CHAPTER-4
Implementation

4.1 Action Plan for implementation of TSP

As per the guidelines of Planning Commission (2006), the TSP was to be implemented by constitution of dedicated unit in every ministry/department and oversight by Ministry of Tribal Affairs.

4.1.1 Utilisation of TSP funds

The basic objective of Tribal Sub-Plan is to channelize the flow of outlays from central Ministries/departments by earmarking funds for the development of Scheduled Tribes in the States, at least in proportion to their population. However, even though funds from central level were released under trifurcated head Gen/SC/ST to the states and states to district implementing agencies, the accounts for such expenditure was not maintained separately at each level. At the grass root level, there was no proper earmarking of TSP funds and hence, no assurance that the final objective of earmarking was getting fulfilled could be derived. Though TSP is a planning based strategy, allocations or earmarking were not based on tribal specific plans.

In view of this, audit selected two sectors viz. Education & Health in tribal concentrated districts of the states for examination of the methodology followed for utilisation of TSP funds. Schemes under these two sectors were also chosen on the basis of allocation of funds under TSP. The allocation of TSP funds for the year 2011-12 to 2013-14 under these schemes is given below:

Scheme-wise Financial Position of TSP funds during 2011-14

(` in crore)

Name of Scheme	Period	Total allocation of funds	Funds earmarked under TSP head'796'	Funds released under TSP
Education Sector				
Sarva Shiksha Abhiyan	2011-12	61734.36	6518.23	2276.26
	2012-13	69875.30	7475.67	2632.90
	2013-14	49130.24	5265.57	2910.09
	Total	**180739.90**	**19259.47**	**7819.25**
Mid-Day Meal	2011-12	9901.91	1110.66	1087.49
	2012-13	10867.90	1277.26	1172.75
	2013-14	10927.21	1417.23	1339.82
	Total	**31697.02**	**3805.15**	**3600.06**

Rashtriya Madhyamik Shiksha Abhiyan	2011-12	2512.45	273.73	273.73
	2012-13	3172.63	342.81	342.81
	2013-14	3123.00	366.99	366.99
	Total	**8808.08**	**983.53**	**983.53**
Restructuring and Reorganization of the Centrally Sponsored Scheme on Teachers Education	2011-12	500.00	Not available	57.88
	2012-13	500.00		76.62
	2013-14	500.00		60.46
	Total	**1500.00**		**194.96**
Information and Communication Technology	2011-12	500.00	53.50	53.21
	2012-13	352.70	37.50	37.45
	2013-14	559.14	42.28	42.28
	Total	**1411.84**	**133.28**	**132.94**
Health Sector				
National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke	2011-12	125.00	10.00	9.92
	2012-13	300.00	24.60	0.02
	2013-14	300.00	32.70	9.32
	Total	**725.00**	**67.3**	**19.26**
National Programme for Health Care for the Elderly	2011-12	75.00	0.00	Nil
	2012-13	150.00	12.30	4.82
	2013-14	50.00	5.45	0.30
	Total	**275.00**	**17.75**	**5.12**
Immunisation	2011-12	871.00	101.90	97.09
	2012-13	1605.00	171.51	116.65
	2013-14	1605.00	174.94	157.31
	Total	**4081.00**	**448.35**	**371.05**
Infrastructure Maintenance	2011-12	4280.00	327.00	395.36
	2012-13	4928.00	527.64	625.43
	2013-14	4928.00	537.13	534.15
	Total	**14136.00**	**1391.77**	**1554.94**
Flexible Pool for State PIPs	2011-12	9890.00	1334.00	1334.00
	2012-13	10789.51	1155.21	1291.08
	2013-14	11111.01	1211.07	1267.54
	Total	**31790.52**	**3700.28**	**3892.62**

Shortcomings in Implementation

4.2. Lack of oversight by the Ministry of Tribal Affairs

Planning Commission's guidelines stipulated that the Ministry of Tribal Affairs (MOTA) should be involved in the process of finalisation of Annual Plan of the Central Ministries/Departments. Audit noticed that the Ministry of Tribal Affairs was neither involved in the annual planning exercise nor there were any guidelines detailing the processes for such oversight.

The Ministry of Tribal Affairs stated (October 2014) that it had not been invited to contribute to the process of formulation and finalisation of Annual Plan of any Central Ministries/Departments.

Thus, Planning Commission guidelines remained only on paper in the absence of any oversight role being exercised by the Ministry of Tribal Affairs which is a clear failure of governance.

4.3 Delayed formation of dedicated unit and formulation of TSP guidelines by the Ministry

The Planning Commission recommended for implementation of TSP from the financial year 2011-12 by central ministries/departments. As per the guideline, a dedicated unit was to be constituted in every central ministry/department as nodal unit for formulation and implementation of TSP. Audit noticed that there were delays in formation of nodal units in the ministries/departments. A chronology of delays in formation of such nodal units is exhibited below:

June 2012	A nodal unit i.e. National Monitoring Committee (NMC) for Education was constituted after a delay of one and a half years.
July 2012	Apart from the constitution of NMC, a standing committee for assistance of NMC and six task forces for assistance of the standing committee were also constituted.
April 2013	The work of preparation of guideline on implementation of TSP in the ministry was assigned to the standing committee which was submitted for recommendation of the NMC.
October 2013	After recommendation, guidelines were circulated to all the concerned departments of the MHRD after a delay of two and a half years. This in turn delayed the actual implementation of TSP.
October 2013	The MHRD issued guidelines on implementation and also uploaded it on the ministry's website. The guidelines were to be implemented by all organizations under the administrative control of the ministry. Para 2 (iv) (b) of the above guidelines provides that all organizations under the administrative control of the Ministry of HRD will designate a nodal unit or a committee or Project Approval Board (PAB) in case of centrally sponsored schemes to oversee the implementation of TSP in their respective organisations/programmes. These units/committees/PABs after estimating the gap in the educational development of STs, prioritize the development needs of STs through a consultation process and shall prepare TSP in respect of these organisations/schemes with the approval of the competent authority.

December 2013	After the issue of guidelines, the UGC could formulate the nodal unit.
May and June 2014	After the formulation of Nodal Unit only two meetings of the nodal unit were conducted in May and June 2014 (after a delay of 5 months).
April 2014	Only draft guidelines on implementation of TSP in UGC had been forwarded to the Ministry for approval which was awaited.

4.4 Non creation of (IEC) key activities under NPCDCS and NPHCE (Transfer to scheme portion)

The guidelines of National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke provides that, Central Government will prepare prototype Information, Education & Communication (IEC) material on cancer, diabetes, hypertension and cardiovascular diseases including stroke to sensitize community about risk factors to promote healthy life style and inform about services available through various electronic, print media and other channels.

Audit noticed that no such Information, Education & Communication (IEC) activities were carried out for the benefit of the tribal people by the scheme cell in both the programmes during the period 2011-12 to 2013-14.

4.5 State specific findings under selected schemes

As mentioned in Para 2.1.2 of Chapter 2 of this report, Audit examined a few major components of five major schemes implemented by the Department of School Education and Literacy and Department of Health and Family Welfare in states having tribal population. Audit noted that the TSP fund had been amalgamated with other funds and no segregation was available at the state level. Results of examination of selected schemes are discussed in the following paragraphs**.**

4.5.1 Education

4.5.1.1 Sarva Shiksha Abhiyan (SSA)

SSA was launched by GOI, Ministry of Human Resource Development (MHRD) in 2001-02 for ensuring elementary education for all children aged 6 to 14 years in the country, with its focus on adequate school infrastructure, personnel, academic support, specific focus on disadvantaged social groups (including Scheduled Tribes). To provide

additional components for education of girls at elementary level, GOI introduced the National Programme for Education of Girls at Elementary Level (NPEGEL) and Kasturba Gandhi Balika Vidyalaya (KGBV) Scheme as an additional support to the SSA in 2003 and August 2004 respectively.

