CHAPTER VII : SERVICES UNDER REPRODUCTIVE AND CHILD HEALTH (RCH)

7.1 Introduction

Reproductive and Child Health Programme-II (RCH-II) was launched in 2005 as a part of the Mission as the principal vehicle for reducing Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and Total Fertility Rate (TFR). Some of the main components of the programme are: care in pregnancy including identification of complications, but excluding management of complications requiring surgery or blood transfusion, all aspects of essential newborn care, care for common illnesses of newborn and children – identify, stabilize and refer life threatening conditions beyond the approved skill sets of the mid- level care provider, immunization, all aspects of prevention and management of malnutrition, excepting those that require institutional care, all family planning services, provision of safe abortion services-medical and surgical and identification and management of anaemia.

7.2 Institutional Deliveries

7.2.1 Target and achievement

As per Framework of Implementation (2005-12), one of the expected outcomes of NRHM at community level was improved facilities for institutional deliveries. In order to motivate women to deliver at health facilities, Janani Suraksha Yojana (JSY) was launched in April 2005 under NRHM as a scheme with the provision for conditional cash transfer to a pregnant woman for institutional care during delivery and the immediate postpartum period. Audit observed:

a) In the 28 States, the percentage of registered pregnant women opting for institutional delivery[1] during 2011-16 ranged from 34 to 98. In six States (**Arunachal Pradesh, Jammu and Kashmir, Manipur, Meghalaya, Uttar Pradesh** and **Uttarakhand**), this percentage was less than 50 with the lowest percentage being recorded in **Manipur** (38) and **Meghalaya** (34). State-wise details are in **Annexure-7.1**.

b) In 14 States of **Andhra Pradesh, Arunachal Pradesh, Chhattisgarh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand[2], Madhya**

[1] Institutional delivery includes deliveries at public and private health facilities.
[2] Figures for 2014-15 only.

Pradesh, Manipur, Meghalaya, Odisha, Punjab, Rajasthan and **Uttarakhand**, there was shortfall against the targets set out for institutional delivery during 2011-16. Shortfalls ranged from 4 to 54 *per cent*, with the highest percentage being recorded in two States of **Arunachal Pradesh (54) and Uttarakhand (52)**. In **Andaman** and **Nicobar Islands, Bihar, Kerala, Mizoram, Sikkim, Tripura** and **West Bengal,** no targets for institutional deliveries were fixed by the respective State Health Societies. During the exit conference, the Ministry stated that though some States have not fixed targets, overall institutional deliveries have significantly increased on account of NRHM.

Audit attempted to ascertain the adequacy of physical infrastructure and service delivery facilities through surveys. It was observed that 161 of the 514 PHCs surveyed under facility survey, did not have the facility for delivery. In **Kerala**, all the selected 12 PHCs and more than 50 *per cent* PHCs in six States of **Himachal Pradesh, Odisha, Tripura, Uttar Pradesh, Uttarakhand,** and **West Bengal,** did not have facility for delivery.

The reasons for shortfall in the institutional delivery as gathered during facility survey were distance of the health facilities from villages, lack of access by public transport, unhygienic surroundings of the centres, etc.

7.2.2 Antenatal Care

One of the major interventions under NRHM is to register all the pregnant women within 12 weeks or 1st trimester of pregnancy and provide them services, such as four antenatal check-ups (ANC)[3], 100 Iron Folic Acid (IFA) tablets, two doses of Tetanus Toxoid (TT) vaccine, proper diet and vitamin supplements. Audit observed:

(a) Registration and Checkups

In twenty States **(Andhra Pradesh, Arunachal Pradesh, Bihar, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Punjab, Rajasthan, Sikkim, Telangana, Tripura, Uttar Pradesh, Uttarakhand,** and **West Bengal),** complete data of ANCs was not maintained.

[3] 1st ANC - at the time of registration during first trimester, 2nd ANC - during 20-24 weeks of pregnancy, 3rd ANC – during 28-32 weeks of pregnancy, 4th ANC – during 34-36 weeks of pregnancy.

In four States viz. **Assam, Gujarat, Jammu and Kashmir** and **Tamil Nadu,** registered pregnant women received lesser number of ANCs as given in **Annexure-7.2**.

In **Arunachal Pradesh**, as per the information provided by SHS, all the 1,56,905 registered pregnant women in the State during 2011-16, received the first ANC at the time of registration. However, in four selected districts, Audit observed that only 8,694 (20 *per cent*) of the 42,701 registered pregnant women, got ANC at the time of registration.

