Executive Summary

Introduction

The National Rural Health Mission (NRHM) was launched in April 2005 with the objective of providing accessible, affordable and quality health care to the rural population, especially the vulnerable sections. The Reproductive and Child Health (RCH) programme is a primary sub-component of NRHM and aims at improving the health outcome indicators viz., Infant Mortality Rate and Maternal Mortality Ratio, also mentioned in the Millennium Development Goals. The key features to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resource management, rigorous monitoring and evaluation against standards.

Why did we conduct this performance audit?

NRHM was earlier reviewed between April and December 2008 covering the period 2005-06 to 2007-08; the audit findings were incorporated in the C&AG's Report No. 8 of 2009-10. Audit observed various deficiencies in fund flow management, planning and monitoring, community participation, convergence, infrastructure development and capacity building, procurement and supply of medicines and equipment, IEC (information, education and communication) activities, achievements in healthcare etc. The expenditure on the programme was ₹ 1,06,179 crore during 2011-16. Considering the substantial investment in the programme and as RCH indices were pursued under the Millenium Development Goals for laying the foundation for a healthy mother and child, it was decided to take up the performance audit of the Reproductive and Child Health under NRHM to review its progress. This performance audit covered the period from 2011-12 to 2015-16.

Main findings

(A) Fund Management

(i) Financial management at both Central and State levels was not satisfactory with substantial amounts persistently remaining unspent with the State Health Societies at the end of each year. In 27 States, the unspent amount increased from ₹ 7,375 crore in 2011-12 to ₹ 9,509 crore in 2015-16**.**

(Para: 2.2)

(ii) Funds amounting to ₹ 5,037.08 crore and ₹ 4,016.37 crore released in 2014-15 and 2015-16 to the State treasuries were transferred to State Health Societies with delays ranging from 50 to 271 days.

(Para: 2.3)

(iii) In six States **(Andhra Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Telangana** and **Tripura)**, ₹ 36.31 crore was diverted to other schemes.

(Para: 2.4)

(B) Availability of Physical Infrastructure

(i) The shortfall in the availability of Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) in the 28 States/UT, ranged between 24 and 38 *per cent*. The shortfall was more than 50 *per cent* in five States **(Bihar, Jharkhand, Sikkim, Uttarakhand** and **West Bengal).**

(Para: 3.1)

(ii) Survey of 1,443 SCs, 514 PHCs, 300 CHCs and 134 District Hospitals (DHs) countrywide revealed that some of these were functioning in unhygienic environment and/or were inaccessible by public transport. Other infrastructural issues such as poor condition of the buildings, non-availability of electricity and water supply, non-availability of separate wards for male and female beneficiaries, labour room not being functional, etc., were observed in a number of SCs, PHCs, CHCs and DHs.

(Para: 3.2 and Para: 3.3)

(iii) Shortfall in construction of SCs, PHCs in 25 States and CHCs in 17 States ranged between 32 to 44 *per cent*. In four States **(Kerala, Manipur, Mizoram** and **Uttar Pradesh)**, 400 works costing ₹ 2,207.67 crore were awarded on nomination basis. In five States **(Assam, Gujarat, Jammu and Kashmir, Karnataka** and **Manipur)**, 22 works were dropped/abandoned due to various reasons such as absence of clear title of land, site issues etc.

(Para 3.4)

(iv) In 20 States **(Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Jammu and Kashmir, Jharkhand, Kerala, Madhya Pradesh, Manipur, Maharashtra, Mizoram, Odisha, Rajasthan, Tamil Nadu, Telangana, Tripura, Uttar Pradesh, Uttarakhand** and **West Bengal)**, 1,285 works, though completed, were not commissioned or made functional.

(Para 3.4.5)

(C) Availability of Medicine and Equipment

(i) In 17 States (**Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Meghalaya, Punjab, Rajasthan, Tamil Nadu, Telangana, Tripura, Uttarakhand** and **West Bengal**), 428 equipment (ultrasound, X-ray, ECG, cardiac monitors, auto analyzer, incinerator, OT equipment, blood storage unit etc.) costing ₹ 30.39 crore were lying idle/unutilised due to non-availability of doctors and trained manpower to operate the equipment, lack of adequate space for their installation, etc.

