Chapter-VII

Implementation of Centrally Sponsored Schemes

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Implementation of Centrally Sponsored Schemes

Health being a State subject, the Central Government supplements the efforts of the State Governments in delivery of health services through various schemes of primary, secondary and tertiary care. The findings with respect to audit of implementation of centrally sponsored schemes in the State are discussed in the succeeding paragraphs:

7.1 National Urban Health Mission (NUHM)

The National Health Mission (NHM) is the flagship health sector scheme of GoI which encompasses two Sub-Missions, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening, Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable and quality healthcare services that are accountable and responsive to people's needs.

To address healthcare needs of urban population, particularly urban poor, the Ministry of Health and Family Welfare has formulated NUHM as a Sub-Mission under an over-arching NHM to provide equitable and quality primary healthcare services to the urban population with special focus on slum and vulnerable sections of the Society. NUHM was implemented in all six selected districts.

7.1.1 Mapping and Vulnerability Assessment

NUHM guidelines (2017) required conduct of "Mapping and Vulnerability Assessment" to understand the available resources, service gaps and health needs of the urban residents, with a deliberate focus on the special needs of the vulnerable groups. It was recommended to conduct city mapping either through GIS (Geographical Information System) or through a manual consultative process. Vulnerability assessment was to assess vulnerability status of wards, slums and slum households in the city, to understand the vulnerability status of a particular slum and each household in the slum. 'Vulnerability Mapping and Assessment' was required to be done on a periodic basis. This may not be an extensive exercise and can be conducted in a sampled way as an annual exercise which can be linked to the annual planning and budgeting process.

Urban Community Health Centers (UCHCs) were to be made operational for every 2.5 lakh population, Urban Primary Health Centers (UPHCs) were to be made operational with population of approximately 50,000-60,000 and were to

be located preferably within a slum or near a slum area within half a kilometer radius, catering to a slum population of approximately 25,000-30,000.

It was observed that NUHM was implemented in all the six selected districts, but city mapping was conducted only in district Bathinda through GIS. Further, 16 UPHCs in Ludhiana city, five in Bathinda city, two in Fatehgarh Sahib district, two in Gurdaspur city, two in Hoshiarpur city and two in Moga city were established within a distance limit of three to five kilometers radius from identified slum areas, against the NUHM guidelines of setting up UPHCs within half a kilometer radius of slum areas. Moreover, six UCHCs in Ludhiana city were also established within a distance limit of five to seven kilometres radius from the identified slum areas, against the NUHM guidelines of setting up UCHCs within half a kilometer radius of slum areas. This defeated the NUHM's objective of equitable and quality primary healthcare services to the urban population with special focus on slums and vulnerable sections of the society.

7.1.2 Outreach sessions

The framework of the NUHM lays significant emphasis on improving the reach of health services to the vulnerable groups. Outreach services play an important role in systematically delivering various benefits of health services to those who need them the most and find it difficult to access the centre-based services. Outreach services under NUHM consciously target the slum dwellers and other vulnerable groups in towns and cities.

Details of outreach sessions held in the test-checked districts during the period 2016-2022 are shown in **Table 7.1.**

Table 7.1: Status of outreach sessions held in test-checked districts

Name of District	Target	Achievement	Shortfall	Shortfall (%)
Bathinda	1,075	930	145	13.49
Fatehgarh Sahib	432	285	147	34.03
Gurdaspur	399	342	57	14.29
Hoshiarpur	432	364	68	15.74
Ludhiana	4,224	2,369	1,855	43.92
Moga	408	330	78	19.12

Source: Information furnished by State Health Society, Punjab

Colour Code:

Green denotes 'less shortage'
Yellow denotes 'moderate shortage'

Audit observed that outreach camps were organised with a shortfall of 13.49 *per cent* in Bathinda, 34.03 *per cent* in Fatehgarh Sahib, 14.29 *per cent* in Gurdaspur, 15.74 *per cent* in Hoshiarpur, 43.92 *per cent* in Ludhiana and 19.12 *per cent* in Moga. The main reasons for non-achievement of target were

non-availability of budget, deputation of staff on COVID duty and shortage of staff.

The reply of the State Government was awaited (February 2024).

7.2 Kayakalp Programme

After the launch of "Swachh Bharat Abhiyan (SBA)'' in October 2014, "Kayakalp'' initiative was launched by the Ministry of Health and Family Welfare in May 2015 to:

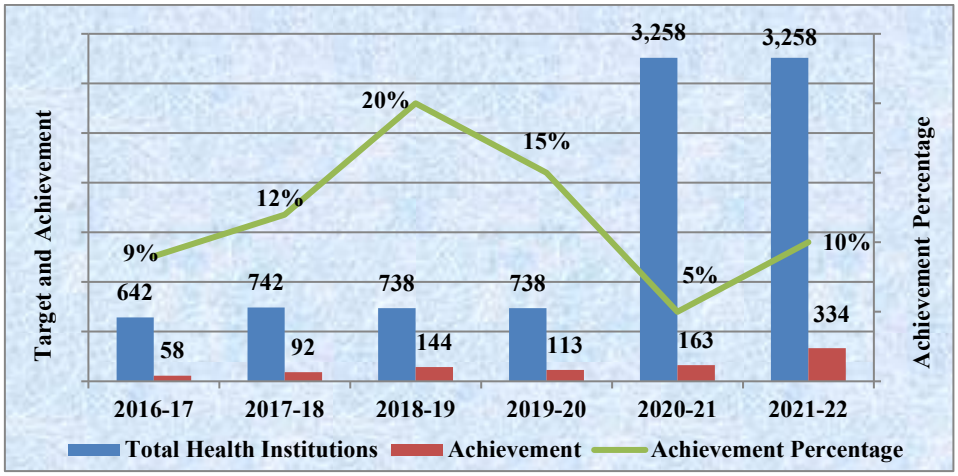
(i) promote cleanliness, hygiene and infection control practices in public healthcare facilities, through incentivising and recognising such public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness and infection control;

(ii) inculcate a culture of ongoing assessment and peer review of performance related to hygiene, cleanliness and sanitation; and

(iii) create and share sustainable practices related to improved cleanliness in public health facilities linked to positive health outcomes.