In **West Bengal**, as of March 2016, 18 *per cent* of PHCs were yet to start ANC clinics.

Facility survey by Audit disclosed:

Out of 2,380 health facilities (DH-123, CHC-300, PHC-514, and SC-1,443) in 29 States/UT, 167 facilities (DH-1 CHC-9, PHC-86 and SC-71), did not have the facility for ANC. The percentage of health centres which did not have facility for ANC was significantly higher in five States - **Arunachal Pradesh** (SC-65 and DH-25), **Nagaland** (SC-17), **Odisha** (CHC-19 and PHC-53), **West Bengal** (PHC-41) and **Tripura** (PHC-29).

Proper documentation of this vital component was non-existent in 20 out of 28 States/UT. Resultantly, the facilities were unable to track the actual administration of ANCs vis-à-vis the requirements or take corrective measures. Audit observed that shortage of ANM and Health Workers and staff nurses in SCs, PHCs and CHCs were one of the major limiting factors in this regard.

(i) Iron Folic Acid

Under NRHM, 100 IFA tablets are to be provided to all the registered pregnant women. Audit observed shortfalls in the range of 3 to 75 *per cent* in all the 28 States/UT during 2011-16. In 11 States/UT **(Andaman and Nicobar Islands, Andhra Pradesh, Gujarat, Haryana, Jammu and Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Meghalaya, Rajasthan** and **Tamil Nadu),** more than two *per cent* of the registered pregnant women were found to have severe anaemia[4], with the highest in **Jammu and Kashmir** (6.11), **Haryana** (3.92) and **Karnataka** (3.6), as given in **Annexure-7.3.**

[4] In severe anaemia, the haemoglobin count is less than 7 g/dl whereas in anaemia, it is less than 11 g/dl.

In **Andaman and Nicobar Islands**, records indicated that more than 100 IFA tablets had been given to registered pregnant women during 2013-14, 2014-15 and 2015-16 which ranged between 204 and 664 *per cent*. Importantly, the cases of severe anaemia increased from 1.33 *per cent* in 2014-15 to 2.75 *per cent* in 2015-16.

In **Tripura**, 21 to 62 *per cent* pregnant women did not receive 100 IFA tablets during 2011-12 to 2015-16. Audit observed that 54.4 *per cent* pregnant women were suffering from anaemia in **Tripura**, the highest (60.6 *per cent*) being recorded in North Tripura District.

The Ministry replied that the issue of shortfall of IFA distribution is an implementation issue and pertains to the concerned State governments as Ministry merely allocates funds as per state demand/request as per the prescribed guidelines. However, the fact remains that the guidelines of giving 100 IFA tablets was not being always adhered to and there were large number of cases of anaemia.

(ii) Tetanus Toxoid Immunisation

In four states (**Arunachal Pradesh, Jammu and Kashmir, Manipur** and **Meghalaya**), less than 50 *per cent* of pregnant women were immunized with both TT1 and TT2 while in six states (**Chhattisgarh, Haryana, Jharkhand, Rajasthan, Tripura** and **West Bengal**), the figure ranged between 50 to 80 per cent.

In **Haryana,** in the selected district of Bhiwani, the percentage of pregnant women receiving both doses of TT vaccine decreased from 94 to 57 during 2015-16 as compared to 2011-12. In **Uttarakhand**, in Pauri district, 39 *per cent* and 40 *per cent* of pregnant women were not immunized by TT1 and TT2 respectively.

Separate data for each of the two doses of TT immunization was not maintained by **Mizoram**, and, therefore the actual number of pregnant women, who had not received both the doses, remained unascertainable.

The Ministry stated that a single dose of TT is sufficient to provide complete immunization against tetanus in a pregnant woman provided that she has been vaccinated with TT within past three years and most of the pregnant women fall in this category. The contention of the Ministry is not correct in the absence of verifiable data at the facility level in this regard.

(b) Home deliveries attended to by Skilled Birth Attendant (SBA)

Since any pregnancy can develop complications at any stage, timely provision of obstetric care services is extremely important for management of such cases and as such, every pregnant woman needs to be taken care of by SBA during pregnancy, childbirth and the post-partum period.

