is to implement aborty after octain modifications.	
internet commectivity in field and therefore the same is incorporated in the DHIS 2 software for reporting henceforth. Continuing training and hencholding support is envisaged through PHC level also it is reviewed. Continuing training and hencholding support is envisaged through PHC level also it is reviewed. 2010. 2010. 2010. 2011. Government of India is planming purposes in State also in planming purposes in State and Software is being used. IDST data will be inhostrated. Hardware for the data is to find a source for the data. 2010. 2010. 2010. 2011. Government of India is planming purposes in State also utilized to set up being utilized for all planming purposes in State is being used. IDST data will be inhostrated. Hardware for the data. 2013. An annum of Rs 40 latts is being the inhostrated. In DHIS, there is no other source for the data.	Integrated Disease Surveillance Project (IDSP) is functioning, to detect early warning signals of impending outbreaks, and auveillance units have been set up, as planned. Neccessary manpower as well hardware and accessories has been supplied to the units. However at the state level, there was some constraint of apoce in the Diroctorese to house the video confirence unit, as there was no vacant space available in the Directorate or at the NRHM Office. After efforts some space was vacated and Video- Confirencing Unit has been at up. Audit may also note that the equipments such as Hardware and accessories were not lying idle as the same was used at the office of the Additional Director of Health Services (Public Health) for regular communication with the national level.
report generation, the SHS developed multiple applications with common modules that resulted is data redundancy, dupfication in data entry and increase in the workload at all lowels. The Same Data Officer stated (July 2009) that action was under way to integrated Disease Surveillance Project and the State Disease Control and Monitoring Cell with the SHS.	Integrated Disease Surveillance Project The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect early warning signals of impending outbreaks and to algonals of impending outbreaks and to help initiate as effective response in a timely names: arveillance units were at up the Central, States and district levels with hall states and district levels with hall state headquarters, district headquartars and all governinent modical colleges on a Satellike Broadband Hybrid Network.
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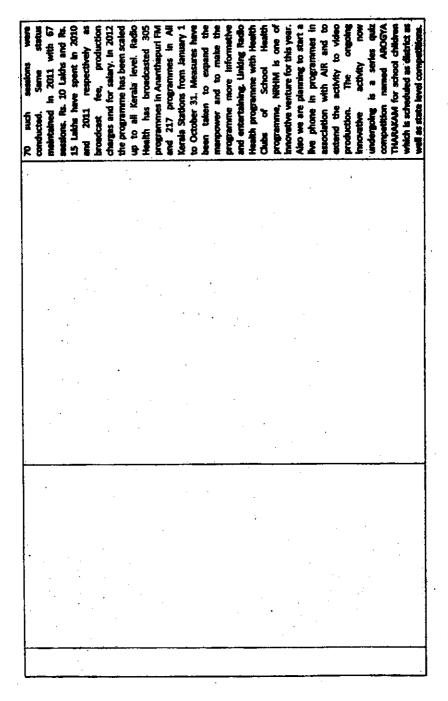
103 2008-09. The expenditure incurred on All the 14 District Surveillance Units (DSU) were supplied with March 200 8 E So .52 crore up Whenever there as manpower was also provided to rencing unit at the State] Manager ne total oc of Rs 33.76 lath. Neces - However, rising trend of illness, in any area, Ē hardware accessories costin nd soven medical co ozecuted the project was Rs 2.74 crore. Accessoria Ğ, moured for Rs 54.82 1 e Director of H ad not been set up as of 10.00 Rs 19.60 Renot PSS S actions are to se and control th of Rs 21.06 lakh. provided utiy, harde Officers/Rapid videoconferenci basis. ę P.S. X WOR 500 oplied to t a Z videoconfi ğ Sunday) s. th civil 500 9.69 DSU **DVO** 8

	A study was conducted by The Research Institute. Rajagri College of Social Science, College of Social Science, College of Social Science, Research Reach Reach In Thirturenantingurum on July 2009. The Report sorge: The Reach Reac
	The concept of FM Radio Health emerged as a pilor project on a real time basis to caperiment with the use of mass modia tool as a means of communication with the community. Such a concept is a valid tool in the social sector, and was experimented for the first time in the health sector, and was experimented for the first time in the health sector, and was experimented for the first time in the interval as a result of various discumsions and reviews done at various forums and model for community based model for communication. In fact, the model emerged as a result of various discumsions and reviews done at various forums and model for community based model for community based model for community based areach a concept on a pilot basis. In these the accumstances, radio M health emerged as a mational community demand and hence was approved on a pilot basis in the district of Trivandrum. This was a novel concept and has been with the district of Trivandrum. This was a novel concept of a various forums of the Ministry of Health and family welfare, Government of India as a true innovation. The import of the study is exceeded by the community is not been approciated at various forums of the Ministry of Health is being conducted by Regifti College of Social Sciences, a reputhed institution in the community are a successful innovation and hence has proved by the community may note that the FM Radio health is perceived by the community as a successful innovation and hence has proved by the community are a successful innovation and hence has proved by the community as a successful innovation and hence has proved by the community as a successful innovation and hence has proved by the community as a successful innovation and hence has proved by the community as a successful innovation and hence has proved by the community as a successful innovation and hence has proved by the community as a successful innovation and hence has proved by the community as a successful innovation.
intention of the Government of detecting impending outbreaks and initiating an effective response could not be adhieved. Government stated (September 2009), that the video- conferencing usit works were completed within two months time.	Laformation, Education and Communication activities and Communication activities Radio Health, launched by DHS, Thiruwanathapuram in Septomber 2008 aimed to create positive obtages in the halth habits and behaviour of people by ensuring wider community participation through interactive and inmovative radio programmes. It mainly focussed on primary kealth care and preventive apport of health by giving interactive apports of health by giving in
-	11.1

Radio Health has so far broadcasted 681 thirty minutes Ĩ THUBBER È 8 2 program E pu Ë 8 plays. vere also SHS. Ministry of Velfare as a true school well the community and ot man be Health pprecisted at various Communication like Health M been street 2 Assembly constituencies, had Ë camps, **Drogramm** conived by I Programme Government o į conducted ad been movation OLUDS cultural health Health 2009)

1097/2014.

23) Sept. 2006 to 34, outcome 2013. Earlier Radio Health was becadcasted only through Anaethapuri Ri, 4 days/weel Anaethapurin, 54 days/weel Anaethapurin, 54 days/weel Anaethapurin, 54 days/weel Anaethapurin, 54 days/weel Anaethapurin, 54 days/weel Anaethapuri, 4 days	has been extended to the entire state from January 1, 2013	through various FM and A stations of All India Radio; as	minutes programme on all day in Aramuthapuri FM and Sday ber week in All Kerala Natwo	Stations of AIR.	2010 and 2012, Radio Health	ammes and A.	21	production was smilled to une new studio from	Thirwananthapuram District NRHM office in 2010, Out-reach	activities and outdoo	recordings scarted for involve community in red	programmes; a total number of
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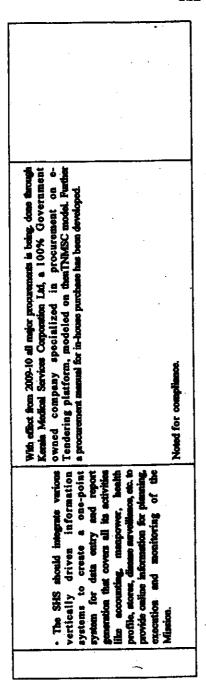
At present, the Annual Action Plan is prepared from Ward level itself wherein community participation is commund.		
As per the framework, NRHM carvisages involving communities in At present, the Armaal planning, implementations and monitoring through participations of Parchayati Raj Institutions (PRIs), Non- provenmental Organizations (NGOs) and Community Based organizations (CBOs) at each level, and this procees has been by ensured. Organizations (CBOs) at each level, and this procees has been by and large statistical (CBOs) at each level, and this procees has been by and large statistical (CBOs) at each level, and this procees has been by and large statistical (CBOs) at each level, and this procees has been by and large statistical framework of the local budies. Use been farmed within the overall framework of the local budies is a conscious decision that improved community participation at the ward level is the key to auccess of the scheme, and accordingly ward level committees have been constituted in lieu of the village	level committee. Under NRHM, a project for providing transport facilities on emergency deliveries has been worded out as "Karala Emergency Medical Project (KEMPy". This initiative will take care of the requirements of providing transport facilities on emergency deliveries. In the circumstances, the revolving funds have not been set up. The hanch of NRHM in Kerala has provided a unique opportunally for restructuring the health featurery system as well as far developing better health financing mechanism. Health institutions have been strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen strengthened and will be further strongthened during the next free veen selected so for and have been trained and engaged on the bearis of one peri 1000 population in tribal areas, urban sium and constal areas. Critical support infrastructure such as operation theatre, labour room, wards, OPD rooms, electricity, generator, telephone, ambulance, computer etc. are essential and have been provided to improve the health article. In addition the law been provided to improve the health envice. In addition the	WHSC in Korala are very active and doos immunization, note natal
	Government Beolded (February 2007) to constitute Ward Health and Smithtion Committee Ward Health and Smithtion Committee (WHSC) at the ward level instead of at the village level. In all the 24 Sca under the three test-chocked district, WHSC, had been constituted. However, no revolving funds for providing referral and transport facilities on emergency deliveries had been set up in any of the WHSCs though envisaged under the acheme. Government stated (September 2009) that it was a connectous decision to constitute. Ward Level Committees within orwall framework of the local bodies in hicu of Village Level bodies in suproved community perticipation was the key to success of the scheme.	
22		

Conclusion Check ups and village level activities. Conclusion Action Taluari: Al present, the Assent Action Plan is prepared from the form book and interviewer in prepared into the matter of the Assent Action Plan is a second from the final from the form book and district level plan. Conclusion Village level bealth plans are being prepared the plans. Description of NRHM in Kensta has upprediction with LSOD and experts on bashin relations and the final from the final plans. Village level bealth instructions are being prepared to firm block and district level plans. Mathematicane in bealth institutions are various levels, upprediction with LSOD and experts on bashin relations and the first to committee the bashin institutions are various level in action to committee the action Plans. Village level bealth institutions are being prepared to firm block and district level plans. Mathematicane in bealth institutions are actional plans. Village bealth institutions are brain provide the first level plans. Mathematicane in bealth institutions are action plans. The execution of the planning proceeds in the planning proceeds in the planning proceeds in the planning proceed action Plans. Mathematicane action plans. The execution of the planning proceed action plans. Mathematicane action plans. The execution of projects by the project of the project of the project of the planning proceed activities in a critical plan brank. Mathematicane activities in a critical plan breactive plan by project by the first breactive plan acound action			
nchurion noticution of NRHM in Kernia has proved the fund flow to badth intrations at various jevels, upgraded astructure in badth institutions and ped in facilitating their routine agement. It has led to the creation of and Hasth and Sanhadon Committees I Honpiaul Minegement Committees I Honpiaul Minegement Committees in innovations files and the ability in furvementageuren daritet o Hasthy in da level as Anneal Action Plana re prepared without the planning process a flawed as Anneal Action Plana the action of projects by the set by specifying the project tivities in a critical path resulted the released by GOI, huge announds the level aby GOI, huge announds re lapt in bast dapied in thme.	check ups and village level activities. Action Takau: At present, the Annemi Action Plan is prepared from Ward level itself wherein community participation is ensured.	village lovel hours plans are boung prepared use year as consultation with LSCO and capacits on halits related issues. These will be aggregated to form block and district level plans.	
		unction of NRHM in Kerala has void the fined flow to bealth kions at various levels, upgraded mucture in bealth institutions and in facilitating their routine gennert. It has led to the creation of Health and Sanisation Committees forginal Management Committees forgetial Management Committees in the Static Stability in varianthapuran district to create moverions life Kadio Healdh' in varianthapuran district to create in avances. Docentrafied in a scheme the planning the Pergective Plan and without using level data, obtained through bold and facility surveys. execution of projects by the without the Perspective it is a critical path resulted at affecting to the time achedulo. . the SHS could not spend the released by GOI, huge anound	_

	Though funds were available, the entitled grants were available, the entitled grants were available, the che CHCs and PHCs. Release of funds to be CHCs and PHCs. Release of funds to be conciled. Upgradution were also noticed. Upgradution were done noted. Upgradution were show press and SCs were proceeding at a deficiencies in moderal and pre- serve press and screen the funds and screen the funds and pre- medical masspower, infratructure deficiencies in moderal and pre- medical masspower, infratructure deficiencies in moderal and pre- medical masspower, infratructure deficiencies in moderal and the State Photomement of drags, arenjeal and opervise the principles of financial propriety and deathered definitions.	This has been done in 2012-	
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1· ·	sustainability of NRHM inditatives oven after the Mission period.		
		This has been done in 2010-11	This has been done in 2012-
	consolidated Action Plans at the Village, block and district levels so that actual		ń.
	Proposals in the Action Plan should be made on the basis of the absorption		
	capacity of the Mission and the funds released should be utilised without		The entire amount has been
	undue delays to avoid retention of huge balances in bank deposits.	Noted	released to the institutions during 2012-13 and the
	Corpus grants, maintenance grants and untied grants should be released		society has no bank fixed deposits.
	emunity to all the entitled health care	The catire amount has been released to the institutions during 2010-	8
	· Priority should be accorded to		
	complete all the upgradation works for which approvals have been received.	Actions initiated to complete all the pending works.	
	Steps should be taken to fill up the regular vacancies of medical and para-		Out of the 54 spillover works during 2012-13, 32 works
	medical suff in the CHOs and PHOs and nost contractual staff under	-	have already been completed
	NRHM as per requirements to achieve Intian Public Health Standards.	Director of Health Services has been addressed to fill up, the vacant problem. Contractual contrast work has made on a mod hand memory	
			Contractual postings would be
•	• The principles of finances propriety should be observed in all the		undo on a broat puede this men.
	protorement processes to avoid undue ferour to the suppliers.		

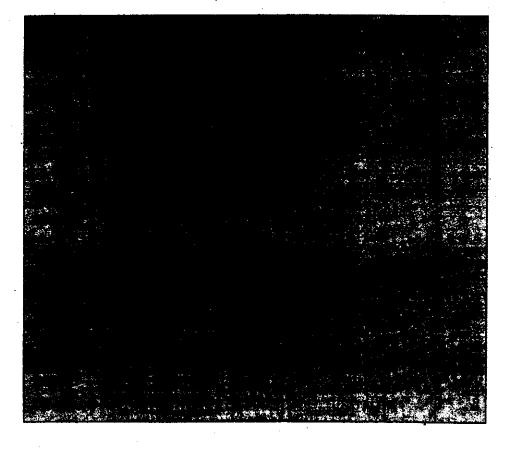
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1.2.6.2 Perspective Plan

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

A. Outcome Indicators



1097/2014.