Those DHs, SDHs, CHCs, PHCs, UPHCs and HWCs which have achieved high levels of cleanliness, hygiene and infection control were to be recognised and felicitated with awards. Status of achievers under Kayakalp programme in the State is given in **Chart 7.1**.

Chart 7.1: Status of achievers under Kayakalp programme in the State

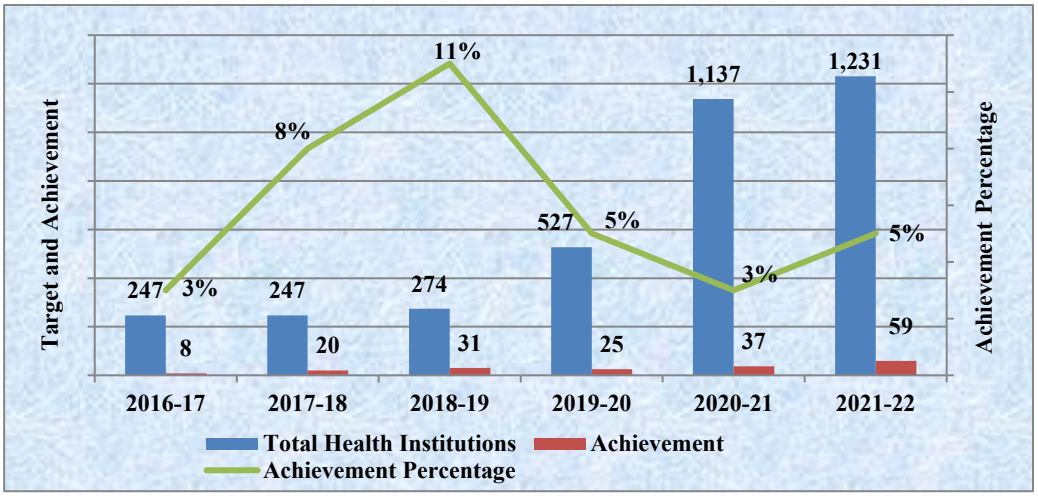


Source: Information supplied by Punjab Health Systems Corporation

It is evident from the chart that as on 31 March 2022, against 3,258 public health institutions, only 10 *per cent* health institutions (334) were found eligible for Kayakalp awards. Moreover, the number of health facilities receiving Kayakalp award in percentage terms increased during the period 2016-17 to 2018-19 but decreased during the period 2018-19 to 2020-21. However, in terms of absolute figures, there was a continuously increasing trend during the six-year period 2016-2022 except for the year 2019-20.

Audit further observed in the six selected districts that during 2021-22, 59 out of total 1,231 health institutions achieved Kayakalp status with a shortfall of 95 *per cent*. Year-wise break-up showing the target-cum-achievement in the test-checked six districts is shown in **Chart 7.2**.

Chart 7.2: Status of achievers under Kayakalp programme in test-checked districts



Source: Information supplied by the respective Deputy Medical Commissioners

It is evident from the above chart that the number of health facilities receiving Kayakalp award did not register growth commensurate with the rising number of total health institutions during the six-year period of 2016-2022 even though the award was to be given only on the criteria of maintenance of cleanliness and hygiene.

The reply of the State Government was awaited (February 2024).

7.3 Achievement under National Quality Assurance Programme

National Quality Assurance Standards have been developed keeping in mind the specific requirements for public health institutions as well as global best practices. Standards are meant for providers to assess their own quality for improvement as well as facilities for certification. Under National Quality Assurance Programme, two types of certifications are envisaged at State and National level of certification. Financial incentives are also given as per level and scope of certification.

Audit observed that against the total number of 3,258 public health institutions, only 17 (0.52 *per cent*) were National Quality Assurance Standards (NQAS) certified as of March 2022. Non-certification could be attributed to inadequate human resources, infrastructure challenges, lesser number of capacity building induction training/orientation of administrators, etc. Year-wise certification of health institutions during the period 2016-2022 in the State is shown in **Table 7.2.**

Table 7.2: Number of health institutions receiving NQAS certification in the State

Year	Total number of health institutions of the State to be covered under NQAS	Total number of health institutions certified under NQAS	Number of health institutions not certified
2016-17	214	0	214
2017-18	214	4	210
2018-19	738	7	731
2019-20	738	11	727
2020-21	3,258	14	3,244
2021-22	3,258	17	3,241

Source: Information supplied by Punjab Health Systems Corporation

Further, it was observed that only five out of 245 health institutions were NQAS certified in the test-checked six districts with a shortfall of 98 *per cent*. Moreover, none of the DHs in the test-checked districts were certified under NQAS scheme. Non-attainment of NQAS certification indicates that these health institutions could not ensure minimum 70 *per cent* of the health services at par with quality standards set by National Health Systems Resource Centre, MoHFW, GoI. Facility-wise achievement of NQAS certification in test-checked six districts is given in **Table 7.3.**

Table 7.3: Number of health institutions (HI) that achieved NQAS in test-checked districts

Type of HI	Bathinda		Fatehgarh Sahib		Gurdaspur		Hoshiarpur		Ludhiana		Moga	
	Number of HIs	NQAS certified HIs	Number of HIs	NQAS certified HIs	Number of HIs	NQAS certified HIs	Number of HIs	NQAS certified HIs	Number of HIs	NQAS certified HIs	Number of HIs	NQAS certified HIs
DH	1	0	1	0	1	0	1	0	1	0	1	0
SDH	3	0	1	0	1	0	3	2	4	1	0	0
CHC	9	1	5	0	13	0	12	0	11	0	6	0
PHC	24	1	13	0	30	0	32	0	51	0	21	0
Total	**37**	**2**	**20**	**0**	**45**	**0**	**48**	**2**	**67**	**1**	**28**	**0**

Source: Information supplied by the respective Deputy Medical Commissioners

The reply of the State Government was awaited (February 2024).

7.4 Implementation of Rashtriya Bal Swasthya Karyakram (RBSK)

As per Operational Guidelines issued (February 2013) by the Ministry of Health and Family Welfare, GoI, Rashtriya Bal Swasthya Karyakram (RBSK) is a Child Health Screening and Early Intervention Services Programme to provide comprehensive care to all the children in the community. The objective of this initiative is to improve the overall quality of life of children through early detection of birth defects, diseases, deficiencies, development delays and disability.