Test check of records of selected Type 'A' Sub Centres of 120 districts of 28 States/UT revealed that in ten States of **Assam, Bihar, Chhattisgarh, Jharkhand, Odisha, Punjab, Rajasthan, Sikkim, Tripura and Uttar Pradesh,** 50 to 80 *per cent* home deliveries were not attended to by SBAs. In four other States **(Haryana, Kerala, Meghalaya** and **West Bengal),** more than 80 *per cent of* home deliveries were not attended to by SBAs. In 38 selected SCs of **Jammu and Kashmir**, none of the home delivery cases were attended to by SBAs during 2011-16 due to their shortage. The Ministry replied that the States are being continuously advised through video conferences, monitoring visits, etc., to address these issues.

7.2.3 Post-natal care

As per guidelines of RCH-II, most obstetric complications and maternal deaths occur during delivery and in the first 48 hours after childbirth. This makes the intra-partum period (defined as labour, delivery and the following 24 hours) a particularly critical time for recognising and responding to obstetric complications and seeking emergency care to prevent maternal deaths. The best way to do so is to maximise facility based deliveries or skilled attendance during home births in 'difficult to reach areas', referring women to emergency care in case of complications and monitoring mothers in the postpartum period.

(a) New-borns visited by Health Worker/ASHA within 24 hours

Test check of records of selected Type 'A' Sub centres of the 120 districts of 28 States/UT revealed that more than forty *per cent* of new-borns were not visited by health worker within 24 hours of the home delivery in **Jharkhand, Madhya Pradesh, Manipur, Mizoram, Odisha, Rajasthan, Sikkim** and **Uttar Pradesh**. In **Sikkim,** the figure was significantly higher at 85 *per cent*. Data relating to visits to new-borns was not maintained in Muzaffarnagar, Budaun and Jaunpur districts of **Uttar Pradesh**.

7.2.4 Referral Services

To ensure accountable health delivery, NRHM aims to establish referral chain from village to hospital i.e. assured referral linkages either through Government/public-private partnership model for timely and assured referral

to functional PHCs/FRUs in case of complications during pregnancy and child birth.

In four States of **Arunachal Pradesh, Assam, Manipur, and Meghalaya**, audit observations in providing referral services, are given in **Table-7.1** below:

Table-7.1: State-wise audit observations in providing referral services

Sl No.	Name of State	Comments
1.	Arunachal Pradesh	In none of the selected 31 SCs, 11 PHCs and 6 CHCs of the selected districts, register for referral cases were maintained.
2.	Assam	In only 67 *per cent* of complicated cases referred, ambulance was provided.
3.	Manipur	In all the five selected PHCs, vehicles were not provided for referral service depriving the beneficiaries of the intended benefits.
4.	Meghalaya	Only four out of seven functional FRUs in six districts were equipped with blood bank/storage facility.

7.2.5 Deliveries with obstetric complications

In Tamil Nadu and **Kerala,** deliveries with obstetric complications were observed in 21 and 19 *per cent* cases respectively. In nine other States of **Assam, Chhattisgarh** (position for selected districts only), **Haryana, Jammu and Kashmir, Meghalaya, Odisha, Punjab, Sikkim,** and **West Bengal,** more than ten *per cent* of such deliveries were observed. Data for the same was not provided by the states of **Gujarat** and **Tripura.** In 13 States/UT (**Andaman and Nicobar Islands, Haryana, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Meghalaya, Odisha, Punjab, Sikkim, Uttarakhand** and **West Bengal),** audit observed an increasing trend of obstetric complications over the years. Details are given in the **Annexure-7.4**.

7.2.6 Infant Mortality Rate, Maternal Mortality Ratio and Total Fertility Rate

The Ministry in its documents 'Framework of Implementation (2005-2012)' and 'Framework of Implementation' of the Mission (2012-17)' laid down the outcome indicators including IMR, MMR and TFR and framed time specific targets for their achievement. Similarly, targets with respect to these outcome indicators have also been specified in the Millennium Development Goals (MDG) outlined by the United Nations in the year 2000. A comparison of the outcome indicators in both documents is given below in **Table-7.2**:

