CHAPTER 1: INTRODUCTION

1.1 Background

The National Rural Health Mission (NRHM) was launched on 12 April, 2005 throughout the country with special focus on 18 States, viz. eight Empowered Action Group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand), eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices. The aim of the Mission is to provide *accessible, affordable, accountable, effective and reliable* healthcare facilities in the rural areas of the entire country, especially to the poor and vulnerable sections of the population. The key strategy of the NRHM is to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programmes and Integrated Disease Surveillance Project. It also addresses the issue of health in the context of a sector wide approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health and advocates convergence with related social sector departments such as Women and Child Development, AYUSH, Panchayati Raj etc.

The NRHM seeks to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. The Mission envisages increasing expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2-3% of GDP over the mission period (2005-2012).

1.1.1 Objectives of the programme

The main objectives of the NRHM are:

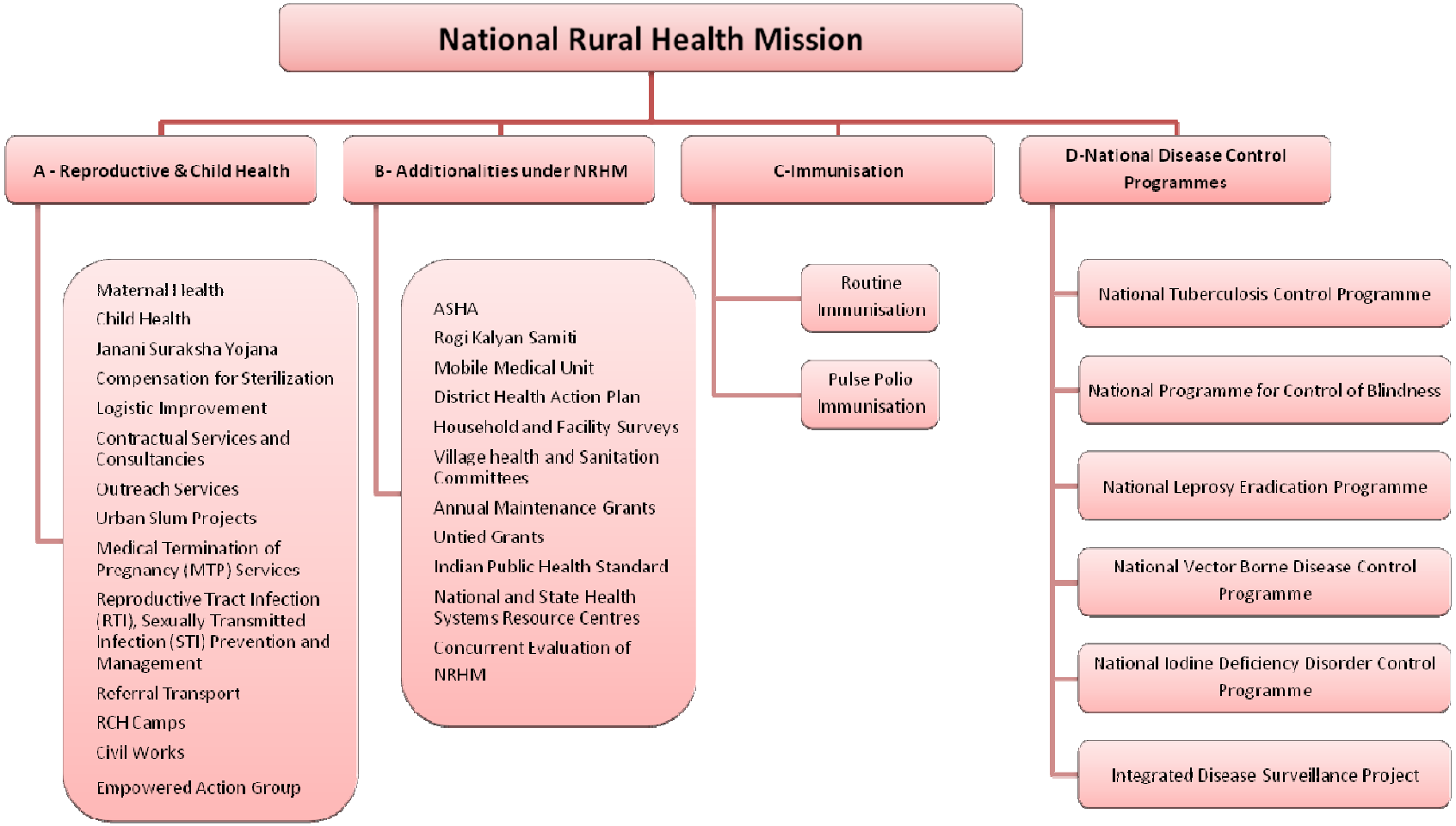
- Reduction in child and maternal mortality;
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Access to integrated comprehensive primary health care;
- Population stabilization, gender and demographic balance;
- Revitalize local health traditions & mainstream AYUSH; and
- Promotion of healthy life styles.