Kamin State have achieved population stabilization as TFR is already 1.7. However as per the tread, the TFR may fail to 1.6 in the next 5 years.

B. Output Indicators

							<u></u>
	. ·		2012-			2015-	
	•		13	2013-14	2014-15	16	2016-17
A		1	Enternal .	Vealth		<u> </u>	·
1	Institutional Deliveries (%)	99.8	99.9	99.9	100	100	100
2	24x7 Facilities (Sub- District)	175	175	180	180	185	185
3	Functional First Referral	65	75	80	95	100	113

			·				
	Units					1	
			Child he	alth			
4	Sick New Born Care Units	-11	11	12	14 -	18	20
5	New Born Care Corners	91	95	100	120	125	130
6	Stabilization Units in FRUs	65	70	75	80	85	90
7	Pull Immunization (%)	\$1.9	83	\$5	\$7	92	95
С		Pope	dation St	biligation	L		· ·
8	Male Sterilization	3%	5	10	15	20	25
9	Female Sterilization	97%	95	90	85	80.	75
10	No. of IUD insertions	60000	60200	60450	60650	60875	61000
D		1	Disease C	entrol	,,	_	
	Annualized New Smear					[
11	Positive Detection Rate of	73	90	86	88	90	90
	TB (%)						•
	Success Rate of New Smear	83	95	85	85	90	95
12	Positive Treatment initiated on DOTS (%)	91	100	91	95	99	100
13	ABER for malaria (%)	6%	8%	9%	10 %	10 %	10 %
14	API for malaria (per 1000 population)	0.06	0.06	0.06	0.06	0.06	0.06
	Annual New Case Detection	0.28	0.28	0.28	0.27	0.26	0.25
	Rate for Leprosy (per 1,00,000 population)						

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16	Cataract Surgaries performed	626000	121000	123000	125000	127000	130000
B	Training				L	l	I
19	Doctors trained on EmOC						
20	Doctors trained on LSAS	283	300	310	315	325	330
21	Doctors trained in NSV/ Conventional vascetomy	#	125	150	175	200	225
2	Doctors trained in Abdominel Tubectomy (Minilap)	293	310	315	325	350	360
23	Doctors trained in Inparoscopic Tubectomy	176	200	225	250	275	300
24	Personnel trained in IMNCI		140 MOs 840 JPHN		420 MOs 2520	MO	680 MOs 6200
	Community Processes			L	<u> </u>		L
25	Functional VHSCs	19560	19560	19560	19560	19560	19560
26	ASHAs with Drug kits	23350	27741	31000	31000	31000	31000
27	ASHAs trained in 6 th and 7 th		10000	15000	20000	25000	30000
1	modules]	ļ				
G	modules Improved Management				<u> </u>		<u> </u>
G 28		Continuou s process	Continu ous process	Continuou s process	Continuous process	Continu ous process	Continuou s process

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(number of functional ILR points) H Infrastructure Construction of sub-centre 30 1 buildings Construction of PHC 10 25 40 60 28 31 buildings Construction of CHC 24 32 40 8 16 32 87 buildings Construction of District 25 30 35 33 13 15 20 **Homital buildings** Construction of Other 10 2 4 8 10 14 34 Hospital buildings **MMU and Referral Transport** Ŧ 16 16 24 26 32 No. Of Functional Mobile 20 5 5 Floating 35 Floating 7 2 2 2 Medical Units Dispens Dispens 65 arica Ambalanc **es** – 35 KEMP KEMP will KEMP KEMP will KEMP Due for . will be will be will be be be condemna up functional function functional No. Of Emergency and functional tion-185 icaled to 36 al in all in all in all in all ali **Referral Transport vehicles** Districts Districts Districts Districts Condemn Districts ed -36 KEMP -50

J	Operationalisation of MC1	rs					
37	% of registration of pregnant women in MCTS	60	100	100	100	100	100
38	% of registration of children in MCTS	15	100	100	100	100	100
39	% of facilities (SC, PHC, CHC, DH & others) uploading data	80	100	100	100	100	100
40	% of facilities having internet connectivity	90	100	100	100	100	100
<u>4</u> 1	% of data validated at State level		100	100	100	100	100
K	Operationalisation of HM	18					
42	% of facilities (SC, PHC, CHC, DH & others) uploading data	100 % reporting to state server. No facility wise reporting to central server.	100 % state server. 100 % to central server	100 % state server. 100 % to central server	100 % state server. 100 % to central server	100 % state server. 100 % to central server	100 % state server. 100 % to central server
43	% of districts uploading committing HMIS data within a week of reporting month/quarter	100 %. In 3 weeks time	100 %. In 2 weeks time	100 %. In 2 weeks time	100 %. In 1 weeks time	100 %. In 1- weeks time	100 %. In 1 weeks time
			6	· .	}		

44 Collocation of AYUSH at bealth facilities			 	 	 	_
44 health facilities		Collocation of AYUSH at				
	44	health facilities				

L	Human Resources								
L1	Category	Number of Sanctioned post	Number of vacant post	Target for Filling up of vacant posts					
			egalast sanctioned	2012-13	, 2013-14				
45	Gynecologists	283	45	9	0%				
46	Pediatricians	203	24	90 %					
47	Anesthetists	136	39	80 % or on call					
48	Other Specialists	1062	287	80 %					
48	Doctors	2702	342	90 %					
49	Staff Nurses	7303	218	9	5%				
50	LHV	<u> </u>	1						
51	ANM / JPHN	5575	235	9	5%				
45	MPW	397(field worker)	129	9	5%				
46	Laboratory	776	178		0%				
	Technicians								
47	Phermacists	1514	51	\$	0%				
48	Others	27431	2820	9	0%				

			201	-11		2011-12			
		GQI Appro ved	Amoun t disburs ed by district	Institut ions receive d smouth .t	Expen diture	GOI , Appro ved	Amount disburse d by district	No. of institutio	Expendi ture
	Ward	1836.9 0	1602.2 0	16022	1325.5 7	1956.0 0	1929.30	19293	2009.05
Untied funds	Subcontr + *	523.50	501.43	5014	396.96	540.30	473.63	4736	472.46
÷	PHC	165.25	177.99	711	120.17	208.50	180.42	721	178.71
	CHC	211.50	122.25	244	100.42	155.50	133.00	266	127.45
Annual mainten	Subcentr •	332.80	211.75	2117	133.70	370.90	110.30	1102	127.61
-	PEC	330.50	328.48	656	196.79	\$34.00	165.47	330	177.40
grant	CHC	423.00	233.75	233	153.32	311.00	166.98	166	134.80
	PEC	661.00	412.51	412	461.20	\$34.00	621.3061	621	479.99
	СНС	423.00	244.63	244	142.02	311.00	221.918	221	278.50
HMC	Tabat/D B/W&C/ others	105.00	428.96	85	391.34	245.00	239	47	247.37
T	piel	5012.4 5	4263.9 5	25738	3421.4 9	5766.2 0	4241.33	27503	4233.34

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Annessere 3

ASHA - DISTRICT DETAILS

Districts	Total target	Total Selects d	Currenti 7 working ASHAs	Total Train ed - Modu ie I	Total Train ed - Modul e II	Total Train ed - Modul e III	Total Trained - Module IV	Total Trained Module 5
KASARGOD	1377	1285	990	1056	1105	971	758	688
KANNUR	2500	2431	2185	2431	2374	2063	2057	2100
WAYANAD	839	839	776	928	825	908	816	681
KOZHIKODE	2800	2592	2048	2048	2048	2045	2041	2033
MALAPURAM	4000	3991	3626	3948	3774	3747	3585	3425
PALAKKAD	2800	3306	2701	3233	3097	3035	2933	2647
THRISSUR	3205	3205	2717	2983	2872	2800	2619	2144
ERNAKULAM	3100	2683	2413	2569	2452	2278	2025	1900
IDUKKI	1200	1188	1137	1188	1116	1065	1073	1137
KOTTAYAM	1965	2031	1732	2031	1965	1836	1685	1590
ALAPUZHA	2300	2375	2297	2375	2300	2225	2150	2054
PATHANAMTHIT TA	1340	1340	1212	1340	1244	1189	1141	1086
KOLLAM	1729	1729	1618	1729	3641	1481	1320	1189
ŦVM	3600	3901	3399	3901	3419	3178	3006	2646
TOTAL	32755	32896	28911	31760	30232	28821	27289	25320

1.2.10.1 Maternal Health.

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

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

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

Year	Kerala
2005	0.67
2006	0.67
2007	0.19
2008	0.21

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

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

Maternal Death shows significant decrease after the implementation of NRHM.

	*DLHS-3 (2007-04)			*DLHS-2 (2002-04)		
Total	Rural	Urban	Total	Rural	Urban	
99.8	99.8	100.0	99.7	99.6	99.8	
95.3	95.2	95.5	96.5	96.2	97.5	
74.3	74.6	73.3	74.1	74.5	72.9	
72.3	72.5	71.4	69.5	69.9	68.5	
99.4	99.3	99.9	97.6	97.1	99.0	
	Total 99.8 95.3 74.3 72.3	Total Rural 99.8 99.8 95.3 95.2 74.3 74.6 72.3 72.5	Total Rural Urban 99.8 99.8 100.0 95.3 95.2 95.5 74.3 74.6 73.3 72.3 72.5 71.4	Total Rural Urban Total 99.8 99.8 100.0 99.7 95.3 95.2 95.5 96.5 74.3 74.6 73.3 74.1 72.3 72.5 71.4 69.5	Total Rural Urban Total Rural 99.8 99.8 100.0 99.7 99.6 95.3 95.2 95.5 96.5 96.2 74.3 74.6 73.3 74.1 74.5 72.3 72.5 71.4 69.5 69.9	

*Latest District Level Household Survey (DLHS) reports

12.

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

	Budget approved	for 2012-1	3 and Expenditure received till an	armet 31et	·
	•		Inpose in Lakiks		
	Summary	Badget for 2012-13	Romarks	Expenditur e as on 31.8.2012	% ef
A	RCH II	16155.2 6		4563.57	28
B	Mission Flexi Pool	24669.3 7		4339.63	18
С	Immunisation	1088.95		367.54	34
•	Sub Total	41913.5 7		9278.74	22
D	NDCP				
	NPCB	702.91	· · · ·	95.45	14
	RNTCP	1086.07		155.60	14
	IDSP	210.09		17.39	
	NVBDCP	972.00		242.34	25
	NIDDCP	102.46		4.28	4
· · · ·	NLEP	87.01		4.25	5
	Subtotal NDCP	3160.54		519.31	16
	Total	45074.1 1		9798.85	22
	RCH-II				
	Budget Head	Budget		Expenditor e se ce	% af
		2012-13	Uait cost	38.09.2012	4 2 0
A.1	Maternal Health (including JSY)	3875.86		609.18	16
A.I.1.4	RTI/STI services at health Services	68.00	through KSACS		0
A.1.3.1	RCH Outreach Camps	47.00	235 camps @20000/-	11.83	25
A.1.3.2	Monthly Village Health and Nutrition Day	232.40	19365VHND/month @ Rs. 100/- for ASHA incentive	13.45	0
A.1.4	JSY	1212.66		401.66	33
A.1.4.1	Home deliveries	1.25	250 deliveries @Rs.500/-	0.04	3
A.1.4.2	Institution Deliveries	908.85	Rural-110403 deliveries @ Rs.700/-, Urban-22672@Rs 600/-	319.48	35
	Incentive to ASHA for JSY	302.56	123971 rural and urban @Rs.200/- and 9104 tribal @Rs.600/-	82.14	27

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	· · · · ·		······		1
A.1.5	Maternal Doath Review	3.25	200 death investigation @ Rs.500/-, 50 deaths for incentive @ Rs.500/- and Rs.2 lakhs for printing of formats	0.00	0
			Serraning of blood 12000units @Rs.500/-, MCP card 5.5 lakhs		
	Others (Blood		@Rs.5/-, 3 lakhs for 10 blood	1.1.1	1
A.1.6	transfusion and MCP card printing)	121.50	storage centre, 4 lakts for training at state lovel	0.24	i o
A.1.0		2191.45			
A.1.7	JSSK (for Prognant Women)			182.01	8
/			Rs.350/normal delivery for		1
		1	123541 ceans and		1
	Drugs and		Rs.1600/conserven for 21802	64.30	8
A.1.7.1	consumables	781.22	cases Rs.200/delivery for 145343	04.30	┼╴╸
A.1.7.2	Diagnostic	290.69	Cases	21.85	8
A.1.7.3	Blood Transfusion	21.80	Rs.300/delivery for 7267 cases	18.36	84
<u>A.I.(.)</u>	DECU I TELESCONTON	21.00	100*3*72673 for normal		
		e a	delivery, 100+7+21802 for		
A.1.7.4	Diet	370.63	CORDEFEED	33.37	9
A.1.7.5	Referral Transport	726.71	Rs.500/- for 145343 deliveries	44.13	6
				13.24	<u> </u> -
A.2	Child Health	1231.82		0.00	1
A.2.2	Facility Bared	1006.87	operational cost for 65 NBSU @	0.00	
	Care/FBINC		Rs.1.75 lakhs p.s., 20 likhs for		
	Caldrinic		NBCC, NBSU-142.36 lakhs for		
			infrastructure, Rs.173.76 lks for		
			equipment and operational cost of Rs. 1 lakh for 49 units, SNCU-		
			337lks for infrastructure, 145	·	
			lakhs for equipment and		
		-	operational cost @ Rs.2 lkh for	•	
			13 units	0.00	0
A.2.5	Care of Sick	60.00		0,00	· .
	Children and Severe Malnutrition		Screening tests for thyrold-PH		
		· ·	lab	•	0
A.2.6	Management of		· · ·		
	Diarrohes, ARI and Microsophient				1
	Malmatrition		setting up of 700 ORT corners		
		7	@Rs.1000/-	0.00	
A.2.7	Other CH activities		1		*****
	(CDS project)	0.00		0.00	

