PAST THE 10-YEAR MARK

NHM'S ROLE IN IMPROVING INDIA'S PERFORMANCE ON MATERNAL AND CHILD HEALTH INDICATORS

INTRODUCTION

Globally there has been an increased focus on concerns related to maternal and child health. First, the **Millennium Development Goals** (MDGs) until 2015, and then the **Sustainable Development Goals** (SDGs) until 2030 where SDG Goal 3 incorporated specific indicators related to maternal and child health into health and well-being to encourage country-wise progress. However, the situation, though improving, remains quite grim in India. The MDG targets for maternal and newborn child health, set to be achieved by 2015, still remain unrealised.

	MMR per lakh live births	IMR per thousand live births	Under-5 mortality per thousand live births	TFR
At present (latest available records)	167	39	49	2.3
MDG 2015 target	109	29	42	-

In 2016, the highest disease burden in India was due to **child and maternal malnutrition**, this being the leading risk factor for health causing 14.6 percent of the country's total disability-adjusted life years DALYs* (PHFI, et al., 2016).

Assessing countries with the highest and lowest coverage rates of 12 interventions and practices to address maternal and child malnutrition (based on data from 2005-2015), **India has the second lowest rank in the category of iron-folic acid supplements received by pregnant women**; and this despite a nation-wide dedicated programme being under operation since the turn of the century.

ACCORDING TO THE GLOBAL NUTRITION REPORT 2017, INDIA HAS THE LARGEST NUMBER OF WOMEN AFFECTED BY ANAEMIA IN THE AGE-GROUP OF 15-49 YEARS.

* *DALYs is the sum of the number of years of life lost due to premature death and a weighted measure of the years lived with disability due to a disease or injury. The use of DALYs to track disease burden is recommended by India's National Health Policy of 2017.*

The **National Rural Health Mission** (NRHM), launched in 2004-05 with an aim to '**address infirmities and problems across primary health care and bring about improvement in the health system and the health status of those who live in the rural areas**', focussed on maternal and child healthcare from the start. This was prioritised as India was an appallingly poor performer on maternal and child health indicators. Under these heads, the main targets under NRHM were reduction in **Infant Mortality Rate** (IMR), **Maternal Mortality Ratio** (MMR) and **Total Fertility Rate** (TFR). In 2013, the primary healthcare service coverage was expanded across the country under the

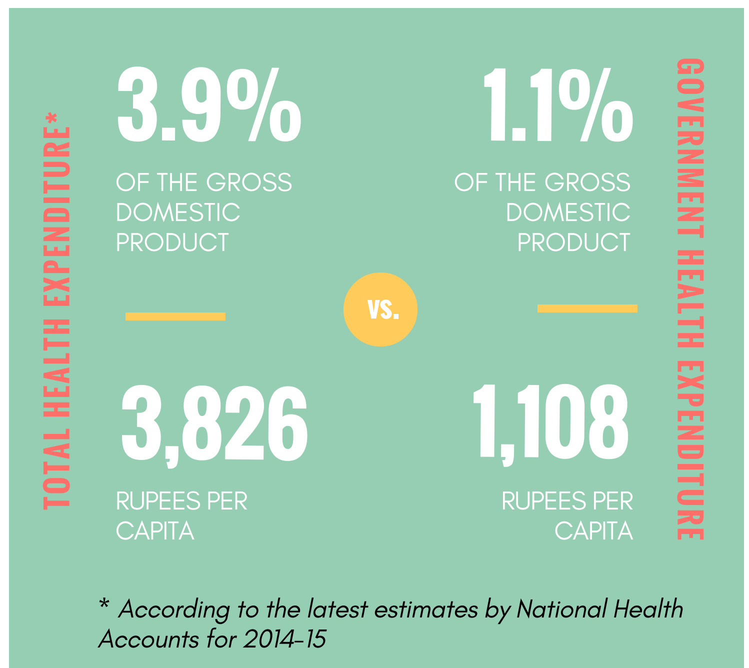
National Health Mission (NHM), which subsumed the NRHM and the National Urban Health Mission (NUHM). The NHM has helped in **overhauling the structure of primary healthcare** in India and laid down processes and procedures in the scheme of **decentralised planning and implementation**. The building up of a cadre of such front-line service providers as Accredited Social Health Activists (ASHAs) is attributable to this flagship programme. The Department of Health and Family Welfare spends the largest amount of its funds on NHM and is now provided through the Treasury route.

In 2017, the **Office of the Comptroller and Auditor General of India** (CAG) assessed the performance of NRHM, especially focusing on its impact on improving reproductive and child health (RCH). The comprehensive performance audit, which covers the period from 2011-12 to 2015-16, touches upon certain specific aspects of the programme such as **financial management, infrastructural facility and quality of health care** and suggests ways to bring about **improvement in programme delivery**.