(i) Shortage of manpower under RBSK

As per Paragraphs 5.2 and 5.3 of RBSK guidelines (February 2013), a Mobile Health Team (MHT) is required to be constituted consisting of four members, two Doctors (AYUSH) one male and one female, with a bachelor's degree from an approved institution, one ANM/Staff Nurse and one Pharmacist, to conduct the screening of children in the age group of six weeks to six years in Anganwadis and 6-18 years in Government and Government-aided schools.

Audit observed that 90 MHTs were constituted in the six test-checked districts as on 31 March 2021 but 20 teams had no male doctors and 28 teams were operational without female doctors. Besides, it was also noticed that no nurse/ANM was posted in 40 teams and 44 teams were working without pharmacists. This affected services of MHT.

On being pointed out in audit, the Department admitted the facts and stated that requirement of manpower had been sent to the higher authorities.

(ii) Non-achievement of targets

As per RBSK guidelines, Block micro plan for school and community visits, monthly outreach plan based on the mapping of educational institutions and Anganwadis and enrollment in them is required to be prepared and targets so fixed were required to be achieved.

The position of children screened in schools and Anganwadis against the target under RBSK during the period 2016-2021 in the six test-checked districts is given in **Table 7.4.**

Table 7.4: Details of children screened in schools and Anganwadis during 2016-2021 under RBSK

Particulars	Target	Achievement	Shortfall	Shortfall (In *percentage*)	No. of children noticed with diseases	No. of children treated
No. of schools to be visited and achievement thereagainst	30,091	27,712	2,379	8	3,01,140	1,97,260
No. of children to be screened and achievement in schools thereagainst	34,97,651	30,27,035	4,70,616	13		
No. of Anganwadi centres to be visited and achievement thereagainst	40,600	37,430	3,170	8		
No. of children to be screened and achievement in Anganwadis thereagainst	20,02,921	12,61,520	7,41,401	37		

Source: Departmental data

Audit observed that shortfall in visits to schools and Anganwadis against the target was eight *per cent.* Moreover, target of screening of children at visited

schools and Anganwadis was short by 13 *per cent* and 37 *per cent* respectively. Further, out of screened children, seven *per cent* children were noticed with diseases of which only 66 *per cent* children were treated. Thus, neither were targets achieved nor were all the children identified with diseases treated under RBSK.

On being pointed out in audit, the Department admitted the facts and stated that Mobile Health Team staff was engaged in the management of COVID-19 pandemic and are now being reverted to their original duties. It was further stated that a better mechanism would be devised to follow up each referral case. It was noticed in audit that most of the children suffered from serious health conditions *viz.* club foot, congenital cataract, cleft lip, hearing impairment, goitre, thalassemia, congenital heart disease, etc. Every effort should be made by the Department to fully screen all children and ensure that each child gets the required medical attention to prevent morbidity and mortality.

(iii) Non-availability of medicines/drops/ointment

Government of India, Ministry of Health and Family Welfare prescribed (March 2014) list of 27 essential drugs/medicines and local drops/ointments for Mobile Health Teams under RBSK for on-the-spot treatment of common ailments and minor acute conditions. These medicines can be dispensed by local ANM.

Audit observed that no essential medicines/drops/ointments except Iron and Folic Acid (IFA) and Albendazole were available with 90 MHTs in the six test-checked districts during 2016-2021. The very purpose of providing on the spot treatment of common ailments and minor acute conditions of children was defeated due to non-availability of medicines with MHTs.

On being pointed out in audit, the Department stated that there was no mention of medicines/drops/ointments in Operational Guidelines of RBSK. The reply of the Department is not convincing as the directions of GoI (March 2014) were clear in this regard.

(iv) Shortage of manpower in District Early Intervention Centres (DEIC)

As per RBSK guidelines, an Early Intervention Centre will be established at the District Hospital to provide referral support to children detected with health conditions during health screening. A team consisting of Pediatrician, Medical Officer, Paramedics will be engaged to provide services. There is also a provision for engaging a manager who would carry out mapping of tertiary care facilities in Government institutions for ensuring adequate referral support.

Audit observed that in the test-checked three[1] out of total five DEICs established in Bathinda, Hoshiarpur, Ludhiana, Rupnagar and Tarn-Taran at District Hospital level, there was a shortage of manpower ranging between 38 *per cent* and 85 *per cent* as detailed in ***Appendix 7.1***. Further, no Physiotherapist was posted in any DEIC. Besides, it was also noticed that in DEIC Hoshiarpur, only Lab Technicians and Social Workers were working against the requirement of 13 categories of staff. Thus, shortage of staff in DEICs affected the treatment facility and the referral support services could not be provided as envisaged. Moreover, three more DEICs costing ₹ 2.70 crore were to be set up at Gurdaspur, Patiala and Ferozepur, as per PIP for the year 2019-20 but no work was initiated till December 2022.

On being pointed out in audit, the Department admitted the facts and stated that matter for recruitment of DEIC staff had been sent to NHM.

7.5 Family Welfare Scheme

India was the first country in the world to launch a National Programme for Family Planning in 1952. Following its historic initiation, the Family Planning programme has undergone many transformations in terms of policy and actual programme implementation. Post International Conference on Population and Development (ICPD) 1994 held in Cairo, there was a de-emphasis on Family Planning globally with the donors substantially reducing the funding for Family Planning (FP) programmes. However, subsequently it was realised that without increasing use and access to contraceptives, it would be difficult to impact the high maternal, infant and child mortality. Thereafter a gradual shift occurred from clinical approach to the reproductive child health approach. The National Population Policy (NPP) in the year 2000 brought about a holistic and a target-free approach which accelerated the reduction of fertility. Current family planning efforts include contraceptive services, spacing methods, permanent methods, emergency contraceptive pills, etc. Out of the above-mentioned family planning methods, spacing methods and emergency contraceptive pills are discussed in the succeeding paragraphs:

7.5.1 Non-disbursement of compensation to sterilisation acceptors (Male/Female)

As per guidelines (September 2007) issued by MoH&FW, GoI, for compensation package to acceptors of sterilisation, the mission steering group of National Rural Health Mission has considered and approved further revision in the compensation package to acceptors of sterilisation with particular boost to male participation in family planning i.e. Vasectomy and Tubectomy in public health facilities and accredited private health facilities to all categories in

[1] In three District Hospitals (i) Bathinda; (ii) Hoshiarpur; and (iii) Ludhiana.