4.5.1.1(i) Deficiencies in establishment of Kasturba Gandhi Balika Vidhyalaya (KGBV)

Para 3.7.2.1 of SSA guidelines and para 2.1.1 of KGBV guidelines provide that the KGBV residential schools at the upper primary level for girls belonging predominantly to the SC, ST, OBC, etc. are to be set up in blocks where the female rural literacy is below 46.13 *per cent*.

Audit noted shortfalls in establishment/construction of KGBV. In Maharashtra, J&K and Gujarat, these schools were running in rented buildings and the facilities like hostel and essential infrastructure like toilets, compound walls, play grounds, etc. had not been provided. Deficiencies noticed in these States are further detailed in **Annex-15.**

Picture-1: KGBV building (under Construction) Doongi, Rajouri, J&K being used by locals as cattle shed

Picture-2: Under construction building of KGBV, Doongi, Rajouri, J&K since 2007-08

Picture-3: Private house illegally constructed within the campus of KGBV, Khangela, Dahod, Gujarat

4.5.1.1(ii) Non establishment and non-functioning of 'Model Cluster School for Girls'

NPEGEL guidelines provide that establishment of 'Model Cluster School for Girls' is to be carried out by State Government in Blocks that have at least 5 *per cent* of the ST population (Census 2001) and where the SC/ST female literacy is below 10 *per cent*. Audit noticed deficiencies as detailed below in seven States:

- In **Maharashtra,** no MCSG was opened in 18 districts after March 2011
- In **Gujarat**, no MCSG was opened under NPEGEL. However, grants received under NPGEL were utilised for the benefit of girl students in existing primary and upper primary schools.
- In **Assam**, in the Karbi Anglong district, 14 MCSGs were established up to 2012-13 which remained non-functional due to non-allocation of further funds.
- In **Andhra Pradesh**, 'National Programme for Education of Girls at Elementary Level (NPEGEL)' was discontinued due to non-receipt of funds from Government of India from 2013-14 onwards. Consequent to this, the Model Cluster Schools for Girls established in Andhra Pradesh were abolished with effect from 2013-14.
- In **Jammu & Kashmir**, in 3 districts (Reasi, Poonch and Anantnag) no funds were received from the State government during 2012-13 and 2013-14 for NPEGEL.

- In **Jharkhand**, out of total 210 blocks in the State 209 blocks were covered through 2961 MCSGs which were closed during 2013-14 due to non-receipt of funds from GOI.
- In **Rajasthan**, 709 MCSGs were opened in 9 blocks of 4 selected districts, out of which 107 were only for girls.
- MCSGs were also established for boys contrary to guidelines
- No funds were received from GOI during 2011-14.

Thus due to non-establishment of MCSG and non-functional MCSG, the ST population could not get the intended benefit under the scheme.

4.5.1.1(iii) Lack of basic amenities and facilities

SSA guidelines provide that basic infrastructure like, toilet and drinking water facilities, fencing/boundary wall and other school infrastructure is to be provided.

Audit took up the examination of school infrastructure with a view to ascertain its availability and quality in the selected districts where ST population was significant.

Audit scrutiny of the records revealed that in **Manipur, J&K** and **Gujarat** there was lack of basic amenities and facilities such as safe drinking water, boundary wall. Details of deficiencies are given in **Annex-16.**

Picture-4: Unsafe drinking water used for drinking by students in MCS (UPS) Fatehpur, Rajouri, J&K

Picture-5: Damaged compound wall and girls' toilet of Primary School, Chandpuri Faliya, Dantol, Panchmahal, Gujarat

Picture-6: Toilet blocks of Upper Primary School, Varoli Talat, Valsad district, Gujarat, in damaged condition,

4.5.1.1 (iv) Non distribution of school uniforms

SSA guidelines provide that state governments were to incorporate provision for school uniforms as entitlement of the child in Right to Education Act or Rules and ensure distribution thereof to the school children.

Audit noticed that school uniforms had not been distributed as per norms in the States of **Maharashtra, Chhattisgarh, Jharkhand, J&K, Assam** and **Andhra Pradesh** as per details in **Annex 17.**

4.5.1.1(v) Exclusion issues of ST students

SSA guidelines provide that the exclusion issues of ST students were to be addressed by providing teaching in local language by recruiting native speakers to remove a sense of alienation among the children by developing educational material in local languages; special training for non-tribal teachers to work in tribal areas including knowledge of the tribal dialect.

Audit observed that requisite guidelines to address specific problems of ST students were not followed as there were deficiencies in appointment of native teachers, non-availability of text books in local languages etc. These deficiencies persisted in the States of **Madhya Pradesh, Jharkhand, Chhattisgarh, Gujarat, Assam, Maharashtra** and **J&K**. Details are given in **Annex-18.**

4.5.1.1(vi) Shortage of teachers

Manual on Financial Management and Procurement of SSA provides for one teacher for every 40 children in primary and upper primary schools. A minimum of 2 teachers for primary schools and 1 teacher for every class in the upper primary schools may be appointed.

Audit noticed that in the states of **Chhattisgarh, Gujarat** and **Assam**, there was shortage of teachers and as a result, students were deprived of quality education. State specific details are given in **Annex 19.**

4.5.1.2 National Programme of Mid-day Meal (NPMDM)

NPMDM was introduced mainly for disadvantaged children as it was expected to exert a positive influence on enrolment and attendance in schools. TSP grant under Mid-day Meal Scheme was based on respective District Information System for Education (DISE) percentage of ST population in respect of STs for all states/UTs.

4.5.1.2(i) Deficiencies in Annual Work Plan and Budget (AWP&B)

MDM guidelines provide that each state was to prepare an Annual Work Plan & Budget (AWP&B) based on information maintained at school level and aggregated at block, district and state levels.

Audit noticed that in the test checked districts in eight states, the Annual Work Plan & Budget were neither prepared with aggregated data from

schools/blocks nor there were any special plan or projects for ST students details are given below:

Sl. No.	States	Deficiencies
1.	Assam	• AWP&B was prepared during 2011-14 without aggregating data from school, block and district level. • 6 out of 8 test checked district did not prepare AWP&B.
2.	Karnataka	• 72 schools in 9 districts and 18 talukas did not prepare AWP&B. • No separate work plan for TSP was prepared.
3.	West Bengal	• Plan for 2011-13 was prepared without any input from lower tier units.
4.	Jammu & Kashmir	• AWP&B was not prepared for block & school levels.
5.	Bihar	• 113 out of 128 test checked school did not prepare AWP&B.
6.	Rajasthan	• In 90 selected schools, AWP&B was not prepared.
7.	Tamil Nadu	• No AWP&B was prepared at school level.
8.	Manipur	• No AWP&B was prepared at school, block and district levels.

Thus lack of bottom up approach in planning was clearly visible and the AWP&B at State level did not have any separate plan for tribal students despite earmarking of funds under TSP. This highlights inadequate implementation of TSP strategy in the planning process.

4.5.1.2(ii) Absence of kitchen cum store

The essential infrastructure for implementation of the mid-day meal scheme was provision for pakka kitchen-cum-store, kitchen devices and clean drinking water. However, during audit of selected schools, deficiencies relating to kitchen sheds, kitchen devices and clean drinking water were noticed in 10 States/UTs' having tribal population which received funds under TSP component of MDM. **(Annex-20)**

As a result of non-availability of kitchen sheds, complete infrastructure in kitchen, kitchen devices and sufficient drinking water, the children were exposed to health hazards as the meals were being prepared and served in open and un-hygienic conditions.

