Chapter VII

Implementation of Centrally Sponsored Schemes

Chapter VII

Implementation of Centrally Sponsored Schemes

The GNCT of Delhi was one of the States selected for implementation of the programme of National Health Mission. The key strategy of NHM was to bridge gaps in health care facilities, facilitate decentralized planning in the health sector and provide an overarching umbrella for the existing programmes of the Health and Family Welfare Department.

It was observed that enough efforts have not been made by the Delhi State Health Mission (DSHS) to achieve the goals and objectives of the Projects/programmes of National Health Mission Scheme as funds approved for programmes of NHM were not fully utilised.

Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCH+A) is the most important component/programme under National Health Mission (NHM) for improvement of Maternal and Child Health care.

It was observed that coverage for providing free diet and other facilities (free diagnostic) to pregnant women under Janani Shishu Suraksha Karyakram (JSSK) was inadequate. Maternal Death Review (MDR) which is an important strategy to reduce maternal mortality was inadequately conducted.

It was noticed that post-natal check after 14 days of delivery was not done in most cases during 2016-21. Audit observed that target of 100 *per cent* child immunization was not achieved. The Health Management Information System (HMIS), which serves as a tool for monitoring the performance of health systems, was found containing inconsistent and erroneous data and thus, did not represent actual status of implementation for proper monitoring of the programme. DSHS had not established 44 Tobacco Cessation Centres approved for the purpose of counselling common people to help them quit tobacco consumption. During 2016-17 to 2020-21, DSHS did not implement National Mental Health Programme as no expenditure was incurred despite availability of funds.

7.1 Introduction

Health being a State subject, the Central Government supplements the efforts of the State Governments in delivering health services through various schemes of Primary, Secondary and Tertiary care. Central Sector and Centrally Sponsored Schemes (CSS) are extended to the States by the Union Government under Article 282 of the Constitution.

Government of India (GoI) launched the National Rural Health Mission (NRHM) in April 2005. The National Urban Health Mission (NUHM) launched in May 2013 was subsumed as a sub-mission along with NRHM

under Nation Health Mission (NHM). The main objective of NHM was to provide equitable, affordable, reliable and effective health care facilities to poor and vulnerable sections of the population. NHM laid emphasis on reductions in Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR), while carrying forward the Government's efforts in the field of prevention and control of communicable, non-communicable as well as endemic diseases with the involvement of community in planning and monitoring of the Schemes. The key strategy of NHM was to bridge gaps in health care facilities, facilitate decentralized planning in health sector and provide an overarching umbrella for the existing programmes of Health and Family Welfare Department of the State including Reproductive and Child Health-II and various disease control programmes.

7.2 Organizational Set-up

At the State level, Delhi State Health Mission (DSHM) launched in 2006 and headed by the Chief Minister of Delhi, follows the guidelines of the NHM, GoI and implements various health programs of NHM in Delhi. The activities under the NHM are carried out through the Delhi State Health Society (DSHS), an autonomous body of DSHM, which serves as an additional managerial and technology capacity for implementation of health programs under overall aegis of NHM.

DSHS has a Governing Body and an Executive Committee chaired by Principal Secretary of the Department and the Mission Director, NHM as its Member Secretary. The State Programme Management Unit (SPMU) acts as secretariat to DSHS and is headed by the Mission Director. There are 11 Integrated District Health Societies (IDHSs) in Delhi. District Collector is the chairperson and Chief District Medical Officer (CDMO) is the Member Secretary of each IDHS.

7.3 Funding Pattern

The Ministry of Health & Family Welfare (MoHFW), GoI provides a resource envelope to support the implementation of an agreed Delhi State Programme Implementation Plan (PIP) submitted by the GNCTD to the Centre. Delhi State PIP is the aggregation of eleven District Health Action Plans including activities to be carried out at State level. The Central and State share of Centrally Sponsored Schemes/programmes under NHM was 60:40 from 2018-19 but prior to 2018-19, NHM was fully funded by GoI. Grant-in-aid from GoI is transferred by the GNCTD to the account of DSHS for smooth implementation of programmes under NHM as per government approved operational guidelines.

7.4 Pattern of Assistance

Pattern of Assistance governs the Grants-in-Aid from Government and other assistance in any form to DSHS, which has to be utilized for various functions

as enumerated in the Memorandum of the Association (MoA) and Rules DSHS. MoHFW and Department of Health and Family Welfare (Department), GNCTD signed (May 2019) a Memorandum of Understanding (MoU), revised from time to time, valid upto May 2022. As per the MoU, Delhi State Health Mission (DSHM) is responsible for implementation of the programs/activities envisaged under the Mission. DSHM was also to ensure that funds made available to support the agreed State PIP under this MoU are used for financing the State Program Implementation Plan and for routine expenditure that are the responsibility of the State Government.

7.5 Reproductive, Maternal, New-born Child and Adolescent Health (RMNCH+A)

Reproductive, Maternal, New-born Child and Adolescent Health (RMNCH+A) is the most important component/programme under NHM for improvement of Maternal and Child Health care. The Programme includes maternal health, child health and family planning services. The aim of the programme is that every pregnant woman (PW) receives care at delivery, deliveries are institutional and other family planning services are provided.

7.5.1 Funds received and expenditure under RCH Flexipool

RMNCH is funded through RCH Flexible Pool which is one of the components of NHM funding. During 2016-17 to 2021-22, out of total funds of ₹ 164.35 crore available for RMNCH to GNCTD, ₹ 94.98 crore (57.79 *per cent)* remained unutilized. Underutilization of funds ranged from 58.90 *per cent* (2016-17) to 93.03 *per cent* (2019-20) indicating that GNCTD was not implementing the programme adequately. It was also noticed that Closing balance (2018-19) did not match with Opening balance of next financial year (2019-20) in the accounts of DSHS.

During 2016-17 to 2017-18, against the available funds of ₹ 403.92 lakh, only ₹ 40.67 lakh (10.07 *per cent*) was utilised under training component.

The Department replied (March 2022) that due to COVID 19, many hospitals were converted to COVID hospitals, hence regular and preventive child health services were affected. It also stated that human resource is critical and their recruitment was an issue in running the programme.

Reply was not acceptable, as the situation was the same during the period prior to pandemic also.

7.5.2 Maternal Healthcare

Maternal health care package with its focus on health of women during pregnancy, childbirth and post-partum was a vital component of NHM due to its profound effect on the health of women, immediate survival of the new-born and long-term well-being of children. Key strategies to improve maternal health included improved access to skilled obstetric care through

facility development, increased coverage and quality of antenatal and postnatal care, increased access to skilled birth attendance, institutional delivery, etc. The Delhi Government is implementing various programmes i.e. Janani Suraksha Yojana (JSY), Janani Sishu Suraksha Karyakram (JSSK), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and LaQshya[1] etc. for achieving maternal health.

7.5.3 Strategic interventions under maternal healthcare

Strategic interventions for maternal healthcare are discussed in the following paragraphs.

a. Ante Natal Care (ANC)

Guidelines for Antenatal Care and Skilled Attendance at Birth, 2010 issued by MoH&FW, GoI aimed to provide four ANCs to all registered pregnant women for ensuring proper investigations like haemoglobin, blood grouping, urine examination, administration of two doses of Tetanus Toxoid (TT) and providing 100 Iron Folic Acid (IFA) tablets. The first ANC was to be provided within 12 weeks, second within 14-26 weeks, third within 28-34 weeks and fourth check-up within 36 weeks up to term of pregnancy to monitor the progress.

The position of ANC registration and services provided in Delhi during April 2016 to September 2022 as per Health Management Information System (HMIS) portal are as shown in **Table 7.1**.