High Focus States and BPL/SC/ST in Non-High Focus States. Punjab was considered in the category of Non-High Focus States.

Compensation scheme for sterilisation acceptors provides compensation[2] for loss of wages to the beneficiaries and also to the service provider team for conducting sterilisation. Under this scheme, the Government of India releases compensation for sterilisation acceptors to both females and males.

Audit observed that in the six test-checked districts, 8,749 out of total 59,950 cases of sterilisation acceptors were not paid compensation during the audit period. Further, the details of sterilisation acceptors during the period 2016-2022 in test-checked districts are given in **Table 7.5.**

Table 7.5: Number of Sterilisation acceptors (Tubectomy/Vasectomy) in test-checked districts

Year	Bathinda	Fatehgarh Sahib	Gurdaspur	Hoshiarpur	Ludhiana	Moga
Tubectomy						
2016-17	2,331	317	2,263	1,122	8,454	1,756
2017-18	2,107	238	2,045	1,073	5,041	1,665
2018-19	1,904	156	1,866	1,109	5,114	1,168
2019-20	1,875	255	1,327	923	4,174	1,088
2020-21	1,119	90	1,116	687	1,005	674
2021-22	1,178	59	836	511	954	798
Vasectomy						
2016-17	54	8	100	20	66	19
2017-18	86	12	54	32	41	9
2018-19	158	6	67	20	165	5
2019-20	59	2	91	42	197	16
2020-21	33	0	36	28	60	1
2021-22	14	1	15	6	26	3

Source: Information provided by District Family Welfare Officers in test-checked districts

The main objective of the compensation scheme was to boost the participation of men and women in family planning. Thus, non-payment to sterilisation acceptors, as above, would discourage the masses to go for sterilisastion, as is also evident from the data (**Table 7.6**), which shows that number of sterilisation acceptor by and large decreased during the period 2016-2022. Further, non-achievement of targets of sterilisation, as depicted in **Table 7.7**, would also impair the objective of the scheme.

[2] Vasectomy acceptor (for all) - ₹ 1100; Tubectomy acceptor (for BPL+SC/ST) - ₹ 600; and Tubectomy acceptor (for Non-BPL + Non SC/ST) - ₹ 250.

7.5.2 Achievement of targets for sterilisation 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 induced abortion and eliminate most of these deaths. The target and achievement of various components of family planning services in the State is given in **Table 7.6.**

Table 7.6: Targets and achievements of sterilisation and spacing methods in the State of Punjab (2016-2022)

Family Planning services	Target	Achievement	Achievement (%)
Vasectomy	16,000	5,705	35.66
Tubectomy	2,65,000	1,59,432	60.16
IUCD insertion	15,25,000	8,17,146	53.58
Condom users	Not fixed	13,88,91,165	-
Oral pills users	Not fixed	68,15,277	-

Source: Information furnished by the Department of Health and Family Welfare

Thus, the achievement against the fixed target in vasectomy, tubectomy and IUCD insertion was significantly low i.e. 35.66 *per cent*, 60.16 *per cent* and 53.58 *per cent* respectively. Moreover, targets for condom users and oral pills users were not fixed during the period 2016-2022.

Further, the details of targets and achievement of various components of family planning services in the five[3] test-checked districts are given in **Table 7.7.**

Table 7.7: Targets and achievements of Sterilisation and Spacing methods in test-checked districts during 2016-2022

Family Planning services	Target	Achievement	Achievement (%)
Vasectomy	4,902	1,404	28.64
Tubectomy	93,238	52,973	56.81
IUCD insertion	4,36,613	2,29,119	52.48
Condom users*	5,82,140	5,23,769	89.97
Oral pills users*	1,58,568	1,14,794	72.39

Source: Information provided by District Family Welfare Officers in test-checked districts

** Data pertains to four test-checked DHs except for Bathinda which had not fixed targets; and records of Hoshiarpur were not provided to Audit.*

Audit observed that achievement in sterilisation cases ranged between 28.64 *per cent* and 89.97 *per cent* during 2016-2022 which showed that targets

[3] (i) Bathinda; (ii) Fatehgarh Sahib; (iii) Gurdaspur; (iv) Ludhiana; and (v) Moga. Records of Hoshiarpur were not provided to Audit.

were not achieved in sterilisation and spacing methods. Further, four[4] out of six test-checked districts had fixed targets for condom users and oral pills users and no targets were fixed in Bathinda whereas Hoshiarpur district did not furnish information. Achievement of targets for condom users and oral pills users in four districts ranged between 54 *per cent* and 96 *per cent* during the period 2016-2022.

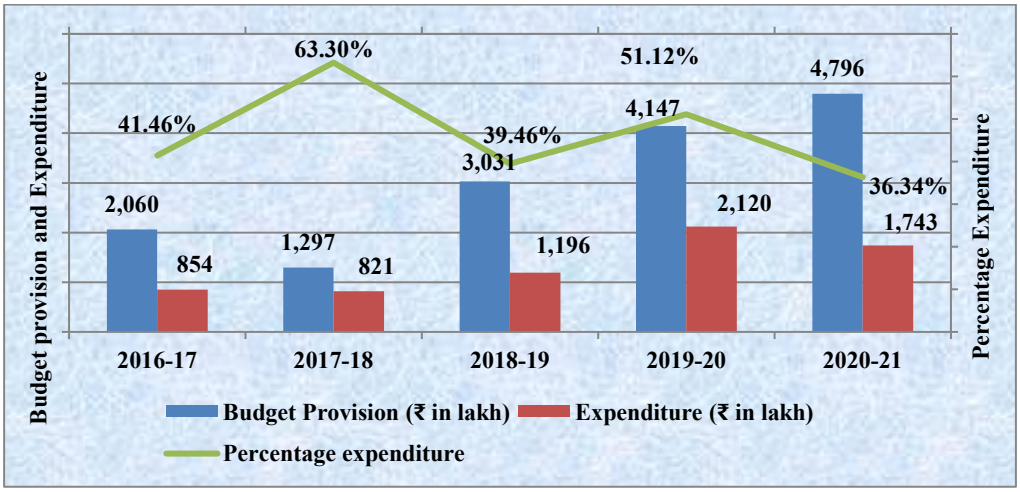
The reply of the State Government was awaited (February 2024).

