# HEALTH AND FAMILY WELFARE DEPARTMENT

## 1.3 National Rural Health Mission

***National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India (GoI) throughout the country to bring about significant improvements in health systems and health status of the people, especially those in rural areas. The Mission seeks to provide accessible, affordable and quality health care which is accountable and responsive to the needs of the people.***

***The Mission was to be funded by the Governments of India and Meghalaya in the ratio of 90:10 and its goals were to be achieved under the aegis of State Health Mission headed by the Chief Minister. The State Health Society was to implement the Mission throughout the State. The major observations noticed during the Performance Audit on NRHM are given below:***

**Highlights:**

**There was a shortfall of 43 *per cent* in the number of Sub Centres in the State. Out of eleven districts, only seven districts had a district hospital. Also, out of eight First Referral Units (FRU), four were categorised as FRUs even though they did not have the critical facility of blood storage.**

***(Paragraphs 1.3.9.1 & 1.3.9.2)***

**Excess procurement without proper assessment led to expiry of drugs. There was shortage of essential drugs in the test checked health facilities and drugs were procured at higher rate.**

***{Paragraphs 1.3.9.10 (i), 1.3.9.10 (ii) & 1.3.9.10 (iii)}***

**Some of the test checked district hospitals and Community Health Centres were not equipped with essential equipment while others had equipment which were lying idle.**

***{Paragraphs 1.3.9.10 (v) & 1.3.9.10 (vi)}***

**Mobile Medical Units were discontinued in three districts due to under performance. There were 118 ambulances which were not fitted with essential medical equipment.**

***(Paragraphs 1.3.9.11 & 1.3.9.12)***

**There was shortage of doctors and nurses in the test checked district hospitals and Community Health Centres.**

***(Paragraphs 1.3.10.1 & 1.3.10.2)***

**A large number of pregnant women did not show up for antenatal care. Many pregnant preferred to deliver at home rather than at health facilities. There was shortfall in achievement of immunisation as well as sterilisation targets. There was shortfall in payment of Janani Suraksha Yojana incentives inspite of availability of funds.**

***(Paragraphs 1.3.11.1, 1.3.11.2, 1.3.11.5, 1.3.11.6 & 1.3.11.4)***

**There was variation between the data in Health Management Information System (HMIS) and the actual figures in the test checked health facilities. Monitoring of the Mission in terms of methods adopted for planning, quality of data being uploaded, number of meetings to be held by SHM and SHS were not satisfactory.**

***{Paragraphs 1.3.12.2, 1.3.12.4 (iii), 1.3.12.1 & 1.3.12.4 (i)}***

## *1.3.1 Introduction*

***Background***

The National Rural Health Mission (NRHM) was launched by the Honourable Prime Minister on 12 April 2005 throughout the country. The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections.

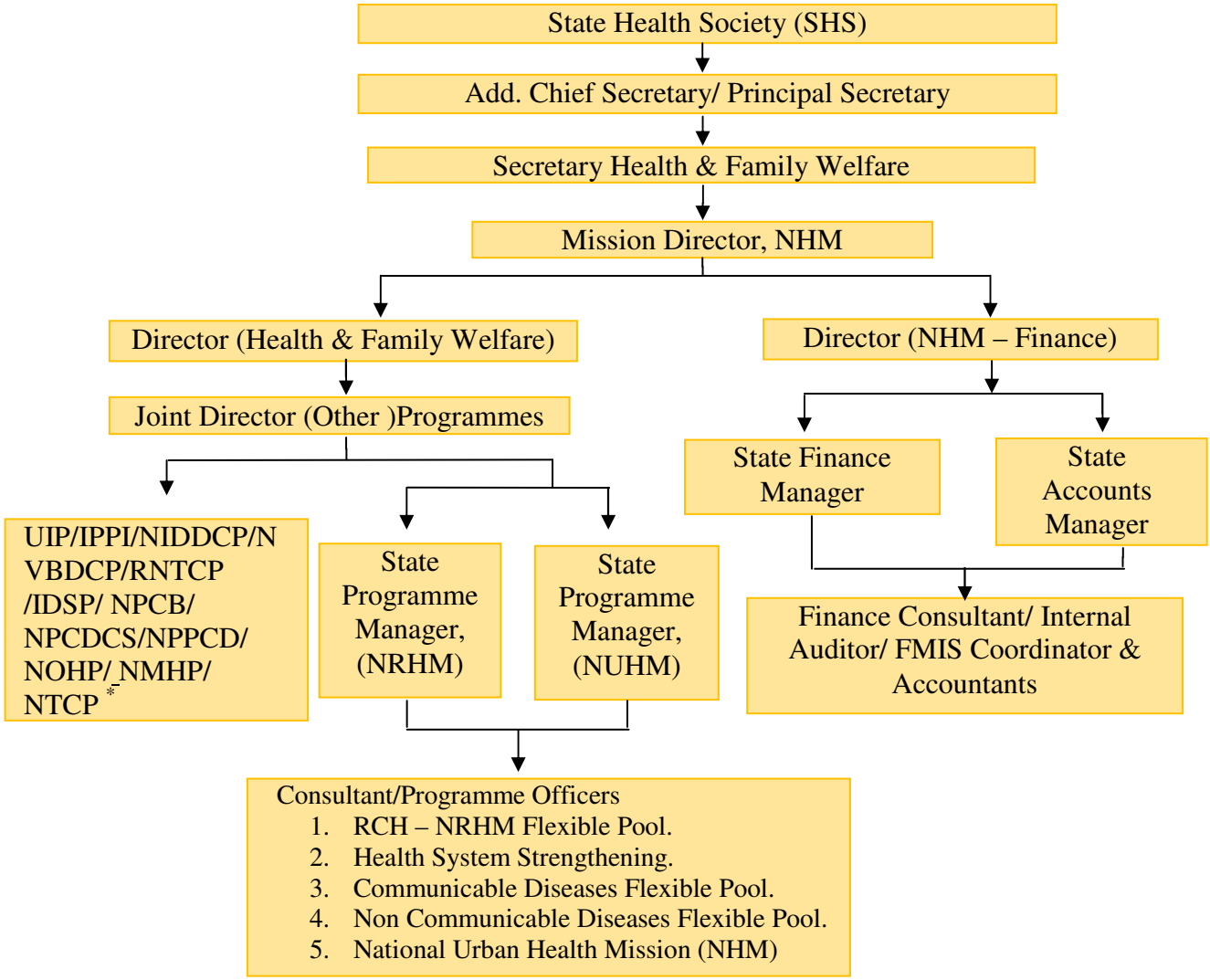
On 15 May 2013, the NRHM was subsumed as a sub mission of an over arching National Health Mission (NHM). The objectives of NRHM were to reduce child and maternal mortality; provide universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunisation; prevent and control communicable and non-communicable diseases, including locally endemic diseases; provide access to integrated comprehensive primary health care ; ensure population stabilisation, gender and demographic balance; revitalise local health traditions and mainstream AYUSH[31] and promote healthy life styles.

[31] Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy

### *Organisational Structure*

The organisational structure of NHM in Meghalaya is as shown below:

**Organisational Structure of NHM**




*UIP – Universal Immunisation Programme; IPPI – Intensified Pulse Polio Immunisation; NIDDCP – National Iodine Deficiency Disease Control Programme; NVBDCP – National Vector Borne Disease Control Programme; RNTCP – Revised National Tuberculosis Control Programme; IDSP – Integrated Disease Surveillance Programme; NPCB – National Programme for Control of Blindness; NPCDCS – National Programme for Prevention & Control of Cancer, Diabetes, Cardio Vascular Disease & Stroke; NPPCD – National Programme for Prevention & Control of Deafness; NOHP – National Oral Health Programme; NMHP – National Mental Health Programme; NTCP – National Tobacco Control Programme.

### *1.3.2 Financial inputs and fund flow arrangements*

The funds given to State Health Societies mainly consist of the following components:

a) Grants-in-aid through the Ministry of Health & Family Welfare, Government of India (GoI)

b) Contribution by the State Government

As per the NRHM framework, the funding pattern between the GoI and State Government was 90:10. The funding to States was based on the approved Programme Implementation Plans (PIPs)[32].

The details of funds released to SHS and expenditure incurred there-against during the period covered by Audit is shown below:

**Table 1.3.1: Financial position**

*(₹ in crore)*

| Year | Opening balance | Funds received from | | | | Total funds available | Expenditure incurred | Closing balance (percentage) |
|---|---|---|---|---|---|---|---|---|
| | | GoI | State | Other Sources | Total received | | | |
| 2011-12 | 63.72 | 45.37 | 42.30 | 0.05 | 87.72 | 151.44 | 103.42 | 48.02 (32) |
| 2012-13 | 48.02 | 107.08 | 11.56 | 0.00 | 118.64 | 166.66 | 103.74 | 62.92 (38) |
| 2013-14 | 62.92 | 80.91 | 34.11 | 0.02 | 115.04 | 177.96 | 94.06 | 83.90 (47) |
| 2014-15 | 83.90 | 110.97 | 26.70 | 0.06 | 137.73 | 221.63 | 97.70 | 123.93 (56) |
| 2015-16 | 123.93 | 91.69 | 12.67 | 0.00 | 104.36 | 228.29 | 54.57 | 173.72 (76) |
| **Total** | | **436.02** | **127.34** | **0.13** | **563.49** | | **453.49** | |

*(Source: SHS)*

It can be seen from the above table that there were huge closing balances at the close of each year ranging between ₹ 48.02 crore (32 *per cent*) and ₹ 173.72 crore (76 *per cent*). This indicated that the implementation of the scheme was slow due to which there was shortfall in availability of health facilities (district hospitals, first referral units, sub centres), equipment, drugs, manpower, *etc.* which led to poor performance of the State in terms of antenatal care, post natal care, immunisation, family planning, *etc.* as discussed in the succeeding paragraphs.

### *1.3.3 Audit Objectives*

NRHM is a comprehensive healthcare scheme which encompasses several programmes of Ministry of Health and Family Welfare. Out of the many outcome indicators, we have selected only three health care indicators {infant mortality rate (IMR), maternal mortality ratio (MMR) and total fertility rate (TFR)} for analysis in this report under Reproductive and Child Health (RCH). The audit objectives were developed to:

a) assess the impact of NRHM on improving Reproductive and Child Health in the State by the:

   i. extent of availability of physical infrastructure

[32] After receipt of PIPs from the State, GoI finalises the PIP and suggestions made are recorded in the form of Record of Proceedings (RoPs). These finalised PIPs are also termed as RoPs.

ii. extent of availability of health care professionals
iii. quality of health care provided

b) assess the mechanism of data collection, management and reporting which serve as indicators of performance.

### *1.3.4 Audit criteria*

The following are the sources of audit criteria for the Performance Audit of NRHM:

a) NRHM Framework for Implementation (2005-12)
b) NHM Framework for Implementation (2012-17)
c) Indian Public Health Standards (IPHS)[33] – Guidelines (2007 & 2012) for Sub-Centres, Primary Health Centres, Community Health Centres, Sub-Divisional Hospital and District Hospital.
d) Operational guidelines for Quality Assurance in public health facilities 2013.

### *1.3.5 Audit Sampling*

In Meghalaya, three districts (*viz* West Khasi Hills, Ri Bhoi and West Garo Hills) and two blocks from these three districts were selected using Simple Random Sampling Without Replacement (SRSWOR). Within each selected block, two Public Health Centres (PHCs) and six Sub Centres (SCs) were also selected using SRSWOR. In addition, all the district hospitals (DHs) within the selected district and all the Community Health Centres (CHCs) within the selected blocks were also covered under the Performance Audit. The list of selected districts and health facilities are shown in ***Appendix 1.3.1***. From each selected SC, 10 beneficiaries were selected using SRSWOR for the purpose of beneficiary survey.

### *1.3.6 Scope and coverage of audit*

The Performance Audit covered the period from 2011-12 to 2015-16 and examined the records of the State Health Society (SHS), three District Health Societies (DHS), five DHs, three CHCs, 12 PHCs and 36 SCs during April 2016 to August 2016. Audit also surveyed 108 ASHAs and 354 beneficiaries from the selected 36 SCs.

### *1.3.7 Audit methodology*

The Performance Audit commenced with an entry conference held on 15 April 2016 wherein the audit objectives, criteria, scope and methodology were discussed. It was attended by the Secretary, Health Department cum Mission Director, NHM, Meghalaya and officers of the Health Department.

The audit evidence was collected through issue of questionnaires, examination of records, joint physical verification, photographic evidence and beneficiary survey. An exit conference was held on 28 November 2016 with the Secretary to the Government

[33] Though the State had not implemented IPHS norms, this criteria was used as a benchmark by Audit since the State did not have its own norms.

of Meghalaya-cum-Mission Director, National Health Mission, Meghalaya and replies of the Department have been incorporated at appropriate places.

### *1.3.8 Acknowledgement*

The Indian Audit and Accounts Department acknowledges the cooperation of the Health Department of the State Government and the National Health Mission, Meghalaya in providing necessary information and records for audit.

## *Audit Findings*

### *1.3.9 Availability of physical infrastructure*

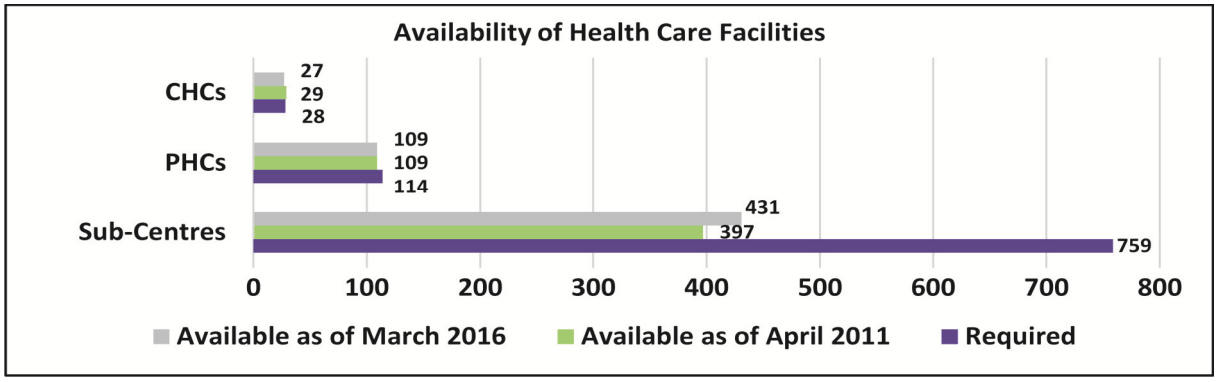
NRHM aims to bridge gaps in existing capacity of rural health infrastructure by establishing functional health facilities such as DHs, CHCs, PHCs and SCs through revitalisation of existing physical infrastructure and fresh construction or renovation wherever required.

#### *1.3.9.1 Availability of Health Centres against the requirement*

As per Indian Public Health Standard (IPHS) norms, every district is expected to have a DH. In the seven erstwhile districts of Meghalaya, there are 10[34] hospitals categorised as district hospitals. Even though four new districts *viz* East Jaintia Hills, South West Khasi Hills, North Garo Hills and South West Garo Hills were created between July and August 2012, none of the new districts had a DH till March 2016.