1.1.2 Organisational structure

1.1.2.1 Central level

At the national level, NRHM is led by a Mission Steering Group (MSG) headed by the Union Minister of Health and Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health and Family Welfare. The

Programmes covered under NRHM



MSG was empowered to approve financial norms in respect of all schemes and components which were part of NRHM. The EPC had the flexibility to change financial norms approved by the MSG within a range of (+) 25 *per cent*. The MSG and the EPC were required to periodically monitor progress of the Mission.

Besides, a Mission Directorate has been set up at the Central level for planning, implementation and monitoring of the mission activities and day-to-day administration. The Directorate is headed by a Mission Director at the level of Additional Secretary to the Govt. of India. Under the Mission Directorate, there were three Joint Secretary level officers during the period of audit.

Besides, the programmes of family welfare amalgamated into the NRHM such as the Reproductive and Child Health – II (RCH-II) and Immunisation – Routine and Pulse Polio are headed by the respective Joint Secretaries under the overall control of the Secretary, Health and Family Welfare. The various programmes for disease control such as National Vector Borne Disease Control Programme, Revised National Tuberculosis Control Programme, National Programme for Control of Blindness, National Leprosy Eradication Programme, National Iodine Deficiency Disorder Control Programme and Integrated Disease Surveillance Project are administered through respective Programme Divisions headed by Director/Deputy Director General and function under the overall control of the Director General of Health Services. The disease control programme divisions were reporting to the Mission Director through their respective Joint Secretaries.

1.1.2.2 State level

At the State level, the NRHM functions under the overall guidance of the State Health Mission (SHM), headed by the Chief Minister. The activities under the Mission are carried out through the State Health Society (SHS), which was formed by integrating all the societies set up for the implementation of various disease control programmes. The Governing Body of the Society, headed by Chief Secretary/Development Commissioner of the State, meets at least once in every six months. The Executive Committee of the SHS, headed by Principal Secretary/Secretary, H&FW meets at least once in every month. For administrative convenience, the States may constitute Programme Committees for various National Programmes for more focused planning and review of each activity. The State Programme Management Support Unit (SPMSU) acts as the Secretariat to the State Health Mission as well as the State Society and is headed by an Executive Director/Mission Director. The SPMSU has experts in technical areas like CAs, MBAs and MIS Specialists etc.

1.1.3 Financial inputs and fund flow arrangements

1.1.3.1 Financing pattern

Funds are released by the Central Government to the States through two separate channels, i.e. through State Finance Departments and directly to the different Societies/ State Health Society (SHS). The funds routed through the State Finance Departments are released quarterly depending on the norms prescribed for various activities under these schemes, based on infrastructure available in the States.

The funds are provided to SHSs on the basis of approval of State Programme Implementation Plans (PIPs) by the Government of India. The States/UTs are required

to reflect their requirements in a consolidated Programme Implementation Plan (PIP) having various sections for individual programmes under parts (a) RCH, (b) Additionalities under NRHM, (c) Immunisation, (d) Revised National Tuberculosis Control Programme (RNTCP), (e) National Vector Born Disease Control Programme (NVBDCP), (f) Other National Disease Control Programmes (NDCPs) and (g) Inter-sectoral issues. During 2005-06 and 2006-07, hundred percent grants were provided to States. From the Eleventh Plan Period (2007-12) States are to contribute 15 *per cent* of the funds required. At the State and District levels, Financial Management Group (FMG) under respective Programme Management Support Unit (PMSU) is responsible for centralised processing of funds releases, accounting for the expenditure reported from the subordinate units, monitoring of Utilisation Certificates and audit arrangements. They are also responsible for collecting, compiling and submitting Statements of Expenditure (SOEs), Financial Management Reports (FMRs), UCs and audit reports from District Health Societies to SHS and from SHSs to GOI. The diagrammatic presentation of funds flow is given in **Annex 1.1**.

1.1.3.2 Budget estimates and expenditure

The budgetary estimates and expenditure under NRHM during 2005-08 were as under (programme-wise details in **Annex 1.2**):

Table1.1: Budget estimates and expenditure

(Rs. in crore)

Year	Budget Estimates	Actual Expenditure
2005-06	7,189.20	6284.58
2006-07	9,000.00	7486.62
2007-08	10,890.00	10,380.25
Total	**27079.20**	**24151.45**

1.2 Audit Objectives

Performance audit was taken up with the objective of verifying whether:

I. The planning of the implementation of the Mission as well as monitoring and evaluation procedures at the level of Village, Block, District, State and Centre were oriented towards its principal objective of ensuring accessible, effective and reliable healthcare to the rural population;