7.6 National Tuberculosis Elimination Programme (NTEP)

The National Tuberculosis Elimination Programme (NTEP) provides technical and managerial leadership to anti-tuberculosis activities in the country. As per the National Strategic Plan 2017-2025, the programme has a vision of achieving a "TB free India", with strategies under the broad themes of "Detect, Treat, Prevent and Build pillars for universal coverage and social protection". The programme provides various free of cost, quality tuberculosis diagnosis and treatment services across the country through the government health system.

As per the Financial Management Report (FMR) of NHM Punjab, the budget provision and expenditure incurred on NTEP by the NHM[5], Punjab is shown in **Chart 7.3**.

Chart 7.3: Budget provision and expenditure under NTEP in the State



Source: Information supplied by State Health Society, Punjab

Audit observed that Government of India had been regularly making budget provision for NTEP, but the expenditure incurred by NHM ranged between 36.34 *per cent* and 63.30 *per cent* during the years from 2016-17 to 2020-21.

The reply of the State Government was awaited (February 2024).

[4] (i) Fatehgarh Sahib; (ii) Gurdaspur; (iii) Ludhiana; and (iv) Moga.

[5] National Health Mission (NHM), Punjab receives funds in 60:40 ratio from GoI and Government of Punjab.

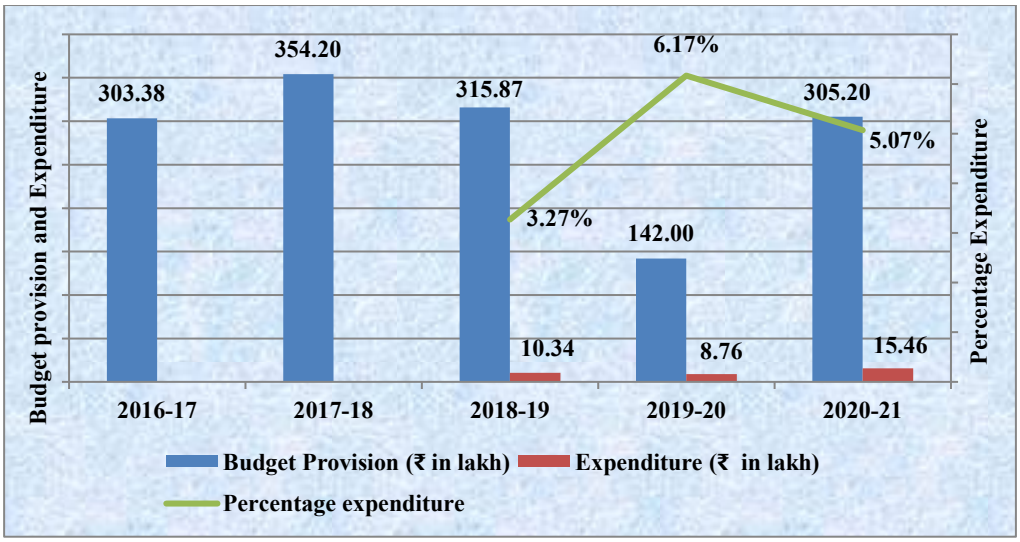
7.7 National Mental Health Programme

The objective of Mental Health Programme is to provide mental health services including preventive, promotion, and long-term continuing care at different levels of district level healthcare system. The audit findings observed in the implementation of Mental Health Programme are discussed in the succeeding paragraphs:

7.7.1 Non-utilisation of funds under National Mental Health Programme (NMHP)

As per the Financial Management Report (FMR) of NHM, the budget provision and expenditure incurred on National Mental Health Programme by NHM, Punjab during the period 2016-2021 is shown in **Chart 7.4.**

Chart 7.4: Budget provision and expenditure under NMHP in the State



Source: Information supplied by State Health Society, Punjab

Audit observed that the Government of India had been regularly making budget provision for National Mental Health Programme but the whole budget remained unspent during the period 2016-2018 and expenditure incurred during the period 2018-2021 ranged between 3.27 *per cent* and 6.17 *per cent* only.

On being pointed out in audit, the Department admitted the facts and did not assign any reason for non-utilisation of budget.

7.7.2 Implementation of Mental Health Programme in selected districts

As per NMHP, 2015 (Part 2(E)), the services at DHs include Outpatient services, counselling services and in-patient services. Further, in out-patient services, given the scarcity of the skilled manpower in mental health specialities in the country, the OPD services in mental health/psychiatry services shall be provided by doctors who may be trained General Duty Medical Officers (GDMOs). However, in districts where trained MO is not available, the services

of a private psychiatrist may be utilised. In counselling services, all patients (and their attendants, if available and only if the patients agree to involve them) assessed by the trained doctor, should receive counselling/psycho-social interventions/psycho-education, as per the clinical needs. In-patient services include patients of mental disorders, who require in-patient management, should be admitted in a dedicated ward which is exclusively meant for this purpose.

Further, as per NMHP, 2015, (Part 2(F)) services at CHCs will include: (i) outpatient services for walk-in patients and patients referred by the PHC will be provided by the trained medical officer. In addition to this, in-patient services will also be provided for emergency psychiatry illnesses; (ii) Counselling services shall be provided by the Clinical Psychologist/trained Psychologist; and (iii) Continuing care and support to persons with severe mental disorder (SMD).

Audit observed in 15 test-checked health institutions (DHs/CHCs) that availability of services under NMHP is shown in **Table 7.8**:

Table 7.8: Availability of mental health services in test-checked health institutions

Sr. No.	Particulars	DHs (6)	CHCs (9[6])
1.	Whether trained General Duty Medical Officers (Psychiatrist)/trained medical officer were available in DHs/CHCs	6	0
2.	Whether Clinical Psychologist/trained Psychologist were available in DHs/CHCs	5	0
3.	Whether provisions of Out-patient services for walk-in-patient and patients referred by the PHC is provided by MO	6	5
4.	Whether early identification, diagnosis and treatment of common mental disorders (anxiety, depression, psychosis, schizophrenia, Manic Depressive Psychosis) are available	6	5
5.	Whether In-patient services are available for emergency psychiatry illnesses	5	1
6.	Whether counseling services provided by the Clinical Psychologist/trained Psychologist	5	1
7.	Whether continuing care and support to persons with Severe Mental Disorder (SMD) provided to the patients. (This includes referral to district hospital for SMD patients and follow up based on treatment plan drawn up by the Psychiatrist at the district hospital)	6	1

Source: Information supplied by test-checked health institutions

[6] (i) Bhucho Mandi; (ii) Bassi Pathana; (iii) Amloh; (iv) Fatehgarh Churian; (v) Naushera Majja Singh; (vi) Shamchaurasi; (vii) Sidhwan Bet; (viii) Bagha Purana; and (ix) Nihal Singh Wala. Records of three CHCs (Mehraj, Mahilpur and Sudhar) were not provided to Audit.