A comparison of the requirement of CHCs, PHCs and SCs *vis-a-vis* the actual availability during the beginning and at the end of the audit period (April 2011 and March 2016 respectively) is shown in the chart below:

**Chart 1.3.9.1 – Availability of CHCs/PHCs and SCs**




*(Source: Information furnished by SHS)*

It can be seen from the above chart that despite the shortfall of 392 SCs as of March 2011, the State had added only 34 new SCs (four *per cent*) during the period from April 2011 to March 2016. At the end of March 2016, the State was short of one CHC

[34] As per information furnished by SHS, there are 10 district hospitals in the State of which 7 are district hospitals and the remaining are Ganesh Das Hospital, Tura MCH Hospital and Mairang hospital. However, as per the RHS, there are 12 district hospitals which includes TB hospital and Meghalaya Institute of Mental Health & Neuro Science (MIMH&NS) These two hospitals were not included in the calculation since they are specialist hospitals for TB and mental health respectively.

(four *per cent*) and five PHCs (four *per cent*). There was however, a shortfall of 328 SCs (43 *per cent*) as of March 2016.

The shortage of DHs and SCs was one of the factors responsible for shortfall in achievement of targets such as institutional deliveries, antenatal care, *etc.* as discussed in the succeeding paragraphs. The necessity to have more SCs in the State was also observed in the beneficiary survey as 74 *per cent* of the 354 women surveyed stated that they visited SCs/Anganwadi centres *etc.* for their ANC services (as discussed in ***paragraph 1.3.12.5***).

In reply (December 2016), the Secretary, Health Department stated that the plan to set up district hospitals in the new districts had been initiated and the State would be able to operationalise them only after necessary approval for land and funds are accorded. With regards to shortfall of SCs, the Secretary, Health Department accepted the fact and stated that shortage of human resources were responsible for non-operationalisation of SCs.

### *1.3.9.2 Shortage of First Referral Units*

As per the NRHM Framework for Implementation (2005-12), the Mission aims to operationalise CHCs as First Referral Unit (FRU). An existing facility (DH, CHC) can be declared as fully operational FRU only if it is equipped to provide round-the-clock services for emergency obstetric and new born care, in addition to all emergencies that any hospital is required to provide. There are three critical determinants of a facility being declared as a FRU: i) emergency obstetric care including surgical interventions like caesarean sections; ii) new born care; and iii) blood storage facility on a 24-hour basis.

In Meghalaya, there are eight functional FRUs in seven out of 11 districts till the date of audit (August 2016). Moreover, out of the eight FRUs, as of September 2015, four[35] were categorised as FRUs even though they did not have the critical facility of blood storage. Further, the State had also failed to upgrade and categorise the rest of the DHs and CHCs as FRUs.

The Secretary, Health Department stated that though the process of operationalisation of DHs and CHCs to FRU in accordance with NRHM framework is ongoing but shortage of specialist doctors (Gynaecologists & Anaesthetists) hinders the State from achieving the target. The reply is however, silent regarding why four existing health facilities were categorised as FRUs even though they did not have the critical facility of blood storage.

### *1.3.9.3 Health facility not operationalised.*

In order to create awareness in the AYUSH system of medicines and to provide quality services to people, Government of India (GoI) sanctioned (March 2012) an amount of ₹ 2.54 crore for construction of a '10 bedded AYUSH hospital at Bhoirymbong CHC'. Out of the sanctioned fund, ₹ 2.02 crore was earmarked for construction purposes and the remaining ₹ 0.54 crore was for procuring equipment

[35] Ampati CHC, Nongpoh DH, Nongstoin DH & Williamnager DH

and furniture. The construction work of the hospital building was completed in January 2014 at a cost of ₹ 2.02 crore and handed over to the Medical Officer in charge of Bhoirymbong in October 2014.

Till the date of audit (July 2016), only AYUSH OPD services were available and the hospital was not fully functional. Equipment and furniture had not been procured and rooms in the AYUSH buildings were lying unutilised, thus depriving the populace of quality AYUSH services. On being pointed out, the Jt. Mission Director, NHM stated that the hospital had not become functional due to lack of manpower. The reply was not tenable since manpower requirements should have been considered from the time when the building was sanctioned/considered.

In reply (December 2016), the Secretary, Health Department stated that the there was only one AYUSH physician and one AYUSH helper sanctioned under Mainstreaming of AYUSH programme under NHM but there was no sanctioned post approved by the State Government.

The reply confirms the audit finding as manpower requirements should have been considered by the Department/State Government from the time the building was considered/sanctioned.

#### *1.3.9.4 Non upgradation of infrastructure*

IPHS fixes benchmarks for infrastructure, manpower, equipment, drugs, quality assurance in public health facilities. Most importantly, they also define the level of services, both essential (minimum assured services) and desirable which should be aspired to be achieved by the SC, PHC and CHC.

Even though as of March 2016 there were 431 SCs, 109 PHCs and 27 CHCs in the State, none of them were targeted or upgraded to IPHS standard during the period covered by audit (2011-16).

The Secretary, Health Department while accepting (December 2016) the audit finding stated that the State had not rolled out the standard operating protocols for SCs, PHCs, CHCs and DHs which would ensure that minimum assured services could be provided in accordance with the IPHS norms.

#### *1.3.9.5 Poor infrastructure in the selected five district hospitals*

One of the main objectives of the DH is to provide comprehensive secondary health care services to the people in the district at an acceptable level of quality and being responsive and sensitive to the needs of people and referring centres. In order to provide quality healthcare, basic infrastructural requirements such as functional Operation Theatres (OTs), proper physical infrastructure, generators, functional toilets, proper waste management, citizen charter, *etc.* were supposed to be available.

The main issues noticed in the five selected DHs were:

- Though OT was available in all the five DHs, it was not functional in three[37] DHs because of lack of anaesthetists and surgeons.
- Neonatal room was not available in Mairang and Nongstoin DHs. In reply (December 2016), the Secretary, Health Department stated that the Medical Superintendent, Mairang DH had been instructed to identify the space and make the neonatal rooms functional.
- In Nongpoh DH, it was noticed that there were leaking pipes and overflowing septic tanks next to the kitchen. The Secretary, Health Department stated (December 2016) that the leakage had since been repaired.
- Generator was not available in Nongstoin district hospital. In reply (December 2016), the Secretary, Health Department stated that the Hospital Management Society had been directed to install the generator at the earliest.

*Leaking pipes and overflowing septic tank located next to kitchen area of Nongpoh DH*

- There was no prescribed system for disposal of human anatomical waste in Nongpoh DH due to which human anatomical waste such as placenta was handed over to the relatives. The Secretary, Health Department stated (December 2016) that the Hospital Management Society had been instructed to identify a site within the hospital premises for construction of Deep Burial Pit.
- Nongstoin and Nongpoh DHs were not equipped with fire protection measures. The Secretary, Health Department (December 2016) stated that the fire protection/ safety measures were included in the State Disaster Management Plan. The reply was not tenable since fire protection equipment should have been available in the hospitals.
- Telephone was not available in four DHs[38].

### *1.3.9.6 Poor infrastructure in the three selected CHCs*

As per IPHS norms, CHCs should serve as a referral centre for four PHCs and also provide facilities for obstetric care and specialist consultations. It should have 30 indoor beds with one OT, X-Ray, labour room and laboratory facilities. NRHM seeks to bring CHCs at par with the IPHS to provide round the clock hospital-like services.

The issues noticed in the three selected CHCs were:

- OT was not available in Umsning and Bhoirymbong CHCs. The Secretary, Health Department replied (December 2016) that OTs were not available due to space constraints. The reply was not tenable since absence of OT services would hamper the CHCs from handling surgical emergencies and deprive the patients from proper surgical care. In Riangdo CHC, though OT was available it was not utilised due to absence of specialist manpower.

[37] Nongstoin DH, Mairang DH and Nongpoh DH.
[38] Nongstoin DH, Mairang DH, Nongpoh DH and Tura MCH hospital.

**Rusted labour table in Riangdo CHC**

**Toilet outside female ward in Riangdo CHC used for storage**

**Flooding in Bhoirymbong CHC during rain due to faulty system**

- In Riangdo CHC, the toilet outside the female ward was used as a store room due to which there were no separate toilets for males and females. In reply (December 2016), the Secretary, Health Department admitted the fact and had directed (December 2016) the Executive Engineer, Health Engineering Wing to take care of the problem.
- In Bhoirymbong CHC, due to faulty drainage system, water would overflow from the drains and flood almost all the rooms in the CHC during heavy rainfall. The Secretary, Health Department stated (December 2016) that the drainage system had since been repaired and rectified.
- Generator was not available in Umsning CHC.
- Riangdo and Umsning CHCs were not equipped with fire protection measures. The Secretary, Health Department (December 2016) stated that the fire protection/ safety measures were included in the State Disaster Management Plan. The reply was not tenable since fire protection equipment should have been available in the CHCs.
- Telephone was not available in any of the three CHCs.
- New born care stabilisation unit (NBSU) was not available in Umsning and Riangdo CHCs. In the NBSU of Bhoirymbong CHC, a radiant warmer, though available was not functioning**.** In reply (December 2016), it was stated that the NBSUs were not functional due to space constraints and that the Health Engineering Wing had been directed to take necessary action.
- There was no reception room in Umsning CHC due to shortage of space. There was leakage in many rooms and staff quarters of Umsning CHC. In reply (December 2016), the Secretary, Health Department informed that the Executive Engineer, Health Engineering Wing had been directed to take necessary action.


***Hole in ceiling of immunisation room Umsning CHC from where rain water leaks***

***Cracks in a beam of Umsning CHC from where water seeps through.***

***Seepage of water in staff quarter of Umsning CHC***

### *1.3.9.7 Poor infrastructure in the 12 selected PHCs*

PHC is the first contact point between village community and the medical officer. PHCs are envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. It acts as a referral unit for Sub Centres and refer out cases to CHCs and DHs.

The issues noticed in the 12 selected PHCs were:

- Rambrai, Nonglang and Marngar PHCs did not have newborn corner, which serves as resuscitation space and outlets for newborns. The Secretary, Health Department (December 2016) admitted the fact and stated that newborn corner in Marngar PHC was under construction while proposal for newborn corner in Rambrai and Nonglang PHC would be placed in the Annual Action Plan of 2017-18.
- Maweit, Rambrai, Kyrdem and Mellim PHCs did not have emergency rooms. The Secretary, Health Department stated (December 2016) that the emergency rooms were not available due to space constraints.
- Six[39] PHCs did not have a generator while the generators in two[40] PHCs were not functioning. In response, the Secretary, Health Department assured (December 2016) that the proposal for new generators in the six PHCs would be placed during 2017-18. He also stated that the Hospital Management Society of the other two PHCs had been instructed to repair the generators.
- Nonglang PHC did not have separate toilets for male/ female. In response, it was stated that the Health Engineering Wing had been directed (December 2016) to take necessary action.
- Shallang PHC did not have water supply. The Secretary, Health Department stated (December 2016) that the PHC needed to obtain a No Objection Certificate (NOC) from the village durbar to avail a fresh water connection from Public Health Engineering Department but the same was not accorded by the durbar.

[39] Shallang PHC, Rambrai PHC, Nonglang PHC, Byrnihat PHC, Kyrdem PHC & Mellim PHC
[40] Marngar PHC and Asanang PHC

| | | |
|---|---|---|
|  |  |  |
| ***Toilet near general ward in Shallang PHC is in dirty condition because of water supply not being available*** | ***A toilet in the premises of Shallang PHC drains into an open septic tank*** | ***Screen and bed used for patient examination are in rusted condition in Shallang PHC*** |

- One of the toilet in the premises of Shallang PHC drains directly into an open septic tank. In reply (December 2016), the Secretary, Health Department stated that the Septic tank was under repair.
- Shallang, Rambrai, Kyrdem and Mellim PHCs did not have functional overhead tanks. The Secretary, Health Department stated that the Health Engineering Wing had been directed (December 2016) to take necessary action.
- Maweit PHC did not have a citizen charter. In response (December 2016), the Secretary, Health Department stated that the District Medical & Health Officer (DMHO) had since been directed to take necessary action.
- None of the 12 selected PHCs had telephone connections. In reply (December 2016), it was stated that the covered areas do not have network connectivity and the State was exploring other avenues of gaining access through other networks (like mobile services *etc.*).
- Six[41] PHCs did not have boundary walls while four[42] PHCs had partial boundary wall. The Secretary, Health Department stated that the Health Engineering Wing had been directed (December 2016) to take necessary action.
- Shallang PHC was functioning from an old building. The rooms were small and there was leakage of water in all the rooms. Many of the walls of the PHC as well as staff quarters were cracked. In response, the Secretary, Health Department stated (December 2016) that the DMHO had been directed to inspect the facility and submit proposals for major repairs.
- The labour table in Nonglang PHC was rusted. In reply, it was stated that the Medical Officer of the facility had been instructed to get the labour table painted till a new labour table was procured.

[41] Shallang PHC, Rambrai PHC, Nonglang PHC, Mawlasnai PHC, Kyrdem PHC and Babadam PHC
[42] Maweit PHC, Byrnihat PHC, Asanang PHC and Dadenggre PHC

| | | |
|---|---|---|
|  |  |  |
| ***Rusted labour table in Nonglang PHC*** | ***Part of ceiling has collapsed in MO's Quarter of Nonglang PHC due to seepage of water*** | ***Walls inside the MO's quarters of Nonglang PHC is damp and partially damaged due to leakage of water*** |

### *1.3.9.8 Poor infrastructure in the 36 selected SCs*

The SC is the most peripheral and first contact point between the primary health care system and the community. SCs are assigned tasks relating to interpersonal communication in order to bring about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunisation, diarrhoea control and control of communicable disease programmes.

The issues noticed in the 36 selected SCs were:

- Labour tables were not available in 19[43] SCs. In reply (December 2016), it was stated that most of the SC buildings were very old and lacked proper space due to which, having a labour table would make the working area too congested. The reply was not tenable since the Department should have renovated the existing SCs in a phase manner and ensured that proper space was available.
- 17[44] SCs did not have water supply.
- There were no overhead tanks in 31[45] SCs.
- Riangdim SC, Kyrshai SC, Narang SC and Boldakgre SC did not have toilets.
- 22[46] SCs did not have boundary walls while four SCs had partial boundary walls.

[43] Kyrdum, Nongmisei, Nongdaju, Riangdim, Kyrshai, Mawdumdum, Mawrynniaw, Langja, Mawdoh, Baridua, Mawlein, Umsawnongbri, Narang, Pillangkata, Amjong, Kyrdemkulai, Mawlyndep, Waribokgre, Boldakgre.

[44] Kyrdum, Porkhadoh, Nongdaju, Seinduli, Kyrshai, Miangshang, Mawdumdum, Mawrynniaw, Langja, Umsawnongbri, Narang, Amjong, Gambeggre, Chisakgre, Mellim, Okkapara & Boldagre.

[45] Kyrdum, Porkhadoh, Nongmisei, Nongdaju, Seinduli, Riangdim, Kyrshai, Miangshang, Mawdumdum, Mawrynniaw, Langja, Mawdoh, Mawlein, Umsawnongbri, Narang, Tyrso, Amjong, Kyrdemkulai, Mawlyndep, Dakopgre, Gambegre, Chisakgre, Mellim, Okkapara, Rambagre, Waribokgre, Damalgre, Baljek, Galwangre, Boldakgre & Chisakgre.

[46] Kyrdum, Porkhadoh, Seinduli, Riangdim, Mawrynniaw, Mawdoh, Baridua, Mawlein, Narang, Pillangkata, Amjong, Kyrdemkulai, Mawlyndep, Mawtari Mawdoh, Dakopgre, Chisakgre, Mellim, Rambagre, Damalgre, Baljek, Galwangre, Boldakgre & Chisakgre.