Table-7.2 : Outcome indicators

Sl. No.	Framework of Implementation (2005-2012)	Framework of Implementation (2012-17)	Millennium Development Goals (2015)
1.	Infant Mortality Rate (IMR) reduced to 30/1,000 per 1,000 live births by 2012.	Reduce IMR to 25/1,000 live births	Reduce IMR to 27 per 1,000 live births
2.	Maternal Mortality Ratio (MMR) reduced to 100 per 1,00,000 live births by 2012.	Reduce MMR to 100/1,00,000 live births	Reduce MMR to 109 per 1,00,000 live births
3.	Total Fertility Rate (TFR) to 2.1 by 2012.	Reduce TFR to 2.1	

The data of Statistical Reports of Sample Registration System (SRS) 2013 and 2014 of Office of the Registrar General of India shows the following position[5]:

- **IMR** - Against the target for reduction of IMR to 27 per 1,000 live births by 2015, as per MDG, the IMR was 39 deaths per 1,000 live births as per data of SRS 2014. IMR was higher than 40 in six States of **Assam** (49), **Bihar** (42), **Chhattisgarh** (43), **Madhya Pradesh** (52). **Odisha** (49) and **Uttar Pradesh** (48).

- **MMR** – Against the target for reduction of MMR to 109 per 1,00,000 live births, the MMR was at 167 in 2011-13 as per SRS 2013. MMR was higher than 200 in nine States of **Assam** (300), **Bihar** (208), **Chhattisgarh** (221)**, Jharkhand** (208), **Madhya Pradesh** (221), **Odisha** (222), **Rajasthan** (244), **Uttar Pradesh** (285) and **Uttarakhand** (285).

- **TFR** - Against the target of reduction of TFR to 2.1 by 2012, TFR was beyond 2.1 in nine States of **Assam** (2.3), **Bihar** (3.2), **Chhattisgarh** (2.6), **Gujarat** (2.3), **Haryana** (2.3), **Jharkhand** (2.8), **Madhya Pradesh** (2.8), **Rajasthan** (2.8) and **Uttar Pradesh** (3.2), as per SRS 2014.

Thus, the goals have only been partially achieved.

[5] As per para 1.4 of Chapter-I of India Country Report 2015 of Ministry of Statistics and Programme Implementation, the difficulties faced while statistically tracking the MDGs in the country, are mainly a) Issues of data gaps, b) non-availability of annual data updates, c) irregular periodicity of National Family Health Survey and d) incomplete coverage of the population.

7.3 Janani Suraksha Yojana

To encourage institutional delivery, a scheme 'Janani Suraksha Yojana (JSY)' was launched to provide all pregnant women with cash assistance ranging from ₹ 500 to ₹ 1400. The cash assistance[6] was to be provided to the mother in one go at the health centre immediately on arrival and registration for delivery. In the case of home delivery, disbursement was to be done at the time of delivery or around seven days before the delivery by ANM/ASHA/any other link worker. Audit observed:

7.3.1 Payment of cash assistance to beneficiaries

In six States **(Himachal Pradesh, Karnataka, Punjab, Rajasthan, Sikkim,** and **West Bengal),** 40 *per cent* or more of the beneficiaries did not receive cash assistance under JSY**.** In six States (**Assam, Haryana, Jammu and Kashmir, Manipur, Odisha** and **Uttarakhand**), cases of delayed payments of cash assistance for the period 2011-16, ranging up to 11 to 1,366 days were observed. In **Bihar**, 12,925 cheques amounting to ₹ 1.73 crore were not delivered to beneficiaries. Similarly, in **West Bengal**, 37 to 59 *per cent* of beneficiaries did not receive payments made by cheque as many of them did not have bank accounts. The state level data relating to the eligible women under JSY and payments made to them, was not maintained/provided by 10 States of **Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Haryana, Jammu and Kashmir, Jharkhand, Meghalaya, Mizoram** and **Odisha.**

In **Bihar**, out of 10 selected DHSs, in one DHS of Munger, the number of mothers to whom cash assistance was paid was more than the number of institutional deliveries (including C-section) carried out each year. During 2011-16, against 1,05,980 deliveries, cash incentives were paid to 1,18,703 beneficiaries, indicating possible misappropriation of funds.

In **Uttarakhand**, in four health facilities at (a) DH Chamoli, (b) Government Combined Hospital, Kotdwar, (c) CHC, Joshimath, Chamoli and (d) PHC, Narayanbagar, payment of JSY cash assistance was made to unauthorized persons in 6,648 (47 *per cent*) cases. In **Assam** 3,863 cases of payment of JSY money to persons other than the beneficiaries, were observed.