Table 7.1: Antenatal Services provided to PW

Year	Total Pregnant Women (PW) registered for ANC	Number of PW Registered within first trimester (12 weeks)	Number of PW received four ANC checkups	Number of PW not received four ANC checkups	Pregnant women who received TT1	Pregnant women who received TT2	Pregnant women who received 100 IFA tablets
2016-17	9,93,842	3,25,393	5,63,171	4,30,671	2,87,858	2,52,056	5,24,760
2017-18	9,82,022	3,25,818	3,61,594	6,20,428	2,86,564	2,28,339	4,41,010
2018-19	9,31,041	3,35,500	4,07,668	5,23,373	2,97,500	2,35,993	4,77,566
2019-20	7,21,322	3,27,469	4,07,582	3,13,740	2,32,814	1,85,663	4,68,981
2020-21	5,35,699	2,36,122	2,86,493	2,49,206	2,08,543	1,58,210	4,30,465
2021-22	462620	211345	319256	143364	248712	193422	378351
2022-23 (upto Sept. 2022)	270703	119879	184685	86018	146783	122289	204707
Total	**48,97,249**	**18,81,526**	**25,30,449**	**23,66,800**	**17,08,774**	**13,75,972**	**29,25,840**
Percentage		**38.42**	**51.67**	**48.33**	**34.89**	**28.10**	**59.74**

Source: Health Management Information System (HMIS)

It can be seen from **Table 7.1** that out of 48.97 lakh registered pregnant women, 23.67 lakh (48.33 *per cent*) were not provided all four ANC during April 2016 to September 2022. Further, 18.82 Lakh (38.42 *per cent*) women

[1] Labour room quality improvement initiative

had registered within the first trimester of pregnancy. There was shortfall in percentage of women who received Tetanus Toxoid (TT) shots as only 34.89 *per cent* and 28.10 *per cent* women had received TT-1 and TT-2 respectively. Similarly, 59.74 *per cent* pregnant women had received 100 Iron folic acid tablets during April 2016 to September 2022.

Audit observed that Department was not able to keep track of pregnant women who were registered for ANC and ensure whether all of them received stipulated quantum of ANC check-ups, TT and IFA tablets at timely interval.

The Department stated (July 2022) that the reason for shortfall was due to multiple registration of pregnant women for ANC at two or more facilities. It further stated that all the facilities have been instructed to report registered ANC pregnant women on HMIS portal.

Reply is not acceptable as the Department should have ensured entry of unique record of pregnant women registered for ANC in the system.

Recommendation 7.1: The Government should ensure that all registered pregnant women are followed-up for complete ante-natal care and post-natal check-up. Besides, TT vaccine and IFA tablets should be provided to all registered pregnant women.

b. Testing of pregnant women for HIV and STIs/RTIs infections

The RMNCH+A Guidelines issued by GoI (January 2013) identified parent-to child transmission of Human Immunodeficiency Virus (HIV) as a major route for new and emerging HIV infections in children and suggested universal confidential HIV screening of PW to be included as an integral component of routine ANC check-up. Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) are associated with a number of adverse pregnancy outcomes including abortion, stillbirth, preterm delivery, low birth weight, postpartum sepsis and congenital infection. Therefore, STI/RTI management must be linked to pregnancy care. Audit observed that out of 48.97 lakh PW registered for ANC check-ups during April 2016 to September 2022, 17.72 lakh (36.18 *per cent*) and 9.26 lakh (18.91 *per cent*) were tested for HIV and STIs/RTIs respectively during April 2016 to September 2022. Audit noted that 7,720 instances of pregnant mothers afflicted with HIV were detected during the period. The possibility of more such cases escaping detection due to non-testing of PW could not be ruled out.

The Department stated (July 2022) that the reason for shortfall in HIV & RTI testing is due to duplication/triplication of same PW getting registered at two to three facilities.

Reply is not acceptable as the Department should have ensured entry of unique record of pregnant women registered for ANC in the system.

Recommendation 7.2: All registered pregnant women should be screened for HIV and RTI/STI tests.

c. Caesarean Section Deliveries

As per WHO, C-sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. The ideal rate for C-Sections should be between 10 and 15 *per cent*. As per NFHS – 5 (2019-21), national average of C-sections deliveries was 21.25 *per cent*. Further, C-section deliveries at private institutions were on higher side (42.8 *per cent*) as compared to those at public health facility centres (17.7 *per cent*).

As per HMIS portal, during April 2016 to September 2022, against 15.94 lakh institutional deliveries, the percentage of C-Section deliveries was 31.67 *per cent*. The variation in percentage ranged between 29.19 *per cent* (2017-18) and 34.66 *per cent* (2021-22).

The Department stated (July 2022) that health facilities were instructed to avoid unnecessary caesarean section. It further stated that caesarean section audit guidelines have been disseminated to all public and private facilities for them to conduct audit and share the report every month. However, Department had not attached the copy of the said guidelines and the date on which the guidelines were issued.

d. Discharging of mothers within 48 hours of delivery and Post Natal Care

As part of Post Natal Care (PNC), a PW has to stay for minimum 48 hours after delivery. NRHM guidelines also provide that the first 48 hours of the post-partum[2] period followed by first one week are the most crucial period for the health and survival of both the mother and the new-born. In all cases, at least three postnatal visits to the mother and six postnatal visits to the new-born are to be made within six weeks of delivery/birth. In case of home based delivery, the first visit should take place within twenty-four hours of birth. In case of institutional deliveries, second and third visit should occur on third and seventh day after delivery.

The status of post-partum check-up of mothers during April 2016 to September 2022 is shown in **Table 7.2**.

[2] A Postpartum (or postnatal) period begins immediately after the birth of a child and extends for about six weeks, as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state by that time.

Table 7.2: Status of Post-partum check-up of mother

Period	Total deliveries (Home + Institutio-nal)	Number of Institutional Deliveries conducted (Including C-Sections)	Out of total institutional deliveries number of women discharged within 48 hours of delivery	Women receiving 1st post-partum check-up between 48 hours and 14 days	Women receiving 1st post-partum check-up between 48 hours and 14 days (in *per cent)*
2016-17	271514	255017	99065	168874	62.20
2017-18	271991	260117	110520	171179	62.94
2018-19	283717	271485	110124	149479	52.69
2019-20	286281	275161	107041	142984	49.95
2020-21	206603	195481	82631	78265	37.88
2021-22	227936	217255	90350	78165	34.29
Up to Sept 2022	123602	119643	46609	37634	30.45
	1671644	**1594159**	**646340**	**826580**	

Source: HMIS portal

From **Table 7.2**, it can be seen that

- out of 15.94 lakh cases of reported institutional deliveries during April 2017 to September 2022, mothers were discharged within 48 hours of delivery in 6.46 lakh cases (40.54 *per cent).*
- out of 16.71 lakh deliveries, only 8.27 lakh (49.45 *per cent*) mothers received post-partum check-up between 48 hours and 14 days after delivery.

According to National Rural Health Mission guidelines, the first 48 hours after delivery are the most critical in the entire post-partum period. Most of the major complications of the post-partum period, such as postpartum hemorrhage and eclampsia, which can lead to maternal death, occur during this period. Thus, due to inadequate hospital facilities, medical care of mother and the new born especially during the 48 hour post-delivery in all cases could not be ensured.

The Department stated (July 2022) that due to high bed occupancy rate in hospitals, there was doubling of women with their new-born on one bed and to avoid an increased risk of infection for mothers and new-born, the health facilities were discharging mothers within 48 hours of delivery for non-high risk deliveries. It also stated that hospitals have been instructed to discharge women after 48 hours of delivery.

As per RCH portal, during 2016-17 to 2021-22, only 55,015 PW (2.92 *per cent*) received all the prescribed PNC check-ups out of 18.88 lakh women registered for PNC whereas 6.29 lakh (33.35 *per cent*) women registered for PNC did not receive any PNC. Thus, Department was not able to keep track of women registered for PNC and did not ensure that all of them received stipulated quantum of PNC check-ups at timely interval.

e. Home based deliveries not attended by trained health professional

Government of India (GoI) considers a Skilled Birth Attendant (SBA) to be a person who can handle common obstetric and neonatal emergencies and is able to timely detect and recognise when a situation reaches a point beyond his/her capability, and refers the woman/new born to an appropriate facility without delay. SBA is defined as a trained health professional for conducting deliveries e.g. Doctor/Nurse/Auxiliary Nurse and Midwife (ANM) whereas Non-SBA includes Trained Birth Attendants, relatives, etc.

