EXECUTIVE SUMMARY

1. Background

The National Rural Health Mission (NRHM) was launched in April 2005 to provide accessible, affordable, accountable, effective and reliable healthcare facilities in the rural areas of the entire country especially to poor and vulnerable sections of the population. The key strategy of the NRHM was to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, and provide an overarching umbrella to the existing disease control programmes run by the Ministry of Health and Family Welfare. The Union Cabinet, while approving the Framework for Implementation of the NRHM in July 2006, provided a considerable degree of delegation of financial and administrative powers to the Mission. The Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) were authorised to modify norms of approved schemes. The MSG was also empowered to approve financial norms in respect of all schemes and components that were part of NRHM. Though the Mission was launched in April 2005, the Cabinet's approval of the Framework for Implementation of the NRHM in July 2006 effectively provided the impetus for accelerating the Mission's activities.

The cutting edge of the Mission's programme and activities lies in the States and its success would, to a large measure, be closely linked to the effectiveness of the State Health Societies in implementation of the activities envisaged under the Mission. While the Ministry is ultimately responsible for providing the overall policy framework, guidance and acting on feedback, its efforts need to be complemented in equal measure by the States.

The Mission seeks to initiate key changes in the health sector, varying from the encouragement and development of planning capacity and community participation to an emphasis on convergence with other indicators of a 'good' life - safe drinking water, sanitation etc. The long-running disease control programmes have been brought under a more cohesive implementation structure and Indian Public Health Standards guiding infrastructure and facilities established.

2. Audit scope and methodology

The performance audit on implementation of the NRHM was conducted during April-December 2008 in the Ministry of Health and Family Welfare, State Health Societies (SHS) of 33 States/UTs, District Health Societies (DHS) of 129 districts and 2369 health centres at block and village levels covering the period from 2005-06 to 2007-08. The purpose of undertaking the performance audit of the implementation of activities under the Mission is to highlight the positive trends and developments, while simultaneously pointing out possible areas of weakness or shortcomings in field-level operations that could hinder progress towards achievement of the Mission's overall goals.

3. Planning and monitoring

The NRHM initiated decentralised bottom-up planning. This, however, had been hindered by non-completion of household and facility surveys and State specific perspective plans. In nine States, district level annual plans were not prepared during 2005-08 and in 24 States/UTs block and village level annual plans had not been prepared at all. The results of the outsourcing of plan preparation had been mixed, with district plans outsourced to private agencies in eight States not being prepared in time. The Mission would, in the next few years, need to emphasise strongly on generating planning capacities, as this was a basic building block for all subsequent top-down health interventions.

4. Community participation

While the Mission places considerable emphasis on decentralisation by developing a novel framework of community participation in planning and monitoring, the initial phase of establishing and orienting committees at various levels was yet to be completed. Village level health and sanitation committees were still to be constituted in nine States. The Rogi Kalyan Samitis (RKS) formed at many health centres, aiming at community ownership of healthcare delivery systems, were characterised by weak or absent grievance redressal mechanisms, outreach and awareness generation efforts. The broad guidelines on the RKS issued by the Ministry left sufficient flexibility to States to ensure the committee's effective functioning tailored to local conditions. However, no RKS in any State/UT received all the stipulated central grants. In 13 States/UTs, the Samiti failed to generate internal resources, while in the remaining States no mechanism existed to monitor the generation of a third of the RKS funds from internal resources as prescribed. Funds for local action through untied grants and annual maintenance grants to health centres remained mostly unspent and there was a need to generate greater awareness on the importance of their effective utilisation. The structure of the Mission also requires more cohesion – with the mainstreaming of health societies at the State and district levels not having fully taken place.

5. Convergence

The NRHM adopted an intersectoral convergence approach to healthcare by seeking to synergise women and child development, hygiene and sanitation, public works and panchayati raj institutions in planning and execution. However, the committee on intersectoral convergence under the chairmanship of the Mission Director did not meet frequently and the follow up action on its instructions was not monitored. This had meant that efforts at convergence required strengthening. The participation of Non-Governmental Organisations (NGOs) in the Mission's activities had not been facilitated and their contribution towards capacity building and service delivery was not effectively monitored. 71 per cent of the districts countrywide were yet to be covered under the Mother NGO scheme. The Ministry is now seeking to revise guidelines to ensure more effective NGO participation in the Mission.