### *1.3.9.9 Shortfall in availability of staff quarters*

As per IPHS, all the essential medical and para-medical staff should be provided with residential accommodation so that essential staff are available 24 x 7.

The availability of staff quarters was test checked in the selected DHs, CHCs and PHCs. It was seen that there was a shortfall in the availability of staff quarters as shown below:

**Table 1.3.2 - Availability of staff quarters**

| No. and Type of facility checked | Quarters for | Requirement as per availability of Staff | Actual Staff Quarters available | Shortfall (-) / Excess (+) with respect to staff available |
|---|---|---|---|---|
| 5 district hospitals | Doctors | 77 | 42 | -35 (45) |
| | Staff Nurse | 168 | 53 | -115 (68) |
| | Paramedical staff & Others | 84 | 61 | -23 (27) |
| 3 CHCs | Doctors | 16 | 13 | -3 (19) |
| | Staff Nurse | 32 | 23 | -9 (28) |
| | Paramedical staff & Others | 34 | 31 | -3 (9) |
| 12 PHCs | Doctors | 14 | 17 | 3 (21) |
| | Staff Nurse | 39 | 41 | 2 (5) |
| | Paramedical staff & Others | 130 | 34 | -96 (74) |

*(Source: information furnished by the health centres)*

It can be seen from the above that there was a shortfall of 45 *per cent* and 19 *per cent* in doctors' quarters in the selected DHs and CHCs respectively. Similarly, there was also a shortfall of 68 *per cent* and 28 *per cent* in nurse's quarters in the selected DHs and CHCs. The shortfall of quarters for paramedical and other staff in the selected DHs, CHCs and PHCs ranged between 9 *per cent* and 74 *per cent*.

Availability of residential quarters for essential medical /paramedical staff, especially in the rural areas is an important factor to help improve the service delivery of health facilities since it would help in providing round the clock services. The Secretary, Health Department while admitting the shortfall in quarters stated (December 2016) that all health facilities that are designated delivery points and requires residential provision would be jointly assessed by the Health Engineering Wing and DMHOs and proposals would be submitted to the State Government or GoI in 2017-18.

### *1.3.9.10 Medicines and equipment*

Medicines are an integral part of the health care services. Timely procurement of drugs, smooth distribution to the health facilities, uninterrupted availability to patients, minimisation of out of pocket expenses and availability of essential drug were some of the core issues that were required to be attended to.

In case of equipment, availability of essential functional equipment in all health facilities; regular needs assessment, timely indenting and procurement, identification of unused/faulty equipment, regular maintenance, competitive and transparent bidding processes were some of the issues that were to be addressed.

The audit findings relating to procurement, distribution and availability of medicines and equipment are as brought out in the succeeding paragraphs.

***(i) Improper assessment and procurement of medicines***

Mention was made in Paragraph 1.5 of the Report of the Comptroller & Auditor General of India for the year ended 31 March 2014 stating that during 2010-11 to 2012-13, the Jt. Mission Director, NRHM, Meghalaya had procured medicines for distribution to various medical institutions, (DHs, CHCs and PHCs) in the State. These medicines were procured without properly ascertaining the requirement from the medical institutions and also without coordinating with the Directorate of Health Services (Medical Institutions), Meghalaya to avoid overstocking and procurement of similar medicines already in stock. As a result, the Mission Director, NRHM, Meghalaya did not receive any indent from the medical institutions and consequently medicines valuing ₹ 4.03 crore lost their shelf life due to overstocking. Inspite of the lapses pointed out by audit, the Department did not put in place any systemic procedure to analyse the requirement of drugs in the various health centres till 2015-16.

The procurement of drugs *vis-a-vis* the amount approved by GoI in the Record of Proceedings (RoP) and actual utilisation of fund for procurement of drugs during 2011-16 is shown below:

**Table 1.3.3 – Excess procurement of drugs**

*(₹ in crore)*

| Year | Amount approved | | Total | Drugs procured | | Total | Excess (+) / Less (-) |
|---|---|---|---|---|---|---|---|
| | Essential Drugs | Speciality Drugs | | Essential Drugs | Speciality Drugs | | |
| 2011-12 | 4.25 | 4.45 | 8.70 | 9.38 | 24.20 | 33.58 | +24.88 |
| 2012-13 | 6.77 | 1.46 | 8.23 | 3.62 | 0.59 | 4.21 | -4.02 |
| 2013-14 | 0 | 1.08 | 1.08 | 0 | 0 | 0 | -1.08 |
| 2014-15 | 4.00 | 2.04 | 6.04 | 0.63 | 0 | 0.63 | -5.41 |
| 2015-16 | 2.00 | 1.44 | 3.44 | 7.99 | 0 | 7.99 | + 4.55 |
| **Total** | | | **27.49** | | | **46.41** | **+18.92** |

*(Source: Replies furnished by SHS)*

SHS procured excess drugs valuing ₹ 24.88 crore and ₹ 4.55 crore in 2011-12 and 2015-16 respectively than that approved in the RoP while during 2012-13 to 2014-15, it procured lesser drugs (₹ 10.51 crore) than the amount approved by GoI. Thus during 2011-16, SHS procured excess drugs valuing ₹ 18.92 crore than that approved by GoI. The payment for the excess procurement was made through RCH Flexipool with the approval of the Mission Director.

As a result of lack of systematic procedure to analyse requirement of drugs, improper assessment and procurement, it was noticed that many of the essential drugs (mandated as per the State list) which were required at various health facilities were not available during the period covered by audit as discussed in the subsequent paragraph.

In reply (December 2016), the Department while accepting the audit finding stated that these lapses would be rectified once DVDMS (Drugs and Vaccines Distribution

Management System) is implemented. The implementation was in process as of date of audit (May 2016).

### *(ii) Availability of drugs in DHs, CHCs & PHCs*

Medicines and equipment are an integral part of health system. The State of Meghalaya had formulated a State Essential Drug List (SEDL)[46]. The availability of medicines as listed was test checked in the selected five DHs, three CHCs and 12 PHCs and it was seen that most of the drugs were not available as shown below (Details shown in **Appendix 1.3.2).**

**Table -1.3.4 – Non-availability of drugs in DHs, CHCs & PHCs**

| Type of facility | No. of drugs required as per SEDL | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|---|---|---|
| 5 DHs | 355 | 63 and 86 *per cent* | 74 and 87 *per cent* | 77 and 87 *per cent* | 75 and 85 *per cent* | 68 and 85 *per cent* |
| 3 CHCs | 228 | 64 and 78 *per cent* | 66 and 82 *per cent* | 65 and 85 *per cent* | 65 and 83 *per cent* | 66 and 76 *per cent* |
| 12 PHCs | 180 | 47 and 83 *per cent* | 43 and 81 *per cent* | 54 and 79 *per cent* | 58 and 81 *per cent* | 62 and 84 *per cent* |

*Source: Records maintained at health facilities*

It can be seen from the above that during 2011-16, 13 *per cent* to 37 *per cent* of drugs were available while 63 *per cent* to 87 *per cent* of drugs were not available in the DHs. Similarly, in CHCs, 15 *per cent* to 36 *per cent* of drugs were available while 64 *per cent* to 85 *per cent* of drugs were not available. In the PHCs, 16 *per cent* to 57 *per cent* of drugs were available while 43 *per cent* to 84 *per cent* of drugs were not available during 2011-16. Hence, while there was excess procurement leading to expiry of drugs, there was extra expenditure on purchase of drugs and at the same time, drugs which were listed in the SEDL were not available at the health facilities.

In response, the Secretary, Health Department stated (December 2016) that the logistics and supply of drugs in the State had been overlooked in the previous years and hence, the State had taken a conscious decision to form a Joint Procurement Committee (JPC) in March 2015 which would henceforth look into the matters relating to procurement and supply of drugs. Accordingly, the JPC had requested for proposal of DVDMS and had also advised the State to use the same to ensure that such lapses do not happen in future.

### *(iii) Extra expenditure of ₹ 0.26 crore due to payment of higher rates*

During 2011-13, the Jt. Mission Director, NRHM, Shillong procured medicines[47] valuing ₹ 1.10 crore at rates which were higher than the rates approved by Director of Health Services (Medical Institutions) during the same period. This expenditure could

[46] The date on which the list was formulated was not furnished to audit, though called for.

[47] Amoxycillin 250 mg cap, Amoxycillin 500 mg cap, Ampicillin 250 mg cap, Ampicilin 500 mg cap, Cephalexin 250 mg cap, Cephalexin 500 mg cap, Ciprofloxacin 250 mg cap and Ciprofloxacin 500 mg cap.

have been limited to ₹ 0.84 crore had it been purchased as per the approved rate of DHS (MI). Thus, an extra expenditure of ₹ 0.26 crore was incurred under NRHM due to purchase of medicines at higher rates ***(Appendix 1.3.3)***.

In reply (December 2016), the Secretary, Health Department stated that the State had decided to update the SEDL to finalise a single rate contract for all drugs so as to avoid duplication of rates between all branches of the Health Department.

### *(iv) Procurement of equipment*

During 2011-16, an amount of ₹ 17.55 crore was approved for procurement of equipment. The details of the amount utilised by SHS for procuring equipment is shown in the table below:

**Table 1.3.5 – Funds utilised for procurement of equipment**

***(₹ in crore)***

| Year | Amount approved | Amount utilised | Excess (+) / Less (-) |
|---|---|---|---|
| 2011-12 | 7.76 | 0.64 | - 7.12 |
| 2012-13 | 0.43 | 3.07 | + 2.64 |
| 2013-14 | 4.80 | 0.00 | - 4.80 |
| 2014-15 | 1.52 | 0.00 | - 1.52 |
| 2015-16 | 3.04 | 2.79 | - 0.25 |
| **Total** | **17.55** | **6.50 (37 *per cent*)** | **- 11.05** |

*(Source: Information furnished by SHS)*

Even though many health facilities were lacking in equipment (as discussed in succeeding paragraph), it can be seen from the table above that the SHS utilised only an amount of ₹ 6.50 crore (37 *per cent*) for procuring hospital equipment during 2011-16. Even out of this short procurement of equipment, audit noticed the following:

*OT in Riangdo CHC lying unutilised*

- In the selected CHC (Riangdo), OT and surgical equipment valuing ₹ 16.62 lakh procured during December 2014 was lying unutilised till date of audit (July 2016) due to lack of skilled manpower. Thus, the expenditure of ₹ 16.62 lakh remained unfruitful. In reply, the Secretary, Health Department admitted (December 2016) the fact that the OT equipment were lying idle and stated that it was because the trained Medical Officer was transferred from the facility before the OT equipment were installed. The fact is that the equipment were not utilised.

*Table top incinerator lying idle in Nongstoin DH*

- In two selected DHs (Nongpoh and Nongstoin), table top incinerators for management of bio-medical waste costing ₹ 3.72 lakh (₹1.86 lakh per unit) procured during December 2014 was lying unutilised till date

of audit (July 2016) as no training was imparted to the staff on how to utilise the equipment.

- For Mairang DH and Tura MCH hospital, three table top incinerators costing ₹ 5.58 lakh, for which supply order was issued during December 2014 were never delivered. The details of the payment made to the supplier was not furnished though called for. The DHs had failed to follow up and ensure that the equipment gets delivered as per the supply order.

Hence, the expenditure of ₹ 9.30 lakh (₹ 1.86 lakh X 5 units) incurred on procurement of the table top incinerators for Nongpoh, Nongstoin, Mairang and Tura MCH hospitals was wasteful.

This indicated that due attention was not paid to properly assess the actual requirements of equipment, their receipt and utilisation.

### *(v) Non-availability of equipment in District Hospitals, CHCs &PHCs*

As per IPHS, equipment for blood storage, X-Ray, Ultra Sound, *etc.*, were required to be provided in the DHs and CHCs. Test check in the five selected DHs and three CHCs however, revealed that many types of equipment were not available or not functioning as shown below:

**Table 1.3.6 Availability of equipment in five DHs and three CHCs**

| Name of equipment | Number and type of facilities test checked | Available | Available but not functioning | Not available |
|---|---|---|---|---|
| Echo | 5 DHs | - | - | 5 |
| Blood Storage equipment | 5 DHs | 2 | 1 | 2 |
| | 3 CHCs | - | - | 3 |
| Ultra Sound | 5 DHs | 3 | 1 | 1 |
| | 3 CHCs | - | - | 3 |
| ECG | 5 DHs | 3 | 1 | 1 |
| | 3 CHCs | 1 | 1 | 1 |
| X-Ray | 5 DHs | 5 | - | - |
| | 3 CHCs | 1 | 1 | 1 |

*(Source: Replies furnished by facilities)*

From the above, it can be seen that:

- Echo was not available in any of the five DHs (100 *per cent*)
- Blood Storage equipment were not available/not functioning in three DHs (60 *per cent*) and not available in any of the three CHCs (100 *per cent).*
- Ultra Sound was not available/not functioning in two DHs (40 *per cent)* and not available in any of the three CHCs (100 *per cent).*
- ECG was not available /not functioning in two DHs (40 *per cent)* and not available/not functioning in two CHCs (66 *per cent).*
- X-Ray facility was available in all five DHs and in one CHC. It was not available /not functioning in two CHCs.

### *(vi) Equipment lying idle/ non functional*

As a measure to ascertain the utilisation of equipment by the Health facilities, a Joint Physical verification by the officers of the health facilities and members of the audit

team was conducted during July 2016. The findings of the Joint Physical Verifications were as follows:

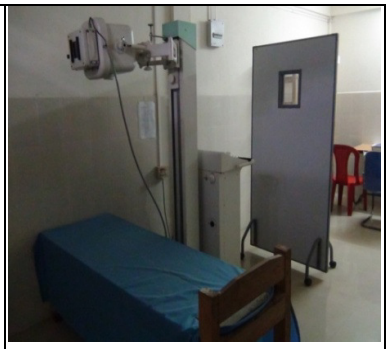
- OT in Nongstoin and Nongpoh DHs were lying idle and were not utilised because of lack of specialist doctors. In reply (December 2016), the Secretary, Health Department stated that the OT in Nongpoh was used for sterilisation cases. But the fact remained that the OT was not used for cases other than sterilisation due to absence of an anaesthetist.

*OT in Nongstoin DH lying unutilised*

- In Nongpoh DH, an ultrasound machine though available was not registered (as mandated under PCPNDT[49] Act) and hence could not be used. In reply, the Secretary, Health Department stated (December 2016) that the registration of the Ultra Sound machine was under process. Similarly, an X-Ray machine available in Bhoirymbong CHC was not used as it was not registered.

***Anaesthetist machine lying idle in Nongpoh DH***

***Non functional 500 MA X-Ray Nongpoh DH***



***Functional X-Ray machine lying unutilised in Bhoirymbong CHC***

- In Nongpoh district hospital, the main X-Ray machine (500 MA) was not functional due to which a portable X-Ray machine (60 MA) meant for Trauma Centre was used by the hospital.
- Though blood storage facility was not available in Nongstoin and Nongpoh District Hospitals, blood storage equipment were procured and were lying idle. The Secretary, Health Department while accepting the observation (December 2016) stated that a blood bank was under construction.
- Radiant warmers in Riangdo and Umsning CHC were not functioning. In reply, the Secretary, Health Department stated (December 2016) that the radiant warmers were not functioning because the cost of repairs was too high and there was no financial resource for repairs. The reply was not tenable since it can be seen from Table 1.3.5 above that the Department had utilised only 37 *per cent* of funds during 2011-16 for equipment.