NFHS-5 report also noted that home births conducted by skilled health personnel[3] reduced to 2.3 *per cent* during 2019-21 from 3.6 *per cent* in 2015-16. Further, Home Based New-born Care (HBNC) stipulates home visit by ASHA for early detection of disease and promoting hygienic practises.

As per HMIS portal, during April 2016 to September 2022, out of 77,485 home based deliveries, only 2,076 (2.68 *per cent)* were attended by SBA.

Thus, home based deliveries under hygienic conditions and under the supervision of Skilled Birth Attendant (SBA) were not being ensured.

The Department stated (July 2022) that SBAs are available in the community at the time of delivery, but in most cases, Dais were conducting delivery for such clients, therefore, is recorded as non-SBA.

Reply confirms the fact that in most cases, deliveries were attended by Dais who may not have adequate training to deal with various complications that may arise during childbirth.

f. Low birth weight (LBW) babies

WHO defined Low Birth Weight (LBW) babies as infants with a birth weight of 2,499 grams or less. At the National Level, average LBW is 12.4 *per cent*. As per programme guidelines, low birth weight (LBW) are more likely to have impaired growth, higher mortality and risk of chronic adult diseases.

RCH programme under NHM provides *inter alia* screening of pregnant women for anaemia and Iron Folic Acid (IFA) supplementation, Calcium supplementation etc. during pregnancy.

The status of ANCs to all registered pregnant women has been discussed in para 7.5.3 (a) wherein only 59.74 *per cent* pregnant women had received 100 Iron folic acid tablets during April 2016 to September 2022.

As per HMIS portal, during April 2016 to September 2022, 3.55 lakh (22.10 *per cent)* out of 16.06 lakh weighed at birth were born with LBW. Percentage of LWB during the said period ranged between 19.60 *per cent* (2017-18) to 26.04 *per cent* (2021-22).

[3] Doctor/nurse/LHV/ANM/midwife/other health personnel.

It can be seen that LBW hovered around 22 *per cent* which was more than the national average of 12.4 *per* cent which indicates that the efforts of GNCTD in ensuring proper care to PW was inadequate.

The Department stated (July 2022) that instructions have been issued to all facilities to conduct nutritional counselling, testing haemoglobin levels of all PWs and linking undernourished PW to nearest Anganwadis for nutritional support/dietary supplement.

g. Maternal Death Review (MDR)

Maternal Death Review (MDR) is an important strategy to improve the quality of obstetric care and reduce maternal mortality. Every health facility is required to conduct death audit of all deaths happening in the facility and send the reports to CMO of the district concerned. The MDR Committee of CMO is required to review all the reports and take adequate steps to prevent such deaths wherever possible in future. The status of maternal death review during 2016-21 is shown in **Table 7.3**.

Table 7.3: Status of maternal death review

Period	Number of maternal deaths reported during the period	Maternal Deaths reviewed by District MDR Committee of CMO	Percentage of Maternal Death Reviewed
2016-17	508	262	51.57
2017-18	584	354	60.62
2018-19	610	230	37.70
2019-20	603	339	56.22
2020-21	517	216	41.78
2021-22	638	332	52.04
2022-23 (upto Sep 22)	317	250	78.86
Total	**3777**	**1983**	**52.50**

Source: Information furnished by Department

As can be seen only 1983 (52.50 *per cent*) of the maternal deaths occurred in Delhi during April 2016 to September 2022 were reviewed. In the absence of comprehensive review of maternal deaths, Government was not in a position to institute measures to prevent maternal deaths due to similar reasons in future.

The Department stated (August 2022) that all districts conduct MDR regularly under the chairmanship of CDMO within their permissible limits. Further, the staff working in the districts and at facilities were involved in Covid related activities in Financial Year 2020-21.

The reply is not acceptable as percentage to MDR review prior to COVID-19 ranged between 37.70 *per cent* (2018-19) to 60.62 *per cent* (2017-18) only.

7.5.4 Implementation of schemes

Audit of various programme/schemes under NHM are discussed below:

7.5.4.1 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NHM being implemented since 2005 with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among PW below poverty line, SC PW, ST PW etc. This scheme integrated cash assistance with delivery and post-delivery care. As per Guidelines, the cash assistance of ₹ 700/- under JSY was admissible only to mothers belonging to BPL families who hailed from rural areas and ₹ 600/- to those from urban areas in Delhi, being a high performing State.

During the period 2016-21, only 50,975 PW (54 *per cent)* were registered under JSY for benefits against target of 94,000. Percentage of PWs registered against the target during the said period ranged between 27 *per cent* (2020-21) to 72 *per cent* (2016-17).

Overall, only 51 *per cent* of the budget was utilized during 2016-17 to 2020-21. Percentage utilization of funds during the said period ranged between 23 *per cent* (2020-21) to 70 *per cent* (2017-18).

Department stated (March 2022) that deserving people belonged to migratory population and they did not have complete documents such as Bank account, Aadhaar card etc. It also stated that due to change in payment to DBT mode, the district and facility staff including account personnel's were not conversant in making payment via PFMS Portal and the JSY registration could not be boosted much in view of the very low amount of incentive.

Audit also analysed the data in selected three districts, which revealed that -

- Only 254 (5.32 *per cent*), 5,372 (5.72 *per cent*) and 1821 (3.23 *per cent*) PW were identified as beneficiaries to be paid incentives against 4,772, 93,897 and 56,405 deliveries reported in South-East, North-West and New Delhi districts respectively during 2018-19 to 2020-21.
- Out of 254, 5,372 and 1,821, only 18 PW, 773 and 72 PW belonging to South-East, North-West and New Delhi Districts respectively got incentives during the period 2018-19 to 2020-21. The reason for not paying the incentive under the scheme was not found in the reports.

Thus, the reply is not acceptable as the Department failed to provide financial support even to the identified beneficiaries. Moreover, the staff deployed at the facilities were not made conversant for streamlining the payment through PFMS. This showed lackadaisical attitude of the Department towards disadvantaged people.

7.5.4.2 Janani Shishu Suraksha Karyakram (JSSK)

JSSK, launched in June 2011, is an initiative to assure cashless services including normal deliveries, C-sections, and treatment of sick new-born (upto 30 days after birth) to all PW in all public health institutions. The entitlement

for PW under JSSK included zero expense delivery including C-section, free drugs and consumables, free diagnostics, free diet during stay in health institutions, free provision of blood, free transport facilities from home to health institutions and drop back from health institutions.

a. Out of pocket expenditure per delivery under JSSK

The objective of the JSSK scheme was to provide free and cashless service to all PW and sick neonates accessing public health institutions. As per National Family Health Survey-5 (NFHS-5) report for the period 2019-21, the out of pocket expenditure per delivery in Public health Centres (urban areas) in Delhi was ₹ 2,577.

The Department stated that out of pocket expenditure per delivery was ₹ 8,518 during 2015-16 which declined to ₹ 2,548 in 2019-21.

Fact remains that the objective of providing PW free delivery in public health institutions including cases of Caesarean section could not be achieved.

b. Free diet and other facilities to PW

The success of the scheme depends on the knowledge of entitlements of the service seekers and the capacity of the state to deliver service commitments. Total number of PW registered as per HMIS portal for ANC for the period 2016-17 to 2020-21 was 41.64 lakh, out of which only 12.50 lakh beneficiaries[4] (30 *per* cent) benefited by availing free services such as diet, transportation, drug and consumable etc.

Overall, only 22 *per cent* and 70 *per cent* beneficiaries availed free transport and free diet facilities respectively. Percentage of beneficiaries who availed free transport during the said period ranged between 14 *per cent* (2019-20) to 28 *per cent* (2018-19) and who got free diet ranged between 63 *per cent* (2018-19) to 80 *per cent* (2016-17).