[6] Direct Benefit Transfer (DBT) mode of payment has been started with effect from 1.1.2013

7.3.2 Other financial irregularities

The target group of JSY aimed to cover all pregnant women belonging to the BPL household to enable them to deliver in health institutions. As per the scheme guidelines, the cash assistance of ₹ 700 under JSY is admissible only to mothers of BPL families who were from rural areas in High Performing States like **Kerala**. SHS, Kerala had extended (March 2012) the benefit of ₹ 700 to "all women who are delivering in government hospitals" irrespective of their BPL/APL status. SHS made changes in the scope and targeted group for JSY cash assistance without obtaining the approval of State and Central Governments.

The Ministry accepted the audit observation and stated that the State has been asked to explain the reason for this irregular practice.

7.4 Immunization

7.4.1 Vitamin A solution

RCH-II programme advocated providing Vitamin A solution for all children less than three years of age. In most states however, the administration of Vitamin A solution was erratic with shortfalls of more than 50 *per cent*.

7.4.2 Short supply/wastage of vaccines

In **Assam**, during November 2014, 55,000 vials (5,50,000 doses) of Pentavalent vaccine were shipped by Serum Institute of India Ltd., Pune. The shipment was received at Guwahati in December 2014 in a damaged condition. However, the damaged vials (12000 doses) costing ₹ 15.51 lakh had not been replaced till August 2016.

In **Uttar Pradesh**, vaccines to various districts were in short supply by 17 to 72 *per cent*. The major shortfalls in supply were in the case of BCG[7] (20-57 *per cent*) and Hepatitis (33 to 95 *per cent*). Significant excess consumption of Hepatitis (68 *per cent*), DPT (54 *per cent*) and BCG (43 *per cent*) vaccines over the prescribed norms with the possibility of their mis-utilisation was observed.

[7] Bacillus Calmette–Guérin

7.4.3 Availability of cold chain equipment

All vaccines are very sensitive either to heat or freezing. To maintain these vaccines at the prescribed range of temperature, cold chain equipment like Ice Lined Refrigerator (ILR), Deep Freezers (DF), vaccine carriers, etc., are provided from time to time by Government of India to the State.

Audit observed that the cold chain facility was inadequate in the selected districts in the four states as detailed below**:**

- In **Arunachal Pradesh**, in all the selected four DHs, six CHCs and 11 PHCs, walk-in-coolers and walk-in-freezers were not available. Ice Lined Refrigerators were not available in two out of 11 PHCs. In one CHC and two PHCs, out of six CHCs and 11 PHCs respectively, deep freezers were not available.

- In **Assam**, in 11 out of 30 PHCs of the state, no cold chain equipment was found to store vaccines and in four out of these 11 PHCs, vaccine carrier was also not found available. In three PHCs, though freezer and logistics were available but generator facility was not available.

- In **Himachal Pradesh**, in four, out of 12 selected PHCs, facility of cold chain was not available.

- In **Uttar Pradesh**, in eight, out of the 28 selected CHCs, the required temperature record book to record the temperature maintained in deep freezer and ice lined refrigerator was not maintained.

7.4.4 Infant diseases

Audit observed increasing trend in the incidence of infant diseases like diptheria, neonatal tetanus and whooping cough cases in the seven States as detailed below:

- Increasing trend of diphtheria cases from 70, 26 and 32 in 2011-12 to 6,795, 171, and 600 in 2015-16 was seen in the States of **Andhra Pradesh, Rajasthan and Telangana** respectively**. In Madhya Pradesh**, out of 762 cases of diphtheria during the period 2011-16, 486 cases pertained to 2012-13.
- 46, 45 and 52 cases of neonatal tetanus were seen in the state of **Madhya Pradesh** during the year 2011-12, 2012-13 and 2013-14 respectively.

- An increasing trend of whooping cough was seen from 'nil' case in 2011-12 to 463 cases in 2014-15 in the state of **Haryana**, from 137 in 2013-14 to 756 cases in 2015-16 in the state of **Karnataka,** from 25 in 2011-12 to 152 in 2015-16 in **Rajasthan.** Out of the 72 cases of whooping cough during 2011-16 in **Meghalaya**, 43 pertained to 2015-16.

7.5 Family Planning

As per framework for implementation of NHM (2012-17) meeting unmet needs for contraception through provisioning of a range of family planning methods was to be prioritized.