[49] PCPNDT Act – Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994

| | | |
|---|---|---|
|  |  |  |
| ***Non-functional Digital X-Ray machine in Tura DH*** | ***Blood storage equipment lying idle in Nongstoin DH*** | ***Radiant warmers in Umsning CHC were not functional*** |

- The digital X-Ray machine installed in March 2013 in Tura DH was not functioning since September 2015.
- A Computerised Tomography (CT) Scan machine costing ₹ 1.12 crore was installed in Tura DH in April 2006 but it had not functioned since its installation[50].
- An automatic voltage input stabilizer installed in March 2007 in Tura DH stopped functioning after 2 (two) months of its installation due to which the blood bank refrigerators had no power supply backup.

*CT Scan machine in Tura DH is non-functional since April 2006*

- X-Ray machine in Umsning CHC which was not functioning since September 2012 was repaired during January 2016. It however, broke down just after 3(three) months of repair and was lying without repair till the date of audit (July 2016). The Secretary, Health Department stated (December 2016) that proposal for new X-Ray machine would be proposed in the Annual Action Plan of 2017-18.

### *1.3.9.11 Mobile Medical Units*

Taking health care to the door steps of the public in the rural areas, especially in underserved areas through Mobile Medical Units (MMU) is a key intervention towards achieving goals of the NRHM. In Meghalaya, out of 11 districts, MMU service was available only in seven districts.

As per GoI's direction[51], the performance of MMUs in a district should not be less than 500 patients or less than 20 camps in a month. According to the report submitted by NRHM, Meghalaya, seven units of MMUs had collectively held 276 camps from April to July 2015. This translates to an average of 9.86 camps per district per month instead of the target of 20 camps per month. Out of seven districts, only four[52] could achieve the target of 20 camps per month. Since the performance of the rest of the

[50] The matter regarding the non-functional CT Scan was reported in Paragraph 5.1.14 of the Report of the C&AG for the year ended 31 March 2011

[51] Recorded in the RoP of 2015-16

[52] West Khasi Hills, East Khasi Hills, Ri-Bhoi and South Garo Hills districts

three districts[53] was below par in terms of number of camps per month and number of patients seen, GoI ordered the State to discontinue the MMUs of the three districts.

Thus, due to under performance, the State had lost MMU services in three out of 11 districts besides not having this facility in four[54] other districts in the State.

On being pointed out, the Secretary, Health Department, in his reply (December 2016) stated that the MMUs were discontinued as GoI had not given their approval for the same.

### *1.3.9.12 Ambulance Service*

Ambulance with equipment are essential for referral transport system during the medical emergency and disaster. Life-saving emergency medicines including oxygen should be made available in the ambulances. One of the services launched under NRHM was the National Ambulance Service (NAS) whereby people can call an ambulance by dialling 108 to attend to patients of critical care, trauma and accident victims *etc.* or 102 to attend to the needs of pregnant women and children though other categories are not excluded.

The findings in respect of the Ambulance service are as follows:

- In Meghalaya only '108' ambulance services was available while '102' ambulance service had not been operationalised. The Secretary, Health Department informed (December 2016) that the proposal for '102' ambulance service was proposed to GoI during 2015-16 and 2016-17 but it was not approved.
- As of March 2016, there were 47 ambulances in the State operating under '108' service. Out of these, six were not equipped with essential medical equipment. The Secretary, Health Department replied (December 2016) that the six ambulances had since been equipped with essential medical equipment.
- The State also had 118 ambulances of which 64 were procured during 2011-12 and 2012-13. None of the 118 ambulances were however, fitted with essential medical equipment and as such were used mostly for referral[55] purposes. The Secretary, Health Department informed (December 2016) that the 118 ambulances were not equipped with essential medical equipment since GoI had approved the budget only for purchase of the ambulances and even their maintenance and operational expenditure were being borne by the health facilities themselves. The State Government should however, ensure that ambulances being used as patient transport vehicle should have basic professional equipment for first aid and nursing care.

*Adequate physical infrastructure viz buildings, equipment, drugs, ambulance etc. would be the basic necessity for effective delivery of health care services. It was however, noticed that there were shortage of DHs, FRUs, SCs, AYUSH building,*

[53] East Garo Hills, West Garo Hills and Jaintia Hills
[54] South West Khasi Hills, East Jaintia Hills, South West Garo Hills & North Garo Hills.
[55] Assured free transport for pregnant woman and new born/infants.

*blood storage facility in the State. It was also noticed that CT Scan, Ultra Sound, X-Ray etc. were lying idle and most of the health care units were deprived of telephone connections. There were shortages of essential drugs in the DHs/CHCs/PHCs. The survey also revealed that 16 per cent to 90 per cent of the surveyed ASHAs were not provided with necessary equipment/drugs such as thermometer, pregnancy kit, disposable delivery kit, blood pressure monitor, weighing scale, paracetamol, iron pills and deworming pills* (as discussed in ***paragraph 1.3.12.5***). *The above hindered the efforts of the State in improving the health status of expectant and new mothers as well as children.*

### *1.3.10 Availability of health care professionals*

The Framework for Implementation (2012-17) strategises increasing the number of key staff in consonance with IPHS and assured services for strengthening the health facilities. The IPHS lays down minimum essential manpower required for a functional DH, CHC, PHC and SC. The audit findings in respect of the manpower position are discussed in the succeeding paragraphs.

#### *1.3.10.1 Shortfall in availability of manpower at District Hospital*

The shortfall of manpower in the 10[56] district level hospitals located in seven districts *vis-a-vis* IPHS norms (2012) as of March 2016 is shown in the table below:

**Table 1.3.7 – Manpower position of DHs**

***(In numbers)***

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage as against IPHS norm (percentage) |
|---|---|---|---|---|
| Specialist Doctors | 160 | NA | 71 | -89 (56) |
| General Doctors | 130 | NA | NA | - |
| Staff Nurse | 450 | NA | 371 | -79 (18) |
| Paramedical staff | 310 | NA | 87[57] | - |

*(Source: Information furnished by SHS)*

From the table above, it can be seen that in the DHs there were shortages of 56 *per cent* and 18 *per cent* in the post of specialist doctors and staff nurses respectively. The shortage/excess in respect of paramedical staff could not be ascertained since the Department failed to furnish information on number of persons in position in respect of Storekeeper, CSSD Assistant, Dental Technician, Rehabilitation Therapist & Bio Medical Engineer.

The position of manpower in the five selected DHs is as shown below:

[56] As per information furnished by SHS, there are 10 district hospitals in the State of which 7 are district hospitals and the remaining are Ganesh Das Hospital, Tura MCH Hospital and Mairang hospital. However, as per the Rural Health Statistics (RHS), there are 12 district hospitals which includes TB hospital and Meghalaya Institute of Mental Health & Neuro Science (MIMH&NS) These two hospitals were not included in the calculation since they are specialist hospitals for TB and mental health respectively.

[57] Only partial information was furnished by NHM, Meghalaya.

**Table 1.3.8 – Manpower position of selected DHs**

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage (-) /Excess (+) against IPHS norms | Shortage (-) / Excess (+) against sanctioned strength norms |
|---|---|---|---|---|---|
| Specialist Doctors | 80 | 63 | 29 | -51 | -34 |
| General Doctors | 65 | 31 | 48 | -17 | +17 |
| Staff Nurse | 225 | 169 | 168 | -57 | -1 |
| Paramedical staff | 155 | 48 | 60 | -95 | +12 |

*(Source: Information furnished by the five selected DHs)*

From the above, Audit observed as follows:

- In comparison with IPHS norms, there was a shortfall of 51 specialist doctors, 17 general doctors, 57 staff nurses and 95 paramedical staff.
- In comparison with sanctioned strength, there was a shortfall of 34 specialist doctors and one staff nurse while there was an excess of 17 general doctors and 12 paramedical staff.

Audit noticed that shortage in availability of doctors (both specialist and general) had an adverse impact on the service delivery of the facilities since C-section was not performed in three[58] out of five test checked DHs. Further, OTs of Nongstoin and Nongpoh DHs were also lying unutilised due to absence of manpower as discussed in ***paragraph 1.3.9.10 (vi).***

### *1.3.10.2 Shortfall in availability of manpower at CHCs*

The shortfall of manpower in the 27 CHCs *vis-a-vis* IPHS norms (2012) as of March 2016 is shown in the table below:

**Table 1.3.9 – Manpower position of CHCs**

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage (-) / Excess (+) against IPHS norms (*percentage*) |
|---|---|---|---|---|
| Specialist Doctors | 135 | NA | 78 | -57 (42) |
| General Doctors | 135 | NA | 70 | -65 (48) |
| Staff Nurse | 297 | NA | 230 | -67 (23) |
| Paramedical staff | 351 | NA | 101[59] | - |

*(Source: Information furnished by SHS)*

From the table above, it can be seen that in the CHCs there were shortages of 42 *per cent,* 48 *per cent* and 23 *per cent* in the posts of specialist doctors, general doctors and staff nurses respectively. The shortage/excess in respect of paramedical staff could not be ascertained since the Department failed to furnish information on number of persons in position in respect of Pharmacist (Ayush), Ophthalmic Assistant, Dental Assistant, Cold Chain & Vaccine Logistic Assistant, OT Technician, Rehabilitation Worker, Counsellor and Dresser.

[58] Nongpoh DH, Nongstoin DH & Tura DH
[59] Only partial information was furnished by NHM, Meghalaya

The manpower position in the three selected CHCs is shown below:

**Table 1.3.10 – Manpower position of selected CHCs**

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage (-) / Excess (+) against IPHS norms | Shortage (-) / Excess (+) against sanctioned strength norms |
|---|---|---|---|---|---|
| Specialist Doctors | 15 | 0 | 1 | -14 | +1 |
| General Doctors | 15 | 16 | 15 | - | -1 |
| Staff Nurse | 33 | 21 | 32 | -1 | +11 |
| Paramedical staff | 39 | 13 | 22 | -17 | +9 |

*(Source: Information furnished by three selected CHCs)*

From the above, Audit observed as follows:

- The selected CHCs do not have any sanctioned post for specialist doctors. One specialist doctor was however, posted in Bhoirymbong CHC.
- In comparison with IPHS norms, there was a shortfall of 14 specialist doctors, one staff nurse and 17 paramedical staff.
- In comparison with sanctioned strength, there was a shortfall of one general doctor while there was an excess of 11 staff nurses and nine paramedical staff.

Audit noticed that the service delivery of the facilities was impacted on account of shortage in availability of doctors (both specialist and general) with the consequence that surgery and C-section were not performed in any of the test checked CHCs. Further, OT and surgical equipment were also lying unutilised in the Riangdo CHC due to absence of skilled manpower as discussed in ***paragraph 1.3.9.10 (iv).***

### *1.3.10.3 Shortfall in availability of manpower at PHCs*

The shortfall of manpower in the 109 PHCs *vis-a-vis* IPHS norms (2012) as of March 2016 is shown in the table below:

**Table 1.3.11 – Manpower position of PHCs**

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage (-) / Excess (+) against IPHS norms *(percentage)* |
|---|---|---|---|---|
| General Doctors | 109 | NA | 99 | -10 (9) |
| Staff Nurse | 327 | NA | 176 | -151 (46) |
| Paramedical staff | 545 | NA | 544 | -1 |

*(Source: Information furnished by SHS)*

From the table above, it can be seen that in the PHCs there were shortages of nine *per cent* and 46 *per cent* in the posts of general doctors and staff nurses respectively.

The manpower position in the twelve selected PHCs is shown below:

**Table 1.3.12 – Manpower position of selected PHCs**

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage (-) / Excess (+) against IPHS norms | Shortage (-) / Excess (+) against sanctioned strength norms |
|---|---|---|---|---|---|
| General Doctors | 12 | 17 | 14 | +2 | -3 |
| Staff Nurse | 36 | 27 | 39 | +3 | +12 |
| Paramedical staff | 60 | 43 | 74 | +14 | +31 |

*(Source: Information furnished by 12 selected PHCs)*

From the above, Audit observed as follows:

- In comparison with IPHS norms, there was an excess of two general doctors, three staff nurses and 14 paramedical staff.
- In comparison with sanctioned strength, there was a shortfall of three general doctors while there was an excess of 12 staff nurses and 31 paramedical staff.

Even though there was no shortfall in the number of doctors in the selected PHCs, Audit observed that there was irrational deployment of doctors since four[60] of the selected PHCs had two doctors each while two[61] PHCs did not have any doctor. As a result, the average number of deliveries during 2015-16 in the four PHCs with two doctors each was 102 while the average number of deliveries in the two PHCs without a doctor was only 33.

### *1.3.10.4 Human resources at Sub Centres*

The manpower position in the 36 selected SCs is shown below:

**Table 1.3.13 – Manpower position of selected SCs**

| Type of post | Minimum Essential number of staff as per IPHS | Sanctioned strength of the facility | Person in position | Shortage (-) / Excess (+) against IPHS norms | Shortage (-) / Excess (+) against sanctioned strength norms |
|---|---|---|---|---|---|
| ANM | 36 | 72 (36 regular + 36 contractual) | 66 | +30 | -6 |
| Health Worker (Male) | 36 | 0 | 0 | -36 | -36 |

*(Source: Information furnished by 36 selected SCs)*

From the above, Audit observed that:

- There was an excess of 30 ANMs (83 *per cent)* with respect to IPHS while the shortfall against sanctioned strength was six (eight *per cent).*
- No male health worker was posted in any of the 36 selected SCs.

*There was not only shortage of doctors and nurses across DHs and CHCs in the State as against IPHS norms, there was also irrational deployment of doctors in the PHCs.*

[60] Asanang PHC, Darenggre PHC, Maweit PHC & Mellim PHC
[61] Mawlasnai PHC & Nonglang PHC

*Shortage of necessary medical and paramedical staff at the health centres affected the goal of reliable and quality health services in the rural area. The effect of shortage of manpower was also observed during beneficiary survey as 24 per cent of the women surveyed stated that they received ANC services from doctors/nurses while the remaining received it only from ANMs/ASHAs* (as discussed in ***paragraph 1.3.12.5***).

*Shortage of key staff resulted in non-availability of services like surgery and C-Section in DHs and CHCs. Also, OTs was lying idle in two DHs and one CHC due to want of manpower.*

### *1.3.11 Quality of health care provided*

The Mission objectives included reduction in child and maternal mortality, population stabilisation, universal access to public health care services with emphasis on services addressing women's and children's health and universal immunisation. This was sought to be achieved by laying down targets for achieving certain indicators. Targets in respect of institutional deliveries, immunisation, and family planning were fixed by GoI. The performance of the State on improving Reproductive and Child Health (RCH) with respect to the target fixed are discussed below:

#### *1.3.11.1 Antenatal care*

Early detection of complications during pregnancy through antenatal (ANC) check-up is important for preventing maternal mortality and morbidity. Quality ANC includes minimum of at least four ANCs including early registration, first ANC in first trimester along with physical and abdominal examinations, two doses of tetanus toxoid (TT) immunisation and consumption of Iron Folic Acid (IFA) tablets. Mobilising the pregnant women for ANCs is one of the activities to be performed by Accredited Social Health Activist (ASHA). As of March 2016, against the requirement of 6519, there were 6429 ASHAs available (99 *per cent*). For these kind of services, the SC is the most peripheral and first contact point between the primary health care system and the community.