Picture-7: Unhygienic Cooking environment at the Kitchen of GMS, Krishnanalla, Hutbay, A&N Islands

Picture-8: Open Kitchen at GMS, Tamaloo, Carnicobar, A&N Islands

4.5.1.2 (iii) Grievances Redressal Mechanism

As per MDM Scheme Guidelines, a grievance redressal mechanism was to be established in each school.

The grievance redressal mechanism was found to be non-existent/ deficient in seven States as per the details below:

Sl No.	States	Observations
1.	J&K, Gujarat, Andhra Pradesh and Karnataka	In test checked districts/schools no Grievances Redressal Mechanism was established.
2.	West Bengal	Out of 6 districts and 20 blocks test checked, complaint register were maintained in 4 districts.
3.	Maharashtra	In 10 selected districts, out of 115 schools test checked, 39 did not have grievance redressal mechanism.
4.	Madhya Pradesh	Out of 84 selected schools in 10 districts, there was no grievances redressal mechanism in 48 schools.
5.	Tamil Nadu	Out of 192 selected schools of 9 districts, only 55 had grievance redressal mechanism. 130 schools did not have any mechanism.

4.5.1.2 (iv) Mismanagement of food grains

Under Mid-Day Meal Scheme, GOI provides assistance to State Government for supply of free food grains for primary classes (I-V) and upper primary classes (VI-VIII).

Audit noticed that supply of food grains, cooking cost and utilisation of funds for MDM was not found to be sufficient and regular to meet the needs of the children in the selected states of **Chhattisgarh, Assam, Andhra Pradesh, Rajasthan, West Bengal** and **Tripura.** Deficiencies are detailed briefly in **Annex-21.**

4.5.1.3 Rashtriya Madhyamik Shiksha Abhiyan (RMSA)

The Government of India launched (June 2009) a Centrally sponsored scheme 'Rashtriya Madhyamik Shiksha Abhiyan (RMSA) for universalisation of access to and improvement of quality of education at secondary and higher secondary stage during the 11th Five Year Plan. Under RMSA the vision for secondary education is to make good quality education available, accessible and affordable to all young persons in the age group of 14-18 years.

4.5.1.3(i) Improper infrastructure

RMSA guidelines provide that Civil works under RMSA should start with a proper assessment of the infrastructure requirement for each district and there needs to be adequate infrastructure for each school including toilets, drinking water, etc.

Audit noticed that the selected schools in the states of **Madhya Pradesh, Assam, Rajasthan, Tripura, J&K, Tamil Nadu** and **Gujarat** were functioning with deficient infrastructure, devoid of better teaching and learning facilities and atmosphere. State specific findings are detailed in **Annex-22.**

Picture-9 : Dokmoka Higher Secondary School, Karbi-Anglong, Assam – Building incomplete even after lapse of 12 months from due date of completion

Picture-10 : Sankar Dev Mission high School, Udalguri, Assam – Building incomplete even after lapse of nine months from due date of completion

Picture-11: Government Secondary School, Rahdunagari, Gujarat – Students of Class-IX studying on verandah floor

4.5.1.3 (ii) Community mobilization & innovative interventions

Framework for RMSA provides for extending interventions and resource support such as, providing textbook, workbooks and stationery etc., uniforms, footwear, bicycle/wheelchair, boarding and lodging facility and stipend for day scholars, etc. to the children belonging to SC/ST/OBC etc. at secondary and higher secondary levels. During examination of records in 13 state, audit noticed instances of non-receipt of grants, lack of support

to ST children in terms of text books, bicycles etc. Audit also found cases of non-availability of records, mismatch in enrolment data, non-provision of stipend, boarding lodging, uniforms etc. as per details in **Annex-23.**

4.5.1.3(iii) Non availability of residential accommodation facility to the teachers

RMSA guidelines envisage construction of residential quarters for teachers in remote/hilly areas/in areas with difficult terrain. Quarters were to be built as residential clusters with accommodation for teachers of all schools within a particular area with preference to female teachers.

In **Tripura**, except in one residential school, residential accommodation facility was not available for the teachers posted in the rural and difficult hilly areas. It was further noticed that in none of the schools accommodation facility for the lady teachers was available.

In **Gujarat**, Project Approval Board (PAB) approved (July 2011) ` 2.40 crore for 40 residential quarters (` 6.00 lakh per quarter) for 25 Government secondary schools[6] in tribal areas. However, Audit observed that these quarters had not been constructed as of August 2014 as site was not identified for the quarters and the teachers of tribal areas were deprived of the housing facilities even after lapse of more than three years of approval by the PAB.

4.5.1.4 Strengthening of Teacher Training Institutions (TES)

The Centrally Sponsored Scheme of Restructuring and Reorganisation of Teacher Education was initiated in 1987 pursuant to the formulation of the National Policy on Education 1986 (NPE). The scheme has been revised in XII Plan in order to meet the exceptional challenges for the Teacher Education System.

4.5.1.4(i) Non establishment of SC/ST and Minority Cell for education

An Education cell for SC/ST and Minority Cell was to be established within the structure of SCERT. Scrutiny of records revealed that in **West Bengal** and **Kerala**, no such cells were established. Similarly, there ought to be a Programme Advisory Committee in SCERT with nominated members from SC/ST right groups. Such Committee was also not established in SCERT.

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[6] Banaskantha (three), Dahod (two), Surat (four), Vadodara (three) and Valsad (13)

4.5.1.4 (ii) Non establishment of District Institute of Education and Trainings(DIETs)

As per TES Guidelines, the DIETs were created by the Government of India, Ministry of Human Resource Development to strengthen elementary education and support the decentralization of education to the district level for teachers' professional development. The DIET is located at an important level of decentralization i.e. District.

Audit noticed in the following five States some DIETs were not functioning as per details given below:-

Sl. No.	State/UT	No. of Dist.	Number of DIETs Sanctioned	Number of DIETs Functional	Number of DIETs not sanctioned/ non functional
1.	Assam	27	23	18	9
2.	Jharkhand	22	22	19	3
3.	Nagaland	08	08	06	2
4.	Rajasthan	33	32	32	1
5.	West Bengal	18	18	16	2
				Total	**17**

It is evident from the above that in 5 States, 17 DIETS were either not sanctioned or were non-functional.

Examination of records revealed instances of non-establishment of DIETs in **Maharashtra** and **Tamil Nadu**. Specific findings are given below:

In **Maharashtra**, the District Institute of Education and Trainings (DIETs) were established in every district except Mumbai due to non-availability of site.

In **Tamil Nadu,** as against 32 districts, DIET was established in 29 districts. It was noticed that the DIETs in the selected districts did not maintain community wise data of teachers trained and hence audit could not ascertain the number of ST teachers benefitted by this programme.

As a result, adequate training to the teachers could not be imparted and the very purpose of improvement in the status and professional competence of teachers was frustrated.

4.5.1.4 (iii) Under performance of DIETs

Audit observed that in J&K**,** neither sufficient infrastructure was available (except in DIET Leh) nor any of the activities viz. training of newly recruited teachers and Head teacher at DIET, developing training material for trainees, organising capacity building workshop for DIET lecturers to develop their proficiency and seeing whether new curriculum syllabus and text books development for I to VIII Standard in line with RTE-2009 had been carried out in the DIETs in test checked districts despite availability of optimum staff in Rajouri and Poonch Districts. Principal DIET's Rajouri and Reasi attributed the lapse to non-availability of funds and release of funds at fag end of the year. Principal DIET Poonch attributed lapse to non-availability of hostel facility and computer room and admitted that efforts would be made to carry out these activities in future.