The Department stated (March 2022) that PW are provided a number of services during their antenatal services and during delivery services i.e diet, drugs and consumables, blood transfusion, diagnostics and transport. Therefore, so much record keeping for each individual PW and sick infant is practically not feasible by health facilities for each service. Thus, they provide an approximate figure in proportion to PW registered for ANC and deliveries conducted by health facilities.

c. Inconsistency of data in JSSK Scheme

As per Annual Reports for the years 2017-18 to 2020-21, 9.83 lakh beneficiaries got free drugs and consumables and 6.62 lakh got free diet. However, as per HMIS portal, only 7.59 lakhs and 5.37 lakhs beneficiaries

[4] As per annual report of JSSK.

availed free drugs and consumables and free diet respectively. The same data inconsistency was found in diagnostic services as well.

The Department stated (March 2022) that it is making efforts for uniformity in submission of report.

d. Complaints/grievance cases under JSSK

Grievance redressal guidelines issued by Ministry of Health and Family Welfare, GoI *inter alia* stipulates setting up a health helpline system through help desks, call centre and web portal. As per Annual Reports, no complaints/ grievance related to free entitlements was received during 2016-21. It shows that either State and District level JSSK/RCH Nodal officers were not reporting grievances cases or the Department did not create and disseminate information about the redressal mechanism, if any, amongst general public.

The Department stated (March 2022) that Delhi Government is making all efforts to provide free services under JSSK scheme. If any complaints received from PW or her relative at any facility, they are addressed there and then.

Audit is of the view that even if the complaints are addressed, they need to be analysed for systemic deficiencies and corrective action and therefore, proper records need to be maintained in this regard.

7.5.4.3 Pradhan Mantri Surakshit Matritva Abhiyan programme

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) was launched by MoH&FW in June, 2016. PMSMA provides for fixed day assured, comprehensive and quality antenatal care universally to all pregnant women (in 2nd and 3rd trimester) on the 9th of every month. While antenatal care is routinely provided to pregnant women, special ANC services are provided by OBGY specialists/ Radiologist/ Physicians at government health facilities under PMSMA. One of the critical components of the Abhiyan is identification and follow-up of high risk pregnancies and red stickers are added on to the Mother and Child Protection cards of women with high risk pregnancies.

a. State and District Level meetings not conducted under PMSMA Programme

As per operational framework for PMSMA, preparatory activities included establishment of State and District Level Coordination Committees and regular meetings were required to be conducted to spearhead the programme in the right direction. Audit observed that although the State Level Committee was constituted in May 2016, only one meeting was conducted (May 2016) during the years 2017-18 to 2020-21 and no meeting was held at District level. Thus, there was no state and district level coordination and monitoring of the scheme.

The Department stated (July 2022) that all districts were instructed (June 2016) to identify District PMSMA Nodals for constitution of a District Level Committee and names were to be shared with the Government. It further stated that details of District Level Committee were not shared by districts.

This shows lack of monitoring for ensuring compliance on the instructions issued by Department.

b. Coverage of PW under the scheme

As per information furnished by the Department, total 3.82 lakh PW were registered under PMSMA. As per guidelines, one ultrasound is recommended for all PW during 2nd/3rd trimesters of pregnancy. The percentage of PW who underwent USG test on the fixed day during the period 2016-17 to 2020-21 ranged between 8.84 *per cent* (2019-20) to 16.56 *per cent* (2018-19).

During 2016-17 to 2020-21, Audit noted that 16,557 (4.33 *per cent*) out of 3.82 lakh PW registered under PMSMA were identified as high-risk PW. The percentage variation of high risk PW identified during 2016-17 to 2020-21 ranged between 1.61 *per cent* (2018-19) to 10.74 *per cent* (2020-21). Out of 16,557 identified high risk PW, details of only 7164 cases (44.75 *per cent*) were shared with respective ANMs and ASHAs of different blocks of urban areas for follow up.

As regards to the shortfall in the percentage of women who received USG on the fixed day, Department stated (July 2022) that if USG is conducted in routine antenatal clinics by facilities, the number of USGs will automatically decrease.

The reply is not convincing as no information regarding actual number of PWs who underwent USG at routine antenatal clinics was furnished in support of reply.

c. Counselling services to PW

PMSMA guidelines provide that before leaving the hospital/facility, every PW needs to be counselled, individually or in groups, for acquiring knowledge relating to nutrition, post-partum family planning, etc.

Department did not maintain any data of counselling services provided to PW in the absence of which Audit could not verify whether these were actually provided.

d. Monthly report not submitted to MoHFW, GoI

PMSMA guidelines stipulate that ANMs are to compile the information of the services provided during PMSMA and submit the same to facility In-charge who in turn would submit it to the District authorities. States must compile the reports submitted by the districts and submit it to MoHFW within 15 days of conducting the camps as required under PMSMA. Audit noted that

District-wise reports to be submitted to MoHFW were not compiled by the Department. There were 506 facilities registered on the portal which were required to upload monthly reports on the portal. During 2018-19 to 2021-22, facilities uploading monthly reports on the portal ranged between 60 *per cent* (2019-20) and 25 *per cent* (2018-19) depicting incomplete reporting of the scheme.

The Department stated (July 2022) that PMSMA portal was launched much later after the launch of PMSMA program and in the last two years, many facilities have enrolled on PMSMA portal but some organizations such as CGHS, Private facilities etc. were not participating actively in PMSMA programme and therefore, not consistently submitting the reports on PMSMA portal.

Reply is misleading as it did not comment on lack of reporting in respect of facilities directly under its supervision.

e. Specific services not provided to pregnant women under the programme

As per guidelines, ANM and Staff Nurses are required to ensure that all basic laboratory investigations are done before the beneficiary is examined by the OBGY/Medical Officer.

The status of specific services provided to PW under the programme are shown in **Table 7.4**.

Table 7.4: Status of services provided to PW under PMSMA

Period	Total number of pregnant women Received Antenatal care under PMSMA	Total number of pregnant women Received Antenatal care by an OBGYN specialist	Total number of pregnant women Received Antenatal care by MBBS doctor	PW Tested for Haemoglobin	PW Tested for Blood Group	PW Tested for Urine albumin	PW Tested GDM by OGTT	PW Tested for HIV under PMSMA
2016-17	40116	0	0	21208	0	0	8785	11661
2017-18	99063	0	36	54075	0	35	37637	24021
2018-19	95002	366	1275	46470	798	830	31496	24727
2019-20	86550	36683	57608	41245	25193	36711	22238	69516
2020-21	31077	14817	18158	10625	8188	11549	6532	19261
2021-22	44516	17807	26647	15760	11165	17201	8878	28194
2022-23 (upto Sept 2022)	24571	10818	14279	7444	5626	8578	4521	16230
Total	**420895**	**80491**	**118003**	**196827**	**50970**	**74904**	**120087**	**193610**
In percentage		19.12	28.04	46.76	12.11	17.80	28.53	46.00

Source: PMSMA portal

The overall percentage of PW who underwent basic laboratory investigations for haemoglobin, blood group, urine albumin and HIV was 46 *per cent,* 12 *per cent,* 18 *per cent* and 46 *per cent* respectively.

It can be seen from the above table that only 47.16 *per cent* (1,98,494 out of 4,20895) PW registered had received antenatal by OBGYN specialist and MBBS doctors during the period from April 2016 to September 2022.

The Department stated (July 2022) that reason could be some error in understanding the data by health facilities, therefore appropriate data was not submitted.

The reply is not acceptable as audit comment is based on beneficiaries registered under PMSMA programme only and data integrity was also Department's responsibility.

7.5.4.4 LaQshya programme under NHM

LaQshya Programme launched in 2017 aims to improve quality of care in Labour Room and Maternity Operation Theatres (OTs) in public health facilities which will be assessed through NQAS (National Quality Assurance Standards). Every facility achieving 70 *per cent* score on NQAS was to be certified as LaQshya certified facility.

As per guidelines, all LaQshya related data was required to be uploaded on the portal for prompt report generation as well as visualization of dashboard to monitor progress. Department stated (December 2021) that LaQshya portal was made live from 19 July 2019 and it was using DSHM State Portal for submission of internal assessment of hospitals under NQAS and LaQshya.