(Para: 4.3)

(ii) In 24 States (**Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Odisha, Punjab, Rajasthan, Sikkim, Tamil Nadu, Telangana, Tripura, Uttar Pradesh, Uttarakhand** and **West Bengal**), instances of non-availability of essential drugs were observed. In eight of these States, essential medicines/ consumables such as Vitamin-A, contraceptive pills, ORS packets, RTI/STI[1] drugs, essential obstetric kits, etc., were not available in selected health facilities.

(Para: 4.5)

(iii) In 14 States **(Assam, Bihar, Haryana, Jharkhand, Karnataka, Kerala, Maharashtra, Manipur, Odisha, Punjab, Telangana, Tripura, Uttar Pradesh** and **West Bengal)**, medicines were issued to patients without ensuring the prescribed quality checks and without observing the expiry period of drugs, thus exposing the patients to health risks.

(Para: 4.6)

(iv) Mobile Medical Units were not operational in four States of **Chhattisgarh, Himachal Pradesh, Mizoram** and **Uttar Pradesh** while these were partially operational in 10 States of **Bihar, Gujarat, Haryana, Jammu and Kashmir, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Odisha** and **Tripura.**

(Para: 4.7)

(v) High percentage of 3,588 Accredited Social Health Activists (ASHAs) surveyed did not have disposable delivery kits and blood pressure monitors.

(Para: 4.9)

[1] RTI-Reproductive Tract Infection, STI-Sexually Transmitted Infection.

(D) Availability of Human Resources

(i) Shortages of doctors and paramedical staff were observed in almost all selected facilities, compromising the quality of health care being administered to the intended beneficiaries. In the selected CHCs of 27 States, the average shortfall of five types of Specialists (General Surgeon, General Physician, Obstetrician/Gynaecologist, Paediatrician and Anaesthetist) ranged between 77 to 87 *per cent*. In selected 236 CHCs in 24 States/UT, only 1,303 nurses were posted against the required 2,360.

(Para: 5.1 and Para 5.4)

(ii) In 13 States **(Andhra Pradesh, Arunachal Pradesh, Assam, Chhattisgarh, Haryana, Himachal Pradesh, Karnataka, Madhya Pradesh, Odisha, Punjab, Rajasthan, Uttar Pradesh** and **Uttarakhand)**, 67 PHCs were functioning without any doctor.

(Para: 5.5)

(iii) In 13 States **(Andhra Pradesh, Chhattisgarh, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Rajasthan, Sikkim, Tripura, Uttar Pradesh** and **Uttarakhand)**, ANM/Health Worker (Female) was not posted in 80 SCs (10 *per cent*). Similarly, Health Workers (Male) were not posted in 749 SCs (65 *per cent*) in 22 States.

(Para: 5.6)

(E) Quality of Health Care

(i) The institutional framework for implementation of National Quality Assurance Programme (NQAP) was either not in place or was not effective in assuring quality of services across all levels viz. national, state, district and facility.

{Para: 6.1.1 (A), (B) and (C)}

(ii) Out of 716 facilities in 19 States, internal quality assurance team was constituted in only 308 facilities (43 *per cent*). In 541 health facilities of 15 States, the system of periodic internal assessment was formulated only in 114 (21 *per cent*) facilities.

{Para: 6.1.1 (D)}

(iii) Key Performance Indicators (KPIs) were not monitored in 267 facilities of eight States (**Arunachal Pradesh, Andhra Pradesh, Himachal Pradesh, Jharkhand, Mizoram, Telangana, Uttarakhand** and **Uttar Pradesh).** Out of 411 facilities in 10 States, only 79 facilities (19 *per cent*) monitored the KPIs.

{Para: 6.1.1 (D) (iv)}

(iv) In 18 States, against the requirement of ₹ 132.83 crore, reflected in State Programme Implementation Plans during 2013-16, ₹ 85.64 crore was allocated. States were not able to utilize even the allocated amount with the spending remaining low at ₹ 42.89 crore.

(Para: 6.1.5)

(v) Shortfalls, ranging from 29 to 100 *per cent,* in holding of meetings by the monitoring committees at State level (State Health Mission and State Health Society) were noticed.

(Para: 6.2)

(F) Services under Reproductive and Child Health

(i) In 20 out of 28 States, non-maintenance of records of administration of Antenatal Checkups (ANCs) of pregnant women was noticed.