In **Bihar,** in 10 selected districts it was observed that the DIET in Kaimur and Banka did not have sufficient strength of teachers. There was shortfall of three to seven teachers during 2011-13.

The DIET, Purnia remained unrecognised by NCTE up to November 2013 which resulted in non-enrolment of students during the period.

In **Andhra Pradesh,** in 2 DIET[7]s (out of seven sampled), the infrastructure facilities like buildings for class rooms, library, laboratory and office were not in a good condition and some buildings needed to be reconstructed. Further, posts of teaching staff were also kept vacant.

In **Rajasthan**, 32 DIETs were in operation up to 2012-13, but no State share was released by the State Government during 2011-12 as 100 *per cent* Central Assistance Scheme (CSS) was provided by the Central Government for DIET/ Block Institute of Teacher Education (BITE).

4.5.1.4 (iv) Training of newly recruited Teachers and Head Teachers

Training is an important mandate of DIETs. Audit observed deficiencies in this respect as detailed in the following table:

[7] Warangal and Nellore

Sl. No.	Name of State/UT	Audit observations
1.	West Bengal	During 2011-14, training for newly recruited teachers was not provided in any of the five[8] test checked DIETs.
2.	Jammu and Kashmir	Shortfall in training of ST teachers was observed in three districts (0-100 *per cent*), Reasi (100 *per cent*) Anantnag (43 to 50 *per cent*), Leh (65 to 70 *per cent*). Neither data indicating total number of ST teachers available in the Poonch and Rajouri district nor specific data about number of ST teachers trained in DIETs was maintained in DIETs Poonch and Rajouri.
3.	Madhya Pradesh	In 10 selected tribal dominated districts, out of 12050 ST teachers, 8025 were imparted training.
4.	Andhra Pradesh	Training programmes to newly recruited teachers and Head teachers were not organized in any of the DIETs in seven sampled districts as a result of non-release of funds by the state government.
6.	Rajasthan	In nine selected DIETs as against 15833 ST teachers selected for training, only 8154 ST teachers were trained during 2011-12 to 2013-14.
7.	Andaman & Nicobar	No training was imparted to ST teachers in 2012-13.

4.5.1.4(v) Non establishment of Block Institute of Teacher Education (BITE)

As per TES Guidelines**,** it was decided to establish 196 Block Institute of Teacher Education (BITEs)- one such Institute in a block of each of the 90 Minority Concentration Districts (MCDs) and the SC/ST dominated districts (other than the block in which a DIET is sanctioned), for which Central assistance would be provided. The BITE shall be a pre-service elementary teacher education institution.

Scrutiny of records of the eight States brought out the following:

Sl No.	Name of State	Audit observations
1.	J&K	No BITEs were established in SC/ST dominated blocks.
2.	Kerala	Though, State Government released ` 31.00 lakh in June 2013 for establishment of BITE in Waynad district, the same has not been established.

[8] Bardhman, Pachim Medinipur, Purulia, Bankura and Jalpaiguri

3.	Maharashtra	The GOI sanctioned five BITEs in the State viz. Khamgaon, Basmat, Navapur Gangakhed and Mangrulpir in 2011-12. The State Government earmarked and allocated land for establishment of the BITE in Khamgaon in 2012-13 and for Mangrulpir in 2013-14. However, the BITES are yet to be made functional till 2013-14.
4.	Madhya Pradesh,	No BITEs were established.
5.	Rajasthan	
6.	Tamil Nadu	
7.	Assam	14 Districts[9] in Assam were identified as the Minority/SC/ST concentration areas for establishment of BITEs in the block level. But no BITE was established in any of these districts.
8.	Bihar	No BITE was setup up to March 2014 in any of the 10 test checked districts.

4.5.1.5 Information and Communication Technology (ICT) in Schools

The scheme of Educational Technology (ET) was started in 1972. The National Task Force on Information Technology and Software Development (IT Task Force) constituted by the Prime Minister in July, 1998 made specific recommendations on introduction of IT in the education sector including schools for making computers accessible through the Vidyarthi Computer Scheme, Shikshak Computer Scheme and School Computer Schemes.

4.5.1.5(i) Non implementation of ICT Scheme

Audit noticed instances of non-implementation of scheme in the test checked districts with significant ST presence during 2011-14, as detailed below :

a. In **Andaman & Nicobar,** the MHRD during 2012-13 sanctioned ` 5.38 lakh under Tribal Sub-Plan to A & N Administration for implementing the Central Sponsored Scheme namely 'Information and Communication Technology (ICT) in schools'. But the amount could not be utilised as the Administration did not receive the Letter of Authority from MHRD.

[9] Barpeta, Bongaigaon, Cachar, Darrang, Dhubri, Goalpara, Hailakandi, Karbi Anglong, Karimganj, Kokrajhar, Morigaon, Nagaon, Kamrup, N. C. Hills

b. In **Gujarat**, out of 96 RMSA schools of test checked districts, only 34 RMSA schools were covered under the ICT.

c. In **Assam,** records of 32 out of 33 selected schools[10] were test checked. ICT scheme was implemented in only12 out of these 32 schools.

d. In **Tamil Nadu,** TSP funds amounting to ` 15.05 crore (GOI share ` 11.29 crore plus State share ` 3.76 crore), though sanctioned during 2011-12 were, however, lying idle as of November 2014.

Non implementation of the Scheme led to denial of benefit of computer education to the students of the tribal districts.

4.5.1.5(ii) Non establishment of Smart School

As per guidelines, one Smart School would be established in each district by conversion of one of the existing State Government schools to serve as role model and to share infrastructure and resources with the neighbourhood schools also. For establishment of a smart school 40 computers alongwith other accessories were to be provided to the selected school under the scheme.

Audit noted that no smart school was established in any of the test checked district in States viz. **Tripura, Assam, Gujarat, Andhra Pradesh, Tamil Nadu** and **Karnataka**. Audit also observed that GOI, MHRD did not sanction smart school for **Maharashtra** and in case of **Rajasthan** though the Directorate of Education had submitted proposal to establish seven smart schools in February and November 2011 to the GOI, MHRD did not sanction any smart school.

Thus the intended facility could not be created and benefits could not be availed by students of tribal districts.

4.5.1.5(iii) Non development of infrastructure

As per scheme guidelines, each school would be provided with 10 PCs or 10 nodes connected through a server along with peripherals. The scheme also provides for broadband connectivity, generators in schools having unreliable power supply, induction and refresher training to average 10 teachers.

[10] 16 high schools and 16 higher secondary schools, one school did not furnish the records.

Audit noted deficiencies in development of ICT infrastructure in four States viz. **West Bengal, Tripura, Rajasthan** and **Assam**. States specific findings are detailed in **Annex24.**

4.5.1.5 (iv) Non imparting of induction and refresher training

As per guidelines, first time induction training in ICT should be provided to all teachers in the sanctioned schools for a period of 10 days (8 hours per day).

Refresher trainings on use of ICT in teaching should be provided to all teachers of the sanctioned schools every year for 5 days (8 hours per day).

Audit noticed that in the States **Tripura, Kerala, West Bengal, Maharashtra, Assam** and **Rajasthan** induction/refresher training was not provided as required under the Scheme as per details in **Annex 25**.