II. There was adequate community participation in planning, implementation and monitoring of the Mission;

III. Convergence and regulation of the Mission activities with other departments, programmes and non-governmental stakeholders was ensured for achieving the broad objectives of the programme;

IV. The public spending on healthcare increased to the desired level as envisaged in the Mission objective/vision. Assessment and release of funds in the decentralized set up and their utilization and accounting was prompt and adequate;

V. Capacity building and strengthening of physical and human infrastructure at different levels took place as planned and targeted;

VI. The procedures and system of procurement of equipment, drugs and services, supplies and logistics management were cost effective, efficient and ensured improved availability of drugs, medicine and services;

VII. The information, education and communication (IEC) programme was implemented in an efficient, cost effective manner and led to increased awareness about preventive aspects of healthcare; and

VIII. The performance indicators and targets fixed specially in respect of reproductive and child healthcare, immunisation and disease control programmes were achieved or the outcomes point towards achieving them.

The findings of Audit with reference to each of the eight objectives of the performance audit have been presented in separate chapters, i.e. Chapter 2 to Chapter 9.

1.3 Performance Indicators/Audit Criteria

The criteria/performance indicators used for the assessment of the performance included: -

- Outcome indicators for reduction/amelioration of disease or at least an assurance of movement in that direction;
- Increase in health care facilities at sub-district levels;
- Increase in number of inpatients and outdoor patients seeking health services;
- Increase in number of institutional deliveries, immunization, family planning cases etc.;
- Decrease in morbidity and mortality due to various diseases;
- Improvement in infrastructure, equipment, supply of medicines, diagnostic services at healthcare facilities at sub-district levels as per Indian Public Health Standards (IPHS);
- Increase in number of personnel providing health care services and management of healthcare facilities;
- Improvement in awareness of health care issues;
- Community planning and participation in management; and
- Compliance with general financial and administrative rules and procedures.

1.4 Scope and Methodology

1.4.1 Scope and coverage of audit

The Performance Audit was carried out during April to December 2008 by examining the documents in the Ministry and in 26 States[1] and seven Union Territories. The period of audit coverage was from April 2005 to March 2008.

1.4.2 Audit methodology

The Performance Audit of the NRHM commenced with an entry conference with the Ministry in April 2008, in which the audit methodology, scope, objectives and criteria were explained. Simultaneously, in each state an entry conference was held by the Accountant General with the Principal Secretary/Commissioner, Health and Family Welfare. The audit methodology mainly consisted of document analysis, responses to audit queries, physical collection and testing of samples. Records relating to the

[1] All states and union territories other than Goa and Nagaland

NRHM were examined:

- by the Director General of Audit, Central Expenditure at the central level in various programme divisions of the Ministry between April 2008 and December 2008.
- by the (Principal) Accountants General (Audit) at the State level (in 26 States and seven UTs) in State Health and Family Departments, State Health Societies, District Health Societies, Community Health Centres, Primary Health Centres and Sub Centres between April 2008 and November 2008.

The Audit observations are based on analysis of information and data collected during the audit, from SHS, DHS and health centres. Audit findings were communicated separately to the State Health and Family Welfare Departments and exit conferences were conducted by the Accountants General with the auditee to discuss audit findings. The results of the performance audit were discussed with the Ministry in an exit conference on 30 September 2009.

1.4.3 Audit Sampling

The performance audit was conducted in 129 districts selected as per the following statistical sampling plan: -

- Each State was divided into various regions on the basis of geographical contiguity and in accordance with the regions outlined in the National Family Health Survey-3.
- Districts were chosen using Probability Proportional to Size with Replacement (PPSWR)[2] independently from various regions with size measure being the total amount of grants-in-aid released to respective District Health Societies during the years 2005-08 from the State.
- In each sample district, three Community Health Centres were selected using Simple Random Sampling without Replacement (SRSWOR).
- In each sample block, two Primary Health Centres were selected using SRSWOR and in each sample PHC, two Sub Centres were selected using SRSWOR.

Thus, in each selected district 3 CHCs, 6 PHCs and 12 Sub-Centres had been audited. State wise list of the selected districts are listed in **Annex 1.3.**

1.4.4 Reporting methodology

The results of audit at both the central and the State level were taken into account in arriving at audit conclusions. While framing the conclusions and recommendations, good practices and positive findings /success stories of programmes have also been reported to illustrate the fact that these can be replicated in other areas of the Mission. **The audit findings, conclusions and recommendations on each stated objective of the Performance Audit have been discussed in the following chapters**.

1.4.5 Acknowledgement

We place on record our sincere appreciation for the cooperation of the Ministry of Health and Family Welfare and State nodal departments in facilitating our audit.

[2] Probability Proportional to Size with Replacement (PPSWR) sampling is cluster sampling where larger clusters have a higher chance of selection. Thus, districts receiving larger amount of grants-in-aid had higher chances of selection.