6. Funds flow management

A significant development is the increase in outlays on public health in recent years, both at the Centre and in the States. During the period 2005-06 to 2007-08, the total outlay/expenditure on the NRHM was Rs. 24,151.45 crore. During the first two years the Centre was contributing 100 *per cent* of the funds. Thereafter, the States were to contribute 15 *per cent* of funds during the 11th Five Year Plan (2007-12). However, many of the States were yet to contribute their share to the Mission and this issue needs to be addressed. Many high focus States where diseases are endemic and health indicators poor, were however, receiving relatively lesser central grants, as high unspent balances of previous years remained, indicating that capacity building needs to be focussed on. Release of funds to the State Societies and consequently to district and block levels required further streamlining to ensure prompt and effective utilisation of funds. Funds advanced by the SHSs to lower level formations continue to be treated as expenditure by the SHS, regardless of whether these have actually been utilised. The practice of equating release with expenditure and short accountal of unspent balances had meant that Reproductive and Child Health (RCH) Flexi-pool funds of Rs. 862.61 crore had been released to States/UTs in excess. Various existing programmes such as the Empowered Action Group Scheme, RCH-I and National Maternity Benefit Scheme had been closed down with the initiation of the NRHM, but the unutilised balances under these programmes had not been settled and remained with States. The Ministry's efforts at e-banking suffered from some delays and most States were yet to adopt e-banking.

7. Infrastructure development and capacity building

The Mission has developed the Indian Public Health Standards (IPHS) to assist health centres improve their quality of health care and thus upgrade the capacity of the health delivery system. However, the ratio of population to health centres remained low with the targeted number of new health centres not being established. Basic facilities (proper buildings, hygienic environment, electricity and water supply etc.) were still absent in many existing health centres with many Primary Health Centres (PHCs) and Community Health Centres (CHCs) being unable to provide guaranteed services such as inpatient services, operation theatres, labour rooms, pathological tests, X-ray facilities and emergency care etc. While the Mission had renewed focus on capacity building and infrastructure development, much remains to be done. During 2005-07, Rs. 720.20 crore was released to the SHSs for upgradation of CHCs to IPHS without receiving proposals and plans of action and consequently, most funds remained unspent. The quick-response Mobile Medical Units, meant to take medical care to the patient's doorstep in far flung regions, had not been operationalised in many States even though substantial funds had been released for the purpose.

The innovative practice of engaging Accredited Social Health Activists (ASHAs) has had a positive impact on taking healthcare to and enhancing awareness of the patient. However, the shortage of service providers at different levels in different States/UTs continues to pose a challenge. While contract workers have been engaged to fill vacancies, there are still shortages of specialist doctors at CHCs, adequate staff nurses at CHCs/PHCs and Auxiliary Nursing Midwife (ANMs) / Multi-purpose Worker (MPWs) at Sub Centres.

8. Procurement and supply of medicines and equipment

While the Ministry had set up an Empowered Procurement Wing (EPW) and developed a comprehensive procurement manual centrally, in 26 States/UTs, no procurement manual had been prepared. Neither was a formulary list of drugs available nor was standard bid documents adopted in 13 States. Inadequate procurement planning also effected equipment utilisation in the States with Rs. 3.96 crore of equipment lying unutilised in six States. Cold chain equipment worth Rs. 10.43 crore and telemedicine facility equipped Mobile Medical Units on which Rs.10.72 crore had been spent, remaining non-functional due to lack of supporting infrastructure in Jharkhand. In nine States, the stock of essential drugs, contraceptives and vaccines adequate for two months consumption as required under norms were not available in any of the test checked PHCs and CHCs.

9. Information, education and communication

The Ministry had diversified its Information, Education and Communication (IEC) efforts, but the expenditure remained centralised. The importance and potential of localised efforts and simple mass-media (theatre, audio etc.) to sustain direct communication with the rural population at the block and village level had not been explored fully.

10. Achievements in healthcare

The increased patient inflow at PHCs and CHCs and improved institutional deliveries and immunisation were an indicator of the Mission's positive impact on healthcare delivery. However, it was evident that sustained efforts were still required, since a majority of registered pregnant women were still not using the health centres for institutional delivery, particularly in Empowered Action Group (EAG) States where cases of delayed payments and irregularities characterised the implementation of the Janani Suraksha Yojana (JSY). Micro birth plans and MCH cards for registered pregnant women, which were essential for the implementation and monitoring of the JSY and ensuring post-natal care, were not prepared in most states. No proper mechanism for collection and reporting of data on maternal and neo-natal deaths was seen in the audited districts of 17 States.