Thus, ST students were deprived of ICT knowledge. Further the absence of proper refresher training compromises the quality of ICT education.

4.5.2 Health

4.5.2.1 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS)

NPCDCS was launched by GOI, Ministry of Health & Family Welfare (MHFW) for reducing the burden of Non Communicable Disease (NCDs) such as cancer, diabetes, cardiovascular diseases and stroke which are major factors reducing potentially productive years of human life, resulting in huge economic loss. During 2011-14, 100 identified Districts in 21 States have been taken up and covered under this programme.

4.5.2.1(i) Non conduct of behaviour and life style changes activities

Operational Guidelines provide for creating general awareness through various approaches such as mass media, community education and interpersonal communication, Information, Education and Communication (IEC) materials to sensitize community about risk factors, to promote healthy life style etc. are to be disseminated to states.

- Audit observed that Information, Education and Communication (IEC) campaigns were not organised for creating awareness among public in **Madhya Pradesh (2011-12), Jharkhand, West Bengal (Jalpaiguri**

district), Sikkim (2011-13), Jammu & Kashmir (2011-12), Bihar, Karnataka, Maharashtra and Chhattisgarh (2011-12).

- In **Madhya Pradesh (**except Chhindwara districts**), Sikkim, Odisha (2011-14) Karnataka, Jammu & Kashmir (Leh: 2011-14 & Kargil: 2011-12) and Chhattisgarh (2011-12)**, no camps were organized and no mass media and community education was carried out.

4.5.2.1(ii) No screening of persons for early diagnosis

As per Operational Guidelines, strategy for early diagnosis of chronic non-communicable diseases consists of opportunistic screening of persons above the age of 30 years at the point of primary contact with any of the health care facility, be it at village, CHC, District hospital, tertiary care hospital etc. to identify those individuals who are at a high risk of developing diabetes and CVD, warranting further investigation/action.

- Audit observed that in **Madhya Pradesh (Dhar and Ratlam District), Jharkhand, Maharashtra (2011-12)** and **Chhattisgarh (2011-13),** no screening of the individuals who were at high risks of developing common NCDs by the health Centres, was conducted.

4.5.2.1(iii) Treatment facilities not provided

Operational Guidelines provide for establishing "NCD clinic" and availability of investigation facilities at Districts NCD clinic and outsourcing certain laboratories investigation (mammography, X-ray and ultrasound) which are not available at district hospital.

- Audit observed that in **Madhya Pradesh, Kerala, West Bengal (in test checked CHCs/PHCs), Andhra Pradesh,** and **Assam** Investigation/tests for comprehensive examination of cancer diseases were not available at district NCD clinic.

- In **Madhya Pradesh (Dhar and Ratlam districts)** and **Andhra Pradesh**, the unavailable facilities of investigation/test were not outsourced.

- In **Bihar, Karnataka, Madhya Pradesh, Andhra Pradesh** and **Assam,** no home based palliative care were provided to serious patients.

- In **Karnataka and West Bengal,** no transport facilities were available to cater to serious patients.

4.5.2.1(iv) Deficiency in training activities

As envisaged in Operational Guidelines, Central NCD cell prepared a plan for central level training programmes. A pool of master trainers were to be generated with capacity to organize and impart training at State and districts level. Prototype of training kits for each category of trainee was to be prepared by Central NCD Cell. At the State level, training programme comprising the medical and paramedical staff posted at various levels was to be prepared for capacity building of human resources.

- Audit observed that in **West Bengal (Darjeeling), Maharashtra, Madhya Pradesh** and **Assam,** sufficient master trainers were not available in the States.
- In **Madhya Pradesh** and **Sikkim,** Training calendars and training modules were not prepared.
- In **Madhya Pradesh, Sikkim, Karnataka**, training kits were not available.

Other deficiencies/shortcomings noticed in audit are given in **Annex 26**.

4.5.2.1(v) Non-establishment of Tertiary Cancer Centres (TCCs)

Operational guidelines, envisage that the State Government should identify the Government Medical Colleges/District Hospital/Govt. Institution for financial assistance under TCC scheme. Each Centre will be eligible for a one-time financial assistance of maximum ` 6.00 crore with the Central and the State share of 80:20.

- Audit observed that in **Madhya Pradesh,** no hospital or health institution was identified by the State Government as Tertiary Cancer Centre.

- In **Sikkim,** audit observed that during 2012-13, the GOI sanctioned ` 480.00 lakh under TCCs for construction activities/procurement of equipment. The funds were to be released to the STNM Hospital. However, the SHS, NCD neither transferred the funds to the STNM Hospital nor took any action for procurement of equipment. As a result, funds were lying in the Society's account since 2012-13.

4.5.2.2 National Programme for Health Care for the Elderly (NPHCE)

NPHCE was launched by GOI, Ministry of Health & Family Welfare (MHFW) to provide separate and specialized comprehensive health care to the senior citizens at various levels of State health care delivery system including outreach services. Preventive and promotive care, management of illness, health manpower development for geriatric services, medical rehabilitation and therapeutic intervention and IEC are some of the strategies envisaged in the NPHCE.

4.5.2.2(i) Not conducting IEC and mass media activities

As per Operational Guideline, NCD cell will prepare prototype IEC material on Health Care of the Elderly to sensitize community about care, promotion of healthy life style etc.

The scheme also provides for public awareness through various channels of communication including camps to be organized by the State NCD cell to sensitize public about the health care of the elderly, promotion of healthy life style etc.

- Audit observed that Information, Education and Communication (IEC) campaigns were not organised for awareness of the public in the test checked districts of **Madhya Pradesh (during 2011-2013), Sikkim, Jammu & Kashmir-Kargil Dist. (2011-12), Bihar, Karnataka, Maharashtra** and **Chhattisgarh.**

- In **Madhya Pradesh (2011-13), Maharashtra, Jharkhand, Sikkim, Assam, Andhra Pradesh, Jammu & Kashmir (Kargil District 2011-13) & (Leh District 2011-14), Karnataka, Bihar,** and **Chhattisgarh**, no camps were organized and no mass media and community education through posters, banner etc. was conducted to educate the people.

We also observed state specific deficiencies in use of format prescribed for clinical services (Madhya Pradesh) non-receipt of publicity material from GOI (Sikkim) as per details in **Annex 27**.

4.5.2.2 (ii) No health facilities provided

Operational Guidelines provide that Central NCD cell will provide support and monitor functioning of eight Regional Geriatric Centres strengthened and supported under NPHCE.

Guidelines also envisaged dedicated facilities/services to the elderly at DHs, CHCs, PHCs and SHCs level by providing additional wards, clinics, diagnostic facility, domiciliary visits, human resource, machinery and equipment, consumables and drugs etc and ten-bedded geriatric ward for in-patients care of the elderly to be established in each DH and separate geriatric clinic was also to be established at each DH, CHC and PHC.

The annual check-up of all the elderly at village level needs to be organised by PHSC/PHC/CHC level and information updated in Standard Health Card for the Elderly developed by the SHS. The support materials for elderly people like walking sticks, callipers, infrared lamp, shoulder wheel, pulley, walker etc. should be made available at the sub-centre level. Audit observed that:

- In **Assam** and **Madhya Pradesh (Dhar District)**, no geriatric clinic at District Hospital was established for providing regular dedicated OPD services to the elderly.

- In **Karnataka**, equipment and supportive devices were not available in any of the SCs/PHCs. In **West Bengal** only nebulizer was available in the centres.

- In **Madhya Pradesh (**all nine CHCs test checked CHCs, 14 PHCs out of 16 PHCs and 28 SHCs out of 34 SHCs)**, West Bengal, Karnataka** no home based palliative care to the home bound/bedridden elderly persons were provided in the test checked districts.