7.5.1 Availability of facility for sterilisation

As per facility survey of 300 CHCs, 121 (40 *per cent*) did not have the facilities for tubectomy and vasectomy. In **Andaman and Nicobar Islands, Kerala, Manipur, Meghalaya, Nagaland** and **Tripura,** none of selected CHCs had the facility for tubectomy and vasectomy. In **Arunachal Pradesh** (83 *per cent*), **Assam** (62 *per cent*), **Chhattisgarh** (75 *per cent*)**, Gujarat** (62 *per cent*), **Haryana** (57 *per cent*), **Himachal Pradesh** (50 *per cent*), **Madhya Pradesh** (67 *per cent*) and **Punjab** (50 *per cent*), did not have the facilities for tubectomy and vasectomy.

7.5.2 Poor participation of male sterilization in terminal methods

The proportion of male sterilisation (vasectomy) to total sterilization was only 2.3 *per cent* in 28 States/UT indicating gender imbalances. State wise performance showed that in **Mizoram**, only one vasectomy had been performed out of total 9,251 sterilization operations. Percentage of vasectomy to the total sterilization was less than one *per cent* in seven States/UT of **Andaman and Nicobar Islands, Arunachal Pradesh, Bihar, Gujarat, Karnataka, Meghalaya** and **Tamil Nadu,** it was between one to four *per cent* in 10 States (**Andhra Pradesh, Kerala**, **Maharashtra, Odisha, Rajasthan, Telangana, Tripura, Uttar Pradesh, Uttarakhand** and **West Bengal**). State-wise details are in **Annexure-7.5**.

7.5.3 Payment of incentive for sterilization cases and cash compensation for failure/death cases following sterilization

The guidelines provide for payment of incentive as compensation for loss of wages to persons who undergo sterilisation in the range of ₹ 600 to ₹ 1,100. Audit observations relating to two states are given below in **Table-7.3**:

Table-7.3: Discrepancies in payment of incentive for sterilisation

Sl. No.	Name of State	Comments
1.	Chhattisgarh	In the DH Bilaspur, though the rates for compensation for female and male sterilization were revised from ₹ 600 and ₹ 1,100 to ₹ 1,400 and ₹ 2,000 respectively with effect from November 2014, the compensation at revised rates were not paid to the beneficiaries which led to short payment of ₹ 2.91 lakh.
2.	Uttar Pradesh	In 10 selected districts, 2,462 beneficiaries who had undergone sterilization operation during 2015-16, were not paid cash incentive of ₹ 40.57 lakh.

Compensation on account of failure of sterilization/major complications/ death following sterilization

Under the Family Planning Indemnity Scheme, States/UTs would process and make payment of the claims to the beneficiaries of sterilization in the event of death ₹ 50,000 (in case of death within 8-30 days from the date of discharge from the hospital) and ₹ 2.00 lakh (in case of death within 7 days from the date of discharge from the hospital inclusive of death during process of sterilization)/ failure (₹ 30,000)/ complications (₹ 25,000). Audit observations in respect of three states of **Bihar, Jammu and Kashmir** and **Odisha** are given below in **Table-7.4**:

Table 7.4: Compensation on account of failure of sterilization/major complications/death following sterilization

Sl. No.	Name of State	Comments
1.	Bihar	During 2011-15, in 106 cases, compensation to the beneficiaries was not paid.
2.	Jammu and Kashmir	Against 157 cases of failure of male and female sterilization during 2011-16, 29 cases for compensation were recommended

Sl. No.	Name of State	Comments
		by the committee constituted for the purpose. Out of these 29 cases, compensation was paid in only seven cases.
3.	Odisha	Out of 6.44 lakh sterilization cases (Tubectomy, Vasectomy/NSV) conducted during 2011-16 (up to February 2016), 3,964 cases of failure/major complication/death were reported. As of August 2016, compensation of ₹ 2.98 crore had been paid to only 1,038 cases (26 *per cent*).

7.6 Rashtriya Bal Swasthya Karyakram (RBSK)

7.6.1 Introduction

RBSK was launched in February 2013, with the aim of screening over 27 crore children from 0 to 18 years for 4 'D's *viz.* Defects at birth, Diseases, Deficiencies and Development delays including disability. The children diagnosed with illnesses shall receive follow up including surgeries at tertiary level free of cost under NRHM. Examination of records in the Ministry showed the following:

7.6.2 Partial establishment of DEICs

The programme envisaged establishment of District Early Intervention Centre (DEIC) at the District Hospital to provide referral support to the children detected with health problems during health screening. Overall 393 DEICs had been approved in 675 districts in the country. Of this, only 92 DEICs were in position as of 2015-16. State-wise analysis of this data revealed the following position:

1) In 325 districts in 10 non-NE high focus States[8], only 18 DEICs (6 *per cent*) were approved and were in position. Six States of **Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Rajasthan and Uttar Pradesh** did not have DEICs.