A.2.8	Infant Death Audit		<u> </u>		1 -
			650 doutes- Rs.200/- for POL, Rs.200/- for DA to doctors, Rs.100/- for continuency.		
		. 5.33	Rs.2.06 lakhs for printing		0
	JSSK (for eick neematus up to 39				
A.2.10	days) Diagnostic	<u>152.62</u> 43.62	21802 neanates @Rs.200/-	<u>6.62</u> 2.29	4
	Referral Transport	109.00	21802 noonaios @Rs.500/-	4.33	4
A.3	Family Pleasing	553.53	21002 IBOIMES (20X3.500-	148.84	27
<u></u>	Dissemination of	5.00			- 41
	menuels		2 likis for printing, 1 lakh each for one state level and 2 regional		
A.3.1.1	Female Starilisation	28.35	level training	0.00	0
A.3.1.2	Camps		405 camps @7000/-	3.96	14
A.3.1.3	NSV Camps	21.70	62 camps @35000/-	1.85	9
A.3.1.4	Compensation for female starilisation	388.50	6085 cases @Rs.1500/-	1 09.87	28
A.3.1.5	Compensation for male storilisation	91.28	38850 cases @Rs.1000/-	32.48	36
A.3.2	IUD Services	13.70	68520@ Rs.20/-	0.68	5
	Repairs of Laproscopes	5.00	repair of 5 laproscopes @ Rs.1	0.00	0
A.4	ARSH	663.71		45.15	7
-	Adolescent services at health facilities.		11 new clinics at DH level @ Ra.1.26 leiths, operating expense @Rs.3.6 likhs for 14 existing clinics, sensitation workshop at AW and tribal 3 batch each for 14 districts @ Rs.8300/-per		
A.4.1		7].22	batch	2.24	3.
	School Health		printing of measures, health club, join diary, school register, biring of vehicles, website meintenance		
A.4.2	<u> </u>	577.49	etc	28.73	5
A.4.3	Other activities	15.00	Strenthening of state ARSH team -Rs.5 lakhs, Assessment studies Rs.10 lakhs	14.18	[.] 95
	Urban RCH		selery of 50 MO @ Rs.27000/-, 300 JPHN@11620/- and 9 health Supervisor@Rs.16180/-, Rs.34.90 lakhs for other urban RCH activities like review		
A.5		632.69	meeting, training, printing etc.	256.69	41

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A.6	Tribel RCH	131.98	440 TMU camp @Rs.1000/- ,PHC/CHC camps 400 @Rs.3000/-, special medical camps 26@Rs.12000/-, Adolescent Health education class 24@Rs.1500/-, Rs.8.10 lakhs for Adolescent health club, Rs.9.90 liths for special education campaign, Rs.51.14 lakhs for sickle cell anemia, Rs.40 liths for tribal hospital, Kottathera	17.47	13
		049531		2077,44	42
A.8 A.8.1.1	ANMs, Supervisory Nurses, LHVs	2630.35	738 ANM/JPHN @11620/- month, 960 SN @ Rs.13900/-	1174.20	45
A.8.1.2	Laboratory Technicians, ,MPWs	221.71	159 LT @116204	101.91	46
A.8.1.3	Specialists (Amethetists, Pediatricians, Ob/Gyn, Surgeons, Physiciana, Dental Surgeona, Radiologist, Sonologist, Sonologist, Pathologist, Specialis t for CHC)				
		453.12	118 Specialists @32000/-	143.03	32
A.8.1.4	PHNs at CHC, PHC level			0.00	*****
A.8.1.5	Medical Officers at CHCs / PHCs	2663.64	266 MBBS doctors @32000/-, 595 CRS @23000/-	914.57	34
A.8.1.6	Additional Allowances/ Incentives to M.O.s of PHCs and CHCs				*****
A.8.1.7	Others - Computer Assistants/ BCC Co- ordinator etc	326.69	Pharmacists, physiotherapists, CSR/X-ray/SCG Technician/ Radiographer, Nutritionist etc	322.74	99
A.8.1.1 0	Other Incentives Schemes		Contract in the second s		
	(Pl.Specify)	200.00	Call Allowance to doctors	43.00	21
A.9	Training	873.86		49.67	6

			· · · · · · · · · · · · · · · · · · ·		
	MH Training				
A9.3		159.21	Bemoc training 1 per district @ Rs.5 lakhs, training on safe abortion services to MO- 3MO/district @ Rs.30230/MO, RTI/STI training-Rs.5.08 lakhs for TOT, LT training 14*Rs.51290, MO 14*Rs.84065, staff nume 14*Rs.75440, Pro markel counselling training for JPHN Rs.50000- for 14 batch, 100 batches of post marital counselling training @ Rs.35000/-	0.68	0
A9.4	IMEP training	9.20	15 batches @ Ra.61405/-		0
	CH Training	1			<u> ~</u>
A9.5	FP Training	62.92	IMNCI - TOT Rs.2.52 liths, JPHNs 4 batch @ Rs.2.26 liths, MO 3*Rs.2.26 liths per batch, Staff Nurse 3 *Rs.2.26 liths per batch, training on lactation magt Rs.21.19 liths, NSSK Training- TOT Rs.94000', MO and SN 14 batches *Rs.94000'- Laproscopic sterilisation-TOT Rs.71000'-, for MO, SN and OT assistants 14 batches @ Rs.71240, refresher training 14 batches @ Rs.71240, Minilap training-TOT-Rs.44000', for MO 14 batches *Rs.43900', refresher training 14 batches *Rs 43900', NSV-for MO 14 batches *Rs.26175', refresher training 14 batches *Rs.25175'-, IUD insertion-TOT-1.67 liths, MO -14.81 liths for 14 batch, SN-14.81 liths for 14 batch, ANM/LHV 14.81 liths for 14 batch, ANM/LHV 14.81 liths for 14 batch, Contraseptive update	0.00	0
A9.6		133.06	seminars16*Rs.40000/-, PPIUD- TOT 1.67 lichs, MO -14.81 lichs for 14 batch, SN-14.81 lich for 14 batch, refresher training 14.81 lichs for 14 batch	3.85	3

	Mission Flazi peol	1426.64		484.58 -	#
	Total -A	6		4563.57	28
A.11	Vuinerable group- Geriatric care	5.00	Approved an initial budget of Rs.5 liths for training		0
A.10	Programme Management	1691.30	HR cost at last years rates, other expenses , financial management training. Audit fees	723.87	43
9.11.3	capacity bldg	1/84 24	· · ·	32.16	*****
A9.8	Other trng &	470.89	<u>Rs.60000/-</u>	13.01	3
•			district cordinators 1*	,	
			, training on Child rights and abuse 52*Rs.32210/-, trg for		
	1		416*Rs.25756/-, computer training for JPHN 52*Rs.42600/-		
			416°Rs.29400/-, Training to HD4/PTA president		
	1 1		Training to teachers		
			Induction training for New JPHN for SHP 37*Rs.61950/	-	
			BCC training Rs.78.90 lkhs,		
			Rs.3.12 lakhs, Training st Koshikode institute 34.48 lkhs.		
			223 @ Rs.15000/-, ASHA/AWW training on MH		
			*Rs.39000/-; teachers training		
			translation-Rs.20000/-, for IPHN/AWW 14 batches		
			workshop for module		
			, TOT for WIPS Rs.2.21lkhs, district TOT 4*Rs.1.47 lkhs,		
			cordinators Ibatch @ Rs. 57000/-		
	· ·		training Rs.4.8 likhs, counsellors28*Rs.18107-, ARSH		
			programme management trining- 7 likhs, Blood storage unit		
	Other Training				
A9.7		38,58		0.00	0
	· ·		28"Rs.36000/-, JPHN 28"Rs.40000/-		.
			for MO28*Rs.40000/-, SN		
			training for state and district programs managers 4*1.471kbs.		

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	Selection & Training	,	584.911khs for training 1-6 module, 20 1khs for printing modules, Rs.40 1khs for BCC kit	146.07	22
B.1.1.1		644.91	for ASHA	145.07	22
B.1.1.2	Procurement of ASHA drug kit	113.11	7540 new kits @ Rs.350/-, replenishment of 23350kits @ Rs.350/-, Rs.5 lkhs for kitting charge		0
B.1.1.3	Incentive	630.97	Prognanat women tracking 15*31549 ASHA @ Ra.20'-, Child tracking 10*31549*Ra.50'-, monthly review mosting 31549 asha @ Ra.100/nm	259.51	41
B1.1.4	Awards to ASHA's/Link workers	8.67	Rs.1000/-PHC for 839 PHC, Rs.2000/- for 14 district		0
B1.1.5	ASHA Resource Centre/Mentoring Group	28.98	Lumpsum		0
B.2	Untied funds	2789.13		1364.61	49
<u>B.2</u>	СНС/ТНОН	145.20	310*Rs.50000 (Approved 93.68%)	46.80	32
	РНС/24х7 РНС	187.39	835*Ra.25000 (Approved 89.77%)	47.96	26
	Subcentres	520.04	5407*Rs.10000 (Approved 96.18%)	110.84	21
	VHSC	1936.50	19365*Rs.10000	1159.01	60
B.3	Annual Maintenance Grants	415.92		151.29	36
	СНС/ТНОН	158.38	310*Rs.100000 (Approved 51.09%)	59.44	38
<u></u>	PHC/24x7 PHC	112.30	835*Rs.50000 (Approved 26.90%)	58.20	52
	Subcentre	145.24	3709*Rs.10000 (Approved 39.16%)	33.65	23
B.4	Hospital Strengthening	4255.06		154.01	4
	District/General Hospitals	936.14	3 institutions-DH Palakkad - 172.50 lkhs, Kannur - 311.48 lkhs and Kanhangad-100 lkhs, 352.16 lakhs for spillover works	8.85	1

<u>.,</u>	Others-W&C		Renovation of W&C Kottayam- 31.20 lichs, Aleppuzha-42 lichs,		
		1221.59	Palakkad-56.70 lkhs, Mangattuparambu -242.78 lkhs and new work at Idukti-67.50 lkhs, Kollam -700 lakhs, Rs.81.41 lakhs for spill over works	21.37	2
	Thebit/Government	1788.23	Rs.1713.23 likhs spill over wrks, Rs.75 likhs for THQH Suithan Bathary	68.36	4
	SC rent and Contingencies	53.10	885*Rs.500/- pm	4.18	8
	Logistic Management	256.00	For vehicles at Block, district and Urban activity	51.26	20
	New Constructions/ Resovation and Setting up (CHC,PHC,SC)				
B.5		2511.66		213.30	. 8
B5.1	CHC	245.83	5 institution- Nochumangad Ra. 34,65 likha, Pathenapuram Ra. 34,65 likha, Kumarakam Ra. 75 likha, Pazhayangadi Ra. 37.50 lakha, Karanapuram Ra. 15 likha, Ra. 36,88 lakha for apill over works	0.15	0
B5.2	PHC	81.65	Rs.31.65 likhs for spill over works, Rs.50 lakhs for PHC Kurumbalangode	0.00	0
B5.4	Setting up of infra wing for civil works	63.38	salary of engineers	23.11	36
B5.5	Other renovations- Quarters	300.00	4 institution-construction of new Quarters in THQH Nedumkandam-90 likbs, Vythiri- 67.50likbs, CHC vathikudi- 67.50liks, GH Kalpeta-75 likbs	0.00	0
	Major Civil works for Opr of FRU		Rs.447.7 lakhs for spill over works, Rs.90 lks for THQH Punakur, Rs.50 lks for THQH Kadakkal, Rs.31.3 lakhs for THQH Kodunealloor, Rs.400		
B5.7		1019.00	Ikhs for THQH Thirurangadi	165.00	10

·····	Civil Works for	Г	······		······
1	Operationalising				
	Infection	· ·		1	
	Management &				
	Environment Plan at	1			·
	health facilities		· · · · ·	1	1
B5.9		326.00	Lunpsun		0
i	Strengthening of			T	1.
	Existing Training		5 institution -Training institute		i i
	Institutions		Malaparamba-46.80iks,		
			Thumpemon-25.20, Thrianu- 41.40, Kottayam-37.80, Idukki-	ļ	1
B5.10.1	Ì	200.40	49.20	25.03	12
	New Training			23.03	
	Institutions/School		6 institution -Training institute	1	
			at Trivendrum-45lkhe, Kennur-		
	2		45lichs, Mipm-46.80lics,	1	1
			Alappuzha-45 lks, pikd-		i
B5.10.2	·	275.40	48.60liths, Kargo-45liths	l	0
B.6	Corpus Grants to HMS/RKS		· · · · · · · · · · · · · · · · · · ·		
B'0	District/General	1026.73		234.68	23
	Hospitals				
	СНС	130.00	2675 licha	39.35	30
	PHC	310.00	310°Rs.100000	67.51	22
	Inc		835*Rs.100000 (Approved		
		542.33	64.95%)	116.25	21
	Others-Speciality and MCs		19*Rs.500000 (Approved		
		44.40	46.74%)	11.57	26
	District Action		DHAP Rs.1 lakh per district,		
	Plans (Including Block, Village)		CHP-201khs per district, Rs.2		1
<u>B.7</u>	DUCE, Vigner)	296.89	lichs for state level	5.20	2
	Pancheyath Rej				
<u>B.8</u>	Initiative	0.00		0.00	
	Mainstreaming of		salary of 750 MO @ Rs.20740/-		
	AYUSH		Vehicle Rs.52 likhs, Rs.24.63		
			lichs for 19 other category of		
Б.9	l _.	1943.23	staff for EKM	622.42	32
9.10	BCC/IEC	708.83		196.31	15
	Strongthening and				
i	development of BCC				
	Strategy	26.80		1.35	5
·	For MH	160.16		64.22	40
	For CH	156.72		2.12	1
	For FP	145.06	•	10.47	7
	For ARSH	135.59	Lumpsum	1.42	1

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	Health Mela	0.00		0.00	
<u></u>	Others	84.50	1	26.72	32
B.11	MMU-Referral Transport	409.12	16 MMU @ Ra.19.87 lkhn/year, 5 floating dispensary @ 18.24 lkhn/year	73.93	18
D.11	Referral Transport			1333	
	-KEMP				
			Rs.70.20 likes for operational expanses GOI share of 20% of		
			Rs.1.7 lks for 25 ambulances at		i
		ļ	TVM, Rs.400 liths for cost for		
	1		purchase of 20 ALS ambulance		
	· ·	· ·	@ Rs.20 lks, Rs.42.12 lkhs for Open @ Rs.1.2lks for 3 months-		
			60% for first year, 151.63 lichs		
			for Operational cost for 18		•
	·		ambulance running at Alpy,		
			Rs.32.7ikhs for special strategy for inseccessible areas		
			109*Re.5000*6 months.		
			Rs.1556.50 liths for cost of 283		
			patient transport ambulance		
			Ra.5.5 lkh, Ra.509.03 jokhs for canex for control room at TVM.		
			Ra.679.2 lais for opex for		
			patient transport ambulance for 3		
B.12		3441.38	months @ Rs.1.2 lks	137.22	4
B.13	PTT/NGOs	34.00		0.00	0
	MNGO		Describes and the form first late		
			Baseline survey in four districts @ Rs.1 iskh each at Idukki.		
		ł	Malappuran, Wayd and kargd,		
			and first phase intervention for 6		
		34.00	month @ Rs.125000/-pm	0.00	0
<u>B.14</u>	Innevations-	227.05		0.00	0
•	Setting up of Disivels Unit		Rs.15 lkin for 14		
-		210.00	institution(DH/GH)	0.00	0
	Total station survey	17.05	·	0.00	0
B.15	Community Monitoring	665.87		198.31	28
	Quality Assurance		NABH NABL KASH Printing		1
			of meanels, training, Blood bank		Ì
B.15.2		543.28	accreditation for Aluva	123.82	23
	11D/ISA/IIS	1			1