- In **Karnataka, Maharashtra, Madhya Pradesh (CHCs), Assam (District & CHCs),** annual check-up or simple screening of elderly was not conducted.

We also observed state specific deficiencies as requisite health interventions were not available in **Sikkim, Andhra Pradesh, West Bengal, Karnataka** and **Jharkhand** as per details in **Annex 28**.

4.5.2.2 (iii) Deficiencies in training activities

As per Operational Guidelines, training calendar and plan for training of personnel of various facilities will be prepared, describing training institutions, duration, broad curriculum etc. for training under the

programme by the State NCD Cell. Prototype of training kits for each category of trainee was to be prepared by Central NCD Cell.

- In **Jharkhand (CHC), West Bengal, Andhra Pradesh,** no training was conducted for personnel of various facilities under the programme.

- In **Madhya Pradesh, Sikkim** neither any training calendar of various levels was prepared nor training imparted at various levels to build the capacity of deployed human resource.

- In **Assam, Karnataka,** no training kits for each category of trainee were found to be supplied from the central level.

We also observed state specific deficiencies about shortage of funds, staff (**Jammu** & **Kashmir** and **Madhya Pradesh**) and inadequate arrangement of geriatric clinics (**Karnataka**) etc. Details are given in **Annex 29**.

4.5.2.3 Immunisation

Immunisation is one of the key areas under National Rural Health Mission (NRHM) launched in 2005 imparting benefits to the children under the Routine Immunisation and Pulse Polio Immunisation. The Immunisation of children against seven vaccine preventable diseases i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B had been the corner-stone of routine improvisation.

4.5.2.3 (i) Infant diseases

(a) Less control over Infant diseases

- In 12 tribal districts of **Gujarat**, there was increase in cases of measles by 368.23 *per cent* and cases of acute respiratory infection (ARI) for less than five years infant by 28.66 *per cent* during 2013-14 compared to 2012-13.

- Audit observed that there was increase in cases of ARI in infants less than five years in age during 2012-13 and 2013-14 compared to 2011-12 and 2012-13 even though the immunisation activities were organized/conducted in **Gujarat, Rajasthan** and **Tamil Nadu**.

- In **Karnataka** and **Tamil Nadu**, the infant diseases like measles, respiratory infection and diarrhoea are not fully controlled.

(b) Shortfall in targets and achievements

During scrutiny of records in audit, we observed shortfall in achievement of target of immunised children in 13 states[11]. Details of state wise observations are included in **Annex 30**.

(c) Deficiencies in check-ups & IFA tablets to pregnant women

During scrutiny of records in audit in 12 States, we observed there were huge gaps between the pregnant women registered for antenatal check-ups and subsequent check-ups. Details of state wise observations are included in **Annex 31**.

(d) Shortfall in training

There were shortfalls in imparting training to various medical staff and para-medical staff in nine states. Details of state wise observation are included in **Annex 32**.

4.5.2.4 Infrastructure Maintenance Scheme (IMS)

IMS is implemented by the GOI, Ministry of Health & Family Welfare (MHFW) through State Government at the district and sub-district level, to enable easy service delivery. The infrastructural set up consists of Family Welfare Bureaus at State & District level, Sub-Centres, Urban Family Welfare Centres, Urban Health Posts, Training Schools and Centres to impart basic training to medical and para-medical health professionals. Under these schemes, the grant-in-aid is released in four advance quarterly instalments through Treasury route for various components/activities i.e. rent, contingency, stipend etc.

From May 2012, the expenditure on salary of regular staff component was to be borne by GOI for implementation of family welfare programme. Expenditure on all other component/activities will be borne by the respective State/UT Government.

[11] Tamil Nadu, Jharkhand, Tripura, Manipur, Madhya Pradesh, Sikkim, Assam, Jammu & Kashmir, Bihar, Odisha, Gujarat, Chhattisgarh and Rajasthan.

4.5.2.4 (i) Inadequate infrastructure

State Family Welfare Bureau (SFWB) is to be established at State level in the Directorate, Health Services where a Family Welfare Section established to look after the family planning activities. Similarly, DFWBs were established at district level in the office of the Chief Medical and Health Officer (CMHO).

- In **Manipur**, there was shortage of health centres i.e. 7 CHCs against the requirement of 11 CHCs, 38 PHC against requirement of 47 and 134 PHSCs against requirement of 312. Some of the photographs of non-functional CHCs are shown below:

Picture-12: Discontinued construction work at CHC Mao, Manipur

Picture-13:Non-functional Operation Theatre at CHC Mao, Manipur

The constructed staff quarters at a total cost of ` 27.96 lakh[12] at PHC Maram were lying unused. Similarly, compound wall and generator shed were stated to be completed at a total cost of ` 12.60 lakh at PHC Maram. However, no such structure was seen during the joint physical verification. The photographic evidences are shown below:

Picture-14:Unoccupied staff quarter at Maram PHC, Senapati District, Manipur

Picture-15:Unoccupied staff quarter surrounded by bushes at Maram PHC, Senapati District, Manipur

[12] As per status report of SHMS, 2014, ` 13.98 lakh has been paid

Similarly, Makhan Centre PHSC, Senapati district was not functional as the building was occupied by a family. There was no building at Shajouba PHSC and the health centre was being operated from a private house.

Picture-16:Non-functional Makhan Centre PHSC, Senapati District, Manipur

Picture-17:Poor condition of Labour Room of Maram Khullen PHSC, Senapati District Manipur

Other deficiency/shortcoming noticed in audit about reimbursement of irregular bills (**Rajasthan**) and non-procurement of vehicles (**Gujarat**) are given in **Annex-33**.

4.5.2.4 (ii) Shortage of health facility

The sub-centre is the most peripheral and first contact point between the primary health care system and the community. The NRHM framework had set the target of providing one Sub Centre (SC) for 3000 population, one PHC for 20000 population and one CHC for 80000 population in tribal areas, one Male Health Worker was required to operate these centres. In addition, one LHV was entrusted with six sub-centres for supervision. The salary of ANM & LHV was to be borne by GoI and salary of Male Health Worker was to be borne by the state governments.

- In10 districts of **Sikkim** and **West Bengal,** against the requirement of 1607 SCs, 243 PHCs and 61 CHCs for tribal population, 891 SCs, 88 PHCs and 24 CHCs were available against norms, depriving the tribals of the required health facilities.

Audit also observed shortfalls such as non-recruitment to the post of Male Health Workers and Lady Health Visitors (in **Madhya Pradesh**), creation of infrastructure not as per prescribed norms, assets lying unutilised due to lack of basic amenities (in **Sikkim**), establishment of sub-centres without following the population norms (in **Rajasthan, Karnataka**), etc. Details are given in **Annex 34**.

4.5.2.4 (iii) Non availability of UFWCs

Urban Family Welfare Centres (UFWCs) were to be established at District Hospital and Civil Hospital in urban area to make publicity and awareness about family planning and to motivate eligible couples for accepting family welfare, mother and child health, immunisation and reproductive child health services.

UHPs were to be located in urban slum areas to execute an integrated delivery system including antenatal, natal and postnatal care of mothers, immunisation of children, treatment of minor ailments and advice and services to family planning acceptors.

Audit observed various shortcomings such as non-availability of plans and activities, targets and achievements of UFWCs and UHPs (in **Madhya Pradesh**), non-establishment of UFWCs (in **West Bengal**), etc. Details of state wise observations are included in **Annex 35**.