From above, it is apparent that:

i. No post of trained medical officer in CHCs were sanctioned, however, mental health/psychiatry services were being provided by other medical officers in five[7] CHCs. Clinical Psychologist/trained Psychologist were available in all DHs except DH Gurdaspur and no post of Clinical Psychologist/trained Psychologist was sanctioned for CHCs. However, in CHC Nihal Singh Wala, Clinical Psychologist/trained Psychologist service was provided through outsourced staff.

ii. Provisions of Outpatient services for walk-in-patient and patients referred by the PHCs were not available in four CHCs (Bhucho Mandi, Fatehgarh Churian, Naushera Majja Singh and Bagha Purana).

iii. Provision for early identification, diagnosis and treatment of common mental disorders (anxiety, depression, psychosis, schizophrenia, Manic Depressive Psychosis) were not available in four CHCs (Bhucho Mandi, Fatehgarh Churian, Naushera Majja Singh and Bagha Purana).

iv. In-patient services for emergency psychiatry illnesses were not available in eight CHCs (Bhucho Mandi, Bassi Pathana, Amloh, Fatehgarh Churian, Naushera Majja Singh, Sidhwan Bet, Bagha Purana and Nihal Singh Wala) and DH Gurdaspur.

v. Counseling services were not available in eight CHCs (Bhucho Mandi, Bassi Pathana, Amloh, Fatehgarh Churian, Naushera Majja Singh, Shamchaurasi, Sidhwan Bet and Bagha Purana) and DH Gurdaspur.

vi. Continuing care and support to persons with Severe Mental Disorder (SMD) was not provided to the patients in eight CHCs (Bhucho Mandi, Bassi Pathana, Amloh, Fatehgarh Churian, Naushera Majja Singh, Shamchaurasi, Bagha Purana and Nihal Singh Wala).

The reply of the State Government was awaited (February 2024).

7.7.3 Availability of Mental Health Programme drugs in selected health institutions

As per instructions issued (May 2018) by Ministry of Health and Family Welfare, Government of India, 20 types of psychotherapeutic drugs/medicines for seven types of mental health conditions should be available at DHs and 14 types of drugs should be available at CHCs/PHCs.

[7] CHCs at (i) Bassi Pathana; (ii) Amloh; (iii) Shamchaurashi; (iv) Sidhwan Bet; and (v) Nihal Singh Wala.

As per data supplied by test-checked health institutions (DHs: 6, CHCs: 12 and PHCs: 23[8]), the shortfall (*percentage*) in availability of mental health drugs is given in ***Appendix 7.2*.**

Audit observed that:

i. Shortfall in DH Bathinda was 45 *per cent*; in DH Fatehgarh Sahib was 55 *per cent*; in DH Gurdaspur was 95 *per cent*, in DH Hoshiarpur was 75 *per cent*, in DH Ludhiana was 20 *per cent* and in DH Moga was 50 *per cent*.

ii. Shortfall ranging between 50 *per cent* and 100 *per cent* was seen in 12 test-checked CHCs.

iii. Shortage of drugs was 100 *per cent* in 20[9] PHCs and in three[10] PHCs, shortage of drugs ranged between 86 *per cent* and 93 *per cent.*

The extent of shortage of mental health services at the level of CHCs and shortage of mental health drugs in the health institutions indicated that mental healthcare in the State is a neglected area.

The reply of the State Government was awaited (February 2024).

7.8 National Programme for Healthcare for the Elderly (NPHCE)

The National Programme for Healthcare 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 Citizens.

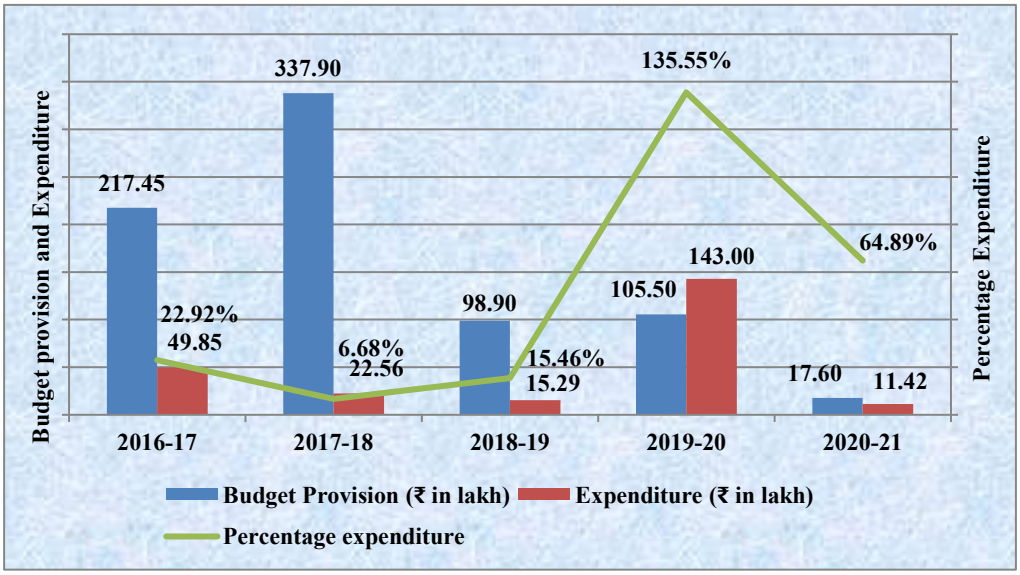
As per the Financial Management Reports (FMR) of NHM, the budget provision and expenditure incurred on National Programme for Healthcare for the Elderly (NPHCE) in the State during the period 2016-17 to 2020-21 is shown in **Chart 7.5**.