The SHS did not prescribe year wise targets for various terminal methods of family planning in 15 States/UTs, and there were shortfalls as high as 62 per cent in coverage in another 11 States. Vasectomy accounted for only four per cent of total sterilisation cases.

Targets for immunisation were fixed on an ad hoc basis in 15 States/UTs and despite higher rates of immunisation, the incidence of infant and child disease increased in nine States. In the audited districts of 22 States/UTs there was a shortfall in the administration of the first and second doses of vitamin A due to the drug's short supply at health centres. Despite holding two National Immunisation Days, six Special National Immunisation Days (and additional rounds in selected districts of Bihar and Uttar Pradesh), 1640 new polio cases had been detected in 17 States/UTs during 2005-08.

Quality control in programmes remained important as in spite of a complete ban on cataract surgery in camps under the National Programme for Control of Blindness

(NPCB), in 14 States/UTs 19.52 lakh cataract surgeries were performed in camps, which was 47 per cent of the total cataract surgeries in these States.

The targeted rate of 10 percent of annual blood examinations under the National Vector Borne Disease Control Programme had not been achieved in 11 States and the Annual Parasitic Incidence for Malaria was higher than the stipulated rate of less than 0.5 per thousand in all the three years in 14 States/UTs.

Despite the launch of the National Iodine Disorder Disease Control Programme (NIDDCP) in 1992 and the NRHM's focus on controlling deficiency-generated diseases, the programme suffered from an inadequacy of staff and IDD labs. Under the Integrated Disease Surveillance Project, the Centre was receiving reports from only 58 per cent of all districts and the inordinate delay in setting up of laboratories was adversely affecting the Project.

11. Conclusion

Yet, it is important to remember that health programmes played a preventive and ameliorative role and there was progress where programmes were implemented with an emphasis on proper coverage and quality. If the NRHM could bring greater cohesiveness to the implementation of various programmes, then the impact would be far reaching.

The NRHM's attempt to rejuvenate the healthcare delivery system has succeeded in raising hopes and consequently, demands from the public health system. A focused prioritisation of interventions and adaptability based on feedback from States are necessary to help the Mission deliver on its goals. In this context, key recommendations arising from the performance audit are summarized below:

- *The SHSs and DHSs should expedite the household and facility surveys and prepare State and district perspective plans, reflecting convergent functions of various government departments. The future annual State Programme Implementation Plans (PIPs) and district health plans should be based on long term requirements and results of baseline surveys.*

- *Monitoring framework may be strengthened so as to ensure periodic impact assessment of activities for timely interventions.*

- *The new health centres should be established in the under-served areas. Health infrastructure at CHCs and PHCs must be made functional with all essential infrastructure, equipment and manpower to ensure improvement in quality of healthcare in rural areas at an affordable cost.*

- *States should fill sanctioned posts of medical and support staff at health centres and revise the sanctioned strength to meet the NRHM requirements. Full induction training may be given to all ASHAs to make their services viable and effective.*

- *The RKS may be constituted and registered at all the remaining health centres with priority over other dimensions of community participation. The Samiti should be made a constructive partner in functioning of the health centres and to enable this,*

the accountability structure under the RKS may be clearly defined and management capacity may be generated.

- *Funds flow arrangement should be rationalised to ensure minimum unspent/excess amount is left outside government accounts.*
- *The Ministry should review its interface banking arrangements in consultation with the Ministry of Finance. Interface banking should be preferred with public sector banks having maximum outreach and which offered the best possible terms.*
- *There should be reasonable distribution of funds among various media of communication. IEC strategy and impact assessment should be rationalised with appropriate norms and criteria.*
- *Disaggregated State-wise targets may be set in view of overall targets set by the Ministry for the country and State-wise progress may be measured on the basis of disaggregated targets and data. The opportunity to consolidate real-time data captured by ANM and health workers may be made use of.*
- *The monitoring and reporting mechanism under Janani Suraksha Yojana should be strengthened so as to ensure availability of reliable information with the State and District Health Societies. This would help mitigate the risk of fraud and irregularities in grant of cash compensation under the JSY. The Ministry may emphasise that nodal personnel encourage data integrity under JSY at the Ministry and SHS level.*