53%

OF THE DEPARTMENT OF HEALTH AND FAMILY WELFARE'S BUDGET IS SPENT ON NATIONAL HEALTH MISSION

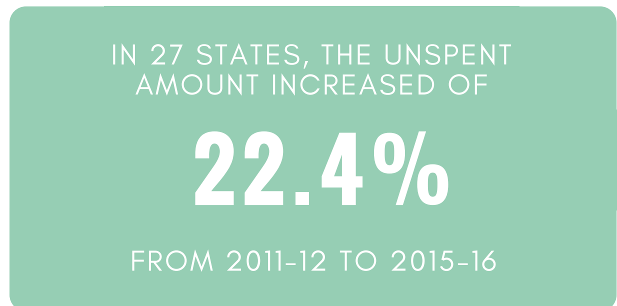
Given that the **out of pocket (OOP) expenditure stands at nearly 63% of the total health expenditure**, there is an urgent need to step up the government spending towards healthcare - both at the level of centre and at the level of states. In addition to increasing the overall quantum of spending, there is also the utilisation and implementation part. The survey conducted by CAG and the observations and field level independent research clearly points towards the fact that, as far as the healthcare sector is concerned, the house needs to be put in order. There is a critical need for smoothing out the anomalies and **less than satisfactory provisioning of healthcare services across states and across facilities**. Priority has to be accorded in plugging the gaps in planning and implementation at all levels of governance.

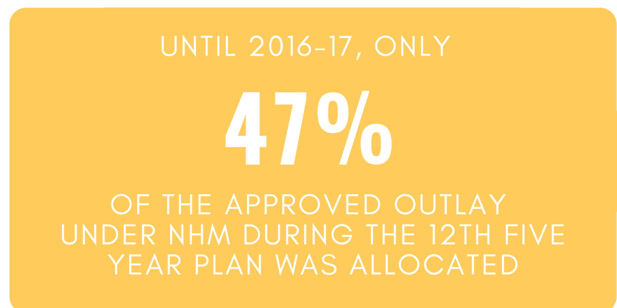


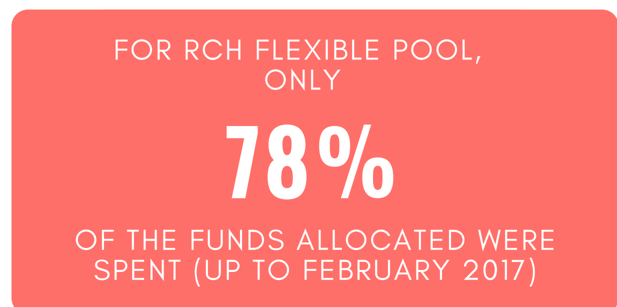
FINANCIAL MANAGEMENT

The financial management under RCH component of NHM was found to be less than satisfactory at both central and state levels. **Substantial amounts persistently remained unspent with the State Health Societies** at the end of each year.

The CAG report observes that substantial unspent balances indicate that funds were released by the Centre without reckoning the absorptive capacity of the concerned states which calls for **rationalising the procedure for release of funds.**







DELAYS IN TRANSFER

For a smooth flow of funds, the structure of NHM consisted of the **State Health Societies** to which funds were directly transferred from the Centre and then to the **District Health Societies** and subsequently to the implementing units. Citing incidence of corruption, the **funds are being routed through the Treasury since 2013-14**. This channel, however, has reportedly resulted in **huge delays in fund transfer**. This evidently has affected the implementation of programmes at the ground level.

DELAYS IN FUND TRANSFER RANGE FROM

50 TO 271

DAYS

DIVERSION OF ALLOCATED PROGRAMME FUNDS

In addition to unspent balances and delays in fund transfer, there is the problem of diversion of funds. According to the operational guidelines, it must be ensured that the funds provided for various programmes are used for the purpose for which they were given and are not mixed with other funds. However, according to the CAG audit, in as many as six states, **funds were diverted to other state schemes**. In addition to these anomalies it was also brought to notice that in some cases the **funds were being released without the approval of Project Implementation Plan** (PIP) of the concerned states which runs counter to the spirit of decentralised planning as envisaged under the programme.

LIMITED CAPACITY TO SPEND

In addition to timely availability of adequate funds, other issues that are crucial for effective service delivery are the existence of sound infrastructure and adequate human resources. As has been well acknowledged in government reports and evident from data the survey of the CAG for NHM found **severe shortages in infrastructure and human resources**.

Shortages in Infrastructure

MORE THAN

50%

SHORTFALL IN THE AVAILABILITY OF SCs, PHCs AND CHCs IN FIVE STATES (AGAINST NORMS SET BY IPHS STANDARDS)

ANOTHER ANOMALY OBSERVED WAS THAT IN SOME NON-TRIBAL AREAS THE AVAILABILITY OF FACILITIES WAS IN EXCESS OF IPHS NORMS BUT DEFICIENT IN TRIBAL AREAS

IN FIVE STATES, IN

65.4%

OF SELECTED FACILITIES, A SHORTFALL IN AVAILABILITY OF INFRASTRUCTURE RESULTED IN COVERAGE OF MORE POPULATION THAN THE PRESCRIBED NORMS

OTHER INFRASTRUCTURAL ISSUES: Facilities with unhygienic environment, inaccessible by public transport or located at a distance of more than three kilometres from the remotest village, poor condition of the buildings, non-availability of electricity and water supply, non-availability of separate wards for male and female beneficiaries, non-functional labour rooms