66.65

printing of new registers, review of existing registers, training etc

B.15.3

HMIS/GIS

59.38

•			·····	1	
: B.154		25.25	HW/SW procurement-3.50khs, Geo Spatial pending payment 16 lkhs, MdzE for ARSH 5.75 lkhs	0.00	0
B.13.4	e-governanace	63.43	ILIS, MOLE IN ARCHI 3.13 MM	0.00	┝──
			Selaries of M&E consultant.		1
		ŀ	MCTS, GIS, SDO, DEO etc -		
			Rs.20.64 likhs, mobility for M&E		
			officers-3 lkhs, Workshop and		
			training for M&E-3 lichs,		l
B.15.5	Other M&E	29.89	publication of reports-3.25 lks	5.11	17
B.16	Procurement	868.25		0.00	0
	Equipment	90.00	18 laproscopes @ Rs.5 lichs	0.00	0
	Drugs	1	Iron synap for children Rs.15/100ml/2700000 childreda-		
			405 lkhs, Vitamin A 1.1lkh		
	1		bottles @ Rs.50/- 55 lkhs, IFA		
		-	and Albendazole tablets-318.25		
		778:25	lichs	0.00	0
	New Initiatives/	3447.20	1	610.28	Γ
	Stratogic				
B.18	Interventions				18
	Pain and Pallistive				
	Care	435.51	· · · · · · · · · · · · · · · · · · ·	111.95	26
	ICCONS	400.00		400.00	100
	Montal Health		Ongoing CMHP in Kozhikode		
		1	Minm and Kasergod @ Ra.31.15		l I
			Ikhs each, Scaled up project for 5		
			Districts Kollam,		
	1		Pathanamhitta, Alappuzha,		1
•			Kottayam and Palakkad @39.56		
			lakhs each, Epidemiological		1
		1	Survey to Identify the Mentally ill Persons in Kerala at a total		1
		435.95	cost of Rs.105.13 likhs	47.98	11
	NCD	0.00		27.54	
	Radio Health	72.91		2.64	4
	Menstrual Hygiene	1			1
	Project			0.61	_
	Gender Based	1			
	Violence	50.00		0.7525	2
	Nutritional				1
	Supplement	1			1.
	programme	70.00	in Wayanad district		0
	Rehabilitation			10.04	3
	Endosuifan patients	560.10	in Keseragod district	18.80	<u> </u>

	Seberimala	1422.73			0
<u> </u>	Research, Studies,	1-44			
B.19	Analysis	0.00		0.50	
B.21	State level bealth resources center (SEISRC)	100.00	:	7 <u>1.26</u>	71_
B.22	Support Service	103.21	-	1.74	2
<u>B.44</u>	BNTCP	71.68		0.99	1
	TDEP	29.85		0.75	3
	NLEP	1.68		0.00	0
	Total-B	24669.3 7		4339.63	18
	Immunication				
C.1	RI strengthening project (Review meeting, Mobility support, Outreach services etc)	141.39	Mobility support Rs. 1 lkh for state, 50000/- each for districts, review meeting, printing of cardisfocus on slum and underserved areas, AVD, selary of contractual staff, ASHA incentive etc.	28.34	20
C.2	Salary of Contractual Staffs	18.12	Rs.500/PERC/CHC, Rs.1000/- for district per year	5.29	29
C.3	Training under Immunisation	45.56		7.10	16
C.4	Cold chain maintenance	6.72		1.69	25
C.5	ASHA Incentive	483.72 .		115.44	24
C.6	Pulse Polio operating costs	393.44		209.68	53
	Total-C	1088.95		367.54	34
	TOTAL (A+B+C)	41913.5 7		9270.74	22
	GRAND TOTAL (A+B+C+D)	49074.1 1		9798.05	2

비운		NAME OF INSTITUTION	AS America	DATE OF COMMENCEM	DATE OF COMPLETION	TOTAL EXPENSION
1	TRIVANDRUM	W&C Thycaud	Rt. 14,956,557	01.04.2008	30.12.2009	Rs. 12.341.093
2	TRIVANDRUM	Repeir work stGH Thinwanethaourem	Rs. \$82,000	09.04.2009	08.04.2010	Rs. \$17,012
-	TRIVANDRUM	Telimedicine centre GH	Re. 339,946	12.01.2010	25.01.2010	Rs. 327.316
4	TRIVANDRUM	DPM office, at W&C Thycaud	Rs. 2,526,082	06.09.2009	31.03.2010	Rs. 2,753,985
	TRIVANDRUM	Cold chein work at GH TVM	Ra. 362,768	29.11.2010	18.11.2010	Ns. 362,764
÷	TRYANDRUM	CHC KANYAKULANGARA	Re: 10,78,075 Re: 70,93,531	19.02.2008	17.10.2006	R. 1079.074
-	THYANDRUM	CHC NEDUMANGAD	Ru:31.00.975	13.04.2008	15.02.2009	Rs. 7.017.396 Rs. 3.175.682
	TRIVANDRUM	CHC WITHURA	Pa. 3.958.055	21.04.2009	20.11.2008	As. 4151,000
	TRIVANORUM	CHC VELLANAOU	R:33.99.251	25.02.2009	23.12.2009	Rs. 3.578.483
	TRIVANDIUM	CHC KZSAVAPURAM	Ma: 55, 54, 322	01.09.2008	30.07.2000	Rs. 3.878.632
	TRIVANDRUM	CHC MANAMOUR	Rs:30.31_437	10.02,2009	31.07.2000	71.2.949.710
	TRIVANDOUM	Kanilrunksion	Rs. 3.001,466	27.03.2006	15.01.2009	Nr. 4,589,895
	TRVANDRUM	R.L.O. TVPM	Ra. 1.104.051	20.04.2008	08.08.2008	Rs. 804,092
	TRIVANDINAM	DHS Office	Rs. 2.901.111 Rs. 1.072.810	04.06.2008	15.11.2008	Rs. 2.729.044
17	TRIVANDRUM	NRHM Car Parking	Re. 2.878,237	25.06.2009	22.09.2009	Rs. 1.078.099
	TRIVANDRUM	Chirayinkaeshu THQH				Rs. 3.501,733
		(Additional Works)	Rs. 2,194,165	22.04.2009		Rs. 2,284,433
	TRIVANDRUM	Chiravinkeeshu THQH (UIt)	14.1438.000	17.04.2009	23.02.2010	Rt. 1,438,000
		Chirayinkeedhu THQH (DS Set)	Rs. 1,082,362	24.02.2010		Rs. 1.043,912
21	TRIVANORUM	PHC Vattiyoorkavu	Rs. 7,732,589	20.04.2009	09.04.2010	Rs. 7,732,589
	TRIVANDRUM	Nature Cure Hospital, Variala	Rs. 5,746,553	18.01.2010	25.09.2010	Rs. 5,510, 926 °
	THYNDRUM	GH Varkala	Ry. 2.006,000	21.09.2010	20.12.2010	Ns. 1.065.228
24	TRIVANDRUM	OT Nedumenged	Rs. 1,255,837	17.10.2011	13.01.2012	Ra. \$99,103
	TRIVANDRUM	Nenovetion of Synaec ward Nedwormed	Rs. 975,000	17.10.2011	13.01.2012	Rs. 972,000
	TREVANORUM	OT Chirandahaazhu	No. 6,497,338	12.12.2011	18.01.2012	Rs. 3.663,000
	KOLLAM	CHC KADAIXAL	Rs:14,63,884	06.03.2008	29.04.2000	Rt. 1.280.843
	KOLLAM	CHC PATHANAPURAM	Re:17.67.601	06.03,2008	28.02.2000	Rs. 1.646.702
	KOLLAM	CHC OACHIRA	Rc:27,35,582 Rc:14,75,233	17.02.2008		Nu. 2.916.440
	KOLLAM	CHC MAYYANADU	Rs:23,72,917			Rs. 1,239,382 Rs. 2,255,810
12	KOLLAM	CHC THREEKADAVOOR	Rs:33,48,205			Rs. 4,223,867
33	KOLLAM	Kunders Govt Hospital	Rs. 24.874,281			s. 20.176.926
	KOLLAM	PHC Theidumbhagan	Rs. 2.442,765			tr. 1.561.619
	PATHANAMTHITTA	CHC KANJETTUKARA	Rs:47.02,738			5.121.173
	PATHANAMITHITTA PATHANAMITHITTA	CHC EHADHBAANGALAM	As:31.01.765			5.2400.710
	PATHANAMINITA	CHC RANKE PERMADU	Re:58,89,646			N. 5.518.011
	PATHANAACTHITTA	CCU Pathangethitta	Rs. 1,890,371			4.19,235,356
	PATHANAMTHITTA	OT at TH Thiruvelle	Rs. 2,062,743			4.1,772,317
41	PATHANAMINITTA	OY & Traume care at 6H pathenemthits-Civil & Electrical	Rs. 1.200.000			ts. 1, 663,000
	PATHANAMTHITTA	OTA Treums care at 6H pethenemthitis-Laminer flow		17.02.2011	03.03.2012	is. 400,000
9	PATHANAMTHITTA	OT at GH Adoor	Rs. 4,509,000	18.08.2011	7.03.2012	3. 3.077.000
44	ALAPUZHA	IDRV Clinic at TDMC Vandanam	Rs. 165,392			u. 153,537
15	ALAPUZHA	Ayurvedz Hospital Mavailidupra	As. 2,910,441		15.12.2010 A	1. 4,144,775
	ALAPUZHA	THQH Charthele	Rs. 10,276,356	06.11.2009		1. 9,178,005
	ALAPUZHA	Concernent de la concernent de				s. 20,755,274
	ALAPUZHA	THQH Charthele A/C work	Rs. 2,500,000			s. 1,860,257
	ALAPUDHA	THQH Cherthele (CSSD)	Ru. 755,710			1755.710
9	ALAPLICHA					. 2,698,685

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91. 18.	DISTRICT	NAME OF INSTITUTION	AS Amount	BAYE OF COMMENCEME MT	DATE OF COMPLETION	TOTAL DIPENDITURE
	ALAPUZHA	CHC MUHAMMA	Rs 37,46,545	10.09.2009	18.08.2010	R. 1630.161
	KOTTAYAM	DH Kotteirem	Ps. 194,865	28.12.2008	17.01.2000	34.104.005
	KOTTAYAM	CHC EDAYARIKKAPUZHA	81:27,88,761	20.12.2008	28.30.2008	2.107.024
	KOTTAYAM	CHC KARUKACHAL	NE ALELESA	18.01.2009	30.12.2009	2.022.284
	KOTTAYAM	CHC KOODALLOOR	Re:40.33,468	01.04.2008	31.01.2009	No. 348.345
	KOTYAYAM	CHC PAIKA	Ne:27.67.990	17.11.2008	15.06.2009	N. 2401.720
57	KOTTAYAM	CHC ERUMEL	Ra:31.96.762	11.05.2008	11.11.2009	N. 2461429
	KOTTAYAM	CHC ULLANADU	N:32,13,201	26.04.2008	30.06.2009	Rs. 2.867.784
	KOTTAYAM	CHC VAIKOM	Re. 3.182,684	25.07.2008	30.04.2009	As. 3.156.356
	KOTTAYAM	CHC MUNDAMIUNINU	Rs. 2.468.320 Rs:15.37.322	22.69.2008	31.07.2009	Rs. 2.058.542
	NOTTAYAM	Liphin Theirvolegerumbu	Rt. 2.544,484	01.06.2008	08-10.2008	Ns. 1.056.192
	KOTTAYAM	OH Kotteven	Ra. 19,616,527	13.10.2010	13.07.2012	Rs. 21.500.000
64		CHC UPPUTHURA	Rc 28.87.461	25.09.2009	15.01.2010	41.2.420.500
65	HOURC	CHC VANDIPERIYAR	Re: 21.72.007	25.05.2000	21.01.2010	Pa. 1.871,479
	IDUICE	CHC PURAPUZHA	Rc 25.87.996	16.05.2009	14.12.2009	Na. 2.106.656
		CHC NEDUMKANDOM	Rg 26,36,140		19.12.2009	Ra. 1.984.752
	IDUKI	CHC RALAKKAD	Re: 25.09.310	21.11.2008	09.12.2009	R. 2415.301
	ilipulaci	CHC ADIMALI	Re: 26.25,764	20.11.2008	18.06.2009	a. 2 215 548
70	IOUKKS	TH Thogupushe	Rt. 9,424,731	20.04.2011	01.08.2011	
71	ERNAKULAM	ArGH Keruvellopedy	Rt. 30,712,621	27.12.2008	07.12.2010	31, 31,259,640
72	ERNAKULAM	Repair & maint, Of PCU GH Erenelwiem	Ns. 482,877	27.12.2008	20.02.2009	Ru. 451,287
73	ERNAKULAM	<u></u>	Rs. 3,344,207	28.02.2009	30.06.2009	Rs. 3,265,050
74	ERNAKULAM	GH Ernelwiem(NABH)	Rr. 23,317,370	28.02.2009	11.10.2010	Rs. 17,429,159
75	ERNAKULAM	Renovation of W & C Mettanchery	Rs. 23,503,079	09.02.2009	18.09.2009	R1. 6,459,362
	ERNAKULAM	THQ Thripunkhera	Ra. 6.971.001		29.10.2009	Na. 7,901,397
	ERNAKULAM ERNAKULAM	Hursing school Employem Treining Centre Thrippunithere	Rs. 15,031,443 Rs. 5,991,500		15,03,2010 31,05,2009	Rs. 18-528.363 Rs. 6.778.060
7	ERNAKULAM	THOH Aluve	- 16 310 100	127.04 147		
	ENNAKULAM	PHC, Angemely, Ernekulem	Rs. 16,210,108 Rs. 6,397,235	27.04.2000	31.12.2009	Rs. 14,907,643
	ERNAKULAM	Steff, Qtrs, GH Emelalem	Rs. 3,220,329	15.10.2000	06.09.2010 05.09.2010	Au 5,182,250
	ERNAKULAM	THOH, Muvattupushe, Emekulem	Rs. 13,949,699	27.11.2000	20.09.2010	No. 3,453,670 No. 10,679,930
8	ENNAKULAM	PHC Nerlyamangalam	Rs. 1.990.584	10.09.2010	26.08.2011	Rs. 1.864.547
2	ERNAKULAM	PHC Kuttemputhe	Rs. 1.010.300		08.02.2011	Ra. 1.010.300
	ERNAKULAM	GH Ernstwarn(Dielysis Unit)	Rt. 1.971.200			Rt. 1.485.920
	ERNAKULAM	CHC CHENGAMANAD	Re:71,46,565	16.02.2008	31.01.2009	Ru. 6.626.796
	ERNARULAM	CHC VENGOLA	Rs:24.17.115	16.02.2008	15,11,2008	Rs. 2.682.891
	ERNAKULAM	CHC PIRAVAM	As:70.15,432		07.12.2008	N. 8.568.535
	ERNAKULAM	CHC KUMBALANGI	Re. 3.618.594		20.01.2010	Rs. 4.040.257
	ERNAKULAM	CHC KEECHERI	Rs. 3,742.051		28.04.2009	4.3.971.212
	EPNAKULAM	CHC KALADY	Re. 2.895,780	20.03.2009		<u>h. 3.751.015</u>
	ERNAKULAM	CHC EZHIKKARA CHC VADAVUKODE	R4. 2.813.070			Ns. 3.234.375
	THRESSUR	CHC ALAPPAD	Re: 3.167.140 Re: 49.50.880		20.04.2009	Rs. 3,060,806
	THRESUR	CHIC PUTHENCHIRA	Re:37.48.356			<u>Rs. 4,950,890</u> Rs. 3,723,038
	THRISSUR	CHC MULLASSERY	Re-43.12.812			AL. 3.321.400
	THRISSUR	CHC CHELAKKARA	Re:26.83.595	ولي ويعاد المتحدين بالمتحدين		N. 2.550.200
	THRISSUR	CHC THIRUMILWAMALA	8:26.53,634			2.626.003
99	THRESSUR	CHC PAZHANJA	14. 2.616.689			1.3.347.797
	THRESSUR	CHC CHERPU	No.67.752			A. 5.625.905
	THRISSLIR	Anthikad PHC	Rs. 2.461.247			Rs. 2.315.540
	THREELAR	OT Vedekenchery	Rt. 2,063,030			ta. 1.772.000
03	PALAKKAD	CHC NENMARA	8:24.87.648	25.03.2004		1,2272.275
	PALAKKAD	CHC KUZHALMANNAM	Ax31,15,405			A. 1.006.374
05	PALAKKAD	CHC ELAPULLY	N#34,44,169		1.10.2009	4.2.928.394
	PALAKKAD	CHC KODUVAYOOR	Rs:24,25,924	19.12.2008	18.09.2009	AL 2.074.348