The implementation of the programme could not be examined in Audit as the Department neither provided data from LaQshya/ DSHM portal nor did it provide access to above portals.

However, Audit noted that against a target of 18 facilities in 2020-21, only three public health facilities were certified as LaQshaya certified facilities under the programme.

The Department stated (July 2022) that three more hospitals are in process for certification.

7.5.4.5 Health care of children through MAA (Mothers' Absolute Affection) Programme

Ministry of Health and Family Welfare, GoI launched (August 2016) Mother's Absolute Affection (MAA) in an attempt to bring undiluted focus on the promotion of breastfeeding and provision of counselling services for supporting breastfeeding through health systems.

As per indicators on child feeding practices of NFHS-5 (2019-21), 51.2 *per cent* children under age of 3 years were breastfed within one hour of birth[5] while,

[5] Based on the last child born in the 3 years before the survey

64.3 *per cent* children under the age of 6 months were exclusively breastfed[6] in Delhi.

a. Shortage of staff for MAA

Staff nurse, RMNCH+A counsellors and medical officers were responsible for communication and counselling of mothers/caregivers on Infant and Young Child Feeding (IYCF). As per the Annual report MAA programme (2020-21), Audit noted significant shortage of staff in respect of Medical officer (32 *per cent)* and Staff nurse (58 *per cent*). Shortage of staff indicates low priority assigned to infant/child health services by the Department.

Department stated (May 2022) that there was shortage of staff, but recruitment of staff was not under the Directorate of Family Welfare.

Reply is not acceptable as GoI had approved human resources every year in the Record of Proceeding and Directorate of Family Welfare/DSHM should have ensured that vacant posts were filled timely.

Recommendation 7.3: The Government should ensure proper recruitment of Human Resource as approved in the ROP under NHM so that the programmes of NHM can be implemented properly and smoothly.

b. Shortage of dedicated space/room for breastfeeding mothers

As per Guideline of MAA, all health facilities should have a dedicated space/room for breastfeeding mothers who come for consultation and desired a private space for breastfeeding. It was noticed that space/room for breastfeeding was available at only 205 out of 338 health facilities/Centres under MAA Programme in Delhi.

The Department stated (May 2022) that most of the health facilities/Centres were providing all health care services inclusive of Immunisation/ANC only in two rooms.

c. MAA coordination committee not constituted

As per Guideline of MAA, a Coordination Committee formed at State level may oversee the implementation of suggested activities mentioned in the guidelines.

Audit found that no MAA coordination committee was constituted by the Department.

The Department stated (May 2022) that activities under MAA programme are being monitored and reviewed at the facility, District and State levels.

Reply is not acceptable as, in the absence of coordination committee, activities cannot be monitored adequately.

[6] Based on the youngest child living with the mother

7.5.4.6 Home Based New-born Care Programme (HBNC)

As per operational guidelines of HBNC, the key activities under HBNC constitute "Care for every new-born through a series of home visits by a ASHA in the first six weeks of life, extra home visits for preterm and low birth weight babies by ASHA or ANM, and follow up for sick new-born after they are discharged from the facilities".

During 2016-17 to 2020-21, 47.89 *per cent* (6.26 lakh out of 13.08 lakh) infants registered, got home based new born care and extra home visits by ASHAs after they were discharged from healthcare facilities. Further, against a target of 1.6 lakh new-born to be visited under HBNC in Delhi, the achievement was only 55,593 (33.17 *per cent*) during 2020-21.

7.5.4.7 Implementation of Severe Acute Malnutrition (SAM) programme

Severe acute malnutrition is defined as very low weight-for-height/length, or a mid-upper arm circumference < 115 mm, or by the presence of nutritional edema. Lack of exclusive breast feeding, late introduction of complementary feeds, feeding diluted feeds containing less amount of nutrients, repeated enteric and respiratory tract infections, ignorance, and poverty are some of the factors responsible for SAM. Children with SAM have nine times higher risk of dying than well-nourished children.

As per NFHS-5 (2019-21), 21.8 *per cent* of under-5 children were underweight (weight-for-age), 30.9 *per cent* were stunted (height-for-age) and 11.2 *per cent* wasted (weight-for-height) and 4.9 *per cent* children were severely wasted (weight-for-height). Further, as per NFHS-5 (2019-21), 69.2 *per cent* of children in age group 6 months-59 months were anaemic.

As per guidelines, every district should have one Nutrition Rehabilitation Centre (NRC). Eight NRCs were operational (against the requirement of 11) since 2017-18. In March 2019, GoI directed that NRC should be 10 bedded. As per revised norms, only two NRCs (August 2022) remained operational in Delhi and the remaining six NRCs did not fulfil this criterion but no other facility fulfilling the criteria was designated as NRCs by the Department. Thus, as per revised norms there were only two NRCs in 11 districts of Delhi.

Further, posts of Medical Officer, Cook cum Caretaker, Attendant and Medical Social Worker were not filled-up in these two functional NRCs, as required under guidelines of SAM.

7.5.4.8 Implementation of Rashtriya Bal Swasthya Karyakram under NHM

The Government of India launched (February 2013) the Rashtriya Bal Swasthya Karyakram (RBSK) which envisages setting up of District Early Intervention Centres (DEIC) at the district hospital level. As per scheme

guidelines, at least three dedicated Mobile Health Teams in each block would be engaged to conduct screening for children in the age group of 6 to 18 years.

Audit found that GoI approved RoP in 2018-19 for implementation of RBSK through Comprehensive New-born Screening (CNS) wherein the Department had set target (2020-21) of operationalising three District Early Intervention Centres. Audit noted that no DEIC/ Mobile Health Team was constituted (May 2022).

Further, the Delhi Government launched (January 2020) the Neonatal Early Evaluation Vision (NEEV) program which is for screening of around 1.5 lakh new-born babies in two years for visible functional and metabolic defects. However, Mission NEEV became functional only in November 2021 and only 21,237 children were screened (March 2022). The cases were referred for appropriate follow-up.

Department stated (May 2022) that it will establish one Centre of Excellence – Early Intervention Centre at LNH and three DEICs at other hospitals to cover identified health conditions for early detection.

Recommendation 7.4: Effort should be made to ensure that care envisaged under the scheme for new-born are provided in a timely manner.

7.5.5 Discrepancies in Child Death Review (CDR)

Child Death Review is an important strategy to understand the geographical variation in causes leading to new-born and child deaths, and thereby initiating state-specific child health interventions. Analysis of child deaths provide information about the medical causes of death, helps to identify the gaps in health service delivery and social factors that contribute to child deaths.

As per operational guidelines of Child Death Review, First Brief Investigation (FBI) shall be conducted for all child deaths. The FBI should be done within two weeks after the notification of death and report should be submitted to Block Medical Officer (BMO) within one month of notification of death. Further, reports prepared by office of the District Nodal Officer (DNO) were to be shared every month in the meeting of the District Child Death Review Committee[7] (DCDRC). Subsequent to DCDRC meeting, the DM shall review a sample of cases submitted to him by the DNO/CMO.

Further, a State Level Task Force (SLTF) headed by Principal Secretary (Home and Family Welfare) was constituted in April 2017 for circulation of key decisions to all stakeholders with clear timeline for action. The SLTF was to meet every six months or earlier. State Nodal Officer (SNO) will compile

[7] Consisting of Chief Medical Officer/Civil Surgeon (Chairperson), Additional Chief Medical Officer, District Nodal Officer (Member Secretary), Pediatrician, Obstetrician/Gynecologist etc.

reports from all districts for onward transmission to the national level in the State level Reporting Form (Form 5d).

Audit noted the following:

i) First brief investigation was conducted in 798 cases (3.65 *per cent*) out of 21,870 child deaths reported during 2017-18 to 2020-21. Further, no review of child death was conducted by DMs as required under the guidelines.