The number of registered pregnant women who registered within the first trimester, who received three ANC services, who were given two TT immunisation doses and who were given 100 IFA tablets during the period 2011-16 are shown below:

**Table 1.3.14 - Pregnant women registered and receiving ANC services**

| Year | Total No. of pregnant women registered | No. registered within first trimester (percentage) | No. of pregnant women who received 3 check-ups during pregnancy (percentage) | No. of pregnant women given 1st and 2nd Tetanus Toxoid (TT) immunisation (percentage) | No. of pregnant women given100 IFA tablets (percentage) |
|---|---|---|---|---|---|
| 2011-12 | 119912 | 31316 (26) | 54807 (46) | 63573 (53) | 50293 (42) |
| 2012-13 | 123528 | 32646 (26) | 62003 (50) | 66183 (54) | 66170 (54) |
| 2013-14 | 132393 | 44097 (33) | 67818 (51) | 70665 (53) | 42796 (32) |
| 2014-15 | 129575 | 41777 (32) | 71430 (55) | 71631 (55) | 53231 (41) |

| Year | Total No. of pregnant women registered | No. registered within first trimester (percentage) | No. of pregnant women who received 3 check-ups during pregnancy (percentage) | No. of pregnant women given 1st and 2nd Tetanus Toxoid (TT) immunisation (percentage) | No. of pregnant women given100 IFA tablets (percentage) |
|---|---|---|---|---|---|
| 2015-16 | 131943 | 42274 (32) | 75356 (57) | 74207 (56) | 46707 (35) |
| **Total** | **637351** | **192110** | **331414** | **346259** | **259197** |

*(Source: information furnished by SHS)*

From the above table, Audit observed that, as against the total number of pregnant women who registered themselves:

- the number of pregnant women who registered within the first trimester (within 12 weeks) was low and ranged between 26 *per cent* and 33 *per cent*;
- the number of registered pregnant women who received 3 ANC check-up ranged between 46 *per cent* and 57 *per cent*;
- the percentage of pregnant women who were given tetanus toxoid immunisation dosage was between 53 *per cent* and 56 *per cent*; and,
- the number of pregnant women who were given 100 IFA tablets ranged between 32 *per cent* and 54 *per cent.*

Hence, it is clear from the above that the State had failed to motivate the pregnant women to obtain ANC services even though it had 99 *per cent* of the required ASHAs. This was also attributable to the fact that there was less number of SCs in the State as pointed out in ***paragraph 1.3.9.1***. The results of the beneficiary survey conducted in 36 SCs revealed that 52 *per cent* of the women surveyed registered their pregnancy within the first trimester (as discussed in ***paragraph 1.3.12.5***) whereas the percentage of pregnant women who registered within the first trimester in the State as a whole ranged only between 26 *per cent* and 33 *per cent*. This indicated that early registration of pregnancy was better in areas where SCs were available compared to those where there were no SCs.

In reply (December 2016), the Secretary, Health Department agreed that the number of registered pregnant women who received ANC was low and stated that schemes like Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakaram (JSSK) and Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) were being rolled out to improve the situation.

### *1.3.11.2 Shortfall in institutional deliveries*

The target and achievement of institutional deliveries (ID) in the State and in the three selected districts were as under:

**Table 1.3.15 - Target and achievement of institutional deliveries**

| Year | State level | | West Khasi Hills | | Ri Bhoi | | West Garo Hills | |
|---|---|---|---|---|---|---|---|---|
| | T[61] | A | T | A | T | A | T | A |
| 2011-12 | NA | 38511 | 10431 | 2800 (27) | 2441 | 1308 (54) | 8328 | 5138 (62) |
| 2012-13 | NA | 41266 | 6770 | 2826 (42) | 2247 | 1526 (68) | 9378 | 5631 (60) |

[61] Targets for ID was furnished only for JSY

| Year | State level | | West Khasi Hills | | Ri Bhoi | | West Garo Hills | |
|---|---|---|---|---|---|---|---|---|
| | T[62] | A | T | A | T | A | T | A |
| 2013-14 | NA | 43541 | 7265 | 3382 (47) | 2522 | 1418 (56) | 7348 | 6305 (86) |
| 2014-15 | NA | 44369 | 7743 | 3800 (49) | 2463 | 1656 (67) | 8452 | 5886 (70) |
| 2015-16 | NA | 46014 | 7788 | 3752 (48) | 2941 | 1853 (63) | 9207 | 5679 (62) |

Note: T – Target, A - Achievement.
*(Source: Information furnished by SHS and districts)*

During the period from 2011-16, the achievement of ID in West Khasi Hills and Ri Bhoi districts were low and ranged between 27 *per cent* and 49 *per cent* and 54 *per cent* and 68 *per cent* respectively. In West Garo Hills district, the achievement in ID ranged between 60 *per cent* and 86 *per cent*.

The achievement of ID was also low when compared against home deliveries (HD) as shown in the table below:

**Table 1.3.16 - Achievement of institutional deliveries**

| Year | State level | | West Khasi Hills | | Ri Bhoi | | West Garo Hills | |
|---|---|---|---|---|---|---|---|---|
| | ID | HD | ID | HD | ID | HD | ID | HD |
| 2011-12 | 38511 (49) | 39652 (51) | 2800 (31) | 6336 (69) | 1308 (23) | 4481 (77) | 5138 (43) | 6830 (57) |
| 2012-13 | 41266 (51) | 39435 (49) | 2826 (30) | 6734 (70) | 1526 (26) | 4312 (74) | 5631 (44) | 7176 (56) |
| 2013-14 | 43541 (52) | 40563 (48) | 3382 (31) | 7414 (69) | 1418 (25) | 4258 (75) | 6305 (48) | 6770 (52) |
| 2014-15 | 44369 (51) | 41951 (49) | 3800 (33) | 7700 (67) | 1656 (27) | 4566 (73) | 5886 (45) | 7096 (55) |
| 2015-16 | 46014 (53) | 41080 (47) | 3752 (39) | 5951 (61) | 1853 (31) | 4135 (69) | 5679 (44) | 7098 (56) |
| **Total** | **213701** | **202681** | **16560** | **34135** | **7761** | **21752** | **28639** | **34970** |

*(Source: information furnished by SHS and districts)*
*ID: Institutional deliveries. HD: Home deliveries.*

It is evident from the above table that during 2011-16:

- ID was poor in the State and ranged only between 49 *per cent* and 53 *per cent* while HD ranged between 47 *per cent* and 51 *per cent.* During the five year period test checked by Audit, ID increased marginally by 4 *per cent*.
- In the three selected districts, the number of HD was always higher than the IDs. In West Khasi Hills district, while the ID ranged between 31 *per cent* and 39 *per cent*, the HD ranged between 61 *per cent* and 70 *per cent*. In Ri Bhoi district, while the ID ranged between 23 *per cent* and 31 *per cent*, the HD ranged between 69 *per cent* and 77 *per cent*. In West Garo Hills district, while the ID ranged between 43 *per cent* and 48 *per cent*, the HD ranged between 52 *per cent* and 57 *per cent*.

One of the reason for low ID in the State was due to lack of infrastructure in SCs as pointed out in ***paragraph 1.3.9.8***. Moreover, out of 431 SCs in the State, only 62 (14 *per cent*) had the facilities for conducting deliveries.

The beneficiary survey also revealed that pregnant women found it convenient to deliver at home rather than at health institutions offering delivery services as these facilities were too far away. Had the SCs been equipped with facilities for conducting deliveries, the beneficiaries would have been encouraged towards ID rather than resorting to HD.

The Secretary, Health Department accepted (December 2016) the fact that HD was more than ID and also attributed the reasons to social traditional customs and beliefs, especially in the rural areas. He further stated that the number of ID would be increased through the PMSMA initiative.

### *1.3.11.3 Post natal care*

Maternal mortality is a key indicator for maternal and child health. Maternal mortality can result from multiple reasons, such as medical, socio-economic and health system-related factors. Ensuring 48 hours stay in hospital during childbirth is an important component for identification and management of emergencies occurring during post natal period and reducing MMR.

The position of women who were discharged after 48 hours in the three selected districts is shown below:

**Table 1.3.17 - Position of women discharged after 48 hours in the selected districts**

| Year | West Khasi Hills | | | Ri Bhoi | | | West Garo Hills | | |
|---|---|---|---|---|---|---|---|---|---|
| | No of ID | No discharged after 48 hours | Percen-tage | No of ID | No discharged after 48 hours | Percen-tage | No of ID | No discharged after 48 hours | Percen-tage |
| 2011-12 | 2800 | 2487 | 89 | 1308 | 916 | 70 | 5138 | 3299 | 64 |
| 2012-13 | 2826 | 2055 | 73 | 1526 | 789 | 52 | 5631 | 3466 | 62 |
| 2013-14 | 3382 | 951 | 28 | 1418 | 961 | 68 | 6305 | 4642 | 74 |
| 2014-15 | 3800 | 1085 | 29 | 1656 | 1546 | 93 | 5886 | 4567 | 78 |
| 2015-16 | 3752 | 818 | 22 | 1853 | 478 | 26 | 5679 | 4325 | 76 |

*(Source: information furnished by districts)*

It is seen from the table above that:

- In West Khasi Hills District, the percentage of women who were discharged within 48 hours came down drastically from 89 *per cent* in 2011-12 to 22 *per cent* in 2015-16. The DM&HO, West Khasi Hills attributed the main reason for high number of discharges taking place before 48 hours to most of the women being farmers/ workers and not preferring to stay more than one day, especially when they are healthy. He further stated that since the implementation of JSSK, there had been a lot of improvement as the women got benefit from the scheme.
- In Ri Bhoi District also, barring 2014-15, the percentage of women who were discharged within 48 hours fell from 70 *per cent* in 2011-12 to 26 *per cent* in 2015-16.
- In West Garo Hills however, the percentage of women who were discharged within 48 hours rose from 64 *per cent* in 2011-12 to 76 *per cent* in 2015-16. The DM&HO, West Garo Hills attributed the reason for discharge before 48 hours to inadequate number of beds.

The findings of the beneficiary survey (as discussed in ***paragraph 1.3.12.5***) corroborated the above findings as 72 *per cent* of the women surveyed who delivered in an institution stated that they were discharged within 48 hours of delivery.

While agreeing with the above findings, the Secretary, Health Department stated (December 2016) that the post natal mother prefers to go home if there was no complication whereas in some cases, it was due to heavy turnover of pregnant women and there was shortage of beds in the facilities.

### *1.3.11.4 Payment of JSY incentive*

Janani Suraksha Yojana (JSY) launched during 2005 aims at reducing maternal and neonatal mortality by encouraging and increasing institutional deliveries. A financial incentive of ₹ 600 in urban and ₹ 700 in rural areas for institutional deliveries were to be provided while the incentive of ₹ 500 was to be provided for home deliveries both in urban and rural areas. Only those pregnant women who had received three ANC check ups were however, eligible for payment.

As per the JSY guidelines, the amount of incentive to be given to JSY beneficiaries was to be paid in one instalment at the time of delivery irrespective of the place of delivery.

The targets fixed in the Record of Proceedings (RoP) of 2012-16 and actual payment made for JSY in Meghalaya is shown below:

**Table 1.3.18 – Target and actual payment made for JSY**

**(₹ in lakh)**

| Year[63] | Physical Target as per ROP | | Amount approved in ROP | | Actual number of beneficiaries | | Payment made | | Excess (+)/ savings (-) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | HD | ID | HD | ID | HD | ID | HD | ID | HD | ID |
| 2012-13 | 500 | 1300 | 25.00 | 119.50 | 5000 | NA | 25.00 | 98.00 | 0 | -21.50 |
| 2013-14 | 5000 | 21500 | 25.00 | 144.50 | 5000 | 17074 | 25.00 | 117.86 | 0 | -26.64 |
| 2014-15 | 5000 | 31000 | 25.00 | 208.00 | 5768 | 24474 | 28.34 | 290.92 | 3.34 | 82.92 |
| 2015-16 | 5000 | 34200 | 25.00 | 256.00 | 6308 | 23399 | 31.54 | 148.65 | 6.54 | -107.35 |
| **Total** | | | **100.00** | **728.00** | | | **109.88** | **655.43** | **9.88** | **-72.57** |

*(Source: Information furnished by SHS)*

For the period from 2012-13 to 2015-16, it can be seen that the State incurred an excess expenditure of ₹ 9.88 lakh towards payment of JSY incentives for HD. In case of utilisation of JSY fund for ID, the State failed to achieve the target and had savings of ₹ 72.57 lakh at the end of 2015-16.

Despite JSY funds being available, several JSY beneficiaries did not receive their financial incentive during 2011-16. The position of JSY beneficiaries in the State and in the three selected districts who did not receive financial incentives during 2011-16 is shown in the table below:

[63] Information relating to 2011-12 was not furnished by the Department.

**Table 1.3.19 - JSY beneficiaries who did not receive financial incentives**

| Year | Total No. of pregnant women registered under JSY | | | | Total no. of women registered with JSY but did not receive JSY incentive money (percentage) | | | |
|---|---|---|---|---|---|---|---|---|
| | State | West Khasi Hills district | Ri Bhoi district | West Garo Hills district | State | West Khasi Hills district | Ri Bhoi district | West Garo Hills district |
| 2011-12 | 36715 | 3832 | 2737 | 8380 | NA | 1538 (40) | 1575 (58) | 4180 (50) |
| 2012-13 | 39235 | 4613 | 3200 | 8414 | NA | 2611 (57) | 2035 (64) | 5245 (50) |
| 2013-14 | 53715 | 7415 | 4687 | 12714 | 34641 (64) | 4642 (63) | 3412 (73) | 7607 (60) |
| 2014-15 | 65740 | 9267 | 6855 | 13551 | 35498 (54) | 5618 (61) | 4035 (59) | 6659 (49) |
| 2015-16 | 79592 | 9123 | 8404 | 14549 | 49885 (63) | 4858 (53) | 4168 (50) | 7653 (53) |

*(Source: Information furnished by SHS & districts)*

It can be seen from the above table that during 2013-16, 54 *per cent* to 64 *per cent* of pregnant women registered in the State under JSY were not given their due incentive. In the selected districts, 40 *per cent* to 63 *per cent*, 50 *per cent* to 73 *per cent* and 49 *per cent* to 60 *per cent* of pregnant women registered under JSY in West Khasi Hills, Ri Bhoi and West Garo Hills districts respectively were not given their due incentive during 2011-16.

In reply, the Secretary, Health Department stated (December 2016) that the reasons for shortfall in payment of JSY were because the beneficiaries did not produce necessary documents and failed to collect their benefits. It was also stated that not all registered pregnant women were eligible for payment unless they received the mandatory three ANC check-ups.

The reply was not tenable because it was the duty of the ASHAs to identify pregnant woman from BPL families as a beneficiary of the scheme, bring the women to the sub-centre / PHC for registration, assist the woman to obtain BPL certification if BPL card was not available, provide and / or help the women to receive at least three ANC, and counsel her for institutional delivery. Shortfall in payment of JSY incentives throughout the period covered by Audit indicated that the ASHAs did not fulfil their role allotted to them in aiding the registered pregnant women. Moreover, it was also seen from the survey conducted by Audit that 65 *per cent* of the ASHAs surveyed worked three or less days in a week (as discussed in ***paragraph 1.3.12.5*).**

### *1.3.11.5 Immunisation of infants and children*

Immunisation of infants and children against the six preventable diseases namely Tuberculosis, Pertusis, Diptheria, Tetanus, Poliomyelitis and Measles is the major thrust of the child health care delivery system in the country. A child who receives one dose each of Bacillus Chalmette Guerin (BCG), Measles vaccines and three doses of Diphtheria, Pertussis and Tetanus (DPT) and Polio vaccines is considered to be a fully immunised child. One of the objectives of Universal Immunisation Programme (UIP) is to reduce IMR by fully immunising above 80 *per cent* of the children and sustain routine immunisation after.