4.5.2.4(iv) Deficiencies in basic training for ANM/LHVs/MPWs (Male)

Auxiliary Nurse Midwife (ANM) and Lady Health Visitor (LHV) were to be appointed to impart proper training to the ANMs/LHVs to provide quality services to mother & child health and family planning in the rural areas. Similarly, training centres for Multi-Purpose Worker (Male) were to be established to impart basic training of family welfare, mother & child health, Immunisation etc.

Audit observed various shortcomings such as posts of Principals in training schools lying vacant (in **Madhya Pradesh**), not conducting training since 1992 (in **Jharkhand**), diversion of training fund into General, TSP and SCSP (in **Chhattisgarh**) and mismatch of reported expenditure etc. Details of state wise observations are given in **Annex 36**.

4.5.2.5 Flexible Pool for State Programme Implementation Plan (FPSPIP)

The National Rural Health Mission, now National Health Mission, has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. Funds under NRHM are pooled together and provided for implementation of various programmes under it. One of the programmes is Flexible Pool for State Programme Implementation Plans (FPSPIPs) which is divided into (A) Reproductive Child Health Flexible

Pool (RCHFP) and (B) Mission Flexible Pool (MFP) under which funds are utilized for the respective programme implementation activities.

(A) Reproductive Child Health Flexible Pool (RCHFP)

4.5.2.5(i) Inadequate maternal health facilities

Maternal health is an important aspect for the development of any country in terms of increasing equity and reducing poverty. The survival and well-being of mothers is not only important for them but is also central to solving broader economic, social and developmental challenges.

- During examination of records and data in the test checked districts with significant ST population, we observed inordinate delays in payment of Janani Suraksha Yojana (JSY) incentives in **Jammu and Kashmir**, inadequate encouragement of institutional deliveries in **Sikkim,** shortage of health institutions in hilly/tribal areas in **Assam** and absence of infrastructure etc. **(West Bengal** and **Rajasthan)**. Detailed state specific findings are given in **Annex 37(a)**.

- In **Rajasthan, West Bengal, Jammu and Kashmir, Madhya Pradesh, Kerala, Tripura** and **Gujarat**, inadequate availability of First Referral Units and 24X7 PHCs was noted, as detailed in **Annex 37(b)**.

4.5.2.5(ii) Lack of child health facilities

Audit observed that in **Bihar, Jammu & Kashmir** and **Maharashtra** essential medicines like ORS, Zinc, Antibiotics (contrimoxazole), Iron & Folic Acid and Vitamin A were not available in CHCs/PHCs. Further, in **Assam, Madhya Pradesh, Kerala, Karnataka, Rajasthan** and **Tamil Nadu**, there was lack of facilities i.e. Newborn Care Corner (NBCC), Special Newborn Care Units (SNCU) and Newborn Stabilization Units (NBSUs). Details of state specific findings are given in **Annex 38.**

4.5.2.5(iii) Inadequate training for family planning

Audit observed that there were cases of inadequate training of Laproscopic Sterilisation, Minilap training and training for family planning for medical officers and staff in **Andhra Pradesh, Madhya Pradesh, Jammu & Kashmir, Chhattisgarh** and **Gujarat**. Further, we also observed non-promotion of menstrual hygine scheme in **Madhya Pradesh, Jammu &**

Kashmir, West Bengal and **Gujarat**. State wise detailed observations are given in **Annex 39**.

4.5.2.5 (iv) Not conducting of ARSH activities

Adolescent Reproductive and Sexual Health (ARSH) was included in RCH-II programme as a key technical strategy to mainly focus on reorganizing adolescent population that would yield dividends in terms of delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complication including access to early and safe abortion service **.**

Audit observed that in the test checked districts with significant ST presence of **Jharkhand, West Bengal, Jammu & Kashmir, Gujarat and Chhattisgarh,** there were instances of non-establishment of helpline and IEC activities of ARSH, non-conduct of one day orientation workshop in **Chhattisgarh & Madhya Pradesh.** State wise detailed observations are given in **Annex 40**.

Further, in **Manipur,** a Mobile Medical Unit (MMU) was to be provided in each district for ensuring out-reach of healthcare services in medically unserved/underserved areas. During 2011-14, 18 mobile vans were accordingly procured at a cost of ` 3.89 crore. However, these vehicles were not utilized in the test checked districts. Further, the Directors of the District Health Societies hired vehicles as and when outreach camps were conducted. The DHS, Senapati did not maintain log book nor operational records of the MMUs. Thus, idling of the MMUs and non-maintenance of log books and operational records affected the NRHM's aim of providing specialised health facilities to the unserved/underserved TSP areas.

(B) Mission Flexible Pool

4.5.2.5 (v) Unspent untied grant

NRHM framework stipulate that untied grants of ` 10,000 and ` 25,000 and ` 50,000 were to be provided to every SC, PHC and CHC respectively to be used for any local health activity in accordance with the guidelines issued by the Ministry. The untied grant was to be used for house hold surveys, health camps, sanitation drives, revolving fund etc. to carry out the works of emergent nature which are normally not covered under the schemes decentralized at the district level. These funds are mainly

allocated for filling up the missing gaps and for completing the incomplete public utility assets.

Audit observed that as on 31st March 2014, ` 3.87 crore in untied grants was lying unspent at various CHC, PHC and SHC in four States. Details are as under:

(` in crore)

State	Amount	Observations
Madhya Pradesh	1.41	• Against the available fund of ` 33.88 crore, an amount of ` 32.47 crore was utilised and fund of ` 1.41 crore remained unspent during the year 2011-12 to 2013-14. • In eight out of ten test checked district, 27.65 *per cent* untied funds could not be utilized during 2011-12 to 2013-14.
Tamilnadu	0.56	• An amount of ` 5.72 crore was released towards Untied funds during 2011-12 to 2013-14, to the selected nine districts and these districts had an unutilised balance of ` 0.56 crore as at the end of March 2014. The selected 93 PHCs in these nine districts had an unutilised balance of ` 0.06 crore as at the end of March 2014.
Jammu & Kashmir	0.66	• Out of released funds of ` 5.87 core only ` 5.21 crore was utilized at CHC and PHC level leaving a sum of ` 0. 66 crore as unutilised during 2011-12 to 2013-14. • In test checked six districts ` 0.47 crore (21.91%) untied funds could not be utilised during 2011-12 to 2013-14.
Gujarat	1.24	• As on 31 March 2014, ` 1.24 crore was lying unspent at various Sub-Centres, PHC and CHC levels in selected districts.
Chhattisgarh	--	In 15 CHCs and 34 PHCs it was observed that: • Seven[13] CHCs were released Untied Fund in excess of stipulated amount for one to three years No funds were released to CHC, Vijaynagar since last two years In case of CHC Lailunga, UF were not released in one year while thrice the

[13] Wadrafnanagr, Nangoor, Kota, Marwahi, Gorella, Dhorpur, Bishrampur

		stipulated amount was released in the next year. • 16[14] PHCs were released Untied Fund in excess of stipulated amount for one to three years while three[15] PHCs were not released funds for two to three years, two[16] PHCs were not released funds for one year and were released thrice the amount in next year. No information was given by three[17] PHCs.
Total	**3.87**	

Large unutilised untied grant indicates that the concerned functionaries including in-charge of PHCs were not sensitized regarding use of these funds.

4.5.2.5 (vi) Unspent Rogi Kalyan Samiti grant

RKS is set up primarily for efficient community management of health care centres up to the PHC/CHC level. A grant of ` 1 lakh per PHC/CHC and ` 5 lakh per DH was to be given to the states for PHC/CHC/DH, wherein RKS had actually been constituted.