The Department stated (May 2022) that the family of the deceased child moves to their ancestral village after death of child. It also stated that review by DM was not possible as in some districts, DCDR committee was not formed.

Reply is not acceptable, as it is the responsibility of the State Government to obtain the medical causes of death within two weeks after the notification of death.

ii) During 2017-18 to 2020-21, only 17 DCDRC[8] meetings were conducted by eight districts for analysis of death cases.

The Department stated (May 2022) that prescribed number of meetings could not be held due to delay in formation of DCDR committees in few districts.

iii) Only one meeting was held by SLTF during 2017-21 which indicates that lessons learnt from child death reviews were not being circulated amongst stakeholders for necessary corrective action.

The Department stated (May 2022) that multiple mails were sent to the districts and compiling of State reports could be initiated only from October 2020.

Reply confirms inadequacy in reviewing child deaths and delay in taking corrective action.

iv) Audit noted that the SNO did not compile CDR Reports of all districts and so did not forward the same to national programme managers in the Ministry of Health and Family welfare during 2016-21. Further, the Department instructed in March 2018 that RCH Nodal Officers of all districts are required to ensure reporting on CDR and its submission on 5th of every month to the State headquarters, but Districts had started sharing CDR reports only from October 2020, which was sent to GoI after Compilation.

The Department stated (May 2022) that there was delay in reporting from hospitals.

[8] North East (4), South East (2), Central (1), South (4), South West (2), East (1), New Delhi (1) and West (2)

The reply is not acceptable, as the Department was responsible for ensuring timely receipt of reports from the hospitals for compilation and submission to GoI.

7.5.6 Child Immunisation

Routine immunization is an important strategy for child survival, focusing on preventive care to reduce morbidity against preventable diseases. As per HMIS portal, coverage of children up to one year of age during April 2016 to September 2022 in respect of some vaccines was much less than the desired 100 *per* cent, such as BCG (82.70 *per cent*), OPV-0 (70.03 *per cent*), DPT-1 (3.87 *per cent*), Measles (89.48 *per cent*) and Hepatitis-B (66.86 *per cent*). The coverage of immunization in other age groups (i.e above one year) could not be ascertained as data in this regard was not furnished by the DSHS. Further, all children in the age group of nine months to five years were required to be administered nine Vitamin 'A' doses. However, only 13.80 lakh (65.03 *per cent*) out of 21.22 lakh children were administered the first dose and information on number of infants who were given remaining Vitamin-A doses (except doses 5 & 9) was not captured at the State level.

Reply of the Department was awaited.

7.5.7 Comprehensive Abortion Care

According to RMNCH+A guidelines, eight *per cent* of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term health complications. Therefore, safe and comprehensive abortion care is an essential component of overall pregnancy care. Under NRHM, 24x7 PHCs were to provide abortion by Manual Vacuum Aspiration (MVA) facilities and medical methods, whereas comprehensive Medical Termination of Pregnancy (MTP) services were to be available at all district hospitals and Sub-district level hospitals with priority given to Community Health Centres as delivery points.

Audit observed that MTP services were not provided in seven (16 *per cent*) out of 44 sub-district/district level hospitals and 20 (87 *per cent*) out of 23 CHCs. Thus, the Government failed to ensure adequate facilities as envisaged under RMNCH+A for safe abortion.

Department stated (July 2022) that Comprehensive Abortion Care (CAC) in Delhi is being provided through all district and sub-district hospitals that were serving as delivery points. Regarding existing maternity homes in Delhi, designated as CHC Non-FRU, only three maternity homes were providing CAC services.

The reply is not acceptable as the Department was well aware of the shortage of CAC services and as such, these services should have been provided through more maternity homes.

7.5.8 Achievement of targets for Sterilization and spacing methods

Family planning has undergone a paradigm shift and emerged as a key intervention to reduce maternal and infant mortalities and morbidities. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities. Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induce abortion and eliminate most of these deaths. The target and achievement of various components of family planning services in NCT of Delhi is given in **Table 7.5**.

Table 7.5: Targets and achievements of Sterilization and Spacing methods in State of NCT Delhi (2016-21).

Family Planning services	Target	Achievement	Achievement (%)
Vasectomy	7,600	3,131	41
Tubectomy	1,00,000	76,375	76
IUCD insertion	3,95,000	3,97,213	101

Source: Information supplied by Department

Above tables show that there was maximum achievement in IUCD insertion (more than 100 *per cent*); while the minimum achievement was in vasectomy services (41 *per cent*). Delhi was lagging behind in achieving the target under different segments of family planning programmes highlighting the inadequacy in implementation of the programme. Reasons for shortfall were not on record. This indicated that implementation of family planning programme in the State was not adequate and effective.

7.6 Accredited Social Health Activist (ASHA)

ASHA works as an interface between the community and the public health system to promote health care at household level. ASHAs would reinforce community action for universal immunisation, safe delivery, new-born care and prevention of waterborne and other communicable diseases. As per guidelines, ASHA must be primarily in the age group of 25 to 45 years and literate with formal education up to Eighth Class. Further, GoI prescribed two levels of training for ASHAs, viz. induction training (in module I to V, of 23 days over 12 months) and capacity building (in module VI to VII, in four rounds of five days each).

Audit observed that there was a marginal shortage of five *per* cent (309 out of 6,345) of ASHA as of March 2021. 196 ASHA's did not have the desired education of upto 8th standard. Training to ASHAs was also inadequate as only 2,446 (40.52 *per cent*) ASHAs were provided induction training (module I to V).

Further, Home Based Care for Young Child training was due for 3,989 (66.08 *per cent*) ASHA's and non-communicable disease (NCD) training was due for 2,165 (35.87 *per cent*). However, 96 *per cent* ASHAs were imparted capacity building training (Modules 6 and 7).

Department's reply was awaited (December 2022).

7.7 Lapses in data collection and reporting system under HMIS

Health Management Information System (HMIS) is a Government to Government (G2G) web-based management information system that has been put in place by Ministry of Health & Family Welfare (MoHFW), GoI to monitor NHM and other Health programmes. HMIS has been utilised in grading of health facilities, identifications of aspirational districts, review of State Programme Implementation Plan (PIPs), etc. Further, HMIS captures facility-wise information i.e. service delivery on monthly basis, training data on quarterly basis and Infrastructure on annual basis.

As per HMIS report, for 2020-21[9], shortfall in reporting on portal was noticed in health centres such as Community health Centres (50 *per cent)*, sub-district hospitals (28 *per cent)* and district hospitals (14 *per cent*).

Common validation rules for HMIS data provides that number of doses of OPV1, OPV2 and OPV3 vaccines administered should be equal to that of DPT1, DPT2 and DPT3 respectively. Audit noted that against 14.86 lakh OPV1 vaccine administered during 2016-17 to 2020-21, the number of DPT1 was only 65,169 which raises questions regarding accuracy of the data.

7.8 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

7.8.1 NCD Clinics, Cardiac Care Unit (CCU) and Day Care Facilities for cancer patients not established

As per Operational Guidelines of NPCDCS, 2013 issued by DGHS, MoH&FW, GoI, all districts shall have regular Non-Communicable Diseases (NCD) clinic for screening, management and counselling and awareness generation etc. Four bedded Cardiac Care Units (CCUs) were to be established/strengthened in identified district hospitals. Identified district hospitals were to provide a day care chemotherapy facility for the cancer patients on simple chemotherapy regimens alongwith necessary equipment.

Audit noted that the Government did not establish any of the above institutions/facilities in Delhi even after nine years thereby depriving the people of Delhi of adequate treatment facilities. Audit noted that Department had not proposed for establishment of clinics in the PIPs for approval by the MoH& FW, GoI.

[9] Reports for the period 2016-17 to 2019-20 was not available.

Department accepted (August 2022) that NCD Clinics could not be established. With regard to CCUs, department stated that CCUs were not established due to absence of a dedicated fund and day care chemotherapy facilities for cancer patients were not provided as major hospitals provide such facilities.

The reply is not acceptable as proposals for setting up CCUs were not taken up by the Department in the PIPs with the GoI. Further, day care chemotherapy facilities envisaged were over and above those available in major hospitals.