The shortfall in achievement of targets relating to routine immunisation is given in ***Appendix 1.3.4*** and summarised in the table below:

**Table 1.3.20 - Shortfall in immunising children**

| Sl. | Particulars | Range of shortfall |
|---|---|---|
| 1 | Children in the age group of 0 to two years | 47 *per cent* to 52 *per cent* |
| 2 | Children below the age of five years | 68 *per cent* to 72 *per cent* |
| 3 | Children below the age of ten years | 39 *per cent* to 73 *per cent* |
| 4 | Children who were to be administered Vitamin A solution. | 69 *per cent* to 93 *per cent* |

The shortfall in administration of vaccines would make a child more susceptible to diseases compared to those who had been immunised. Also, giving Vitamin A supplements to children increases their resistance to disease and improves their chances for survival, growth and development. The State should take necessary steps to increase the number of fully immunised children.

It was also seen that there was an increasing trend of whooping cough and large number of cases of measles as seen in the Table below:

**Table No 1.3.21 - Trend of Infant Diseases**

| Year | Number of cases | |
|---|---|---|
| | Whooping cough | Measles |
| 2011-12 | 15 | 1173 |
| 2012-13 | 2 | 535 |
| 2013-14 | 5 | 591 |
| 2014-15 | 7 | 474 |
| 2015-16 | 43 | 603 |

Immunisation is one of the factors for reducing IMR. Shortfall in immunisation hinders the effort of the State towards this direction. Even though the IMR of the State had come down during 2015-16 (30) as compared to 2011-12 (52), it had still not met the target set for IMR (26) by GoI.

### *1.3.11.6 Family Planning*

India was the first country that launched a National Family Planning Programme in 1952, emphasising fertility regulation for reducing birth rates to the extent necessary to stabilise the population at a level consistent with the socio-economic development and environment protection. The NRHM provides a policy framework for advancing goals and prioritising strategies to meet the reproductive and child health needs of the people of India, and to achieve replacement level of total fertility rate (TFR) of 2.1 by 2017. The programme envisages encouraging family planning by adopting terminal /spacing method of sterilisation.

### *(i) Target and achievement of sterilisation – terminal method*

The target and achievement of terminal methods of sterilisation (Vasectomy /Non Scalpel Vasectomy, Tubectomy and Laparoscopic tubectomy) for the period covered by Audit are shown below:

**Table 1.3.22 - Target and achievement of terminal methods of sterilisation**

***(Figures in numbers)***

| Year | Vasectomy/NSV | | Tubectomy | | Laparoscopic Tubectomy | |
|---|---|---|---|---|---|---|
| | Target | Achievement (percentage) | Target | Achievement (percentage) | Target | Achievement |
| 2011-12 | 500 | 56 (11) | 5000 | 2941 (59) | NA | 16 |
| 2012-13 | 200 | 18 (9) | 3000 | 2765 (92) | NA | 9 |
| 2013-14 | 200 | 14 (7) | 3500 | 2493 (71) | NA | 55 |
| 2014-15 | 200 | 22 (11) | 3000 | 2116 (71) | NA | 67 |
| 2015-16 | 50 | 11 (22) | 3000 | 2517 (84) | NA | 73 |
| **Total** | **1150** | **121 (11)** | **17500** | **12832 (73)** | **-** | **220** |

*(Source: Information furnished by SHS)*

It can be seen from the above that though the State reduced its target for Vasectomy from 500 in 2011-12 to 200 in 2012-13 and further down to 50 in 2015-16, it still failed to achieve the target. During 2011-16, only 121 cases (11 *per cent*) of vasectomy were performed in the State. No vasectomy was performed in West Khasi Hills and Ri Bhoi districts during 2011-16. In case of tubectomy, 12832 cases (73 *per cent*) were performed in the State. For laparoscopic tubectomy, the State did not specify any target but it can be seen that only 220 cases were performed. Regarding the low performance on vasectomy, the Secretary, Health Department stated (December 2016) that it was very difficult to motivate men to accept family planning methods.

### *(ii) Target and achievement of sterilisation – spacing method*

One of the most common spacing method is through insertion of intrauterine device (IUD). The other methods are through distribution of oral pills and condom pieces. During the period covered by Audit, no targets were set for distribution of oral pills or condom pieces. The Department however, distributed 3.39 lakh of oral pills and 18.89 lakh of condom pieces under NRHM during 2011-16.

The target and achievement of IUD insertion in the State and in the three selected districts during 2011-16 is shown below:

**Table 1.3.23 - Target and achievement of IUD insertion**

| Year | IUD insertion | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | State | | West Khasi Hills district | | Ri Bhoi district | | West Garo Hills district | |
| | T[64] | A | T | A | T | A | T | A |
| 2011-12 | 10000 | 4678 (47) | 250 | 62 (25) | 500 | 490 (98) | 1671 | 1454 (87) |
| 2012-13 | 10000 | 4795 (48) | 424 | 169 (40) | 500 | 511 (102) | 1731 | 1274 (74) |
| 2013-14 | 10000 | 4440 (44) | 576 | 117 (20) | 500 | 276 (55) | 1735 | 1317 (76) |
| 2014-15 | 10000 | 4723 (47) | 480 | 168 (35) | 500 | 431 (86) | 1821 | 1238 (68) |
| 2015-16 | 7000 | 4414 (63) | 1002 | 163 (16) | 500 | 535 (107) | 1821 | 1279 (70) |

*(Source: Information furnished by SHS & districts)*

The achievement in IUD insertions in the State for the period from 2011-16 ranged between 44 *per cent* and 63 *per cent* while the achievement in West Khasi Hills and

[64] T – Target , A - Achievement

West Garo Hills during the same period ranged between 16 *per cent* and 40 *per cent* and 68 *per cent* to 87 *per cent* respectively. Even though Ri Bhoi exceeded the targets during 2012-13 and 2015-16, it fell short of the targets set during 2011-12, 2013-14 and 2014-15 by 2 *per cent*, 45 *per cent* and 14 *per cent* respectively. While agreeing to the audit observation on IUD, the Secretary, Health Department stated (December 2016) that the Medical and paramedical staff were asked to provide counselling to the clients.

Thus, it can be seen from the above paragraphs, that there was shortfall in achievement of targets in various components of family planning methods, due to which the TFR in the State increased from 2.9 in 2011-12 to 3.0 in 2015-16 as against the target of 2.1 fixed by GoI.

The Secretary, Health Department stated (December 2016) that the State would be conducting an assessment in family planning to understand and ascertain the reasons for low acceptance of family planning methods and strategies would be planned on the basis of this assessment.

### *1.3.11.7 Quality Assurance*

In 2013, the GoI launched the Quality Assurance Programme which aims at improving the quality of health services provided to the people. The main aim of the Quality Assurance Programme was to enhance satisfaction level among users of the Government Health facilities and also to improve patient /client level outcomes at the facility level.

As per the operational guidelines for Quality Assurance (QA), a State level Quality Assurance Committee (SQAC) headed by a Secretary level officer along with the State Quality Assurance Unit (SQAU) was to be formed in every State. Similarly, in the districts, a District level Quality Assurance Committee (DQAC) along with District Quality Assurance Unit (DQAU) was to be formed. In the district hospital level, a District Quality Team (DQT) was to be formed to supervise and monitor QA activities.

In Meghalaya, the SQAC and DQAC were formed in February 2014. As per the guidelines, the SQAC was required to conduct review meetings at six monthly intervals. It was however, noticed that till March 2016, only one meeting as against the requirement of four was held in the State. Though the SQAU had been set up, it was noticed that there were no QA activities performed by the SQAU upto March 2016.

At the district and district hospital level, the DQAU and DQT had not been set up as a result of which, no facility had been assessed and there was virtually no monitoring for quality assurance in the State.

On being pointed out (November 2016) the Secretary, Health Department stated (December 2016) that the SQAC and DQAC were reconstituted in August 2016 and few health facilities had also been assessed for quality assurance.

*Even though the Mission objectives included reduction in child and maternal mortality, population stabilisation, universal access to public health care services with emphasis on services addressing women's and children's health and universal immunisation, Audit noticed deficiencies in providing antenatal and postnatal care, shortfall in institutional deliveries, shortfall in immunisation leading to increasing incidents of whooping cough and measles and shortfall in achieving family planning targets. There was also absence of quality assurance activities in the State. All these deficiencies translate into higher Infant Mortality, Maternal Mortality and Total Fertility Rate.*

### *1.3.12 Indicators of performance*

#### *1.3.12.1 Data collection and reporting system*

As per Health Management Information System (HMIS) Service Provider Manual, all SCs, PHCs and CHCs were to send their data to the concerned blocks in the format prescribed for their facility. At the Block level, after data entry is complete, the aggregated reports were to be generated, scrutinised, verified and uploaded on HMIS portal wherever such facility for uploading existed. Following this, paper report duly signed by the designated authority was to be retained by the block and another copy along with the electronic copy of the data was to be sent to the district office. Similarly, at the District level, reports should be generated based on the verified data received from the Blocks. A paper copy of the generated report must be retained at the District Office and a copy (alongwith electronic copy) is to be sent to the State Office.

During audit scrutiny, it was seen that all the selected SCs, PHCs, CHCs were submitting the report to the block office every month and this data was then uploaded to the State portal from the block level.

At the block level, though the SCs, PHCs and CHCs were submitting their reports regularly, the signed copies (hard copies) of the aggregated reports which were generated at the block level were not available. In the district level also, signed copies of the aggregated reports were not available.

Similarly, at the State level, the signed copies of the State aggregated reports which were a combination of all the district reports were not available. In the absence of the signed copies of the aggregated reports at the block, district and State level, Audit could not verify whether the data was accurate and correctly verified prior to its being uploaded and also whether any alteration in data had taken place after consolidation.

Availability of the aggregated reports at the block, district and State level would have helped the Department to later verify the uploaded data and also put a system in place to discourage alterations to data, if at all it takes place after consolidation. It was however, noticed that there were variations in the HMIS data *viz-a-viz* figures as per the registers maintained at all the selected health facilities as detailed in the paragraph below. In the absence of aggregated hard copies, it was not possible to detect where the error occurred.

In reply, the Secretary, Health Department stated that the hard copies of the aggregated reports were not kept at the block, district and State level but only an electronic form was generated. The data in the HMIS formats were checked and verified by the Medical Officer in charge of the facility. The reply was not acceptable since the guidelines clearly stipulated that paper report duly signed by the designated authority should be generated and retained at all levels.

### *1.3.12.2 Data quality and reliability*

In order to verify the accuracy of HMIS data, data elements for the year 2015-16 were cross verified with the figures as per the registers maintained at all the selected health facilities. It was seen that there was discrepancy between the figures reported in the HMIS with the actual figures as per the registers (details are shown in ***Appendix 1.3.5***).

*A data element is an indicator (such as total number of pregnant women registered for ANC, number of women registered under JSY, number of pregnant women who received Tetanus Toxoid-1 etc.) which becomes information and can be acted upon and used for programme monitoring and management*

In the five selected DHs, it was seen that against 15 data elements, the variation between the HMIS figures and the registers ranged between 6 *per cent* and 26 *per cent*. In the three selected CHCs, the variation between the HMIS figures and the resisters against five data elements ranged between 8 *per cent* and 82 *per cent*. In the 12 selected PHCs, the variation between the HMIS figures and registers against 10 data elements ranged between 8 *per cent* and 81 *per cent.* In the 36 selected SCs, the variation between the HMIS figures and registers against ten data elements ranged between 5 *per cent* and 162 *per cent.*

This indicated that data were being captured without proper verification at various levels. Data discrepancy is fraught with the risk of providing inaccurate indicators for the management to plan, implement and monitor health programmes effectively.

In reply, the Secretary, Health Department stated that the data for the five selected DHs in ***Appendix 1.3.5*** was a summation of the data collected from the facility and their respective notional facilities (SCs). The reply was not acceptable since there were no indication of any notional facilities being taken into account in any of the records seen by Audit in the test checked districts and DHs.

### *1.3.12.3 Information, Education & Communication*

The Information Education Communication (IEC) strategy under NRHM aimed to spread awareness on the preventive aspects of health care and ensuring behavioural changes that relate to better child survival and women's health.

The implementation of IEC in the State was done through television/radio/street plays/ dancing competition/dramas/hoardings/advertisements in the print media and

printed material in regional languages as well as by organising health melas and health camps. The amount of funds approved in RoPs and expenditure incurred during the period from 2011-16 is shown below:

**Table 1.3.24 – Funds allocation and expenditure on IEC**

***(₹ in lakh)***

| Year | IEC | |
|---|---|---|
| | **Amount approved in RoP** | **Expenditure incurred *(percentage)*** |
| 2011-12 | 212.86 | 175.07 (82) |
| 2012-13 | 343.18 | 254.13 (74) |
| 2013-14 | 66.98 | 105.55 (100) |
| 2014-15 | 240.23 | 84.39 (35) |
| 2015-16 | 235.91 | 184.31 (78) |
| **Total** | **1099.16** | **803.45 (73)** |

*(Source: Information furnished by SHS)*

From the above, it could be seen that the Department spent ₹ 8.03 crore (73 *per cent*) out of funds allotted during 2011-12 to 2015-16 on IEC related activities. Despite the expenditure of ₹ 8.03 crore, the Department had not been able to create awareness amongst the intended beneficiaries to the extent required. Audit had noticed issues such as:

- A large number of pregnant women were not availing the free ANC services even after registration.
- Many pregnant women still preferred to deliver at home rather than at health institutions.
- Though the State had an IMR of 30 there were still a large number of cases where children were not fully immunised.
- Even though a financial incentive of ₹ 600/- and ₹ 700/- was provided for in the rules to be paid in urban and rural areas respectively for institutional deliveries, the percentage of institutional deliveries in the State was only 49 *per cent* to 53 *per cent* during the period from 2011-12 to 2015-16. This was due to the fact that either the scheme was not adequately publicised or the incentive was not paid properly which discouraged the pregnant women from opting for institutional deliveries.
- Even though health is a matter of primary importance there were issues such as Shallang PHC not being issued a 'No Objection Certificate' by the village durbar to avail a fresh water connection from the community source.

The Department therefore, needs to focus on creating awareness and popularise the scheme among the rural beneficiaries.

### *1.3.12.4 Monitoring and evaluation*

#### *(i) Shortfall of meetings at State level*

At the State level, the Mission functions under the overall guidance of the State Health Mission (SHM) headed by the State Chief Minister. The SHM was required to provide health system oversight, consider policy matters related with health sector, review progress in implementation of NRHM, inter-sectoral coordination, *etc.*

The State Health Society (SHS) was to carry out the functions of the Mission and would be headed by the Chief Secretary. The SHS further consisted of the Governing Body headed by the Chief Secretary and an Executive Committee headed by the Principal Secretary. The functions of the SHS – Governing Body were to approve / endorse the State Action Plan, consider proposals for institutional reforms in the H&FW sector, review implementation of the Annual Action Plan, check status of follow up action on decisions of the State Health Mission, *etc.* whereas the functions of the SHS - Executive Committee were to execute the approved State Action Plan.