[8] PHC Paldi did not produce record.

[9] (i) Mandi Kalan; (ii) Bhai Rupa; (iii) Lehra Mohabbat; (iv) Jodhpur Pakhar; (v) Sanghol; (vi) Bhari; (vii) Nanowal; (viii) Ranjit Bagh; (ix) Behrampur; (x) Dorangala; (xi) Dhianpur; (xii) Ghawaddi; (xiii) Mansooran; (xiv) Otalon; (xv) Sowaddi Kalan; (xvi) Chakowal; (xvii) Possi; (xviii) Mand Mandher; (xix) Patto Hira Singh; and (xx) Malian Wala.

[10] (i) Nandpur Kalour; (ii) Thathi Bhai; and (iii) Sukhanand.

Chart 7.5: Budget provision and expenditure under NPHCE in the State



Source: Information supplied by State Health Society, Punjab

Audit observed that the Government of India had been regularly making budget provision for National Programme for Healthcare of the Elderly (NPHCE) during the year 2016-17 to 2020-21, but NHM had utilised only 22.92 *per cent*, 6.68 *per cent*, 15.46 *per cent* and 64.89 *per cent* in the years 2016-17, 2017-18, 2018-19 and 2020-21 respectively whereas in 2019-20, expenditure was incurred in excess of the budget provision.

Keeping in view the increasing life expectancy, focused approach needs to be adopted for geriatric care.

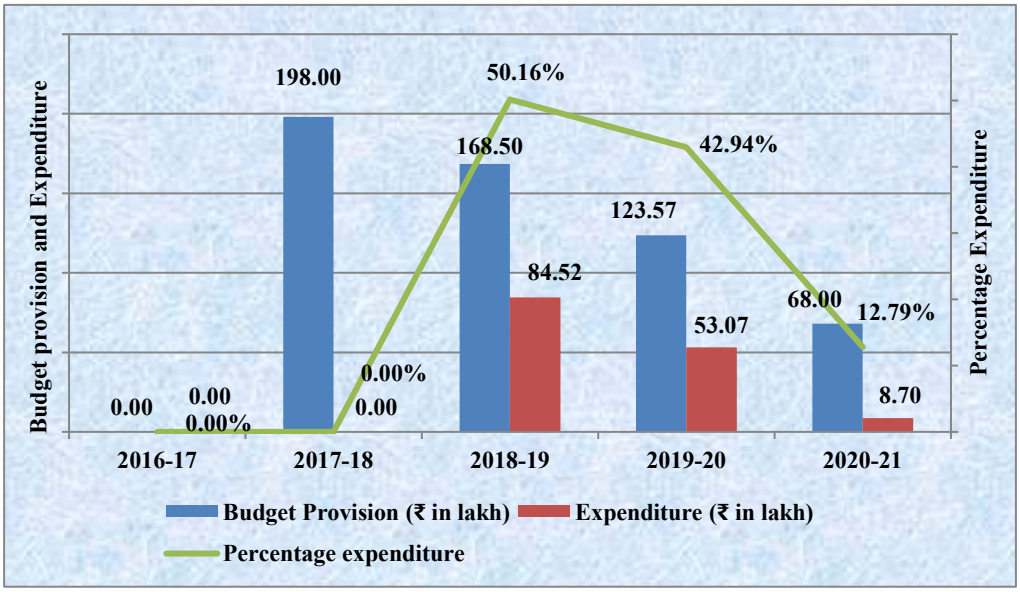
The reply of the State Government was awaited (February 2024).

7.9 National Tobacco Control Programme (NTCP)

Government of India launched the National Tobacco Control Programme (NTCP) in the year 2007-08, with the aim to - (i) create awareness about the harmful effects of tobacco consumption; (ii) reduce the production and supply of tobacco products; (iii) ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA); (iv) help the people quit tobacco use; and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control.

As per Financial Management Report (FMR), the budget provision and expenditure incurred on National Tobacco Control Programme (NTCP) by NHM, Punjab is shown in **Chart 7.6**.

Chart 7.6: Budget provision and expenditure under NTCP in the State



Source: Information supplied by State Health Society, Punjab

Audit observed that the Government of India had been regularly making budget provision for NTCP, but NHM had incurred expenditure which ranged between 12.79 *per cent* and 50.16 *per cent* only during the year 2018-19 to 2020-21 whereas no expenditure was incurred against budget provision of ₹ 198.00 lakh during 2017-18.

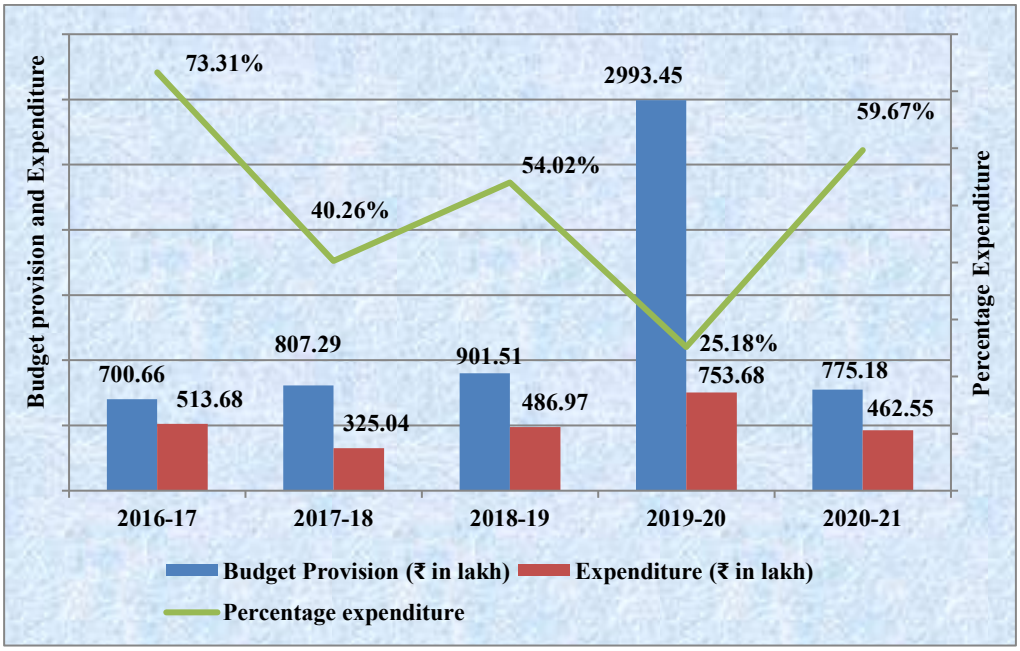
The reply of the State Government was awaited (February 2024).