7.8.2 Training of Medical and Para Medical Staff

As per operational Guidelines of NPCDCS 2013, State NCD Cell is responsible for organizing state and district level trainings for capacity building. Training was to be provided to Medical Officers, Medical Specialists, ANMs/Health Workers, Programme Officer, Programme Coordinator, Finance cum Logistics Officer, DEO etc.

During 2018-19 to 2020-21, ₹ 36 lakh was sanctioned for training against which only ₹ 0.73 lakh was incurred. Audit noted that only six trainings programmes were organized at state level and 10 at district level during 2016-21. Only 10 *per cent* (84 out of 806) Medical Officers and 16 *per cent* (281 out of 1759) ANMs were given training.

Department stated (August 2022) that trainings could not be organized due to unavailability of dedicated fund, delay in receipt of ROP and COVID 19.

Reply is not acceptable as sufficient funds were available with DSHS during 2018 to 2021.

Recommendation 7.5: Arrangement for proper trainings for doctors and para medical staff should be ensured as prescribed.

7.8.3 Public Awareness Activities not conducted

The State NCD Cell is responsible to conduct public awareness regarding health promotion and prevention of NCDs. For Information, Education & Communication (IEC) activities, ₹ 50 lakh was approved each year for 2018-19 to 2020-21.

Audit noted that only ₹ 5.46 lakh (3 *per cent)* was incurred during the period 2018-19 to 2020-21. Thus, adequate efforts were not made to create awareness about the Scheme amongst general public.

Department stated (August 2022) that funds were not utilized due to Record of Proceeding being received in last week of August and June for the years 2018-19 and 2019-20 respectively and also due to Covid-19 in 2020-21. Department further stated that due to frequent change of State Programme Officer (SPO) as also the main focus being on Population based screening (Pilot Project) during 2019-20, sufficient budget could not be utilised.

Despite late receipt of approval, Department could have made efforts to utilize the funds available for IEC activities as and when received.

7.8.4 Review meetings

State NCD Cell is responsible for monitoring the programme through review meetings on a quarterly basis to assess physical and financial progress and discuss constraints in implementation of the programme. Review meetings were to be held every quarter to monitor the programme.

During 2016-17 to 2020-21, only eight review meetings were held against the prescribed 20 meetings.

Department stated (August 2022) that review meetings could not be held due to administrative reasons, frequent change of SPO and Covid-19 pandemic.

The reply is not acceptable as reasons cited are purely administrative in nature.

7.8.5 Shortage of staff for implementing of NPCDCS

All posts proposed in the PIP and approved in ROPs every year by the Government of India are to be filled up by Delhi State Health Mission.

For these posts, first time recruitment rules were to be finalized by the DSHM, which was not done.

Audit noted that the posts of State Programme Officer, State Programme Coordinator and Finance-cum-Logistics Consultant were vacant and the work was being looked after by officials from other offices as additional charge. At district level also, the posts of District Programme Officer, District Programme Coordinator and Finance-cum-Logistics Consultant were vacant.

Department stated (August 2022) that the proposal for filling up sanctioned post under the programme was initiated, however, it was not approved due to pending finalization of recruitment rules for the sanctioned posts.

Reply is not acceptable, since Department was responsible for timely finalization of recruitment rules.

7.9 National Programme for Control of Blindness

National Programme for Control of Blindness & Visual Impairment (NPCB&VI) was launched in the year 1976 with the goal of reducing the prevalence of blindness. Audit noted the following:

7.9.1 Training of Eye surgeons, Nurses not conducted

Para 3 of Pattern of Assistance, NPCB&VI envisaged training of personnel, supply of high-tech ophthalmic equipment, strengthening follow up services and regular monitoring of services by which programme objectives were to be achieved. Audit noticed that no trainings for Eye Surgeons and Nurses were conducted during 2016-21.

District Programme Officer (North West) stated (April 2022) that due to shortage of staff and administrative reasons, trainings could not be conducted and needful would be done in due course.

7.9.2 Screening Camp for Refractive error detection and free distribution of spectacles

Para 3 of Pattern of Assistance, NPCB&VI envisaged reduction in the backlog of blindness through identification and treatment of blind and organize screening of school children for detection of refractive errors and other eye problems and provide free glasses to poor children. Screening of school going children would go a long way in controlling occurrence of blindness through early detection

Audit noticed that regular annual screening was not done by all three selected districts (New Delhi, North West and South East) during 2016-17 to 2020-21. No teacher was trained by any of the three IDHSs for screening of school children for refractive errors during 2016-21.

DPO (North West) stated (April 2022) that due to administrative reasons, teacher's training could not be organised and needful would be done in due course.

As regards free distribution of spectacles, Department had distributed free spectacles to only 37 *per cent* (17,106 out of 46,300) children targeted during 2016-22.

DPO (North West) stated (April 2022) that due to unavailability of spectacles on GEM portal, the same could not be distributed.

Reply is not acceptable, as Department could have explored other sources for procurement.

Recommendation 7.6: Efforts should be made to ensure the implementation of National Programme for Control of Blindness & Visual Impairment.

7.9.3 Data/information on MIS portal not updated

A web portal has been designed by GoI for NPCB&VI to enter data/information at Central Level, State level and District level.

Audit examination of the portal revealed that the necessary data/information e.g. number of patients, details of hospitals, details of NGOs, details of screening camps etc. has not been entered completely. The portal was also not updated at State level/District level.

DPO (North West) stated (April 2022) that due to administrative reasons and shortage of staff MIS portal could not be updated and needful would be done in due course.

7.9.4 District Ophthalmic Board and Redressal Committee not found

As per guidelines of NPCB&VI, a District Ophthalmic Board consisting of Eye Specialists was to be constituted to examine children and adolescents admitted to blind schools. The State Government was also required to constitute a Redressal Committee for all disputes pertaining to programme implementation including NGO participation.

Audit observed that Redressal Committee was not constituted by DSHS and the selected three IDHSs did not form District Ophthalmic Board.

DPO (North West) stated (April 2022) that due to administrative reasons, Ophthalmic Board could not be formed and needful would be done in due course.

Recommendation 7.7: The Government should ensure arrangements for proper training of doctors, para medical staff etc under each disease programme as prescribed in the Operations Guidelines of diseases programme under NHM.

Recommendation 7.8: Ensure prompt formation of Redressal Committee and District Ophthalmic Board under NPCB.

7.10 National Tobacco Control Programme

The main objectives of the National Tobacco Control Program (NTCP) are awareness/sensitization/training and enforcement of tobacco control Acts (Cigarette and Other Tobacco Product Act 2003). Other activities include implementing tobacco control in coordination with various department like police, transport, food safety, etc. to make Delhi tobacco free.

Audit noted the following:

- **State Level Coordination Committee and Tobacco Cessation Centres (TCCs)**

As per National Tobacco Control Program (NTCP) guidelines 2015, every State is required to form a State Level Coordination Committee[10] (SLCC). This committee would be responsible for the overall implementation of National Tobacco Control Programme and provisions of Cigarette and Other Tobacco Product Act 2003, in the State. The Guidelines further provide for quarterly meetings to be held to review the progress of work.

Audit noted that State Level Coordination Committee (SLCC) was not constituted (May 2022).

DSHS had to set up Tobacco Cessation Centres (TCCs) to help those people who wish to quit tobacco consumption in any form. Audit noted that DSHS has targeted setting up of 33 Tobacco Cessation Centres (three in each district)

[10] Headed by Chief Secretary or his nominee and Pr. Secretary/Secretary (Health) as member secretary

during 2019-20 and 11 additional TCCs (one in each district) during 2020-21. However, only one Tobacco Cessation Centre[11] was established against the targets of 44 TCCs (July 2022).

Department stated (November 2022) that SLCC has been constituted. As regards TCCs, it was stated that work for establishment of TCCs in other districts is under process.

