Executive Summary

Purpose of Audit

National Rural Health Mission (NRHM) was launched in India in April 2005 with a view to providing accessible, affordable and quality health care to the rural population, especially the vulnerable sections. In Assam, NRHM became operational in November, 2005.

Reproductive and Child Health (RCH) is the most important programme under NRHM for improvement of Maternal and Child Health care. Considering the substantial expenditure (₹ 4,461.92 crore) incurred by the State under the programme during 2011-16 and with a view to assess the impact of NRHM on RCH, the Performance Audit (PA) of the programme was taken up. In the PA, efforts of the State Health Mission (SHM) on improving RCH in terms of availability of infrastructure, health care personnel, the quality of health care provided, achievement relating to Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR) and related health information and management system under the programme were reviewed highlighting the areas of concern which need to be addressed for achieving the intended goals.

Results in brief

It was noticed in audit that 98.13 *per cent* children up to one year of age were immunised and 98.57 *per cent* of the target for pulse polio administration was achieved under the programme which was high but 100 *per cent* immunisation to eradicate Polio from the State was yet to be achieved. Increase in institutional deliveries and providing Post Natal Care facility was also seen. The percentage of Pregnant Women (PW) who received 3rd Ante Natal Care (ANC) in the 28 to 32 weeks of pregnancy increased from 71 to 87 *per cent* during 2012-16. The rate of still birth had also reduced simultaneously and came down from 2.55 to 2.05 *per cent*. There were, however, areas of concern like shortfall in infrastructure and health care professionals, 85 *per cent* of home deliveries remained unattended by Skilled Birth Attendant (SBA), PW/mothers had to spend their own money for conducting deliveries in government health centres against the norm of free and no expense delivery, non-achievement of target of reduction in MMR, IMR and TFR and some other related issues which would require action on the part of the NRHM, Assam on priority basis.

Principal findings

- Annual Plans were not prepared by following bottom-up decentralised approach during the period 2011-16. Perspective Plan (PP) identifying gaps in health care facilities, areas of interventions and year-wise resource and activity needs, had not been prepared by the districts test checked and SHM during the Mission period (2005-17).

(Paragraphs: 2.2 and 2.3)

- There was shortfall in yearly utilisation of available funds during 2011-16 (ranged between 21 to 50 *per cent*) under the programme in the State. GoI short released ₹ 2,166.37 crore (₹3,648.03 crore released out of ₹ 5,814.40 crore approved) during 2011-16 due to less utilisation of funds by the State.

(Paragraphs: 3.1 and 3.3)

- There were instances of short release and delay in release of funds by the Government of Assam (GoA). Other financial irregularities such as cases of misappropriation, undue financial aid to contractors, idle expenditure on abandoned works and equipment *etc.*, were also noticed.

(Paragraphs: 3.4, 3.5.6, 3.5.7, 3.6 and 3.7)

- There were shortage of health centres against the requirement as per norms, instances of delay in construction, non-handing over of new health centres were noticed. Health care infrastructure was unevenly distributed with instances of concentration of facilities within the same premises against the norms. In some areas, overburdening of health centres was also observed.

(Paragraphs: 4.1, 4.2 and 4.4)

- Nearly 37 to 70 *per cent* of Maternal and Child Health related calls were attended by '108' Ambulance Service beyond the stipulated time of 30 minutes. Cases of deaths caused due to delay in arrival of Ambulance, were also noticed.

(Paragraphs: 4.8)

- In the outreach areas of Char[1], there was significant shortage of health care facilities. MMR in Upper Assam, predominantly populated with Tea Gardens[2] population, was significantly higher at 404 compared to 301 of State as a whole. In the test checked six blocks covering Tea Garden areas, 38 *per cent* of maternal deaths were from Tea Garden population.

(Paragraphs: 4.10.2 and 4.10.3)

- Instances of shortage of equipment and essential drugs, idle machineries, expiry of drugs, prescribing medicines in brand name *etc.,* were noticed in health centres.

(Paragraphs: 4.11.1, 4.11.3, 4.12.2, 4.12.3, 4.12.4 and 4.12.5)

[1] The riverine areas of the river Brahmaputra are locally known as Char areas.
[2] Inhabitants/ workers of Tea Gardens of the State.

- There was shortage of health care professionals which was coupled with irrational deployment of manpower. There was overall shortage of 567 doctors, 786 Specialist Doctors and 2833 Staff Nurses in the State with reference to Indian Public Health Standards (IPHS).

(Paragraphs: 5.1 and 5.2)

- In the selected health centres, deficiencies were noticed in providing laboratory services, functional health care and other support services besides deficiency in ensuring the infection control practices.

(Paragraphs: 6.2)

- During 2011-16, out of the total deliveries, 16 *per cent* home deliveries were reported and 85 *per cent* of the home deliveries were not attended by the Skilled Birth Attendants (SBA). Besides, numbers of Sub-centres (SCs) were found without availability of SBA and labour table for conducting deliveries.

(Paragraphs: 7.1 and 7.4)

- Complete four ANC check-ups could only be provided to 69.64 *per cent* Pregnant Women (PW) under the programme. There were shortfall in distributing Iron Folic Acid (IFA) tablets and providing Tetanus Toxide (TT) injections to PW. In 35 to 56 *per cent* cases of institutional deliveries, mothers were discharged from hospitals before 48 hours' of mandatory stay under the programme during 2011-16 in the State Government.

(Paragraphs: 7.2 and 7.5)

- PW/mothers had to spend their own money[3] for conducting deliveries in government health centres against the norm of free and no expense delivery. Cases of Adverse Event Following Immunisation[4] were found to be on an increasing trend during 2011-16.

(Paragraphs: 7.7.2 (ii) and 7.10)

- The Health Management Information System (HMIS) which serve as a tool of monitoring the performance of the health systems, was found containing inconsistent and erroneous data and thus, did not represent actual status of implementation for proper monitoring of the programme.

(Paragraphs: 8.4)

[3] ₹ 950 to ₹ 8,100 per delivery.

[4] A medical incidence that takes place after an immunisation, causes concern and is believed to be caused by immunisation.

- The State was lagging behind in achieving the national targets in respect of MMR, IMR and TFR. Instances have been noticed where less reporting of number of maternal and infant deaths was made by the selected districts to the State.

(Paragraphs: 9.2 and 9.3)

Principal Recommendations

- Annual plans should be prepared by following bottom-up decentralised and community-owned approach in order to address the gaps and needs in health care at grass root levels.
- Health centres should be evenly located equipped with rational deployment of health care professionals at easily accessible places to cover the populace in equitable manner.
- Emphasis should be given for improving the health care facilities in Char and Tea Garden areas.
- Quality Assurance Activities by the concerned State level and District level Committees needs to be reviewed as per guidelines and by conducting patient satisfaction survey to ascertain the quality of health care to beneficiaries.
- Effective system of data maintenance and its validation with basic records should be put in place before uploading in the Health Management Information System to make it reliable to monitor the actual progress of performance indicators under the programme.