2) Similarly, against 95 districts in eight NE States[9] of **Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim** and **Tripura**, 52 DEICs were approved and only three DEICs (3 *per cent*) were in position. Six States of **Arunachal Pradesh, Assam, Manipur, Meghalaya, Nagaland** and **Tripura** had no DEICs.

[8] Bihar, Chhattisgarth, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand.

[9] Aruanchal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura.

3) In 232 districts in 11 non-high focus States[10], only 69 DEICs (3 *per cent*) out the total approved were in position. Four States of **Karnataka, Punjab, Tamil Nadu** and **Telangana,** did not have DEICs.

7.6.3 Inadequate Mobile Health Teams

As per scheme guidelines, for children in the age group 6 to 18 years, at least three dedicated Mobile Health Teams in each Block will be engaged to conduct screening of children. Out of 17,016 mobile health teams required (5,672 x 3) for 5,672 blocks in the country (except **Kerala**), only 12,036 teams were approved, against which 9,315 teams (55 *per cent*) were in position during 2015-16 as detailed below:

- In respect of 10 non-NE high focus States (excluding **Himachal Pradesh**), out of 8,439 mobile teams required for covering 2,813 blocks, 5,823 teams were approved and 4,432 teams (53 *per cent*) were in position during 2015-16. In **Rajasthan**, no team was in position. Shortage of more than 50 *per cent* in availability of mobile health teams was noticed in **Chhattisgarh** and **Jharkhand**.

- In respect of eight NE States, out of 1,587 mobile teams required for covering 529 blocks, 581 teams were approved and 540 teams (34 *per cent*) were in position during the year 2015-16. Shortage of more than 50 *per cent* in availability of mobile health teams was noticed in **Arunachal Pradesh, Assam, Manipur, Mizoram, Nagaland, Sikkim** and **Tripura**.

- The position in 11 non high focus States (except **Telangana**) was better as against requirement of 6,870 mobile teams required for covering 2,290 blocks, 6,385 teams were approved and 5,406 teams (79 *per cent*) were in position during the year 2015-16. In **Andhra Pradesh**, no team was in position.

7.6.4 Incomplete coverage of anganwadi centres and schools

As per scheme guidelines, the screening of children in the age group of 6 weeks to 6 years in the anganwadi centres should be conducted at least twice a year and at least once a year for school children to begin with by the dedicated Mobile Health Teams.

[10] Andhra Pradesh, Goa, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana and West Bengal.

Out of 16,21,258 anganwadi centres in the country as of August 2016, screening was conducted once only in 9,80,178 (60 *per cent*) of the anganwadi centres.

Out of 14,71,189 Government and Government aided schools in the country, only 6,93,174 schools (47 *per cent*) were covered.

Conclusion

The assessment of delivery of services under various parameters under RCH such as antenatal care, institutional deliveries, administration of Iron and Folic Acid tablets, vitamin supplements, immunization, etc., revealed shortfalls. 161 of the 514 PHCs surveyed under facility survey, did not have the facility for delivery. The reasons for shortfall in the institutional delivery were distance of the health facilities from villages, lack of access by public transport, unhygienic surroundings of the centres, etc. In selected Sub Centres of 120 districts of 28 States/UT, in ten States, 50 to 80 per cent home deliveries were not attended to by Skilled Birth Attendants. All these deficiencies translate into higher IMR, MMR and TFR. The data of services provided at various facilities was poorly maintained. Deficiencies were also noticed in the implementation of JSY. All point to lack of internal controls at all levels.

Recommendations:

- IEC activities should be improved, so that the public is encouraged to adopt institutional delivery.
- Data for all type of services should be maintained at all healthcare facilities.
- Adequate distribution of IFA tablets and complete administration of TT vaccine to all pregnant women should be ensured by each healthcare facility.
- Attendance of SBAs should be ensured in all home deliveries.
- Timely payment of JSY incentive to each entitled beneficiary should be ensured.