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Я. Мь.	DISTRICT	NAME OF INSTITUTION	AS Amount	DATE OF COMMENCEME	DATE OF COMPLETION	TOTAL EXPENDITURE
107	PALAKKAD	CHC NANNYODE	Rs:27.83.348	18.06.2008	31.03.2009	Rs. 2.741.880
108	PALAKKAD	CHCALATHOOR	Au:19.59.583	30.05.2008	31.03.2009	Rs. 1.902.912
109	PALAKKAD	CHC VADARKANCHERY	Rt:11.40,690	19-04-2008	18.07.2009	Rs. 742.746
	PALAKKAD	CHCAMBALAPPARA	R:26,75,208	05.05.2008	05.08.2009	Re. 2,461,063
	PALARKAD	CHC CHERPULASSERY	Re:29.16.585	05.03.2009	20.10.2009	Rt. 2.719,210
	PALAKAD	CHC KADAMPAZHIPURAM	Rs:25.26.077	25.04.2008	24.02.2009	Rt. 2.071.215
	PALAKKAD	CHCAGAU	Re13.45.186	25.11.2008	24.06.2009	Rp. 1.143.623
	PALAKAD	CHC ALANALLOOR	Rs. 2.433.267	21.04.2009	10.11.2009	Rt. 2.595.328
	PALAKKAD	DH Pelekked(OLD Work)	Rs. 23,000,000		02.11.2010	Re. 15,207,169
	PALAKKAD	TH Chilther	Re. 4.231.906	01.03.2010	15.12.2010	Rs. 4,265,472
	PALAKKAD	OT at TH Ottepelern	84.1.553.594	02.07,2011	20.09.2011	Rg. 1,379,000
	PALAKKAD	OT at TH Childur	74.1.627,776	23.06.2011	20.09.2011	Rs. 1.594,000
	PALAKKAD	OT at TH Alathur	Rs. 1.772.637	30.05.2011	20.09.2011	Rs. 1.725.000
	PALAKKAD	OT at TH Mannerked	Rs. 1.613.291	3.01.2012	15.05.2012	RE. 1.443,000
	MALAPURAM	OICKUTTPPURAM	Rs. 2.939,440	27.05.2009	25.01.2010	Rt. 2,937,640
		CHC VENSARA	Re:32,69,411	12.08.2008	23.09.2009	Rs. 2,731,490
			Re:31.26.920	19,06,2008	03.08.2009	Rs. 3.050,177
	MALAPURAN	CHC MALAPPURAM	Re:25,01,497	15.01.2009	10.09,2009	Rs. 2.707.506
	MALAPURAM	CHC KONDOTTY	Rs. 5.383,823	28.10.2009	27.07.2010	Rs. 5,596,910
	MALAPURAN		Re:17.26.282	27.05.2008	20.07.2009	Rs. 1.625.114
_	MALAPURAM	OIC AREAKODE	N:34.41.454	29.12.2008	20.04.2010	Rs. 3,289,596
	MALAPURAM	CHC WANDOOR	Rs. 2,494,470 Rs:22,64,249	13.05.2008	30.11,2009	Rs. 2,374,374
	MALAPURAM	CHC PURATHOOR	Rs:25.83.092	21.05.2008	02.042009	Rs. 2,099,715 Rs. 2,470,281
	MALAPURAM	TH'Nilambur	Rs. 5.166.399	15.05.2010	14.01.2011	Rs. 5,118,785
	MALAPURAM	Traumacare at GH Kuttippuram	Rs. 950,000	15.10.2011	15.12.2011	Rs: 800,286
133	MALAPURAN	OT at TH Tirur	Rs. 1.082.000	12.07.2011	12.09.2011	Rs. 069,000
134	MALAPURAM	OT at TH Niembur	Rs. 890,870	06.07.2011	28.08.2011	Rs. 774,000
135	MALAPURAM	OT at TH Perinthalmone	Rr. 1.512.611	01.07.2011	29.08.2011	Rs. 1,294,000
136	KOSHIKODE	STP Kozhildode		08.01.2008	23.03.2009	Rs. 43,121,433
117	KOZHIKODE	Extre Work STP Kozhikode			31.07,2010	Rs. 21,653,675
	KOZHIKODE	New Building, IMCH, Kozhikode	- Rs. 477,790,000	7.4.2009	31.03.2011	Rs. 245,243,713
	KOZHIKODE	Renovation IMCH, K.Kode		30.3.2009	31.12.2010	Rs. 109,404,513
	KOZHIKODE	iMCH K.Kode(A/C Work)	1	L	26.03.2011	Rs. 2,085,000
	KOZHIKODE	IMCH K.Kode(Fire Fighting)	4	28.01.2011	31.01.2012	Rs. 8,494,915
	KOZHIKODE	IMCH K.Kode(Uit)		<u></u>	27.06.2011	Rs. 5,952,750
	KOZHIKODE	W&CKozhikkode PH-I	Rs. 15,863,909	14.08.2008	31.03.2009	Rs. 12,736,978
	KOSHIKODE	W & C Kozhikode PH-II(NABH)	Rs. 11,978,308	<u> </u>	30.04.2010	RL 7,533,097
	KOZHIKODE	GH Nedepurem	Rt. 12,467,983	04.01.2009	15,01,2011	84. 12.994.668
146	KOZHIKODE	Dentel College, Kozhikode	Rs. 2,118,600		31.01.2011	Rs. 2,080,800
146 147	KOZHIKODE KOZHIKODE	Dental College, Koshilode THQH Vedelare	Rs. 2,118,500 Rs. 1,190,000	07.0.2012	31.01.2011 31.01.2012	Rs. 2,000,800 Rs. 2,113,777
146 147 148	kozhikode Kozhikode Kozhikode	Dental College, Koshilode THQH Vadakare CHC THAMARASSERY	Rs. 2,118,600 Rs. 1,190,000 Rs:32,79,346	07.0.2012 08.06.2008	31.01.2011 31.01.2012 14.02.2009	Rs. 2,080,800 Rs. 2,113,777 Rs. 2,978,478
146 147 148 148	kozhikode Kozhikode Kozhikode	Dentel College, Kozhilode THCH Vedelare CHC THAMARASSERY CHC NARIXUNI	Rs. 2,118,600 Rs. 1,190,000 Rs:32,79,346 Rs. 2,962,722	07.0.2012 08.06.2008 17.04.2009	31.01.2011 31.01.2012 14.02.2009 30.04.2010	Rs. 2,000,000 Rs. 2,113,777 Rs. 2,978,478 Rs. 2,794,923
146 147 148 149 190	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental College, Koxhilode THCH Vedakare CHC THAMARASSERY CHC MARKUNG CHC MARKUNG CHC MUKKOM	Rs. 2,118,600 Rs. 1,190,000 Rs:32,79,346 Rs. 2,962,722 Rs:29,20,109	07.0.2012 08.06.2008 17.04.2009 11.05.2008	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009	Rs. 2,000,000 Rs. 2,113,777 Rs. 2,978,478 Rs. 2,794,923 Rs. 2,788,204
146 147 148 199 151	Kozhikode Kozhikode Kozhikode Kozhikode Kozhikode Kozhikode	Dental Collega, Koxhijode THQH Vadatare CHC THAMARASSERY CHC NARIXLIRU CHC NARIXLIRU CHC THALAKULATHUR	Rs. 2,118,600 Rs. 1,190,000 Rs.32,79,346 Rs. 2,962,722 Rs:29,20,109 Rs:54,39,353	07.0.2012 08.06.2008 17.04.2009 11.05.2008 24.06.2009	31.01.2011 31.01.2012 14.02.2009 30.04.2010 20.03.2009 02.05.2010	Rs. 2,000,000 Rs. 2,113,777 Rs. 2,978,478 Rs. 2,794,923 Rs. 2,794,923 Rs. 2,795,204 Rs. 5,352,107
146 147 149 199 191 191	Kozhikode Kozhikode Kozhikode Kozhikode Kozhikode Kozhikode	Dental College, Koxhijode THQH Vedetare CHC THAMARASSERY CHC NARKUNG CHC MURKOM CHC MURKOM CHC HALAQUATHUR CHC KODUVALLY	Rs. 2,118,600 Rs. 1,190,000 Rs:32,79,346 Rs. 2,962,722 Rs:29,20,109 Rs:54,39,353 Rs. 3,309,656	07.0.2012 08.06.2008 17.04.2009 11.05.2008 24.06.2009 26.02.2009	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009 62.05.2010 02.11.2009	Rs. 2,080,800 Rs. 2,113,777 Rs. 2,978,478 Rs. 2,794,923 Rs. 2,794,923 Rs. 2,795,924 Rs. 5,352,107 Rs. 3,295,959
146 147 149 199 191 191 191 191 191	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental College, Koxhljode TH/QH Vadalara CHC THAMARASSERY CHC NARIKUNA CHC MUKKOM CHC THALAQUATHUR CHC THALAQUATHUR CHC KODWALY CHC FRAMBRA	Rs. 2,118,600 Rs. 1,190,000 Rs:32,79,346 Rs. 2,962,722 Rs:29,20,109 Rs:54,39,353 Rs. 3,309,656 Rs:5,12,112	07.0.2012 08.06.2008 17.04.2009 11.06.2008 24.06.2009 26.02.2009 21.05.2008	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009 02.05.2010 02.11.2009 29.08.2008	Rs, 2,080,800 Rs, 2,113,777 Rs, 2,978,478 Rs, 2,794,923 Rs, 2,798,204 Rs, 5,352,107 Rs, 3,225,959 Rs, 512,112
	KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE	Dental College, Koxhljode THQH Vadstare CHC THAMARASSERY CHC MARKING CHC MUKKOM CHC THALAKUAATHUR CHC THALAKUAATHUR CHC KODUVALLY CHC REAMBRA CHC BALUSSERY	Rs. 2,318,600 Rs. 1,390,000 Rs. 2,962,722 Rs:29,62,722 Rs:29,82,723 Rs:54,99,353 Rs:54,29,353 Rs:512,112 Rs: 27,15,572	97.0.2012 98.06.2008 17.04.2009 11.06.2008 24.06.2009 26.02.2009 21.05.2008 07.01.2009	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009 02.05.2010 02.11.2009 29.08.2008 31.03.2010	As, 2,080,800 As, 2,313,777 As, 2,578,478 At, 2,778,478 As, 2,778,204 As, 5,352,404 As, 5,352,407 As, 3,285,859 As, 512,112 As, 2,559,402
146 147 148 190 151 151 151 155	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental Collega, Koxhljode THQH Vadelare CHC THAMARASSERY CHC THAMARASSERY CHC MUKKOM CHC MUKKOM CHC MUKKOM CHC MUKKOM CHC KODUVALY CHC PERAMBRA CHC PERAMBRA CHC ULLIVER	Rs 2,118,600 Rs 1,190,000 Rs 22,79,346 Rs 2,962,722 Rs 23,0109 Rs 54,99,353 Rs 3,309,556 Rs 51,2112 Rs 27,15,572 Rs 27,45,968	97.0.2012 98.06.2008 17.04.2009 11.06.2008 24.06.2009 26.02.2009 21.05.2008 97.01.2009 12.12.2008	31.01.2011 31.01.2012 34.02,2009 30.04.2010 20.03.2009 02.05.2010 02.11.2009 31.03.2010 31.03.2010 12.11.2009	As, 2,000,800 Rs, 2,113,777 As, 2,774,478 As, 2,774,478 As, 2,794,972 As, 3,295,204 As, 5,352,107 As, 3,295,359 As, 2,559,402 As, 2,559,506
146 17 14 19 19 19 19 19 19 19 19 19 19 19 19 19	KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE	Dental College, Koxhljode THQH Vadalare CHC THAAAARASSERY CHC NARIKURK CHC NARIKURK CHC THALAKULATHUR CHC KODUVALLY CHC FERAMBRA CHC FERAMBRA CHC BAUJSSERY CHC KUTTIYADI	Rs 2,118,600 Rs 1,190,000 Rs 2,293,46 Rs 2,962,72 Rs 2,962,72 Rs 2,901,09 Rs 54,99,353 Rs 3,309,656 Rs 57,15,572 Rs 27,45,968 Rs 4,23,522	07.0.2012 08.06.2008 17.04.2009 11.06.2008 24.06.2009 26.02.2009 21.05.2008 07.01.2009 12.12.2008 21.05.2008	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009 02.05.2010 02.11.2009 21.03.2010 12.11.2009 05.07.2008	At, 2,080,800 Rt, 2,113,777 Rt, 2,774,478 Rt, 2,794,478 Rt, 2,794,873 Rt, 2,794,873 Rt, 3,295,804 Rt, 3,295,804 Rt, 3,255,807 Rt, 3,255,800 Rt, 3,65,800 Rt, 3,65,800 Rt, 3,65,210
	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental College, Koxhljode TH/QH Vadslare CHC THAMARASSERY CHC NARIKUNG CHC MARKOM CHC THALAQUAATHUR CHC KODUVALY CHC FRAMBRA CHC BALUSSERY CHC ULIYER CHC BALUSSERY CHC ULIYER CHC RATTARY	R4. 2,118,600 R5. 1,590,000 R5. 2,962,722 R5:29,20,109 R5:29,20,109 R5:24,90,353 R5. 3,909,656 R5:5,12,112 R5:27,15,572 R5:27,45,968 R5:42,3,522 R5:42,3,522	07.9.2012 (08.06.2008 17.04.2009 11.05.2008 24.06.2008 24.06.2009 21.05.2008 07.01.2009 12.12.2008 07.01.2009 05.12.2008	31.01.2011 31.01.2012 30.04.2010 30.04.2010 30.04.2010 30.04.2010 30.04.2010 30.03.2009 31.03.2010 31.03.2010 12.11.2009 12.11.2009 05.07.2009 06.09.2009	As, 2,000,000 Rs, 2,113,777 Ag, 2,978,478 As, 2,784,973 As, 2,788,204 As, 5,352,307 As, 3,2788,204 As, 3,235,859 As, 3,259,402 As, 1,965,403 As, 1,965,403
	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental Collega, Koxhijode THQH Vadatara CHC THAMARASSERY CHC NABIKIARI CHC MABIKIARI CHC THALAKUAATHUR CHC THALAKUAATHUR CHC THALAKUAATHUR CHC BALUSSERY CHC BALUSSERY CHC BALUSSERY CHC ULIYERI CHC KUTTIYADI CHC THERUVALLOOR	R4. 2,118,600 Rs. 1,90,000 Rs. 2,92,722 Rs: 2,962,722 Rs: 2,962,722 Rs: 2,92,109 Rs: 5,12,109 Rs: 5,12,112 Rs: 27,15,572 Rs: 27,45,966 Rs: 4,23,522 Rs: 2,24,877	07.0.2012 08.05.2008 17.04.2009 11.05.2008 24.05.2009 25.02.2009 21.05.2008 07.01.2009 12.12.2008 05.12.2008 05.12.2008 13.01.2009	31.01.2011 31.01.2012 34.02.2009 30.04.2010 20.03.2009 02.05.2010 02.11.2009 31.03.2010 12.11.2009 05.07.2008 05.07.2009 15.10.2009	As, 2,080,800 Rs, 2,113,777 Ag, 2,978,478 Ar, 2,794,973 As, 2,758,204 Rs, 3,295,859 As, 3,295,859 As, 3,295,859 As, 3,259,802 As, 2,559,809 As, 1,965,803 As, 3,008,877
	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental College, Koxhljode THQH Vadejare CHC THAMARASSERY CHC THAMARASSERY CHC MARKUNA CHC MUKKOM CHC MUKKOM CHC THALAKULATHUR CHC KODUVALLY CHC VERAMBRA CHC ALUSSERY CHC ULLYERI CHC KUTTIYADI CHC KUTTIYADI CHC VYTHIBI	Rs. 2,118,600 Rs. 1,190,000 Rs. 22,79,346 Rs. 2,962,722 Rs: 29,201,09 Rs: 54, 39,353 Rs. 3,009,656 Rs: 51,2,112 Rs: 27,15,572 Rs: 27,48,968 Rs: 4,23,522 Rs: 22,48,968 Rs: 4,23,522 Rs: 22,48,975	07.0.2012 (08.05.2008 137.04.2009 131.06.2008 24.05.2009 25.03.2009 25.03.2009 12.12.2008 12.12.2008 12.12.2008 13.01.2009 05.12.2008 05.12.2008	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009 02.05.2010 02.11.2009 21.03.2010 12.11.2009 05.07.2006 08.09.2009 31.12.2009 31.12.2009	As, 2,080,800 Rs, 2,113,777 As, 2,978,478 As, 2,794,923 Rs, 2,794,923 Rs, 2,785,204 Rs, 5,352,107 Rs, 3,295,859 Rs, 512,112 Rs, 2,580,802 Rs, 2,580,808 Rs, 367,210 Rs, 305,813 Rs, 3,095,813 Rs, 3,095,813
140 14 14 19 13 13 13 15 15 15 15 15 15 15 15 15 15 15 15 15	KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE KCZHIKODE	Dental College, Kosthijode THQH Vadalara CHC THAMARASSERY CHC RARIELAN CHC MUKKOM CHC THALAQUAATHUR CHC FRAMBRA CHC PERAMBRA CHC BALUSSERY CHC BALUSSERY CHC BALUSSERY CHC CORKATTARY CHC CORKATTARY CHC THRIVALLOOR CHC VYTHIBI CHC VYTHIBI CHC THAROOE	Rs 2,118,600 Rs 1,190,000 Rs 1,190,000 Rs 2,962,722 Rs 2,962,722 Rs 2,962,722 Rs 2,105 Rs 5,12,112 Rs 27,15,572 Rs 27,15,572 Rs 27,45,668 Rs 4,23,522 Rs 22,24,877 Rs 22,24,877 Rs 22,24,877 Rs 22,24,877	07.0.2012 (08.06.2008 17.04.2009 11.06.2008 24.06.2009 26.07.2009 21.05.2009 21.05.2009 12.12.2008 21.05.2009 12.12.2008 05.12.2008 05.12.2008 05.12.2008	31.01.2011 31.01.2012 14.02,2009 30.04.2010 20.03.2009 92.05.2010 92.05.2010 91.03.2010 12.11.2009 95.07.2008 95.07.2008 95.10.2009 15.10.2009 15.12.2009	As, 2,080,800 Rs, 2,113,777 As, 2,778,478 As, 2,794,472 Rs, 2,794,472 Rs, 2,794,472 Rs, 2,754,404 Rs, 3,252,407 Rs, 3,255,404 Rs, 2,559,402 Rs, 2,559,402 Rs, 2,559,402 Rs, 3,67,219 Rs, 2,003,877 Rs, 2,003,877 Rs, 2,003,977 Rs, 2,907,920 Rs, 966,360
	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental Collega, Koxhljode THQH Vadalara CHC THAMARASSERY CHC RABIKUNG CHC MAIKKOM CHC THALAQUAATHUR CHC KODUVALY CHC THALAQUAATHUR CHC BALUSSERY CHC BALUSSERY CHC ULIYER CHC BALUSSERY CHC THIRUVALLOOR CHC THIRUVALLOOR CHC THIRUVALLOOR CHC THIRUVALLOOR CHC THAROOE CHC THAROOE CHC KALPETA	R4.2,118,600 R5.1,590,000 R5.2,78,346 R5.2,962,772 R529,20,109 R529,20,109 R529,20,109 R529,20,109 R529,20,109 R529,20,009 R521,212 R527,25572 R527,25572 R523,224,877 R523,22,004 R515,222,185 R515,222,185 R515,095,82	07.0.2012 08.05.2006 17.04.2009 11.05.2008 24.05.2009 25.02.2009 12.12.2008 07.01.2009 12.12.2008 05.12.2008 13.01.2009 05.12.2008 05.12.2	31.01.2011 31.01.2012 31.02.2009 30.04.2010 20.03.2009 62.05.2010 62.05.2010 12.11.2009 31.03.2009 31.03.2010 12.11.2009 05.07.2008 15.10.2009 31.12.2009 15.12.2009 15.12.2009	As, 2,080,800 Rs, 2,113,777 Ag, 2,978,478 As, 2,784,973 As, 2,784,973 As, 2,784,973 As, 2,784,904 As, 3,275,950 As, 3,275,950 As, 3,275,950 As, 1,965,483 Rs, 3,003,977 As, 2,597,920 As, 1,965,483 As, 3,600 As, 1,465,901
	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental Collega, Koxhijode THQH Vadagara CHC THAMARASSERY CHC NARIKURA CHC THALAKUAATHUR CHC THALAKUAATHUR CHC THALAKUAATHUR CHC THALAKUAATHUR CHC KODUVALLY CHC THALAKUAATHUR CHC BALUSSERY CHC BALUSSERY CHC BALUSSERY CHC ULLIYERI CHC MASATTARY CHC THARVALLOOR CHC YTHIRI CHC THARVALLOOR CHC YTHIRI CHC THARVALLOOR CHC YTHIRI CHC THARVALLOOR CHC YTHIRI CHC THARVALLOOR CHC MERLANGACY	R4. 2,118,600 R5. 1,190,000 R5. 2,962,722 R5. 2,962,722 R5. 2,962,722 R5. 2,962,722 R5. 2,109 R5. 2,109 R5. 2,109 R5. 2,109 R5. 2,12 R5. 2,24,877 R5. 2,37 R5. 2,	07.0.2012 08.05.2008 17.04.2009 11.05.2008 24.05.2009 25.02.2009 21.05.2009 12.1.2.2008 07.01.2009 12.12.2008 05.12.2008 05.12.2008 05.12.2008 05.12.2008 05.12.2008 05.2008 05.2009 05.	31.01.2011 31.01.2012 34.02.2009 30.04.2010 20.03.2009 92.05.2010 92.05.2010 12.11.2009 95.07.2008 95.07.2008 95.10.2009 15.10.2009 15.12.2009 15.12.2009 15.12.2009 10.01.2009	As, 2,000,800 Rs, 2,113,777 Ag, 2,978,478 As, 2,768,204 Rs, 5,352,107 Rs, 2,758,204 Rs, 5,352,107 Rs, 3,253,559 Rs, 1,2539,402 Rs, 1,955,408 Rs, 1,955,408 Rs, 1,955,400 Rs, 2,455,901 Rs, 2,455,901 Rs, 2,455,901 Rs, 2,47,537
	KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE KOZHIKODE	Dental Collega, Koxhljode THQH Vadalara CHC THAMARASSERY CHC RABIKUNG CHC MAIKKOM CHC THALAQUAATHUR CHC KODUVALY CHC THALAQUAATHUR CHC BALUSSERY CHC BALUSSERY CHC ULIYER CHC BALUSSERY CHC THIRUVALLOOR CHC THIRUVALLOOR CHC YTHIRI CHC THAROOE CHC KAPETA	R4.2,118,600 R5.1,590,000 R5.2,78,346 R5.2,962,772 R529,20,109 R524,90,353 R5.3,909,656 R55,12,112 R5,27,15,572 R5,27,45,968 R54,23,522 R52,24,877 R523,26,004 R515,22,185 R515,09582	07.0.2012 08.05.2006 17.04.2009 11.05.2008 24.05.2009 25.02.2009 12.12.2008 07.01.2009 12.12.2008 05.12.2008 13.01.2009 05.12.2008 05.12.2008 05.12.2008 05.12.2008 05.12.2008 05.12.2008 05.12.2008 05.12.2008	31.01.2011 31.01.2012 31.02.2009 30.04.2010 20.03.2009 62.05.2010 62.05.2010 12.11.2009 31.03.2009 31.03.2010 12.11.2009 05.07.2008 15.10.2009 31.12.2009 15.12.2009 15.12.2009	As, 2,080,800 Rs, 2,113,777 Ag, 2,978,478 As, 2,784,973 As, 2,784,973 As, 2,784,973 As, 2,784,904 As, 3,275,950 As, 3,275,950 As, 3,275,950 As, 1,965,483 Rs, 3,003,977 As, 2,597,920 As, 1,965,483 As, 3,600 As, 1,465,901