As per the framework for implementation 2005-12, the State Health Mission and SHS - Governing Body were to meet at least twice a year while the SHS- Executive Committee was required to meet every month. From May 2013, the framework for implementation 2012-17 came into effect and it stipulated that the Governing Body should meet annually while the Executive Committee should meet at least thrice a year. The actual numbers of meetings held by the SHM, the SHS - Governing Body and the SHS- Executive Committee during the period covered by Audit is shown below:

**Table 1.3.25 – Details of Meeting held at State level**

| Name of Committee | No. of meetings required to be held during 2011-13 | No. of meetings required to be held during 2013-16 | Total meetings to be held | No. of meetings actually held during 2011-16 | Shortfall |
|---|---|---|---|---|---|
| State Health Mission | 4 | 3 | 7 | 0 | 7 |
| SHS- Governing Body | 4 | 3 | 7 | 5 | 2 |
| SHS- Executive Committee | 24 | 9 | 33 | NA | - |

***Source: Information furnished by SHS***

- It can be seen from the above that during 2011-16, the SHM did not meet even once though seven meetings were to be held.
- The SHS – Governing Body met only five times out of the required seven meetings but minutes of the meetings were not produced to Audit, though called for (August 2016). Thus, implementation of NRHM in Meghalaya was bereft of any guidance at the SHM level during 2011-16.
- No records were available to indicate the number of meetings held by SHS - Executive Committee. The Department replied (September 2016) that Executive Meetings were held on a regular basis chaired by the Mission Director. The Department however, could not furnish the exact number of meetings held and

only furnished one sample copy of minutes of meetings held in support of their reply.

The Secretary, Health Department accepted (December 2016) the fact that SHM meetings were not held since 2011 and also that SHS meetings were held once in a year but not as per the framework for implementation on the number of meetings to be conducted.

### *(ii) Shortfall in formation of VHSNC*

One of the key elements of the NRHM is formation of the Village Health, Sanitation and Nutrition Committees (VHSNCs). Among other things, the VHSNCs were to provide an institutional mechanism for the community to be informed of health programmes and government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes.

The position of formation of VHSNCs in the State was not furnished though called for (August 2016). The position of formation of VHSNCs in the three selected districts during 2011-16 is as shown below:

**Table 1.3.26 - Position of formation of VHSNCs in three districts**

| Year | WEST KHASI HILLS | | | RI BHOI | | | WEST GARO HILLS | | |
|---|---|---|---|---|---|---|---|---|---|
| | No. of VHSNCs required | | | No. of VHSNCs required | | | No. of VHSNCs required | | |
| | To be formed | Actually formed | Shortfall | To be formed | Actually formed | Shortfall | To be formed | Actually formed | Shortfall |
| 2011-12 | 1136 | 1028 | 108 | 596 | 490 | 106 | 1617 | 1617 | - |
| 2012-13 | 1136 | 1028 | 108 | 596 | 490 | 106 | 1617 | 1617 | - |
| 2013-14 | 1170 | 1081 | 89 | 596 | 494 | 102 | 1617 | 1617 | - |
| 2014-15 | 1170 | 1081 | 89 | 596 | 495 | 101 | 1627 | 1627 | - |
| 2015-16 | 878 | 807 | 71 | 596 | 521 | 75 | 1161 | 1161 | - |

*Source: Information furnished by districts*

It can be seen from the above that West Khasi Hills and Ri Bhoi districts consistently failed to form the required number of VHSNCs during 2011-16 while West Garo Hills had no shortage during the same period. There was a shortfall of 71 and 75 numbers of VHSNCs in West Khasi Hills and Ri Bhoi districts respectively as of March 2016. Thus, 146 villages in two districts were deprived of an institutional mechanism for the community to be informed of health programmes and government initiatives. In reply (December 2016), the Secretary, Health Department stated that the VHSNCs were required to be formed at revenue villages and the reason for shortfall in the two districts were because the villages had not been verified by the office of the Block Development Officer. The Department should take up the matter with the respective Block Development Officers for early completion of the verification process.

### *(iii) Approval of Plans by SHS*

As per guidelines, NRHM should follow a bottom-up approach for planning and budgeting. This planning process requires setting up of planning teams and committees at various levels *i.e.* at Habitation/ Village, SC (Gram Panchayat), PHC (Cluster level), CHC/Block level and District level. The process begins at the block

where the Block Health Action Plan (BHAP) should be prepared based on inputs/discussions with the implementing units. These BHAPs are then aggregated at the district to form an Integrated District Health Action Plan (IDHAP) which is further sent to the State level. The DHAPs of all districts are compiled and aggregated at the State level for framing the State Program Implementation Plan (SPIP). All SPIPs are reviewed and approved by the SHS-GB.

Audit scrutiny revealed that though VHSNCs were formed at the village level, there were no records of any plans prepared at the village or the block level. The District Plans were prepared at the district level without any record of participation from the village level to block level.

Further, as per NRHM guidelines, baseline facility survey and annual facility surveys were required to be conducted. The baseline facility survey of any health facility, say CHC, would indicate the interventions which were available at the beginning of the Mission. This survey when repeated after a gap would provide the details of improvement which came about due to the investments made under the NRHM and would provide valuable inputs for monitoring the progress. In Meghalaya, baseline facility survey and annual facility surveys were not conducted during 2011-16. Despite these shortcomings, all SPIPs were approved by the SHS-GB.

In reply, the Secretary, Health Department stated (December 2016) that the SPIP was reviewed and approved by SHS before submission to GoI. The reply was however, silent on the other issues pointed out in the paragraph.

*Successful implementation of the Mission greatly depends on proper monitoring and evaluation. Audit however, noticed that there was no system in place to cross verify the accuracy of uploaded data and there was irregularity in data quality and reliability. There was also shortfall in number of meetings at the Mission level (SHM) and governing body (SHS-GB). Therefore the purpose of forming these bodies were not achieved as envisaged. The district plans were prepared without any record of participation from the village / block level.*

### *1.3.12.5 Beneficiary and ASHA survey*

A survey of 354 beneficiaries and 108 ASHAs from the 36 selected SCs was carried out during audit. The findings of the survey are discussed below:

- Out of 354 beneficiaries who responded, 99 *per cent* stated that they knew who an ASHA and ANM worker was.
- Out of 350 beneficiaries who registered their pregnancies, only 181 (52 *per cent)* said they registered within the first trimester, 149 (42 *per cent)* said they registered within the second trimester and 20 (6 *per cent)* said they registered in the third trimester. This indicated that registration of pregnant women in the first trimester was low. ASHAs should be instructed to motivate pregnant women to register within the first trimester.

- Out of 353 respondents, only 86 (24 *per cent)* stated that they received ANC services from the doctor/nurse while 267 (76 *per cent)* of the respondents stated that they received ANC services only from the ANM/ASHA.
- Out of 354 respondents, only 91 (26 *per cent)* stated that they visited DHs/ private hospitals/ CHCs/ PHCs for their ANC services while the remaining 263 (74 *per cent)* stated that they visited SCs, Anganwadi centres, *etc.*, for their ANC services. This indicated that the State needs to reduce its shortage of SCs since many pregnant women preferred visiting the SCs for their ANC services.
- 213 respondents stated that they delivered at home. Some of the reasons for delivering at home rather than at the health facilities as stated by the beneficiaries were because the health facilities were too far/ lack of transportation (77 responses), they did not feel it necessary (39 responses), child was born before reaching the facility (65 responses), and other reasons such as no attendants, prefer to deliver at home, did not feel the requirement, delivery before due date, previous deliveries also being at home, *etc.* This indicated the State had not managed to motivate pregnant women to adopt ID.
- Out of 138 respondents who delivered at an institution, 99 (72 *per cent)* were discharged within 48 hours of their delivery. This indicated that adequate emphasis was not given to manage post natal emergencies by ensuring that the pregnant women stayed at the hospital for at least 48 hours after delivery.

The results of the survey of 108 ASHAs are discussed below:

- Out of 108 ASHAs who responded, only 24 (22 *per cent*) of the ASHAs stated that they were trained and had the necessary equipment to conduct a normal delivery.
- Out of 107 ASHAs who responded, 69 (65 *per cent)* stated that they worked only three or less days.
- ASHAs were expected to be equipped with certain equipment and drugs so as to enable them to perform their duties. The result of the survey showing the availability of basic equipment with ASHA is shown in the table below:

**Table – 1.3.27 - Availability of basic equipment with ASHA**

| **Type of equipment/ drug (Number of ASHAs who responded)** | **No. of ASHAs having it in possession and knowing how to use** | | **No. of ASHAs having it in possession but not knowing how to use** | | **No. of ASHAs not having the equipment/ drug** | |
|---|---|---|---|---|---|---|
| Thermometer (108) | 72 | 66 *per cent* | 5 | 5 *per cent* | 31 | 29 *per cent* |
| Disposable delivery kit (108) | 8 | 7 *per cent* | 3 | 3 *per cent* | 97 | 90 *per cent* |
| Pregnancy kit -Nischay kit (108) | 58 | 54 *per cent* | 0 | 0 | 50 | 46 *per cent* |
| Blood Pressure Monitor (107) | 3 | 3 *per cent* | 17 | 16 *per cent* | 87 | 81 *per cent* |
| Weighing Sale for newborns (108) | 89 | 82 *per cent* | 2 | 2 *per cent* | 17 | 16 *per cent* |
| Paracetamol Tablets (108) | 90 | 83 *per cent* | 0 | 0 | 18 | 17 *per cent* |
| Iron Pills (107) | 66 | 62 *per cent* | 1 | 1 *per cent* | 40 | 37 *per cent* |
| Deworming Pills (108) | 66 | 61 *per cent* | 5 | 5 *per cent* | 37 | 34 *per cent* |

### *1.3.12.6 Assessment of performance*

The main aim of NRHM was to achieve the goals set under the National Health Policy and the Millenium Development Goals which were reduction of infant mortality rate (IMR), maternal mortality ratio (MMR) and total fertility rate (TFR). The achievement of these key health indicators at the start of 2011-12 and the end of 2015-16 are shown below:

**Table 1.3.28 - Achievement of key health indicators**

| Name of health indicator | GoI target for the year | | State position for the year | |
|---|---|---|---|---|
| | 2005-12 | 2012-16 | 2011-12 | 2015-16 |
| IMR (per 1000 live births) | 30 | 26 | 52 | 30 |
| MMR (per one lakh live births) | 100 | 100 | 229 | 211 |
| TFR | 2.1 | 2.1 | 2.9 | 3.0 |

*(Source: Information furnished by SHS)*

It can be seen from the above table that although there was an improvement in IMR and MMR from 2011-12 to 2015-16, the TFR increased from 2.9 during 2011-12 to 3.0 in 2015-16. Also, the achievement of the State fell short of the target set by GoI.

It was further seen that during the period from 2011-16, the number of cases of maternal deaths in the State was always above 200 per one lakh live births which was way above the target of 100 per one lakh live births set by GoI as can be seen from the table below:

**Table 1.3.29 – Cases of maternal deaths**

| Year | Out of total no. of deliveries, no. of cases of maternal deaths | Total no. of live births (male / female) | | Total live birth | Rate of maternal deaths per lakh as calculated by Audit |
|---|---|---|---|---|---|
| | | Male | Female | | |
| 2011-12 | 229 | 39265 | 37407 | 76672 | 299 |
| 2012-13 | 232 | 40326 | 38717 | 79043 | 294 |
| 2013-14 | 241 | 42401 | 40392 | 82793 | 291 |
| 2014-15 | 187 | 43781 | 41076 | 84857 | 220 |
| 2015-16 | 211 | 43930 | 41834 | 85764 | 246 |
| **Total** | **1100** | **209703** | **199426** | **409129** | **269** |

(Source: Information furnished by SHS)

Further, the average number of deaths calculated per one lakh live births during the period 2011-16 was 269 which was higher than the figures projected by the Department. Hence, the various deficiencies pointed out in the preceding paragraphs such as lack of health infrastructure, drugs and manpower not only resulted in depriving the populace of health benefits but the State had failed even to reduce maternal deaths.

### *1.3.13 Conclusion*

Performance audit disclosed shortages in availability of required healthcare facilities such as PHCs and SCs, unavailability of essential drugs, lack of infrastructure in the health facilities, equipment lying unutilised *etc.* Required infrastructural facilities *viz.* operation theatres, blood bank facility, water supply, telephone connections, *etc* were not found available in selected healthcare facilities. In other cases, infrastructure was created but were lying unutilised for want of required personnel to operate them. Shortages in availability of required manpower, especially medical specialists was a serious impediment in the proper delivery of healthcare services. A large number of pregnant women did not show up for antenatal care while a number of them did not receive the full dose of IFA tablets. 47 *per cent* to 51 *per cent* of registered pregnant women preferred to deliver at home rather than at health facilities. There was shortfall in achievement of immunisation as well as sterilisations. There was shortfall in payment of JSY incentive despite of availability of funds. All these indicated that the State Government had failed to connect the scheme with the people who are the stakeholders. The Quality Assurance Committees at various levels did not meet at the prescribed intervals to assess the quality of the services being delivered. Mismatch of data as per HMIS and data as per original records maintained at the healthcare facilities was noticed. Monitoring of the Mission by SHM headed by the Chief Minister was absent while monitoring by SHS headed by the Chief Secretary was minimal thus indicating that adequate priority was not being accorded to the health sector in the State. Considering that there is a strong correlation between facilities created and health outcomes (IMR, MMR and TFR), the deficiencies were responsible in preventing the State from achieving the targets set by GoI.