- **Enforcement squads/ teams not formed**

As per NTCP guidelines 2015, every district is required to constitute an enforcement squad for monitoring compliance with tobacco control laws in their jurisdiction and for taking action against any violation in the district.

Audit noted that none of the three selected districts (South, New Delhi and North West) had constituted enforcement squad team during 2016-21 (except North West District which constituted the squad only for the year 2016-17).

Department stated (November 2022) that Delhi is one of few States/UTs which has its own tobacco law since 1997 and all the districts have teams for enforcement of tobacco laws and their constitution may be different from the constitution prescribed in the guidelines.

Reply is not acceptable as no documentary evidence in support of the reply was attached.

- **Lack of monitoring of Challan Books distribution**

As per NTCP 2015 operational guidelines, Challan books should be printed at State level or as decided by the State and distributed to all concerned authorities[12] in the State to impose and collect fine against violation of Cigarette and Other Tobacco Product Act (COTPA). The amount so collected should be used for tobacco control activities. Enforcement and monitoring of provisions of COPTA 2003 was to be ensured by State Tobacco Control Cell (STCC).

Audit noted that total number of Challan books printed with allotted series at State Tobacco Control Cell (STCC) was not on record. Further, the system of distribution of Challan books to all concerned authorities in the State during the period 2016-21 was also defective, as printed Challan books were not serially distributed to the agencies concerned and 231 Challan books were missing. Moreover, there was no mechanism set up by STCC for reconciliation of issued Challan books and total fine recovered. As per records made available to audit, STCC had collected fine of ₹ 81.47 lakh during 2019-20 whereas Delhi Police had collected fine of ₹ 90.17 lakh during

[11] TCC at RML Hospital under IDHS, New Delhi

[12] Director/Medical Superintendent of Hospitals, all Gazette officers of State/Central Government, Head of College/School/Institution, police officers not below the rank of SI, etc.

eight months period (May 2019 to December 2019). STCC also failed to provide sufficient number of Challan books to Delhi Police and Delhi Police got printed four thousand Challan books from May 2018 to July 2020 (about two years). As per record, no consent was taken by Delhi Police from State Tobacco Control Cell for printing of Challan books.

Thus, the possibility of misuse of the challan books and fine collected from the violators cannot be ruled out. Moreover, there was no record about revenue actually generated from challan books and the amount utilized for tobacco control activities.

- **Irregular running of Hookah bars**

As per study report[13], Hookah produces high toxic substances and gases like carbon monoxide, tar, metals and other carcinogenic chemicals which can increase the risk of cancer and heart problems and is just as much harmful as cigarette smoking. The Cigarettes and Other Tobacco Products Act is being implemented by STCC.

Audit noted that STCC was pursuing the matter of illegal hookah bars in restaurants with Delhi Police since April 2014. Examination of STCC records revealed that 20 restaurants/eating houses (June 2016) were serving hookah bars without license. STCC (July 2017) had found presence of significant amount of nicotine in the seized samples. Audit found that records relating to action taken against such hookah bars was not available with State Tobacco Control Cell. Moreover, STCC has not maintained any register of inspection/surprise checks in hotels/restaurants.

Government stated (November 2022) that action against hookah bar is being taken by the STCC/DTCC in coordination with Delhi Police.

Reply is not acceptable as documents regarding action taken by STCC/DTCC against illegal hookah bars running in these restaurants/eateries/hotels, were not found in the records during audit nor furnished with reply.

Recommendation 7.9: Ensure timely establishment of Tobacco Cessation Centers (TCCs) for providing facilities to common people.

7.11 National Leprosy Eradication Programme

As per National Health Policy 2017, the proportion of Grade-2 cases amongst new cases will become the measure of community awareness and health systems capacity to carry out leprosy elimination, keeping in mind the global goal of reduction of Grade-2 disability to less than one per million by 2020. The policy envisaged proactive measures targeted towards elimination of leprosy from India by 2018**.**

[13] Center for Disease Control and Prevention.

Audit observed that Grade-2 cases amongst new cases remained above 10 per million during 2016-17 to 2019-20 but came down to 4.50 per million in 2020-21. Although this shows a significant improvement, the occurrence was still much above the desired level of one per million. In spite of this, GNCTD did not implement Leprosy Case Detection Campaign (LCDC) instituted by GoI in August 2016 aimed at elimination of leprosy by 2018. Activities under LCDC included two days State level workshop, Orientation training for field level workers etc. which would have facilitated early detection of Leprosy cases and prevention of Grade-2 disabilities. GoI had also written (May 2018) to GNCTD that the incidence of Grade-II disability in Delhi were consistently high during the last three years and requested for conducting LCDC activities. However, GNCTD did not conduct any activity and no annual target was fixed for leprosy control/eradication.

Reply of the Department was awaited.

7.12 National Mental Health Programme (NMHP) not implemented

As per paragraph 4.7 National Health Policy 2017 on mental health, it is required to work on the main fronts which include increasing/creation of specialists trough public financing and develop special rules to give preference to those willing to work in public systems, create network of community members to provide psycho-social support to strengthen mental health serves at primary level facilities and leverage digital technology in a context where access to qualified psychiatrists is difficult. Para 13.4 of National Health Policy also provides that training community members to provide psychological support to strengthen mental health services in the country. Collaboration with Government would be an important plank to develop a sustainable network for community/locality towards mental health.

Audit observed from the accounts of the DSHS that there was an opening balance of ₹ 92.20 lakh on 1 April 2016. Further, DSHS earned interest of ₹ 21.32 lakh during 2016-21, but nil expenditure was incurred and whole amount of ₹ 1.13 crore remained unspent as of 31 March 2021. This clearly shows that the above programme has not been implemented by the Society. The reasons for non-implementation of the programme are awaited.

7.13 Implementation of National Programme for the Health Care for the Elderly (NPHCE)

The Ministry of Health & Family Welfare had launched the "National Programme for the Health Care of Elderly" (NPHCE) during 2010-11 to address various health related problems of elderly people. The National Programme for the Health Care for the Elderly (NPHCE) is an articulation of the international and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP) adopted by the

Government of India in 1999 and Section 20 of "The Maintenance and Welfare of Parents and Senior Citizens Act, 2007" dealing with provisions for medical care of senior citizen. The programme is State oriented and basic thrust of the programme is to provide dedicated health care facilities to the senior citizens (>60 year of age) at various levels of primary, secondary and tertiary health care.

As per PIPs, RoPs and consolidated utilization certificates, the budget provision and expenditure incurred on National Programme for Health Care of the Elderly (NPHCE) by NHM, NCT of Delhi during the period 2016-17 to 2021-22 is as given in **Table 7.6**.

Table 7.6: Budget provision and expenditure under NPHCE in State of NCT Delhi

(₹ in lakh)

Period	Amount Proposed in PIPs	Amount Approved by GoI in RoPs	Opening Balance as Balance Sheet	Fund Received from GoI	Interest Received	Total Expendi-ture incurred	Un-spent Balance
2016-17	352.75	259.34	0.00	34.50	0.08	0.00	34.58
2017-18	41.80	41.80	34.58	0.00	2.45	0.00	37.04
2018-19	90.80	49.80	37.04	0.00	1.31	0.17	38.18
2019-20	115.40	36.80	38.18	0.00	1.32	0.00	39.49
2020-21	21.90	21.90	39.49	0.00	1.21	0.00	40.71
2021-22	21.90	21.90	40.71	0.00	1.20	8.00	33.90
Total	**644.55**	**431.54**	**----**	**34.5**	**7.57**	**8.17**	**----**

From the above table, it is evident that DSHS received ₹ 34.50 lakh against approved amount of ₹ 431.54 lakh. However, DSHS has incurred only ₹ 8.17 lakh (1.89 *per cent*) against the ₹ 431.54 lakh approved during the period 2016-22. As per the Records of Proceeding (RoP) of DSHS for the period 2020-21, GoI approved 38 posts of Nurses for Geriatric Care (22), Physiotherapist/Occupational Therapist (04) and Consultant Medicine (MD) (12) under the NPHCE, but all the posts remained vacant as of March 2021.