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	KANNAJR	UPHIN, RPHIL, Kannus	As. 270,000	30.08.2010	10.00.2010	DL MEASE
167	KANNAR	MMH DH Kennur(New York)	Nr. 8.225.051	0.01.2011	30.09.2011	No. 6.107.104
161	KANNUK	THO Hospital Thatperantou	65.11.596.729	19.2.2009	23.08.2011	Re. 11.206.156
169	KANINUR	Teluk Hospitel Koothuperambu	Pa. 33,200,138	8.2.2009	25.08.2011	Rs. 12,905,231
170	KANNUR	CHC PERAVOOR	Rs 25.95.926	20.07.2008	15.04.2009	89. 1.763.664
171	KANNKIR	CHC PANOOR	Re:22.13.342	15.11.2008	30,12,2009	Rs. 2.047,920
172	KANNUR	CHC PINARAY	15:27.54,787	18.08.2009	2/10/2010	Rs. 3.303.623
	KANNER	CHC IRIVIAN	Re:44.00.375	26.02.2008	3/5/2010	Rs. 5.355,438
174	KANDIUR	CHC PAPPINISSERY	Re:29.17.247	26.02.2008		Rs. 2.006.605
175	KANNKIR	CHC MAYYIL	8:45,38,564	26.02,2008	30.11.2009	R. 4.598.618 .
176	KANNAR	CHC INITY	Na:15.46.237	05.06.2008	15.01.2009	At. 1.220.362
177	KASANGODE	OH Kanhenged	Rs. 2.350.000	27.10.2006	23.06.2009	Rt. 1.209.909
174	KASANGODE	PHC Arrendesheram	Rs. 1.500.000	13.04.2011	15.07.2011	Rs. 1.271.148
173	KASANGODE	PHC Cheemeni	Rt. 2,500,000	15.04.2011	15.09.2011	Rs. 2.112.650
180	KASAROODE	PHC Panantheor	Rs. 3.500,000	15.04.2011	30.08.2011	Rt. 2,735,250
181	KASANGODE	PHC Bedleduka	Rs. 2,000,000	15.04.2011	15.08.2011	Rt. 1.501.355
182	KASANGODE	PHC Mogilier	Rs. 1.000,000	15.04.2011	30.06.2011	Rs. 677.487
183	KASARBODE	PHC Panethedy	Na. 4,500,000	15.04.2011	30.08.2011	Rt. 3.044.933
184	KASARGODE	Kanhanged Nursing School	N. 15.417.604	22.3.2009	31.3.2010	Rs. 11.422.696
185	KASARGODE	CHC THRIKARIPUR	Rg:25.58.586	01.01.2004		Rt. 2.649,462
186	KASARGODE	CHC PANATHODY	Rs:18.79.084	23.12.2008	20.01.2010	Rs. 1.195,610
187	KASARGODE	CHC NILESWARAM	Rs: 2510399	20.12.2008	28.04.2000	Rt. 2.103.040
188	KASANGODE	CHC BEDIADUCCA	Re: 22,40,360	20.12.2008	24.10.2009	RL 2.826.005
189	KASARGODE	JPHN Kessygode	Rs. 2313,190			Na. 2.270.008