Audit noticed under utilization of grants released to RKS, resultantly there were unspent grants of ` 10.97 crore in five States. In the case of Madhya Pradesh the Government of India short released ` 10.12 crore. In Manipur, during joint field verification, it was noticed that undistributed medicines had expired. Further, doctor (AYUSH) was also not posted in Mao CHC and Maram PHC since the last three years. These facts indicate lack of community participation due to non-formation of RKS in these centres. State specific findings are in **Annex 41**.

[14] Jamwantpur, Badkagaon, Murkol, Bastar, Adawal, Kurandi, Belgehna, Kargi Kala, Dhober, Seoni, Basti Bagra, Keonchi, Barakela, Nawanagar, Songara, Rewti
[15] Bhanpuri, Kandarai, Latori
[16] Mukdega, Rajpur
[17] Sisiranga, Bargiduh, Raghunathpur

4.5.2.5 (vii) Unutilised Annual Maintenance Grants

Annual Maintenance Grant (AMG) is provided mainly for improvement and maintenance of physical infrastructure to facilitate strengthening of infrastructure and to provide basic necessities. This is provided only for government owned buildings and not for rented buildings. As part of the National Rural Health Mission, an AMG should be provided to various units i.e. CHCs ` 1.00 lakh *per annum* and PHCs ` 50,000/- *per annum* and SHC ` 10000/- *per annum*.

In **Madhya Pradesh, Jammu & Kashmir, Gujarat, Tamilnadu, Rajasthan** and **Chhattisgarh,** AMGs were not utilized to the extent of ` 2.84 crore. Government of India also short released ` 8.48 crore to Madhya Pradesh. State specific findings are in **Annex 42**.

Thus, due to non-utilisation of annual maintenance grants, rural population of the States was deprived of the full benefits of the scheme.

4.5.2.5 (viii)Shortage of Accredited Social Health Activist (ASHA)

The NRHM framework envisages providing one ASHA in every village with a population of 1000. For tribal, hilly, desert areas, the norms could be relaxed for one ASHA per habitation depending on the workload.

In **Madhya Pradesh, West Bengal, Jammu & Kashmir, Rajasthan and Karnataka**, there was shortage of ASHA as on 31st March 2015. State specific findings are in **Annex 43**.

4.5.2.5 (ix) Shortage of health care Infrastructure

As per PIP, requirement of new construction and expansion of heath care infrastructure was to be mapped out according to population norms. Further, exercise for up gradation and strengthening of health facilities in the light of Indian Public Health Standards (IPHS) norms was to be carried out in respect of deployment of human resource, quality care and delivery of services.

During examination of records, Audit noticed that there was shortage of heath care infrastructure as per norms in selected districts of selected States with significant ST presence as per details below:

State	Particulars
Madhya Pradesh	• The districts were not fully equipped with essential drugs and material to cater the health services
Sikkim	• Shortage of water supply in these sub-centres • Baby warmer for safety of new born baby was not provided at Syari Kopibari PHSC. • Absence of basic amenities and absence of hygiene and health safety of the patient and the health workers • Equipment worth ` 20.38 lakh remained idle • Sub-centres were running without basic medicines • There was 29 expired medicines noticed in two sub-centres (Basilakha and Pelling) and District Hospital, West.
Kerala	An amount of ` 20.15 lakh was released for the construction of three additional sub centres (estimated cost ` 69 lakh), the work was not started as of March 2014, as the identified site was not suitable for the construction.
Maharashtra	• Shortfall in creation of basic infrastructure
Gujarat	• In selected districts, there was shortage of infrastructure
Rajasthan	• Medical Officers were not posted in 6 PHCs (Dungarpur-3 and Udaipur-3)
Jammu & Kashmir	• A sum of ` 146.08 lakh out of 433.45 lakh (34%) was lying unspent during 2013-14
West Bengal	In test check of CHCs and PHCs, there were lack of health facilities
Chhattisgarh	In 15 CHCs and 34 PHCs of eight district hospitals, out of total 3121 works sanctioned during 2010-11 to 2012-13, only 675 works (22 *per cent*) could be completed while 1578 works (50 *per cent*) were in progress and 868 works (28 *per cent*) could not be started till date of audit.

Detailed deficiencies noticed in audit about shortage of equipments, infrastructures, drugs etc. are given in **Annex 44.**

Further, audit also observed in **Assam**, acute shortage of infrastructure and health care facilities such as inpatient services (IP), delivery services, new-born care, emergency services at PHC level, blood storage facility, ultra sound scanner, X-ray, paediatric care of sick children etc.

- Separate utilities for male and female were not available at Sub-centre level.
- No operation theatre facilities existed in any of the test checked 10 PHCs.
- Oxygen cylinder, wheel chair, Stretcher, NBSU facilities were not available at PHC level.

- In eight selected districts, referral transport i.e. Palki or similar facilities for bringing pregnant women upto the road head was not available.

A few photographs depicting the deplorable infrastructure facilities in the Health Centres are given below:

Picture-18: New born baby kept in an unhygenic condition at Goraimari CHC in Kamrup district (Assam)

Picture-19: Operation theatre turn to a garage at Goroimari CHC in Kamrup District (Assam)

Picture-20:Patient kept in waiting room due to want of specified patient bed at Telam PHC in Dhemaji District, Assam

Picture-21: Non functional X-Ray machine at Dheminjuli CHC in sonitpur District, Assam

Joint physical inspection with the departmental officer (August 2014) revealed that the Bashbari CHC in Kokrajhar district and Sildubi SC in Karbi Anglong district were non-functional although the CHC building was stated to be completed long back except the electrical works and as per the PIP submitted the SC was functional.

Picture-22: Non functional Bashbari CHC in Kokrajhar District, Assam

Picture-23: Non-functional Sildubi sub-centre in Karbi Anglong District, Assam

In **Manipur**, there were no arrangements for maintenance and upkeep of equipment or disposing of the obsolete equipment available on record with the department. Further, the department did not conduct any physical verification of stores and stock.

4.5.2.5 (x) Shortage of manpower

As per PIP, provision of human resource was to be based on gap analysis with adequate/incentivized provision for difficult and hard to reach areas. Existing vacancies were to be filled by the State Government and NRHM for augmentation of considerable contractual human resources at all levels

During examination of records, Audit noticed that there was shortage of medical and para-medical manpower as per norms in selected districts and selected States with significant ST presence.

In **Madhya Pradesh, Assam, Chhattisgarh, Gujarat, Tamilnadu, West Bengal** and **Manipur,** there was shortage of medical and para-medical manpower in the selected States. Details are given in **Annex 45**.

4.5.3 Conclusion

Audit observed from the above findings that implementation of the schemes in districts with significant ST presence was marked by various shortcomings and lapses. The basic objectives of the TSP i.e. share of resources to be spent for the benefit of the STs, substantial reduction in poverty, creation of productive assets, human resource development through adequate education and health services and provision of physical and financial security could not be achieved in full as reflected in the above findings. Despite the allocation to ST, there were no mechanisms within these programmes to monitor their advancement.

Recommendations:

- *Planning process needs to be strengthened with community involvement especially in the tribal dominant blocks to ensure the benefit for tribal communities under the respective schemes.*
- *State Government should be asked to form a structure at the State level/District level to monitor and review the implementation and monitoring of the TSP fund.*
- *There is a need to strengthen the nodal unit at the State/District level to assess the infrastructural gap and development needs in the tribal inhabited areas and converge the funding available under schemes such as PMGSY, RKVY etc.*