Shortages in Human Resources

77-87%

IS THE AVERAGE SHORTFALL OF SPECIALISTS* IN THE SELECTED CHCs IN 27 STATES

SHORTAGES OF HUMAN RESOURCES FOR HEALTHCARE COMPROMISES THE QUALITY OF HEALTHCARE FOR THE BENEFICIARIES: MARGINALISED COMMUNITIES COMPLETELY DEPENDENT ON PUBLIC PROVISIONING

IN SELECTED CHCs IN 24 STATES/UTs, ONLY

1,303

NURSES WERE POSTED AGAINST THE REQUIRED 2,360

OTHER HUMAN RESOURCES ISSUES - STAFF QUARTERS

- **SHORTAGE OF STAFF QUARTERS**
- **LOW OR NON-OCCUPANCY OF STAFF QUARTERS -**

Reasons: Non-availability of basic amenities like toilets, electricity, and water supply in the quarters, dilapidated condition of quarters, inconvenient location and non-posting of doctors

** General Surgeons, General Physicians, Obstetricians/Gynaecologists, Paediatricians and Anaesthetists*

LOGISTICS BLOCKS - MEDICINES AND EQUIPMENT

In addition to the shortages of human resources and less than adequate facilities for them, another area of concern is the **non-availability of medicine and equipments and non-utilisation of the available material**. In about 17 states, equipments such as ultrasound, X-ray, ECG, cardiac monitors, auto analyser, incinerator, OT equipment, blood storage units were lying unutilised due to **non-availability of doctors and trained manpower** to operate the equipment, and also **lack of adequate space for their installation**. In selected health facilities across many states, essential medicines/consumables such as vitamin-A, contraceptive pills, ORS packets, RTI/STI drugs, and essential obstetric kits were not available. A high percentage of the ASHAs surveyed did not have disposable delivery kits and blood pressure monitors thermometer, pregnancy kit and weighting scale and medicines such as de-worming pills, paracetamol tablets and iron pills essential for providing basic RCH services.

+ 54%

OF THE ANMs POSTED IN THE AUDITED SCs WERE NOT TRAINED AS SKILLED BIRTH ATTENDANTS (SBAs)

Survey of select healthcare facilities revealed that across many states the prescribed allopathic drugs were not available as per IPHS and as per state list of essential medicines. Also, there were instances found where medicines were issued to patients without ensuring the prescribed quality checks and without observing the expiry period of drugs.

In addition there were other deficiencies noticed in services rendered by the ambulances such as delayed response time and not attending to calls.

+89%

OF FUNDS ALLOTTED FOR THE PROCUREMENT OF AMBULANCES UNDER THE NATIONAL AMBULANCE SERVICE REMAINED UNUTILISED

The **National Quality Assurance Programme** (NQAP) was started in 2013 to ensure an **inbuilt and sustainable quality for public health facilities** that would deliver quality health services. However, it is observed that the institutional framework for implementation is either not in place or is not effective in assuring quality of services across all levels of governance. There were various problems found by the CAG survey such as **non existence of internal quality assurance team, no system of periodic internal assessment, non-monitoring of Key Performance Indicators** (KPIs), and **gaps in meetings by the monitoring committees** at state level.

Quality of implementation was also assessed by CAG audit for specific programmes. For instance, under the **Janani Suraksha Yojana** (JSY), there were such issues as **non-payment of incentive** to beneficiaries and **delayed payment** to beneficiaries. In some cases, payment to 12,723 excess beneficiaries had been made. Shortfalls were also observed in terms of **antenatal care** (registration and check-ups, iron folic acid administration and tetanus toxoid immunisation).

SHORTFALLS IN THE **ADMINISTRATION OF IRON FOLIC ACID** (IFA) TABLETS IN ALL THE 28 STATES

IN FOUR STATES, **LESS THAN 50% OF PREGNANT WOMEN** WERE IMMUNISED WITH BOTH DOSES OF **TETANUS TOXOID VACCINE**

RECORDS OF ADMINISTRATION OF ANTENATAL CHECK-UPS OF PREGNANT WOMEN NOT MAINTAINED IN 20 OUT OF 28 STATES

CONCLUSION

The Parliamentary Standing Committee Report (2017) observed that **RCH is a critical area of intervention for the maternal and child health** and therefore it is imperative that the funds allocated are made an effective policy tool and used gainfully and optimally. It has also noted that there is a **crucial need for the states to increase investment towards reproductive and child healthcare**, and the **higher devolution** recommended by the Fourteenth Finance Commission could be utilised towards **filling the resource gaps of the states**. For this, it has been recommended by the Committee that the Centre devises and ensures arrangements for the states to step up their funding for RCH.

Thus, in addition to ensuring that adequate resources are allocated towards the health sector in general and interventions for maternal and child healthcare in particular, there also needs to be a stress on **ensuring proper implementation of the schemes and programmes**. The overall health system needs to be strengthened so that the resource allocation towards specific interventions can be utilised in the best possible manner and desired outcomes achieved.

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