SL. DISTINC	T	NAME OF INSTITUTION	AGENCY	Amount	Status,
1 TRIVAN	DRUM	CHC PALODE	ICHRWS	2400000	Completed
2 TRIVAN	DRUM .	PHC Chenkai	LSGI	2100000	Completed
3 KOLLAN	A	CHC Kuletingushe	KHRWS	2000000	Completed
4 KOLLAN	A	THQH Punelur	KHRWS	10000000	Completed
5 KOLLAN	4	PHC Paravoor (Fisheries Disp)	LSGI	1500000	Completed
6 KOLLAN	A	CHC Hedungolem	PWD	4000000	Completed
7 PATHAN	AMTHITTA	CHC ADOOR	KHRWS	2000000	Completed
8 PATHAN	AMTHITTA	DH Kozhencherry	KHRWS	2190000	Completed
9 KOTTAY	AM	PHC Poonier	KHRWS	2000000	Completed
10 ERNAKI	JLAM	CHÇ-Kothamengalem	PWD	6000000	Completed
11 THRISSI	JR	THQH Kunnemkulern	KHRWS	5000000	Completed
12 THRISSI	床	THCH Minjakaisada	KHRWS	10000000	Completed
13 THRISSI	ж.	PHC Andethode	LSGI	2500000	Completed
14 MALAP	PURAM	THQH Perinthalmenna	KHRWS	· 5200000	Completed
15 MALAPI	PURAM .	THQH Nilembur	KHRWS	5000000	Completed
16 KOZHIK	KODE	CHC Feroke	KHRWS	12500000	Nearing
17 WAYAN	<u>DAI</u>	GH Kalpetta	KHRWS	27000000	Nearing
18 WAYAN	D	THCH Vythiri	KHRWS	10000000	Completed
19 WAYAN	MD	CHC Meenengedi	KHRWS	5000000	Completed
20 WAYAN	IAD	THQ Sulthanisethery	LSGI	5000000	Completed
21 KANNU	R	PHC Initiaur	LSGI	4000000	Completed
22 KASAR	GOD	THQH Kesaragod	PWD	17000000	Completed

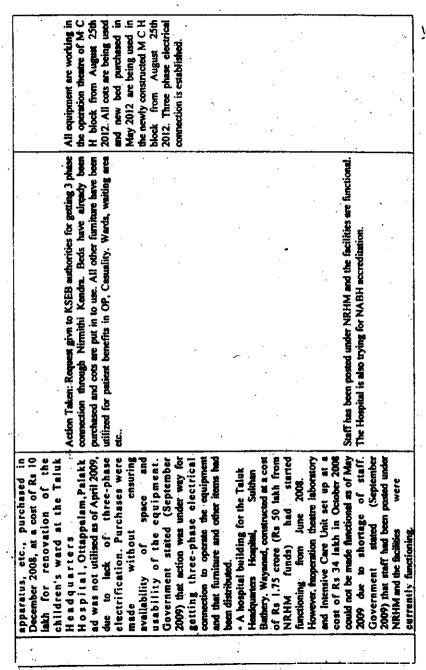
		NUMBER NEW WO	NICS (2012-201	3}	
IL No.	DISTRICT	NAME OF INSTITUTION	Project cent	Status	Date of
	B.4.1.1 Strength	ning of District Hospitals/Opnoral	Hemitals		
1	Pelekked.	OH Pelakkad	17250000	Work in progress	
2	Kannur	DH Kannur	31147868	Work started	27.50.2012
3	Kaseragod	DH Kenhenged	10000000	Tender under finalisation	
	9.4.1.5 Strength	ning of Other Institutions - Wome	n & Children I	teapitais	2
4	Kollern	W&C Kollem	70000000	Tender finalised	
5	Alapputhe	W&C Alappushe	4200000	Tender under finalisation	
6	Kotteyem	W&C Kotteyern	3120000	Work started	22.10.2012
7	icheiti	W&C Iduidé .	6750000	Work tendered	
	Pelokind	W&C Pelekked	5670000	DPR under preparation.	
9	Kannur	W&C Mengettuperambe	24278000	Work started	25.10.2012
	6.4.2. Strengther	ing of SDH, CHCs, PHCs			
10	Kollem	THOH Karungapeliy	46750000	Tender finalised	
11	Wayanad	THQH Sultan Bethery	7500000	AS to be issued	
		uctions / Renevation - CHCs			
12	Kollern	CHC Pathenepuram	3465000	Work re tendered	
13	Kottevem	CHC Kumerakom	7500000	Tender finalised	
14	Kannur	CHC Pachayongodi	3750000	Work tendered	
15	Kannur	CHC Kannepurem	1500000	Work started	11.10.2012
		uctions / Renovation - PHCs	<u> </u>		
15	Meleppuram	PHC Kurumbelangode	5000000	Work tendered	
		uction/Renovation of Govt. Dispa	neries/Other	NT.	
17	liduidd	THQH Nedurakandam	9000000	DPR under preparation	
18	ich de ba	THOM Vathildaudi	6750000	Work tendered	-
19	Wayanad	THOH Wydairl	6750000	Tender Bhallood	
20	Wayened	GH Kalpetta	7500000	Tender Shellood	
		uning of Bristing Training Institut			
21	Pathecemtbitta	Training institute, Thumpemon	4004512	Work Gibdered	
22	Thrissur	Training Institute, Thrissur	4140000	Tender finalised	
23	Kottavam	Training institute, Kottayem	3780000	Tender finalised	1.
24	idukki	Training Institute, iduldi	3200000	Work tendered	+
		ining institutions			
25	Trivindrum	Training Institute, Trivendrum	4500000	Work tandered	
26	Alapouche	Training institute, Alappuche	4500000	Work tendered	
27	Pelekkad	Training Institute, Pelaidad	4860000	OPR under preparation	
28	Meleocurem	Training Institute, Meleppurem	4680000	Tender finelised	
29	Kanour	Training Institute, Kennur	4500000	Work tundered	1
30		Training Institute, Kaseragod	4500000	Tender finelised	1
50	Kasaragod				+
		Works for Operationalization of P THOH Purpler	9000000	Tender finelised	-
31	Kolliam	THOM Kadakini	5000000	Work started	04.11.201
32	Kollen		3130000	Work tendered	
33	Thrissur Melappuram	THQH Kodungsloor THQH Thirungsdi	40000000	Tender finalised	

	NINHA SPILL OVER WORKS (2012-2015)							
SI. No.	S. DISTRICT NAME OF INSTITUTION Amount Status							
	B.4.1.1 Strengthen	ing of District Haspitals/dian	eral Heepitals					
1,	Kottayam	DH Kotteyem	21100000	Completed				
2	Trivendrum	GH Trivendrum	56700000	in Progress				
3	Ernekularn	GH Emekulari	1971200	Completed				
	B.4.1.5 Strengthen	ing of Other Institutions - W	onten & Children	hospitais				
4	Emeksiem	W&C Mettancherry	23503079	Hearing completion				
5	Kozhikode	імсн	12630579	Completed				
	8.4.2. Strengtheni	ng of SDH, CHCs, PHCs	,					
. 6	Triventirum	THQH Neyyatiniars	\$230000	Nearing completion				
7	Kottayam	THCH Veikom	15700000	Tender finalised				
8	Ernekulem	THQH N.Pprevoor	22700000	In Progress				
9	Emalatem	THQH Muvettapuzhe	19633000	in Progress				
10	Thrissur	THQH Wedelanchery	7425400	DPR under revision				
11	Thrisour	THQH Kunnemkulum	5000000	Completed				
12	Palakkad	THQH Mannaritad	6979000	Nearing completion				
13	Palakkad	THQH Ottapalem	8378000	Work started				
14	Malappuram	THQH Perinthalmanna	5200000	Completed				
15	Wayanad	THQH Vythiri	10000000	Completed				
16	Weyened	THQH Kalpatta	27000000	Progress				
17	Ernekulam	THQH Perumbevoor	20699000	à la Progras				
18	Thrissur	THQH Irinjalakuda	10000000	Completed				
19	Malappuram	THQH Nilembur	500000	Completed				
20	Kozhikode	THCH Fecole	12500000	Nearing completion				
-21	Kollám	THOM Puneloor	10000000	Tender finalised				
Ž2	Kannur	THQH Peyyenur	46609608	In Progress				
	B.S.1 New Constructions / Renovation - CHCs							
23	Trivendrum CHC Nadumenged		9750000	in Progress				
24	Alappuzhe	CHC Muthukulam	2460000	Civilwork completed, Electrical & Plumbing work				
25	Alappuzha	CHC Edethue	2250000	Civilwork completed, Electrical & Plumbing wo ²¹ . sanctioned				
26	Weyenad	CHC Meenangedy	5000000	Completed				

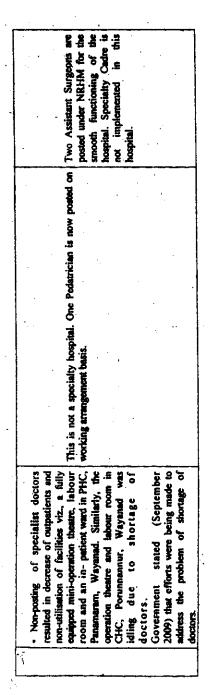
	NINHA SPILL OVER WORKS (2013-2013)					
R. No.	DISTRICT	NAME OF INSTITUTION	Ameunt	Status		
	8.5.2 New Constructions / Renovation - PHCs					
27	Kannur	PHC Eramem kuttur	5000000	Completed		
28	Kennur	PHC Kedennepelly	1400000	Completed		
29	Kannur	PHC Cheruthezhem	5000000	Completed		
30	Kanniz	PHC Perunthetta	700000	Completed		
	8.5.7 Major Civil V	Vortes for Operationalization of	ef FRUs			
31	Trivendrum	THQH- Chirayanidzhu	4000000	Work partially complete.		
32	Trivendrum ,	THQH Nedumeryped	1355000	Completed		
33	Trivandrum	THQH Neyyetinkara	5843000	In Progress		
34	Pathanamthitta	THQH Thiravelle	2670000	Completed		
35	Pathenemthitta	GH Adoor	4509000	Completed		
36	Kottaym	THQH Kenjirapeliy	1492000	Completed		
37	Kotteym	THQH Pale	2400000	DPR under preparation		
34	iduktó	THQH Adimali	4750000	Completed		
39	ldukki	THOH Thoduputhe	3764193	in Progress		
40	Aleppuzhe	THQH Keyemkulem	4993000	Completed		
41	Alappuzha	THQH Harlped	4863000	Completed		
42	Alappuzha	THQH Chenganoor	4940000	Completed		
43	Alappuzhe	THQH Mavelikkars	3373400	Completed		
44	Emekulem	THQH Muvettupushe	3000000	Completed		
45	Ernekulern	THQH Perumbevoor	2902000	Completed		
46	Ernekulam	THQH Angameli	2000000	OPR under preparation		
47	Thrissur	THQH Vadaikanchery	2621500	Completed		
48	Palaided	THQH Mannerlad	2097000	Completed		
49	Palakkad	THCH Ottapelem	2226000	Completed		
50	Palaiduad	THQN Chiltoor	2060000	Completed		
51	Palekkad	THQH Alathopr	2489000	Eye OT in progress		
52	Kozh ikode	W&C Kozhikode	2213711	Nearing completi.		
53	Kozhikode	THOH Vadakara	7074764	Completed		

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Factual Foattoes: The institutional surveys of 2008-09 in the public health institutions pointed out inadequacy of equipments, infinatructure and manpower as the critical factors preventing better	health services from the hospitals. This is because the health care delivery system has remained fragmented and uncontrolled for decades, and the growing demand of the community for better hospital services makes in necessary that quality assurance mechanisms.	interchantise the exercise of making corrections in the health sector is under the purview of the Mission, and in fact our focus is not just on merely assuring compliance with minimum acceptable standards, but to set forth a system of constant improvements in the hospitals so that commitment of the Government to improve the quality of	patient care is translated into reality and create greate efficiency, accountable & responsible governance in hospitals. With this in view, the deficiencies in facilities and equipments mentioned in the audit report is being addressed. Only 115 CHCs were taken up for up-gradution and PHCs were not envisaged. Efforts under the Mission would take time, and overnight deficiencies cannot be removed. While it is able for the Mission to correct the imbalances	in equipments and infrastructure, it would require some time horizon to set right the manpower gaps, because of scarcity of Doctors in the market. However every effort will be made to see adequecy of Doctors at the institutions. Similarly, excess staff nurses in some of the institutions nay be viewed not against the ratio fixed decades ago, but against our goal of attaining a ratio of nut to their	
Deficiencies in approximition of CHCE and PHCs compared to IPHS norms NRHM envisages bringing of	health tratitutions at par with IPHS to provide round-the-clock services. In order to ascertain the facilities evailable, Audit obtained relevant information forces	from 71 CHCs and 83PHCs from all the districts. Audit southy revealed the following: • Manpower As per IPHS norms, seven specialists	and nine staff nurses with supporting staff were required in each CHC. Forty hine CHCs did not have any specialists, while 21 CHCs had less than the prescribed Number of specialists and only one CHC had the full complement of specialists. As regards staff nurses, nine	CHCs had raine or more staff rurses, 57 had less then nine and four CHCs had no staff rurse. According to IPHS norms, each PHC was required to have a Modical Officer, three required to have a Modical Officer, three	Ladormoury Technician. Ten PHCs did not have a full time Medical Officer. Eleven PHCs had three or more staff nurses, while 42 had less than three and 30 did not have any staff nurse. It was also