7.10 National Programme for Control of Blindness

The National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100 *per cent* centrally sponsored programme with the goal of achieving a prevalence rate of 0.3 *per cent* of the population. The four-pronged strategy of the programme is: strengthening service delivery, developing human resources for eye care, promoting outreach activities and public awareness and developing institutional capacity.

As per Financial Management Report (FMR) of NHM Punjab, budget provision and expenditure incurred on National Programme for Control of Blindness (NPCB) by NHM, Punjab during the period 2016-17 to 2020-21 is shown in **Chart 7.7.**

Chart 7.7: Budget provision and expenditure under NPCB in the State



Source: Information supplied by State Health Society, Punjab

Audit observed that the Government of India had been regularly making budget provision for National Programme for Control of Blindness (NPCB) during the year 2016-17 to 2020-21, but the expenditure by NHM ranged between 25.18 *per cent* and 73.31 *per cent* only during the years 2016-17 to 2020-21.

The reply of the State Government was awaited (February 2024).

7.11 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NHM being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. For pregnant women of below poverty line (BPL) and those belonging to the Scheduled Castes (SC)/Scheduled Tribes (ST) going to a public health institution for delivery, entire amount of ₹ 700 and ₹ 600 for rural and urban areas respectively should be disbursed in one go, at the health institution. Moreover, ₹ 500 was to be given for home deliveries of BPL and SC/ST pregnant women. The mother and the ASHA (wherever applicable) should get their entitled money at the health centre immediately on arrival and registration for delivery.

The number of deliveries under JSY and incentive paid to beneficiaries during the period 2016-2022 as provided by the test-checked districts is shown in **Table 7.9**.

Table 7.9: Incentive paid under JSY during the period 2016-2022 in test-checked districts

Name of district	Number of deliveries under JSY	Number of beneficiaries to whom incentive under JSY was paid	Number of beneficiaries to whom incentive under JSY was not paid
Bathinda	17,709	13,469	4,240
Fatehgarh Sahib	14,505	4,493	10,012
Gurdaspur	19,959	16,375	3,584
Hoshiarpur	29,580	23,248	6,332
Ludhiana	31,329	31,329	0
Moga	16,816	15,241	1,575
Total	**1,29,898**	**1,04,155**	**25,743**

Source: Information supplied by the respective District Family Welfare Officers

Audit observed that out of 1,29,898 beneficiaries, cash assistance was not provided to 25,743 beneficiaries (20 *per cent*) in five districts. The main reasons for disbursement of less cash assistance were non-deposit of JSY Card, non-providing of bank details and other supporting documents by the beneficiaries.

The reply of the State Government was awaited (February 2024).

7.12 Immunisation of children

Immunisation is an important and effective health intervention for children. Vaccines have been so effective that some diseases that were once feared are now either eradicated or easily manageable. Yet, in the recent past many new diseases are emerging too. This makes immunisation of a child even more important. Target/achievement in immunisation against DPT, TT10 and TT16 of children of five years to 16 years age in the State is given in **Table 7.10.**

Table 7.10: Target/achievement in immunisation of children aged 5 years to 16 years

Year	DPT		TT10		TT16		Achievement (%)		
	Target	Achievement	Target	Achievement	Target	Achievement	DPT	TT10	TT16
2016-17	4,48,000	4,02,360	4,82,000	3,01,266	5,26,000	2,33,828	90	63	44
2017-18	4,52,000	3,91,814	4,86,000	3,05,893	5,31,000	2,41,274	87	63	45
2018-19	3,94,358	3,84,955	4,97,600	2,99,549	5,97,800	2,45,091	98	60	41
2019-20	4,38,800	3,79,849	5,01,545	3,17,861	6,02,534	2,59,440	87	63	43
2020-21	4,41,802	3,82,150	4,62,220	2,71,704	4,84,220	1,99,232	86	59	41
2021-22	4,41,690	3,44,311	5,07,780	2,30,095	6,10,000	1,66,640	78	45	27

Source: Information furnished by DH&FW, Punjab

Audit observed that achievements against the targets of Diphtheria Pertussis Tetanus (DPT) Booster II up to 5 years children ranged from 78 *per cent*

to 98 *per cent*, Tetanus Toxoid 10 (TT 10) for 10 years children ranged from 45 *per cent* to 63 *per cent* and TT 16 for 16 years children ranged from 27 *per cent* to 45 *per cent* during the period 2016-17 to 2021-22. This indicated the dismal performance of immunisation in the State, particularly for TT 10 and TT 16.

The reply of the State Government was awaited (February 2024).

7.13 Conclusion

Inadequacies in identification and mapping of needs of vulnerable population resulted in projection and tailoring of National Schemes to State/local requirements. Various inconsistencies were noticed in implementation of Centrally Sponsored Schemes under NHM as it was seen that MHTs were functioning with inadequate staff strength in six test-checked districts which adversely affected the screening of children. Only two out of 27 essential medicines/drops/ointments were available with MHTs despite having been prescribed by GoI. Health institutions aspiring to achieve Kayakalp status were significantly on a lower side and NQAS certified health institutions also did not show steady growth. DEICs were also inadequately staffed and construction of new DEICs was delayed. It was also noticed that funds were not utilised completely on implementation of National Health Programmes under NHM and there was an acute shortage of drugs for mental health problems. Besides, achievement against the fixed target for sterilisation and spacing methods was significantly low.

7.14 Recommendations

In light of audit findings, the State Government may consider;

(i) mapping and vulnerability assessment of dependent population to understand the available resources, service gaps and health needs of the urban residents;

(ii) provision of adequate manpower to ensure effective implementation of Rashtriya Bal Swasthaya Karyakram;

(iii) improving the absorptive capacity of National Health Programmes under NHM through proper utilisation of allocated funds;

(iv) motivating health institutions to aspire for achievement of Kayakalp status and NQAS certification; and

(v) Prioritising immunisation of infants.