(Para: 7.2.2 (a)

(ii) Shortfalls in administration of Iron Folic Acid tablets were noticed in all the 28 States. Similarly, in four states (**Arunachal Pradesh, Jammu and Kashmir, Manipur** and **Meghalaya**), less than 50 *per cent* of pregnant women were immunized with both doses of Tetanus Toxoid vaccine (TT1 and TT2).

(Para: 7.2.2 (a) (i) and (ii)

(iii) Against the target of Infant Mortality Rate (27 per 1,000 live births) to be achieved by 2015 as per the Millenium Development Goals, the achievement was 39. IMR was higher than 40 in the six States of **Assam** (49), **Bihar** (42), **Chhattisgarh** (43), **Madhya Pradesh** (52). **Odisha** (49) and **Uttar Pradesh** (48).

(Para: 7.2.6)

(iv) Against the target of Maternal Mortality Ratio (109 per 1,00,000 live births) to be achieved by 2015 as per the Millenium Development Goals, the achievement was 167. 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).

(Para: 7.2.6)

(v) Deficiencies were noticed in the implementation of Janani Suraksha Yojana, such as non-payment of incentive to beneficiaries, delayed payment to beneficiaries, payment to 12,723 excess number of beneficiaries, etc.

(Para: 7.3.1)

(G) Data Collection, Management and Reporting

(i) During 2015-16, about 13,000 facilities did not report data on Health Management Information System (HMIS). In the absence of reporting by all the facilities, the overall position on health indicators remained unascertainable.

(Para: 8.3.1 (i)

(ii) Audit observed significant discrepancies in the data as reported in HMIS vis-à-vis the information available as per basic records/registers in the selected health facilities of 14 States.

(Para: 8.3.3)

(iii) There was no adequate computerization, networking and human resources in the selected facilities. As a result, the facilities had to upload the reports on HMIS portal from the district headquarters or the nearest internet accessible area. This resulted in delayed availability or non-availability of data.

(Para: 8.5)

(iv) The prescribed records for Health Management Information System (HMIS) were either not maintained or poorly maintained in most of the selected health facilities. As a result of inadequate reporting and poor record management across all states, the quality of data reported in HMIS was erroneous and unreliable.

(Para: 8.6)

(v) Analysis of HMIS data revealed that for some major RCH parameters, the achievement shown was more than hundred *per cent*, such as number of pregnant women who availed the benefit of ANC, immunisation, was more than the number of pregnant women registered. The data was, therefore, unreliable.

(Para: 8.8.1)

(vi) 14 to 64 *per cent* of the health facilities were not reporting infrastructure data on HMIS for 2015-16 due to which the MIS reports failed to present a comprehensive picture.

(Para: 8.9.1)

(vii) 8 to 12 *per cent* of the data fields were not filled up by various health facilities making the data reporting under MIS reports unreliable.

(Para: 8.9.2)

Summary of important recommendations:

i. Funds flow management should be rationalised keeping in view the absorptive capacity of State Health Societies. The Ministry should monitor and maintain the details of interest earned on the unspent balances by these societies to ensure better utilization of funds.

ii. Ministry may ensure that all civil works are reviewed by concerned authorities in all States in the light of extant rules for removing the delays/impediments and ensure faster completion and commissioning of buildings.

iii. Availability of all essential drugs and equipment should be ensured at all health facilities. Mobile Medical Units and ambulances should be made fully operational and equipped with the required manpower and equipment.

iv. The Ministry should scrupulously follow up with States to ensure that the sanctioned posts of health care professionals are filled up to meet the NRHM requirements.

v. The Ministry and the States should secure compliance with the operational guidelines for quality assurance at all levels. Assessment of health facilities on the defined parameters should be documented and reviewed on a consistent basis for taking appropriate follow up action. Provision for monitoring the implementation of National Quality Assurance Programme may be made in the Health Management Information System. The Ministry/State governments need to strengthen the monitoring mechanism at all levels.

vi. IEC activities should be improved, so that the public is encouraged to adopt institutional delivery. Adequate distribution of IFA tablets and complete administration of TT vaccines to all pregnant women should be ensured by each healthcare facility.

vii. The Ministry should formulate a clearly documented organizational structure with identified positions for data management responsibilities. A documented and structured training programme for the personnel involved in data recording, reporting, aggregation, verification and feeding should be put in place. The reliability of data in HMIS by providing for proper validation controls at all levels should be improved. A mechanism for verification of data before uploading on the HMIS should be incorporated.