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ingulamentod in all the institutions. Action is being taken for the upgradation of institutions to the IPHS norm. For increasing mamoures	are being 1 of Assistant 570 posts of S being newly departmen	proposals for New creation of post of Pharmacist and Lab Technicians are under processing.			Steps are being taken to provide blood storage units in all the institutions wide	deliveries.
the existing scenario and hence the supply of equipments and other littms is now being revised based on the actual physical requirement. Regarding the manpower the Director of Health Services is being addressed to fill up the unfilled regular vacancies.			· · · · · · · · · · · · · · · · · · ·			-
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24. Note: 30 30 Source: Details collected through questionnaires from 71 CHCs Source: Details collected through questionnaires from 71 CHCs Source: Details collected through questionnaires from 71 CHCs Source: Details collected through questionnaires from 71 CHCs Reteined: proceeding to PHS anome. (D37 major proceeding to PHS anome. (D37 major procee				-
encompany services Encoded services Services Services Services Services Services Services Respinent According to 1PLS norms, 1037 major questionalizes from 71 CHCs Respinent According to 1PLS norms, 1037 major groups of equipment are necessary to make an operational freatment and Coparational. Out of 32 CHCs which had goestion theatres, 27 did and have even 30 per eact of equipment are necessary to make an operational freatment and Coparational. Out of 32 CHCs which had goestional. Out of 32 CHCs which had goestional. Direct dort which had goestional deplotant services are in place in the stars. Restand health, which had goestional definersy, point makematal health, and achies and referral developes are of goestimes, bit which had devicely to an excitence of pregnancy is there are an operational definersy, postered and which make makematal health, which had are an excitence of pregnancy is the pregnancy is exerting and which make makematal health, which had are an excitence of pregnancy is the pregnancy is exerting and which make makematal health, which services are in place in the stars. Registration makematal health, which had are not break of register of the context makematal health, which had are not break of register of the context makematal health, who dese and referral		hour		
Source: Details collected through cuestionanies from 71 CHCs Benchment According to IPHS norms, 1037 major Vores of equipment are necessary to make to pression heathr (01) operational dot of 32 CHCs which had operational the deficiencies in infraeructural dot of 32 CHCs which had operational dot of 32 CHCs which had operational dot of 32 CHCs which had operational the deficiencies in infraeructural dot of 32 CHCs which had operational dot of 32 CHCs which had operational dot of 32 CHCs which ensure had the deficiencies in infraeructural had the deficiencies in infraeructural had the pregnant women before they dot at the pregnant women before they the had the pregnant women before they the had the correct dots at the pregnant women before they the had the pregnant women before they dots of frequent kere in the fore they had the pregnant women before they the had the correct dots of frequent services which ensure at the pregnant women before they the had the pregnant women before they the had the pregnant women before they dots of frequent women before they the had the pregnant women before they the had the correct dots of frequent services which ensure the had the pregnant women before they the pregnant women before they the had the pregnant women before they		emergency services		
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aub centre level. The plan also includes collecting BPL or necessary proofs/certificates, and timely submission of the completed ISY formats in the health centre, arranging transport for the beneficiary to the nearest health care facility in case of any complication and maternal Mortality Ratio in Kerala has been reduced to 95 from 110 as per Special Bulletin on Maternal Mortality in India (2004-06), published by Sample Registration System. Kerala has the lewest	in It is 254.		1.
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a supportants. Public Haulth -birth plan at eneficiary of ojana (JSY), antenatal TT injections, Ith centre for	delivery, re. Audit ro birth a any of	alatktad, Wayamad), women mocived ing 2005- cds, there cds, there cds, there cds, there de co beceiving	ng 2005-09,
innice Public Junice Public micro-bird micro-bird micro-bird fan fan to benefit an to an to an to an to benefit an to an to an	e place of elivery, et elivery, et annic that mic awn up it .	ted districts (Palakkad, apuram and Wayanad), 6.139 pregnant women mly 4.30.156 received and check ups daring 2005- 9. In thes daring 2005- 16 in the number of women receiving tral check ups.	ging from ticed duri 8 and 2
on correct det and vitamen applements. It is mandatory for a justice Public Health Nurse to prepare a micro-birth plan at Nurse Devel for each beneficiary of the Janaii Suraktha Yojana (JSY), containing dates of antenatal checkups and TTinjoccions, identification of the health centre for	referral services, the place of delivery, exposted date of delivery, etc. Audit scrutiny revealed that micro birth plans were not drawn up in any of the seloched 24 Scs.	In the selected districts (Palakkad, Thinvananthapuram and Wayarad), out of 5,14,139 pregnent women registered, only 4,30,156 received three antennal check ups during 2005- 66 to 2008-09. In these districts, there were no significant variations over were no significant variations over three antennal check ups. Although all the pregnant women registered were required to be registered were required to be	provided with the understant for 100 days shortfalls ranging from 16 to 44 per cent were noticed during 2005- 06 to 2007-08.
			5558 2
on correct of It is mandar Nurse to pr the SC lev the Janani containing checkups identificanti	refen scrut o the s	- Alter the state of the state	

Rs 23.95 laith was disburred to 7,985 beneficiaries in three Taluk Hospitals and two District Hospitals towards transportation cost under JSY, which was inadmissifie. ISP, which was inadmissifie. The percentage of institutional deliveries of pregnant women registered at the hospitals in the adocted districts ranged from 77 to 96 in Palakkad, 61 to 104 in Thirvwanshippuram and 85 to 89 in Wayanad. Inanualization Readia lanear landon Readia lanear landon Readia lanear landon the subce of courtie formunisation in the State had achieved 95 to 99 per cent and metada has been the conterstone of routine formunisation the State had achieved 95 to 99 per cent adverses in pulse polio immunisation the test-checked districts during 2007-09. The targets and achieved no context of Diphtheria (DT) and T immunisation carried out
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procure vitamin A solution ind other items in the RCH Medical through Corporation e of DT in children Conco **Checke** of this the boline in d I up to 7 yours as per (E S e Second booster DT cod by DPT. DPT c NRHM Kenla are being te above 5 madv d Because bommended Dencentas 2 Services Limited) KMCL. with a Steps Ē Idministering of Vitamin A solution to The RCH-II programme emphasizes rophylaxis against blindness amongst children due to deficiency of Vitamin A equires the first dose at nine months of all children below three years of age. As per information furnished by the Director of Health Services, during to 2008-09, 19,30,592 fully immunised children was in the range of is to **as** per cent during the period and periods of vaccine uncovered 22.13.479 children between th above five years declined children of 10 years and 16 years also (September leavin steadily during 2005-06 to 2008-09 shortage occurred in 2007-08 and 2008 cont. TT b declined during 2005-06 to 2007-01 but showed an increase during 2008-09. winnering Vitam did not show significant variations esupply from GOL seen that DT coverage minister ð Teterus (DP) (V = 0)children Viz. BOQ, Mor nercentage to 60 per stated I DOW GUOD 2009) that long Vaccine Shortfall. In Government 2,82,887 09 due to in 3 A solution children. 2002-002 out of vacch Person Egg Pile Bile The

1.	Using the computers purchased in CHCs & PHCs etc and using DHIS2 software, we are getting the data through online before 5 th working day of every month. In DLHS2 the IDSP also have been Integrated with in this time. After proper serutiny and verification. (updated HMIS data) are being day of the following working day of the following
	As per the essence of the NRHM Frame work, the state has made efforts in the right direction to put in a strong Health Management Information System (MIS) network in the state. Under IDSP monitoring for surveillance activities is in place. Further under the HMIS the Districts are being linked from the PHC level to the state level. Audit may note that the development of software for computer based HMIS to capture the health data from all the health institution is an exercise that involves development of application computer based HMIS to capture the health data from all the health institution is an exercise that involves development of application oflyare and this has already been initiated. HMIS Software is not ready made software. The HMIS Implementation for State is taken up with specific objectives surrounding data reporting formats which is in three with requirements at national level.
age along with the measles vaccine, the second dose along with DPT/OPV and the subsequent three doses at six- monthly intervals. Scrutiny of records in the three tess checked districts revealed a seedy decline in the percentage of children supplied with all five doses during 2005-06 to 2008-09, the densils of which are given in Appendix II. The main reason for the steady decline was the short supply of Vitamin A at health centres.	Government stated (September 2009) that the shortfall in a administering Vlammin A solution was due to shoppage of supply by GOI from addition to be adoptage of supply by GOI from 2007.00. 1.2. Health Management Information System (MIS) network information system is to be in place for monitoring for surveillance activities is facilitating the smooth flow of HMIS the Districts are being linkof from information system is to be in place for monitoring for surveillance activities is facilitating the smooth flow of HMIS the Districts are being linkof from adding. The SHS purchased 1033 facilitating the smooth flow of HMIS the Districts are being linkof from adding. The SHS purchased 1033 computer based HMIS to capture the latter facilitation is an carentise that involves and supplication have add this has already been information and soft of the HMIS institution is an carenter that involves that involves the transporting purpose and supplication for the HMIS implementation for State purpose and supplication having customized FW reprocured at a cost of Rs 1.06 crore out paper reporting with real time data application having customized FW reprocured to the following multiple turne with requirements at antional level.

	functioning been given the charge district to verify the of the data. On ev working day the qi treviewed by Demoj on 10 th you be Additional DHS Office. On 12 th Additional DHS Office. On 12 th State kevel in State kevel in Medical Officers con before the Principle S (H). In Districts. HMIS reviewed by District Officer (DMO). working day in their meeting. In block le PHC level also it is re
The Data reporting milestones Envisaged for State were- • Paper reporting to continue till Mar 09 • From April 09 only reporting through DHIS 2 software shall be done down from peripheral sub centres The HMIS Project implementation for Kerala State envisaged the	 following objectives: I. Establishing State level server and Loading the HMIS (DHIS2) application on the server 2. Installing offline application in all reporting Health institutions 3. Sugity up of district based systems for each of the 14 districts. 4. Training programs for State. district and block level Health staff 3. Sugity of the relation of the server and Loading the HMIS institutions 3. Sugity of district based systems for each of the 14 districts. 4. Training programs for State. district and block level Health staff 1. Iterwise, the project is implemented keeping above objectives in mind and all milestones including objectives 1, 2, 3 and 4 are achit-ved before April 09 to realize data reporting from field. As a result, the GOI web portal now carries data for April, May 09 generated through the DHIS2 software as envisaged for entire State. The data for June 09 is nearing completion. This effort is one of its kinds in the country and Gujarta is the only other State to take up Health facility level reporting also through the DHIS 2 software. AddI Director & State Surveillance Unit. IDSP, under the supervision of Add Director & State Surveillance Ufficer (PH). R districts are generated and being reported (weekty basis) to GOI bistricts are generated and being reporting IDSP data from the state Surveillance Ufficer (PH). R ddI Director & State Surveillance Ufficer (PH). R ddI Director & State Surveillance Ufficer (PH). R ddI Director & State Surveillance Ufficer (PH). R denting training and herefore the supervision of internet connectivity in field and therefore the supervision of internet connectivity in field and therefore the supervision of internet connectivity in field and therefore the supervision of internet connectivity in field and therefore the supervision of internet connectivity in field and therefore the supervision of internet connectivity in field a
software applications: - Health Management Information System (HMIS) viz., DHIS 2 developed by M/s HISP India Limited, creatisation working in collaboration	 with the University of Osio, Norway. A dynamic web-based surveillance system for monitoring disease incidence for the Integrated Disease Surveillance Project on a weekly basis. A Geospatial Kerala Health Information System developed by the Kerala State Remote Sensing and Environment Centre for tracking thespread and frequency of diseases and An MS-excel based format for data the State Diseases on daity basis by the State Disease control and Monitoring Cell. All these applications were independently operation. All these applications were independently driven information system for data sets relating to health parameters for their operation.

at in The data in DHJS2 / HMISJis being utilised for all planning gais purposes in State arge (District/Central Level. As we have stopped paper reporting of forms 6 to 10, in DHS, there is no other source for the data. The software GIS: - An amount of Rs 40 lakhs is also utilized to set up GIS in the state. The software is developed by Kerala State Remote Sensing Centre. The scheme is to implement shorty after certain	
programs in districts for 17 days every month till end of project in The data in DHJS2 / HM/RJJis 2010. Action Taken: From April 2011, Government of India is planning in punching DHIS 2 system. which is web-based system. Hardware sand Software is being used, IDSP data will be integrated. BHS, there is no other source for the data. GIS: - An amount of Rs 40 lakhs is also utilized to set up GIS: in the state. The software is developed by Kerala Sonte Remote Sensing Centre. The scheme is to implement	Integrated Discasse Surveillance Project (IDSP) is functioning, to detect early warning signals of impending outbreaks, and surveitlance units have been set up, as planned. Necessary manpower as well hardware and accessories has been supplied to the units. However at the state level, there was some constraint of space in the Directorate to house the video conference unit, as there was no vacant space available in the Directorate or at the NRHM was no vacant space available in the Directorate or at the NRHM vas no vacant space available in the Directorate or at the NRHM onfice. After efforts some space was vacated and Video- Coffice. After efforts some space was vacated and Video- Conferencing Unit has been set up. Audit may also note that the equipments such as Hardware and accessories were not lying idle as the same was used at the office of the Additional Director of Health Services (Public Health) for regular communication with the national level.
in data redundancy, duplication in data entry and increase in the worthoad at all levels. The Scare Data Officer stated (July 2009) that action was under way to integrated Disease Surveillance Integrated Disease Surveillance Project and the State Disease Control and Monitoring Cell with the SHS.	1.2. Integrated Disease Surveillance 10.4 The Integrated Disease Surveillance Project (IDSP) was launched in November 2004 to detect carly warning signals of imponding outbreaks and to help initiate an effective response in a timely manner, surveillance units were set up at the Central, State and district levels with linkages, with all State headquarters, district headquarters and all government medical colleges on a Satellite Broadband" Hybrid Network. Data is collected on a weekly (Monday- Sunday) basis. In any area, it is investigated of illness, in any area, it is investigated of illness, in any area, it is investigated.

which GO! released Rs 4.82 crore up to 200 mpending outbreaks and initiating an 8 2008-09. The expenditure incurred on diagnose and control the outbreak. Data All the 14 District Surveillance of Rs 21.06 lakh. Civil works for completed in the districts at a cost of Rs m the State level March 2009 Services nanpower, remained idle. Moreover, the nalysis actions are to be undertakten by he project was Rupees nine crore, of expenditure of Rs 19.60 takts, besides the Units (DSU) were supplied with hardware accessories costing a tota mention of the Government of detecting medical collenes at a Rs 33.76 lakh. Necessary manpower was also provided to a he respective districts. The total cost - However, ğ Team Surveillance 20M procured for Rs 54.82 linkly. could executed the project was Rs 2.74 crore. Accessories Response units 5,01 provided sp Consequently, hardware.) SSU videoconferencing unit response **J** and not been set up a videoconferencing as the Director works Ś Officers/Rapid 19.60 lakh. 9 ğ affective supplied cost of SSC DSUs <u>Par</u> civil

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

STATUS OF IMMUNISATION OF CHILDREN ABOVE FIVE YEARS

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s 11
9 53

STATUS OF ADMINISTRATION OF VITAMIN A SOLUTION TO CHILDREN

	2005-06	lines.	39435	8	37999	*	41564	
	2906-07	47475	12272	- 26	11802	25	11767	2
Palakind	2007-08	£7095	3170	46	22344	1	17044	
	2008-09	47430	21523	- 13	18442	. 39	[3955	2
	2005-06	59900	50061		49090	82	48042	
	2006-07	60485	2059		19985	33	23700	
. Thirovenenthepures	2007-08	61920	20010		27187	4	21355	
	2008-09	57630	21,305	. 37	20628	36	19108	
	2095-86	75150	13542	-18	12498	17	12733	2
	2008-07	7.00		6	4132	5	7430	3
Wayanad	-2007-08	65418	8712	در 1	8428	B	5845	