### *1.3.14 Recommendations*

The recommendations of Audit are:

- *Establishment of new PHCs and SCs should be as per norms, functional FRUs should be established in all the districts and efforts should be made to upgrade the existing health infrastructure to IPHS standard.*
- *SHS should strengthen its procurement system of equipment and drugs and ensure availability of essential drugs at the health facilities.*
- *Provision of essential medical and paramedical staff should be ensured in the Health facilities.*
- *Effort should be made to motivate institutional deliveries, provide ANC services, ensure universal immunisation and encourage family planning.*
- *Quality Assurance activities should be taken up as per the guidelines so as to ensure quality service at all health facilities.*
- *Regular monitoring by SHM, SHS and by Quality assurance units should be carried out regularly and their recommendations vigorously followed.*

## Appendix – 1.3.1

## The lists of offices / units/ hospitals, *etc.* selected for 'Performance Audit of NRHM'

## (Reference: Paragraph 1.3.5)

| **State Level** | ***State Health Society i/c State Programme Management Unit & Engineering wing*** | | | | | |
|---|---|---|---|---|---|---|
| **District Level** | ***District Health Society, West Khasi Hills*** | | ***District Health Society, Ri Bhoi*** | | ***District Health Society, West Garo Hills*** | |
| | ***District Hospital, Nongstoin & Tirot Singh Memorial Hospital, Mairang*** | | ***District Hospital, Nongpoh*** | | ***Tura Civil Hospital & Tura MCH Hospital*** | |
| **Block Level i/c CHC Level** | ***Mawshynrut block*** | ***Nongstoin block*** | ***Umsning block*** | ***Umling block*** | ***Gambeggre block*** | ***Rongram block*** |
| | ***Riangdo CHC*** | ***-*** | ***Umsning CHC & Bhoirymbong CHC*** | ***-*** | ***-*** | ***-*** |
| **PHC Level** | ***1. Nonglang PHC***<br>***2. Shallang PHC*** | ***1. Rambrai PHC***<br>***2. Maweit PHC*** | ***1. Mawlasnai PHC***<br>***2. Kyrdem PHC*** | ***1. Marngar PHC***<br>***2. Byrnihat PHC*** | ***1. Darengre PHC***<br>***2. Mellim PHC*** | ***1. Asananggiri PHC***<br>***2. Babadam PHC*** |
| **Sub Centre level** | ***Under Nonglang PHC***<br>***1. Langja SC***<br>***2. Kyrdum SC***<br>***3. Nongmisei SC***<br><br>***Under Shallang PHC***<br>***1. Nongdaju SC***<br>***2. Riangdim SC***<br>***3. Seinduli SC*** | ***Under Rambrai PHC***<br>***1. Kyrshai SC***<br>***2. Mawdoh SC***<br>***3. Mawdum-dum SC***<br><br>***Under Maweit PHC***<br>***1. Mawrynniaw SC***<br>***2. Miangshang SC***<br>***3. Porkhadoh SC*** | ***Under Mawlasnai PHC***<br>***1. Tyrso SC***<br>***2. Kyrdemkulai SC***<br>***Mawleiñ SC***<br><br>***Under Kyrdem PHC***<br>***1. Mawbsein SC***<br>***2. Mawlyndep SC***<br>***3. Mawtari Myrdon SC*** | ***Under Marngar PHC***<br>***1. Umsawnongbri SC***<br>***2. Narang SC***<br>***3.Umsawnongkharai SC***<br><br>***Under Byrnihat PHC***<br>***1. Amjong SC***<br>***2. Baridua SC***<br>***3. Pillangkata SC*** | ***Under Darengre PHC***<br>***1. Chisakgre SC***<br>***2. Dakopgre SC***<br>***3. Gambegre SC***<br><br>***Under Mellim PHC***<br>***1. Mellim SC***<br>***2. Okkapara SC***<br>***3. Damalgre SC*** | ***Under Asananggiri PHC***<br>***1. Baljek SC***<br>***2. Waribokgre SC***<br>***3. Rombagre SC***<br><br>***Under Babadam PHC***<br>***1. Babadam SC***<br>***2. Boldakgre SC***<br>***3. Chidekgre SC*** |

## Appendix – 1.3.2
## Statement showing availability of drugs in test checked DHs, CHCs and PHCs

### (Reference: Paragraph 1.3.9.10 (ii))

*(Figures in brackets represents the percentage)*

| Name of health facility | Total number of drugs required as per the State Essential Drug List | 2011-12 | | | 2012-13 | | | 2013-14 | | | 2014-15 | | | 2015-16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Drugs available and sufficient | Available but not sufficient | Drugs not available | Drugs available and sufficient | Available but not sufficient | Drugs not available | Drugs available and sufficient | Available but not sufficient | Drugs not available | Drugs available and sufficient | Available but not sufficient | Drugs not available | Drugs available and sufficient | Available but not sufficient | Drugs not available |
| Nongstoin DH | 355 | 36 (10) | 14 (4) | 305 (86) | 44 (12) | 18 (5) | 293 (83) | 50 (14) | 24 (7) | 281 (79) | 61 (17) | 16 (5) | 77 (78) | 62 (17) | 7 (2) | 286 (81) |
| Mairang DH | 355 | 96 (27) | 2 (1) | 257 (72) | 72 (20) | 2 (1) | 281 (79) | 69 (19) | 2 (1) | 284 (80) | 68 (19) | 1 (0) | 286 (81) | 71 (20) | 1 (0) | 283 (80) |
| Nongpoh DH | 355 | 118 (33) | 14 (4) | 223 (63) | 72 (20) | 19 (5) | 264 (75) | 67 (19) | 14 (4) | 274 (77) | 70 (20) | 18 (5) | 267 (75) | 69 (19) | 43 (12) | 243 (68) |
| Tura DH | 355 | 46 (13) | 8 (2) | 301 (85) | 46 (13) | 6 (2) | 303 (85) | 43 (12) | 8 (2) | 304 (86) | 48 (14) | 8 (2) | 299 (84) | 48 (14) | 11 (3) | 296 (83) |
| Tura MCH Hospital | 355 | 15 (4) | 46 (13) | 294 (83) | 12 (3) | 33 (10) | 310 (87) | 24 (7) | 22 (6) | 309 (87) | 37 (10) | 16 (5) | 302 (85) | 41 (12) | 11 (3) | 303 (85) |
| Bhoirymbong CHC | 226 | 11 (5) | 38 (17) | 177 (78) | 14 (6) | 27 (12) | 185 (82) | 9 (4) | 24 (11) | 193 (85) | 13 (6) | 26 (12) | 187 (82) | 37 (16) | 18 (8) | 171 (76) |
| Umsning CHC | 226 | 41 (18) | 41 (18) | 144 (64) | 32 (14) | 35 (15) | 159 (71) | 19 (8) | 38 (17) | 169 (75) | 37 (16) | 18 (8) | 171 (76) | 34 (15) | 27 (12) | 165 (73) |
| Riangdo CHC | 226 | 46 (20) | 32 (14) | 148 (66) | 46 (20) | 32 (14) | 148 (66) | 48 (21) | 30 (13) | 148 (66) | 49 (22) | 29 (13) | 148 (65) | 48 (21) | 29 (13) | 149 (66) |
| Byrnihat PHC | 180 | 71(39) | 17 (9) | 92 (52) | 71 (39) | 18 (10) | 91 (51) | 66 (37) | 17 (9) | 97 (54) | 54 (30) | 12 (7) | 114 (63) | 53 (29) | 8 (4) | 119 (67) |
| Marngar PHC | 180 | 17 (9) | 30 (17) | 133 (74) | 16 (9) | 26 (14) | 138 (77) | 16 (9) | 25 (14) | 140 (77) | 16 (9) | 25 (14) | 139 (77) | 28 (16) | 19 (11) | 133 (75) |
| Kyrdem PHC | 180 | 21 (12) | 15 (8) | 144 (80) | 23 (13) | 12 (17) | 145 (80) | 28 (16) | 12 (7) | 140 (77) | 29 (16) | 9 (5) | 142 (79) | 32 (18) | 8 (4) | 140 (78) |
| Mawlasnai PHC | 180 | 67 (37) | 28 (16) | 85 (47) | 69 (38) | 34 (19) | 87 (49) | 47 (26) | 31 (17) | 102 (57) | 49 (27) | 27 (15) | 104 (58) | 48 (27) | 20 (11) | 112 (63) |
| Nonglang PHC | 180 | 12 (7) | 43 (24) | 125 (69) | 13 (7) | 43 (24) | 124 (69) | 14 (8) | 42 (23) | 124 (69) | 14 (8) | 35 (19) | 131 (73) | 16 (9) | 30 (17) | 134 (74) |
| Rambrai PHC | 180 | 29 (16) | 34 (19) | 117 (65) | 27 (15) | 34 (19) | 119 (66) | 25 (14) | 35 (19) | 120 (67) | 23 (13) | 35 (19) | 122 (68) | 23 (13) | 32 (18) | 125 (69) |
| Maweit PHC | 180 | 43 (24) | 13 (7) | 124 (69) | 43 (24) | 13 (7) | 124 (69) | 43 (24) | 13 (7) | 124 (69) | 43 (24) | 13 (7) | 124 (69) | 64 (36) | 4 (2) | 112 (62) |
| Shallang PHC | 180 | 5 (3) | 45 (25) | 130 (72) | 5 (3) | 45 (25) | 130 (72) | 5 (3) | 45 (25) | 130 (72) | 5 (3) | 46 (25) | 129 (72) | 4 (2) | 47 (26) | 129 (72) |
| Asanang PHC | 180 | 41 (23) | 5 (3) | 134 (74) | 40 (22) | 4 (2) | 136 (76) | 37 (21) | 4 (2) | 139 (77) | 46 (26) | 0 | 134 (74) | 45 (25) | 5 (3) | 130 (72) |
| Babadam PHC | 180 | 31 (17) | 15 (9) | 134 (74) | 34 (19) | 12 (7) | 134 (74) | 23 (13) | 14 (8) | 143 (79) | 24 (13) | 14 (8) | 142 (79) | 40 (22) | 11 (6) | 129 (72) |
| Mellim PHC | 180 | 16 (9) | 14 (8) | 150 (83) | 21 (12) | 16 (9) | 143 (79) | 30 (17) | 9 (5) | 141 (78) | 26 (14) | 9 (5) | 145 (81) | 20 (11) | 9 (5) | 151 (84) |
| Darenggre PHC | 180 | 51 (28) | 14 (8) | 115 (64) | 56 (31) | 14 (8) | 110 (61) | 53 (29) | 7 (4) | 120 (67) | 53 (29) | 7 (4) | 120 (67) | 57 (32) | 9 (5) | 114 (63) |

*(Source: Records maintained at health facilities)*

## Appendix – 1.3.3
## Statement showing purchase of medicines at Higher Rate
## (Reference: Paragraph 1.3.9.10 (iii))

| Sl. No. | Name of Medicines | Medicine purchased during 2011-13 | | | Approved rate (Per 100) as per DHS (MI) | Excess rate (Per 100) paid (4-6) | Avoidable Extra Expenditure (3x7) |
|---|---|---|---|---|---|---|---|
| | | Quantity | Rate (Per 100) | Amount Paid | | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 1 | Amoxycilin 250 mg Cap | 675000 | 114.00 | 769500 | 89.00 | 25 | 168750 |
| 2 | Amoxycilin 500 mg Cap | 1391200 | 200.00 | 2782400 | 134.00 | 66 | 918192 |
| 3 | Ampicillin 250 mg Cap | 674000 | 108.50 | 731290 | 85.00 | 23.50 | 158390 |
| 4 | Ampicillin 500 mg Cap | 1400000 | 189.00 | 2646000 | 153.00 | 36 | 504000 |
| 5 | Cephalexin 250 mg Cap | 374000 | 150.00 | 561000 | 127.52 | 22.48 | 84075 |
| 6 | Cephalexin 500 mg Cap | 859900 | 272.00 | 2338928 | 225.00 | 47 | 404153 |
| 7 | Ciprofloxacin 250 mg Tab | 300000 | 96.00 | 288000 | 69.85 | 26.15 | 78450 |
| 8 | Ciprofloxacin 500 mg Tab | 492500 | 186.00 | 916050 | 128.15 | 57.85 | 284911 |
| | | | | | | **Total:** | **2600921** |

## Appendix – 1.3.4

**Statement showing the targets and achievement of immunisation in the State**
**(Reference: Paragraph 1.3.11.5)**

| Year | Target for complete immunisa-tion (0 months – 2 years) | Actual Achievement (for all vaccines as prescribed) | | | | Target (5 years) | Actual Achieve-ment (for all vaccines as prescribed) | Percen-tage | Target (10 years) | Actual Achievement (for all vaccines as prescribed) | Percen-tage | Target for administration of vitamin A | Actual achievement (1st to 5th dose) | Percen-tage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Upto one year fully immunised | 12-23 months fully immunised | Total | Percen-tage | | | | | | | | | |
| **2011-12** | 155827 | 58582 | 22147 | 80729 | 52 | 78307 | 22106 | 28 | 81319 | 39245 | 48 | NA | 149739 | - |
| **2012-13** | 165036 | 64855 | 19058 | 83913 | 51 | 78742 | 25299 | 32 | 81770 | 49547 | 61 | 360394 | 110423 | 31 |
| **2013-14** | 164917 | 68383 | 18833 | 87216 | 53 | 81564 | 25702 | 32 | 84701 | 50626 | 60 | 373314 | 25082 | 7 |
| **2014-15** | 170168 | 68528 | 19609 | 88137 | 52 | 83912 | 25086 | 30 | 87139 | 33951 | 39 | 384058 | 115383 | 30 |
| **2015-16** | 175091 | 66242 | 18433 | 84675 | 48 | 86255 | 25866 | 30 | 89572 | 24248 | 27 | 394782 | 100597 | 25 |
| **Total** | **831039** | **326590** | **98080** | **424670** | **51** | **408780** | **124059** | **30** | **424501** | **197617** | **47** | **1512548** | **501224** | **33** |

*(Source: Information furnished by SHS)*

## Appendix – 1.3.5
## Statement showing variation in data recorded in HMIS and data as per records of the test checked health facilities
## (Reference: Paragraph 1.3.12.2)

| Ref No | Data element | Test check in 5 selected District Hospital | | |
|---|---|---|---|---|
| | | As per HMIS | As per records | Difference (*per cent*) [Col3-Col4] |
| 1 | 2 | 3 | 4 | 5 |
| 1. | Total number of pregnant women registered for ANC | 3369 | 3831 | - 462 (14) |
| 1.1 | Of which number registered within first trimester (within 12 weeks) | 902 | 1025 | - 123 (17) |
| 2 | Number of women registered under JSY | 2521 | 3008 | - 487 (19) |
| 3 | Number of pregnant women who received 3 ANC checkup | 2361 | 2714 | - 353 (15) |
| 4.1 | Number of pregnant women who received TT1 | 1675 | 1987 | - 312 (19) |
| 4.2 | TT2 or Booster | 2337 | 2665 | - 328 (14) |
| 7.1 | Number of pregnant women having Haemoglobin level < 11 | 4194 | 5058 | - 864 (21) |
| 16 | Number of women getting post partum check up between 48 hours and 14 days | 2578 | 2744 | - 166 (6) |
| 17 | Number of PNC maternal complications attended | 315 | 233 | 82 (26) |
| 33.01 | Number of children given BCG | 3115 | 3480 | - 365 (12) |
| 33.02 | Number of children given DPT1 | 1032 | 1210 | - 178 (17) |
| 33.03 | Number of children given DPT2 | 1162 | 1368 | - 206 (18) |
| 33.04 | Number of children given DPT3 | 1351 | 1574 | - 223 (17) |
| 33.11 | Number of children given hepatitis B3 | 1329 | 1552 | - 223 (17) |
| 33.15 | Number of children given DPT booster | 1054 | 797 | - 156 (15) |
| **Ref No** | **Data element** | **Test check in 3 selected CHCs** | | |
| | | **As per HMIS** | **As per records** | **Difference (*per cent*)** |
| 4.1 | Number of pregnant women who received TT2 or booster | 1171 | 960 | 211 (18) |
| 7.1 | Number of pregnant women having Haemoglobin level < 11 | 1165 | 1066 | 99 (8) |
| 33A | Number of children between 9 to 12 months who received JE 1st dose | 148 | 269 | - 121 (82) |
| 43 | Number of children suffering from diarrhoea and dehydration | 815 | 573 | 242 (30) |
| 45 | Number of children admitted with respiratory infection | 439 | 319 | 120 (27) |
| **Ref No** | **Data element** | **Test check in 12 selected PHCs** | | |
| | | **As per HMIS** | **As per records** | **Difference (*per cent*)** |
| 5 | Total number of pregnant women given 100 IFA tablets | 772 | 1036 | - 264 (34) |
| 7.1 | Number of pregnant women having Haemoglobin level < 11 | 2327 | 2151 | 176 (8) |
| 31 | Number of condom pieces distributed | 4173 | 3420 | 753 (18) |
| 35.6 | Number of children given OPV1 | 2181 | 2992 | - 811 (37) |
| 37.2 | Number of children (more than 10 years) given TT10 | 376 | 682 | - 306 (81) |
| 40.1 | Number of children (more than 16 months) given JE | 1711 | 1492 | 219 (13) |
| 49 | Number of children admitted with respiratory infection | 739 | 247 | 492 (67) |
| 62a | Number of patients who availed AYUSH services | 21253 | 12617 | 8636 (41) |
| 64c | Number of ANC women tested | 449 | 639 | - 190 (42) |
| 67.3 | Number of patients who tested positive for plasmodium Falcipuram | 2291 | 1658 | 633 (28) |